**UNIT 3: HUMAN RELATIONS**

**TOPIC 2: INTERACTING WITH THE SPECIAL NEEDS POPULATION**

**GOAL:** THE STUDENT WILL KNOW ASPECTS OF INTERACTING WITH THE SPECIAL NEEDS POPULATION.

**SUB-GOALS:**

The student will know the symptoms displayed by a person with "major depression."

The student will be able to define the term "mental illness."

The student will know the symptoms of "bipolar disorder in the manic phase."

The student will know the signs of "schizophrenia."

The student will know the symptoms of "schizophrenia."

The student will know the signs of a person with an "anxiety disorder."

The student will know the types of "de-escalation techniques."

The student will know the behaviors to be avoided in "de-escalation techniques."

The student will know the "phrases of communication."

The student will know the indicators of "suicidal thought."

The student will know methods of responding to chemical abusers.

The student will know the indicators of a person with "autism."

The student will know intellectual abilities affected by dementia.

The student will know the signs of a person with "alzheimer's disease."

The student will know the categories of life changes regarding the elderly - mentally/physically challenged.

The student will know the interaction skills needed for dealing with elderly persons.

The student will know the interaction skills for the vision impaired.

The student will know the interaction skills for the hearing impaired.

The student will know the options for emergency admission due to mental illness.

**REQUIRED HOURS:** SIXTEEN (16) HOURS

**STUDENT PERFORMANCE OBJECTIVES:**

1. Given a multiple choice question, **the student will choose the option which states 4 of the common symptoms displayed by a person with "Major Depression,"** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

2. Given a multiple choice question, **the student will choose the option which defines the term "Mental Illness"** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

3. Given a multiple choice question, **the student will choose the option which states 6 of the symptoms of "Bipolar Disorder in the Manic Phase"** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

4. Given a multiple choice question, **the student will choose the option which states 4 of the common signs of "Schizophrenia,"** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

5. Given a multiple choice question, **the student will choose the option which states 2 of the symptoms of "Schizophrenia,"** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

6. Given a multiple choice question, **the student will choose the option which states 3 signs of "Anxiety Disorder",** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

7. Given a multiple choice question, **the student will choose the option which states 5 of the De-escalation Techniques,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

8. Given a multiple choice question, **the student will choose the option which states 5 behaviors that should be avoided when engaged in De-escalation,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

9. Given a multiple choice question, **the student will choose the option which states 4 of the phrases to aid in communication,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

10. Given a multiple choice question, **the student will choose the option which states 2 of the Indicators of Suicidal Thought,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

6\. Given a multiple choice question, **the student will choose the option which states 3 Methods of Responding to Chemical Abusers,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

7. Given a multiple choice question, **the student will choose the option which states 2 of the indicators of "Autism,"** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

8. Given a multiple choice question, **the student will choose the option which states the 3 intellectual abilities affected by Dementia,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

9. Given a multiple choice question, **the student will choose the option which states 5 signs of "Alzheimer's Disease,"** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

10. Given a multiple choice question, **the student will choose the option which states 5 categories of life changes regarding the elderly-mentally/physically challenged,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

11. Given a multiple choice question, **the student will choose the option states 4 interaction skills needed in dealing with elderly persons,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

12. Given a multiple choice question, **the student will choose the option which states 2 of the Interaction Skills for the Vision Impaired,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

13. Given a multiple choice question, **the student will choose the option which states 2 of the Interaction Skills for the Hearing Impaired,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

19. Given a multiple choice question, **the student will choose the option which states the 4 criterion for Emergency Admission,** as given in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

20. Given a multiple choice question containing a narrative situation, **the student will choose the option that identifies the underlying concept or the best course of action to be taken by a peace officer,** based on the application of the SPOs in the Basic Training Curriculum of the Ohio Peace Officer Training Commission.

**INSTRUCTOR REFERENCES:**

National Institutes of Health: “Cerebral Palsy: Hope Through Research,” NINDS. Publication date July 2001. NIH Publication No. 93-159.

Butler MG. Prader-Willi Syndrome: current understanding of cause and diagnosis. AM J Med Genet. 1990 Mar; 35(3): 319-32.

Yeargin-Allsopp M, Rice C, Karapurkar T, Doernberg N, Boyle C, Murphy C. Prevalence of Autism in a U.S. Metropolitan Area. *Journal of the American Medical Association,* 2003.

The Harvard Mental Health Letter. Sept. 2002.

National Institutes of Health Publication No. 3879 – Anxiety Disorders.

National Institute of Mental Health, “Facts about Anxiety Disorder,” Fact Sheet Publication No. OM-99 4152. Printed January, 1999.

U.S. Department of Health and Human Services. *Mental health: a report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

The Ohio Police Chief, “A Police Officer’s Guide: When in Contact With People Who Have Mental Retardation”

The Ohio Police Chief, “Dealing With Special Populations: Some Guiding Principles”

The Ohio Police Chief, “Protecting and Serving Those with Alzheimer’s Disease” by Chief Philip K. Potter, CLEE

Closing The Gap: The Help-Seeking Behavior of Minorities; Julia Mayo, PhD, Chief, Clinical Studies; Department of Psychiatry, Saint Vincent's Hospital and Medical Center; New York, NY http://www.omhrc.gov/ctg/full-mhm.htm

Gilliand B. & James, R. (1996). Listening and responding in CIT - crisis intervention, In Memphis C.I.T. Manual, Memphis Police Department: Memphis, Tenn. 158 – 165

Kausch, O., Resnick, P.J., "Psychiatric Assessment of the Violent Offender," Handbook of Psychological Approaches with Violent Offenders: Contemporary Strategies and Issues, V.B. Van Hasselt & M. Herson (Eds.), Klewer Academic/Plenum Publishers, New York, p. 439-457, 1999

Scott, C.L.: "Juvenile Violence," The Psychiatric Clinics of North America, 22:71-83, 1999

**Websites of Interest**:

www.nami.org

www.psychiatrymatters.md

www.ncjrs.org

www.mentalhealth.org

www.psych.org

www.mh.state.oh.us

www.surgeongeneral.gov

www.psychlaws,org

www.suicidology.org

**TEACHING AIDS:**

Handouts
Chalk/Chalkboard
Lectern
Overhead Projector
Prepared Overheads
Multimedia Projector

## STUDENT REFERENCES:

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| Handout #1 | Ohio Revised Code §5122.01 |
| Handout #2 | Ohio Revised Code §5122.10 |
| Handout #3 | Types of Personality Disorders |
| Handout #4 | Anxiety Disorders: The Most Commonly Diagnosed Psychiatric Conditions |
| Handout #5 | Dementia **(SPO #13)** |
| Handout #6 | Guidelines when Communicating with a Person who has (or seems to have) Alzheimer's Disease or Some Other Form of Dementia |
| Handout #7 | State and Federal Victims Services |
| Handout #8 | Commonly Prescribed Psychotropic Medications |
| Handout #9 | Application for Emergency Admission (Form DMH-0025) |
| Handout #10 | Fisher v. Harden: 398 F. 3D 837 |
| Handout #11 | Five Indicators of Suicidal Thought **(SPO #10)** |
| Handout #12 | Steps for Responding to a Person in a Suicidal Crisis |
| Handout #13 | Stages of Alcohol Withdrawal |
| Handout #14 | Ohio Revised Code §2901.21 |
| Handout #15 | Ohio Revised Code §5126.30 – 5126.34 |
| Handout #16 | Methods for Responding to Chemical Abusers **(SPO #11)** |
| Handout #17 | Other Indicators that a Person may have Autism |
| Handout #18 | Other Developmental Disabilities |
| Handout #19 | Ohio Revised Code §2305.51 |

# *SPECIAL NOTE TO COMMANDERS AND INSTRUCTORS*

**INSTRUCTORS ARE OBLIGED TO REVIEW EACH LESSON PLAN THEY TEACH FOR ACCURACY, CURRENT INFORMATION AND APPLICABILITY TO THE COMMUNITY DEMANDS. IF IT IS FOUND THAT INFORMATION IN A PARTICULAR LESSON PLAN IS OUT OF DATE OR FOR ANY REASON REQUIRES CHANGES OR UPDATES, PLEASE NOTIFY THE OHIO PEACE OFFICER TRAINING COMMISSION - PORTIA GONZALEZ-McDADE - AT 1-800-346-7682 OR FAX TO (740) 845-2675. COMMENTS MAY BE MAILED TO OPOTC, P.O. BOX 309, LONDON, OH 43140.**

**INSTRUCTORS ARE ALSO EXPECTED TO:**

* **BEAR IN MIND THE LEGAL, MORAL, PROFESSIONAL AND ETHICAL IMPLICATIONS OF INSTRUCTING IN A COMMISSION-APPROVED PROGRAM.**
* **USE ANY AND ALL OPPORTUNITIES WHICH MAY ARISE DURING INSTRUCTION OF THE REQUIRED MATERIAL TO POINT OUT TO THE STUDENTS THE LEGAL, MORAL, PROFESSIONAL AND ETHICAL RESPONSIBILITIES THEY WILL BEAR TO THEIR EMPLOYERS AND COMMUNITIES WHILE SERVING IN AN OFFICIAL CAPACITY.**
* **USE SCENARIOS AND EXAMPLES SPECIFIC TO EACH LESSON PLAN TO GENERATE ACTIVE DISCUSSIONS CONCERNING THE ETHICAL IMPLICATIONS OF THE TOPIC/SKILL BEING TAUGHT. EMPHASIS SHOULD BE PLACED ON THE BENEFITS OF ETHICAL BEHAVIOR AND THE CONSEQUENCES OF UNETHICAL BEHAVIOR.**

**I. PREPARATION**

A. Introduction

1. Instructor

2. Course

B. Purpose of this section of your training:

1. To explain interaction skills for mentally disturbed, developmentally disabled and mentally ill people

2. To explain some of the problem areas faced by elderly and mentally/physically challenged persons

3. To explain some of the disorders that afflict all levels of society

C. SPOs

**II. PRESENTATION**

A. Officers are imbued with a take charge attitude and use command presence to help deal with criminals, victims, and to handle problems with which they have been called upon to deal

1. This attitude can actually inflame the situation and cause the mentally ill individual to escalate his/her behavior

2. You can have more control and authority over the person in a mental health crisis by using verbal and non-verbal communication that signifies a desire to help the person, while still maintaining officer safety.

3. The effective officer is one, who, at times, is able to camouflage his/her combat readiness

B. **MENTAL ILLNESS CAN BE DEFINED AS: A SUBSTANTIAL DISORDER OF THOUGHT, MOOD, PERCEPTION, ORIENTATION, OR MEMORY THAT GROSSLY IMPAIRS JUDGMENT, BEHAVIOR, CAPACITY TO RECOGNIZE REALITY, OR ABILITY TO MEET THE ORDINARY DEMANDS OF LIFE.**

**SPO #2**
**OVERHEAD #1**

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| 1. The first observations of mental illness were made by Dorothea Dix prior to the Civil War<br><br>2. Mental illness was noted in homeless people on the streets, or in jails or prisons<br><br>3. Reform movements to create institutions were established<br><br>4. Institutionalization was supposed to allow for more humane methods to be employed<br><br>5. In the 1950's, societal perception turned away from institutionalization<br><br>a. Institutional scandals<br><br>b. Advent of medications<br><br>c. Outcry from civil liberty organizations<br><br>6. De-institutionalization became a "battle cry" or "call to arms"<br><br>a. Mentally ill persons were placed into communities with the expectation of continuing treatment and support<br><br>b. It was found, however, that resources and treatments were more challenging to provide in a decentralized environment compared to a centralized institution | |
| 7. In 2005 modern society<br><br>a. Mentally ill people represent a large segment of the population in most communities<br><br>b. Mentally ill people represent approximately 1/3$^{rd}$ of the homeless population<br><br>c. 16% of jail and prison populations suffer from mental illness<br><br>d. 7% - 10% of all calls involve mental illness<br><br>e. 22% of the U.S. population suffer from mental illness (1 in 5 adults) | **OVERHEAD #2** |

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| 8. Society has come full circle on what actions should be taken with mental illness | |
| 9. Law enforcement has become the defacto mental health first responder in society | |
| 10. Training in this area has traditionally been limited | |
| 11. The results have been problematic for law enforcement and mentally ill people | |
| 12. People with mental illness are 4 times more likely to die in encounters with the police than are members of the general population | **O.R.C. 2305.51**<br>**HANDOUT #19** |
| 13. The first call of your career may be this type of situation | |
| 14. Each call will be unpredictable | |
| 15. Proper preparation with training will increase your readiness and safety awareness | |
| 16. Injuries and death decrease due to training | |
| 17. Law Enforcement is increasing the training component | |
| 18. Mental health resources have been generally unknown to law enforcement | |
| 19. Incarceration had been a frequent recourse for the mentally ill | |
| 20. Collaborations have been formed to change this pattern and provide the necessary help for those who are mentally ill | |
| 21. Public safety resources must, by necessity, exceed resources for other social services | |
| C. Mental illness can be manifested in many forms | |
| 1. They may be grouped into four (4) major categories: | **OVERHEAD #3** |
| a. Mood | |

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| b. Thought<br><br>c. Personality<br><br>d. Other<br><br>2. Mental illness can occur in one or more categories | |
| D. Depression can be defined as: a feeling of sadness, the “blues,” feeling down, or not enjoying activities that once provided enjoyment<br><br>1. Usually these feelings are related to some life event<br><br>a. Problem or loss<br><br>b. Refers to an illness<br><br>c. A disorder of the brain in which a change in the chemical balance of the brain causes serious symptoms | **OVERHEAD #4** |
| 2. **COMMON SYMPTOMS DISPLAYED BY A PERSON WITH MAJOR DEPRESSION INCLUDE, BUT ARE NOT LIMITED TO:**<br><br>a. Profound feelings of sadness, “blues”:<br><br>1. Lasting more than a few days<br><br>2. Maybe even weeks<br><br>b. Deep feelings of helplessness and hopelessness; profound pessimism<br><br>c. Thoughts and feelings of guilt and self-blaming<br><br>d. Diminished feelings of self-worth<br><br>e. Lack of energy or ability to do normal activities, sometimes even including simple and routine activities<br><br>f. Loss of interest in normal activities, such as family, friends, hobbies, etc., and tendency toward isolation<br><br>g. Feelings of irritability | **SPO #1**<br>**OVERHEAD #5** |

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| 3. Physical symptoms may include some or all of the following:<br><br>a. Changes in eating patterns (either more or less than normal)<br><br>b. Changes in sleeping patterns (difficulty sleeping, sleeping a lot)<br><br>c. Increased feeling of being tired<br><br>d. Loss of sex drive<br><br>e. Constipation<br><br>4. A person may experience a “psychotic depression”<br><br>a. The depression is accompanied by:<br><br>1. Hallucinations (seeing or hearing things that are not real) and/or,<br><br>2. Delusions (fixed, rigid beliefs that have no basis in reality)<br><br>b. Some people suffer from acute episodes of depression, meaning that they only have occasional serious episodes<br><br>c. Others suffer from chronic depression, meaning that they have continuing problems over the course of their lives | |
| E. Bipolar disorder can be defined as: a brain disorder that causes unusual shifts in a person’s mood, energy, and ability to function<br><br>1. Bipolar disorder is formerly known as manic-depressive illness<br><br>2. The symptoms of bipolar disorder are severe<br><br>a. They can result in:<br><br>1. Damaged relationships<br><br>2. Poor job performance | **OVERHEAD #6** |

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| 3. School performance<br><br>4. Possible suicide<br><br>b. Bipolar disorder can be treated<br><br>3. Bipolar disorder also varies among people<br><br>a. More than 2 million American adults, or about 1 percent of the population age 18 and older in any given year, have bipolar disorder<br><br>b. Bipolar disorder typically develops in late adolescence or early adulthood<br><br>c. Some people have their first symptoms during childhood<br><br>d. Some develop them late in life<br><br>e. Usually, not immediately evident as an illness<br><br>f. People may suffer for years before it is properly diagnosed and treated<br><br>g. Bipolar disorder is a long-term illness<br><br>h. It must be carefully managed throughout a person's life | |
| 4. **SYMPTOMS OF A PERSON IN THE MANIC PHASE OF BIPOLAR DISORDER:**<br><br>a. Feelings of great happiness and euphoria<br><br>b. Sometimes, sudden outbursts or irritability, rage, and/or paranoia<br><br>c. Grandiose ideas and feelings of inflated self-importance (great plans or ideas for activities, and feeling of being capable of doing great things to realize those plans or ambitions)<br><br>d. Rapid flights of ideas or thoughts (called lability or referred to as being labile) | **SPO #3**<br>**OVERHEAD #7A, 7B** |

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| e. At the extremes, a person's thoughts may race so that his or her words come out in a non-stop rush and may not make sense because they seem so disconnected and forced<br><br>f. Sometimes, risky or reckless behavior (driving very fast, buying sprees, indiscreet sexual advances, high-risk recreational activities, (e.g. hang-gliding)<br><br>g. Great energy, and enhanced physical activity for long periods of time – sometimes, a person can go for days with little or no sleep<br><br>h. Often, feelings of great creativity, insight, and understanding of the world and of connections between things<br><br>i. Sometimes these feelings are associated with religious or spiritual ideas or concepts<br><br>j. Behavior that is often obnoxious to others (saying or doing things that are often offensive to others, and are outside of normally-accepted social boundaries)<br><br>k. Great increases in sexual energy and desire<br><br>l. In extreme cases, ideas or thoughts that are clearly out of touch with reality<br><br>1. Some of these behaviors may also be associated with other illnesses or conditions besides bipolar disorder<br><br>2. The effects of some drugs can cause similar behaviors | |
| F. Schizophrenia is a chronic, severe, and disabling brain disease<br><br>1. It is commonly held that schizophrenia is the same as "split personality"<br><br>2. This is incorrect<br><br>3. Approximately 1 percent of the population develops schizophrenia during their lifetime | **OVERHEAD #8** |

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| a. More than 2 million Americans suffer from the illness in a given year<br><br>b. Schizophrenia affects men and women with equal frequency<br><br>c. It appears earlier in men most often during their<br><br>1. Late teens or<br><br>2. Early twenties<br><br>d. It usually appears in women during their<br><br>1. Twenties<br><br>2. Early thirties<br><br>e. Schizophrenia is a Thought Disorder<br><br>4. A person with chronic schizophrenia does not typically recover normal functioning on his/her own and must receive continuing treatment that includes medications<br><br>5. Symptoms of thought disorders vary from person to person | |
| 6. **COMMON SIGNS OF SCHIZOPHRENIA** and other thought disorders:<br><br>a. Disordered thinking and speech<br><br>b. Delusions<br><br>c. Hallucinations<br><br>d. Unusual realities<br><br>f. Poor hygiene or grooming<br><br>g. Inappropriate or muted feelings or emotions<br><br>h. Inappropriate behaviors or actions including:<br><br>1. Social behaviors | **SPO #4**<br>**OVERHEAD #9** |

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| 2. Dressing inappropriately for the weather | |
| 7. **SYMPTOMS OF SCHIZOPHRENIA ARE:** | **SPO #5**<br>**OVERHEAD #10** |
| a. Key Symptoms<br>1. Extreme suspiciousness<br>2. Delusions that others are persecuting or plotting against a person<br>3. Possibly grandiose thinking | |
| b. Individuals can frequently be:<br>1. Very angry<br>2. Aloof<br>3. Argumentative<br>4. Difficult<br>5. Violent<br>6. Suicidal | |
| c. People with this particular disorder can be one of the greatest potential threats to law enforcement and others | |
| G. Psychosis can be defined as: a loss of contact with reality, typically including delusions (false ideas about what is taking place or who one is) and hallucinations (seeing or hearing things which aren't there) | **OVERHEAD #11** |
| 1. Potential Causes include:<br>a. Alcohol<br>b. Certain Drugs<br>c. Brain Tumors<br>d. Epilepsy<br>e. Psychotic Depression | |

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| f. Stroke<br><br>g. Alzheimer's<br><br>h. Other Brain Disorders | |
| 2. Key Symptoms: | **OVERHEAD #12** |
| a. Loss of touch with reality<br><br>b. Seeing, hearing, feeling, or otherwise perceiving things that are not there (hallucinogenic)<br><br>c. Disorganized thought and/or speech<br><br>d. Emotion is exhibited in an abnormal manner<br><br>e. Unfounded fear/ suspicion<br><br>f. Mistaken perceptions (illusions)<br><br>g. False beliefs (delusions)<br><br>3. Psychosis can prevent a person from functioning normally<br><br>4. During psychotic states, there can be an inability to care for oneself<br><br>5. Without treatment, the possibility of self-harm or harm to others is increased<br><br>6. Delusion can be defined as: a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everybody else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary<br><br>7. The belief is not one ordinarily accepted by other members of the person's culture or sub-culture.<br><br>8. Delusion is not necessarily tied directly to psychosis<br><br>9. Some delusions include:<br><br>a. Delusions of paranoia (others are plotting against them) | |

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| b. Grandiose Delusions (exaggerated ideas of one's importance or identity)<br><br>c. Somatic Delusions (a healthy person believing that he/she has a terminal illness)<br><br>10. Hallucination can be defined as: a sensory perception (seeing, hearing, feeling, tasting, and smelling) in the absence of an outside stimulus.<br><br>11. Hallucinations are not tied directly to psychosis<br><br>H. Personality Disorders Are Defined as:<br><br>1. A mental disorder characterized by inflexible, deeply ingrained, maladaptive patterns of adjustment to life that cause either subjective distress or significant impairment of adaptive functioning<br><br>a. Is pervasive and inflexible<br><br>b. Has an onset in adolescence or early adulthood<br><br>c. Is stable over time<br><br>d. Leads to distress or impairment<br><br>2. Exact causes are not certain<br><br>3. It is generally thought that many personality disorders result from difficult, negative, or traumatic childhood experiences | |
| 4. Two of the more commonly-known personality disorders are:<br><br>a. Antisocial personality disorder (three or more of the following symptoms<br><br>1. Failure to conform to social norms<br><br>2. Deceitfulness<br><br>3. Impulsivity; failure to plan ahead<br><br>4. Reckless disregard for the safety of self or others | **OVERHEAD #13**<br>**HANDOUT #3** |

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| 5. Consistent irresponsibility<br><br>6. Lack of remorse after having hurt, mistreated, or stolen from another<br><br>b. Borderline personality disorder is identified by a pervasive pattern of experience and behavior that is abnormal with respect to any two of the following<br><br>1. Control of impulses<br><br>2. Thinking<br><br>3. Mood<br><br>4. Personal relations<br><br>5. Suicidal<br><br>I. Anxiety Disorders are a very common category of mental disorders<br><br>1. They can be very troubling and uncomfortable for people, and can certainly cause a person to experience a crisis situation<br><br>2. Some people experience feelings of anxiety at abnormal levels requiring intervention<br><br>a. Feelings start as a “normal” response to a realistic situation or concern | |
| b. **SIGNS OF ANXIETY DISORDER INCLUDE:**<br><br>1. A person may feel extremely upset and unable to control feelings and situations<br><br>2. He or she may feel very worried and upset<br><br>3. May exaggerate the significance of an actual or imagined event or situation<br><br>4. The person may “catastrophize”<br><br>5. The person may worry all the time – typically way out of proportion to realistic causes | **SPO #6**<br>**OVERHEAD #14** |

6. A person who is excessively anxious may also have physical symptoms
   a. Headaches
   b. Stomach aches
   c. Sleeping problems
   d. Difficulty breathing

3. People who experience episodes of extreme anxiety have continuing episodes
   a. An anxiety episode is rarely just a one-time event
   b. It is instead a pattern of responding to life situations
   c. It is a very uncomfortable way to be, and some seek treatment for it

4. Neither normal anxiety nor excessive anxiety is necessarily a diagnosable mental disorder
   a. A person’s feelings of excessive anxiety can evolve into a diagnosable anxiety disorder
   b. Feelings of normal anxiety and normal depression go hand-in-hand

5. Such emotional responses can escalate into more significant emotional crisis situations

6. Specific Anxiety Disorders
   a. A key difference between these disorders and “normal” or “excessive” anxiety is:
      1. They usually occur without any connection to a specific life event or circumstance
      2. Anxiety disorders are often chronic
      3. A person may have many episodes over the course of his or her life

4. They can cause great discomfort and can have a significant impact on the ability to function in everyday life

b. Anxiety disorders: these are the most commonly diagnosed psychiatric conditions

**OVERHEAD #15**
**HANDOUT #4**

1. Generalized Anxiety Disorder
2. Panic Disorder
3. Phobias
4. Obsessive-Compulsive Disorder
5. Post-Traumatic Stress Disorder

J. Dementia

1. **INTELLECTUAL ABILITIES AFFECTED BY DEMENTIA**

**SPO #13**
**OVERHEAD #16**
**HANDOUT #5**

a. Thinking
b. Memory
c. Reasoning

2. It is severe enough to interfere with a person's abilities to:

a. Care for himself or herself
b. Socialize
c. Plan for the future

3. Dementia is not a disease

a. Dementia is a description of a group of symptoms that can accompany other diseases or physical conditions

b. These symptoms most commonly include:

**OVERHEAD #17**

1. Confusion as to time, place or person
2. Shortened attention span

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| 3. Changes in short term memory<br><br>4. Changes in language capability or trouble finding words<br><br>5. Changes in ability to calculate, plan or reason<br><br>6. Changes in personal care habits<br><br>7. Changes in personality<br><br>c. Research<br><br>1. 10% of people over the age of 65 have Alzheimer's Disease or a related dementia<br><br>2. Doubles every five years beyond 65<br><br>3. Persons as young as 35 have been diagnosed with Alzheimer's disease – very rare<br><br>4. In younger people, it is typically much more aggressive<br><br>K. Alzheimer's disease: the most common form of dementia<br><br>1. Alzheimer's is a progressive disease that attacks brain cells | |
| 2. It causes a person to lose control over various abilities:<br><br>a. Language<br><br>b. Social awareness<br><br>c. Mood<br><br>d. Self-care ability<br><br>e. Planning<br><br>f. Reasoning<br><br>g. Judgment | **OVERHEAD #18** |

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| 3. People in the terminal stages of Alzheimer's disease eventually lose:<br>a. Control of all physical functions<br>b. May no longer feel pain<br>c. May no longer feel hunger<br>d. May no longer feel thirst<br>e. May be unable to fight off even the most basic of infections | |
| 4. **COMMON SIGNS OF ALZHEIMER'S DISEASE INCLUDE:**<br>a. Seems to be lost<br>b. Seems to be agitated or angry<br>c. Doesn't seem to grasp the nature or seriousness of the situation<br>d. Can't seem to relate to time<br>e. Repeats questions or statements<br>f. Gives inappropriate responses to questions<br>g. Is dressed inappropriately<br>h. Has a blank facial expression<br>i. Is out of touch with reality | **SPO #14**<br>**OVERHEAD #19** |
| 5. Problems of younger people with Alzheimer's disease:<br>a. Keeping a job<br>b. Driving safely<br>c. Participating in familiar hobbies<br>d. Activities become impossible | |
| 6. Recognizing a Person with Alzheimer's Disease or another form of Dementia | **OVERHEAD #20** |

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| a. Memory loss and impaired thinking<br>b. Difficulty performing familiar tasks<br>c. Problems with language and communication<br>d. Disorientation as to time and place<br>e. Poor or diminished judgment<br>f. Problems following directions<br>g. Misplacing things<br>h. Changes in mood, personality, or behavior<br>i. Impaired visual or spatial skills<br>j. Loss of motivation<br>k. Changes in normal sleep patterns | |
| 7. Guidelines for communicating with a person who has (or seems to have) Alzheimer's disease or some other form of dementia:<br>a. First, identify yourself as a law enforcement officer and state the purpose of your being there no matter how obvious it may seem<br>b. Speak slowly and maintain a low-pitched voice<br>c. Use short familiar words<br>d. Ask "yes" or "no" questions<br>e. Ask one question at a time, allowing plenty of response time<br>f. If necessary, repeat the question, using the exact previous wording. Victims with Alzheimer's Disease may grasp only parts of the initial question<br>g. Maintain good eye contact while communicating | **HANDOUT #6** |

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| h. Substitute non-verbal for verbal communication (prompting is a good technique) | |
| i. If available, solicit help of a care giver to assist you with communicating | |
| 3. The mentally ill person may be experiencing some paranoia about interacting with a law enforcement officer | |
| a. Use persuasion rather than force whenever possible | **OVERHEAD #21** |
| b. Make the scene safe | |
| c. Identify signs or symptoms of mental illness | |
| d. Determine whether a serious crime has been committed | |
| e. Evaluate the need for immediate transport to: | |
| 1. Mental Health Facility | |
| 2. Jail | |
| f. Arriving at the scene | **Fisher v. Harden,**<br>**398 F. 3d 837, 2005 Fed. App.**<br>**HANDOUT #10** |
| 1. Assess the situation | |
| 2. Gather information | |
| a. Individuals | |
| b. Bystanders | |
| c. Family members | |
| g. Locate the person in crisis and begin interaction | |
| 4. De-escalation Techniques require a balance of: | |
| a. Respect | |
| b. Firmness | |
| 5. Be empathetic, not sympathetic | |

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| a. Empathy defined as: the ability to imagine oneself in another's place and understand the other's feelings, desires, ideas, and actions. | **OVERHEAD #22** |
| b. Sympathy defined as: a feeling or an expression of pity or sorrow for the distress of another; compassion or commiseration. | |
| 6. **PHRASES TO AID IN COMMUNICATION** | **SPO #9**<br>**OVERHEAD #23** |
| a. "We (I) want to help." | |
| b. "How can we (I) help?" | |
| c. "This can be worked out." | |
| d. "This can be worked out if you will help" | |
| e. "We (I) need your help." | |
| f. "That's good." | |
| g. "We (I) don't want anyone to get hurt." | |
| h. "We (I) know you don't want to hurt anyone." | |
| 7. **DMH – 0025 APPLICATION FOR EMERGENCY ADMISSION** | **SPO #19** |
| a. Emergency Admission Options | |
| 1. Represents a substantial risk of physical harm to himself as manifested by evidence of threats of, or attempts at, suicide or self-inflicted bodily harm;<br>2. Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness; | |

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| 3. Represents a substantial or immediate risk of serious physical impairment or injury to himself as manifested by evidence that he is unable to provide for and is not providing for his basic physical needs because of his mental illness and that appropriate provision for such needs cannot be made immediately available in the community; or… | |
| 4. Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself | |
| b. AKA "Pink Slip" | |
| 8. Ohio Revised Code Statute | |
| a. 5122.01 | **HANDOUT #1** |
| b. 5122.10 | **HANDOUT #2** |
| L. **DE-ESCALATION TECHNIQUES** | **SPO #7**<br>**OVERHEAD #24A, 24B** |
| 1. Officers should: | |
| a. Remain calm and avoid overreacting and under-reacting | |
| b. Provide or obtain on-scene emergency aid when treatment of an injury is urgent | |
| c. Follow procedures indicated on medical alert bracelets or necklaces | |
| d. Indicate a willingness to understand and help | |
| e. Speak simply and briefly, and move slowly | |
| f. Remove distractions, upsetting influences, and disruptive people from the scene | |
| g. Understand that a rational discussion may not take place | |

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| h. Recognize that the person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds (“voices”), or the environment | |
| i. Be friendly, patient, accepting, and encouraging, but remain firm and professional | |
| j. Be aware that a uniform, gun, and handcuffs may frighten the person with mental illness, and reassure the person that no harm is intended | |
| k. Recognize and acknowledge that a person's delusional or hallucinatory experience is real to him or her | |
| l. Announce actions before initiating them | |
| m. Gather information from family or bystanders | |
| n. If the person is experiencing a psychiatric crisis, ask that a representative of a local mental health organization respond to the scene | |
| 2. **BEHAVIORS TO AVOID WHILE ENGAGED IN DE-ESCALATION:** | **SPO #8**<br>**OVERHEAD #25** |
| a. Moving suddenly, giving rapid orders or shouting | |
| b. Forcing a discussion | |
| c. Maintaining direct, continuous eye contact | |
| d. Touching the person (unless essential to safety) | |
| e. Crowding the person or move into his or her zone of comfort | |
| f. Expressing anger, impatience or irritation | |
| g. Assuming that a person who does not respond cannot hear | |
| h. Using inflammatory language, such as “crazy,” “psycho,” “mental,” or “mental subject” | |
| i. Challenging delusional or hallucinatory statements | |

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| j. Misleading the person to believe that officers on the scene think or feel the way the person does | |
| M. The Crisis Intervention Team: | |
| 1. Also known as "CIT" | |
| a. Recognized as a National Best Practice for Law Enforcement | |
| b. Composed of professional law enforcement officers who usually volunteer for the assignment | |
| c. Designed for the "First Responder" | |
| d. Established by the Memphis Police Department in 1988 | |
| 2. Training provided to: | |
| a. Law Enforcement Officers | |
| b. Probation Officers | |
| c. Parole Officers | |
| d. Emergency Medical Technicians (EMT's) | |
| 3. Specially trained in Crisis Interaction Skills | |
| 4. State and Federal Victim Services are identified | **HANDOUT #7** |
| 5. Focus is placed on two factors: | |
| a. Communication | |
| b. Intervention | |
| 6. Emphasis is placed upon three areas: | |
| a. Recognition of mental health signs and symptoms | |
| b. Substance abuse | |
| c. Effects of medications | **HANDOUT #8** |
| 9. Medications are available for a variety of mental illnesses | **HANDOUT #9** |

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| a. Side effects<br>1. Dry Mouth<br>2. Constipation<br>3. Blurred Vision<br>4. Drowsiness<br>5. Decreased Sexual Desire<br>6. Menstrual Changes<br>7. Stiff Muscles on one side<br>a. Neck<br>b. Jaw<br>8. Restlessness<br>9. Slurred Speech<br>10. Muscle Stiffness<br>11. Tremors<br>a. Hands<br>b. Feet<br>b. Agranulocytosis: A decrease in the production of white blood cells, which occurs only when taking clozapine, requires monitoring of the blood every two weeks<br>c. Tardive Dyskinesia:<br>1. Most serious side effect<br>2. Involuntary facial movements<br>3. Jerking movements of the body<br>4. Twisting movements of the body | **OVERHEAD #26A, 26B** |

5. Usually involves older citizens

6. Affects 15% to 20% of those who have taken older antipsychotic drugs for years

7. Decreases slowly from the body when medication ceases

d. Failure to take the medications can, in many cases, cause a relapse of symptoms

e. A primary reason is because of undesirable side effects from the medication

f. Many tend to self-medicate with alcohol and/or illicit drugs

g. SAMI (Substance Abuse and Mental Illness) AKA "Dual Diagnosis

N. Suicidal People

1. Law enforcement officers often have to deal with suicidal people

2. You may encounter a suicidal person in a variety of contexts, including:

a. A disturbance call at a residence or a public place, in which you subsequently learn that a subject is feeling suicidal

b. A call about a person threatening suicide – in some cases, a person who is armed

c. EMS call regarding a person who has harmed him or herself – perhaps by taking an overdose of pills or cutting his or her wrists

d. A call from a mental health or crisis intervention agency involving a report of a person with suicidal ideas

3. Why People Consider Suicide

a. **FIVE INDICATORS OF SUICIDAL THOUGHT**

**SPO #10**
**OVERHEAD #27**
**HANDOUT #11**

1. Emotional pain

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| 2. Mental illness<br><br>3. Alcohol and drug use<br><br>4. Rational decision<br><br>5. Manipulation of others<br><br>b. Suicidal thoughts may occur in one or more areas<br><br>4. Guidelines for Responding to Suicidal People<br><br>a. When responding to a person in a suicidal crisis, your key goals are to:<br><br>1. Keep the subject and others safe<br><br>2. Control the situation<br><br>3. Do what you reasonably can to help arrange follow-up care or intervention | |
| b. Steps for responding to a person in a suicidal crisis<br><br>1. Conduct a continuing threat assessment<br><br>2. Try to get the person to talk<br><br>3. Show empathy<br><br>4. Negotiate solutions<br><br>5. Determine what action to take<br><br>5. Responding to an Armed Subject Threatening Suicide<br><br>a. These situations are all extreme<br><br>b. Specifics may vary<br><br>1. The subject may be armed with a firearm<br>2. An edged weapon<br><br>3. Some other form of weapon<br><br>4. Subject may be alone | **HANDOUT #12** |

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| 5. Have others with him or her | |
| c. The primary issue of safety: | |
| 1. Of the subject… | |
| 2. Of other citizens involved… | |
| 3. Of responding law enforcement personnel | |
| d. Gaining control of the situation is critical | |
| 1. How you respond depends on… | |
| 2. Your threat assessment… | |
| 3. Whether anyone is in imminent danger | |
| e. Try to gain control of a situation through Professional Communication verbalization skills | |
| 1. That may take time | |
| 2. Always try to use it | |
| 3. Do not hurry | |
| f. A particular concern is a subject trying to commit “suicide by cop” | **OVERHEAD #28** |
| 1. A person acting in such a way as to force the police to kill him or her, rather than committing suicide himself or herself | |
| a. If the person is simply armed and refusing to drop the weapon… | |
| b. But has not actually threatened anyone with it… | |
| c. The proper response depends on the circumstances | |
| g. Law enforcement agencies are using “less-than-lethal” weapons | |
| h. Familiarize yourself (before a crisis situation) with the policies and procedures of your agency for use of less-than-lethal force options | |

i. Deadly force may be a first and last resort to stop a threat

j. It is only to be employed when use of lesser force options has been precluded

k. Your threat assessment in the particular circumstances is the basis for your actions

O. People Under the Influence of Alcohol or Other Drugs

1. As a law enforcement officer, you will encounter many people under the influence of alcohol or other drugs

   a. Some will be under the influence when you deal with them, which can cause them to act:

      1. Strangely

      2. Foolishly

      3. In a bizarre manner

      4. Dangerously

   b. Others will be experiencing withdrawal from a substance, which can also cause concerning behaviors

   c. Intoxication and withdrawal also present potentially serious medical problems and concerns

2. Chemical abusers constitute one of the three main categories

   a. This group includes people who:

      1. Abuse alcohol or

      2. Drugs

      3. Both

   b. It includes chronic abusers

   c. Some people whom you encounter will be addicts

1. They are physically and/or psychologically dependent on a habit-forming substance

2. Alcoholics are people who are addicted to alcohol

3. People who abuse substances may also have a mental disorder or a developmental disability

4. This aspect can complicate your response

3. Abuse of alcohol is one of the most significant social problems in the United States

   a. It causes health problems

   b. It is the source of a huge amount of personal and family heartache

   c. It results in millions of dollars in lost work time

   d. Alcohol abuse also creates problems for law enforcement officers

4. General Indicators of Intoxication

   a. The level and degree of alcohol intoxication depends on:

      1. What the person has had to drink

      2. The amount of alcohol consumed

      3. The time frame during which it was consumed

      4. Whether or not the person has eaten while drinking

      5. The person's body weight

   b. A subject may be:

      1. Mildly intoxicated

      2. Extremely intoxicated

5. The effects of use and abuse of drugs vary greatly

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| a. Many subjects will have used a combination of alcohol and drugs | |
| b. Some subjects will have taken more than one type of drug | |
| c. You are not likely to know for sure what substances a person has used | |
| 6. Such general indicators include: | **OVERHEAD #29** |
| a. Slurred speech | |
| b. Odor of an alcoholic beverage on the breath | |
| c. Inability to stand or walk normally | |
| d. Confusion or disorientation | |
| e. Lethargy (slow, sleepy, uninspired behavior) | |
| f. Unusual or severe aggressiveness or agitation, or unusually obnoxious behavior | |
| g. Abnormal breathing, such as breathing which is very rapid and/or shallow | |
| h. Tremors (“shakes”) | |
| i. Excessive irritability, being quick to anger | |
| j. Unusual restlessness, inability to stand or sit still or stay on task for long | |
| k. Feeling of being very hot or very cold | |
| l. Strange, unusual, or bizarre behavior | |
| 7. Indicators that are specific to possible drug use include: | |
| a. Track or needle marks on a person’s arms or legs | |
| b. Presence of drugs or drug paraphernalia | |
| c. Pupils of the eyes either very dilated (large) or pinpoint | |

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| d. The subject may appear to be experiencing:<br><br>1. Delusions (ideas or thoughts that are not based in reality)<br><br>2. Hallucinations (seeing things that are not there, or hearing voices, or sometimes smelling things that are not there)<br><br>e. These symptoms may indicate:<br><br>1. Drug intoxication<br><br>2. Alcohol withdrawal<br><br>3. Mental illness<br><br>4. Some combination<br><br>8. Indicators of Possible Alcohol or Drug Withdrawal<br><br>a. Withdrawal defined: A phenomenon that occurs when a person who has used significant amounts of alcohol of drugs, usually over a long time, stops taking them<br><br>1. The person's body has become used to the substance(s)<br><br>2. Reacts in specific ways to the change that occurs<br><br>3. When they are no longer provided<br><br>b. Withdrawal from alcohol is potentially the most serious type of withdrawal<br><br>1. Withdrawal can be a medical emergency<br><br>2. People can die from this | **OVERHEAD #30** |
| c. Alcohol withdrawal typically occurs in stages<br><br>9. Legal Requirements: People Who are Intoxicated or Incapacitated<br><br>a. Ohio law distinguishes between people who are intoxicated and people who are incapacitated | **HANDOUT #13** |

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| b. Ohio Revised Code §2901.21 defined (intoxicated) | **HANDOUT #14** |
| c. Ohio Revised Code §5126.30 thru 5126.34 defined (incapacitated) | **HANDOUT #15** |
| 10. **METHODS OF RESPONDING TO CHEMICAL ABUSERS** | **SPO #11**<br>**HANDOUT #16** |
| a. Always consider a person under the influence of alcohol or drugs a potential threat | |
| b. Try to assess the person's physical condition | |
| c. Remember that a crisis situation is a matter of perception | |
| d. Avoid arguing with a person under the influence of alcohol or drugs | |
| e. Remember that the person may have additional problems | |
| f. Recognize that apparent intoxication may be caused by other conditions | |
| g. Know your options for resolving the situation | |
| 11. People with Developmental Disabilities | |
| a. Law enforcement officers will respond to calls involving people who have some form of developmental disability | |
| b. Developmental disability is defined as: | **OVERHEAD #31** |
| 1. A severe, chronic (continuing) disability which originated during birth or childhood, is expected to continue indefinitely, and which substantially restricts the person's functioning in several major life activities | |
| a. It is caused by a mental or physical impairment or some combination | |
| b. It begins before the person reaches the age of 18 | |

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| 2. The disability results in substantial functional limitations in, at least, three areas:<br>a. Self-care<br>b. Receptive language<br>c. Expressive language<br>d. Learning<br>e. Mobility<br>f. Self-direction<br>g. Capacity for independent living<br>h. Economic self-sufficiency<br>3. People with such disabilities require life-long services and supports or other forms of assistance<br>12. Mental Retardation<br>a. This is the most common form of developmental disability<br>b. The key characteristic of mental retardation is reduced intellectual functioning<br>c. A person with retardation also has diminished ability to adapt to the daily demands of the normal social environment, including:<br>1. Communication<br>2. Academic or vocational skills<br>3. Independent living skills<br>d. To be diagnosed with retardation, this disability has to originate before the age of 18<br>e. Mental retardation may result from any of several causes:<br>1. Prenatal (before birth) problems | **OVERHEAD #32** |

a. Illnesses

b. Viruses

c. Infections

2. Maternal use of:

a. Alcohol

b. Drugs

c. Tobacco

d. Exposure to pollutants or chemicals

f. Difficulties during childbirth that cause the child's brain to be deprived of oxygen or events that occur after a child is born:

1. Brain injury

2. Malnutrition

3. Infection

4. Exposure to toxic chemicals

g. Retardation may also result from genetic or hereditary causes

1. It is not a form of mental illness

2. It is not a disease

3. It cannot be cured

h. People with mental retardation can also experience different symptoms

1. Hallucinations

2. Delusions

3. Severe depression

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| 13. Indicators that a person may have mental retardation include:<br><br>a. Apparent inability to understand things as well as other people<br><br>b. Concrete thinking<br><br>1. Apparent difficulty in understanding or processing abstract ideas or concepts<br><br>2. Immature behavior in certain social situations or acting below age level<br><br>c. Most mentally retarded people encountered will be either mildly or moderately mentally retarded<br><br>d. Many are quite capable of holding a job and living independently with limitations<br><br>e. People with severe retardation or profound retardation are less likely to function independently and are often victims of crimes<br><br>f. A person with mental retardation may experience a crisis situation for any of several reasons:<br><br>1. He or she may be traumatized as a victim of crime<br><br>2. May have a disturbing argument or confrontation with someone<br><br>a. Family member<br><br>b. Employer<br><br>c. Other person<br><br>3. Sometimes people who are retarded are "scapegoated"<br><br>a. Set up by others…<br><br>b. To do things that they would not otherwise do | **OVERHEAD #33**<br><br>**AMERICAN ASSOCIATION ON MENTAL RETARDATION** |

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| P. Autism is defined as: a neurologically-based developmental disability that seriously affects a person's communication, decision-making and socialization skills<br><br>1. Affects more than 12 million people in the world<br><br>2. Affects four times as many males as females<br><br>3. Autism is a complex disorder that includes multiple levels of functioning<br><br>a. Mild<br><br>b. Severe<br><br>4. Some people with autism have:<br><br>a. Severe mental retardation<br><br>b. Others have superior abilities<br><br>5. Almost all with autism have significant problems responding appropriately in social situations<br><br>6. There is no cure for autism<br><br>7. Recognizing People with Autism<br><br>a. It may be difficult to recognize that a person has autism<br><br>1. He or she may have and present an autism information card<br><br>2. May wear a medical-alert bracelet<br><br>3. May have information sewn or imprinted on clothing<br><br>4. A non-permanent tattoo | **OVERHEAD #34** |
| b. **INDICATORS OF AUTISM MAY INCLUDE:**<br><br>1. Verbal difficulties<br><br>2. Unusual physical behaviors<br><br>3. Inappropriate social responses | **SPO #12**<br>**OVERHEAD #35**<br>**HANDOUT #17** |

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| Q. Other Developmental Disabilities<br><br>1. Cerebral Palsy can defined as: a group of chronic conditions affecting body movements and muscle coordination<br><br>2. Epilepsy (seizure disorder) can be defined as: a physical condition that occurs when there is a sudden, brief change in the way that the brain works<br><br>3. Traumatic Brain Injury (aka TBI) can be defined as: a sudden physical assault on the head causing damage to the brain<br><br>4. Prader-Willi Syndrome can be defined as: a complex genetic disorder that includes short stature, mental retardation or learning disabilities, incomplete sexual development, characteristic problems, low muscle tone, and an involuntary urge to eat constantly<br><br>5. Fetal Alcohol Syndrome (aka FAS) can be defined as: a pattern of physical and mental defects which develops in some unborn babies when the mother drinks too much alcohol during pregnancy<br><br>R. Problems that could be expected when communicating with the elderly and mentally/physically challenged:<br><br>1. Reduced or impaired physical mobility<br><br>2. Loss of hearing, identified as slight to total deafness<br><br>3. Diminished vision, ranging from impaired to blindness<br><br>4. Mental capacity extending from normal, but a little slower, to incapacitated<br><br>R. Issues and life changes concerning the aged<br><br>1. Physical appearance<br><br>2. Emotional changes<br><br>3. Death of a spouse<br><br>4. Problems in marriage | **OVERHEAD #36**<br>**HANDOUT #18** |

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| 5. Retirement<br><br>6. Sensory loss | |
| S. **CATEGORIES OF LIFE CHANGES AND ISSUES REGARDING THE ELDERLY AND THE MENTALLY/PHYSICALLY CHALLENGED**<br><br>1. Physical issues<br>a. Mobility<br>b. Appearance<br>c. Disease<br>d. Long term care<br><br>2. Death and dying<br>a. Spouse<br>b. Family<br>c. Peers<br>d. Friends<br><br>3. Marriage problems<br>a. Empty nest<br>b. Life style change<br>c. Stress<br>d. Anxiety<br><br>4. Abuse<br>a. Spouse<br>b. Family<br>c. Others<br>d. Self | **SPO #15**<br>**OVERHEAD #37** |

5. Sensory impairment
    a. Loss of sight
    b. Loss of hearing
    c. Loss of speech, etc.
6. Medication problems
    a. Too much
    b. Too little
    c. Lack of medication
    d. Depression
7. Alcohol
    a. Abuse
    b. Mixing with medication
8. Retirement or lack of employment
    a. Decline in money which affects:
        1. Food
        2. Shelter
        3. Clothing
    b. Loss of employment
    c. Loneliness
    d. Feeling of failure to accomplish life goals
    e. Being unprotected
    f. Loss of control
9. Emotional problems: All of the above with the addition of fear in everyday life

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| T. **INTERACTION SKILLS NEEDED IN DEALING WITH ELDERLY PERSONS** | **SPO #16**<br>**OVERHEAD #38** |
| 1. Obtain all possible information<br>2. Show respect<br>3. Body language can be interpreted<br>4. Position yourself to best be seen<br>5. Touch is OK, only if necessary<br>6. Provide reassurance and security<br>7. Control your voice by tone, volume, pace<br>8. Keep communication simple<br>9. Explain what you are doing<br>10. Try not to restrain them<br>11. Having family and/or friends present is beneficial | |
| U. Crisis intervention skills for the mentally/physically challenged | |
| 1. **INTERACTION SKILLS FOR THE VISION IMPAIRED** | **SPO #17**<br>**OVERHEAD #39** |
| a. Introduce yourself<br>b. Speak and act normally<br>c. Ask first before giving assistance<br>d. Always warn the person of any hazards, steps, curbs, walkways, etc. | |
| 2. **INTERACTION SKILLS FOR THE HEARING IMPAIRED** | **SPO #18**<br>**OVERHEAD #40** |
| a. Position yourself to best be seen<br>b. Make sure you are understood<br>c. A nod doesn’t mean someone understands | |

d. Find a mutual communication means:

   1. Normal speech
   2. Being told to "speak-up"
   3. Reading lips
   4. Signing
   5. Notes and messages

V. Community referral handbook

1. Each officer should be equipped with a community referral handbook which lists all the community agencies in that jurisdiction
2. To use a community referral handbook choose the problem which has the highest priority for the individual
3. While talking to the individual, do a mental scan for an agency which provides service for the identified problem
4. Make every attempt to "Personalize" the agency to which you refer the individual
5. Clarify any questions the individual may have concerning the agency in question
6. Complete a referral slip with a copy to the individual and one for your files
7. Be sure that you keep advised on new agencies that open in your jurisdiction and add them into your referral handbooks

**III. PRACTICE**

A. Distribute the practice exercise

B. Have students complete

C. Review exercise with students

D. Be available for questions

**IV. TEST/SPOS**

HANDOUT 24

OVERHEAD 1

SPO #2

# MENTAL ILLNESS

A SUBSTANTIAL DISORDER OF THOUGHT, MOOD, PERCEPTION, ORIENTATION, OR MEMORY THAT GROSSLY IMPAIRS JUDGMENT, BEHAVIOR, CAPACITY TO RECOGNIZE REALITY, OR ABILITY TO MEET TO ORDINARY DEMANDS OF LIFE.

# OVERHEAD 2

## MODERN SOCIETY

1. MENTALLY ILL PEOPLE REPRESENT A LARGE SEGMENT OF THE POPULATION IN MOST COMMUNITIES
2. MENTALLY ILL PEOPLE REPRESENT APPROXIMATELY 1/3$^{RD}$ OF THE HOMELESS POPULATION
3. 16% OF JAIL AND PRISON POPULATIONS SUFFER FROM MENTAL ILLNESS
4. 7% - 10% OF ALL CALLS INVOLVE MENTAL ILLNESS
5. 22% OF THE U.S. POPULATION SUFFERS FROM MENTAL ILLNESS (1 IN 5 ADULTS)

# MENTAL ILLNESS MAJOR CATEGORIES

- MOOD
- THOUGHT
- PERSONALITY
- OTHER

# DEPRESSION

A FEELING OF SADNESS, THE “BLUES,” FEELING DOWN, OR NOT ENJOYING ACTIVITIES THAT ONCE PROVIDED ENJOYMENT

OVERHEAD 5

SPO #1

# SYMPTOMS OF MAJOR DEPRESSION

- PROFOUND FEELINGS OF SADNESS, "BLUES"
- DEEP FEELINGS OF HELPLESSNESS; PROFOUND PESSIMISM
- THOUGHTS AND FEELINGS OF GUILT AND SELF-BLAMING
- DIMINISHED FEELINGS OF SELF-WORTH
- LACK OF ENERGY OR ABILITY TO DO NORMAL ACTIVITIES, SOMETIMES EVEN INCLUDING SIMPLE AND ROUTINE ACTIVITIES
- LOSS OF INTEREST IN NORMAL ACTIVITIES, SUCH AS FAMILY, FRIENDS, HOBBIES, ETC., AND TENDENCY TOWARD ISOLATION
- FEELINGS OF IRRITABILITY

# BIPOLAR DISORDER

A BRAIN DISORDER THAT CAUSES UNUSUAL SHIFTS IN A PERSON'S MOOD, ENERGY, AND ABILITY TO FUNCTION

OVERHEAD 7-A

SPO #3

# SYMPTOMS OF A PERSON IN THE MANIC PHASE OF BIPOLAR DISORDER

- FEELINGS OF GREAT HAPPINES AND EUPHORIA
- SOMETIMES, SUDDEN OUTBURSTS OR IRRITABILITY, RAGE, AND/OR PARANOIA
- GRANDIOSE IDEAS AND FEELINGS OF INFLATED SELF-IMPORTANCE
- RAPID FLIGHTS OF IDEAS OR THOUGHTS (CALLED LABILITY REFERRED TO AS BEING LABILE)
- AT THE EXTREMES, A PERSON'S THOUGHTS MAY RACE SO THAT HIS OR HER WORDS COME OUT IN A NON-STOP RUSH AND MAY NOT MAKE SENSE BECAUSE THEY SEEM SO DISCONNECTED AND FORCED
- SOMETIMES, RISKY AND RECKLESS BEHAVIOR
- GREAT ENERGY, AND ENHANCED PHYSICAL ACTIVITY FOR LONG PERIODS OF TIME

OVERHEAD 7-B

SPO #3

- OFTEN, FEELINGS OF GREAT CREATIVITY, INSIGHT, AND UNDERSTANDING OF THE WORLD AND OF CONNNECTIONS BETWEEN THINGS
- SOMETIMES THESE FEELINGS ARE ASSOCIATED WITH RELIGIOS OR SPIRITUAL IDEAS OR CONCEPTS
- BEHAVIOR THAT IS OFTEN OBNOXIOUS TO OTHERS
- GREAT INCREASES IN SEXUAL ENERGY AND DESIRE
- IN EXTREME CASES, IDEAS OR THOUGHTS THAT ARE CLEARLY OUT OF TOUCH WITH REALITY

# SCHIZOPHRENIA

A CHRONIC, SEVERE, AND DISABLING BRAIN DISEASE

OVERHEAD 9

SPO #4

# COMMON SIGNS OF SCHIZOPHRENIA

- DISORDERED THINKING AND SPEECH
- DELUSIONS
- HALLUCINATIONS
- UNUSUAL REALITIES
- POOR HYGIENE OR GROOMING
- INAPPROPRIATE OR MUTED FEELINGS OR EMOTIONS
- INAPPROPRIATE BEHAVIORS OR ACTIONS

OVERHEAD 10

SPO #5

# SYMPTOMS OF SCHIZOPHRENIA

KEY SYMPTOMS:

- EXTREME SUSPICIOUSNESS
- DELUSIONS THAT OTHERS ARE PERSECUTING OR PLOTTING AGAINST A PERSON
- POSSIBLY GRANDIOSE THINKING

INDIVIDUALS CAN FREQUENTLY BE:

- VERY ANGRY
- ALOOF
- ARGUMENTATIVE
- DIFFICULT
- VIOLENT
- SUICIDAL

PEOPLE WITH THIS PARTICULAR DISORDER ARE PROBABLY THE GREATEST POTENTIAL THREATS TO LAW ENFORCEMENT OFFICERS AND OTHERS

OVERHEAD 11

# PSYCHOSIS

A LOSS OF CONTACT WITH REALITY, TYPICALLY INCLUDING DELUSIONS (FALSE IDEAS ABOUT WHAT IS TAKING PLACE OR WHO ONE IS) AND HALLUCIANTIONS (SEEING OR HEARING THINGS WHICH AREN'T THERE)

# KEY SYMPTOMS OF PSYCHOSIS

- LOSS OF TOUCH WITH REALITY
- SEEING, HEARING, FEELING, OR OTHERWISE PERCEIVING THINGS THAT ARE NOT THERE (HALLUCINOGENIC)
- DISORGANIZED THOUGHT AND/OR SPEECH
- EMOTION IS EXHIBITED IN AN ABNORMAL MANNER
- UNFOUNDED FEAR/ SUSPICION
- MISTAKEN PERCEPTIONS (ILLUSIONS)
- FALSE BELIEFS (DELUSIONS)

# COMMONLY KNOWN PERSONALITY DISORDERS

- ANTISOCIAL PERSONALITY DISORDER
- BORDERLINE PERSONALITY DISORDER

OVERHEAD 14

SPO #6

## SIGNS OF ANXIETY DISORDERS

- A PERSON MAY FEEL EXTREMELY UPSET AND UNABLE TO CONTROL FEELINGS AND SITUATIONS
- HE OR SHE MAY FEEL VERY WORRIED AND UPSET
- MAY EXAGGERATE THE SIGNIFICANCE OF AN ACTUAL OR IMAGINED EVENT OR SITUATION
- THE PERSON MAY “CATASTROPHIZE”
- THE PERSON MAY WORRY ALL THE TIME – TYPICALLY WAY OUT OF PROPORTION TO REALISTIC CAUSES
- A PERSON WHO IS EXCESSIVELY ANXIOUS MAY ALSO HAVE PHYSICAL SYMPTOMS

# MOST COMMONLY DIAGNOSED ANXIETY DISORDERS

- GENERALIZED ANXIETY DISORDER
- PANIC DISORDER
- PHOBIAS
- OBSESSIVE-COMPULSIVE DISORDER
- POST-TRAUMATIC STRESS DISORDER

OVERHEAD 16

SPO #13

# DEMENTIA

DEMENTIA IS A DESCRIPTION OF A GROUP OF SYMPTOMS THAT CAN ACCOMPANY OTHER DISEASES OR PHYSICAL CONDITIONS

- THINKING
- MEMORY
- REASONING

NOTE: DEMENTIA **IS NOT** A DISEASE

# COMMON SYMPTOMS OF DEMENTIA

- CONFUSION AS TO TIME, PLACE OR PERSON
- SHORTENED ATTENTION SPAN
- CHANGES IN SHORT TERM MEMORY
- CHANGES IN LANGUAGE CAPABILITY OR TROUBLE FINDING WORDS
- CHANGES IN ABILITY TO CALCULATE, PLAN OR REASON
- CHANGES IN PERSONAL CARE HABITS
- CHANGES IN PERSONALITY

# ABILITIES LOST DUE TO ALZHEIMER'S DISEASE

- LANGUAGE
- SOCIAL AWARENESS
- MOOD
- SELF-CARE ABILITY
- PLANNING
- REASONING
- JUDGMENT

OVERHEAD 19

SPO #14

# COMMON SIGNS FOR PEOPLE WITH ALZHEIMER'S DISEASE

- SEEMS TO BE LOST
- SEEMS TO BE AGITATED OR ANGRY
- DOESN'T SEEM TO GRASP THE NATURE OR SERIOUSNESS OF THE SITUATION
- CAN'T SEEM TO RELATE TO TIME
- REPEATS QUESTIONS OR STATEMENTS
- GIVES INAPPROPRIATE RESPONSES TO QUESTIONS
- IS DRESSED INAPPROPRIATELY
- HAS A BLANK FACIAL EXPRESSION
- IS OUT OF TOUCH WITH REALITY

# OTHER FORMS OF DEMENTIA

- MEMORY LOSS AND IMPAIRED THINKING
- DIFFICULTY PERFORMING FAMILIAR TASKS
- PROBLEMS WITH LANGUAGE AND COMMUNICATION
- DISORIENTATION AS TO TIME AND PLACE
- POOR OR DIMINISHED JUDGMENT
- PROBLEMS FOLLOWING DIRECTIONS
- MISPLACING THINGS
- CHANGES IN MOOD, PERSONALITY, OR BEHAVIOR
- IMPAIRED VISUAL OR SPATIAL SKILLS
- LOSS OF MOTIVATION
- CHANGES IN NORMAL SLEEP PATTERNS

# INTERACTING WITH THE MENTALLY ILL

- MAKE THE SCENE SAFE
- IDENTIFY SIGNS OR SYMPTOMS OF MENTAL ILLNESS
- DETERMINE WHETHER A SERIOUS CRIME HAS BEEN COMMITTED
- EVALUATE THE NEED FOR IMMEDIATE TRANSPORT TO:
  - MENTAL HEALTH FACILITY
  - JAIL
- USE PERSUASION RATHER THAN FORCE WHENEVER POSSIBLE
- ARRIVING AT THE SCENE
  - ASSESS THE SITUATION
  - GATHER INFORMATION
    - INDIVIDUALS
    - BYSTANDERS
    - FAMILY MEMBERS
- LOCATE THE PERSON IN CRISIS AND BEGIN INTERACTION

# EMPATHY VS. SYMPATHY

EMPATHY DEFINED AS: THE ABILITY TO IMAGINE ONESELF IN ANOTHER'S PLACE AND UNDERSTAND THE OTHER'S FEELINGS, DESIRES, IDEAS, AND ACTIONS.

SYMPATHY DEFINED AS: A FEELING OR AN EXPRESSION OF PITY OR SORROW FOR THE DISTRESS OF ANOTHER; COMPASSION OR COMMISERATION.

OVERHEAD 23

SPO #9

# PHRASES TO AID IN COMMUNICATION

- "WE (I) WANT TO HELP."
- "HOW CAN WE (I) HELP?"
- "THIS CAN BE WORKED OUT."
- "THIS CAN BE WORKED OUT IF YOU WILL HELP."
- "WE (I) NEED YOUR HELP."
- "THAT'S GOOD."
- "WE (I) DON'T WANT ANYONE TO GET HURT."
- "WE (I) KNOW YOU DON'T WANT TO HURT ANYONE."

OVERHEAD 24A

SPO #7

# DE-ESCALATION TECHNIQUES

## OFFICER'S SHOULD:

- REMAIN CALM AND AVOID OVERREACTING AND UNDERREACTING
- PROVIDE OR OBTAIN ON-SCENE EMERGENCY AID WHEN TREATMENT OF AN INJURY IS URGENT
- FOLLOW PROCEDURES INDICATED ON MEDICAL ALERT BRACELETS OR NECKLACES
- INDICATE A WILLINGNESS TO UNDERSTAND AND HELP
- SPEAK SIMPLY AND BRIEFLY, AND MOVE SLOWLY
- REMOVE DISTRACTIONS, UPSETTING INFLUENCES, AND DISRUPTIVE PEOPLE FROM THE SCENE
- UNDERSTAND THAT A RATIONAL DISCUSSION MAY NOT TAKE PLACE
- RECOGNIZE THAT THE PERSON MAY BE OVERWHELMED BY SENSATIONS, THOUGHTS, FRIGHTENING BELIEFS, SOUNDS (“VOICES”), OR THE ENVIRONMENT

OVERHEAD 24B

- BE FRIENDLY, PATIENT, ACCEPTING, AND ENCOURAGING, BUT REMAIN FIRM AND PROFESSIONAL
- BE AWARE THAT A UNIFORM, GUN, AND HANDCUFFS MAY FRIGHTEN THE PERSON WITH MENTAL ILLNESS, AND REASSURE THE PERSON THAT NO HARM IS INTENDED
- RECOGNIZE AND ACKNOWLEDGE THAT A PERSON'S DELUSIONAL OR HALLUCINATORY EXPERIENCE IS REAL TO HIM OR HER
- ANNOUNCE ACTIONS BEFORE INITIATING THEM
- GATHER INFORMATION FROM FAMILY OR BYSTANDERS
- IF THE PERSON IS EXPERIENCING A PSYCHIATRIC CRISIS, ASK THAT A REPRESENTATIVE OF A LOCAL MENTAL HEALTH ORGANIZATION RESPOND TO THE SCENE

OVERHEAD 25

SPO #8

# BEHAVIORS TO AVOID WHILE ENGAGED IN DE-ESCALATION

- MOVING SUDDENLY, GIVING RAPID ORDERS OR SHOUTING
- FORCING DISCUSSION
- MAINTAINING DIRECT, CONTINUOUS EYE CONTACT
- TOUCHING THE PERSON (UNLESS ESSENTIAL TO SAFETY)
- CROWDING THE PERSON OR MOVE INTO HIS OR HER ZONE OF COMFORT
- EXPRESSING ANGER, IMPATIENCE OR IRRITATION
- ASSUMING THAT A PERSON WHO DOES NOT RESPOND CANNOT HEAR
- USING INFLAMMATORY LANGUAGE, SUCH AS “CRAZY,” “PSYCHO”, “MENTAL”, OR “MENTAL SUBJECT”
- CHALLENGING DELUSIONAL OR HALLUCINATORY STATEMENTS
- MISLEADING THE PERSON TO BELIEVE THAT OFFICERS ON THE SCENE THINK OR FEEL THE WAY THE PERSON DOES

# SIDE EFFECT

- DRY MOUTH
- CONSTIPATION
- BLURRED VISION
- DROWSINESS
- DECREASED SEXUAL DESIRE
- MENSTRUAL CHANGES
- STIFF MUSCLES ON ONE SIDE
  - NECK
  - JAW
- RESTLESSNESS
- SLURRED SPEECH
- MUSCLE STIFFNESS
- TREMORS
  - HANDS
  - FEET

AGRANULOCYTOSIS: A DECREASE IN THE PRODUCTION OF WHITE BLOOD CELLS, WHICH OCCURS ONLY WHEN TAKING CLOZAPINE, REQUIRES MONITORING OF THE BLOOD EVERY TWO WEEKS

TARDIVE DYSKINESIA:

- MOST SERIOUS SIDE EFFECT
- INVOLUNTARY FACIAL MOVEMENTS
- JERKING MOVEMENTS OF THE BODY
- TWISTING MOVEMENTS OF THE BODY
- USUALLY INVOLVES OLDER CITIZENS
- AFFECTS 15% TO 20% OF WHO HAVE TAKEN OLDER ANTIPSYCHOTIC DRUGS FOR YEARS
- DECREASES SLOWLY FROM THE BODY WHEN MEDIATION CEASES

OVERHEAD 27

SPO #10

# INDICATORS OF SUICIDAL THOUGHT

- EMOTIONAL PAIN
- MENTAL ILLNESS
- ALCOHOL AND DRUG USE
- RATIONAL DECISION
- MANIPULATION OF OTHERS

# SUICIDE BY COP

A PERSON ACTING IN SUCH A WAY AS TO FORCE THE POLICE TO KILL HIM OR HER, RATHER THAN COMMITTING SUICIDE HIMSELF OR HERSELF

- IF THE PERSON IS SIMPLY ARMED AND REFUSING TO DROP THE WEAPON…
- BUT HAS NOT ACTUALLY THREATENED ANYONE WITH IT…
- THE PROPER RESPONSE DEPENDS ON THE CIRCUMSTANCES

# GENERAL INDICATORS OF PEOPLE UNDER THE INFLUENCE OF ALCOHOL OR OTHER DRUGS

- SLURRED SPEECH
- ODOR OF AN ALCOHOLIC BEVERAGE ON THE BREATH
- INABILITY TO STAND OR WALK NORMALLY
- CONFUSION OR DISORIENTATION
- LETHARGY (SLOW, SLEEPY, UNINSPIRED BEHAVIOR)
- UNUSUAL OR SEVERE AGGRESSIVENESS OR AGITATION, OR UNUSUALLY OBNOXIOUS BEHAVIOR
- ABNORMAL BREATHING, SUCH AS BREATHING WHICH IS VERY RAPID AN/OR SHALLOW
- TREMORS (“SHAKES”)
- EXCESSIVE IRRITABILITY, BEING QUICK TO ANGER
- UNUSUAL RESTLESSNESS, INABILITY TO STAND OR SIT STILL OR STAY ON TASK FOR LONG
- FEELING OF BEING VERY HOT OR VERY COLD
- STRANGE, UNUSUAL, OR BIZARRE BEHAVIOR

# DELUSION VS. HALLUCINATION

DELUSIONS (IDEAS OR THOUGHTS THAT ARE NTO BASED IN REALITY)

HALLUCINATIONS (SEEING THINGS THAT ARE NOT THERE, OR HEARING VOICES, OR SOMETIMES SMELLING THINGS THAT ARE NTO THERE)

# DEVELOPMENTAL DISABILITY

A SEVERE, CHRONIC (CONTINUING) DISABILITY WHICH ORIGINATED DURING BIRTH OR CHILDHOOD, IS EXPECTED TO CONTINUE INDEFINITELY, AND WHICH SUBSTANTIALLY RESTRICTS THE PERSON'S FUNCTIONING IN SEVERAL MAJOR LIFE ACTIVITIES

# DEVELOPMENTAL DISABILITY FUNCTIONAL LIMITATIONS

- SELF-CARE
- RECEPTIVE LANGUAGE
- EXPRESSIVE LANGUAGE
- LEARNING
- MOBILITY
- SELF-DIRECTION
- CAPACITY FOR INDEPENDENT LIVING
- ECONOMIC SELF-SUFFICIENCY

# INDICATORS THAT A PERSON MAY HAVE MENTAL RETARDATION, INCLUDE:

- APPARENT INABILITY TO UNDERSTAND THINGS AS WELL AS OTHER PEOPLE
- CONCRETE THINKING
    - APPARENT DIFFICULTY IN UNDERSTANDING OR PROCESSING ABSTRACT IDEAS OR CONCEPTS
    - IMMATURE BEHAVIOR IN CERTAIN SOCIAL SITUATIONS OR ACTING BELOW AGE LEVEL
- MOST MENTALLY RETARDED PEOPLE ENCOUNTERED WILL BE EITHER MILDLY OR MODERATELY MENTALLY RETARDED
- MANY ARE QUITE CAPABLE OR HOLDING A JOB AND LIVING INDEPENDENTLY WITH LIMITATIONS
- PEOPLE WITH SEVERE RETARDATION OR PROFOUND RETARDATION ARE LESS LIKELY TO FUNCTION INDEPENDENTLY AND ARE OFTEN VICTIMS OF CRIMES

# AUTISM

A NEUROLOGICALLY-BASED DEVELOPMENTAL DISABILITY THAT SERIOUSLY AFFECTS A PERSON'S COMMUNICATION, DECISION-MAKING AND SOCIALIZATION SKILLS

OVERHEAD 35

SPO #12

# INDICATORS OF AUTISM MAY INCLUDE

- VERBAL DIFFICULTIES
- UNUSUAL PHYSICAL BEHAVIORS
- INAPPROPRIATE SOCIAL RESPONSES

# OTHER DEVELOPMENTAL DISABILITES

CEREBRAL PALSY CAN BE DEFINED AS: A GROUP OF CHRONIC CONDITIONS AFFECTING BODY MOVEMENTS AND MUSCLE COORDINATION

EPILEPSY (SEIZURE DISORDER) CAN BE DEFINED AS: A PHYSICAL CONDITION THAT OCCURS WHEN THERE IS A SUDDEN, BRIEF CHANGE IN THE WAY THAT THE BRAIN WORKS

TRAUMATIC BRAIN INJURY (AKA TBI) CAN BE DEFINED AS: A SUDDEN PHYSICAL ASSAULT ON THE HEAD CAUSING DAMAGE TO THE BRAIN

PRADER-WILLI SYNDROME CAN BE DEFINED AS: A COMPLEX GENETIC DISORDER THAT INCLUDES SHORT STATURE, MENTAL RETARDATION OR LEARNING DISABILITIES, INCOMPLETE SEXUAL DEVELOPMENT, CHARACTERISTIC PROBLEMS, LOW MUSCLE TONE, AND AN INVOLUNTARY URGE TO EAT CONSTANTLY

FETAL ALCOHOL SYNDROME (AKA FAS) CAN BE DEFINED AS: A PATTERN OF PHYSICAL AND MENTAL DEFECTS WHICH DEVELOPS IN SOME UNBORN BABIES WHEN THE MOTHER DRINKS TOO MUCH ALCOHOL DURING PREGNANCY

OVERHEAD 37

SPO #15

# CATEGORIES OF LIFE CHANGES REGARDING THE ELDERLY AND THE MENTALLY/PHYSICALLY CHALLENGED

- PHYSICAL ISSUES
- DEATH AND DYING
- MARRIAGE PROBLEMS
- ABUSE
- SENSORY IMPAIRMENT
- MEDICATION PROBLEMS
- ALCOHOL
- RETIREMENT OR LACK OF EMPLOYMENT
- EMOTIONAL PROBLEMS: ALL OF THE ABOVE WITH THE ADDITION OF FEAR IN EVERYDAY LIFE

OVERHEAD 38

SPO #16

# INTERACTION SKILLS NEEDED IN DEALING WITH THE ELDERLY

- OBTAIN ALL POSSIBLE INFORMATION
- SHOW RESPECT
- BODY LANGUAGE CAN BE INTERPRETED
- POSITION YOURSELF TO BEST BE SEEN
- TOUCH IS OK, ONLY IF NECESSARY
- PROVIDE REASSURANCE AND SECURITY
- CONTROL YOUR VOICE BY TONE, VOLUME, PACE
- KEEP COMMUNICATION SIMPLE
- EXPLAIN WHAT YOU ARE DOING
- TRY NOT TO RESTRAIN THEM
- HAVING FAMILY AND/OR FRIENDS PRESENT IS BENEFICIAL

OVERHEAD 39

SPO #17

# CRISIS INTERVENTION SKILLS FOR THE VISION IMPAIRED:

- INTRODUCE YOURSELF
- SPEAK AND ACT NORMALLY
- ASK FIRST BEFORE GIVING ASSISTANCE
- ALWAYS WARN THE PERSON OF ANY HAZARDS, STEPS, CURBS, WALKWAYS, ETC.

OVERHEAD 40

SPO #18

# CRISIS INTERVENTION SKILLS FOR THE HEARING IMPAIRED:

- POSITION YOURSELF TO BEST BE SEEN
- MAKE SURE YOU ARE UNDERSTOOD
- A NOD DOESN'T MEAN SOMEONE UNDERSTANDS
- FIND A MUTUAL COMMUNICATION MEANS

§ 5122.01. Definitions

As used in this chapter and Chapter 5119. of the Revised Code:

(A) “Mental illness” means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

**(B) “Mentally ill person subject to hospitalization by court order” means a mentally ill person who, because of the person’s illness:**

**(1) Represents a substantial risk of physical harm to *self* as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;**

**(2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;**

**(3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person’s basic physical needs because of the person’s mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or**

**(4) Would benefit from treatment in a hospital for the person’s mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person.**

(C)(1) “Patient” means, subject to division (C)(2) of this section, a person who is admitted either voluntarily or involuntarily to a hospital or other place under section 2945.39, 2945.40, 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter, who is under observation or receiving treatment to such place.

(2) "Patient" does not include a person admitted to a hospital or other place under section 2945.39, 2945.40, 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised Code to the extent that the reference in this chapter to patient, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 [2945.40.2] of the Revised Code.

(D) "Licensed physician" means a person licensed under the laws of this state to practice medicine or a medical officer of the government of the United States while in this state in the performance of the person's official duties.

(E) "Psychiatrist" means a licensed physician who has satisfactorily completed a residency training program in psychiatry, as approved by the residency review committee of the American medical association, the committee on post-graduate education of the American osteopathic association, or the American osteopathic board of neurology and psychiatry, or who on July 1, 1989, has been recognized as a psychiatrist by the Ohio state medical association or the Ohio osteopathic association on the basis of formal training and five or more years of medical practice limited to psychiatry.

(F) "Hospital" means a hospital or inpatient unit licensed by the department of mental health under section 5119.20 of the Revised Code, and any institution, hospital, or other place established, controlled, or supervised by the department under Chapter 5119. of the Revised Code.

(G) "Public hospital" means a facility that is tax-supported and under the jurisdiction of the department of mental health.

(H) "Community mental health agency" means any agency, program, or facility with which a board of alcohol, drug addiction, and mental health services contracts to provide the mental health services listed in section 340.09 of the Revised Code.

(I) "Licensed clinical psychologist" means a person who holds a current valid psychologist license issued under section 4732.12 or 4732.15 of the Revised Code, and in addition, meets either of the following criteria:

(1) Meets the educational requirements set forth in division (B) of section 4732.10 of the Revised Code and has a minimum of two years' full-time professional experience, or the equivalent as determined by rule of the state board of psychology, at least one year of which shall be post-doctoral, in clinical psychological work in a public or private hospital or clinic or in private practice, diagnosing and treating problems of mental illness or mental retardation under the supervision of a psychologist who is licensed or who holds a diploma issued by the American board of professional psychology, or whose qualifications are substantially similar to those required for licensure by the state board of psychology when the supervision has occurred prior to enactment of laws governing the practice of psychology;

(2) Meets the educational requirements set forth in division (B) of section 4732.15 of the Revised Code and has a minimum of four years' full-time professional experience, or the equivalent as determined by rule of the state board of psychology, in clinical psychological work in a public or private hospital or clinic or in private practice, diagnosing and treating problems of mental illness or mental retardation under supervision, as set forth in division (1)(1) of this section.

(1) "Health officer" means any public health physician; public health nurse; or other person authorized by or designated by a city health district; a general health district; or a board of alcohol, drug addiction, and mental health services to perform the duties of a health officer under this chapter.

(K) "Chief clinical officer" means the medical director of a hospital, or a community mental health agency, or a board of alcohol, drug addiction, and mental health services, or, if there is no medical director, the licensed physician responsible for the treatment a hospital or community mental health agency provides. The chief clinical officer may delegate to the attending physician responsible for a patient's care the duties imposed on the chief clinical officer by this chapter. Within a community mental health agency and shall be a licensed physician or licensed clinical psychologist who supervises diagnostic and treatment services. A licensed physician or licensed clinical psychologist designated by the chief clinical officer may perform the duties and accept the responsibilities of the chief clinical officer in the chief clinical officer's absence.

(L) "Working day" or "court day" means Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a holiday.

(M) "Indigent" means unable without deprivation of satisfaction of basic needs to provide for the payment of an attorney and other necessary expenses of legal representation, including expert testimony.

(N) “Respondent” means the person whose detention, commitment, hospitalization, continued hospitalization or commitment, or discharge is being sought in any proceeding under this chapter.

(O) “Legal rights service” means the service established under section 5123.60 of the Revised Code.

(P) “Independent expert evaluation” means an evaluation conducted by a licensed clinical psychologist, psychiatrist, or licensed physician who has been selected by the respondent or the respondent’s counsel and who consents to conducting the evaluation.

(Q) “Court” means the probate division of the court of common pleas.

(R) “Expunge” mean:

(1) The removal and destruction of court files and records, originals and copies, and the deletion of all index references;

(2) The reporting to the person of the nature and extent of any information about the person transmitted to any other person by the court;

(3) Otherwise insuring that any examination of court files and records in question shall show no record whatever with respect to the person;

(4) That all rights and privileges are restored, and that the person, the court, and any other person may properly reply that no such record exists, as to any matter expunged.

(S) “Residence” means a person’s physical presence in a county with intent to remain there, except that:

(1) If a person is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which the person maintained the person’s primary place of residence at the time the person entered the facility;

(2) If a person is committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised Code, residence means the county where the criminal charges were filed.

When the residence of a person is disputed, the matter of residence shall be referred to the department of mental health for investigation and determination. Residence shall not be a basis for a board's denying services to any person present in the board's service district, and the board shall provide services for a person whose residence is in dispute while residence is being determined and for a person in an emergency situation.

(T) "Admission" to a hospital or other place means that a patient is accepted for and stays at least one night at the hospital or other place.

(U) "Prosecutor" means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer who prosecuted a criminal case in which a person was found not guilty by reason of insanity, who would have had the authority to prosecute a criminal case against a person if the person had not been found incompetent to stand trial, or who prosecuted a case in which a person was found guilty.

(V) "Treatment plan" means a written statement of reasonable objectives and goals for an individual established by the treatment team, with specific criteria to evaluate progress towards achieving those objectives. The active participation of the patient in establishing the objectives and goals shall be documented. The treatment plan shall be based on patient needs and include services to be provided to the patient while the patient is hospitalized and after the patient is discharged. The treatment plan shall address services to be provided upon discharge, including but not limited to housing, financial, and vocational services.

(W) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.

(X) "Post-release control sanction" has the same meaning as in section 2967.01 of the Revised Code.

§ 5122.10. Emergency hospitalization; temporary detention; limitations.

Any psychiatrist, licensed clinical psychologist, licensed physician, health officer, **parole officer, police officer, or sheriff may take a person into custody**, or the chief of the adult parole authority or a parole or probation officer with the approval of the chief of the authority may take a parolee, an offender under a community control sanction or a post-release control sanction, or an offender under transitional control into custody and may immediately transport the parolee, offender on community control or post-release control, or offender under transitional control to a hospital or, notwithstanding section 5119.20 of the Revised Code, to a general hospital not licensed by the department of mental health where the parolee, offender on community control or post-release control, or offender under transitional control may be held for the period prescribed in this section, if the psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, **police officer, or sheriff has reason to believe that the person is a mentally ill person subject to hospitalization by court order under division (B) of section 5122.01 of the Revised Code, and represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination.**

A written statement shall be given to such hospital by the transporting psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, chief of the adult parole authority, parole or probation officer, or sheriff stating the circumstances under which such person was taken into custody and the reasons for the psychiatrist's, licensed clinical psychologist's, licensed physician's, health officer's, parole officer's, police officer's, chief of the adult parole authority's, parole or probation officer's, or sheriffs belief. This statement shall be made available to the respondent or the respondent's attorney upon request of either.

**Every reasonable and appropriate effort shall be made to take persons into custody in the least conspicuous manner possible. A person taking the respondent into custody pursuant to this section shall explain to the respondent: the name, professional designation, and agency affiliation of the person taking the respondent into custody; that the custody-taking is not a criminal arrest; and that the person is being taken for examination by mental health professionals at a specified mental health facility identified by name.**

If a person taken into custody under this section is transported to a general hospital, the general hospital may admit the person, or provide care and treatment for the person, or both, notwithstanding section 5119.20 of the Revised Code, but by the end of twenty-four hours after arrival at the general hospital, the person shall be transferred to a hospital as defined in section 5122.01 of the Revised Code.

A person transported or transferred to a hospital or community mental health agency under this section shall be examined by the staff of the hospital or agency within twenty-four hours after arrival at the hospital or agency. If to conduct the examination requires that the person remain overnight, the hospital or agency shall admit the person in an unclassified status until making a disposition under this section. After the examination, if the chief clinical officer of the hospital or agency believes that the person is not a mentally ill person subject to hospitalization by court order, the chief clinical officer shall release or discharge the person immediately unless a court has issued a temporary order of detention applicable to the person under section 5122.11 of the Revised Code. After the examination, if the chief clinical officer believes that the person is a mentally ill person subject to hospitalization by court order, the chief clinical officer may detain the person for not more than three court days following the day of the examination and during such period admit the person as a voluntary patient under section 5122.02 of the Revised Code or file an affidavit under section 5122.11 of the Revised Code, the chief clinical officer shall discharge the person at the end of the three-day period unless the person has been sentenced to the department of rehabilitation and correction and has not been released from the person's sentence, in which case the person shall be returned to that department.

# TYPES OF PERSONALITY DISORDER

## Antisocial Personality Disorder

Most people with this disorder are males. Key features include: a continuing pattern of behavior that shows disregard for or abuse of the rights of other people; disregard of the wishes or feelings of others; manipulative and/or deceitful behavior; a pattern of impulsive behavior (acting on the spur of the moment, without thinking ahead to the consequences); irritability or aggressiveness; a pattern of irresponsibility in regard to work, family obligations, and so on; and lack of remorse or guilt for their actions – partly because they tend to always blame other people for their actions rather than take blame or responsibility themselves. Such individuals are often charming and verbally persuasive.

People with antisocial personality disorder are sometimes referred to as “sociopaths,” although this is not a specific mental health term.

These can be difficult people to deal with because they act out a lot, do not take responsibility for their actions, and are often argumentative – particularly when challenged. Some can be dangerous people. Many use and abuse alcohol and drugs consistently, and can be even more unpredictable and potentially dangerous when under such influence. People with this disorder often get involved with law enforcement. They often commit crimes such as stealing, destroying property, and drug dealing.

## Borderline Personality Disorder

The essential feature of this disorder, as set forth in DSM-IV, is “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins in early adulthood and is present in a variety of contexts.” This is a disorder that affects approximately 2% of the population. Most people diagnosed with it are women. Many people with this disorder are victims of trauma – often during childhood or adolescence – including physical, sexual, and/or extreme emotional abuse.

Key symptoms of borderline personality disorder include: emotional instability, with frequent shifts of feelings from depression to irritability to anxiety, etc.; displays of inappropriate and intense anger, with temper tantrums or deep brooding; and intense but stormy relationships with other people. People with this disorder tend to view other people, at any given time, as either all-good or all-bad, depending on whether they think the person is meeting their needs at that particular moment. Their assessments of others shift frequently. Also, they tend to be quite impulsive in all aspects of their lives – behaving on the spur of the moment based on their emotions, rather than rationally thinking ahead to the consequences of their actions.

Such individuals frequently use alcohol and drugs to self-medicate, and are often long-term substance abusers. Many are also prone to episodes of depression, sometimes including suicidal behavior. Their substance abuse and depression are often patterns of response to a personal history of neglect and abuse suffered during the person’s formative years.

Many people with this disorder make suicide attempts. Some also engage in self-injurious behavior, including cutting themselves or sometimes burning themselves with cigarettes or matches, but their doing so is not necessarily a suicide attempt. The motivations for such self-injurious behavior can be complicated, and sometimes have to do with experiencing pain in order to feel “real”. People who do this often say that hurting themselves gives them a feeling of relief.

They often experience intense emotional crises, usually in response to a received problem or disappointment with another person or persons in their life. A person may get extremely upset and volatile in such a circumstance. You may respond to a person during such a crisis, perhaps in the context of a domestic disturbance call, a disturbance in a public place, a suicidal person contact, or other situation. The subject may be intoxicated during such a contact.

As noted, many people with borderline personality disorder are victims of trauma, often including physical and/or sexual abuse. Many such victims of trauma may have difficulties with being placed in restraints, such as handcuffs, or with being required to remove clothing. Being placed in restraints, for example, may cause them to re-live their trauma and thus cause feelings of extreme distress. This does not necessarily mean that you should not place them in restraints, but at least be aware of the possible implications of restraints for them. It if is possible to use an alternative to handcuffs, consider doing so.

Treatment for personality disorders primarily consists of talk therapy to help people better understand their behavior patterns and to develop more constructive behaviors. There are no medications that specifically treat or cure a personality disorder, although people with such disorders frequently take psychiatric medications for conditions associated with their disorder, such as depression and anxiety.

Many people with personality disorders have not, in fact, specifically been diagnosed as having such a disorder. Most will not have sought the help of a medical or mental health professional for a personality disorder, and they do not even usually know about such disorders or recognize that they have a problem based on the disorder.

Thus, during a contact with a subject, you are unlikely to be in a position to be able to identify him or her as a person with a personality disorder, either in general or in regard to a specific disorder. Again, your job is to be aware of behaviors and to respond to people exhibiting such behaviors. Nevertheless, it is useful to know that such disorders are often the basis for the behavior that you will see.

# ANXIETY DISORDERS: THE MOST COMMONLY DIAGNOSED PSYCHIATRIC CONDITIONS

## Generalized Anxiety Disorder

Sometimes referred to as GAD, this disorder may be diagnosed by a clinician if a person displays symptoms for at least six months. The symptoms include fairly constant and excessive anxiety, and feelings of tension and worry. Some people describe their feelings as being "shaky" or "keyed-up" or "on edge". These feelings are accompanied by other symptoms, which may include restlessness, being easily fatigued, difficulty concentrating, muscle tension, disturbed sleep, and irritability. A person may experience pain and discomfort from headaches, stomachaches, backaches, and so on. The feelings of worry and anxiety are pervasive and control a person's life, even when there are no identifiable real-life situations or concerns that would cause the feelings of anxiety or worry. For example, people with this disorder often worry excessively about financial concerns, their jobs, family issues, relationship issues, possible misfortunes to themselves or others, or even minor matters like routine car repairs, and cannot will themselves not to worry about these things.

Many people with this disorder are so troubled by the feelings of anxiety that they self-medicate with alcohol and/or drugs. That is how they may try to calm themselves down and fall asleep. Unfortunately, some then get addicted to the alcohol or drugs, causing further problems for them. Also, some people who suffer from this disorder for a long time develop major depression as well, which then requires treatment. Or, a person may experience chronic low-grade depression, referred to as "dysthmia". Thus, chronic anxiety and depression often are seen in the same person.

## Panic Disorders

Panic disorders are another common category of anxiety disorders. The key feature of this is panic attacks, which are very uncomfortable feelings of extreme anxiety that come out of the blue and are not usually associated with any specific event or "trigger". A person experiencing a panic attack may feel flushed, perspire greatly, have a rapid heartbeat, have the "shakes", feel dizzy and light-headed, and feel very out of control.

Someone may feel that he or she can't breathe, and may feel that he or she is about to have a heart attack or even die. Such an attack typically lasts for a short time, such as 15-30 minutes, although individual episodes could be longer or shorter. But even those 15-30 minutes can seem like an eternity to a person undergoing a panic attack. The frequency of a person's panic attacks can vary widely. Some people have frequent attacks, such as each week, continuing for months. Other people may have a number of attacks within days, but then not experience any more attacks for many weeks or months. Once a person has experienced panic attacks, they are usually very concerned about having further episodes of such attacks.

Research has shown that 25% to 30% of people with panic disorder have suicidal thoughts at some point. Depression is a common co-occurring disorder.

Research has indicated that the cause of panic attacks is probably partly psychological and partly biological. However, stressful life events are thought to be a factor in the severity of the disorder. Medications have proven effective for many people in blocking the frequency and severity of panic attacks.

## Phobias

DSM-IV, the diagnostic manual of the American Psychiatric Association, defines a phobia as "a persistent, irrational fear of a specific object, activity, or situation (the phobic stimulus) that results in a compelling desire to avoid it. This often leads either to avoidance of the phobia, the avoidance of the object, activity or situation by a person must seriously interfere with the person's ability to function normally. A person may have a great fear about a certain activity, such as bungee jumping, but if he or she simply avoids engaging in that activity in routine life, it is not a phobia.

A specific phobia is a marked and persistent fear of a specific, identifiable situation or object. Examples are fear of heights, fear of flying, fear of snakes, or fear of being in closed-up spaces (claustrophobia). The person may recognize that his or her fear is unreasonable or excessive, but cannot help responding to the "phobic stimulus" either by avoiding it entirely or by experiencing it with extreme anxiety that is similar to the symptoms of a panic attack.

## Social phobia

Which is also sometimes known as “social anxiety disorder” – is fear of social situations, including social performance situations such as speaking in public or participating in certain types of events in which other people are present. Some people, for example, have a phobia about eating or drinking in front of other people. A person with this disorder may be petrified of being embarrassed and/or of having to do something with other people watching and maybe judging them, and that fear causes panic-like feelings. Again, a person may realize that his or her fear is unreasonable, but can’t help it. Both specific and social phobias are treatable in most people.

## Obsessive-Compulsive Disorder

This disorder, commonly referred to as “OCD”, is primarily characterized by recurrent obsessions or compulsions that are severe and that cause significant distress and/or impairment for a person with the disorder. Obsessions are defined in DSM-IV as “persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress.” Some examples of obsessions include: the need to have things or objects in a particular order, such as on a dresser or desktop; repeated thoughts about contamination, such as fear of being contaminated by germs through shaking hands or touching another person; and repeatedly doubting whether one has locked a door or turned off a stove.

Compulsions are defined as “repetitive behaviors or mental acts the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification.” Examples include; repeated hand-washing, cleaning things over and over, counting things, repeatedly checking on things (such as whether a door is in fact locked), or demanding assurances about something from other people. An obsession, which is an idea or thought, often leads to a compulsion, which is a behavior based on that idea or thought. For example, a person who has an obsession with contamination by germs may then have the compulsion to wash his hands fifty times a day. The person feels intense anxiety about contamination until he washes his hands, which temporarily brings relief from the anxiety caused by that obsession. But that relief is usually short-lived, and the person feels compelled to repeat the hand-washing again and again. People with OCD typically experience a lot of distress and discomfort due to the disorder. Such people may or may not recognize the unreasonableness or excessiveness of their obsessions and compulsions. Or, they may recognize that only to some extent.

## Post-Traumatic Stress Disorder

This disorder, often referred to as PTSD, always develops in response to some real-life event that a person experiences. In that sense, it is unlike the other anxiety disorders, which may or may not be related to real-life experiences. People may develop the symptoms of post-traumatic stress disorder following direct experience of a highly traumatic event that usually involves serious injury, threatened death, actual death, or a serious threat to physical wellbeing. Or, a person may simply witness these stress factors rather than directly experience them. The person experiencing or witnessing the terrible event(s) feels intense fear, helplessness, or a sense of horror.

The symptoms of PTSD then develop as a response to the highly traumatic event. Those symptoms involve re-experiencing the traumatic event in some way, including through nightmares or night terrors or flashbacks. For example, a person who has been through a frightening or traumatic war incident may experience feelings of horror upon hearing a car backfire, because the sound reminds him of guns or bombs. Or a woman who was the victim of sexual abuse may relive the horror of that experience when touched by any other man, even when that touch is not meant to be threatening or abusive. The person may have recurrent and distressing memories and/or dreams about the traumatic event, and may experience intense psychological distress when exposed to stimuli – sounds, sights, smells, experiences – that symbolize or resemble something about that event.

Some people with PTSD experience a sense of emotional “blunting”, meaning that their emotional responses to people and events are numb or distant. They maybe unable to remember important aspects of the traumatic event, may feel detached or estranged from other people, and/or they may be unable to have loving feelings toward other people.

When medical or mental health professionals diagnose anxiety disorders, they do so on the basis of specific diagnostic criteria. Some of these criteria were noted above. An important consideration in making such diagnoses is that the clinician must rule out the possibility that the symptoms of anxiety are caused by a medical or substance abuse problem. There are, for example, a number of medical conditions that can cause a person to experience feelings of great anxiety. Some include: cardiac (heart) conditions; thyroid problems, such as hyperthyroidism; seizure disorders; diabetes; respiratory conditions such as pneumonia, pulmonary disease, or hyperventilation; or vitamin deficiencies. Anxiety can also be the result of reactions to prescribed or over-the-counter medications.

Substance abuse can also cause significant anxiety symptoms. Anxiety can result from alcohol intoxication or withdrawal, as well as from abuse of a number of illegal or illicit drugs, including cocaine, methamphetamines, hallucinogens, cannabis (marijuana), and inhalants. Use of the drug Ecstasy can cause feelings of intense anxiety.

HANDOUT 5

SPO #13

# DEMENTIA

Though not part of the “normal” aging process, some people show signs of changes in their memory and intellectual functions as they age. Most commonly, such changes are associated with Alzheimer’s disease and other forms of dementia.

You will respond to situations involving people who have Alzheimer’s disease or another form of dementia. Thus, you should know basic facts about dementia, how to recognize it, and how best to respond to a person with dementia.

## WHAT IS DEMENTIA?

The term dementia refers to the loss of intellectual abilities, such as thinking and memory and reasoning, that is severe enough to interfere with a person’s ability to care for himself or herself, socialize, and plan for the future.

Dementia is not a disease in itself, but rather a description of a group of symptoms that can accompany other diseases or physical conditions. These symptoms most commonly include the following:

- Confusion as to time, place or person
- Shortened attention span
- Changes in short term memory
- Changes in language capability or trouble finding words
- Changes in ability to calculate, plan or reason
- Changes in personal care habits
- Changes in personality

Dementia is usually separated into two categories: reversible and irreversible. Gone untreated, all dementia can lead to progressive decline. However, reversible dementia means that the dementia is caused by a condition that, if treated properly, will cure it or at least slow the rate of decline. Reversible dementia that goes untreated for long periods of time can lead to irreversible changes. Conditions causing reversible and irreversible dementia can include the following:

HANDOUT 5

SPO #13

REVERSIBLE DEMENTIA (TYPES)

- Depression
- Malnutrition
- Dehydration
- Infection
- Medication/drug interactions
- Vitamin B-12 deficiency
- Hydrocephalus
- Hypoglycemia/hyperglycemia

IRREVERSIBLE DEMENTIA (TYPES)

- Alzheimer's disease
- Vascular disease (small strokes)
- Frontotemporal Dementias
- Lewy Body Disease
- Parkinson's Disease
- Huntington's Disease
- Creutzfeld-Jakob Disease
- Alcohol-related dementia

# HANDOUT 5

## SPO #13

Because some dementia causes can be treated and even cured, it is very important for family members and others to seek and obtain a thorough medical and psychiatric diagnosis of a person so as to identify treatable conditions. Early assessment and intervention in all cases Is essential for effective treatment either to reverse the condition, if possible, or to slow the rate of progression in the case of irreversible dementia.

In the case of Alzheimer's disease and most other irreversible dementias, the changes are often subtle and come on over time, not always showing a clear indication of a problem.

Most irreversible dementias such as Alzheimer's disease are most commonly associated with older adults. In fact, research has indicated that almost 10% of people over the age of 65 have Alzheimer's or a related dementia, and that figure doubles every five years beyond 65. The Alzheimer's Association estimates that as many as 50% of persons over the age of 85 have Alzheimer's disease or a related form of irreversible dementia. In more rare instances, persons as young as 35 have been diagnosed with Alzheimer's disease. The progression of the disease in younger people is typically much more aggressive than that seen in older adults.

## GUIDELINES FOR COMMUNICATING WITH A PERSON WHO HAS (OR SEEMS TO HAVE) ALZHEIMER'S DISEASE OR SOME OTHER FORM OF DEMENTIA

- FIRST, IDENTIFY YOURSELF AS A LAW ENFORCEMENT OFFICER AND STATE THE PURPOSE OF YOUR BEING THERE NO MATTER HOW OBVIOUS IT MAY SEEM
- SPEAK SLOWLY AND MAINTAIN A LOW-PITCHED VOICE
- USE SHORT FAMILIAR WORDS
- ASK "YES" OR "NO" QUESTIONS
- ASK ONE QUESTION AT A TIME, ALLOWING PLENTY OF RESPONSE TIME
- IF NECESSARY, REPEAT THE QUESTION WITH THE EXACT PREVIOUS WORDING – VICTIMS WITH ALZHEIMER'S DISEASE MAY GRASP ONLY PARTS OF THE INITIAL QUESTION
- MAINTAIN GOOD EYE CONTACT WHILE COMMUNICATING
- SUBSTITUTE NON-VERBAL FOR VERBAL COMMUNICATION (PROMPTING IS A GOOD TECHNIQUE)
- IF AVAILABLE, SOLICIT HELP OF A CARE GIVER TO ASSIST YOU WITH COMMUNICATING

## STATE AND FEDERAL VICTIMS SERVICES

ACTION Ohio Coalition for Battered Women
36 W. Gay St., Suite 311
Columbus, OH 43215-2840
614-221-1255
1-888-622-9315

Buckeye State Sheriffs' Association
6230 Busch Blvd., Ste. 260
Columbus, OH 43229
614-431-5500

Court of Claims of Ohio
150 E. Gay St., 23 rd Floor
Columbus, OH 43215
614-466-7447

FBI Victim Specialist
500 S. Front St., Ste. 1050
Columbus, OH 43215
614-744-2123

Mothers Against Drunk Driving (MADD)
5900 Roche Dr., Ste. 250
Columbus, OH 43229
614-885-6233
1-800-552-8641

Office of the Attorney General
Consumer Protection Division
30 E. Broad St., 14th Fl.
Columbus, OH 43215-3400
1-800-282-0515
614-466-8831

Office of the Attorney General
Crime Victims Services Section
Ohio Victims of Crime Compensation Program
150 E. Gay St., 25TH Fl.
Columbus, OH 43215
1-800-582-2877
614-466-5610

Office of the Attorney General
Ohio Missing Children's Clearinghouse
150 E. Gay St., 25TH Fl.
Columbus, OH 43215
1-800-325-5604

Office of Criminal Justice Services
140 E. Town St.
Columbus, OH 43215
614-466-7782

Ohio Coalition on Sexual Assault
933 N. High St., Ste. 120B
Columbus, OH 43085
614-781-1902

Ohio Court Appointed Special Guardian
Guardian Ad Litem
CASA/GAL Association
261-B East Livingston Ave.
Columbus, OH 43215
1-800-891-6446
614-224-2272

Ohio Dept. Of Health
Rape Prevention Project
246 N. High St.
Columbus, OH 43215
614-466-5332

Ohio Dept. of Mental Retardation and Developmental Disability (MRDD)
Major Unusual Incident (MUI) Investigation
1601 W. Broad St.
Columbus, OH 43222-1055
614-995-3817
614-995-3810

Ohio Dept. Of Rehab. and Correction
Office of Victim Services
1050 Freeway Dr.
Columbus, OH 43229
1-888-824-8464
614-728-9947

Ohio Dept. of Youth Services
Office of Victim Services
51 N. High St., 3rd Floor
Columbus, OH 43215
1-800-872-3132

Ohio Domestic Violence Network
4807 Evanswood Dr., Ste. 201
Columbus, OH 43229
1-800-934-9840
614-781-9651

Ohio Office of Criminal Justice Services
Family Violence Prevention Center
140 E. Town St., 14TH Floor
Columbus, OH 43215
614-466-7782

Ohio Prosecuting Attorneys Assn.
196 E. State St., Ste. 200
Columbus, OH 43215
614-221-1266

# HANDOUT 7

Ohio Victim Witness Association
Greene Co. Prosecutor's Office
61 Greene St.
Xenia, OH 45285
937-376-5087

Parents of Murdered Children National Chapter
100 E. Eighth St.
Cincinnati, OH 45202
888-818-7662

Southwest Ohio Critical Incident Stress Management Team
P.O. Box 62445
Cincinnati, OH 45262-0445
1-800-212-1322 (on-call pager)
513-563-2172

U.S. Attorney Office (Northern Region)
801 W. Superior Ave., Ste. 400
Cleveland, OH 44113
216-622-3600

U.S. Attorney Office (Southern Region)
303 Marconi Blvd., Ste. 200
Columbus, OH 43215
614-469-5715

## Commonly Prescribed Psychotropic Medications

| Antipsychotics (used in the treatment of schizophrenia and mania) | Anti-depressants | Anti-obsessive Agents |
|---|---|---|
| TYPICAL ANTIPSYCHOTICS | TRICYCLICS | Anafranil (clomipramine) |
| Haldol (haloperidol) | *Anafranil (clomipramine) | Luvox (clomipramine) |
| Loxitane (loxapine) | Asendin (amoxapine) | Paxil (paroxetine) |
| Mellaril (thioridazine) | Elavil (amitriptyline) | Prozac (fluoxetine) |
| Moban (molindone) | Norpramin (desipramine) | Zoloft (sertraline) |
| Navane (thiothixene) | Pamelor (nortriptyline) | |
| Prolixin (fluphenazine) | Sinequan (doxepin) | **Antianxiety Agents** |
| Serentil (mesoridazine) | Surmontil (trimipramine) | Ativan (lorazepam) |
| Stelazine (trifluoperazine) | Tofranil (imipramine) | BuSpar (buspirone) |
| Thorazine (perphenazine) | Vivactil (protiptyline) | Centrax (prazepam) |
| Trifalon (perphenazine) | | *Inderal (propranolol) |
| | SSRIs | *Klonopin (clonazepam) |
| ATYPICAL ANTIPSYCHOTICS | Celexa (citalopram) | Lexapro (escitalopram) |
| Abilify (aripiprazole) | Lexapro (escitalopram) | Librium (chlordiazepoxide) |
| Clozaril (clozapine) | *Luvox (fluvoxamine) | Serax (oxazepam) |
| Risperdal (risperidone) | Paxil (paroxetine) | *Tenormin (atenolol) |
| Seroquel (quetiapine) | Prozac (fluoxetine) | Tranxene (clorazepate) |
| Zyprexa (olanzapine) | Zoloft (sertraline) | Valium (diazepam) |
| | | Xanax (alprazolam) |
| **Mood Stabilizers (used in the treatment of bipolar disorder)** | MAOIs | *Antidepressants, especially SSRIs, are also used in the treatment of anxiety. |
| Depakene (valproic acid) | Nardil (phenelzine) | |
| Depakote | Parnate (tranylcypromine) | |
| Eskalith | | **Stimulants (used in the treatment of ADHD)** |
| Lithobid (lithium) | OTHERS | Adderall (amphetamine |
| Lithonate | Desyrel (trazadone) | And dextroamphetamine) |
| Lithotabs | Effexor (venlafaxine) | Cylert (pemoline) |
| *Lamictal (lamotrigine) | Remeron (mirtazapine) | Dexedrine |
| *Neurontin (gabapentin) | Serzone (nefazodone) | (dextroamphetamine) |
| *Tegretol (carbamazepine) | Wellbutrin (bupropion) | Ritalin (methylphenidate) |
| *Topamax (topiramate) | | *Antidepressants with stimulant properties, such as Norpramin and Wellburtrin, are also used in the treatment of ADH |
| | **Anti-Panic Agents** | |
| | Klonopin (clonazepam) | |
| | Paxil (paroxetine) | |
| | Xanax (alprazolam) | |
| | Zoloft (sertraline) | |
| | *Antidepressants are also used in treatment of panic disorder. | |

Listed above are the brand names, followed by the generic in parenthesis. A second chart below provides cross-referencing by generic name.

# HANDOUT 8

| Generic Name | Brand Name | Current Uses |
|---|---|---|
| alprazolam | Xanax | anxiety, panic |
| amitriptyline | Elavil, Endep | depression (tricyclic) |
| amoxapine | Asendin | Psychotic depression |
| amphetamine | Adderall | ADD |
| aripiprazole | Abilify | schizophrenia (atypical) |
| buproprion | Wellbutrin | depression, ADD |
| buspirone | BuSpar | Anxiety |
| carbamazepine | Tegretol | bipolar disorder |
| chloriazepoxide | Librium | Anxiety |
| chlorpromazine | Thorazine | schizophrenia (typical) |
| citalopram hydrobromide | Celexa | depression (SSRI) |
| clomipramine | Anafranil | OCD, depression (tricyclic) |
| clonazepam | Klonopin | Anxiety |
| clorazepate | Tranxene | Anxiety |
| clozapine | Clorazil | schizophrenia (atypical) |
| desipramine | Norpramin | depression (tricyclic), ADD |
| dextroamphetamine | Adderall, Dexedrine | ADD |
| diazepam | Valium | Anxiety |
| divalproex sodium | Depakote | bipolar disorder |
| doxepin | Adapin, Sinequan | depression (tricyclic) |
| escitalopram | Lexapro | depression (SSRI), anxiety |
| fluoxetine | Prozac | depression (SSRI), OCD, panic |
| fluphenazine | Prolixin, Prolixin Decanoate | schizophrenia (typical) |
| fluvoxamine | Luvox | OCD, depression (SSRI) |
| haloperidol | Haldol, Haldol Decanoate | schizophrenia (typical) |
| imipramine | Tofranil | depression (tricyclic), panic |
| lithium carbonate | Eskalith, Lithobid | bipolar disorder |
| lithium citrate | Cibalith S | bipolar disorder |
| lorazepam | Ativan | Anxiety |
| loxapine | Loxitane | schiophrenia (typical) |
| maprotiline | Ludiomil | depression (tricyclic) |
| mesoridazine | Serentil | schiophrenia (typical) |
| methylphenidate | Ritalin | ADD |
| mirtazapine | Remeron | Depression |
| molindone | Moban | schiophrenia (typical) |
| nefazodone | Serzone | Depression |
| nortriptyline | Pamelor | depression (tricyclic) |
| olanzapine | Zyprexa | schizophrenia (atypical) |
| oxazepam | Serax | Anxiety |
| paroxetine | Paxil | depression (SSRI), OCD, panic |
| pemoline | Cylert | ADD |

# HANDOUT 8

| Generic Name | Brand Name | Current Uses |
|---|---|---|
| perphenazine | Trilafon | schizophrenia (typical) |
| phenelzine | Nardil | depression (MAOI) |
| prazepam | Centrax | Anxiety |
| prochlorperazine | Compazine | schizophrenia (typical) |
| protriptyline | Vivactil | depression (tricyclic) |
| quetiapine | Seroquel | schizophrenia (atypical) |
| risperidone | Risperdal | schizophrenia (atypical) |
| sertraline | Zoloft | depression (SSRI), ODC, panic |
| thioridazine | Mellaril | schizophrenia (typical) |
| thiothixene | Navane | schizophrenia (typical) |
| tranylcypromine sulfate | Prarnate | depression (MAOI) |
| trazodone | Desyrel | depression (tricyclic) |
| trifluoperazine | Stelazine, Vesprin | schizophrenia (typical) |
| trimipramine | Surmontil | depression (tricyclic) |
| valproic acid | Depakene | bipolar disorder |
| venlafaxine | Effexor | Depression |

*Although this medication has been approved by the FDA for the treatment of other disorders, it has not been approved for this particular use. Some evidence of this medication's efficacy for such use does exist however. This type of medication use is referred to as "off label."

# HANDOUT 9

## APPLICATION FOR EMERGENCY ADMISSION

In Accordance with Sections 5122.01 and 5122.10 ORC

TO: The Chief Clinical Officer of ______________________________ (Behavioral Healthcare Organization - BHO/Facility Name) ____________ (Date)

The undersigned has reason to believe that:

______________________________ (Name of Person to be Admitted)

1. Is a mentally ill person subject to hospitalization by court order under division B of Section 5122.01 of the Revised Code, i.e., this person

   ☐ (1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;

   ☐ (2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;

   ☐ (3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or

   ☐ (4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself.

2. Represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination.

Therefore, it is requested that said person be admitted to the above named facility.

### STATEMENT OF BELIEF

Must be filled out by one of the following: a psychiatrist, licensed clinical psychologist, licensed physician, health or police officer, sheriff or deputy sheriff.

(Statement shall include the circumstances under which the individual was taken into custody and the reason for the person's belief that hospitalization is necessary. The statement shall also include a reference to efforts made to secure the individual's property at his residence if he was taken into custody there. Every reasonable and appropriate effort should be made to take this person into custody in the least conspicuous manner possible.)

______________________________
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Original - Medical Record, Copy - Suspense File
DMH-0025 (Rev. 8/02)

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APPLICATION FOR EMERGENCY ADMISSION
DMH-MedR-1030

# HANDOUT 9

## APPLICATION FOR EMERGENCY ADMISSION

In Accordance with Section 5122.10 ORC

Name of Person to be Admitted

### STATEMENT OF BELIEF (continued)

| Signature | |
|---|---|
| Title/Position/Badge or License No. | Place of Employment |

### STATEMENT OF OBSERVATION BY PSYCHIATRIST, LICENSED PHYSICIAN, OR LICENSED CLINICAL PSYCHOLOGIST, IF APPLICABLE

Place of Observation (e.g., community mental health center, general hospital, office, emergency facility)

| Signature | Title |
|---|---|

| Approved ☐ Yes ☐ No | Signature of Chief Clinical Officer | Date |
|---|---|---|

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APPLICATION FOR EMERGENCY ADMISSION
DMH-MedR-1030

WILLIAM E. "BUSTER" FISHER, et al., Plaintiffs-Appellants,
v. TOM E. HARDEN, in his official capacity as Sheriff of
Morrow County, Ohio, et al., Defendants-Appellees.

No. 02-3996

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

05a0096p.06;
398 F.3d 837; 2005 U.S. App. LEXIS 3276; 2005 FED App. 0096P
(6th Cir.)

June 11, 2004, Argued
February 25, 2005, Decided
February 25, 2005, Filed

COUNSEL: ARGUED: James D. McNamara, Columbus, Ohio, for Appellants.

Douglas J. Suter, ISAAC, BRANT, LEDMAN & TEETOR, Columbus, Ohio, for Appellees.

ON BRIEF: James D. McNamara, Columbus, Ohio, for Appellants.

Douglas J. Suter, ISAAC, BRANT, LEDMAN & TEETOR, Columbus, Ohio, for Appellees.

JUDGES: Before: KEITH, CLAY, and GIBBONS, Circuit Judges. KEITH, J., delivered the opinion of the court, in which CLAY, J., joined. GIBBONS, J., delivered a separate dissenting opinion.

OPINION BY: DAMON J. KEITH

OPINION: [*839] [***1]

DAMON J. KEITH, Circuit Judge. The Plaintiff-Appellant, William E. "Buster" Fisher, filed a complaint on December 4, 2000, in which, pursuant to 42 U.S.C. § 1983, he charged the Defendants-Appellees, Sheriff Tom E. Harden, Deputy Stephen Alexander, Deputy Molly Alexander, and Deputy Mark Leary (collectively "the Defendants"), with having violated his right against an unreasonable seizure as guaranteed by the Fourth and Fourteenth Amendments to the United States Constitution. On May 9, 2002, the Defendants filed a joint [**2] motion for summary judgment. The district court subsequently issued an opinion and order on August 6, 2002, in which it granted the Defendants' request for a summary judgment on the grounds that (1) they had a reasonable suspicion that Fisher was suicidal, and, as a consequence, their actions in affecting a seizure of Fisher were protected by the doctrine of qualified immunity, and (2) there was no genuine [***2] issue of material fact on Fisher's claim that the County failed to adequately train and supervise the deputies. In this appeal, Fisher asserts that the officers who seized him did not have probable cause to justify a mental health seizure, and that Harden failed to adequately train and supervise his deputies. n1 For the reasons set forth below, we REVERSE, in part, and AFFIRM, in part, the judgment of the district court. [**3]

## FACTUAL BACKGROUND

The facts relevant to this cause occurred on the afternoon of July 10, 2000, in a rural farming area of Morrow County, Ohio. The area consists of wide open farming land, with heightened visibility in all directions. On that day, Fisher, a seventy-seven-year-old retired farmer, had gone out to shoot groundhogs, an activity in which he routinely engaged in an effort to help protect his neighbors' crops. Dressed in bib overalls, Fisher had taken with him a folding chair, his rifle, and a tripod that he used to help him aim his rifle and hold it steady. He positioned himself, sitting in the folding chair, upon an elevated railroad grade on one of his neighbor's property.

Fisher sat at a distance of approximately 250 yards from County Road 59, a rural road that runs through this area of Morrow County. A passerby noticed Fisher off in the distance sitting on railroad tracks and found his presence there quite unusual. Upon gathering that this was possibly a suicidal person, the passerby telephoned the Morrow County Sheriff's Department and reported, incorrectly, that [*840] a man had his feet tied to the railroad tracks. The Sheriff's Department subsequently dispatched [**4] a "Code 58," which indicates a possible suicide.

Two of the Defendants, deputies Stephen Alexander and Molly Alexander, who are husband and wife, responded to the dispatch. Upon their arrival on the scene, the officers located Fisher, who was still seated in his folding chair approximately 250 yards away. Mr. Alexander used the cruiser's microphone and speaker system to arouse Fisher's attention and instruct him to come toward the officers. Fisher stood up, gathered his belongings, and began walking along the railroad tracks toward the officers. As Fisher proceeded toward them, the officers noticed he was carrying a rifle slung over his shoulder. They drew their firearms, crouched behind their open cruiser doors, and ordered Fisher to lay down the rifle before coming any closer. The officers acknowledged that initially Fisher appeared unable to hear their first command, and they responded with additional instructions for him to lay down his rifle. Upon hearing their command at a distance of nearly 200 yards away, Fisher readily complied with their request. The officers instructed Fisher further to lay down his folding chair and tripod. Again, once Fisher could hear their request, [**5] he readily complied. n2 [**6] [***3]

For the next couple of minutes, the officers observed Fisher walk toward the road, with nothing in his hands. As he walked deliberately toward them, it became apparent to Mr. Alexander that Fisher was an older gentleman. The officers conceded that he approached them in a normal fashion, and did not act out or say or do anything out of the ordinary. Nonetheless, they kept their weapons drawn and trained upon him. As Fisher arrived at the road, Mr. Alexander directed him to walk backwards toward Mrs. Alexander. After he finally reached them, the officers commanded Fisher, still at gunpoint, to lay face down on the roadway, and handcuffed him behind his back.

Fisher immediately went into cardiac arrest. After unsuccessfully attempting to stand Fisher on his feet, the officers left him handcuffed and lying on the ground. [*841] Presumably unaware of the seriousness of Fisher's condition, Mr. Alexander immediately went to retrieve the objects that Fisher had placed on the ground. Shortly thereafter, a woman who lived nearby and another Defendant, Deputy Mark Leary, separately arrived at the scene. The woman, who had been unable to attain sufficient attention from the Alexanders, informed [**7] Leary that Fisher suffered from a heart condition. Leary, observing Fisher's distressed state, uncuffed him, turned him on his back and called for medical assistance. Fisher was life-flighted to Riverside Hospital in Columbus, Ohio, for emergency care. Although Fisher survived, he is permanently disabled as a result of the incident.

Approximately five months later, to wit, December 4, 2000, Fisher filed a complaint against the Defendants in the United States District Court for the Southern District of Ohio. In the complaint, Fisher charges, among other things, that the officers violated his right, as guaranteed by the Fourth and Fourteenth Amendments to the United States Constitution, to be free from unreasonable seizure without probable cause, and that Sheriff Tom Harden failed to adequately train and supervise his deputies. On August 6, 2002, the district court granted the Defendants' motion for a summary judgment. In doing so, the district court determined that the officers were entitled to qualified immunity because Fisher had failed to establish a constitutional violation, and that there was no genuine issue of a material fact to support his claim against Harden for a failure [**8] to train and supervise his deputies. This appeal followed.

HANDOUT 11

SPO #10

**FIVE INDICATORS OF SUICIDAL THOUGHT**

Emotional Pain

A person may be undergoing a severe emotional crisis due to a life situation that is causing a lot of stress, leading to feelings of depression and anxiety. The person's coping abilities are temporarily severely reduced. These very uncomfortable feelings may cause a person to have thoughts of suicide. The person does not usually want to be dead, but instead wants a way out of the psychological and emotional pain they are experiencing, and perceives suicide as the way out of that pain. This is probably the most common situation that you will encounter.

Sometimes a person undergoing such a crisis will think about suicide for a while, but in other cases he or she will make a sudden, impulsive decision to take his or her life. Such an impulsive decision often follows a particularly perturbing event, such as a serious argument with another person, losing a job, hearing very bad news, or being arrested.

Mental Illness

Other suicidal people are mentally ill, and having thoughts of suicide as a result of an aspect of the illness. Serious depression is probably the form of mental illness most commonly associated with suicidal feelings. There is a very high correlation between major depression and suicidal thoughts and behavior. As noted, one reason for this is that deep feelings of helplessness and hopelessness are commonly associated with depression. That is, a seriously depressed person feels that things are terrible, that they will not get better, and that they are powerless to make things better. They are not thinking in a rational or balanced way, of course, and cannot be convinced rationally to see things differently.

In other cases, a person may be having delusional thoughts in which self-harm is predominant. Remember that delusions are ideas or thoughts that are not based in reality, but of which the person is convinced. Or, a person may be experiencing hallucinations, such as voices telling him or her to kill him or herself. Sometimes a person's illness may cause so much discomfort that the person considers suicide as a way to end that discomfort. For example, a person with severe continuing anxiety may feel that he or she simply can't go on having those feelings, and that ending his or her life is the option to end the discomfort. Or, a person who hears voices that are accusatory or mocking or belittling may see suicide as a way to end the tortured feelings caused by the voices.

HANDOUT 11

SPO #10

Alcohol and Drug Use

Alcohol and drug use can be factors in a person's suicidal thoughts and feelings, in a number of ways. For one thing, alcohol and drugs negatively affect judgment and reasoning, and may cause a person to act in ways that he or she might not act when not affected by the chemical substances. A person may, for example, act much more impulsively when drinking or using drugs.

In some cases, the effects of alcohol or drugs may be so uncomfortable or distressing that a person may want to be dead. Alcohol withdrawal, for example, can be extremely unpleasant, both physically and psychologically, as can withdrawal from some drugs. Some illegal or illicit drugs can cause intoxication effects that may be associated with thoughts or behavior that can result in danger to one's self or to other people.

In rarer cases, a person who is an alcoholic or drug addict may simply be so discouraged by the inability to stop drinking or using drugs as to have thoughts of suicide. Such persons may feel like failures, may feel that they have hurt or let down their loved ones or others, and may feel that others would be better off without them.

Remember that many people have co-occurring disorders, most commonly meaning that they have both a substance abuse disorder and a mental disorder. This "double whammy" is problematic in many ways, because the two disorders can worsen the effects of each other. For example, if a person is having suicidal thoughts or feelings due to a mental disorder, those thoughts and feelings may be compounded when the person is drinking or using drugs.

Rational Decision

Some people will make a rational decision that they want to be dead. Most people who think about suicide do not really want to die, but instead just want their psychological or emotional feelings of pain to end and perceive suicide as the way to accomplish that. But some people actually want to end their lives. For example, a person may have a terminal illness and does not wish to suffer longer or be a burden to others.

Manipulation of Others

Some people use suicide threats or suicidal behavior as a way to manipulate others. They do not wish to be dead and are not feeling that suicide is a way to end emotional pain, but instead are using suicide as a way to get something they want. Example: "If you leave me, I'll kill myself."

Some people go further than just threatening suicide—they actually make suicide attempts as a way to manipulate others. For example, such persons might attempt suicide to get people to feel sorry for them or to get attention that they think they could not have gotten otherwise. Some such people kill themselves accidentally.

As the officer responding to a person in crisis, you cannot determine whether a suicidal person is being manipulative or really intends to commit suicide. Even if you suspect the person is being manipulative, always treat suicide threats and suicidal behavior as being real.

## STEPS FOR RESPONDING TO A PERSON IN SUICIDAL CRISIS

1. Conduct a Continuing Threat Assessment

Remember that people in crisis are unpredictable. Your first priority is to ensure safety. Conduct a threat assessment before you walk into a situation, and continue to assess throughout your contact. If the situation is clearly dangerous—for example, if the subject is armed with a weapon and threatening suicide, good tactics are critical. When dealing with a suicidal person, safety is always an issue. Even when a person seems to be calmer and more in control, he or she can be a threat to his or her own safety and the safety of others.

Always ask about weapons, including edged weapons, and check for weapons. Be aware of the possibility of weapons being brought out, even when you have checked. If you are in a residence, do not allow the subject to go into the kitchen, where there are knives. Even when a person is sitting on a couch or chair, he or she may have a knife or other weapon hidden under a cushion. Suspect that possibility and remain alert, and check for such items as soon as you can.

If the person needs immediate medical care—for example, if the person has cut him or herself or taken poison or an overdose of medication, call EMS and provide whatever immediate care you are trained to do.

If you respond to a suicidal person in a residence and you smell gas, the situation is extremely hazardous. Do not operate anything electric—do not turn on a light switch or activate any electrical appliances. Do not use your flashlight or radio. Any spark—even from static electricity—could cause a gas explosion. Leave the house immediately (with the suicidal person, if possible) and request fire to respond.

2. Try to Get the Person to Talk

Try to get the person to talk and then listen carefully, so you can assess the situation and find out what is going on. Sometimes you will have information in advance that a person is suicidal, and sometimes you will not know that until you arrive at a scene. You may become aware that a person is in a suicidal crisis because of what that person says. Note, however, that often a person will make subtle hints about suicidal feelings rather than talk directly about thoughts of suicide. For example, the person may say, “She’d be better off without me” or, “He’ll soon be sorry he treated me this way.”

As always, getting a person to talk and listening carefully is your best way to find out what is going on. First, try to get the subject to calm down and be as physically comfortable as possible. Then, ask questions and get the person to talk, if possible. Suicidal thoughts and feelings can be difficult to talk about, but it is always best to talk about them directly rather than to avoid the subject. As you learned during the section in this text on serious depression, some questions that are appropriate for you to ask include these:

> "Can you tell me what's going on?"
>
> "Are you thinking of killing (or hurting) yourself?"
>
> If the person answers yes: "Have you thought about how you would do it?
>
> Have you thought about when you would do it?"
>
> "Have you made previous suicide attempts?"

Other very good questions to ask are

> "Is there anything that would help you now?
>
> "Is there anything we can do to help you get through this?"

Ask these questions in a neutral, straightforward manner so that you do not give the subject the message that you consider the person "crazy" or strange for having suicidal feelings.

Listen to what the person says, using your best active listening skills. Ask follow-up questions as necessary. Doing so will not only help you better understand and assess the situation so as to decide on appropriate action, but it may also help the subject. Remember that talking things out is always better than acting things out. So if you can provide an opportunity for the subject to talk about his or her difficult feelings and thoughts, that may help prevent him or her from acting out those feelings by attempting or committing suicide.

By getting the subject to talk and by listening, you also stall for time. Time is your ally in a suicidal crisis situation. There is rarely a need to resolve such a situation quickly. Whenever you can take the time to try to defuse a subject's difficult feelings and calm a situation, that is a good approach. Another reason for asking these questions and documenting the answers is that it will help you decide whether to initiate an Emergency Detention of the subject. Dangerousness to self is one of the criteria for Emergency Detention, and the answers to your questions may help to establish dangerousness. You may observe other things that suggest dangerousness, such as supplies of pills, or cuts or burns on a person's arm. As noted, some people who hurt themselves are not actually suicidal, but do so for other psychological reasons. In such a case, a good question to ask is "Did you feel the need to be dead or just hurt yourself?" The answer may help you determine an appropriate disposition.

3. Show Empathy

Show empathy for the person and his or her situation. Remember that your attitude and demeanor during an encounter with a person in crisis makes a big difference in the outcome of that encounter. A person experiencing a suicidal crisis is someone in a lot of pain. If you can show some human empathy for the person, it will probably help them get through the crisis a bit better. One way of showing empathy is to let the person know that you can identify with their feelings. For example, if the person is depressed because of a failed marriage, you might say (if it's true), ""Yeah, I've been through a divorce myself. It made me feel terrible." Remember, do not say "I know how you feel." You don't.
You can also say things like,

> "I sense you're really down on yourself right now."

> "I know talking about this is really rough, but we can take it slow."

4. Negotiate Solutions

Once you have talked to a person who is in a suicidal crisis and tried to assess what is going on with him or her, try to find out what specifically can be done to help the person. As noted, it may be a good idea to ask that directly. What the answer will be depends on the circumstances. In some cases, a person may indicate that he or she needs to go to a hospital or other care facility. In other cases, the person may want to talk to a particular person or entity. If you don't ask, you may not know.

You may have to negotiate with the person. For example, he or she may want something that is not feasible, such as to be left alone or to be allowed to go to a particular location, and you cannot allow those requests. You may then have to keep talking and try to get the person to agree to another option that will ensure safety of the person and control of the situation. Never promise anything that you cannot deliver or do not have the authority to follow up on. That is never a good idea. Remember that your credibility is critical at all times, and especially so when you are responding to a troubled person.

Use whatever tools or techniques you can, in the time available, to try to get the person through the crisis situation. You are not a therapist, but you are a first responder, and your goal is to do what is possible and feasible to get the person through the suicidal crisis situation (which may last for only a short while) to a point that he or she is better able to make good decisions. Time is your ally. Do what you can in the time that you have, rather than rushing to resolve the situation—and perhaps ending up with a worse situation. Here are some tools or techniques that you can try: Non-suicide agreement. A useful tool to consider is a non-suicide agreement, or pact. It can be a verbal agreement. It simply means that you specifically ask the subject if he or she will agree not to attempt suicide for a short, specific period of time—such as three hours or six hours. For the agreement to be reasonable the time frame must be short and definite. It is best to indicate what will happen during or by the end of that time—perhaps getting someone to see the person, getting him or her into a hospital, etc.

Example:

“Mary, we’re going to try to get some help for you, but it may take a little while. Can I have your agreement that you won’t try to kill yourself between now and 8:00 a.m., when we can get you in to the clinic?”

The value of this is that it provides structure for the person, and buys time for the person to get through the crisis. It gives the subject the message that you trust him or her to follow through with an agreement, which is empowering to the person. It may or may not work, but it is often worth trying. It is a tool that many therapists use, and so can you. However, it is a technique that depends on a sense of trust between you and the subject. For that reason, you should generally use it only with people you know and with whom you have a decent relationship.

A non-suicide agreement is not a binding contract, and should not be thought of as such. It is just a potential tool.

Appeal to reality/consequences of behavior. In some cases, you may be able to make a rational appeal to a suicidal person. People in suicidal crises are not usually thinking clearly and rationally, and they do not necessarily think about the possible consequences of their behavior, particularly the long-term consequences. So if you can identify a person's "hooks"—people or things that are important to them, you may be able to use this information. As with the non-suicide agreement, it is generally best to use this technique if you know the person and have a relationship with him or her, but that is not an absolute requirement.

For example, you might say something like, "Joe, have you thought about how your death will affect others?" In fact, Joe may not have thought about how his children or wife or others would be affected by his suicide, and your reminding him of that may affect his thinking and actions.

Or, you may say things like:

"How do you think your mother and/or father will deal with you killing yourself?"
"You know, if you kill yourself, you'll never see Susie grow up, graduate, and get married. I can tell you care about her a lot."

"You've told me you've made some pretty important breakthroughs on your job. If you killed yourself, you'll never have that satisfaction again."

This approach may or may not work in a given situation, but it is at least a tool to consider using. In fact, it will simply not work with some people in a suicidal crisis. Some people are so desperate that they believe their loved ones actually would be better off without them, and are not subject to logical or reasonable arguments to the contrary. This does not mean that it is not worthwhile to try to appeal to a person about possible consequences of suicide, just realize that it will not work with some people.

5. Determine What Action to Take

Once you have ensured safety and achieved control of a situation, then you should try to determine the next appropriate steps to help a person in a suicidal crisis. What these steps are depends on the circumstances. Some options include:

A. Releasing the subject to his or her family and providing the subject and family members with a referral (names and telephone numbers) to local sources of assistance such as local or county crisis intervention or substance abuse agencies, suicide-prevention hotlines, etc.

B. Contacting family members or friends of a person. In some cases, you may decide to initiate a contact with a subject's family or friends, to inform them of the situation and to enlist their assistance.

C. Contacting local crisis intervention specialists to see the person either immediately or very soon. This may include a law enforcement crisis intervention team if available or local or county mental health/crisis intervention personnel.

D. Get the person to agree to a voluntary psychiatric evaluation. You may need the assistance of local crisis intervention specialists or local mental health resources to arrange this.

E. Initiating an emergency detention. As a law enforcement officer, you have the legal authority to take a person into custody, without their consent, for an emergency detention if he or she meets the legal criteria of being dangerous (to self or others) and is mentally ill, drug dependent or developmentally disabled. The purpose of an emergency detention is to make it possible for the person to be evaluated to see if he or she meets the criteria for involuntary civil commitment. If you feel you cannot safely leave the person alone or with friends or family, an emergency detention may be the appropriate choice. This option is discussed in detail in a later section of this text.

These are just some of the options available to you. How to determine the most appropriate choice in such a situation is a matter of local policy and procedure. In some cases, you may be required or advised to check with a supervisor or other person in your agency. Or policy may indicate that you are to contact a designated mental health or crisis intervention agency for advice on the best thing to do. As always, know and follow your agency's policies.

## STAGES OF ALCOHOL WITHDRAWAL

1. Stage 1 occurs in the first day or so after the person has stopped drinking. Initial signs and symptoms may include tremors, profuse sweating, disorientation, and possibly delusions and/or hallucinations.

2. Stage 2 begins within 7 to 48 hours after the person has stopped drinking, and may include seizures.

3. Stage 3 takes place between 12 and 48 hours after the person's last drink. The person may experience auditory hallucinations—that is, hear voices. These voices may be taunting or persecuting.

4. Stage 4 is the final stage, and may occur within 72 to 96 hours after the person's last drink. In this stage, the person may experience delirium tremens, often known as "DTs." These are characterized by some or all of the following:

   Profound confusion and disorientation

   Delusions and vivid hallucinations in which the person sees various creatures—usually animals or snakes or bugs—in various postures around him or her, or feels things crawling on his or her skin˜ Shaking˜Feeling of severe agitation and fright˜Rapid pulse and breathing˜ Pale skin˜ Sweating˜High fever, along with possible seizures or convulsions˜ Vomiting˜Curling into a fetal position.

   If you observe a person displaying these last signs and symptoms—that is, indicators of possible delirium tremens—consider it a medical emergency and arrange for immediate emergency medical care. Remember: a person can die from this serious stage of alcohol withdrawal.

   Withdrawal from drugs is not the same as alcohol withdrawal. There is no withdrawal at all from some drugs (such as hallucinogens), and the nature of withdrawal varies depending on the particular drug for those drugs that do cause withdrawal symptoms. With some drugs (such as stimulants), withdrawal may mostly result in apathy and long periods of sleep. With others, withdrawal can be more of a medical and psychological problem for the person. Withdrawal from depressants such as barbiturates, for example, can result in convulsions, delirium, and—in rare cases—death.

## OHIO REVISED CODE §2901.21

(A) Except as provided in division (B) of this section, a person is not guilty of an offense unless both of the following apply:

(1) The person's liability is based on conduct that includes either a voluntary act, or an omission to perform an act or duty that the person is capable of performing;

(2) The person has the requisite degree of culpability for each element as to which a culpable mental state is specified by the section defining the offense.

(B) When the section defining an offense does not specify any degree of culpability, and plainly indicates a purpose to impose strict criminal liability for the conduct described in the section, then culpability is not required for a person to be guilty of the offense. When the section neither specifies culpability nor plainly indicates a purpose to impose strict liability, recklessness is sufficient culpability to commit the offense.

(C) Voluntary intoxication may not be taken into consideration in determining the existence of a mental state that is an element of a criminal offense. Voluntary intoxication does not relieve a person of a duty to act if failure to act constitutes a criminal offense. Evidence that a person was voluntarily intoxicated may be admissible to show whether or not the person was physically capable of performing the act with which the person is charged.

(D) As used in this section:

(1) Possession is a voluntary act if the possessor knowingly procured or received the thing possessed, or was aware of the possessor's control of the thing possessed for a sufficient time to have ended possession.

(2) Reflexes, convulsions, body movements during unconsciousness or sleep, and body movements that are not otherwise a product of the actor's volition, are involuntary acts.

(3) "Culpability" means purpose, knowledge, recklessness, or negligence, as defined in section 2901.22 of the Revised Code.

(4) "Intoxication" includes, but is not limited to, intoxication resulting from the ingestion of alcohol, a drug, or alcohol and a drug.

## OHIO REVISED CODE § 5126.30 THRU 5126.34

(A) "Adult" means a person eighteen years of age or older with mental retardation or a developmental disability.

(B) "Caretaker" means a person who is responsible for the care of an adult by order of a court, including an order of guardianship, or who assumes the responsibility for the care of an adult as a volunteer, as a family member, by contract, or by the acceptance of payment for care.

(C) "Abuse" has the same meaning as in section 5123.50 of the Revised Code, except that it includes a misappropriation, as defined in that section.

(D) "Neglect" has the same meaning as in section 5123.50 of the Revised Code.

(E) "Exploitation" means the unlawful or improper act of a caretaker using an adult or an adult's resources for monetary or personal benefit, profit, or gain, including misappropriation, as defined in section 5123.50 of the Revised Code, of an adult's resources.

(F) "Working day" means Monday, Tuesday, Wednesday, Thursday, or Friday, except when that day is a holiday as defined in section 1.14 of the Revised Code.

(G) "Incapacitated" means lacking understanding or capacity, with or without the assistance of a caretaker, to make and carry out decisions regarding food, clothing, shelter, health care, or other necessities, but does not include mere refusal to consent to the provision of services.

(H) "Emergency protective services" means protective services furnished to a person with mental retardation or a developmental disability to prevent immediate physical harm.

(I) "Protective services" means services provided by the county board of mental retardation and developmental disabilities to an adult with mental retardation or a developmental disability for the prevention, correction, or discontinuance of an act of as well as conditions resulting from abuse, neglect, or exploitation.

(J) "Protective service plan" means an individualized plan developed by the county board of mental retardation and developmental disabilities to prevent the further abuse, neglect, or exploitation of an adult with mental retardation or a developmental disability.

(K) "Substantial risk" has the same meaning as in section 2901.01 of the Revised Code

(L) "Party" means all of the following:

(1) An adult who is the subject of a probate proceeding under sections 5126.30 to 5126.33 of the Revised Code;

(2) A caretaker, unless otherwise ordered by the probate court;

(3) Any other person designated as a party by the probate court including but not limited to, the adult's spouse, custodian, guardian, or parent.

(M) "Board" means a county board of mental retardation and developmental disabilities.

HANDOUT 16

SPO #11

## METHODS OF RESPONDING TO CHEMICAL ABUSERS

Always Consider a Person Under the Influence a Potential Threat

Those who have used alcohol and/or drugs are unpredictable and they may be volatile and even dangerous. Such an individual may be quite cooperative one moment, and uncooperative or resistive the next moment. Never be complacent when dealing with such individuals, and always take precautions and actions that best ensure your safety and that of others.

One of the common effects of use of alcohol or other drugs is loss of normal inhibitions or other social controls that a person has when not affected by the chemicals. Thus, a person may behave in a very obnoxious or threatening or even dangerous way when intoxicated, and that behavior should affect your threat assessment. A person who is under the influence of alcohol or drugs should always be considered a greater potential threat to officers and citizens in any situation.

People who are under the influence of certain drugs can be particularly dangerous. For example, PCP (“angel dust”) may cause people to behave in a very bizarre way, experiencing vivid hallucinations and delusions—often paranoid delusions that others are out to hurt or kill them. Such a person may be very strong and violent, believing that you or others want to harm them. Such people can also be suicidal.
Similarly, a person who has taken LSD, a hallucinogenic drug, may experience a “bad trip,” in which he or she may experience extreme anxiety and confusion and a feeling of loss of control.

Cocaine users may behave in a “manic” way, or appear quite anxious and restless. They may experience severe mood swings. Cocaine is a stimulant. A person who has overdosed on cocaine may be quite agitated and may experience hallucinations and/or convulsions.

Ecstasy causes users to behave in bizarre ways. People under the influence of this drug can be dangerous.

The key point is that people who have taken drugs are unpredictable and potentially dangerous to you and others. You generally do not know what drugs they have taken, nor do you know what the drugs have been mixed with, nor do you know whether the person is also mentally ill. There are a lot of variables. Always consider people under the influence to be unpredictable. Therefore, never presume that you know how a subject will react to your presence and to your verbal directions in a given situation—even when you have dealt with that subject previously. Always maintain proper distancing and continue to assess threat and take proper tactical actions accordingly.

HANDOUT 16

SPO #11

The other side of this coin is that people who behave badly when under the influence of a substance are often very different when they are not under that influence. Thus, a subject whom you encounter may be quite obnoxious and difficult—swearing at you, being uncooperative, maybe even fighting—and then the next day, when sober, may be normal and perhaps even embarrassed and apologetic about their behavior.

Try to Assess the Person's Physical Condition

You have a responsibility to assess an individual's condition. Under the law, if a person is incapacitated due to alcohol, you have a duty to place that person in protective custody.

If you suspect alcohol or drug use, ask such questions as:

"What have you had to drink?"

"How much have you had to drink?"

"When did you take your last drink?"

"Have you used any other substances / drugs? If so, what? How much?

When?"

Try to get the person to voluntarily agree to a preliminary breath test (PBT). Also try to assess the person's physical condition, in terms of their ability to walk and talk, and so on.

Observe the person for indications of deteriorating condition, as the level of alcohol or drugs increases in his or her system. Watch for such signs as:

- Decreasing level of consciousness
- Speech becoming more slurred
- Face getting more slack
- Decreasing ability to understand or respond
- Decreasing ability to walk or stand up straight

SPO #11

Also, be aware of possible serious injuries that may need medical attention. A person who has used alcohol or drugs may have fallen down and hurt himself. He may or may not show that he is in pain, because alcohol and drugs may dull the pain. A person may even have a broken limb and not show much pain, and may not even know that he is seriously injured. So be aware of such possible injuries, and if appropriate provide medical attention for the person.

Remember that a Crisis Situation is a Matter of Perception

Remember that a crisis situation is a matter of perception to a person experiencing the crisis. What may seem like a routine, non-crisis incident to you may be perceived very differently by a subject. For example, you may stop a man for drunk driving and may issue him a citation. To you, that is a routine procedure. But the subject may perceive this as a very significant event: he will now have this on his driving record, may lose his license, his insurance will increase, his wife may be very upset with him, and so on. To him, it is very much a crisis situation, and he may react accordingly—perhaps by becoming very upset and even confrontational. He becomes a short-term EDP. At the very least, try to understand the significance of such an event to the subject, and do not minimize the significance of the event to him.

Never Argue with a Person Under the Influence of Alcohol or Drugs

It is not to your advantage to argue with a person who is under the influence of alcohol and/or drugs. Such a person is usually not rational, and may even enjoy or provoke arguments. Arguing can escalate emotions in a situation, and that is not what you want to happen. It is usually better to state your expectations for the subject's compliance clearly and directly and then take appropriate actions, following the DONE concept that you have learned about in Professional Communication and DAAT training.

According to this concept, you should stop talking and take action under the following conditions:

- Danger
- Overriding concern
- No progress
- Escape

SPO #11

Be prepared for a subject to be challenging and argumentative. You may hear such remarks as, “Why are you guys hassling me?” in a belligerent tone. You may need to be more authoritative. You may also need to repeat yourself. Persons under the influence of alcohol have a diminished capacity to process words and information. For that reason, you should speak slowly and give only one command at a time.

Remember That the Person May Have Additional Problems

Many people who abuse alcohol and/or drugs also have other issues: they may also have a mental illness, be developmentally disabled, and so on. People who are substance abusers and are mentally ill are said to have a “dual diagnosis.” Dual diagnosis is fairly common. In particular, people who have depressive disorders and/or anxiety disorders often use alcohol or drugs, partly as a way to self-medicate their persistently uncomfortable feelings. Also, people with certain personality disorders—including antisocial personality disorder and borderline personality disorder—are often substance abusers.

The dual diagnosis of mental illness and substance abuse is problematic because the two disorders together make each one worse. A confused person becomes more confused, a hostile person more threatening and assaultive, and a suicidal person more likely to engage in self-harmful behavior, and so on. Thus, the potential threat to you and others from such a person is more than if the person were just a substance abuser or just mentally ill. Also, with some people their mental disorder and their alcohol or drug use increases the likelihood that they will engage in antisocial and criminal behavior.

Again, you may or may not know that a person has both a mental disorder and a substance abuse problem. You may only be aware of his or her behavior, not the cause of that behavior. However, if you are aware that a subject has a history of mental illness and is also a substance abuser, that information should make you aware that this particular person is potentially more unpredictable and dangerous.

Recognize That Apparent Intoxication May Be Caused by Other Conditions

Some medical conditions mimic the indicators of substance abuse, as well as of mental illness. For example, a person with diabetes may experience a diabetic coma or insulin shock, and those signs and symptoms may be interpreted as mental illness or substance abuse. They are similar in some ways. Or, a person may have a seizure, which could be due to alcohol withdrawal or could be due to epilepsy. A person may experience visual or auditory hallucinations and/or indicators of paranoia (extreme suspiciousness) as a result of mental illness, or use of certain drugs, or as a result of alcohol withdrawal.

HANDOUT 16

SPO #11

If you smell the odor of an intoxicant (such as beer or whiskey) on a person's breath or clothing, that may tell you that he or she has used alcohol. But it does not mean that alcohol is the only issue; the person may have used other drugs as well, may be mentally ill, and may have another medical condition or problem in addition to the alcohol use. Remember, it is not your job to diagnose a person's condition—that is, to determine the reason for the signs and symptoms you observe. Your job is to assess whether or not a situation seems to be serious enough to require medical attention, including emergency care.

Know Your Options for Resolving the Situation

If a person is intoxicated, but not incapacitated, you have various options for resolving the situation. Depending on the circumstances, these may include:

- Doing nothing, if the person appears to be safe and is not causing a disturbance
- Taking the person home, if he or she consents
- Leaving the person in the care of a sober friend or family member
- Taking the person to a detoxification facility for voluntary admission if the person and the facility staff agree
- Your agency may have specific policies for dealing with intoxicated persons. You should know and follow these.
- If the person is incapacitated by alcohol, you have no choice: you must place him or her in protective custody and take him or her to a treatment facility.
- Of course, if the person needs medical attention for injuries or other conditions, you must provide for that as well.

## INDICATORS OF AUTISM MAY INCLUDE

Verbal difficulties

Approximately 50% of people with autism are entirely nonverbal. Others may only repeat what was said to them, or may communicate with sign language, picture cards, or use gestures and pointing. Those who do speak may do so in a passive, monotone voice, possibly with unusual pronunciations or words. He or she may sound computer-like, and/or may not use an appropriate volume for a given situation.

Persons with autism may not understand verbal directions or commands such as, "Stop," "Come here," or "Stand here." He or she may seem not to listen, or may not seem to care about what is being said. Or he or she may not make normal eye contact, which can give the impression that he or she is not listening or has something to hide. The person may not be able to give important information or answer questions. He or she may not respond to a request for clarification, or may not understand or accept statements or answers from officers.

The person may appear argumentative, stubborn or belligerent. He or she may say "No!" in response to many questions, or may ask "Why?" incessantly. When uncomfortable for any reason, a person with autism may engage in repeated questions ("What if…? What's your name?…"); or may continually argue; or may ramble on about such things as a favorite sports team, train or bus schedules, names of cities, etc. People with autism are usually very honest—sometimes too honest. They are often very blunt and not tactful, and do not or cannot tell lies.

Unusual physical behaviors

Often people with autism have physical behaviors that can seem very odd or bizarre. They may walk in an unusual way—such as walking on their toes, or using a pigeon-toed gait or a running style. They may appear drunk, or as though high on drugs, or having a psychotic episode. The person may stare at you or direct a fixed gaze somewhere else.

In the case of a sudden change in routine or unusual sensory input (e.g., lights, sirens, presence of dogs) a person with autism may respond with an escalation of behaviors often associated with autism. These can include repetitive behaviors such as pacing, hand flapping, or twirling hands; hitting oneself; or screaming. Temper tantrums are often a response to fear, confusion or frustration, and represent an effort to stop the disturbing stimulus.

Persons with autism may also have a seizure disorder, although this will not ordinarily be obvious to someone who does not know them.

Inappropriate social responses

People with autism may have difficulty with appropriate personal space, and may stand too close or too far away. He or she may have difficulty interpreting facial expressions (e.g., smiles, frowns, raised eyebrows, etc.) or body language (e.g., command presence or a defensive posture). Similarly, the person may have difficulty recognizing jokes or teasing remarks.

A person with autism may not recognize potentially dangerous situations, and/or may not be able to distinguish between serious problems and minor ones. He or she may not know how or where to get help for problems. Persons with autism may not recognize a police vehicle, badge or uniform, or, even if they do recognize these symbols of authority, they may not understand what is expected of them.

# RESPONDING TO PEOPLE WITH AUTISM

## Keep sensory stimuli to a minimum

If possible, turn off sirens and flashing lights and remove or limit other sensory stimuli. If feasible, keep dogs from the scene. Even ordinary lights, sounds, touch, and/or verbal directions may not be well tolerated, and the person may react with repetitive behaviors often associated with autism. If the person's behavior escalates, maintain a safe distance until his or her inappropriate behaviors lessen—but remain alert to the possibility of further outbursts or impulsive acts.

## Check for injury and medical information

Check for the presence of medical alert jewelry or tags, or other information indicating that a person has autism. Remember that a person may also have a seizure disorder, and there may be information about that specifically. Evaluate the person for injury. He or she may not ask for help or show any indications of pain, even though injury seems apparent.

If possible, avoid touching the person—especially near the face and shoulders. If touching seems necessary, alert the person first. Try to avoid standing close to or directly behind a person with autism.

If you take an individual you know or suspect has autism into custody and convey him or her to jail, be sure to let jail staff know about the possibility of autism. This is information that is important for the individual's safety. You may suggest to staff that they place the person by himself, rather than in general population, pending an evaluation by a mental health professional. That will help avoid risk of abuse and/or injury to the person with autism.

## Use effective communication techniques

When you are dealing with a person with autism, you should talk in a calm voice and repeat things as necessary. Be patient and use a normal tone of voice—talking more loudly will not help the person understand better. Expect delayed responses to questions or commands. Wait for the person to respond and wait for him or her to make eye contact. If the person seems comfortable, you can ask him or her to "Look at me." However, do not interpret limited or no eye contact as meaning that the person is being deceitful or disrespectful. Do not force or expect eye contact.

Use short, direct phrases, such as: “Stand up now.” and “Go to the car.” Avoid idioms or figurative expressions such as “What’s up your sleeve?” or “Are you pulling my leg?” because the person will probably not understand these phrases. You may want to consider using alternate ways of communicating with the person, through visual techniques such as writing, drawing stick figures, or sign language (if you or someone knows that), or—if available—picture or phrase books.

## OTHER DEVELOPMENTAL DISABILITIES

### Cerebral Palsy

Cerebral palsy is a term used to describe a group of chronic conditions affecting body movements and muscle coordination. It is characterized by an inability to fully control motor function, particularly muscle control and coordination. Some people with this condition experience muscle spasms or other involuntary movements. Some cannot talk or walk; others can. Cerebral palsy is caused by brain damage, usually during fetal development or infancy.

A person with cerebral palsy may experience a crisis situation like anyone else. He or she may, for example, become easily frustrated if something unusual happens, or if unable to communicate with someone or to get around easily.

It is important to be patient with people with this disability. They may have great difficulty communicating verbally, and it can be too easy to become impatient. Take time, and, if necessary, seek the assistance of a person who has experience in communicating with the person. Remember that a person with cerebral palsy may or may not have associated mental impairment.

### Epilepsy (Seizure Disorder)

Epilepsy is a physical condition that occurs when there is a sudden, brief change in the way that the brain works. When brain cells are not working properly, for any of a variety of reasons, a person's consciousness, movements or actions may be altered for a short time. These altered states are known as epileptic seizures. In some cases, a person can have a convulsion with complete loss of consciousness. In other cases, a person will just have a brief period of fixed staring. Or, a person may engage in brief periods of unconscious "automatic behavior," such as buttoning or unbuttoning a shirt, and may not remember doing so later.

If you observe behaviors such as these, be aware that it could be a seizure. Do not assume that a person is acting "weird" on purpose.

### Traumatic Brain Injury

Traumatic brain injury (TBI) occurs when a sudden physical assault on the head causes damage to the brain. This may result from an accident, a fight, or other head trauma. Shaken baby syndrome is a severe form of head injury that occurs when a baby has been shaken forcibly enough to cause extreme brain injury. TBI does not refer to brain injuries that happen during birth.

The signs of brain injury vary, depending on the part of the brain that was injured and the severity of the injury. Signs of injury may include difficulties with:

- Abstract thinking and reasoning or understanding words
- Memory, attention, or problem-solving
- Speech
- Walking or other physical activities
- Seeing and/or hearing

Learning Brain injury can also sometimes cause strange behaviors or behavior patterns. If you see a person exhibiting these behaviors, at least keep in mind that brain injury may be the cause. It could be a medical emergency, or at least a situation that calls for medical evaluation to determine the cause of the behavior.

## Prader-Willi Syndrome

PWS is a complex genetic disorder that includes short stature, mental retardation or learning disabilities, incomplete sexual development, characteristic behavior problems, low muscle tone, and an involuntary urge to eat constantly, which, coupled with a reduced need for calories, leads to obesity.

Although PWS is associated with an abnormality of chromosome 15, it is generally considered not to be an inherited condition, but rather a spontaneous genetic birth defect that occurs at or near the time of conception. PWS is found in people of both sexes and all races.

About 1 in 14,000 people in the U.S. are estimated to have PWS, and the birth rate may be even higher. Prader-Willi syndrome is one of the 10 most common conditions seen in genetics clinics and is the most common genetic cause of obesity that has been identified.

People with PWS have a flaw in the part of their brain (the hypothalamus) that determines hunger and satiety (fullness). These people never feel full enough, so they have a continuous urge to eat. To compound this problem, people with PWS need considerably fewer calories than normal to maintain an appropriate weight. The obesity that results is the major cause of illness and death in this disorder. As in the general population, obesity in PWS can cause high blood pressure, respiratory difficulties, diabetes and other problems.

There's more to PWS than the obesity. People with PWS have a characteristic appearance and speech quality, significant learning disabilities or mental retardation, and various other problems. A number of these features must be present for a clinical diagnosis of PWS, and specific genetic tests are available to confirm the diagnosis.

In addition to sometimes extreme attempts to obtain food, people with PWS are prone to temper outbursts, stubbornness, rigidity, argumentativeness, and repetitive thoughts and behaviors. Strategies to deal with these problems usually include structuring the person's environment, implementing behavioral management techniques, and occasionally drug therapy.

People with PWS can accomplish many of the things their "normal" peers do -- attend school, enjoy community activities, get jobs, and even move away from home. However, they need a lot of help. School children with PWS are likely to need special education and related services, such as speech and occupational therapy. In community, work and residential settings, adolescents and adults often need special assistance to learn and carry out responsibilities and to get along with others. In all settings, people with PWS need around-the-clock food supervision. As adults, most affected individuals do best in a special group home for people with PWS, where food access can be restricted without interfering with those who do not need such restriction. Although in the past many died in adolescence or young adulthood, it is thought that prevention of obesity will allow a person with PWS to live a normal lifespan.

## FETAL ALCOHOL SYNDROME

Fetal alcohol syndrome (FAS) is not specifically a developmental disability, according to the Wisconsin statutory definition. However, it is a condition that is not uncommon and shares certain characteristics with developmental disabilities.

Fetal alcohol syndrome is a pattern of physical and mental defects which develops in some unborn babies when the mother drinks too much alcohol during pregnancy. Symptoms include growth deficiencies, such as small body size and weight, deformed facial features, poor coordination, and mental retardation or problems with learning. Many people with FAS are also hyperactive as children, and may have poor impulse control and poor judgment. Many experience behavior problems throughout their lives, which can lead to involvement with the criminal justice system.

You are unlikely to know that a person has been affected by FAS. The person may not be aware of it. However, such a person is potentially an EDP because of his or her poor judgment, poor impulse control, and other behavior problems, and therefore may be more of a threat risk.

**§2305.51**

## Immunity of mental health professional or organization as to violent behavior by client or patient

(A) (1) As used in this section:

(a) "Civil rights" has the same meaning as in section 5122.301 [5122.30.1] of the Revised Code.

(b) "Mental health client or patient" means an individual who is receiving mental health services from a mental health professional or organization.

(c) "Mental health organization" means an organization that engages on or more mental health professionals to provide mental health services to one or more mental health clients or patients.

(d) "Mental health professional" means an individual who is licensed, certified, or registered under the Revised Code, or otherwise authorized in this state, to provide mental health services for compensation, remuneration, or other personal gain.

(e) "Mental health service" means a service provided to an individual or group of individuals involving the application of medical, psychiatric, psychological, counseling, social work, or nursing principles or procedures to either of the following:

(i) The assessment, diagnosis, prevention, treatment, or amelioration of mental, emotional, psychiatric, psychological, or psychosocial disorders or diseases, as described in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association;

(ii) The assessment or improvement of mental, emotional, psychiatric, psychological, or psychosocial adjustment or functioning, regardless of whether there is a diagnosable, pre-existing disorder or disease.

(f) "Knowledgeable person" means an individual who has reason to believe that a mental health client or patient has the intent and ability to carry out an explicit threat of inflicting imminent and serious physical harm to or causing the death of a clearly identifiable potential victim or victims and who is either an immediate family member of the client or patient or an individual who otherwise personally knows the client or patient.

(2) For the purpose of this section, in the case of a threat to a readily identifiable structure, "clearly identifiable potential victim" includes any potential occupant of the structure.

(B) A mental health professional or mental health organization may be held liable in damages in a civil action, or may be made subject to disciplinary action by an entity with licensing or other regulatory authority over the professional or organization, for serious physical harm or death resulting from failing to predict, warn of, or take precautions to provide protection from the violent behavior of a mental health client or patient, only if the client or patient or a knowledgeable person has communicated to the professional or organization an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more clearly identifiable potential victims, the professional or organization has reason to believe that the client or patient has the intent and ability to carry out the threat, and the professional or organization fails to take one or more of the following actions in a timely manner:

(1) Exercise any authority the professional or organization possesses to hospitalize the client or patient on an emergency basis pursuant to section 5122.10 of the Revised Code;

(2) Exercise any authority the professional or organization possesses to have the client or patient involuntarily or voluntarily hospitalized under Chapter 5122. of the Revised Code;

(3) Establish and undertake a documented treatment plan that is reasonably calculated, according to appropriate standards of professional practice, to eliminate the possibility that the client or patient will carry out the threat, and, concurrent with establishing and undertaking the treatment plan, initiate arrangements for a second opinion risk assessment through a management consultation about the treatment plan with, in the case of a mental health organization, the clinical director of the organization, or, in the case of a mental health professional who is not acting as part of a mental health organization, any mental health professional who is licensed to engage in independent practice;

(4) The mental health professional or organization is not liable in damages in a civil action, and shall not be made subject to disciplinary action by any entity with licensing or other regulatory authority over the professional or organization, for disclosing any confidential information about a mental health client or patient that is disclosed for the purpose of taking any of the actions.

(D) The immunities from civil liability and disciplinary action conferred by this section are in addition to and not in limitation of any immunity conferred on a mental health professional or organization by any other section of the Revised Code or by judicial precedent.

(E) This section does not affect the civil rights of mental health client or patient under Ohio or federal law.

# STUDENT WORKSHEET

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2. Define the term “Mental Illness:”

3. List the Symptoms displayed by a person with Bipolar Disorder in the Manic Phase:

4. List the Signs of Schizophrenia:

5. List the Symptoms of Schizophrenia:

6. List the signs of a person with an Anxiety Disorder:

7. List the De-escalation Techniques:

# STUDENT WORKSHEET

8. List the Behaviors that should be avoided when engaged in De-escalation:

9. List the Phrases to Aid in Communication:

10. List the Indicators of Suicidal Thought:

11. List the Methods for Responding to Chemical Abusers:

12. List the indicators of a person with Autism:

13. List the intellectual abilities affected by Dementia:

14: List the signs of a person with Alzheimer's Disease:

15. List the categories of life changes regarding the elderly-mentally/physically challenged:

16. List the interaction skills needed in dealing with elderly persons:

17. List the interaction skills for the Vision Impaired:

18. List the interaction skills for the Hearing Impaired:

19. List the options for taking a person into custody due to that person's mental illness:

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