

STATE OF OREGON
DEPARTMENT OF PUBLIC SAFETY STANDARDS AND TRAINING
LESSON PLAN OUTLINE

TITLE: Mental Health & Disabilities
SECTION: Community / Police Relations 206, Basic Police
TIME: 12 hours (Classroom: 8 Scenario: 4)
REVIEWED: November 2006

Learning Goal:

To develop the ability to recognize and resolve situations involving clients who are mentally ill and other citizens with disabilities.

Instructional-Performance Objectives

Upon completion of instruction, students will be able to:

- 206.001 Identify common mental illnesses and other disabilities in a law enforcement context.
- 206.002 Identify basic information regarding suicide and appropriate law enforcement responses.

Materials Required – Instructor

Instructor Appendix: Schizophrenia exercise
PowerPoint
Dry Erase Board
Flip Chart easel and paper
Marking pens

Materials Required - Student

Oregon Criminal Code book
Oregon Vehicle Code book
Student Resource Manual
Student Resource Appendix
Notepaper
Pencil or pen

Instructor Notes:

- 1) This class is a building block class. Student should not have scenarios dealing with the mentally ill or disabilities prior to this class. It is critical that the students have an understanding on how to respond appropriately using the Crisis Intervention Tactics.
- 2) There are several statutes listed within this lesson plan and in the student's resource manual. We do not duplicate the content of statutes contained in the Oregon Criminal Code or the Oregon Vehicle Code in the Student Resource Manual. Students are

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advised to bring their books to class. They should be prepared to reference those statutes during class. Any statute that is referenced and is applicable to this lesson plan and is not in the Oregon Criminal Code or Vehicle Code will be found in the Student Appendix.

3) The schizophrenia exercise is found in the Instructor Appendix.

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PRESENTATION OUTLINE

- I. Mental Illness Introduction
 - A. Primary responder to incidents involving citizens with a mental health issue who are:
 - 1. Committing crimes.
 - 2. Acting strange or bizarre in public and are making others in the community feel unsafe.
 - 3. Impacting the livability of a community due to a person's inability to seek help and/or the lack of community resources.
 - B. As law enforcement professionals, you will be responding to people with an illness when you are dispatched to these incidents.
 - 1. People do not choose to have a mental illness.
 - 2. The community will have a greater understanding and learn how you, as a professional, treat a person with a mental health disability. If you treat them with compassion and empathy, just as you would with someone who has cancer or diabetes, you set the example for members of the community.
 - 3. As law enforcement professionals, you are sworn to uphold the rights of all people.
 - a. We, as a profession, must refrain from labeling these people as "nuts," "crazy," "wacko," in reference to someone with a mental health disability. You would never use cultural or religious epithets in communicating to healthy citizens, so why would you use derogatory names for people suffering with a mental illness.
 - b. Descriptions of behavior are always appropriate in reports to other officers, supervisors, medical or mental health care professionals.
 - c. You will also gain respect and admiration from varying community groups if you make a conscious effort not to stigmatize people with a mental health disability or tolerate others who stigmatize them.
 - C. Significance of Stigma¹
 - 1. "Stigma as an obstacle—For our nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must no longer be tolerated. Research on brain and behavior that continues to generate ever more effective treatments for mental illnesses is a potent antidote to stigma."
 - 2. "Impact of stigma—Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others."

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II. Documentation

- A. By documenting in detail, when appropriate, incidents involving allegedly mentally disabled or developmentally disabled persons, you may develop a positive rapport that can assist you or other officers in future crisis incidents with this person. Good reports will also:
1. Give a framework to future reports when an investigation, on proven allegations develops, even when a person is not healthy enough to be deemed a reliable source of information.
 2. Be used as evidence in a civil commitment process and will be important for commitment investigators to use.

NTF: All statutes not found in the ORS Criminal Code are at the back of the Student Resource Manual.

- B. Legal requirement to write a report.
1. Mandatory reports and investigations (ORS 430.737) The Legislative Assembly finds that for the purpose of preventing abuse and safeguarding and enhancing the welfare of adults who are mentally ill or developmentally disabled, it is necessary and in the public interest to require mandatory reports and thorough and unbiased investigations of allegedly abused mentally ill and developmentally disabled adults.
 2. Abuse report; content (ORS 430.743). (1) When a report is required under ORS 430.765 (1) and (2), an oral report shall be made immediately by telephone or otherwise to the designee of the Department of Human Services or a law enforcement agency within the county where the person making the report is at the time of contact. If known, the report shall include:
 - a. The name, age and present location of the allegedly abused adult;
 - b. The names and addresses of persons responsible for the adult's care;
 - c. The nature and extent of the alleged abuse, including any evidence of previous abuse;
 - d. Any information that led the person making the report to suspect that abuse has occurred plus any other information that the person believes might be helpful in establishing the cause of the abuse and the identity of the perpetrator; and
 - e. The date of the incident.
 3. When a report is received by the department's designee under this section, the designee shall immediately determine whether the reported victim has sustained any serious injury. If so, the designee shall immediately notify the department. If there is reason to believe

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a crime has been committed, the designee shall notify the law enforcement agency having jurisdiction within the county where the report was made. If the designee is unable to gain access to the allegedly abused adult, the designee may contact the law enforcement agency for assistance and the agency shall provide assistance. When a report is received by a law enforcement agency, the agency shall immediately notify the law enforcement agency having jurisdiction if the receiving agency does not. The receiving agency shall also immediately notify the department in cases of serious injury or death.

III. Myths about Mental Health Disorders ².

Top Ten Myths about Mental Illness

Myth: Psychiatric disorders are not true medical illnesses like heart disease and diabetes. People who have a mental illness are just "crazy."

Fact: Brain disorders, like heart disease and diabetes, are legitimate medical illnesses. Research shows there are genetic and biological causes for psychiatric disorders, and they can be treated effectively.

Myth: People with a severe mental illness, such as schizophrenia, are usually dangerous and violent.

Fact: Statistics show that the incidence of violence in people who have a brain disorder is not much higher than it is in the general population. Those suffering from a psychosis such as schizophrenia are more often frightened, confused and despairing than violent.

Myth: Mental illness is the result of bad parenting.

Fact: Most experts agree that a genetic susceptibility, combined with other risk factors, leads to a psychiatric disorder. In other words, mental illnesses have a physical cause.

Myth: Depression results from a personality weakness or character flaw, and people who are depressed could just snap out of it if they tried hard enough.

Fact: Depression has nothing to do with being lazy or weak. It results from changes in brain chemistry or brain function, and medication and/or psychotherapy often help people to recover.

Myth: Schizophrenia means split personality, and there is no way to control it.

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Fact: Schizophrenia is often confused with multiple personality disorder. Actually, schizophrenia is a brain disorder that robs people of their ability to think clearly and logically. The estimated 2.5 million Americans with schizophrenia have symptoms ranging from social withdrawal to hallucinations and delusions. Medication has helped many of these individuals to lead fulfilling, productive lives.

Myth: Depression is a normal part of the aging process.

Fact: It is not normal for older adults to be depressed. Signs of depression in older people include loss of interest in activities, sleep disturbances and lethargy. Depression in the elderly is often undiagnosed, and it is important for seniors and their family members to recognize the problem and seek professional help.

Myth: Depression and other illnesses, such as anxiety disorders, do not affect children or adolescents. Any problems they have are just a part of growing up.

Fact: Children and adolescents can develop severe mental illnesses. In the United States, one in ten children and adolescents has a mental disorder severe enough to cause impairment. However, only about 20 percent of these children receive needed treatment. Left untreated, these problems can get worse. Anyone talking about suicide should be taken very seriously.

Myth: If you have a mental illness, you can will it away. Being treated for a psychiatric disorder means an individual has in some way "failed" or is weak.

Fact: A serious mental illness cannot be willed away. Ignoring the problem does not make it go away, either. It takes courage to seek professional help.

Myth: Addiction is a lifestyle choice and shows a lack of willpower. People with a substance abuse problem are morally weak or "bad".

Fact: Addiction is a disease that generally results from changes in brain chemistry. It has nothing to do with being a "bad" person.

Myth: Electroconvulsive therapy (ECT), formerly known as "shock treatment," is painful and barbaric.

Fact: ECT has given a new lease on life to many people who suffer from severe and debilitating depression. It is used when other treatments such as psychotherapy or medication fail or cannot be used. Patients who receive ECT are asleep and under anesthesia, so they do not feel anything.

IV. Categories and Common Characteristics of Mental Health Disorders

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- A. Mental illness is a biologically based brain disease characterized by perceptual disturbance, mood lability (changeable/undergoing frequent change), and lack of motivation and in extreme cases, suicidality. Mental illness can impact all areas of a person's functioning including:
1. Social: difficulty getting and/or maintaining necessities of life i.e. food, clothing, and shelter
 2. Occupational: difficulty acquiring and/or maintaining employment
 3. Interpersonal functioning: difficulty maintaining relationships with friends, co workers, partners, spouses, parents, children.
- B. What a person with mental illness might experience who has symptoms of Thought Disorders
1. Hallucinations that might cause people to see, hear, feel, taste or sense things that aren't there
 2. Talk to self
 3. Disorganized thoughts
 4. Paranoia, delusions, or bizarre thoughts
 5. Minimal display of emotions
 6. Poor hygiene/malodorous (smelling bad)
 7. May wear multiple layers of clothing or inappropriate clothes for the weather
 8. May have multiple bags filled with what might appear to be garbage
- D. Three Major Types of Mental Illness
1. Schizophrenia is a "...mental disorder characterized by persistent defects in the perception or expression of reality. A person experiencing untreated schizophrenia typically demonstrates disorganized thinking, and may also experience delusions or auditory hallucinations. Although the disorder primarily affects cognition, it can also contribute to chronic problems with behavior or emotions."³
 - a. Effects 1-2% of entire population
 - b. Will last for a lifetime, but can be controlled with medication, therapy and assisted living conditions. Some people can be institutionalized for life. Others can function well in a halfway house and others can do well with minimal supervision (High, medium and low functioning)
 - c. Commonly known as the "split personality" diagnosis, which is incorrect. Very few will develop multiple personality disorder
 - d. The "first break" usually occurs from 18-25 years old. Symptoms are now present.
 - e. Medications that are used are called anti-psychotics (Thorazine, Haldol, Mellaril, Risperdal, Zyprexa, Seroquel). Medication levels sometimes need to be re-balanced.
 - f. Symptoms of schizophrenia include:

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NTF: When discussing this section, it is important to be very clear on the distinction between Delusions and Hallucinations and make sure the students understand how they are different.

- 1) Delusions - a false belief that is contrary to reality. It could resemble an elderly person with dementia.
- 2) Types of delusions include
 - a) Persecutory: "Everyone is plotting against me"
 - b) Grandiose: "I am God"
 - c) Religious: "I can talk to God directly"
 - d) Nihilistic: "The world will end next week"
 - i. Example: Heaven's Gate Cult⁴
 - ii. 1990s mass suicide in San Diego
- 3) Hallucinations is hearing and seeing things that are not real
 - a) Auditory are the most common (80 % of the time)
 - b) People will tell you there are voices inside them they cannot control (imagine a radio station you can't turn off)
 - c) Visual hallucinations are less common (Meth and Coke users will have tactile sensations) (20 % of the time)
- 4) Disorganized symptoms (Due to no social service help)
 - a) The person may be dressed poorly
 - b) Bad hygiene
 - c) May not be able to hold an idea long enough to answer a simple question. They may pace and talk in circles or do other repetitive behavior.
- g. Schizophrenia Class exercise – See instructor Scenario appendix for detailed directions.
 - 1) Divide up into groups of 4.
 - 2) 2 will get the script of voices
 - 3) 1 will sit in a chair
 - 4) 1 will do the questioning
 - 5) Exercise is to simulate what a schizophrenic person has to deal with 24/7
 - 6) OR – show DVD "I'm still here", a film that show how Jim Fitzgerald lived with schizophrenia.

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2. Bipolar is the new term for Manic Depression. It means the person will have mood swings, sometimes from the lows of depression to the highs of mania. If a person has more than 4 episodes (up and down swings) in a year, then the term “Rapid Cycling” can be applied.
 - a. Bi-polar is hereditary. Example: Ernest Hemmingway’s family. His father and two sisters in addition to himself committed suicide.⁵
 - b. Medications that are used are called “mood stabilizers” (Lithium, Depakote)
 - c. Mania side of the swing will be given Anti-psychotics
 - d. Depressive side of the swing will be given Anti-depressants

3. Major depression – a persistent state of depression that significantly affects a person’s mood, thoughts, relationships and daily activity
 - a. One of the leading causes of disability in US
 - b. Strikes as much as 5% of entire population
 - c. Twice as many women effected than men
 - d. Medications are called anti-depressants (Prozac, Zoloft, Paxil, Effexor, Wellbutrin)
 - e. ECT or electroconvulsive therapy is still used to treat severe forms of depression
 - f. Depression has a direct link to suicide

4. Other disorders for discussion
 - a. Five major types of Anxiety disorders⁶
 - 1) Generalized is excessive uncontrollable worry about everyday things.
 - 2) Obsessive-Compulsive Disorder (ODC) is characterized by uncontrollable obsessions and compulsions which the sufferer usually recognizes as being excessive or unreasonable.
 - a) Obsessions are recurring thoughts or impulses that are intrusive or inappropriate and cause the sufferer anxiety. (Persistent hand washing, extreme orderliness.)
 - b) Example: Monk on the TV series
 - 3) Panic Disorder (& Agoraphobia) is defined as the abrupt onset of an episode of intense fear or discomfort, which peaks in approximately 10 minutes, and includes at least four of the following symptoms: a feeling of imminent danger or doom; the need to escape; palpitations; sweating; trembling; shortness of breath or a smothering feeling; a feeling of choking; chest pain or discomfort; nausea or abdominal discomfort; dizziness or lightheadedness; a sense of things being unreal, depersonalization; a fear of losing

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- control or "going crazy"; a fear of dying; tingling sensations; chills or hot flushes.
- 4) Post-Traumatic Stress Disorder (PTSD) ... traumas such as a serious accident, a natural disaster, or criminal assault can result in PTSD. (PPB CIT manual defines PTSD as: ... exposure to an extreme traumatic event that involves direct personal experience of an event that involves actual or threatened death, serious injury, or other threat of physical integrity of another person; witnessing an event as described above; learning about unexpected or violent death, serious harm, or threat or death or injury by a family member or other close associate.) This topic will be more thoroughly covered in future academy classes (Critical Stress Awareness and Emotional Survival)
 - 5) Social Phobia (or Social Anxiety Disorder) is characterized by an intense fear of situations, usually social or performance situations, where embarrassment may occur.
- b. Personality disorders⁷ The DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, defines a personality disorder as an enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Currently, there are 10 distinct personality disorders identified in the DSM-IV.
- 1) Paranoid - Marked distrust of others, including the belief, without reason, that others are exploiting, harming, or trying to deceive him or her; lack of trust; belief of others' betrayal; belief in hidden meanings; unforgiving and grudge holding.
 - 2) Schizoid - Primarily characterized by a very limited range of emotion, both in expression of and experiencing; indifferent to social relationships.
 - 3) Schizotypal - Peculiarities of thinking, odd beliefs, and eccentricities of appearance, behavior, interpersonal style, and thought (e.g., belief in psychic phenomena and having magical powers).
 - 4) Antisocial - Lack of regard for the moral or legal standards in the local culture, marked inability to get along with others or abide by societal rules. Sometimes called psychopaths or sociopaths.
 - 5) Borderline - Lack of one's own identity, with rapid changes in mood, intense unstable interpersonal relationships, marked impulsivity, instability in affect and in self image.

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- 6) Histrionic - Exaggerated and often inappropriate displays of emotional reactions, approaching theatricality, in everyday behavior. Sudden and rapidly shifting emotion expressions.
- 7) Narcissistic - Behavior or a fantasy of grandiosity, a lack of empathy, a need to be admired by others, an inability to see the viewpoints of others, and hypersensitive to the opinions of others. (Example: Ward Weaver: 2004 convicted for the murder of Ashley Pond and Miranda Gaddis. The girls were found missing in Jan/March 2002 in Oregon City, OR.)
- 8) Avoidant - Marked social inhibition, feelings of inadequacy, and extremely sensitive to criticism.
- 9) Dependent - Extreme need of other people, to a point where the person is unable to make any decisions or take an independent stand on his or her own. Fear of separation and submissive behavior. Marked lack of decisiveness and self-confidence.
- 10) Obsessive-Compulsive - Characterized by perfectionism and inflexibility; preoccupation with uncontrollable patterns of thought and action.

E. Common characteristics of mental health disorders

1. Perception (hallucinations)
2. Orientation (person, place, time awareness, etc)
3. Thinking (delusions, paranoia)
4. Judgment/insight (poor decision making)
5. Feeling (incongruent, variable, extreme)
6. Behaviors (actions, movement)
7. Environment (unusual items or unusual use of items)

V. Disabilities and ADA

A. Public Law 101-336. Text of the Americans with Disabilities Act, Public Law 336 of the 101st Congress, enacted July 26, 1990. SEC. 3.

DEFINITIONS. As used in this Act...

- (2) Disability.--The term "disability" means, with respect to an individual--
- (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
 - (B) a record of such an impairment; or
 - (C) being regarded as having such an impairment. ⁸

B. Examples: epilepsy, cerebral palsy, visually impaired, etc.

C. ADA is not a special right. It is a guarantee of basic civil rights for persons with disabilities and will provide reasonable accommodation. (The instructor should research and provide recent and applicable examples demonstrate. Eg: If you arrest someone and they are blind. If you take

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away their ability to guide themselves (their cane or a dog) then you then need to give them your arm and be their guide.

- VI. Developmental Disabilities (DD) 114 Stat. 1684 Public Law 106-402 Oct. 30, 2000⁹
 - A. Federal Developmental Disability definition:
(8) DEVELOPMENTAL DISABILITY.- (A) IN GENERAL. -The term 'developmental disability' means a severe, chronic disability of an individual that- (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:
 - (I) Self-care.
 - (II) Receptive and expressive language.
 - (III) Learning.
 - (IV) Mobility.
 - (V) Self-direction.
 - (VI) Capacity for independent living.
 - (VII) Economic self-sufficiency; and
 - (v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.
 - B. Not treatable with drugs or therapy but many persons are able to learn and become independent.
 - C. Degree of impairment varies greatly from person to person.
 - D. Common developmental disabilities
 - 1. Mental retardation
 - 2. Autism
 - 3. Cerebral palsy
 - 4. Epilepsy or other physical or neurological disabilities (manifest prior to age 22).
 - 5. People with developmental disabilities may have multiple disabling conditions.
- VII. Mental Retardation (MR)
 - A. Definition:
 - 1. Impairment of overall intelligence and ability to process information.
 - 2. Not treatable with drugs or therapy but many persons are able to learn and become independent.
 - 3. Degree of impairment varies greatly from person to person.
 - 4. IQ less than 70.

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- B. Characteristics:
 - 1. May not communicate or behave at age level.
 - 2. May not understand consequences of situations/actions.
 - 3. May not behave appropriately in criminal justice situations.

- C. Other factors concerning mentally retarded individuals:
 - 1. Short attention span.
 - 2. Easily distracted.
 - 3. Eager to please others.
 - 4. Low tolerance to stress.
 - 5. Thought processes of a concrete nature.
 - 6. Acute dislike of the term “mental retardation” applied to the individual. Preference is “developmentally disabled.”

VIII. Tactics on How to Respond to Persons with DD and MR Issues.

- A. Developmental disabilities and mental retardation are distinctly different from other mental health disorders and disabilities
 - 1. DD and MR are diagnosed (manifest) at birth or in early childhood and last throughout the individual’s life span.
 - 2. DD and MR are disabling conditions, not disorders.
 - 3. DD and MR require accommodation for the disability and are not remediated or “cured” by medical intervention or medications.
 - 4. DD and MR do not lead to other mental health issues like psychosis.
 - 5. Behaviors presented by people who are DD or MR are not psychotic or necessarily related to other mental health conditions.
 - 6. People with diagnoses of DD or MR may have other disabling conditions present—including mental health related disorders.

- B. Techniques to use when dealing with a Suspect, Victim or Witness who is MR/DD
 - 1. Use simple language.
 - 2. Avoid questions that tell the person the answer you expect.
 - 3. Miranda warning – proceed slowly and gives praise and encouragement.
 - 4. Avoid frustrating questions about time, complex sequences or reasons for behavior.

IX. Autism

- A. Definition – autism is a developmental disability that typically appears during the first three years of life.

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1. Autism is a broad-spectrum neurological disorder. Broad spectrum means that there are a variety of symptoms that may be involved and that no two people are affected to the same extent.
2. It is not a mental or psychological disorder.
3. Autism impacts the normal development of the brain in the areas of social interaction and communication skills. This disorder makes it hard for them to communicate with others and relate to the outside world.
4. The cause is unknown. Some cases appear to have genetic ties, but other sources of brain injury are suspected as well (chemical toxins, allergic reactions, exposure to certain viruses).
5. There is no cure. Medication may help in certain cases. The effects may be minimized through early education and training.

B. Incidence

1. Autism is four times more prevalent in boys than girls and has no racial, ethnic or social boundaries. Family income, lifestyle and education levels have no effect.
2. "The autism epidemic that is rising 22% annually. Latest statistics are that one in 120 Oregon children have autism".¹⁰
3. Seizures occur in 25% of people with autism, while only .001% of the normal population exhibit seizures.
4. The number of diagnoses with autism is expected to double over the next forty years.
5. Autism is the third most common developmental disability – more common than Down Syndrome, but many people are still unaware of how autism affects people and how to effectively work with these individuals.

C. How do you recognize a person with autism?

They often look perfectly normal. However, you may recognize one or more of the following speech or behavior characteristics:

1. 50% are non-verbal
2. Limited range of speech (limited vocabulary)
3. Echo laic speech (echoes or repeats everything you say)
4. Rambling speech
5. Monotone speech (computer-like, no inflection)
6. Difficulty expressing needs, may use gestures or pointing
7. Unusual or repetitive physical actions
 - a. Hand flapping
 - b. Finger flicking
 - c. Twirling an object.
8. Spins objects or self, rocks back and forth, paces, etc.
9. Temper tantrums (screaming, hitting, biting, hair pulling, banging head) if anything disrupts daily routine or obsessive behaviors
10. Inappropriate response (defiant, sassy, laughing, etc.)

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11. No response to sound or verbal communication (may appear deaf)
 12. Unusual gait. May walk pigeon-toed, use double-footing on stairs and may run with a “duck-waddle” motion.
 13. Information on ID card/bracelet or clothing tags
- D. Where are law enforcement personnel most likely to encounter a person with autism?
1. Anywhere in the community
 2. At a family home (supervised by a parent or caregiver)
 3. Assisted living residential facilities (each facility should have a contact person/caregiver that is familiar with each resident).
 4. Public and private schools, including transportation modes
 5. Supervised and unsupervised workplaces (supervised workplaces probably have a vocational counselor that sets goals and oversees the daily progress of each worker with autism).
- E. Circumstances when law enforcement personnel may come in contact with a person having autism
1. In response to a medical emergency involving the individual or a caregiver for the individual. 25% may have seizures by the age of 21.
 2. In response to a call for assistance:
 3. Situation where child or adult has run or wandered away
 4. Self-abusive or aggressive (may hurt self or others)
 5. The person is in an unfamiliar place and is not recognized by anyone and may be acting “weird”
 6. The person has become escalated (tantrum-like behavior that includes screaming, hitting, kicking, pushing, biting, hair pulling, head banging). The person doesn’t know how to be mean; he/she just doesn’t understand the consequences of his actions.
 7. In response to a situation where a parent/caregiver’s actions are misinterpreted as something other than bringing the person with autism under control.
 8. Throwing rocks/pebbles at houses, cars or windows
 9. Sitting in strangers’ front porch swing or rocking chair
 10. Running into traffic
 11. Climbing out of windows
 12. Jumping into pools, lakes or other water sources
 13. Climbing trees
 14. Running into other people’s houses
 15. Looking into windows of houses
 16. Wearing a t-shirt and shorts in freezing rain and not being cold
 17. Rearranging or “ordering” items in a store display. (Because people with autism like to pick things up randomly, and/or rearrange them in the display, some store clerks may think that they are shoplifters)

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18. A high-functioning individual with autism following a customer around the store may be perceived as stalking rather than trying to be helpful.

F. Characteristics commonly seen in people with autism:

1. Common communication problems of a person with autism.
2. May be nonverbal or may repeat what is said to them.
3. May appear argumentative, stubborn or belligerent.
4. May say “no” or “why” in response to all questions.
5. May be poor listeners, may not seem to care what you are saying.
6. May have difficulty recognizing jokes, teasing and verbal/nonverbal emotional responses.
7. May have passive, monotone voice with unusual pronunciations; may have problem with using correct volume for the situation.
8. May not be able to give information or able to answer questions.
9. Usually very honest; do not lie; very blunt, not tactful.

G. Situations where persons with autism may be targeted as a victim.

1. Child abuse. Children with autism lack the social awareness and communication skills needed to establish peer relationships. They may be too naïve and self-centered to know that an offender’s behavior is wrong.

A child’s inability to perform at the same intellectual and physical level as other children the same age adds stress and frustration to parents, and sometimes places a child at a greater risk of physically abusive punishment.

2. Robbers and con artists. Robbers and con-artists look for people whose appearance or behavior is different from the crowd; i.e., one who dawdles or moves slowly in a crowd, one who has no eye contact or who stares, one whose type of dress is unusual to the area, etc.
3. Hate crimes. Hate crimes target people that are “different” in terms of race, nationality, religion and disability. Research indicates that hate crimes against those with disabilities is on the rise. Watch for kids torturing kids that are “different.”

H. Ways that law enforcement agencies are working with individuals having autism, their families and organizations.

1. Describe forms of identification that may be used by an individual having autism and his/her family.
2. Many people with autism have been taught to give an id card, name, address and phone number to a police officer, if asked politely.
3. Parents may carry a photo-id and a fingerprint card for each child with autism.

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4. ID bracelet (like medic-alert) can give name and phone numbers.
5. Clothing tags can have name and phone numbers.
6. Parents can distribute information sheets about their child to local police, neighbors and nearby businesses.

X. Epilepsy

- A. Definition: Epilepsy is a chronic disorder of the central nervous system characterized by brief disruptions in the normal electrical activity in the brain. Where the disruption occurs in the brain and how much of the brain is involved dictates what observers see as seizure symptoms.
- B. Take Another Look video (part two)
- C. Facts about persons with seizure disorders / epilepsy:
 1. At least 35,000 Oregonians have epilepsy.
 2. Hidden disability until seizure occurs.
 3. Bizarre behavior should not automatically be presumed to be something other than seizure.
 4. Common myths: contagious, mental illness, mental retardation, demon possession, put something in mouth, can swallow tongue.
 5. Always check for medical identification.
- D. Seizure recognition
 1. Seizure types¹¹
 - a. Partial seizures during partial seizures the disturbance in brain activity begins in or involves one part of the brain. These seizures are sometimes known as 'focal' seizures. A person's experiences during the seizure will depend on which part of the brain is being affected.
 - 1) Simple partial seizures - consciousness is not impaired. The seizure may be confined to either rhythmical twitching of one limb or part of a limb, or to unusual tastes or sensations such as pins and needles in a specific part of the body. Simple partial seizures sometimes develop into other sorts of seizures and so they may be referred to as a 'warning' or 'aura'.
 - a) Simple partial seizures do not affect awareness. The person can describe the odd sensations or feelings they are experiencing during the seizure.
 - b) Simple partial seizures may cause shaking in one part of the body or may affect any of the five senses making things look, sound, taste, feel or smell different from what they really are.

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- 2) Complex partial seizures differ from simple partial seizures in that consciousness is affected and so the person may have limited or no memory of the seizure. The seizures may be characterized by a change in awareness as well as automatic movements such as fiddling with clothes or objects, mumbling or making chewing movements, or wandering about and general confusion. The person may respond if spoken to. Complex partial seizures most often involve the temporal lobes of the brain, in which case the person may be said to have 'temporal lobe epilepsy', however they can also affect the frontal, parietal and occipital lobes.
When more complex movements are already underway when the seizure begins, it may continue in a clumsy and disorganized sort of way. In rare instances, complex partial seizures may cause running, screaming, flailing and other behaviors that are frightening to see and result in calls to the police.
 - 3) **Secondarily generalized seizure** - For some people either of these partial seizures may spread to involve the whole of the brain. The person will lose consciousness. If this spread is rapid, the person may not be aware of the partial seizure onset.
- b. **Generalized seizures** - In these seizures the whole of the brain is involved and consciousness is lost. They often occur with no warning and the person will have no memory of the event. The seizure may take one of the following forms:
- 1) **Tonic-clonic convulsive seizure** - the most recognized generalized type of seizure. Sometimes it is called a 'grand mal' seizure. In the first part of the seizure the person becomes rigid and may fall. The muscles then relax and tighten rhythmically causing the person to convulse. At the start of the seizure the person may bite their tongue or cry out. Breathing may become labored and they may be incontinent. After the seizure, the person may feel tired, confused, have a headache and may need to rest to recover fully.
 - 2) **Tonic seizures** involve general stiffening of the muscles without rhythmical jerking. The person may fall to the ground with consequent risk of injury but generally recovery is quick.
 - 3) **Atonic seizures**, also known as drop attacks. These involve a sudden loss of muscle tone, causing the

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person to fall. Again, there is consequent risk of injury but recovery is generally rapid.

- 4) Myoclonic seizures involve brief and abrupt jerking of one or more limbs. These often happen within a short time of waking up, either on their own or with other forms of generalized seizure.
 - 5) Absence seizures occur most commonly in children and are sometimes referred to as 'petit mal'. The person experiences a brief interruption of consciousness and becomes unresponsive. They may appear 'blank' or 'staring' usually without any other features, except perhaps for a fluttering of the eyelids. Absence seizures often last for only a couple of seconds and as they are subtle they may go unnoticed.
 - 6) Some seizure patterns may not fit into any of the above categories or may include elements of different seizures. These are called unclassifiable seizures.
- E. Seizure triggers - conditions that provoke seizures: lack of sleep; stress; not taking medication as prescribed (on schedule); environmental stimuli such as flickering/flashing lights, very loud noises, temperature extremes; hypoglycemia; excessive caffeine; alcohol; dehydration; illness and/or fever; hyperventilation.
- F. First-aid - Maintain control of situation but:
1. Do not put anything in mouth
 2. Do not hold down
 3. Do not pry mouth open or attempt to get hold of tongue
 4. Do not act aggressively or attempt physical restraint
 5. Do not leave disoriented person unattended. They are most vulnerable when consciousness is impaired. Remain on scene until person is fully conscious and aware.
 6. Do not deny epilepsy medications
 7. Do not rush or crowd person's personal space. Do not touch. Touching may cause agitation and aggression.
 8. If restraint is needed (when person is so dangerous or violent that they or another person is likely to be harmed) use minimum amount of force necessary. Wait till person is full conscious and responsive before restraint.
 9. Blankets, sheets and towels are best restraint devices
 10. Do not restrain if it could obstruct breathing
 - a. If restraint is needed (when person is so dangerous or violent that they or another person is likely to be harmed), use minimum amount of force necessary.
 - b. Wait until the person is fully conscious and responsive before restraint.

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- c. Use no restraint that could obstruct breathing.

- G. Complex partial seizures
 - 1. Time the seizure.
 - 2. Check for medical identification
 - 3. Reassure bystanders by taking control of the situation in a confident, non-confrontational manner.
 - 4. Speak calmly and reassuringly to person having seizure.
 - 5. Try to avoid touching the person, touching can cause involuntary aggressive response.
 - 6. Do not restrain.
 - 7. Shepherd away from hazards.
 - 8. Stay back if person acts angry or aggressive.
 - 9. Remain on the scene until person is fully conscious and alert.
 - 10. After the seizure, the person may be confused, fatigued, have a severe headache and have amnesia about the event.

- H. First aid for generalized tonic clonic (grand mal)
 - 1. Track length of seizure
 - 2. Look for medical identification
 - 3. Put nothing in the mouth
 - 4. Loosen tight clothing at neck, remove eyeglasses
 - 5. Turn person on one side
 - 6. Do not restrain / hold down
 - 7. Protect head and move harmful objects out of the way
 - 8. Allow the seizure to run its course; you cannot stop the seizure once it has started.
 - 9. Call 9-1-1 only if the generalized tonic clonic (grand mal) seizure lasts more than five minutes
 - 10. Call 9-1-1 if person is pregnant, has diabetes, is injured or has seizure in water
 - 11. After the seizure the person will be very fatigued, may have a headache and will need time to rest and recuperate.

- I. How to differentiate seizure activity from other issues
 - 1. As with other epileptic seizures, these automatic behaviors can be distinguished from mental illness, antisocial behavior or intoxication by their episodic nature, their sudden appearance in an otherwise normally behaving individual and subsequent confusion followed by steady return to normal behavior. Although mental illness can also be episodic it is usually not as sudden in onset or as rapid in resolution as an epileptic seizure.
 - 2. Recognize that seizures can be the answer when faced with unusual behavior or lack of response and that seizure behavior is involuntary, not directed.
 - 3. Look for medical identification.

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4. Ask bystanders about what happened
 - a. When did the episode start?
 - b. Was the person acting normal before?
 - c. Does anyone know the person?
 - d. Does the person have epilepsy?
 5. How responsive or aware is the person?
 6. Are they able to communicate with you?
 7. Are their actions purposeless and not directed?
- J. Faking vs. Real seizures - Assume it is a seizure and perform first aid unless you are convinced by level of awareness and response that it could not possibly be a real seizure. Example: person convulsing on ground is able to hear and respond to you during seizure.
- K. Driving and seizure
1. Oregon is a mandatory physician reporting state.
 2. Anyone over the age of 14 who is being treated for seizure disorder (epilepsy) must be reported to DMV by their physician.
 3. Any person with epilepsy applying for driver's licensing is required to provide a certificate from their physician stating that they have been seizure free a minimum of six months.
 4. Monitoring of their seizure disorder will continue until the person has been seizure free at least two years. Ongoing monitoring will then cease.
5. Any physician treating a person with a seizure disorder must report an episode of loss of consciousness to DMV.
- a. Medical officers at DMV review the person's case and determine whether their license will be temporarily suspended.
 - b. Suspensions usually last three to six months.
 - c. Certain individuals who have intermittent seizures may still be allowed to drive (e.g., persons who have strictly nocturnal (nighttime) seizures)
- XI. Visual Impairment - Blindness
- A. Persons who are visually impaired/blind – this does not necessarily mean no vision
1. Legally blind is if vision cannot be corrected to better than 20/200 in best eye (i.e., looking through several layers of wax paper), or having less than a 20 degree field of vision (i.e., looking through the small ends of Dixie cups)
 2. Not required to carry a white cane (not all individuals with visual impairments choose to use a white cane)
 3. Vehicular traffic is required to provide right of way to individuals using a white cane

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- a. Failure to stop and remain stopped for blind pedestrian (ORS: 811.035)
 - b. Rights for blind or blind and deaf pedestrians (ORS 814.110)
 - c. Unlawful use of white cane (ORS 814.120)
4. White canes are not to be used as weapons.
 5. Visual impairment may not be obvious; if in doubt about the level of sight, ask the person to tell you how much vision is impaired
 6. A blind person may peer closely to you, your face or badge
 7. Speak directly to the blind person, not to the companion or a bystander.
- B. Guide Dogs - Guide dogs and the blind person work as a team; the guide dog is a working animal directed totally by the human; the animal is not a guard dog and should not be used in this way; a guide dog is allowed anywhere a blind person goes.
1. Dog guide in place of public accommodation or on public transportation for person who is blind (ORS 346.620)
 2. Some blind people use guide dogs. The dog and human function as a team. The human makes all the decisions, and gives commands to the dog. The dog should be treated as one might treat a briefcase in the hand of a professional (although larger and with more fur). The animal is a working animal, and should be in harness. The harness may identify the school which trained the dog. The dog may have a tattoo in its ear, or on its inner thigh, identifying it as a dog guide. It is not a guard dog. State and federal statues allow this team to go ANYWHERE. The blind person may choose to take their guide dog into businesses, restaurants, kitchens, toilets, onto buses, trains and planes. Apartment owners may not discriminate in rental, even if there is a “no pets” clause. At the same time, a guide dog user is trained in how to keep the dog within their control, and to relieve the animal without causing undue social concern (removing the “litter”).
- C. Individuals touching other people - Not appropriate for a blind person to grope others but often they reach for common markers or landmarks to find a particular place to stand or lean.

It is considered socially inappropriate for blind individuals to “grobe” or touch other people (touching faces is NOT common). Blind men who ask to “hug” women to “see what they look like” are going well beyond socially accepted norms (and know it). Many blind people will reach out to find a common maker or landmark (at a bus stop, finding a particular place to stand or lean), but will in general avoid groping motions, because of not wanting to “grobe” a person accidentally. Socially acceptable touch between a blind person and a stranger is limited to taking the other

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person's elbow when walking together, when traveling in the same direction. Only the blind person's fingertips and thumb need to touch the elbow. Rubbing against the guide's chest, or asking to hold hands is not accepted amongst strangers.

- D. Eye movements - Tendency to shift eyes more often; rely on traffic noise to decide when to cross street; most travel their known routes; rely on noises, smell of the wind, changes in temperature (shadows of buildings), textures on ground, inclines and slopes to travel safely

Blind or visually impaired people may shift their eyes more often to see more in the surrounding environment, or because they have a medical condition which causes involuntary eye movement. Blind people may look over your shoulder, in order to better see you with their remaining vision. Blind people may not look at you at all, though most will turn their head and position their face and eyes toward you in your direction (knowing that this is considered polite in our sighted society).

- E. Blind people as witnesses - The blind may use other descriptors as witnesses to crimes, such as tone of voice, smell. It may be necessary to recreate noises and ask if this was the sound they heard

Blind people who have witnessed a crime may have other descriptors of the criminal not usually noticed by sighted folks (tone of voice, smell). Blind people may not be able to tell you where someone appeared on the scene or which direction they headed away to (unless they heard foot falls echoing in the distance).

- F. Printed Documents - Read out loud anything (in its entirety) to a blind person before requiring a signature. May use talking watches or other devices for taking notes or reading

If you have print documents that a blind person must understand before signing or accepting, you will have to read aloud the entire document to the person. Do not just summarize. You may summarize in addition to reading aloud the entire document. Do not assume that a blind person can read print of any size. Blind people often don't use or understand maps. Ask them what directions they can best use, if they ask for assistance. Saying "the bus stop in the middle of the next block" doesn't tell a blind person which street or which side of the street, how long the block is, where the middle of the block is, or how many buses stop there. Blind people may not be able to identify paper money that is given in change. Blind people rely on shopkeepers, tellers at the bank, friends and family and public servants to identify bill denomination so that they can sort and carry money.

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- G. Arresting or Holding a Blind/Visually Impaired Person, Cane & Guide Dog
1. First and foremost, we recommend that you follow the written policies and procedures of your department. Your department can also contact the local ADA coordinator or the Department of Justice.
 2. The ADA requires that you offer (provide) reasonable accommodations. This does not always mean providing the accommodations requested by the suspect. We recommend that you consider carefully any accommodation that might jeopardize you, other staff or other suspects.
 3. In a hold or arrest situation, at the station, you are going to remove items which might endanger the suspect or others being held, like shoes, jewelry, walking sticks, pets. We recommend that you do as you would with others being held or arrested, remove white canes and guide dogs as you would with other personal property.
 4. We recommend that staff (not other inmates) provide “sighted guide” for the suspect. A “sighted guide” walks before the blind person. The blind person then holds the guide’s elbow lightly with their hand. The guide’s body movement (up stairs, down stairs, opening doors) gives information to the blind person.
 5. We recommend that you orient the blind or visually impaired person to the holding area or cell. Show them where the toilet, bed, chair, bench and door are.
 6. We recommend you consider fully the amount and limitations of a suspect’s vision. If the suspect can’t see objects that are people-sized they may be at risk in a large holding area with other inmates. Some jails will place a blind or visually impaired person alone in a smaller area, or in a supervised setting like an infirmary.
 7. We recommend that you hold a white cane with other belongings. We recommend that you call the local animal shelter for care of the guide dog. Guide dog schools have varying policies regarding ownership of the dog. Some schools retain ownership of the dog. The local animal shelter should be prompted to hold the dog and harness then contact the school that issued the guide dog for further instructions.

XII. Communicating with People who are Deaf or Hard of Hearing

A. ADA Guide for Law Enforcement Officers

As a law enforcement officer, you can expect to come into contact with people who are deaf or hard of hearing. It is estimated that up to nine percent of the population has some degree of hearing loss, and this percentage will increase as the population ages.

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Under the Americans with Disabilities Act (ADA), people who are deaf or hard of hearing are entitled to the same services law enforcement provides to anyone else. They may not be excluded or segregated from services, be denied services, or otherwise be treated differently than other people. Law enforcement agencies must make efforts to ensure that their personnel communicate effectively with people whose disability affects hearing. This applies to both sworn and civilian personnel.

Your agency has adopted a specific policy regarding communicating with people who are deaf or hard of hearing. It is important to become familiar with this policy.

- B. Requirements for Effective Communication – The ADA requires that:
1. Law enforcement agencies must provide the communication aids and services needed to communicate effectively with people who are deaf or hard of hearing, except when a particular aid or service would result in an undue burden or a fundamental change in the nature of the law enforcement services being provided.
 2. Agencies must give primary consideration to providing the aid or service requested by the person with the hearing disability.
 3. Agencies cannot charge the person for the communication aids or services provided.
 4. Agencies do not have to provide personnel prescribed devices such as hearing aids.
 5. When interpreters are needed, agencies must provide interpreters who can interpret effectively, accurately and impartially.
 6. Only the head of the agency or his or her designee can make the determination that a particular aid or service would cause an undue burden or a fundamental change in the nature of the law enforcement services being provided.

Your agency's policy explains how to obtain interpreters or other communication aids and services when needed.

- C. Communicating with People who are Deaf or Hard of Hearing
Officer may find a variety of communication aids and services useful in different situations.
1. Speech supplemented by gestures and visual aids can be used in some cases.
 2. A pad and pencil, a word processor, or a typewriter can be used to exchange written notes.
 3. A teletypewriter (TTY, also known as a TDD) can be used to exchange written messages over the telephone.
 4. An assistive listening system or device to amplify sound can be used when speaking with a person who is hard of hearing.

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5. A sign language interpreter can be used when speaking with a person who knows sign language.
6. An oral interpreter can be used when speaking with a person who has been trained to speech read (read lips). Note: Do not assume that speech reading will be effective in most situations. On average, only about one third of spoken words can be understood by speech reading.

The type of situation, as well as the individual's abilities, will determine which aid or service is needed to communicate effectively.

D. Practical Suggestions for Communicating Effectively

1. Before speaking, get the person's attention with a wave of the hand or a gentle tap on the shoulder.
2. Face the person and do not turn away while speaking.
3. Try to converse in a well-lit area.
4. Do not cover your mouth or chew gum.
5. If a person is wearing a hearing aid, do not assume the individual can hear you.
6. Minimize background noise and other distractions whenever possible.
7. When you are communicating orally, speak slowly and distinctly. Use gestures and facial expressions to reinforce what you are saying.
8. Use visual aids when possible, such as pointing to printed information on a citation or other document.
9. Remember that only about one third of spoken words can be understood by speech reading.
10. When communicating by writing notes, keep in mind that some individuals who use sign language may lack good English reading and writing skills.
11. If someone with a hearing disability cannot understand you, write a note to ask him or her what communication aid or service is needed.
12. If a sign language interpreter is requested, be sure to ask which language the person uses. American Sign Language (ASL) and Signed English are the most common.
13. When you are interviewing a witness or a suspect or engaging in any complex conversation with a person whose primary language is sign language, a qualified interpreter is usually needed to ensure effective communication.
14. When using an interpreter, look at and speak directly to the deaf person, not to the interpreter.
15. Talk to your normal rate, or slightly slower if you normally speak very fast.
16. Only one person should speak at a time.

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17. Use short sentences and simple words.
18. Do not use family members or children as interpreters. They may lack the vocabulary or the impartiality needed to interpret effectively.

E. What Situations Require an Interpreter?

Generally, interpreter services are not required for simple transactions – such as checking a license or giving directions to a location – or for urgent situations – such as responding to a violent crime in progress.

Example: An officer clocks a car on the highway going 15 miles per hour above the speed limit. The driver, who is deaf, is pulled over and is issued a noncriminal citation. The individual is able to understand the reason for the citation because the officer points out relevant information printed on the citation or written by the officer.

Example: An officer responds to an aggravated battery call and upon arriving at the scene observes a bleeding victim and an individual holding a weapon. Eyewitnesses observed the individual strike the victim. The individual with the weapon is deaf. Because the officer has probable cause to make a felony arrest without an interrogation, an interpreter is not necessary to carry out the arrest.

However, an interpreter may be needed in lengthy or complex transactions – such as interviewing a victim, witness, suspect, or arrestee – if the person being interviewed normally relies on sign language or speech reading to understand what others are saying.

Example: An officer responds to the scene of a domestic disturbance. The husband says the wife has been beating their children and he has been trying to restrain her. The wife is deaf. The officer begins questioning her by writing notes, but her response indicates a lack of comprehension. She requests a sign language interpreter. In this situation an interpreter should be called. If the woman's behavior is threatening, the officer can make an arrest and call for interpreter to be available later at the booking station.

It is inappropriate to ask a family member or companion to interpret in a situation like this because emotional ties may interfere with the ability to interpret impartially.

Example: An officer responds to the scene of a car accident where a man has been seriously injured. The man is conscious, but is unable to comprehend the officer's questions because he is deaf. A family member who is present begins interpreting what the officer is saying.

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A family member or companion may be used to interpret in a case like this, where the parties are willing, the need for information is urgent, and the questions are basic and uncomplicated. However, in general, do not expect or demand that a deaf person provide his or her own interpreter. As a rule, when interpreter service is needed, it must be provided by the agency.

List your agency's contact information for obtaining an interpreter, an assistive listening device, or other communication aid or service here.

XIII. Cognitive Disorders, Dementia, Excited Delirium and Brain Trauma

- A. Cognitive Disorders: The class of disorders consisting of significant impairment of cognition or memory that represents a marked deterioration from a previous level of functioning.¹²
- B. Dementia: Cognitive impairment involving a generalized and progressive deficit in the areas of memory, the learning of new information, the ability to communicate, in making good judgments, and in motor coordination. This loss of intellect, memory, or mental capacity, is usually accompanied by personality and behavior changes. Depending on the type, some dementias are reversible, while others are not. Dementia due to a brain tumor may be reversible but dementia due to Alzheimer's is not.¹³

This is a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment and impulses. This is more likely to affect the elderly.

- C. Excited Delirium (Sudden in custody death)
 - 1. Definition: "Excited Delirium has been described as "a state of extreme mental and physiological excitement," characterized by exceptional agitation and hyperactivity, overheating, excessive tearing of the eyes, hostility, superhuman strength, aggression, acute paranoia, and "endurance without apparent fatigue."¹⁴
 - 2. Symptoms¹⁵
 - a. Bizarre and/or aggressive behavior
 - b. Shouting
 - c. Paranoia
 - d. Panic
 - e. Violence towards others
 - f. Unexpected physical strength
 - g. Sudden tranquility
 - 3. Recommendations¹⁴
 - a. Coordinate in advance with EMS.

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- b. Train dispatchers to recognize ED
 - c. EMS should be dispatched and stand by
 - d. The first responding officers should focus on containing the suspect
 - e. When the first responding officers identify ED, ask for backup
 - f. With backup, get the suspect under control and receive medical treatment
 - g. Consider empty-hand, mechanical tactics may be more difficult to achieve. Pain-based techniques may be ineffective. A choice may be use of Conducted Energy devices.
 - h. Adjust your restraint tactics. The prone position is typically used because of safety and control advantages. It may make it more difficult for the person to breathe. This is a when dealing with ED.
 - j. Get the suspect into the hands of medical personnel or to a hospital ASAP
 - k. Medical personnel should have their own protocols for dealing with ED cases
- D. Brain damage¹⁶: the brain is a highly specialized tissue, far more complex than today's 21st century supercomputers. Due to this magnificent complexity, even the slightest damage can have extreme consequences. The brain can be damaged in a variety of ways, and depending on the areas damaged and the severity of the damage, it can prove relatively harmless to fatal. Some causes of brain damage are below.
- 1. *Genetics* - A dysfunctional hereditary gene could have been passed on to the offspring which prevented the full development of a healthy brain.
 - 2. *Blow* - A sufficient blow to the head can supersede the skulls defenses (particularly at the temple) and can therefore allow structural damage to occur.
 - 3. *Lack of Blood* - Lack of blood to the brain can cause severe problems for the cells associated with the brain. A human can survive for four minutes without oxygen before the brain damage becomes so severe there is no realistic chance of survival. A stroke is an event where there is a blood shortage to the brain, which is caused by a blood clot
 - 4. *Tumors* - Cancer has been a major non-infectious disease more recognized over the last decade, and more cases of brain tumors are detected nowadays due to more sophisticated techniques. The continued growth of these cancerous cells puts pressure on the brain, which can cause a blood clot or directly cause brain damage due to the pressure of the tumor pressing against it.

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XIV. How to Differentiate between Mental Health Disorders and Substance Abuse

Sometimes you cannot differentiate between the two.¹⁷

- A. (April 2000) “Co-occurrence of substance abuse – Approximately 15 percent of all adults who have a mental disorder in one year also experiences a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.”
- B. Ask if involved with mental health services
- C. Note unique odors (alcohol, marijuana, etc.)
- D. Ask if recently drinking or using drugs
- E. Ask if taking prescription medication and what for
- F. Note slurred speech (intoxication)
- G. Observe neologisms or rhyming of words (mental illness)
- H. The best indicator is blood or urine evaluations
- I. Delirium tremens (alcohol withdrawal)
- J. Methamphetamines (psychotic-like state)
- K. Track marks on body (drugs)
- L. Hallucinations; auditory/olfactory (mental illness; visual/somatic; intoxication withdrawal)
- M. Environmental cues (drug paraphernalia, alcohol bottles)

XV. Introduction to Suicide

- A. There is no typical suicide victim. It happens to young and old, rich and poor, sick and well. However, there are some common warning signs which, when acted upon, can save lives. Often you will be the first responder to private homes, schools, businesses, nursing facilities, hospitals and the community in general. The caller (self, friend, etc.) feels the situation is at a crisis level and law enforcement is needed as the person is dangerous to themselves. Dangerous in that they are thinking about suicide (suicidal ideation), possibly have made plans, have attempted suicide or have killed themselves. There have been suicide-by-cop, or police assisted suicide deaths in Oregon. These situations can be some of the most dangerous you will encounter.
- B. Definition: Suicidal ideation, attempts, or completion are often the result of unresolved problems that reduce a person’s ability to cope. It is rarely the result of a single conflict, problem, or cause, although a single event may act as a trigger. Suicidal feelings, thoughts and behavior are almost always associated with symptoms of depression, anxiety or other mental illness.

“Suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution.” Dr. Ed Shneidman, Psychache, 1993.

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- C. Facts¹⁸
1. Males
 - a. Suicide is the eighth leading cause of death for all U.S. men
 - b. Males are four times more likely to die from suicide than females
 - c. Suicide rates are highest among Whites and second highest among American Indian and Native Alaskan men
 - d. Of the 24,672 suicide deaths reported among men in 2001, 60% involved the use of a firearm
 2. Females - Women report attempting suicide during their lifetime about three times as often as men
 3. Youth - The overall rate of suicide among youth has declined slowly since 1992. However, rates remain unacceptably high. Adolescents and young adults often experience stress, confusion, and depression from situations occurring in their families, schools, and communities. Such feelings can overwhelm young people and lead them to consider suicide as a "solution." Few schools and communities have suicide prevention plans that include screening, referral, and crisis intervention programs for youth.
 - a. Suicide is the third leading cause of death among young people ages 15 to 24. In 2001, 3,971 suicides were reported in this group
 - b. Of the total number of suicides among ages 15 to 24 in 2001, 86% were male and 14 were female
 - c. American Indian and Alaskan Natives have the highest rate of suicide in the 15 to 24 age group
 - d. In 2001, firearms were used in 54% of youth suicides
 4. The Elderly - Suicide rates increase with age and are very high 65 years and older. Most elderly suicide victims are seen by their primary care provider a few weeks prior to their suicide attempt and diagnosed with their first episode of mild to moderate depression older adults who are suicidal are also more likely to be suffering from physical illnesses and be divorced or widowed
 - a. In 2001, 5,393 Americans over age 65 committed suicide. Of those, 85% were men and 15% were women
 - b. Firearms were used in 73% of suicides committed by adults over the age of 65 in 2001

D. The Mythology of Suicide¹⁹

- Myth: People who talk about killing themselves rarely commit suicide
Fact: Most people who commit suicide have given some verbal clues or warning of their intention.

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- Myth: The tendency toward suicide is inherited and passed from generation to generation.
Fact: Although suicidal behavior does tend to run in families, it does not appear to be transmitted genetically.
- Myth: The suicidal person wants to die and feels that there is no turning back.
Fact: Suicidal people are usually ambivalent about dying and frequently will seek help immediately after attempting to harm themselves.
- Myth: All suicidal people are deeply depressed.
Fact: Although depression is often closely associated with suicidal feelings, not all people who kill themselves are obviously depressed. In fact some suicidal people appear to be happier than they've been in years because they have decided to "resolve" all of their problems by killing themselves. Also, people who are extremely depressed usually do not have the energy to kill themselves.
- Myth: There is no correlation between alcoholism and suicide.
Fact: Alcoholism and suicide often go hand in hand. Alcoholics are prodded to suicidal behavior and even people who don't normally drink will often ingest alcohol shortly before killing themselves.
- Myth: Suicidal people are mentally ill.
Fact: Although many suicidal people are depressed and distraught, most could not be diagnosed as mentally ill; perhaps only about 25 percent of them are actually psychotic.
- Myth: Once someone attempts suicide, that person will always entertain thoughts of suicide.
Fact: Most people who are suicidal are so for only a very brief period once in their lives. If the person receives the proper support and assistance, he/she will probably never be suicidal again. Only about 10 percent of the people who attempt later kill themselves.

NTF: Be sure to emphasize the following myth.

- Myth: If you ask someone about their suicidal intentions, you will only encourage them to kill themselves.
Fact: Actually the opposite is true. Asking someone directly about their suicidal intentions will often lower their anxiety level and act as a deterrent to suicidal behavior by encouraging the ventilation of pent-up emotions through a frank discussion of their problems.
- Myth: Suicide is quite common among the lower class.

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Fact: Suicide crosses all socioeconomic distinctions and no one class is more susceptible to it than another.

Myth: Suicidal people rarely seek medical attention.

Fact: Research has consistently shown that about 75 percent of suicidal people will visit a physician within the month before they kill themselves

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E. Suicide warning signs¹⁷

The first step in preventing suicide is to identify and understand the risk factors. A risk factor is anything that increases the likelihood that persons will harm themselves. However, risk factors are not necessarily causes. Research has identified the following risk factors for suicide

1. Previous suicide attempt(s)
2. History of mental disorders, particularly depression
3. History of alcohol and substance abuse
4. Family history of suicide
5. Family history of child maltreatment
6. Feelings of hopelessness
7. Impulsive or aggressive tendencies
8. Barriers to accessing mental health treatment
9. Loss (relational, social, work, or financial)
10. Physical illness
11. Easy access to lethal methods
12. Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or suicidal thoughts
13. Cultural and religious beliefs – for instance, the belief that suicide is a noble resolution of a personal dilemma
14. Local epidemics of suicide
15. Isolation, a feeling of being cut off from other people

F. Patrol tactics for handling a call from a suicidal person:

1. Identify the threat a suicidal person may pose and safe approach to such persons.
2. Take threats seriously
3. Use caution, as suicidal people may at times be homicidal and/or want to be shot by law enforcement
4. Work-with-others: solicit information from a family member or friend who knows about or is close to the suicidal person.
5. Have access to county mental health crisis workers or mental health protocols, and crisis hot line numbers.
6. Your job is threefold:
 - a. Safety of yourself, the suicidal person and environment
 - b. Coordinate the available and appropriate resources to resolve the immediate crisis.
 - c. Think civil vs. criminal burden of proof
 - 1) Civil: preponderance of the evidence
 - 2) Criminal: beyond a reasonable doubt
 - 3) You only need “civil” burden of proof
7. Be yourself – if you are concerned, your voice and manner will show it.

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8. Listen, be nonjudgmental and empathetic – he or she will feel better no matter how negative they seem. The fact that you received the call is a positive sign.
 9. Avoid arguments or personal problem solving. It's not how bad the problem is, but how badly it's hurting the person who has it.
 10. Ask the person if they are thinking of suicide or doing anything to harm themselves. If the answer is yes, ask if they have a plan "have you thought about how you would do it?" Ask, "When might you be doing it?"
 11. Time frame. Ask if they have the means to carry out the plan.
 12. Do not leave a suicidal person alone if they are acutely suicidal. Let them know you need to call someone.
 13. When possible, have the means removed. This could include having a friend and/or family member remove pills, guns, knives and alcohol.
 14. Reference student handout material on handling persons with mental illness / CIT model.
- G. Suicide by cop or police assisted suicide. There have been several police-assisted suicide cases in Oregon both in large and small cities. "Suicide by cop" is an act whereby a person presents a threat to a police officer in order to compel the officer or officers to use deadly force to stop that threat. The result is a suicide at the hands of a police officer.
1. Research studies²⁰ shows
 - a. 10-15% of officer involved shootings are police-assisted suicides.
 - b. 96 % are male.
 - c. Weapons ranged
 - 1) Firearms (over 40%)
 - 2) Stabbing instruments (over 40%)
 - 3) Firearms replicas (over 5%)
 - d. 58 % asked to be killed by police
 - e. 58 % had a psychiatric history
 - f. 38 % previously attempted
 - g. 50 % were intoxicated
 - h. 42 % domestic violence history
 - i. 38 % had a criminal history.
 2. The immediate thought at the time of seven people who forced an officer to shoot:
 - a. "My life is over anyway, so they might as well shoot me."
 - b. "I deserve to die."
 - c. "Now they'll (she or family) see how much I hurt."
 - d. "This is my only way out."
 - e. "I'm in control – not you or anybody else."
 - f. "If you want to shoot, it doesn't matter."

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- g. "I'm better off dead."
- 3. Police officer reacting to the aftermath of "suicide by cop" display symptoms of post-traumatic stress disorder, which adversely affects their ability to perform their duties. In many instances, the timing, speed at which the encounter escalated and the officer's perception of immediate danger to self or others left him or her no choice but to use deadly force. Yet, second-guessing on the part of the officer is common.

XVI. Oregon Revised Statutes

- A. Civil Commitment Process (Applicable statutes listed in the Student Resource Appendix):
 - 1. Conditions:
 - a. Danger to self (including unable to meet basic needs)
 - b. Danger to others
 - c. Need immediate care, custody or treatment
 - d. Mentally ill
 - 2. Statutes
 - a. Initiation (ORS 426.070)
 - b. Court determination of mental illness (ORS 426.130)
 - c. Custody; authority of peace officers (ORS 426.228)
 - d. Physician hold (ORS 426.231)
 - e. Physician emergency admission (ORS 426.232)
 - f. Authority of community mental health and developmental disabilities program director and of other persons (ORS 426.233)
- B. Criminal Commitment Process (Statutes within Chapter 161 of the Oregon Criminal Code book)
 - 1. Effect of mental disease or defect (ORS 161.295)
 - 2. Mental disease or defect excluding fitness to proceed (ORS 161.360)
- C. Other Applicable Statutes
 - 1. Definitions for ORS 430.735 to 430.765 ORS 430.735 (Note: 2007 Oregon legislature amended definition of "adult" and "adult protective services")
 - 2. Investigation of abuse report (ORS 430.745)
 - 3. Photographs of victim during investigation (ORS 430.747)
 - 4. Immunity of persons making reports in good faith (ORS 430.753)
 - 5. Confidentiality of records (ORS 430.763)
 - 6. Duty of officials to report (ORS 430.765)

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XVII. Community Resources

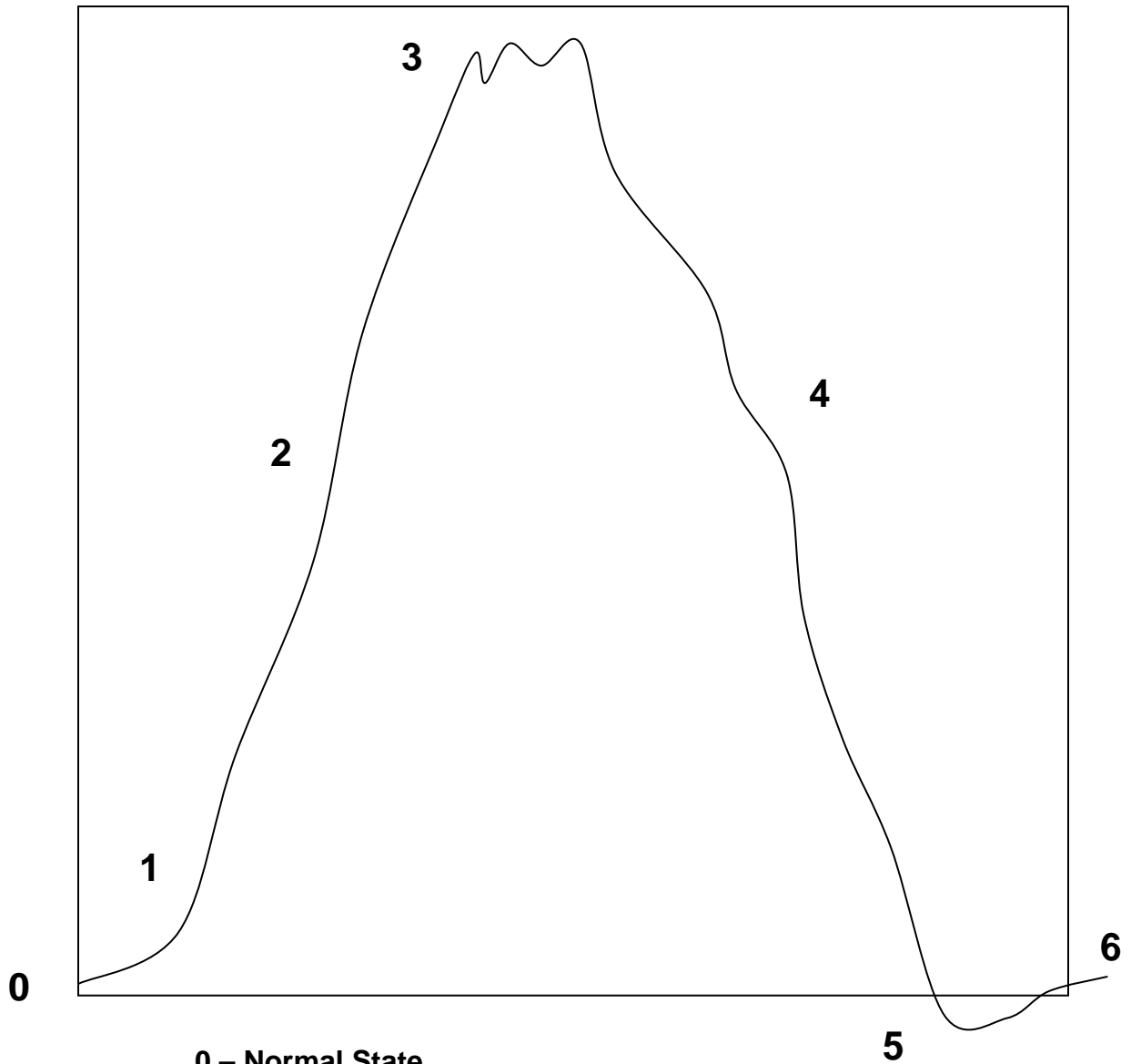
- A. Family physicians
- B. Mental health practitioners
- C. County mental health programs
- D. Local hospital emergency rooms and psychiatric units
- E. State mental hospital system

XVIII. Crisis Intervention Team (CIT) Tactics

- A. Approaching the scene
 - 1. Receive the call
 - 2. Gather Information before you arrive
 - 3. Monitor your own emotional state
 - 4. Leave prejudice/bias/predisposition behind
- B. On the Scene - Assess the situation and stabilize
- C. Crisis Intervention
 - 1. Crisis cycle
 - a. Intervention at each stage of the cycle
 - b. Different levels of understanding, perception and development at each stage
 - c. Look at face, voice, and posture for signs of what level they are at

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“The Crisis Cycle”



- 0 – Normal State
- 1 – Stimulation
- 2 – Escalation
- 3 – Crisis
- 4 – De-escalation
- 5 – Post crisis depletion
- 6 – Stabilization

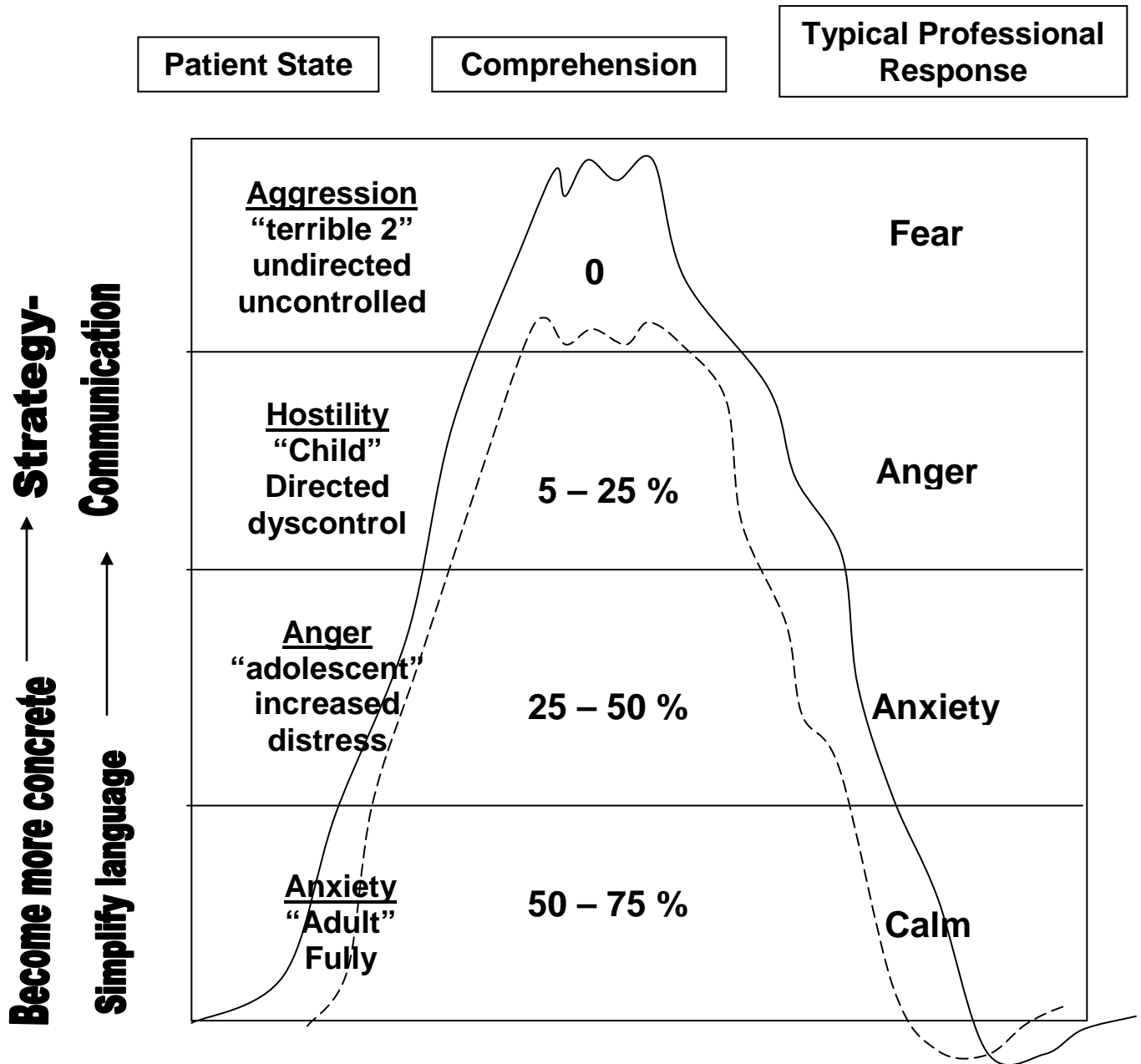
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Basic Psychiatric Life Support Model

Patient State	% of Comprehension
<p align="center"><u>Aggression</u> “terrible 2” undirected uncontrolled</p>	<p align="center">0 – 5 %</p>
<p align="center"><u>Hostility</u> “Child” Directed dyscontrol</p>	<p align="center">5 – 25 %</p>
<p align="center"><u>Anger</u> “adolescent” increased distress</p>	<p align="center">25 – 50 %</p>
<p align="center"><u>Anxiety</u> “Adult” Fully</p>	<p align="center">50 – 75 %</p>

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Crisis Cycles with Basic Psychiatric Life Support Model



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2. Stages of Cycle
 - a. Normal state
 - 1) 100% perception and ability to reason
 - 2) Acts as an adult
 - 3) Person experiences no emotional content
 - 4) Officer is calm
 - 5) Can problem solve
 - b. Stimulation (internal/external)
 - 1) 50-75 % perception and ability to reason and/or understand. The officer will recognize agitated behavior
 - 2) Acts as a teenager
 - 3) Person experiences anxiety
 - 4) Officer is calm
 - 5) Actions an officer should take
 - a) Use simple sentences
 - b) Use calming body language
 - c) Keep voice low and calm
 - c. Escalation
 - 1) 5-24% perception and ability to reason/understand
 - 2) Loud, aggressive, flushed
 - 3) Acts as an 8-year old having a tantrum
 - 4) Person experiences fear; frustration
 - 5) Officer is anxious
 - 6) Actions an officer should take
 - a) Use firm, 1 to 3 word phrases
 - “Please – sit down.”
 - “Please – stop that.”
 - b) Make one immediate request
 - c) Repeat continually
 - d) Body language and voice firm, but calm
 - d. Crisis
 - 1) 0-5 % perception and ability to reason/understand
 - 2) Out of control
 - 3) Acts like terrible two's
 - 4) Person experiences anger
 - 5) Officer is fearful / frustrated
 - 6) Actions officer should take
 - a) Use firm, one word commands
 - “Stop”
 - “No”
 - “Sit-down”
 - b) Repeat continually

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- c) Make decision regarding use of physical force
- e. De-escalation
 - 1) As the consumer de-escalates, officer uses the same techniques down the de-escalation
 - 2) Consumers may suffer post-crisis depression
 - 3) Escalation can cycle up and down
- 3. Things to remember
 - a. Take your time
 - b. Person cannot remain in crisis state forever
 - c. Constantly read feedback from the consumer
 - d. Stop doing anything that escalates the consumer
 - e. Continue anything that de-escalates the consumer
 - f. Reinforce: Have only one officer talk to the consumer at a time; trade off with another officer if you are not effective (Officers have a hard time believing that they are not effective, but this needs to happen.)
 - g. Ask if a person is thinking of taking their life or harming themselves. So often we ask individuals if they are suicidal or homicidal, but do not address the fact that they want to cut on themselves – not just kill themselves. Many times people do not have thoughts of killing themselves, but do have ideas of harming themselves (maiming or punishing)
- 4. Communication Skills
 - a. Verbal Skills
 - 1) Tell person you are there to help
 - 2) Introduce self by first name
 - 3) Ask and use their name
 - 4) Do not involve yourself in their delusions; show you understand that they believe it is really happening
 - 5) Ask clarifying questions in terms of “I” statements
 - a) “I don’t understand this”
 - b) “I’m afraid that you’ll hurt yourself”
 - c) “I can’t figure out why”
 - 6) Use personalized statements - . “You’re holding that rock makes me nervous”
 - 7) Do not argue
 - 8) Actively listen
 - a) Do not be afraid of silence
 - b) Wait for responses
 - c) Echo their feelings “You seem to be angry”
 - 9) Show concern and understanding
 - a) Nod head while they are talking

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- b) Indicate listening with “I see” or “Uh, huh”, etc
 - 10) Treat person with respect
 - 11) Do not use offensive terms or sarcastic remarks
 - 12) Tell people what you are going to do and do not make promises you cannot keep
 - 13) If person becomes agitated, change subject
- b. Non-verbal skills
- 1) Feedback loop
 - a) Watch reactions of the consumer to you
 - b) Stop action if it escalates the consumer
 - 2) Open body language
 - a) Rule of Palm – talk with your palms open
 - b) Stand slightly to the side/balanced
 - c) Take safe, but not defensive stance
 - i. More relaxed posture
 - ii. Head tilted
 - iii. Be ready/appear relaxed
 - d) Keep hands off paraphernalia
 - 3) Eye Contact
 - a) Try to make eye contact
 - i. Some people like it as sign of personal contact / rapport
 - ii. May make some people nervous
 - b) Try to remain at eye level
 - 4) Body Space
 - a) Rule of 3 - Remain at least 3 arms length away at first contact
 - b) May need to move in to establish personal
 - 5) Move slowly and announce action to the consumer
- c. Questions to Ask
- 1) Ask what is happening that caused the crisis
 - 2) Ask about past history
 - a) Case worker
 - b) Counselor
 - c) Treatment
 - 3) Ask how they resolve similar situations in the past

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- 4) Ask what clinic they go to or where they go for treatment
- 5) Ask if they are taking medication
- 6) Ask the names of their medication
- 7) Ask about the side-effects from their medication
- 8) Ask if they would like to see a doctor
- 9) Ask if they are thinking of taking their own life
 - a) How?
 - b) Do they have the means? (gun, knife, pills)
 - c) Have they ever tried it before?
- 10) Ask if they are hearing voices and are they telling you to do something?
- 11) Ask permission to approach: "May I come closer to talk to you?"

d. Officer Safety reminders

- 1) Never deny the possibility of violence - persons with mental illness are not more violent than the "normal" population but may be more unpredictable
- 2) If hearing voices, ask what the voices are saying
- 3) Keep relaxed approach, but not complacent
- 4) Watch the consumer's hands
- 5) Upon transport, always handcuff even if this risks re-exciting the consumer; tell the person what you are going to do and why

D. The Basic Rules of Intervention –

1. The Rule of Time (Take as much time as you need)
2. The Rule of Three (Stay at least 3 arms length away)
3. The Rule of Five (You may have to repeat yourself up to 5 times)

NTF: Make sure to note to the students that how you say "it" the first time and then say "it" the fifth time, you should have the same tone and the volume each time.

4. The Rule of Palms (Show your palms to the person)
5. The Rule of Echoes (Repeating back to someone what they said/feel)
6. The Rule of Calm (Project a calm demeanor)

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EXERCISE

Description: Class exercise to simulate schizophrenia.

1. Divide the class into groups of 4. Each will have a specific role.
2. One person will sit in a chair, and needs to be told that they will soon start to hear voices. They can't get up from the chair, or cover their ears. They will listen to any questions directed at them, and try to answer them.
3. One person will have a list of questions to ask the seated person including familiar ones like, name, D.O.B., and other's. This person will stand directly in front of the seated person.
4. Two people will stand on each side of the seated person, and have a script with them. They will also get a piece of paper and roll it up into a tube big enough to speak into. They will then put the open end about 1-2 inches from the seated person's ears and start talking in a low voice. They will stick with the script and talk faster and slower as needed. They can also talk louder and softer as they see fit.
5. The goal of this exercise is to simulate what someone with schizophrenia would go through on a nearly constant basis. A good analogy would be to try and imagine a radio station in a room you can't leave, and you can't turn the station off.
6. Refer to the attached sheets for the questions and "Voices" script.

Voices #1

I am God
I am God
You are worthless
You are a FAILURE!
You are USELESS!
Hurt Yourself
Hurt Yourself
Hurt Yourself
Get up and RUN!
Get up and RUN!
GET UP AND RUN!
That Cop is Gonna Kill You!!!
Better Run Now!
Better Run Now!
Better Run Now!

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VOICES #2

YOU'RE A BAD PERSON.
EVERYBODY HATES YOU.
YOU SHOULD NOT BE ALLOWED TO LIVE.
NOBODY CARES ABOUT YOU.
YOU SHOULD DIE.
LIAR!!! LIAR!!! LIAR!!!
WHAT MAKES YOU THINK THAT YOU SHOULD GO ON WITH YOUR LIFE?
YOU NEVER DO ANYTHING RIGHT.
THIS SHOWS WHAT A JERK YOU ARE.
YOU SHOULD DIE.
YOU HAVE NO REAL FRIENDS.
YOU ARE SELF CENTERED AND SELFISH.
LIAR!!! LIAR!!! LIAR!!!
YOU'RE A WORTHLESS PERSON.
NOBODY CARES.
YOU ALWAYS FAIL.
YOU'RE LAZY.
NOTHING YOU DO IS IMPORTANT.
YOU SHOULD DIE.
YOU NEVER DO ANYTHING RIGHT.
YOU'RE A FAILURE.

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COMMONLY ASKED QUESTIONS ABOUT THE AMERICANS WITH DISABILITIES ACT AND LAW ENFORCEMENT

I. Introduction

Police officers, sheriff's deputies, and other law enforcement personnel have always interacted with persons with disabilities and, for many officers and deputies, the Americans with Disabilities Act (ADA) may mean few changes in the way they respond to the public. To respond to questions that may arise, this document offers common sense suggestions to assist law enforcement agencies in complying with the ADA. The examples presented are drawn from real-life situations as described by police officers or encountered by the Department of Justice in its enforcement of the ADA.

1. Q: What is the ADA?

A: The Americans with Disabilities Act (ADA) is a Federal civil rights law. It gives Federal civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in State and local government services, public accommodations, employment, transportation, and telecommunications.

2. Q: How does the ADA affect my law enforcement duties?

A: Title II of the ADA prohibits discrimination against people with disabilities in State and local governments' services, programs, and employment. Law enforcement agencies are covered because they are programs of State or local governments, regardless of whether they receive Federal grants or other Federal funds. The ADA affects virtually everything that officers and deputies do, for example:

- receiving citizen complaints;
- interrogating witnesses;
- arresting, booking, and holding suspects;
- operating telephone (911) emergency centers;
- providing emergency medical services;
- enforcing laws;
- and other duties.

3. Q: Who does the ADA protect?

A: The ADA covers a wide range of individuals with disabilities. An individual is considered to have a "disability" if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

Major life activities include such things as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. To be substantially

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limited means that such activities are restricted in the manner, condition, or duration in which they are performed in comparison with most people.

- The ADA also protects people who are discriminated against because of their association with a person with a disability.

Example: Police receive a call from a woman who complains that someone has broken into her residence. The police department keeps a list of dwellings where people with AIDS are known to reside. The woman's residence is on the list because her son has AIDS. Police fail to respond to her call, because they fear catching the HIV virus. The officers have discriminated against the woman on the basis of her association with an individual who has AIDS.

4. Q: What about someone who uses illegal drugs?

A: Nothing in the ADA prevents officers and deputies from enforcing criminal laws relating to an individual's current use or possession of illegal drugs.

II. Interacting with People with Disabilities

5. Q: What are some common problems that people with disabilities have with law enforcement?

A: Unexpected actions taken by some individuals with disabilities may be misconstrued by officers or deputies as suspicious or illegal activity or uncooperative behavior.

Example: An officer approaches a vehicle and asks the driver to step out of the car. The driver, who has a mobility disability, reaches behind the seat to retrieve her assistive device for walking. This appears suspicious to the officer.

- Individuals who are deaf or hard of hearing, or who have speech disabilities or mental retardation, or who are blind or visually impaired may not recognize or be able to respond to police directions. These individuals may erroneously be perceived as uncooperative.

Example: An officer yells "freeze" to an individual who is running from an area in which a crime has been reported. The individual, who is deaf, cannot hear the officer and continues to run. The officer mistakenly believes that the individual is fleeing from the scene. Similarly, ordering a suspect who is visually impaired to get over "there" is likely to lead to confusion and misunderstanding, because the suspect may have no idea where the officer is pointing.

- Some people with disabilities may have a staggering gait or slurred speech related to their disabilities or the medications they take. These characteristics, which can be associated with neurological disabilities, mental/emotional disturbance, or hypoglycemia, may be misperceived as intoxication.

Example: An officer observes a vehicle with one working headlight and pulls the vehicle over. When the driver hands the registration to the officer, the officer notices that the driver's hand is trembling and her speech is slurred. The officer concludes that the individual is under the influence of alcohol, when in fact the symptoms are caused by a neurological disability.

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Example: A call comes in from a local restaurant that a customer is causing a disturbance. When the responding officer arrives at the scene, she discovers a 25-year-old man swaying on his feet and grimacing. He has pulled the table cloth from the table. The officer believes that the man has had too much to drink and is behaving aggressively, when in fact he is having a seizure.

What can be done to avoid these situations?

Training, sensitivity, and awareness will help to ensure equitable treatment of individuals with disabilities as well as effective law enforcement. For example:

- When approaching a car with visible signs that a person with a disability may be driving (such as a designated license plate or a hand control), the police officer should be aware that the driver may reach for a mobility device.
- Using hand signals, or calling to people in a crowd to signal for a person to stop, may be effective ways for an officer to get the attention of a deaf individual.
- When speaking, enunciate clearly and slowly to ensure that the individual understands what is being said.
- Finally, typical tests for intoxication, such as walking a straight line, will be ineffective for individuals whose disabilities cause unsteady gait. Other tests, like breathalyzers, will provide more accurate results and reduce the possibility of false arrest.

6. Q: What if someone is demonstrating threatening behavior because of his or her disability?

A: Police officers may, of course, respond appropriately to real threats to health or safety, even if an individual's actions are a result of her or his disability. But it is important that police officers are trained to distinguish behaviors that pose a real risk from behaviors that do not, and to recognize when an individual, such as someone who is having a seizure or exhibiting signs of psychotic crisis, needs medical attention. It is also important that behaviors resulting from a disability not be criminalized where no crime has been committed. Avoid these scenarios:

- A store owner calls to report that an apparently homeless person has been in front of the store for an hour, and customers are complaining that he appears to be talking to himself. The individual, who has mental illness, is violating no loitering or panhandling laws. Officers arriving on the scene arrest him even though he is violating no laws.
- Police receive a call in the middle of the night about a teenager with mental illness who is beyond the control of her parents. All attempts to get services for the teenager at that hour fail, so the responding officer arrests her until he can get her into treatment. She ends up with a record, even though she committed no offense.

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7. Q: What procedures should law enforcement officers follow to arrest and transport a person who uses a wheelchair?

A: Standard transport practices may be dangerous for many people with mobility disabilities. Officers should use caution not to harm an individual or damage his or her wheelchair. The best approach is to ask the person what type of transportation he or she can use, and how to lift or assist him or her in transferring into and out of the vehicle.

Example: An individual with a disability is removed from his wheelchair and placed on a bench in a paddy wagon. He is precariously strapped to the bench with his own belt. When the vehicle begins to move, he falls off of the bench and is thrown to the floor of the vehicle where he remains until arriving at the station.

- Some individuals who use assistive devices like crutches, braces, or even manual wheelchairs might be safely transported in patrol cars.
- Safe transport of other individuals who use manual or power wheelchairs might require departments to make minor modifications to existing cars or vans, or to use lift-equipped vans or buses. Police departments may consider other community resources, e.g., accessible taxi services.

8. Q: What steps should officers follow to communicate effectively with an individual who is blind or visually impaired?

A: It is important for officers to identify themselves and to state clearly and completely any directions or instructions -- including any information that is posted visually. Officers must read out loud in full any documents that a person who is blind or visually impaired needs to sign. Before taking photos or fingerprints, it is a good idea to describe the procedures in advance so that the individual will know what to expect.

9. Q: Do police personnel need to take special precautions when providing emergency medical services to someone who has HIV or AIDS?

A: Persons with HIV or AIDS should be treated just like any other person requiring medical attention. In fact, emergency medical service providers are required routinely to treat all persons as if they are infectious for HIV, Hepatitis B, or other bloodborne pathogens, by practicing universal precautions. Many people do not know that they are infected with a bloodborne pathogen, and there are special privacy considerations that may cause those who know they are infected not to disclose their infectious status.

- Universal precautions for emergency service providers include the wearing of gloves, a mask, and protective eyewear, and, where appropriate, the proper disinfection or disposal of contaminated medical equipment. Protective barriers like gloves should be used whenever service providers are exposed to blood.

Example: Police are called to a shopping mall to assist a teenager who has cut his hand and is bleeding profusely. As long as the attending officers wear protective gloves, they will not be at risk of acquiring HIV, Hepatitis B, or any other bloodborne pathogen, while treating the teenager.

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- Refusing to provide medical assistance to a person because he or she has, or is suspected of having, HIV or AIDS is discrimination.

Example: Police are called to a shopping mall, where an individual is lying on the ground with chest pains. The responding officer asks the individual whether she is currently taking any medications. She responds that she is taking AZT, a medication commonly prescribed for individuals who are HIV-positive or have AIDS. The officer announces to his colleagues that the individual has AIDS and refuses to provide care. This refusal violates the ADA.

III. Effective Communication

10. Q: Do police departments have to arrange for a sign language interpreter every time an officer interacts with a person who is deaf?

A: No. Police officers are required by the ADA to ensure effective communication with individuals who are deaf or hard of hearing. Whether a qualified sign language interpreter or other communication aid is required will depend on the nature of the communication and the needs of the requesting individual. For example, some people who are deaf do not use sign language for communication and may need to use a different communication aid or rely on lip-reading. In one-on-one communication with an individual who lip-reads, an officer should face the individual directly, and should ensure that the communication takes place in a well-lighted area.

- Examples of other communication aids, called "auxiliary aids and services" in the ADA, that assist people who are deaf or hard of hearing include the exchange of written notes, telecommunications devices for the deaf (TDD's) (also called text telephones (TT's) or teletypewriters (TTY's)), telephone handset amplifiers, assistive listening systems, and videotext displays.
- The ADA requires that the expressed choice of the individual with the disability, who is in the best position to know her or his needs, should be given primary consideration in determining which communication aid to provide. The ultimate decision is made by the police department. The department should honor the individuals' choice unless it can demonstrate that another effective method of communication exists.
- Police officers should generally not rely on family members, who are frequently emotionally involved, to provide sign language interpreting.

Example: A deaf mother calls police to report a crime in which her hearing child was abused by the child's father. Because it is not in the best interests of the mother or the child for the child to hear all of the details of a very sensitive, emotional situation, the mother specifically requests that the police officers procure a qualified sign language interpreter to facilitate taking the report. Officers ignore her request and do not secure the services of an interpreter. They instead communicate with the hearing child, who then signs to the mother. The police department in this example has violated the ADA because it ignored the mother's request and inappropriately relied on a family member to interpret.

- In some limited circumstances a family member may be relied upon to interpret.

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Example: A family member may interpret in an emergency, when the safety or welfare of the public or the person with the disability is of paramount importance. For example, emergency personnel responding to a car accident may need to rely on a family member to interpret in order to evaluate the physical condition of an individual who is deaf. Likewise, it may be appropriate to rely on a family member to interpret when a deaf individual has been robbed and an officer in hot pursuit needs information about the suspect.

Example: A family member may interpret for the sake of convenience in circumstances where an interpreter is not required by the ADA, such as in situations where exchanging written notes would be effective. For example, it would be appropriate to rely on a passenger who is a family member to interpret when an individual who is deaf is asking an officer for traffic directions, or is stopped for a traffic violation.

11. Q: If the person uses sign language, what kinds of communication will require an interpreter?

A: The length, importance, or complexity of the communication will help determine whether an interpreter is necessary for effective communication.

- In a simple encounter, such as checking a driver's license or giving street directions, a notepad and pencil normally will be sufficient.
- During interrogations and arrests, a sign language interpreter will often be necessary to effectively communicate with an individual who uses sign language.
- If the legality of a conversation will be questioned in court, such as where Miranda warnings are issued, a sign language interpreter may be necessary. Police officers should be careful about miscommunication in the absence of a qualified interpreter -- a nod of the head may be an attempt to appear cooperative in the midst of misunderstanding, rather than consent to a confession of wrongdoing.
- In general, if an individual who does not have a hearing disability would be subject to police action without interrogation, then an interpreter will not be required, unless one is necessary to explain the action being taken.

Example: An officer clocks a car on the highway driving 15 miles above the speed limit. The driver, who is deaf, is pulled over and issued a noncriminal citation. The individual is able to understand the reasons for the citation, because the officer exchanges written notes with the individual and points to information on the citation. In this case, a sign language interpreter is not needed.

Example: An officer responds to an aggravated battery call and upon arriving at the scene observes a bleeding victim and an individual holding a weapon. Eyewitnesses observed the individual strike the victim. The individual with the weapon is deaf, but the officer has probable cause to make a felony arrest without an interrogation. In this case, an interpreter is not necessary to carry out the arrest.

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12. Q: Do I have to take a sign language interpreter to a call about a violent crime in progress or a similar urgent situation involving a person who is deaf?

A: No. An officer's immediate priority is to stabilize the situation. If the person being arrested is deaf, the officer can make an arrest and call for an interpreter to be available later at the booking station.

13. Q: When a sign language interpreter is needed, where do I find one?

A: Your department should have one or more interpreters available on call. This is generally accomplished through a contract with a sign language interpreter service. Communicating through sign language will not be effective unless the interpreter is familiar with the vocabulary and terminology of law enforcement, so your department should ensure that the interpreters it uses are familiar with law enforcement terms.

14. Q: Is there any legal limit to how much my department must spend on communication aids like interpreters?

A: Yes. Your department is not required to take any step that would impose undue financial and administrative burdens. The "undue burden" standard is a high one. For example, whether an action would be an undue financial burden is determined by considering all of the resources available to the department. If providing a particular auxiliary aid or service would impose an undue burden, the department must seek alternatives that ensure effective communication to the maximum extent feasible.

15. Q: When would an officer use an assistive listening device as a communication aid?

A: Assistive listening systems and devices receive and amplify sound and are used for communicating in a group setting with individuals who are hard of hearing.

- At headquarters or a precinct building, if two or more officers are interrogating a witness who is hard of hearing, or in meetings that include an individual who is hard of hearing, an assistive listening device may be needed.

16. Q: What is a TDD and does every police station have to have one?

A: A telecommunications device for the deaf (TDD) is a device used by individuals with hearing or speech disabilities to communicate on the telephone. A TDD is a keyboard with a display for receiving typed text that can be attached to a telephone. The TDD user types a message that is received by another TDD at the other end of the line.

- Arrestees who are deaf or hard of hearing, or who have speech disabilities, may require a TDD for making outgoing calls. TDD's must be available to inmates with disabilities under the same terms and conditions as telephone privileges are offered to all inmates, and information indicating the availability of the TDD should be provided.
- TDDs typically cost \$200-300 each and can be used with a standard telephone. It is unlikely that the cost of purchasing a TDD will be prohibitive. Still, a small department with limited resources could arrange to share a TDD with a local courthouse or other entity, so long as the TDD is immediately available as needed.

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17. Q. What about "911" calls? How are those made accessible to people with speech or hearing disabilities?

A: Individuals with hearing and speech disabilities must have direct access to "911" or similar emergency telephone services, meaning that emergency response centers must be equipped to receive calls from TDD and computer modem users without relying on third parties or state relay services. It is important that operators are trained to use the TDD when the caller is silent, and not only when the operator recognizes the tones of a TDD at the other end of the line. For additional information, please refer to the Department of Justice's publication, *Commonly Asked Questions Regarding Telephone Emergency Services*. For information about how to obtain this and other publications, see the resources section at the end of this document.

18. Q: Procedures at my office require citizens to fill out forms when reporting crimes. What if the person has a vision disability, a learning disability, mental retardation or some other disability that may prevent the person from filling out a form?

A: The simplest solution is to have an officer or clerk assist the person in reading and filling out the form. Police officers have probably been doing this for years. The form itself could also be provided in an alternative format. Providing a copy of the form in large print (which is usually as simple as using a copy machine or computer to increase type size) will make the form accessible to many individuals with moderate vision disabilities.

IV. Architectural Access

19. Q: Does the ADA require all police stations to be accessible to people with disabilities?

A: No. Individuals with disabilities must have equal access to law enforcement services, but the ADA is flexible in how to achieve that goal. The ADA requires programs to be accessible to individuals with disabilities, not necessarily each and every facility. Often, structural alterations to an existing police station or sheriff's office will be necessary to create effective access. In some situations, however, it may be as effective to use alternative methods, such as relocating a service to an accessible building, or providing an officer who goes directly to the individual with the disability. Whatever approach to achieving "program access" is taken, training of officers and deputies, well-developed policies, and clear public notice of the approach will be critical to ensuring successful ADA compliance.

Example: A police station in a small town is inaccessible to individuals with mobility disabilities. The department decides that it cannot alter all areas of the station because of insufficient funds. It decides to alter the lobby and restrooms so that the areas the public uses -- for filling out crime reports, obtaining copies of investigative reports for insurance purposes, or seeking referrals to shelter care -- are accessible. Arrangements are made to conduct victim and witness interviews with individuals with disabilities in a private conference room in the local library or other government building, and to use a neighboring department's accessible lock-up for detaining suspects with disabilities. These measures are consistent with the ADA's program accessibility requirements.

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Example: An individual who uses a wheelchair calls to report a crime, and is told that the police station is inaccessible, but that the police department has a policy whereby a police officer will meet individuals with disabilities in the parking lot. The individual arrives at the parking lot, waits there for three hours, becomes frustrated, and leaves. By neglecting to adequately train officers about its policy, the police department has failed in its obligation to provide equal access to police services, and has lost valuable information necessary for effective law enforcement.

20. Q: What about holding cells and jails that are not accessible?

A: An arrestee with a mobility disability must have access to the toilet facilities and other amenities provided at the lock-up or jail. A law enforcement agency must make structural changes, if necessary, or arrange to use a nearby accessible facility.

- Structural changes can be undertaken in a manner that ensures officer safety and general security. For example, grab bars in accessible restrooms can be secured so that they are not removable.
- If meeting and/or interrogation rooms are provided, those areas should also be accessible for use by arrestees, family members, or legal counsel who have mobility disabilities.

21. Q: Is there a limit to the amount of money my agency must spend to alter an existing police facility?

A: Yes. It is the same legal standard of "undue burden" discussed earlier with regard to the provision of communication aids. Your agency is not required to undertake alterations that would impose undue financial and administrative burdens. If an alteration would impose an "undue burden", the agency must choose an alternative that ensures access to its programs and services.

22. Q. We are building a new prison. Do we need to make it accessible?

A: Yes. All new buildings must be made fully accessible to, and usable by, individuals with disabilities. The ADA provides architectural standards that specify what must be done to create access.

- Either the Uniform Federal Accessibility Standards (UFAS) or the ADA Standards for Accessible Design (without the elevator exemption) (ADA Standards) may be used. UFAS has specific scoping requirements for prisons that require, among other things, that 5% of all cells be made accessible to individuals with mobility disabilities.
- Unlike modifications of existing facilities, there is no undue burden limitation for new construction.
- In addition, if an agency alters an existing facility for any reason -- including reasons unrelated to accessibility -- the altered areas must be made accessible to individuals with disabilities.

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V. Modifications of Policies, Practices, and Procedures

23. Q: What types of modifications in law enforcement policies, practices, and procedures does the ADA require?

A: The ADA requires law enforcement agencies to make reasonable modifications in their policies, practices, and procedures that are necessary to ensure accessibility for individuals with disabilities, unless making such modifications would fundamentally alter the program or service involved. There are many ways in which a police or sheriffs department might need to modify its normal practices to accommodate a person with a disability.

Example: A department modifies a rule that prisoners or detainees are not permitted to have food in their cells except at scheduled intervals, in order to accommodate an individual with diabetes who uses medication and needs access to carbohydrates or sugar to keep blood sugar at an appropriate level.

Example: A department modifies its enforcement of a law requiring a license to use motorized vehicles on the streets, in order to accommodate individuals who use scooters or motorized wheelchairs. Such individuals are pedestrians, but may need to use streets where curb cuts are unavailable.

Example: A department modifies its regular practice of handcuffing arrestees behind their backs, and instead handcuffs deaf individuals in front in order for the person to sign or write notes.

Example: A department modifies its practice of confiscating medications for the period of confinement, in order to permit inmates who have disabilities that require self-medication, such as cardiac conditions or epilepsy, to self-administer medications that do not have abuse potential.

Example: A department modifies the procedures for giving Miranda warnings when arresting an individual who has mental retardation. Law enforcement personnel use simple words and ask the individual to repeat each phrase of the warnings in her or his own words. The personnel also check for understanding, by asking the individual such questions as what a lawyer is and how a lawyer might help the individual, or asking the individual for an example of what a right is. Using simple language or pictures and symbols, speaking slowly and clearly, and asking concrete questions, are all ways to communicate with individuals who have mental retardation.

- Informal practices may also need to be modified. Sometimes, because of the demand for police services, third party calls are treated less seriously. Police officers should keep in mind that calling through a third party may be the only option for individuals with certain types of disabilities.

VI. Resources

24. Q: It sounds like awareness and training are critical for effective interaction with individuals with disabilities. How can I find out more about the needs of my local disability community?

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A: State and local government entities were required, by January 26, 1993, to conduct a "self-evaluation" reviewing their current services, policies, and practices for compliance with the ADA. Entities employing 50 or more persons were also to develop a "transition plan" identifying structural changes that needed to be made. As part of that process, the ADA encouraged entities to involve individuals with disabilities from their local communities. Continuing this process will promote access solutions that are reasonable and effective. Even though the deadlines for the self-evaluation, transition plan, and completion of structural changes have passed, compliance with the ADA is an ongoing obligation.

25. Q: Where can I turn for answers to other questions about the ADA?

A: The Department of Justice's toll-free ADA Information Line answers questions and offers free publications about the ADA. The telephone numbers are: 800-514-0301 (voice) or 800-514-0383 (TTY). Publications are also available from the ADA Website www.ada.gov.

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