INTRODUCTION

I. Course Objectives
   A. Identify signs and symptoms of mental illness
   B. Recognize various developmental disabilities
   C. Increase awareness and knowledge of community services available
   D. Improve crisis intervention skills

II. Role play scenario
   A. Uniformed Officer interacts with a person who suffers from Paranoid Schizophrenia and is having a crisis.

III. Schedule
   A. Monday - Lecture
   B. Tuesday - Site Visits, Panel Presentation
   C. Wednesday - Lecture
   D. Thursday - Role Plays, CIT Panel and Graduation

IV. Participants
   A. Recognize outside agencies in attendance

IV. Myth vs. Reality
   A. What do you believe to be true about mental illness? (Discussion)

V. Pre-Test Exam given

ALZHEIMER'S DISEASE

I. Definition of Dementia
- A. Dementia is a syndrome or condition, NOT an illness in itself.
- B. Dementia is a collection of symptoms that may include confusion, disorientation, forgetfulness, impaired judgment, difficulty making decisions, personality changes, difficulty with language, visuo-spatial misperception.
- C. Dementia has many causes, some are treatable and/or reversible, most are not. Alzheimer's Disease is the leading cause of dementia in the elderly in the United States today. It is NOT a normal condition of aging.

II. Causes of Dementia
- A. **D**: drugs
- B. **E**: endocrine system problems
- C. **M**: metabolic disturbances
- D. **E**: ears and/or eyes (problems with vision/hearing)
- E. **N**: nutritional deficits
- F. **T**: trauma
- G. **I**: infection
- H. **A**: atherosclerosis

III. The Four A's of Alzheimer's Disease
- A. AMNESIA: memory, planning, judgment are affected.
- B. APHASIA: language, the ability to understand and express, is affected.
- C. APRAXIA: the ability to do ordinary tasks is impaired.
- D. AGNOSIA: knowing, perceiving, recognizing correctly are all affected.

IV. Where Problems Occur
- A. Social disinhibition
- B. Wandering
- C. Driving
- D. Family conflict
- E. Catastrophic reactions
- F. Actual or potential physical violence

V. Managing the Environment
- A. The KISS Principle: Keep it simple; avoid the use of logic and reasoning. One message at a time. Simple language, clear delivery. Use the broken record technique if necessary.
- B. Mirror: What you project is what you will receive most of the time. Best chance for success is a calm controlled presentation.
- C. Distract: Change their focus.
- D. Remove the Trigger: "Excuse" helpful family members, friends, or neighbors.

VI. Presentation of Self

A. Calm: Calm confidence can set the tone for interaction. The person may not always understand the language you use, but will read emotional tone.
B. Respectful manner: A gentle, directive touch may be appropriate.
C. Low voice tone: A high-pitched, rapid speech provokes anxiety. High-pitched tones are more difficult to hear.
D. Non-threatening posture: your uniform is a recognized symbol of authority. Confusion and anxiety place the person with dementia in a defensive posture.
E. Indirect or angular approach to person

BIPOLAR DISORDER

I. Definition
  A. Formerly termed Manic Depression or Manic Depressive Illness
  B. Biochemical disorder of the brain causing cycles of mania and depression
  C. Mood episodes are not caused by a substance or medical condition

II. Manic Episode
  A. Persistently elevated, expansive, irritable mood $\geq$ 1 week
    1) Overconfidence, grandiosity
    2) Decreased need for sleep
    3) Pressured speech, racing thoughts, distractibility
    4) Continuous high energy
    5) Increased spending, risk-taking, sexuality, decreased judgment
    6) Psychosis (paranoia, grandiose delusions, auditory hallucinations)
  B. Marked social, occupational impairment
  C. Hypomaniac episode is similar, less severe, no psychosis

III. Major Depressive Episode
  A. Two Weeks or longer with 5 or more of:
    1) Persistently depressed mood
    2) Markedly diminished interest or pleasure
    3) Significant change in appetite
    4) Difficulty sleeping or sleeping too much
    5) Agitation or psychomotor slowing
    6) Fatigue or loss of energy
    7) Feelings of worthlessness, inappropriate guilt
    8) Poor concentration, indecisiveness
    9) Recurrent thoughts of death
  Marked social, occupational impairment

Mixed Episode
  Criteria are met for manic episode and major depressive episode nearly every day for a week period (e.g.: no sleep for two weeks & paranoid & suicidal)
  Mood disturbance is severe

Secondary Mood Disorders with Manic Features
  Substance Induced Mood Disorder
    Steroids, alcohol, cocaine, LSD, PCP, MJ, stimulants (e.g. meth) anti-depressants, ECT, light therapy
Mood Disorder due to general medical condition
  <u>Neurological</u>-multiple sclerosis, right CVA, trauma, brain tumor, epilepsy
  <u>Reproductive</u>-peripartum
  <u>Infectious</u>-Aids, influenza, syphilis
  <u>Endocrine</u>-thyroid, cortisol

Differential Diagnosis
Schizoaffective Disorder - thought disorder (psychosis) more prominent
Personality Disorder- interpersonal conflict, emotional instability more prominent
Agitated Major Depression - no increase in energy or mood
ADHD - attention, concentration problem is more prominent

VII. Possible Causes
A. Genetics
1) 50% have a parent with a mood disorder
2) One parent bipolar-14% risk in offspring
3) High risk of related disorders in families
B. Infectious
1) Viruses affecting brain in utero
2) Higher incidence in people born in winter & cities
C. Early Brain Trauma
1) Fetal exposure to famine
2) Loss of oxygen during delivery

VIII. Causes
A. Interacting influences pose risks to a growing, developing brain
B. Biological vulnerability + environmental stress activates episodes

IX. Medications
A. Mood Stabilizers (Lithium, Depakote, Tegretol, possibly Lamictal, Zyprexa) help prevent manic and depressive episodes.
B. Antidepressants (like Prozac, Zoloft, Paxil, Wellbutrin, Effexor) relieve depression but can trigger mania.
C. Antipsychotics (like Risperdal, Zyprexa, Haldol, Ziprazadone, Geodon, Aripiprozol) for psychosis
D. Anxiolytics (like BuSpar, Ativan) for agitation, anxiety
E. Dozens of promising new medications

X. Why Stay on Medications?
A. Symptom control and relapse prevention
B. Relapse rate after abruptly stopping meds 50% in 5 months[1]
C. Half of patients abruptly stop med in first year[2]
D. Going on and off meds can lead to that med not working
E. Suicide risk
* 25% Attempt Suicide
* 15 % Commit without medication
* 1% Commit with medication

XI. Crisis Intervention:

A. Listening
1) Identify the emotion the person is experiencing. People's emotions are always valid for them, and are key clues to what is really going on.
2) Mirror that emotion with statements like " It sounds very frustrating" "It must be scary to…" "You sound pretty stressed…"
3) Validate (Normalize) that emotion with statements like " I can see why you are so upset. Anyone would feel upset in your shoes." Never say, "Don't get upset" or "You shouldn't feel that way"

B. What to say
A. Reassure patient of safety. "I'm not going to hurt you. I'm not going to let anyone else hurt you."
B. Do not challenge delusions. Instead, focus on the emotion, not the content of what the person is saying. "It's overwhelming to have a new baby" "It's so traumatic to lose someone you love" "It's scary to be alone"

C. Staying focused
1) Keep your message simple Patients take things literally. "What happened" not "How did you arrive at this sorry state"
2) Stay focused on the present "We're getting in the car and I'm taking you to the doctor"
3) Keep a low voice Interrupt and redirect pressured or rambling speech
4) Get illness information, med bottles from family or others at the scene

XII. Resources

A. Advocacy Groups
1) National Alliance for the Mentally Ill
2) Depressive & Manic Depressive Association
3) Mental Health Association

B. Books, web sites, videos
C. Family therapy, individual therapy
D. County systems & Social Services
E. Private legal & financial counsel
F. Research studies

XIII. Bipolar Disorders Clinic

A. Leading edge research and state of the art treatment
B. Medication, education, support, therapy
C. Assessment, medications, hospitalization often are free if patient qualifies for a study
D. Collaboration on multi-site studies provides doctors and staff real-time information about effectiveness of new treatments

DEVELOPMENTAL DISABILITIES

I. Definition

A. Welfare and Institutions Code Section 4512(a) defines Developmental Disabilities as occurring before age 18, a substantial handicap, mental retardation, cerebral palsy, epilepsy, autism, or a condition similar to MR (HI)

II. Lanterman Developmental Disabilities Services Act

A. Mandates treatment and services
B. Protects civil liberties (PAI)
C. Treatment in the least restrictive condition
D. Education
E. Medical care
F. Social interaction
G. Community participation
H. Recreation opportunities
I. Freedom from harm, including unnecessary physical restraint, isolation, excessive medication, abuse, or neglect.
J. Created 21 Regional Centers
   1) San Andreas covers Santa Clara County
K. Case managers
L. Coffelt - Agnews, Stockton, Napa and Sonoma
M. Americans with Disabilities Act requires access to state and local services and programs

III. General Characteristic Of Persons With Developmental Disabilities

A. Range from mildly affected to severely affected
B. Receptive or expressive communication
C. Seizures
D. Muscle control/Speech
E. Confusion/disorientation
F. Self endangering / inappropriate natural/logical consequences
G. Purposeless behavior (purposive)

IV. Types Of Law Enforcement Calls

A. Suspicious person
B. Disoriented person
C. Hostile person
D. Unknown person
E. Disturbance
F. Medical emergency
G. Indecent exposure
H. Under the influence
I. What is the intent?
J. Low verbal, behavioralizing
K. Head banging - headache?
L. Behavior may be misinterpreted find informant if possible

M. Family dispute, EPS, weekends
N. Regional Center and NorCal

V. People First
A. A Person with a disability
B. Establish rapport first
C. Do not ignore the person for the companion
D. Show interest and respect
E. How would you want to be Tx
F. Ability not disability - uses a chair, uses ASL,
G. Disability is not a disease
H. Don't patronize

VI. Mental Retardation
A. Subnormal intellect with deficits in adaptive function (ADL)
B. IQ below 70, Avg. 100, 2 SD
C. MA/CA to Deviation IQ (aging)
D. Show Deviation IQ Chart
E. Typically mild - work & live community, moderate - sheltered work & RCH, severe- day program & ICF/4i

VII. Mental Retardation Characteristics
A. Does not communicate at age level - mimics, abstract words, latency
B. Short attention- easily distracted
C. Immature social relationship- prefers children's toys, easily influenced, please others
D. Over-compliant- agrees with everything
E. Poor sense of time "passing"
F. Difficulty with phone, money bus, memory (variable)
G. Not understand consequences of their actions (natural/logical)
H. Act impulsively-ready, fire, aim
I. Try very hard to please
J. Limited coping strategies

VIII. Mental Retardation Cues
A. Benefits Identity Card (BIC)
B. Meds
C. Special education
D. Sheltered workshop
E. Regional Center or case manager
F. Social worker, job coach, therapist, companion
G. Live with others? Phone number? Informant

IX. Communicating With
A. Simple words, slow and clear
B. Concrete terms
C. Avoid yes or no questions

D. Repeat for reliability
E. Praise and encouragement
F. Frustration - time out / move on

X. Mental Retardation vs. Mental Illness
A. Low IQ
B. Poor social skill
C. Rational-understanding
D. Condition
E. Educate, train, independence
F. Any IQ, genius
G. Good socially
H. Onset any age
I. Irrational
J. Tx - normal
K. Meds, Psch.Tx

XI. Cerebral Palsy
A. Cerebral - part of the brain
B. Palsy- impaired motor function.
C. 500K persons in US
D. 90% congenital
E. 10% HI (cars, falls, abuse)
F. Oxygen depravation, low birth wt, premature, pregnancy infection
G. No correction
H. Wheelchair, awkward gait, poor coordination, grimacing, poor speech, learn dis.- assume not

XII. Cerebral Palsy Communicating
A. “Afflicted” No, person with
B. Not the CP, person with
C. “Crippled, Disease, Suffers” No
D. Encouraging, not correcting
E. Extra time
F. Don’t pretend to understand
G. Repeat what you heard
H. Encourage person to relax
I. May walk with stagger (drugs)
J. Stress - worsening speech

XIII. Epilepsy
A. Many types of seizures (20)
B. 2 M persons with epilepsy
C. Most well controlled on meds
D. Seizures usually 1-2 minutes
E. Best let seizure run its course

F. Most causes unknown
G. HI, stroke, brain tumor, illness
H. Anti-convulsant drugs, surgery
I. General tonic clonic - brain swamped w/ electrical impulses (grand mal)
J. Petite mal, children, only a few seconds, look like day dream
K. Complex partial "psychomotor" trance, involuntary movement, screaming, running, disrobing

XIV. Responding to a Seizure
A. Turn person on their side, move furniture, let person recover
B. EMT if: lasts 5min., repeat seizure, injured, drug induced, pregnant, first seizure

XV. Subtle Signs of a Seizure
A. Staring, tics, rhythmic, purposeless sounds, head drop, eyes roll, chewing
B. Do not take away seizure
C. Meds non-stop seizure, coma, death
D. Check for Medic Alert

XVI. Autism
A. Autism translates to "alone"
B. Before age 3
C. All areas of functioning
D. Brain disorder, cause unknown
E. Difficulty relating to others
F. Impaired communications
G. Need routine, structure
H. Limited intellect?
I. Avoid eye contact
J. Repetitive movement (rock, spinning)
K. Not deliberately aggressive
L. Unfamiliar sit cause agitation
M. Non responsive to questioning
N. Non verbal communications: Can I see ID, use signals, make simple behavioral choice (sit here, or sit there)
O. Be calm, take time, find care provider

XVII. Questions/Discussions

LEGAL ISSUES – CIVIL COMMITMENTS/5150

I. *Lanterman-Petris-Short Act*

Enacted in 1969 to end inappropriate indefinite involuntary commitment of individuals with mental health disabilities

The intent was to balance the need for public safety while safeguarding individual rights

Civil Commitment Flow Chart

72-hour hold
14-day certification
Second 14-day certification
180-day post certification
Temporary conservatorship
Permanent conservatorship

Who Else Has 5150 Authority?

A. Designated facility staff
B. Outpatient mental health staff with 5150 cards

IV. *Criteria for 72-hour Hold*

A. Peace Officer has probable cause to believe that:
   1) As a result of a mental health disorder,
      a) Person is danger to self or danger to others or gravely disabled, and
      b) Person is unwilling or unable to be a voluntary patient.

V. *Definition of Grave Disability*

A. A person is gravely disabled if as a result of a mental disorder, he or she is unable to provide himself with food, clothing or shelter.

VI. *Definition of Mental Disorder - What It's Not*

A. Poverty
B. A "vagabond" lifestyle, deliberately chosen
C. Drug or alcohol use or addiction, unless it has caused a mental disorder
D. Developmental disability

VII. *Danger to Self - What to Look For*

A. Words or actions showing intent to commit suicide or bodily harm
B. Words or actions indicating gross disregard for personal safety
C. Words or actions indicating a specific plan for suicide
D. Means available to carry out suicide plan

VIII. *Danger to Others - What to Look For*

A. Threats against particular individuals
B. Attempts to harm certain individuals
C. Means available to carry out threats or attempts
D. Words or actions indicating gross disregard of others' personal safety

IX. *Other Legal Issues*

A. A person who knowingly provides false information which leads to a 72-hour hold is liable in a civil action by the detained party

X. *Peace Officer Rights*

A. No peace officer transporting a person to a designated facility shall be instructed by mental health personnel to take the person to jail solely because of the unavailability of an acute bed
B. No mental health employee shall prevent the peace officer from entering a designated facility with the person to be assessed

XI. *72-hour Hold How to Treat Detained Person*

A. Be honest with the individual about where he or she is being taken, and why
B. Let person make a phone call or leave a note for their family
C. If no responsible relative is present to assume responsibility for the person's personal property, the officer should ensure that it is secure

XII. *Advisement*

A. "My name is"
B. "You are not under arrest"
C. "You are being taken for examination by mental health professionals at"
D. "You will be told your rights there"
E. "You may bring personal items with you and you may make a phone call or leave a note"

XIII. *The 72-hour Hold Application Form*

A. Fill it in completely!
B. Critical information:
   1) Date and time
   2) Your signature
   3) Identity, phone numbers of witnesses, family members
   4) Detailed description of probable cause

XIV. *Probable Cause Documentation*

A. W&I Code §5150.2 requires that documentation shall include detailed information about the factual circumstances and observations constituting probable cause for the peace officer to believe that the individual required psychiatric evaluation

XV. *Americans with Disabilities Act*

A. The ADA entitles people with disabilities to the same services and protections that police departments provide to anyone else.
B. People with disabilities may not be excluded or segregated from services, or otherwise provided with lesser services or protection than provided to others.
C. People with disabilities are entitled to reasonable accommodations

XVI. *Reasonable Accommodations*

A. Law enforcement agencies and personnel must make reasonable adjustments and modifications in their policies, practices and procedures on a case-by-case basis.

B. *Examples of Reasonable Accommodations:*

- Provide person with access to medication or water
- Take more time
- Show more sensitivity
- Communicate in a manner that person will be more likely to understand
- Give person physical space

LEGAL ISSUES - WEAPONS

VI.

I. W&I 5150 Definition

A. When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled…a peace officer may, upon probable cause, take the person into custody and place him or her in an approved mental health facility for 72 hour treatment and evaluation.

II. Legal Issues in 5150 Situations

A. Probable Cause
B. Application in Writing
C. Booking: VMC or Jail?
D. 4th Amendment Limitations

III. W&I 8102 Possession of Firearm or Deadly Weapon by 5150

A. Police <u>shall</u> confiscate and retain
B. Notify of procedure for return
C. Book as evidence

IV. W&I 8103(a)(1)-(f)(1): Possession of Firearm or Deadly Weapon by Specified Person

A. PC Section 2968 - 2972 (*Mentally Disordered Offender*)
B. W&I Section 6316 MDSO (*Mentally Disordered Sex Offender*)
C. PC SECTIONS 1026 - 1026.5 (*Not Guilty By Reason Of Insanity*) WI 8103 (b)(1)
D. PC SECTIONS 1368 - 1370 (*Incompetent To Stand Trial*) WI 8103 (d)(1)
E. PC Section 5150 (*Danger To Self Or Others*); Requires: a) Taken into custody; b) Assessed; and c) Admitted because a danger. WI 8103 (f)(1)

V. Criminal History Checks

A. Look for any CII reference to "Department of Mental health", "Mental health Cus/Supv", "DMH", "CAHO ATASCADERO", or any other reference to a state hospital.

VI. Questions/Discussion

MAJOR DEPRESSION

I. *Who Suffers from Major Depression*
   A. Depression affects over 17 million Americans each year
   B. Fewer than half of the persons suffering with depression seek treatment
   C. About 1:4 women and 1:10 men develop depression during their lifetime
   D. Depression costs tens of billions of dollars annually in related medical care, lost productivity, family disruption and mortality
   E. Onset usually occurs between ages 25-44
   F. Those older than 50 or younger than 25 who develop a first episode have a more protracted course than those who develop the illness in the interim years

II. *Depression in Children*
   A. Childhood depression is not rare.
      1) 1% of preschoolers, 2% of school-age children and 5-7% of adolescents become depressed
      2) Depression occurs equally among boys and girls in childhood
      3) Twice as many girls as boys become depressed in adolescence

II. Lifetime Risk Factors
   A. Depression occurs in all cultures throughout the world, however, expression of symptoms are influenced by ethnicity and culture
   B. Major Depression has a lifetime mortality rate (i.e. suicide) of 15%
   C. Research indicates that 50-85% of persons experiencing Major Depression will experience a subsequent episode.

III. *Suicide Risk Factors*
   A. Over age 45
   B. Male
   C. White
   D. Lives alone
   E. Poor health

IV. *Other Facts About Suicide*
   A. Rate of suicide in adolescent males has almost tripled; rate in females has doubled
   B. Rates double to quadruple in elderly persons, especially white males
   C. Chemical dependence increases the suicide rate 5 fold
   D. Approximately 30,000 Americans commit suicide each year

V. *Suicide Co-Morbidity*
   A. 90% of the persons who completed suicide were psychiatrically ill at time of death (1990)
   B. The presence of mood disorders in persons who attempt suicide ranges from 45% to 77%
   C. Anxiety, particularly panic, is a major short term risk factor for suicide
   D. Ironically, patients are at their highest risk for suicide, not when they are in the depths of their depression, but when they start to get better

E. Individuals frequently contact a medical practitioner prior to their suicide attempt; tragically, the patient's risk of suicide often goes unrecognized

Signs and Symptoms of Major Depression

Five or more symptoms present during the same two week period or longer

One of the symptoms must be depressed mood or loss of interest of pleasure

Symptoms must occur most of the day, nearly every day.

Symptoms due to a medical condition, delusions, or hallucinations don't count.

Depressed mood

Markedly diminished interest or pleasure in all, or almost all, activities.

Significant weight loss when not dieting or weight gain or change in appetite.

Insomnia or hypersomnia

Psychomotor agitation or retardation

Fatigue or loss of energy

Feelings of worthlessness or excessive or inappropriate guilt

Diminished ability to think or concentrate, or indecisiveness

Recurrent thoughts of death

Recurrent suicidal ideation with or without a specific plan

Suicide Attempt

"Major Depression is a medical condition that affects the brain, mind and body."

Personality Disorders

Depressive Behaviors in Preschoolers

Apathy
Listlessness
Social Withdrawal

Depressive Behaviors in School-age Children

Somatic symptoms- headaches, stomach aches
Separation anxieties and phobias
Behavioral problems

Depressive Behavior in Adolescents

Hopelessness
Thoughts of death or suicide
Antisocial behavior
Substance Abuse

XI. *What is the Cause of Major Depression?*
- A. Major Depression is usually caused by a combination of factors, both biological and psychological
- B. Major Depression is NOT caused by character weakness

XII. *Biological Characteristics*
- A. Chemical imbalance primarily involving norepinephrine and serotonin
- B. Strong family history
- C. Long-standing
- D. May not be clear trigger event

XIII. *Psychological Factors*
- A. Stresses
- B. Losses
- C. History of abuse or neglect
- D. "Non-psychological mind-set"

XIV. *Treatment*
- A. The optimal treatment for Major Depression is probably a combination of biological and psychological approaches
- B. The most common types of psychotherapy are Cognitive Behavioral, Interpersonal and Psychodynamic

XV. *Cognitive Behavioral Therapy*
- A. Depression is thought to be secondary to cognitive distortions
- B. Treatment involves examining cognitive distortions, keeping a diary to track thoughts and feelings and assertiveness training
- C. Generally 12-20 sessions

XVI. *Interpersonal Psychotherapy*
- A. Depression is thought to be due to interpersonal problems

B. Treatment involves role playing and feedback regarding interpersonal communication
C. Generally 12-20 sessions

XVII. *Psychodynamic Psychotherapy*

A. Depression thought to be due to unconscious conflict over a loss
B. Treatment involves interpretation of the unconscious material, review of historical basis of conflict, ventilation and subsequent catharsis
C. May be short term (12-20 sessions) or ongoing

XVIII. *Medication*

A. In general, antidepressant medications are indicated when the person's symptoms have been present for 2 or more weeks and severely impact their social and/or occupational functioning.

XIX. *The "Upside" to Using Medication*

A. Dozens of antidepressants available
B. Effective in 50-70% of patients
C. Newer antidepressants are generally well tolerated and safe to use

XX. *The "Downside " of Antidepressant Medications*

A. Newer drugs are expensive
B. Side effects are a problem for some patients
C. Stigma

XXI. *Partial Hospital Programs*

A. Useful for those patients whose functioning is severely compromised by depressive symptoms, but who are not acutely suicidal

XXII. *Inpatient Hospitalization*

A. Indicated when the person is a potential danger to themselves or others or, because of a mental illness, they are unable to provide for their basic needs
B. Average length of inpatient stay is 5-7 days
C. Inpatient hospitalization is generally reserved for individuals who are acutely suicidal and/or homicidal.

XXIII. Electroconvulsive Therapy (ECT) is indicated when:

A. A person has had 3 or more unsuccessful antidepressant medication trials
B. The person is so acutely suicidal that to wait for an antidepressant to work would put the person in grave danger
C. The person is unable to tolerate antidepressant medications

XXIV. *Guiding Principals*

A. Patients with Major Depression experience excruciating psychic pain and feel extremely vulnerable, hopeless and helpless
B. They are often ashamed and feel weak for not being able to "pull themselves out of their gloom."

C. Major Depression colors a person's thinking
D. The person may feel that no one could possibly care about him/her, or that anyone or anything could possibly stop the pain they are experiencing

NON VIOLENT CRISIS INTERVENTION

I. Nonviolent crisis intervention takes skill.

A. Personal safety should come first.
B. This type of work takes time; the intervention should not be rushed.
C. Listening is more important than talking.

II. There are important qualities in a successful intervention.

A. Respect and acceptance means recognizing the other person has a right to his/her own thoughts/ feelings/behaviors and deserves to be respected
B. Empathic understanding requires attending to what is said, accurately restating the message, and verbally reflecting the person's feelings
C. Genuineness means being authentic and sincere
   1. Being spontaneous and flexible doesn't make the crisis worse.
   2. Consistency in thought and action develops credibility.
   3. "I" statements personalizes the conversation.
   4. Saying "we" or "they" detracts from the genuineness.
D. Staying in the "here and now" keeps the person in touch with reality.

III. Active listening requires a level of proficiency.

A. *Focusing* on what the other person is saying and doing and excluding distractions works to stabilize the crisis.
B. *Fully attending* to verbal and nonverbal messages helps the listener determine if what the person is saying/doing/feeling fits together and is congruent.
C. *Paraphrasing* is verbally reflecting the meaning of the person's message.
   1. This shows the listener is attentive.
   2. It provides an opportunity to clarify the message.
D. *Emotion labeling* is a powerful tool.
E. It helps to *identify the issues and feelings* that drive the person's behavior.
F. *Mirroring* is both an attending and listening technique, which demonstrates interest and understanding.
   1. It avoids an interrogation style questioning.
   2. A non-confrontational presence is established.
   3. Rapport is developed.
   4. The person is provided the opportunity to vent.
G. *Asking open-ended questions* gives the person an opportunity to talk.
H. *Avoid the use of the word "why"* –it makes people defensive.
I. *Modeling attending behavior verbally and nonverbally* lets the person in crisis know he/she is being heard and that his/her emotional content is real and legitimate.
   1. It also signifies that the listener is open to further communication.
   2. Skillfully pausing during the conversation works to an advantage.
   3. An emotionally overwrought person will find it difficult to sustain the heightened emotions when there is no response.
   4. Silence encourages the speaker to fill the void.

IV. *Setting limits* is a method of taking control of a potentially escalating situation.

A. Limits avoid personal power struggles.
B. They establish clear consequences.

C. Successfully setting limits gets the other person to listen.

V. A crisis occurs in four stages.
  A. A precipitating event causes the anxiety.
  B. Disorganization begins as the person becomes defensive and unable to cope.
  C. Disequilibrium occurs when the person loses control and acts out.
  D. Providing an appropriate intervention allows for tension reduction and helps the individual reorganize.

VI. Nonverbal behaviors communicate a message.
  A. Proxemics, or personal space, is an important consideration.
    1. An "extension of self" exists 36" beyond the physical body.
  B. Motion and posture of the body transmits a message.

VII. Paraverbals are the vocal parts of speech excluding the words
  A. Tone, volume, and cadence or how we say something has a significant impact on attempts to defuse a crisis.

VIII. Things to avoid in crisis intervention.
  A. Do not deny the possibility of violence when there are signs of agitation.
  B. Do not make promises that cannot be kept.
  C. Do not argue, give orders, or disagree unless absolutely necessary.
  D. Do not allow the interference of family members and bystanders.
  E. Do not deny the individual the opportunity to save face.
  F. Do not invade personal space unless safety is an issue.
  G. Do not rush, crisis interventions take time.

IX. Race and ethnicity are not factors or predictors of violence.
  A. Violent behavior is multi-determined.
  B. Research is showing that violence may have a biological base.
  C. Violent behavior cannot be predicted with certainty.

PANEL PRESENTATION / CONSUMER AND FAMILY PERSPECTIVES

I. Schizophrenia Exercise
   A. Divide class into consumers, "voices" and those giving directions
   B. Start the exercise
   C. Discuss the various reactions to the exercise.

II. Panel Presentation
   A. What is it like to live with mental illness?
   B. Encounters with the police
      1. Good and bad

III. Crisis intervention techniques when working with a person who has a mental illness
   A. Speak calmly, slowly and clearly
   B. Try to get them to focus
   C. Despite their behavior, they may be afraid
   D. Explain to the person what is going to happen

IV. Crisis intervention techniques when working with family members of consumers
   A. Acknowledge their difficulties and validate their feelings
      1. Understand there may be negative feelings toward police
   B. Offer appropriate assistance
   C. Explain what is going to happen

V. Questions and answers

PERSONALITY DISORDERS

I. What is Personality?
   A. The particular set of thoughts, feelings and behavior that make you who you are.
      1. It is relatively stable
      2. It is affected by heredity and environment
         a. Heredity – Inherited biologically from your parents
         b. Environment – Upbringing, early experiences, later achievements/ disappointments

II. What is a Personality Disorder?
   A. An enduring pattern of perceiving, relating to, and thinking about the environment and oneself.
      1. Inflexible and maladaptive
      2. Cause – Significant functional impairment or subjective distress
         a. The individual may or may not experience distress – it is the individual's behavior that may distress others.
      3. Believed to originate in childhood and continue throughout adulthood.
   B. Found in 10 to 13% of general population.
      1. Some are rare
      2. Some tend to be found in males more frequently; others are more common in females.

III. Types of Personality Disorders – Three clusters, ten types.
   A. Cluster A – Odd eccentric types, who perceive reality in a distorted fashion. (Highlighted types will be discussed further.)

B. ***Paranoid*** – males
C. Schizoid – males
D. Schizotypal – males

B. Cluster B – Overly impulsive, emotional or erratic
1. ***Antisocial*** – males
2. ***Borderline*** – females
3. Histrionic – males/females
4. Narcissistic – males

C. Cluster C – Excessively anxious, fearful
1. Avoidant – males/females
2. Dependent – males/females
3. ***Obsessive-compulsive*** – males

IV. ***Paranoid*** Personality Disorder

A. Pervasive distrust and suspiciousness of others to the degree that they feel others wish them harm.
1. Preoccupied with loyalty and trustworthiness
2. Scrutinize actions of others, looking for signs of betrayal

B. Jealousy is common in regard to sexual partners
1. Significant others may be subject to constant challenges involving their whereabouts, affections and fidelity.

C. Highly critical of others, but don't accept criticism.

V. ***Antisocial*** Personality Disorder

A. Pervasive pattern of disregard for the rights and feelings of others
1. Show little remorse
2. Provide superficial rationalizations for hurting or mistreating someone

B. Tend to manipulate others for power, profit or material gratification *(see VII. Manipulation)*

VI. ***Borderline*** Personality Disorder

A. Pervasive pattern of instability of interpersonal relationships, self image, emotions and control over impulses.
1. Sudden changes in opinions, plans, sexual identity, and friends
2. Goals, values and occupational aspirations can shift quickly and often

B. Fear of abandonment or rejection can lead to unreasonable demands, panic attacks, and bursts of anger.

C. Manipulates others to get care and attention *(see VII. Manipulation)*

D. Self mutilation (by cutting or burning) and recurrent suicidal behavior are major problems

E. Childhood abuse (physical and/or sexual) is frequently reported

VII. ***Obsessive Compulsive*** Personality Disorder

A. Preoccupation with neatness, orderliness, perfection and control at the expense of flexibility and efficiency
B. Does not have any one identifiable obsession or compulsion
   1. Tends to be an ultra perfectionist and “control freak”
C. Work oriented; spend little time going to movies, parties or anything that isn’t related to work.

VIII. Age, Gender and Treatment
A. Personality disorders generally begin by early adulthood; some can be traced back as far as childhood.
B. Some disorders (antisocial and borderline) tend to subside with age.
C. Gender differences among the disorders may be due to social role stereotypes and/or biological difference between the sexes.
D. Treatment varies based upon the disorder and the individual
   1. Sometimes chemical imbalances contribute to moods, perceptions or behavior that is counterproductive.
      a. Medication is appropriate
   2. Individual or group psychotherapy works for others
   3. Drug treatment and psychotherapy are often combined

IX. Manipulation

A. Mode of interaction, which controls others
   1. Self-defeating – negatively affects relationships
   2. Uses flattery, aggressive touching, playing one person against another
   3. Deliberate "forgetting"
   4. Power struggles
   5. Tearfulness
   6. Demanding
   7. Seductive behaviors

B. Strategies for Dealing with Manipulation
   1. Set limits and enforce consistently
   2. Offer constructive opportunities for control, contracting
   3. Use clear and straightforward communications
   4. Avoid rejecting or rescuing
   5. Monitor your own reactions

X. Communication Techniques

A. Be honest, respectful, non-retaliatory
B. Listen to understand
C. Avoid labeling
D. Avoid ultimatums
E. Avoid power struggles
F. Focus on person's behaviors
G. Offer empathic statements
H. Assist person to think rationally
I. Convey your interest in a successful outcome

Syllabus

Title: **CIT POLICY AND PROCEDURES**

Time: 30 Minutes

Goal: To provide the student with an overview of procedures for handling CIT calls for service.

Objective:

1. Students will become familiar with procedures for receiving and dispatching CIT calls for service.
2. Students will learn the proper disposition codes and reporting criteria for CIT calls.

Methodology:

1. Lecture/PowerPoint presentation

Materials:

1. Written materials
2. Laptop computer/projector

Testing: Review at end of class

Overview: This course is designed to make students aware of the policies and procedures for dispatching CIT calls.

POST TRAUMATIC STRESS DISORDER (PTSD)

I. ***Definition of Trauma***

A. An event outside the usual realm of experience that is markedly distressing.
    1. Usually involves the actual or perceived threat of death or serious injury, or a threat to the physical integrity of self or others.

B. The most frequently experienced traumas are:
    1. Witnessing someone being badly injured or killed
    2. Being involved in a fire, flood or natural disaster
    3. Being involved in a life threatening accident
    4. Combat exposure

II. Definition of Post-Traumatic Stress

A. Very intense arousal to a traumatic stressor.

B. It overwhelms an individual's coping mechanisms, leaving him/her feeling out of control and helpless.

III. Definition of Post Traumatic Stress Disorder (PTSD)

A. It is a diagnosis, which is characterized by a set of symptoms.
    1. Excessive excitability and arousal
    2. Numbing withdrawal and avoidance
    3. Repetitive, intrusive memories or recollections of the trauma and/or events related to the trauma

B. The symptoms must last more than one month.

C. The symptoms must cause significant distress or impairment in the individual's life.

IV. Signs and Symptoms of PTSD

A. Behaviors may include hostility, anger, violence, detachment, withdrawal, isolation, feeling numb, unresponsiveness, substance abuse, and domestic violence.

B. Physical symptoms may include excessive sweating, dizzy spells, increased heart rate, elevated blood pressure, rapid breathing.

C. Cognitive symptoms may include paranoia, lack of concentration, unreasonableness, and reduced ability to feel emotion, distrust, stubbornness, and the sense of a foreshortened future.

V. Associated Disorders of PTSD

A. Depression

B. Panic disorder

C. Substance abuse

VI. Crisis Intervention Skills with PTSD

A. Stay calm

B. Acknowledge the individual's feelings

C. Identify the specific sources of anger
D. Focus on the problem and its resolution
E. Remain respectful

Syllabus

Title: **ROLE-PLAY SCENARIOS**

Time: 4 Hours

Goal: Provide students with the opportunity to practice crisis intervention techniques in role-play situations involving the mentally ill.

Objective: Officers - Students will learn to better utilize crisis intervention techniques to de-escalate potentially volatile situations in the field.

Dispatchers – Students will learn phone/communication techniques to assist them in calming individuals in crisis and staying in control of the conversation.

Methodology:

2. Lecture
3. Skill practice

Materials:

1. Props for various role-plays
2. Role-players (5-6)
3. Written scripts for each role-player

Testing: None

Overview: Role-plays are conducted on the final day of the CIT Academy and are designed to give students the opportunity to practice communication skills and use information learned during the 40-hour course. During these role-plays, students will interact with role-players presenting a variety of persons with mental illnesses and /or developmental disabilities who are in crisis. Based upon their learning, students will be able to recognize the illness and/or disability and practice their skills to defuse the situation.

SCHIZOPHRENIA

I. Diagnosis
   A. Positive symptoms
      1. Delusions
      2. Hallucinations
      3. Distorted perception
   B. Negative symptoms
      1. Flat-blunted emotions
      2. Lack energy/motivation
      3. Lack interest/pleasure
   C. Disorganized symptoms
      1. Confused thinking
      2. Disorganized speech
      3. Disorganized behavior

II. When does schizophrenia begin?
   A. Any age
   B. Adolescent to 40
   C. Children rare
   D. First episode, denial

III. Course of schizophrenia – Mild, stable
   A. Medications important
   B. Takes meds
   C. 1-2 relapses by 45
   D. Mild symptoms

IV. Course of schizophrenia - Moderate
   A. Medications important
   B. Takes meds
   C. Several relapses by 45
   D. Persistent symptoms between relapses

V. Course of schizophrenia – Severe, unstable
   A. Medications important
   B. +/- Medications - numerous relapses
   C. Many bothersome symptoms; poor ADL
   D. Drug, alcohol, medical problems

VI. Stages of recovery
   A. Acute episode
   B. Stabilization after acute
   C. Maintenance phase

VII. Important to diagnose & treat
   A. Stabilize psychotic symptoms
   B. Reduce relapse
   C. Ensure appropriate behavior
   D. Decrease drug, alcohol use
   E. Decrease suicide risk
   F. Minimize relationship problems and life disruption
   G. Reduce stress/burden on family
   H. Begin rehab

VIII. Causes of Schizophrenia
   A. Inherited
      1. Positive family history 1:100
      2. Parent, sibling 10%
      3. Both parents 40%
      4. No symptom 30% - rare
   B. Environmental
      1. Stressors
      2. Drug/alcohol

IX. Medications
   A. Conventional anti-psychotic
      1. Haldol
      2. Mellaril
      3. Thorazine
      4. Navane
      5. Prolixin
      6. Stelazine
      7. Atypical anti-psychotic
      8. Clozapine
      9. Risperidol
      10. Zyprexa
      11. Seroquel
   B. Side effects
      1. Muscle movements
      2. Tardive dyskinesia

X. Psychosocial treatment
   A. Client/family education
   B. Collaborative decision making
   C. Medication & symptom monitoring
   D. Case management (ADL, $, etc.)
   E. Housing
   F. Day treatment

XI. Other issues

A. Early warning relapse signs
B. Suicide risk
C. Strength model vs. problem model

Syllabus

Title: **SITE VISITS**

Time: 5 Hours Total (Visits are individually arranged)

Goal: To familiarize students with the various community services available for those who have a mental illness and/or a developmental disability.

Objectives:

1. Students will visit various community mental health treatment centers and/or training sites for those who have a developmental disability.

2. Students will be given the opportunity to interact with consumers and staff at each of the facilities visited.

Methodology: Small Groups

Materials: Written material (in binder)
Vans, drivers (5-6)

Testing: Not applicable

Overview: By participating on scheduled onsite visits to mental health programs/ developmental disability programs and then using the resource guide, students will become familiar with the array of services available to those in need.

TRAUMATIC BRAIN INJURY

Definition of Traumatic Brain Injury

Traumatic brain injury (TBI), a subcategory of acquired brain injury, is an insult to the brain, not of a degenerative or congenital nature but caused by an external physical force, that may produce a diminished or altered state of consciousness, which results in an impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments may either be temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

Statistics

1.5 million Americans will sustain a TBI annually.
80,000 Americans annually experience the onset of long-term disability following TBI
50,000 Americans will die annually as a result of TBI
There are currently 5.3 million Americans living with a disability as a result of TBI
The risk of TBI is highest among adolescents, young adults and those older than 75.
The leading causes of brain injury are vehicle accidents, falls, and violence.

Range of Severity

Mild Brain Injury
- Loss of consciousness of approximately 30 minutes or less
- After 30 minutes, an initial Glasgow Coma Scale (GSC) of 13-15
- Post traumatic amnesia (PTA) not greater than 24 hours
- Any loss of memory for events immediately before or after the accident
- Any alteration in mental state at the time of the accident (e.g., feeling dazed, disoriented, confused)
- Focal neurological deficit(s) that may or may not be transient
- May be injured from whiplash or mild concussion
- May or may not seek medical attention, but often not hospitalized
- May return to work, but experience decreased job performance resulting in job loss

Moderate Brain Injury
- Unconscious for one to twenty four hours
- Hospitalized
- May or may not be able to return to work
- May need supportive living arrangements

Severe Brain Injury
- Unconscious for more than 24 hours
- Need a great deal of structure or supervision for living
- Return to work and independent living is even more difficult

Catastrophic Brain Injury
May remain comatose or semi-comatose
Usually live the remainder of their lives in skilled nursing facilities, or, for some, at home with full time attendant care

Evaluation and Treatment Through the Continuum of Care
Roles of Healthcare Providers in the treatment of TBI
Depending on the severity of injury, a visible problem may or may not show up on traditional medical testing equipment, such as X-ray, CT Scan, MRI or EEG. Physician specialties primarily involved with evaluation and treatment of brain injury include: trauma, neurosurgeons, neurologists and/or physical medicine and rehabilitation professionals.
Emergency Medical Services (EMS) to the community

Characteristics Identifying Persons with TBI
Deficits may range from barely noticeable to extreme
It is important to remember each person with a brain injury is different
Individuals experience different problems and changes in functional ability
Each person, who has this type of injury, will experience a unique set of problems
Although a person may be able to enter a community setting, they are not "cured"
Unlike many other injuries/illnesses, brain injury causes profound life-long changes, resulting in any combination of the following
Social affective
Changes in behaviors and emotional control
Decreased cognitive and intellectual abilities
Changes in physical, psychomotor and regulatory abilities

Identifying Someone Who Has a Brain Injury
Verbal Issues: Poor speech, monotone, vulgarity, swearing, talks too loud or too soft, broken speech, difficulty "finding" words.
Social Issues: Doesn't recognize "personal space," fabricates stories, lies, goes off on tangents, interrupts conversation, inappropriate conversation, poor eye contact, inappropriate social interaction (overly friendly or formal).
Personality Issues: Irritable, egotistical, doesn't listen, argumentative, asks a lot of questions, manipulative, appears unmotivated, moody-laughs or cries easily, depressed, face shows little or no emotion, appears angry.
Behavioral Issues: Wanders off, runs away, impulsive (acts without thinking), repeated invasion of personal space, short-fuse-unable to control anger.
Cognitive Issues: Easily distracted, "spaces out" difficulty understanding, difficulty with reality, seems confused, slow to answer questions, decreased safety awareness, poor memory, difficulty organizing (time, paper, etc.).

Responding to a Person with TBI: General Management Approaches

- Treat the individual as an adult
- Be patient
- Try not to overstimulate the individual
- Be consistent
- Set the example for calm and controlled behavior for the individual
- Expect the unexpected, variability is the rule
- Redirect the individual
- Persons with brain injury are more sensitive to stress

Responding to a Person with TBI: Behavior Management Strategies

- Confusion
  - Do not overstimulate when confused
  - Always explain what you intend to do
  - Expect difficulty when there a necessary changes in routine
  - Redirect confused behavior, DO NOT confront
  - Ask individual to provide date, time, location, etc, to promote orientation.
- Impaired ability to carry out plan of action
  - Explain activities in a clear, simple manner
  - Continually repeat sequences of tasks
- Impaired alertness and mental fatigue
  - Allow frequent rests
  - Break activities, questioning into 10-15 minute intervals
  - Utilize multisensory modes for explanation
  - Allow extra time for responses
  - Repeat instructions, commands, etc., ask the individual to reiterate what she/he has been told
- Poor emotional control
  - Avoid criticism
  - Do not remind them of prior problems with the law
  - Ignore overly negative behavior, if possible
  - Expect hostile angry feelings directed at police – redirect when necessary, try not to argue
- Memory deficits
  - Pair new learning with old, if possible as old learning is generally preserved
  - Write down as many things as possible
  - Review with family member or a third party familiar with individual
  - Frequently cue and rehearse
  - Demonstrate, utilized memory signals
  - Utilize photographs and highly visual materials
- Attention deficits (refers to impaired selective attention, perseveration, vigilance or semi-inattention)
  - Ensure that you have the individual's attention, then redirect for perseverative problems

- DO NOT confront
- Utilize individual's natural interests
- Use demonstrations, as well as verbal instructions
- Reinforce
- Allow success
- Minimize distractions
- Provide verbal analysis to aid awareness
- For semi-inattention, continually verbally cue attention to neglected side

Impaired receptive language functioning
- Be certain you have their attention before speaking
- Ask individual to repeat instructions; repeat and redefine words
- Use multisensory modalities
- Speak slowly, but in an adult manner
- Limit background distractions and noises
- Try to keep information given to a minimum, so as not to overload
- Give step-by-step instructions
- Use pauses between phrases and instructions
- Humor and figures of speech may not be understood

Impaired expressive language
- Encourage speech
- DO NOT rush the individual
- Determine if individual uses any augmentive device for communication
- Try to find meaning in jargon or nonsensical communication
- If extreme frustration is occurring, supply the word or phrase
- A family member may be able to provide information

Impaired abstraction and judgment
- Keep explanation simple
- Explain reasons behind activities
- Supply abstract information

Egocentrism
- Encourage them to watch behavior in others
- Encourage them to "look" at their own behavior and analysis

Depression and withdrawal (as awareness of deficits increase and cognitive function improves, depression and withdrawal become worse)
- Beware of suicide risk
- Enlist peer support, if available
- Bring in ancillary psychological support, rehabilitation counselor, etc.
- Try to determine any problems with substance abuse

Impulsivity
- Express your expectation
- Give the impression that the individual can control her/his behavior
- Identify situation where the individual can practice impulse control

Agitation and irritability

Redirect behavior
If physical aggression occurs, don't induce guilt, it doesn't work
Avoid surprises
Some restraint procedures may induce anxiety
Reduce stimulation during agitated outbursts
Keep voice calm and low, reorient, redirect and model calm behavior
Try to get the individual to sit down
Allow family member to act as intermediary
Maintain routine and structure, provide structured activity