Crisis Intervention Training (CIT) 40 HR

Instructor Guide

Course #1850

Revised September 2025

INSTRUCTOR MANUAL

Crisis Intervention Training 40 HR Course

ABSTRACT

This guide is designed to assist the instructor in providing a comprehensive 40-hour training for Crisis Intervention and to teach the course learning objectives. The learning objectives are the minimum required content of the Crisis Intervention Training 40 HR Course. This course is a required course to be completed no later than the second anniversary of the date the officer is licensed or the date an officer applies for an intermediate proficiency certificate, whichever date is earlier. The begin date to satisfy this requirement is April 1, 2018.

Note to Trainers: It is the responsibility of the coordinator to ensure this curriculum and its materials are kept up to date. Refer to curriculum and legal resources for changes in subject matter or laws relating to this topic as well as the Texas Commission on Law Enforcement website at www.tcole.texas.gov for edits due to course review.

Target Population: Peace Officers working toward their intermediate proficiency certificate on or after April 1, 2018, and within 2 years of licensing date for those licensed on or after April 1, 2018.

Student Pre-Requisites:

- None

Instructor Pre-Requisites:

- If taught by a law enforcement officer s/he must be a certified TCOLE Instructor and
    - Currently serving as a Mental Health Officer or serving as a member of a Crisis Intervention Team for at least two years in your Department, OR
    - Mental Health Peace Officer certification (TCOLE) or Crisis Intervention Training Instructor (CIT)
- The course may also be instructed by a licensed mental health professional who possesses a Master's degree or higher in a field of mental or behavioral health, if that mental health professional has at least two years working with law enforcement personnel and/or crisis intervention and is co-instructed by a peace officer.
- It is **STRONGLY RECOMMENDED** a Subject Matter Expert co-teach the CIT, particularly the mental health diagnostic portion of the curriculum. For these purposes a SME may be defined by:
    - A licensed mental health professional (Master's Degree or higher in field of mental or behavioral health) with experience in crisis intervention
    - Accessing a local mental health professional who meets the above-mentioned qualifications may be achieved via contacting local mental health practices, clinics, hospitals, or facilities. Local universities and colleges are also a promising option. Additional resources include the Texas Psychological Association, and psychologytoday.com.
    - Further information to assist in finding a co-presenter can be found in the Appendix

The goal behind the team-teach (LEO and MHP) approach is that the students will greatly benefit from the presence and experience of the experts in their respective fields and will model the collaborative efforts between community law enforcement personnel and community services.

Length of Course: 40 hours

Method of Instruction:

- Lecture
- Discussion
- Scenario and role-play activities (utilization of mental health community representatives to complete this activity is recommended)
- Videos/PowerPoint

Assessment: Assessment is required for completion of this course to ensure the student has a thorough comprehension of all learning objectives. Training providers are responsible for assessing and documenting student mastery of all objectives in this course.

Instructor Resource Guide

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References

TCOLE 40-Hour CIT Training Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
0800	Welcome & Introductions	Cognitive Disorders	Suicide	Roadside Intervention & Problem Solving Exercise	Role-Play Scenarios
0830	Unit 1: Basic Understanding & Definition of the Problem				
0900		Developmental Disorders		Guest Speaker	
0930	Origin of the Training & Community Relations		Guest Speaker		
1000		PTSD			
1030	Unit 2: Defining Crisis			Unit 6: Deinstitutionalization	
1100	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
1130					
1200	Unit 3: Mental Health Adversity and Stigma	Guest Speaker	Unit 5: Information Gathering Three-point Assessment Rapport LEAPS	Deinstitutionalization	Role-Play Scenarios
1230					
1300				Unit 7: Legal Considerations	
1330	Unit 4: Personality Disorders Mood Disorders Psychotic Disorders Substance Use Disorders	Trauma Affected Veterans		Unit 8: Jail Diversion Options	Unit 9: Accessing local resources
1400					
1430					
1500				Test review	
1530					
1600				Prep for scenario-based training	TEST
1630					

This schedule may be adapted as needed to accommodate guest speakers or classroom exercises.

However, this training MUST be given in a full 40-hour block and cannot be broken up into multiple various weeks of instruction.

Learning Objectives

1.1 The student will discuss the origins of Crisis Intervention Training (CIT). *Pg 11*

1.2 The student will discuss the problem of mental health crisis as it pertains to law enforcement. *Pgs 12 - 14*

1.3 The student will discuss SB 1849 and the legislative mandates that resulted. *Pg 16*

1.4 The student will reiterate the goal of CIT. *Pg 17*

1.5 The student will explain CIT's impact on community relations. *Pg 18*

1.6 The student will define the meaning of "crisis" as it pertains to CIT. *Pg 20*

1.7 The student will list several potential causes for a mental health crisis. *Pg 21*

1.8 The student will develop an increased awareness of mental illness and the adversity that surrounds a mental health diagnosis. *Pg 22*

1.9 The student will define "insanity" and discuss how the term is defined in Texas. *Pg 23*

1.10 The student will explore the concept of 'normal' versus 'abnormal' behavior. *Pg 24*

1.11 The student will review national and statewide statistics related to mental health, physical health, and the prevalence of these issues in the population. *Pgs 25 - 26*

1.12 The student will explore several reasons why many people do not seek treatment for mental illness. *Pg 26*

1.13 The student will explore the concept of 'stigma.' *Pgs 27 – 30*

1.14 The student will describe the role and complications of psychotropic medications. *Pg 31*

1.15 The student will describe some of the reasons people stop taking medications. *Pg 31*

1.16 The student will dispel common myths regarding mental illness. *Pgs 33 - 34*

1.17 The student will review various mental illnesses and the impact such illnesses can have on a person's life. *Pgs 35 - 104*

1.18 The student will identify behaviors associated with personality disorders. *Pgs 36 - 41*

1.19 The student will identify behaviors associated with mood disorders. *Pgs 42 - 48*

1.20 The student will identify behaviors associated with thought disorders. *Pgs 49 - 52*

1.21 The student will identify symptoms associated with the ingestion of specific types of drugs and controlled substances. *Pgs 53 - 63*

1.22 The student will identify symptoms and behaviors associated with cognitive disorders. *Pgs 64 - 73*

1.23 The student will explore the causes of traumatic brain injury (TBI). *Pgs 65 - 68*

1.24 The student will describe the symptoms and behaviors associated with dementia and Alzheimer's Disease. *Pgs 69 - 71*

1.25 The student will identify methods most effective in talking to someone with dementia. *Pg 72*

1.26 The student will describe developmental disorders, and recognize the symptoms and behaviors associated with Autism Spectrum Disorders. *Pgs 74 - 77*

1.27 The student will define the term 'intellectual disability' and discuss what that means in terms of law enforcement interaction. *Pgs 78 - 83*

1.28 The student will distinguish the degrees of intellectual disability. *Pg 79*

1.29 The student will discuss effective communication methods for individuals that have an intellectual disability. *Pgs 80 - 83*

1.30 The student will list some of the causes of Post-Traumatic Stress. *Pg 84*

1.31 The student will recognize symptoms and behaviors of an individual experiencing PTSD. *Pg. 86*

1.32 The student will discuss the effects of trauma on veterans. *Pgs. 87 - 91*

1.33 The student will define a moral injury. *Pg 90*

1.34 The student will define survivor's guilt. *Pg 91*

1.35 The student will recognize the symptoms and behaviors of PTSD in a veteran. *Pgs 92 - 93*

1.36 A The student will use techniques to build rapport with veterans or others experiencing PTSD. *Pg 96*

1.36 B The student will describe the relationship between Inter-Personal Violence (IPV) and PTSD. *Pg 96*

1.37 The student will discuss the statistics and terminology of suicide and suicide prevention. *Pg 97*

1.38 The student will recognize symptoms and behaviors that indicate an increased suicide risk. *Pg 98*

1.39 The student will list protective factors against suicide. *Pg 99*

1.40 The student will use a suicide risk assessment. *Pg 100*

1.41 The student will assist an individual to name and contact personal support resources. *Pg 101*

1.42 The student will discuss statistics and trends in law enforcement suicide. *Pg 102*

1.43 The student will discuss ways to change current mental health culture. *Pg 103 - 104*

1.44 The student will discuss a variety of advanced modes of communication to assist in dealing with someone in a crisis and be able to display them in interaction and role play. *Pgs 105 - 124*

1.45 The student will discuss and be able to effectively utilize an initial Three-Point Assessment. *Pg 107*

1.46 The student will discuss and utilize the '5 Universal Truths of Human Interaction'. *Pg 110*

1.47 The student will implement tactics for gaining trust and building rapport. *Pgs 111 - 112*

1.48 The student will define the 80/20 rule. *Pg 112*

1.49 The student will be exposed to the LEAPS model of communication, be able to list its components, and demonstrate proficiency in its use. *Pgs 115 - 121*

1.50 The student will list and describe the crisis intervention skills involved in communicating with people experiencing mental illness. *Pg 121*

1.51 The student will identify examples of 'I' statements versus 'you' statements. *Pg 122*

1.52 The student will define the terms tactical transparency. *Pg 123*

1.53 The student will discuss options for responding appropriately to verbal abuse. *Pg 124*

1.54 The student will define the term "deinstitutionalization" and discuss the criminal justice system and its relationship with those suffering from mental illness. *Pgs 125 - 128*

1.55 The student will explore the relationship between homelessness, mental illness, and victimization. *Pgs 129 - 134*

1.56 The student will explore legal considerations for police intervening in a mental health crisis and learn about the provisions that pertain to law enforcement duties in the Health and Safety Code. *Pgs 135 - 139*

1.57 The student will read, fill out, and demonstrate proper implementation of a police officer's emergency detention. *Pgs 136 - 137*

1.58 The student will discuss transportation options and officer safety. *Pg 139*

1.59 The student will define the term 'diversion' and discuss programs and options for avoiding the incarceration of those experiencing mental illness. *Pgs 140 - 142*

1.60 The student will discuss Mental Health Court as a form of diversion. *Pg 142*

1.61 The student will discuss community and referral resources and options within his/her respective geographical area. *Pgs 143 - 145*

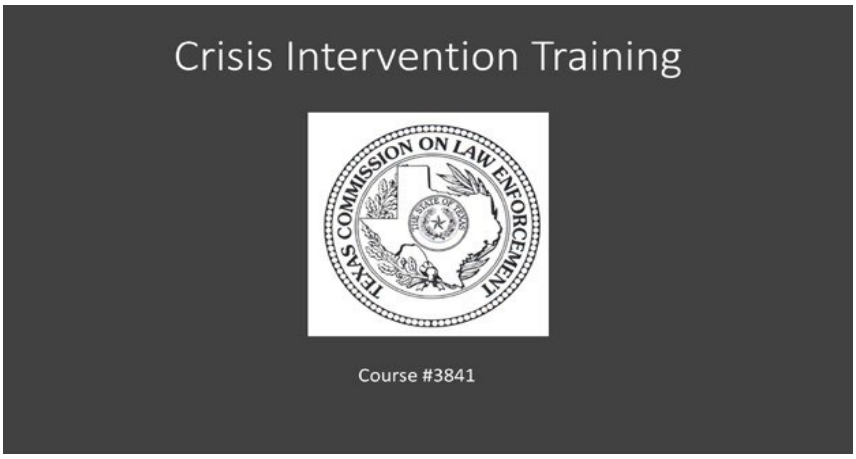
Guide for Using this Instructor Manual

- Each teaching unit is indicated by a Unit Header
- Indicates the duration of each teaching segment
- Prior to introducing each slide, the page numbers listed provide reference to where the information can be found in the Student Resource Manual (SRM).
- Each slide in the PowerPoint presentation is represented in this manual, along with the teaching points
- Indicates Student/Class activities or videos
- Indicates suggestions for questions to prompt class discussion

Welcome and Introductions

30 mins

SRM = N/A



As Participants Arrive

- Ask them to write their name clearly on the sign-in sheet
- Ensure students have either a printed or electronic Student Resource Manual

Slide 1 and Welcome

Welcome the students and introduce yourself. You may also provide students with the following information:

- Inform students that this is a 40-hour course consisting of lecture, PowerPoint presentation, videos, and role-playing exercises. There will also be guest speakers and class discussion.
- Directions to the bathroom
- Estimated time and duration of lunch break
- Estimated frequency and duration of breaks
- Request students silence their cell phones

Unit: 1 Developing a Basic Understanding of Crisis Intervention (CIT)

60 mins

Opening Statement

SRM = pg. 7

Unit Goal 1.0: Exploration of the topic of mental health to include de-escalation and crisis intervention techniques

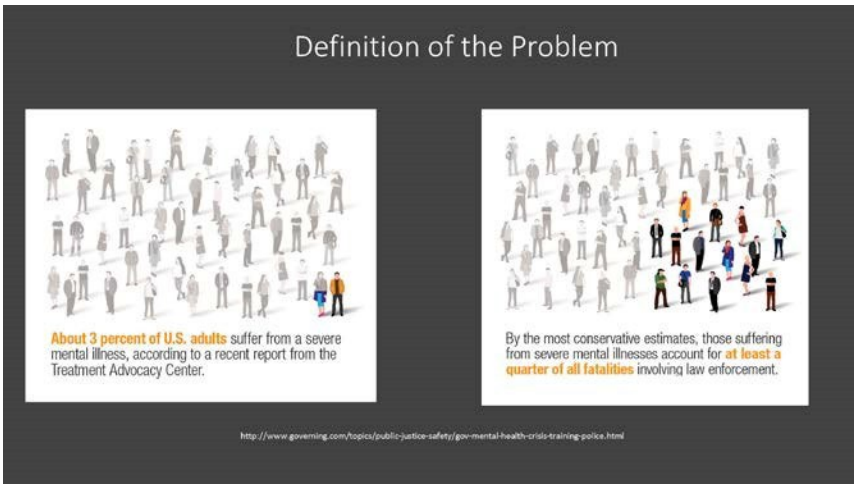
1.1 The student will discuss the origins of Crisis Intervention Training

With increasing frequency, law enforcement is being called upon to respond to individuals in serious mental health crises. It is necessary for law enforcement personnel to understand mental illness, and the tactics and techniques that have been proven to work most effectively when responding to individuals in these situations. These tactics and techniques are different than those routinely taught to officers to manage conflict. Generally, the underlying elements behind mental illness-related behavior is usually not criminal or malicious. Utilizing the information from this course, and implementing effective strategies can help keep the officer safe, keep the public safe, and greatly reduce civil liability.

Definition of the Problem

SRM = pg. 7

1.2 The student will be able to discuss the problem of mental health crisis as it pertains to law enforcement



- Re-occurring situations in which law enforcement uses unnecessary, excessive or deadly force during encounters with individuals in mental health crisis.

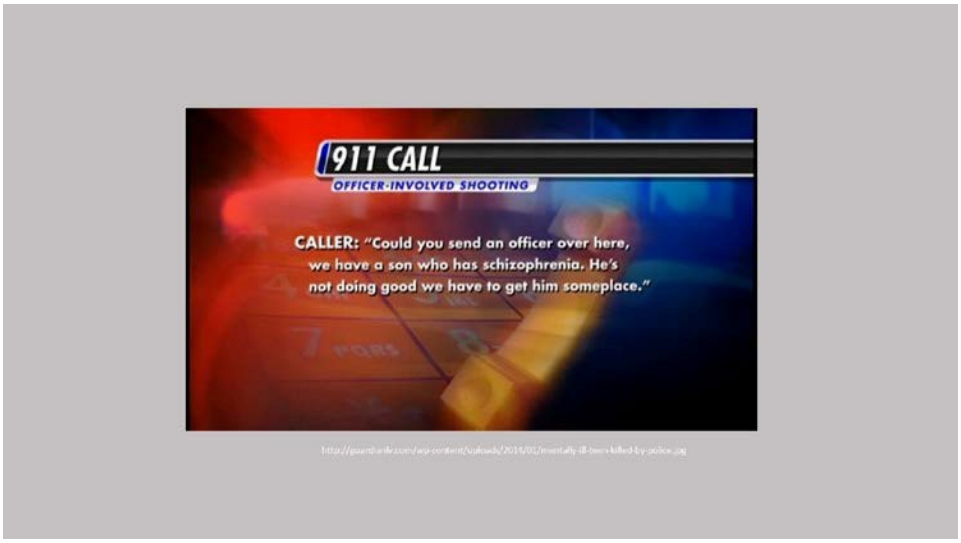
- Although individuals with mental illness comprise fewer than 4 in every 100 adults in America, individuals with mental illness generate no less than 1 in 10 calls for police service...an estimated 1 in 3 individuals transported to hospital emergency rooms in psychiatric crisis are taken there by police (Torrey, et al., 2010).

- Deinstitutionalization and lack of community mental health resources resulted in incarceration instead of treatment. Approximately 40,000 to 72,000 people in prison, would likely have been in mental hospitals in the past (APA, 2014).

- The Treatment Advocacy Center in Washington, D.C. reports that the "risk of being killed when approached or stopped by law enforcement in the community is 16 times higher for individuals with untreated serious mental illness than for other civilians" (Fuller, D., Lamb, R., Biasotti, M. & Snook, J, 2015).

- National data on police shootings is unclear "and fail to provide a clear picture of how often, and under what circumstances police in the United States use force." (Police Executive Research Forum (PERF), 2016).

- Washington Post investigative reporters undertook a large research endeavor in an attempt to better classify and identify police use of force. Their findings indicated 990 fatal officer-involved shootings in 2015, and in 25% of those shootings the subject displayed signs of mental illness (Lowery, L., Et al, 2015).



- Often, family members call police in an attempt to assist with a family member who is exhibiting problematic or troubling behavior due to mental illness, and the family is desiring their loved one be transported to a hospital or mental health facility. In some cases, when the police arrive, the subject is holding an implement that may be perceived as potentially harmful and results in a deadly force encounter, leading the family and the community to ask if other de-escalation tactics could have been used (Police Executive Research Forum (PERF), 2016).

- Historically, law enforcement officer training has not focused heavily on crisis intervention or de-escalation tactics.

Show Video: Learn about the issues and facts related to police – mental health (1.18 minutes)
https://www.youtube.com/watch?v=5_1x7ApO5mk

- Of the calls your department receives, what estimated percentage would you (or other officers) speculate are related to mental health or require some form of intervention?
  - Is this percentage an increase or decrease from prior years?
  - What does the class think has contributed to the increase or decrease in calls to first responders for crisis intervention?

Origin of the Training and Community Relations

60 mins
SRM = pg. 8

- The program was conceived in Memphis TN., after police shot a 26-year-old man with mental illness.

  - "In September 1987, White Memphis police officers answered a 911 call. A young African American man with a history of mental illness was cutting himself with a knife and threatening suicide. Police officers are trained to respond with deadly force when they perceive their lives are in danger. At the outset of the incident, it appeared that the only life in danger was the young mans, from self-inflicted wounds. As they were trained to do at the time, officers at the scene confronted the man and demanded he drop his weapon. At this, he became more upset and ran at the officers who, in fear for their own safety, opened fire and killed him….Although the welfare of both officers and the mentally ill in situations of confrontation had been a concern for some time, this death, with its racial overtones, was the catalyst that resulted in the creation of CIT a year later" (Vickers, B., 2000).

Show Video: Origins of Crisis Intervention Training (10.10 minutes)
https://www.youtube.com/watch?v=y99kODtyVhk

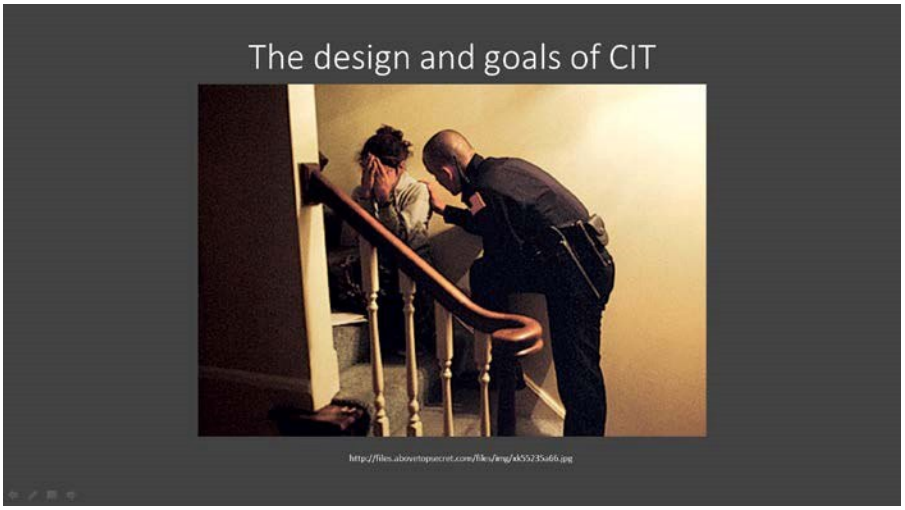
Texas SB 1849 legislation
SRM = pg. 8

1.3 The student will discuss SB 1849 and the legislative mandates that resulted.

- Law enforcement officers are required to learn de-escalation techniques to reduce the use of force.
- "Each law enforcement agency shall make a good faith effort to divert person suffering from mental health crisis or substance abuse to proper treatment."
- Establishes an easier process by which people with mental illness and/or intellectual disability can receive personal bond (Whitmire, J., 2017).
- Changes to the Occupations Code pertaining to this training and other requirements are in Section 1701.253 of the Occupations Code with an amendment to subjections (j) and adding section (n).
- View the Bill Analysis and the code changes in the annex.

The design and goals of CIT
SRM = pg. 9

1.4 The student will be able to reiterate the goal of CIT.



- "The primary goal of CITs involves calming persons with mental illness who are in crisis and referring them to mental health care services, rather than incarcerating them. This goal…includes lessening injuries to officers, alleviating harm to the person in crisis, promoting decriminalization of individuals with mental illness, reducing the stigma associated with mental disorders, and using a team approach when responding to crises" (Jines, 2013).

- Crisis Intervention Training is foremost about officer safety. It is designed to educate law enforcement officers in the basic elements of specific mental illnesses and prepare them to utilize practical applications of de-escalation techniques. This training is intended to assist officers in being able to recognize the signs and symptoms of mental illness and to respond effectively, appropriately, and professionally.

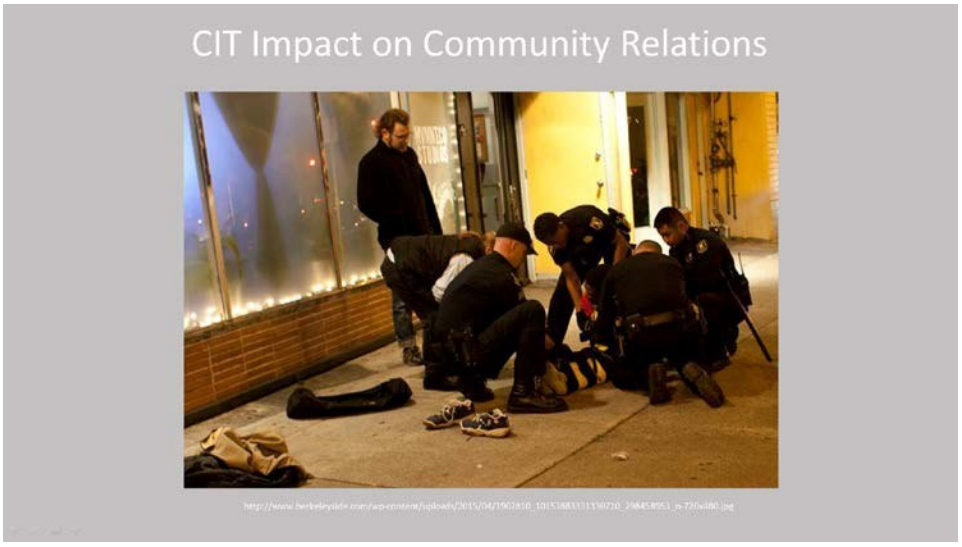
- Educate officers on how to identify behaviors that may indicate the presence of mental illness, and provide officers with de-escalation skills to mitigate violence and increase officer and public safety.

- Provide information on how to safely transport someone in mental health crisis to an appropriate resource or facility.

CIT impact on Community Relations

SRM = pg. 9

1.5 The student will be able to explain CIT's impact on community relations.



- "CIT has been shown to positively impact officer perceptions, decrease the need for higher levels of police intervention, decrease officer injuries, and re-direct those in crisis from the criminal justice to the health care system" (Dupont & Cochran, 2000).

- "CIT may have a transformative effect on officers' attitudes by increasing exposure to and familiarity with mental illness. CIT is rated very positively by officers" (Bonfine, Ritter, & Munetz, 2014).

- Officers' attitudes about the impact of CIT on improving overall safety, accessibility of services, officer skills and techniques, and the preparedness of officers to handle calls involving persons with mental illness are positively associated with officers' confidence in their abilities or with officers' perceptions of overall departmental effectiveness. There is further evidence that personal contact with individuals with mental illness affects the relationship between attitudes that CIT impacts overall safety and perceived departmental effectiveness" (Bonfine, Ritter, & Munetz, 2014).

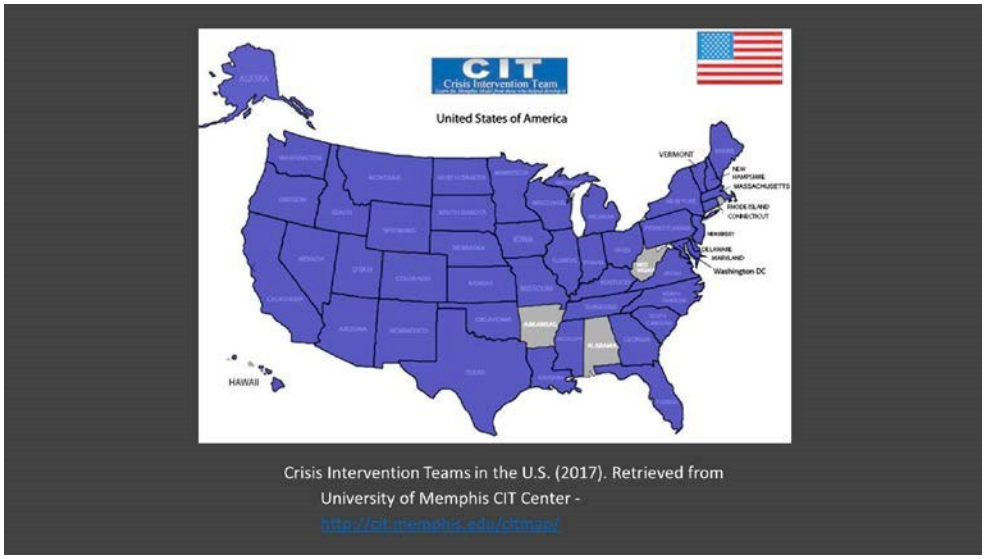
- Individuals with mental illness are traditionally not career criminals. Law enforcement is highly scrutinized by the public and private sectors when force is utilized in these cases, even when provocation is evident.

- Reduce complaints, financial liability, and lawsuits as well as increase public trust and confidence in law enforcement among people suffering from mental illness, their families, and the community at large.

Show Video: Texas Mental Health Crisis (8.45 minutes)
https://www.youtube.com/watch?v=47lggzhpb1g

Efficacy of CIT programs

SRM = pg. 10



Crisis Intervention Teams in the U.S. (2017). Retrieved from University of Memphis CIT Center - http://cit.memphis.edu/citmap/

- 46 of the 50 states have CIT programs. Arkansas, Alabama, West Virginia, and Rhode Island are the only states that do not have CIT programs.

- Northwestern University conducted a study of the Houston Police Department's officer involved shootings and found that those officers responding to calls designated as CIT-related calls were 82% less likely to use their guns then when they responded to other types of calls (Colucci, McCleary, & Ng, 2014).

- "The Bexar County sheriff's office, which cosponsors the San Antonio CIT program, has trained nearly 90 percent of its roughly 1,430 sworn officers… From 2003 to 2009, the unit was using force in its daily work, more than 50 times a year. Since 2009, when all its deputies were trained in crisis intervention, the unit, as of October, had used force just seven times total…and has saved San Antonio and Bexar County nearly $100 million over an eight-year period" (Helman, S. 2016).

- Research has indicated Crisis Intervention Training improves officer comfortability, knowledge, and attitudes towards individuals with mental illness (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006).

- The National Alliance on Mental Illness outlines several research findings which denote how CIT training resulted in the decline in officer injuries while involved in mental health related calls, decreased police shootings, and decreased need for SWAT team emergencies (NAMI.org).

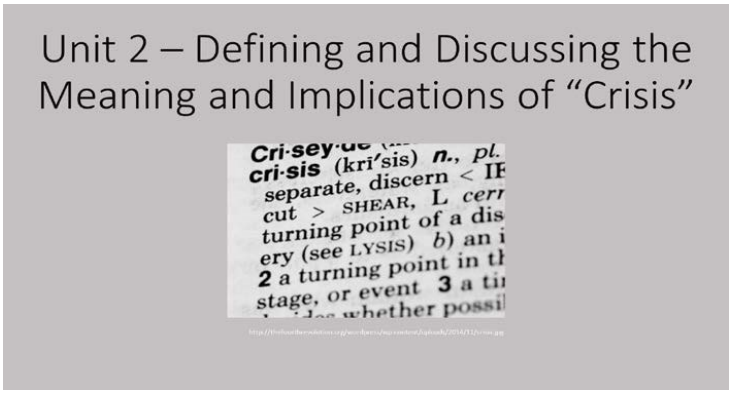
Unit 2: Defining and Discussing the Meaning and Implications of "Crisis"

30 mins

Define "crisis"

SRM = pg. 11

1.6 The student will be able to define the meaning of "crisis" as it pertains to CIT.



- "A paroxysmal attack of pain, distress, or disordered function" or an "emotionally significant event or radical change of status in a person's life" (Merriam-Webster dictionary, 2017).

- The crisis may have been precipitated by a loss, or a challenging situation and may result in the person feeling confused, alarmed, overwhelmed, desperate, hopeless, helpless, enraged, or terrified.

- A person in crisis may be more prone to acting instinctually (self-preservation) rather than with logical thought; non-compliance may be the result of a combination of these factors rather than an intentional act of defiance.

Ask students what they think may prompt a crisis, and the behavior they might see as a LEO from someone experiencing a crisis.

Discuss different degrees of severity for crises and consider what might constitute a crisis for an individual suffering from a mental illness.

1.7 The student will be able to list several potential causes for a mental health crisis.

The following types of events might result in a person feeling as though he/she is in a crisis situation:

- death of a loved one
- death of a pet
- getting locked out of the house/car
- layoff or termination from work
- financial difficulty
- divorce, separation, or child custody
- legal difficulties

- External factors that can contribute to a situation escalating into a crisis include:
  - Expectations the person cannot meet
  - Lacking a sufficient support system or being disconnected from sources of support
  - Substance abuse

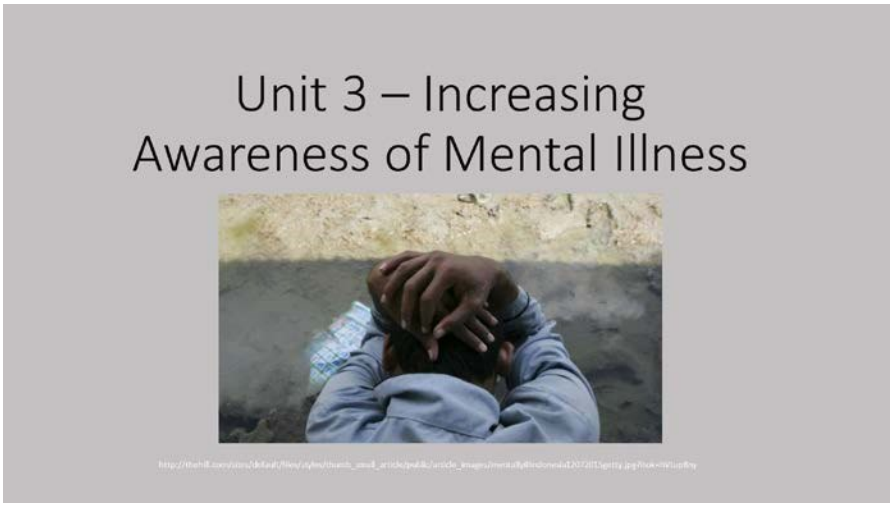
- Due to individual, environmental, cultural, and circumstantial factors, any one person might react to or perceive a crisis situation differently than another person. This might be especially true for an individual suffering from a mental illness due to the possibility of disrupted emotions or thought distortions.

Unit 3: Increasing Awareness of Mental Illness and Associated Adversity

90 mins

Present official definitions of mental illness and discuss the differences based on the context.
SRM = pg. 12

1.8 The student will develop an increased awareness of mental illness and the adversity that surrounds a mental health diagnosis.



- "Mental illness refers to a wide range of mental health conditions—disorders that affect your mood, thinking, and behaviors" (Mayo Clinic, 2017). Examples of mental illness include depression, anxiety, schizophrenia, bipolar disorder, borderline personality disorder, eating disorders and addictive behaviors.

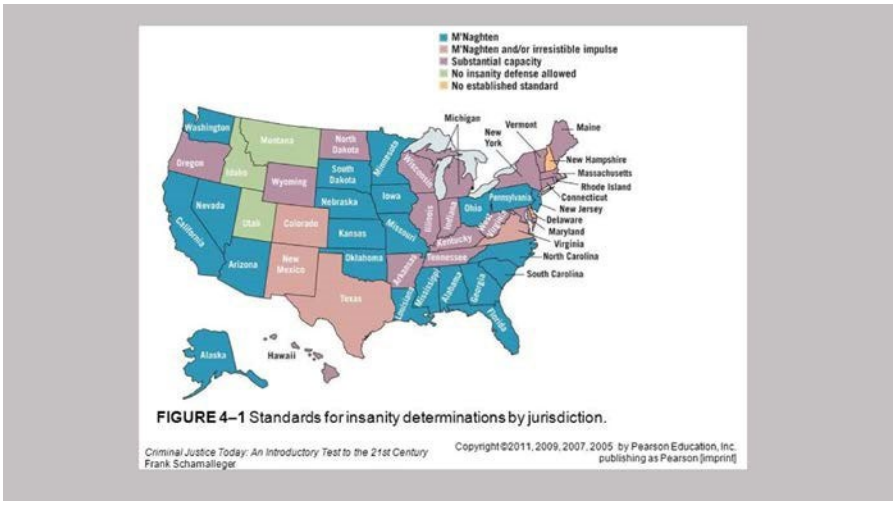
- Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function" (Mayo Clinic, 2017).

- "A mental illness is a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis" (National Alliance for Mental Illness (NAMI), 2017).

Mental illness is diagnosed based on behaviors and thinking as evaluated by a psychiatrist, psychologist, licensed professional counselor, licensed social worker, or other qualified professionals using a tool known as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, most commonly called the DSM-5. (American Psychiatric Association, 2013)

SRM = pg. 12

1.9 The student will be able to define "insanity" and discuss how the term is defined in Texas.



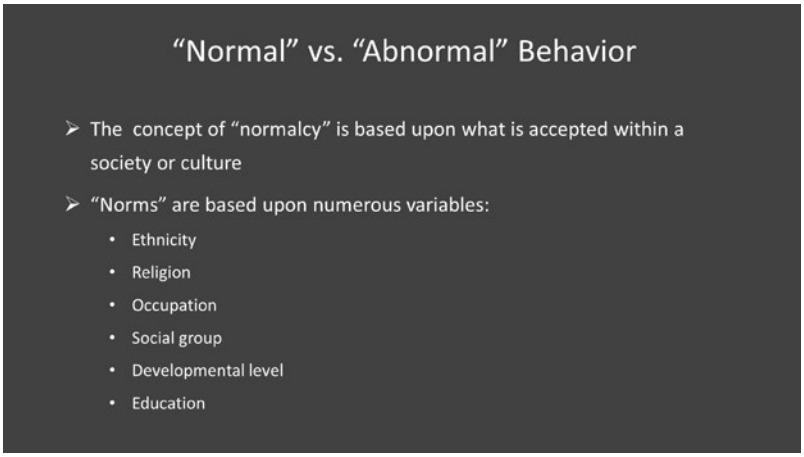
Insanity (Legal Term)

- A general definition of insanity is "an unsoundness of mind or lack of the ability to understand that prevents one from having the mental capacity required by law to enter into a particular relationship, status, or transaction or that releases one from criminal or civil responsibility" (Merriam-Webster dictionary, 2017).
- Varies state to state.

- According to the Texas Penal Code, Section 8.01, insanity “is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong. The term "mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.”
- The term ‘insanity’ is not a psychological term, but is a legal term used as a defense to avoid criminal consequences for certain acts.

SRM = pg. 12

1.10 The student will explore the concept of ‘normal’ versus ‘abnormal’ behavior.



- ‘Abnormal’ Versus ‘Normal’ Behavior:
  - A sharp dividing line between ‘normal’ and ‘abnormal’ behavior does not exist and is often based upon social norms for specific societies, cultures, and subcultures.
    - Consider the difference in norms and customs for most Texans compared to those of an indigenous tribe in the Amazon jungle. If practiced in the other culture or society, those practices may be deemed ‘abnormal.’

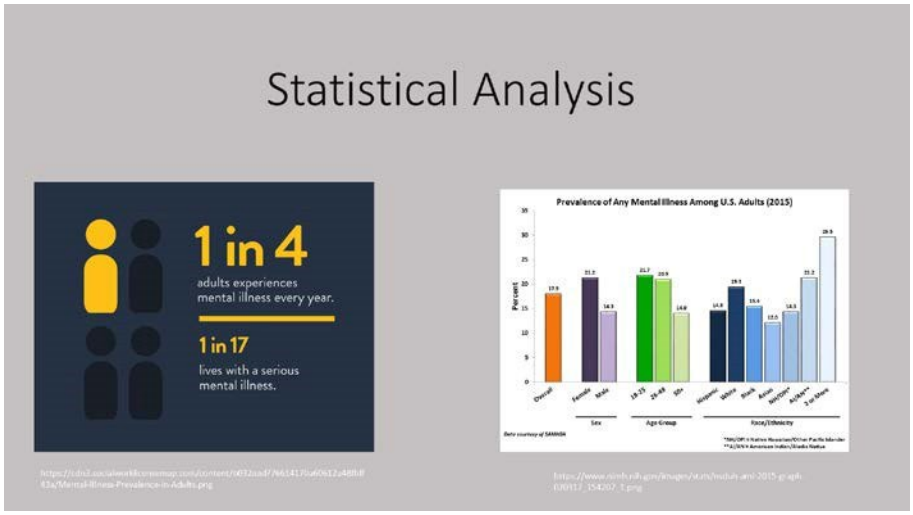
Solicit examples from the class about what might be “normal” in one culture or society, but “abnormal” in another culture and society.

Ask students how some behaviors might be deemed “abnormal” and prompt law enforcement involvement.

Basic Mental Health Statistics

SRM = pg. 13

1.11 The student will be exposed to national and statewide statistics related to mental health, physical health, and the prevalence of these issues in the population.



- In 2015, there were an estimated 43.4 million adults aged 18 or older in the United States with mental illness within the past year. This number represented 17.9% of all U.S. adults, or 1 out of every 5 people (NIMH, 2015).

- These mental illnesses ranged from mild to severe.

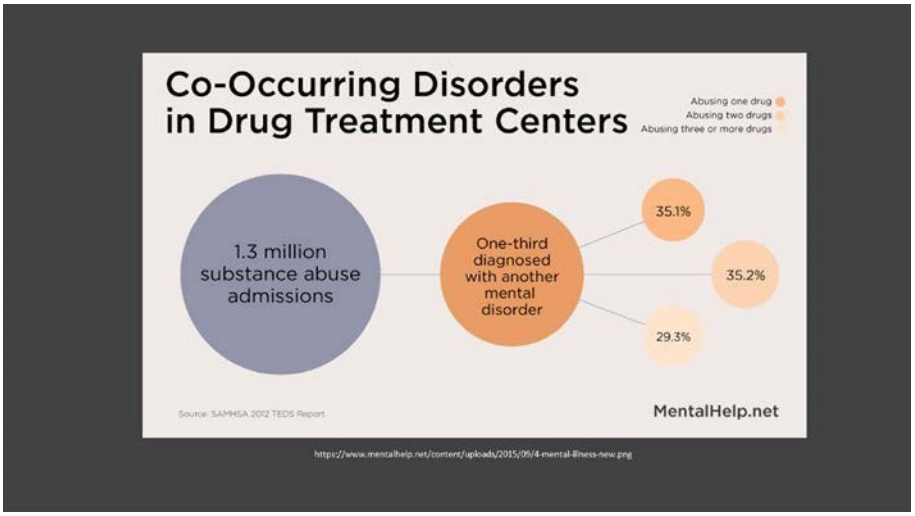
- The majority of individuals with mental illness live productive lives.

- Some individuals suffer from *serious* mental illness, which means severe impairment and limits in one or more major life activities (financial, occupational, social).

- Others may suffer from *persistent* mental illness, which is indicated by long durations of impairment.

- There are also episodes of mental illness that are situational in nature and may be due to stress, grief, or substance abuse. The duration and severity of these episodes is often based upon a number of factors including coping skills, social support, treatment, and substance use.

SRM = pg. 13



- The 43.4 million with mental illness does not include substance use disorders, such as drug- or alcohol-related disorders.

- For statistics and other information about drug- and alcohol-related disorders, please visit the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

1.12 The student will explore several reasons why many people do not seek treatment for mental illness.

- Anyone can experience mental illness, regardless of age, gender, race, education level, or socioeconomic level.

- Mental illnesses are more common than cancer, diabetes, heart disease or AIDS.

- Approximately 1 in 25 adults in the U.S. (9.8 million, or 4%) experience a serious mental illness in a given year that substantially interferes with or limits one or more major life activities. (NAMI, 2017).

- 21.4% of youth age 13-18 experience a severe mental disorder, and approximately 13% of children age 8-15. (NAMI, 2017).

- With recognition, proper treatment (to include medication and therapy), and a commitment to wellness, people who experience mental illness can live rewarding, satisfying, and productive lives.

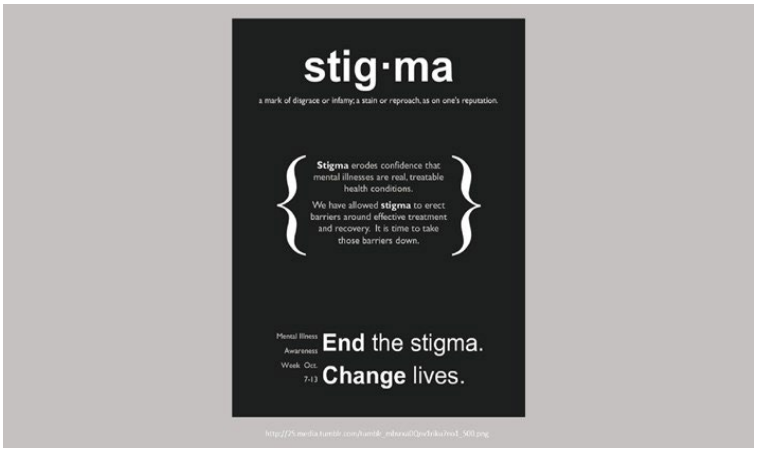
- Mental illness can - and should - be treated (NAMI, 2017)

- Unfortunately, nearly two-thirds of all people with a diagnosable mental illness do not seek treatment (Mental Health America of Texas, 2017).

Disability Weights Activity – see associated appendix for instructions and materials

Discuss the reasons that many people are reluctant to seek treatment for mental illnesses
SRM pg. 13

1.13 Students will explore the concept of 'stigma.'

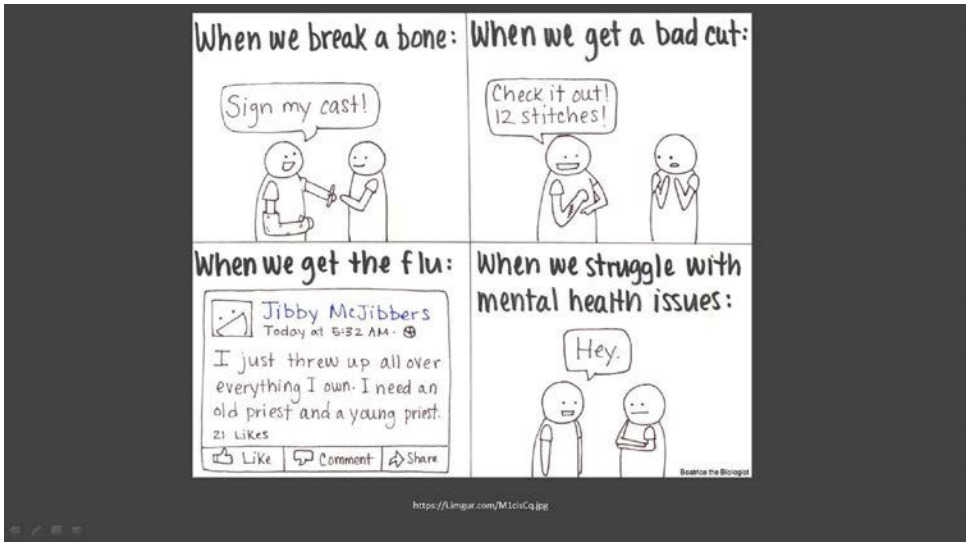


- Stigma is a mark of disgrace or shame (dictionary.com). It is made up of various components, including:
    - Labeling someone with a condition
    - Stereotyping people with that condition
    - Creating a division (a superior 'us' and a denigrated 'them')
    - Discriminating against someone on the basis of a label

- There remains a stigma attached to mental illness and prejudices against individuals that suffer from mental illness. Mental illness continues to be widely misunderstood by the general public. Therefore, it is important to increase education and awareness especially among those that might interact with individuals experiencing mental illness.

Show Video: *What if we talked about physical health like we talk about mental health?* (1.30 minutes)
https://www.youtube.com/watch?v=Bor9xVnbIz8

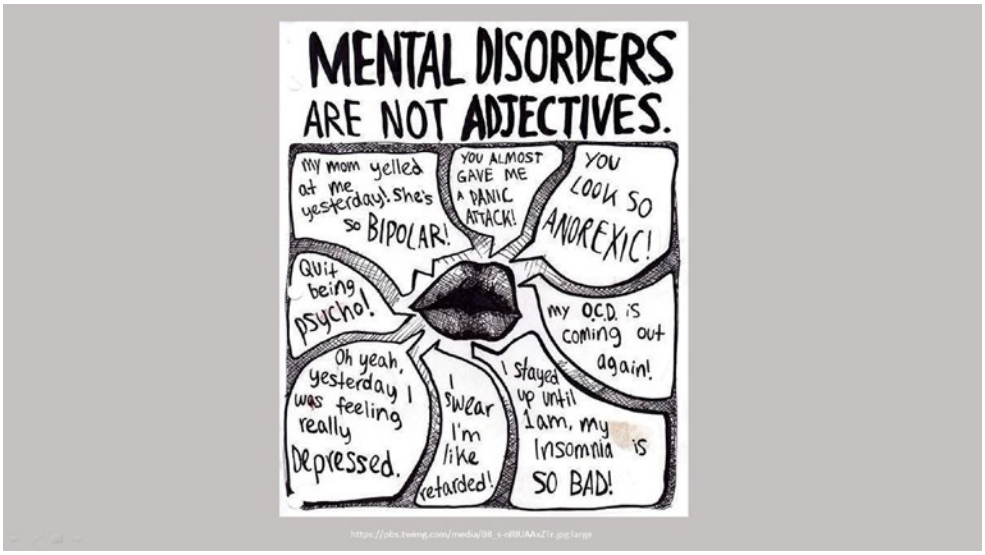
SRM = pg. 14



- Stigmas encourage inaccurate perceptions. The term 'mental illness' in itself, alludes to false information. 'Mental' suggests an illegitimate medical condition that is 'all in your head,' and therefore a sign of weakness. The term 'mental' suggests a separation from a physical illness, when in fact they are entwined. A vast body of research supports the assertion that there are physical and measurable changes in the brain associated with mental illness, suggesting that a biological component exists.

- It is also a common stereotype that persons with a mental illness are dangerous and unpredictable, although statistics do not substantiate that belief. In fact, "The clear majority of people with mental health problems are not more likely to be violent than anyone else. Only 3% - 5% of violent acts can be attributed to individuals living with a serious mental illness." (U.S. DHHS, 2017).

SRM = pg. 14

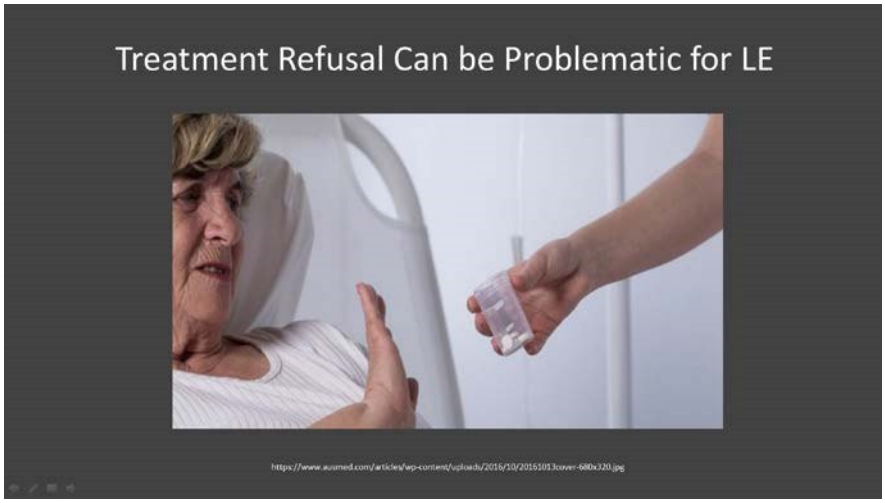


- These stigmas perpetuate a negative stereotype of people with mental illness that fuels fear and mistrust and reinforces distorted perceptions, leading to further stigma. Stigma can lead to devastating consequences. Some people refuse treatment for fear of being 'labeled.' The stigma can lead to isolation due to shame and embarrassment. Discrimination in the workplace continues. Victims may still lose jobs through the stress of coworker gossip, lack of social connection, and lack of promotion. The stigma even extends into the medical community, where health insurance coverage is more limited for mental illnesses than for physical illnesses.

- In many cases, individuals struggle to gain access to treatment, have difficulty seeing the same mental health professional or physician, or need additional financial resources to pay for costly diagnostic procedures and treatments.

- Individuals are often discouraged and/or unable to persist in finding the best treatment options for their condition and circumstances, since there is no "one size fits all" treatment.

SRM = pg. 14

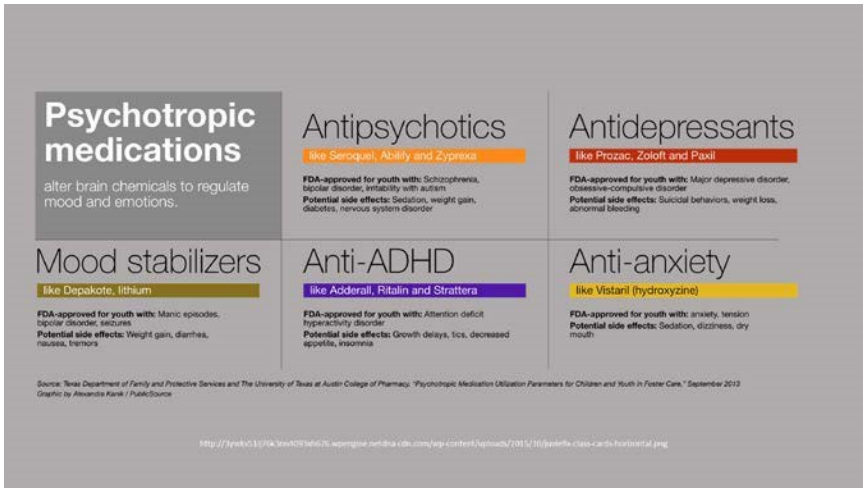


- For individuals with access to medications, they often decline or discontinue the medications for a variety of reasons, including:
- Many people, especially those in creative fields, feel that medications squash creativity, artistry, and remove the drive to create.
- Just as with other medications, psychiatric medications can be lethal if one mixes medications, mixes with alcohol (or other drugs) is allergic, or takes too much.
- It is common for individuals suffering from mental illness to discontinue medications because they start to feel better and believe that they no longer need them.
- Medication non-compliance is a continuous problem for law enforcement because abrupt medication cessation is a primary cause of crisis incidents.

Discuss the role and complications of psychotropic medications

SRM = pg. 15

1.14 Students will be able to describe the role and complications of psychotropic medications.

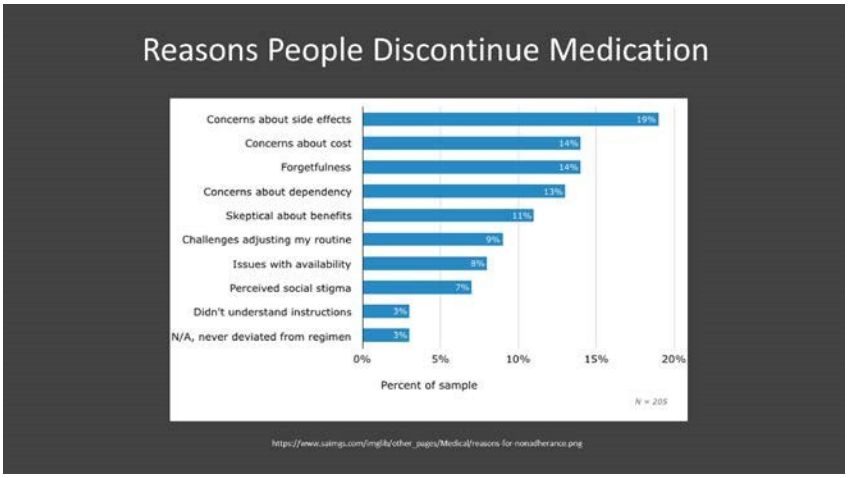


The term "psychotropic medication" refers to any medication capable of affecting the mind, emotions, and behavior.

- Medication can be an essential part of an effective treatment plan and is often used to treat some of the following conditions and symptoms:
  - Psychosis
  - Anxiety
  - Depression
  - ADHD
  - Impulse control
  - Mood swings (also known as lability)

- Medication can help the person attain a degree of symptom relief that enables him/her to engage more fully in therapy and learning how to manage the condition through coping skills and self-care.

SRM = pg. 15



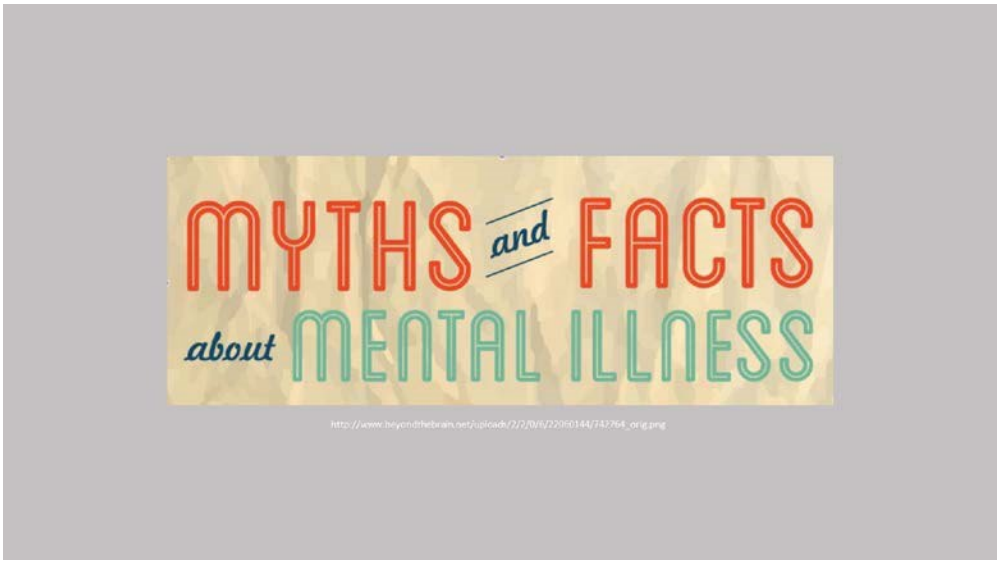
- Medication is not always necessary, and that decision should be made collaboratively with the affected person and his/her support system. This may include a physician, therapist, psychologist, social worker, family advocate, and sometimes a psychiatrist.

1.15 Students will describe some of the reasons people stop taking medications.

- Treatment compliance is an ongoing struggle for many individuals, for reasons including:
  - Lack of health insurance coverage
  - Expense of medications
  - Unpleasant side effects, including weight gain (sometimes extreme), severe constipation, sexual dysfunction, or a feeling of being dissociated, floaty, or out of sync with their body. ○ Many of the side effects are not permanent
- Neurological damage can occur if an individual has had to take a form of medication in high doses for many years.
  - Lack of access to consistent mental health treatment.
  - The experience of taking medications daily for life.

Dispel prominent myths regarding mental illness can reduce undeserved stigma
SRM = pg. 16

1.16 Students will be able to dispel common myths regarding mental illness.



- Myth: Mental illness does not affect the average person.
- Reality: No one is immune from mental illness. “43.7 Million Americans struggle with mental health conditions annually” (MHA, 2017). The impact of stigma is tragic because mental health challenges are actually very common. There are good treatments (Abrams, 2017).

- Myth: Mental illness is an indication of weakness or character flaws, and people can snap out of it if they try hard enough.

- Reality: A combination of factors contribute to mental illness, including genetic predispositions, trauma, a history of abuse, medical illness, brain chemistry, and recreational drug use. (U.S. DHHS, 2017).

- Myth: A person with a mental illness is also intellectually challenged.
- Reality: There are some persons with a dual diagnosis, but the conditions are fundamentally different. Many people with mental health diagnoses are extremely intelligent, creative, and innovative.

- Myth: If you have a mental illness, you are ‘crazy’ all the time.
- Reality: Some mental illnesses are temporary. Many can be actively managed with medication and behavior modification, so that the illness is virtually undetectable. People suffering from even the most severe mental illness are in touch with reality as often as they are actively psychotic.

- Myth: If people with other disabilities can cope on their own, people with mental illness should be able to do so as well.

- Reality: Most people who have a disabling illness need treatment to return to optimal functioning. Physician oversight and physical therapy fills this role for a physical illness, just as therapeutic intervention is needed for those experiencing mental illness.

- Myth: Most people who struggle with mental illness are homeless, live in group homes or are in mental hospitals.

- Reality: About two-thirds of Americans who have a mental illness live in the community and lead productive lives. (Mental Health America, 2017)

- Myth: I can't do anything for a person with a mental health problem.

- Reality: Everyone can make a difference for someone with mental health concerns. "Only 44% of adults with diagnosable mental health problems and less than 20% of children and adolescents receive needed treatment" (U.S. DHHS, 2017). It may be life changing to help someone access mental health services.

Unit 4: Mental Health Conditions Most Commonly Encountered by Law Enforcement Officers

6 hours (unit total; each subsection has its respective time listed)
SRM pg. 17

1.17 The student will review various mental illnesses and the impact such illnesses can have on a person's life.

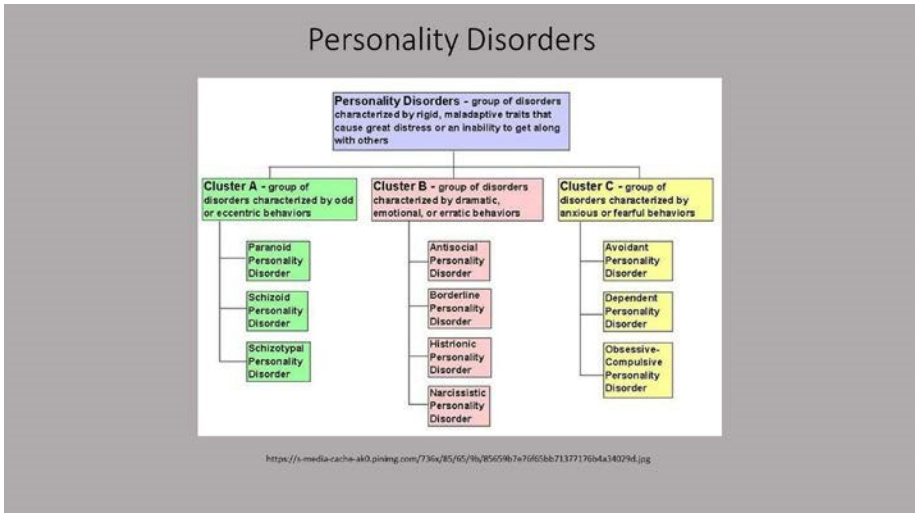
- Think of mental health conditions as falling along a continuum. The severity of each condition varies from person to person (mild, moderate, severe). Some individuals experience 'chronic' or long-term conditions, while others experience more "acute" or immediate symptoms. Those symptoms, and their severity can change; occasionally being acute, and then receding. Mental health conditions often occur simultaneously, for example, individuals often suffer from substance abuse issues in addition to other mental health conditions.

  All diagnostic information provided below is sourced from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, 2013.

Personality Disorders

60 mins
SRM = pg. 17

1.18 The student will be able to identify behaviors associated with personality disorders.

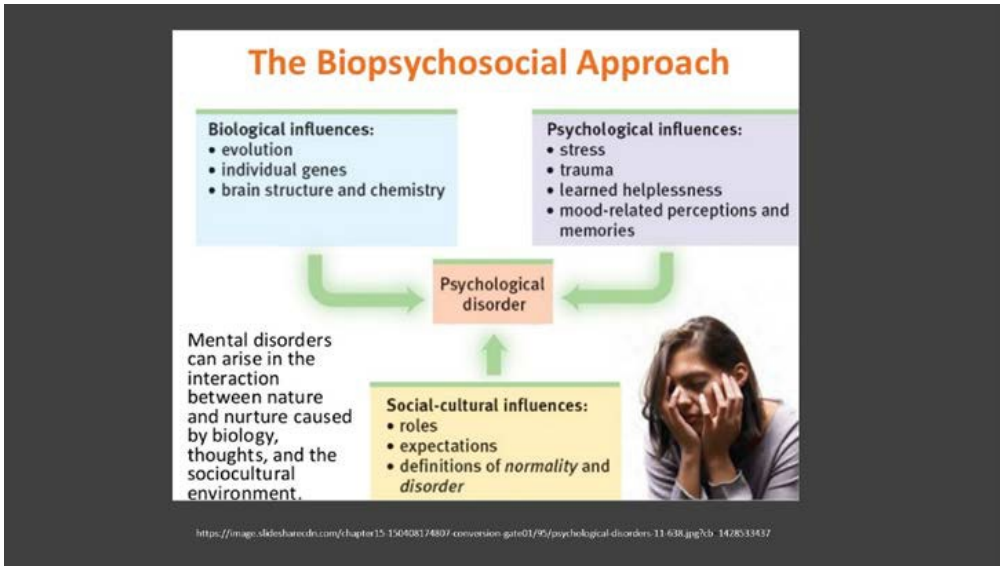


- "A personality disorder is an <u>enduring pattern</u> of thinking, feeling, and behaving that is relatively stable (inflexible) over time, and that deviates markedly from the person's culture." This deviation in thinking and behaving may affect one's perceptions of themselves and others; emotional reactions; the ability to maintain healthy interpersonal relationships; and/or ability to manage impulses.

- People with personality disorders may become involved in the criminal justice system because their way of thinking and perceiving their environment and others may lead them to lawbreaking behaviors. Individuals with personality disorders often also exhibit some form of mood, depression, or anxiety concerns, and frequently substance abuse.

Causes of Personality Disorders

SRM = pg. 17

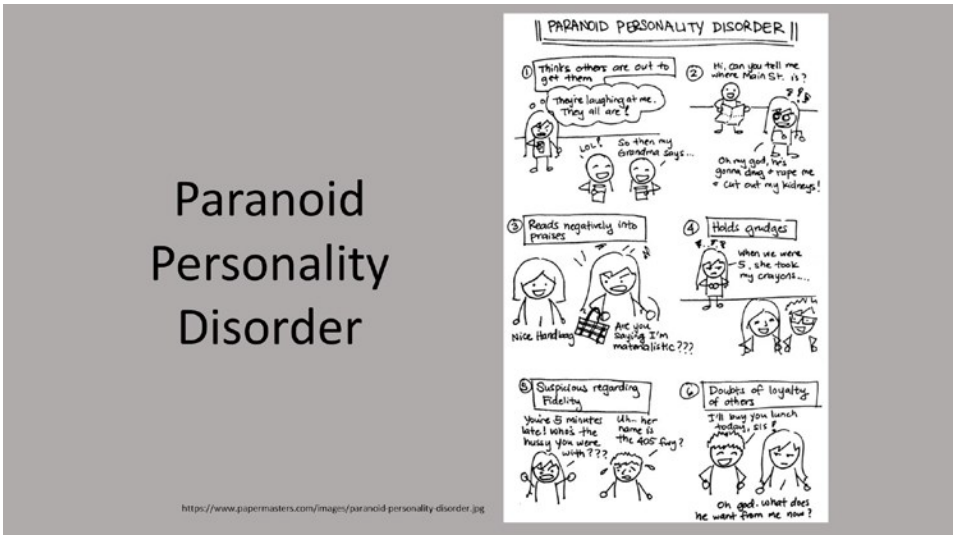


- Personality disorders often become evident in adolescence or early adulthood. It is believed that most personality disorders are caused by a combination of environmental and genetic factors. Environmental factors often include childhood history of instability, verbal/physical abuse, neglect, and poor peer relationships. One does not have to exhibit all the example behaviors in order to meet the criteria for a diagnosable personality disorder.

- Personality disorders that may be most frequently encountered by peace officers include paranoid personality disorder, antisocial personality disorder, borderline personality disorder, and narcissistic personality disorder.

Paranoid Personality

SRM = pg. 18



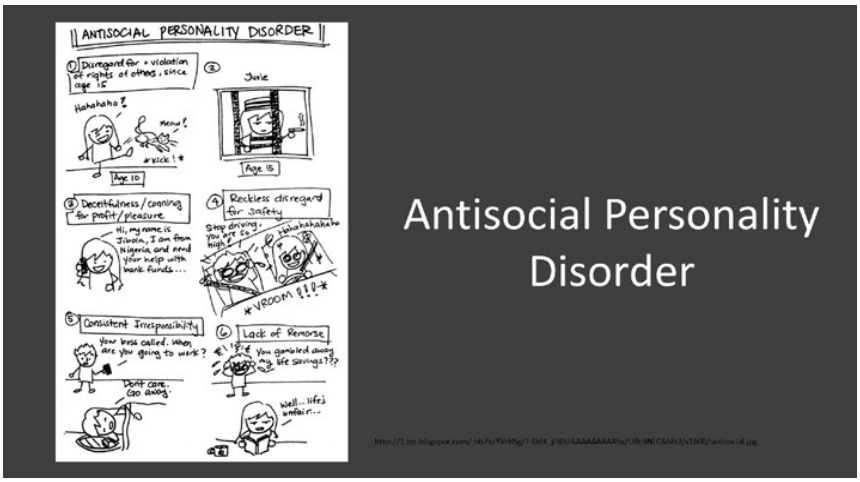
- A pervasive distrust and suspiciousness of others.
- Tendency to interpret the actions of others as deliberately threatening or demeaning.
- Believes (without basis) that others are exploiting, harming, or deceiving him/her.
- Reluctant to confide in others for fear of betrayal.
- Perceives attacks on his/her character and is quick to react angrily.
- May initially appear objective, rational, and unemotional but may quickly devolve into combativeness, stubbornness, and sarcasm.
- Have a high need for control and autonomy, due to their lack of trust.
- Tend to be rigid, critical, and cannot accept criticism.

How might one effectively community with someone exhibiting these traits?

- Be straightforward, unemotional, honest, respectful, and as transparent as possible without impacting officer safety.
- Allow the person to vent, but be aware of the subject self-escalating if they begin to become amped up by their tirade – in which case you want to empathize but redirect their attention to another matter without being dismissive or disrespectful.

Antisocial Personality Disorder

SRM = pg. 18



- This use of the term 'antisocial' is not akin to the societal use of the word to describe someone who does not want or enjoy being social.
- Pervasive pattern of disregard for and violation of the rights of others, occurring since age 15.
- A pattern of rule-breaking and failure to conform to social norms (infringing upon the rights of others) and/or consistently engaging in illegal behavior.
- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal gain.
- Aggressiveness as indicated by repeated physical altercations (including the use of weapons) and/or a history or propensity to harm animals.
- Consistent irresponsibility as indicated by failure to sustain gainful employment or honor financial obligations.
- Lack of remorse.
- Lack of willingness to accept accountability or consequences of his/her actions.
- When considering the continuum of severity, this diagnosis could as easily apply to the gang member or the wall-street executive.
- More frequently diagnosed in males.

How do you think one can effectively communicate with someone exhibiting these characteristics?

- Focus on what is personally advantageous to the individual.
- Do not attempt to appeal to his/her conscience.
- Do not share personal or sensitive information, because the person is more likely to use the information against you or in an attempt to manipulate you.
- These types of individuals can be driven to recklessness when bored, so try to keep the person engaged and occupied.
- Such individuals are often savvy of the criminal justice system, so do not attempt to lie or mislead the individual on the consequences they may be facing.
- Be no-nonsense, straight forward, unemotional, problem-solving focused, and respectful.

Borderline Personality Disorder (BPD)

SRM = pg. 18

- A pervasive pattern of instability of interpersonal relationships, self-image, emotional expression, and poor impulse control.
- May exhibit frantic efforts to avoid abandonment.
- A pattern of unstable relationships marked by idealizing and devaluing partners.
- Self-damaging impulsivity (excessive spending, promiscuous unprotected sex, substance abuse, other recklessness).
- Recurrent suicidal behavior.
- Poor anger control.
- Emotional over-reactivity.
- More frequently diagnosed in females.
- It is a common misunderstanding that 'Borderline Personality Disorder' is a designation meaning someone almost experiencing another kind of mental illness. Such as; 'borderline schizophrenia,' or a 'borderline substance abuser.' This is simply a mistake of language.

How might one effectively communicate with someone exhibiting these traits?

- A calm, empathetic, reassuring, non-reactive, supportive and even nurturing stance may be most effective.

Narcissistic Personality Disorder

SRM = pg. 19

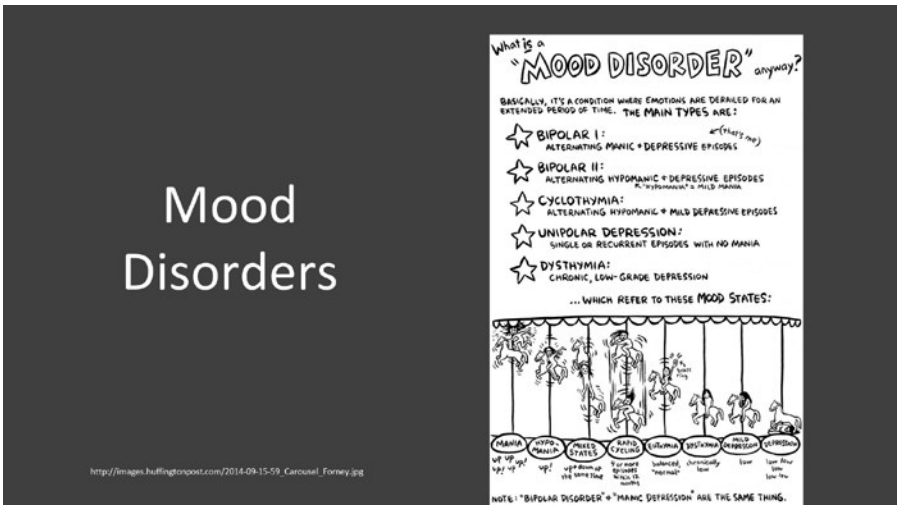
- Persistent grandiosity, need for admiration, and lack of empathy.
- Exaggerates achievements, talents.
- Expects to be recognized as superior.
- Believes s/he is 'special' and should be treated accordingly (entitlement).
- Exploits others.
- Often believes oneself to have special powers or to be the chosen leader of the world or universe (see delusions) (Bernstien, 2017).
- Demonstrates arrogant, haughty, or judgmental behaviors/attitudes.
- More frequently diagnosed in males.

- How might one effectively communicate with someone exhibiting these traits?
- Remain rational, solution-focused, and unemotional.
- Do not engage in attempting to dissuade the person of their lofty self-view.
- Individual will be driven by self-gain, and less concerned about the well-being of others.

Mood Disorders

30 mins
SRM = pgs. 20

1.19 The student will be able to identify behaviors associated with mood disorders.

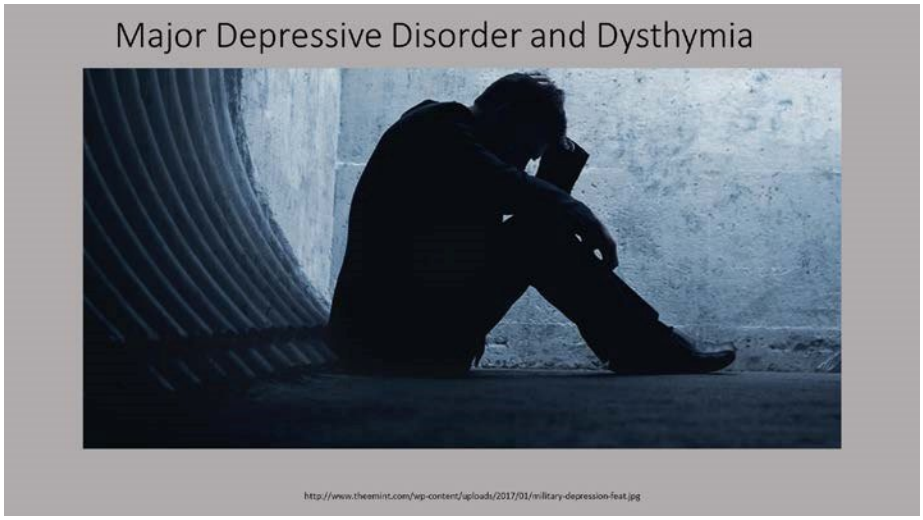


- Mood disorders are demonstrated by disturbances in emotional reactions and feelings. In other words, one's emotional experience (mood) is inconsistent with his/her circumstances. Examples of mood disorders include depressive disorders and bipolar disorders.

- Causes: Researchers (SAMHSA, 2017) believe that a complex imbalance in the brain's chemical activity plays a prominent role in mental illness selectivity in the individual. Environmental factors can also be a trigger or buffer against the onset. Mood disorders also have a genetic component, meaning that they tend to run in families.

Major Depressive Disorder and Dysthymia

SRM = pg. 20

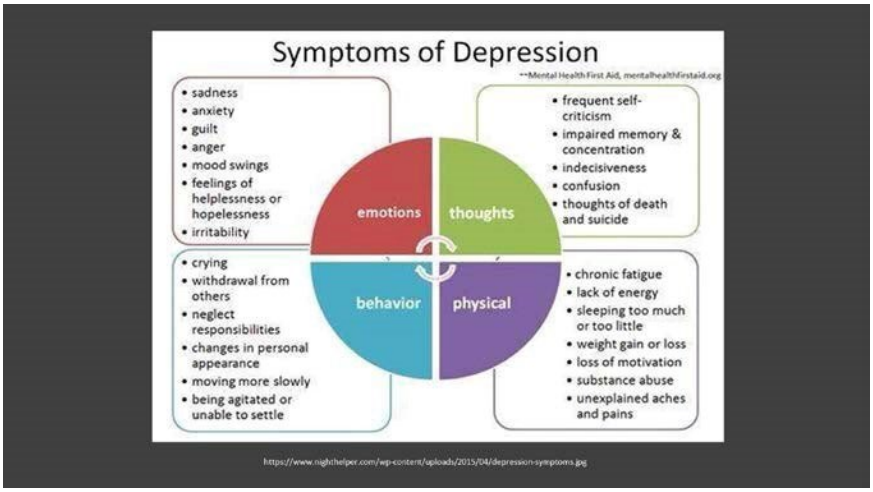


Two common mood disorders likely to be encountered by law enforcement officers are Depression and Bi-Polar Disorder:

Depression:

- There are two common forms of depression: one is Major Depression Disorder, and the other is Dysthymia.
- Major depressive disorder (MDD) is not just feeling sad or "blue." This is an intense level of depression that persists for at least two weeks.
- Dysthymia is a mild or moderate level of depression that persists for at least two years.
- Depression is one of the most common mental disorders in the U.S. (NIMH.nih.gov)
- "In 2015 an estimated 16.1 million American adults had at least one major depressive episode." (NIMH, 2017)
- Nearly twice as many woman as men suffer major depressive episodes.
- Average age of onset is mid-twenties, but depressive episodes can start much earlier.
- Most people have experienced some form of depression in their lifetime or had repeated bouts with depression.
- Depression is a natural reaction to trauma, loss, death, or change.

Common symptoms of depression



- Common Symptoms may include:
  - Prolonged feelings of hopelessness, helplessness, or excessive guilt.
  - Loss of interest in usual activities.
  - Difficulty concentrating or making decisions.
  - Low energy or fatigue.
  - An inability to enjoy usually pleasurable activities.
  - Appetite change (over or under-eating) resulting in weight loss or gain.
  - Changes in sleeping habits (sleeping more or less; an inability to fall asleep, or waking up early in the morning and not being able to go back to sleep).

- Depression and suicide: The single most common factor in suicidal behavior or death by suicide is that the individual is experiencing depression. (See section concerning Suicide).

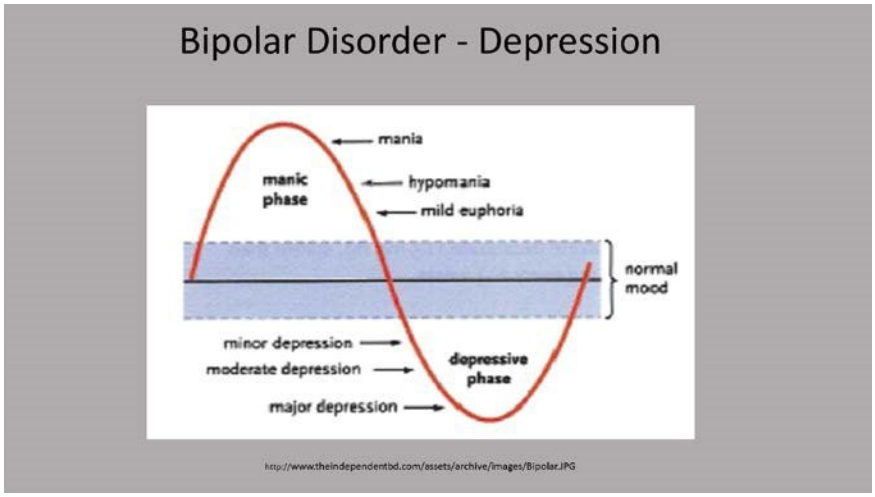
Show Video: Robin Williams on Depression in His Own Words (2.54 minutes)
https://www.youtube.com/watch?v=Fm0isCG1aBM

Bipolar Disorder
SRM = pg. 21

- Bipolar disorder is a mental illness involving cycles between extreme activity and emotional highs (mania) and depression (see above). The strongest predictors of bipolar syndrome appear to be baseline anxiety/depression which increases the risk of bipolar disorder from 2% (baseline risk due to family history) to 49% (Bernstein, 2017).
- 20% of adults with bipolar disorder had symptoms beginning in adolescence (Bernstein, 2017).
- The lifetime prevalence rate is appx 4% of the U.S. population will experience a bipolar episode within their lifetime (MHA, 2017).
- More commonly diagnosed in women than men.
- Average age of onset is appx 25.
- Suicide risk is 15x higher than the general population.
- Outcome studies show that compared with unipolar depression, bipolar disorder causes more work disability and overall poorer outcome (Bernstein, 2017).
- Impulsivity is usually the reason for law enforcement interaction, which results from exhibitionism, shop-lifting, substance abuse, or other illegal activities.
- People usually only seek professional assistance during the depressive phase, as the manic phase is reportedly very pleasant, energetic, and creative.

Depressive Phase

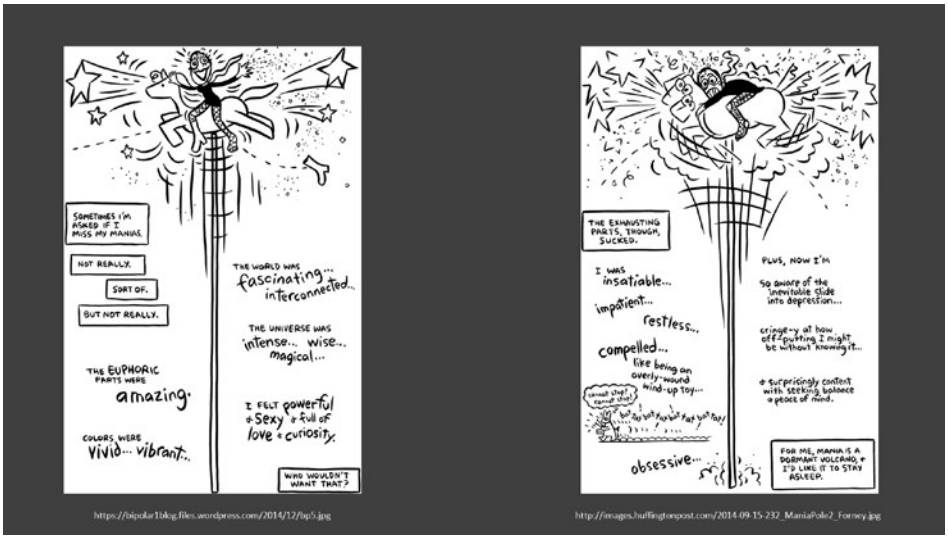
SRM = pg. 21



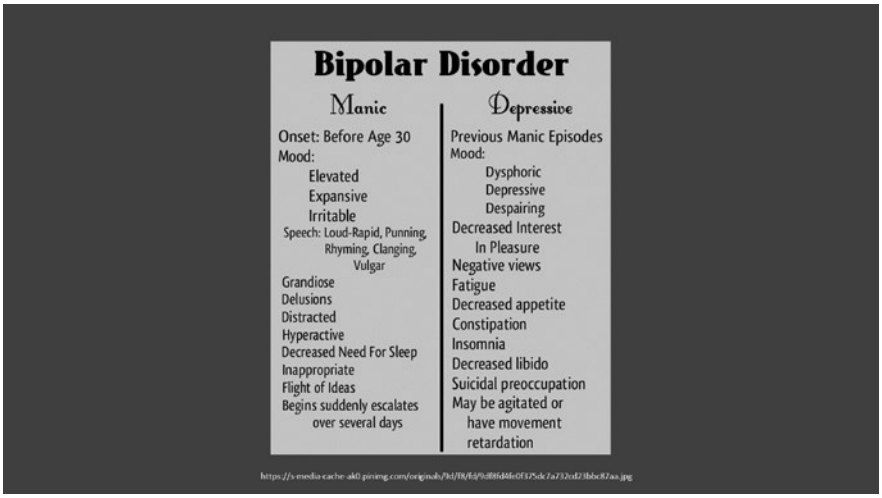
May include:

- Prolonged feelings of sadness or hopelessness
- Feelings of guilt and worthlessness
- Difficulty concentrating or deciding
- Lack of interest
- Low energy
- Changes in activity level
- Inability to enjoy usual activities
- Fatigue

Manic Phase
SRM = pg. 21


SOMETIMES I'M ASKED IF I MISS MY MANIAS
NOT REALLY.
SORT OF.
BUT NOT REALLY.
THE EUPHORIC PARTS WERE amazing.
COLORS WERE vivid... vibrant...
THE WORLD WAS fascinating... interconnected...
THE UNIVERSE WAS intense... wise... magical...
I FELT powerful + sexy + full of love + curiosity.
WHO WOULDN'T WANT THAT?
https://bipolar1blog.files.wordpress.com/2014/12/bp5.jpg
THE EXHAUSTING PARTS, THOUGH, SUCKED.
I WAS insatiable... impatient... restless... compelled... like being an overly-wound wind-up toy...
cannot stop cannot stop!
but but but

SRM = pgs. 21



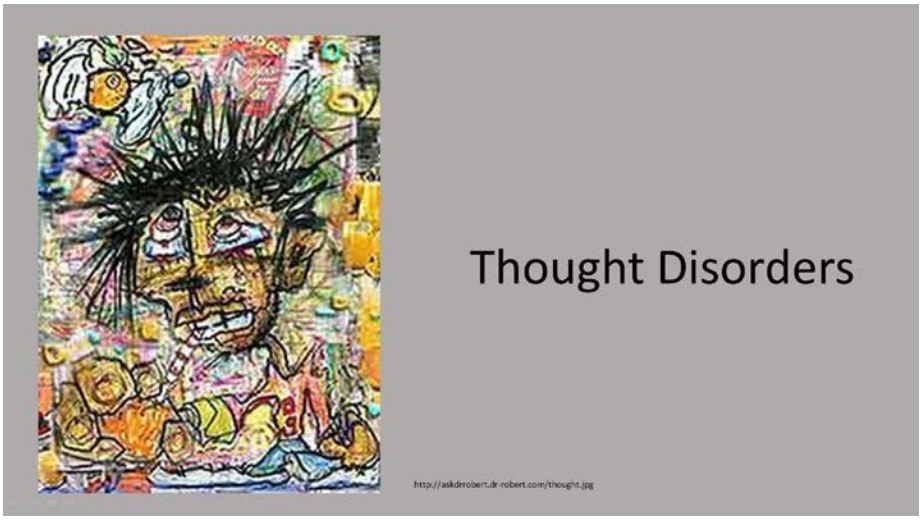
- Each phase of mood lasts at least four days.
- People usually only seek professional assistance during the depressive phase, as the manic phase is reportedly very pleasant, energetic, and creative.

Show Video: Depressive and Bipolar Disorders: Crash Course (9.59 minutes)
https://www.youtube.com/watch?v=ZwMlHkWKDwM

Thought disorders

30 mins
SRM = pgs. 22

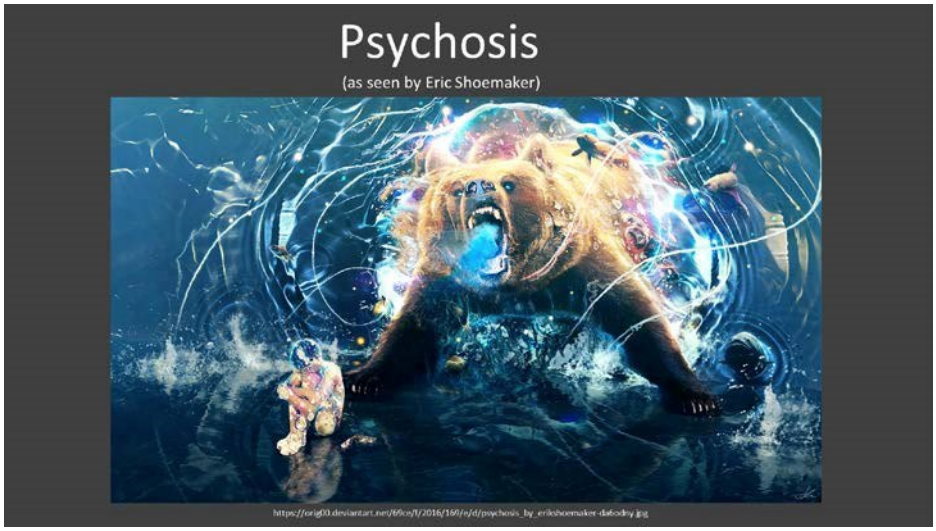
1.19 The student will be able to identify behaviors associated with thought disorders.



- A thought disorder can include psychosis or a schizophrenia spectrum diagnosis. Psychosis can be present with other diagnoses, such as substance intoxication, bipolar disorder, and even major depressive disorder. Physical circumstances can also induce a psychotic state. Potential conditions include: organic brain disorders (brain injury or infections to the brain) and drug or alcohol withdrawal.

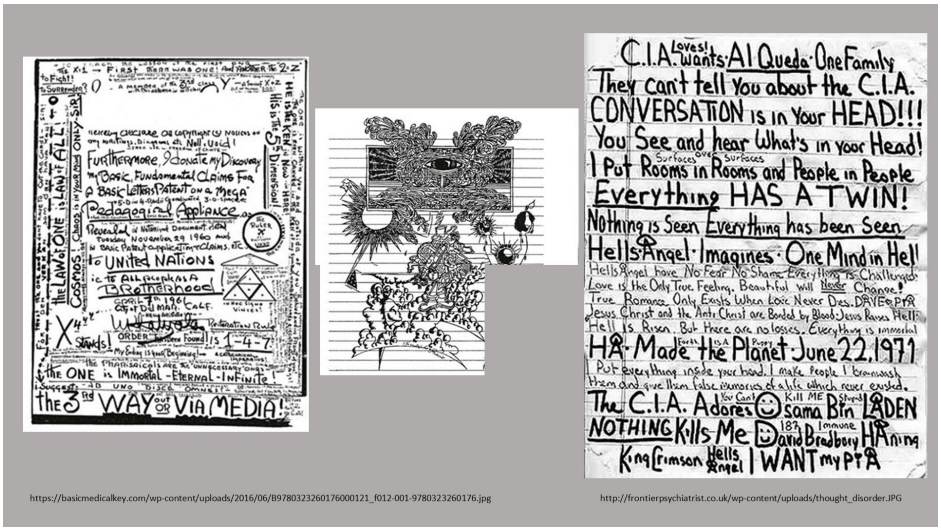
- "Scientists believe many different genes may increase the risk of schizophrenia, but that no single gene causes the disorder by itself. Scientists also think that interactions between genes and aspects of the individual's environment are necessary for schizophrenia to develop. Environmental factors may include exposure to viruses, pre-natal nutrition, problems during birth, or psychosocial factors" (NIMH, 2017).

Psychosis
SRM = pg. 22



- Psychosis is an illness involving a distortion of reality that may be accompanied by delusions and/or hallucinations. The individual may have sensory experiences that are not real (see or hear things that others cannot see or hear) or may believe things that have no factual basis (that s/he is Jesus Christ). To the affected person, these hallucinations and delusions are real. Active MRI scans show that the neural pathways that are engaged when one hears a voice speaking to them, are the same neural pathways that are activated during an auditory hallucination.

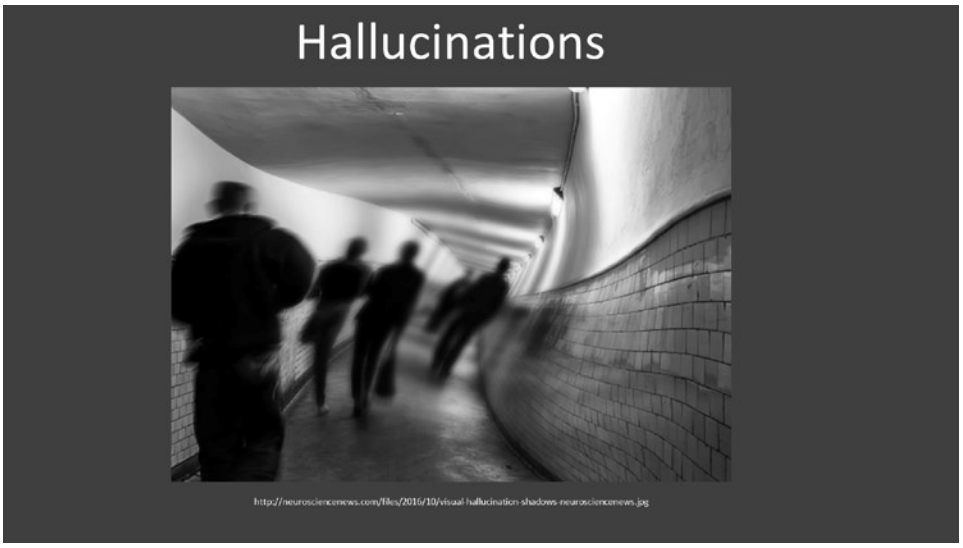
Delusions



- Definition of Delusion - fixed false beliefs that are maintained despite overwhelming evidence to the contrary.

- Bizarre delusions are things could not occur in real life (aliens removed all the person's organs and they continue to function without any internal organs).
- Non-bizarre delusions are events that could occur in real life (phone tapped by the FBI, people are out to get me).

Hallucinations
SRM = pg. 22

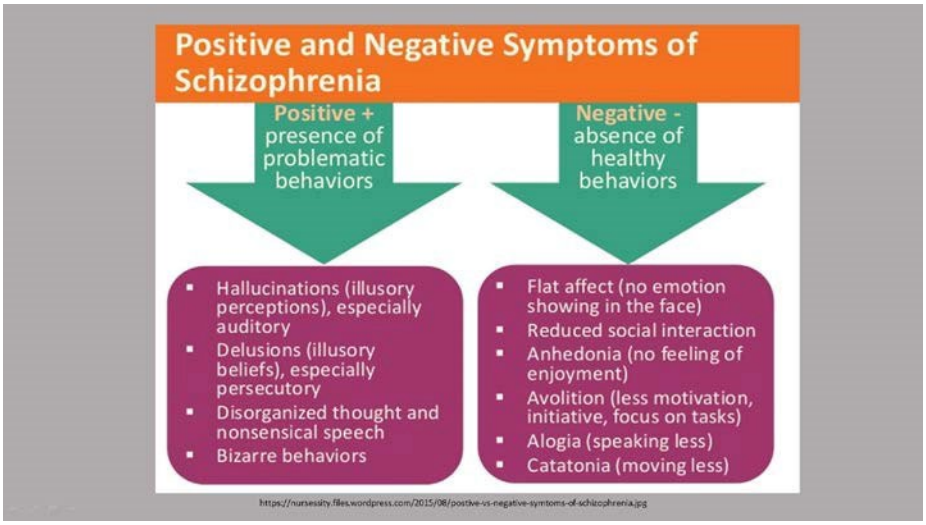


- Definition of hallucinations - distortions in sensory input, causing the individual to experience hearing, seeing, feeling, or smelling something that is not apparent to others.

  - Auditory hallucinations are most common, followed by visual hallucinations.
  - Tactile hallucinations are less frequent, but happen, sometimes resulting in self injury.
  - A person may experience more than one auditory hallucination at a time.
  - Hallucinations can make it very difficult for someone to focus on a conversation, hear, understand, or respond to what is being said.

Additional symptoms of a thought disorder

SRM pgs. 22



- Reduction in emotional expressiveness. No change in emotional expression despite environment, conversation, or activity.
- Nonsense speech or rambling narratives (often referred to as 'word salad.')
- Confusion.
- Limited ability to follow instructions.
- Decreased comprehension and ability to express thoughts, intentions, or experiences.
- Disheveled appearance; a person may be malodorous; may have many layers of clothes on; dressed inappropriately for the season.
- Appears to be responding to stimuli not evident to the observer (listening to something the observer cannot hear; talking to someone the observer cannot see).
- Poor impulse control.

Show Video: *Understanding Psychosis (4.59 minutes)*
https://www.youtube.com/watch?v=GUEb7hPHf3M

Substance Use Disorders

30 mins
SRM = pgs. 23

1.21 The student will be able to identify symptoms associated with the ingestion specific types of drugs and controlled substances.

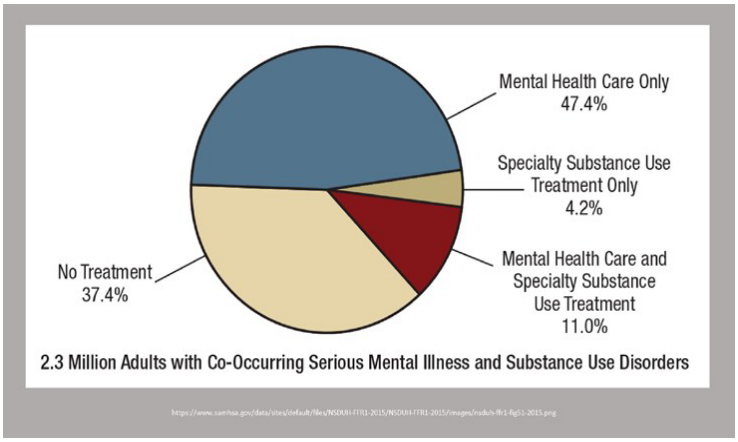
- "The essential feature of a substance use disorder is a cluster of mental, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (DSM-V, 2015).

- Individuals often begin abusing substances as a form of self-medication to treat some of the symptoms previously discussed, such as depression, insomnia, or anxiety.

- Prolonged abuse of any drug (alcohol, dangerous drug, controlled substance, or other substance) may cause chemical dependency or addiction. These chemicals influence consciousness, brain, and body functions. If used long enough or in large dosages, they may cause permanent damage to the central nervous system. This can create a wide range of psychological reactions that can be classified as disorders.

Co-Occurring Mental Illness and Substance Use Disorders

SRM = pg. 23

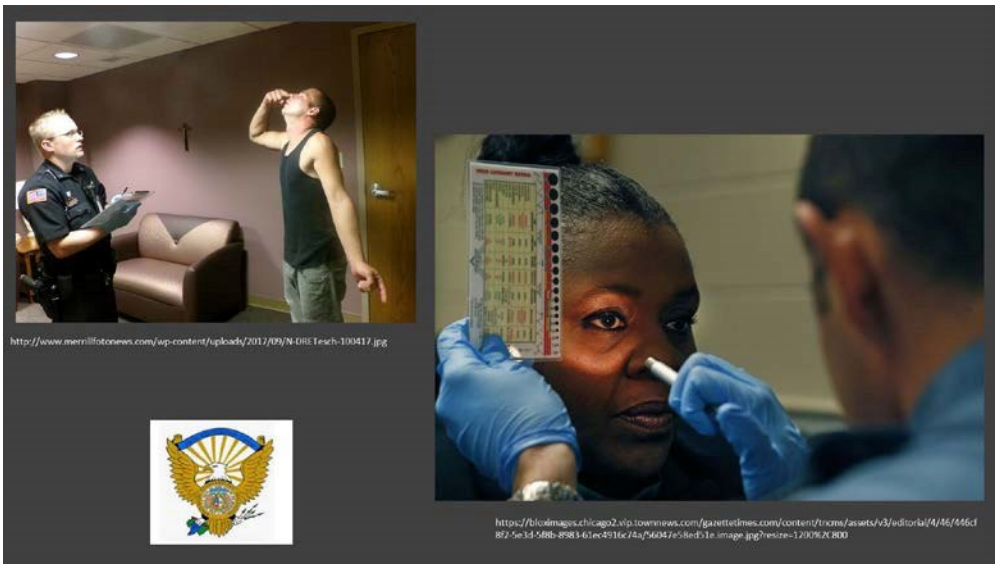


- Illegal drug and alcohol usage is also a primary concern for individuals with a mental illness. These substances can have an adverse effect when used in combination with prescribed medications, and/or when used to self-medicate. In addition, combining drugs or alcohol with medications may result inconsistent medication absorption, dangerous chemical combinations, and a lack of medical monitoring.

- Substance abuse treatment is a critical element in a comprehensive system of care. Research conducted over the last decade has shown that the most successful models of treatment for people with co-occurring disorders provide integrated mental health and substance abuse services.

Show Video: *Drug use problems and mental health: Comorbidity explained (2.25 minutes)*
https://www.youtube.com/watch?v=5RbEotf0jqI

SRM = pg. 23



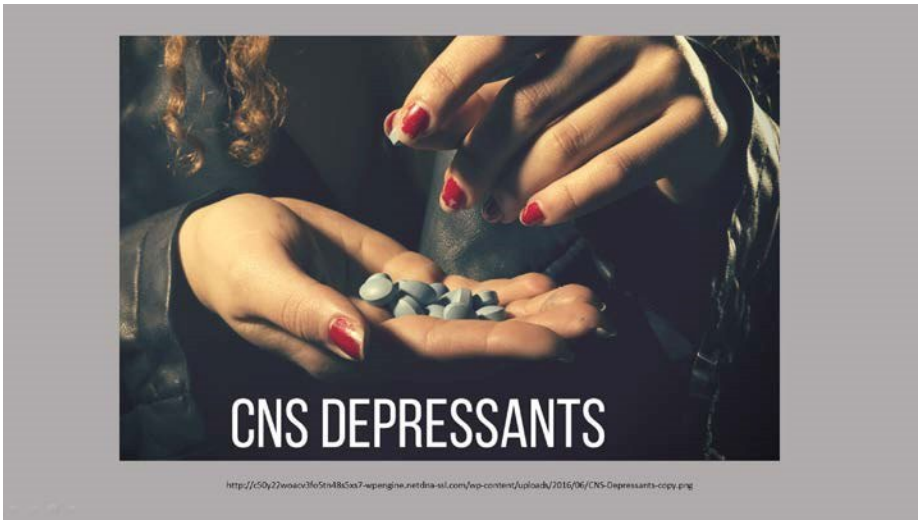
- Substances are defined by category and familiar types in the category. These descriptions are courtesy of the International Drug Evaluation and Classification Program (2017). The behavioral or physical manifestations of intoxication, and signs of overdose are provided from the Drug Recognition Expert Matrix (MN DPS, 2017), and is the legally accepted standard for categorizing drugs and their effects. You will either recall this from SFST training, or will soon have it in SFST training.

- It is important to remember that it is rare to see someone intoxicated from the ingestion of just one type of drug, dangerous drug, or other substance. Especially as it pertains to prescription medications and psychotropic drugs, there is very often a mix of substances influencing the symptoms and physical manifestations that are visible.

- An annex of this training includes a more comprehensive listing of specific drugs, their DRE category, as well as their pharmaceutical category (if any) (Washington State Patrol, 2015). We must reiterate that examples of each drug category include both LEGAL prescription drugs, illegal drugs, and dangerous drugs. Understand that the categories below are based on the physiological reactions in the body to the drugs, not necessarily the behavioral or psychiatric changes that they may elicit.

Central Nervous System (CNS) Depressants

SRM = pg. 24



- CNS depressants slow down the operations of the brain and the body.
    - Examples of CNS depressants include alcohol, barbiturates, Clonopin, Cymbalta, Dilantin, Elavil, GHB (Gama hydroxybutryrate), Haldol, Lexapro, Paxil, Risperidal, Rohypnol, Seroquil, Serzone, Tegretol, Valium, Xanax and Zyprexa.
    - Some indications of depressant ingestion include: Incoordination, disorientation, sluggishness, thick or slurred speech, 'drunk' behavior, stumbling, and fumbling (MN DPS, 2017).
    - Methods of administration include oral ingestion and occasionally injection.
    - Overdose signs are shallow breathing, cold skin, dilated pupils, rapid weak pulse, or coma.

Central Nervous System (CNS) Stimulants

SRM = pg. 24

- CNS stimulants accelerate the heart rate and elevate the blood pressure and 'speed-up,' or over-stimulate, the body.
    - Examples of CNS stimulants include Adderall, amphetamines, cocaine, 'crack' cocaine, ephedrine, khat, methamphetamine (crank, meth), phentermine, Sudafed, and Vyvanse.
    - Some indications of Stimulant ingestion include: anxiety, body tremors, dry mouth, euphoria, exaggerated reflexes, excited, eyelid tremors. grinding teeth (also called bruxism), increased alertness, insomnia, irritability, redness to nasal area, restlessness, runny nose, talkative.
    - Methods of administration include insufflation, smoking, injection, and oral ingestion.
    - Overdose signs are agitation, increased body temperature, hallucinations, and seizures.

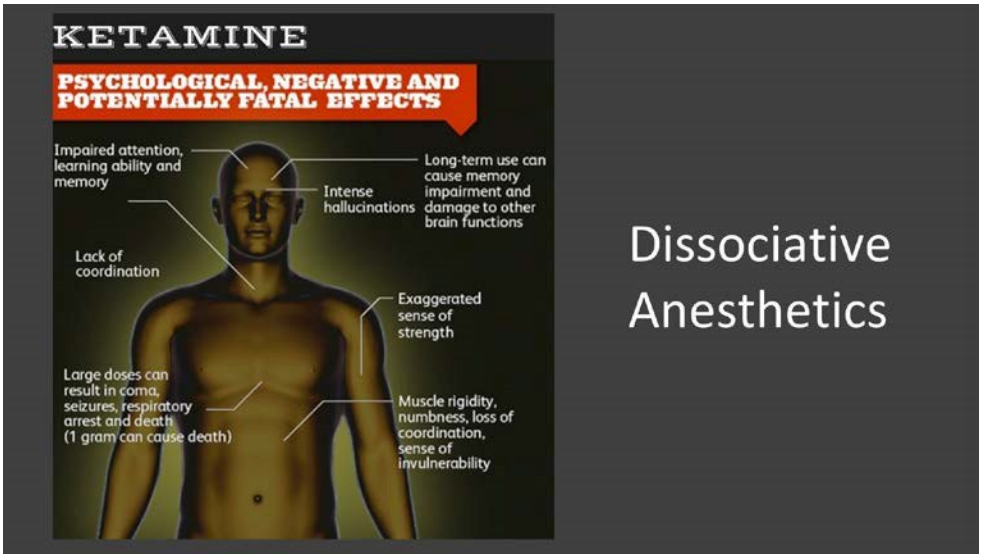
Hallucinogens

SRM = pg. 24

- Hallucinogens cause the user to perceive things differently than they appear to others.
  - Examples include Ayahuasca, DMT, LSD, peyote, psilocybin. MDMA, Molly, or Ecstasy are overlap drugs, and can cause hallucinations, but act more like stimulants in the body.
  - Some indications of Hallucinogen ingestion include: body tremors, dazed appearance, difficulty with speech, disoriented, hallucinations, memory loss, nausea, paranoia, perspiring, poor perception of time and distance, synesthesia, uncoordinated.
  - Methods of administration include ingestion, insufflation, smoking, injection, and eye drops.
  - There is no known threshold for hallucinogen overdose. However, for MDMA overdose the symptoms are the same as stimulant overdose.

Dissociative Anesthetics

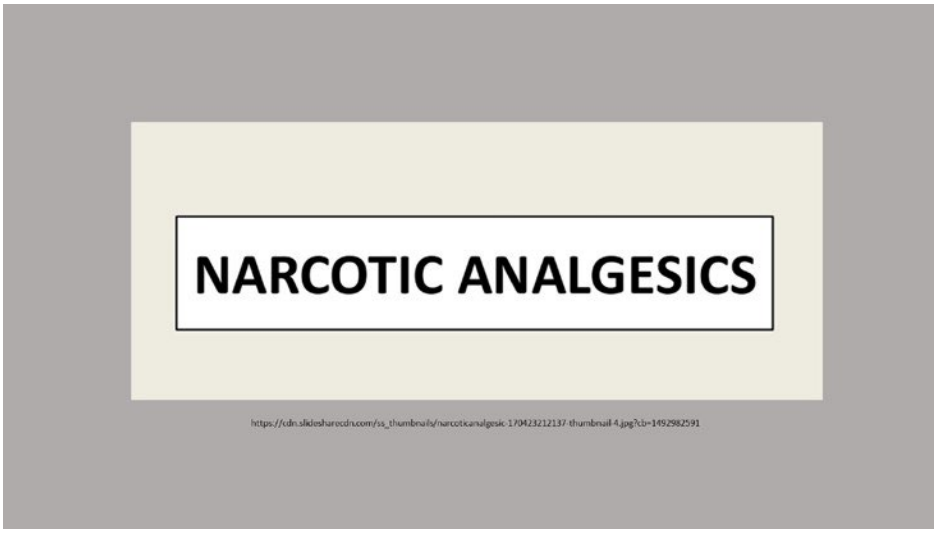
SRM = pg. 24



- Dissociative anesthetics include drugs that inhibit pain by cutting off or dissociating the brain's perception of the pain.
    - PCP, its analogs, ketamine, flecainide, are examples of dissociative anesthetics.
    - Some indications of Dissociative Anesthetics are: blank stare, confused, chemical odor, cyclic behavior, difficulty w/speech, disoriented, early HGN onset, hallucinations, incomplete verbal responses, increased pain threshold, non-communicative, perspiring, possibly violent, sensory distortions, slow or slurred speech.
    - Methods of administration include smoking, ingestion, injection, or eye drops.
    - There is no known threshold for overdose on Dissociative Anesthetics, however delusions can be so strong as to create suicidal behavior. Body temperature can become high enough to be deadly. Often the state known as 'excited delirium' is created by this type of drug, a combination of drugs, or the synergy between drugs and mental health problems.

Narcotic Analgesics

SRM = pg. 25



- Narcotic analgesics relieve pain, induce euphoria, and create mood changes in the user.
  - Examples of narcotic analgesics include opium, codeine, heroin, Demerol, Dilaudid, morphine, Methadone, Suboxone, Subutex, Vicodin, and Oxycontin.
  - Some indications of Narcotic Analgesics include: depressed reflexes, drowsiness droopy eyelids (also known as ptosis), dry mouth, euphoria, facial itching, nausea, puncture marks, slow, low, raspy speech, slowed breathing.
  - Methods of administration include injection, ingestion, smoking, and insufflation.
  - Overdose indications are slow, shallow breathing, clammy skin, seizures, and coma.

Inhalants
SRM = pg. 25

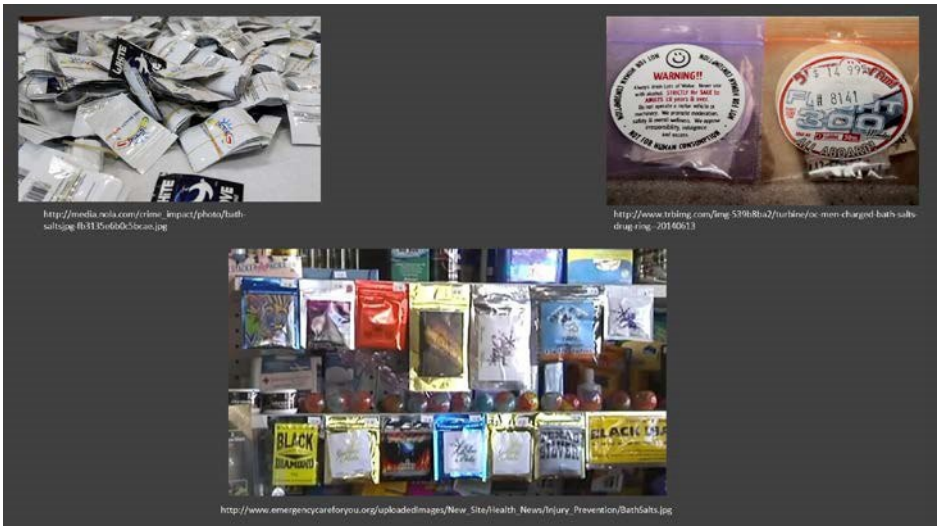
- Inhalants include a wide variety of breathable substances that produce mind-altering results and effects.
    - Examples of inhalants include Toluene, plastic cement, Dust off (canned air), paint, gasoline, paint thinners, hair sprays, and various anesthetic gases (like 'whip-its' or nitrous oxide).
    - Some indications of Inhalant ingestion include: Bloodshot, watery eyes, confusion, disoriented, flushed face, intense headaches, lack of muscle control, noncommunicative, odor of substance, possible nausea, residue of substance, slow, thick, slurred speech.
    - The method of administration is inhalation.
    - Overdose indications are seizures and coma.

Cannabis
SRM = pg. 25

- Cannabis is the scientific name for marijuana. The active ingredient in cannabis is delta-9-tetrahydrocannabinol, or THC.
  - This category includes cannabinoids and synthetics like K2, Spice, Yucatan Fire, JWH, RCH, UR-114 and XLR-11.
  - Some indications of Cannabis ingestion include: body tremors, disoriented debris in mouth, eyelid tremors, Impaired perception of time & distance, increased appetite, marked reddening of conjunctiva, odor of burnt marijuana, possible paranoia, and relaxed inhibitions.
  - Methods of administration include ingestion and smoking.
  - There is no known overdose level for Cannabis.
  - CBD oil - While some companies produce CBD oil that's completely THC-free, others formulate products that contain a slight amount of THC. But often, these products only carry roughly 0.5% THC or less.

Other substances

SRM = pg. 25



- Other substances, sometimes known as 'bath salts' have made an appearance. Bath Salts are frequently analogs of other drugs, or some mix of solvents and chemicals. Some of the substances known to have been sold as bath salts are: alpha PVP, ethylone, MDPV, methoxelamine, methylone, and pentylone. Behavior is hard to predict, as is overdose. This may also be a cause of the idiopathic excited delirium.

- Kratom – affects the same opioid brain receptors as morphine, appears to have properties that expose users to the risks of addiction, abuse, and dependence (FDA, 2018). In Thailand, it is a controlled substance and is a commonly abused illegal drug (Huus, 2012). In the U.S., kratom is listed as a "drug of concern" by the DEA. Kratom may be mixed with a caffeinated beverage, or codeine-containing cough syrup, perhaps most often to create the drink called 4×100. This drink is said to have effects similar to alcohol intoxication (Huus, 2012).

Cognitive Disorders

60 mins
SRM = pg. 26

1.22 The student will be able to identify symptoms and behaviors associated with cognitive disorders.

- Cognitive disorders include Alzheimer's Disease and other forms of dementia, as well as Traumatic Brain Injury (TBI). Cognitive disorders consist of significant cognitive decline in one or more areas:

  - Attention: ability to sustain attention to a task; ability to pay attention to something despite other distractions; ability to do two things at once.

  - Executive function (judgment/decision making): impaired ability to plan, make decisions, hold information briefly in one's mind (a telephone number), ability to learn from mistakes.

  - Learning and memory: ability to repeat words or digits; ability to recall recent information; ability to apply information.

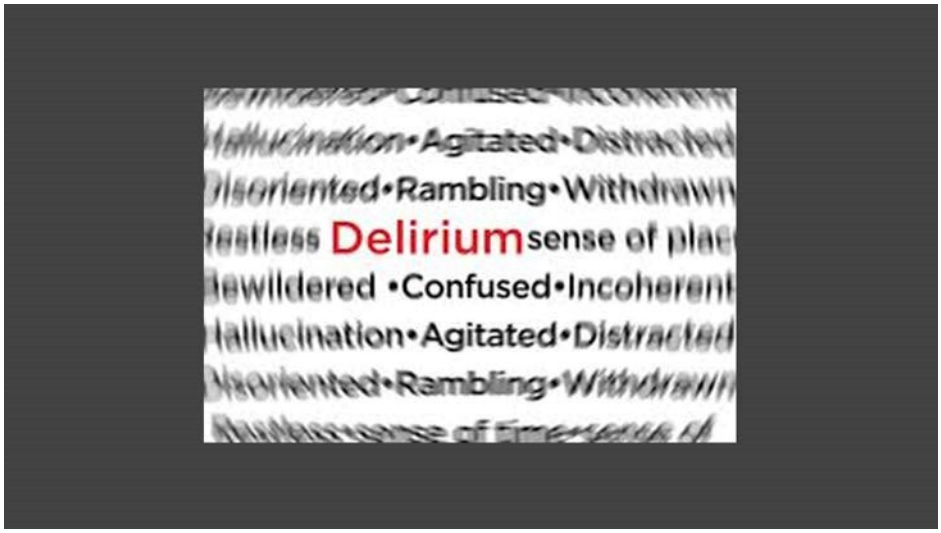
  - Language: ability to find the correct labels or words for an object or situation; misuse of names, verbs, or other word choices; comprehension.

  - Perceptual-motor: eye-hand/body coordination.

  - Social awareness: identification in changes in others' facial expression; emotional intelligence.

Delirium

SRM = pg. 26

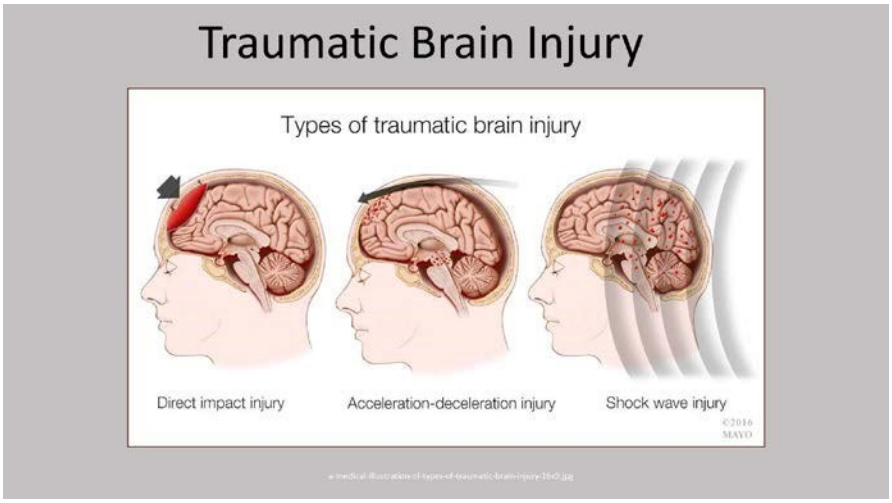


- Can be drug induced, medication induced, or due to a medical condition
- Develops over a short period (hours or days)
- Attentional deficits (reduced ability to direct, focus, sustain, or shift attention)
- Memory deficit.
- Disorientation.
- Often creates an inability to comprehend speech, or follow instructions.

Traumatic Brain Injury

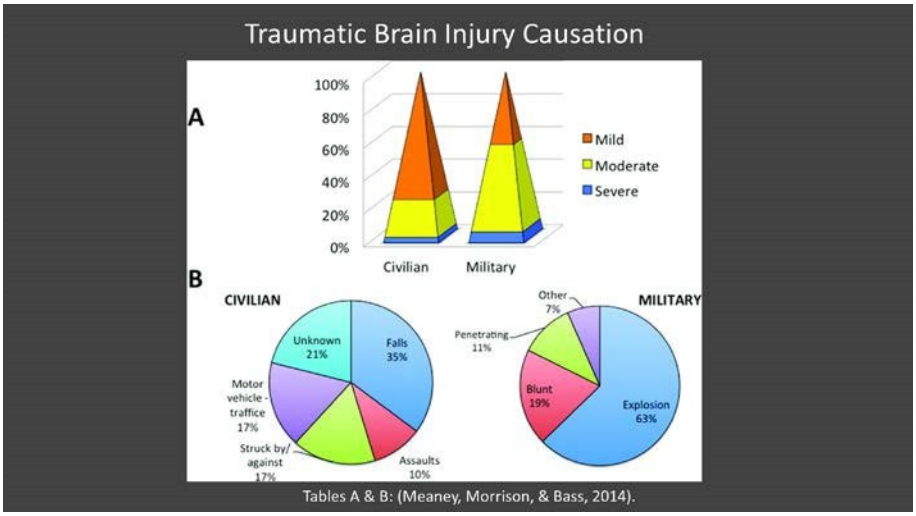
SRM = pg. 26

1.23 The student will explore the causes of traumatic brain injury (TBI).



"Caused by impact to the head, or other mechanisms of rapid movement or displacement of the brain within the skull, as can happen with blast injuries" (Meaney, Morrison, & Bass, 2014).

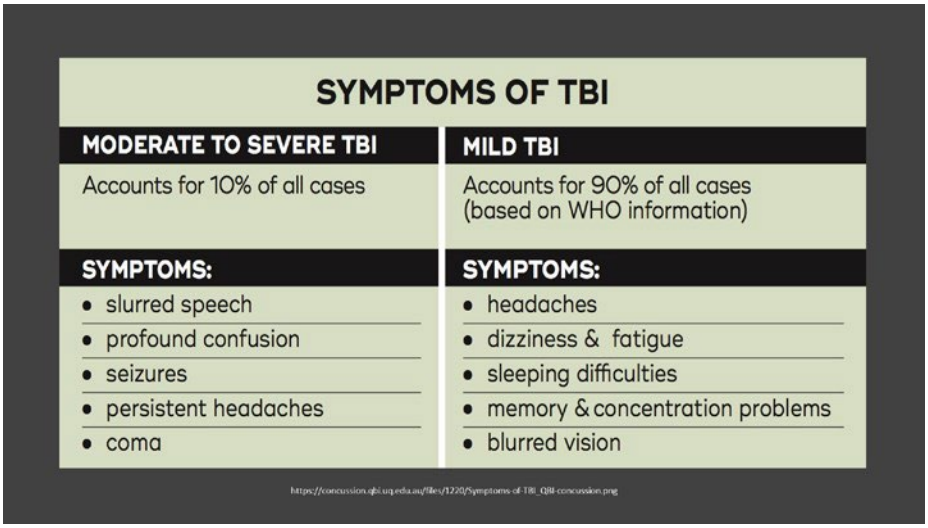
TBI Causation
SRM = pg. 26



Tables A & B: (Meaney, Morrison, & Bass, 2014).

- TBI can occur from proximity to a blast, blunt force trauma, and penetrating injuries.
- TBI is the leading cause of death in adults under age 45 (motor vehicle accidents) and is the second leading cause of death adults over 65 (Meaney, Morrison, & Bass, 2014).

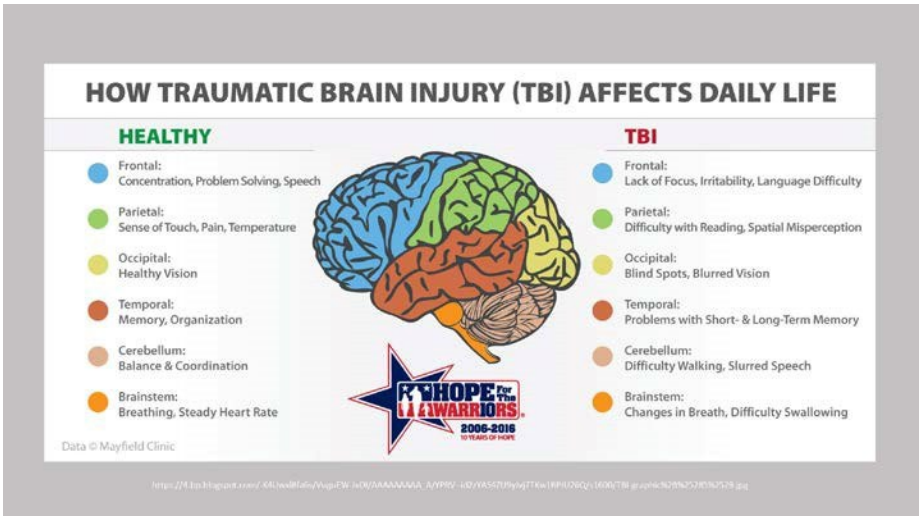
TBI Symptoms and Severity
SRM = pg. 26



- The severity of TBI is often delineated between mild, moderate, and severe (Northeastern University, 2010).
  - Mild TBI accounts for 75% of TBIs.
  - Moderate TBI accounts for approximately 22% of TBIs and is characterized by identifiable persistent deficits (in the above mentioned cognitive domains) that a person will experience the remainder of his/her life.

- Severe TBI accounts for approximately 3% of TBIs and is usually associated with other bodily injury and requires intensive medical intervention.
- Mild TBI is most common among the civilian population whereas moderate TBI is more prevalent among the military population.

<u>TBI Impact on Daily Life</u>
SRM = pg. 27



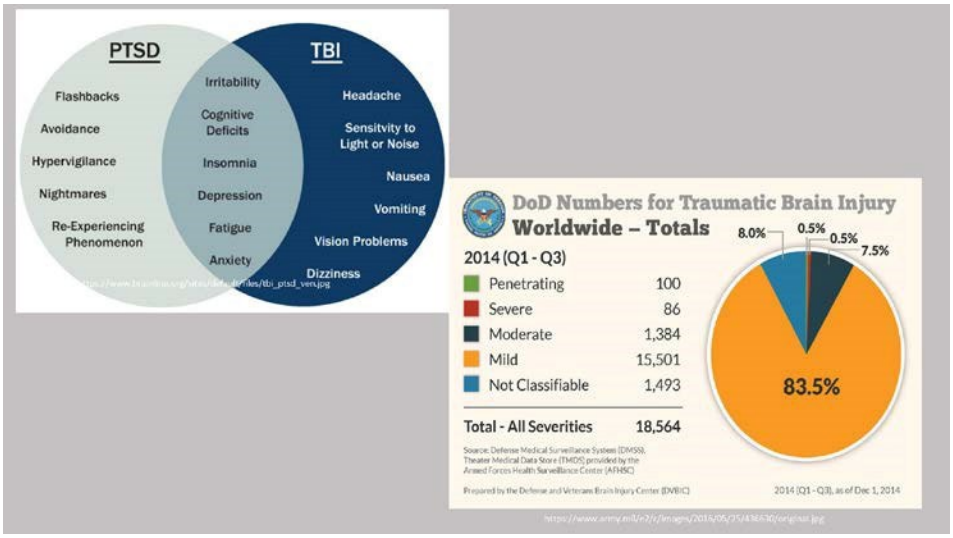
- Research has demonstrated a decline in life satisfaction following moderate to severe TBI. Life satisfaction is associated with factors including ability to maintain employment and thus earn sufficient income, quality of social relationships, ability to engage in leisure activities, and level of acquired disability

- It has been estimated there are upwards of 1.7 million ER visits among civilians in the U.S. each year due to head injuries.
  - Of those treated approximately 275,000 are hospitalized and 52,000 die (CDC, NIH, DoD, & VA Leadership Panel, June 2013).

- The presentation (symptoms) vary by person and severity of TBI; areas of attention, executive function, learning and memory, language, eye-hand coordination, and social awareness are all subject to effect.

TBI Among Military

SRM = pg. 27



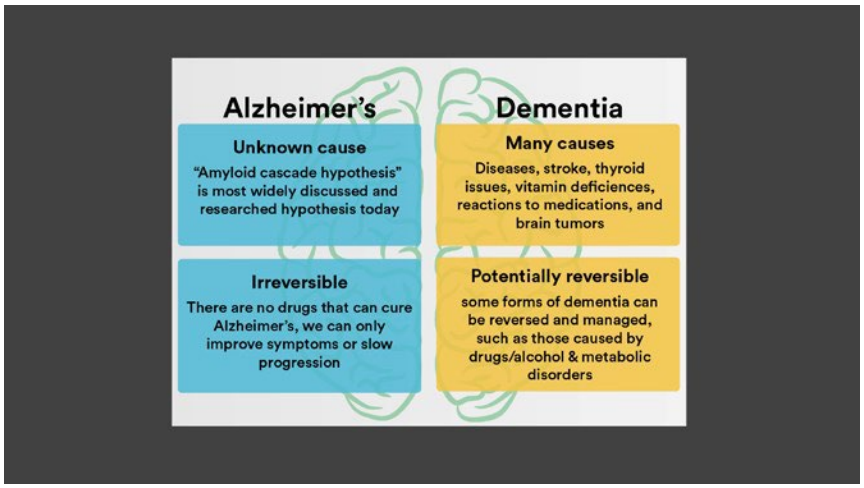
- It is speculated the rate of TBI among military personnel is higher but is under-reported and under identified (Hyder, Wunderlich, Puvanachandra, Gururaj, & Kobusingye, 2007).

    - The Department of Defense reported in 2011 that 33,149 military service members were diagnosed with TBI (U.S. Department of Defense (DoD), 2017).
    - The rate of TBI among military members increased significantly among the OIF/OEF military service members due to the frequency of explosion-related exposures (CDC, NIH, DoD, & VA Leadership Panel, June 2013).

Dementia and Alzheimer's Disease

SRM = pg. 27

1.24 The student will describe the symptoms and behaviors associated with dementia and Alzheimer's Disease.



- "Dementia is a name for a group of symptoms caused by disorders that affect the brain" (National Institutes of Health (NIH), 2017).

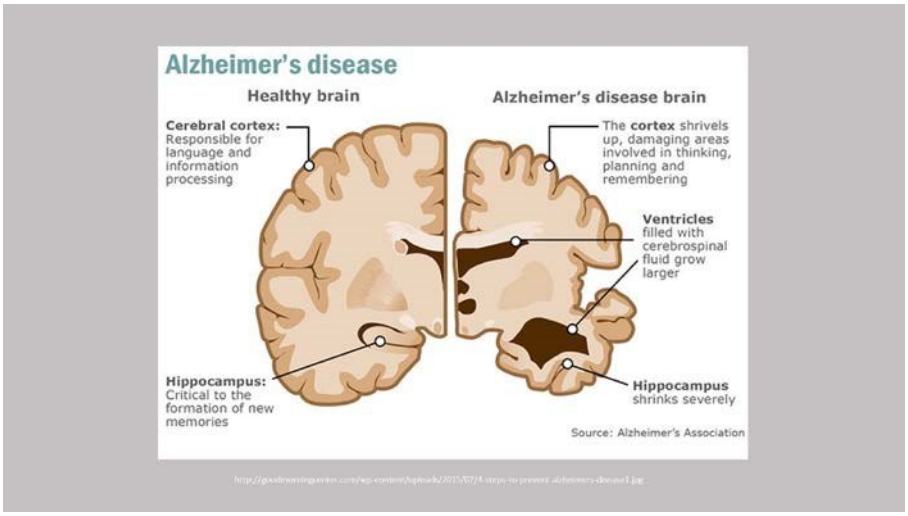
- It is a degeneration of mental functioning involving thinking, memory, and reasoning. Dementia severity can range from mild (some impairment in day to day living) to severe (completely reliant upon others for basic needs).

- Although memory loss is a common sign of dementia, memory loss alone does not mean someone has dementia (NIH, 2017).

- Dementia is not a normal part of the aging process, but up to half of all people over the age of 85 are affected by some form of dementia (National Institute on Aging (NIA), 2017).

- Dementia can be cause by a number of different health conditions, including vascular disease, brain damage, stroke, as well as other conditions.

SRM = pg. 27



- "Alzheimer's disease is a progressive and irreversible brain disease affecting approximately 5.2 million Americans (Hebert, Weuve, Scherr & Evans, 2013).

- The disease slowly impairs one's mental functions (memory, speech, comprehension, planning, and decision making), and ability to care for one's self. It also often results in additional psychiatric and behavioral concerns including agitation, psychosis, and depression.

Show Video: *Experience of Alzheimer's (8.03 minutes)*
https://www.youtube.com/watch?v=LL_Gq7Shc-Y

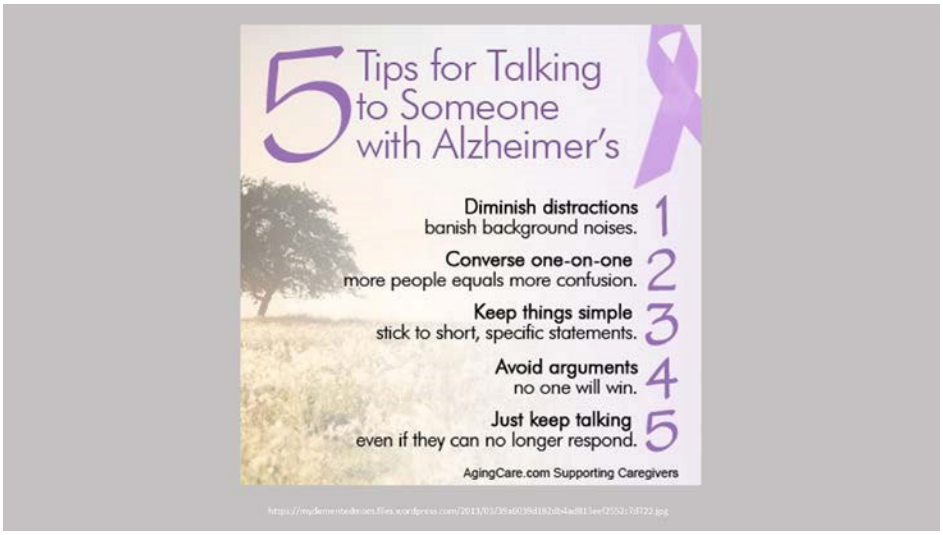
SRM = pg. 28

- "In more than 90% of people with Alzheimer's disease, symptoms do not appear until after age 60" (U.S. Department of Health & Human Services – ASPE, 2017).

- Researchers continue to attempt to identify causal factors of Alzheimer's disease, but the current consensus is that AD is caused by a combination of genetic, environmental and lifestyle factors.
    - Medications can assist with managing symptoms, but there is no cure.

Communication tips for someone with Alzheimer's or Dementia
SRM = pg. 28

1.25 The student will be able to identify methods most effective in talking to someone with dementia.



- "Six out of 10 people with Alzheimer's will wander," either on foot in via car, and "if not found within 24 hours, up to half of those who wander risk serious injury or death" (Alzheimer's Association, 2017).
- Communication considerations (https://www.nia.nih.gov/health/alzheimers/caregiving):
  - Speak clearly and concisely; resist the urge to speak loudly
  - Due to potential difficulty with language comprehension, consider using 'yes' or 'no' questions
  - If the person appears to have difficulty with verbal comprehension, you may try using nonverbal prompt and/or written prompts
  - Be patient if the subject does not immediately follow requests or commands and/or if the subject is having difficulty communicating his/herself. The subject is likely not being intentionally resistive but is likely to be acting out of fear, confusion, and may have some delusional thought processes
  - Provide reassurance of the person's safety
  - Check for an identification bracelet, pendant, key chain, wallet card, or clothing number that may have the person's Safe Return ID number and emergency contact.

Show Video: *How to Talk so Alzheimer's Can Hear You (14.56 minutes)*
https://www.youtube.com/watch?v=X6UMQmi09Ms

Possible interactions with law enforcement

SRM = pg. 28

- Possible interactions with Law Enforcement (Alzheimer's Association, 2017).
  - Car accidents & erratic driving
    - Due to confusion, diminished physical abilities, and/or memory impairment a person with AD may fail to obey street signs or traffic laws and may flee the scene
    - A person with AD may drive similarly to someone under the influence, yet when an officer discerns no presence of alcohol or other substances, dementia (or AD) may be the cause
  - False reports & victimization
    - A person with AD may lose or misplace items and call 911 to report a theft.
    - In some cases, reports of a burglary-in-progress or intruder, turns out to be a family member, a delivery person, a home health aide, or even a spouse.
  - Indecent Exposure
    - A person with AD may forget social norms and have diminished impulse control
    - It is common for a person with AD to leave the house without proper attire, or to undress in public
  - Shoplifting
    - Due to memory impairment, a person with AD may forget to pay for items
  - Homicide
    - The presence of a weapon may lead to unexpected danger, as a person with AD may believe his/her loved one is an intruder.

Show Video: *Alzheimer's Combative Behavior (11.37 minutes)*
https://www.youtube.com/watch?v=XMfItlc8hL0

Developmental Disorders

60 mins
SRM = pg. 29

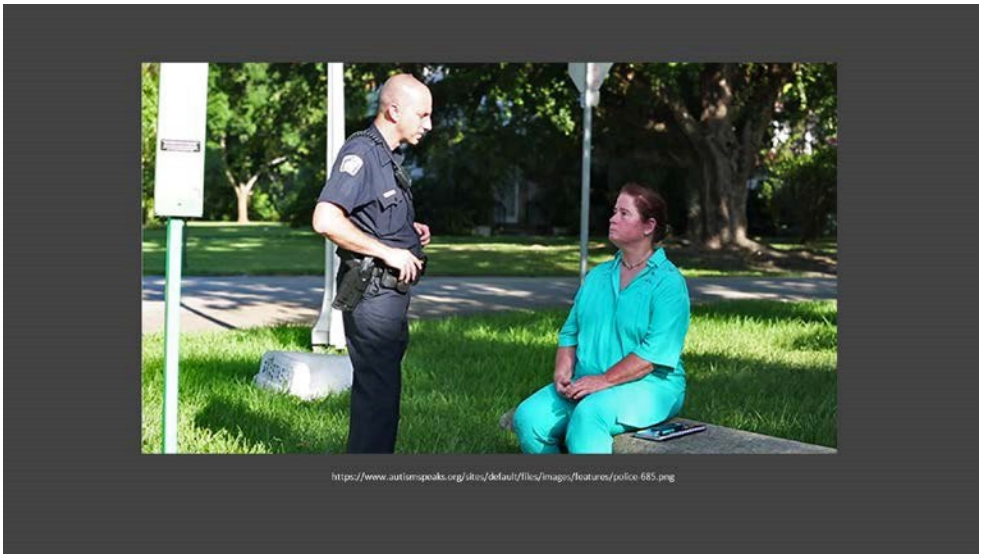
1.26 The student will describe developmental disorders, and recognize the symptoms and behaviors associated with Autism Spectrum Disorders.

- Definition:" A condition that an individual may have had since birth or childhood which has prevented them from full social or vocational independence in adulthood, and which continues throughout their lifespan" (DSM – V).

Autism Spectrum Disorder

- Autism spectrum includes the diagnosis of Asperger's.
- Persons with Autism suffer from sensory disorders that keep them from effectively filtering and blocking painful sensations (Marco, Hinkley, Hill, & Nagarajan, 2011). Their sensory disorders can cause extreme pain from loud noises and bright light that can move them toward frustration and acts of aggression.

SRM = pg. 29



- Officers in contact with these individuals will notice certain behaviors such as fear of touch, repetitive behavior (such as rocking, striking themselves, or noises), insistence on routine, extreme anxiousness in new situations, and a tendency to become confused easily.

  - When interviewing, be patient, calm, and detached, which tends to help prevent agitation in questioning process.

  - Avoid physical contact or limiting personal space, which may result in an unintended use of force situation.

  - Some people on the Autism spectrum cannot communicate verbally, or use only a cluster of words.

  - Please interact with a trusted care-provider in determining the best way to conduct an interview.

  - Illustrative materials, repetition (clarification) of previous statements, praise, encouragement, and attentive listening will assist in the exchange process.

Examples of behavioral characteristics of someone with ASD

SRM = pg. 29

- Autism is often indicated by an inability to have typical interpersonal exchanges, including conversations, emotional recognition, sharing and understanding of thoughts, feelings, or social courtesies.
  - May avoid eye contact.
  - May not answer questions, or may respond with something unrelated.
  - May repeat (echo) words said to him/her without providing a response to question or statement.
  - Volume of speech may not be appropriate to circumstance (may speak very loudly or softly).
  - A person with Autism may have difficulty understanding or comprehending the natural give-and-take (rhythms) of verbal exchange. They may also have difficulty expressing self in a manner that is comprehensible to the officer.

- A person on the Autism spectrum may display restricted, repetitive patterns of behavior, interests, or activities.
  - May be fixated on a word, topic, object, sound.
  - Difficult to redirect attention and concentration away from object
  - Person may become distraught if object of attention is removed or withheld.
  - Individual may exhibit repetitive motor movements, such as rocking, hand motions, head banging, or biting (Australian Autism Alliance, 2017)

- Atypical motor movements may be evident, such as walking on tiptoes or unusual gait.
  - Can be impulsive and potentially aggressive, without provocation.
  - Differences typically become noticeable by age 3.

The spectrum of Autism severity
SRM = pg. 30

The severity of the condition ranges from severe (sometimes non-verbal, highly reactive to change, surprise, strangers; with co-occurring intellectual disability) to mild (able to function, maintain employment, and live independently while also creating and maintaining reciprocal relationships). A common anecdote about Autism spectrum disorders is; If you've met one person with Autism, you've met one person with Autism. The manifestations of the disorder are so widely varied that it is difficult to draw any sweeping characterizations.

Show Video: *Autism and First Responders (26:16)*
https://www.youtube.com/watch?v=TNBV66MLGXc

Intellectual Disability (ID)

SRM = pg. 30

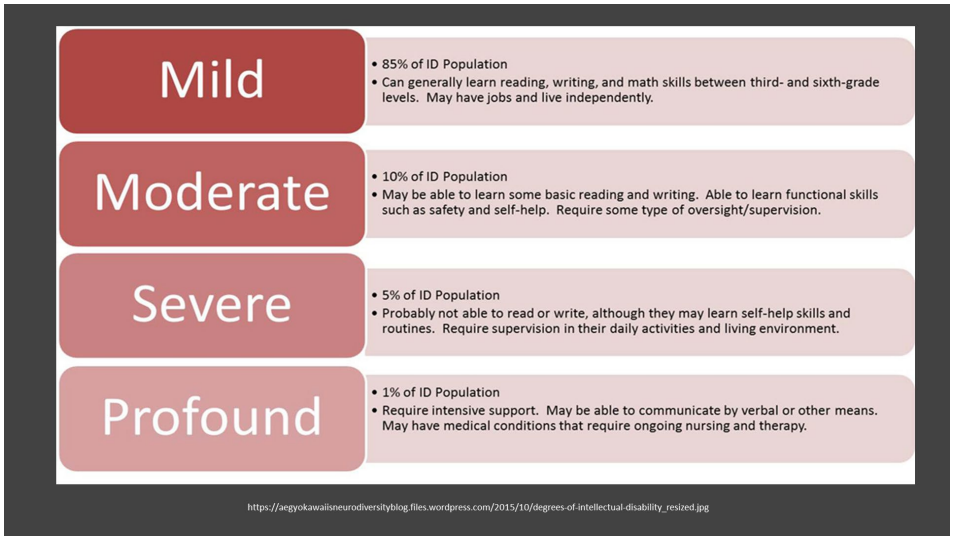
1.27 The student will be able to define the term 'intellectual disability' and discuss what that means in terms of law enforcement interaction.

- This disability includes deficits in intellectual and adaptive functioning (failure to meet developmental and socio-cultural standards for intellectual and personal independence standards) (DSM-V).
- ID is detectible in infancy or early childhood, and by definition, must be diagnosed by the age of 18.
- This is a fixed mental condition that, unlike many mental illnesses, cannot be "cured."
- Limitations may include deficits in communication, self-care, home living, personal safety, academic functioning, occupational abilities

Degrees of Intellectual Disability

SRM = pg. 30

1.28 The student will be able to distinguish the degrees of intellectual disability.



- (Average IQ = 90-109)
    - Borderline Intellectual Functioning: IQ 70-79
    - Mild Intellectual Disability: IQ 50-69
    - Moderate Intellectual Disability: IQ 35-50
    - Severe Intellectual Disability: IQ 20-50
    - Profound Intellectual Disability: IQ below 20

Communication considerations for someone with an ID

SRM = pg. 30

1.29 The student will discuss effective communication methods for individuals that have an intellectual disability.

Strategies to use during officer contact in determining possible Intellectual Disability:

- <u>Criminal Activity</u>

  Subject may likely be noticeably older than others involved in offense
  Apparent the subject is a follower rather than leader of criminal activity
  May readily confess, due to lack of full understanding of the circumstances
  Behavior at the scene (remained at the scene while others ran)
  May have been used as a pawn by more sophisticated offenders

SRM = pg. 30

- <u>Speech/Language</u> Obvious Speech defects
  Limited ability to speak or comprehend at age-normative level
  Marked difficulty maintaining attention or conversation
  Difficulty describing facts in detail

- <u>Social Behavior</u>
  Adult associating with children or early adolescents
  Ignorance of personal space
  Non-age appropriate behavior

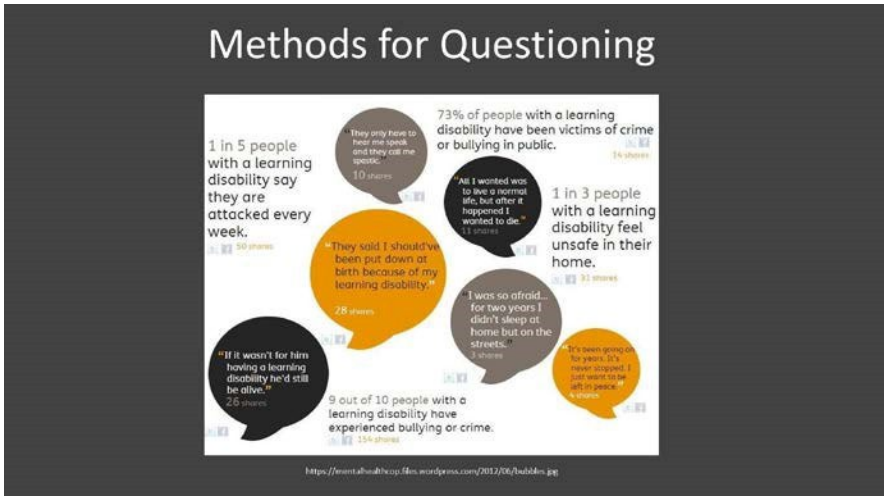
SRM = pg. 31

Performance Tasks that can be utilized to help determine if a ID problem exists

- Ask them to read or write a simple statement.
- Give directions to their home.
- Tell time.
- Count to 100 by multiples of five.
- Define abstract terms (such as emotions or feeling terms).
- Explain how to make change from a dollar.

Note: an inability to read or write is illiteracy, and in and of itself, does not indicate ID.

SRM = pg. 31



Questioning methods:

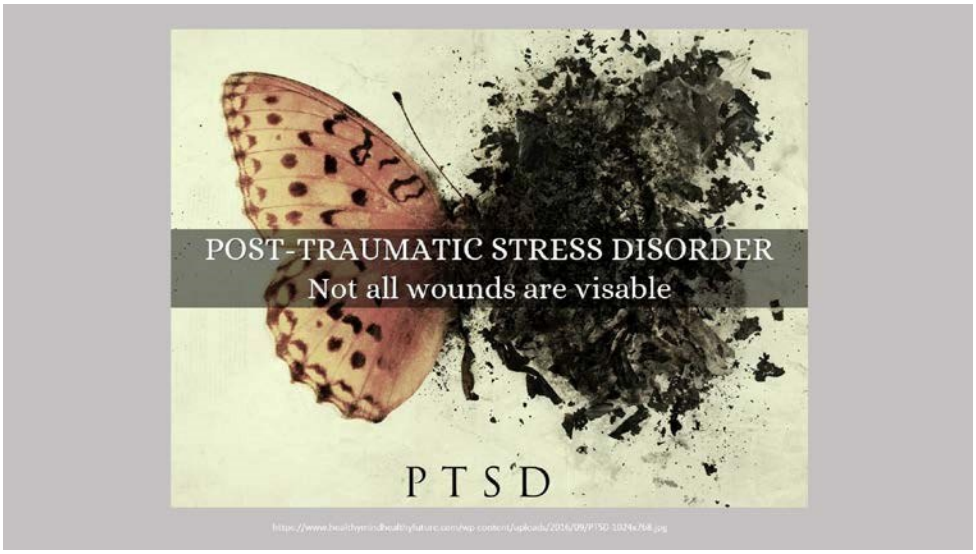
- Be patient for a reply.
- Repeat question as needed.
- Ask short, simple questions using simple language.
- Speak slowly.
- Ask open-ended (but uncomplicated) rather than "yes/no" questions.

Show Video: *More Alike than Different (5:16)*
https://www.youtube.com/watch?v=Jg2ZBPw2LyE

Posttraumatic Stress Disorder

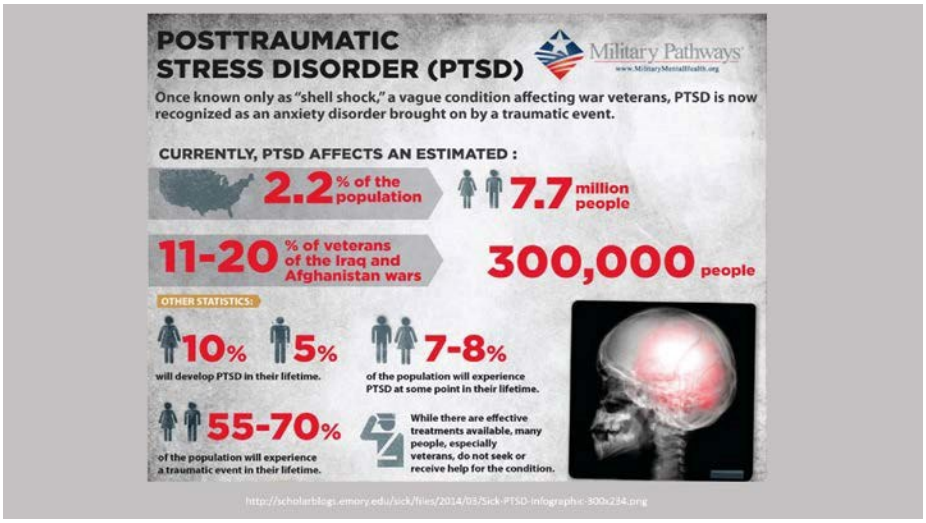
60 mins
SRM = pgs. 32

1.30 The student will list some of the causes of Post-Traumatic Stress.



- Post-Traumatic Stress can develop after a person is exposed to a traumatic event, including actual or threatened death, injury, or sexual violence (MHA, 2017). A person may have experienced the traumatic event(s) directly, or may have witnessed the even occur to someone else. Examples of events that can result in PTSD include but are not limited to:
    - Physical violence (abuse, assault, physical attack, robbery, domestic violence).
    - Sexual violence (rape, sexual abuse, sex trafficking, noncontact sexual abuse).
    - Combat (civilian or military).

SRM = pg. 32



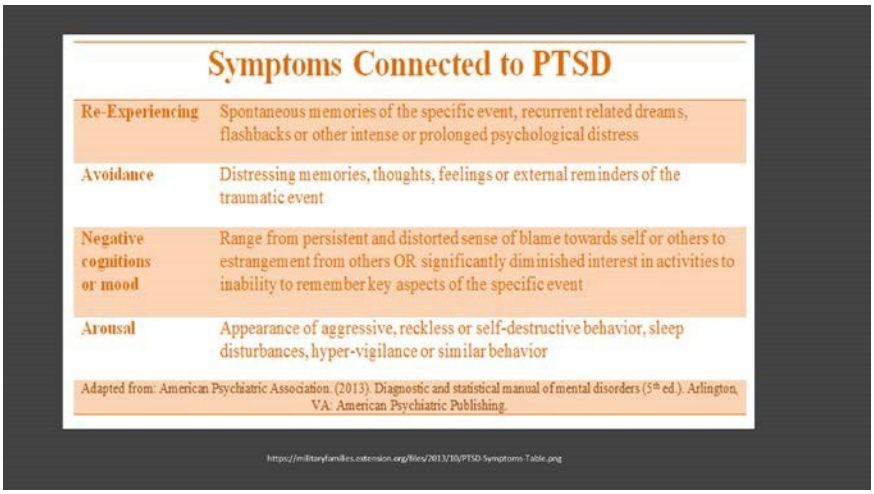
- Approximately 7-8% of the general population will experience PTSD at some point in their lifetime. About 8 million adults have PTSD during a one year period, and this is only a small group of those who have experienced trauma. 10% of all women will develop PTSD, during a lifetime, compared to only 4% of men (Veteran's Administration (VA), 2017).

- A number of variables play into why some people may develop PTSD from a trauma exposure, while others will not. Some of those variables include (SAMSA, 2014):
    - The intensity of duration of the trauma.
    - Frequency of exposure.
    - Lasting injury or impairment from the trauma.
    - How much control the person felt during the traumatic event.
    - Intensity of emotional reaction during the event.
    - Level and quality of support received (or perceived access to support) following the event.

Symptoms Connected to PTSD

SRM = pg. 32

1.31 The student will be able to recognize symptoms and behaviors of an individual experiencing PTSD

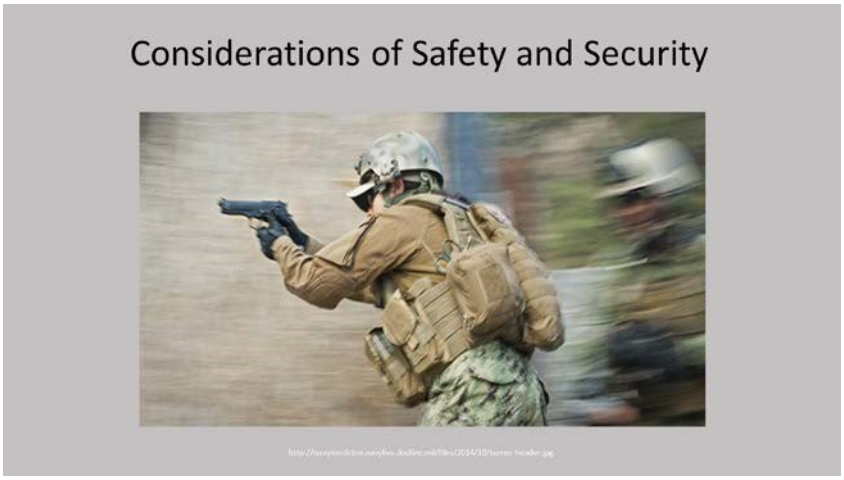


- Intrusion symptoms:
  - Recurrent unwanted dreams, images, or memories.
  - Feeling or acting as if the event is occurring in the present.
  - Intense distress at reminders of the trauma.
  - Avoidance.
  - Efforts to avoid distressing memories, thoughts, or feelings reminiscent of the trauma.
  - Avoidance of people, places, things, or other reminders of the trauma.
  - (For example, a person who was assaulted by someone in uniform may avoid or refuse to talk to, or make eye contact with someone in uniform).

- Negative changes in mood and thought patterns:
  - Persistent and exaggerated negative beliefs and expectations.
  - Self-blame, also known as survivor's guilt.
  - Persistent feelings of fear, horror, shame, guilt, anger.
  - Loss of interest or participation in events, gatherings, or social activities.
  - Persistent inability to experience positive emotions.

SRM = pg. 33

1.32 The student will discuss the effects of trauma on veterans.



- Increased arousal and reactivity such as:
  - Irritability.
  - Heightened startle response.
  - Recklessness.
  - Hypervigilance.
  - Difficulty concentrating.
  - Sleep disturbance.
  - Fatigue.

- Additional considerations:
  - Safety: When someone with PTSD is in a crisis situation s/he is experiencing a recurring, primal activation of the natural "fight or flight" response and their primary goal is survival.

  - Sensitivity: Individuals with PTSD are often on high alert (hypervigilant) and when confronted with ambiguous information or context the person is more likely to attribute dangerousness to the situation and react as if she is threatened.

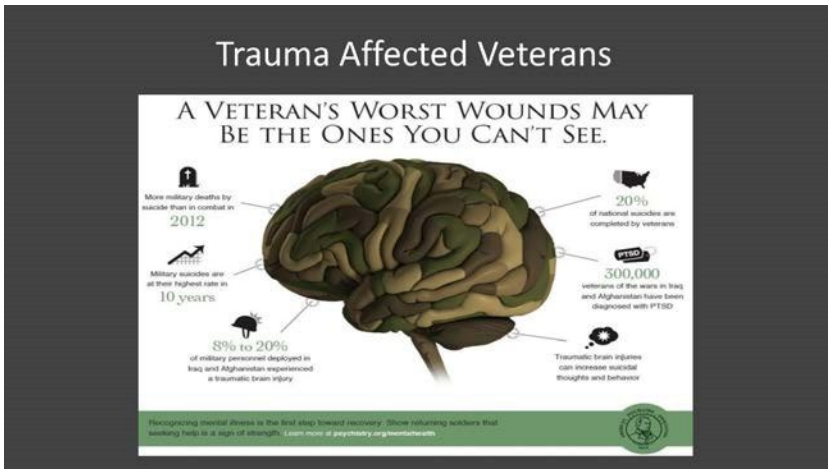
- Triggers
  - This term refers to sensory stimuli that causes one to recall a previous traumatic memory and subsequently have a physiological reaction to a (real or imagined) threat.

  - This can include people, places, sights, sounds, smells, and textures.

Trauma affected Veterans

120 mins
SRM = pgs. 33

Show Video: *Your time in Iraq makes you a threat to society (9.01 minutes)*
https://www.youtube.com/watch?v=X6AYmzunPlQ&feature=youtu.be



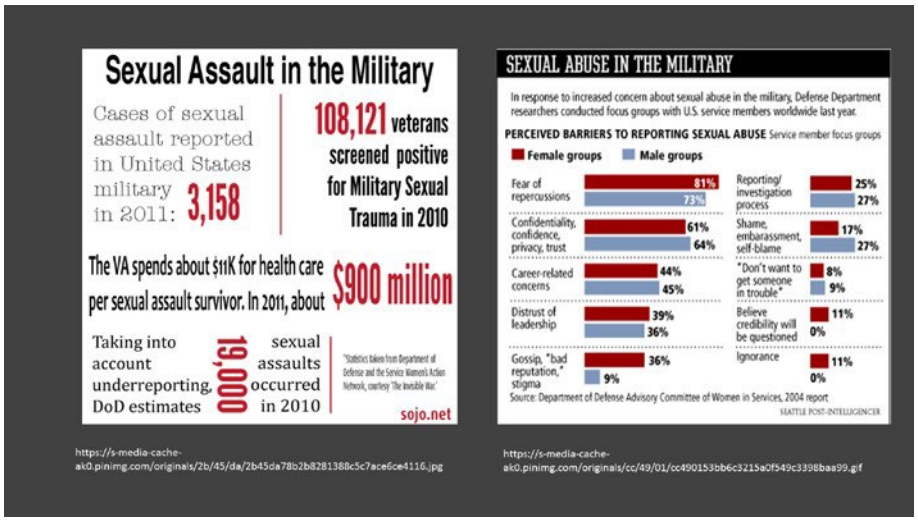
- (VA, 2017) Rates of PTSD will differ based upon the sub-population of Veteran (wartime versus nonwartime).
- Operation Iraqi Freedom (OIF) and Enduring Freedom (OEF): "Approximately 11-20% of OIF/OEF Veterans have PTSD in a given year."
- "Approximately 12% of Gulf War Veterans have PTSD in a given year" (VA, 2017).
- "Approximately 15% of Vietnam Vets were diagnosed with PTSD at the time of the most recent study in the late 1980s. It is estimated 30% of Vietnam Vets have had PTSD in their lifetime" (VA, 2017).
- The rate of deployments has increased, while the number of military personnel to serve those missions has decreased, resulting in multiple deployments for our service members, thereby increasing the potential for trauma exposure (VA, 2017).
- There were more deaths by suicide than combat in 2012 (VA, 2017).
- In 2016 the rate of military suicide was the highest it had been in 10 years (VA, 2017).
- 20% of national suicides are completed by Veterans (VA, 2017).

- A trauma-affected Veteran of recent conflicts may have encountered a number of variables that can serve as trauma-triggers, including:
    - Adversaries indistinguishable from civilians.
    - Women and children used as suicide bombers or other forms of threat.
    - Roadside debris at risk of being an IED.

- Texas ranks 2nd in the United States in number of Veterans.
    - In 2014, 1.5 million Texans were military veterans. (Texas Legislative Council, 2016).
    - According to the Housing Assistance Council (2018), there are 1,564,501 veterans in Texas which amounts to 8.2% of Texas's adult population.

- Traumatic exposures can include:
    - Physical injuries.
    - Witnessing/experiencing/participating in combat.
    - Military sexual trauma.
    - Moral injuries.

SRM = pg. 34



- Military Sexual Trauma (MST) is also a contributing factor to PTSD.

    - MST includes unwanted sexual touching or grabbing; threatening or offensive remarks about a person's body or sexual activities; threatening or unwelcome sexual advances.

    - MST is unique in that it is perpetrated by a trusted brother or sister-in-arms.

    - 23% of women reported sexual assault when in the military.

    - Over half of all Veterans with MST are men.

    - 55% of women and 38% of men have experienced sexual harassment while in the military (VA, 2017).

Moral Injuries

1.33 The student will be able to define a moral injury.

	Psychological Trauma	Moral Injury
Precipitating Event	Threat of death or injury	Act that violates deeply held moral beliefs and/or values
Individual's Role at Time of Event	Witness or victim	Perpetrator, witness, or victim
Predominant Painful Emotions	Fear, horror, helplessness	Guilt, shame, anger
What is lost?	Safety	Trust

Albright, Currier, and Hamner, "Post-Service Identity: The Role of Moral Injury on the Military to Civilian Transition," CIMVHR Annual Forum, 2016.

- A moral injury is the damage done to one's conscience when the person perpetrates, witnesses, or fails to prevent acts that violate that person's morals, ethics, or codes of conduct (Miller, 2017).

- In terms of Veterans, a moral injury can occur in the course of combat due to killing or harming others, witnessing death or dying, or giving and receiving orders that are counter to the person's moral beliefs (Maguen & Litz, 2016).

- The impact of moral injury can be emotional and behavioral.

- Emotional impact may include:
  - Shame, guilt, grief, regret, anxiety about possible consequences, or anger.

- Behavioral impact may include:
  - Alienation and withdrawal, self-harm (including suicidal ideation or attempts), substance abuse.

Survivor's Guilt
SRM = pg. 34

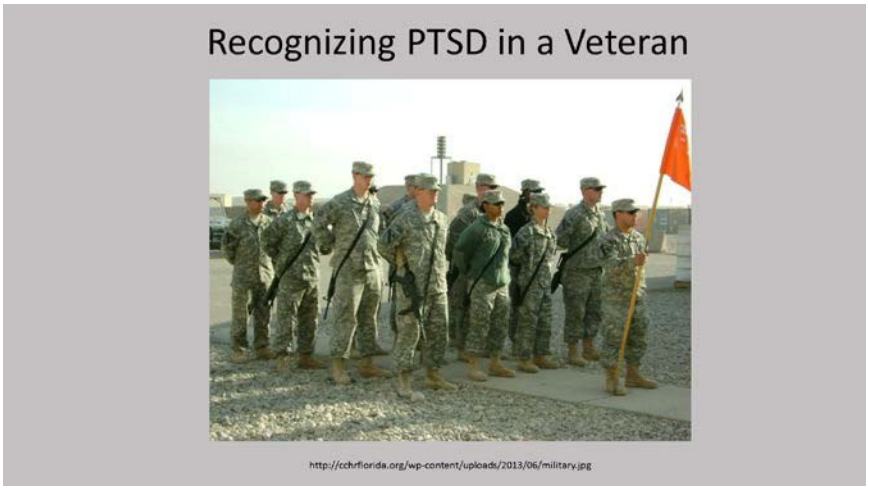
1.34 The student will be able to define survivor's guilt.

- Survivor's guilt can arise when someone survives something that other(s) do not and can lead to he or she feeling that they should have been the one to die instead.
- The concept was first introduced after the Holocaust.
- Survivor's Guilt often results in an individual asking why they survived when others did not or what they could have done differently.
- This type of guilt can exacerbate feelings of depression, anxiety, or other PTSD-related symptoms.

Recognizing PTSD in a Veteran

SRM = pg. 35

1.34 The student will be able recognize the symptoms and behaviors of PTSD in a veteran.



- Intrusion symptoms (an internal thought or feeling not outwardly obvious) (VA, 2017).
    - Person may appear distracted, defensive, or inattentive – this may not be disrespectful or misleading behavior but a mental re-experiencing of prior trauma.
    - May be overly reactive when touched (person may be experiencing sensory activation of prior trauma) or easily startled.

- Avoidance symptoms
    - A vet who is avoidant may directly interfere with an officer's ability to perform duties due to his/her reluctance to engage verbally or otherwise.
    - A vet who was involved in a violent vehicular attack may resist getting in a patrol car (or any car as a passenger).
    - A vet who experienced an attack in a heavily-populated area may become agitated when unexpectedly caught in any crowd, especially when his/her vantage or exit is impeded.

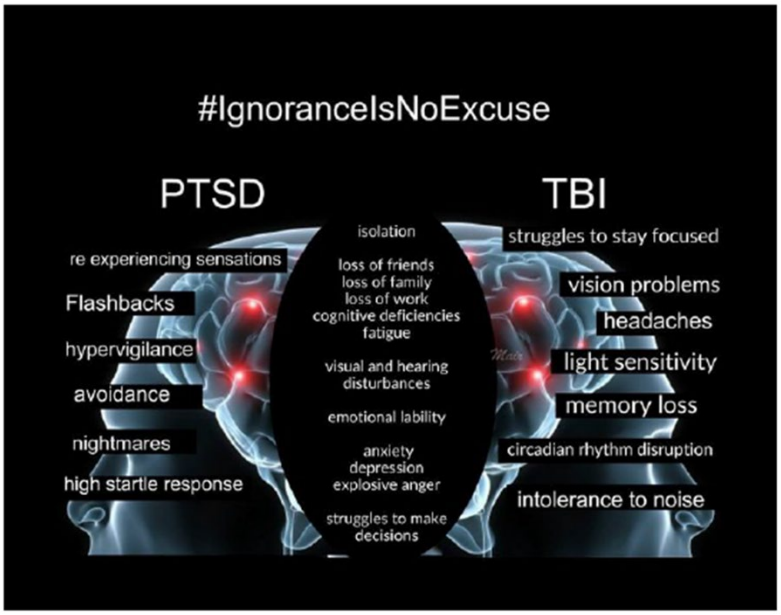
Recognizing Behaviors Indicating PTS in a Veteran

SRM = pg. 35

- Negative thoughts or mood.
  - May result in difficulties establishing rapport or developing trust.
  - Veteran may exhibit or express interpersonal alienation, distrust of officer(s), 'the system,' and become generally isolated.
  - Generalized distrust-make it unlikely that a veteran will trust that decisions being made on her behalf are in their best interest, or for altruistic purposes.

- Hyperarousal / Hypervigilance
  - This is the most likely symptom a LEO will encounter with a vet.
  - The veteran may appear on edge, hyper-reactive, or overly alert.
  - A veteran may feel easily threatened or become aggressive or violent when you try to restrain him.
  - A veteran may carry weapons due to feeling unsafe; may be more likely to use the weapon due to misinterpretation of behavioral cues as dangerous or threatening.
  - A veteran may feel extremely threatened by anyone approaching her, particularly if approached from behind.

PTSD and TBI
SRM = pg. 35



As previously discussed, many Veterans may suffer from both PTSD and TBI. The combination of those conditions results in a complex dynamic that impacts mood, emotion, behavior, and thought processes.

Show Video: Recognizing signs of PTSD and TBI (5.30 minutes)
https://www.youtube.com/watch?v=mEVA0T7QR1E

Veterans and the criminal justice system
SRM = pg. 35

- Since the civil war, there has always been an increase in post-war Veteran crime.
- Following the Vietnam War nearly ½ of Vietnam Vets with PTSD had been arrested or jailed at least once, and 34% were arrested or jailed more than once. (Kulka, et al., 1988)
- 10-12% of OEF/OIF Veterans have been involved with the criminal justice system since returning from deployment (Tsai, et al., 2012).
- From 2006-2011 violent crime committed by active duty Army soldiers stateside and abroad increased by 31% (DOD, 2012).
- Substance abuse-related issues are the most common reason Veterans become involved in the criminal justice system (White, et al., 2012).

Building rapport with a Veteran
SRM = pg. 36

1.36 The student will be able to use techniques to build rapport with veterans or others experiencing PTSD.

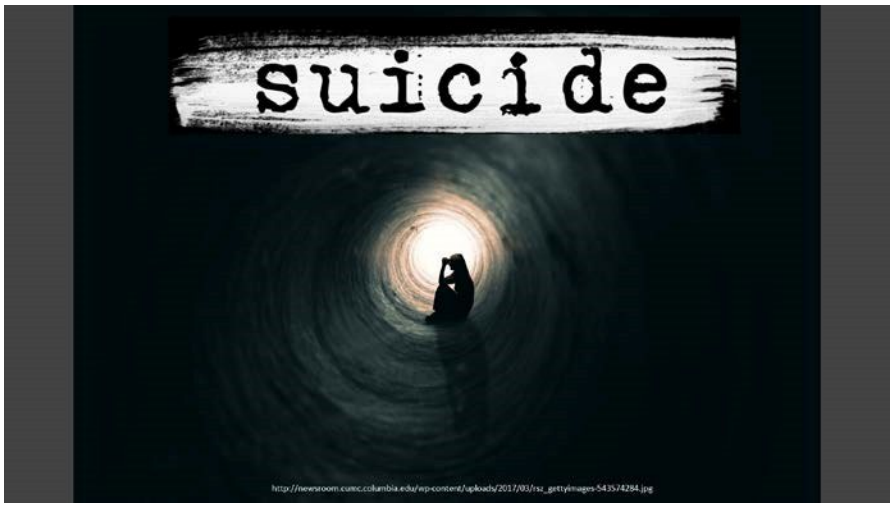
- Veterans share many commonalities with law enforcement, including:
  - Experience being in control during difficult situations, the need to repress emotional or instinctual responses.
  - A desire for public and personal safety.
  - A desire to serve their community and country.
  - Trained to adhere to rules, structure, and command.
  - A personal ethos based in self-sacrifice.

Show Video: *Encountering a Veteran with Post-Traumatic Stress (7.13 minutes)*
https://www.youtube.com/watch?v=giyLcnknD2o

Suicide

90 mins
SRM = pgs. 37

1.37 The student will discuss the statistics and terminology of suicide and suicide prevention.



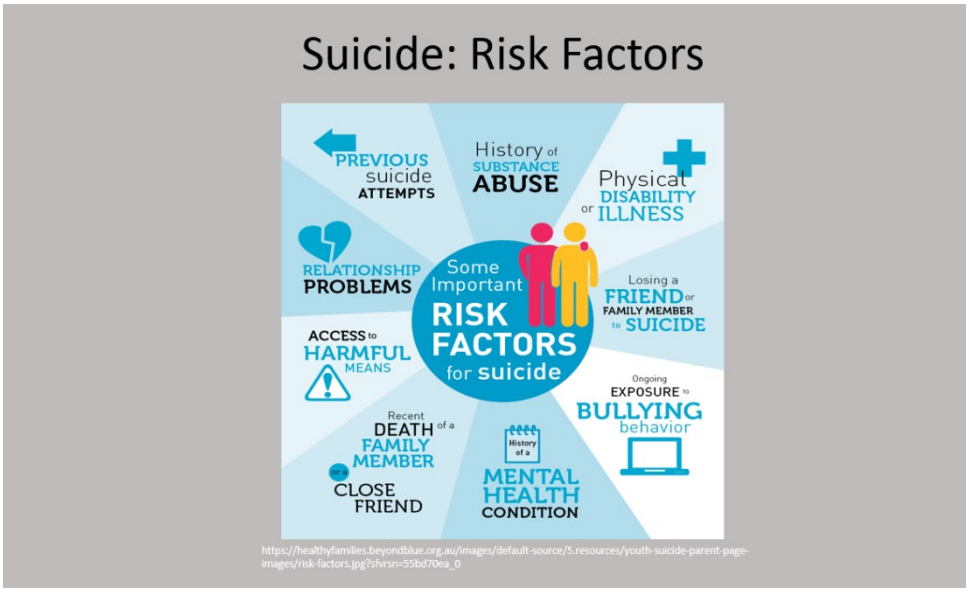
Show Video: *Attempted Suicide by Cop* (7.03 minutes)
https://www.youtube.com/watch?v=aObLNZWva4Y

- Between 2005 and 2009, "Texas lost over 12 thousand people to suicide, ranking suicide as the top cause of injury death for all ages in Texas, with a suicide rate of 10.8 per 100,000. In 2010, suicide was the 9th leading cause of death in Texas" (CDC, 2012)
- There were 121 suicides per day, at a rate higher than the rate of homicide; this averages to one person every 11.9 committing suicide (CDC, 2016).
- Suicide is the second leading (second only to wrecks) cause of death among 15-24 year-olds (CDC, 2016).
- Suicide is the 10th leading cause of death in the U.S. (AFSP, 2017) ○ There are 3.3 more suicides by men than women, but 3x more attempts by women than men (CDC, 2016).
- White males accounted for 7 out of 10 suicides in 2015 (AFSP, 2017).
- On a daily basis, 18-22 Veterans commit suicide per day (VA, 2017).
- In 2015 firearms accounted for 49.8% of suicide deaths, followed by suffocation (26.8%) and poisoning (15.4%) (AFSP, 2017).

Known, and quantifiable suicide risk factors (SFSP, 2017)

SRM = pg. 37

1.38 The student will be able to recognize symptoms and behaviors that indicate an increased suicide risk.



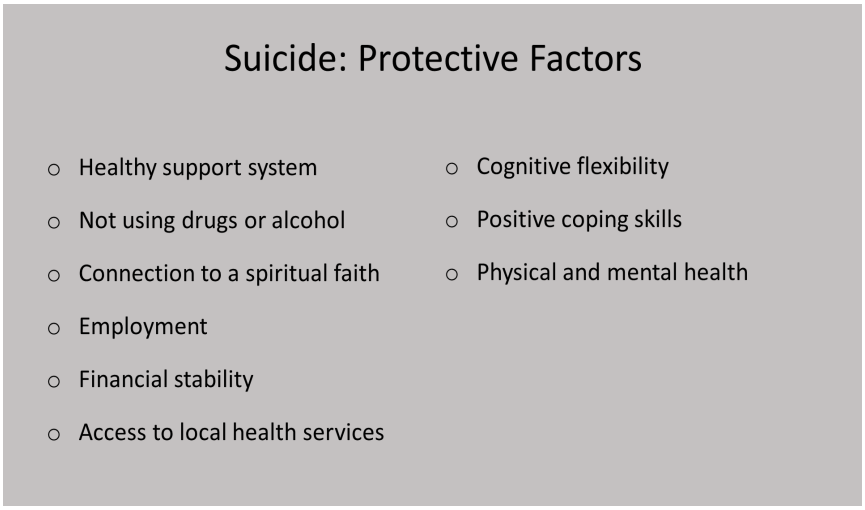
- Male, age 15-34.
- Depression.
- Substance intoxication.
- Previous suicide attempts.
- Feelings of hopelessness/helplessness/powerlessness.
- Specific plan, intent, and means to complete the plan.
- Lack of support system or connection to loved-ones.
- Recent loss (divorce, child custody, retirement, death of loved one, or loss of job).
- Feeling one is worth more to his/her loved one's dead than alive (feels like a burden to family).

Show Video: The Kevin Hines Story (13.41 minutes)
https://www.youtube.com/watch?v=loiGNZTfu6g

Protective Factors against Suicide

SRM = pg. 37

1.39 The student will be able to list protective factors against suicide.

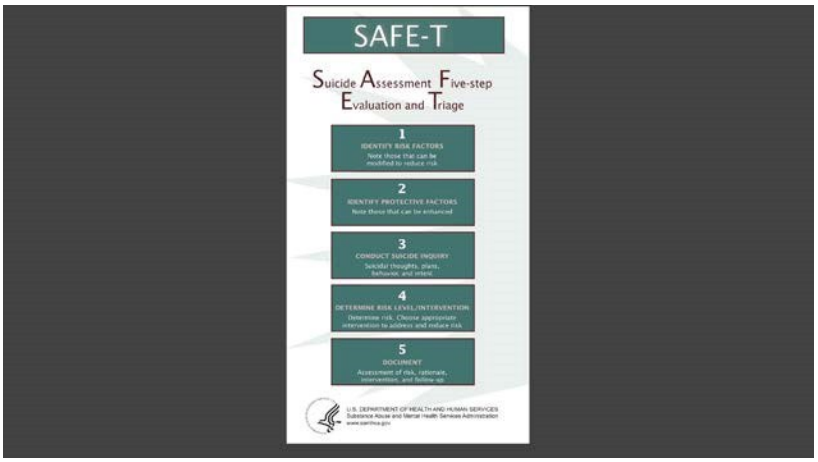


- Protective Factors (SPRC, 2017)
  - Healthy support system
  - Not using drugs or alcohol
  - Connection to a spiritual faith
  - Employment
  - Financial stability
  - Access to local health services
  - Effective mental health care
  - Connectedness to individuals, family, community, and social institutions
  - Problem-solving skills
  - Contacts with caregivers
  - Cognitive flexibility
  - Positive coping skills
  - Physical and mental health

Suicide risk assessment

SRM = pg. 38

1.40 The student will be able to use a suicide risk assessment.



- PLAN - Determine whether the subject has a specific plan.
  - Has the person been thinking of hurting or killing him/herself?
  - (If yes) Has s/he made a plan? What arrangements or preparations have been made.
- METHOD:
  - Has the person decided upon a method or a location?
- MEANS:
  - Does the individual have the means to carry out the plan/chosen method?
- INTENT:
  - How determined is the person to follow through with his/her plan?
  - Listen for cues of doubt/uncertainty, or statements of certainty.
  - Do not be shy about asking questions to ascertain the level of intent, such as, “How certain are you that this is the decision you want to make?”

Intervening with a Suicidal Subject

- Listen, listen, listen!
- Use positive communication skills, such as eye contact (if applicable), minimize distractions and interruptions, ask open-ended questions
- Do not use guilt (such as 'you don't want to do this to your kids/family')
- Validate the person's pain
- Put your personal opinions, thoughts, judgments aside
- Do not leave the person alone
- Ask them if there is someone you can call for them
- Try to find the "hook" that has kept them alive thus far, "Why have you avoided hurting or killing yourself in the past?"
- Inquire about how they have successfully overcome stressful times in their past

Show Video: *Suicide De-Escalation (2.03 minutes)*
https://www.youtube.com/watch?v=wjiqxJtsSsc

1.41 The student will be able to assist an individual to name and contact personal support resources.

Additional considerations when evaluating the levels of suicidal risk (Norris & Clark, 2015):

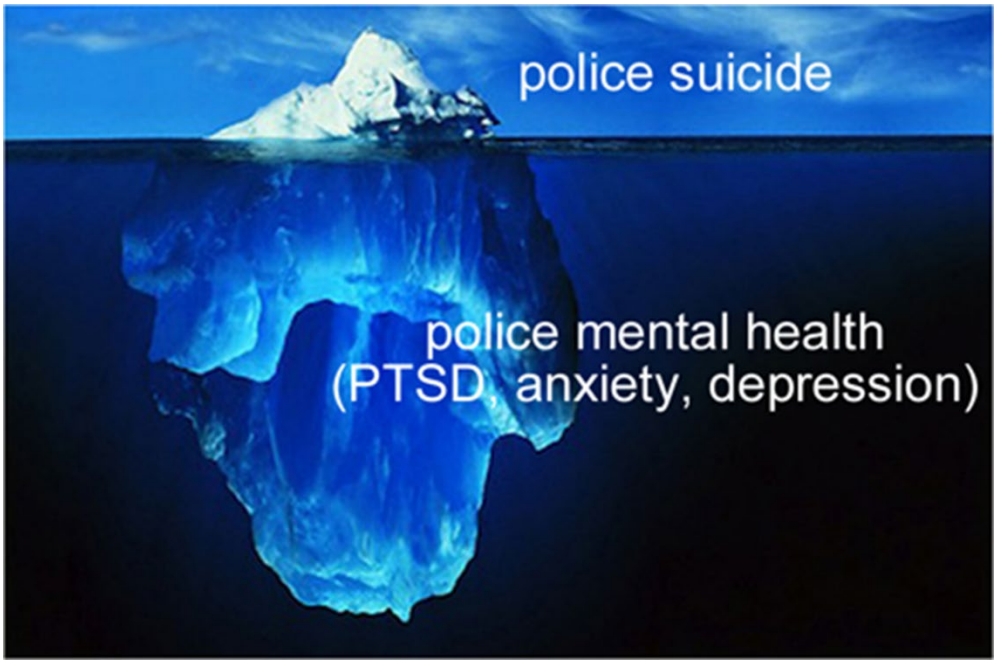
- Symptoms
  - Is the person exhibiting active symptoms such as psychosis, substance intoxication, or extremely slow or rapid speech patterns?

- Nature of current stressor
  - Is this current stressor chronic or acute?
  - Chronic stressor is a greater risk (such as a terminal illness)

- Offer practical suggestions
  - Suicide hotline numbers, information on how to seek treatment, perhaps provide assistance helping the person locate a resource (see resource appendix for a listing of Federal, State, County, Local, and charitable resources)
  - Consider existing social supports such as, religious affiliation, social services, family, neighbors.

First Responder Suicide
SRM = pg. 39

1.42 The student will discuss statistics and trends in law enforcement suicide.



- An organization called Badge of Life (2018), estimates that "More cops die of suicide than die of shootings and traffic accidents combined."

- Badge of Life has collected data between 2008 and 2017, and found that there is an average of 130 law enforcement suicides every year, or eleven per month. Unfortunately, that number is believed to be higher, due to agencies' desire to report deaths in other ways (O'Hara, 2018).

- "Based on available figures, the average age for a police suicide was 42 years. Time on the job averaged 16 years. 96 percent of suicides were males. By the end of the year, five chiefs/sheriffs were known to be lost, six lieutenants, and nine sergeants. The remainder of suicides were officers and deputies" (O'Hara, 2018).

- According to NAMI (2018), Almost 1 in 4 police officers has thoughts of suicide at some point in their life. In the smallest departments, the suicide rate of officers is almost four times the national average. The suicide rate for police officers is four times higher than the rate for firefighters. Between 7-19% of police officers have symptoms of posttraumatic stress disorder. In comparison, only 3.5% of the general population experiences PTSD. More police die by suicide than by homicide: the number of police suicides is 2.3 times that of homicides.

Show Video: *Stigma 12 July 28 (9.47 minutes)*
https://www.youtube.com/watch?v=qEcPAIxKHGY&feature=youtu.be

SRM = pg. 39

1.43 The student will discuss ways to change current LE mental health culture.

<u>How Can We Change the Culture?</u>

- O'Hara says, "Based on 24 years of experience on the job, I believe that work-related stress and depression are far more prevalent in police work than reports suggest. Law enforcement is one of the most toxic, caustic career fields in the world. But, while injuries like PTSD are increasingly acknowledged within the military, its prevalence in civilian police work goes virtually unnoticed" (2018).

- Instead of continuing to ignore the problem, the law enforcement community needs to address mental health and suicide head-on, devising what they call a "cradle to the grave" approach for officers. Cadets in police academies must be informed of the emotional toll of police work and taught coping techniques.

- In the meantime, current programs should certainly be continued—because they do help. Peer support efforts, for example, are valuable and do provide relief from daily, routine issues and problems. Confidentiality in these programs, often, is not as available as it is with a private therapist or psychologist, however, and additional resources must be identified and utilized by departments to deal with truly personal issues.

- One measure of hope has to do with a new and younger generation of police officers that are coming into the fold. Long lasting attitudes, stigmas and fears about discussing mental health are gradually eroding. There is still a chance that, as these officers continue to permeate the ranks and fill the

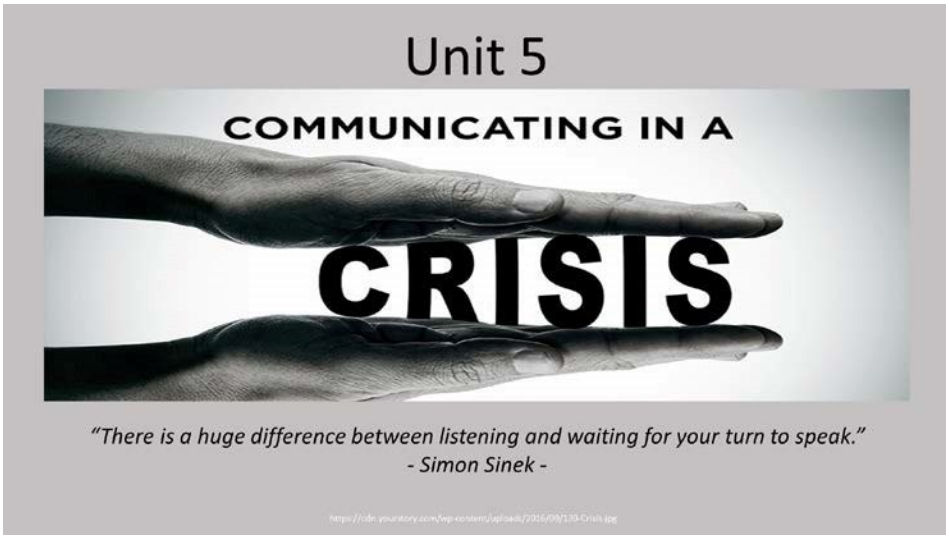
leadership, more law enforcement personnel will not only seek help “when it’s needed,” but do so before it’s needed.

Show Video: Officer Needs Assistance Documentary Trailer (8:08)
https://www.youtube.com/watch?v=VkqFjvoa6iQ

Unit 5: Effective Communication Skills to Aid in Working with a Possible Mental Health Crisis

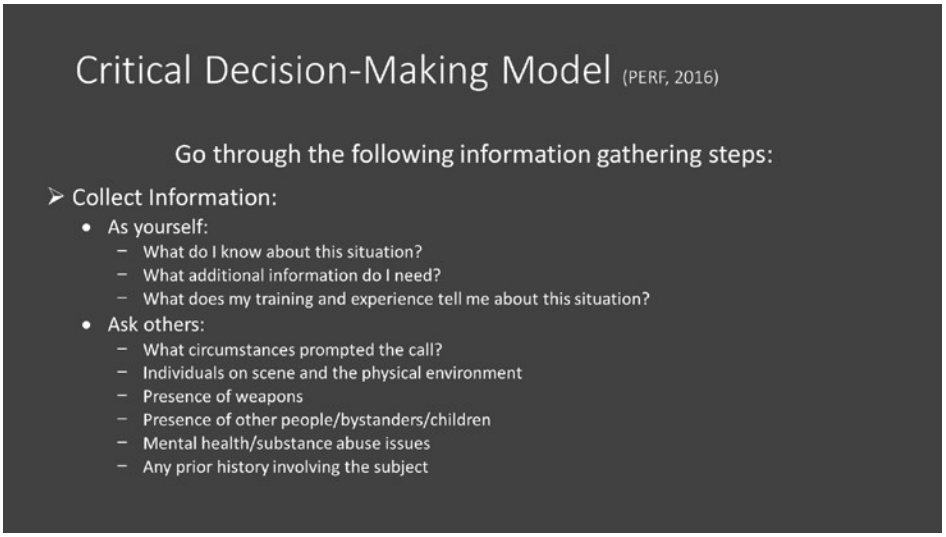
5 hours (unit total; each subsection has its respective time listed)
SRM = pg. 40

1.44 The student will be introduced to a variety of advanced modes of communication to assist in dealing with someone in a crisis, and be able to display them in interaction and role play.



Information Gathering

20 mins



Advanced Modes of Communication for Persons Experiencing Crisis

SRM= pg. 40

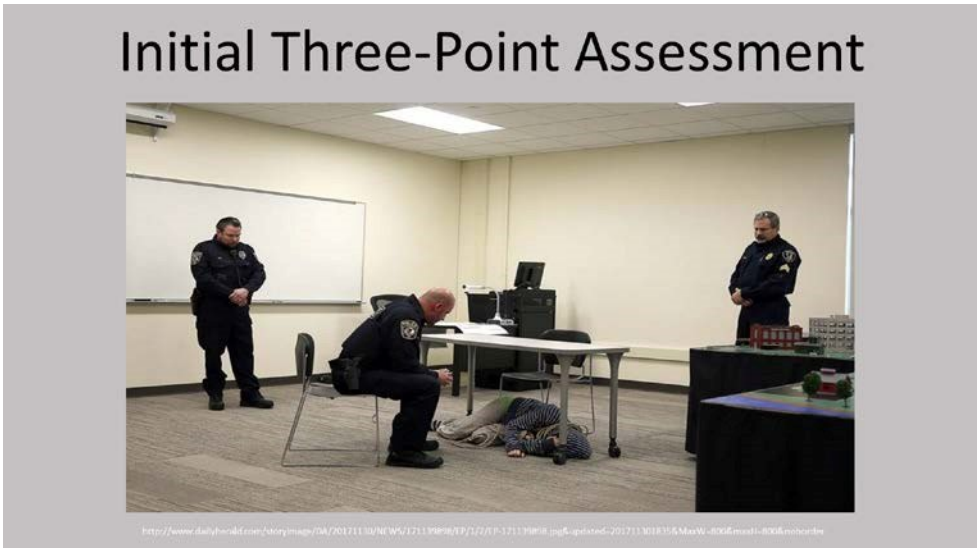
- Remember that you aren't trying to diagnose the person or resolve the underlying issues.
- Your top priority is to verbally defuse the situation to the best of your ability.
- Consider this three-phase process:
    - Safety – of the public, the subject, and the police
    - Stability – attempt to stabilize the person through verbal and non-verbal de-escalation skills
    - Problem solving - Try to get the person into a rational frame of mind (lessen emotional reactivity). Increases the likelihood of future compliance and resolution
- Do not rush into situations (unless necessary)! Patience can increase the safety of everyone involved
- Focus on calming the situation and minimizing the level of stress

Initial Three-Point Assessment

30 mins

SRM = pgs. 40 – 41

1.45 The student will discuss and be able to effectively utilize an initial Three-Point Assessment.



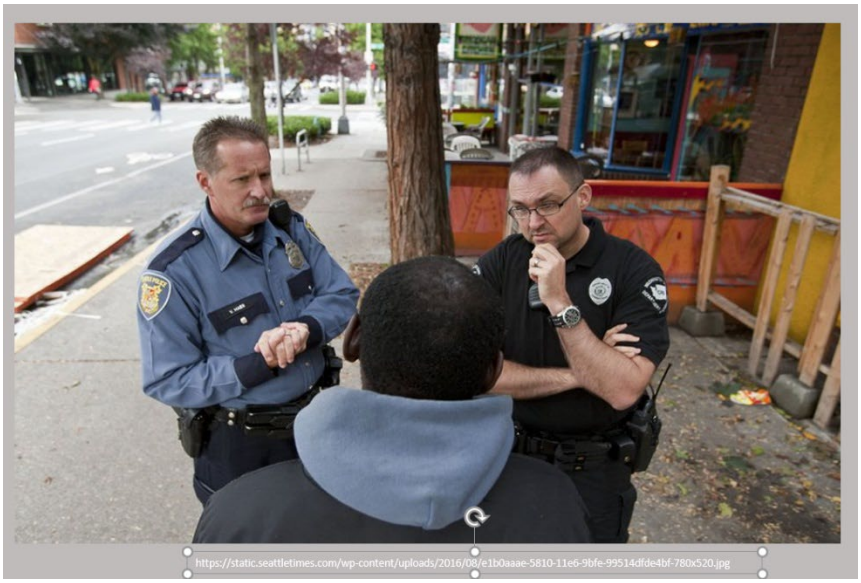
This quick assessment can be used in an attempt to roughly determine a subject's mental health status

- 1. Level of comprehension
  - Does the person understand what you're saying?
  - Can the person follow instructions?
  - Is person able to answer basic questions related to orientation (i.e. person, place, time)?
  - When person speaks do their comments make sense related to the circumstances?
  - How is the person speaking (quickly, slowly, slurred, mumbled)?

- 2. Behavior
  - How is the person practicing basic self-care (Disheveled, dressed appropriately for season)?
  - Is the person caring for hygiene (bathing)?
  - When was the last time the person ate, or drank anything?
  - How is the person's physical coordination?
  - Compliant or non-compliant? If non-compliant could it be due to mental health issues?

- 3. Emotion
  - What is the prevailing emotional state? (anger, sadness, euphoria, anxious)
  - Is the emotional state appropriate to the context of the situation?
  - Does the person exhibit quickly fluctuating emotional expressions? (laughing to crying)
  - Is person exhibiting extreme or baseless suspiciousness or paranoia?
  - Is person's facial expression and body language consistent with their stated mood?

<u>Additional guidelines from PERF, 2016</u>:
SRM = pg. 41



- Do not rush the person or crowd his personal space. Any attempt to force an issue may quickly backfire in the form of violence.

- He may be waving his fists, or a knife, or yelling. If the situation is secure, and if no one can be accidentally harmed by the individual, you should adopt a non-threatening, nonconfrontational stance with the subject.

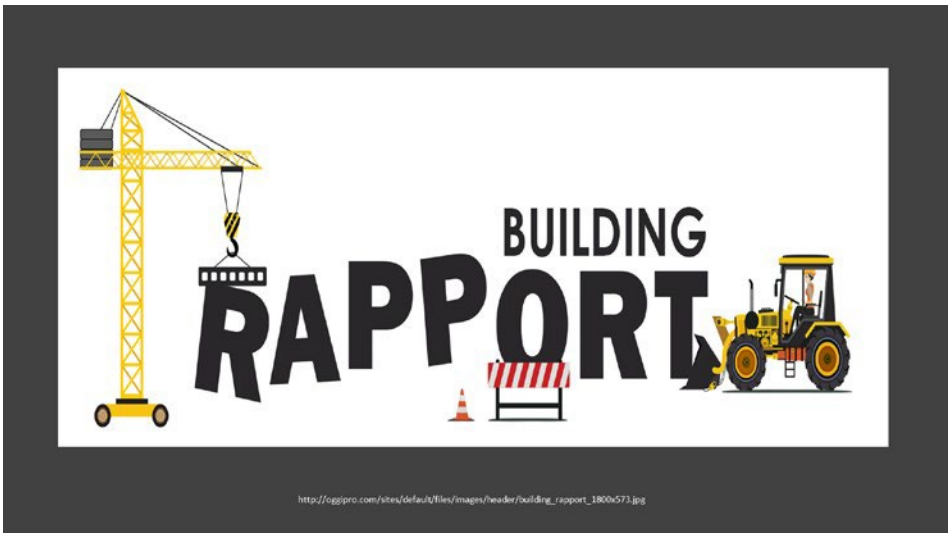
- Excessively emotional or even violent outbursts by those with mental illness are often of short duration. It is better to let the outburst dissipate rather than wrestle with a person who is under extreme emotional stress. Bizarre behavior alone is not reason for physical force.

- What works best and what is most beneficial is patience and communication.

- The tone and outcome of a police-subject interaction are almost always impacted by the degree to which an officer can build rapport with the subject(s).

Building Rapport

60 mins
SRM = pg. 41



- Importance of rapport

  - Rapport is defined as “a friendly, harmonious relationship; especially: a relationship characterized by agreement, mutual understanding, or empathy that makes communication possible or easy” Synonyms for rapport include “communion or fellowship” (MerriamWebster, 2017).

  - The degree of rapport can often determine the course of the interaction (positive or negative)

The 5 Universal Truths of Human Interaction
SRM = pg. 41

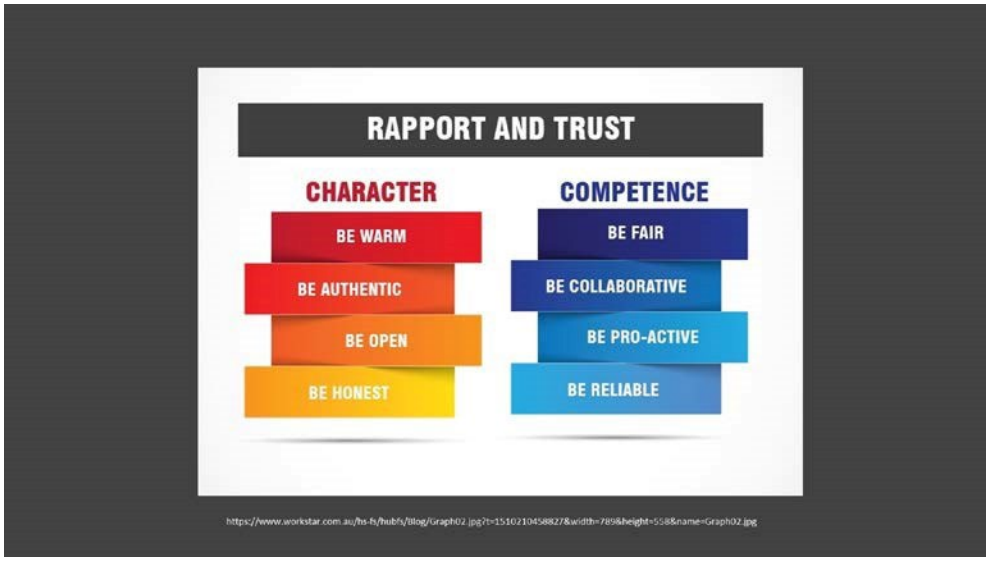
1.46 The student will discuss and utilize the '5 Universal Truths of Human Interaction'.

- The 5 Universal Truths of Human Interaction as described by Dr. Thompson are:
  - ALL cultures want to be treated with Dignity and Respect.
  - ALL people would rather be asked than told what to do.
  - ALL people want to know why they are asked or told to do something.
  - ALL people would rather have options than threats.
  - ALL people want a second chance to make matters right.
    (Thompson, 2017)

Building Rapport and Trust

SRM = pgs. 41

1.47 The student will be able to implement tactics for gaining trust and building rapport.



- Importance of rapport
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  - The degree of rapport can often determine the course of the interaction (positive or negative)

- Tactics for gaining trust and building rapport
  - Honesty and sincerity are essential for rapport and trust.
  - Individuals suffering from mental health issues can be very attuned to nuances of communication (dismissiveness, ulterior motives, condescension, non-verbal cues, labeling).
  - Use the person's name (the name that they prefer to be called).
  - Be patient and try to match their conversational speed.
  - Maintain a calm tone of voice.
  - Do not minimize or discount the subject's point of view.

- Make sure that you validate the positive things that the person has done while you have been talking.
- Gain confidence by forewarning that certain things may take place.
    - For example: 'You have been very straightforward with me and I am going to be straightforward with you. You are going to have to be handcuffed when you ride in the car, for your safety, and for mine.'
- Good eye contact (but not confrontational or unending eye contact).
- Minimal distractions.
- Do not interrupt while the person is speaking.
- Validate and empathize.
- Use engaged body language (lean forward into the conversation, or nod).
- Remember, it's not what you say, but how you say it.
    - Try an example phrase with emphasis on different parts of the sentence to demonstrate this principle.

1.48 The student will be able to define the 80/20 rule.

- Consider the 80/20 rule; listen for 80% of the time and talk for 20%, this will enable the you to gather more information and make an ongoing situational assessment.

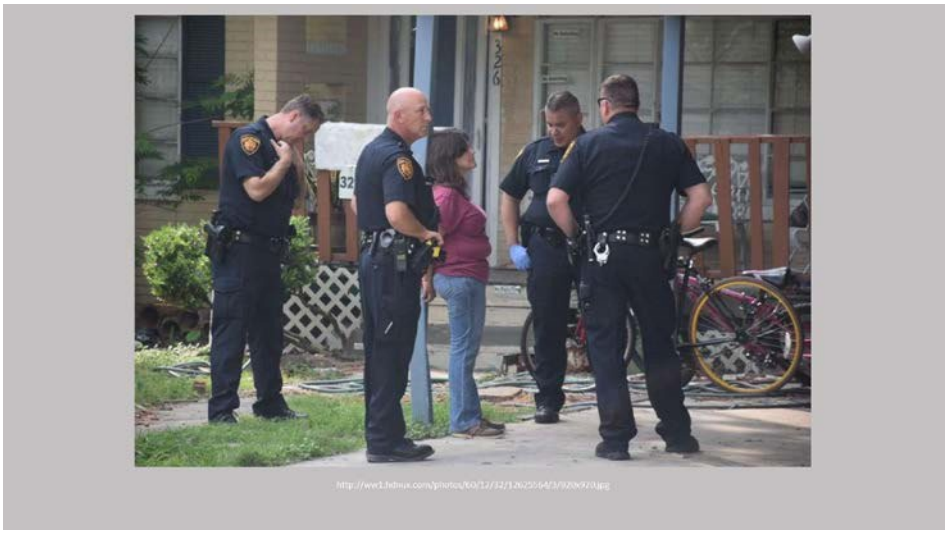
How rapport is damaged and repaired
SRM = pg. 42

Ask the class how they can tell when they have established rapport with a subject.
Ask students how they can tell when rapport has been fractured.
Ask students to identify what they believe can fracture rapport.
Ask students if they think rapport can be repaired, and if so, how.

- What can fracture rapport?
    - Making judgments
    - Dishonesty
    - Failure to follow through on one's end of an agreement
    - Aggression
    - Tone of voice (dismissive, condescending, insincere)
    - Exhibiting disinterest
    - Labeling
    - Patronizing/condescending

- How can fractured rapport be repaired?
    - Acknowledging what went wrong, and taking responsibility for one's part in the dissolution
    - Apologizing
    - Expressing sincerity
    - Taking corrective action

Non-Verbal Communication
SRM = pg. 42



Non-Verbal Communication (PERF, 2016).

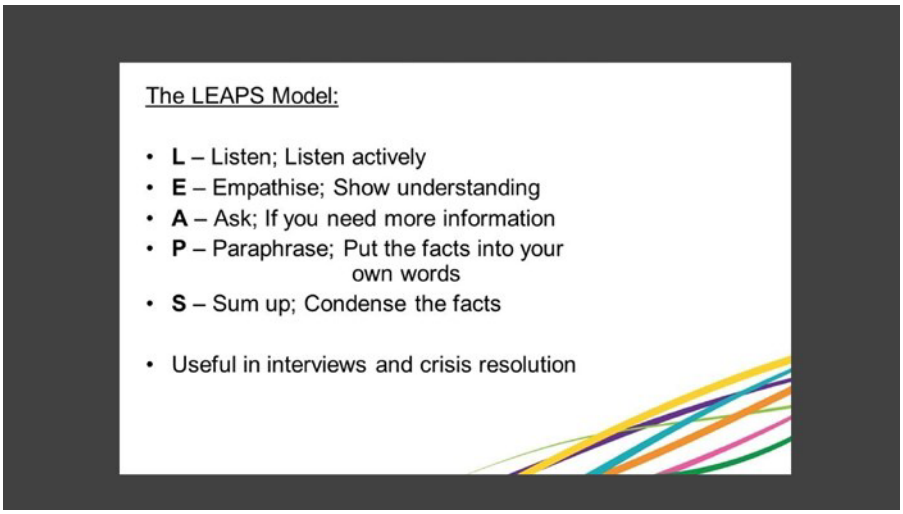
- Friendly and helpful – behaviors that convey safety, respect, and a desire to help. Can be conveyed verbally, and nonverbally (through neutral body language, and pleasant facial expression)
- Aggressive and hostile – behaviors that communicate a distance from or even a danger to another individual (blading, hand on grip of pistol)
- Ambiguous – These behaviors are open to interpretation and can have a wide range of meanings to individuals in crisis. Often if the posture is not overtly friendly, it is interpreted as dangerous.
- People in crisis may not be able to understand your statements or commands, but can often read your non-verbal cues and sense your level of concern, empathy, investment, and genuineness.

Introduce the L.E.A.P.S. model of communication (IKON, 2017)

120 mins

SRM = pgs. 43

1.49 The student will be exposed to the LEAPS model of communication, be able to list its components, and demonstrate proficiency in its use.



LISTEN

- Most individuals do not listen, they simply wait for their turn to reply. Failing to listen carefully prolongs confrontation and prevents full understanding of the situation and individual.
- Listening is the fundamental skill that will help you accurately identify a problem, understand the totality of the circumstances, and know how to respond effectively and appropriately.
- Listening enables you to recognize the content of what is being said, as well as the emotional component of the message.
- If an individual is angry, allowing the person to ventilate some of that anger provides them the opportunity to defuse, while you gather information through listening.
- Let them do most of the talking in the beginning; this provides them the opportunity to vent and you the opportunity to learn more about how to best intervene.

EMPATHIZE

- This step in the communication requires you to put yourself in the other person's shoes and consider the problem or issue from their perspective.
- Empathy can often be expressed through a statement of understanding. When one is able to accurately identify what, the person is *feeling,* this can aid in building trust. An example might be: 'It sounds like you feel betrayed;' 'It sounds like you're worried and angry;' 'That must be really painful for you'.
- You do not have to agree with the other person's point of view. You are simply verbalizing your understanding of the person and their point of view and feelings.
- Empathizing demonstrates to the individual that you are genuinely listening, that what they have said is important to you, and that your goal is to help them.
- The key to expressing empathy is to remain non-judgmental and to simply verbalize the emotional content of what was said (not your interpretation of events or circumstances).

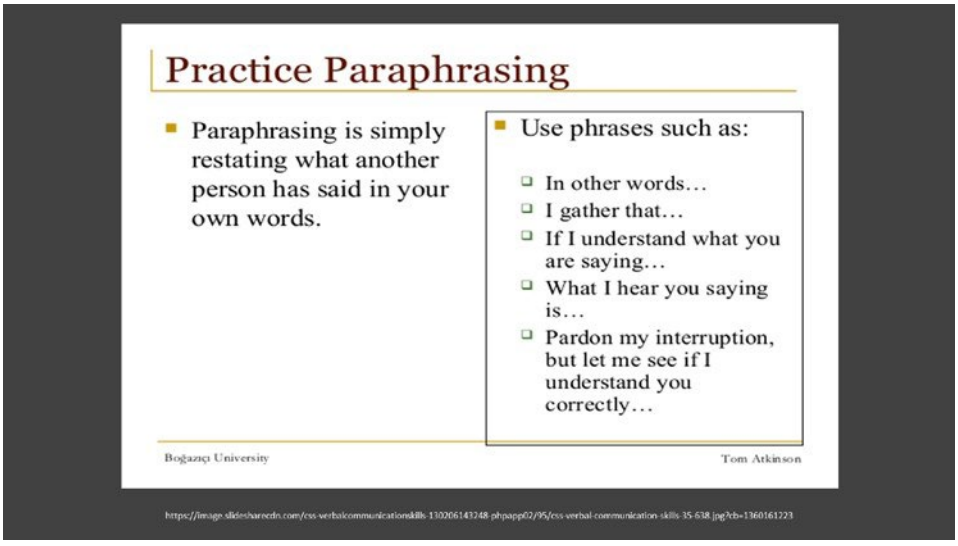
Ask More Questions

- This is another opportunity to demonstrate to the person that you are interested, and want to assist the person to problem solve.

- Remember the basics: Who, What, When, Where, How

- Asking questions can help you identify if the person is ready for your assistance, and can help defuse some of the emotion from the situation.

PARAPHRASE



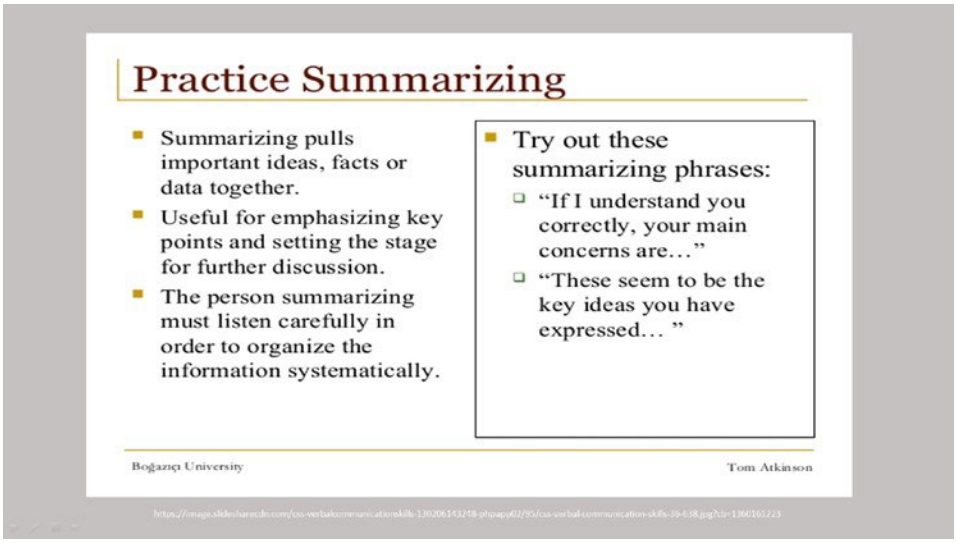
- Reiterate what has been said to you in your own words. An example might be: 'Let me be sure I understand what you've said…'

- As you put the facts into your own words it will either
    - provide confirmation that things are as you have interpreted, and the person's agreement with you will strengthen rapport because you 'get it', or

- provide the person an opportunity to correct your perception, which can also strengthen rapport. Either way, paraphrasing allows rapport to be built.

- Paraphrasing ensures you understand the situation precisely and clearly.
- Provides you the opportunity to take control of the situation
- As the end of paraphrasing the problem, ask 'Did I get that right?' or 'Did I miss anything?'

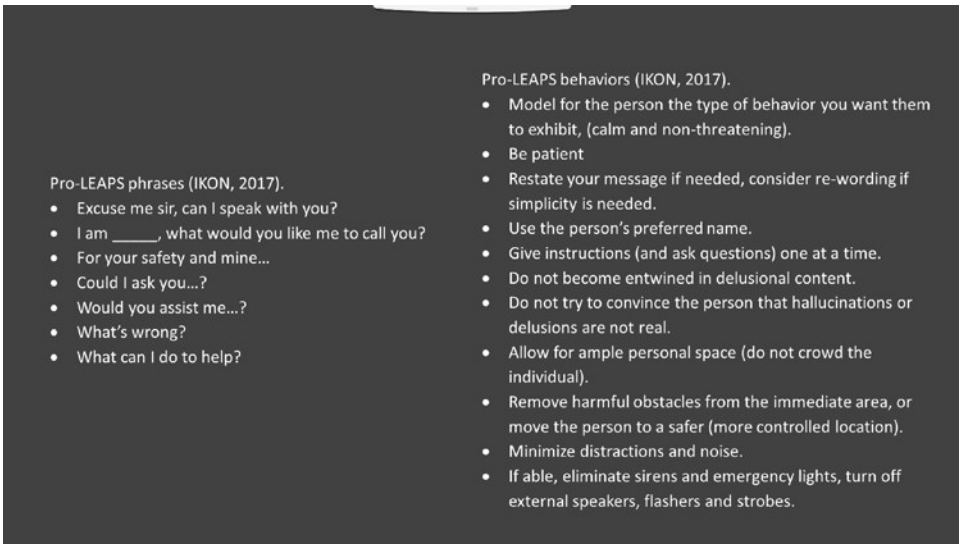
SUMMARIZE



This is your opportunity to bring it all together. You summarize their point of view, the options available, and what will happen next. The process through LEAPS is not only forward moving, but it can reverse steps or go from the end back to the beginning.

Pro-LEAPS Phrases and Behaviors

SRM = pg. 44



- Pro-LEAPS phrases (IKON, 2017).
  - Excuse me sir, can I speak with you?
  - I am _____, what would you like me to call you?
  - For your safety and mine…
  - Could I ask you…?
  - Would you assist me…?
  - What's wrong?
  - What can I do to help?

- Pro-LEAPS behaviors (IKON, 2017).
  - Model for the person the type of behavior you want them to exhibit, (calm and nonthreatening).
  - Be patient
  - Restate your message if needed, consider re-wording if simplicity is needed.
  - Use the person's preferred name.
  - Give instructions (and ask questions) one at a time.
  - Do not become entwined in delusional content.
  - Do not try to convince the person that hallucinations or delusions are not real.
  - Allow for ample personal space (do not crowd the individual).
  - Remove harmful obstacles from the immediate area, or move the person to a safer (more controlled location).
  - Minimize distractions and noise.
  - If able, eliminate sirens and emergency lights, turn off external speakers, flashers and strobes.

- Anti-LEAPS phrases
  - Calm down.
  - What's your problem?
  - You people… • Come over here.
  - I'm not going to tell you again…
  - Because these are the rules.
  - Because I said so.

Show Video: *LEAPS in Action (3.10 minutes)*
https://www.youtube.com/watch?v=NPNtVmKAJUQ

- What did you notice about the subject while he was interacting with the initial officer?
- The initial officer's tone was condescending and was escalating the subject
- The subject's physical demeanor was aggressive and escalating
- What changes did you notice in the subject's physical demeanor when the junior officer began speaking to him?

Reflecting Statements

1.50 The student will be able to list and describe the crisis intervention skills involved in communicating with people experiencing mental illness.

Basic Reflective Listening Formula		
Tentative Opening	Feeling	About/Because/When/Thought
It sounds like	You feel mad	About
I hear you saying	You feel glad	Because of
If I heard you correctly	You feel afraid	When
You seem to be saying	You feel confused	About
I'm not sure I follow	You feel ashamed	Because of
Did I hear you say	You feel lonely	When

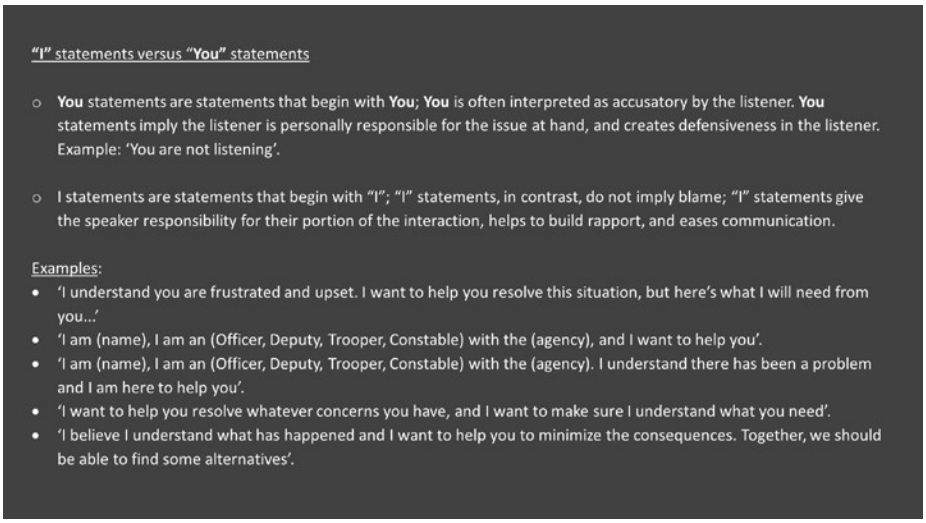
- Reflecting Statements

  - These are neutral responses to statements made by the subject to encourage him/her to continue talking.
  - Reflecting statements are intended to encourage communication.
  - They can be verbal, or non-verbal such as nodding, leaning in, and making eye contact
  - Examples include: 'I see…' 'Tell me more about that'; 'That might be an option'; 'What other options can we consider?'

‘I’ statements versus ‘You’ statements

SRM = pg. 45

1.51 The student will identify examples of ‘I’ statements versus ‘you’ statements.



- **You** statements are statements that begin with **You**; **You** is often interpreted as accusatory by the listener. **You** statements imply the listener is personally responsible for the issue at hand, and creates defensiveness in the listener. Example: ‘You are not listening’.

- I statements are statements that begin with “I”; “I” statements, in contrast, do not imply blame; “I” statements give the speaker responsibility for their portion of the interaction, helps to build rapport, and eases communication.

- Examples:
    - ‘I understand you are frustrated and upset. I want to help you resolve this situation, but here’s what I will need from you...’
    - ‘I am (name), I am an (Officer, Deputy, Trooper, Constable) with the (agency), and I want to help you’.
    - ‘I am (name), I am an (Officer, Deputy, Trooper, Constable) with the (agency). I understand there has been a problem and I am here to help you’.
    - ‘I want to help you resolve whatever concerns you have, and I want to make sure I understand what you need’.
    - ‘I believe I understand what has happened and I want to help you to minimize the consequences. Together, we should be able to find some alternatives’.

- “I” statements are good for making observations, as well as giving instructions. Try to use emotion words in response to the subject’s actions or statements:
    - ‘Mr. Smith, I feel nervous when you …. Please (insert directive)’.
    - ‘Mrs. Perry, I am worried you are going to harm yourself. Please (insert directive)’.

Tactical Transparency

SRM = pg. 45

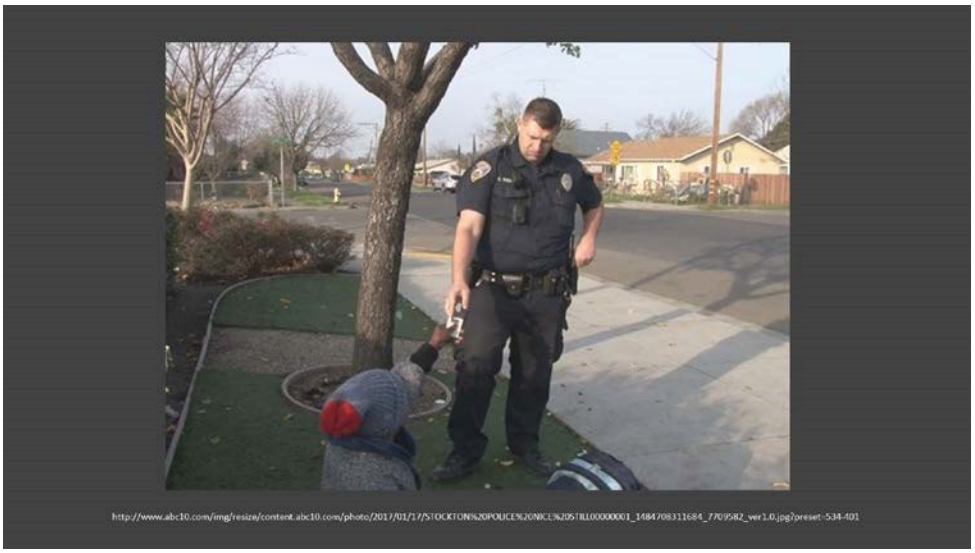
1.52 The student will be able to define the terms tactical transparency.

- This refers to explaining an action before initiating it, so the person with whom you are interacting knows what to expect.
- This tactic may be particularly useful in crisis situations, particularly for individuals suffering from PTSD, Autism Spectrum Disorders, or who are otherwise highly reactive and may tend to interpret events or behaviors as threatening.
- The purpose of tactical transparency is to provide the subject with a clearer interpretation of your behavior as a police officer, and to convey your mutual interest in assuring the safety of everyone involved.
- This method is utilized only when it is safe to do so, when there is adequate support (backup, medical personnel), and when there is no indication of impending violence. In this instance, as in all others, officer safety is paramount (PERF, 2016).

<u>Responding to Verbal Abuse</u>

SRM = pg. 45

1.53 The student will discuss options for responding appropriately to verbal abuse.



Verbal abuse

- Ignore demeaning language, do not give weight to that type of statement.
- Focus on deflecting and redirecting the individual. Examples are: 'I appreciate that, but…', 'I understand that, but…', 'I hear that, but…', 'I got that, but…', 'I'm sorry you feel that way, but…'

Inquire About Provider Information

If speaking with a subject who is exhibiting mental health concerns, you may inquire as to whether the person is receiving mental health treatment and if they have the contact information for their provider, or if there is a friend/family member they would like for you to call.

60 minutes

SRM = pg. 46

1.54 The student will define the term “deinstitutionalization” and discuss the criminal justice system and its relationship with those suffering from mental illness.

Deinstitutionalization is a term that has been used to describe the policy of relocating people experiencing severe mental illness out of residential mental health facilities and the subsequent closure of many of those facilities. This process did not provide a substitute so that individuals with mental health concerns could receive needed medication, stabilization, or therapy to assist them in living successfully in the community (Torrey, 1997)

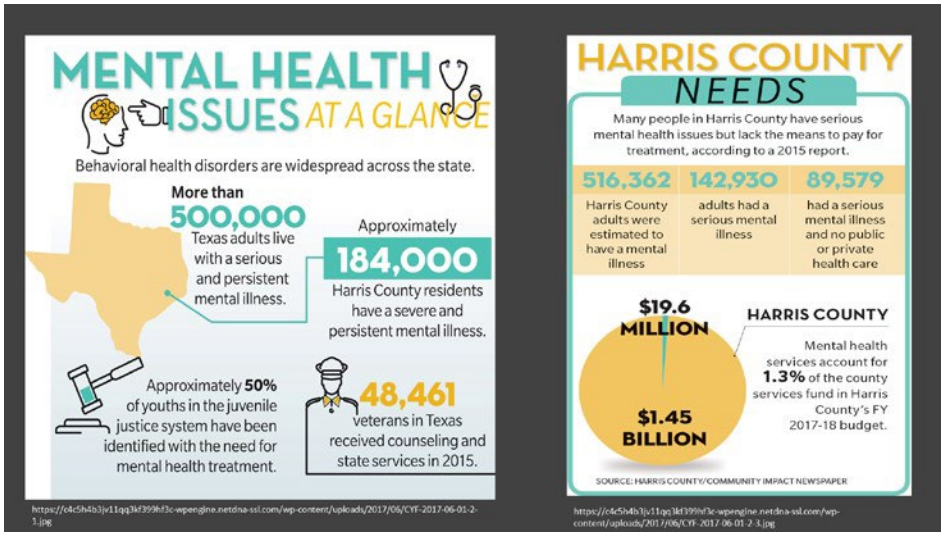
Show Video: Deinstitutionalization (6.28 minutes)
https://www.youtube.com/watch?v=AiTy-fxukY4

o **Make note to the students that the terminology in this video, such as, “retarded” or “consumer” is no longer considered acceptable terminology.**

SRM = pg. 46

- Deinstitutionalization began in 1955. Between 1980 and 1995, the total number of individuals incarcerated in American jails and prisons increased 216 percent, despite the fact that the population only grew by 16% (Torrey, 1997).
- Much of the increased rates of incarceration are due to deinstitutionalization, so those with mental illness are routed through the criminal justice system, rather than through the mental health system (Torrey, 1997).
- "Many mentally ill persons who seek treatment do not receive it. Mental hospital beds per capita in the U.S. are lower than they have been since 1850" (Torrey, 2010).
- "Over the last half-century, mental hospital capacity has dwindled, while prison and jail capacity has vastly expanded. Mentally ill prisoners comprise a large fraction of the jail and prison population" (Torrey, 2010).

Harris County mental health at a glance
SRM = pg. 46

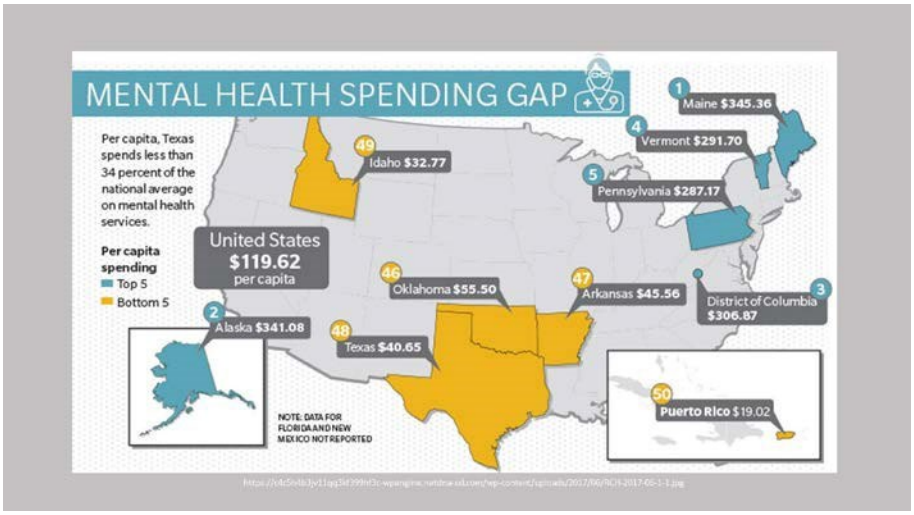


- The Harris County Jail houses over 9,000 inmates, more than 20% of which take medication for mental health conditions, meaning the jail "treats more psychiatric patients than all 10 of Texas' state-run public mental health hospitals combined" (DePrang, 2014).

- Harris County has one of the most underfunded public mental health systems in Texas, a state which also consistently ranks among the lowest in the nation for mental health spending. Due to the lack of public mental health services many individuals go without treatment and subsequently experience a crisis putting them into contact with law enforcement officers, and often the judicial system.

Monetary concerns related to public mental health needs

SRM = pg. 46



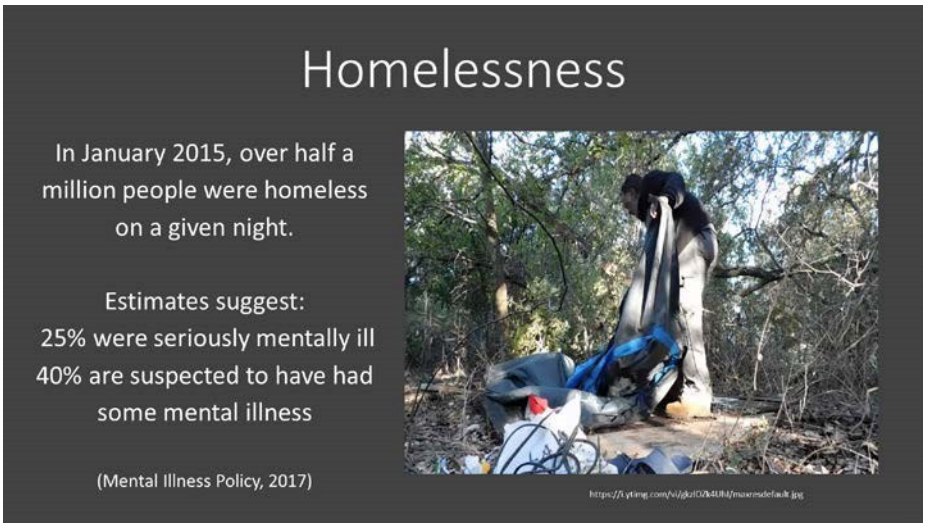
- Due to the major cuts to public mental health services in 2003, "law enforcement calls about people in psychiatric crisis jumped from fewer to 11,000 in 2003, to more than 27,000 in 2012" (DePrang, 2014), thereby eradicating the expected monetary savings from making the initial mental health budget cuts.

- "Compared to imprisonment, treating a mentally ill person in a mental hospital is at least four times as expensive, on a month-by-month basis" however, mental health treatment can prevent future incarcerations, making it the more long-term cost-effective option (Kopel, 2015).

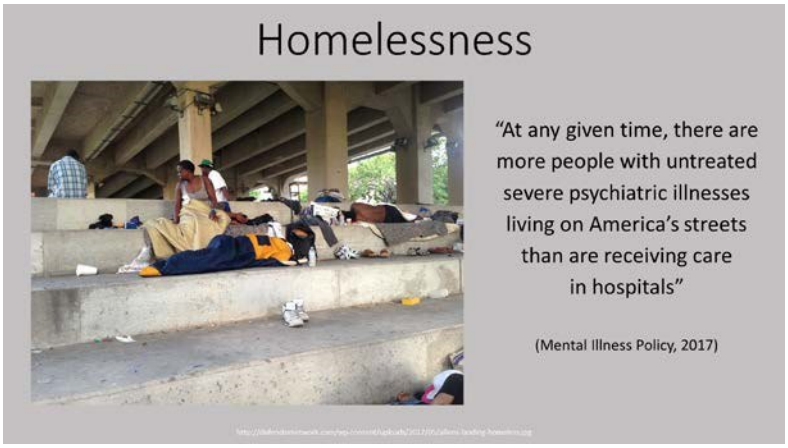
<u>Homelessness</u>

SRM = pg. 47

1.55 The student will explore the relationship between homelessness, mental illness, and victimization.



- "In January 2015, the most extensive survey ever undertaken found 564,708 people were homeless on a given night in the United States. Depending on the age group in question, and how homelessness is defined, the consensus estimate as of 2014 was that, at minimum, 25 percent of the American homeless—140,000 individuals—were seriously mentally ill at any given point in time. Forty-five percent of the homeless—250,000 individuals—had any mental illness. More would be labeled homeless if these were annual counts rather than point-in-time counts" (Mental Illness Policy, 2017).

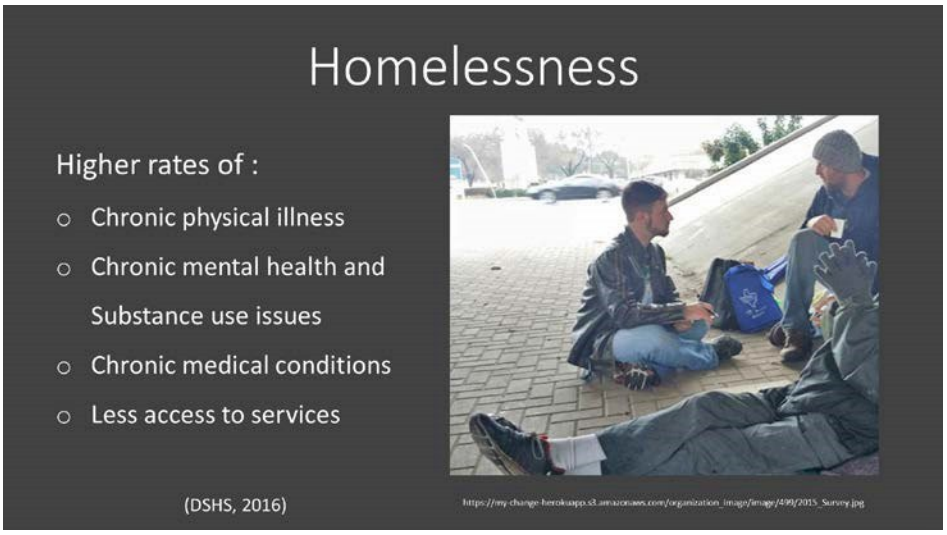


- "At any given time, there are more people with untreated severe psychiatric illnesses living on America's streets than are receiving care in hospitals" (Mental Illness Policy, 2017).

- "In 2006, Markowitz published data on 81 US cities, looking at correlations between the decreasing availability of psychiatric hospital beds and the increase in crime, arrest rates, and homelessness. As expected, he found direct correlations. This is consistent with past studies in Massachusetts and Ohio

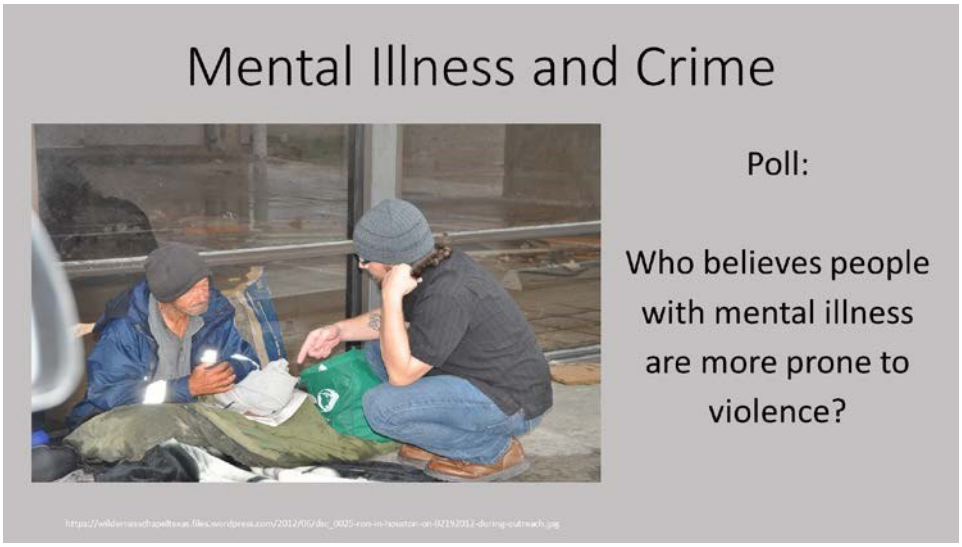
that reported that 27 and 36 percent of the discharges from state mental hospitals had become homeless within six months." (Mental Illness Policy, 2017).

- In 2016, the Texas Department of Housing and Community Affairs (TDHCA) indicated that homeless persons with mental illness remain homeless longer due to isolation from family and friends, barriers to employment and low income status, poor physical health and more contact with the legal system (greater frequency of criminal records thereby affecting their ability to acquire gainful employment and appropriate housing) (TDHCA, 2016).



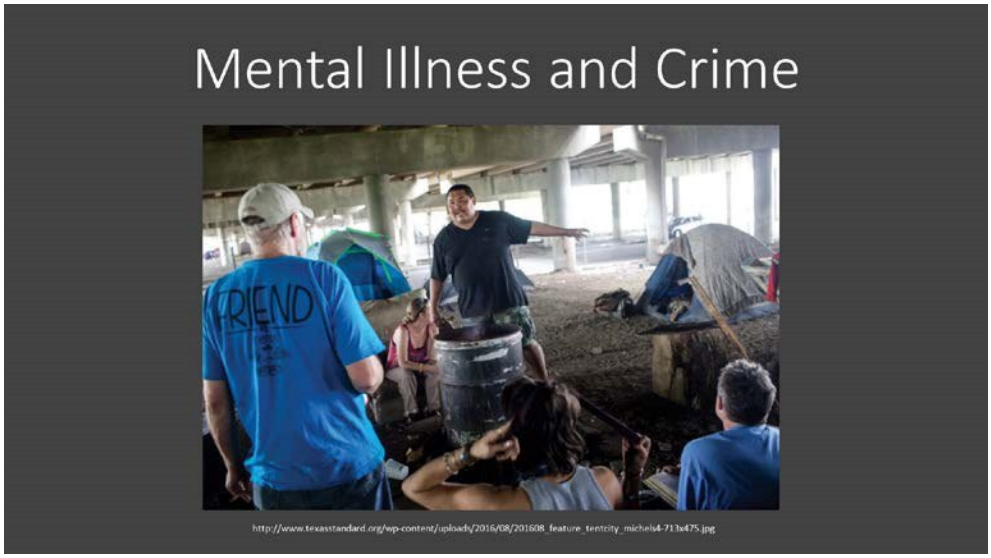
- "Individuals who are homeless typically have more chronic physical and mental health problems and substance abuse issues than do the general population. Homeless individuals are also at greater risk for infectious diseases and have higher rates of chronic medical conditions such as diabetes and heart disease…Episodes of psychosis or major depression may lead to homelessness and homelessness itself can worsen chronic medal (or mental health) conditions….Treatment and preventative care can be difficult for the homeless to access because they often lack insurance coverage, or they are unable to engage health care providers in the community" (DSHS, 2016).

Persons with mental illness as perpetrators of crime
SRM = pg. 47



- The vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3%-5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population. You probably know someone with a mental health problem and don't even realize it, because many people with mental health problems are highly active and productive members of our communities" (Mental Illness Policy.Org, 2017).

SRM = pg. 48



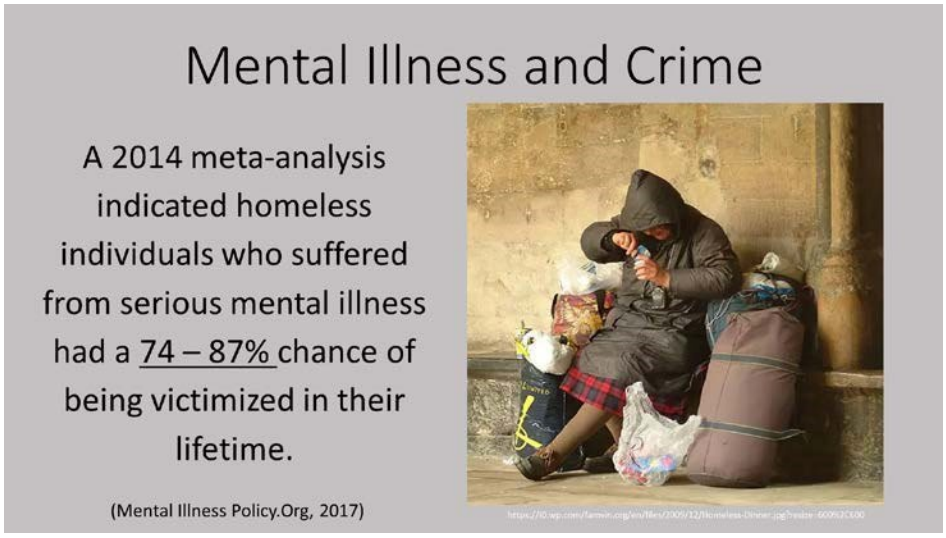
- "Only about 4% of interpersonal violence in the United States can be attributed to mental illness…yet nearly 40% of news stories about mental illness connect it to violent behavior that harms other people" (Sifferlin, 2016).

- The perpetuated false belief that someone capable of a violent crime must be mentally ill is based in stigma, fear of the unknown (mental illness), and a desire to distance oneself from another capable of a heinous act (only a mentally ill person could kill someone, so anyone who kills someone must be mentally ill) (Mental Illness Policy.Org, 2017).

- Individuals with serious and persistent mental illness are likely to also struggle with maintaining gainful employment and thus may suffer homelessness, and are at risk for abusing substances, thereby increasing the potential rate of crime, but not specifically due to mental illness (APA, 2014).

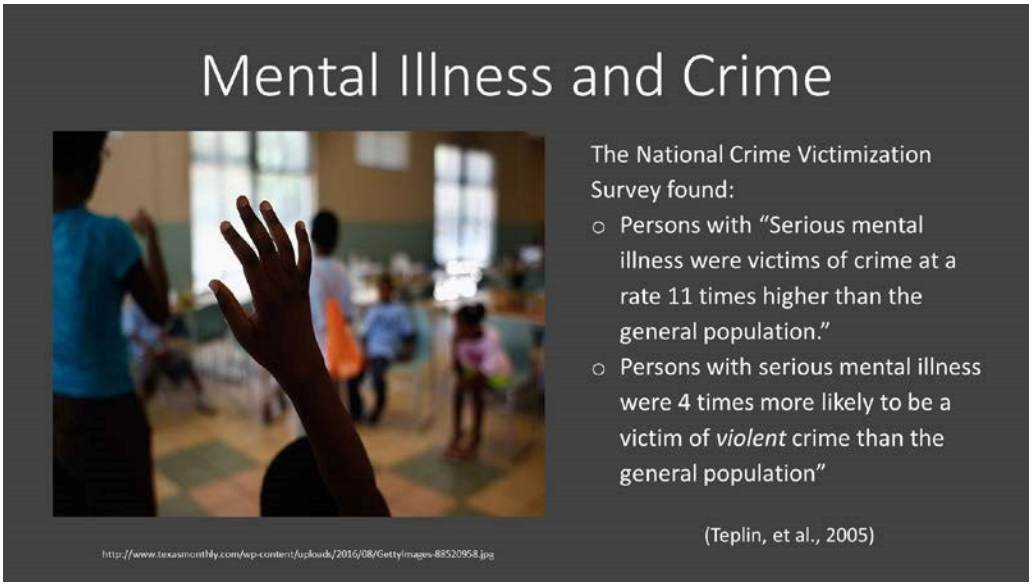
Persons with mental illness as victims of crime

SRM = pg.



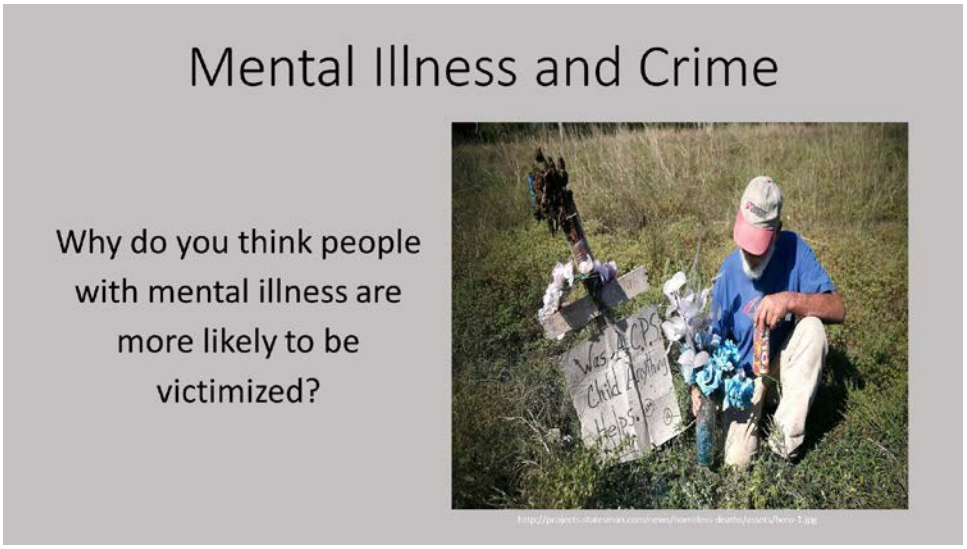
"A 2014 analysis of six American studies of victimization among homeless individuals with serious mental illness reported lifetime rates of victimization from 74% to 87%." This means that people with mental illness had a 74-87% chance of being victimized in their lifetime (Mental Illness Policy.Org, 2017).

"Women who were homeless and mentally ill were especially vulnerable; in a study in Washington, DC 63% of the women had been raped in the previous year" (Roy, et al, 2014).



Research based upon the National Crime Victimization Survey indicated persons with "Serious mental illness had been victims of crime at a rate 11 times higher than the general population." The research also demonstrated that persons with serious mental illness were 4 times more likely to be a victim of *violent* crime than the general population" (Teplin, et al., 2005).

People with mental illness are more vulnerable to crime than others. They often live in poor communities, areas with higher crime rates. They can be unable to make safe decisions, such as avoiding an empty, dark street (Mental Illness Policy.Org, 2017).



Examples of crimes of which people with mental illness are commonly victims:

- Children with mental illness may be more vulnerable to molestation or abuse
- Their report may be less likely deemed valid or reliable by authority figures
- These victims may have greater difficulty identifying a behavior as abusive
- These victims may have difficulty identifying the perpetrator
- These victims may not have the ability to provide enough qualitative evidence (report) leading to a conviction
- Adults with a mental illness may be easily robbed or become a victim of a con artist.

Unit 7: Legal considerations for a police officer intervening during a mental health crisis

60 minutes

Texas Health and Safety Code

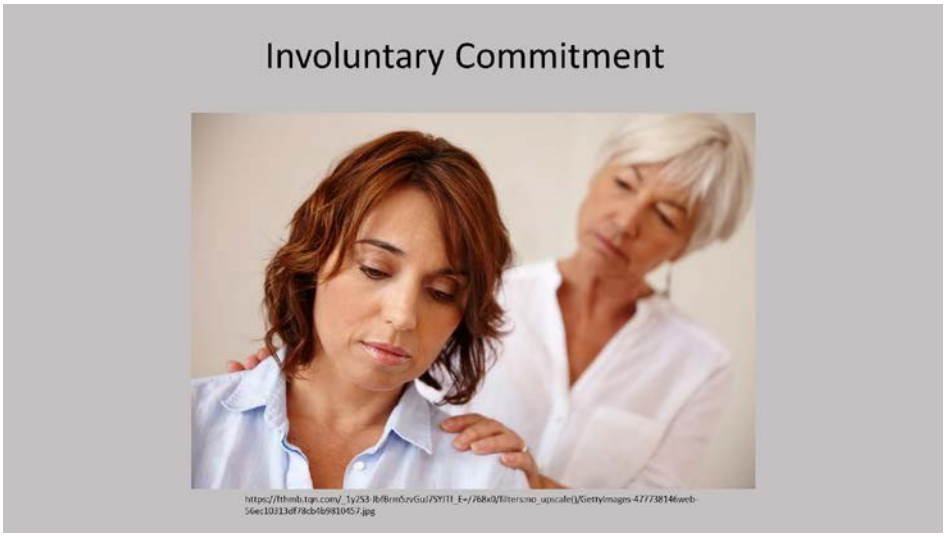
SRM = pg. 49

1.55 The student will explore legal considerations for police intervening in a mental health crisis, and learn about the provisions that pertain to law enforcement duties in the Health and Safety Code.

- Title 7 – Mental health and intellectual disability
- Subtitle C – Texas Mental Health Code
- Chapter 573 – Emergency Detention
- Subchapter A – Apprehension by a peace officer or transportation for emergency detention by a guardian

Involuntary Commitment
SRM = pg. 49

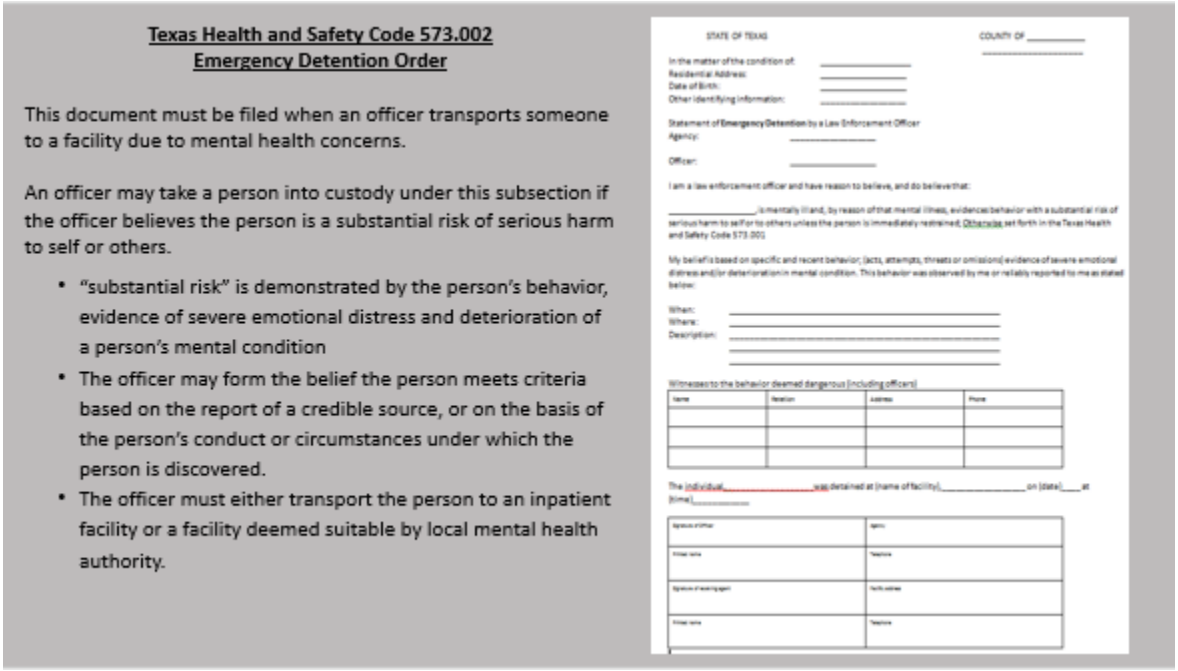
1.57 The student will read, fill out, and demonstrate proper implementation of a Police Officer



Emergency Detention.

- Warrantless Apprehension, also called a Police Officer Emergency Commitment or Detention (POEC) Please see Statute attached in Appendix for reference

Emergency Detention Orders
SRM = 49



Texas Health and Safety Code 573.002
Emergency Detention Order

This document must be filed when an officer transports someone to a facility due to mental health concerns.

An officer may take a person into custody under this subsection if the officer believes the person is a substantial risk of serious harm to self or others.

- "substantial risk" is demonstrated by the person's behavior, evidence of severe emotional distress and deterioration of a person's mental condition
- The officer may form the belief the person meets criteria based on the report of a credible source, or on the basis of the person's conduct or circumstances under which the person is discovered.
- The officer must either transport the person to an inpatient facility or a facility deemed suitable by local mental health authority.

STATE OF TEXAS COUNTY OF

In the matter of the condition of:
Residential Address:
Date of Birth:
Other identifying information:

Statement of **Emergency Detention** by a Law Enforcement Officer
Agency:
Officer:

I am a law enforcement officer and have reason to believe, and do believe that:

_____ is mentally ill and, by reason of that mental illness, evidences behavior with a substantial risk of serious harm to self or to others unless the person is immediately restrained; Otherwise set forth in the Texas Health and Safety Code 573.001

My belief is based on specific and recent behavior, (acts, attempts, threats or omissions) evidence of severe emotional distress and/or deterioration in mental condition. This behavior was observed by me or reliably reported to me as stated below:

When:
Where:
Description:

Witnesses to the behavior deemed dangerous (including officers):

Name	Relation	Address	Phone

The individual _____ was detained at (name of facility) _____ on (date) ____ at (time) _____

- Emergency Detention Order - TX Health and Safety Code Section 573.002

    - When an officer transports someone due to mental health concerns, the officer must file a notification of detention with the receiving facility.
    - This serves as a magistrate's order for emergency apprehension and detention.
    - Is considered a civil court order issued by a magistrate.
    - Provides for emergency apprehension and transportation for evaluation.
    - An officer may take a person into custody if the officer has reason to believe and does believe (the same as a criminal affidavit).
    - The person is a person with mental illness AND because of that mental illness there is substantial risk of serious harm to person or others unless person is immediately restrained ("substantial risk" is demonstrated by the person's behavior, evidence of severe emotional distress and deterioration of a person's mental condition).
    - The officer believes there is not sufficient time to obtain a warrant.
    - The officer may form the belief the person meets criteria based on the report of a credible source, or on the basis of the person's conduct or circumstances under which the person is discovered.
    - An officer who takes a person into custody under this subsection shall:
    - Immediately transport person to the nearest appropriate inpatient mental health facility, or
    - A MH facility deemed suitable by local mental health authority, if an inpatient facility is not available.

- **Have the students fill in a copy of the Emergency Detention order (from the form in the Annex, or using the one in the HSC) using details you provide or another scenario. Check them during a break to ensure understanding.**

Limitation of liability:

- People acting in good faith, reasonably and without negligence are not civilly or criminally liable. (Texas Health and Safety Code, Sec. 571.019(a))

SRM = pg. 50

Finding a Local Mental Health Authority:

Access the Department of State Health Services website:

https://www.dshs.texas.gov/mhservices-search/

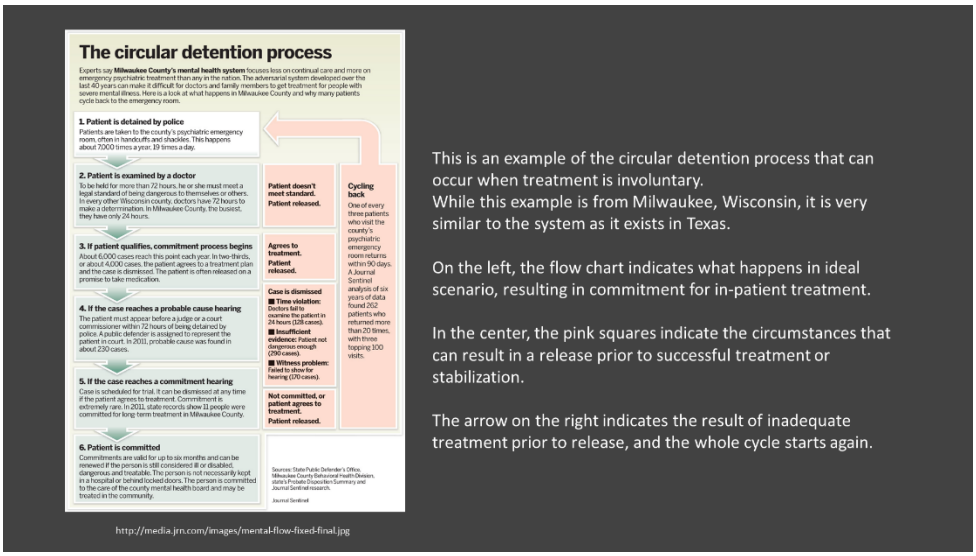
Enter the county, city, or zip code

OR:

http://www.dshs.texas.gov/mhsa-crisishotline/

These options will take you to the 24/7 mental health crisis hotlines, which you can call to access your local mental health authority.

- Explain to Students the process of locating and contacting a mental health authority in their service area.



This is an example of the circular detention process that can occur when treatment is involuntary.
While this example is from Milwaukee, Wisconsin, it is very similar to the system as it exists in Texas.

On the left, the flow chart indicates what happens in ideal scenario, resulting in commitment for in-patient treatment.

In the center, the pink squares indicate the circumstances that can result in a release prior to successful treatment or stabilization.

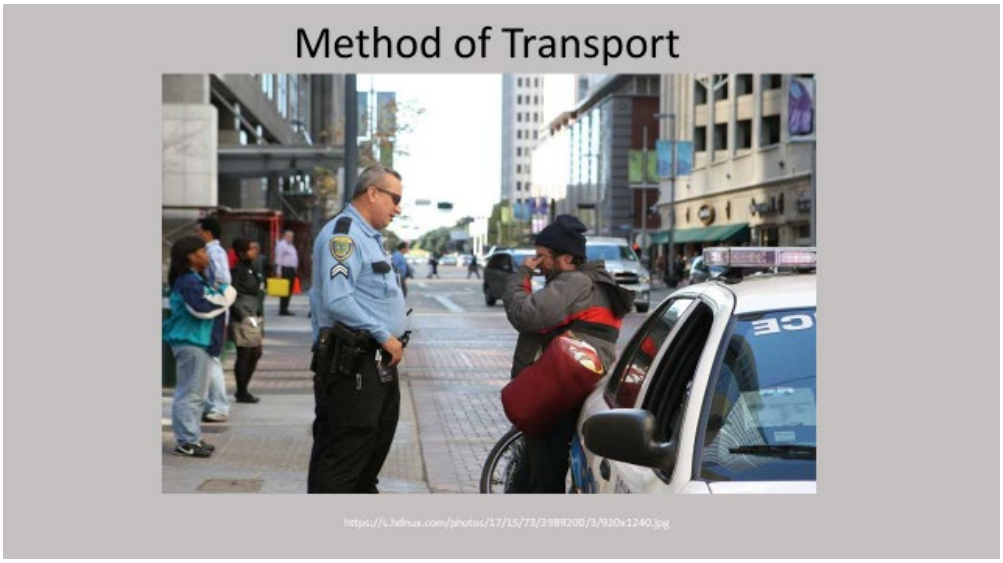
The arrow on the right indicates the result of inadequate treatment prior to release, and the whole cycle starts again.

- Review the inpatient detention process as it occurs in Texas, using this example of a very similar process.
- Discuss the differential process based upon whether or not the person receives adequate treatment prior to release.

Determining appropriate method of transport

SRM = pg. 50

1.58 The student will discuss transportation options and officer safety.



- Follow departmental policy and procedure
- Be aware of the distance to an approved medical facility for examination or admission ○ Evaluate the behavior or physical condition of person:

Violent	Ambulatory-non-ambulatory
Comatose	Sedated

Show Video: *Mental Health Impacts Law Enforcement (2.26 minutes)*
https://youtu.be/-KUhGZ3-Wxo?t=17

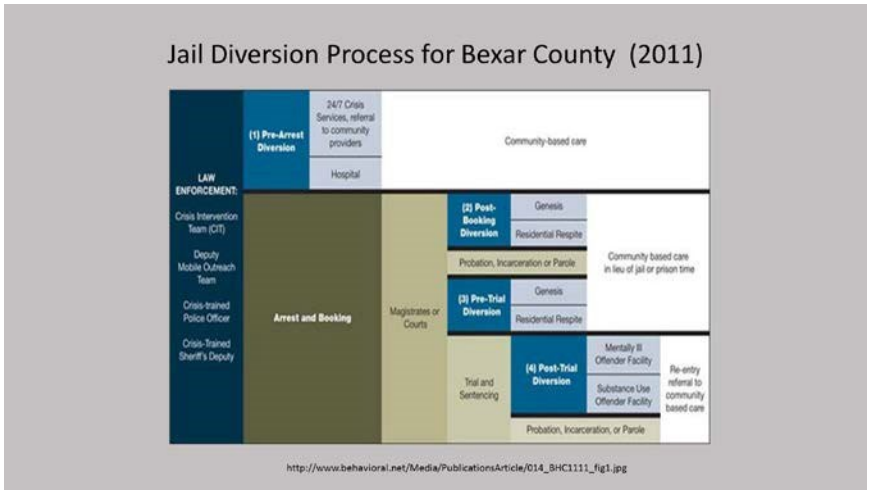
Unit 8: Jail Diversion Programs and Alternative Options

60 minutes
SRM = pgs. 51

1.59 The student will define the term 'diversion' and discuss programs and options for avoiding the incarceration of those experiencing mental illness.

Senate Bill 1849 (Whitmire, 2017) states that "the department shall require each local mental health authority to incorporate jail diversion strategies into the authority's disease management practices for managing adults with schizophrenia and bi-polar disorder to reduce the involvement of those clients with the criminal justice system."

Diversion Efforts
SRM = pg. 51



- Pre-arrest Diversion - Diverting someone from the criminal justice system (no arrest or charges made), and guiding them toward a different form of intervention:

- Mental health treatment facility
- Hospital - This may be a good option for a first-time, low level offender who would only be further hampered by having an arrest record.

- Jail Diversion Goals:
  - Decriminalization of persons with mental illness (Byron, 2014).
  - Increased public safety
  - Reduction of inappropriate incarceration of persons with mental illness
  - Reduce violence and victimization (Mental Illness Policy.Org, 2017).
  - Costs incurred by taxpayers when a person with mental illness is arrested, incarcerated, and/or hospitalized are decreased
  - Lower recidivism rates among people with mental illness (Byron, 2014).

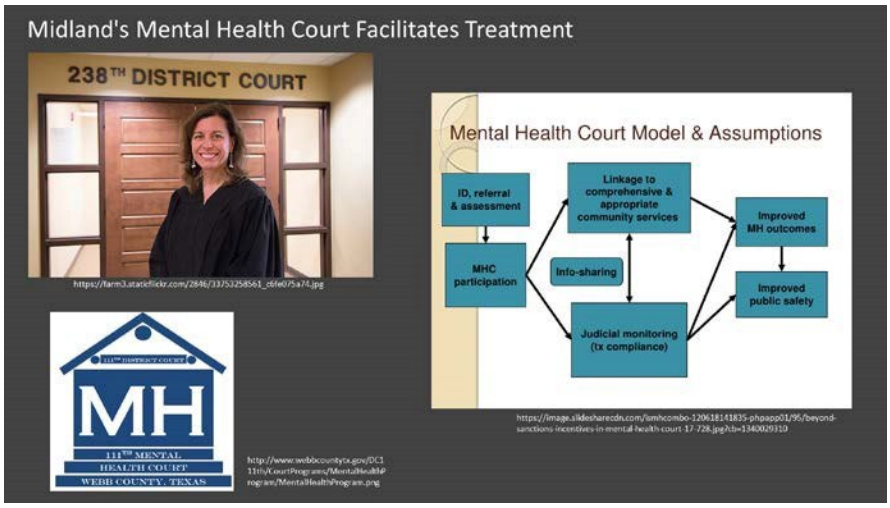
- Florida implemented a specific pre-arrest diversion program in 2013 wherein 80% of diverted offenders completed the 90-day program, only 6% of whom were re-arrested (IACP, 2015).

- Post-arrest Diversion (Pretrial Diversion Programs)
  - Voluntary for offenders, and provides an alternative criminal case processing.
  - Successful completion of the program typically results in lessening or dismissal of the charge(s).

Mental Health Courts

SRM = pg. 51

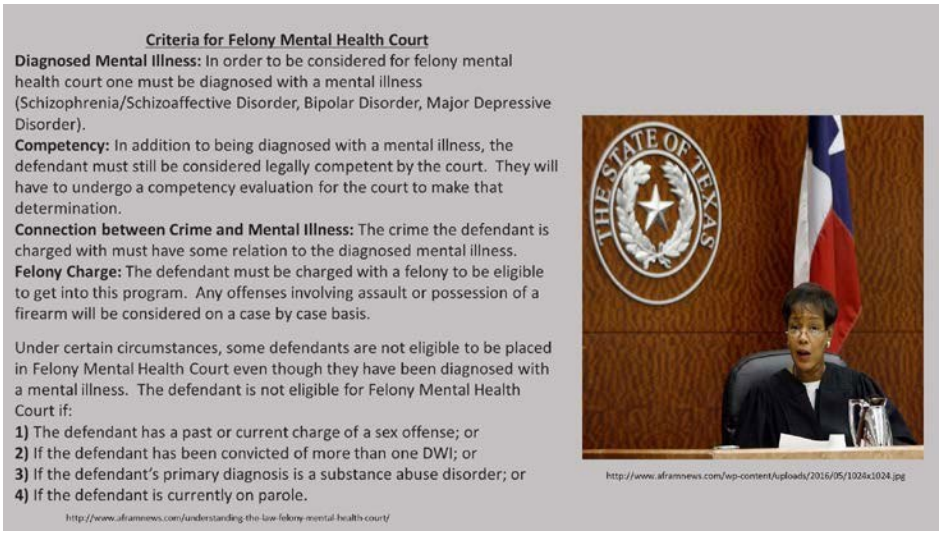
1.60 The student will discuss Mental Health Court as a form of diversion.



- "A type of court that combines judicial supervision with community mental health treatment and support services in an effort to reduce criminal recidivism; improve quality of life of people with mental illnesses and increase their participation in effective treatment; and to reduce court-and corrections-related costs." (Almquist & Dodd, 2009).

- These courts include substance-abuse courts, and Veterans courts (which take into account a Veteran's military history, PTSD, and other considerations)

- The majority of mental health court participants have a serious mental illness in addition to a co-occurring substance abuse disorder.



- All incentives and sanctions are based upon the individuals' specific charges, history, and needs.

- Referrals to mental health courts typically come from defense attorneys, judges, jail staff, or family members.

- Mental health courts have grown from 4 in 1997 to over 300 in 2017. "Offenders who are arrested and complete the mental health court program have a much lower recidivism rate than their peers: 20 percent versus 72 percent." (Andrews, 2015).

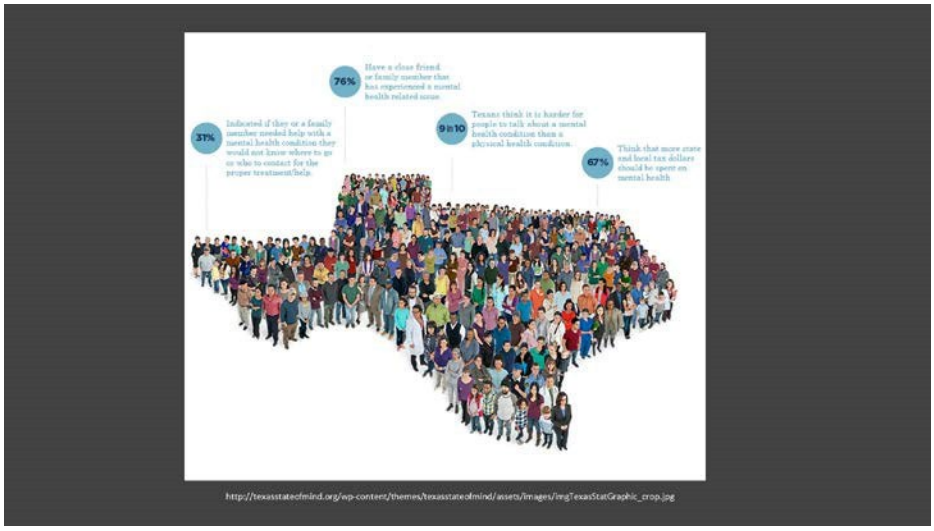
Show Video: *Mental Health Courts (2:16)*
http://www.myhighplains.com/news/potter-county-mental-health-court-off-to-good-start/327456745

Unit 9: Accessing Mental Health Resources in Your Area

60 minutes
SRM = pg. 52

1.61 The student will discuss community and referral resources and options within his/her respective geographical area.

The quality and availability of mental health treatment options vary by location, and often depend on community priorities and budgeting constraints. Even within a community, available services depend on timing, resources, and program eligibility criteria. Too often, community mental health resources are just in short supply. High costs of prescription drugs and lack of health care also sometimes make it impossible for an indigent, homeless, unstable, or disorganized person to get access to needed medications.



In addition to the previously mentioned resource challenges, there is also an impasse with the willingness of mental health providers to participate in criminal justice initiated programs. Just like society's stigmas and discriminations against mentally ill individuals, the mental health system often discriminates against people who have been arrested or incarcerated due to stereotypical concerns about criminal behavior and lack of experience working with this population.

- If speaking with a subject who is exhibiting mental health concerns, you may inquire as to whether the person is receiving mental health treatment and if they have the contact information for their provider, or if there is a friend or afamily member they would like for you to call.

- If you are able to contact the provider, keep in mind that provider is limited information they can provide to you, due to patient confidentiality. However, you can provide information to the provider and ask how the provider recommends you proceed (hospital, clinic, questions to ask).

- Hospital emergency rooms are an option. Visit your local hospital. Talk to the charge nurse, or ER doctor and see how they handle mental health emergencies. Talk to your EMS crews, see what they have done in the past, how they would like to do things, or if they have any specially trained MCOT (mobile crisis outreach teams).

- See Annex for Federal & State resources as well as text, internet, and social media modalities.