Crisis Intervention Training for Officers

Outline

Statement of Purpose:

This course will provide the officers with the minimum topics of the required POST Officer Crisis Intervention Course. The Officer will review the necessary knowledge, training tactics, and policies to effectively interact with the mentally ill. The course will consist of lecture, discussion, and role-playing in addition to policies and legal issues on the topic of the mentally ill and Crisis Intervention.

Course Objectives:

During this course the student will review the following:

I. History and Expectations of the CIT course
II. Overview of Mental Health
III. Documenting Mental Health Holds (5150W&I)
IV. Cultural Responsiveness
V. Patient's Rights
VI. Psych. Medication
VII. Prohibited Laws related to Mental Health Holds
VIII. Police Officer Wellness
IX. Developmental Disabilities
X. Suicide Assessment
XI. Excited Delirium
XII. De-escalation

Day 1 - Monday

I. Welcome to Crisis Intervention Training [CIT] [PowerPoint Slides to Guide] (45 Mins)
    a. 'Meet and Greet' over coffee and donuts
    b. Expectations Have Changed [Instructor lead group discussion]
        i. Pose the statement to the class and elicit discussion
            1. Whose expectations have changed?
                a. Community
                b. Media
        ii. Commanders
                a. Courts

2. Why have those groups of people change their expectations?
    a. High profile cases involving mental illness
    b. Law suits from calls involving mental illness
    c. Case law now dictates how LE handles calls involving mental illness

c. History of CIT [Instructor directed]
    i. Give background on what lead to CIT being created
        1. 1988, in Memphis TN
        2. Officer involved shooting with a suicidal man, armed with a knife
        3. At one point the individual advanced on officers and was shot and killed
    ii. Describe Next Steps after OIS
        1. Rather than place blame, the community came together to talk about ways to potentially prevent that kind of tragedy from happening again
        2. Formed a Task Force to address the issue to include
            a. Law enforcement
            b. Board of Education
            c. University of TN
            d. Local mental health programs
            e. National Alliance on Mental Illness
            f. Consumers
                i. Have class define “consumer”
                ii. Define: An individual who identifies as having a mental health challenge.
            g. Family members
    iii. Goal for task force and the creation of CIT
        1. To broaden the scope of understanding and present a more compassionate view of mental illness for officers on the street.
    iv. Objectives for officers attending CIT
        1. Identify the most common psychiatric disorders.
        2. Understand symptoms, behaviors and medications associated with each disorder
        3. Broaden their scope of understanding: Youth & Older Adults
        4. Familiarize themselves with local programs and facilities

5. Expand their knowledge with regards to developmental disabilities
6. Develop an understanding of Criminal Justice Mental Health
7. Demonstrate more effective intervention and de-escalation techniques

d. Questions from students [Student directed]
e. Stomp Out Stigma [Video]
f. Alameda County CIT Evaluation Video [Video]
g. Expectations [Instructor directed]
    i. Be a super listener
    ii. Be respectful
        1. All instructors are Alameda County experts from their field and volunteer to come be a part of CIT to benefit the community as a whole
    iii. Participate
        1. Having a variety of agencies in the same class lends itself to a broader array of examples and unique stories to learn from one another, so please share your experiences and participate in the discussions
    iv. Logistics
        1. POST ID Numbers – needed for credit
        2. Access Cards
        3. Oakland PD CIT ID cards – increased security
        4. Breaks
        5. Bathroom locations
        6. Cafeteria location
        7. Rosters – please get on both
        8. Lunch Suggestions – handout
        9. Resource Table – located in the back of the room
    v. Keeping you engaged
        1. To keep you engaged, use the items to keep your hands busy and off of your phones!
            a. Play doh
            b. Pipe cleaners
h. Introductions [Student directed]
    i. Share your Name, Agency and time on the department
i. BINGO - ?? Who am I?

I. Overview of Mental Health (3 Hrs.)

A. Introduction
B. Pre-Test Worksheet - Side 1; Work with a partner [SMALL GROUP ACTIVITY]
    1. Do the behaviors meet the criteria for an involuntary mental health hold?
    2. Set aside
C. Purpose of Training [LECTURE / POWER POINT]
    1. Why police officers can benefit from a class about mental illness
        a. Data shows 1 in 4 officer involved shootings involve someone experiencing a mental health crisis
        b. Mental Health Calls for service have increased as much as 400% in past 5 years
        c. With our failing mental health system so inadequate, law enforcement agencies have increasingly become de facto first responders to people experiencing mental health crisis
D. Stigma of Mental Illness
    1. What is stigma:
        a. Fighting Stigma Against Mentally Ill [Video]
        b. An attempt to label a group of people as less worthy of respect than others
        c. A mark of shame, disgrace or disapproval that results in discrimination
    2. Why Fear asking for Help?
        a. It's all in their heads
        b. It's behavioral and therefor a choice
        c. People with mental illness are dangerous
        d. You cannot lead a "normal" life
        e. Medications are habit forming
        f. Certain Diagnosis ALWAYS involve violence
        g. "If you just think positive..."
    3. Fighting Stigma
        a. Never use terms like crazy, lunatic, psycho, or retarded, and correct people who do
        b. Include Mental Illness in discussions about acceptance of diversity, just as you would discuss culture, religious beliefs, physical disabilities, and sexual orientation
        c. Education
        d. Attitude about suicide will begin to change as people begin to recognize that suicidal behavior is a symptom of a mental illness, not a sign of weakness of character
    4. Define Mental Illness
        a. Mental illnesses refer to disorders generally characterized by dysregulation of mood, thought, and/or behavior, as

recognized by the Diagnostic and Statistical Manual, 4th edition, of the American Psychiatric Association (DSM-IV).
   b. Per the CDC
5. Mental Health Stats
   a. 1 in 4 adults- approximately 61.5 million Americans- experience mental illness in a given year.
   b. Approximately 20% of youth ages 13 to 18 experience severe mental disorders in a given year.
   c. Approximately 1.1% of American adults— about 2.4 million people—live with schizophrenia.
   d. Approximately 6.7 percent of American adults−about 14.8 million people−live with major depression.
   e. Approximately 18.1% of American adults- about 42 million people- live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), generalized anxiety disorder and phobias.
   f. About 9.2 million adults have co-occurring mental health and addictions disorders
   g. One half of all the life time cases of mental illness begins by age 14 and three quarters by 24
   h. 70% of youth in juvenile justice systems have at least one mental health condition and at least 20% live with a severe mental illness

E. Depression
1. Signs & Symptoms Worksheet Part 1 [LEARNING ACTIVITY]
   a. Instruct students to work with a partner to list 2-3 signs or symptoms related to depression for each category; Psychological, Behavioral, Physical
   b. Call on 6 groups to share their responses with the class
2. [VIDEO]
   a. Drew Carey
   b. Robin Williams
3. Psychological Signs & Symptoms [LECTURE / POWER POINT]
   a. Sad mood
   b. Numb
   c. Worthlessness
   d. Guilt and shame
   e. Anxiety
   f. Hopelessness
   g. Helplessness
   h. Suicidal thoughts
4. Behavioral Signs & Symptoms
   a. Agitation
   b. Irritability

c. Crying
d. Psychomotor retardation
e. Social Isolation
f. Refusal to get out of bed
g. Decrease/ increase in appetite
h. Self-Injury
    a. Cutting
    b. Burning

5. Physical Signs & Symptoms
    a. Lack of Energy
    b. Sleep Pattern Change
    c. Appetite Change
    d. Somatic Complaints
    e. Decreased sex drive/ Energy

F. Bipolar
1. Signs & Symptoms Worksheet Part 2 [LEARNING ACTIVITY]
    a. Instruct students to work with a partner to list 2-3 signs or symptoms related to bipolar for each category; Psychological, Behavioral, Physical
    b. Call on 6 groups to share their responses with the class
2. Define
    a. Mood swings that can range from very low (depression) to very high (mania)
3. Statistics
    a. Most commonly starts in teenager and young adults
    b. However, can affect all ages
    c. About 25-50 % will make at least 1 suicide attempt
    d. Nearly 1 in 5 will succeed
    e. Bipolar individuals who abuse drugs/ alcohol have increased risk of suicide
4. Mania
    a. A distinct period of abnormally, persistently elevated, expansive, or irritable mood
    b. Feels “good”, like a “high” OR may make one irritable and angry
    c. In this state people can do very risky things
    d. May include: inflated self-esteem or grandiosity; decreased need for sleep; pressure to keep talking; racing thoughts; distractibility; increased activity or agitation; more self-confidence; and/ or psychosis
5. Manic - Signs & Symptoms
    a. Racing thoughts [psychological]
    b. Rapid speech [physical]
    c. Distractibility [behavioral]

d. Require less sleep [behavioral]
e. Poor Judgment/ Lack of Insight [behavioral]
f. Fidgety [physical]
g. Impulsive Spending [behavioral]
h. Impulsive sexual behaviors [behavioral]
i. Delusions [psychological]
j. Hallucinations [psychological]

6. Manic - Self Image
   a. Inflated Self -Esteem
   b. Grandiose
   c. Excitable
   d. Unrealistic beliefs in one's abilities
   e. Lavish spending
   f. Sexual indiscretions
   g. Abuse of alcohol or drugs
   h. Ill-advised business decisions
7. Graphic Slide – Visual example of mood swing

G. Schizophrenia
1. Signs & Symptoms Worksheet Part 3 [LEARNING ACTIVITY]
   a. Instruct students to work with a partner to list 2-3 signs or symptoms related to schizophrenia for each category; Psychological, Behavioral, Physical
   b. Call on 6 groups to share their responses with the class
2. General Background Info
   a. Onset Can occur at any age, however generally symptoms appear between 18 and 24
   b. Children Rare
      a. "Jani - Born Schizophrenic" [VIDEO]
   c. Inherited
   d. Lionel Aldridge
      a. 2-time Superbowl Champ
   e. John Nash
      a. Nobel Peace Prize / Mathematician
      b. A beautiful Mind
   f. Brian Wilson
      a. The Beach Boys
3. Signs & Symptoms
   a. Delusions [psychological]
   b. Hallucinations [psychological]
   c. Paranoia [psychological]
   d. Nonsensical conversation [psychological]
   e. Violent or aggressive behavior [behavioral]
   f. Flat/-blunted emotions / social withdrawal [behavioral]
   g. Lack energy or motivation [behavioral]

h. Lack interest in activities that one use to enjoy [behavioral]

4. 5 symptoms that can develop and make an individual with schizophrenia more difficult to interact with
   a. Paranoia
   b. Denial of illness
   c. Stigma
   d. Demoralization
   e. Terror of being psychotic
5. 6 Steps to handling paranoia
   a. Place yourself beside the individual rather than face to face
   b. Avoid direct eye contact
   c. Speak indirectly / avoid “I” “You”
   d. Identify rather than fight, the individual
   e. Don’t rationalize / share mistrust
   f. Postpone psycho-education
6. Psycho-social Treatment:
   a. Education
   b. Medication and symptom monitoring
   c. Case management
   d. Housing
   e. Drug / Alcohol, Day Treatment
7. Risk of Suicide
   a. About 40% will make at least one attempt
   b. Between 10%- 15% will succeed

H. Anxiety
1. Signs & Symptoms Worksheet Part 4 [LEARNING ACTIVITY]
   a. Instruct students to work with a partner to list 2-3 signs or symptoms related to anxiety for each category; Psychological, Behavioral, Physical
   b. Call on 6 groups to share their responses with the class
2. Common Types of anxiety
   a. Generalized Anxiety
   b. Obsessive Compulsive (OCD)
      a. Howie Mandel [VIDEO]
   c. Agoraphobia
      a. Would not leave her home for weeks at a time
   d. Social Phobia, Social Panic, and Agoraphobia
3. Panic Attack/ Disorder
   a. Leah Has a Panic Attack [VIDEO]
   b. Matchstick Men [VIDEO]
   c. MM- Clip [VIDEO]
4. Substance Induced Anxiety
   a. Severe anxiety or panic which is caused by alcohol, drugs, or medications

   b. Caffeine, over the counter meds, and prescribed meds
   c. Alcohol and illegal drugs such as cocaine and LSD
   d. Can start while under the influence, during withdrawal, or up to a month after use.
5. Physical Symptoms
   a. Tightness or pain in chest
   b. Heart palpitations
   c. Dry mouth
   d. Feeling faint
   e. Tension
   f. Nausea
   g. Stomach pain
   h. Vomiting
   i. Headaches
6. Behavioral Symptoms
   a. Avoidant
   b. Hyper-vigilant
   c. Startle Response
   d. Inappropriate response to stressor
   e. Freezing
7. Emotional
   a. Dissociation

I. Trauma
1. Signs & Symptoms Worksheet Part 5 [LEARNING ACTIVITY]
   a. Instruct students to work with a partner to list 2-3 signs or symptoms related to trauma for each category; Psychological, Behavioral, Physical
   b. Call on 6 groups to share their responses with the class
2. Define
   a. A deeply distressing or disturbing experience
   b. Trauma is defined by the person experiencing the event
3. Posttraumatic Stress
   a. American Sniper [VIDEO]
   b. AM- PTSD [VIDEO]
4. Acute Stress
   a. Lasts for 2 days to 4 weeks
5. Based on Life Experience / Exposure Can look like something else
   a. Often Misdiagnosed / Mislabeled
   b. SNL's Darrell Hammond's Painful past [VIDEO]
6. Presentation
   a. Adults
   b. Children/ Teens
   c. Dissociative Identity Disorder

d. What is “Normal”

7. Signs & Symptoms
    a. Appear shaken/Disoriented
    b. Withdrawn or not present
    c. Anxiety
    d. “Night Terrors”
    e. Irritably
    f. Poor Concentration
    g. Mood Swings
    h. Can Manifest as anger/sadness/emotional outburst
    i. Physically can appear pale/racing heartbeat

J. Personality Disorders
    1. Narcissistic
        a. Characterized by excessive sense of self, extreme preoccupation of themselves, and lack of empathy for others; Believe to be superior to others
            a. Hitler
            b. Stalin
            c. Kanye West
            d. Donald Trump
    2. Dependent
        a. Excessive need to be taken care of; has other assume the responsibility for the major areas of their life.
        b. Cannot show disagreement with others for fear of being rejected. Difficulty in doing things on their own.
    3. Antisocial
        a. Characterized by lack of conscience; persistent lying; difficulties with right and wrong
            a. Jeffrey Dahmer
               Charles Manson
    4. Borderline
        a. Characterized by difficulty regulating emotions and thoughts, impulsive and reckless behavior, and unstable relationships with others.
            a. Amy Winehouse
            b. Britney Spears
            c. Lindsey Lohan

K. Post -Test Worksheet - Side 2; Work with a partner [SMALL GROUP ACTIVITY]
    1. Do the behaviors meet the criteria for an involuntary psychiatric hold?
    2. Did your answers change based on information presented??

L. Contact Information

M. Wrap-Up

1. Questions

Day 1 - Monday

II. Writing Effective 5150's [PowerPoint Slides to Guide] (60 Mins.)

III. Making it Legal (Rather than Clinical)
   a. Signature
   b. Date
   c. Advisement

IV. Explicit Probable Cause
   a. A clear articulation of the circumstances under which the persons condition was brought to the attention of law enforcement
   b. What do the courts expect?

V. Known Facts…
   a. What leads a person of ordinary care and prudence to believe or to entertain a strong suspicion that the person detained is:
      i. Danger to Self
      ii. Danger to Others
      iii. Gravely Disabled
   b. Document specific behaviors and verbalizations which, if taken together with rational inferences, reasonably warrant the officers belief or suspicion

VI. Examples
   a. Disorganized Thought Patterns
      i. Inability to make logical thought connections or concentrate – Be specific
   b. Rapid flow of unrelated thoughts
      ii. Quote the person on the form
   c. Delusions
      iii. Bob believes the government is monitoring his movements
   d. Hallucinations
      iv. Bob is scratching and picking at his legs and states that "bugs are coming out of his skin"

v. Bob is interacting (talking back) with the voices he says are talking to him.

e. Disorientation
   vi. Bob is experiencing abnormal memory loss related to date, time and location
f. Physically slow
g. Agitated (Describe in detail)
h. Loss of connection to reality or experiencing psychosis

VII. Other Important Information to Include?
   a. Has drugs or alcohol on board
   b. Has difficulty understating or following conversations or directions
   c. Why is this important?

VIII. Witness Information
   a. Why is this crucial for law enforcement officers?

IX. Behaviors
   a. Did you observe the behaviors?
   b. Are you reporting behaviors that have been told to you?

X. Can you place someone on a 5150 hold for refusing medical treatment?
   i. Pose the statement to the class and elicit discussion

XI. Self-Committal vs. Placing the Hold

XII. Your Calls for Service

XIII. Questions?

I. Introduction
II. Cultural Responsiveness – (1 Hrs.)
    a. Faces of the World
        i. Video Clip [INSTRUCTOR LEAD]
            1. At the conclusion of the clip [which shows the older Caucasian female turning off the loud music as opposed to the African American male in his 20's who drove up in the car turning it down] ask the class, by show of hands… who knew the "boom box" was on the porch rather than in the car.
            2. Make the point that initial assumptions can skew our interpretation of the call for service
        ii. Introduction of Instructors [INSTRUCTOR LEAD]
            1. Purpose and Role of the Cultural Competency Coordinator / Ethnic Services Manager at Behavioral Health Care Services.
            2. Position within county mental health which ensures equal access to culturally appropriate programs and services
        iii. What does Cultural Responsiveness even mean? [LEARNING ACTIVITY]
            1. In groups of 2; use provided 3X5 cards
                a. First, write a basic concept of what you think cultural responsiveness means.
                b. Second, on the back, write how you think it relates to a class on mental illness.
    b. Definition of Cultural Responsiveness [INSTRUCTOR LEAD]
        i. Cultural responsiveness is the ability to learn from and relate respectfully with people of your own culture as well as those from other cultures.
        ii. How to do that on a call for service.
            1. Acknowledge cultural differences; don't assume you know all about the particular culture.
            2. Allow the youth and family to educate you about how a crisis is handled in their culture and family.
            3. Don't stereotype youth of color; Look at each situation and person independently.
               Be familiar with the predominant local populations in your service area.

4. Be alert to acculturation issues between the values and norms of foreign born parents and their children who grew up here.
5. Know how to access specific cultural and language resources.

c. Which cultures / Ethnic Groups are represented in the communities you serve?
d. Define: Culture vs Ethnic Group [INSTRUCTOR LEAD]
    i. **Culture** is the way of life that consists of the general customs and beliefs of a particular group of people. It generally means the non-biological or social aspects of human life which is basically anything that humans learn in a society. A bit similar to ethnicity, but is often used to refer specifically to the symbolic markers used by ethnic groups to distinguish themselves visibly from each other.
    ii. **Ethnicity** or **Ethnic Group** refers to a category of people who regard themselves to be different from other groups based on common ancestral, cultural, national, and social experience. That being said, ethnicity is primarily an inherited status. One must share a common cultural heritage, ancestry, history, homeland, language/dialect, mythology, ritual, cuisine, art, religion, and physical appearance to be considered as a member of an ethnic group.
e. Take a deeper look into few common cultural groups [LEARNING ACTIVITY]
    i. Distribute the provided folders, which contain information from NAMI, to 7 small groups
        1. African American
        2. LGBT
        3. Latino
        4. Veteran
        5. Muslim
        6. Asian American and Pacific Islander
        7. American Indian and Alaska Native
    ii. Instruct each group to review the information in the folders and decide on facts that would play a role in an officer's response to a location, involving the cultural or ethnic group, to address a mental health crisis.
    iii. Considerations [Put last slide of power point up for reference]

1. What are the stigmas associated with mental illness for this group?
2. What should I look and listen for?
3. How might the group define or describe references to mental health behaviors?

iv. The group will record the points on the provided chart paper
v. The group will teach the class about their assigned group and make the information relevant to their next call for service.
vi. Feedback; the instructors will fill in or clarify any of the information presented by the groups

f. Wrap Up [INSTRUCTOR LEAD]
i. Questions

I. Introduction: Patient's Rights & LPS Investigations (2 Hrs.)
a. Mental Health Association
Francesca Tenenbaum
Director of Patient's Rights Advocates

II. Lanterman Petris-Short Act
a. Enacted in 1969
b. Intention was to end the inappropriate, indefinite, involuntary commitment of mentally disordered persons

III. Further Intentions of LPS
a. To protect both Public Safety and Individual's rights

IV. Laws based on concepts of:
a. Consumers have input into treatment plans
b. Treatment in the manner least restrictive of personal freedom

V. Criteria for Detainment
a. Clarification on what you already know:
b. Danger to self
c. Danger to others
d. Gravely disabled

VI. Application for psychiatric evaluation
a. It is a legal document
b. Not a clinical document
c. It is based on probable cause – evidence of behavior

VII. When should you 5150?
a. Probable caused determined
b. Evidence of behavior

c. Result of mental illness
d. Person meets criteria
e. To detain for psychiatric evaluation

VIII. Standard for 5150 Criteria
a. “Dangerousness”
b. Due to a mental disorder

IX. Danger to Self
a. Active
b. Intentional
c. Suicidal
- Threat
- Gesture
- Attempt

X. Danger to Others
a. Active
b. Harm to Others
- Threats
- Violence
- Destroying things
- Setting fires

XI. Legal Definition of Grave Disability
a. Due to mental disorder
b. Unable to provide for food, clothing, shelter

XII. Gravely Disabled
a. Passive
b. Unintentional harm to self
c. Symptoms of the mental illness cause the person to neglect basic survival needs
d. Behavior or mental illness
e. Causes neglect to point of endangering health
f. Extreme lack of sleep
g. Poor hygiene = health hazard
h. Symptoms cause neglect of nutrition
- Signs of malnutrition/unhealthy weight loss
- Nothing edible in house
- Dieting for weight loss ≠ Grave disability
- Expressing paranoia about food
i. Homelessness may or may not constitute evidence of grave disability

XIII. Grave Disability is NOT
   a. Homeless lifestyle
      - Can describe self-care plan
      - Finds safe places to sleep
      - Uses community services to get food, shelter, medical care, hygiene
      - Can locate safe food in garbage cans
   b. Bizarre behavior
   c. Dieting for health reasons
   d. Choosing not to take medications
   e. Refusing recommended medical treatment
      - Poor food choices with diabetes, heart disease
      - Declining treatment for terminal illness

XIV. Reminder:
   a. A psychologist or psychiatrist may evaluate the “Application” and detain the individual for treatment or release them
   b. The paperwork law enforcement submits is not an admission ticket, it only gets the person seen by the doctor

XV. Break-Out Groups: Scenarios

Groups will be given scenarios and asked to work out questions to ask and what additional information they might seek from the consumer and family members or witnesses.

Scenario #1

   a. A family member has called to report that his brother was threatening his mother with a knife. You ask the client about his mental health history and the client tells you that he has been compliant with his medications and his brother misunderstood the interaction with his mother

XVI. Evidence Needed to Determine Probable Cause
   a. Brothers details of incident:
      - History of disputes?
   b. Information from mother:
      - Her perception of facts?
      - Is there mental illness?
      - Mother feels threatened?
   c. Mothers perception:
      - Intent to use knife for harm?
      - Consumer’s affect?
      - Friendly? Angry? Paranoid?

- Sibling relationship?

XVII. Questions for Consumer:
   a. His perception
   b. His current affect
   c. Friendly, angry, etc.
   d. Symptoms of mental illness escalated?
   e. Had knife? For what?
   f. Intended harm with knife?
   g. Currently intending harm?
   h. Feels he needs mental health help now?

XVIII. Scenario #2
   a. There is a call from a hospital not designated to place patients on psych holds. A patient on the medical ward decides to pull out his IV and ask to be discharged against medical advice. They would like an officer to come place the patient on a 5150.

XIX. Evidence Needed to Determine Probable Cause
   a. Why in medical hospital?
   b. History of diagnosis of MI?
   c. What was the treatment?
   d. Why is she refusing treatment?
   e. Intent to harm self?
   f. Any threats? Other than litigation?
   g. What are the consequences of leaving AMA?
   h. Does she know the consequences of leaving AMA?
   i. Plan once she leaves the hospital?

XX. Scenario #3
   a. In the course of interviewing a client, the person tells you he hasn't gone home for a week and has been riding public transportation during the day and walking the streets at night. He says he can't go home because the neighbors are projecting mind-controlling microwaves at his house

XXI. Is there Probable Cause?
   a. These facts support grave disability on their face
   b. Because of the symptoms of mental illness, the consumer is not utilizing available shelter and not finding safe alternative shelter

XXII. Further Information to Gather and Document
   a. Is he making sense?
   b. Can he answer questions?
   c. Why does he believe neighbors are hurting him?

d. Has he been injured by his activities?
e. Victimized on the street?
f. Where is he eating and what?
g. Does he have income?
h. Does he get MH treatment?

XXIII. Scenario #4
a. During your assessment of a client, the person is coherent enough to relay to you that he got upset during a disagreement with a family member. That family member reports that a client is refusing to take his medication, and has been violent in the past when off medication

XXIV. Evidence to Determine Probable Cause
a. Does consumer make statements of intent to harm others?
b. Does consumer admit stopping meds?
c. Why did he stop meds?
d. Intending to start meds again?
e. Does consumer agree that he has gotten violent?
f. Showing evidence of violence currently?

XXV. Historical Info
a. What does reporting person mean by “violent”?
b. Threats to harm?
c. Damage to property?
d. Physical assault on someone?
e. Injury to a person?
f. Is there an AB1424 form to review for historical info?
g. When was the last time the person was violent? Recent?
h. How often has the person stopped meds and been violent?
i. Has he been violent every time he has stopped meds?
j. How long after stopping meds does he exhibit violent behavior?
k. Is the historical information recent, relevant and support probable cause?

XXVI. Scenario #5
a. You conduct a welfare check on a man living alone. His mother called to report that he has been hearing voices and she wants him 5150’d. She said she is afraid he will kill himself. He answers the door in a tutu, smiling and reciting poetry loudly. He has cotton in his ears and has loud music turned up high.

XXVII. Evidence to Determine Probable Cause
a. Explain family concern
b. Inquire as to his well being

c. Appears well nourished?
d. Uninjured?
e. Bizarre behavior or MI?
f. History of mental illness?
g. Past hospitalization?
h. Is he alone? Other people?
i. Is anyone hurting him?
j. Does his speech make sense?
k. Oriented to name, place, approximate date?
l. Does he want help?
m. Anyone telling him to harm self/others?
n. If not “Holdable” will he reassure family?

XXVIII. Scenario #6
a. You are on a call to assess a situation for a 5150. Citizens called to say one of the people living in the house with them is off medications and they are afraid of her. While interviewing a client, you ask the person if she is currently under the care of a mental health professional. She tells you that she is seeing a psychiatrist, but she may not be able to show up at her next appointment because she is a secret agent for the CIA and expects she will be called away to her next mission before the appointment

XXIX. Evidence to Determine Probable Cause
a. Why afraid?
b. Threats? Violence?
c. Sleeping? Eating?
d. Destruction of living environment?
e. Making statements involving harm?

XXX. Potential Observations and Questions for Consumer
a. Clean or disheveled?
b. Calm or agitated?
c. Angry at roommates?
d. Does she know what they are afraid?
e. What is the mission?
f. Is the mission to hurt someone?
g. Does the mission involve weapons?
h. Is the mission a secret?
i. Has she ever had a mission to hurt someone?
j. Have past missions involved weapons?

XXXI. Scenario #7

a. Man staring at a tree. The person thinks he is lost. Reported missing person at risk. Known to have schizophrenia and takes medication twice a day. The family states in their report that before they lost track of him, he had been inconsistent in taking his medications. When you talk to the man, he says he hasn't been taking medication but doesn't know how long. When you ask if he has thoughts about killing himself, he answers that he will overdose on pills.

XXXII. Evidence to Determine Probable Cause
- a. Can he answer questions?
- b. Is he calm, agitated or afraid?
- c. What does his statement about pills mean?
- d. Does he intend to overdose?
- e. Is he afraid of taking pills/ fearing overdose?
- f. Ask him if he is hurt or ill
- g. Does he seem to be free of physical injury?
- h. Is he oriented to name, place, and approximate date?
- i. Does he know where his home is?
- j. Has he been staying somewhere safe?
- k. Has he been staying with anyone else?
- l. Has he been victimized by another person?
- m. Has he been getting food?
- n. Does he have a way to get money?
- o. Does he have a consistent source of income?

XXXIII. 5150 Analysis
- a. Flow chart discussion
- b. Consumer in the community
- c. Acute Hospitalization
- d. Sub-Acute or long-term care

XXXIV. Mental Health Association

Family caregiver advocacy specialist and contact info.

Can be located in the lobby of JGP

XXXV. Review your Department policy and procedures for dealing with mental health incidents involving weapons

XXXVI. Getting Rights Restored
- a. A person may ask the Superior Court in the county in which he/she lives for a hearing to restore their rights

b. When discharged from the hospital, and on request from the patient, facility completes the request form for a hearing for relief which is sent to the Superior Court in the Patient's county of residence.
c. If the patient requests a hearing after discharge, the patient should contact Department of Justice at (916) 263-0767

XXXVII. QUESTIONS??

Welcome Back Day 2 – Recap/Housekeeping (45 Mins)

I. Psych Meds & Weapons (1.5Hrs.)
   a. Medications can play a role in treating several mental disorders and conditions. Treatment may also include psychotherapy (also called "talk therapy") and brain stimulation therapies (less common). In some cases, psychotherapy alone may be the best treatment option. Choosing the right treatment plan should be based on a person's individual needs and medical situation and under a mental health professional's care.
   b. Why don't people just take their Meds?
      i. Lack of Insight
      ii. Lengthy Process to get it Right.
      iii. Maybe they are?
      iv. Side Effects
      v. Stigma
      vi. Access
         1. Financial
         2. Transportation
   c. Psych Meds App
   d. Medications to treat depression
      i. Common medications
         1. Prozac
         2. Lexapro
         3. Celexa
         4. Paxil
         5. Zoloft
      ii. Side effects
         1. 40% will experience some type
         2. 25% will include weight gain or decreased sex drive
   e. Medications to treat bipolar disorder
      i. Common medications

1. Depakote
2. Topamax
3. Lithium
4. Tegretol

ii. Common side effects

1. Agitation
2. Decreased sexual drive
3. Insomnia
4. Suicidal thoughts
5. Weight gain

f. Medications to treat schizophrenia

i. Common medications

1. Abilify
2. Risperidone [Risperdal]
3. Haldol
4. Olanzapine [Zyprexa]
5. Clozapine [Clozaril]
6. Quetiapine [Seroquel]

ii. Side Effects

1. Drowsiness

g. Antipsychotic Medications

i. Both types of anti-psychotic meds can relieve symptoms of psychosis, they have 4 limitations:

1. They do not actually cure schizophrenia
2. Psychotic Symptoms often return if the person stops taking the medication
3. The medication can produce a number of very unpleasant side effects that can cause people to stop taking them
4. Although they can block dopamine activity almost instantly (within minutes) the psychotic symptoms usually do not subside until 4-6 weeks and it can take several months before the full benefits are felt.

h. Questions

II. Firearms and Other Deadly Weapons

a. 8102 WIC

i. Provides that whenever a person who has been detained or apprehended for examination of his or her mental condition or who is a person described in WIC 8100 or 8103, is found to own, have

in his or her possession or under his or her control, any firearm whatsoever , or any other deadly weapon, the firearm or other deadly weapon SHALL be confiscated by any LE agency or peace officer who shall retain custody of the firearm or other deadly weapon.

b. 8100 WIC:
    i. A person shall not have in his or her possession…purchase or receive, any forearms whatsoever or other deadly weapon… if he or she has been admitted to a facility and is receiving in-patient care…
c. 8103 WIC:
    i. No person who after October 1, 1955, has been adjudicated by a court of any state to be a danger to others as a result of a mental disorder or mental illness, or who has been adjudicated to be a mentally disordered sex offender, shall purchase or receive, or attempt to purchase or receive, or have in his or her possession, custody, or control any firearm or any other deadly weapon unless there has been issued to the person a certificate by the court of adjudication upon release from treatment or at a later date stating that the person may possess a firearm or any other deadly weapon without endangering others, and the person has not, subsequent to the issuance of the certificate, again been adjudicated by a court to be a danger to others as a result of a mental disorder or mental illness.
d. What to confiscate for safekeeping
    i. Any firearm(s) and/or other deadly weapon used as a weapon at any time during the course of the incident shall be confiscated for safekeeping at the time of the involuntary psychiatric detention.
e. Safekeeping Considerations
    i. File Check – Gun
    ii. Consent Search…
        1. Make sure the person is able to give informed consent
    iii. Weapon does not have to be used during the incident
f. Evaluate the reasonableness when removing “Other Deadly Weapons”
    i. Example #1 – Kitchen Knives
        1. If they are being used as a weapon connected to the dangerous behavior, confiscate them.

2. If they are not connected to the dangerous behavior and you cannot articulate the necessity to “clean out the kitchen drawers” do not confiscate them.

ii. Example #2 –

1. If the individual is impulsive, unpredictable and has demonstrated dangerous behavior (inside a home) with a machete hanging on the wall, or a baseball bat in plain sight… it is reasonable to confiscate those items for safekeeping…

g. Prohibited Person

i. To determine if an individual is a Prohibited Person and shall not have in his or her possession the ability to purchase or receive, any firearms whatsoever or other deadly weapon.

h. Mental Health Firearms Prohibition System

i. Can only be done during the course of a criminal investigation involving a firearm

ii. If a prohibited person is in possession of a firearm and/or other deadly weapon… the person is subject to arrest per 8100 WIC (M) and the item shall be confiscated as evidence.

i. Search Warrant

i. 1524. (a) A search warrant may be issued upon any of the following grounds

1. (10) When the property or things to be seized include a firearm or any other deadly weapon that is owned by, or in the possession of, or in the custody or control of, a person described in subdivision (a) of Section 8102 of the Welfare and Institutions Code.

ii. To recover firearms or other deadly weapons for Safekeeping

1. When the detention is made in an alternate location and the weapon is known to be located at a private dwelling.
2. If you leave and have to re-enter a private dwelling where firearms or other deadly weapons are located.
3. Officers obtain credible information regarding firearm(s) and/or other deadly weapon(s) which are not in plain sight inside a private dwelling or the individual refuses to give consent to search the private dwelling.

j. On-Scene Responsibilities

i. Prior to making contact

1. Gather information from 3rd party
2. Firearms check [if applicable]
3. Call the person out" [Use Time and Distance if applicable]

ii. Evaluate individual
1. Gather and Document Historical Data (AB1194)
2. Consider Reliable and Credible witness information (5150.05WIC)
3. Document if applicable and list witness(s)
4. Run a File Check – Person
5. Run a File Check – Gun
6. Request a MHFPS check on Service [Mental Health Firearms Prohibition System] when investigating a criminal matter
7. Does the person come back as a Prohibited Person from the DOJ?
8. If yes, and in possession of firearm(s) and/or other deadly weapon(s) the person is subject to arrest

iii. Complete the Application for an Involuntary Psychiatric Detention

iv. 5150 Advisement
1. Officers shall take custody of any firearms and/or other deadly weapons [per 8102 WIC] and check box on 5150 form

v. In plain sight?
1. If Not… warrant needed
2. Officers already left the dwelling?
a. Get a Search Warrant
3. Different Location?
a. Get a Search Warrant
4. Uncooperative third party
a. Get a Search Warrant
5. When in doubt…
a. Get a Search Warrant

vi. Provide the individual being detained with a completed Receipt and Notice of Rights for confiscated firearm(s) / other deadly weapons

vii. Complete a FBR Report (not an FC)
1. Marking Weapons Unit for notification

viii. Complete Property Section Forms

k. Weapons Unit

i. Law Enforcement Gun Release Program
    1. Effective Jan 1, 2005
    2. PC 12021.3
    3. Requires a person who claims title to any firearm that is in the custody or control of a court or law enforcement agency and who wishes to have the firearm returned…
ii. Submit a LEGR Application form for a determination by the DOJ as to whether he or she is eligible to possess a firearm.

l. Returning Seized Firearms
    i. LE Agency cannot return a firearm to an individual unless a DOJ gun release letter with gold seal is presented to the LE Agency.
    ii. LE Agency must verify via AFS that the firearm is not stolen.
    iii. Handguns are recorded by DOJ in AFS in the individual's name who seeks the return.

m. Mental Health Firearms Prohibition
    i. 5 Year prohibition
        1. 5150 WIC - Taken into custody
        2. 5151 WIC – Assessed and evaluated AND
        3. 5152 WIC – Admitted to the mental health facility
    ii. Lifetime prohibition
        1. 5250 WIC - 14 day certifications
        2. 5350 WIC - 30 day certifications
        3. Conservatorship by court order

n. Returning "Other Deadly Weapons"
    i. Pursuant to 8100 W&I, A person shall not have in his or her possession, purchase or receive any firearm whatsoever or other deadly weapon if he or she has been admitted to a facility…
    ii. Because there is no application process to apply to get their weapon back, like there is for firearms…
        1. The weapons unit will run a CLETS MHFPS query to determine if the individual is deemed a "prohibited" person by the DOJ
            a. If the person is "prohibited" , the individual is not eligible to have the weapon(s) returned.
            b. If not, the confiscated items can be returned pending no legal action

2. Weapons unit has 30 days to initiate a petition to Superior Court for a hearing to determine if returning the firearm/weapon would likely endanger person/others
3. Time extension is possible, but must be filed within 60 days after subject's release
4. If the person is prohibited from firearms(s), do not return the firearm despite any court order to do so.
5. Prohibited person may sell/transfer forearms(s) to a 12071PC licensed forearms dealer.
6. Forward prohibited person/firearm information to the prosecuting agency.
7. Weapons unit must notify subject of the necessity to contact court clerk to schedule a hearing.

o. Disposition of the seized firearm
    i. Pursuant to PC 12028
        1. Retain and institutionalize as agency firearm
            a. Record purpose in AFS – For official use only
        2. Destruction
            a. After 180 day notice or court order
        3. Public Auction
            a. To 12071 PC licensed dealer
p. Release of Firearm Advisement
q. Contact Information

I. Police Wellness (1.0 Hrs.)
II. "Code 9: Officer Needs Assistance"
    a. PTSD in Law Enforcement
III. What are our Stressors?
    a. Ask the class what are their "Triggers" in everyday life
IV. What can happen if we don't handle our stress appropriately?
    a. Alcoholism
    b. PTSD
    c. Diabetes
    d. Ulcers
    e. Depression
    f. Suicide
V. Police Officers live an average of 9 years less than general population

a. Research by PhD, Author and former Police Officer John Violanti reveals that police officers live an average of 9 years less than the general population.
b. Is this surprising to anyone? Is this a shock?

VI. How do you protect you mind at work?
a. Your department issues safety gear (bullet proof vest, tools, etc.)
b. Practice “Mindfulness”

VII. Emotional Wellness = Work
a. It takes “work” to keep your mind healthy

VIII. What Society Tells us About Happiness
a. Work Hard
b. Buy things
c. Adapt to new thing
d. Work harder
e. Accomplish great things
f. Adjust to new success
g. Is this REALLY happiness?

IX. What Science tells us About Happiness
a. 50% is Genetic
- Mom & Dad
b. 40% is Intentional Activity
- Your thoughts & Actions
c. 10% is Outside Circumstances
- Money
- House
- Marriage

X. Bottled Up Feelings

XI. Feelings/Emotions

XII. What are our appropriate coping mechanisms?
a. Working out
b. Watching TV
c. Counseling
d. Talking it out
e. Hobbies

XIII. Practice Meditation

XIV. Mindful Revolution

XV. Fear of Stigma is part of illness
a. We don’t ask for help because we think it shows weakness

b. Colleagues think there is something “wrong” with us
c. We can’t handle the stress of the job

XVI. I am Grateful for…

I. Introduction: Developmental Disabilities (1.15 hr.)
   a. Andy Hoang: Crisis Response Project
   b. Sandra Regan: RCEB Forensic Specialist
II. Regional Center of the East Bay (RCEB)
   a. Mission:
      Regional Center of the East Bay supports persons with developmental disabilities and their families with the tools needed to achieve lives of quality and satisfaction and builds partnerships that result in inclusive communities.
   b. The Lanterman Act (a California Law) states that Regional Centers must provide support services that help people with developmental disabilities stay in their local communities and lead lives like everyone else. Each support service has guidelines written in an understandable way.
   c. 21 Regional Centers in the state of California
III. Overview of RCEB
   a. RCEB serves people with developmental disabilities from birth to death
   b. Services are voluntary
   c. A client may be referred for RC services at any age
   d. Most developmental disabilities are diagnosed before the 18th birthday
   e. Eligibility includes:
      a. Intellectual Disability (formerly “Mental Retardation”)
      b. Cerebral Palsy
      c. Epilepsy (seizure disorders)
      d. Autism
      e. 5th category
      f. Down Syndrome
IV. A person will not qualify for RCEB with:
   a. Solely mental illness
   b. Solely learning disorders
   c. Solely physical disability, unrelated to a neurological disorder
   d. Solely alcohol or drug addiction
   e. Many clients have mental illness and/or addictions in addition to a developmental disability [this may lead to more police involvement]
V. How can RCEB help?

a. Provide support for the parents of children with developmental disabilities – respite, childcare, afterschool programs, summer camps
b. Provide early intervention to children with Autism to help learn social and communication skills
c. Provide adult clients with support so that they can live independently
d. Nursing care, dental care, durable equipment
e. Day activity programs and supported employment

VI. Community Care Facilities/ Residential Facilities

a. Community Care Facilities (CCF) are licensed through the California State Department of Social Services, Community Care Licensing
b. These homes provide different levels of care and supervision (levels 2-4)
c. These homes are usually paid for through a combination of Social Security and/or Supplemental Security Income and RCEB supplemental funding
d. Homes are subject to quarterly visits, unannounced visits and sanctions
e. A CCF is a client's home and should reflect the client's preferences and choices
f. Concerns regarding the safety of a home, staff training, high turnover can be addressed to RCEB Quality Assurance Supervisor Margy Kang

VII. At Risk Clients

a. Our clients are vulnerable to abuse and neglect
b. Non-verbal clients can't tell us what is wrong
c. Adult clients often rely on SSI benefits for total income and may live in high crime neighborhoods
d. Clients with intellectual disabilities are easily influenced and are often "easy targets"
e. Clients with addictions and/or mental illness can be difficult to serve

VIII. Can you think of characters from movies or TV shows that may qualify for RCEB services?

a. Class discussion about characters they can think of [Instructor lead]

IX. What is CRP?

a. CRP is a mobile crisis team that is a vendor of the Regional Center
b. CRP covers both Alameda and Contra Costa counties
c. CRP is available 24 hours a day, 7 days a week, 365 days a year
d. CRP crisis counselors are mandated reporters

X. What will CRP do?

CRP Goals:

a. Decrease police Involvement
b. Prevent 5150's/hospitalizations
c. Increase client success in the community
d. Increase staff's ability to handle future crises

CRP works specifically to provide:

a. Intensive crisis prevention
b. Emergency crisis intervention
c. Follow-up services

XI. What will CRP not do?

a. Physical restraint
b. Be left alone with a client
c. Search for runaways or AWOL clients
d. Work with a client under the influence of alcohol/drugs
e. Work with a client who is non-compliant, refusing to follow program, and is not escalating towards physical aggression

XII. When should CRP be called?

a. When a client is making suicide threats
b. Severely depressed
c. Verbally threatening to hurt someone
d. Throwing objects
e. Engaging in property destruction
f. Threatening to run away
g. Hitting, kicking, etc.
h. In some way a danger to self or others
i. If 911 is called, CRP should also be called

XIII. Indicators: Intellectual Disability

a. Highly suggestible
b. Short attention span
c. May not understand consequences or social rules
d. Poorly developed living skills
e. Immature behavior
f. Difficulty with simple tasks
g. Delays in oral language development

XIV. Autism

a. Cause unknown
b. Autism is a developmental disorder that may be recognizable within the first 3 years of life

c. Effects development of communication and social skills
d. 1 in 42 boys have autism v. 1 in 189 girls
e. 1 in 68 children are diagnosed with autism
f. [Video – Autism/Intellectual Disabilities]

XV. Indicators: Autism
Common behaviors:
a. Disconnect with others/inability to read emotions
b. Head banging/arm flapping/major tantrums
c. Rocking/spinning/fidgeting
d. Pacing/repetitive motions
e. Lack of personal space/ afraid of germs
f. May be non-verbal/may ask personal questions
g. Lack of eye contact/sensitivity to sounds; crowds; lights
h. Specific routines and rituals

XVI. Law Enforcement and Autism [Video – Perspective of individuals interactions with DD persons]
a. Video illustrating appropriate responses and Autism safety for First Responders

XVII. Autism: concerns
a. Accompanying medical conditions, especially seizures
b. May run away or towards an officer
c. Sensory issues (sounds, smell, touch, taste, sight: hyper/hypo)
d. Self-stimulating behaviors and unusual attachment to objects
e. May be attracted to shiny objects (badge, belt, weapon)

XVIII. Autism Videos
a. Adult: Severe autism
b. Non-verbal; epilepsy, OCD
c. Self-injurious behavior (SIB); physical aggression

XIX. Autism videos
a. Adult: Severe autism
b. Non-verbal; epilepsy; OCD
c. Rocking, Stimming

XX. Autism concerns
a. Wandering (away from home, into traffic, towards water)
b. May invade personal space of others
c. May not respond to “stop” or other commands
d. Increase or decrease in pain threshold (may be oblivious to injury)
e. Extreme reactions to changes in routine

XXI. Autism: Social Skills
   a. Fails to respond to own name
   b. Appears not to hear you (how could this be dangerous in the community in relationship to the police?)
   c. Resists cuddling and holding
   d. Lacks empathy, unaware of others' feelings
   e. Prefers playing alone – being in own world

XXII. [Video: Law Enforcement & Autism]

XXIII. Ways to indicate non-verbal
   a. Individual makes noises: screaming, babbling, one-word phrases, and repetitive wording including a person's name, toy, store, book and TV show
   b. May not maintain eye contact
   c. It's hard to know if the individual understands English as the first language
   d. Easiest way to find out is ask their care taker: parents, group home, or day program

XXIV. Ways to communicate with a non-verbal individual in the community
   a. State short commands: "Come with me", "Where is your staff?" "Let's go for a ride."
   b. Facial expressions: be aware of emotional expressions when interacting with an individual
   c. Gesturing and pointing to what you want them to do
   d. If care taker is around, ask what they use to communicate

XXV. Video: Police Interaction with a client in the community [Video]

XXVI. Safety words you can use when an individual is being aggressive:
   a. "Put your hands in your pocket"
   b. "Safe hands"
   c. "Personal space" with your hand out in front of you
   d. Try to avoid the word no, this may be a trigger word for some. Use "stop", "Don't do that."

XXVII. De-escalation Techniques
   a. Avoid stopping repetitive behaviors (calming): rocking back and forth, clapping, snapping, etc.
   b. Watch for seizures
   c. Turn off lights and sirens; turn down radio
   d. Maintain safe distance
   e. Stay alert to the possibility of outbursts or impulsive acts

XXVIII. Crisis Communication with DD

a. Use simple vocabulary words
b. Ask one straightforward question at a time
c. Create short sentences
d. Redirection
e. Wait for the answer before proceeding
f. Avoid asking leading questions
g. Clear the area of other clients
h. Minimize the amount of people
i. Identify trigger/ Antecedent and remove it
j. Give client control by offering choices
k. Check back for confirmation that client has correctly understood

XXIX. CRP can assist Law Enforcement by:
a. Providing officers additional support for clients and care providers
b. Providing additional information if CRP has had previous intervention with client
c. Save officers time if they do not deem that their presence is necessary
d. CRP can work with clients and caregivers
e. Avoid misuse of law enforcement
f. Additional resources and interventions
g. Prevent necessity for future police involvement

XXX. Questions officers can ask care providers
a. Does client make use of CRP services?
b. If client utilizes CRP, has CRP been called?
c. Does client have any health concerns (heart problems, asthma, etc.) which could cause hindrance to physical restraint
d. Does client take medication and, if so, has he/she taken it?
e. If a client is out in the community, does he/she live in a group home?
f. Does the client have a behavioral plan and has it been followed?

XXXI. QUESTIONS?

Contact Info.

Suicide Assessment (Segment 1) (1.0 Hrs.)

A. Introductions: Crisis Support Services

B. Training Goals:

1. Recognize when a person may be at risk for Suicide

2. Identify warning signs and risk factors that may lead to suicide

3. Gain an understanding of how to identify risk

C. Crisis support Services of Alameda County

1. 24-Hour Crisis Line

2. National SP Lifeline Network

3. Text Line

D. The Scope of the Problem:

1. Who is at risk?

E. High Risk Groups:

1. Adults 65 and older

2. Those with mental illness

3. Adolescents 15-24 years old

4. Middle Aged 45-54 years old

F. Suicide in the US

1. In 2014 there were 42,773 suicides

2. 16,294 were aged 45-64

3. Ranks second as a cause of death among youth (15-24)

4. Is the 10th leading cause of death

5. Males complete suicide 3.74 times that of females

G. Common Methods of Suicide:

1. 50.6% Used a firearm

2. 25.1% used suffocation/hanging

3. 16.6% used poisoning

4. Males method of choice most often is firearms

5. Females method of choice most often is poisoning

H. Understanding Suicidal Behavior:

1. Group discussion about suicidal behaviors to gain a better understanding of the suicidal mind

2. Discussion Questions:

- Why do people kill themselves?

- Is it ever acceptable to die by suicide?

I. The Interpersonal Theory of Suicide

1. Capability of suicide “I’m not afraid to die”

2. Perceived burdensomeness “I am a burden”

3. Failed Belongingness “I am alone”

4. Lethal or non-lethal attempt

J. Chronic Risk Factors:

1. Prior Suicide attempt

2. Prior suicidal ideations

3. Family history of suicide

4. Psychiatric hospitalization

5. Physical/sexual abuse

6. Trauma History

K. Acute Risk Factors:

1. Recent Suicide Attempt

2. Current Suicidal ideations

3. Increased substance abuse

4. Sleep deprivation

5. High level of anxiety

6. Reckless/risk taking behavior

L. Suicide Warning Signs:

1. Talking or writing about death or suicide

- Direct cues such as: “I wish I were dead”

- Indirect cues such as: “Nobody will care if I don’t wake up tomorrow”

2. Isolating from family, friends, social support

3. Obtaining the means to kill him or herself

4. reckless/risk taking behavior

M. Additional Suicide Warning Signs:

1. Purposelessness/lack of meaning in life

2. Feeling like they are a burden to others

3. Heightened anxiety

4. Feeling trapped

5. change in eating and/or sleeping habits

6. Feeling disconnected – withdrawing from family and friends

7. Hopelessness/helplessness/worthlessness

8. Feelings of strong anger or rage

9. Extreme mood swings, depression

N. Precipitating Events that Increase Risk

1. Recent Medical diagnoses/illness

2. Relationship break-up

3. Withdrawal from drugs/alcohol

4. Significant loss (death, job, etc.)

5. Recent traumatic event

6. Command hallucinations

7. Delusions – thoughts of being persecuted

O. Suicide by Cop (SbC)

1. Is a term used to describe a suicidal incident whereby the suicidal subject engages in a consciously, life-threatening behavior to the degree that it compels a police officer to respond with deadly force

P. Warning Signs of Potential SbC

1. Subject demonstrates intent to die

2. Subject understands the finality of the act

3. Subject must confront police officer to the degree that it compels officer to act with deadly force

4. The subject actually dies

Q. Factors that Influence SbC

1. Disruption of relationship

2. Critical family issues

3. suicide ideations

4. History of mental illness

5. Substance abuse

6. Past suicide attempts

7. Domestic dispute

8. Unwillingness to surrender to officer

R. Protective Factors:

1. Access to medical & psychological care

2. Restricted access to lethal means

3. Connectedness to family and community support

4. Skills in problem solving

5. Cultural and religious beliefs

6. Contact with care givers

S. Next Steps:

1. Risk Assessment

2. Evaluating Suicide Risk

3. Safety Planning

T. Suicide Crisis Intervention: What you can doo

1. Make contact quickly and begin building rapport

2. Identify the scope of the problem, assess for immediate danger

3. Help the suicidal person explore alternatives, try to include the suicidal person in decisions, give options

U. Listening & Communication Skills

1. Self-control

- Are you escalating a situation or de-escalating it?

2. Be direct

- Use simple, and direct sentences

3. Remain patient

4. Listen

5. Remain objective

6. Be compassionate – you are seeing this person on the worst day of their life

V. Determining Risk

1. Gather information from individual from family, friends, neighbors

2. Is the person under the influence?

3. Is the person symptomatic of mental illness?

4. Has there been a recent crisis?

W. Find Out About…

1. What else is going on for this person?

2. Anniversary of a traumatic event?

3. Have they been isolating or withdrawing?

4. Recent rejection?

5. Do they have a terminal illness or recent health diagnoses?

6. Mental Health history?

7. Trouble with law enforcement

X. Questions to ask

1. Ask Directly and Openly “Are you feeling Suicidal?”

2. Do you have a plan?

3. Are the means available?

4. Have you done anything to harm yourself already?

5. Have you ever tried to kill yourself before?

Y. Safety Planning

1. Use the Crisis line

2. Remove the means

3. Assessment & Intervention

4. Explore coping skills

Z. Last Thoughts…

1. Most important question to a potentially suicidal caller is: “Where do you hurt and how can I help?”

Closing and contact Info for Crisis Support

PO Box 3120, Oakland CA 94609

Suicide Assessment (Segment 2) (1.0 Hrs.)

A. Suicide: The Silent Epidemic
   1. Every 12.3 someone in the US dies by suicide
   2. Every 12.4 seconds someone is left to make sense of it
B. American Foundation for Suicide Prevention
   1. Founded in 1987 by scientists and family members who lost someone to suicide
C. What is Stigma?
   1. An attempt to label a particular group of people as less worthy or respect than others
   2. A mark of shame, disgrace or disapproval that results in discrimination
D. Stigma Leads to…
   1. In Mental Illness…
      - Fear, mistrust, and violence against people living with mental illness and their families
      - Family & friends turning their backs on people with mental illness
      - Not seeking help – only 1 in 5 seek help
   2. In Suicide…
      - Not talking about the person who died
      - Friends and family members alienating the family of the deceased
E. Facing the Facts
   1. Research shows: 20% of us will have a suicide within our immediate family
   2. 80% of us will personally know someone who dies by suicide
   3. 90% of people who die by suicide have a diagnosable psychiatric disorder at the time of their death
   4. 42,773 people in the US died by suicide in 2014
   5. Everyday approx.. 117 Americans take their own life
   6. There are an estimated 25 attempted suicides for every suicide death
   7. Over 1 million attempts in the US
   8. Translates to 1 attempt every 30 seconds
F. National Suicide Facts
   1. Currently suicide is the 10th leading cause of death in the US
   2. 2nd ages 10-24
   3. 2nd ages 25-34
   4. 4th ages 35-53
   5. 8th ages 55-64
   6. 17th ages 65+
G. In California 2014

1. 4.025 people died by suicide
2. Approx 11 suicides per day
3. Leading non-fatal self-inflicted injury – Poisoning age 25-44: 3,434 injuries

H. Method Age and Number of Deaths:
1. Other Ages 25-44: 87
2. Poisoning Ages 45-64: 388
3. Jump Ages 25-44: 73
4. Hanging Ages 25-44: 404
5. Firearm Ages 45-64: 560
6. Cut/Pierce Ages 45-64: 46

I. Questions??

J. The Story of Amanda Lyn Doughty (Apr. 29, 1986 – Oct 26, 2004)

Children and Youth with Mental Illnesses (1. 45 Hrs.)

A. What does mental illness look like in children?

1. Video: Nami Understanding Mental Illness.

2. Mental Status in Children: [LECTURE / POWER POINT]

B. Common Diagnosis in Children

1. Small group exercise: Answer the following questions.

2. Make a list of common child diagnosis that you are aware of?

3. How are the behaviors or symptoms different in children from adults?

C. Problematic Behaviors in Children

1. Behavioral problems Video: Inside the world of childhood schizophrenia

2. overview of differences [LECTURE / POWER POINT]

3. Juvenile Justice Video: Children at Risk.

4. Statistics [LECTURE / POWER POINT]

5. overview of differences [LECTURE / POWER POINT]

D. Assessment: Which questions do I ask? (10 minutes) [LECTURE / POWER POINT]

1. Questions for parents.

2. Interviewing children

3. Safety Planning

E. Youth & Mental Health Jeopardy

1. Class is divided into 4 teams and provided a “Buzzer” that emits light and sound

2. Starting group is selected (typically by the youngest person in the room)

3. The groups pick a topic and point value and are asked the related questions.

F. Topics:

1. Mental Health Behaviors in Youth

2. Stages of Development

3. Adolescent Suicide

4. Youth in Society

5. Communicating with Youth

G. Handouts:

1. Self Harm & “Cutting” and safe alternatives to cutting.

Welcome Back Day 3: Re-Cap/Housekeeping (45 Mins.)

Combat to Community / Veteran Population 3.0 Hrs.)

A. Introduction
   1. Instructors will introduce themselves and their interest in veterans' issues. Establishing credentials within law enforcement are important as the facilitator, role model and teacher.
   2. Explain three reasons why this course is important, including:
      a. Law enforcement and veterans will interact. As of January 2009, 1.8 million troops had been deployed to support the *Global War on Terror* (GWOT).
      b. Veterans have a unique culture that includes commonly shared attitudes, values, goals and practices that often (but not always) characterize service in the military. This culture is not always immediately apparent to law enforcement or the civilian community.
      c. Law enforcement and veterans are similarly trained, but have very different experiences. Recently returning veterans have been exposed to repeated deployments in intense areas of conflict.
      d. Goal of the class
         1. Additional tools for effective community policing
         2. Identifying veterans in crisis and offering help
         3. Utilizing skill set as a resource for veterans.
      e. This class WILL NOT provide:
         1. A get out of jail free card.
         2. A substitute for the training you already have
         3. Civilians telling you how to do your job.

B. Video and discussion "House Clearing"
   1. In this short clip, the U.S. Marines are trapped on a rooftop in Iraq. The Marines take enemy fire. This is an example of a typical experience in combat.
   2. Facilitated discussion
      a. How might a military veteran's career experience differ from the career experience of a law enforcement officer?
      b. Intense fighting can be experienced regularly over a single deployment (typically ranging from 6 – 15 months). There is little time for emotional or physical recovery and treatment for potential issues is often delayed or avoided in support of a mission.
      c. What similarities do you see in the way that you are trained and the way that law enforcement is trained?
      d. Traumatic experiences and regimented practices. Intense emotional response during "trauma"

C. Overview of Combat Experience
1. Individuals experience war and combat very differently. More importantly, experiences for veterans who have served on behalf of the *Global War on Terror* are greatly different than the experiences of veterans and military of prior conflicts.
2. The differences between *Global War on Terror* and prior conflicts:
   a. Multiple deployments
   b. Lengthier deployments
   c. 360 degrees of fighting (no “front” lines)
   d. Urban combat with no clear enemy.
3. The Veteran Experience
   a. A brief overview of what veterans may experience in combat
      1. Commonly shared attitudes, values; goals and practice that often (but not always) characterize service in the military
      2. Potential resources to refer veterans to for supportive services.
      3. Tools for interaction in certain circumstances with combat veterans.
   b. Outcomes – at the end of this course, students will be able to:
      1. Name at least three major issues for returning *Global War on Terror* Veterans
      2. Articulate at least three ways in which they can appropriately respond to the needs of veterans in the context of their work

D. Defining Veterans: Myths, Legends, and Stereotypes
1. Activity: What does a veteran look like?
   a. Can you tell if someone had served in the military?
   b. If so, how?
   c. What can you do or ask to better identify former military personnel in your community?
   d. Debrief activity

E. Military veteran stereotypes
1. All veterans are in crisis
2. Veterans are old men
3. All veterans have served in combat
4. Veterans are not in our communities
5. You have to be in combat to “get” Post Traumatic Stress Disorder (PTSD)

F. Stereotype debunking:
1. Veterans are a culturally diverse group of people that include both men and women of all ages
   a. A*ctive Duty:* Individuals whose full-time job is the military
   b. *Reservist:* Individuals who enlisted with the intention of the military being a part-time job, but can be called upon to perform full time duties

c. *National Guard:* Traditionally state forces are trained primarily to respond to domestic disasters but can be activated to respond for federal purposes. Eligibility for services & benefits are dependent on how Guard members are activated. Average age is 37
d. *Women:* As of April 2008, there were 101,577 female *Global War on Terror* veterans. Women do see combat and have difficulty gaining recognition for combat service. They join in room clearings, are exposed to IED's, search women, & have transport roles. Women veterans are more likely to be homeless than men. Many female service members may have experienced military sexual trauma

2. Every individual has a different war experience. They will identify the war differently
   a. *Global War on Terror* (GWOT): Refers to military actions and typically military service after September 11, 2001
   b. *Operation Iraqi Freedom* (OIF): Indicates service in Kuwait, Iraq, or surrounding areas in 2003 until present
   c. *Operation Enduring Freedom* (OEF): Typically refers to service in Afghanistan, but can include Horn of Africa, Philippines, and Bosnia
3. The term "veteran" has different meanings to different people, agencies and institutions
   a. Not every person will identify as a veteran
   b. There is a difference between the legal definition of a veteran that entitles an individual to benefits and understood definition of veteran that includes individuals that have served in the military

G. PTSD In Veterans: Signs, Symptoms, Strategies
1. Case Study: Provide example of combat veteran, Sgt. Travis Twiggs who killed himself as a result of debilitating PTSD. Police were not informed of his veteran status and did not have an opportunity to employ tactics that may have saved him.
2. Classic Symptoms of PTSD:
   a. Avoidance and numbing (3): These factors contribute to general stress, and can make it more difficult for affected Veterans to seek help and support
      1. Avoid thoughts, feelings
      2. Avoid activities, places, or people
      3. Can't recall part of trauma
      4. Decreased interest in activities
      5. Estrangement from others
      6. Restricted range of emotion
      7. Sense of foreshortened future
   b. Hyper arousal (2):
      1. Sleep problems - It is not uncommon for Veterans with PTSD to be on extremely limited (1-4 hrs./night) sleep for months or even years

2. Irritability or outbursts of anger - This symptom may appear in the form of someone who is incredibly angry at an objectively simple issue (i.e. overreacting)
3. Difficulty concentrating - This symptom can lead to difficulty following complex, multi-part directions.

c. Hyper vigilance - This symptom may lead to someone driving down the shoulder of a road to avoid traffic, because they do not feel safe sitting still in traffic (a reality of driving in Baghdad)

d. Exaggerated startle response - This symptom commonly results in someone who is particularly scared of or sensitive to any loud noises or physical touches. Make sure you do not sneak up on a Veteran with PTSD.

e. Re-experiencing (1):
1. Repeated distressing memories
2. Repeated distressing dreams
3. Flashbacks (acting or feeling event was happening)
a. This symptom may cause someone to not respond to your requests, directions, and commands. We teach the “grounding technique” later on specifically to combat these symptoms
4. Psychological distress at triggers
5. Bodily reactivity to triggers
a. These last two symptoms are particularly important, because you do not necessarily know what may trigger someone. Veterans who served in Iraq describe being triggered by sand, or even by the sound of children playing (which preceded a grenade attack in Baghdad). Police with firearms and shouting directions may be a trigger, but the possibilities are endless.

H. PTSD and Risk of Offending
1. PTSD and increased assaults/weapons charges
2. PTSD increases risk factors (e.g. stress) for violence

I. There are Common Myths & Facts About PTSD
1. Myth: It is easy to differentiate PTSD, Substance Use, TBI & Dementia
2. Myth: PTSD is related to mental strength and character
a. Vulnerability Factors for PTSD include:
1. Previous Trauma
2. Age and Duration of Trauma
3. Type of Trauma
4. Degree of social support
3. Myth: All PTSD comes from Combat
a. PTSD comes from Rape, Combat, Accidents, Childhood events, witnessing horrible acts and experiencing natural disasters.
4. Myth: Veterans with PTSD are angry and bitter people

a. Anger in PTSD may be associated with:
   1. Reduced impulse control
   2. Significant reduction in quality and quantity of sleep
   3. A response to feeling helpless (embarrassed)
   4. Feeling perpetually "unsafe" and anxious
   5. Chronic Pain
   6. Depression

J. *ACTIVITY: Traffic Stop & Grounding Technique* –
This demonstration shows how intrusive thoughts and images may be affecting a Veteran during a routine (simulated) traffic stop. The activity can be anxiety provoking for the audience, thus we close with the "grounding technique" that we will teach the audience to do in the next section.

K. *ACTIVITY: Arousal & Grounding*
Human arousal is time-limited. Grounding techniques are used to help Veterans focus on real stimuli (including the officer) and not traumatic thoughts or images in their head. This activity teaches one such brief grounding technique that can significantly reduce arousal levels.

L. PTSD Pitfalls & Potentials – These are not specific recommendations for specific circumstances. Rather, they are a set of guiding principles that help in deescalating Veterans with PTSD
   1. Task focused vs. Veteran focused – The fastest and safest way to complete a task may be to focus on the needs of the Veteran at that time
   2. Betrayal vs. Loyalty – Vets are sensitive to betrayal by the government (including police). Maximize opportunities to convey gratitude and support for their service, and demonstrate willingness to help
   3. Trapped options vs. Controlled options – It is possible to phrase "options" in a manner that is actually threatening and increases a Veteran's sense of being trapped. However, presenting viable options may help an officer control the boundaries within which a situation may progress.
   4. Threatening nonverbal vs. Verbal transparency – Officers have to engage in a number of nonverbal behaviors (e.g. standing at an angle with firearm inaccessible) that can be misperceived by trained Veterans as threatening and aggressive. If an officer verbalizes this behavior, it can minimize misinterpretation and actually help to build rapport.

M. Three Main Points:
   1. There can be many problems that may arise as a result of military service:
      a. Major depression
      b. Alcohol abuse
      c. Often used as effort to sleep
      d. Narcotic addiction

e. Often beginning with pain medication for injuries
f. Military sexual trauma
g. Suicide
h. Job loss
i. Family dissolution, instability, violence
j. Homelessness
k. Violence towards self and others
l. Incarceration

2. Help for veterans can take time and can be extremely difficult for veterans to obtain who have severe problems
   a. Average wait time: 183 days for an initial decision
   b. The backlog of disability claims has risen to 600,000 claims
   c. Time frame for a claim decision; including appeals, can exceed ten years.
3. Invisible injuries such as Traumatic Brain Injury and Post Traumatic Stress may impact the way veterans communicate and deal with day-to-day life
   a. *Symptoms of Traumatic Brain Injury:*
      1. Memory loss (especially short term)
      2. Short attention span
      3. Trouble concentrating / impaired reasoning
      4. Headaches
      5. Confusion

N. Examining the effects of war
1. Video “Driving” In this short clip, the U.S. Military is driving and receiving fire. This clip illustrates more of the experiences that may impact the way in which veterans translate their experiences in the civilian world.
2. Battle mind: When combat thinking comes back to the community There are behaviors that are appropriate for military training that become less useful in the civilian world. Ultimately, war can effect:
   a. How you communicate
   b. What you do to survive
   c. Your perception of acceptable behavior
   d. The way you drive
   e. Feeling secure
   f. Vigilance, constantly on alert for danger
3. Effective Emotional Responses in Combat:
   a. Emotional Control vs. Anger or Detachment
   b. Mission and Operational Security vs. Secretiveness
   c. Lethally Armed vs. Unarmed
   d. Non-defensive (combat) vs. Aggressive Driving
   e. Targeted vs. Inappropriate Aggression
   f. Buddies (Cohesion) vs. Withdrawal

O. Meeting and Greeting Veterans and Their Families
1. Building Rapport - How can law enforcement build rapport with veterans they come in contact with?
a. Ask factual logistical questions about their experience – What kinds of factual logistical questions would be helpful to law enforcement?
b. Avoid "Judging" Statements and Questions about the war – What kind of "judging statements" and questions might antagonize a veteran?

P. Video "Dance, Dance, Revolution"
1. In this short clip, the U.S. Military dance and play in Iraq. The clip is intended to humanize the military experience.
a. *Activity:* Case Studies and Group Discussion: Battle mind vs. Civilian Society

Q. Conclusion
1. Wrap up and Review
a. Name at least three major issues for returning *Global War on Terror* Veterans
b. Articulate at least three ways in which they can appropriately respond to the needs of veterans in the context of their work.

Consumer and Family Panel [working lunch] (3.0 Hrs.)

A. Introduction of Consumer and Family Member panel
B. [Instructor lead] Group will participate in Schizophrenic experience. Students are provided an auditory device in which they will hear different sounds, ranging from bells, horns and voices saying things. Images cycle through on the front monitor while the sound devices play.
C. Students are then asked to complete a written exercise with the auditory and visual distractions.
D. Students will provide feedback to instructor on their experience in this exercise. Discuss as a group if it was difficult to perform written assignment with distractions while emphasizing how a subject with schizophrenia might have trouble deciphering from the voices they hear in their head and what an officer is telling them.
E. [Small group discussion] Engage in small group discussions which will feature a family member or a consumer. The small group discussion will be lead by the consumer or family member. This exercise will give the students an opportunity to interact with, ask questions of and hear the experiences of those individuals whose lives have been affected by mental illness [This panel is the perspective of an individual with bi-polar disorder who attempted suicide]
B. Case Study Family Panel Discussion (Q and A)

Two guest speakers will discuss the family's perspective of living with a person with mental illness. [This panel is the perspective of an individual who has experience with substance abuse disorder]

C. Case Study Subject Panel Discussion (Q and A)

Two guest speakers will discuss their struggles and successes as a person diagnosed with a mental illness [This panel is the perspective of a family member who has experience with a family member living with Schizophrenia]

I. Introduction: Responding to Older Adults (1.0 Hrs.)
   a. Purpose is to educate personnel on how to best interact and communicate with older adults and intervene in the most appropriate way
II. Calls for Service
   a. Pose question to class: What kind of calls for service do you think of when think of the older adult population?
      - Care facility
      - DOA
      - 5150 Hold
      - Missing/found person
      - Hoarding or unsafe living conditions
      - Welfare check
      - Elder Abuse: physical, mental, financial
III. What leads to calls for older adults?
   a. Vulnerability due to functional dependency on others
   b. Medical frailty
   c. Cognitive impairment
   d. Dwindling support system
   e. Caregiver burnout
   f. Financial incentives
IV. Mental vs. Medical
   a. Focus on the true nature of the call so officers can determine the most appropriate disposition
V. Dementia
   a. There are several different types of Dementia. The key point here is that Alzheimers is a form of dementia

b. A medical workup is appropriate for elders exhibiting signs of Dementia. This is significant if the onset is sudden. There may be a reversible medical reason that should be addressed

VI. 50% of people 85 and over have some form of Dementia
   a. Consider background knowledge when receiving information

VII. Alzheimers
   a. Most common type of Dementia
   b. Estimated 5,400,000 people living with Alzheimers in the U.S.
   c. Very progressive and disabling disease impacting all areas of functioning

VIII. Behaviors Related to Alzheimers Disease
   a. Memory loss – Most common
   b. Challenges planning and solving problems
   c. Difficulty completing familiar tasks
   d. Confusion with time and place
   e. Trouble understanding visual images and special relations
   f. Trouble speaking and writing
   g. Misplacing things
   h. Decreased/poor judgment
   i. Withdrawing from social activities or work
   j. Changes in mood and personality

IX. Visual Reference
   a. Illustrations to show cognitive impairment as the disease progresses
   b. Illustration to show the loss in mass of a diseased brain vs. healthy brain

X. Cognitive vs. Psychiatric
   a. Differentiating between the two is important
   b. Loss of cognitive function is not treated with anti-psychotic medications

XI. Cognitive Symptoms:
   a. Amnesia
   b. Aphasia
   c. Apraxia
   d. Agnosia

XII. Major Psychiatric Symptoms:
   a. Personality changes
   b. Depression
   c. Hallucinations
   d. Delusions

XIII. Coding a call and the Correct Disposition
   a. Medical vs. Psychiatric

XIV. When is it Medical?
- a. Alzheimers is a medical condition
- b. Look for other symptoms associated with a medical condition

XV. When is it Psychiatric?
- a. Look for details that communicate a psych history
- b. Is there a threat of suicide?
- c. History of depression, suicidal ideations, attempts in the past?

XVI. Questions to ask:
- a. How is the behavior different from typical?
- b. What does the caller think should happen?
- c. Has this happened in the past? If so…what happened?

XVII. Scenario #1
- a. RP reports 77-year old male recently diagnosed with Alzheimers stated he wasn't going to let the disease take his life. RP is concerned for subject.
- b. What questions will you ask?
- c. What will you code the call?
- d. What is the most appropriate disposition?

XVIII. Scenario #2 – Grave Disability
- a. Found elderly female at 0325hrs. Subject appears to be l her early 70's dressed in a robe and slippers. Subject has no ID and can provide no identifying details. No missing persons reports matching.
- b. What is the most appropriate action to take?
- c. What medical conditions would you consider?

XIX. What Fuels Aggression?
- a. Fear
- b. Loss of control
- c. Frustration
- d. Lack of ability to communicate
- e. Common reaction to hallucinations and delusions

XX. Other Nuggets of Info…
- a. Medications at the back of the blue Resource Book
- b. Signs and symptoms of Dementia on page 11-12

XXI. Helpful Questions for a Missing Older Adult
- a. Page 13-14 in the blue Resource Book

XXII. In-Home Support Services
- a. State run program administered by the counties. Pays for in home care giver
- b. For elders with functional impairments

c. Recipients can choose their own caregiver (family member, friend, neighbor)

XXIII. Communicating with persons with Alzheimers

a. Video

Site Tour Discussion (1.0 Hrs.)

A. Site Tour / COVID Virtual

B. The purpose of site visits is to give the officers an opportunity to see, first hand, the variety of programs provided to people with mental illness and / or substance abuse issues. It's a chance to meet and observe clients in settings where they are learning to live with their illness.

C. Locations

1. Clinical Settings

a. John George Psychiatric Pavilion: 2060 Fairmont Drive, San Leandro, 94578

b. Willow Rock Juvenile Facility: 2050 Fairmont Drive, San Leandro, 94578

c. Cherry Hill Detox Facility: 2035 Fairmont Drive, San Leandro, 94578

Cherry Hill is a detox facility which will allow students an opportunity to see an alternative to jail or a psychiatric hold and learn when a detox placement is appropriate

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Welcome Back Day 4: Re-Cap/Housekeeping (30 Mins)

I. Crisis De-escalation (3.5 Hrs.)

A. Instructor introduction

B. Why crisis de-escalation

i. Because the community demands it

1. Awful but lawful approaches are no longer tolerated

ii. Because the courts expect it

1. Quezada v. County of Bernalaillo (1991)
2. Glenn v. Washington County (2011)
3. Hayes v. County of San Diego (2011)
4. Sheehan v. City and County of San Francisco (2015)

iii. Case Law Take Aways
1. Ask “Do we need to be here?”
2. Use time and distance whenever possible
3. Gather as much information as possible before acting
4. Get all of the resources you need on scene before acting, if possible

iv. Because it increases officers confidence

v. Because there is a need to know it
1. 319 Million people in the US
2. 8 Million have serious mental illness
3. ½ of those receive no treatment
4. 10% of LE calls for service involve someone with a SMI
5. 25-50% of all subjects killed by LE are mentally ill

vi. VIDEO: Lester Part 1

C. What is crisis de-escalation

i. De-escalation is what we use during a potentially dangerous, or threatening situation in an attempt to prevent a person from causing harm to us, themselves or others

ii. VIDEO: Lester Part 2
1. De-escalation is not always possible
2. De-escalation does not always work

iii. Good crisis de-escalation

iv. One size does not fit all
1. Our job is to control, redirect and influence other people

D. What is a crisis

E. Managing crises

F. VIDEO: Guy rips open shirt

i. Officer safety considerations
1. Avoid complacency
2. Develop present moment awareness
3. Contact / cover
4. Keep your OODA loop moving
5. Anger seeks a target
6. Detect and act upon danger early

7. Know which psychiatric symptoms are dangerous
8. Alpha versus Beta Command

G. Personal Characteristics of effective crisis de-escalators
   i. Creativity/flexibility
   ii. Life experience
   iii. Poise
   iv. Belief that people can change
   v. Leaving ego out of it

H. Video: [Officer yells at motorist]

I. Starting with the big picture
   i. We cannot reason with highly agitated people
   ii. Our job is to reduce the level of arousal so discussion becomes possible

J. Levers to reduce agitation; Words
   i. Words should reflect your response, not your reaction
   ii. Use open ended & closed ended questions
   iii. Use reassuring words whenever possible
   iv. First question should not be “are you taking your meds?”
   v. Words should not contain judgement
   vi. “Sir, I need you to calm down”

K. Levers to reduce agitation; Tone, inflection, pitch
   i. People pick up more on these than they do the content of speech
   ii. Will immediately betray your impatience, judgement etc.
   iii. Will also immediately demonstrate your concern and compassion

L. VIDEO: [Driver Goes Crazy over Speeding Ticket]

M. Levers to reduce agitation; Non-verbal
   i. Hands
   ii. Arms
   iii. Will also immediately demonstrate your concern and compassion
   iv. Proximity
   v. Physical contact

N. De-escalation Tactics; Listening
   i. The 120 second investment
   ii. “Seek first to understand, then to be understood”
   iii. Undivided attention
   iv. Demonstrate that you are listening
   v. Don’t have to like the person

O. VIDEO: It’s not about the Nail

P. De-escalation Tactics; Directing/redirecting the conversation
   i. From the “then and there” to the “here and now”
   ii. From Things the person doesn’t control, to what they control
   iii. Guide person’s thoughts to neutral territory
Q. De-escalation Tactics; Contain emotions
   i. People regress when in crisis
   ii. Children need to be contained (whether they’re aware of it or not)
   iii. Set limits (verbal & physical)
R. De-escalation Tactics
   i. Provide face saving alternatives
S. De-escalation Tactics
   i. Allow yourself to be influenced by the other
T. De-escalation Tactics; The human touch
   i. Authentic contact calms and heals
      1. Self-disclosure
      2. Empathy
      3. Verbal, nonverbal & tactics are in alignment
      4. Authentic contacts are also good for your wellness

Excited Delirium (1.0 Hr.)

A. What is it?
1. [Video] Washington’s Most Wanted
2. Police & medical professionals describe experiences with and signs and symptoms of Excited Delirium

B. Excited Delirium Syndrome:
1. This is a descriptive label, not a medical or psychological term

C. Metabolic Symptoms:
1. Acid Increase in the body (Metabolic Acidosis)
2. Cardiac events (Hyperkalemia) Potassium increases in the body
3. Hypoxia: Oxygen Deprivation (Changes in breathing, lack of oxygen)
4. Why is this important for officers to be aware of when trying to restrain a subject?

D. Characteristics:
1. Highly associated with: Males
2. Middle Age
3. Chronic Illicit Substance Abuse
4. Mental Illness
5. Bipolar disorder or schizophrenia

E. What kinds of stimulants?

1. Methamphetamine
2. Cocaine
3. Crack
4. PCP
5. Bath Salts
6. Ecstasy

F. Risk and Consequences

1. Officer safety and risk to public
2. Liability
3. Safety is paramount due to chaotic behavior
4. Potential injury or instantaneous death to subject
   - Within 5 minutes of onset of symptoms
   - Death in custody reporting act (DIRCA) 2000 is a federal law requiring reporting of in-custody deaths. (The Institute for Prevention of In-Custody Deaths)
5. Subjects survival depends upon rapid recognition and treatment, including chemical sedation, decreased environmental stimulation, intravenous fluids, and other supportive interventions

G. How Officer Awareness Can Help

1. Better recognition of possible signs of Excited Delirium/Agitated Chaotic Event
2. Early coordination of resources (multiple officer response, modified restraint, medical services)
3. Coordinated response to contain a subject as quickly and safely as possible and connect them to IMMEDIATE MEDICAL ATTENTION

H. Estate of Armstrong vs. Village of Pinehurst

1. Armstrong was diagnosed with bipolar and paranoid schizophrenia; had not taken his meds in 5 days
2. Poking holes through his leg and his sister convinced him to go to the hospital
3. Armstrong fled the hospital; doctor placed him on a 5150 Hold
4. Officers found him outside the hospital; Armstrong clung to a pole and refused to let go
5. Officers drive-stunned Armstrong 5 times over 2 minutes
6. Officers pried Armstrong from the post. Armstrong was pinned to the ground, handcuffed and became unresponsive

I. Court Ruled

1. Taser deployment is a “Serious use of Force”

2. "Physical Resistance" is not the same thing as "risk of immediate danger"
3. Use of a Taser is unreasonable in response to resistance that does not raise a risk of immediate danger
4. Is the person actively combative and posing an immediate threat to themselves/others or is the force being used because the person is non-compliant?
5. Officers should be using time, distance and de-escalation if the person is not posing an immediate threat to themselves/others

J. How does it relate to Excited Delirium?

1. Officers must quickly recognize what kind of call they are responding to and if excited delirium plays a factor
2. In cases of excited delirium, it is a medical emergency that requires immediate action; therefore, time, distance and de-escalation may not be possible and Taser use may be a good option
3. Officers must still cautiously assess what level of force is reasonable to effect a resolution (i.e., getting subject medical attention or placing them on a hold, especially absent any crime) and be able to articulate the use of force.

K. Highlight the Symptoms you Observe [Learning Activity]

1. Excited Delirium Symptoms video #1

L. Highlight the Symptoms you Observe [Learning Activity]

1. Excited Delirium Symptoms video #2

M. Critical Thinking Questions

1. Do you think the incident is a medical emergency? What characteristics in the video support your answer?
2. What characteristics did you hear in the initial call that indicated the incident might be Excited Delirium?
3. What actions did the officer take that were effective for the incident?

N. Considerations

1. Response
   - Policy? How many Officers? What should be considered?
2. On Scene
   - Recognition? CIT? De-Escalation? Use of Force? Restraint? Coordination of medical attention?
3. Report
   - Documentation?

O. Re-Cap

1. Stress the importance of recognizing when it might be an Excited Delirium incident, how this will guide our response, and how this response can have a huge impact on the outcome (avoiding in-custody deaths, liability, etc.)

Role Play Scenarios / COVID Milo (1.5 Hrs.)

A. Introductions: Briefing / Objective
If Milo is used: Proficiency skills should be demonstrated as follows:
-De-escalation skills
-Crisis communication
-Skills of influence
-Tactical adaptability

B. The purpose of the role playing is to give the students the opportunity to work through different scenarios in a safe, forgiving environment.

C. The object being to work on communication and focus on finding the “Hook” using verbal persuasion to gain the subjects trust and compliance.

D. **Scenarios:**

1.Roommate/Manic Behavior:
- A new roommate who was connected by Craigslist is now exhibiting manic symptoms and not on medication. Needs to be determined of 5150 is appropriate based on her behaviors

2. Paranoid:
- Mother calls because her 18-year old son has been acting bazaar for several days. He is paranoid of the neighbors across the street and admits to hearing messages from a walkie-talkie. It needs to be determined if he meets criteria to be placed on an involuntary hold for further evaluation

3. Cutting:
- A young teen is suspected of cutting on her wrist at school and a counselor calls police for help in determining what actions to take with the student

4. Jumper:

- A passerby alerts the police department that they see someone leaning over the side of a rooftop parking structure

5. Found Senile:
- An old man is observed in a hospital gown and appears lost.

E. Warning Signs Quick Review [Handout]

E. Scenarios Review and Course De-Brief