

Crisis Intervention Training Refresher



Course #3843
March 2022

Crisis Intervention Training Refresher

ABSTRACT

Crisis Intervention Training Refresher provides a review of the key concepts, safety techniques, and communication skills taught in the Crisis Intervention module (Chapter 29) of the Texas Commission on Law Enforcement (TCOLE) Basic Peace Officer Curriculum.

TCOLE rule 218.3 states,

(a) “Each licensee shall complete the legislatively mandated continuing education in this chapter. Each appointing agency shall allow the licensee the opportunity to complete the legislatively mandated continuing education in this chapter. This section does not limit the number or hours of continuing education an agency may provide.

(b) Each training unit (2 years).

(1) Peace officers shall complete at least 40 hours of continuing education, to include the corresponding legislative update for that unit.

(2) Telecommunicators shall complete at least 20 hours of continuing education.

(c) Each training cycle (4 years).

(1) Peace officers who have not yet reached intermediate proficiency certification shall complete: Cultural Diversity (3939), Special Investigative Topics (3232), **Crisis Intervention (3843)** and De-escalation (1849).

This course can also be utilized to meet any Crisis Intervention training requirements set forth by the Texas Police Chief Associations Recognition Program.

Note: This course (#3838) will not meet the 40-hour CIT requirement mandated by legislature

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

Target Population: Texas Peace Officers

Student Prerequisites:

- Crisis Intervention Training (TCOLE 1850)

Instructor Prerequisites:

- Certified TCOLE Instructor in either the CIT Train the Trainer Course or the Mental Health Peace Officer Course
- Documented subject matter expert

Length of Course: 8 hours minimum

Required Equipment:

- None

Training Delivery Method(s):

- Instructor-led, classroom-based

Method(s) of Instruction:

- Lecture
- Discussion
- Scenarios
- Videos

Facility Requirements:

- Standard classroom

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

In addition, the Commission highly recommends a variety of testing/assessment opportunities throughout the course which could include: oral or written testing, interaction with instructor and students, case study and scenario, and other means of testing student's application of the skills, as the instructor or department deems appropriate.

Unless otherwise indicated, the minimum passing score shall be 70%.

Reference Materials:

- Alzheimer's Association. (2017). Alzheimer's Disease Guide for Law Enforcement. Retrieved from http://www.alz.org/national/documents/SafeReturn_lawenforcement.pdf
- American Psychiatric Association. 2017. *Diagnostic and statistical manual of mental disorders: DSM-5*. Arlington, VA: American Psychiatric Association.
- Australian Autism Alliance. (2022). What is Autism?. Retrieved from <https://www.autismspectrum.org.au/about-autism/what-is-autism>

- Bernstein, B. E. (2017). Pediatric Bipolar Affective Disorder. *Drugs and Diseases*. Retrieved from <http://emedicine.medscape.com/article/913464-overview>
- Bonfine, N., Ritter, C., & Munetz, M. R. (2014). Police officer perceptions of the impact of Crisis Intervention Team (CIT) programs. *International Journal of Law and Psychiatry*, 37(4), 341-250. doi:10.1016/j.ijlp.2014.02.004
- Dupont R., & Cochran S. (2000). Police response to mental health emergencies – Barriers to change. *The Journal of the American Academy of Psychiatry and the Law*. 28(3):338–344
- Food and Drug Administration. (2019). FDA and Kratom. Retrieved from <https://www.fda.gov/NewsEvents/PublicHealthFocus/ucm584952.htm>
- Huus, K. (2012). Asian leaf ‘kratom’ making presence felt in US emergency rooms. Retrieved from <https://www.nbcnews.com/news/world/asian-leaf-kratom-making-presence-felt-us-emergency-rooms-flna487433>
- International Association of Chiefs of Police. (2022). 7 Drug Categories. Retrieved from <https://www.theiacp.org/7-drug-categories>
- Jines, J. (2013) Crisis Intervention Teams: Responding to Mental Illness Crisis Calls. *The FBI Law Enforcement Bulletin*. <https://leb.fbi.gov/2013/january/crisis-intervention-teams-responding-to-mental-illness-crisiscalls>
- Mayo Clinic. (2022). Diseases and Conditions: Mental Illness. Retrieved from <http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/definition/con-20033813>
- Mental Health America of Greater Dallas. (2022). Stigma. Retrieved from <https://mhadallas.org/stigma/>
- Merriam-Webster Dictionary. Crisis. (2017). Retrieved from <https://www.merriamwebster.com/dictionary/crisis>
- National Alliance on Mental Illness (NAMI). (2017). Mental Health Conditions. Retrieved from <https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions>
- National Institute on Aging. (2017). What is Dementia? Retrieved from <https://www.nia.nih.gov/health/what-dementia>
- National Institute on Alcohol Abuse and Alcoholism (NIAAA). (2017). <https://www.niaaa.nih.gov/>
- National Institute on Drug Abuse (NIDA). (2017). <https://www.drugabuse.gov/>
- National Institutes of Health (NIH). (2017). Dementia. From the U.S. National Library of Medicine. Retrieved from <https://medlineplus.gov/dementia.html>
- National Institutes on Mental Health (NIMH). (2017). <https://www.nimh.nih.gov/>
- NIMH. (2015). Any Mental Illness Among U.S. Adults. Retrieved from <https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml>

- Norris, D., & Clark, M. S. (2015). Evaluation and Treatment of the Suicidal Patient. *American Family Physician*, 85(16), 602-605. Retrieved from <http://www.aafp.org/afp/2012/0315/p602.html>
- O'Hara, A. (2018). Police Suicides in 2017. Retrieved from <http://lawofficer.com/exclusive/2017-police-suicides-continuing-crisis/>
- Police Executive Research Forum. (2016). Guiding Principles on Use of Force. <http://www.policeforum.org/assets/guidingprinciples1.pdf>
- Police Executive Research Forum. (2016). Integrating Communications, Assessment, and Tactics. Critical Issues in Policing, 1-72. Retrieved from <http://www.policeforum.org/assets/icattrainingguide.pdf>
- SPRC. (2017). Understanding Risk and Protective Factors for Suicide: A primer for preventing suicide. Retrieved from <https://www.sprc.org/sites/default/files/migrate/library/RiskProtectiveFactorsPrimer.pdf>
- Sifferlin, A. (2016). Most Violent Crimes are Wrongly Linked to Mental Illness. *Time Magazine*. Retrieved from <http://time.com/4358295/violent-crimes-mental-illness/>
- Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime Victimization in Adults with Severe Mental Illness: Comparison With the National Crime Victimization Survey. *Archives of General Psychiatry*, 62(8), 911–921. <http://doi.org/10.1001/archpsyc.62.8.911>
- Texas Commission on Law Enforcement, Course #1850: Crisis Intervention Training Course.
- Texas Commission on Law Enforcement, Course #1000720: Basic Police Officer Course, Module 29: Crisis Intervention Training.
- TDHCA. (2016). 2016 State of Texas Low Income Housing Plan and Annual Report (Texas Department of Housing and Community Affairs). Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/16SLIHP.pdf>
- Texas Penal Code. (2017) West Publishing.
- Veteran's Administration. (2017). How Common is PTSD. Retrieved from <https://www.ptsd.va.gov/public/ptsdoverview/basics/how-common-is-ptsd.asp>
- Washington State Police Toxicology Laboratory. (2015). Drug Category Reference. Retrieved from http://www.wsp.wa.gov/breathtest/docs/webdms/DRE_Forms/Publications/drug/Drug%20Reference%20Spreadsheet_03-2015.pdf

Crisis Intervention Training Refresher Course

Learning Objectives

UNIT 1 The Importance of CIT in Law Enforcement

- 1.1 **Learning Objective:** The student will be able to discuss the origins of Crisis Intervention Training (CIT).
- 1.2 **Learning Objective:** The student will be able to explain the goal of CIT.
- 1.3 **Learning Objective:** The student will be able to explain CIT's impact on community relations.
- 1.4 **Learning Objective:** The student will be able to define the meaning of crisis as it pertains to CIT.

UNIT 2 Mental Illness

- 2.1 **Learning Objective:** The student will be able to list several potential causes for a mental health crisis.
- 2.2 **Learning Objective:** The student will be able to express an increased awareness of mental illness and the adversity that surrounds a mental health diagnosis.
- 2.3 **Learning Objective:** The student will be able to define insanity and how the term is used in Texas
- 2.4 **Learning Objective:** The student will be able to discuss the concept of normal versus abnormal behavior.
- 2.5 **Learning Objective:** The student will be able to cite several reasons why many people do not seek treatment for mental illness.
- 2.6 **Learning Objective:** The student will be able to discuss the concept of stigma.

UNIT 3 Personality, Mood, and Thought Disorders

- 3.1 **Learning Objective:** The student will be able to identify behaviors associated with personality disorders.
- 3.2 **Learning Objective:** The student will be able to identify behaviors associated with mood disorders.
- 3.3 **Learning Objective:** The student will be able to identify behaviors associated with thought disorders.

UNIT 4 Drugs and Substance Abuse

- 4.1 Learning Objective:** The student will be able to identify symptoms associated with the ingestion of specific types of drugs and controlled substances.
- 4.2 Learning Objective:** The student will be able to describe the role and complications of psychotropic drugs.
- 4.3 Learning Objective:** The student will be able to describe some of the reasons people stop taking medications.

UNIT 5 Cognitive and Developmental Disorders

- 5.1 Learning Objective:** The student will be able to identify symptoms and behaviors associated with cognitive disorders.
- 5.2 Learning Objective:** The student will be able to describe the symptoms and behaviors associated with dementia and Alzheimer's Disease.
- 5.3 Learning Objective:** The student will be able to identify methods most effective in talking to someone with dementia.
- 5.4 Learning Objective:** The student will be able to describe developmental disorders, and recognize the symptoms and behaviors associated with Autism Spectrum Disorders.
- 5.5 Learning Objective:** The student will be able to define the term intellectual disability and what that means in terms of law enforcement interactions.
- 5.6 Learning Objective:** The student will be able to discuss effective communication methods for individuals that have an intellectual disability.

UNIT 6 Post-Traumatic Stress Disorder

- 6.1 Learning Objective:** The student will be able to list some of the causes of Post-Traumatic Stress.
- 6.2 Learning Objective:** The student will be able to recognize symptoms and behaviors of an individual experiencing PTSD.

UNIT 7 Suicide

- 7.1 Learning Objective:** The student will be able to recognize known and quantifiable suicide risk factors.
- 7.2 Learning Objective:** The student will be able to list protective factors against suicide.
- 7.3 Learning Objective:** The student will be able to list a suicide risk assessment.
- 7.4 Learning Objective:** The student will be able to demonstrate assisting an individual to name and contact personal support services.
- 7.5 Learning Objective:** The student will be able to discuss statistics and trends in law enforcement suicide.

UNIT 8 Culture, Assessment, and the Legal Process of Crisis Intervention

- 8.1 Learning Objective:** The student will be able to discuss ways to change current mental health culture.
- 8.2 Learning Objective:** The student will be able to discuss the initial Three-Point Assessment.
- 8.3 Learning Objective:** The student will be able to determine the relationship between homelessness, mental illness, and victimization.
- 8.4 Learning Objective:** The student will be able to explain the legal considerations for police intervening in a mental health crisis and the provisions that pertain to law enforcement duties in the Health and Safety Code.
- 8.5 Learning Objective:** The student will be able to discuss community and referral resources and options within his/her respective geographical area.

Crisis Intervention Refresher Course

UNIT 1. The Importance of Crisis Intervention Training in Law Enforcement

1.1 The student will be able to discuss the origins of Crisis Intervention Training (CIT).

With increasing frequency, law enforcement is being called upon to respond to individuals in serious mental health crises. It is necessary for law enforcement personnel to understand mental illness, and the tactics and techniques that have been proven to work most effectively when responding to individuals in these situations. These tactics and techniques are different than those routinely taught to officers to manage conflict. Generally, the underlying element behind mental illness-related behavior is usually not criminal or malicious.

Utilizing the information from this course, and implementing effective strategies can help keep the officer safe, keep the public safe, and greatly reduce civil liability.

1.2 The student will be able to explain the goal of CIT.

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

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

CIT educates officers on how to identify behaviors that may indicate the presence of mental illness and provide officers with de-escalation skills to mitigate violence and increase officer and public safety. CIT also provides information on how to safely transport someone in mental health crisis to an appropriate resource or facility.

1.3 The student will be able to explain CIT’s impact on community relations.

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

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

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

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

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

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

Crisis is “a paroxysmal attack of pain, distress, or disordered function” or an “emotionally significant event or radical change of status in a person’s life” (Merriam-Webster, 2017).

The crisis may have been precipitated by a loss or a challenging situation and may result in the person feeling confused, alarmed, overwhelmed, desperate, hopeless, helpless, enraged, or terrified. A person in crisis may be more prone to acting instinctually (self-preservation) rather than with logical thought; non-compliance may be the result of a combination of these factors rather than an intentional act of defiance.

UNIT 2. Mental Illness

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

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

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

External factors that can contribute to a situation escalating into a crisis include:

- Expectations the person cannot meet
- Lacking a sufficient support system or being disconnected from sources of support
- Substance Abuse

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

2.2 The student will be able to express an increased awareness of mental illness and the adversity that surrounds a mental health diagnosis.

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

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

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

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

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

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

INSTRUCTOR NOTE: The definition will vary state to state.

According to the Texas Penal Code, Section 8.01, insanity “is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong. The term ‘mental disease or

defect' does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct."

The term 'insanity' is not a psychological term, but is a legal term used as a defense to avoid criminal consequences for certain acts.

2.4 The student will be able to discuss the concept of normal versus abnormal behavior.

The concept of "normalcy" is based upon what is accepted in a society or culture. "Norms" are based upon numerous variables:

- Ethnicity
- Religion
- Occupation
- Social group
- Developmental level
- Education

A sharp dividing line between 'normal' and 'abnormal' behavior does not exist and is often based upon social norms for specific societies, cultures, and subcultures.

INSTRUCTOR NOTE: Consider the difference in norms and customs for most Texans compared to those of an indigenous tribe in the Amazon jungle. If practiced in the other culture or society, those practices may be deemed 'abnormal.'

2.5 The student will be able to cite several reasons why many people do not seek treatment for mental illness.

Mental illness can, and should, be treated (NAMI, 2017). Unfortunately, nearly two-thirds of all people with a diagnosable mental illness do not seek treatment (Mental Health America of Texas, 2017). 21.4% of youth age 13-18 experience a severe mental disorder, and approximately 13% of children age 8-15. (NAMI, 2017). With recognition, proper treatment (to include medication and therapy), and a commitment to wellness, people who experience mental illness can live rewarding, satisfying, and productive lives.

2.6 The student will be able to discuss the concept of stigma.

Stigma is a mark of disgrace or shame. It is made up of various components, including:

- Labeling someone with a condition
- Stereotyping people with that condition
- Creating a division (a superior 'us' and a denigrated 'them')
- Discriminating against someone on the basis of a label

There remains a stigma attached to mental illness and prejudices against individuals that suffer from mental illness. Mental illness continues to be widely misunderstood by the

general public. Therefore, it is important to increase education and awareness especially among those that might interact with individuals experiencing mental illness.

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

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

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

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

Individuals are often discouraged and/or unable to persist in finding the best treatment options for their condition and circumstances, since there is no "one size fits all" treatment. Treatment refusal can be problematic for law enforcement. For individuals with access to medications, they often decline or discontinue the medications for a variety of reasons, including:

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

UNIT 3. Personality, Mood, and Thought Disorders

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

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

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

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

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

Paranoid Personality Disorder:

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

Antisocial Personality Disorder:

- This use of the term ‘antisocial’ is not akin to the societal use of the word to describe someone who does not want or enjoy being social.
- Pervasive pattern of disregard for and violation of the rights of others, occurring since age 15.
- A pattern of rule-breaking and failure to conform to social norms (infringing upon the rights of others) and/or consistently engaging in illegal behavior.

- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal gain.
- Aggressiveness as indicated by repeated physical altercations (including the use of weapons) and/or a history or propensity to harm animals.
- Consistent irresponsibility as indicated by failure to sustain gainful employment or honor financial obligations.
- Lack of remorse.
- Lack of willingness to accept accountability or consequences of his/her actions.
- When considering the continuum of severity, this diagnosis could as easily apply to the gang member or the Wall Street executive.
- More frequently diagnosed in males.

Borderline Personality Disorder:

- A pervasive pattern of instability of interpersonal relationships, self-image, emotional expression, and poor impulse control.
- May exhibit frantic efforts to avoid abandonment. A pattern of unstable relationships marked by idealizing and devaluing partners. Self-damaging impulsivity (e.g. excessive spending, promiscuous unprotected sex, substance abuse, other recklessness).
- Recurrent suicidal behavior.
- Poor anger control.
- Emotional over-reactivity.
- More frequently diagnosed in females.

Note: It is a common misunderstanding that 'Borderline Personality Disorder' is a designation meaning someone almost experiencing another kind of mental illness. Such as; 'borderline schizophrenia,' or a 'borderline substance abuser.' This is simply a mistake of language.

Narcissistic Personality Disorder:

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

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

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

circumstances. Examples of mood disorders include depressive disorders and bipolar disorders.

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

Two mood disorders most likely to be encountered by law enforcement officers are Depression and Bipolar Disorder.

Depression:

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

Common symptoms of depression may include:

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

The single most common factor in suicidal behavior or death by suicide is that the individual is experiencing depression.

Bipolar Disorder:

- Bipolar disorder is a mental illness involving cycles between extreme activity and emotional highs (mania) and depression. The strongest predictors of bipolar syndrome appear to be baseline anxiety/depression which increases the risk of bipolar disorder from 2% (baseline risk due to family history) to 49% (Bernstein, 2017).

- 20% of adults with bipolar disorder had symptoms beginning in adolescence (Bernstein, 2017). Average age of onset is approximately 25.
- The lifetime prevalence rate is approximately 4% of the U.S. population will experience a bipolar episode within their lifetime (MHA, 2017).
- More commonly diagnosed in women than men.
- Suicide risk is 15 times higher than the general population.
- Outcome studies show that compared with unipolar depression, bipolar disorder causes more work disability and overall poorer outcome (Bernstein, 2017).
- Impulsivity is usually the reason for law enforcement interaction, which results from exhibitionism, shop-lifting, substance abuse, or other illegal activities.
- Each phase of mood lasts at least four days.
- People usually only seek professional assistance during the depressive phase, as the manic phase is reportedly very pleasant, energetic, and creative.

The depressive phase of bipolar disorder may include:

- Prolonged feelings of sadness or hopelessness
- Feelings of guilt and worthlessness
- Difficulty concentrating or deciding
- Lack of interest
- Low energy
- Changes in activity level
- Inability to enjoy usual activities
- Fatigue
- May include:
 - Abnormally high, expansive, joyful, angry, or irritated mood
 - Inflated self-esteem
 - Decreased need for sleep
 - More talkative than usual
 - Flight of ideas or feeling of thoughts racing
 - Excessive risk-taking

The manic phase of bipolar disorder may include poor insight into one's disorder or behaviors and poor judgment accompany mania. Therefore, the person's financial accounts or important relationships may be in such disarray as to lead to adverse outcomes, including loss of important friends and family support or connections, serious financial setbacks, job losses, legal problems, and homelessness (Bernstein, 2017).

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

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

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

Symptoms of a thought disorder:

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

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

Delusions: Fixed false beliefs that are maintained despite overwhelming evidence to the contrary. Bizarre delusions are things that could not occur in real life (e.g. aliens removed all the person's organs and they continue to function without any internal organs). Non-bizarre delusions are events that could occur in real life (e.g. phone tapped by the FBI, people are out to get me).

Hallucinations: Distortions in sensory input, causing the individual to experience hearing, seeing, feeling, or smelling something that is not apparent to others. Hallucinations can make it very difficult for someone to focus on a conversation, hear, understand, or respond to what is being said.

- Auditory hallucinations are most common, followed by visual hallucinations. A person may experience more than one auditory hallucination at a time.
- Tactile hallucinations are less frequent, but happen, sometimes resulting in self injury.

UNIT 4. Drugs and Substance Abuse

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

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

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

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

Mental illness can co-occur with substance abuse.

- Illegal drug and alcohol usage is also a primary concern for individuals with a mental illness. These substances can have an adverse effect when used in combination with prescribed medications, and/or when used to self-medicate. In addition, combining drugs or alcohol with medications may result inconsistent medication absorption, dangerous chemical combinations, and a lack of medical monitoring.
- Substance abuse treatment is a critical element in a comprehensive system of care. Research conducted over the last decade has shown that the most successful models of treatment for people with co-occurring disorders provide integrated mental health and substance abuse services.
- Substances are defined by category and familiar types in the category. These descriptions are courtesy of the International Drug Evaluation and Classification Program (2017). The behavioral or physical manifestations of intoxication, and signs of overdose are provided from the Drug Recognition Expert (DRE) Matrix (MN DPS, 2017), and is the legally accepted standard for categorizing drugs and their effects. You will either recall this from SFST training, or will soon have it in SFST training.
- It is important to remember that it is rare to see someone intoxicated from the ingestion of just one type of drug, dangerous drug, or other substance. Especially as it pertains to prescription medications and psychotropic drugs, there is very often a mix of substances influencing the symptoms and physical manifestations that are visible.
- An annex of this training includes a more comprehensive listing of specific drugs, their DRE category, as well as their pharmaceutical category (if any) (Washington State Patrol, 2015). We must reiterate that examples of each drug category include both legal prescription drugs, illegal drugs, and dangerous drugs. Understand that the categories below are based on the physiological reactions in the body to the drugs, not necessarily the behavioral or psychiatric changes that they may elicit.

Central Nervous System (CNS) Depressants:

CNS depressants slow down the operations of the brain and the body.

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

Central Nervous System (CNS) Stimulants:

CNS stimulants accelerate the heart rate and elevate the blood pressure and 'speed-up,' or over-stimulate, the body.

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

Hallucinogens:

Hallucinogens cause the user to perceive things differently than they appear to others.

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

Dissociative Anesthetics:

Dissociative anesthetics include drugs that inhibit pain by cutting off or dissociating the brain's perception of the pain.

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

Narcotic Analgesics:

Narcotic analgesics relieve pain, induce euphoria, and create mood changes in the user.

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

Inhalants:

Inhalants include a wide variety of breathable substances that produce mind-altering results and effects.

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

Cannabis:

Cannabis is the scientific name for marijuana. The active ingredient in cannabis is delta-9-tetrahydrocannabinol, or THC. This category includes cannabinoids and synthetics like K2, Spice, Yucatan Fire, JWH, RCH, UR-114 and XLR-11.

- Some indications of cannabis ingestion include: body tremors, disoriented debris in mouth, eyelid tremors, impaired perception of time and distance, increased appetite, marked reddening of conjunctiva, odor of burnt marijuana, possible paranoia, and relaxed inhibitions.

- Methods of administration include ingestion and smoking.
- There is no known overdose level for Cannabis.
- While some companies produce CBD oil that's completely THC-free, others formulate products that contain a slight amount of THC. But often, these products only carry roughly 0.5% THC or less.

Other Substances:

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

Kratom affects the same opioid brain receptors as morphine, appears to have properties that expose users to the risks of addiction, abuse, and dependence (FDA, 2018). In Thailand, it is a controlled substance and is a commonly abused illegal drug (Huus, 2012). In the U.S., kratom is listed as a "drug of concern" by the DEA. Kratom may be mixed with a caffeinated beverage, or codeine-containing cough syrup, perhaps most often to create the drink called 4x100. This drink is said to have effects similar to alcohol intoxication (Huus, 2012).

4.2 The student will be able to describe the role and complications of psychotropic drugs.

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

Medication can be an essential part of an effective treatment plan and is often used to treat some of the following conditions and symptoms:

- Psychosis
- Anxiety
- Depression
- ADHD
- Impulse control
- Mood swings (also known as lability)

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

4.3 The student will be able to describe some of the reasons people stop taking medications.

Treatment compliance is an ongoing struggle for many individuals, for reasons including:

- Lack of health insurance coverage
- Expense of medications

- Unpleasant side effects, including weight gain (sometimes extreme), severe constipation, sexual dysfunction, or a feeling of being dissociated, floaty, or out of sync with their body.
- Many of the side effects are not permanent

Neurological damage can occur if an individual has had to take a form of medication in high doses for many years.

Others may stop due to lack of access to consistent mental health treatment or simply due to not wanting to take medications daily for life.

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

UNIT 5. Cognitive and Developmental Disorders

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

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

- Attention: Ability to sustain attention to a task; ability to pay attention to something despite other distractions; ability to do two things at once.
- Executive function: Impaired ability to plan, make decisions, hold information briefly in one's mind (e.g. telephone number), ability to learn from mistakes.
- Learning and memory: Ability to repeat words or digits; ability to recall recent information; ability to apply information.
- Language: Ability to find the correct labels or words for an object or situation; misuse of names, verbs, or other word choices; comprehension.
- Perceptual-motor: Eye-hand/body coordination.
- Social awareness: Identification in changes in others' facial expression; emotional intelligence.

5.2 The student will be able to describe the symptoms and behaviors associated with dementia and Alzheimer's Disease.

"Dementia is a name for a group of symptoms caused by disorders that affect the brain" (National Institutes of Health (NIH), 2017). It is a degeneration of mental functioning involving thinking, memory, and reasoning. Dementia severity can range from mild (some impairment in day to day living) to severe (completely reliant upon others for basic needs).

Although memory loss is a common sign of dementia, memory loss alone does not mean someone has dementia (NIH, 2017). Dementia is not a normal part of the aging process,

but, up to half of all people over the age of 85 are affected by some form of dementia (National Institute on Aging (NIA), 2017).

Dementia can be caused by a number of different health conditions, including vascular disease, brain damage, stroke, as well as other conditions. “Six out of 10 people with Alzheimer’s will wander,” either on foot in via car, and “if not found within 24 hours, up to half of those who wander risk serious injury or death” (Alzheimer’s Association, 2017).

The Aging and Disability Resource Centers (ADRCs), run by the Texas Health and Human Services Commission can be excellent resources for officers who come across an elderly adult who may need assistance. More information, can be found at www.hhs.texas.gov/adrc.

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

Communication considerations for communicating with individuals dealing with dementia:

- Speak clearly and concisely; resist the urge to speak loudly.
- Due to potential difficulty with language comprehension, consider using ‘yes’ or ‘no’ questions.
- If the person appears to have difficulty with verbal comprehension, you may try using non-verbal prompt and/or written prompts.
- Be patient if the subject does not immediately follow requests or commands and/or if the subject is having difficulty communicating him/herself. The subject is likely not being intentionally resistive but is likely to be acting out of fear, confusion, and may have some delusional thought processes.
- Provide reassurance of the person’s safety.
- Check for an identification bracelet, pendant, key chain, wallet card, or clothing number that may have the person’s Safe Return ID number and emergency contact.

Source: (<https://www.nia.nih.gov/health/alzheimers/caregiving>)

Possible interactions law enforcement will have with individuals dealing with dementia include:

- Car accidents and/or erratic driving
 - Due to confusion, diminished physical abilities, and/or memory impairment a person with may fail to obey street signs or traffic laws and may flee the scene.
 - May drive similarly to someone under the influence, yet no presence of alcohol or other substances.
- False reports & victimization
 - A person with may lose or misplace items and call 911 to report a theft.
 - In some cases, reports of a burglary-in-progress or intruder, turns out to be a family member, a delivery person, a home health aide, or even a spouse.

- Indecent Exposure
 - A person with may forget social norms and have diminished impulse control.
 - It is common for the person to leave the house without proper attire or to undress in public.
- Shoplifting - Due to memory impairment, a person may forget to pay for items.
- Homicide - The presence of a weapon may lead to unexpected danger, as a person may believe his/her loved one is an intruder.

5.4 The student will be able to describe developmental disorders and recognize the symptoms and behaviors associated with Autism Spectrum Disorders.

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

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

- When interviewing, be patient, calm, and detached, which tends to help prevent agitation in questioning process. It is best to interact with a trusted care-provider to determine the best way to conduct an interview.
- Avoid physical contact or limiting personal space, which may result in an unintended use of force situation.
- Some people on the autism spectrum cannot communicate verbally, or use only a cluster of words. Illustrative materials, repetition (clarification) of previous statements, praise, encouragement, and attentive listening will assist in the exchange process.

Examples of behavioral characteristics for someone with autism spectrum disorder:

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

- Person may become distraught if object of attention is removed or withheld.
- Individual may exhibit repetitive motor movements, such as rocking, hand motions, head banging, or biting (Almquist, 2017).
- Atypical motor movements may be evident, such as walking on tiptoes or unusual gait.
 - Can be impulsive and potentially aggressive without provocation.
 - Differences typically become noticeable by age 3.

INSTRUCTOR NOTE: The severity of the condition ranges from severe (sometimes non-verbal, highly reactive to change, surprise, or strangers; with co-occurring intellectual disability) to mild (able to function, maintain employment, and live independently while also creating and maintaining reciprocal relationships).

5.5 The student will be able to define the term intellectual disability and what that means in terms of law enforcement interactions.

Intellectual disability includes deficits in intellectual and adaptive functioning (failure to meet developmental and socio-cultural standards for intellectual and personal independence standards) (DSM-V). Intellectual disability is detectable in infancy or early childhood, and by definition, must be diagnosed by the age of 18. It is a fixed mental condition that, unlike many mental illnesses, cannot be “cured.”

Limitations may include deficits in communication, self-care, home living, personal safety, academic functioning, occupational abilities.

5.6 The student will be able to discuss effective communication methods for individuals that have an intellectual disability.

Strategies to use during officer contact in determining possible intellectual disability include:

- Criminal Activity
 - Subject may likely be noticeably older than others involved in offense.
 - Apparent the subject is a follower rather than leader of criminal activity.
 - May readily confess, due to lack of full understanding of the circumstances.
 - Behavior at the scene (remained at the scene while others ran).
 - May have been used as a pawn by more sophisticated offenders.
- Speech/Language
 - Obvious speech defects.
 - Limited ability to speak or comprehend at age-normative level.
 - Marked difficulty maintaining attention or conversation.
 - Difficulty describing facts in detail.
- Social Behavior
 - Adult associating with children or early adolescents.
 - Ignorance of personal space.
 - Non-age appropriate behavior.

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

INSTRUCTOR NOTE: An inability to read or write is illiteracy and in and of itself does not indicate intellectual disability.

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

UNIT 6. Post-Traumatic Stress Disorder

6.1 The student will be able to list some of the causes of Post-Traumatic Stress.

Post-traumatic stress can develop after a person is exposed to a traumatic event, including actual or threatened death, injury, or sexual violence (MHA, 2017). A person may have experienced the traumatic event(s) directly, or may have witnessed them occur to someone else. Examples of events that can result in post-traumatic stress disorder (PTSD) include but are not limited to:

- Physical violence (abuse, assault, physical attack, robbery, domestic violence)
- Sexual violence (rape, sexual abuse, sex trafficking, noncontact sexual abuse)
- Combat (civilian or military)

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

A number of variables play into why some people may develop PTSD from a trauma exposure, while others will not. Some of those variables include (SAMSA, 2014):

- The intensity of duration of the trauma.
- Frequency of exposure.
- Lasting injury or impairment from the trauma.
- How much control the person felt during the traumatic event.
- Intensity of emotional reaction during the event.
- Level and quality of support received (or perceived access to support) following the event.

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

Symptoms connected to PTSD:

- Intrusion symptoms:
 - Recurrent unwanted dreams, images, or memories.
 - Feeling or acting as if the event is occurring in the present.
 - Intense distress at reminders of the trauma.
 - Avoidance.
 - Efforts to avoid distressing memories, thoughts, or feelings reminiscent of the trauma.
 - Avoidance of people, places, things, or other reminders of the trauma. For example, a person who was assaulted by someone in uniform may avoid or refuse to talk to, or make eye contact with someone in uniform.
- Negative changes in mood and thought patterns:
 - Persistent and exaggerated negative beliefs and expectations.
 - Self-blame, also known as survivor's guilt.
 - Persistent feelings of fear, horror, shame, guilt, anger.
 - Loss of interest or participation in events, gatherings, or social activities.
 - Persistent inability to experience positive emotions.

UNIT 7. Suicide

7.1 The student will be able to recognize known and quantifiable suicide risk factors.

- Male, age 15-34
- Depression
- Substance intoxication
- Previous suicide attempts
- Feelings of hopelessness/helplessness/powerlessness
- Specific plan, intent, and means to complete the plan
- Lack of support system or connection to loved-ones
- Recent loss (divorce, child custody, retirement, death of loved one, or loss of job)

- Feeling one is worth more to his/her loved one's dead than alive (feels like a burden to family)

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

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

Source: SPRC, 2017

7.3 The student will be able to list a suicide risk assessment.

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

7.4 The student will be able to demonstrate assisting an individual to name and contact personal support resources.

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

- Symptoms
 - Is the person exhibiting active symptoms such as psychosis, substance intoxication, or extremely slow or rapid speech patterns?
- Nature of current stressor
 - Is this current stressor chronic or acute?

- Chronic stressor is a greater risk (such as a terminal illness)
- Offer practical suggestions
 - Suicide hotline numbers, information on how to seek treatment, and help the person locate a resource.
 - Consider existing social supports such as, religious affiliation, social services, family, neighbors.

7.5 The student will be able to discuss statistics and trends in law enforcement suicide.

An organization called Badge of Life (2018), estimates that “More cops die of suicide than die of shootings and traffic accidents combined.” Badge of Life has collected data between 2008 and 2017, and found that there is an average of 130 law enforcement suicides every year, or eleven per month. Unfortunately, that number is believed to be higher, due to agencies’ desire to report deaths in other ways (O’Hara, 2018). “Based on available figures, the average age for a police suicide was 42 years. Time on the job averaged 16 years. 96% of suicides were males. By the end of the year, five chiefs/sheriffs were known to be lost, six lieutenants, and nine sergeants. The remainder of suicides were officers and deputies” (O’Hara, 2018).

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

UNIT 8. Culture, Assessment, and the Legal Process of Crisis Intervention

8.1 The student will be able to discuss ways to change current mental health culture.

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

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

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

One measure of hope has to do with a new and younger generation of police officers that are coming into the fold. Long lasting attitudes, stigmas and fears about discussing mental health are gradually eroding. There is still a chance that, as these officers continue to permeate the ranks and fill the leadership, more law enforcement personnel will not only seek help “when it’s needed,” but do so before it’s needed.

8.2 The student will be able to discuss the initial Three-Point Assessment.

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

1. Level of comprehension

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

2. Behavior

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

3. Emotion

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

8.3 The student will be able to determine the relationship between homelessness, mental illness, and victimization.

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

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

“In 2006, Markowitz published data on 81 US cities, looking at correlations between the decreasing availability of psychiatric hospital beds and the increase in crime, arrest rates, and homelessness. As expected, he found direct correlations. This is consistent with past studies in Massachusetts and Ohio that reported that 27 and 36 percent of the discharges from state mental hospitals had become homeless within six months.” (Mental Illness Policy, 2017).

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

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

8.4 The student will be able to explain the legal considerations for police intervening in a mental health crisis and the provisions that pertain to law enforcement duties in the Health and Safety Code.

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

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

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

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

Persons with mental illness as victims of crime:

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

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

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

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

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

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

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

Involuntary Commitment:

- Warrantless Apprehension, also called a Police Officer Emergency Commitment or Detention

Emergency Detention Order:

- Emergency Detention Order - TX Health and Safety Code Section 573.002
 - When an officer transports someone due to mental health concerns, the officer must file a notification of detention with the receiving facility.

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

Limitation of Liability:

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

INSTRUCTOR NOTE: Explain to Students the process of locating and contacting a mental health authority in their service area. Review the inpatient detention process as it occurs in Texas, using this example of a very similar process. Discuss the differential process based upon whether or not the person receives adequate treatment prior to release.

8.5 The student will be able to discuss community and referral resources and options within his/her respective geographical area.

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

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

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

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

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