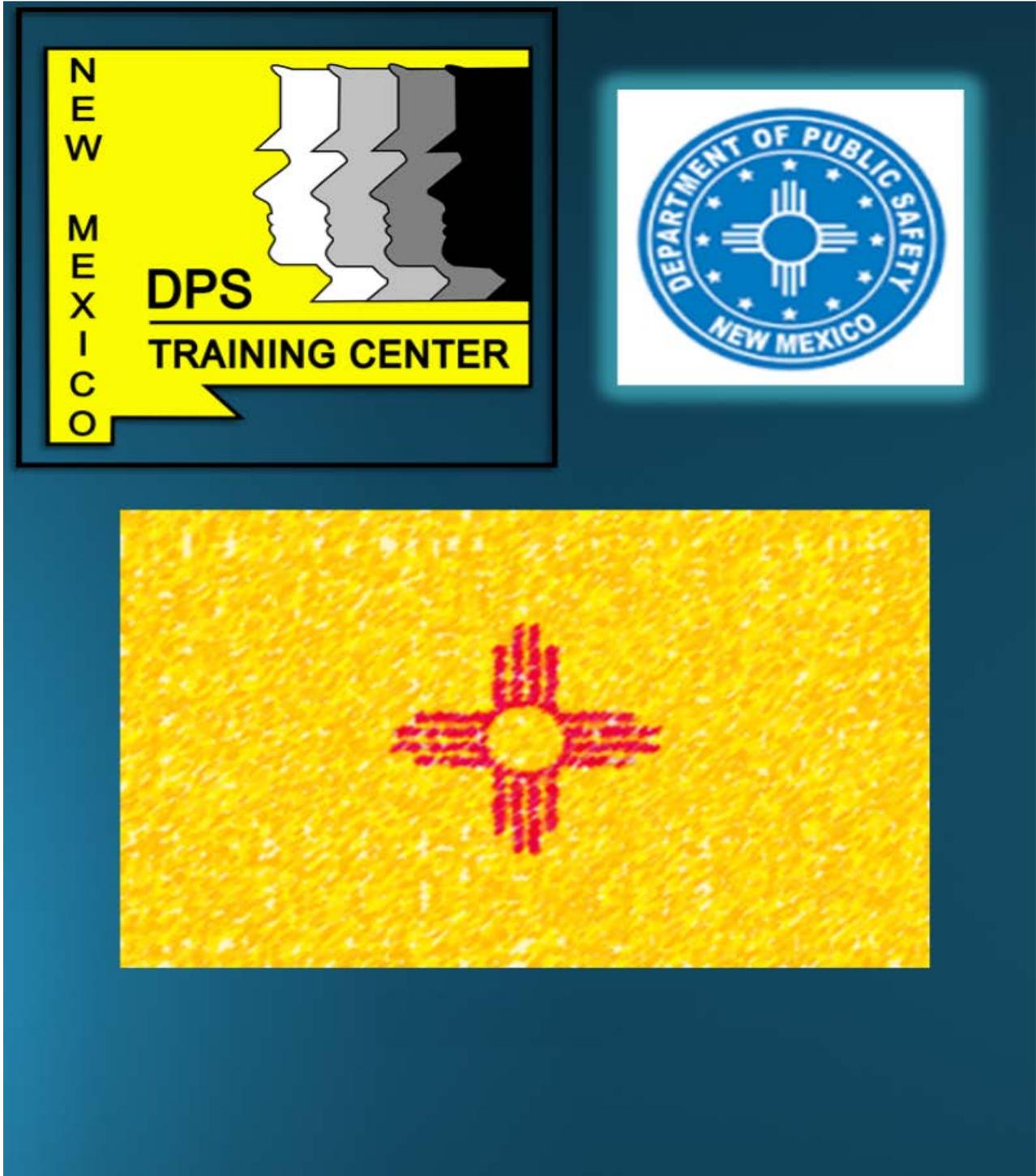


Lesson Plan / Instructor Guide



COURSE TITLE:

**Dealing with Persons with Mental Impairments
Biennium Refresher**

INSTRUCTIONAL GOAL:

To provide the student with the awareness of crisis management, including crisis intervention, confrontation, de-escalation practicum and proper interaction with persons with mental impairments.

INSTRUCTIONAL OBJECTIVES:

Upon completion of this block of instruction the participant will:

- 1) List the eight general characteristics of psychosis
- 2) List 4 behaviors an officer should display when interacting with a person with mental illness to maximize safety
- 3) Describe the four major steps for obtaining an involuntary commitment order by a law enforcement officer.
- 4) Demonstrate your ability to de-escalate others through in-class video or role-play practicum

INSTRUCTIONAL METHODS:

Lecture w/Power Point

HANDOUTS:

None

COURSE DURATION:

3 hours

CURRICULUM REFERENCES:

NMLEA (2017) Biennium Interaction with Persons with Mental Impairments lesson plan

EQUIPMENT, PERSONNEL, AND SUPPLIES NEEDED:

Computer, projector, screen

TARGET AUDIENCE:

NM Certified Law Enforcement Officers

INSTRUCTOR RATIO:

1:60

EVALUATION STRATEGY:

Discussion

AUTHOR & ORIGINATION DATE:

NMLEA ATB Staff

Jan. 2018

REVISION / REVIEW DATE(S):

[Dates of any reviews/revisions]

REVISED / REVIEWED BY:

[Your name or your agency name]

Introduction

A. *Mental disorders* were once thought to affect very few, but today we know the opposite is true. Many people with these conditions lead full, productive, and satisfying lives. Despite living with a diagnosis such as substance use disorder, eating disorder, depression, bipolar disorder, or schizophrenia, people go to work, vote, own homes and businesses, and contribute to their communities. Even as negative myths abound, there is hope and renewed optimism regarding the outcomes of living with mental health challenges. It is important for first responders to distinguish between the person experiencing a mental health crisis and the problem or circumstance itself. It is neither accurate nor fair to define people by their perceived conditions and we must continue to work to overcome the stigma and discrimination associated with mental illness not only in public safety but in our communities as well. Consider how we view other health issues, have you ever heard someone referred to as "a cancer," or "a broken leg?" Yet, we often do hear people referred to as "manic depressives" or "schizophrenics" or "crazy" This kind of derogatory labeling is disrespectful and creates a formidable barrier to successful interactions and interventions.

Responding to individuals in serious mental health crises has been historically problematic for law enforcement personnel. A lack of education and understanding of mental illness and de-escalation/crisis intervention techniques have led to the following consequences in many law enforcement agencies:

- ❖ **Litigation.** Responding to individuals in serious mental health crises has become one of the most litigious areas of law enforcement. Mental health consumers are injured and killed by law enforcement officers at a rate higher than the average population. Many law enforcement agencies across the nation have been sued for shooting individuals in serious mental health crises.
- ❖ **Injuries.** Officers and consumers are injured during these encounters at a rate significantly higher than the average population.
- ❖ **Low Public Confidence.** Many family members of individuals with mental illness are afraid to call the police because they fear the police may kill their family member.
- ❖ **Incarceration of the Mentally Ill.** Jails and prisons have become the mental hospitals of the 21st century. Over 500,000 inmates in jails and prisons across the United States have mental illness. Yet there are fewer than 50,000 individuals with mental illness in state mental hospitals. The largest mental health facility in the United States is the Los Angeles County Jail, which averages 3,000 mentally ill inmates a day. Many of these individuals cycle in and out of jails and prisons on petty, nuisance-type crimes. One reason for this is the lack of alternative facilities for the mentally ill. A second reason is a lack of knowledge of mental illness among many law enforcement officers.

- ❖ **Lack of Self-Confidence among Police.** Many officers lack confidence in their ability to adequately respond to individuals in serious mental health crises. This is due to a lack of education about mental illness and de-escalation/crisis intervention techniques that have been proven to help de-escalate these situations.

Additionally, America today is suffering from a [severe shortage of psychiatric hospital beds](#) (Treatment Advocacy Center, 2008). Ninety percent of state hospital beds across the country have been eliminated since 1960, and substantial numbers of the surviving beds may be further impacted by current economic conditions affecting state budgets.

B. Statistics

- Approximate number of Americans over 18 with severe mental illness: 7.7 million (3.3% of the population)*
- Approximate number of Americans over 18 with severe bipolar disorder: 5.1 million (2.2% of the population)*
- Percentage untreated in any given year: 51%*
- Approximate number of Americans over 18 with schizophrenia: 2.6 million (1.1% of the population)*
- Percentage untreated in any given year: 40%*
- Approximate number of Americans over 18 with **untreated** severe mental illness: 3.6 million*
- Approximate number of Americans over 18 with untreated severe mental illness who are homeless: 200,000
- Approximate number of Americans over 18 with untreated mental illness who are in jails or prisons: 319,000
- Approximate percentage of homicides committed by Americans with severe mental illness: 10% (approximately 1,600/year)
- Approximate number of annual suicides by Americans with severe mental illness: 6,000
- Approximate percentage of people with schizophrenia who suffer impairment of insight (anosognosia): 50%
- Approximate percentage of people with bipolar disorder who suffer impairment of insight: 40%

* National Institute of Mental Health, 2010

A 10-year study of Medicaid mental health care spending in Florida found nearly a 1000% increase in spending on antipsychotics prescribed for depression with no clear evidence of improvement in how people fared ("[Spending on depression up, quality of care lagging](#)," Reuters Health, Dec. 6). The use of hospitalization and antidepressants fell during the study period.

"With the decline in use of hospitalization and antidepressants going generic, the cost of treating depression could have been expected to be falling over this period, but this didn't happen," author

Thomas G. McGuire, a professor of health economics at Harvard Medical School in Boston and an author of the study, told Frederik Joelsing of Reuters Health "Patients were getting more drugs, mainly more antipsychotics, driving total treatment costs up not down."

Reporting in the Archives of General Psychiatry, McGuire and his co-authors wrote, "The juxtaposition of increased mental health care spending per (Medicaid) enrollee without a substantial improvement in depression quality of care is striking" ("[Ten-year trends in quality of care and spending for depression](#)," Dec. 2011).

Though psychotic disorders such as schizophrenia, schizoaffective disorder and bipolar with severe psychosis affect only an estimated 3.3% of the US population, antipsychotics were the top-selling class of medicines in the U.S. in 2009 with \$14.6 billion in sales.

We always say treatment works and that medication is typically essential to effective treatment of psychotic disorders, but using it to medicate other psychiatric conditions without producing results may make cents but doesn't make sense - either for the taxpayers footing the bill or the consumers receiving powerful drugs with serious potential side effects.

Los Angeles County's pilot assisted outpatient treatment (AOT) program has reaped enormous rewards for its participants – and for LA taxpayers. Now county supervisors will consider supporting the state's extension of Laura's Law beyond its current expiration date. "It is vital that this life-saving program be extended to help the mentally ill recover and live productive lives," said Supervisor Mike Antonovich, who initiated the Los Angeles pilot of Laura's Law, as [assisted outpatient treatment](#) (AOT) is called in California. Antonovich said the pilot program has "successfully stabilized and reintegrated participants back into the community" and resulted in:

- a 78% reduction in incarcerations among participants,
- a 77% reduction in hospitalizations among them, and
- a reduction in taxpayer costs for incarceration and hospitalization by 40%.

In the wake of highly publicized tragedies including the police beating death of Kelly Thomas, a homeless man with untreated schizophrenia in Orange County, and a protracted manhunt and eventual police shooting of suspect Aaron Bassler, a man with untreated severe mental illness in Mendocino County, several California counties are actively considering implementing the 10-year-old state law. California's AOT law is unique because it requires each of the state's 58 counties to opt in individually. Only Nevada County has fully implemented Laura's Law – and won state and national awards in the process. The LA pilot is the other county program in effect.

Frontline officers in law enforcement, detention, corrections, probation, firemen and emergency medicine are confronted with the individuals with brain disorders in crisis. Lack of education and

experience coupled with negative attitudes and beliefs result in death, injuries and civil lawsuits. HB93 enables New Mexico to meet the critical training need for an intermediate level of training between the training provided in the basic training academy, and the advanced level 40-hour Crisis Intervention Training (CIT) certification course.

C. Fighting the Stigma

It is important for first responders to distinguish between the person experiencing a mental health crisis and the problem or circumstance itself.

It is neither accurate nor fair to define people by their perceived conditions and we must continue to work to overcome the stigma and discrimination associated with mental illness not only in public safety but in our communities as well.

Consider how we view other health issues, have you ever heard someone referred to as "a cancer," or "a broken leg?"

Yet, we often do hear people referred to as "manic depressives" or "schizophrenics" or "crazy" This kind of derogatory labeling is disrespectful and creates a formidable barrier to successful interactions and interventions.

Stigma assumes many forms, both subtle and overt. It appears as prejudice and discrimination, fear, distrust, and stereotyping.

Typically, people fear mentally ill persons because they are thought to be unpredictable.

Even though the mentally ill have a reputation of being dangerous, and certainly the media highlights those who are, violence committed by the mentally disturbed (as a group) is at the same rate as the general population. ***More mentally ill are likely to be victims than perpetrators.***

Fewer than 2% of former mental patients pose a danger to society. These former patients are typically anxious, passive, and fearful themselves.

D. Characteristics of Psychosis

- *Drastic changes in behavior (ask family for norm)*
 - *Loss of Memory/disorientation*
 - *Paranoia (people want to hurt them)*
 - *Grandiose Ideas ("I am superman")*
-

- *Delusions/Hallucinations (see things/hear voices)*
- *Exaggerated or bizarre physical ailments*
- *Extreme fright or anxiety (startles easily)*
- *Fight cues (muscle tension, pacing, yelling)*

1) Antisocial Behavior

Definition: mental condition in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others.

Tend to antagonize, manipulate or treat others harshly. They show no guilt or remorse for their behavior.

Violate the law. They may lie, behave violently or impulsively, and have problems with drug and alcohol use. Usually don't have jobs and/or drop out of school.

- Aggression toward people and animals
- Destruction of property
- Deceitfulness
- Hostility, agitation, aggression/violence
- Serious violation of rules (sometimes just to see what it feels like)
- Repeated criminal behavior with no remorse

2) Autism

If you've met one person with autism then you've only met one person with autism. Children and adults with autism spectrum disorders are as varied in their interests, personalities, character, temperaments, and communication styles as anyone else. It's possible to have autism and have a cheerful, moody, serious, or cranky personality type. One person with autism might appear relatively comfortable with eye contact and another might panic when looked in the eye. It's even possible to be an affectionate touchy-feely sort of individual, with autism, or to be one that avoids even the slightest touch. Human behavior is far too complex and unpredictable to pigeon-hole anybody. No two persons behave exactly alike, with or without autism.

Regardless of whether we perceive them to be high-functioning, low-functioning, or somewhere in between, there are two identifying features of autism spectrum disorders, along with a tendency to engage in atypical repetitive behaviors, that unite all persons with autism, they all have difficulty with **socialization and communication**.

They often won't understand what's appropriate or safe in a given situation.

They often won't understand what others want or need from them.

They often won't understand that their actions may negatively impact others or even themselves.

That is exactly what drives them so often into conflict with other persons and ultimately with the police.

B. Why are they a Police Problem?

Persons with an ASD are 7 times more likely to encounter the police than other individuals, because their unique communication styles and social characteristics may frighten or disturb some people. The subject with ASD will also sometimes become frightened or over-stimulated and engage in challenging or seemingly offensive behaviors. It is estimated that on **4 out 5** occasions, police will be called for an autistic subject, due to their unusual behavior, and not because of dangerous or criminal activity.

C. More often victims

Persons with autism are also more likely to be victimized than other persons. Children and adults are sometimes sexually assaulted by predators who may view them as easy marks, who think they either will not understand they are being violated or be able to testify against their tormentors.

Because of their impaired ability to communicate and socially interact, they may be more likely to be victims of institutional abuse in group homes, treatment facilities, nursing homes, schools, hospitals, and residential facilities.

Children and adults with autism are often bullied, due to their unique social characteristics.

On the street, criminals sometimes take them as easy marks for robbery, pick-pocketing, and other property crimes. They might also be used as drug mules, for retail theft, and otherwise intentionally placed in dangerous situations that they are not aware of.

3) PTSD

A. In What is Post-Traumatic Stress Disorder (PTSD)?

PTSD is a real illness. PTSD can initiate after experiencing a dangerous event, such as war, a hurricane, or bad accident. PTSD causes you to feel stressed and afraid after the danger is over. It affects the victim's life and the people around them. PTSD is a common disorder in which a person experiences disabling anxiety after a traumatic event. People with PTSD cannot stop thinking about the traumatic event and, in many cases, re-live the event repeatedly. PTSD can lead to other problems, such as depression and alcoholism. It can also get in the way of work, daily activities and relationships. PTSD can happen to anyone at any age. Children get PTSD too.

You do not have to be physically hurt to get PTSD. It is possible to arise after you see other people, such as a friend or family member, get hurt.

Living through or seeing something that is upsetting and dangerous can cause PTSD. This can include:

Being a victim of or witnessing violence.

The death or serious illness of a loved one.

War or combat Car accidents and plane crashes.

Violent crimes, like a robbery or shooting.

Rape or sexual abuse.

Kidnapping or torture.

A natural disaster such as a flood, earthquake, hurricane or fire.

B. Diagnosis

Symptoms must last more than one month to be considered PTSD. In order to find out if one has PTSD, they should talk to their doctor or health care provider.

C. Three phases of every encounter:

In "Emotional Shrapnel" by Paul Lilley there are

1. Engage
2. Assess
3. Resolve

4) Bipolar Disorder

- a. Most will have manic or high amounts of racing thoughts, with incoherent pressured speech, and word salad.
- b. Grandiose, invincible, and irritable
- c. Use of mood stabilizers (4-6 pills)
- d. The higher they get, the same for low and long term depression
- e. Go slow and use lots of repetition

5) Schizophrenia

- a. Many homeless contacts
- b. Teen early 20's
- c. Delusional and typically have hallucinations
- d. Not in our world-bizarre, dress bizarre
- e. No social network, isolated withdrawn, may walk away from you talk in bizarre words
- f. Medication to them may be poison, poor judgment
- g. Engage slowly
- h. Ask what they are seeing or hearing for danger (hearing voices more common than seeing things not there)
- i. Keep them focused on you and you may need to repeat yourself MANY times
- j. May have no insight into their disorder
- k. All medication for mental illness have side effects

6) Bipolar Schizoaffective Disorder

- a. Where you have both mood disorders and schizophrenic issues.
- b. Suffer with hallucinations or delusions ***and***
- c. Manic or depressive
- d. Largely interferes with social,
- e. academic and/or work functions
- f. Impoverished/homeless

7) Depression and Anxiety

Most mentally ill subjects have issues with depression and anxiety

They can frequently co-occur

Major depressive disorder lasts for at least 2 weeks and affects a person's

- Emotions, thinking, behavior, and physical well-being
- Ability to work and have satisfying relationships

Depression Symptoms

- Fatigue/lack of energy, sleeping too much or too little,
- Overeating or loss of appetite
- Weight loss or gain
- Headaches
- Crying spells
- Withdrawal from others
- Neglect of responsibilities
- Loss of interest in personal appearance
- Loss of motivation
- Slow movement,
- Use of drugs and alcohol
- Feelings of sadness, anxiety, guilt, anger, mood
- Swings
- Feelings of helplessness, hopelessness, irritability
- Frequent self-criticism, self-blame, pessimism impaired memory and concentration
- Indecisiveness and confusion
- See oneself in a negative light
- Thoughts of death and suicide

8) Dual Diagnosis

The term **dual diagnosis** is used to describe the comorbid condition of a person considered to be suffering from a mental illness and a substance abuse problem.

The concept can be used broadly such as: depression and alcoholism,

or can be restricted to specify *severe mental illness (e.g. psychosis, schizophrenia)* and *substance misuse disorder (e.g. cannabis abuse)*,

or a person who has a *milder mental illness and a drug dependency, such as panic disorder or generalized anxiety disorder and is dependent on opioids.*

According to reports published in the *Journal of the American Medical Association (JAMA)*:

Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse

Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness

Violence is more prevalent among the dually diagnosed

Domestic violence and suicide attempts are more common

Sexual abuse is also more of a problem

9) Developmental Disabilities

Developmental disabilities are a diverse group of severe chronic conditions that are due to mental and/or physical impairments.

The term is used most commonly to refer to disabilities affecting daily functioning in three or more of the following areas:

Capacity for independent living

Economic self sufficiency

Learning

Mobility

Receptive and expressive language, Self-care, Self-direction

10) Traumatic Brain Injury

Traumatic brain injury (TBI), a form of acquired brain injury, occurs when a sudden trauma causes damage to the brain. TBI can result when the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue.

Symptoms of a TBI can be mild, moderate, or severe, depending on the extent of the damage to the brain.

A person with a mild TBI may remain conscious or may experience a loss of consciousness for a few seconds or minutes. Other symptoms of mild TBI include headache, confusion, lightheadedness, dizziness, blurred vision or tired eyes, ringing in the ears, bad taste in the mouth, fatigue or lethargy, a change in sleep patterns, behavioral or mood changes, and trouble with memory, concentration, attention, or thinking.

A person with a moderate or severe TBI may show these same symptoms, but may also have a headache that gets worse or does not go away, repeated vomiting or nausea, convulsions or seizures, an inability to awaken from sleep, dilation of one or both pupils of the eyes, slurred speech, weakness or numbness in the extremities, loss of coordination, and increased confusion, restlessness, or agitation.

11) De-escalating Adolescents

A. Crisis:

An event or a series of events that threatens our ability to respond effectively and find a solution. If we get to the point where we are so stressed that we do not believe we can cope with a situation any more, then we are in a state of crisis. The nature and magnitude of the crisis influences our perception of the crisis—we "expect" people to be able to cope with minor calamities. Every person is different in their ability to respond to a crisis (individual differences)—age, culture, personality, intelligence, health (both physical and mental).

B. Adolescents - Characteristics:

Impulsive and moody.

Risk-taker (believes they are invincible).

Self-centered (seeks gratification).

Easily irrational and emotional.

C. Parenting

The initial guard-rail for adolescent behavior. (structure and stability).

Parent/guardian background may affect their ability to parent effectively. (mental illness, trauma, socio-economic status (SES), substance abuse, etc.)

D. Brain Development

Teenage brain generates more intense impulses. Immature frontal lobe: organizes and controls behavior and impulses. Causes them to live in the “here and now”. Under-developed restraining system (safety consequences, long-term horizons). Hormonal growth spurts- at risk behaviors-sex hormones, aggression. Learn through testing limits.

E. Juvenile Aggression

Youth have 4 needs that they are trying to fulfill:

Love and belonging.

Power and importance.

Fun and pleasure.

Freedom and choice.

Adolescents are very emotional when these needs get frustrated, which leads to unpredictable behavior and reactions.

F. Cutting

Different from suicide. Seeks to injure self to ease psychological/emotional pain. Not done to retaliate against others.

G. Environment

Parental presence may help or hinder.

Power of peers: adolescent behavior is emotionally rooted, making it more difficult to de-escalate the situation when peers are present.

Try to separate.

The person...may be frightened or unsure of what you want.

May be uncooperative or antagonistic.

May be under the influence of drugs, alcohol or both.

H. Communication - De-escalation

Explain to them what you want, what you need, and what will happen (both if compliant and noncompliant).

1. Engage (listen)

Don't judge, adolescents are good at reading adults. - Reflective listening: let them vent but do not get into a logical discussion with them—the goal is to calm them down, emotionally.

2. Assess (clarify, understand)

Interview family members; respect them as the primary source of information.- explain what you are doing and the possible consequences. encouraging, praising or explaining to youth what you need from them is more effective than giving orders - Clothing may be hiding cuts or signs of drug use (i.e. long sleeves during summertime) - Note gender: Females are more likely to be cutters.

3. Resolve (action)

If they remain out of control, be gentle but firm and forecast. - remind them of the consequences if they remain out of control. - talk to family about services available (if signs of family dysfunction are visible.)- do not try to help the parent's parent: do not say "your kid needs a good lecture" or "there is nothing we can do".

I. Building blocks to de-escalation

Patience

Empathy

Professionalism

Compassion

J. Conclusion: Importance

Police officers are in a unique position to make things better within a crisis.

Desperate parents can be guided to appropriate community services by a knowledgeable officer. A sensitive intervention by a police officer can be a reassuring influence on a struggling family.

E. Handling the Mentally Ill and Other Special Populations

A. Four Encounter Types in Crisis Response

1. Loss of reality (LOR)
2. Loss of hope (LOH)
3. Loss of control (LOC)
4. Loss of perspective (LOP)

B. Three Phases of every encounter

1. Engage
2. Assess
3. Resolve

C. Two Safety Skills

1. Patience
2. Empathy

D. One Survival Skill

1. Vigilance

E. Special Populations

Anyone exhibiting diminished capacity

F. Encounter Types

A. Non Crisis Encounter:

Typical subject encounters involve individuals who are able to think without impairment, control their actions, and are able to respond to commands.

Thinking: Usually deliberate and follows a logical sequence related to pre-crisis events.

Actions/Behaviors: Generally a greater ability to control their behavior. Clear about the source of their anxiety.

Level of Compliance: Likely to respond to limit setting and verbal commands.

BEHAVIORS ARE A CHOICE!

G. Special Populations Crisis Encounter:

Subject with diminished capacity encounters involve individuals whose thinking may be impaired, control of their actions is unpredictable, and may not be able to respond to commands.

Thinking: Impaired, illogical, irrational. May not be aware they are ill. May not even be able to articulate events related to pre-crisis state.

Actions/Behaviors: Actions/mannerisms may seem at odds. Behavior may be more unpredictable. Sources of stress may not be clear.

Level of Compliance: May not be fully in reality. May not be fully compliant, yet not a danger. Compliance may have to be continuously negotiated/evaluated.

BEHAVIORS ARE A CHOICE BUT... BEHAVIORS HERE MAY INSTEAD BE A MANIFESTATION OF BRAIN ILLNESS

H. Summary for Special Populations

1. Diminished Capacity.
2. Medical Encounters (vigilance - unpredictable).
3. Crisis (will manifest itself in one of four ways)

I. Three Phases of an Encounter.

1. **Engage**:
Establish rapport

How you are presenting yourself

Introduce yourself, ask the person's name

State the reason you are there in a way that builds trust (make it about safety and empathy)

Scene management – remove distractions, upsetting influences and disruptive people

Patience, empathy, vigilance

Modeling, Mirroring

2. **Assess**

Gather needed info

Ruling in/out mental illness

Medical or drug/alcohol issues

Was a crime committed

Assess lethality if suicide or depression is an issue

Talk to others at the scene

Trust the experts. Family members can be a great source of information

3. **Resolve:**

Voluntary compliance

Decide on course of action

Forecast, tell the person what you are going to do. "I am going to put my hands in your jacket pocket to check for any weapons."

Leading. Tell them what you expect and what you need from them.

4. **Basic Officer Skill Sets:**

Listen,

Clarify – Understand

Action - Resolve

5. Empathy:

Absorbs Tension

Conveys understanding

Persons in crisis feel like they are being listened to

J. De-escalating Psychosis

In the act of de-escalating psychosis there are generally three possible responses you may take and only one of them is effective.

1. Act as if you believe them – Risk losing credibility and trust. Could escalate the subject's anxiety. Make the resolution phase more difficult.
2. Dispute their perception of reality – Increase probability of direct confrontation or withdrawal of the subject. Logic and reason cannot often penetrate the person's psychosis. Make the resolution phase more difficult.
3. Defer your belief in their psychosis – You do not agree or disagree with subject's view. You acknowledge that it is their view. Reflect how it makes the person feel. Take control of the conversation by focusing on what you need to resolve the situation safely.

K. Officer De-escalation Proficiencies

1. Effective communication and stress.

Good officers can communicate effectively even under tremendous stress. The skill is critical to successfully gaining compliance or cooperation from subjects, and in managing situations where arrest, search and seizure, or use of force — which the report notes are "intricately related" — are required.

The RAND study notes:

"Tactical communications as currently taught are too limited in scope and poorly integrated with other instruction. Officers need to learn how, when, and with what type of person certain communication techniques are more effective.

This is particularly important when deadly force might be applied. A person who does not understand English or a person with a mental illness might inadvertently send aggressive signals to the officer.

The officer needs to be adept at selecting from and effectively applying various modes of communication, verbal and nonverbal, under conditions of extreme stress."

"...this skill...is anything but natural...Natural communication is what flows from your lips. It gets people hurt. So, just as it takes up to a year to train students how to fall and punch without getting hurt, tactical communication training takes a long-term approach to teach officers how to interact without getting themselves or someone else hurt." (Tactical Communications, George Thompson Ph.D.)

It's hard enough trying to talk down a belligerent subject during a traffic stop, or following a domestic dispute. But what about subjects who are impaired—not by alcohol or even anger, but by mental illness, developmental disability, or language barriers?

2. Checklist

"Police officers need checklists of what people do when they are mentally ill or disabled," says Dr. Thompson. "Many officers don't know symptoms; they just seek compliance. Often, however, compliance can be achieved even from people with special needs — if the officer knows how to communicate on that individual's level. Emotionally disturbed persons see the problem differently from the way you see it," Thompson explains. "If your subject is coming out of left field, then you have to go into left field to talk to him in a way he'll understand."

3. The Consensus Project Report

In its document "The Consensus Project Report," a program coordinated by the Council of State Governments Justice Center, the Consensus Project identifies factors affecting the training and response of telecommunicators and officers.

Policy Statement #2

Provide dispatchers with tools to determine whether mental illness may be a factor in a call for service and to use that information to dispatch the call to the appropriate responder.

- a. Provide dispatchers with questions that help determine whether mental illness is relevant to the call for service.
- b. Provide dispatchers with tools that determine whether the situation involves violence or weapons.
- c. Provide dispatchers with a flowchart to facilitate dispatch of the call to designated personnel.
- d. Use designated codes and appropriate language when dispatching the call.

Policy Statement #3

Develop procedures that require officers to determine whether mental illness is a factor in the incident and whether a serious crime has been committed—while ensuring the safety of all involved parties.

- a. Stabilize the scene using de-escalation techniques appropriate for people with mental illness.
- b. Recognize signs or symptoms that may indicate that mental illness is a factor in the incident.
- c. Determine whether a serious crime has been committed.
- d. Consult personnel with expertise in mental illness to enhance successful incident management.
- e. Determine, when warranted, whether the person may meet the state criteria for emergency evaluation.

While the report lists dos and don'ts for officers to follow, it points out specifically:

"Most people with mental illness are not violent, but for their own safety and the safety of others officers should be aware that some people with mental illness who are agitated and possibly deluded or paranoid may act erratically, sometimes violently. If the person is acting erratically, but not directly threatening any other person or him- or herself, such an individual should be given time to calm down.

Violent outbursts are usually of short duration. It is better that the officer spend 15 or 20 minutes waiting and talking than to spend five minutes struggling to subdue the person."

Tactical communication must continue to be taught as a matter of protocol, not just as a one-time event.

“Communication is a perishable skill,” says Thompson. “Verbal Judo is a physical skill, because it deflects abuse. Ideally, opportunities to practice via scenarios and debriefings will be presented throughout an officer’s day, as well as during in-service training; Verbal Judo instructors are required to be retrained every three years.”

L. Law Enforcement Specific: Communication Factors

Effective communication skills are the key to any successful interaction, but are especially important when dealing with a mentally ill person in crisis. The law enforcement officer is working under a set of parameters that is unlike that of any other professional, such as:

- A. safety and protection of the general public
- B. the public’s perception of law enforcement officers – microscope
- C. political ramifications
- D. potential restrictions of duration of interaction

The parameters stated above, as well as many others make it imperative for the officer to be highly skilled in the therapeutic communications that are necessary to de-escalate a mentally ill person in crisis situations.

M. Principles of Therapeutic Communication

1. **EMPATHY**

Empathy means to accurately and sensitively understand the other person’s experience, feelings, and concerns. The empathetic officer will accurately sense the person’s feelings as if they were his or her own without becoming lost in the other person’s concerns. If the officer can effectively show empathetic understanding, then he or she will be setting up the conditions whereby the crisis situation may be defused, calmed, and contained. The person in crisis is more likely to feel understood, to feel **a sense** of safety and self control, and to begin to trust the officer. The major components of communicating empathetic understanding are:

- a. **Attending** - To the person’s words, voice, and body language
- b. **Accurate Restatement** - Of the person’s essential message content
- c. **Accurate Reflection** - Of the person’s moment to moment feelings

Empathy is different from Sympathy. When we are sympathetic we become sad, angry, etc. over the other person's dilemma. In crisis intervention, sympathy is not helpful because we lose objectivity and the ability to act in a logical and linear manner.

Conversely, by responding in an empathetic manner; we are attempting to approximate and anticipate as closely as possible the thinking, feeling, and behaving of the recipient of our services. When we are able to perceive the world as the other person does, we are able to establish trust, convey understanding, and open the door to less traumatic or violent intervention.

Officers who practice and use practice and use, (over and over again) the techniques of empathetic understanding will become more proficient and more successful as time goes on. Empathetic responding is a skill that will make officers more successful not only in police work but also in one's daily living.

2. GENUINNESS

Means to interact with the other person without *any* pretensions. The officer who is genuine will be perceived by the other person as;

Being Role Free - The interventionist assumes no facades "I do not pretend to be something I'm not, that is Superman, Rambo, Wonder Woman, or Sigmund Freud. What you see is what you get!" Being role-free conveys to the other person that: I'm real, I'm vulnerable too, I can be afraid, glad, happy, aggravated, caring, supportive, and can experience all the other emotional states anyone else can."

Being Spontaneous - By communicating the interventionist thoughts and feelings in an open and honest manner, the officer is able to adapt to changing conditions without operating out of a "rule book" that may exacerbate the crisis.

Being Consistent - Saying one thing and doing another is not helpful in gaining confidence and credibility. "When I am consistent, my mouth is not saying one thing "I want to be helpful" and my body language is saying another, such as vigorously tapping my flashlight in my hand."

Self Disclosure - This does not mean sharing my innermost - secrets or telling my war stories. It means owning my own feelings about what is going on at the present time.

Using "I" Statements - This means taking responsibility for what is happening. "We," "They" "The Captain," "God," are all ways of distancing oneself from the person and not taking responsibility for one's own feelings, thinking, and acting.

Staying in the "Here and Now" - This means just that. We sometimes call it "immediacy". It is extremely easy and of little help to talk about other people, places and past or future time. Staying in the present is critical in keeping persons in touch with reality and moving toward problem resolution.

3. **ACCEPTANCE**

Acceptance means recognizing that the other person has a right to his or her own thoughts, feelings, or behaviors and deserves to be respected as a human being of intrinsic worth, regardless of that person's station in life, race, religion, ethnic origin, sex, sexual orientation, economic condition, or personal looks. ***The officer who shows acceptance or unconditional positive regard toward the person in crisis will have an immediate advantage in gaining trust and beginning to stabilize or calm the crisis situation.***

At times, acceptance may be extremely difficult when persons act in bizarre, angry, or hostile ways. Most people's actions are motivated by fear, anxiety, and insecurity. No person that we know of decided as a child to use schizophrenia, drug addiction, acute depression, or any other mental illness or affliction as an emotional or vocational choice when they grew up. If we are able to accept a heart patient and take this disability into consideration, then surely we can do the same *for a mental patient.*

The officer who can truly accept all persons encountered in crisis as people of intrinsic worth, without judging, blaming, or other negative responses will be immediately modeling this quality to the person in distress. The person may then begin to sense and take on the quality of acceptance also. That is of enormous value in the crisis intervention process.

4. **"I" OWNING STATEMENTS**

The officer may use "I" owning statements to indicate to the other person, "These are my wants, thoughts, and/or feelings, and I take responsibility for them".

The purpose of "I" owning statements is NOT to resolve the problem of crisis, but rather to communicate to the person that the officer is aware of his/her wants,

thoughts, desires, and/or feelings. The person is also aware that the officer is being honest about his/her own motivations at the present moment. Appropriate use of "I" owning statements does not put the person on the defensive and should not embarrass, diminish, or discount the other person.

Objectives of Assertion - The purpose is to simply and concretely communicate what the officer wants, needs, desires. A clue - K.I.S.S. (Keep it short and simple).

Example of Assertion – “What I'm trying to do is to make sure that nobody gets hurt and that you are safe. What I want you to do right now is to sit down here so we can talk calmly about what is going on with you today, and how I can help.” Or, “What I want you to do now is to come with me so we can get you safe and back on your medication.”

For many people in crisis, because of their agitated state, they will not hear an initial request. Thus, the officer will need to use the "broken record" technique. In a calm, clear voice, the request for compliance needs to be repeated without the officer showing the least bit of disturbance over the person's not hearing the first time.

5. FACILITATING LISTENING

Focusing Total Mental Power into the Other Person's World: The officer must focus to the exclusion of background noise or any other distractions. Much like the excellent athlete, the interventionist excludes all other distractions and concentrates on the goal of stabilizing the crisis situation.

Fully Attending to all the Verbal and Nonverbal Messages: Attending to what the person is doing is as important as what the person is saying. When the two are put together, *they* tell us a great deal about how congruent the person is. Congruency means that what the person is doing, saying, and feeling fits together and makes sense in the given moment in the given situation.

Sensing the Other's Readiness to Enter into Emotional and Positive Physical Contact with Others, Especially the Officer: By asking open-ended questions such as "How?" and "What?" we allow the person to tell his or her tale which gives us information, allows us to make an assessment as to the person's lethality (danger to self, the police officers, and to others), makes the person contact with reality, and facilitates communications.

You will be better off if you stay away from "Why" questions. "Why" questions are likely to put individuals on the defensive. Frankly, most of the time they won't know or have a legitimate reason for "Why" they did what they did.

Hold "Do," "Are," and "Have" questions to a minimum early on. You close the deal with these, i.e. "Do you want me to call your doctor so we can go there?" Early on you'll do better with "How" and "What" which allows the person to ventilate and elaborate.

Modeling Attending Behavior by Both Verbal and Non-Verbal Cues: Modeling this behavior strengthens the relationship bond and pre-disposes the person to begin to trust the officer. By restating and encapsulating the person's statements, we affirm what we have heard is correct. By reflecting emotional content, we affirm feelings as real and legitimate. By our own body language, we show our openness to communication and to helping the person to regain control and calmness and to begin to stabilize the crisis situation.

6. ASSUMPTIONS

Set Limits: Provide routine and negative sanctions against behavior that is pre-disposing toward violence or noncompliance.

Assume that the Person is Frustrated: In the person's mind's eye, he/she perceives there is a reason to be frustrated.

Assume Negative Emotions: Respond positively and confidently by reinforcing and modeling pro-social behavior.

Assume Tension and Arousal: Provide a calm, relaxed atmosphere - and, at the same time, be aware that people can be both powerful and explosive when arousal and adrenaline is high.

Assume a threat to the Person's Self-Esteem and Self-Control: Provide choices; provide a way for the person to save face.

Assume Confusion: Provide a careful explanation of all procedures; be prepared to repeat explanations using the "broken record" technique.

Assume Responsibility by One Person and Act as the Person's Advocate: Be perceived by the person as the one in charge at the moment.

Assume that the Person is Unique: Don't assume that the person or the story he or she is telling is like some other story you have heard. Deal with each new crisis person as a new, emergent situation and say to yourself, "Let me try to understand what this particular person is feeling, thinking, and wanting." Thus, turning over a new leaf with each new crisis person, the officer will avoid the trap of stereotyping and assuming that he or she already knows what the person is feeling, thinking, and wanting even before the person's unique story unfolds. Take the time to let the story unfold or emerge without prejudging the situation.

7. QUICK ASSESSMENT TECHNIQUES:

When beginning initial verbal intervention with the mentally ill individual in crisis, continue your quick assessment techniques, and take the first few minutes to gather further assessment information.

- Is the individual alone or operating with others?
- Is the individual pacing?
- Are they talking to themselves?
- Does this person back away and/or look around?
- Is the individual loud and/or animated?
- Does the individual make eye contact?
- Are their emotions rapidly changing?
- Are they alert, confused, or lethargic (possible OD)?
- Is the individual in touch with reality?
- Assess their mood are they angry crying, overly quiet, or confrontational?
- Are they disheveled or inappropriately dressed?
- Does the individual exhibit rapid speech, slurred speech, or sexual preoccupation?

N. Approaching an Agitated Person:

Maintain your poise and self-control; maintain personal space; keep your voice low and calm; keep your hands out in view; be matter-of-fact; avoid giving "sharp" commands; use simple statements when giving commands; do not challenge verbally or physically, avoid arguing; and do not be critical.

1. Remain Calm;

Remember, the verbally escalating person is beginning to lose control. If the person you are intervening with senses you are losing control, the situation will escalate. Try to keep your cool, even when challenged, insulted or threatened.

2. Isolate the Individual:

Onlookers, especially those who are the peers of the verbally escalating person, tend to fuel the fire. *They* often become cheerleaders, encouraging the individual. Isolate the person you are verbally intervening with. You will be more effective one-on-one.

3. Keep it Simple:

Be clear and direct in your message. Avoid jargon and complex options.

4. Watch Your Body Language:

Be aware of your space, posture and gestures. Make sure your nonverbal behavior is consistent with your verbal message.

5. Use Silence:

Ironically, silence is one of the most effective verbal intervention techniques. Silence on your part allows the individual to clarify and restate. This often leads to a clearer understanding of the true source of the individual's conflict.

6. Use Reflective Questioning:

Paraphrase and restate comments. By repeating or reflecting the person's statement in the form of a question, you'll help the individual gain valuable insight.

7. Watch Your Paraverbals:

Any two identical statements can have completely opposite meanings, depending on how the tone, volume and cadence of *your* voice are altered. Make sure the words you use are consistent with voice inflection to avoid a double message.

O. Setting Limits:

Explain to the individual exactly which behavior is inappropriate; explain why the behavior is inappropriate; give reasonable choices or consequences; allow time; enforce consequences.

P. Miscellaneous Principles and Guidelines

- ✓ Be respectful - talk to adults as adults
- ✓ Be calm, clear, and direct in communication
- ✓ Be as consistent and predictable as you can
- ✓ Set clear limits, rules and expectations
- ✓ Keep a professional distance
- ✓ Accept the person as ill
- ✓ Attribute the symptoms to the illness
- ✓ Don't take symptoms of the illness personally
- ✓ Maintain a positive attitude, even during failures
- ✓ Allow the person to be unable to do things yet retain dignity
- ✓ Notice and praise any positive steps or behavior
- ✓ Offer frequent praise, and separately specific criticism
- ✓ Translate long-term goals into a series of short-term goals
- ✓ Help the person attain realistic short-term goals
- ✓ Take an "I don't know" attitude in response to long term questions

Q. Helpful hints:

Carry a notebook with important contact numbers: such as psychiatrists, psychologists, area mental health agencies, case managers, mental health housing apartments, etc.

Keep a running list of person's names, dates of each intervention, reason for intervention, and result of intervention. This will help you build rapport with people as you remind them of past helpful interventions.

Always remember: You are called or have contact when the person is at their worst and usually off their meds. When they are med compliant, they will be more lucid (clear thinking) and will remember what you said, and how you treated them. This will impact greatly on future interventions.

R. Ten Commandments of De-Escalation:

1. Your safety comes first
2. Keep therapeutic spacing
3. Speak in tones that fit the situation

4. When appropriate use non-threatening posture
5. Personalize the conversation (i.e. use first names)
6. Ask how you can help
7. Don't be afraid to set firm yet calm limits
8. Never validate hallucinations
9. Don't internalize people's negative comments
10. Never forget schizophrenia, bipolar disorder, and major depression are organic and genetic disorders. The person did nothing to inherit them. *So, there by the grace of God go I.*

S. Precautions

1. Don't deny the possibility of violence when early signs of agitation are first noticed.
 2. Don't underestimate information given by others regarding behavioral clues.
 3. Don't engage in behaviors that can be interpreted as aggressive.
 4. Don't allow others to interact simultaneously while you are attempting to talk.
 5. Don't make promises you cannot keep.
 6. Don't allow feelings of fear, anger, or hostility to interfere with self-control and professional demeanor.
 7. Don't argue, give orders, or disagree unless absolutely necessary.
 8. Don't be placating by giving in and agreeing to all the real and imagined ills of the person.
 9. Don't become condescending by using cynical, sarcastic, or satirical remarks.
 10. Don't let your own importance be acted out in a know-it-all manner.
 11. Don't raise your voice, put a sharp edge, or use threats to gain compliance.
 12. Don't mumble, speak hesitantly, or use a tone so low that you can't be understood.
 13. Don't argue over small points.
 14. Don't attempt to reason with anyone under the influence of a mind altering substance.
 15. Don't attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.
 16. Don't allow a crowd to congregate.
 17. Don't corner, or be cornered: (give the person expanded space).
 18. Don't ask "Why?"
 19. Don't deny the opportunity to save face.
 - 20. Don't rush, be rushed, or lose your own cool!**
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