I INTRODUCTION AND GOALS

A Introduction of Instructors an Welcome

B Registration Process

1. POST Roster
   a. Attendance rules of 10%
   b. 4 Hour Course with lecture and exercises

C Goals of the Course

1. With a specifically created a series of interactive videos profoundly impact the way law enforcement officers respond to mentally ill people in crisis.

2. Revisit the processes wherein consumers and family members, especially those from ethnic communities, can collaborate as equal partners with mental health and law enforcement in delivering an innovative and effective response system.

3. Provide law enforcement officers with the practice, refreshing their practical skills, and increasing their knowledge and ability to recognize mentally ill people in crisis; de-escalate crisis situations; increase referrals to partner services and improve outcomes in culturally diverse environments.

4. Using lecture and class exercises meet all the minimum topics and exercises required under the Perishable Skills Program for both Tactical and Interpersonal Communications.

D Objectives of the Course

1. Increase awareness in current law and departmental policy in the use of force and interactions with persons with mental health issues.

2. Increase proficiency in selection of appropriate force options emphasizing verbal interactions.

3. Refresh and improve verbal skills and tactics using the force options simulator.

4. Reduce the statistical facts of injuries to both officers and people with mental illness.

5. Reduce the need for the use of physical force by officers encountering a mentally ill person in crisis

II BACKGROUND LECTURE AND LAWS **IV(c)**

A. The current trend

1. The mental health system
    a. A shift from hospitalization to community-based treatment and recovery.
    b. Just as laws and policies in effect in most states steer mental health clients toward treatment in the "least restrictive setting," so do treatment professionals speak of ensuring patients the greatest possible degree of control over their own treatment choices.
        1) The hope and the opportunity to regain control of their lives, often vital to recovery, are real for consumers and families.
        2) Consumers will play a significant role in shifting the current system to a recovery-oriented one by participating in planning, evaluation, research, training, and service delivery.
    c. With the shift from State to local treatment settings and the passage of AB 109 – The Public Safety Realignment bill, there is a greater possibility of law enforcement contact with individuals with mental health issues.

2. AB 109 – Public Safety Realignment Bill (highlights)
    a. *Low-Level Offenders:* Provides changes to the various offenses in the penal code that would be (prospectively) shifted from state jail to county jail. Allows counties to use GPS to supervise jail inmates, and allows counties to contract back with the state for the provision of an adult offender, if necessary.
    b. *Community Corrections Partnerships:* Provides that the Community Corrections Partnerships in each county (created under SB 678) recommend to its county board of supervisors a plan for how to implement the 2011 Public Safety Realignment. The plan may include recommendations to maximize the effective investment of criminal justice resources in evidence-based correctional sanctions and programs including day reporting centers, drug courts, residential multiservice centers, mental health treatment programs, electronic monitoring, counseling programs, educational programs and work training programs.
    c. *Parole Shift (Post Release Community Supervision):* Provides that counties would be responsible for all those on parole that are convicted of non-serious offenses. It also provides that the county board of Supervisors may determine appropriate incentives, treatment and services and sanctions which include flash incarceration, intensive community supervision, home detention with GPS monitoring, mandatory community service, work training, day reporting, substance abuse treatment programs, mandatory random drug testing and community based treatment program

    d. *Parole Revocation:* Provides that all offenders that are on state parole or post-release supervision (counties) who commit a violation of the terms and conditions shall be subject to revocation by the courts. For those offenders who are awaiting revocation prior to the effect of the bill they

will continue to be subject to revocation by the Board of Parole Hearings. The specifics on how the court will manage the revocation hearings are one of the issues that will be finalized in future implementing legislation.

e. *Juvenile Shift:* Allows counties to enter into a memorandum of understanding with the state to provide for the admission of minors to the Division of Juvenile Justice (DJJ) by July 1, 2011. Except for those counties that have an MOU, DJJ will no longer accept any juvenile offender commitments from the juvenile courts. This does not close DJJ as previously proposed, but does limit commitments in the future.

f. *Implementation:* Provides that the Act shall not be implemented until a community corrections grant plan is created in place and an appropriation is provided to fund the grant program.

B. Lanterman-Petris-Short Act (LPS)

1. Enacted in 1969 to end the inappropriate, indefinite, and involuntary commitment of individuals with mental health disabilities.

2. Intent was to balance the need for public safety while safeguarding the individual rights.

3. Establishes patients' due process rights.

C. What is a Welfare & Institutions Code "51-50"

1. 72-hour hold imposed on a person that is believed to be in need of involuntary psychiatric treatment.

2. A W&I 51-50 hold is an application for admission and not a direct admission form – it gets the individual through the door.

3. Information must be based on probable cause - a statement of facts known to you that would lead a person of ordinary care and prudence to believe or entertain a strong suspicion that the person detained as a result of a mental disorder meets one of three criteria (danger-to-self, danger-to-others, gravely disabled).

4. Danger-To-Self (DTS)
   a. Intent to commit suicide or inflict serious bodily harm, or disregard for personal safety to the point that injury is imminent.
   b. Factors to consider:
      1) Words or actions showing intent for self-harm or suicide.
      2) Words or actions indicating a specific plan.
      3) Means available to carry out plan.

5. Danger-To-Others (DTO)

a. May be inferred from words or actions that person intends to cause harm to a particular individual, or intends to engage in dangerous acts with disregard for the safety of others.

b. Factors to consider:

1) Threats against or attempts to harm certain individuals.

2) Means available to carry out threats or repeated attempts.

6. Gravely Disabled (GD)

a. As a result of a mental health disorder, has the inability to provide the basic needs (food, shelter, clothing).

b. Factors to consider:

1) Signs of malnourishment or dehydration.

2) Unable to articulate plan for obtaining food, or no food in the home.

3) Irrational belief (i.e. food is poisoned, contains tracking device).

4) Destruction of, throwing or giving away clothing to the point the person cannot clothe self.

D. Points of consideration:

1. Homelessness alone does not constitute GD.

2. Odd or eccentric behavior is not equivalent to GD.

3. Behavior must be viewed through cultural eyes.

4. Courts have ruled that if a person can survive safely in freedom with the help of willing and responsible family members, friends, or third parties, then he/she is not considered GD.

5. GD "does not include mentally retarded persons by reason of being mentally retarded alone" - W&I 5008 (h) (3)

6. Clients who are on conservatorship are already considered disabled and should only be placed in a hospital if they are DTS/DTO.

7. Drug and chronic alcoholism alone are not proper grounds for a W&I 51-50 hold.

8. A W&I 51-50 hold cannot be used to authorize medical treatment.

E. Initiators of a “Hold”

1. Selected members of attending staff at evaluation facilities/hospitals that are designated for involuntary detainment by the county.

2. Peace officers, including sheriffs, State Park Rangers, State University peace officers.

3. Other clinicians approved by the county mental health department.

III Practical Application Simulator Scenarios - Recognizing Common Signs and Indicators of Mental Illness: Trainees (in teams of 2) will use interactive videos that depict a variety of situations involving individuals in crisis. Trainees will demonstrate knowledge of the class material. A debriefing after each scenario will take place. The debriefings are conducted with the trainee officers as well as the officers who are observing while they wait their turn. The debriefing is primarily focused on the participating trainee officers but serves as opportunity for the entire class to observe techniques hear feedback on the techniques and methods used by the participants. (2 – hours students observing and participating in officer roles) **IV(a,b)**

A. Verbal Indicators
   1. Illogical thoughts.
      a. Loose associations (a combination of unrelated or abstract topics.
      b. Grandiose ideas (thoughts of greatness, believes self to be Jesus).
      c. Ideas of persecution (e.g. CIA monitoring thoughts through TV set).
      d. Obsessive thoughts (preoccupation with death, guilt).

   2. Unusual speech patterns
      a. Word repetition (using rhyming words or phrases).
      b. Rapid speech (rapid with a sense of urgency).
      c. Extremely slow speech.

   3. Extreme and inappropriate, verbal hostility, excited.
      a. Excited and/or loud.
      b. Unreasonably hostile, argumentative, belligerent.
      c. Threatening harm.

B. Behavioral Indicators
   1. Physical appearance.
      a. Inappropriate dress for the season.
      b. Bizarre clothing or makeup.
      c. Appearance of being homeless.

   2. Body movements.
      a. Strange postures or mannerisms.
      b. Lethargic, sluggish movements or pacing and agitation.
      c. Repetitious, ritualistic movements.
      d. Distracted (concentration disrupted by hallucinations).
      e. Lack of emotional response.
      f. Inflicting injuries on self.

3. Extreme emotional expression.
    a. Overreacting or reacting with the opposite of an expected emotion.
    b. Over-medication, stupor, lethargic.

C. Environmental Indicators
1. Inappropriate use of household items (aluminum foil over windows).
2. Pack ratting.
3. Large plastic bags for storage of item.
4. Presence of feces on walls/floors.
5. Childish objects.

D. Minimum of 2 scenarios for each student **IV(a,b)**
1. Models for Desired Outcomes
    a. Tactical Safety evaluation
        1) Officer to Officer and All Concerned
            a) environment
            b) distance
            c) suspect – citizen regarding demeanor-size
        2) Communication within the Use of Force decision and the elements of effective tactical communications including approach, body language, posturing as concerned with the officers safety and questioning **IV(d,h)**
        3) Need to "de-escalate" **IV(g)**
    b. Active Listening
        1) Skill to listen rather than interrupt
        2) Non-verbal cues
    c. Empathy
        1) Dealing with the "difficult" person(s) **IV(e)**
    d. Rapport
            1) Understanding via listening and appropriate questioning of the individuals using good elements of communication and the use of appropriate verbalization **IV(f)**
    e. Influence – persuasion
    f. Behavioral Change

E Critique and debrief after each scenario.
1. The presentation emphasizes, by use of realistic mental health crisis scenarios, the officer's focus on de-escalating the mental health crisis by the use of verbal skills, rather than other uses of force.
2. In depth discussion of the verbal tools used and those that might also be used to

problem solve the issue presented.

3. Presentation during the “debrief” the statistical and other information developed by studies of the mental health issues and interaction with law enforcement.
   a. Statistical references are compiled from publications as listed in Section V
   b. In California
      1) 11 percent of youths aged 12-17 have received mental health treatment.
      2) Adults 18 and older.
         a) 7 percent reported past-year major depressive episode.
         b) 10 percent reported past-year serious psychological distress.
      3) Using integrated databases from the California Department of Corrections and Rehabilitation, researchers estimated that approximately 20 percent of parolees were identified as having a mental disorder.
         a) Parolees with a mental disorder are substantially more likely to return to custody (52% with mental disorder; 29% without mental disorder.)

IV EVALUATION AND FINAL REVIEW

A Final Thoughts

1. Develop a strategy – offer solutions, not options.

2. Never promise anything you cannot do.

3. Keep your options open.

4. Deal with me now; deal with me later.
   a. Don't just handle the call; solve the problem.
   b. Don't kick the can down the road – if you walk away and have not solved the problem, you are leaving the "problem" for the next officer behind you that goes out on a "repeat call" to the same address under the same circumstances or worse.

V STATISTICAL REFERENCE*S*

A. Issues in Mental Health and Law Enforcement interaction were derived from:

1. United States Public Health Service Office of the Surgeon General (2001), *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Department of Health and Human Services, U.S. Public Health Service.

2. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly

Report, May, 2010

3. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Office of Applied Studies - *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings.*

4. Glaze, L., and T. Bonczar. 2006, Probation and Parole in the Unites States, 2005, Bureau of Justice Statistics, DOJ Publication No. NCJ 215091, Washington, DC.

5. Abraham L.A. Teplin, and G.M. McClelland. 2003. Comorbidity of Severe Psychiatric Disorders and Substance Use Disorders Among Women in Jail, American Journal of Psychiatry 160: 1007–1010.

6. Mental Health, United States, 2008, Substance Abuse and Mental Health Service Administration

7. Major Depressive Episode (MDE) is defined as in the fourth edition in the Diagnostic and Statistic Manual of Mental Disorders (DSM-IV) which specifies a period of at least twp weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms, SAMHSA, National Survey on Drug Use and Health, 2005, 2006, 2007

8. Serious Psychological Distress (SPD) refers to a mental condition that impacts one's ability to participate in family and community life. SPD is associated with mental health problems that are not as severe as those characterized as serious mental illness but still have negative impact on a person's functioning. SAMHSA, National Survey on Drug Use and Health, 2005, 2006, 2007

9. Louden, and J. Skeem, April 2011. Parolees with Mental Disorder: Toward Evidence-Based Practice, UC Irvine Center for Evidence-Based Corrections.