Arizona Peace Officer Standards and Training
Basic Curriculum Lesson Plan

LESSON TITLE: BEHAVIORAL HEALTH CRISIS RESPONSE 3.4

SUBJECT: Behavioral Health Crisis Response

AZ POST DESIGNATION: 3.4

HOURS: 8 (5 hours in classroom, 3 hours scenario based)

COURSE CONTENT: Describe common behavioral health disorders and their associated behaviors. Identify proper techniques for dealing with potential hazards associated with public safety response to calls involving behavioral health crises.

PERFORMANCE OBJECTIVES: With the use of course materials, students will be capable of:

3.4.1 Describe and define stigmas associated with common behavioral health disorders.

3.4.2 Define and describe the symptoms in common types of behavioral health disorders.

3.4.3 Identify possible verbal/nonverbal behaviors encountered when responding to calls involving a person experiencing a behavioral health crisis.

A. Behaviors indicating possible emotional instability:

1. Unresponsive.

2. Unprovoked violence.

3. Disjointed conversation.

4. Delusional or hallucinations.

5. Hearing voices.

6. Talking to self.

7. Pacing or walking in circles.

B. Potentially hostile behaviors:

1. Red, flushed face.

2. Loud voice.

3. Hyperventilation.

4. Anger.

5. Shaking, twitching hands.

6. Items 1-6 on 3.4.3A can also be potentially hostile. actions on the part of the individual

3.4.4 Demonstrate intervention techniques for effectively handling a call involving a simulated suicide.

A. Officer safety considerations.

B. Support groups and services.

C. Effective communication.

D. Conducting a background investigation.

E. Securing the scene.

3.4.5 Identify the legal basis, notification procedures/requirements, procedures for writing and serving an emergency petition, and procedures for restraining and transporting individuals experiencing a behavioral health crisis.

A. Legal basis. (A.R.S. §§36-524 and 36-525)

B. Procedures for restraining and transporting.

3.4.6 Identify officer safety techniques to consider when responding to calls involving individuals in crisis.

A. Ignore verbal abuse.

B. Avoid excitement.

C. Utilize contact and cover.

D. Use adequate and reasonable restraining force.

E. Maintain alertness.

3.4.7 Identify appropriate referral agencies for behavioral health calls for service and contacts.

A. Substance abuse.

B. Family counseling and child guidance.

C. Victim/witness services.

D. Social services/mental health resources.

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INSTRUCTOR REFERENCES:		
CLASS LEVEL:	Student	
TRAINING AIDS:	PowerPoint, Role Play, AZ POST Mental Health Resource Guide, U.S. DOJ Office for Victims of Crime - First Response to Victims of Crime Who Have a Disability http://www.azleg.gov/ArizonaRevisedStatutes.asp	
INSTRUCTIONAL STRATEGY:	Interactive lecture, class discussion, and demonstration	
SUCCESS CRITERIA:	70% minimum score on a written, multiple-choice examination Pass/fail on demonstration requirements	
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I. INTRODUCTION

A. Instructor – (self) introduction.

B. Introduce performance objectives.

1. Describe and define stigma related to behavioral health disorders and its effects on the people who suffer from them.

2. Define and describe the symptoms in common types of behavioral health disorders.

3. Identify verbal/nonverbal behaviors exhibited by individuals experiencing a behavioral health crisis. **P. O. 3.4.3A**

a. Emotionally unstable.

i. Unresponsiveness.

ii. Unprovoked violence.

iii. Disjointed conversation.

iv. Delusions or hallucinations.

v. Hearing voices.

vi. Talking to self.

vii. Pacing or walking in circles.

b. Potentially hostile. **P. O. 3.4.3B**

i. Red, flushed face.

ii. Loud voice.

iii. Hyperventilating.

iv. Angry.

v. Shaking, twitching hands.

vi. Items 1-6 on 3.4.3A can also indicate potentially hostile actions on the part of the individual.

4. Given a simulated suicide call, demonstrate intervention techniques for effectively

handling the call. **P. O. 3.4.4A-E**

5. Identify the legal basis, notification procedures and requirements, and procedures for writing and serving an emergency petition.

6. Identify procedures for restraining and transporting persons in behavioral health crises.

7. Identify officer safety techniques to be considered when handling individuals in crisis. **P. O. 3.4.6A-E**

    a. Ignore verbal abuse.

    b. Avoid excitement.

    c. Utilize contact and cover.

    d. Use adequate and reasonable restraining force.

    e. Maintain alertness.

8. Identify the appropriate referral agencies for crisis and behavioral health calls for service and contacts. **P. O. 3.4.7A-E**

    a. Public health violations.

    b. Substance abuse.

    c. Family counseling and child guidance.

    d. Victim/witness services.

    e. Social services/mental health.

II. UNDERSTANDING STIGMA RELATED TO BEHAVIORAL HEALTH DISORDERS

P. O. 3.4.1

A. What is Stigma?

1. A set of negative and often unfair beliefs that a society or group of people have about something. (Merriam-Webster).

2. A mark of disgrace or infamy; a stain or reproach, as in one's reputation; a mental or physical mark that is characteristic of a defect or disease." (Dictionary.reference.com).
3. Synonyms; shame, disgrace, dishonor, humiliation….

B. Understanding first person language.

1. She has diabetes rather than she IS diabetes.

2. He has cancer rather than he IS cancer.

3. He has bipolar rather than he IS bipolar.

4. She is an individual suffering from a behavioral health disorder, rather than IS mentally ill.

C. Stereotypes/biases.

1. Numerous "causes" of behavioral health disorders. They are not chosen.

2. Reasons for not taking medications.

a. Simply don't want to have to take medications.

b. Stigma/embarrassment.

c. False sense of being "better" so don't need medications.

d. Side effects can be very disrupting, especially while the body adjusts.

e. Financial/lack of insurance.

f. Remembering to take them/inconvenience/cognitive issues.

g. Hassle of "finding the right" medications.

h. Can have withdrawal from psychotropic medications.

i. Less effective every time an individual re-starts medications.

j. Sometimes medications stop working.

III. UNDERSTANDING BEHAVIORAL HEALTH DISORDERS **P. O. 3.4.2**
P. O. 3.4.3

A. Psychotic disorders

1. Individuals with these disorders often lack the ability to distinguish reality from fantasy.

2. Symptoms:

a. Hallucinations. (false perceptions)

b. Delusions. (false beliefs)

c. Disorganized thinking.

d. Decreased ability to function in their working and social environments.

e. Decreased ability to perform self-care.

3. Examples of Psychotic Disorders.

a. Schizophrenia – an illness that results in the inability to think and communicate in an organized logical manner. Individuals with schizophrenia experience psychotic symptoms and a decreased ability to function socially and care for their own basic needs.

b. Brief Psychotic Disorder - a disturbance with a sudden onset of psychotic symptoms. The episode lasts for more than one day but less than a month. The individual returns to their previous level of functioning after the episode.

4. Common Medications.

a. Haldol, Zyprexa and Risperdal.

b. Side effects:

i. Blurred vision.

ii. Tremors.

iii. Stiffness.

iv. Drowsiness.

v. Muscle spasms.

vi. Uncontrolled muscle movements.

vii. Jerking and twisting movements.

5. Police Officer Approach and Special Considerations. **P. O. 3.4.6**

a. One of the primary roadblocks to engaging an individual dealing with schizophrenia is their inability to keep and express their thoughts in an organized and coherent manner. If you ask a second question too soon, the subject may begin to “ponder” both questions simultaneously.

b. Recognize and acknowledge that their delusions or hallucinations are real to them. Don’t say you hear or see them too, or tell the individual that no one is

there. You could ask what the voices are saying to get an idea of what the person is going through.

c. Recognize they may be overwhelmed by sensations, thoughts, sounds, voices, frightening beliefs or their current environment.

d. State requests in brief, clear, simple language.

e. Never argue, logic will not help.

f. Announce your actions.

g. Maintain a calm yet confident demeanor that sends the message you have the situation under control.

h. If emotions and speech are escalating, talk only in the quiet moments.

i. When appropriate, smile and laugh with the person, not at the individual.

B. Mood Disorders.

1. Defined as a group of disorders that involve disturbance of the mood. An individual with a mood disorder does not have the ability to control or regulate their mood.

P. O. 3.4.2 and P. O. 3.4.3

2. Symptoms include abnormally elevated or depressed mood.

3. Examples of Mood Disorders.

a. Major Depression- an abnormally low mood characterized by disturbances in eating, sleeping and concentration.

i. Symptoms include feeling void of emotions.

a) No attachment to life.

b) Sense of hopelessness.

c) Decreased sex drive.

d) Change in appetite.

e) Thoughts of suicide.

ii. Common medications for Depression.

a) Prozac, Paxil or Effexor.

b) Side effects can be dry mouth, constipation, blurred vision, insomnia, dizziness, agitation and confusion.

b. Bipolar Disorder- is characterized by frequent and sudden mood swings from mania to depression with "normal" periods between cycles.

i. Symptoms.

a) Rapid speech.

b) Racing thoughts.

c) Little sleep.

d) Increased sex drive.

e) Impaired judgment.

f) Short attention span.

g) Distractibility.

h) Individuals with mania often give away possessions and spend money excessively.

ii. Common Medications for Bi-Polar.

a) Lithium – can be toxic, can make the individual appear drunk, experience tremors, confusion, dehydration or seizures.

b) Depakote or Lamictal – can cause tremors, dizziness, memory loss.

c) Some medications used to treat Bi-Polar disorder can cause an individual to go into a manic state.

4. Police Officer Approach and special considerations. **P. O. 3.4.6**

a. Bipolar Disorder-Manic Phase.

i. Redirect the individual's behavior and thoughts as he or she begins to escalate.

ii. Use a firm and directive approach.

iii. Set clear limits on behavior.

iv. Reduce environmental stimuli.

v. Guide the individual to “slow down” by helping them to use controlled, rhythmic breathing.

vi. Encourage the individual to be part of the solution to help them “feel in control”.

vii. When possible, allow the individual to pace.

b. Bipolar Disorder – Depressive Phase.

i. Ask the individual if he/she is having thoughts of suicide.

ii. Use a calm and supportive approach.

iii. Empathize with their dilemma.

iv. Give strong reassurance they are safe and you will assist them in getting help.

B. Anxiety Disorders. **P. O. 3.4.2 and P. O. 3.4.3**

1. Persistent, irrational worry is characteristic of anxiety disorders.

2. Symptoms.

a. Associated with irrational worry:

i. Apprehension.

ii. Tenseness.

iii. Fatigue.

iv. Indecisiveness.

v. Restlessness.

vi. Irritability.

b. Physical signs:

i. Increased heart rate.

ii. Sweating.

iii. Increased blood pressure.

iv. Increased rate of breathing or trouble breathing.

v. Muscle tension.

3. Examples of Anxiety Disorders.

a. Agoraphobia – the fear of being trapped in a place or situation. Typical fears include fear of panic attack while away from home, being outside of home alone, standing in a crowd, or being trapped on a bridge.

b. Panic disorder – involves the reoccurrence of unexpected panic attacks and the fear of additional panic attacks.

c. Obsessive Compulsive Disorder – a type of anxiety disorder characterized by irrational obsessions (involuntary preoccupation with a particular thought) or compulsions (the repetition of irrational actions, which results in anxiety if not completed).

4. Common Medications.

a. Ativan (may cause memory loss) Valium and Klonopin.

b. Side effects include sleepiness, dizziness, nausea or irritable bowel.

5. Police Officer approach and special considerations. **P. O. 3.4.6**

a. Maintain a calm and supportive approach.

b. Empathize with their situation.

c. Give strong reassurance of their safety and your willingness to assist them in getting help.

d. If the individual is exhibiting OCD (behaviors) compulsions, do not ridicule what they are doing. Don't tell them their actions are silly or unnecessary, or try to make them stop. If the compulsion jeopardizes officer safety, explain this to the individual and attempt to agree on a possible alternative behavior.

e. Example: if the individual is continually moving their hands in and out of the officer's view, let them know this movement makes you uneasy because it makes you think they may be reaching for something they could use to hurt you (weapon). Ask them if this is something they feel compelled to do, and if they

could move their hands in a way that would allow them to remain in your sight.

D. Personality Disorders. **P. O. 3.4.2 and P. O. 3.4.3**

1. Personality Disorders are defined as manipulative, inflexible behavior patterns that deviate from an individual's culture. The manipulative patterns have an onset during early adolescence and early adulthood.

2. Associated behavior patterns eventually cause personal distress as well as problems in social functioning.

3. Examples of Personality Disorders.

   a. Paranoid Personality Disorder – characterized by a pattern of suspicion and distrust.

   b. Antisocial Personality Disorder – characterized by a lack of caring about the rights or welfare of others. Deceit and manipulation are key features.

   c. Borderline Personality Disorder – characterized by a longstanding pattern of intense and unstable relationships. This individual has an unstable sense of self and fears being abandoned. This often results in intense anger, chronic feelings of emptiness, self-mutilating or destructive behaviors.

   d. Medications are not commonly prescribed, however, anti-psychotics, antidepressants and anti-anxiety agents may be used.

4. Police Officer approach and special considerations. **P. O. 3.4.6**

   a. Paranoid Personality – Officers should neither challenge nor agree with an individual's delusions. Usually no amount of contrary evidence will convince an individual their delusions are incorrect. Focus on the facts, as you know them, and on what you "can" do about the situation.

   b. Antisocial Personality – Often officers are not aware they are encountering an individual with this disorder. Since antisocial types have frequent contact with the police, they are often "street smart" and cannot easily be tricked, but can easily trick others. The ego-driven sociopath has a need for status. Help the individual see the resolution as a "win" for himself or herself.

   c. Borderline Personality – May create chaos on the scene while not even directly involved in the situation. A firm and confident approach is suggested. Set simple, clear limits on speech and behavior. "Remove the audience" when interacting with this individual. Complementing appropriate behavior may result in cooperation. Officers should utilize body worn cameras or have an independent witness to prevent false accusations.

E. Organic Disorders. **P. O. 3.4.2 and P. O. 3.4.3**

1. Organic disorders are classified as a class of conditions directly caused by abnormalities of the brain structure or by alteration of the brain's chemistry.

2. Symptoms.

   a. Confusion.

   b. Memory disturbance.

   c. Disjointed speech.

   d. Impaired thought process.

   e. Psychotic symptoms might be present.

3. Examples of Organic Disorders.

   a. Dementia – Usually occurs in the elderly. Many people refer to dementia as senility. Alzheimer's disease is an example of this type of disorder.

      i. Confusion (especially related to personal information.)

      ii. Disorientation.

      iii. Personality changes.

      iv. Memory problems.

      v. Combativeness.

   b. Substance Abuse characteristics.

      i. Bizarre behavior.

      ii. Slurred speech.

      iii. Bloodshot eyes.

      iv. Runny nose.

      v. Poor coordination.

      vi. Needle marks.

vii. Long-term substance abuse can result in permanent brain dysfunction.

c. Head Trauma – Can result in permanent damage to the brain. ***INSTRUCTOR NOTE:*** *Examples include combat veterans, athletes, victims of Domestic Violence, homeless, and traffic accident victims.*

i. If the injury is new, there may or may not be visual indicators.

ii. Visual clues may include scars, missing teeth, bleeding, head swelling and or bruising.

iii. Cognitive symptoms may include slowed thought processes, impulsiveness, seizures and changes in personality.

d. Medical Causes – numerous causes.

i. Uncontrolled diabetes.

ii. Drug overdose.

iii. New medication.

iv. Stroke or post-seizure state.

e. Medications are not commonly prescribed, however, anti-psychotics, antidepressants and anti-anxiety agents may be used.

4. Police Officer approach and special considerations. **P. O. 3.4.6**

a. Signs and symptoms of some organic disorders such as dementia, head trauma, and drug overdose may resemble or mimic the symptoms of a mental illness. An officer should not hesitate to call for emergency medical treatment.

b. Speak slowly and clearly. Use short words and simple sentences.

c. Ask only one question at a time and wait for a response.

d. Give strong reassurance they are safe and you will assist them in getting help.

F. Developmental/Intellectual Disabilities. **P. O. 3.4.2 and P. O. 3.4.3**

1. Developmental/Intellectual Disabilities are severe, chronic disabilities attributed to cognitive and/or physical impairment, which manifests before age 22 and are likely to continue indefinitely. They result in substantial limitations in three or more of the following areas; self-care, receptive or expressive language, learning, mobility,

self-direction, capacity for independent living and economic self-sufficiency.

2. Approximately 10% of the general population exhibits a developmental disability. 40-60% of individuals with developmental disabilities also have a co-occurring mental illness or other medical condition.

3. Individuals may live and work independently in the community, receive support in their own or family's home, or live in a supervised setting.

4. Arizona Department of Economic Security recognizes these four developmental disabilities:

   a. Cognitive/Intellectual Disability- A condition in which an individual's overall intellectual function is well below average with an intelligence quotient (IW) around 70 or less. Cognitive Disability appears in childhood before the age of 18. The severity of disability ranges from mild, moderate, severe to profound. Signs and symptoms may therefore range from the severe and obvious to an almost undetectable set of behaviors and speech patterns.

      i. Fetal Alcohol Spectrum Disorders (aka: FASD) are birth defects resulting from the birth mother's alcohol consumption during pregnancy. The developing central nervous system is damaged resulting in learning disabilities, low IQ, poor judgment, inability to control impulses, poor attention span and substance abuse. These challenges continue throughout life, so individuals with FASD require structured, stable environments and close supervision throughout their lives. FASD is the leading cause of Cognitive Disability in the United States today. This is the only disability that is 100% preventable.

   b. Autism – a disorder that affects the normal development of the brain relating to social, physical and communicative interaction. Autism is a neurological disorder that manifests itself before the age of 3. Symptoms, characteristics, and levels of functioning of Autism may be present from mild to severe. Individuals with Autism may be sensitive to touch, have a tendency to echo words, be attracted to shiny objects such as an officer's badge, or exhibit rhythmic or repetitive movements such as hand flapping, rocking and spinning.

      i. Recent events, however rare, have created a sense of fear in the autism community. Perception is reality. (Teachers note for video, Body cam video of interaction between Buckeye PD and a teen with autism.

         https://youtu.be/AVCQInFEe0o

      ii. Diagnostic Criteria.

a) Overlapping issues with communication and social skills that manifests in repetitive behaviors. (AZPOST video)

b) Stimming- a self-stimulatory behavior that is marked by a repetitive action or movement of the body (such as repeatedly tapping on objects or the ears, snapping the fingers, blinking the eyes, rocking from side to side, or grunting). (Developmental Disabilities portion-DDD Overview for First Responders, Level 4)

iii. Response and Recognition.

a) Communication-Maybe verbal or non-verbal. Individual's may draw, sign, or use electronic devices.

b) Easily overloaded-In crisis may become easily overloaded.

c) Processing issues-May have a delay in responding to questions or directions. May not respond at all.

d) Sensory- May seek or avoid sensory input to include sounds, touch, smells, sights, and taste. This is specific to the individual. Not everyone is sensory averse.

e) Treatment programs teach coping activities that might appear suspicious. Individuals avoid people and use less traveled areas or alleys. Stimming behaviors can be misidentified as suspicious or aggressive.

f) Inappropriate social skills can lead to police calls regarding touch, personal space, public restrooms, and disturbances.

g) Can become victims through manipulation and lack of self-advocacy.

iv. Tips for Interacting with individuals with autism. **P. O. 3.4.6**

a) Speak slowly with concrete terms.

b) Use visuals if needed and when possible.

c) Repeat simple questions, but do not fixate on them. If you do not get a response, rephrase.

d) Allow time for responses.

e) Pair yourself with the delivery of reinforcement (i.e. requested behavior (calm down) with desired item (chips or iPad).

f) Do not attempt to physically block repetitive behaviors if possible. They are often coping mechanisms.

g) Be sensitive to sensory needs (random touch, sounds, lights).

h) When possible, talk to caregivers to understand individuals' likes and dislikes.

i) Remember people with autism are unique. One person with autism can act completely different from another person with autism.

c. Cerebral Palsy (aka: CP) is caused by brain damage during the prenatal period or within the first few years of life. (Refer to AZPOST Video Unit 7 of behavioral health video)

i. CP manifests as unsteady or jerky movements, unclear speech, delayed responses and seizures.

ii. Individuals with CP may appear to be drunk or under the influence of drugs due to their language and motor challenges.

iii. Although some individuals with CP also have Cognitive Disability, many have IQs in the average and above range.

iv. Many individuals with CP have related medical issues and may require medications.

d. Epilepsy is primarily a seizure-related disorder caused by damage to the brain through the lack of oxygen, head trauma or infection.

i. Epilepsy can affect social behavior, thinking, and motor skills.

ii. Individuals with epilepsy typically have normal intelligence, but are unable to interact or respond during a seizure.

iii. Seizures may manifest as staring, fluttering eyelids, head drop, twitching or full body shaking.

iv. Seizures may leave an individual in a confused and exhausted state for varying lengths of time.

v. Most persons with epilepsy require medications.

5. Police Officer Approach and Special Considerations. **P. O. 3.4.6**

a. The individual may have a tendency to be overwhelmed by police presence.

b. The individual may attempt to run solely out of fear of the uniform.

c. The individual may be willing to confess just to please officers.

d. Talk slowly and clearly, using concrete words and terms.

e. Use visual cues to demonstrate what you want.

f. The individual may need a more thorough explanation of their rights, and possibly an advocate to ensure they truly understand them.

g. Ask the individual or their advocate if they use a device to help them communicate such as an app on their smartphone or tablet.

h. Touching may cause a protective "fight or flight" reaction. If possible, advise them prior to putting your hands on the individual. If they respond negatively do not touch them unless absolutely necessary.

IV POLICE INTERVENTION WITH SOMEONE WHO IS SUICIDAL **P. O. 3.4.4**

A. National statistics confirm that the majority of persons threatening suicide have a mental illness. Many of the same techniques already discussed will apply when responding to these types of calls.

B. It is important to understand suicide and possible indicators of a pending suicide attempt.

1. Myths vs Facts for discussion.

a. When someone talks about suicide, they are looking for attention.

b. If someone wants to end their life, there is nothing you can do.

c. Suicide is a cowardly act.

d. Suicide is a selfish act.

e. Asking someone if they’re considering suicide will put the idea in their head.

f. Suicide is an impulsive, spur-of-the moment decision.

C. It is critical to slow down, and maintain a cautious response and approach.

D. Assess the individual and situation. Follow your agency's policy on responding to suicidal individuals.

1. His/her ability to harm you.

2. His/her ability to harm others.

3. Presence/Report of weapon.

a. If the subject has a gun, do not rush into the apartment, house or structure. Set up a perimeter when possible.

b. The desired outcome is to have the subject exit the apartment, house or structure through negotiation.

c. Typically, negotiations are conducted by telephone in order to build rapport and trust while gathering intelligence information to assess potential threat levels.

E. Officer Safety Considerations. **P. O. 3.4.4**

1. Obtain as much background information as possible prior to response.

2. Establish the presence of weapons, if possible.

3. Use appropriate officer safety approach methods, specifically ensuring you maintain distance to safely communicate.

4. Use contact/cover.

5. Use necessary force to maintain safety.

F. Risk Assessment:

1. Does the individual have a plan to commit suicide, and the means to carry out that plan?

2. Has the individual attempted suicide in the past?

3. Has the individual been drinking or taking drugs?

4. Has the individual been violent today or in the past?

5. Look for signs of self-abuse or unused/full pill bottles.

6. Does the individual have a history of mental illness?

7. What events may have precipitated today's incident?

8. Does the individual take medications? (Have you taken your meds?)

9. Are there other people present?

10. Has the individual shown extreme rage today?

F. Questions to ask the individual in crisis:

1. Are you having thoughts of killing yourself/suicide?

2. How do you plan to commit suicide/kill yourself?

3. When do you intend to carry this act out?

4. What happened to make you feel this way?

5. Where are you right now?

6. What is occurring right now?

7. Is anyone else in danger?

8. Am I in danger if I come to help?

9. Are you or others injured?

10. Have you tried to kill yourself before, and if so, what did you do to regain control of your life?

11. AVOID LECTURING.

12. Have you taken any medications or drugs?

G. Additional Communication Techniques.

1. Let them tell their story.

2. Talk about the finality of death and the reality of suicide.

3. Establish what is still meaningful to this person.

4. Help them put their actions in perspective. What do they hope to achieve? Get past "the only" and talk about the future.

5. Stall for time.

6. Try not to PROBLEM SOLVE.

V. DEMONSTRATE TECHNIQUES FOR EFFECTIVELY HANDLING A SUICIDAL INDIVIDUAL

A. This should be done as a group exercise. Refer to the attached Scenario.

P. O. 3.4.4

VI. BEHAVIORAL HEALTH CALL RESOLUTION **P. O. 3.4.7**

A. Hospitalization. (voluntary or involuntary) ***INSTRUCTOR NOTE:*** *Juveniles cannot be petitioned.*

B. Arrest.

C. Diversion to services.

D. The least restrictive or intrusive alternative should be considered.

E. Treatment should take priority over incarceration when possible.

F. Conduct the investigation.

G. Document actions in a police report.

H. In most cases, criminal charges will be submitted by the officer for review.

I. Call a crisis team or transport to hospital.

J. Methods for obtaining mental health treatment.

1. Request Voluntary Treatment.

2. Court ordered evaluation. (involuntary)

3. Emergency Petition. (involuntary)

VII. IDENTIFY THE LEGAL BASIS AND PROCEDURES/REQUIREMENTS FOR WRITING, REQUESTING AND SERVING AN EMERGENCY DTO/DTS PETITION **P. O. 3.4.5**

A. ARS Title 36 Chapter 5 contains protocol for mental health emergency detention and pick up orders. (Handouts for petition scenario- create generic petition)

1. Officers are responsible for proper handling of situations involving people who are mentally ill and a danger to self (DTS) or danger to others (DTO).

2. Defines danger to self, danger to others, and mentally disturbed persons.

3. Provides guidelines for recognizing and dealing with mentally disturbed people.

B. Officer safety concerns.

1. Research the individual's background.

2. Obtain booking and criminal history information, etc.

3. Check with your County crisis line to obtain a history of violence or other pertinent safety information.

4. Conduct a search of the individual prior to transporting.

5. The individual should be restrained using the least restrictive restraint devices (handcuffs). The officer should take the individual's demeanor and potential for harm to self/others into account. Refer to your agency's policy on detention and transportation.

C. Communication.

1. Command and control techniques used in criminal contacts can be counterproductive when dealing with a subject who is experiencing a behavioral health crisis.

2. Do not threaten the individual.

3. Do not let the individual "push your buttons", ignore verbal abuse.

4. Avoid exciting the individual. Maintain control of your emotions. Do not yell, this only confuses them.

5. If emotions and speech are escalating, talk during the quiet moments. Do not rush them, this only confuses them. (Video/Scenario)

6. Announce your actions. (If safe to do so.)

7. Maintain a calm yet confident demeanor.

VIII. FIRST RESPONDER SAFETY AND INTERACTIONS WHEN HANDLING CALLS AND INTERACTIONS WITH THOSE IN CRISIS OR SUFFERING FROM BEHAVIORAL HEALTH DISORDERS.

A. Initial response. (This section is a review of material for purposes of practical application.)

P. O. 3.4.6

1. Assessment begins the moment the call is received. Gather as much information as possible. The individual's history is most important.

2. Sources of information can be the following:

a. Family members.

b. Case Managers if receiving mental health services.

c. Reporting neighbors or bystanders.

d. Dispatch.

e. Criminal history files.

3. Take time to evaluate the situation.

4. Remember officer safety at all times.

5. Utilize contact and cover.

6. Maintain alertness.

B. Interactions.

1. Command and control techniques used in criminal contacts can be counterproductive when dealing with an individual who is experiencing a behavioral health crisis.

2. Do not threaten the individual.

3. Try to build rapport prior to problem solving.

4. Do not let the individual “push your buttons,” ignore verbal abuse.

5. Avoid exciting the individual and maintain control of your emotions. Do not yell, this only confuses them.

6. If emotions and speech are escalating, talk during the quiet moments. Do not rush them, this only confuses them.

7. Announce your actions. (if safe to do so)

8. Maintain a calm yet confident demeanor.

9. Do not deceive the individual.

10. Use appropriate physical restraints when necessary.

C. Possible behavioral cues.

1. Depressed or tearful.

2. Fearful, Paranoia, Guardedness.

3. Pacing, Hyper-vigilance.

4. Talk to others that are not there.

5. Darting eyes and looking elsewhere as if seeing hallucinations.

6. Angry, irritable, teeth/hand clenching.

7. The individual repeats questions or requires the officer to repeat questions in order to process instructions.

D. Subjects verbal communication. (content and style)

1. Loose associations/fragmented thoughts.

2. Pressured or overly rapid speech.

3. Slowed or very deliberate speech.

4. Grandiose content of speech.

E. Scene assessment.

1. Safety is the top priority: officer safety, public safety and the safety of the individual in crisis.

2. Symptoms of crisis can be interpreted as suspicious activity, criminal activity or non-compliant behavior.

3. The individual in crisis may be struggling to determine what is real or a hallucination.

4. Provide time for them to respond to questions or commands. Allow extra time to grasp and respond because hallucinations may be interfering.

F. Officer Safety Considerations.

1. Ability to physically control the subject.

2. Officer training, experience and intuition.

3. Escape routes. (subject and officer)

4. If possible, slow things down and do not rush.

5. Safety is always the top priority: officer safety, public safety and the safety of the subject in crisis.

6. Officers must continually assess safety and circumstances.

7. Always employ standard tactical safeguards. (use of cover, back-up officer, etc.)

IX. PROPER USE OF RESOURCES ON BEHAVIORAL HEALTH CALLS FOR SERVICE

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A. Some examples of referral agencies for potential situations: (This list is not all-inclusive, refer to a Mental health Resource Guide.)

1. Local behavioral health resources.

   a. County crisis line.

   b. Voluntary drop off centers.

   c. Emergency psychiatric centers.

   d. Health plan/insurance provider 24-hour contact number.

2. Emergency Room.

3. Family counseling and child guidance.

4. Victim/witness services.

5. Substance abuse disorder resources.

X. CONCLUSION

A. Review of performance objectives.

B. Final questions and answers.

C. Instructor closing comment.(s)