

Individuals With Mental Illness or Mental Retardation

BLET: 27E

TITLE: INDIVIDUALS WITH MENTAL ILLNESS OR MENTAL RETARDATION

Lesson Purpose: To present to the student an overview of mental disorders, physical disabilities, communication disorders, and unusual behaviors which a law enforcement officer may encounter and to present methods and procedures to identify, to communicate with, and to assist disabled or disordered persons with maximum safety and efficiency.

Training Objectives: At the end of this block of instruction, the student will be able to achieve the following objectives in accordance with the information received during the instructional period:

1. List the eight general characteristics of psychosis (out of touch with reality).
2. List six behaviors an officer should display when interacting with a person with mental illness to maximize safety.
3. Describe in writing the four major steps for obtaining an involuntary commitment order by a law enforcement officer.
4. Describe in writing appropriate methods for intervention with mentally retarded persons.
5. List ten types of information which aid in identification and evaluation of a potential suicide.
6. Given visual hypothetical situations, determine the following information:
 - a) Is the subject dangerous to self or others?
 - b) What legal authority law enforcement has.
 - c) What action should the officer(s) take.

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7. Identify local mental health resources to obtain help for individuals with mental illness or mental retardation.

Hours: Eight (8)

Instructional Methods: Lecture/Conference

Required Equipment and
Training Aids:

Audio-visual classroom equipment

Video:

*Interacting with Individuals with Mental Illness
or Mental Retardation*, NCJA (1998)

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Date Revised: January 2005
July 2007
January 2010

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TITLE: INDIVIDUALS WITH MENTAL ILLNESS
OR MENTAL RETARDATION - INSTRUCTOR NOTES

1. A large portion of the lesson is devoted to commitment procedures and officer safety issues when dealing with the mentally unstable. Instructors should be very familiar with commitment procedures.
2. There are 16 video scenarios depicting different types and levels of abnormal behavior. They are presented for the purpose of providing new officers with assessment and decision-making skills. While these scenarios are simulations, they include realistic issues officers will face. They are to be shown at the appropriate points in the lesson plan. It is also recommended that the scenarios be followed by role plays which allow students to practice calming techniques, restraining techniques—especially with the use of velcro or leather restraints—and commitment procedures.
3. After viewing each scenario, instructors should ask the following questions:
 - ☐ What information does the officer have?
 - ☐ What other information does the officer need? (Questions to ask complainant)
 - ☐ Is the subject dangerous to self?
 - ☐ Is the subject dangerous to others?
 - ☐ What authority does the officer have in each specific incident?
 - ☐ Departmental policies and procedures should be discussed where appropriate, e.g., when supervisor should be contacted.
4. Instructors must go to the following website to obtain their copies of needed AOC forms: www.nccourts.org. Student lesson plans will contain the forms. The forms include:

AOC-SP-306	AOC-SP-305
AOC-SP-203	AOC-SP-909
AOC-SP-300	AOC-SP-204
AOC-SP-302	AOC-SP-205
AOC-SP-912M	

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5. Abnormal Behavior Video Scenarios

a) **Self-Destruction Level #1**

NOTE: Show video scenario #1 (2 minutes).

Officer knows only what neighbor has observed. Officer should attempt to talk to the neighbor and then the subject. Statements of neighbor's concern would probably be appropriate (class needs to discuss the confidentiality issues of revealing the complainant's name, G.S. 132-1.4). The officer should get a sense of whether the subject is taking her medication, whether she is taking care of herself, or whether she is suicidal.

If the subject does not answer her door, the officer should check windows, telephone her house, and ascertain from the neighbor if she has any family.

The officer has the authority to enter under Urgent Necessity, G.S. 15A-285, if the neighbor has provided sufficient information that she could be suicidal.

b) **Self-Destruction Level #2**

NOTE: Show video scenario #2 (2 minutes).

Clearly this subject appears to be more depressed, but the officer does not have this information. The officer will probably want to telephone the parents for more information, e.g., medication, history of problems, suicidal tendencies, etc.

The class should discuss what information the officer will need before entering the residence. Authority is the same as Level #1.

c) **Domestic Level #1**

NOTE: Show video scenario #3 (2 minutes).

The emergency medical personnel should handle this call. But, if the officer arrives first, he or she should obtain information from the wife concerning what the husband might have consumed, including medications, and any other pertinent information.

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d) **Domestic Level #2**

NOTE: Show video scenario #4 (2 minutes).

Although the emergency medical personnel should handle this call, the officer has the authority to restrain if violent. North Carolina common law authorizes officers to use reasonably necessary force to restrain violent persons subject to medical treatment. The officer should also go with the ambulance to the hospital unless departmental policies direct otherwise.

e) **Domestic Level #3**

NOTE: Show video scenario #5 (2 minutes).

The officer will probably need back-up and the supervisor should also be called. All other people should be removed from the residential area.

Again the officer has authority to restrain. The instructor should review use of deadly force and emergency commitment procedures.

f) **Violence Towards Others Level #1**

NOTE: Show video scenario #6 (2 minutes).

It is important that the officer does not agitate the subject. There is some evidence that the subject may be decompensating (becoming more paranoid), but there is nothing for the officer to base action. For departments that use contact cards, the contact with this subject is an excellent example to report. The contact should note the possibilities of future problems unless the subject's medication is changed or increased.

g) **Violence Towards Others Level #2**

NOTE: Show video scenario #7 (2 minutes).

It is important for the officer to get information from the roommate concerning history of instability, medication, and weapons available to the subject.

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Review of deadly force and emergency commitment procedures would be recommended.

h) **Violence Towards Others Level #3**

NOTE: Show video scenario #8 (2 minutes).

Same information and review as Level #2. The specificity of weapons adds one more level of danger.

i) **Violence Towards Others Level #4**

NOTE: Show video scenario #9 (2 minutes).

Departmental procedures for such emergency situations as this scene need to be discussed (clearing residential area, setting up perimeters). The criminal situation (assault with a deadly weapon) should be dealt with first before the officer becomes concerned with commitment procedures.

j) **Suicide Level #1**

NOTE: Show video scenario #10 (2 minutes).

The officer should help the emergency medical personnel. Once the situation is stable, the woman should be encouraged to consider voluntary commitment. The officer should also give her information about outpatient mental health facilities. The department chaplain or family pastor might also be considered (discuss any related departmental procedures).

k) **Suicide Level #2**

NOTE: Show video scenario #11 (2 minutes).

With elderly people this could be merely a confusion of medication quantity or truly a suicide attempt. The officer is mainly there to help the emergency medical personnel. Again as with Level #1, it may be appropriate to call the department chaplain or family pastor.

l) **Suicide Level #3**

NOTE: Show video scenario #12 (2 minutes).

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The telecommunicator should ask the roommate whether she has tried the door. The officer should obtain information from the roommate about the situation, past mental health history or suicide attempts, possibility of weapons and/or drugs (alcohol also). The officer should then attempt to communicate with the subject. If no response, then the officer has the authority to force entry under urgent necessity, G.S. 15A-285.

m) **Schizophrenic Level #1**

NOTE: Show video scenario #13 (2 minutes).

The mother needs to be contacted and information procured concerning the subject's history of instability and medicine. If information received leads the officer to believe he is dangerous to others, the mother should be encouraged to consider commitment. The officer can also carry through commitment. Emergency commitment would be questionable.

n) **Schizophrenic Level #2**

NOTE: Show video scenario #14 (2 minutes).

This individual is not really a danger to self or others. The officer should try to take her home. If the subject will not go or the department receives more complaints, the individual could be arrested for criminal trespass and the courts may order a pretrial evaluation.

o) **Mentally Retarded Level #1**

NOTE: Show video scenario #15 (2 minutes).

The officer should be supportive of the people who complained. They should be reassured that they had a valid concern and they should be allowed to express their fears. It will also be necessary for the officer to explain the mentally retarded subject's rights and to give a brief explanation about individuals with mental retardation. The officer should then talk to the subject. The facilitator should review the material in outline referring to dealing with people with mental retardation.

p) **Mentally Retarded Level #2**

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NOTE: Show video scenario #16 (2 minutes).

It is important for the officer to be able to recognize characteristics of mental retardation. The officer must be able to decide if this is a case of juvenile delinquency or mental retardation.

6. To promote and facilitate law enforcement professionalism, three (3) ethical dilemmas are listed below for classroom discussion. At their discretion, instructors must provide students with each ethical dilemma listed below. Sometime during the lecture instructors should “set the stage” for the dilemma prior to taking a break. Instructors are encouraged to develop additional dilemmas as needed.
 - a) After transporting an individual to the closest mental health facility with an involuntary commitment order, you are abused by the individual. You do not have the proper paper work and they will not accept the individual. You have a 3-hour return trip with a senior partner. After leaving the hospital on the way back the senior partner stops the car on a county road and orders the person out of the car. What will you do?
 - b) You respond to a call where an individual known to the community is mentally retarded. He is sitting on a table outside the library masturbating. He has urinated and defecated upon himself. He doesn't know right from wrong. What will you do?
 - c) You and your partner respond to a “suicidal person with a gun” call. As you arrive you see the person on a porch. Your partner steps out of the car and yells, “Hurry up! I ain't got all day.” What will you do?

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I. Introduction

NOTE: Show slide, "Individuals with Mental Illness or Mental Retardation."

A. Opening Statement

A working knowledge of psychology is rapidly becoming a necessity for law enforcement personnel. Although clinical assessments by the officer of individuals with whom the officer has contact are neither possible nor significant, it is imperative that every officer has the knowledge to identify, evaluate, and control efficiently and safely a person requiring special consideration.

The law enforcement officer must practice psychology on-the-street rather than in a clinic, office, or university setting. The officer must make, in a minimum amount of time, decisions that would baffle the academic behaviorist, decisions whose ultimate resolutions may involve months or even years of debate and legal considerations. More importantly, errors in the psychologist's decisions are seldom critical; errors in the law enforcement officer's judgment can be life threatening.

B. Training Objectives

NOTE: Show slide, "Training Objectives."

During this block of instruction, we will discuss characteristics of persons with mental illness or mental retardation or persons who are suicidal whom an officer might encounter and techniques to resolve those encounters. Please read carefully the training objectives to ensure an understanding of what is required to be retained.

C. Reasons

Knowing what to do in difficult instances will remove much of the insecurity which prompts rash, inappropriate, and often costly action. This is largely a result of fear, a lack of knowledge, or a general misconception. These are citizens, entitled to full protection, rights, and privileges under the law. Consequently, the need for informed law

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enforcement officers is self-evident, both for the security of these individuals and for the protection from liability of the officer. Professionalism includes a combination of both experience and education. The officer who actively encodes training and is able to apply it on the job increases the chances of a safe encounter with a person displaying abnormal behavior.

II. Body

A. General Information About the Mentally Disordered Person

1. What is abnormal behavior?

NOTE: Show slide, "What Is Abnormal Behavior?"

- a) Psychologists know that anyone can "come apart" under intensive and sustained stress, that all people have problems, periods of depression, and act strange at times.
- b) Some who are different are labeled psychologically abnormal, while others are called creative.
- c) What distinguishes the normal from the abnormal?
 - (1) Conflict:
 - (a) Interpersonal - two or more people.
 - (b) Intrapersonal - within self, conflict they can't deal with.
 - (c) Need to decide whether interpersonal or intrapersonal conflicts involved.
 - i) Other ways to resolve if interpersonal.
 - ii) But intrapersonal may be abnormal if acute.
 - (2) The abnormal has difficulties getting out of their dilemmas by themselves.

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- (3) The abnormal cannot make constructive use of stressful situations.
- d) The social definition of abnormal emphasizes that abnormality is relative to one's culture.¹

NOTE: Cite examples such as shaman or medicine man or woman rites in certain American Indian tribes or "inspired" behavior in certain religions.

- 2. People still have a terrible time accepting mental illness without attaching an aura of strangeness. Since law enforcement officers are part of society, they too must learn to overcome their apprehension of those who display bizarre behavior in order to make an objective decision of whether the individual should be examined by a physician. Officers also need to be aware of their own intrapersonal conflicts.
- 3. Typically, people fear mentally ill persons because they are thought to be unpredictable.
- 4. Even though the mentally ill have a reputation of being dangerous, and certainly the media highlights those who are, violence by the mentally disturbed (considered as a group) is at the same rate as the general population. Fewer than 2% of former mental patients pose a danger to society. These former patients are typically anxious, passive, and fearful themselves. Most people with severe violent crimes are not committed by people with severe mental disorders.²
- 5. While it may be useful to know major categories of mental disorders, the officer mainly needs to know how to react. Actions may take the form of talking, referral, commitment, or arresting.
 - a) To commit or not depends on whether legal requirements are met:

Mentally ill and either dangerous to self or others, or in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness.

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- b) Whether the individual is in touch with reality is an important factor to consider.

B. General Characteristics of Psychosis - Out of Touch with Reality

NOTE: Show NCJA video, *Dealing with Individuals with Mental Illness & Mental Retardation*, "General Characteristics of Psychosis."

1. Major characteristics

- a) Drastic changes in behavior
 - (1) Deterioration of personality
 - (2) Must ask relatives, friends, and neighbors for information to determine normal mode of behavior

- b) Loss of memory

NOTE: Show video scenario #1 - "Loss of Memory" (5 minutes).

- (1) Could be organic, medical problem
- (2) Need medical evaluation
- (3) Other symptoms include disorientation and decreased attention span

- c) Paranoia

NOTE: Show video scenario #2 - "Paranoia" (2 minutes).

- (1) Psychologists and behaviorists warn that anyone can develop paranoia--given the right combination of peer pressure and repeated exposure to one viewpoint (example: militia and extremist groups).

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- (2) Suspiciousness, watchfulness, believe everything has to do with them, guardedness.
- (3) "They're out to get me." "They're planning to kill me."
- (4) Whether these individuals are faced with real dangers or not, they maintain a constant state of preparedness. They appear ever-vigilant against a possibility of attack and derogation.
- (5) Erroneous meaning is suddenly attached to innocent comments. As time passes, delusions of persecution escalate until the individual feels that he or she is under close surveillance everywhere.
- (6) Paranoid individuals detest being dependent, because it's a sign of weakness and inferiority. Also, these individuals are unable to trust anyone.
- (7) Danger cannot always be predicted when dealing with people showing such a high degree of questionable suspiciousness. Paranoid individuals may become aggressive and attempt injury to anyone trying to assist them.
 - (a) Behavior clues of impending violence

NOTE: Show video scenario #3 - "Paranoid with Clues of Impending Violence" (3 minutes).

- i) Facial expression - staring or no eye contact, clenched jaw, flaring nostrils, turning red
- ii) Verbal expression - cursing, talking loudly, threatening, complaining, talking excessively

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- iii) Body language - increased muscle tension, clinched fists, excessive or abrupt movements, pacing, folded arms, head held down
- iv) Appearance - unkempt, clothes representative of aggression, e.g., fatigues
- (b) The officer may feel that the subject is dangerous if the subject displays any of the above listed hostile behavior clues.
- d) Grandiose ideas

NOTE: Show video scenario #4 - "Grandiose Ideas" (3 minutes).

- (1) Believe they are exalted religious leaders or esteemed people from the past.
- (2) Their antics, which may be amusing or pathetic, need not be affirmed or denied, but rather the individual should be asked for more information.
- (3) Mania (rapidly changing ideas, constant talking, exaggerated gaiety, and physical over activity) usually accompanies grandiose ideas.
- e) Delusions/Hallucinations

NOTE: Show video scenario #5 - "Delusions/Hallucinations" (3 minutes).

- (1) Delusions - false beliefs held in spite of invalidating evidence.
- (2) Hallucinations - false sensations. (Example: Command Hallucinations - voices heard by psychotics ordering them to commit acts. Studies show that people are more likely to obey these commands if they can identify the voice, such as God.)

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- (3) Usually related to schizophrenia.
 - (4) Accompanied by flat-sounding voice, no appearance of emotion, and loose association (sentences do not appear to make sense, no connection).
- f) Visions, strange odors, and peculiar tastes

NOTE: Show video scenario #6 - "Visions, Strange Odors and Peculiar Tastes" (4 minutes).

- (1) May be indication of physical or medical cause of mental illness.
 - (2) May need medical evaluation.
 - (3) May be accompanied by hearing voices.
- g) Exaggerated or bizarre physical ailments

NOTE: Show video scenario #7 - "Exaggerated or Bizarre Physical Ailments" (4 minutes).

- (1) Complaints may seem plausible in the early stages of psychosis.
- (2) Safest procedure is to recommend person be checked out by competent medical personnel, even though complaints sound implausible.
- (3) Remain alert to fact that a person may consider the ailment so excruciatingly painful or hopelessly incurable that suicide is the only way left to end the suffering.
- (4) Often accompanies depression.
- (5) Other indicators are slow body movement, soft and flat voice, poor eye contact, and lack of concentration.

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- h) Extreme fright or anxiety

NOTE: Show video scenario #8 - "Extreme Fright or Anxiety" (3 minutes).

- (1) The person is easily startled, shows decreased ability to focus on a single subject, but may be hyper-alert.
 - (2) Accompanying responses are easily startled, decreased concentration, and hyper-alert.
 - (3) Fear is a major emotion for many people with mental illnesses.
 - (4) May be so scared that they speak haltingly, jump at sudden sound, or freeze in absolute terror.
 - (5) The sight of a uniformed officer may have a calming effect, or is likely to cause even greater fear, thus confirming the person's delusions of persecution.
- 2. Outward appearances can be deceiving; some people with a psychosis are indistinguishable from the masses, especially when dealing with situations completely unrelated to their delusions.
 - 3. Generally on medication if have had past psychotic episodes.
 - a) Prescriptions do not guarantee consumption. Several missed doses of medication can cause the person to retreat into bizarre behavior or mixing other drugs or alcohol with the medication can cause the person to display unusual behavior.
 - b) Examples of drugs which treat by stabilizing the chemical reactions in the brain are: Thorazine, Prolixin, Haldol, Mellaril, Stelazine, Artaane, and Lithium. (Thorazine and Mellaril are used for schizophrenia.)
 - c) Examples of drugs which treat by depressing the central nervous system are Valium and Librium.³

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C. General Characteristics of Phobic

NOTE: Show slide, "Phobic Characteristics."

1. Definition: Persistent irrational fear of a specific object, activity or situation which leads the individual to avoid it, if at all possible.
2. Profile
 - a) Panic attacks
 - b) Trembling
 - c) Uncontrollable anxiety
 - d) May use force to escape the problem
3. Subtypes of phobia significant to law enforcement
 - a) Agoraphobia - fear of being alone in public places from which escape might be difficult or help not available in case of sudden incapacitation, i.e., crowds, tunnels, or public transportation.
 - b) Simple phobia, such as claustrophobia - fear of enclosed places which may be seen by an officer during handcuffing, enclosure in a law enforcement vehicle with a shield, or enclosure in a holding cell.

D. General Characteristics of Antisocial Behavior

NOTE: Show slide, "Antisocial Behavior."

1. Definition
 - a) Characterized by inflexible and maladaptive personality traits
 - b) Significant impairment in social and occupational functioning

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2. Profile
 - a) Absence of guilt and tension
 - b) Impulsive and irresponsible nature
 - c) History of many jobs in different locations
 - d) Long criminal history (inability to profit from experience)
 - e) Aggression is common
 - f) No morals
 - g) Con-artist - adept at manipulating others and is charming
 - h) Interested only in himself/herself
 - i) Pleasure of the moment important
 - j) Deceptive, dangerous nature
 - k) Lies about everything
 - l) Likes what he/she does and wants others to leave alone
 - m) May kill for the simple experience of killing and seeing what it was like
 - n) May threaten suicide but seldom is carried out

3. **BE ALERT FOR SIGNS THAT YOU ARE BEING TRICKED, CONNED, OR MANIPULATED!**

- E. Assessment of the Mentally Disturbed Individual Prior to Contact

NOTE: Show slide, "Assessing Individual Prior to Contact."

1. Prior experience with police
 - a) Type of problem

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- b) Prior violence
- c) What worked

NOTE: If your department has CAD (Computer Aided Dispatch), explain how this system can benefit your officers with information from prior incidents.

- 2. Prior to contact with the disturbed person, communicate with complainant
 - a) Family member
 - b) Neighbor
 - c) Complainant
- 3. Assessment at contact
 - a) Appearance - visual frisk
 - (1) Strange clothing
 - (2) Dirty, disheveled
 - (3) Weapons
 - (4) Eyes and face
 - b) Behavior
 - (1) Speech
 - (a) Illogical
 - (b) Very rapid
 - (c) Slurred
 - (d) Very loud or very quiet
 - (e) Irritated, angry, belligerent

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- (2) Body movement
 - (a) Agitated, pacing, abrupt, forceful, furtive
 - (b) Repetitive
 - (c) Slowed
 - (3) Body language
 - (a) Threatening
 - (b) Open
 - (c) Guarded
 - (d) Defensive
 - c) Surroundings
 - (1) Possible places where weapons might be
 - (2) Packages - weapons, junk
 - (3) Companions
 - (4) Other rooms
 - d) Possibility of having taken intoxicants
 - (1) Included in erratic behavior
 - (2) Likely used as an attempt to self-medicate⁴
- F. Methods and Techniques of Dealing with the Mentally Disordered Person

NOTE: Show slide, "Dealing with the Mentally Disordered Person."

1. Ask questions of family, neighbors, or complainant.

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- a) Is the individual on medication? When was the last time the individual took his/her medication? Possibility of other drugs? (i.e., "Where is your medication? Can I see it?") The officer should encourage the family to contact the individual's doctor about the prescription and/or doctor's orders, as well as potential side effects.
 - b) Is he or she often violent? Any weapons?
 - c) What sets her or him off?
 - d) Will he/she go with the family or significant other to the area facility? (The officer should suggest possibilities of voluntary commitment or a family member initiating papers if requisite criteria are met.)
2. Take time to assess the individual and environment unless the person is endangering self or others.
- a) Give the person time to quiet down.
 - b) Try to find out what is going on. Be a good listener.
 - c) Do not give the impression that there is not time for them.
3. Do whatever is possible to provide a nonthreatening environment.
- a) Keep a safe distance.
 - (1) Individual is probably frightened or angry. If he or she is hearing voices and those voices are saying that the officer has come to punish or hurt, the person may turn against the officer without apparent provocation.
 - (2) People have areas of space around them that should be respected.
 - (a) Intimate under 18"
 - (b) Personal - 18" to 36"

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- (c) Social - 3' to 6'
- (d) Public - over 6'
- (3) Officer should remain in social space; however, space is situational. The more threatened the individual feels the more space needed.
- b) Interpersonal communication skills
 - (1) Use normal yet firm voice, convey image of quiet self assurance.
 - (2) Effective listening
 - (a) Reinforce communication with repeating back what the person is saying, using different words-paraphrasing. (i.e., "I understand that you are feeling _____.")
 - (b) Summarize what the individual said, making sure the facts are straight.
 - (c) Use a non-judgmental manner.
 - (3) Avoid trigger words such as mental health, mental hospital, commitment, or crazy.
 - (4) Encourage the person to talk
 - (5) Do not threaten or abuse
 - (6) Avoid behavior that might appear threatening
 - (a) Put night stick in belt.
 - (b) Avoid standing over a sitting individual.
 - (c) Honor personal body space--keep distance.
 - (d) Be aware of facial expressions.

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- (e) If numerous officers, avoid surrounding.
- 4. Minimize unnecessary sensory input, such as noises and crowds. These tend to confuse the subject.
- 5. Call back-up if at all possible. Do not act alone.
- 6. Do not take anger personally. They are not necessarily mad at you.
- 7. Try not to lie to or deceive the individual. Try negotiating instead, i.e., "You might have to go to the hospital, but there are other alternatives."
- 8. Be alert.
 - a) May exhibit burst of extreme strength and may appear impervious to pain, especially if intoxicated by drugs.
 - b) Individual is unpredictable and may not respond in the manner expected by the officer.
 - c) Do not be fooled by a sudden return to reality; the person can just as quickly return to crisis.
- 9. If physical force becomes necessary for apprehension:
 - a) Restraint should preferably not be attempted by one officer alone. Disordered persons often have short bursts of extreme strength.
 - b) The person should be maneuvered into an area where he/she is least likely to be hurt upon being restrained.
 - c) Know where your firearm is at all times.
 - d) If leather restraints are available, use them.
 - e) THINK SAFETY AND TREATMENT--YOU ARE NOT ARRESTING.

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- f) Conduct a thorough search of the person for officer and patient safety, but do so with extreme caution (possibility of needles or blades).
 - g) The officer should always be aware that if his or her life or another's is imminently threatened, necessary deadly force can be used.⁵
10. If involuntary commitment becomes necessary, the following commitment procedures should be followed:
- a) Definitions
 - (1) Mental illness (G.S. 122C-3(21))
 - (a) Adult: an illness which so lessens the capacity of the person to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control.
 - (b) Minor: a mental condition other than mental retardation alone which so lessens or impairs the youth's capacity either to develop or exercise age appropriate or age adequate self-control, judgment, or initiative in the conduct of his activities and social relationships as to make it necessary or advisable for him to be under treatment, care, supervision, guidance or control.
 - NOTE: Emphasize to students that difference between the adult and the minor relates to age and appropriate behavior.**
 - (2) Mental retardation (G.S. 122C-3(22))

The term "mentally retarded" shall refer to an individual with significantly subaverage general

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intellectual functioning and existing concurrently with deficits in adaptive behavior and having been manifested before age 22.

- b) Conditions that must exist for mental commitments

No individual shall be involuntarily committed to a 24-hour facility unless he is mentally ill or a substance abuser, and dangerous to self or others

- c) Types of mental commitments

NOTE: Show slide, "Mental Commitments."

(1) Voluntary commitment (or voluntary admission) - a commitment where the individual "voluntarily" decides to go to a treatment facility. These commitments may be to a mental health facility or a substance abuse facility.

(2) Involuntary commitment - this type of commitment is where an individual meets the above condition and will be placed in a treatment center "against his will." (Requires petition)

(3) Emergency commitment - a type of commitment specifically designed to meet "emergency" or "exigent" circumstances. This type of commitment procedure can be initiated by an officer or other persons to expedite treatment and increase safety for all parties involved. (No petition required)

- c) Procedures for and examples of commitment types

All commitment contact/transportation have the potential for danger to the officer and the subject involved. Always be conscious of officer safety techniques during these procedures.

(1) Voluntary commitment procedures - The officer may transport if requested for a voluntary commitment. If a subject approaches you and

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requests transport to a mental health facility, first ask if the subject has other transportation. If the subject does not, you may choose to transport.

- (a) Steps to follow:
 - i) See if alternative transportation is available
 - ii) Notify telecommunications and supervisor of intent to transport
 - iii) Search and secure subject to be transported
 - iv) Radio beginning mileage
 - v) Report/record general information on subject
 - vi) Walk subject into the admissions office
 - (b) Examples
 - i) You may be parked in a patrol vehicle writing a report when a subject approaches you and requests "a ride."
 - ii) You respond to a domestic disturbance call and the subject agrees that he/she needs to see a doctor because he/she "can't take all this stress."
- (2) Involuntary commitment procedures - papers are filed by a third party or officer for the involuntary commitment of a person to a mental health facility.

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NOTE: Instructors may supplement section (2) above with "Commitment Process" handout. Instructors may obtain copies of related AOC forms at www.nccourts.org. Instructors should review AOC forms with students.

- (a) Steps to follow:
- i) Papers are filed by a third party or a police officer. The papers consist of two forms and can be issued by a magistrate or clerk of superior court:
 - Affidavit - which alleges the behavior of the subject. This information justifies why the subject should be committed and explains the conditions that exist.

NOTE: Refer back to "Conditions that must exist for a mental commitment."
 - Custody Order - gives the law enforcement officer the authority to take the subject into "custody." The individual cannot be placed in a jail or any penal facility.
 - ii) Take custody of the subject. You must attempt to locate the subject within 24 hours. If you do not locate the subject, you must be able to document on the return of the custody order the reason(s) the subject was not located. The papers must be returned if you do

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not locate the subject, and they may be reissued.

Note: The law enforcement officer, to the extent possible, will advise respondents when taking them into custody, that they are not under arrest and have not committed a crime, but are being transported to receive treatment and for their own safety and the safety of others [G.S. 122C-251(c)].

iii) Assessment #1. Transport subject to appropriate facility for the first evaluation by a physician or licensed psychologist.

- Facility

During hours of operations - transport the subject to local mental health clinic/facility.

After hours of clinic operation - transport the subject to a local hospital's emergency room for evaluation.

- Findings of assessment #1

No commitment - A physician/psychologist may feel commitment is not warranted at this time. This will end the process. Return the papers and transport the subject back to his residence, or with the subject's consent, to the house of a consenting

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individual located in the originating county.

Out-patient commitment - Physician/psychologist has to recommend out-patient commitment. This is sometimes used when a subject agrees to take their medication while they are at this facility. Transport the subject back to his residence, or with the subject's consent, to the house of a consenting individual located in the originating county.

In-patient commitment - Physician/psychologist feels that the subject should be committed to a 24-hour facility. The papers are signed documenting the visit, and the officer transports the subject to a 24-hour facility.

If a 24-hour facility is not available, the patient may be temporarily detained at the place of initial evaluation. If a 24-hour facility is not available at the end of seven days, the patient is to be released and reported to the clerk.

- iv) Assessment #2. The 24-hour facility.
 - A 24-hour facility is any mental health facility that

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provides acceptance of clients on a 24-hour basis.

State facilities - Dorothea Dix (Raleigh), Broughton Hospital (Morganton), Cherry Hospital (Goldsboro), and Butner.

Private facilities - Charter Hospitals, etc.

- Findings of assessment #2

No commitment - A physician/psychologist may not feel commitment is warranted at this time. This will end the process. Return the papers and transport the subject back to his residence in the originating county or, if requested by subject, to another location in originating county.

Out-patient commitment - Subject agrees to return on a voluntary basis for treatment. This is sometimes used when a subject agrees to take their medication while they are at this facility. Transport the subject back to his residence in the originating county or, if requested by subject, to another location in originating county.

In-patient commitment - The findings of this

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assessment are that the subject does indeed need to be confined in the facility. The officer should stay with the subject until such time as admissions personnel have relieved the officer of responsibility for the subject.

Note: In some 24-hour facilities, the officer may be asked to secure his/her weapon. This is for the officer's protection, as well as that of the subject. It is important to comply with the rules set by the facility.

- **Examples**

An officer responds to a suicide attempt call. The subject has cut his/her wrists, but refuses medical treatment.

A subject is on medication for mental illness, but refuses to take it. The family calls law enforcement to prevent the subject from hurting him/herself.

(b) **Physician or psychologist petitioners**

- i) The petitioner need not appear personally before the magistrate or clerk of court if the petitioner is a physician or eligible psychologist who has examined the respondent

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and executed the petition (AOC-SP-300) before a notary public.

Note: Involuntary commitment AOC forms can also be obtained at www.nccourts.org.

- In this case, the physician or psychologist petitioner should fill out and attach the "Examination and Recommendation to Determine the Necessity for Involuntary Commitment," DMH 5-72 (rev. 2/97), which indicates the disposition recommended by the physician or psychologist.
 - Personal appearance of the physician/psychologist petitioner before the magistrate/clerk is not required, but someone must deliver the commitment papers (the petition and the examination form) to the magistrate or clerk of court.
- ii) The procedure that follows from the physician/psychologist petition depends upon the recommendation of the petitioner. If the physician/psychologist petitioner recommends:
- Inpatient commitment, and the magistrate/clerk finds probable cause to believe that the respondent meets the criteria for inpatient commitment, then the

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magistrate/clerk must issue an order (AOC-SP-302 custody order) to transport the respondent directly to a 24-hour facility for examination and custody pending a district court hearing. The examination already conducted by petitioning physician or psychologist is equivalent to the first examination.

- Outpatient commitment, and the magistrate/clerk finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the magistrate/clerk must issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed to outpatient treatment. (Form AOC-SP-305 is used; no custody order is issued and respondent is not taken into custody.)
- Substance abuse commitment, and the magistrate/clerk finds probable cause to believe that the respondent meets the criteria for substance abuse commitment, the magistrate/clerk shall either:

Issue an order to transport the respondent directly to a

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24-hour facility for examination and custody pending a district court hearing (AOC-SP-302), or

Issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed (AOC-SP-305), in which case the respondent will not be taken into custody pending the district court hearing.

(c) **Emergency procedures**

There are two emergency procedures authorized by statute in the event that any delay created by utilizing the normal procedure would create a danger of harm to the respondent or others. One applies to the *mentally ill* and does not involve the magistrate or clerk of court. The second is for *substance abusers* and requires the magistrate or clerk of court to issue an order.

i) **Mentally ill**

Anyone, including a law enforcement officer, who has knowledge of a mentally ill individual who both meets the criteria for inpatient commitment and requires immediate hospitalization to prevent harm to himself or others, may transport the individual directly to a physician or eligible psychologist for examination. This does not

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apply to those persons subject to commitment solely as substance abusers.

NOTE: Show slide of text box below.

**mentally ill and dangerous to self or others
+
requires immediate hospitalization to
prevent harm**

Physician's sworn certification: If the physician or psychologist determines that the individual meets the criteria for inpatient commitment, the physician/psychologist must so certify in writing before any official authorized to administer an oath. (Form DMH 5-72-A (rev. 2/97)) The certificate must also state the reason that the individual requires immediate hospitalization and, if the examiner knows or has reason to believe that the individual is mentally retarded, this also must be stated.

Transportation to a 24-hour facility for second examination: The physician/psychologist's certificate (sworn statement) operates as a magistrate's custody order, and a law enforcement officer or other person providing transportation must provide transportation to a 24-hour facility. The examination by the physician/psychologist executing the certificate operates

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as the first examination that is normally conducted pursuant to a custody order, and a second examination is required at the 24-hour facility.

ii) Substance abusers

When an individual subject to substance abuse commitment (i.e., is a substance abuser and dangerous to himself or others) is also violent and requires restraint, and when delay in taking the individual to a physician or eligible psychologist for examination would likely endanger life or property, a law enforcement officer may take the person into custody, take him or her immediately before a magistrate, and petition for an order to take the individual directly to a 24-hour facility.

NOTE: Show slide of text box below.

**a substance abuser who is dangerous to himself or others
+
violent and requires restraint
+
delay creates a danger to life and property**

Only a law enforcement officer may utilize this emergency procedure.

The petition (AOC-SP-909M) must not only state facts supporting a finding of substance abuse and dangerousness (i.e., the normal

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commitment criteria), but also facts that would support a finding that the individual subject to commitment is violent and requires restraint and that the delay caused by using the regular commitment procedure would create a danger to life or property.

In contrast to the regular substance abuse commitment procedure, under the emergency procedure:

- The individual is already in law enforcement custody before the petitioner goes to the magistrate.
- The magistrate orders that the individual be taken directly to a 24-hour facility, rather than to a local physician or eligible psychologist.
- In addition to finding reasonable grounds to believe that the individual is probably a substance abuser and dangerous to himself or others, the magistrate or clerk of court must find by clear, cogent, and convincing evidence that the respondent is violent and requires restraint, and delay in taking the respondent to a physician or psychologist for examination would endanger life or property.

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d) Length of commitments

NOTE: Show slide, "Length of Commitments."

- (1) Individuals with mental illness
 - (a) Maximum of 90 days for involuntary commitments
 - (b) For voluntary commitments - 3 days after subject requests release, if facility chooses to hold while seeking involuntary commitment
- (2) Substance abusers can be committed for up to 180 days.
- (3) In all types of commitments, the subject has the privilege of a hearing that takes place in the facility.

e) Transportation

- (1) To the extent feasible, law enforcement officers shall dress in plainclothes and travel in unmarked vehicles. (G.S. 122C-251(c))
- (2) There must be a driver or attendant who is the same sex as the subject, unless the law enforcement officer allows a family member of respondent to accompany the respondent.
- (3) In providing required transportation, the officer may use reasonable force to restrain the respondent if it appears necessary to protect self, the respondent, or others. No officer may be held criminally or civilly liable for assault, false imprisonment, or other torts or crimes on account of reasonable measures taken. (G.S. 122C-251 (e))

G. Substance Abuse

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NOTE: Show slide, "Substance Abuse."

Various consequences from the abuse of drugs can occur. The interaction of a combination of drugs poses severe and dangerous health problems. People with serious mental problems have their disorders exacerbated by using alcohol and drugs. If they are on medication for their problem and have mixed it with other drugs, they need to be evaluated by professionals in a treatment facility.

1. General effects such as:
 - a) Sedation, depressed respiration, a semi-hypnotic state, contracted pupils, depressed reflexes, and intoxication.
 - b) Lack of pain or fatigue.
 - c) Lack of coordination, restlessness, excitement, disorientation, confusion, and delirium.
 - d) Hallucination, pupil dilation, increased blood pressure and body temperature, depressed appetite, and on occasion, nausea and chills.
2. Withdrawal effects such as:
 - a) Sweaty, fearful, and tremulous.
 - b) Restless, agitated, and convulsions.
 - c) May hallucinate or have delusions.
 - d) Hot and cold flashes, vomiting, diarrhea.
 - e) Emergency medical personnel should be contacted for transporting to emergency room.⁶

H. Handling Substance Abusers

1. Commitment procedures (G.S. 122C-281 to 122C-294)

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- a) The basic procedural steps for involuntary commitment of substance abusers are identical to procedures for committing mentally ill persons, with certain exceptions.
 - b) No similar outpatient commitment procedure.
 - c) Be aware that certain institutions are reluctant to accept substance abusers. Voluntary commitment should be suggested to the appropriate facility, i.e., alcoholic or drug facility.
 - d) The court may order commitment up to 180 days as disposition from a district court hearing as opposed to a maximum of 90 days in mental health cases.
 - e) The substance abuser involuntary commitment provisions should not be confused with procedures for assisting individuals who are intoxicated in public.
2. Remember the assessments and techniques for handling mentally disturbed individuals, especially those who are potentially violent.
- a) Substance abusers, especially those on stimulants, may be impervious to pain and may exhibit extraordinary strength.
 - b) While mentally disturbed individuals can often be calmed down, the substance abusers, especially those on stimulants cannot be calmed down easily. Back-up should be requested and more than two officers may be necessary to prevent injury.
 - c) Unpredictability is a key factor for an officer to keep in mind.
3. Arrest should be considered when there is probable cause that a criminal offense has been committed.
- a) May actually help person to realize that he or she has a problem.

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- b) Try to remember that alcoholism and drug addiction are serious illnesses that require treatment.
- c) Assess the individual's awareness that they are being arrested (i.e., "Do you understand that you are being placed under arrest?").
- d) The abuser's reaction to officer confrontation varies depending upon:
 - (1) Whether the abuser is under the influence of a drug or just in possession of it.
 - (2) The type of drug taken and the effect it is having on the abuser.
- e) Some jail policies state that subjects under the influence of drugs will not be admitted. These subjects must first be transported to a hospital. Be sure to check with your local department for admitting procedures.

I. Methods for Dealing With Mentally Retarded Persons

NOTE: Show slide, "Dealing With Mentally Retarded Persons."

People are often uncomfortable in the presence of abnormal behavior from a rapidly narrowing range of norms. Society looks away, hurries away, or calls law enforcement to put away. We like people who look and act as we do. The mentally retarded person often, even if he/she looks like us, does not act as we expect.

For example, the person who robs the bank and signs the note that he gives the teller, and the person who rushes to a getaway car after a grocery store hold-up and discovers the car keys are lost, make amusing squad room conversation--yet a closer look at these individuals might reveal retardation rather than clumsiness.

1. Definition

NOTE: Show slide, "Definition: Mentally Retarded."

In general, a mentally retarded person is one whose learning capacity is limited. The degree of retardation varies widely,

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from those who must be institutionalized to those who can maintain a routine job.

Many of the persons who are retarded have comparatively minor difficulties with learning and social functioning, and are in the mild or moderate range. Remember, persons with mental retardation are not mentally ill.

2. Psychological profile elements: mental retardation
 - a) May be unable to formulate thoughts and answer questions readily.
 - b) May have speech defects.
 - c) May appear interested in children as they can better understand what children are doing.
 - d) May have slow responses similar to alcohol or drug abuse.
 - e) Often they have poor judgment.
 - f) Often unable to foresee the consequences of an act.
 - g) Easily influenced by an authority figure.
 - h) Often inadequate in their personal relationships.
 - i) Socially immature.
 - j) Resent unkind nicknames/teasing and may do something foolish because of it.
 - k) Some individuals with mental retardation are quite sensitive and very aware that they are different.
 - l) Some individuals with mental retardation, to compensate, may become aggressive in order to feel "important."
 - m) Awareness of being different may be responsible for feelings of inferiority, frustration, and resentments; as a result, less tolerant to stress.

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- n) Fear may be the major characteristic in a confrontation with an officer.
 - o) Potential for violence or aggression exists since the appropriate outlet channels may never have been learned by the mentally retarded person.
3. Criminal profile
- a) Criminal offenses of retarded persons usually result from an interaction of many factors.
 - b) Feelings of inferiority mentioned earlier may cause aggression toward others.
 - c) Study of persons with mental retardation in state prison revealed their single most frequent crime was homicide; greater than 50% of the crimes committed by persons with retardation were crimes of violence against a person.
 - d) Burglary, improper sexual behavior, theft, and vandalism are other common criminal acts committed by persons with mental retardation - usually at the instigation of others.
 - e) A mentally retarded person is easily influenced to be led into criminal behavior.
 - f) This individual is frequently the victim of criminal behavior.
 - g) Mentally retarded offender
 - (1) Although estimates of the number of mentally retarded adult offenders vary, there are proportionately more persons who are mentally retarded in prisons and jails than in the general population. For example, a 1976 H.V. Wood study identified only 3% of Missouri's general population as retarded, while approximately 10% of the correctional institutions' population and

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7% of the probationers and parolees were identified as retarded.

- (2) It has been found that many delinquent acts are due to their level of social and behavioral insight. Moreover, the suspect may not always understand his or her civil rights. In the H.V. Wood Study, 95% of the inmates who are mentally retarded either confessed or pleaded guilty to offenses. Low intellect often leads to internalizing false confession; individuals with mental retardation believe they committed a crime that in reality they did not.

4. Methods to deal with a mentally retarded person

NOTE: Show slide, "Dealing with the Mentally Retarded."

- a) May come in as a missing person complaint - may have gotten lost and is wandering aimlessly.
- b) GO SLOWLY - rapid questions during an interview or confrontation may confuse or frighten the person.
- c) Patience is needed to overcome a communication barrier and alleviate any exaggerated fears.
- d) Rephrase questions into simpler language if it appears person does not comprehend.
- e) Minimize unnecessary sensory input - noises, crowds, as they may confuse the person.
- f) Identification and information concerning parents/guardians important to establish immediately. Many persons who are mentally retarded carry cards with information of important contacts written on them.
- g) If any doubts, ask if they go to a special school.
- h) Misinterpretation of acts

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- (1) Individual may quickly go to their pocket to get contact card on which is written parent, doctor, or employee name and number.
 - (2) Fear of officer may take the form of flight.
- i) If you should need assistance, contact one of the following:

NOTE: Show slide, "Mental Health Resources."

- (1) Association for Retarded Citizens
 - (2) Mental Health, Mental Retardation, and Substance Abuse Service
 - (3) Special Education Department of the School Systems
 - (4) Vocational Rehabilitation Office
- j) Another group of persons with disabilities which is being served more frequently in the community is persons with autism. Autism is a severe disorder of communication and behavior. It is a lifelong developmental disability which seriously impairs the way the brain processes information sent from the senses. Characteristics include:
- (1) Withdrawal from contact with others
 - (2) Very inadequate social relationships
 - (3) Language disturbances
 - (4) Monotonous repetitive body movement
 - (5) Behavior problems in terms of resistance to change and emotional responses⁷

Note: More extensive profile elements for individuals with autism and methods for dealing with autistic

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individuals are contained in the BLET topic, "Dealing with Victims and the Public."

J. Suicide

1. Myths and facts

NOTE: Show slide, "Suicide: Myths and Facts."

a) *"People who talk about suicide won't commit suicide."*

Eighty percent of successful suicides previously either threatened suicide or made a suicide gesture.

b) *"Suicides happen without warning."*

Most often the person clearly warns of his intentions. Less than 50% of suicides result from panic type behavior.

c) *"Improvement after a suicidal crisis means that the suicide risk is over."*

Over one-half of the successful suicides follow within 90 days after the emotional crisis. Increased activity, perhaps even reflecting a new "cheerfulness" may mean that the person has simply finally "decided" to end his/her life, hence the acute anxiety diminishes.

d) *"Suicide and depression are synonymous."*

Depression, though common, is only one of many symptoms that occur.

e) *"Suicide is a single disease."*

It is not a disease, but a form of behavior that occurs at all ages and economic levels with different meanings and motivations.

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f) *"Suicide is immoral."*

Judgment depends on the culture and circumstances. The Greeks (Socrates), the Orientals (Hari-Kari), and certain groups in the South Seas approve.

g) *"Suicide can be controlled by legislation."*

England has a law against suicide, Scotland does not; yet the suicide rate is twice as high in England. The problem of punitive action may encourage lethal behavior rather than just a gesture.

h) *"The tendency to suicide is inherited."*

Children learn from their teachers (parents). This principle accounts for most behavior that is said to be hereditary.

i) *"All suicidal persons are insane."*

Faberow, et al., report, "The majority of persons who commit suicide are tormented and ambivalent: i.e., they are neurotic or have a character disorder, but are not insane."

j) *"Suicide is the 'curse of the poor' or 'disease of the rich!'"*

Suicide does not correlate with economic status.

2. Signs indicating suicide is being considered.

NOTE: Show slide, "Suicide Signs."

a) Drastic behavior changes

(1) Insomnia

(2) Weight loss, appetite loss, self-imposed starvation

(3) Withdrawal from usual pursuits, activities

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- (4) Decrease in sex
- (5) Sadness/crying
- (6) Mood variations
- (7) Lethargy
- (8) Excessive risk taking
- (9) Unreasonable high expectation for success in job or business, academics/athletics

- b) Verbal cues
 - (1) Feeling hopeless/helpless
 - (2) Talking only about past
 - (3) Saying "I'm going to kill myself"

- c) Prior history
 - (1) Prior attempts or family history of suicide
 - (2) History of mental illness

- d) Indirect cues
 - (1) Makes will/changes will
 - (2) Give away prized personal possessions
 - (3) Makes funeral plans

- e) Job history
 - (1) Loss of employment
 - (2) Business reversals

- f) Medical history

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- (1) Recent/chronic illness
 - (2) Hypochondria
 - (3) Refusing to follow doctor's orders or to take medication
 - g) Marital difficulties
 - (1) Recent marital problems
 - (2) Loss of family member, death, or rejection
 - h) Financial difficulties
 - i) Alcoholism
 - j) Psychosis
3. Demographics

NOTE: Show slide, "Suicide: Demographic Characteristics."

- a) Age
 - (1) 1-9: rare
 - (2) 15-19: third leading cause of death
 - (3) 18-21 (college students): 8-12% of deaths - second most frequent cause of death
 - (4) 45+: 66% of suicides are by males over 45 - over 50% of females are over 45
 - (5) 70-80: peak danger age group
- b) Sex
 - (1) Attempted suicide women outnumber men 3:1

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- (2) Completed suicide men outnumber women 70% to 30%
- c) Time of year
 - (1) Most occur in spring or holidays
 - (2) Christmas also has high rate
- d) Ethnic variances
 - (1) Whites have a suicide ratio of approximately twice that of African Americans.
 - (2) Native Americans have highest rate in U.S.; Eskimos have the highest rate in the world.
- e) Police suicide
 - (1) Suicidal rates are higher among professions with high stress potential; law enforcement agencies are included in this group.
 - (a) Different research places law enforcement suicide rate in comparison to the general population at different levels.
 - (b) Highest rate among officers with marital problems, problems not directly related to the job.
 - (2) Need to be alert for suicide warning signs among fellow officers; know how to get help within the department or how to refer to a special assistance program.

4. Methods

NOTE: Show slide, "Suicide Methods."

- a) Sleeping pills and other pharmaceuticals - 12%
- b) Hanging and strangulation - 15%

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- c) Firearms and explosives - 48%
 - (1) Use of pistol versus shotgun more frequent
 - (2) Usually shoot in temple, face, or heart
 - d) Males
 - (1) Attempts: barbiturates
 - (2) Commits: guns, hanging, carbon monoxide
 - e) Females: Attempts/Commits: barbiturates
 - f) "Suicide by Cop" - method used by individuals to force officers to use deadly force against them.
 - (1) Typical scenario includes: an individual with a prior history of mental chronic physical illness, alcohol/substance abuse, incident initiated by subject or third party to ensure police response, suspect forces confrontation, aggressive action toward police, presence of deadly weapon and threatens officer(s), advancement by suspect toward officer(s) even if officer is retreating.
 - (2) Officer options may be limited - must also protect themselves and/or third party.⁸
5. Talking with the suicidal person
- a) If it is a telephone contact, the person's location should be identified if possible.
 - b) If a person appears suicidal, the officer need not be afraid to confront him/her with a question about it. This is not a new idea.
 - c) The officer should try to keep in touch with how he or she is feeling and how the person they are talking with is feeling. Hopelessness can mean they have exhausted

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their resources. Anger is better, if it is directed to someone else.

- d) Reflect their feelings. Allow for as much ventilation of their feeling as is possible. Orient the conversation toward the immediate future, its alternatives, and possible resources.
- e) Try not to be trapped into condoning or rejecting an expressed wish to die.
- f) Crisis intervention can fail and injury or death may be the result. Do not fall into the trap of feeling responsible for other people's decisions to harm themselves or others. Often the officer will need someone to talk to after a serious crisis or during the time offering support to someone on a continuing basis.
- g) Use caution! Remember that a suicide attempt can often turn into a homicide attempt.⁹

NOTE: Show NCJA video, *Interacting with Individuals with Mental Illness or Mental Retardation*, "Abnormal Behavior Scenarios." Refer to Instructor Notes.

NOTE: North Carolina Crisis Centers are included as a handout.

III. Conclusion

A. Summary

This block of instruction covered categories and behaviors of mental disorders, methods for dealing with disordered persons, suicide and drug abuse evaluation and intervention, as well as methods for dealing with mentally retarded persons. The commitment process in North Carolina has also been discussed.

NOTE: Show slide, "Training Objectives."

B. Opportunity for Questions from Class

C. Closing Statement

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The law enforcement officer encounters situations daily in which the separation of fact from fiction is required: the truth from a lie. When dealing with a person displaying deviant behavior, the officer may also find it necessary to separate fact from fantasy, a fantasy which is often as convincing as reality. An officer must always remember that, in order to effectively interact or intervene with such a person, one must deal with that person's perception of reality--not what is, but, in many cases, what is **not**.

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NOTES

1. Vivian Lord, "Special Populations," *Basic Law Enforcement Training* (Salemburg, NC: N. C. Justice Academy, 1984), 9-10.
2. J. Monahan, "Mental Disorder and Violent Behavior," *American Psychologist* 47 (4), 511-521.
3. Lord, 13.
4. Lord, 19.
5. National Mental Health Association, *A Manual for Law Enforcement: Aiding People in Conflict* (Alexandria, VA: National Mental Health Association, 1993).
6. Lord, 27.
7. *Law Enforcement and Handicapped Persons: An Instructors Training and Reference Manual* (Toronto, Canada: National Institute on Mental Retardation, 1975).
8. C. Van Zandt, "Suicide by Cop," *The Police Chief*, July 1993, 24-30.
9. R. Roof and M. Lindsay, "Recognizing Potential Suicidal Behavior in Employees: A Supervisor's Guide," training notes for Baltimore Police Department, 1996, 1-3.