TRAGEDY SPANS CHANGE. IN 1987, THE MEMPHIS, TN POLICE RESPONDED TO A CRISIS CALL INVOLVING A MAN REPORTED TO BE MENTALLY ILL. HE WAS ARMED WITH A KNIFE AND CUTTING HIMSELF. AFTER A BRIEF STANDOFF AND SOME THREATENING ACTIONS ON THE PART OF THE SUBJECT, HE WAS SHOT AND KILLED.

THE LOCAL CHAPTER OF THE NATIONAL ALLIANCE FOR THE MENTALLY ILL (NAMI) VOICED THAT THE POLICE WERE UNITRAINED AND UNPREPARED TO RESPOND TO A CRISIS INVOLVING MENTALLY ILL SUBJECTS. THE MAYOR OF MEMPHIS FORMED A TASK FORCE TO RESEARCH THE VARIOUS MODELS FOR DEALING WITH SUCH A SITUATION. THE RESULT WAS THE SPECIALY TRAINED CRISIS INTERVENTION TEAM (CIT).

THIS IS A PATROL-ORIENTED, 40-HOUR TRAINING COURSE BASED ON THE PREMISE THAT SPECIAL PEOPLE HAVE SPECIAL NEEDS, WILL RESPOND IN A PREDICTABLE WAY, AND DESERVE SPECIAL CARE. THE SOMEWHAT SURPRISING ASPECT OF THIS APPARENTLY TOUCHY-FEELY APPROACH IS THAT FEWER PEOPLE GO TO JAIL, FEWER PEOPLE GO TO MENTAL HOSPITALS, FEWER OFFICERS AND SUBJECTS ARE INJURED, THERE ARE FEWER REPEATE ARRESTS, FEWER PEOPLE PROSECUTED (OR OTHERWISE ENTER THE JUDICIAL SYSTEM) AND MORE PEOPLE ARE IDENTIFIED TO GET THE APPROPRIATE MENTAL HEALTH CARE.

CIT SHOULD BE REQUIRED TRAINING FOR ALL SWAT NEGOTIATORS. HOWEVER, CIT IS ALSO GEARED FOR ALL OFFICERS WHO RESPOND TO ATTEMPTED SUICIDE CALLS AND OTHER CALLS THAT MAY INVOLVE THE MENTALLY ILL. CIT OFFICERS ARE TAUGHT TO RECOGNIZE THE VARIOUS PSYCHIATRIC SYNDROMES, THE BIOLOGIC BASIS FOR SEVERE MENTAL ILLNESS, DE-ESCALATION OF CRISIS SITUATIONS, THE LAW PERTAINING TO THE DETENTION OF THE MENTALLY ILL, AND ACCESS TO EMERGENCY AND NON-EMERGENCY MENTAL HEALTH SERVICES.

DAY ONE

THE FIRST DAY OF CIT TRAINING BEGINS WITH THE MANY MYTHS AND MISCONCEPTIONS OF SEVERE MENTAL ILLNESS. FOR LAW ENFORCEMENT, THE BIGGEST MYTH INVOLVES THE TENDENCY OF THE SEVERE MENTALLY ILL TO BECOME VIOLENT. THAT SIMPLY IS NOT TRUE. BIZZARE BEHAVIOR? YES. HARMFUL TO SELF? POSSIBLE. VIOLENT TO RESPONDING OFFICERS? NO.

THE SEVERELY MENTALLY ILL NECESSITATE AN ENTIRELY DIFFERENT APPROACH. IT CALLS FOR AN ENTIRELY DIFFERENT VOICE TONE, VOICE VOLUME, PERSONAL SPACE, AND BOTH OBSERVATIONAL AND QUESTIONING SKILLS. IS THIS JUST ANOTHER DRUNK? OR IS THERE SOMETHING ELSE HERE? THE EMPHASIS IS ON TOLERANCE, PATIENCE AND UNDERSTANDING. IT IS ACTUALLY NO DIFFERENT THAN THE "LOOKING BEYOND THE TICKET" APPROACH USED DURING A DRUG INTERDICTION VEHICLE STOP.
Bi-polar (Proportion)

Bi-polar, or manic-depressive illness, involves changes in the PROPORTION of normal emotions. About 2% of the population has bi-polar illness, making it one of the most common forms of mental illness.

Normal is happy. Manic is exaggerated elation and poor judgment. Normal is glum. Depressive is persistent and extreme helplessness and hopelessness. Bi-polar illness is often complicated by alcohol or other substance abuse. Psychotic symptoms include hallucinations (seeing, hearing, smelling or otherwise sensing things that do not exist) and delusions (false beliefs and thoughts that are illogical and incorrect, held despite evidence to the contrary).

A person suffering from bi-polar has mood swings from high and irritable to sad and hopeless. The cycles vary greatly in both duration and frequency. The manic phase gets shorter and the depressive phase gets longer. Left medically untreated, 20% of bi-polar victims commit suicide. Almost all people with bi-polar can be helped with treatment to stabilize the severe mood swings.

Mental illness is never an excuse for bad behavior...but it may be a reason.

Schizophrenia (Perception)

Those with schizophrenia suffer from problems with PERCEPTION of the world. These people have faulty perceptions of reality. They see, smell, feel and hear things differently than they really are. The schizophrenic is plagued by realistic and vivid hallucinations and by delusions, of which they are firmly convinced. These people have an emotional reaction to what they see, hear, smell, feel or believe. They may act on these emotions. They cannot be talked into their perception of reality.

Some voices carry on a normal conversation, some chastise, humiliate or harass the person, and some are commands to do dangerous acts.

Dealing with the severely mentally ill requires a completely different approach, tone, posture, language... everything.

Watch your own hand gestures, but most important, build rapport.
Delusional thoughts include paranoid beliefs of persecution, or that they are being cheated, poisoned or conspired against, or that they are a famous or an infamous person, including both good and evil religious figures.

About 1% of the population has schizophrenia, the most distressing and disabling of all the severe mental illnesses. The meds for schizophrenia are less effective than those for bi-polar and major depression, and the side effects are greater. In the best cases, with the newer drugs, relapses into psychotic episodes are “reduced” in intensity and frequency, as opposed to being prevented.

**Major Depression**

Major, or clinical, depression is the real thing. Everyone feels sad, down or blue. However, such feelings pass quickly. Major depression is not a passing mood. It is a mental illness that is persistent and can interfere significantly with the person’s ability to function.

About 5% of the general population has major, or clinical, depression. It is the persistence and severity of the symptoms that distinguish the severe mental illness of major depression from normal mood changes. Major depression is severe enough to require treatment.

The significant symptoms of major depression are feelings of worthlessness, hopelessness, helplessness and guilt. They have no energy and have either great trouble sleeping or sleep too much. Most significantly, these people have repeated thoughts of death and suicide.

While many factors can contribute to major depression, there is no single cause. Of course, stressful events can trigger this, such as loss of a family member or a friend, divorce, custody battles, financial difficulties of all types, chronic medical illness and problems with personal relationships. This is one of the most treatable of all the severe mental illnesses. Up to 90% of all depressed people respond to medication and therapy.

**Detention and Commitment**

The laws associated with mental illness differ by state. Each CIT course will cover the laws that apply to their jurisdiction. Generally, most states will have a number of levels, each increasing in the number of people who must approve of the detention or commitment action.

An Immediate Detention Order is probably going to be a short-term stay (24 hours), which any officer can sign. An Emergency Detention Order will probably be a slightly longer stay (72 hours), and need the approval of a judge and a doctor. A Temporary Commitment will be a much longer stay (up to 90 days) and involves a formal court hearing. A Regular Commitment involves stays for up to one year.

While the reasons for the detention or committal may vary by state, expect to hear a two-pronged approach. First, the person must be suffering from a mental illness, an articulatable and diagnosable mental illness. Second, they either must be 1) dangerous to themselves or others or they must be 2) gravely disabled to the extent that they are unable to protect themselves from harm including unable to sustain themselves.

The judge, and intake staffers at mental hospitals, will want to know, “What happens if we don’t put him in detention?” They will also want to know 1) who called the police, 2) why were you called, 3) what did you observe when you arrived, 4) what are your concerns, and 5) what meds the person is on.

Specifically, what is the immediate concern? What is the risk of violence? What are their unresolved, untreated symptoms? What is their access to weapons? What is their violence history? The biggest predictor of violence is a history of violence.

**On-Site Visits**

Not all CIT courses will have visits to institutions and extensive interviews with the seriously mentally ill...but they should. Most of the second day was spent visiting the public and private mental health facilities in the area. This included the hard, lock-down hospitals.
for potentially violent people under involuntary, court-ordered commitment. It also included visits to day shelters and to facilities that teach both social skills and job skills to the severely mentally ill.

Everyone we met volunteered to see us, and knew that we were police officers. In some ironic twists, some of these people ended up meeting one of their previous arresting officers. They talked about the specifics of their mental illness, the effect it had on their lives, and the meds they were on. They talked about good encounters with police, and the bad ones, how the approach may have gone better. And they answered every question...even the hard and awkward ones.

Is he severely mentally ill? You simply cannot tell by appearance. Ask questions. What meds are you on?

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The patrol lesson here is to expect the word salad, expect extremely long periods of time to answer even simple questions or follow even simple voice commands. Now, this is a potential problem when the question is: “What is your name?” And even more of a problem when the command is: “Show me your hands.” Without one hint of hostility or resistance compliance may take 30 seconds...or longer! Animated hand movements may not be signs of aggression.

Day Two ended with what would be increasingly complicated, confusing and complex role-play scenarios. Each was based on actual, local calls for service. The lessons learned were many. Slow approach. Neutral hand and body position. Even and level voice and tone. Helpful attitude. More emphasis on inquisitiveness than authority. Answer legit questions, but keep them focused on the reason for the call. Assure their safety. Ask about their meds. Don’t make promises you can’t keep.

Suicide

Day Three began with a detailed how-to for assessing the seriousness of suicide talk. Among mental health professionals, it is a threat that deserves additional questioning, and that is it. It is not necessarily a red alert, nor does it mandate hospitalization. In fact, the “S” word is now recognized as the ultimate weapon of emotional manipulation. The CIT officer can reasonable assess how serious the person is about suicide in less the five minutes.

Suicide is serious. It is the 11th leading cause of death in America. Half of the people admitted to community mental health facilities either talk of or have attempted suicide. However, it is also an area with lots of talk and not much action.

The stigma of suicide is no longer shameful. People will make the claim to avoid going to jail, to try to win back a boyfriend, to get into a shelter, or to get a little attention or sympathy. The intent is for the CIT officer to screen out the ones who are not even close to serious...and bring into the mental health system those who are.

Ask them directly. Are you considering killing yourself? Are you consider-
thing got a bit tougher. Those in the roles of the severely mentally ill were closer and closer to real life. And the evaluators were pickier and pickier about the smallest things.

Use their actual name, not “sir.” Get them to focus on the reason for the call. Emphasize their safety. Explain the problem. Work on rapport. Avoid asking them “why” they are doing anything. Watch finger pointing. Don’t join the hallucination. Don’t join the delusion. Don’t discuss or argue politics. Don’t discuss or argue religion. Don’t try using logic. Present to them the reality of why you were called. Explain why you are here. Explain what you want done. Ask questions.

The Meds

Day Four began with a detailed explanation of the meds used to treat severe mental illness. The top priority question in your mind should be: “What medicine are you on?” Followed up by, “What is that supposed to do for you?” A professor of nursing at a major university presented a long and detailed list of psychiatric meds and what illnesses they were used for and the effects of overdoses. For example, Risperdal (risperdone) is used for schizophrenia and bi-polar. Effexor (venlafaxine) is used for major depression. Xanax (alprazolam) is used for anxiety and panic disorders. At least 40 such drugs exist.

Next on the agenda were long and complicated role-play scenarios, which took most of the day. For these scenarios, the intake staffers at both the local hospital and the community mental health center were at their desks waiting for the officers to call. Are we going to clear the scene? Call for family or friends? Transport to medical or mental facility? And would they accept the person? Transport to jail? So many choices. So many judges watching every action and listening to every word.

Yes-no questions don’t help much.

Why questions always go the wrong direction. Tell me what meds you are on. Who is your doctor? Tell them the reality from your perspective. Don’t argue about reality from their perspective. Tell me how we can help. Keep them on track. Slow down in your speech, since they are already confused, or racing in their thoughts. When did you last eat? When did you last sleep?

Teenage Troublemakers

The last day began with a training block on adolescents and mental illness. The theme of the session was that mental illness is never an excuse for bad

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behavior...but it may be a reason. There are no excuses for criminal behavior.

In teens, all emotions are exaggerated two-fold. Everything is extreme, in both the positive and the negative. Adolescents only think of the here and now (no consequences for their actions). And their entire modus operandi is that they resent the power and the authority that both officers and parents have.

Of course, it seems half the kids in America have attention deficit disorder, more correctly known as Attention Deficit Hyperactivity Disorder (ADHD). The problem is that ADHD and bi-polar mimic one another, i.e., some of the ADHD kids are really bi-polar. This misdiagnosis is common!

It is important that accountability be retained. You can't say, you have this problem, here are the meds, and it's not your fault. The real problem is that you are a little punk, totally disobedient, and just plain bad. Meds are no substitute for poor parenting skills.

The real solution is a combination of both treatment AND consequences. Consequences is a code word for punishment. Nurture and discipline...treatment and consequences. By the time the adolescent has a run-in with law enforcement, the soft corrections have probably already been tried. It is now time for a slap of reality, a hard line, an emphasis that there are definite consequences for poor behavior.

This punishment should be predictable, logical, and it should have an impact. The solution is a combination of treatment (talk and meds) and punishment. However, the effects of punishment are temporary and punishment is not the goal...changing behavior is. This will require parenting from the parents.

A few general rules help for dealing with these adolescents. Give clear commands and then give them time to comply. Don't argue with them and don’t try to convince them of anything, since they know everything. Give them time to cool down. Just like adults, they need to save face, so give them these kinds of options.

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