Peace Officer Basic Training

Crisis Intervention

Unit 3 – Topic 4

Ohio Peace Officer Training Commission
Education & Policy Section
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Effective Date:	July 1, 2019
Course Hours:	Twenty-four (24)
Student Goal:	The student will be able to respond to a person in crisis.

OPOTC CURRICULUM COMMITTEE

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CONTENTS

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This lesson plan is based on the following sources. However, it is the responsibility of the instructor to use the most recent references.

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ADDITIONAL RESOURCES

De-escalating Mental Health Crisis eOPOTA course is available at www.ohleg.org

Law enforcement responses to diabetics training materials are available at: http://www.diabetes.org/living-with-diabetes/know-your-rights/discrimination/law-enforcement/law-enforcement-training.html

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ADDITIONAL RESOURCES (cont.)

Videos referenced within lesson plan are available at www.ohleg.org under the current peace officer basic training curriculum, Additional Resources folder for 3-4 Crisis Intervention. Citations are provided below:

Video Title	Approx. (cut) time	Retrieved from	Date URL posted	Posted by (screen name/org.)
A Normal Conversation – Watch A Rookie South Daytona Police Officer Talk Down A Violent, Mentally Ill Man	3:10	https://www.youtube.com/watch?v=vnQECw6JHXM	March 7, 2017	Daytona Beach News-Journal
Alzheimer's – Combative Behavior (Part 1 & 2)	5:03	(Link to uncut version): https://www.youtube.com/watch?v=XMfItlc8hL0	April 1, 2016	K. Belfy
Anderson Cooper Tries A Schizophrenia Simulator	5:03	https://www.youtube.com/watch?v=yL9UJVtgPZY	June 9, 2014	CNN
Autism Stimming Examples	2:54	https://www.youtube.com/watch?v=4ALy6I1J1uo	July 11, 2016	Autism Family
Baseball Bat	2:01	OHLEG		NAMI
Body Camera Footage Shows Tense Moments Before Officer Saved Man From Suicide	2:01	https://www.youtube.com/watch?v=o0EPixnKQoY	March 11, 2018	East Idaho News
Bodycam Shows Officer Detain Autistic Teen	5:29	https://www.youtube.com/watch?v=A8ENK3TQIco	September 21, 2017	Bodycam Channel
Donald Lewis: Killed By Excited Delirium Or West Palm Beach Police	9:59	https://www.youtube.com/watch?v=GdzpoS8pTks	July 15, 2010	Guestbot6000
Dwayne (Bridge)	5:50	OHLEG		
Encountering People With Autism: A First Responders' Training [Answers]	1:52	(Link to uncut version): https://www.youtube.com/watch?v=xtDRIYslWXA	April 24, 2014	Allegheny County Chiefs of Police Association
Excited Delirium – Man With Fence	1:23	https://www.youtube.com/watch?v=Ai2bVK_BGHs	November 23, 2015	CIT & CIP Wisconsin

ADDITIONAL RESOURCES (cont.)

Video Title	Approx. (cut) time	Retrieved from	Date URL posted	Posted by (screen name/org.)
Law Enforcement & Autism (Sahara Cares) [Echolalia]	1:01	(Link to uncut version): https://www.youtube.com/watch?v=NHRFqGVAMu4	March 20, 2013	Clear Horizons Academy
Man In Crisis, Appleton WI (Module 3)	6:00	https://www.youtube.com/watch?v=jizOcTUlfV4	November 30, 2016	Police Executive Research Forum
Man On Bridge, Columbia SC (Module 1)	3:09	https://www.youtube.com/watch?v=58FfkuJZRJE	November 30, 2016	Police Executive Research Forum
Mark The Street Preacher (Part 1)	1:16	OHLEG		NAMI
Mark The Street Preacher (Part 2)	7:17	OHLEG		NAMI
Now, After (PTSD From A Soldier's POV)	5:30	(Link to uncut version): https://www.youtube.com/watch?v=NkWwZ9ZtPEI	December 2, 2010	Blue Three Productions
Patient Cop Gives Drunk Man Every Chance To Go Away	4:08	https://www.youtube.com/watch?v=Om6L_q4oe74	August 11, 2016	Police Activity
Photo Of Police Officer Consoling Teen Goes Viral	2:12	https://www.youtube.com/watch?v=49b8EJFqqPQ	June 10, 2016	CNN
Police Shoot Man Who Opened Fire On Them Following Standoff	10:22	(Link to uncut version): https://www.youtube.com/watch?v=pj7rRBVR0Io	January 17, 2018	Billings Gazette
Sally In The Kitchen	2:43	OHLEG		NAMI
Teen Brain	7:00	https://www.youtube.com/watch?v=-KQb3Mx2WMw	July 11, 2012	ZeFrank1
Trying To Cope With A Severely Autistic Child	1:12	(Link to uncut version): https://www.youtube.com/watch?v=j4PTf7LgsIE	March 14, 2012	The Florida Times-Union
Your Time In Iraq Makes You A Threat To Society: Andrew Chambers At TEDx Marion Correctional Salon 2013	9:01	https://www.youtube.com/watch?v=X6AYmzunPlQ	October 31, 2013	TEDx Talks

COURSE MATERIALS

TEACHING AIDS

X	Erasable Board/Markers		Easel/Notepads
X	AV Equipment	X	Lectern/Table
X	Practice Exercise		
X	Other Facilitator Guides (#1 – #3); access to internet (for instructor & students)		
X	Student Handouts		

INSTRUCTIONAL TECHNIQUES

X	Lecture	X	Group Discussion
X	Demonstration	X	Scenario-based Training
X	Individual Exercise		Hands-on Techniques
X	Role-play	X	Problem Solving
X	Other Implicit bias online activity		

NOTE TO INSTRUCTOR

Instructors are expected to:

- Bear in mind the legal, moral, professional and ethical implications of instructing in a commission-approved program.
- Follow student-to-instructor ratios (if applicable)
- Follow student-to-equipment ratios (if applicable)
- Use any and all opportunities which may arise during instruction of the required material to point out to the students the legal, moral, professional and ethical responsibilities they will bear to their employers and communities while serving in an official capacity.
- Understand that this information provided is the minimum standard. Instructors are expected to go above the minimum.
- Incorporate as many principles of adult learning as possible to include Problem Based Learning (PBL), Student Centered Learning (SCL), active group discussions, scenario activities and other responsible adult learning techniques. Emphasis should be placed on the benefits of ethical behavior and the consequences of unethical behavior throughout.

POWERPOINT PRESENTATIONS
Many lesson plans are accompanied by a very basic PowerPoint Presentation. These are most often a series of slides that include a title slide and the SPOs for the topic. This is intended to be a baseline presentation that instructors are expected to use as a starting point while preparing to teach the topic. Instructors may save the file locally and add slides in support of their teaching efforts. These may include instructor biographical information, expansion of the SPOs, information pertinent to the topic, illustrations, group exercises and other items that will enhance student learning.

Additional Instructor Note:

Remind students that videos included in this lesson plan that depict law enforcement response are not necessarily being presented as being "perfect." Rather, they are presented as a means of promoting discussion on:

- The presenting situation and ones similar to it
- Officer response
- The benefits, drawbacks, and/or challenges presented by (a) the actual law enforcement action taken and/or (b) different potential courses of action or approaches that may have been taken in the alternative.

PREPARATION

A. Introduction

   1. Instructor

   2. Course

B. This course is not a substitute for the 40 hour Crisis Intervention Training (CIT) taken by officers to become CIT officers

C. The purpose of this topic is to …

   1. Recognize that law enforcement encounters with a special populations person can be unpredictable

   2. Understand that these unpredictable encounters can turn violent when de-escalation consists only of command and control techniques

   3. Identify characteristics displayed by persons in crisis and special populations persons

   4. Increase the probability of officer and subject safety by learning de-escalation techniques for interacting with special populations persons

D. SPOs

STUDENT PERFORMANCE OBJECTIVES

At the end of this topic, the student will be able to:

1. Identify the characteristics of a crisis state.
2. List the causes of compromised coping capacity.
3. List the factors that coupled with mental illness produce the greatest increase in the potential for violence.
4. Describe the difference between traditional encounters and special populations encounters.
5. Describe eight techniques of active listening.
6. Use LEAPS and its five basic communication tools that assist in generating compliance.
7. Distinguish the EAR Model's three phases of a crisis encounter.
8. Identify the tactics and behaviors to avoid while engaging in de-escalation.
9. Use the Loss Model to recognize the nature of a person's crisis.
10. Describe the lethality assessment to determine a person's suicidal intent.
11. Determine when each of the typical dispositions for resolving a crisis intervention incident is appropriate.
12. Identify the practical and legal considerations when taking a person into emergency custody.

OVERVIEW

A. Importance

Speaker Presentations –

*At a minimum, two outside speakers are to be present during this course. Speakers must consist of one mental health consumer (preferably one who has had an encounter with law enforcement) and one family member of a mental health consumer (preferably one whose family experience includes a related encounter with law enforcement). If there is an articulated hardship that prevents the speaker from presenting to the class in person, the presentation may be given via video conferencing **provided** that the means used permits real-time, two-way verbal dialogue between the class and the speaker and approval has been received in advance from the Compliance Officer.*

Talking points: In advance of the class, speakers are to be given the talking points provided in Facilitator Guide #1.

Time: At a minimum, each speaker should be given 25 minutes to present and field questions.

Requirements: Because of the different stages of recovery and the fragileness of some consumers and their family members, commanders and their designees must seek speaker referrals via one of the means listed in Facilitator Guide #1. Commanders and their designees **are not permitted to solicit speakers outside of these avenues.*

Commanders, instructors, and speakers (whether participating in person or via video conferencing) must complete and sign the SF146bas — Crisis Intervention Speaker Presentation Certification Sheet. The SF146bas must be presented to the Compliance Officer at the closing audit.

Facilitator Guide #1

The primary purpose of this activity is to promote understanding of special populations and encourage empathy when engaging in special populations encounters

1. It can be challenging for law enforcement to determine what an appropriate response is to situations involving persons in crisis

PERF (2012)

2. An encounter with a person in crisis can take on an even greater element of difficulty when the mental capacity of the person has been compromised, as the person …

PERF (2016)

   a. May not be able to understand an officer's questions or orders

b. May not be able to communicate effectively with officers

3. This confusion and ineffective communication can be misperceived by the officer as resistance to the officer's requests and commands

4. When police officers fail to recognize the nature of the encounter to which they are responding, the end result may be "lawful, but awful" (i.e., force may end up being used when de-escalation techniques could have resolved the situation) ***Lewinski & Ranalli (2018)***

B. Terminology

1. **CRISIS** ***SPO #1 – PPT #5***

a. Definition ***PERF (2018a)***

(1) **An episode of mental and/or emotional upheaval or distress that …**

(2) **Creates instability or danger, and …**

(3) **Causes behavior that is considered disruptive by the community, by friends or family members of the person, and/or by the person**

b. **The elements of disruption and danger are why, in these situations, many people call law enforcement rather than emergency medical services or mental health agencies** ***SPO #1 – PPT #6***

c. **Often there is a precipitating event that triggers the crisis** ***SPO #1 – PPT #7***

(1) **Examples**

(a) **An emotional event (e.g., the death of a loved one, an act of violence, divorce, job loss)**

(b) **Medical event (e.g., a reaction to medication, a reaction caused by a failure to take medication)**

(2) Person's perception and reaction to the event

(a) **The person's perception to the event may be accurate, erroneous, or somewhere in between**

(b) **Regardless of the accuracy of their perception, the person's normal methods of coping and solving problems fail, resulting in …**

i. **A breakdown in control**

ii. **An inability to respond appropriately**

iii. **A feeling of being "overwhelmed"**

2. Person in crisis – a person experiencing a crisis

   a. Crisis phases — ***Shives (2012)***

      (1) Pre-crisis phase – calm or steady state of mind/equilibrium

      (2) Impact phase – point at which the stressful event has happened or is happening

      (3) Crisis phase – in this phase, the person is aware of the stressful event and perceives it as a threat

         (a) Confusion and disorganization occur as the crisis happens and the person is unable to use traditional coping methods

         (b) Trial and error reorganization occur just after the crisis, when the person attempts to put the pieces back together to find some way to handle reality

      (4) Resolution phase – the person regains some degree of control over his/her emotions and works toward a solution

      (5) Post-crisis phase – point at which the person comes out of the crisis and resumes normal life activities to one extent or another

   b. The person may or may not also be experiencing compromised coping capacity

3. Compromised coping capacity – when a person's coping skills (e.g., thinking, reasoning, problem solving skills) are compromised by intoxication, trauma (physical or emotional), or injuries/illness to the brain (e.g., mental illness, autism, dementia, Post-Traumatic Stress Disorder [PTSD]) — ***The term "diminished capacity" is a defined partial legal defense. Even though this partial legal defense is not currently recognized in Ohio, the term "compromised coping capacity" is used to avoid confusion of the two distinct concepts***

a. Not the result of personal weakness

b. Can affect anyone

c. May be a permanent condition (e.g., a birth condition like autism) or temporary (e.g., a highly distressed suicidal individual)

d. Common to all special populations encounters

4. Special populations – a broad term that refers to individuals experiencing a crisis **and** experiencing compromised coping capacity

   a. The thinking, feeling, moods, orientation, and/or memories of a special populations individual have been disrupted

   b. These disruptions, in turn, impact the ability of the special populations individual to relate to others

5. Special populations encounter – a law enforcement encounter with a special populations individual

C. Your response

1. As a peace officer, you will respond to persons in crisis throughout your career

2. Many of those responses will be a special populations encounter

This statistic can be shared for perspective: in 2017, Columbus Division of Police had approximately 16,000 behavioral health-related calls for service [McEntyre (2018)]

3. Both officer and subject safety can be compromised if law enforcement is not properly trained to de-escalate special populations individuals

Torrey, Kennard, Enslinger, Lamb, & Pavle (2010)

4. Training can help prevent injuries, save lives, and reduce the potential for officer liability

UNDERSTANDING COMPROMISED COPING CAPACITY IN SPECIAL POPULATIONS

A. Compromised coping capacity

1. The common element in all special populations encounters is the presence of compromised coping capacity (i.e., the person's damaged or stressed brain is affecting that person's ability to cope)

   a. It can affect a person's thinking (i.e., the person's thinking may be impaired or irrational and may be shown through disorganized, jumbled speech)

   b. It can affect a person's behavior (i.e., the person's actions may seem odd [e.g., mumbling, pacing])

   c. Individuals who are in crisis and dealing with compromised coping capacity may not know that their behaviors or mannerisms are the problem

Question to Class – What types of conditions or factors can affect a person's brain and compromise his/her mental capacity?

Answers provided below.

2. **CAUSES OF COMPROMISED COPING CAPACITY** ***SPO #2 – PPT #8***

   a. **Brain chemistry** (e.g., schizophrenia, depression)

   b. **Deterioration of the brain** (e.g., dementia, Alzheimer's disease)

   c. **Developmental disabilities** (e.g., cerebral palsy, epilepsy) ***PERF (2018a)***

      (1) Result in difficulties in life areas, such as communication, learning, adaptive living skills, self-help, mobility

      (2) Occur before adulthood and require support

(3) May include **intellectual developmental disabilities** ("IDD") (e.g., autism)

"IDD" is a term that officers may hear in the field. A person with an IDD is a person with a disability characterized by significant limitations in both intellectual functioning (i.e., intelligence) and adaptive behaviors (e.g., language, social, and practical living skills). Unlike a mental illness that may develop during any period of life, an IDD originates before the age of 18 and, unlike many mental illnesses that can be stabilized, an IDD is a permanent condition [AAIDD (n.d.); PERF (2018a)]

d. **Damage to the brain through blunt force** (e.g., traumatic brain injury/"TBI")

e. **Damage to the brain through severe stress and trauma** (e.g., Post-Traumatic Stress Disorder/"PTSD")

f. **Unbearable situational stress that causes suicidal thinking or actions** (e.g., death of loved one, job loss, financial problems, troubled personal relationships)

g. **Substance abuse** (i.e., drugs, alcohol)

Note for students that the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) no longer uses the term substance abuse, but instead refers to substance use disorders [SAMHSA (2015)]

3. Because of the role that stress and the brain play in producing crisis behavior, special populations calls are considered unique medical encounters	***Emphasize that these are medical encounters***
B. Mental disorders and mental illness	
1. Prevalence	
a. One in five adults (or roughly 44.7 million persons) in the United States live with mental illness	***NIMH (2017)***
b. The prevalence rate of mental illness in Ohio is approximately 20.26 percent of the population (or roughly 1,777,000 persons)	***Mental Health America (n.d.)***
2. The majority of special populations encounters officers will face – and often the most challenging – involve individuals whose mental capacities have been compromised by mental illness or mental disorders	***Kessler, Chiu, Demler, Merikangas, & Walters (2005)***
3. Mental disorders	***Handout #1***
a. Mental disorders – health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof)	***Goldman & Grob (2006)***
b. Common categories of mental disorders	***It should be emphasized that these categories are not being presented for purposes of diagnosing disorders, but to familiarize students with the terms that can be identifiers of a potential special populations encounter***
(1) Mood disorders (e.g., depression, bipolar disorder) – disturbances in one's emotional reactions and feelings	
(2) Psychotic disorders (e.g., schizophrenia) – distortion of reality that may be accompanied by …	
(a) Delusions	

i. Defined as – fixed beliefs that do not change, even when a person is presented with conflicting evidence	***Delusional Disorder (2017)***
ii. They are not amenable to logic or persuasion	***Burton (2017)***
iii. Examples – unfounded paranoia, such as a belief that communications are being intercepted by aliens; person believes that he/she is a superhero	
(b) Hallucinations	
i. Defined as – a sense perception that arises in the absence of stimulus	***Burton (2017***
ii. They involve hearing, seeing, smelling, tasting, or feeling things that are not actually there	
iii. Examples – a person hearing sounds and voices that are not there, a person sensing that bugs are crawling over his/her body when there are no bugs	
(3) Anxiety disorders (e.g., phobias, PTSD, panic disorder, obsessive-compulsive disorder [OCD]) – involve excessive fear or anxiety that …	***Parekh (2017***
(a) Is out of proportion to the situation or age inappropriate and …	
(b) Hinders the ability to function normally	
(4) Cognitive disorders (e.g., Alzheimer's disease)	***CDC (2011)***
(a) Affect the person's ability to remember, learn new things, concentrate, or make everyday decisions	
(b) Can range from mild to severe	
(5) Substance-related disorders	***TCOLE (2018)***
(a) Prolonged abuse of any drug may cause permanent damage to the central nervous system	
(b) Can cause a wide range of psychological reactions	
(6) Personality disorders (e.g., anti-social, borderline)	

(a) Display personality traits that are inflexible, maladaptive, or inappropriate for the situation

(b) These cause significant problems in the person's life

4. Mental illness

a. It is common for the terms mental illness and mental disorders to be used interchangeably

b. The Ohio Revised Code defines mental illness as "a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life"

R.C. 5122.01(A)

c. Mental illnesses can be categorized as "any mental illness" (AMI) and "serious mental illness" (SMI)

NIMH (2017)

(1) AMI – a mental, behavioral, or emotional disorder that can vary in impact from no impairment to mild, moderate, and even severe

(2) SMI – a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities

Question to Class – What symptoms are associated with mental illness?

Answers provided below.

In this lesson plan, the term mental illness collectively refers to any mental illness or mental disorder, regardless of its cause or severity

5. Symptoms of mental illness

a. Symptoms vary depending on the type and severity of the disorder

b. General symptoms that might suggest mental illness

(1) Confused thinking

(2) Excessive fear, worrying, or anxiety

(3) Strong feelings of anger/outbursts

(4) Delusions or hallucinations

(5) Thoughts of suicide

(6) Denial of obvious problems

(7) Abuse of drugs and/or alcohol

(8) Hyperactivity

(9) Distorted thoughts or paranoia

(10) Inappropriate behavior for situation

6. Mental illness management — ***Handout #2***

   a. Most mental illnesses are manageable, and many people with mental illness are able to stabilize and live full, productive lives — ***NMHAC (1993); PERF (2016)***

   b. However, in 2016, among the 44.7 million adults with AMI, only 43.1% received mental health treatment (i.e., inpatient or outpatient treatment, counseling, and/or prescription medication) — ***NIMH (2017)***

Question to Class – If most mental illnesses are manageable, why are there some people who don't manage their mental illness?

Answers provided below.

   c. Why people don't manage their mental illness

      (1) Severe forms of mental illness may inhibit a person from having insight into his/her illness and the need for treatment – treatment is not sought because of a …

         (a) Lack of awareness of the condition

         (b) Denial of the condition

      (2) Concurrent substance abuse — ***Mental Illness Policy Org. (n.d.)***

      (3) Stop taking their medications because they …

         (a) Fear the potential side effects and/or the potential irreversibility of the side effects

         (b) Do not like the actual side effects

            i. Side effects can be uncomfortable and intolerable — ***TCOLE (2009)***

ii. May be irreversible

iii. Examples – muscle spasms, protruding tongue, eyes rolled back, uncoordinated movements, nausea, headache, blurred vision, weight gain, fatigue

(c) Are having difficulty finding the right medication(s) and/or medication level

(d) Do not think they need medication anymore — ***NMHAC (1993)***

(e) Do not like how they feel on the medicine (e.g., the person doesn't feel like himself/herself; the person likes how he/she feels off of the medicine, such as during the manic phase of bipolar disorder)

(f) May be confused on how or when to take the medications

(g) Have limited access to medications (e.g., too expensive)

(4) Lack of care support or limited care support, which may include lack of or limited …

(a) Personal support systems (e.g., family, friends, empathetic employer)

(b) Community services (e.g., available mental health organizations within a community or neighboring communities; available bed capacity within the mental health service organizations; availability of local mental health professionals)

7. Results of limited resources and unmanaged mental illness — ***PERF (2016)***

a. The public has increased their reliance on law enforcement to provide assistance

b. Individuals with mental illness are three times more likely to be found in jails or prisons than in hospitals — ***Torrey et al. (2010)***

c. A 2013-2014 study in Franklin County, Ohio revealed… — ***Daniels (2015)***

(1) Twenty-two percent of its jail population had a serious mental illness, compared to five percent of the general public

(2) Sixty-eight percent of its jail population that had serious mental illness also had a substance abuse disorder

(3) The average jail stay for persons with mental illness was 32 days compared to 20 days for those without mental illness

For purposes of data collection in Ohio jails, "Serious Mental Illness" is defined as "a mental, behavioral, or emotional disorder of an individual 18 or older (excluding developmental, neurocognitive, and substance use disorders) that is currently diagnosable or has been diagnosed in the past year, of sufficient duration to meet diagnostic criteria specified within the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and resulting in serious functional impairment which interferes with one or more major life activity" [Plouck (2017)]

8. Perception versus reality

Question to Class – Considering the number of interactions that occur with persons who suffer from a mental illness, do you think that people with mental illness are more dangerous than other individuals? Why or why not?

Answers will vary.

Individual Activity and Class Discussion – Check for implicit bias. Students should take the Mental Illness IAT found at https://implicit.harvard.edu/implicit/user/pimh/preliminaryinfo.html.

Once completed, ask students to voluntarily share their results.

Harmening (2014)

a. A common misperception is that people with mental illness are **always** more violent than those without mental illness

b. It is true that crises involving persons with mental illness can be dangerous because the situations are often volatile, unpredictable, and, many times, involve individuals who have lost their ability to think rationally, however …

Torrey et al. (2010)

c. Mental illness **alone** is not a leading cause of violence; rather …

9. Multiple factors combined with mental illness are correlated to an increase in danger of violence when responding to a person with mental illness in crisis (i.e., a special populations individual)

a. **FACTORS THAT COUPLED WITH MENTAL ILLNESS PRODUCE THE GREATEST INCREASE IN THE POTENTIAL FOR VIOLENCE**

SPO #3 – PPT #9

Harvard Medical School (2011)

(1) **History of violence**

(2) **Substance abuse and dependence**

(3) **Personality disorders (e.g., antisocial disorder, conduct disorder)**

(4) **Psychotic thoughts (e.g., paranoid delusions, command hallucinations)**

(5) **Young male**

(6) **Under social stress (e.g., poor, homeless)**

(7) **Recent personal stress, crisis, or loss (e.g., unemployment, divorce, separation, victim of crime in the past year)**

(8) **Early exposure to violence (e.g., family fights, physical or sexual abuse, parent with criminal record)**

b. Other considerations

(1) Regardless of the nature of the encounter, people with mental illnesses are – generally and particularly – fearful of encounters with police

Schaefer Morabito (2014)

(2) This fearfulness can cause them to react negatively to the presence of police and, thereby, cause a like reaction by responding officers – this can quickly ratchet up a situation, which is then difficult to bring back down

Harmening (2014)

(3) However, officers who recognize the situation and respond with procedural justice (i.e., treating these citizens with respect and dignity) can improve that interaction as well as future interactions with special populations individuals

Schaefer Morabito (2014)

UNDERSTANDING SPECIAL POPULATIONS ENCOUNTERS

A. A person whose mental capacity is compromised and who is experiencing a crisis (i.e., a special populations individual) may have unpredictable behavior that can be mistaken for non-compliance

1. Thinking and behavior

a. Thinking – the person's thinking may be impaired or irrational and may be shown through disorganized, jumbled speech

b. Behavior – the person's actions may seem odd (e.g., mumbling, pacing)

2. Reasons for noncompliance

Class Activity and Discussion – Show the video "Anderson Cooper Tries A Schizophrenia Simulator," available in Additional Resources.

As a class, discuss:

•The symptoms of schizophrenia Anderson Cooper experienced through the simulator
•How the symptoms made him feel
•How the symptoms impacted his ability to think and reason
•How experiencing these types of symptoms may interfere with a person's ability to comply with a law enforcement officer's commands

Anchor the discussion with the information below.

Additional Resources

a. Some don't have the cognitive skills to comply with reasonable, lawful orders

Friedersdorf (2015)

(1) Disorganized thinking causes difficulty in reasoning and following simple requests

TCOLE (2017); Van Blaricom (2000)

(2) Hallucinations (i.e., when a subject is hearing or seeing things that are not there) can make the subject's compliance to commands difficult

(3) Paranoid thoughts cause mistrust of others, including officers

b. Some don't have the reasoning ability to grasp the danger of resisting police

Friedersdorf (2015)

c. Reasons for non-compliance are less about a power struggle and more about compromised coping capacity	***TCOLE (2017); Van Blaricom (2000)***
B. **THE DIFFERENCE BETWEEN TRADITIONAL ENCOUNTERS AND SPECIAL POPULATIONS ENCOUNTERS is the increased need to be non-confrontational**	***SPO #4 – PPT #10 TCOLE (2017)***
1. **Special populations encounters frequently benefit from a change in response to one in which de-escalation is the foundation**	
2. De-escalation	***Lewinski & Ranalli (2018)***
a. Using opportunities, knowledge, skills, and abilities to resolve problems with minimal force when possible	
b. For de-escalation to take place …	
(1) There must be an opportunity for it to occur	
(2) The presence or absence of that opportunity, and the scope of that opportunity, will vary between and within special population encounters	
3. The de-escalation paradox	
a. When responding to an emergency, officers are forced to make split second decisions about their safety and the safety of others	***TCOLE (2017)***
b. Those decisions are often based upon command and control tactics	
c. The same command and control techniques often employed to take a typical suspect into custody may escalate into violence during an encounter with a special populations individual	
d. Taking a less physical, less confrontational approach might provide the officer with more authority and control during such an encounter	***Lilley (2012)***

C. Safety considerations

1. De-escalation decision tree – officers must make a continuous threat assessment during a special populations encounter to ensure that everyone at the scene is safe

Handout #3
These safety considerations are applicable when interacting with any person in crisis
Lewinski & Ranalli (2018)

2. An immediate question that officers must ask is whether there is …

   a. Discretionary time (i.e., the situation reasonably appears to allow for time to consider possible available options), or

   b. No discretionary time (i.e., the situation requires an immediate response, without time to safely or effectively consider other options)

Advise students to consider that different levels of aggression can require different levels of response. For example:
Baseline, calm individual = simply communicate
Angry person = use de-escalation tactics
Individual enraged (i.e., in a transitional state between anger and violence) = utilize verbal control through commands, and sometimes physical control
Individual acting with violence = establish safety [Amdur (2018)]

3. Considerations when assessing the situation, threats, and risks

   a. Who is at risk? (E.g., the person in crisis, innocent persons, officers)

   b. Who is causing the risk? (E.g., the person in crisis, other persons, officers, whether due to a non-coordinated response or by using an approach that is less effective for the type of encounter at hand which, thereby, causes it to escalate)

Lewinski & Ranalli (2018)

Lewinski & Ranalli (2018)

c. What are the means, ability, opportunity, and intent of the person in crisis? — ***PERF (2016); PERF (2018c)***

(1) If there is a weapon or an object in the person's hand, consider what the person is doing with it, as it can speak to the person's intent

(2) Be mindful that these facts may change as the situation develops

(3) Be cautious of "transfer of malice" – avoid doing or saying things that could cause the person to transfer hostile and/or enflamed emotions to new, unrelated targets

d. Are you able to make contact (i.e., a connection) with the person exhibiting signs of crisis? — ***Lewinski & Ranalli (2018)***

e. Are additional resources needed to facilitate a peaceful resolution? — ***PERF (2016)***

4. If there is an immediate physical threat and non-compliance with commands, immediate intervention may be appropriate — ***POBT: Unit 2-6 Civil Liability & Use of Force***

a. Courts have held that officers must take into account a person's diminished capacity before using force — ***Roell v. Hamilton Bd. of Commissioners (2017)***

b. If force is needed to gain compliance from a person presenting an immediate physical threat, officers must use the objective reasonableness standard to determine the amount of force necessary to gain compliance

c. This objective reasonableness standard remains applicable in special populations encounters, as well

5. If there is no immediate physical threat and the officers realize they are in a special populations encounter, officers should engage a de-escalation mindset

a. Remain alert

b. View the crisis as a medical encounter

c. Slow down

(1) Slowing the process down is an important element that contributes to a peaceful resolution — ***Thompson (2013)***

(2) The goal is to obtain voluntary compliance and resolve a situation without use of force

Questions to Class – In the following scenarios, and based strictly on the facts presented, what is the most appropriate response (i.e., an immediate command-control type of intervention or attempt de-escalation)?

Scenario 1:

A person in crisis is suspected of being suicidal. There are no weapons. The person is speaking with officers. Neither the person, nor anyone else, is causing a risk of harm.

Is the most appropriate response to use an immediate command-control type of intervention or attempt de-escalation?

Answer: Attempt de-escalation

Scenario 2:

A person in crisis is actively threatening neighbors with a knife and causing an immediate risk of harm. The person is not responsive to officers. Officers, innocent persons, and the person in crisis are at risk of harm.

Is the most appropriate response an immediate command-control type of intervention or attempt de-escalation?

Answer: Immediate intervention

Scenario 3:

A person in crisis was threatening a neighbor with a knife, but is now back in his own apartment and alone. The person in crisis is causing a risk of harm, but, at this point, the primary risk of harm is to himself.

Is the most appropriate response an immediate command-control type of intervention or attempt de-escalation?

Answer: Attempt de-escalation

[Additional Instructor Note: "If the only person causing a risk of harm is also the only person at risk for harm, isolation or de-escalation should be considered." Dr. Bill Lewinski**]**

PERF (2018c)

Lewinski & Ranalli (2018)

Remind students that these are examples only. Real-life situations may involve a multitude of additional factors that may impact what is an appropriate officer response. Officers must continually assess a situation and be alert to any new, developing, or changing risks of harm. Moreover, they should always follow their agency's policies and procedures.

6. Distance + cover = time

   a. When officers are in close quarters with a potential threat and they feel pressed for time, options quickly dwindle — ***PERF (2018c)***

   b. Officers may be able to buy time when … — ***PERF (2016)***

      (1) No bystanders are in danger, and …

      (2) Officers are able to keep distance from the person, and …

      (3) They use cars, fences, or other objects as cover, and …

      (4) They use communication skills to their tactical advantage

   c. More time means more options – officers can use this time to … — ***PERF (2016)***

      (1) Communicate with the person

      (2) Establish rapport and trust

      (3) Strategize

      (4) Get additional resources to the scene

Individual Activity and Class Discussion – Show the video "Mark the Street Preacher (Part 1)" (command and control), available in Additional Resources. Have students complete Worksheet #1.

As a class, discuss the responses.

Instructor can use Worksheet #1A to facilitate the discussion.

Additional Resources

Worksheet #1
Worksheet #1A

D. Fostering a de-escalation mindset

1. A de-escalation mindset may increase the probability of a safe resolution — ***TCOLE (2017); Van Blaricom (2000)***

2. Remaining vigilant, and using empathy and patience, will help frame your communication skills, which in turn can increase the chance of gaining voluntary compliance and achieving a peaceful resolution to the special populations encounter

3. The most powerful weapon when interacting with special populations – or any population – is the ability to communicate — ***Harmening (2014)***

a. Done properly, it is the key to de-escalation

b. Done poorly, it can – and often does – have an opposite effect

COMMUNICATION SKILLS

A. Crisis communication

1. Appropriate for interactions with **any** person in crisis – regardless of whether the person is a member of a special population

2. Goals — ***Harmening (2014)***

   a. Containment

   b. De-escalation

3. Containment must come before de-escalation (e.g., you must stop a fight [i.e., contain] before you are able to make a connection with the individuals that will, in turn, facilitate compliance [i.e., de-escalate])

4. Containment and de-escalation may require different communication skills (e.g., more authoritative tone versus more compassionate tone)

B. Understanding communication differences — ***UK Violence Intervention and Prevention Center (n.d.)***

1. Passive communication

   a. Characteristics of passive communicators

      (1) Fail to assert for themselves or express their feelings or needs

      (2) Allow others to deliberately or inadvertently infringe on their rights

      (3) Often exhibit poor eye contact and slumped posture

   b. Results

      (1) Being passive or nonassertive may make you come across as weak or easily influenced — ***Mayo Clinic (2017)***

      (2) Can lead to the buildup of things that annoy you and may result in inappropriate explosive outbursts that are out of proportion to the triggering point and result in feelings of shame or guilt — ***UK Violence Intervention and Prevention Center (n.d.)***

2. Aggressive

a. Characteristics of aggressive communicators

(1) Try to dominate others

(2) Use humiliation to control others

(3) Have low frustration tolerance

(4) Speak in a loud, demanding, or overbearing voice

(5) Do not listen well and interrupt frequently

(6) Make "you" statements

(7) Have an overbearing posture – they may physically intimidate by … ***Drury (1984)***

(a) Standing over someone

(b) Pointing with a finger

(c) Moving so close to the other person that the other person's personal space is invaded

b. Results

(1) By disregarding the thoughts that others may have, it may leave the impression that you think yourself superior to others ***Mayo Clinic (2017)***

(2) Generates fear and hatred in others ***UK Violence Intervention and Prevention Center (n.d.)***

3. Passive-aggressive

a. Characteristics of passive-aggressive communicators

(1) Mutter to themselves rather than confront the person or issue

(2) Have difficulty acknowledging their own anger

(3) Use facial expressions that don't match how they feel (e.g., smiling when angry) or appear cooperative while purposely doing things to annoy and disrupt

(4) Use sarcasm

b. Results

(1) Alienation from others

(2) Real issues are not fully addressed

4. Assertive – this communication style promotes police legitimacy because it allows you to express yourself effectively while respecting the rights and beliefs of others — ***Mayo Clinic (2017)***

   a. Characteristics of assertive communicators — ***UK Violence Intervention and Prevention Center (n.d.)***

      (1) State needs and wants, and express feelings, clearly, appropriately, and respectively

      (2) Communicate respect for others

      (3) Listen well, without interrupting

      (4) Have good eye contact — ***Be mindful of the role cultural differences can play in a person's eye contact and his/her comfort with direct eye contact***

      (5) Speak in a calm and clear tone of voice

      (6) Have a relaxed body posture

      (7) Avoid hesitation when speaking

         (a) Hesitation (e.g., um, uh) communicates weakness — ***Drury (1984)***

         (b) Speakers who want to sound confident plan, and maybe even practice, what they are going to say so that it can come out smoothly and without undue hesitation

         (c) A strong even flow of speech sounds much more assertive (e.g., "Put that knife down" versus "I, uh, really think that you should, um, put that knife down, uh, right now")

   b. Results — ***UK Violence Intervention and Prevention Center (n.d.)***

      (1) Feel in control

      (2) Feel connected

Class Discussion – Using Facilitator Guide #2 – Communication (Instructor) Demonstration, demonstrate the four communication styles. After each demonstration, ask the class which communication style was demonstrated; ask the participating students how the communication style made him/her feel. — ***Facilitator Guide #2***

Class Activity and Discussion – Ask for three volunteers. Assign each of them a pair of statements from Facilitator Guide #3 – Communication (Student) Demonstration to present to the class. Have the student first present the non-assertive statement and ask the class to identify the communication style (i.e., aggressive, passive-aggressive, passive); then have the student present the statement using an assertive style.

Discuss the differences in how the communication comes across to the receivers (i.e., those hearing the message) and the potential effect the communication style may have on how they respond.

Facilitator Guide #3

Individual Activity and Class Discussion – Have students complete Worksheet #2. Discuss answers as a class. Ask students to explain their answers.

Instructor can use Worksheet #2A to facilitate the discussion.

Worksheet #2
Worksheet #2A

C. The role of listening in communication

1. One of the most important components of effective communication – if not the most important component – is listening

   a. The 80-20 rule – in general, listen for 80% of the time, limit talking to 20% of the time

   PERF (2018b)

   b. This enables you to gather more information and make an ongoing situational assessment

2. Distinguishing hearing and active listening

   Hardiman (2017)

Question to Class – What are differences between hearing and active listening?

Answers provided below.

   a. Hearing

      (1) Reception of sound

      (2) Passive

      (3) Merely hearing what another says prevents officers from contributing to the communication process and causes misunderstandings, mistakes, frustration, and less successful conflict resolution

      Pritchett (1993)

b. Active listening

(1) Listening to understand

(a) Attachment of meaning to sound — ***Hardiman (2017)***

(b) Paying close attention to what others are saying as well as what they may be communicating non-verbally through gestures or body language — ***PERF (2016); PERF (2018b)***

(c) Takes effort

(2) Most persons in crisis have a desire to be heard and be understood — ***McMains & Lanceley (2003)***

(a) Active listening attends to this need (i.e., it demonstrates that you are aware of and sensitive to the person's emotions)

(b) Active listening is critical in developing a relationship that will assist in crisis resolution

i. Officers who use active listening skills acquire additional facts that allow them to form accurate judgments about incidents or individuals — ***Pritchett (1993)***

ii. Armed with more accurate information, officers can identify better alternatives to resolve situations and respond or act more intelligently — ***Emphasize that these skills are not just for this lesson plan, but apply to many areas (e.g., interviewing, interrogation)***

D. **EIGHT TECHNIQUES OF ACTIVE LISTENING**

SPO #5 – PPT #11

Hardiman (2017); Thompson (2013) While presented in a different order in this lesson plan, two helpful pneumonics for the eight techniques are PRIME SOS and MORE PIES

1. **Emotional labeling (i.e., identifying the other person's emotions)**

   a. **Provides the opportunity for the other person to acknowledge his/her emotions and possibly explain their cause**

   b. Examples – "You sound angry," "You seem frustrated," "I hear the sadness in your voice"

   c. **Validates what the other person is saying rather than minimizing it**

   d. **Once the emotions have been acknowledged, there is a better opportunity for the person's balance between emotion and cognition to be restored and facts to be developed**

2. **Reflecting/mirroring (i.e., repeating the last few words or gist of the person in crisis)**

   a. **Helps validate for the other person that you are listening and understanding**

   b. **May encourage the other person to continue speaking**

   c. **Much shorter format than paraphrasing**

   d. Example – if the person gives a lengthy statement that he/she concludes by saying "… and this really made me angry," you might say, "It really made you angry"

3. **Paraphrasing (i.e., restating in your own words the crux of the other person's message)**

   a. **Demonstrates listening and understanding**

   b. **Gives the other person the opening to clarify or correct his/her meaning**

Paraphrasing
Reflecting/mirroring
"I" messages
Minimal encouragements
Emotional labeling
Summarizing
Open-ended questions
Silence and effective pauses

Minimal encouragements
Open-ended questions
Reflecting/mirroring
Emotional labeling
Paraphrasing
"I" messages
Effective pauses and silence
Summarizing
PERF (2018b)
SPO #5 – PPT #12

SPO #5 – PPT #13

c. Example – if the person says, "I am feeling very tired these days, and the meds mess up my drug use. I don't know if it's all worth it," a potential paraphrase is "It sounds like you are experiencing issues with your medication"

CDC (2016)

4. **Summarizing (i.e., extended version of paraphrasing; restating both the other person's message and emotion)**

SPO #5 – PPT #14

   a. **Validates for the other person that he/she has been heard and understood**

   b. Example – "Let me make sure I understand what you are saying – you were let go from your job for no apparent reason (paraphrase) and this makes you angry (labeled emotion)"

   c. **Reflects effort to understand the other person's viewpoint of the situation**

   d. **It is a critical part of active listening, as it can bring a sense of relief to the other person and, thereby, reduce his/her actions that are being emotionally driven**

Individual Activity and Class Discussion – The instructor should write the following on the board:

"I hate my life. My wife is a lazy slob who doesn't work, and my job sucks! It's not worth it anymore. Why even try? Nothing is ever good enough, anyway."

The instructor should read the statement to the class with exasperation in his/her voice.

Have each student write down how he/she would summarize and respond to the statement. Collect the responses.

Class Discussion – The instructor should read several of the responses and have the class discuss them.

Answers will vary, but may include – "To make sure I fully understand what's going on, you're not happy with your current home and work situations, and they have you feeling frustrated and overwhelmed."

5. **Silence and effective pauses (i.e., deliberate silences before or after making a meaningful comment)**

SPO #5 – PPT #15

   a. **Silence**

(1) Consider that the other person may be silent because he/she is gathering his/her thoughts or working up the courage to continue sharing information

(2) **Allowing there to be silence before speaking prevents prematurely cutting off the other person and gives the other person the opportunity to continue speaking**

b. **Pauses – when speaking, pauses …**

(1) **Increase attention and focus when they are used before a meaningful statement** (e.g., "Tell me if I have this right … (pause) … You are angry with your mother because she never showed you love")

(2) **Prompt reflection when they are used after a meaningful statement** (e.g., "You sound angry about the end of your marriage … (pause) … Tell me more about that")

6. **Minimal encouragements (i.e., verbal and non-verbal cues used when listening to indicate attention to the other person's words)** ***SPO #5 – PPT #16***

a. **Examples of verbal minimal encouragements – "uh-huh," "yes," "okay," "go on"**

b. **Examples of non-verbal minimal encouragements – leaning in, nodding head**

7. **Open-ended questions (i.e., questions that require more detailed responses than merely "yes" or "no" to properly answer the question)** ***SPO #5 – PPT #17***

a. **"What" and "How" questions allow you to assess the person's situation**

b. **Avoid "Why" questions, which may imply interrogation**

Question to Class – What are some examples of open-ended questions?

Answers will vary, but may include – What has you upset? How did you get hurt? How did that make you feel?

8. **"I" messages** — ***SPO #5 – PPT #18***

    a. **Involve the speaker labeling his/her emotions and assigning feelings to his/her interpretation of the situation**

    b. **Places focus on the speaker rather than the other person**

    c. **Less likely to provoke a defensive or hostile reaction from the other person**

    d. Examples

        (1) Instead of, "Do you ever stop talking?!" (a "you" statement), replace with, "I know you have a lot to share, but I need to say something now" (an "I" statement)

        (2) Instead of, "You are angry and out of control" (a "you" statement), replace with, "I'm sensing that you are frustrated, and I would like to help find a way to address that" (an "I" statement)

E. Putting it another way – remember LEAPS — ***Thompson & Jenkins (2013)***

1. **FIVE BASIC COMMUNICATION TOOLS THAT ASSIST IN GENERATING COMPLIANCE (i.e., LEAPS)** — ***SPO #6 – PPT #19***

    a. **<u>L</u>isten – actively listen and look interested**

    b. **<u>E</u>mpathize – try to understand where the person is coming from**

    c. **<u>A</u>sk – ask general, open-ended questions and opinion-seeking questions to gain understanding**

    d. **<u>P</u>araphrase – in your own words, repeat the person's message**

    e. **<u>S</u>ummarize – condense all that has been said and indicate the outcome, keeping it brief, concise, and inarguable**

2. The effectiveness of LEAPS is supplemented when utilized in conjunction with other communication tactics geared toward building trust and rapport

F. Communicating to build trust and rapport

1. Active listening is a key component to building trust and rapport — ***TCOLE (2018)***

2. Other communication tactics to build trust and rapport include … — ***TCOLE (2018)***

   a. Being honest and sincere in your speech

   b. Using the person's preferred name

   c. Being patient and matching the other person's conversational speed

   d. Maintaining a calm tone of voice

   e. Not minimizing or discounting the other person's point of view

   f. Validating the positive things the other person has done while you have been talking

   g. Forewarning that certain things may take place (e.g., "You've been straightforward with me, and I am going to be straightforward with you. You are going to have to be handcuffed when you ride in the car for your safety and mine")

   h. Maintaining good eye contact

      (1) One of the most critical nonverbal cues to show attention

      (2) Too much of a good thing …

         (a) Do not glare or stare

         (b) Be mindful of how culture may influence how eye contact is maintained or perceived

   i. Keeping distractions to a minimum — ***TCOLE (2018)***

   j. Not interrupting when the person is speaking

   k. Empathizing — ***TCOLE (2018)***

(1) Empathy is the effort to attempt to understand another person's point of view and see the issue from that person's perspective, whether or not you agree with that point of view or perspective

(2) When you are able to accurately identify what the other person is feeling, it demonstrates listening and interest and lays a foundation for trust

(3) Empathy can be demonstrated by validating the other person's emotive statements (e.g., if a person says, "I was scared he was going to hurt me," reply with "I am so sorry that you experienced that kind of fear")

Kuhr (2018)

l. Using positive body language (e.g., lean forward, nod)

TCOLE (2018)

m. Being mindful that what you say matters

(1) Loaded words

Stress to students that one word can change the whole dynamic of the encounter

(a) Some words cannot be used as neutral and objective descriptions (e.g., lazy, stupid, worthless)

(b) These loaded words and phrases provoke a negative reaction and defensiveness

(2) "You" statements

(a) A "you" statement is "you" followed by a loaded word or phrase

(b) This type of phrase provokes defensiveness

(c) The key is that you discuss the behavior, not the person

Class Activity and Discussion – The instructor should give some examples of "you" statements and have the students come up with ways to reword the statements. Some examples are below.

*"**You** are stupid to drive so fast on this road." Changed to: "A slower speed is much safer for this stretch of road."*

*"**You** are lying." Changed to: "I need complete honesty here, and I'm disappointed that you don't feel you can be honest with me."*

Refer back to the discussion on how replacing "you" statements with "I" statements can reduce defensiveness that might otherwise be caused.

(3) Debates and ultimatums

PERF (2018b)

(a) Can be very counter-productive to reaching a positive resolution

(b) It is better to …

i. Provide options when possible, and verbalize them in a way that make it seem as if the resolution was the person's idea/allows the person to "save face"

ii. Use words of reassurance and words that indicate a sincere interest to help the person

n. Being mindful that how you say it matters

(1) As an officer, it is vital to sound confident; a strong, self-assured tone can be developed through practice

(2) In addition, voice pitch, volume, speed, and tone impact how a message is perceived

Class Discussion – The instructor should say a statement. Each time the sentence is repeated, the instructor should emphasize a different word and then ask the class how emphasizing a new word changed the meaning of the sentence.

For example (putting the emphasis on the bold word):

***I** need you to put the knife down. (Shows the officer is in control)*
*I **need** you to put the knife down. (Emphasis is on what the officer wants)*
*I need **you** to put the knife down. (Emphasis is on the officer giving the person some control)*
*I need you to **put** the knife down. (Emphasis is on the desired action to be performed)*
*I need you to put the **knife** down. (Emphasis is on the weapon)*
*I need you to put the knife **down**. (Emphasis is on where the knife should go)*

Repeat the phrase several more times, modulating voice tone, speed, and volume. As a class, discuss how these additional variables impact perception of the speaker and the speaker's message.

o. Being mindful of the message your body language is conveying

(1) If people don't understand your words because of the crisis they are experiencing, your body language becomes even more important

(2) In many situations, the listener trusts and believes the non-verbal cues more than actual words

PERF (2016) Certain categories of individuals (e.g., veterans, domestic violence victims, child sexual assault survivors) may be particularly sensitized to certain body movements and postures

(3) It is key that your words match what your nonverbal actions are showing (e.g., saying "I am here to help" in a bladed stance with your hand on your weapon does not show the person that you are there to help him/her)

G. Communication and personal zones during a special populations encounter

1. Maintain a reactionary gap

a. A reactionary gap is a safe distance that affords you time to respond to a subject's action and control the space between you and that person

b. Maintaining a reactionary gap will allow basic communication skills to be effective without invading personal space

2. Controlling the zone between you and the other person

Lewinski & Ranalli (2018)

a. Both you and the other person influence the dynamic in the zone; however, …

Alert students to the "emotional contagion" effect (i.e., emotions and attitudes conveyed through words, voice tone, and body language can be contagious)

b. It is the person controlling the zone who most impacts the ability and opportunity for the other person to respond or exert influence

c. When communicating with a person experiencing compromised coping capacity, an officer may experience more challenges controlling the zone	***PERF (2018b)***
3. To initiate communication and rapport in the zone, it is important to …	***Lewinski & Ranalli (2018)***
a. Appear confident	
b. Convey sincere interest in wanting the interaction to succeed	
c. Actively listen	
d. Provide clear instructions, which includes limiting instructions to one at a time and allowing time after each instruction for the person to process it and respond	***Lewinski & Ranalli (2018); PERF (2018b)***
e. Demonstrate patience and concern, as a person with disorganized thinking may need to hear the same point multiple times	***Lewinski & Ranalli (2018)***
f. Explain your actions whenever possible (e.g., I'm opening the door so I can make sure you're safe")	***PERF (2018b)***
Question to Class – What are examples of behaviors that can fracture rapport and negatively change the dynamic? *Answers will vary, but should include the information below.*	
4. The following can fracture rapport and change the dynamic …	***TCOLE (2018)***
a. Making judgments	
b. Dishonesty	
c. Failing to follow through on one's end of an agreement	
d. Aggression	
e. A dismissive, condescending, or insincere tone of voice	
f. Exhibiting disinterest	
g. Labeling	
h. Patronizing or condescending speech or behaviors	

Question to Class – What are examples of behaviors that may help repair rapport that has been fractured?

Answers will vary, but should include the information below.

5. The following can help repair fractured rapport …

PERF (2016)

   a. Acknowledging what went wrong and taking responsibility for one's part in the dissolution

   b. Apologizing

   c. Expressing sincerity

   d. Taking corrective action

Class Activity and Discussion – Show the video "A Normal Conversation – Watch A Rookie South Daytona Police Officer Talk Down A Violent, Mentally Ill Man," available in Additional Resources.

Additional Resources

As a class, discuss the communication skills and tactics presented in this chapter that Officer John used during the interaction with the mentally ill man, Terrance.

Examples of some of the skills and tactics to discuss are:

•Maintaining a reactionary gap
•Taking corrective action when needed (i.e., when Terrance became agitated by the first officer, Officer John assumed control of the conversation and re-initiated it, having Terrance speak to him)
•Sounding self-assured
•Using names (e.g., "Can I call you Terrance", "You can call me John")
•Asking open-ended questions (e.g., "What's going on?")
•Maintaining a calm tone of voice
•Using minimal encouragements ("yes")
•Demonstrating empathy
•Conveying sincere interest in wanting the interaction to succeed
•Demonstrating concern for the man's well-being (e.g., as he handcuffed Terrance; offering to go with Terrance)

Remind students that this video is not being presented as being "perfect." Rather, it is being presented as a means of promoting discussion on:

- ***This and similar situations***
- ***Officer response***
- ***The benefits, drawbacks, and/or challenges presented by (a) the actual law enforcement action taken and/or (b) different potential courses of action or approaches that may have been taken in the alternative.***

Officers should always follow their agency's policies and procedures.

[Additional Instructor Note: It is important to highlight for students that it was John, the rookie officer, who successfully built rapport with Terrance. Good communication skills are

essential for officers at all career levels, and even new officers will be called to, and expected to, employ them. Notably, as evidenced in this video, rank is not the final determiner of how effective an officer can be at communicating and building rapport with another person.**]**

H. Considerations for communicating with individuals with disabilities

1. Officers are required to comply with the Americans with Disabilities Act (ADA); law enforcement agencies are accountable under it — ***USDOJ (2017)***

2. The ADA affects virtually everything that peace officers do

   a. Receiving citizen complaints

   b. Interviewing witnesses

   c. Arresting, booking, and holding suspects

   d. Operating telephone emergency centers (i.e., 911)

   e. Providing emergency medical services

   f. Enforcing laws

   g. Other duties

3. The ADA covers a wide range of individuals with disabilities

4. An individual is considered to have a disability if he/she … — ***USDOJ (2009)***

   a. Has a physical or mental impairment that substantially limits one or more major life activities (e.g., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working)

   b. Has a record of such impairment **or**

   c. Is regarded as having such an impairment

5. Communicating with an individual who is blind or visually impaired

   a. Officers should identify themselves and state clearly and completely any directions or instructions, including any information that is posted visually

b. Officers must read, out loud, the content of the entire document that a visually impaired person needs to sign

c. Before taking photos or fingerprints, it is a good idea to describe the procedures in advance so the individual will know what to expect

6. Interacting with a person who is deaf

a. A sign language interpreter may be necessary for effective communication

b. In simple encounters, a notepad and pen will be sufficient

7. Communicating with individuals who have an intellectual developmental disability (IDD)

a. Remove external distractions and minimize sounds

Question to Class – What are examples of common external sounds and ways to minimize them?

Answers will vary, but may include – turning off cruiser lights and turning down the officer's radio (only if safe to do so); asking to turn down or turn off the television or music; limiting the number of people in a room at a given time; asking to have a barking dog put outside or in another room; shutting a door and/or window to mute external sounds (e.g., voices, traffic, construction, dogs).

b. Use simple language, pictures, or symbols

c. Speak slowly and clearly

d. Ask simple, concrete questions

(1) Example – Instead of "What was he wearing?" ask, "Was he wearing a shirt?" If the person says "Yes," then ask, "What color was the shirt?"

(2) Example – Instead of "How tall was she?" ask, "Was she taller than you?"

Question to Class – How could the following questions be rephrased if communicating with a person with an IDD?

What kind of car did he drive?
Answers will vary, but may include – Did his car have two doors or four? Was his car bigger or smaller than my patrol car? Did his car have a trunk or a back door that lifts up?

How old was she?
Answers will vary, but may include – Did she look younger than you? Did she look older than me?

8. Communications disability database

    a. In accordance with the Ohio Revised Code, the Department of Public Safety shall maintain a voluntary database, available through LEADS, of persons with a communication disability or a disability that can impair communication — ***R.C. 5502.08(B)***

    b. "Communication disability" – a human condition involving an impairment in the human's ability to receive, send, process, or comprehend concepts or verbal, nonverbal, or graphic symbol systems that may result in a primary disability or may be secondary to other disabilities — ***R.C. 3304.23(A)(1)***

    c. "Disability that can impair communication" – a human condition with symptoms that can impair the human's ability to receive, send, process, or comprehend concepts or verbal, nonverbal, or graphic symbol systems — ***R.C. 3304.23(A)(2)***

    d. Being aware of communication challenges before arriving on a scene can improve an officer's ability to determine the appropriate communication skills to employ

I. Importance of utilizing effective communication skills

1. Officers are more effective – and safer – when they can use communication skills to their tactical advantage — ***PERF (2016)***

2. Effectively employing the appropriate communication skills can mean the difference between a positive or negative interaction and outcome

3. Effective communication is an integral part of the EAR (Engage, Assess, Respond) Model that should be used when responding to a person in crisis

EAR MODEL

A. **EAR MODEL – the three phases of a crisis encounter are Engage, Assess, and Resolve (EAR)**

B. This model was created to provide a context for the various de-escalation skills and tactics an officer can use

C. The following general guidelines will assist you during an encounter with a person in crisis, including special populations encounters

1. **Engage**

   a. **Purpose of Engage – to make a connection with the person so you can calm him/her**

   b. **The first 10 seconds of a crisis or special populations encounter are critical in setting the tone for de-escalation**

   c. **Remove distractions from the scene** (e.g., people who are upsetting the person, loud noises)

   d. **Introduce yourself and ask for the person's name**

   e. **State the reason why you are there and let him/her know you are there to help**

   f. **If safety is not compromised, remember that special populations encounters are medical encounters and you should begin to look for identifiers**

   g. **Ask questions** (e.g., "Are you alright?" or "Is there something bothering you?")

   h. **Verbalize the subject's observable characteristics** (e.g., "You look angry" or "You look stressed")

   i. **Ask the person "What help do you need right now?"**

   j. **Model calmness that you want the person to mirror**

SPO #7 – PPT #20
HCCIT (2012); HCCIT (n.d.-b)
Emphasize that this is a fluid model. The Assess and Engage phases may occur simultaneously. Moreover, having situational awareness is a continual assessment that officers are to engage in throughout the encounter
SPO #7 – PPT #21

SPO #7 – PPT #22

k. **In order to make a connection and calm the situation during the Engage phase, you need to be empathetic to the person's situation or state of mind, as individuals who feel they are understood are more inclined to calm down**	***SPO #7 – PPT #23***
l. **Speak softly, simply, briefly, and move slowly**	
m. **If there is more than one officer present, to avoid confusion, have one take the lead in communicating and de-escalating the situation**	
2. **Assess**	***SPO #7 – PPT #24***
a. **Purpose of Assess – to gather the information you need about the situation and the person's condition so that you can determine the needed resolution**	
b. **Remember, your threat assessment is continuous**	
c. **If the encounter changes and there is an imminent risk of harm, use the objective reasonableness standard to determine the amount of force necessary to gain control of the situation**	***POBT: Unit 2-6 Civil Liability & Use of Force***
d. **Recognize that the person may be overwhelmed by frightening beliefs, sounds, or other things in the environment**	
e. **Be patient during the encounter**	***SPO #7 – PPT #25***
f. **Check to see if a crime has been committed**	
g. **If the person perpetrated a crime, your job is to gain control of the situation, which may include trying to de-escalate the person first, and then, provided that no one has been injured, investigate the crime second**	
h. **Ask about medical history**	
i. **Ask about and/or look for signs of drug or alcohol use** (e.g., pupil size, burnt fingertips or lips, drug paraphernalia)	
j. **When possible, and outside of the presence of the person in crisis, talk to other people about the person's medical history, current medications, and ongoing medical treatment**	***SPO #7 – PPT #26***

k. **If you are dealing with a suicidal person, gauge the seriousness of the person's intent using the LAST Model** that is explained later in this lesson plan	
l. **Be tactically mindful, but visibly present as non-threatening**	
m. **A trained officer can conceal his/her combat ready stance while offering an empathetic tone of voice and appearing non-threatening**	***Woody (2005) Demonstrate stance***
n. **If there is more than one law enforcement officer present, have one take the lead**	***SPO #7 – PPT #27***
(1) **Only one of you should speak to the subject, as having more than one person speaking may be confusing and/or agitating to the subject**	***Refer to POBT 6-1 Subject Control Techniques***
(2) **The other officer(s) should provide cover and avoid directly engaging the subject**	
3. **Resolve**	***SPO #7 – PPT #28***
a. **Purpose of Resolve – to bring the encounter to a safe resolution and get the person to obtain the help the person needs**	
b. **The resolution usually depends on whether a crime was committed, if the person meets commitment criteria, and the availability of mental health and diversion resources**	
c. **Refer to the decision tree, which was developed to help officers guide their exercise of discretion**	***Handout #3***
d. **Once you decide on a course of action, forecast your intentions to the person by telling the person what you are about to do or what will happen next** (e.g., "I am going to ask you to come with me" or "I am going to have to pat you down and check for weapons")**; it is important to continually communicate your actions throughout the interaction**	***SPO #7 – PPT #29***
e. **Limit the number of instructions you give at one time**	
f. **If you have to use force, you can expect many special populations people to have a high threshold for pain and greater than normal strength**	

D. **TACTICS/BEHAVIORS TO AVOID WHILE ENGAGING IN DE-ESCALATION**

SPO #8 – PPT #30

Question to Class – What are some tactics or behaviors that should be avoided when engaged in de-escalation? Why?

Answers will vary, but should include the information below.

1. **Moving suddenly, giving rapid orders, or shouting**
2. **Forcing a discussion**
3. **Maintaining direct and continuous eye contact** (i.e., stare down)
4. **Touching the person without letting the person know you intend to do so, unless essential to safety**
5. **Crowding the person or moving into his/her comfort zone**
6. **Expressing anger, impatience, or annoyance**

SPO #8 – PPT #31

7. **Assuming that a person who does not respond is ignoring you**
8. **Using sarcasm or inflammatory language** (e.g., crazy, psycho, mental, mental subject)
9. **Lying or misleading the person to calm him/her down, unless extreme circumstances exist**

E. Flexibility of the EAR Model

1. The EAR Model is flexible in that the phases may need to be reordered or may overlap as each situation differs
2. It is appropriate and encouraged to be used in situations involving any of the four general categories of crisis encounters identified in the Loss Model

LOSS MODEL

A. Loss Model — ***HCCIT (2012); HCCIT (n.d.-c)***

1. In response to any call, officers should be aware that the situation may not be as straightforward as dispatch has relayed
2. In a crisis encounter – and particularly in a special populations encounter – the individual may be experiencing pronounced emotions or feelings (e.g., anxiety, paranoia, despair, anger)
3. As an officer, you will not perform a clinical diagnosis; however, by applying the Loss Model to the situation, you should be able to determine a way to Engage, Assess, and Resolve the situation
4. The Loss Model describes four crisis profiles
   a. Each profile reflects identifiable characteristics
   b. The characteristics are observable and can be reacted to
   c. The characteristics are not diagnostic or clinical symptoms
5. The Loss Model will allow you to focus de-escalation efforts appropriate to the specific type of incident you are facing
6. **THE FOUR CATEGORIES WITHIN THE LOSS MODEL ARE …** — ***SPO #9 – PPT #32 Handout #4 Handout #5***
   a. **Loss of Reality**
   b. **Loss of Hope**
   c. **Loss of Control**
   d. **Loss of Perspective**

B. **Loss of Reality** — ***SPO #9 – PPT #33***

1. **Profile description**
   a. **The person may be frightened, confused, and have difficulty concentrating or communicating**
   b. **The person may appear to be experiencing delusions or hallucinations**
2. **De-escalation goal and communication tactics** — ***SPO #9 – PPT #34***

a. **Neither validate nor deny the existence of what the person is experiencing**

b. **Instead, acknowledge how the person's view of the situation must make him/her feel** (e.g., "I don't hear the voices, but I can see that you are upset by what you are hearing")

(1) **Try to make eye contact**

(2) **Ask simple questions** (e.g., "How are you doing," "Do you take any medications," "How are you feeling?")

c. **Cut through the fear and confusion and get the person to voluntarily comply with your request** ***SPO #9 – PPT #35***

d. **If the person is experiencing "command voices," it is especially important for officer safety that you be aware that the "voices" may be telling the person to do something**

(1) **Try to understand by asking, "Are you hearing voices?"**

(2) **If the response is "Yes," then ask, "What are they telling you?"**

C. **Loss of Hope** ***SPO #9 – PPT #36***

1. **Profile description**

a. **The person may be emotional, very withdrawn, fatigued, feeling overwhelmed, crying, in despair, or presenting suicidal talk or gestures**

b. **He/she may have strong feelings of being helpless, hopeless, and worthless**

c. **He/she may have experienced a recent loss**

2. **De-escalation goal and communication tactics** ***SPO #9 – PPT #37***

a. **Instill some hope within the encounter so that the person can be persuaded to talk to someone or seek help** (e.g., "I have worked with a lot of people in a lot of pain and I have seen them get through this because the pain is temporary. We have really good doctors and treatment agencies in this community and, if you let me, we can start the process of getting help right now")

b. **You should be prepared to address thoughts of suicide** as outlined later in this lesson plan and in accordance with your agency's policies and procedures

D. **Loss of Control** ***SPO #9 – PPT #38***

1. **Profile description**

a. **This person may be angry, irritable, or hostile**

b. **Can present himself/herself as a victim** (e.g., "life is unfair")**; does not feel listened to**

c. **May be manipulative, impulsive, destructive, or argumentative**

2. **De-escalation goal and communication tactics** ***SPO #9 – PPT #39***

a. **Remain professional; do not take what he/she says personally**

b. **Be aware of signs, such as clenched fists, pacing, or flushed cheeks, which may indicate potential violence**

c. **Attempt to calm the person by letting him/her vent; use active listening skills**

d. **When establishing trust within these encounters, try to …**

(1) **Identify the source of the person's anger**

(2) **Acknowledge the emotion and give a directive** (e.g., "I can see why that would upset you, but I need you to lower the knife")

E. **Loss of Perspective** ***SPO #9 – PPT #40***

1. **Profile description**

a. **This person is anxious, worried, or nervous, which can escalate to feeling panicked**

b. **Physical symptoms include trembling, shaking, chest pain, and/or discomfort**

c. **The person could also seem overly energetic or be displaying extreme highs and lows (i.e., mood swings) during the encounter**

2. **De-escalation goal and communication tactics**

SPO #9 – PPT #41

a. **Bring the person's energy down** (e.g., use the person's name and assertively communicate what you need at that time – "Janet, I need you to listen to me")

b. **Calm the person's anxiety through empathy and patience; oftentimes using a soft and calm tone encourages individuals to mirror your tone**

Small Group Activity and Class Discussion – Split the class into four groups. Give half of the groups Worksheet #3 to complete and the other half Worksheet #4 to complete.

Have each group present to the class one of its assigned scenarios and their response. Discuss the scenarios and responses as a class. Continue presentations until each group has presented at least once, and all scenarios have been presented and discussed.

Instructor can use Worksheets #3A and #4A to facilitate the discussion.

Worksheet #3
Worksheet #3A
Worksheet #4
Worksheet #4A

F. The Loss Model is a fluid model (i.e., the person in crisis may experience different model profiles within a single encounter)

1. For example, a man is suicidal and experiencing a Loss of Hope. As a first responder, you observe the sadness, ask questions to determine the lethality, and create a plan to instill hope

2. With this, the man suddenly becomes angry with you. Now you are trying to de-escalate the situation from a Loss of Control perspective

Small Group Activity and Class Discussion – Show the four Loss videos available in Additional Resources:

1. *"Mark the Street Preacher (Part 2)"*
2. *"Dwayne (bridge)"*
3. *"Baseball bat"*
4. *"Sally in the kitchen"*

Divide the class into small groups.

Have each group complete Worksheet #5. As a class, discuss the responses.

Instructor can use Worksheet #5A to facilitate the discussion.

Worksheet #5
Worksheet #5A

3. A peace officer must recognize that each encounter is different and safety is always the officer's first concern

4. Encounters with certain special populations have additional considerations that, if you are aware of them, can further improve the likelihood of a positive resolution to the interaction

   a. Examples

      (1) Persons experiencing excited delirium

      (2) Individuals under the influence of alcohol/drugs

      (3) Suicidal individuals

      (4) Public safety officers/veterans experiencing PTSD

      (5) Persons with Alzheimer's disease or dementia

      (6) Persons with autism

      (7) Aggressive juveniles

      (8) Children in crisis

   b. For the above listed examples, and other special populations encounters, it is important to be familiar with the disposition options available to you as an officer

Remind students that, as an officer responding to these types of encounters, it will be important to be able to articulate the actions they take and why those actions were taken, regardless of an encounter's outcome

SPECIAL POPULATIONS – EXCITED DELIRIUM ENCOUNTERS

A. Overview

1. Excited delirium is generally defined as "altered mental status and combativeness or aggressiveness" — ***Vilke, Bozeman, Dawes, DeMers, & Wilson (2012)***

2. It can result from varied root causes, including biological (e.g., hypoglycemia) and drug intoxication (e.g., cocaine, methamphetamine) factors

3. Like other special populations encounters, excited delirium is a medical emergency — ***Kroll (2013) Handout #6***

4. However, unlike other special populations encounters …

   a. It is relatively rare

   b. Verbal de-escalation is unlikely to work — ***Vilke et al. (2012)***

   c. There is a high risk for sudden death — ***Ross & Hazlett (2018)***

5. The goals in dealing with a person who is experiencing excited delirium are …

   a. Rapid containment and control of the person

   b. Avoiding serious physical harm to the person, officers, and bystanders

   c. Averting in-custody death of the person

B. EAR Model

1. Engage

   a. These situations can be very dangerous for the person experiencing excited delirium and for bystanders and responders

   b. As soon as excited delirium is indicated … — ***Officer.com (2007)***

      (1) Call for backup; request that several officers respond

      (2) Request EMS

      (3) Make this call/these requests while responding to the scene, if possible

c. Unless there is an immediate public safety threat, officers should not approach the individual until substantial law enforcement backup has arrived and paramedics are nearby

Officer.com (2007)

Emphasize officer safety

2. Assess – indicators of excited delirium can include …

Vilke et al. (2012)

a. Confusion

b. Severe agitation

c. Non-compliance or poor awareness to direction from police or medical personnel

d. Hyperthermia (i.e., elevated body temperature) which is evidenced by sweating and often results in the person taking off all of his/her clothes

e. Rapid breathing

f. Violent excitement or emotion

g. Unusual strength and lack of fatiguing from physical exertion

Hyperthermia is an important excited delirium symptom and significantly increases the risk of a sudden arrestee death [Ross & Hazlett (2018)]

3. Resolve

a. It is critical that you use appropriate control and restraint tactics

(1) Be aware there is a high propensity for a person experiencing excited delirium to …

Ross & Hazlett (2018)

(a) Demonstrate aggressive behavior

(b) Have a very high pain tolerance

(2) Remember officer safety and tactical protocols

b. Stabilize the situation (e.g., stop traffic)

c. Isolate the person

Emphasize that, for safety purposes, this should be done with the aid of a substantial number of officers and with medics on the scene

(1) Control the subject as quickly as possible – the longer the physical confrontation goes on with an excited delirium subject, the higher the risk of in-custody death

(2) Contain the subject; make sure he/she cannot hurt others

Vilke et al. (2012)

d. Take safety precautions for the person's well-being

(1) Once the person is controlled, take precautions so that the person is less likely to cause self-injury (e.g., sit the person on grass rather than concrete)

(2) Be aware that the prone position may make it more difficult for the person to breathe; if tactically feasible …

Officer.com (2007)

(a) Place the person in a supine position, or …

(b) Place the person on his/her side (left side preferred)

(3) If the restrained person suddenly stops resisting, monitor him/her for pulse and breathing; initiate CPR as indicated

e. Get immediate emergency medical care for the person

(1) This is true for **every** excited delirium encounter

(2) Excited delirium is a life-threatening medical emergency

(3) All persons exhibiting signs of excited delirium should be immediately transported to the hospital to avoid serious injury or death

Class Activity and Discussion – Show each of the following videos found in Additional Resources:

Additional Resources

•*Donald Lewis: Killed by Excited Delirium or West Palm Beach Police*

•*Excited Delirium – Man with Fence*

•*Man in Crisis, Appleton, WI* [*If time is a factor, this video can be stopped shortly after the 6 minute mark]

Remind students that these videos are not being presented as being "perfect." Rather, they are being presented as a means of promoting discussion on:

- ***This and similar situations***

[Additional Instructor Note: The subjects in the "Donald Lewis" video and the "Excited Delirium" video both died. (Additional information regarding the Donald Lewis incident is available here: http://www.aele.org/law/2009all01/lewis-wpb.html and

https://www.csmonitor.com/USA/Justice/2010/0222/Supreme-Court-rejects-suit-that-argued-excessive-force-by-police.) The subject in "Man in Crisis," who had ingested a large quantity of hallucinogenic mushrooms, was transported to the hospital where he received additional sedation. He survived and was "back to normal" two hours later, with no memory of the incident.

While, in all likelihood, excited delirium cases will not be the most common type of special populations encounters that officers will face, these encounters can be particularly dangerous for officers, and they are extreme medical emergencies for the subjects. Given the volatility and potential for serious physical harm or death to result from these types of encounters, three videos are being presented to emphasize the danger and medical nature of them.**]**

After each video, discuss the subject's behavior and presenting symptoms, the officers' response, and the outcome of the encounter. The following questions should be among the items discussed:

•What indicators of excited delirium were present?

•How many officers were involved in the initial response? How many officers were involved in the ongoing response (i.e., same number, more, fewer)?

•What was the initial response? (E.g., were questions asked, was interaction delayed until a sufficient number of officers and medics were on the scene, was there a pre-planned, coordinated response?)

•Based on what is shown in the video, what, if any, challenges were minimized or created by the initial response?

•What else was going on at the scene that needed to be addressed? (E.g., traffic, bystanders, staging of medics.)

•What additional factors made the situation challenging for the officers? (E.g., sweaty and bloody subject harder to grasp; location of the encounter/ability to isolate the subject and keep him safe.)

•How long did it take to get the subject under control?

•In what position was the subject placed? (E.g., sitting, prone, supine.)

- ***Officer response***
- ***The benefits, drawbacks, and/or challenges presented by (a) the actual law enforcement action taken and/or (b) different potential courses of action or approaches that may have been taken in the alternative***

Officers should always follow their agency's policies and procedures.

•What medical interventions were observable in the video?

•What was the outcome?

Answers will vary.

SPECIAL POPULATIONS – INDIVIDUALS UNDER THE INFLUENCE OF ALCOHOL/DRUGS

A. Overview

1. Individuals who are under the influence of alcohol or drugs are unpredictable

   a. Such an individual can fall under any of the four Loss categories, as the alcohol or drugs may cause anger, sadness, fear, or confusion

   b. This group must always be viewed as a potential threat

2. Law enforcement personnel who encounter an individual that appears drunk or drugged should first assess whether it is a medical emergency before attributing the behavior to the substance alone

   Philadelphia Police Department (2013)

   a. Example – diabetic emergency

      See Additional Resources for more information on diabetes and law enforcement response.

      (1) Low blood sugar can mimic someone under the influence in that there may be a fruity or sweet odor on a person's breath that is similar to alcohol

      (2) A person experiencing a diabetic episode may also exhibit lightheadedness, slurred speech, confusion, poor coordination, or bizarre or angry behavior

      Other examples of conditions that may cause symptoms that mimic signs of intoxication: low blood sugar, autism, multiple sclerosis (MS)

      Handout #7

      (3) They may appear pale or flushed, have excessive sweating, be trembling, and/or be breathing heavily

   b. Ask about any health conditions

   c. Look for …

      (1) Medic alert tags worn around the neck or wrist

      (2) Wallet medical cards

(3) Diabetic supplies (e.g., insulin pumps, insulin bottles, blood glucose meters, insulin injection "pens", lancet devices)

3. Withdrawal from drugs and alcohol is serious and can be fatal

a. Symptoms of alcohol withdrawal usually peak within 24 to 72 hours of the last drink

AAC (n.d.)

b. Symptoms can range from mild to severe

(1) Mild (e.g., anxiety, nausea, abdominal pain, mood swings, heart palpitations)

(2) Moderate (e.g., increased blood pressure, body temperature, and respiration, irregular heart rate, mental confusion, sweating)

(3) Severe/delirium tremens ("DTs") (e.g., hallucinations, fever, seizures, severe confusion)

c. Any person you contact who appears to be exhibiting the symptoms of severe withdrawal or DTs is experiencing a medical emergency – it is important to remember that …

(1) These symptoms can occur without warning

(2) DTs can be fatal without treatment

(3) Medical care for the person should be sought immediately

B. EAR Model

1. Engage

a. Repeat instructions as many times as you feel necessary, but avoid arguing with a person under the influence of alcohol or drugs

b. Recognize that you may not be able to reason with a person under the influence of alcohol or drugs

c. If you cannot get information from that person or others at the scene (e.g., uncontrollably crying, won't talk, can't talk) you may have to go right to the Resolve phase

2. Assess

   a. Obvious signs of alcohol/drug use are slurred speech, an odor of an alcoholic beverage, an inability to stand or walk normally, obnoxious behavior, confusion, developing disorientation, and lethargy (e.g., slow, sleepy, lack of energy)

   b. Consider the person's physical condition to determine whether the behavior is actually caused by other medical conditions (e.g., delirium, diabetic) – asking questions can help you ascertain the nature of the situation

      (1) Example – "Have you eaten today?"

      (2) Example – "Have you hit your head today?"

   c. Alcohol use – any person you contact who appears to be exhibiting the symptoms of alcohol withdrawal or delirium tremens (i.e., "the shakes" or "DTs") is experiencing a medical emergency; seek immediate medical care for the person

   d. Drug use – if you suspect drug use, look for evidence of use such as ...

      (1) The presence of drugs or drug paraphernalia (e.g., needles, papers, roach clips, butane lighter)

      (2) Physical symptoms related to drug use – for example …

         (a) Pupil size (dilated or constricted)

         (b) Redness around the nose

         (c) Burnt fingertips or burnt lips

POBT: Unit 11-7 Drug Awareness
HCCIT (n.d.-b)

If asking about drug or alcohol use, be aware that substance abusers are rarely accurate in describing their pattern of use (i.e., they often underestimate, overestimate, or deny it), and there is a high probability that more than one substance is being abused [FBOP (2018)]

Remind students to follow drug safety protocols

e. Attempt to gain information from friends or family members about the person's drug or alcohol use and his/her medical history

3. Resolve

a. If you are unable to convince the individual to respond to your directions, it is acceptable to use force as you would with any non-compliant subject

b. Get the individual to appropriate resources (e.g., jail, community programs, medical facility)

Class Activity and Discussion – Show the video "Patient Cop Gives Drunk Man Every Chance to Go Away" available in Additional Resources.

As a class, discuss what the officer did well in the video.

Answers will vary, but may include – controlled the zone between him and the intoxicated man, exhibited confidence and patience, did not enflame the situation by responding in kind to the intoxicated man's challenges, repeated instructions.

Discuss how the situation may have ended differently had the officer chosen to mirror the confrontational attitude of the intoxicated man.

As part of these discussions, and as they regard the specific situation portrayed in this video, include the potential impact of each approach on:

•Safety (of the intoxicated man, the officer, and/or bystanders)
•Later assertions of unlawful use of force/unlawful arrest (given the man was filming the event with his phone)
•Public perception by those on the sidewalk and/or watching while the man filmed.

[Additional Instructor Note: Among the valuable takeaways from this video was the ability of the officer to stay composed even when repeatedly challenged by the intoxicated man. Although the encounter ultimately resulted in the arrest of the intoxicated man, the officer was calm and in control throughout the event.**]**

Additional Resources

Remind students that this video is not being presented as being "perfect." Rather, it is being presented as a means of promoting discussion on:

- ***This and similar situations***
- ***Officer response***
- ***The benefits, drawbacks, and/or challenges presented by (a) the actual law enforcement action taken and/or (b) different potential courses of action or approaches that may have been taken in the alternative.***

Officers should always follow their agency's policies and procedures.

SPECIAL POPULATIONS – SUICIDAL INDIVIDUALS

A. Overview

1. Prevalence

a. Suicide is the 10th leading cause of death in the U.S. — ***AFSP (n.d.-b)***

b. Each year, 44,965 Americans die by suicide

c. In Ohio … — ***AFSP (n.d.-a)***

(1) More than twice as many people die by suicide than homicide

(2) On average, one person dies by suicide every five hours

(3) Breaking it down by ages, suicide is the …

(a) Third leading cause of death for ages 10 to14

(b) Second leading cause of death for ages 15 to 34

(c) Fourth leading cause of death for ages 35 to 54

(d) Eighth leading cause of death for ages 55 to 64

(e) Seventeenth leading cause of death for ages 65 and older

2. Many people who die by suicide have no apparent psychiatric diagnosis or history of psychiatric problems

3. Differences between male and female suicides

a. Rates of suicide attempts/deaths by suicide – although the statistics vary …

(1) Women are more likely to attempt suicide than men (approximately 1.2 times more likely); however, … — ***AFSP (n.d.-b); Schimelpfening (2017)***

(2) Men are more likely to be successful in their first attempt

(a) Men die by suicide 3.53 times more often than women — ***AFSP (n.d.-b)***

(b) White males accounted for 7 of 10 suicides in 2016

b. Methods/Means

Schimelpfening (2017)

(1) Men are more likely than women to be successful in their first attempt at suicide because they tend to choose a more lethal method (e.g., firearms, hanging)

(2) Common suicide methods for women include self-poisoning (i.e., overdose) and exsanguination (i.e., bleeding out from a cut such as a "slit wrist")

4. Similarities between male and female suicides

a. Although females tend to use less violent ways (e.g., overdose) to attempt suicide, don't discount the immediacy of the situation because women still may use violent means

b. Additionally, an attempted suicide that does not result in death – whether the attempt is made by a female or male – is the greatest risk factor for suicide in the future

Schimelpfening (2017)

B. Common suicide myths and the facts

Question to Class – Read each myth statement below. Ask the class whether the statement is true or false. As each myth statement is discussed, present the associated fact(s).

1. Myth – asking about suicide will plant the idea in a person's head; Fact …

OSP (n.d.)

a. Asking about suicide does not create suicidal thoughts

b. The act of asking the question simply gives them permission to talk about their thoughts or feelings

2. Myth – people don't talk about committing suicide; Fact …

a. Most people who die by suicide have communicated some intent

b. Someone who talks about suicide gives another the opportunity to intervene before suicidal behaviors occur

3. Myth – if someone really wants to die by suicide, there is nothing you can do about it; Fact …

a. Most suicidal ideas are associated with treatable disorders

b. If you can help the person survive the immediate crisis, you have gone a long way toward promoting a positive outcome

4. Myth – he/she really wouldn't commit suicide (e.g., made plans for a vacation, have young children, made a verbal or written promise); Fact …

    a. The intent to die can override any rational thinking

    b. Someone experiencing suicidal intent must be taken seriously

C. Warning signs of suicide — ***AFSP (n.d.-c)***

1. Talking or writing about death or a wish to be dead

2. Expressing hopelessness, feeling humiliated, trapped, or desperate

3. Losing interest in regular activities or losing the ability to experience pleasure

4. Experiencing insomnia, intense anxiety, or panic attacks

5. Being in a state of extreme agitation or intoxication

6. Becoming socially isolated and withdrawing from loved ones

7. Looking for a way to hurt or kill oneself, such as hoarding medicine, purchasing a new firearm, or searching online for suicide methods

8. Engaging in dangerous or self-harmful behavior (e.g., reckless driving, increased use of drugs and/or alcohol) that may indicate the person no longer values his/her life — ***Cleveland Clinic (2017)***

D. **LETHALITY ASSESSMENT TO DETERMINE A PERSON'S SUICIDAL INTENT** — ***SPO #10 – PPT #42 HCCIT (n.d.-a)***

1. **An officer can assess a person's suicidal intent by asking questions that try to uncover the person's thoughts. This is represented by the LAST Model**

    a. **Lethality of chosen method** (e.g., firearm versus five Tylenol pills) — ***SPO #10 – PPT #43***

    b. **Availability of chosen method – does the person actually possess the means to harm himself/herself** (e.g., owning a gun or having access to drugs versus not owning a gun or not having access to drugs)?

c. **Specificity of the plan – specific details about time, method, etc., versus vague ideas**

d. **Timing – proximity of help** (e.g., someone home at the time of attempt versus no one home, private place versus a place where a person would be found)

2. This model generally addresses individuals contemplating suicide who are depressed

3. Most people who commit suicide are ambivalent about killing themselves (i.e., they don't want to die, but they want their pain to end)

4. Conflicting emotions are reflected in talk, thoughts, actions, and body language

E. EAR Model

1. Engage

a. When talking to a person contemplating suicide, the goal of the officer should be to instill hope that help is available

b. This can be done by getting the individual to focus on the elements of his/her story causing the ambivalence; many times the process of simply talking about problems is sufficient

c. Do not try to fix the person's problems

d. Do not enter into a pact of secrecy with this person

2. Assess – (responding to armed subject threatening suicide)

a. These situations are always very dangerous

b. Officer safety is paramount

c. Gaining control of the situation is critical

d. How you respond depends on your threat assessment and availability of backup

3. Resolve

a. Try to gain control of a situation by using de-escalation skills

(1) This can be done by assuring the person that help is available

(2) You need to be aware of what community resources are available in your area for referral in those circumstances when suicide is a concern

Community resources are discussed later in the lesson plan

Class Activity and Discussion – Show the video "Man on Bridge, Columbia, SC" available in Additional Resources.

As a class, discuss the communication skills and de-escalation tactics utilized by the officer in the video. Examples of discussion points:

•Were there any evident "hot buttons" or "triggers" (i.e., topics that may further agitate the subject and should be avoided)? Answer – his mom (deceased)

•What "hooks" (i.e., topics that may help calm the subject and should be leveraged for advantage) were there? Answer – football; his favorite teams

•How did the officer utilize the hooks? Answer will vary, but may include – to build rapport; to instill hope

•Describe the officer's tone. Answers will vary, but may include – calm; caring; compassionate

•Did the officer ask open-ended questions? Answer – yes

•Describe the officer's body language. Answers will vary, but may include – relaxed, but close enough to act; no abrupt movements

•What are some examples of rapport building techniques the officer used? Answers will vary, but may include – empathy (e.g., "having a bad night tonight"; "none of us want you to hurt yourself, bud")

•Did the officer instill hope? Answer – yes

•If so, how? Answers will vary, but may include – "I'll be out here riding around [tomorrow night] and I'm going to see you on the street and we're going to talk about the Gamecocks or Redskins game"

Additional Resources

Remind students that this video is not being presented as being "perfect." Rather, it is being presented as a means of promoting discussion on:

- ***This and similar situations***
- ***Officer response***
- ***The benefits, drawbacks, and/or challenges presented by (a) the actual law enforcement action taken and/or (b) different potential courses of action or approaches that may have been taken in the alternative.***

Officers should always follow their agency's policies and procedures.

b. Recognize that de-escalation might not work

(1) A particular concern is a subject trying to commit "suicide by cop," in that a person acts in such a way as to force the police to kill him/her, rather than committing suicide himself/herself

(2) Deadly force may be necessary to stop a threat

(Optional) Class Activity and Discussion – Show the video "Police Shoot Man Who Opened Fire On Them Following Standoff" available in Additional Resources.

Prior to viewing, share the following information:

A woman reported that her boyfriend, Ryan Lowell, was threatening suicide. Officers attempted to de-escalate him for an hour. The video being shown is a cut version of the original video, which is much longer.

Following the video, share the following information:

Ryan was given medical aid by officers and transported to the hospital where he was pronounced dead.

As a class, discuss the nature of the events that resulted in Ryan's suicide by cop.

Additional Resources

SPECIAL POPULATIONS – PUBLIC SAFETY/VETERANS

A. Overview

1. Post-Traumatic Stress Disorder (PTSD)

a. PTSD is an anxiety disorder that some people develop after seeing or living through a dangerous event — ***National Center for PTSD (2017)***

b. People who have PTSD may feel stressed or frightened even when they are no longer in danger

c. Some of your calls for service may involve child neglect, physical abuse, sexual assault, physical attacks, and suicides — ***NIH (2009)***

d. Any of these events has the potential to result in trauma to the persons directly or indirectly involved in the actual event or the response

e. While most of the time people can get through a traumatic event, others develop more enduring problems, such as PTSD

f. Who is affected

(1) Seven to eight percent of the population will have PTSD at some point in their lives — ***National Center for PTSD (2017)***

(a) This includes war veterans, peace officers, and survivors of violent crimes, abuse, accidents, disasters; although, …

(b) Anyone can develop PTSD at any age — ***NIH (2009)***

(2) Risk of PTSD tends to be higher for certain traumatic events (e.g., combat, sexual assault) — ***Walser et al. (2017)***

(3) It may not necessarily be one event that causes the PTSD, but a series of events over a period of time (e.g., career in public safety, extended deployments)

(4) Not everyone with PTSD has been through a dangerous event, as some people develop it after someone to whom they are close (e.g., family member or friend) experiences danger or is harmed — ***NIH (2016)***

g. In de-escalating someone who is experiencing a crisis due to PTSD, the EAR Model should be followed, just as in any other response to a person in crisis

2. Unique public safety/veteran considerations

Class Activity and Discussion – In the order presented below, show the following videos available in Additional Resources:

- *"Now, After (PTSD from a Soldier's POV)[CUT VERSION]"*

- *"Your Time In Iraq Makes You a Threat To Society: Andrew Chambers at TEDx Marion Correctional Salon 2013"*

[Additional Instructor Note: The full-length video of "Now, After (PTSD from a Solider's POV) is available here: https://www.youtube.com/watch?v=NkWwZ9ZtPEI. The video was created by U.S. Army Staff Sergeant Kyle Hausmann-Stokes after returning from Iraq. It represents what life was like for him then.

Andrew "Sarge" Chambers, presenter in the TEDx video, is originally from Pickerington, Ohio. Additional information regarding him is available here: https://www.youtube.com/watch?v=X6AYmzunPlQ.**]**

Allow students the opportunity to express their reactions to the stories presented, if they would like to do so.

In addition, as a class, discuss the PTSD symptoms experienced by the veterans shown in the videos. Answers will vary but should include – nightmares, difficulty sleeping, paranoia, fear for personal safety, sweating, hypervigilance, flashbacks, intrusive images, anger, alcohol abuse.

Additional Resources

The purpose of these videos is to promote understanding of how PTSD may impact a veteran's daily life and encourage empathy for how they may be experiencing the world around them

Question to Class – Do you think that responding to a public safety officer or a veteran with PTSD is more or less dangerous than responding to a person suffering from PTSD who is non-law enforcement/non-military? Why or why not?

Answer provided below.

a. Safety factors – it is not the fact that the person has PTSD that necessitates a special consideration; rather …

Walser et al. (2017)

Emphasize these are critical safety considerations

(1) It is the fact that peace officers and veterans probably have access to a weapon and, even more importantly, they know how to use it

(2) This population may be more aggressive, especially if they have been exposed to combat situations, as they have been trained to survive

(3) Most have had training in hand-to-hand combat, which should be an immediate concern to the responding officer

Refer to the "Your Time In Iraq Makes You a Threat To Society" video, in which Andrew Chambers discusses carrying a pistol for his personal safety, tactically moving through the bar, beating the man, and his feelings of rage and fear

b. Suicidal risk factors

AFSP (n.d.-c)

(1) Risk factors that can lead veterans to be more susceptible to suicide include …

(a) PTSD and Traumatic Brain Injury (TBI), as well as …

(b) Major depression

(c) Abuse of alcohol or drugs

(d) Impulsivity and aggression

(2) Factors such as legal problems, financial difficulty, relationship difficulties, unemployment, and other highly stressful life events can increase the effects of the above underlying risk factors

3. Identifying interactions with veterans

Lighthall (2013)

a. Dispatch may routinely inquire about and relay veteran status

b. Look for indicators of military service (e.g., dog tags, military tattoo(s), combat uniform, desert boots, distinct military bearing)

c. Listen for military words or phrases (e.g., "weapon" for gun, "squared away" for things being okay; "Groundhog Day" for sameness of everyday)

d. Ask about the person's military or law enforcement status

B. EAR Model

1. Engage

a. Try to establish a connection using the person's experiences (e.g., public safety, veteran, survivor)

POBT: Unit 12-2 Critical Incident Stress Awareness

When talking with veterans or law enforcement officers in crisis, use the words "behavioral health" and not "mental health." There is a stigma with the term "mental health," which may lead the person to believe you are calling him/her "crazy," and hinder efforts to de-escalate

[Ingles (2007)]

Ingles (2007)

(1) If you have never served, do not lie and tell a veteran that you have

(a) Veterans are often adept at "smelling BS"

(b) You will quickly lose your connection if they suspect you are being dishonest

(c) Be truthful and tell them you have never served

(2) If you have never served, ask if the person would like a veteran to assist, if one is available

Class Discussion – Discuss the military brotherhood/sisterhood, including its meaning, its significance to active and retired military personnel, and how it can be an asset when resolving situations involving a veteran in crisis. The same discussion can be had regarding the law enforcement brotherhood/sisterhood.

(a) Radio and advise that you need an officer who is a veteran to respond

(b) When veterans see that you are going out of your way to accommodate them, it opens a window to gain that connection

b. For veterans, thank them for their service

c. PTSD can be triggered by memories, flashbacks, or nightmares through stimulus (e.g., sights, sounds, smells)

(1) If the person presents with a Loss of Perspective profile (e.g., panicky, nervous, fearful), try to ground him/her by removing the person from a noisy or chaotic environment

(2) Let the person know he/she is safe

2. Assess

a. Usual symptoms include nightmares or flashbacks of the trauma the person faced

b. Be mindful of co-occurring issues that may be happening, including alcohol and substance abuse, as well as suicidal thoughts

c. Ask if the person has a weapon on him/her; if the answer is yes or if you suspect there is a weapon …

This assumes that the person is compliant and voluntarily gives up the weapon

(1) Secure the weapon

Stress safety

(2) Resolve that issue before proceeding

POBT: Unit 6-1 Subject Control Techniques

3. Resolve

a. Provide simple, concrete requests or commands instead of lengthy instructions

b. Trust is critical to resolve this encounter

Community resources are discussed later in the lesson plan

c. Refer the person to military suicide prevention and mental health resources

(Optional) Class Activity and Discussion – Show the video "Body Camera Footage Shows Tense Moments Before Officers Saved Man From Suicide" available in Additional Resources.

As a class, discuss the value of de-escalation in this instance. Answers will vary, but may include – man did not commit suicide, suicide by cop avoided

What were some of the factors mentioned that may have contributed to the suicidal man's state of mind? Answer – PTSD (military veteran), "really bad year," one of his best friends recently died by suicide

How did the situation resolve? Answer – the man was taken into protective custody; he was transported to EIRMC (Eastern Idaho Regional Medical Center) by the officer, who stayed with him four hours for support

Additional Resources

Remind students that this video is not being presented as being "perfect." Rather, it is being presented as a means of promoting discussion on:

- ***This and similar situations***
- ***Officer response***
- ***The benefits, drawbacks, and/or challenges presented by (a) the actual law enforcement action taken and/or (b) different potential courses of action or approaches that may have been taken in the alternative.***

Officers should always follow their agency's policies and procedures.

SPECIAL POPULATIONS – ALZHEIMER'S AND DEMENTIA

A. Overview

Question to Class – Ask students if anyone knows someone with Alzheimer's disease or dementia. If yes, ask those students who are willing to share with the class how the disease has affected the person they know (e.g., any noticeable changes in the person's personality, behaviors).

Answers should be voluntary.

1. Statistics

   a. 5.7 million Americans are living with Alzheimer's disease — ***Alzheimer's Association (2018)***

   b. One in 10 people over 65 years of age have Alzheimer's disease

   c. Thirty-two percent of all people over 85 years of age have Alzheimer's disease

   d. It is estimated that by 2050 there will be nearly 14 million Americans with Alzheimer's disease

2. Common situations in which you may encounter a person with Alzheimer's disease or dementia — ***ALZ Safety Services (2006)***

   a. The person wanders (on foot or by vehicle) and becomes disoriented and lost

   b. Auto accidents

      (1) Because of memory impairment and alterations in perception, the person may fail to obey traffic laws

      (2) If in an accident, the person may flee, unaware of personal injuries or property damage

   c. Erratic driving

   d. Victimization and false reports

      (1) People with dementia are more prone to victimization, particularly by con artists

(2) A person with dementia may call to report a burglary in progress, when the "intruder" is a familiar person, such as a family member or even a spouse whom the person has forgotten

e. Indecent exposure or inappropriate dress for weather conditions

f. Shoplifting because the person forgets to pay for an item

g. Suicide and homicide

(1) Overwhelmed and exhausted caregivers may feel that death is the only solution

(2) Caregivers may be threatened by a person with dementia who mistakenly believes the caregiver is an intruder

B. EAR Model

1. Engage

IACP (2010)

a. Approach from the front, if possible, and, agency policy permitting, remove hat and sunglasses to maintain eye contact

b. Speak in a calm, friendly tone; do not raise your voice or argue

c. Avoid touching the person without first asking or explaining

d. Be prepared for sudden mood or demeanor changes in the person

2. Assess

a. Indicators

(1) Intoxicated-like behavior, such as incorrect words, delusional thoughts, and poor eye contact

(2) Lost or disoriented behavior

(3) Defensive or agitated behavior

(4) Vague answers that don't match the question posed to the person or a destination location that doesn't make sense or exist

(5) Shuffle or reduced gait in movement (although, not always)

(6) Difficulty determining date, time, or year (although this should be determined through normal conversation, not by giving a "reality check")

b. Ask the person to move to a safe, comfortable location

c. Ask yes and no questions

d. Use short, simple words

e. Ask one question at a time, allowing plenty of time for response

ALZ Safety Services (2006)

f. Repeat your question as needed

(1) Use the same wording as before

(2) Watch for agitation

(3) Change or stop questioning if it appears the person is becoming defensive or agitated

g. Use nonverbal communication (e.g., pictures, hand gestures) to help facilitate two-way communication

h. Check for a tracking device, a MedicAlert ID, or SafeReturn ID or clothing labels

i. Run the person's vehicle registration to check for a missing person alert

j. Ask family members or caregivers for the person's medical history

3. Resolve

a. If a traffic stop, consider completing the Ohio Bureau of Motor Vehicles (BMV) Request for Driver License Examination or Recertification Form to recommend having the person's driving skills evaluated

Handout #8

b. Ensure safe transit home with a relative or friend; never give directions or let the person go if he/she seems disoriented, as the person may not realize that he/she is lost

Class Activity and Discussion –

Show parts one and two of the video "Alzheimer's Combative Behavior" available in Additional Resources, and discuss the two-part video as a class.

Prior to starting the videos, share the following background information:

The videos show Kay, who has Alzheimer's disease, and Kristin, her granddaughter and caregiver. As Kristin explained, her grandmother's physical combativeness and aggression, resulting from the progression of the disease, manifested and developed quickly over a several week period. As she stated, this combative behavior can be frightening for the people around the person with Alzheimer's disease, but it can also be equally as terrifying – if not more so – for the person suffering from Alzheimer's.

On the day in question, Kristin had taken Kay with her to get Kristin's children from school. It was a routine that they shared, and one that Kay looked forward to. And, it had been a good day, up until that point.

On this particular day, Kristin and Kay were in the school building less than 15 seconds when Kay had an almost immediate change of demeanor. There was no warning or particular trigger to the event. Kay's behavior became aggressive and frightening to the children. With the aid of another person, Kristin was able to get Kay quickly out of the building and into Kristin's van; however, Kristin was not able to get out of the parking lot before the situation escalated further.

Kay forcefully removed bandages wrapped around Kristin's injured hand, and tried to exit the van while it was moving. Kristin immediately had to stop the vehicle. She had her son exit and return to the school building; Kristin had to physically keep her grandmother in the vehicle so Kay wouldn't wander into traffic or hurt herself.

At the time Kristin starting filming the event, the event had already been going on for about 45 minutes; the total event lasted for approximately an hour.

Additional Resources

The original filming of the event was done with a cell phone camera, which captured the event upside down. The video has been "flipped," and both the original and flipped versions are shown side-by-side in Part 1 for easier viewing

Among the points made by Kristin when discussing the event is the importance of remembering …

•That it is the disease that is causing the behavior
•To keep the person and everyone around that person safe
•To remain calm
•To speak calmly
•To continue to provide reassurances, and
•To just breathe.

After viewing the video, use the following discussion points as prompts for the class discussion:

•Potential for aggressive behaviors in persons with Alzheimer's disease

•Examples of the aggressive behaviors presented in the video (e.g., Kay's speech intensity; hitting Kristin with a bag; grabbing and squeezing Kristin's injured hand; Kay admitting to wanting to hurt Kristin)

•Persons with Alzheimer's disease who are in crisis calling for help, even when aid is being rendered (students should consider the perception of the event from the perspective of the person with Alzheimer's disease)

•The fact that Kay had incomprehensible speech, but the type and intensity of the emotions she was experiencing were clearly being conveyed

•Utilizing patience, active listening skills, and de-escalation techniques when interacting with a person with Alzheimer's disease who is in crisis

•The active listening and de-escalation skills utilized in this video

•The outcome in this video and the time to resolve (i.e., Kay was calmed; it took over an hour)

After discussing the above, pose the following question to the class for discussion:

In what ways might the awareness and points raised by the two-part video and accompanying discussion impact your future interactions, as a law enforcement officer, with persons with Alzheimer's disease who are experiencing compromised coping capacity?

SPECIAL POPULATIONS – AUTISM SPECTRUM DISORDER

A. Overview

1. Autism Spectrum Disorder includes five developmental disorders (ASD) — ***Lashley (2009)***

   a. Autistic disorder

   b. Pervasive development disorder

   c. Rett's syndrome

   d. Asperger's syndrome

   e. Childhood disintegrative disorder

Question to Class – Ask students if anyone knows someone with ASD. If yes, ask those students who are willing to share with the class the types of characteristics they have observed in that person (e.g., toe-walking, unsteady gait, tensing parts of his/her body, jumping, rocking, self-hitting, repetitive motions, hand flapping, fixated interests, rigged thinking patterns/extreme need for routines, lack of social skills).

Answers should be voluntary.

2. Prevalence

   a. 1 in 68 people are affected by autism — ***NIDCD (2018)***

   b. Male:female ratio is 4:1 — ***CDC (2018)***

   c. People with developmental disabilities, including ASD, are seven times more likely to come in contact with police than a member of the general public — ***Debbaudt (2014)***

Class Activity and Discussion – Show each of the following videos available in Additional Resources: — ***Additional Resources***

- *"Bodycam Shows Officer Detain Autistic Teenager"*
- *"Photo of Police Officer Consoling Teen Goes Viral"*

[Additional Instructor Note: The family of Connor, the autistic teenager in the "Bodycam" video, filed suit against the involved officer and the law enforcement agency, seeking compensatory and punitive damages, civil penalties, a corrective injunction ordering the agency to train officers on how to interact with people with disabilities, attorneys' fees, and costs of the suit. Additional information is available here: https://www.courthousenews.com/brutal-police-officer-knew-nothing-of-autism-parents-say/**]**

As a class, discuss each officer's response to the situation he was presented with and the outcome of it. Discuss how an awareness of ASD, or a lack of awareness of ASD, may have impacted the interactions and factored into those outcomes.

3. Characteristics

   a. Do not necessarily display any outward physical characteristics — ***Debbaudt (2014)***

   b. Differing levels of functioning from mild to severe — ***NIDCD (2018)***

      (1) Some with ASD may not be able to communicate using speech or language, while others may have rich vocabularies and be able to talk about specific subjects in great detail

      (2) Approximately 10 percent of children with ASD show "savant" skills, or extremely high abilities in specific areas, such as memorization, calendar calculation, music, or math

      (3) Fifty percent are nonverbal, verbally limited, or won't speak under stress — ***Hitt & Vega (2012)***

   c. Impacted areas of functioning generally include …

      (1) Social interaction

         (a) Presence of narrow or repetitive behaviors (i.e., stimming), such as rocking back and forth, hand flapping, finger flicking, and repetitive speech or sounds — ***Debbaudt (2014)***

Class Activity – Show the video "Autism Stimming Examples," available in Additional Resources.

Additional Resources

Note: ASD behaviors are individualized. This video is not intended to suggest that these particular behaviors will be present or the same among all persons with ASD. This video is presented for example purposes only

(b) Difficulty in adjusting to change

(c) No fear of danger

Farber (2009)

(d) Inappropriate behavior, such as laughing during a serious situation

(e) Tantrums or escalated behavior for no apparent reason

(f) Preference to be alone

(2) Communication – the following are common communication patterns …

NIDCD (2018)

(a) Making statements that have no meaning or relation to the conversation

(b) Repeating words ("echolalia") – the repeated words may be ones just heard or are words heard at an earlier time

Class Activity – Show the video "Law Enforcement & Autism (Sahara Cares) [Echolalia]," available in Additional Resources.

Additional Resources

Note: ASD behaviors are individualized. This video is not intended to suggest that these particular behaviors will be present or the same among all persons with ASD. This video is presented for example purposes only

(c) Using "stock" phrases (e.g., "My name is …") even with persons to whom the information is already known (e.g., family members)

(d) An altered speech pattern or tone (e.g., high-pitched or sing-song voice or robot-like speech)

(e) Non-responsiveness to the speech of others; may be non-responsive to their own names

(f) Often unable to use non-verbals, including gestures and eye contact, to enhance their oral language skills

d. Accompanying medical and mental health issues

(1) Many will wander and are highly attracted to water (e.g., pools, rivers, lakes), putting them at a higher risk for drowning

Lashley (2009)

(2) High risk of seizures

Lashley (2009)

(3) Many have underdeveloped chest muscles

Farber (2009) Stress to students that, due to this condition, people with ASD may have difficulty supporting their airways during restraint. If restrained, they should be put in a position that least restricts their breathing

(4) Hypersensitivity/undersensitivity of the senses

(a) Seventy to eighty percent of people with autism suffer from hypersensitivity **or** undersensitivity of the senses (i.e., touch, sight, hearing, smell, taste)

University of Haifa (2017)

(b) These sensory differences can affect behavior

National Autistic Society (2016)

(c) Too much sensory overload can cause stress, anxiety, and possibly physical pain

(d) The result can be withdrawal, challenging behaviors, or a "meltdown"

(5) Many have psychological problems, such as depression and self-destructive behavior (e.g., head banging, hitting, biting)

Lashley (2009)

Class Activity – Show the video "Trying to Cope With a Severely Autistic Child [CUT]," available in Additional Resources.

Additional Resources

Note: ASD behaviors are individualized. This video is not intended to suggest that these particular behaviors will be present or the same among all persons with ASD. This video is presented for example purposes only

(6) When a person with ASD becomes mentally or physically stressed …

(a) Adrenaline stays up, increasing the time that it takes for them to understand, decompress, and comply

(b) Predictability, order, and routine are often how they manage stress

B. EAR Model

1. Engage

a. Be safe; have any backup officers approach quietly and stay back

Lashley (2009)

b. Introduce yourself

c. Reduce outside stimulation, such as noise and lights

d. Do not alter things in the person's environment as it may trigger him/her to lash out (e.g., if the person is playing a video game, do not turn it off without getting the person's agreement to turn it off)

e. If you move him/her to a different location to talk, give the person time to explore the new environment

f. Don't interfere with the person's repetitive motions; an increase in the speed or destructiveness of the stimming is a signal that the person is becoming more stressed

g. Ignore acting out behaviors (e.g., banging, yelling), model the behaviors you want to see

h. Personal space issues

(1) The person may invade your space

(2) Stay out of kicking and biting range

(a) Address hitting or kicking with a firm tone

(b) Use phrases such as "quiet hands," "quiet feet," "stop hitting," "no kicking," which are how such commands are commonly worded to persons with ASD

i. Be aware that people with ASD are often attracted to shiny objects; the person may attempt to touch your badge, pen, or other shiny objects you may be carrying or have on you

j. Don't expect eye contact, don't force eye contact, and do not read too much meaning into facial expressions, as the expressions are often not reflective of or appropriate to the situation

k. Don't assume because the person cannot speak that he/she is unable to hear or understand you

(1) Use a normal tone of voice

(2) Use nonverbal communication, such as gestures and pictures, to help facilitate communication between you and the person

2. Assess

   a. If responding to a home, look for the Autism puzzle piece symbol, sometimes displayed in a window

   b. Don't read meaning into words alone, as persons with ASD often …

      (1) Repeat back words directed at them

      (2) Answer "yes" then "no" to the same question

      (3) Say a word that apparently seems unrelated to the question but for which the person has made a connection

Handout #9

Class Activity – Show the video "Encountering People With Autism – A First Responders' Training [ANSWERS]" available in Additional Resources.

Additional Resources

Note: ASD behaviors are individualized. This video is not intended to suggest that these particular behaviors will be present or the same among all persons with ASD. This video is presented for example purposes only

   c. Look for a cause of the person's agitation, including the person's basic comforts such as hunger, cold, thirst, tiredness, as persons with ASD will act out if they are unable to communicate their needs

   d. Ask family members or caregivers for the person's medical information and/or behavioral support plan, if available

3. Resolve

   a. Follow a four-step approach

      (1) Address (i.e., use the person's name)

      (2) Direct (i.e., tell the person what you need him/her to do)

(a) Keep your commands very brief, clear, and literal (i.e., no figures of speech)

i. Example – don't say "Take a seat," as the person might pick up a chair; instead say, "Sit in the chair"

ii. Example – don't say "Wait outside," as the person might exit the building; instead say, "Stand in the hallway"

(b) Allow the person extra time (up to 11 uninterrupted seconds) to allow the person to process your command and respond

Lashley (2009)

(3) Control the input (i.e., remove or silence all distractions)

(4) Praise when the person complies (e.g., "Good job. Thank you")

b. Tell the person the "rules"

c. Tell the person what's next

SPECIAL POPULATIONS – JUVENILE AGGRESSION

POBT: Unit 3-7 Juvenile Justice System Golden (2004)

A. Overview

1. Juvenile aggression is not the same as adult aggression

   a. Juveniles have less ability than adults to control their aggression, and they lack experience and maturity to make adult decisions, including those relating to responding to officer commands

   b. Although any individual may display deliberate aggression (i.e., clearly directed aggression with specific intent to harm) or emotional aggression (which is more volatile and unpredictable than deliberate aggression), adults tend to exhibit deliberate aggression more so than juveniles, who are most apt to exhibit emotional aggression

   c. Because juvenile aggression is more volatile and unpredictable than adult aggression, it can also be more dangerous

2. Juvenile aggression is often influenced by three factors

   a. Physical/biological factor

      (1) Juveniles are experiencing hormonal growth spurts that can result in aggressive behavior

      (2) Juvenile brains have less functional activity in the part of the brain that organizes and controls behavior, and greater activity in the part of the brain that associates external stimuli with emotional responses

Additional Resources

Class Activity – Show the video "Teen Brain," available in Additional Resources.

[Additional Instructor Note: Explain to students that, as the video explains, there is a physiological reason why juveniles often have intensified emotional responses to events and exhibit more emotional behavior. Students should also be aware that some juvenile aggression is linked to mental disorders, such as attention deficit hyperactivity disorder (ADHD), and oppositional defiant disorder (ODD). In addition, other mental disorders, such as schizophrenia and bipolar disorder, may begin to manifest during the late teenage years. Alcohol and/or drugs may also be a contributing factor.**]**

b. Socialization factor

(1) There are several important socialization factors (e.g., family, environment, exposure to violence) that are often beyond the control of a juvenile

(2) Friends play a critical role in a juvenile's socialization, and saving face in front of friends is important to juveniles

c. Primary needs factor

(1) All juveniles have four primary needs …

(a) Love and belonging

(b) Power and importance

(c) Fun and pleasure

(d) Freedom and choice

(2) When these needs are unmet, aggression can arise

3. While the skills you will use to Engage, Assess, and Resolve an encounter with an aggressive juvenile have similarities to the de-escalation skills you use with adults, there are some important differences

B. EAR Model

1. Engage

a. Avoid giving away your power — ***Ni (2015)***

(1) Keep your composure

(2) Being less reactive to provocations, such as back talking, questioning or challenging behaviors, dismissive actions, or other rude behaviors allows you to reduce the likelihood of enflaming the situation

(3) Staying in control of your emotions provides a better mindset in which to develop a reasoned judgement on how to approach the situation

b. Utilize assertive and effective communication — ***Ni (2015)***

c. Establish clear boundaries, but be aware that encouraging, praising, explaining, or showing a juvenile what you want him/her to do may be more effective than giving orders — ***Ni (2015); Golden (2004)***

d. Separate juveniles from their peers, siblings, parents, and/or caregiver

Question to Class – Why is it advisable to separate juveniles from their peers, siblings, parents, and/or caregiver?

Answers provided below.

(1) Juveniles are more likely to talk to officers if peer pressure and parental pressure are removed

(2) Juveniles may fear getting in trouble if they say something in front of their parents

(3) Consider the possibility that the juvenile's aggression may be a result of victimization

e. Be extremely cautious if you are inside the bedroom or home of the adolescent, as you do not know what is in the environment. As a safety tactic, see if the juvenile will go outside with you to the porch or the front yard to "get some air"

f. Often adolescents associate law enforcement with going to jail

(1) Alleviate their fears by explaining that your purpose for being on the scene is to try to help the people there that need help, including them, if that is the case

(2) Show empathy — ***Ni (2015)***

g. In order to win the trust of the juvenile, it is important that you do not communicate personal biases against the juvenile's lawful expressions (e.g., tattoos, body piercings, shirt graphics) — ***Golden (2004)***

2. Assess

a. Interview peers and parents/caregivers, as they can be good sources of information

b. Asking the juvenile general questions about school may assist with building rapport with the juvenile and give you a sense of how he/she is thinking

c. Look for signs of cutting or drug use on any exposed skin and ask questions that explore why the juvenile may be cutting or using drugs (e.g., “Can you tell me what happened to your arm?”)

3. Resolve

a. Remember, you are not there to solve family problems; you are there to calm the situation and determine if a crime was committed and/or if the person is in crisis and needs help

b. The potential for escalating aggression is reduced by empowering the youth to act responsibly, rather than by exercising power over him/her – give the juvenile a chance to help solve problems when appropriate — ***Golden (2004)***

c. If the adolescent is non-compliant or gets out of control …

(1) Set firm limits on what is acceptable behavior

(2) Explain, in simple terms relatable to the juvenile, that the limits being imposed are temporary, that his/her compliance will help the situation, and noncompliance might make the problem worse — ***Golden (2004)***

(3) Identify the possible consequences for not complying

d. Forecast your next steps and what you need the juvenile to do to bring the encounter to a resolution

C. More specifics

1. When responding to a situation involving an aggressive juvenile, it is important to assess the danger level and aggression type — ***Handout #10***

2. If there is a clear and present danger, take the necessary action

3. If there is no immediate danger and the juvenile is exhibiting deliberate aggression (i.e., aggression clearly directed with specific intent to harm), consider the following three steps …

a. First step - remind, warn, and/or confront the juvenile

(1) Remind

(a) Provide a verbal clue that the juvenile’s actions are unacceptable

(b) Example – "Do you really need to yell for me to hear you?"

(2) Warn

(a) Inform the juvenile of the consequences for non-compliance

(b) Example – "If you continue to yell, I may have to cite you for Disorderly Conduct"

(3) Confront

(a) Clearly and firmly state the problem and an instruction

(b) Example – "You're yelling and disturbing the peace. Stop now or I'll arrest you"

b. Step two – if the behavior is not stopped, verbally remove the juvenile (i.e., give a verbal order for the juvenile to leave with you)

c. Step three – if de-escalation is not achieved with steps one and two, and depending on the situation, the juvenile may have to be physically removed or restrained

4. If there is no immediate danger and the juvenile is exhibiting emotional aggression (e.g., aggression that starts quickly, involves lashing out at everyone, is an out-of-control act), consider the following three steps …

a. Step one – give the juvenile personal space, but continue to watch him/her and provide assurances that you are there to protect him/her and are ready to talk when the juvenile wants to

b. Step two – reflective listening

(1) Succinctly paraphrase and repeat the juvenile's words

(2) This does four things …

(a) Allows the juvenile to vent frustrations

(b) Allows you to check the accuracy of your understanding of the situation

(c) Allows the juvenile to have a sounding board

(d) Gives the juvenile time to hear his/her own words and think about them

(3) Example

(a) Juvenile – "You damn cops are always hassling me! Why can't you just get out of my face and leave me alone?!"

(b) Officer – "I hear you. The cops are always bothering you. You don't want to be hassled, and I don't want to hassle you either"

c. Step three – counseling positively

(1) Occurs after a juvenile has signaled his/her readiness to engage in a more constructive conversation; the signal may be the juvenile asking a question or leaving a long pause after a period of reflective listening

(2) The objective is not to solve the juvenile's problem, but to help the juvenile develop acceptable options to deal with the immediate situation, and encourage the juvenile to assume responsibility for his/her actions and resolution of the situation

Handout #10

Questions to Class – For each scenario presented, have students determine the danger level of the incident (i.e., clear and present danger or no immediate danger), aggression type, and appropriate response. Students may reference Handout #10.

Scenario 1: *You observe a juvenile male standing over a juvenile female lying in a protective fetal position on the ground. The juvenile male is kicking the juvenile female, spitting on her, yelling profanities, and shouting statements like, "How could you disgrace our family like this, you whore!"*

Question – What type of aggression is being displayed?
Answer – Deliberate aggression

Question – What is the danger level?
Answer – Clear and present danger

Question - What is the appropriate response?
Answer – Take the necessary action

Scenario 2: *You are called to an apartment complex regarding a disturbance. As you approach, you observe a girl standing on a small porch pounding on the apartment door, kicking the small porch chair and table, and picking up a pot and smashing it. She is sobbing and yelling, "I hate all of you - you f*cking ruined my life!" She screams at the neighbors who are standing outside watching her, "What the f*ck are you looking at? Go away!" She continues to thrash around, scream, and cry.*

Question – What type of aggression is being displayed?
Answer – Emotional aggression

Question – What is the danger level?
Answer – No immediate danger

Question - What is the appropriate response?
Answer – While providing reassurances that you are ready to talk when she wants, give her space and time to emotionally vent, listen reflectively when she begins to talk, and engage in more constructive conversation (i.e., counsel positively) when she signals she is ready.

Scenario 3: *You observe a group of juvenile males standing outside a women's intimate apparel store aggressively harassing female shoppers as they enter and leave the store.*

Question – What type of aggression is being displayed?
Answer – Deliberate aggression

Question – What is the danger level?
Answer – No immediate danger

Question - What is the appropriate response?
Answer – In order of progression, (1) remind, warn, and/or confront the males about their behavior; (2) verbally remove them from the area, if necessary; (3) physically remove them from the area, if steps (1) and (2) have been unsuccessful and it is necessary to resolve the situation.

SPECIAL POPULATIONS – CHILDREN IN CRISIS

A. Overview

Kuhr (2015)

1. There are many situations that may create trauma for a child and lead him/her to experience crisis, including …

POBT: Unit 3-5 Child Abuse & Neglect

POBT: Unit 3-7 Juvenile Justice System

   a. Being the victim of violence, including sexual assault

   b. Witnessing a death or act of violence, particularly if it involves a loved one

   c. Being involved in or witnessing a serious accident

   d. Removal of the child or the child's caregiver from the home

2. For many children, these situations present their first direct exposure to law enforcement and the criminal justice system

3. As a first responder, you have the opportunity to identify and reduce the trauma experienced by the child in these and similar situations

4. To do so, it is important to understand the perception of children

B. Awareness items to promote effective interactions

1. Developmental stages affect traumatic reactions in children

   a. Children's reactions to trauma can differ in severity, how they are expressed, and when they are expressed (i.e., in the immediate aftermath of the crisis or much later)

NIMH (2006)

Question to Class – What are some behaviors you might expect younger children to exhibit in response to trauma? What are some behaviors you might expect older children to exhibit in response to trauma?

Answers provided below.

   (1) Younger children may, for example, cling to a parent, cry, whimper, become immobile

   (2) Older children may, for example, isolate themselves, complain of physical discomfort, display symptoms of depression, express feelings of guilt, engage in antisocial behavior

b. Be aware that, particularly for a young child, his/her reaction may largely be influenced by how nearby adults (especially the child's parents or caregivers) are reacting

c. Be sensitive and age appropriate with the words and phrases you use on the scene – children often take our statements literally — ***Kuhr (2015)***

d. Be mindful of what words the child may or may not understand

2. Impact of actual and perceived losses

a. A child may suffer trauma from the actual loss of a parent or caregiver due to the death of the parent or caregiver

(1) Be aware that children may go into denial about the reality of the situation

(2) As a coping mechanism, they will often create in their mind a happier ending

(a) Example – a child may fantasize that a dead loved one is merely asleep

(b) This is often referred to as magical thinking

(3) It is important to avoid euphemisms (e.g., say "died" instead of "passed away") — ***Stafford, Schonfeld, Keselman, Ventevogel, & Lopez Stewart (2009)***

(a) While some words may be easier for us to use, it denies the honest and direct facts

(b) Avoiding euphemisms reduces the option of magical thinking

b. A child may suffer trauma from an actual loss of a parent or caregiver due the parent's or caregiver's incarceration, or through the child's placement with protective services – example … — ***Kuhr (2018)***

(1) A child's disclosure of abuse or sexual abuse by the parent or caregiver may result in the removal of the parent or caregiver from the residence

(2) In such instances, the child may be in crisis knowing that his/her disclosure has changed the family dynamics

c. A child may suffer trauma from a perceived loss of parent (i.e., when the parent or caregiver is suffering his/her own crisis and is unable to be responsive to the child's needs)

(1) It can be very frightening for a child to witness his/her parent or caregiver in distress

(2) Assure the child that everyone experiences trauma differently, and the trauma reactions being expressed by the adults in his/her life are okay

C. Response

1. When responding to children in crisis, follow the National Organization for Victim Assistance (NOVA) prescribed SSVVPP protocol (i.e., Safety and Security, Ventilation and Validation, and Prediction and Preparation) — ***NOVA (1994)***

2. S S – safety and security

a. Protect the child from… — ***NIMH (2006)***

(1) Further harm

(2) Traumatic sights and sounds

(3) Onlookers and media

b. Be kind, but firm, in directing the child away from the site

c. Address safety concerns — ***Kuhr (2015)***

(1) Remind the child that he/she is safe right now (e.g., "You are safe now," "This is a safe place to talk now") — ***Students should be made aware that sometimes removal of the child from the home will be necessary***

(2) Reassure the child that his/her loved ones are safe, when true

(3) Develop a safety plan, if fear is present

d. Provide the child with basic comforts, such as physical rest, food, something to drink — ***See ORC 2151.31 and POBT: Unit 3-5 Child Abuse & Neglect, and POBT: Unit 3-7 Juvenile Justice System***

e. Provide the child with physical symbols of nurturing (e.g., teddy bears, blankets)

f. Use words and gestures of comfort and support

3. V V – ventilation and validation — ***NOVA (1994)***

a. A child in acute distress may… ***NIMH (2006)***

(1) Tremble or sit completely still

(2) Ramble, rage, or become mute

(3) Exhibit erratic behavior or have a flat expression

(4) Engage in behaviors or have different effects than those listed above

b. Be non-judgmental and tolerant of any strong emotions or difficult behavior being displayed

c. Allow the child the opportunity to express reaction to the event and communicate his/her concerns ***Kuhr (2015)***

(1) Beyond emotional ventilation for the child, this may provide investigative information for you

(2) Support the child by …

(a) Giving him/her your full attention

(b) Having your facial expressions and body language reflect interest and concern

(c) Allowing the child to ask you questions, and providing responses that are direct, honest, appropriate, and compassionate

(d) Talking to the child about his/her observations of other people's reactions (e.g., the reactions of loved ones)

(i) Acknowledge that the child may be feeling frightened by the situation and/or the emotions that the child is experiencing or witnessing being displayed by others

(ii) Let the child know everyone will experience, react, and recover from the situation in different ways and at different times

(3) Do not …

(a) Tell the child how you think he/she should be feeling or how the child or others should be behaving ***NIMH (2006)***

(b) Minimize the loss

(c) Ask questions that imply interrogation (i.e., avoid asking questions that begin with "Why did" or "Why didn't")

d. Help the child to understand what is happening in the crisis — ***Kuhr (2018)***

(1) Example – if a death has occurred, the difference between life and death

(a) Again, use words and analogies that the child can understand

(b) Be sensitive to any cultural or religious beliefs of the child and his/her family

(2) Be aware that children may remember some things in detail, and have limited memory of other events; trauma can impact memory — ***This impact to memory may contribute to instances of delayed disclosure***

e. Validate the child with statements such as …

(1) "This is not your fault"

(2) "I am sorry this happened to you"

4. P P – prediction and preparation — ***NOVA (1994)***

a. Predict what will happen next, but avoid …

(1) Making promises that you can't keep (e.g., "You will go home soon") — ***NIMH (2006)***

(2) Using phrases such as "Everything will be OK"

b. Prepare the child by… — ***Kuhr (2015)***

(1) Educating the child about trauma, death, or loss

(a) Remind the child that he/she may experience a lot of different emotions, and that is okay

(b) Let the child know that everyone heals at different speeds, and that is okay, too

(2) Helping the child to identify reasons to look to the future

(3) Giving the child information on how to contact you

D. Communication with children – key steps summarized

Stafford et al. (2009)

1. Let the child set the pace
2. Give adequate time for the child to reveal the whole story, which may mean talking on more than one occasion
3. Provide emotional support and encouragement in ways that are appropriate for the child's culture and stage of development
4. Accept the child's emotions, even if they seem illogical to you
5. Never give false reassurances
6. Listen in an attentive and supportive way; allowing the child to talk about the difficult situation may enable the child to work out his/her own solution
7. Recognize that some regression may be necessary, and children may need personal care more characteristic of younger children in order to overcome the emotional problems they are facing

DISPOSITIONS

A. In general

1. The U.S. Sixth Circuit Court of Appeals has addressed law enforcement response to individuals with special populations; as a law enforcement officer, you should be prepared to articulate …

   a. Why the level of force used was necessary

   b. Whether you had any prior knowledge that the person had a mental illness or a developmental disability

2. Always follow your agency's protocol

Champion v. Outlook Nashville, Inc. (2004)

Question to Class – What are the typical disposition options available to you when resolving a special populations encounter?

Answer provided below.

B. **TYPICAL DISPOSITIONS WHEN RESOLVING A CRISIS INTERVENTION INCIDENT**

1. **Arrest**
2. **De-escalate and refer for follow-up care and support**
3. **Voluntary transport to hospital or community mental health services provider (i.e., a "crisis center")**
4. **Involuntary transport to hospital or community mental health services provider**

SPO #11 – PPT #44 Emphasize to students that the disposition options are not presented in any particular order (i.e., this is not a progressive list); selecting an appropriate disposition will be entirely dependent on the presenting facts

C. **Arrest**

1. **This should not always be your first option**
2. **Appropriate when …**

SPO #11 – PPT #44 Involuntary transport is also commonly referred to as "emergency custody" or "pink slipping"

For information on the application of confidentiality laws to mental health and addiction information,

	see "Sharing Confidential Mental Health and Addiction Information in Ohio: Mental Health and Addiction Providers and Law Enforcement" (2018), available in Additional Resources
a. **There is an arrestable offense and you must make the arrest** (e.g., violent felony, domestic violence)	
b. **There is an arrestable offense and there are no mental health resources readily available for treatment referral**	
D. **De-escalate and refer for follow-up care and support**	***SPO #11 – PPT #46***
1. Objective – resolve the situation on the scene by de-escalating the person in crisis and provide the person with an appropriate referral for follow-up care and support	
2. **Appropriate when …**	
a. **No laws have been broken or the offense falls within the discretion allowed by your agency (e.g., give a warning or issue a summons)**	
b. **There are no emergency medical needs**	
c. **The person is sufficiently in control of his/her emotions and his/her behavior and does not pose a danger of harm to self or others**	
d. **There is a safety plan in place with a family member or friend assuming responsibility for the person's wellbeing**	***SPO #11 – PPT #47***
e. **You are able to make a referral to services with which the person can follow-up**	
f. **Involuntary transport (i.e., "emergency custody") criteria have not been met**	
3. Practical considerations	

a. Consider any known medical or criminal history of the person that might influence your decision

b. Provide the person with your contact information

c. Provide the person with referral information to treatment and support services

d. Follow up with the person to ensure that he/she was able to make contact with services; provide another referral if the first contact did not result in service

E. **Voluntary transport to hospital or community mental health services provider** ***SPO #11 – PPT #48***

1. Objective – to get the person to willingly agree to receive treatment at a community mental health services provider or, in the alternative, at a hospital

2. **Appropriate when …**

   a. **No laws have been broken or the offense falls within the discretion allowed by your agency (e.g., give a warning or issue a summons)**

   b. **There are appropriate community resources available**

   c. **You have the person's consent and you believe the person would benefit from treatment**

   d. **Involuntary transport (i.e., "emergency custody") criteria have not been met and there is no safety plan in place** (e.g., no family member or friend available to assume responsibility for the person's wellbeing)

3. Practical considerations

   a. There may not be a community mental health services provider in the area, making a hospital the only alternative for immediate care

   b. Not every person in crisis will qualify for services at a facility (e.g., Alzheimer's disease is not always classified as a mental illness, and most mental health facilities will not admit Alzheimer's patients) ***TCOLE (2009)***

   c. When options exist, ask the person his/her preference of where to be transported

d. The person may change his/her mind and no longer agree to be transported to a community mental health services provider or hospital; options at that time are to …

(1) Provide the person with referral information to treatment and support services and release him/her in a physically safe location

(2) Involuntary transport of the person to a crisis treatment center or hospital, if the criteria for emergency custody of the person are satisfied

Question to Class – Consider the potential argument of whether a person agreeing to transport when the only options given to the person are be arrested or transported to a community mental health services provider or hospital constitutes a truly voluntary transport.

If involuntary transport is also an appropriate disposition, why might you still want to first present voluntary transport?

Answers will vary, but may include – procedural justice tactics (e.g., give the person a voice); less confrontational resolution to the situation; reduce the likelihood of physical harm to you or the person; treatment more likely to be successful when the person wants to receive it.

F. **Involuntary transport to hospital or community mental health services provider** ***SPO #11 – PPT #49***

1. Overview and terminology

a. The law allows you to take a person with mental illness into emergency custody and immediately transport him/her to a hospital or other designated location under certain circumstances

b. **"Mentally ill person subject to court order" means a mentally ill person who, because of the person's illness, meets one of the following criteria …** ***R.C. 5122.01(B)***

(1) **Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm**

(2) **Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness**

The criteria listed in (1) and (2) are by far the most common criteria used to place someone in emergency custody
SPO #11 – PPT #50

(3) **Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community**

SPO #11 – PPT #51

(4) **Would benefit from treatment for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person**

(5) **Would benefit from treatment as manifested by evidence of behavior that indicates all of the following …**

(a) **The person is unlikely to survive safely in the community without supervision, based on a clinical determination**

(b) **The person has a history of lack of compliance with treatment for mental illness and one of the following applies …**

The criteria listed in (5) deals with noncompliance with treatment; the documentation necessary to satisfy this criteria is very difficult to obtain; typically presented by probate court order for execution by law enforcement
SPO #11 – PPT #52

i. **At least twice within the 36 months prior to the filing of an affidavit seeking court-ordered treatment of the person under R.C. 5122.111, the lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the 36 month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the 36 month period**

SPO #11 – PPT #53

ii. **Within the 48 months prior to the filing of an affidavit seeking court-ordered treatment of the person under R.C. 5122.111, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the 48 month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the 48 month period**

SPO #11 – PPT #54

(c) **The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment**

SPO #11 – PPT #55

(d) **In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others**

(e) **An individual who meets ONLY the criteria in (5)** (which is R.C. 5122.01(B)(5)(a)) **is not subject to hospitalization**

c. "Hospital" means a hospital or inpatient unit licensed by the Department of Mental Health and Addiction Services under R.C. 5119.33, and any institution, hospital, or other place established, controlled, or supervised by the department under R.C. Chapter 5119

R.C. 5122.01(F)

2. **Appropriate when …**

R.C. 5122.10
SPO #11 – PPT #56

a. **The officer has reason to believe that the individual is a "mentally ill person subject to court order" as outlined in R.C. 5122.01** (described above) **and**	***Under Ohio Revised Code 5122.10, officers have authority to complete an Application for Emergency Admissions; however, officers should review their agency's policies***
b. **The individual represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination**	
3. **PRACTICAL AND LEGAL CONSIDERATIONS WHEN TAKING A PERSON INTO EMERGENCY CUSTODY**	***SPO #12 – PPT #57***
a. **Every reasonable and appropriate effort must be made to take persons into custody in the least conspicuous manner possible**	***R.C. 5122.10***
b. **You must provide the person with the following information …**	***SPO #12 – PPT #58***
(1) **Your name, title, and agency**	
(2) **That the person is not under criminal arrest, and**	
(3) **That the person is being taken for examination by mental health professionals at a specified mental health facility which has to be identified by name to the person with mental illness**	
c. **You must provide a written statement (i.e., Application for Emergency Admission) of belief to the hospital, containing …**	***Handout #11*** ***SPO #12 – PPT #59***
(1) **The circumstances under which the person was taken into custody, and**	
(2) **The reason for your belief that emergency admission is appropriate**	
d. **The Application for Emergency Admission form (i.e., "pink slip"), provided by the Ohio Mental Health and Addiction Services, must contain facts which describe specific actions, incidents, or events. The facts provide evidence that a person engaged in conduct which forms the basis for a finding of probable cause to believe that he/she may have a mental illness and is in need of court-ordered hospitalization**	***In re Miller (1992)*** ***SPO #12 – PPT #60***

(1) **Start by listing how you became aware of the person and the situation** (e.g., service call, personal observation)

SPO #12 – PPT #61

(2) **Then list the information gained during the Engage phase**

(a) **Describe what you observed**

(b) **Include facts that were provided to you by the person or others**

(c) **It is essential that you articulate not just what happened, but also …**

SPO #12 – PPT #62

i. **How what happened caused you to believe that the person may be a mentally ill person subject to hospitalization, and …**

ii. **What caused you to believe that he/she represented a substantial risk of physical harm to himself/herself or others if allowed to remain at liberty pending examination**

(3) **Close by stating, "Based on what has been listed, I believe this person is subject to emergency admission"**

SPO #12 – PPT #63

4. Another method for taking a person into custody is pursuant to a probate court order

R.C. 5122.11

a. These orders are primarily served by a county sheriff's office (but may be issued to a health officer or police officer) and follow the same criteria used for emergency admission (i.e., orders of detention)

b. In these cases, the officers would not be required to develop the statement of belief because that was developed in order to have the probate court judge or magistrate sign the form located in R.C. 5122.111

G. Duty to warn

R.C. 2305.51

1. A mental health professional has a duty to warn third parties if the professional has knowledge of an explicit threat by a person to inflict imminent and serious physical harm or cause the death of one or more clearly identifiable victims, and the professional has reason to believe that the person who made the threat has the intent and ability to carry out the threat

2. A mental health professional may choose to address the situation by contacting law enforcement about potential threats

3. Be sure to familiarize yourself with your agency's policies about responding to this type of information received from a mental health professional

Small Group Activity and Class Discussion – Split the class into four small groups. Assign each group one of the scenarios on Worksheet #6. Each group should determine the proper disposition for their assigned scenario.

Have each group present to the class its scenario, disposition determination, and supporting reasoning for their decision.

Discuss as a class.

Instructor can use Worksheet #6A to facilitate the discussion.

Worksheet #6
Worksheet #6A

COMMUNITY RESOURCES

A. Crisis Intervention Team (CIT)

1. The CIT Model (also known as the Memphis Model), is a nationwide model of police-based crisis intervention with community, health care, and advocacy partnerships — ***NAMI, Ohio (n.d.)***

2. Officers who volunteer and are selected for a Crisis Intervention Team receive approximately 40 hours of advanced training in …

   a. Psychiatric disorders

   b. Substance abuse issues

   c. De-escalation techniques and empathy training

   d. Legal issues related to mental health and substance abuse

3. CIT in Ohio — ***Woody (2018)***

   a. Among those CIT trained in Ohio are police officers, deputies, OSHP troopers, college and university police and security officers, corrections officers, probation officers, parole officers, hospital security officers, park rangers, and police dispatchers

   b. CIT is well-integrated into law enforcement agencies throughout the state – statistics …

      (1) 678 out of 968 (or roughly 70%) of all Ohio law enforcement agencies have at least one CIT trained officer on staff — ***Statistics current through June 2018***

      (2) 11,237 out of 24,439 (or roughly 46%) of Ohio's full time, sworn law enforcement officers, across 87 of the 88 Ohio counties, are CIT trained — ***Statistics current through June 2018***

   c. These officers should be viewed by new and experienced officers alike as tremendous resources when engaging in special populations encounters, and called upon when the situation would benefit from their specialized training

B. Resources

1. There are many national, state, and local resources available to assist persons with mental illness and special populations persons

2. It is important to be familiar with the service providers and the types of services available in and around your community

Class Activity – Have students access the internet and visit the Ohio Department of Mental Health and Addiction Services (MHAS) at http://mha.ohio.gov/Default.aspx?tabid=347. Students should research addiction services providers and mental health services providers in their counties and identify the types of services available. Encourage students to add this information to the contacts list in their phones or otherwise keep it in some form for use in the field.

Handout #12

POBT: Unit 3-8 Responding to Victims' Needs and Rights
Emphasize to students that the resources listed in the lesson plans are only a sampling of available services

ROLE-PLAY SCENARIOS

It is strongly recommended that the instructor utilize role-play scenarios to enhance the learning experience. These scenarios will allow students to apply what they have learned through a variety of simulated calls for service. The instructor can use students as role-players or use additional instructors, depending on the resources available. It is the instructor's responsibility to ensure that these scenarios are done in a safe manner. These are not force-on-force but rather critical thinking/judgment scenarios to give students the opportunity to practice.

After the scenario:

- Have students write a narrative based on the scenario they responded to
- Allow students to critique their own performance
- Allow other students to give advice and their thoughts
- Debrief students on what they did right and what they could possibly improve

ROLE-PLAY SCENARIO #1 – DAVIDA

Props: One person to role-play, one responding officer, radio, easel, markers, flipchart

Safety: Establish a safe word for role-players and students to use if the scenario needs to be stopped for any reason.

Setup: Neighbor called the police at 3:00 a.m. to complain about loud music coming from Davida's apartment.

Observable characteristics: Davida, a female, is playing loud music and painting. She is dressed in bright colors, lots of jewelry, and heavy make-up. She has an inflated self-esteem, a decreased need for sleep, and is more talkative than usual. Her thoughts are racing and she is highly distractible as her attention is easily drawn to her painting or the music.

Notes for role-player:
You greet the officers and you are somewhat put off that you had to stop painting to let them in. If the officers ask to turn down the music, you refuse. The music is driving your artistic activity and you need to continue painting because you have a show coming up in New York City. If the officer persists, you turn the volume down just a little bit.

If asked about your sleeping and eating, you admit that you have not slept in two or three days and your art is your food right now! You will sleep and eat when you finish this masterpiece. If asked if you have ever been to the hospital or to see a doctor, you initially deny having been there. You should eventually admit that you go sometimes if needed. However, you are feeling good and do not need to go. Actually, you are feeling so great that you have not been taking your medication lately, it just slows you down anyway, and you have so much work to do for the art show.

ROLE-PLAY SCENARIO #1 – DAVIDA (cont.)

Role-player actions:
The officer will need to lower the volume of the radio, as that was the call that prompted his/her arrival. Reward the officer if he/she is being respectful and seemingly interested in your artwork. The officer should work a little bit to gain your trust, and if he/she does, you should allow him/her to turn down the radio volume. Escalate your manic, frantic behavior if the officer is not being patient and empathetic with you.

Officer goals:
To assess the situation and facilitate an appropriate resolution. Officers need to key into the fact that it will be difficult to de-escalate Davida while she is manic, and they will need to negate her energy by turning the radio down.

Debrief – discuss the following:

- Identify observable characteristics. *Lots of energy, fast talking, racing thoughts*
- What Loss Model profile does this fall under? *Loss of Perspective*
- What did the officer do to escalate and/or calm the situation?
- Ask the role-player how the officer did.
- Discuss officer safety issues.
- How did the officers use empathy to establish a connection with Davida?
- The Assess phase should include questions about medications, doctors, and others that may be called.
- Discuss with the group if the officers' decisions were the best possible.

ROLE-PLAY SCENARIO #2 – CHARLIE

Props: One person to role-play, one responding officer, stack of newspapers

Safety: Establish a safe word for role-players and students to use if the scenario needs to be stopped for any reason.

Setup: Employee of a local convenience store called 911 and reported that a man just walked out of the store with a whole stack of newspapers that he did not pay for. The man is currently sitting on a bench outside the store.

Observable characteristics: Charlie has a delusion (i.e., a fixed, false belief) that "the others" are communicating with each other through messages within the newspaper. He truly believes that if he can keep the papers out of the store, he can break up a huge plot that "the others" have to poison the city's water system.

Notes for role-player:
Although you are very cordial and communicative when the officer arrives, you do not trust him/her. You do not tell him/her the real reason you have taken the newspapers. You are restless and are constantly surveying your surroundings as you expect one of "the others" will soon be coming into the store to get a newspaper. The newspapers are on your lap and you initially will not give them to the officer. If the officer asks you about past treatment or seeing a doctor, you readily admit that you go to the mental health center to see a doctor and that you always take your medications. Do not come out of role.

Role-player actions:
When the officer presses you about returning the newspapers, first you say that they were just on the bench and then you say that you have paid for them. We want the officer to use patience and calmness with you to begin earning your trust. As the officer persists in wanting to take the newspapers back, you still resist but begin to slowly tell him/her you have taken the newspapers (i.e., you do not want certain people to read them and you do not want anyone to get hurt).

Give brief answers – we want the officer to question you about the details of your delusions. At some point, directly ask the officer, "Do you believe me? Do you believe that "the others" are trying to poison the water supply?" If he/she says yes to this question, escalate your behavior and ask, "Why aren't you helping me? Why aren't you trying to stop them?" or "Why aren't you also afraid?" Also, escalate if he/she answers "no" or tries to convince you that your thoughts are not real.

We want the officer to defer a direct answer to this question and acknowledge how the belief is affecting you. If the officer is attentive to your fear and reflects empathy, eventually agree to give up the newspapers.

ROLE-PLAY SCENARIO #2 – CHARLIE (cont.)

Officer goals:
De-escalate Charlie through engagement skills that validate his situation and defer his statements about the delusion; return the papers back to the store and interview the storeowner to determine if charges will be pressed.

Debrief – discuss the following:

- Identify observable characteristics. *Fear, paranoia, distrustfulness, suspicion*
- What Loss Model profile does this fall under? *Loss of Reality*
- What did the officer do to escalate and/or calm the situation?
- Ask the role-player how the officer did.
- Discuss officer safety issues.
- How did the officer use empathy to establish a connection with Charlie?
- The Assess phase should include questions about medications, doctors, and others that may be called.
- Discuss with the group if the officer's decisions were the best possible.
- How should the officer handle the fact that a law was broken?

ROLE-PLAY SCENARIO #3 – JOE

Props: One person to role-play, one responding officer, identification card

Safety: Establish a safe word for role-players and students to use if the scenario needs to be stopped for any reason.

Setup: Dispatcher receives a call from an employee of a gas station. The employee reported that a man who "was stinking of alcohol" was being loud and obnoxious. When you arrive, he is leaning against his car in a parking lot by the river bridge.

Observable characteristics: Slurred speech, unsteady walk, angry disposition, mood swings from sad to angry to apologetic.

Notes for role-player:
When the officer approaches, you communicate with him/her but act as if he/she is an agitation. If he/she asks to see your identification card, you comply and give it to him/her but you get angrier. After receiving a cue from the instructor, you begin to walk towards the bridge.

Role-player actions:
If the officer does not ask your name or introduce himself/herself early, act angrier and pace. Yell loudly that you too are a police officer and you are going to jump into the river.

If the officer is using your name and trying to calmly de-escalate you while trying to negotiate you away from the bridge, you start to calm down. You begin to listen to the officer when he/she asks appropriate questions and seems interested.

Officer goals:
De-escalate Joe through good active listening skills and empathy. The officer should recognize that, being a Loss of Hope profile, it is critical that the officer tries to make a personal connection with Joe as the way to engage him and begin to talk him down.

Debrief – discuss the following:

- Identify observable characteristics. *Suicidal*
- What Loss Model profile does this fall under? *Loss of Hope*
- What did the officer do to escalate and/or calm the situation?
- Ask the role-player how the officer did.
- Discuss officer safety issues.
- How did the officer use hope to establish a connection with Joe?
- The Assess phase should include questions about medications, doctors, and others that may be called.
- Discuss with the group if the officer's decisions were the best possible.

CONCLUSION

A. Summarize material

B. Practice

1. Distribute Practice Exercise to students
2. Have students complete Practice Exercise
3. Review Practice Exercise with students
4. Be available for questions

C. Test/SPOs (if applicable)

HANDOUT #1 – OVERVIEW OF SELECTED SPECIAL POPULATIONS

Special Population	Definition	Examples	Observable Characteristics	LE Encounters
Mental Illnesses	Not present at birth, medical conditions that range in severity. Can disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning.	Major depression, Schizophrenia, Bipolar, PTSD, Panic Disorder	Switching from normal to irrational behavior which may be displayed as depression, moodiness, suspicion, mistrust, hearing or seeing things	Maintain a reactionary distance; if psychotic don't buy-into or try to talk someone out of their false beliefs
Developmental or Intellectual Disabilities	Present at birth or occur during the period of development. People may learn at a slower rate. May have trouble in areas such as self-care, language, mobility, learning, self-direction, or self-sufficiency.	Downs Syndrome, Pervasive developmental disorders	A person can be expected to behave rationally at his/her functional level. May have trouble communicating. Some children may have repeated body movements such as rocking or hand flapping.	May exhibit a desire to please authority figures. Use simple language, speak slowly, and ask one question at a time. Avoid questions that tell the person what you think.
Autism or Autism Spectrum Disorders	Developmental disability that seriously affects a person's ability to communicate, socialize, and make judgments. It is typically observed by age three and is more common in males than females. About 50% of this population is nonverbal.	Autism, Asperger's Syndrome	May have difficulty expressing themselves with words or gestures, facial expressions, and touch. They may have unusual responses to people, attachments to objects, resistance to change in their routines and/or aggressive or self-injurious behavior. May also avoid eye contact, lack a fear of real danger, spin or twirl objects and exhibit finger, arm, or wrist flicking	May inappropriately approach or run towards officers. Speak in direct, short phrases. Avoid figurative expressions (e.g., what is up your sleeve?). Allow for delayed responses. Avoid stopping repetitive behavior unless there is a risk of injury to yourself or others.
Dementia	Descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. It is a progressive decline of memory, thought process, and speech, as well as behavior and movements.	Alzheimer's disease, Huntington's disease	They may seem uncooperative and show memory loss. May be unable to answer your questions or understand the seriousness of the incident. People may have significantly impaired functioning that interferes with normal activities and relationships. May be agitated, experience personality changes, or delusions	Loudness can convey anger; do not assume the person is hearing-impaired. Repeat your questions. Avoid correcting or "reality checks"

HANDOUT #2 – COMMONLY PRESCRIBED MEDICATIONS

Commonly Prescribed Psychiatric Medications

Antidepressants

Norpramin (desipramine)
Elavil (amitriptyline)
Aventyl, Pamelor (nortriptyline)
Anafranil (clomipramine)
Oleptro (trazodone)
Nefazodone
Prozac, Sarafem (fluoxetine)
Wellbutrin (bupropion)
Zoloft (sertraline)
Paxil (paroxetine)
Effexor (venlafaxine)
Pristiq (desvenlafaxine)
Luvox (fluvoxamine)
Remeron (mirtazapine)
Celexa (citalopram)
Lexapro (escitalopram)
Cymbalta (duloxetine)
Viibryd (vilazodone)
Strattera (atomoxetine)
Trintellix (vortioxetine)
Fetzima (levomilnacipran)

MAO Inhibitors

Nardil (phenelzine)
Parnate (tranylcypromine)
Emsam (patch) (selegiline)

Bipolar Disorder Medications

Eskalith, Lithonate (lithium carbonate)
Symbyax (olanzapine-fluoxetine)
Tegretol, Equetro (carbamazepine)
Depakote (divalproex)
Lamictal (lamotrigine)
Trileptal (oxcarbazepine)

Antipsychotics

Low Potency

Thorazine (chlorpromazine)
Clozaril (clozapine)
Seroquel (quetiapine)

High Potency

Trilafon (perphenazine)
Haldol (haloperidol)
Orap (pimozide)
Risperdal (risperidone)
Invega (paliperidone)
Zyprexa (olanzapine)
Geodon (ziprasidone)
Fanapt (iloperidone)
Saphris (asenapine)
Latuda (lurasidone)
Ablify (aripiprazole)
Rexulti (brexpiprazole)
Vraylar (cariprazine)

Anti-anxiety

Benzodiazepines

Valium (diazepam)
Librium (chlordiazepoxide)
Klonopin (clonazepam)
Ativan (lorazepam)
Xanax (alprazolam)

Other Anti-Anxiety Agents

BuSpar (buspirone)
Neurontin (gabapentin)
Atarax, Vistaril (hydroxyzine)
Inderal (propranolol)
Tenormin (atenolol)
Tenex, Intuniv (guanfacine)
Catapres, Kapvay (clonidine)
Lyrica (pregabalin)
Minipress (prazosin)

Anti-Obsessionals

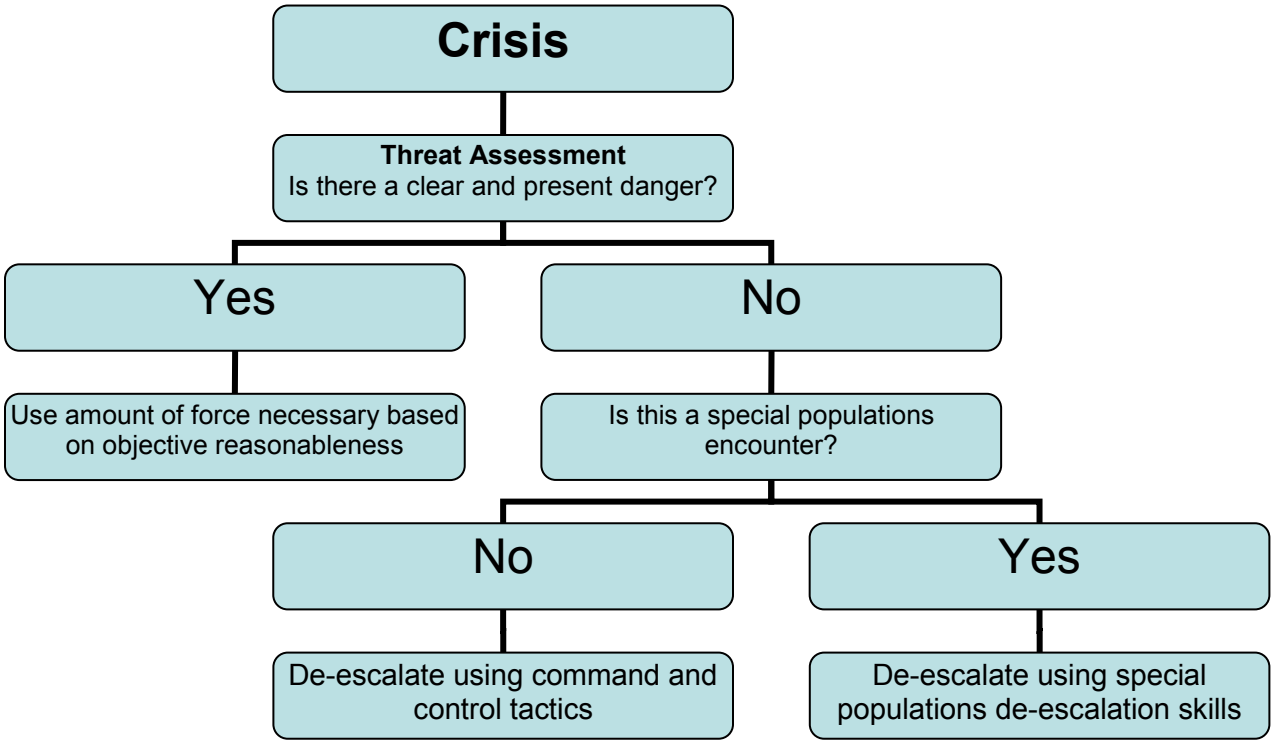
Anafranil (Clomipramine)
All SSRIs

Psychostimulants

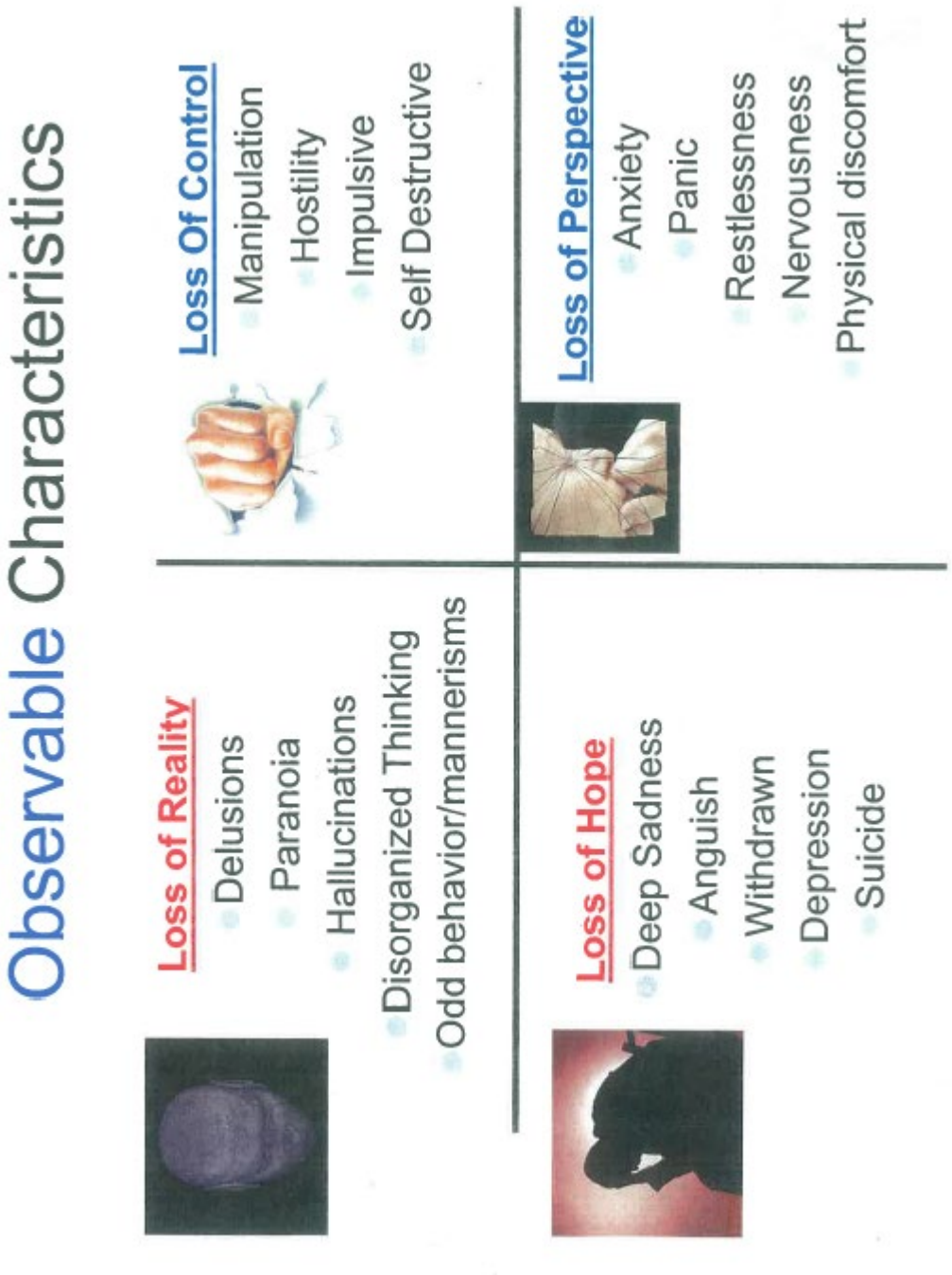
Ritalin (methylphenidate)
Concerta (methylphenidate)
Metadate (methylphenidate)
Methylin (methylphenidate)
Daytrana (patch) (methylphenidate)
Quillivant XR (liquid) (methylphenidate)
Focalin (dexmethylphenidate)
Dexedrine (dextroamphetamine)
Vyvanse (lisdexamphetamine)
Adderall (d- and l-amphetamine)
Nuvigil (armodafanil)
Mydayis (amphetamine salts)
Adzenys (amphetamine sulfate)
Evekeo (amphetamine salts)

(Preston, 2018)

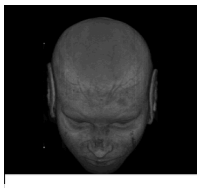
HANDOUT #3 – DE-ESCALATION DECISION TREE



HANDOUT #4 – OBSERVABLE CHARACTERISTICS



HANDOUT #5 – LOSS AND EAR MODELS INTEGRATION



Loss of Reality – Delusions (i.e., false beliefs), Hallucination (i.e., hearing or seeing things). **The goal of this negotiation is to cut through the fear and confusion caused by the psychosis and get the person to voluntarily calm and comply with your requests.**

The person may present as frightened and confused, his/her story may be hard to follow, and he/she may be having difficulty concentrating if he/she is seeing or hearing things at that moment. Remember that the delusions and hallucinations he/she may be experiencing are very real to him/her. If an individual is seeing or hearing things, you must indicate that you understand that those experiences are real and frightening for him/her. Sometimes the person also has a sense that something is wrong (e.g., "you may think I'm nuts", "I know this sounds crazy but…"). Use this to your advantage during the engagement phase to assure the person that you can start the process of getting help. Individuals may also present as pre-occupied or withdrawn exhibiting shuffling, uncoordinated gait; a vacant, "thousand-yard stare"; incoherent mumbling; and other bizarre behavior.

Engagement

- Your presence – You must be acutely aware of any indications that the person is feeling threatened by you. If you detect this, become as nonthreatening as possible and continually ASSURE the person that you are in a position to help him/her.
- Stay a safe distance from the person and don't touch him/her. If for reasons of safety you must touch him/her, tell him/her first what you will be doing.
- Be genuine and patient but direct with your conversation.
- Build empathy; it absorbs tensions. Model the calm demeanor that you want from the person in crisis.
- Don't do a lot of paraphrasing with this type of encounter, rather listen to him/her with the goal of validating his/her feelings (e.g., "that sounds frightening, I can see why you are afraid").
- Don't buy into or deny his/her hallucination or delusion, rather ask basic questions about what he/she is experiencing to get more information about weapons and safety.
- You can validate his/her experience without buying into his/her delusions (e.g., "I can see you are worried or afraid about someone harming you." "I don't know of anyone who wants to hurt you, but I can help you feel safer").
- After listening and validating him/her- don't spend too much time letting him/her talk about his/her hallucination or delusions if it is escalating his/her fear. If he/she is very delusional, try using his/her first name to interrupt their speech and thoughts if he/she is perseverating. You want to keep them in the "here and now".
- It's ok to ask if he/she is frightened for his/her own safety and remind him/her that you are there for his/her safety.
- You may have to repeat assuring messages many times before the individual can respond to it.

Assessment

- Assess issues of safety right away.
- Ask the person if he/she is seeing/hearing things right now. The more demonic or paranoid the theme, the more potential for unpredictable behavior.
- Ask about current treatment and medications he/she may be on and if he/she is current.
- Check and see if there are others in the room that you could talk to if the situation is safe and use him/her as a second source of information.
- Ask if the person has recently taken any drugs or alcohol to rule out drug induced psychosis.

HANDOUT #5 – LOSS AND EAR MODELS INTEGRATION (cont.)

Resolution

- Call for officer backup before the situation gets out of control.
- Forecast (i.e., announce your actions before initiating them) what you will be doing/needing to resolve the crisis (e.g., "I'm going to call for help", or "I'm going to have to pat you down").
- Call mental health backup if treatment or hospitalization is warranted and communicate what you have learned about the person's psychosis, medications, and drug use.

Loss of Hope - Deep depression, extreme sadness, and feelings of being helpless or hopeless. The person will have experienced a recent loss (or losses) that are devastating to him/her. **The goal of this negotiation is first to instill some hope so that the person can be persuaded to talk to someone or seek help.**

This person will either be emotional or very withdrawn. His/her critical thinking and logic skills will be muted and he/she will be feeling deeply weighted down by despair. He/she may not be very talkative. While he/she may think and talk about suicide, he/she is feeling extremely ambivalent about that and you can use that to your advantage by reassuring him/her that you can start the process to get him/her help. If he/she is under the influence of any drugs or alcohol, be careful as this makes the negotiation much more unpredictable. After your assessment phase – you must take control of these encounters (e.g., "Here's what I am going to do, for me to help you I need to…"). You should not feel as if you have to solve his/her problems.

Engagement

- Tone of voice is especially critical for these encounters, be empathetic and patient.
- Use your name and his/her name early and often while you are talking with him/her.
- Always assure the person that you are in a position to help him/her.
- Never assume that because a person is not responding to your statement, he/she is not hearing you. In these situations, there is the temptation to begin acting and talking as if the person were not present. This is a mistake.
- Try and make a personal connection with his/her story by identifying with something in his/her story (e.g., pets, children, profession, hobbies/interests).
- You can make a personal connection by how much you choose to reveal about similar situations you may have faced, though don't make up a story.
- Don't spend too much time on listening to him/her live through his/her anguish as this can make him/her sadder. Once you have heard his/her story and you think he/she will be compliant; take control of the conversation by leading him/her (see below).

Assessment

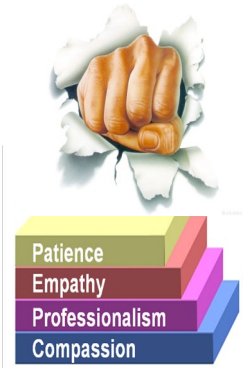
- You must assess seriousness of intent by asking questions related to the persons method and means of dying (e.g., Does he/she have a well thought out plan? Does he/she have access to the means? Does he/she have a history of attempts?)
- People with no hope can often be led; this is how you take control of the conversation. State what you need (e.g., "I need you to put the knife down and go in the next room"; "This is what I'd like you to do").
- Ask if he/she has attempted suicide in the past and if so, how recently?
- Ask about current treatment and medications he/she may be on.

HANDOUT #5 – LOSS AND EAR MODELS INTEGRATION (cont.)

- Ask if the person has recently taken any drugs or alcohol. Be careful as this can make the negotiation much more unpredictable.

Resolution

- Call for officer backup before the situation gets out of control. Convey to the other officers what you have learned about through your Assessment about his/her suicidal history and current seriousness of intent.
- Forecast (i.e., announce your actions before initiating them) what you will be doing/needing to resolve the crisis (e.g., “I’m going to call for help”, “I’m going to have to pat you down”).
- Call mental health backup if treatment or hospitalization is warranted and communicate what you have learned about the person’s suicidal intent, past attempts, medications, and drug use.



Loss of Control - Anger, hostility, rising tensions. The goal of this negotiation is to calm the person by letting him/her vent and using active listening skills.

This person is very angry and wants you to know about it. He/she often presents himself/herself as a victim (e.g., life is unfair, people have messed with you) and in all his/her frustrations, he/she does not feel listened to. Some of these encounters, the person may have learned to use anger and manipulation as a survival skill. You also must allow that even if you do everything correctly, people may still maintain his/her anger because it is what has worked best for him/her in the past. Remember that empathy absorbs tension. You must remain professional while seemingly taking his/her verbal abuse and it will feel to you as if it is personal – it’s not. Be aware of escalating physical excitement that may indicate violence (e.g., clenched fists, pacing, flushed cheeks).

Engagement

- Model the calmness that you want him/her to mirror. Tone of voice is critical in this circumstance. You don't want to use an excitable tone, as it could further incite the angry behavior.
- Do a lot of listening initially. While he/she is venting, let him/her know you are listening by providing “minimal encouragement” (e.g., "Uh huh", "Go on", "Yes"). However, do not let him/her be repetitive over the same grievances as this can escalate him/her.
- Let them know that if you can understand his/her anger, you might be in a position to help him/her.
- Acknowledge their situation, which is not agreement with his/her anger (e.g., "Wow, I can see how something like that would make you angry!", "If that happened to me, I might be angry, too.")
- Apologize for his/her predicament without taking blame. This is simply a statement acknowledging that something occurred that wasn't right. You are not taking responsibility for something that wasn't your fault. For example, if you can't find anything for which to apologize, you can always say, "I'm sorry you’re having such an awful day" or "I'm sorry the situation has you so frustrated."
- Pick your battles but set boundaries if safety is an issue (e.g., “Look, I want to help you but you have to stop waving that knife around.”)

Assessment

- Paraphrasing is a good technique (e.g., “Let me see if I understand why you are angry.”, “You are saying you are upset because…”).
- Deflection is where you interrupt the person if they are escalating and allows you to take control of the conversation (e.g., “I hear you, but, I can’t help you if you are yelling at me.” “I got that, but I need you to calm down so I can listen to you”).

HANDOUT #5 – LOSS AND EAR MODELS INTEGRATION (cont.)

- Be explicit with your negotiations if the person is not calming down (e.g., "I want to believe I can help you. What would it take to calm you down so we can work on what's making you angry?").
- You will need to ask about medications and drug use to see if the rage is being fueled by other things.
- Be aware of scene management to make sure the person's anger isn't "for show" or being further ignited by the presence of others.

Resolution

- Summarize to try and take control of the conversation and state what you need (e.g., "So you are angry because…", "I need to make sure you are calm before we can proceed").
- Give the person reasonable options that will bring the encounter to a successful resolution. Don't be afraid to make it into a negotiation with questions like, "What can I do to help resolve this?"
- Call for officer backup before the situation gets out of control.
- Forecast (i.e., announce your actions before initiating them) what you will be doing/needing to resolve the crisis (e.g., "I'm going to call for help"; "I'm going to have to pat you down").
- Call mental health backup if treatment or hospitalization is warranted and communicate what you have learned about the person's issues, medications, and drug use.

Loss of Perspective – Feelings of anxiety, worry, or nervousness possibly escalating to feeling panicked. **The goal of this negotiation is to calm the person through empathy using active listening skills**.

This person may have exaggerated or irrational fears and have difficulty concentrating. However, he/she remains in reality, unlike someone who is psychotic. He/she may be speaking very rapidly and fearfully and may be difficult to understand. He/she may also be exhibiting physical symptoms of trembling or shaking and even chest pain or discomfort. A panic attack is a sudden surge of overwhelming fear that comes without warning. It is far more intense than the feeling of being 'stressed out' that most people experience. A panic attack is terrifying, largely because it feels 'crazy' and 'out of control' and in such cases, people will avoid certain objects or situations because they fear that these things will trigger another attack.

Engagement

- Tone of voice is critical in this circumstance. You don't want to use an excitable tone, as it could further incite their anxiety; use a calming and in control tone of voice.
- Provide your name and use his/hers often.
- Always assure the person that you are in a position to help. Reassure him/her that he/she is safe right now.
- Paraphrasing is a good technique (e.g., "Let me see if I understand why you are anxious").
- Use active listening skills, however, do not let him/her be repetitive of his/her story as this can escalate him/her.
- If your requests to have the person calm or slow down his/her speech are not effective, you can interrupt the compulsive speech pattern by using his/her name and asking specific concrete questions relevant to your assessment. Your goal is to interrupt the speech to break its pattern and bring it somewhat under control.

HANDOUT #5 – LOSS AND EAR MODELS INTEGRATION (cont.)

- Deflection is where you interrupt the person if he/she is escalating and take control of the conversation (e.g., "Listen, I am sorry to interrupt you but I am trying really hard to understand what's going on, can you please slow down for me?", "I need you to calm down so I can listen to you").

Assessment

- Ask about other similar incidents (e.g., "Has this happened to you before?").
- Ask about current treatment and medications he/she may be taking.
- Ask if there are others in the room that you could talk to if the situation is safe and use him/her as a second source of information.
- Ask if the person has recently taken any drugs or alcohol.
- Be explicit with your negotiations if the person is not calming down (e.g., "I want to believe I can help you, what would it take to calm you down so we can work on what's making you angry?").
- Summarize to try and take back control of the conversation and state what you need (e.g., "So you are anxious because…but I need to make sure you are calm before an officer can help you").
- Be aware of scene management to make sure the person's anxiety isn't being further ignited by the presence of others.

Resolution

- Summarize to try and take control of the encounter ("I know you are upset but…I need to make sure you are calm before we can proceed").
- Call for officer backup before the situation gets out of control.
- Forecast (i.e., announce your actions before initiating them) what you will be doing/needing to resolve the crisis (e.g., "I'm going to call for help"; "I'm going to have to pat you down").
- Call mental health backup if treatment or hospitalization is warranted and communicate what you have learned about the person's anxiety (especially physical manifestations), medications, and drug use.

Source: HCCIT (n.d.-c)

HANDOUT #6 – EXCITED DELIRIUM CHECKLIST

Excited Delirium Checklist

Excited delirium or excited delirium syndrome (ExDS) is only one form of potential sudden death that law enforcement officers may encounter. It is considered causal in about 25% of sudden non-firearm ARD (arrest-related-death) cases and present in about 75%.[1] Excited delirium signs are seen in about 4% of violent arrests.[2]

Other potential causes of unexpected arrest-related deaths (ARDs) include, but are not limited to: SUDEP[3, 4] (sudden unexpected death in epilepsy), sickle cell exertional sudden death,[5] various cardiomyopathies,[6] coronary artery disease, drug induced arrhythmias (including those caused by alcohol[7, 8] and marijuana[9-12]), and psychiatric arrhythmias (whether due to schizophrenia[13] or medications[14]).

Present?	Criterion
911 Call – Emergency Contact for Assistance	
	1. Critical call phrases include, "He just freaked out," "just snapped," "flipped out," or a person is "running around naked."[15]
Law Enforcement	
	2. Agitation, screaming, extreme fear response or panic[16-21]
	3. Violence, assault, or extreme aggression towards others[20, 22-25]
	4. Suspicion of impending death. Typical comments include, "I'm dying," "Please save me," "Help me," or "Don't kill me"[26] Note: a citizen in, say, a car accident may cry for help but that is not in the context of interfering with help.
	5. Incoherence or disorganized speech. Grunting or animal sounds[24, 27] Often described askeening or wailing.[25]
	6. Clothing removal inappropriate for ambient temperature or complete nudity.[2, 20, 21, 25, 28-30]
	7. Disorientation or hallucinations[20, 31-34]
	8. Mania, paranoia, anxiety, or avoidance behavior[16, 20, 35-38]
	9. Constant motion or hyperactivity[2, 16, 25, 34, 39-41]
	10. Does not respond to police presence.[2, 25]
	11. Attracted to bright lights or loud sounds.[25]
	12. Attempted self-cooling or hot to touch.[25] Reported behaviors include splashing water on own body, laying down in frigid ditch water, jumping into fountain or pool.
Capture, Control and Restraint of Subject	
	13. Extreme or "super human" strength[2, 21, 24, 37]
	14. High threshold of or imperviousness to pain[2, 21, 25, 27, 30] Possibly related to high levels of opioid receptors.[42]
	15. Extreme stamina[43,2, 27]
	16. Brief quiet period before collapse likely corresponding with respiratory arrest[16, 19, 27, 44]

HANDOUT #6 – EXCITED DELIRIUM CHECKLIST (cont.)

	17. Profuse sweating.[2, 25] Often reported as subject so dripping wet with sweat that control was more difficult. Being "hot to the touch" is generally sufficient alone to diagnose ED.[2] However, the majority of ED cases are ***not*** hot to the touch so do not demand this finding.[2]
Emergency Medical Services Contact and Intervention	
	18. Presenting cardiac rhythm of PEA (pulseless electrical activity) or asystole.[43, 45-49] Also documented by "No shock advised" with automated external defibrillator (AED)[47]
Emergency Department	
	19. High core body temperature.[17, 18, 21, 24, 35, 50, 51] Note: 95% of ExDS cases will have a core temperature of > 100.6° F but 5% will have normal temperatures.[49]
	20. Acidemia (acidic blood and typically referred to as acidosis in hospitals)[27, 52, 53]
	21. Rhabdomyolysis (if suspect is resuscitated).[17, 51, 54]
Law Enforcement/Forensic Investigator Death Investigation	
	22. History of chronic stimulant abuse or mental illness[16, 22, 31, 36, 41, 45, 55-60] History of violence or drug related arrests, mental health histories and treatments, and drug rehabilitation interventions, etc. Chronic stimulant abuse is found in 90% of ExDS cases but there is much overlap with mental illness.[49]
	23. Damage to shiny objects such as glass, mirrors and lights.[2, 25, 27] Reported behaviors may include attacking a squad car light bar or charging oncoming traffic at night. Occasionally generalized vandalism.
Pathologist – Medical Examiner Investigation	
	24. Minor injuries from fighting against restraints (e.g. handcuffs, hobbles).
	25. Positive Mash (central nervous system biomarkers) test for dopamine transporter assay, brain toxicology, and heat shock proteins.[17, 35, 36, 49, 61-65] Note: the presence of heat shock proteins is not universally accepted as diagnostic.[66]
	26. Positive brain and hair toxicology screen for chronic stimulant abuse.[61, 67-71] Post-incident drug levels may be low to negative.
	27. Myocardial remodeling.[72, 73]

Special thanks for help to: Charles Wetli, MD; Deborah Mash, PhD; Steven Karch, MD; Michael Graham, MD; Michael Brave, JD; and Jeffrey Ho, MD for contributions and edits.

HANDOUT #7 – MEDICAL CONDITIONS THAT MAY MIMIC INTOXICATION

MEDICAL CONDITION SYMPTOMOLOGY CHART

MAJOR INDICATORS	HYPOGLYCEMIA	HYPERACTIVITY DISORDER	SCHIZOPHRENIA	MULTIPLE SCLEROSIS	DEPRESSION	MANIC	SHOCK
HGN	NONE	NONE	NONE	PRESENT *	NONE	NONE	NONE
VERTICAL GAZE NYSTAGMUS	NONE	NONE	NONE	PRESENT *	NONE	NONE	NONE
LACK OF CON-VERGENCE	NONE	NONE	NONE	PRESENT *	NONE	NONE	NONE
PUPIL SIZE	NORMAL	NORMAL	DILATED	NORMAL	NORMAL	DILATED	NORMAL to DILATED
REACTION TO LIGHT	NORMAL/SLOW	NORMAL	NORMAL	NORMAL	NORMAL	SLOW	NORMAL to SLUGGISH
PULSE RATE	UP	UP	UP	NORMAL	DOWN (UP*)	UP	UP
BLOOD PRESSURE	UP	UP	UP	NORMAL	DOWN	UP	DOWN
BODY TEMPER-ATURE	DOWN	NORMAL	NORMAL	NORMAL	NORMAL	UP	DOWN
MUSCLE TONE	FLACCID	RIGID	RIGID	NORMAL	FLACCID	NORMAL	NORMAL
GENERAL INDICATORS	UNCOORDINATED DISORIENTED SLUGGISH THICK, SLURRED SPEECH DRUNK-LIKE BEHAVIOR DROWSINESS DROOPY EYES FUMBLING GAIT ATAXIA TREMBLING EXCESSIVE SWEATING UNEQUAL PUPIL SIZE MOODINESS HUNGER	RESTLESSNESS EXCITED TALKATIVE ANXIETY GRINDING TEETH (BRUXISM) LOSS OF APPETITE INSOMNIA INCREASED ALERTNESS IRRITABILITY	DAZED APPEARANCE VIVID SENSATIONS HALLUCINATIONS PARANOIA VOCAL HALLUCINATIONS DELUSIONS INCOHERENT OR IRRELEVANT SPEECH	SLURRED SPEECH GAIT ATAXIA BLANK STARE FUMBLING DISORIENTED VERTIGO TREMORS MUSCLE WEAKNESS ABNORMAL PUPIL RESPONSES	DROWSINESS DEPRESSED REFLEXES FEELINGS OF MALAISE SUICIDAL THOUGHTS DECREASED APPETITE AGITATION IMPAIRED CONCENTRATION	EUPHORIC IRRITABILITY HYPERACTIVITY RAPID SPEECH INSOMNIA ENERGETIC DELUSIONS HALLUCINATIONS DISORIENTED	ANXIETY CONFUSION BLUISH LIPS/ FINGERNAILS DIZZINESS SWEATING SHALLOW BREATHING CHEST PAIN PALE, CLAMMY SKIN

HYPOGLYCEMIA (LOW BLOOD SUGAR) - NO HGN WILL USUALLY BE PRESENT, BUT THEY MAY HAVE PUPILLARY DILATION OR MENTAL ABNORMALITIES. THESE SUBJECTS WILL SHOW MENTAL DELAYS AND CONFUSION, DIAPHORESIS, AND SURVIVAL-BASED REACTIONS. THESE REACTIONS MAY INCLUDE AGGRESSION AND VIOLENCE AND THEY SHOULD BE TREATED WITH CAUTION.

MULTIPLE SCLEROSIS– HGN GENERALLY NOT PRESENT = HOWEVER, IN LATER STAGES OF THE DISEASE PROCESS SOME NYSTAGMUS NAY BE PRESENT. THESE INDIVIDUALS WILL NOT BE SAFE TO OPERATE A MOTOR VEHICLE AT THIS STAGE OF THEIR DISEASE AND IT IS HIGHLY UNLIKELY THAT AN OFFICER WILL ENCOUNTER THEM DRIVING AT THIS POINT DUE TO SIGNIFICANT PHYSICAL IMPAIRMENT FROM THE DISEASE.

DEPRESSION- PULSE MAY BE UP, BUT USUALLY WILL BE DOWN.

SHOCK- PUPILS MAY BE DILATED DUE TO LOW OXYGEN LEVELS, ESPECIALLY IN LATER STAGES OF SHOCK. IF ANY DOUBT EXISTS REGARDING THEIR SYMPTOMS, CALL EMS.

STROKE- INDIVIDUALS UNDERGOING STROKE MAY PRESENT WITH ONE-SIDED PARALYSIS, CONFUSION, DIFFICULTY SPEAKING, IMPAIRED BALANCE, OR BIZARRE BEHAVIOR. IF ANY DOUBT EXISTS REGARDING THEIR SYMPTOMS, CALL EMS.

HYPERGLYCEMIA (HIGH BLOOD SUGAR) - THESE INDIVIDUALS WILL USUALLY HAVE THREE SYMPTOMS. THESE ARE 1). EXCESSIVE THIRST, 2). EXCESSIVE HUNGER, AND 3). EXCESSIVE URINATION. THE FRUITY SMELL ON THEIR BREATH IS FROM KETOACIDOSIS, WHICH IS A STATE OF PROLONGED HIGH BLOOD SUGAR RESULTING IN HIGH ACID LEVELS IN THE BLOODSTREAM. THESE INDIVIDUALS WILL BE QUITE ILL AND NOT ABLE TO SAFELY OPERATE A MOTOR VEHICLE. THEY WILL BE HYPERVENTILATING, RESTLESS, VERY THIRSTY, FREQUENTLY NAUSEATED, AND UNCOORDINATED ON THEIR FEET. THIS FRUITY SMELL ON THEIR BREATH DOES NOT SMELL LIKE ALCOHOLIC BEVERAGES. IF IN ANY DOUBT, CALL EMS.

Provided by Idaho State Patrol DRE Instructor and Nurse Practitioner Lt. Robert Rausch

OHIO PEACE OFFICER TRAINING COMMISSION

HANDOUT #8 – BMV FORM REQUEST FOR EXAMINATION/RECERTIFICATION

OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

REQUEST FOR DRIVER LICENSE EXAMINATION OR RECERTIFICATION / REPORT OF VIOLATION OF A RESTRICTION OHIO REVISED CODE (R.C.) 4507.20, 4507.14

DRIVER

NAME (LAST)	FIRST	MI

ADDRESS (NUMBER & STREET)	CITY	STATE	COUNTY	ZIP CODE

DRIVER LICENSE #	CDL LICENSE #	STATE OF ISSUANCE IF NOT OHIO

VEHICLE

YEAR & MAKE OF VEHICLE	LICENSE PLATE #

DRIVER CONDITION

CHECK APPROPRIATE BLOCK(S) AND DESCRIBE EXISTING CONDITION.

☐ PHYSICAL _____ ☐ OPERATOR DRIVING EXAM _____
☐ MENTAL _____ ☐ COMMERCIAL DRIVING EXAM _____
☐ OTHER _____ ☐ VISION _____
☐ DRIVING IN VIOLATION OF A RESTRICTION, R.C. 4507.14 (THIS IS NOT A TRAFFIC OFFENSE)

LIST RESTRICTION VIOLATED

INCIDENT

DATE OF INCIDENT	CRASH #	DATE OF CRASH

REPORT OF INCIDENT / COMPLAINT

DATE DRIVER NOTIFIED OF THIS REQUEST

COMPLAINANT / OFFICER

NAME OF COMPLAINANT / OFFICER (LAST)	FIRST	MIDDLE	PHONE #

ADDRESS (NUMBER & STREET)	CITY	STATE	COUNTY	ZIP CODE

By my signature, I agree to be the official source of information for this re-examination report.

SIGNATURE	DATE
X	

(MUST BE REVIEWED AND SIGNED BY HEAD OF AGENCY)

SIGNATURE OF OFFICER
X

APPROVED BY

TITLE	DEPARTMENT

CITY	DATE SUBMITTED

CONTACT PHONE #

Individual should be advised this request is being submitted to:

OHIO BUREAU OF MOTOR VEHICLES
ATTN: DRIVER LICENSE SUSPENSIONS / SPECIAL CASE UNIT
P.O. BOX 16784
COLUMBUS, OH 43216-6784

(OSP-202.02)
BMV 2308 8/12 [760-0310]

RESTRICTED

HANDOUT #9 – AUTISM SYMBOLS

The following are commonly displayed symbols of autism:

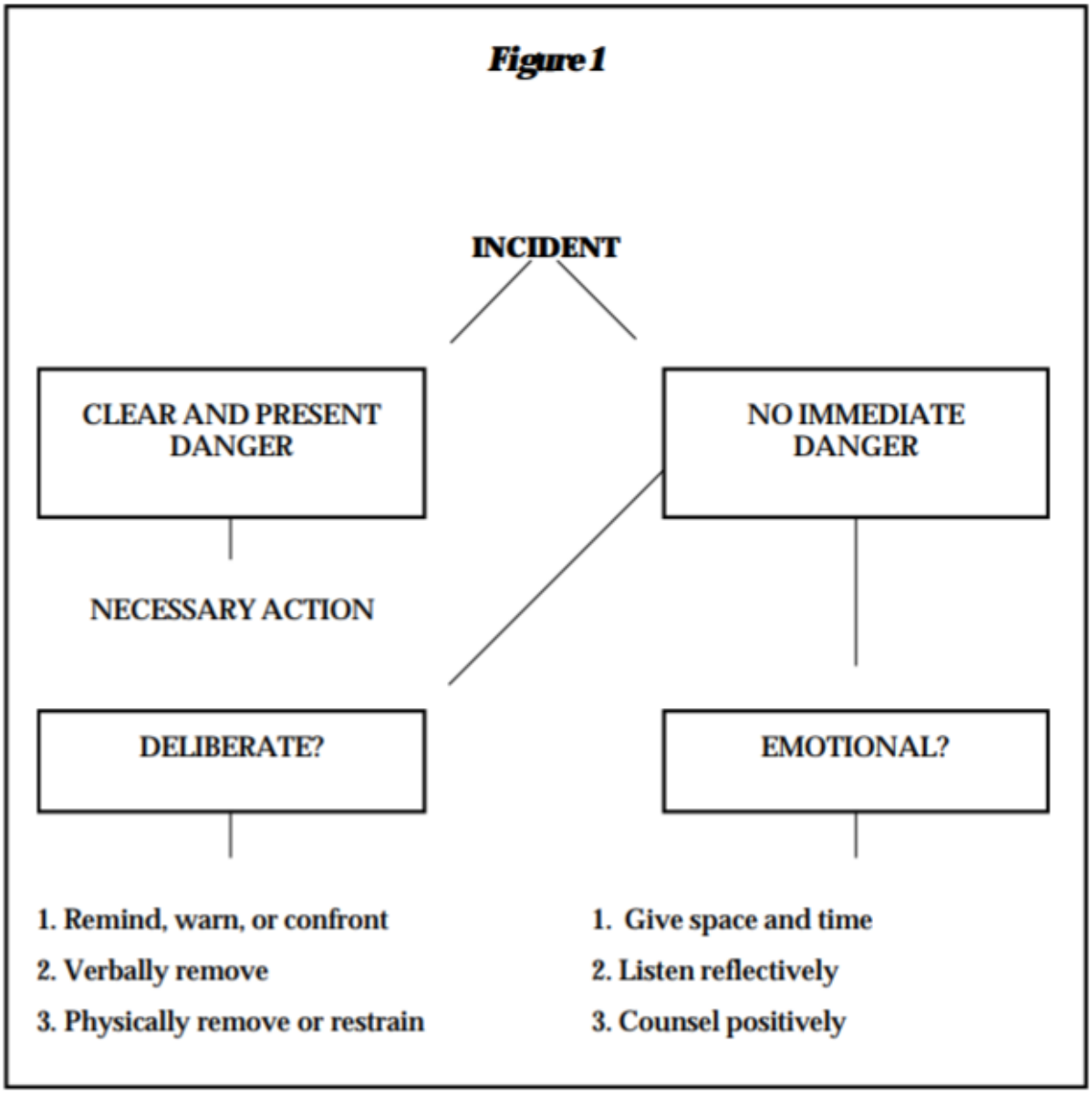
Autism Speaks (n.d.)

Vehicle Type: passenger vehicles, non-commercial trucks, recreational vehicles, house vehicles and non-commercial trailers

Ohio BMV (n.d.)

Autism Awareness Shop (n.d.)

HANDOUT #10 – RESPONSE TO JUVENILE AGGRESSION



Golden (2004)

HANDOUT #11 – APPLICATION FOR EMERGENCY ADMISSION

Ohio Department of Mental Health
Application for Emergency Admission
DMH-0025

In Accordance with Sections 5122.01 and 5122.10 ORC

TO: The Chief Clinical Officer of _____ _____
(Regional Psychiatric Hospital - RPH/Facility Name) (Date/Time)

The undersigned has reason to believe that: _____
(Name of Person to be Admitted)

1. Is a mentally ill person subject to hospitalization by court order under division B Section 5122.01 of the Revised Code, i.e., this person

- ☐ (1) Represents a substantial risk of physician harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
- ☐ (2) Represents a substantial risk of physicial harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physicial harm, or other evidence of present dangeriousness;
- ☐ (3) Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or
- ☐ (4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself.

2. Represents a substantial risk of physicial harm to self or others if allowed to remain at liberty pending examination.

Therefore, it is requested that said person be admitted to the above named facility.

STATEMENT OF BELIEF

Must be filled out by one of the following: a psychiatrist, licensed clinical psychologist, licensed physician, health or police officer, sheriff or deputy sheriff.

(Statement shall include the circumstances under which the individual was taken into custody and the reason for the person's belief that hospitalization is necessary. The statement shall also include a reference to efforts made to secure the individual's property at his residence if he was taken into custody there. Every reasonable and appropriate effort should be made to take this person into custody in the least conspicuous manner possible.)

Original - Medical Record, Copy - Suspense File
DMH-0025 (Rev. 01/11)

Page 1 of 2

APPLICATION FOR EMERGENCY ADMISSION
DMH-MedR-1030

HANDOUT #11 – APPLICATION FOR EMERGENCY ADMISSION (cont.)

APPLICATION FOR EMERGENCY ADMISSION
In Accordance with Section 5122.10 ORC

Name of Person to be Admitted

STATEMENT OF BELIEF (continued)

Signature

Title/Position/Badge or License No. | Place of Employment

STATEMENT OF OBSERVATION BY PSYCHIATRIST, LICENSED PHYSICIAN, OR LICENSED CLINICAL PSYCHOLOGIST, IF APPLICABLE

Place of Observation (e.g., community mental health center, general hospital, office, emergency facility)

Signature | Title

Approved ☐ Yes ☐ No | Signature of Chief Clinical Officer | Date/Time

Original - Medical Record, Copy - Suspense File
DMH-0025 (Rev. 01/11)

Page 2 of 2

APPLICATION FOR EMERGENCY ADMISSION
DMH-ModR-1030

HANDOUT #12 – COMMUNITY RESOURCES

A. National resources

1. Alzheimer's Association www.alz.org
2. Autism Speaks www.autismspeaks.org
3. American Foundation for Suicide Prevention www.afsp.org
4. National Alliance on Mental Illness (NAMI) www.nami.org
5. Veterans' Services
   (1) Veterans Crisis Line
      (a) Phone 1-800-273-8255 / Press 1
      (b) Chat online at www.veteranscrisisline.net/
      (c) Text to 838255
   (2) Military OneSource
      (a) Phone 1-800-342-9647
      (b) Website www.militaryonesource.mil/
   (3) National Resource Directory – www.NRD.gov
   (4) Nurse Triage Veterans Affairs – phone 1-888-838-6446
   (5) Visit service specific suicide prevention programs
      (a) Army https://phc.amedd.army.mil/topics/healthyliving/bh/Pages/SuicidePrevention.aspx
      (b) Navy http://www.public.navy.mil/bupers-npc/support/21st_Century_Sailor/suicide_prevention/Pages/SP%20Resources.aspx
      (c) Air Force http://www.airforcemedicine.af.mil/suicideprevention/
      (d) Marines http://www.mccsmcrd.com/mccs-usmc-directory/

HANDOUT #12 – COMMUNITY RESOURCES (cont.)

B. State resources

1. National Alliance on Mental Illness (NAMI) Ohio www.namiohio.org
2. Ohio Department of Developmental Disabilities (DODD) http://dodd.ohio.gov/Pages/default.aspx
3. Ohio Department of Mental Health and Addiction Services (MHAS) www.mha.ohio.gov
4. Ohio Suicide Prevention Foundation www.ohiospf.org
5. Ohio Suicide Prevention Resource Center https://www.sprc.org/states/ohio

C. Community resources

1. National Alliance on Mental Illness (NAMI) local affiliates
2. Mental Health America (MHA) local affiliates
3. County Alcohol Drug and Mental Health (ADAMH) boards
4. County Developmental Disability boards

WORKSHEET #1 – COMMAND AND CONTROL VIDEO

After watching the *"Mark the Street Preacher (Part 1)" (command and control)* video, answer the following questions within your small group.

1. Describe why command and control approaches may escalate a situation.

_____

_____

_____

2. Think about how the officers physically approached the man. What did the officers do to calm or escalate the citizen's behavior?

_____

_____

_____

3. Describe the dangers the officers faced over the course of the encounter?

_____

_____

_____

4. What could the officers have done differently?

_____

_____

_____

WORKSHEET #2 – DISTINGUISHING COMMUNICATION STYLES

Directions:
Using the abbreviations provided, identify the communication style in each statement as: Passive **(P)**, Passive-Aggressive **(PA)**, Aggressive **(AG)**, or Assertive **(AS)**

Statements that do not reflect the Assertive communication style should be rewritten to be Assertive.

_____1. "Shut up before I shut you up!"

_____2. "Thanks for that information, because it really didn't help me at all but, whatever. That's fine."

_____3. "Thank you for your cooperation."

_____4. "Would you, um, could you please, if you don't mind, I need you to, um, step outside, please."

_____5. "I need you to listen to me now."

_____6. "I think that maybe, just once, we could go with my suggestion because, I know you think they're never as good as yours, but, you know, maybe we could try it."

_____7. "This may just be me, but, um, and I don't know what you think, but I think, maybe, um, we should, you know, wait for backup. I mean, if you think we should wait for backup."

_____8. "You need to get your shit together so I can talk to you because I can't understand anything you are trying to say."

WORKSHEET #3 – SPECIAL POPULATIONS ENCOUNTERS GROUP ONE

Scenario One:

The manager of a fast food restaurant calls you to the scene because a young man has been occupying a booth for over two hours. When you arrive, a woman comes to you and pleads with you not to hurt her son, who she says has a mental illness. Then she yells over to the 34-year-old male, "Let's go! Get up and let's go!" The man is mumbling to himself and periodically yells out obscenities. The mother tells you that her son hears voices.

What do you do?

_____

_____

_____

You approach the man and say, "How are you today?" The mother yells even louder at the man, "Get your ass up and move!" This whole time, the man is staring, unblinking at you. Finally, he slowly gets to his feet and begins backpedaling towards the door of the restaurant keeping his gaze fixed on you.

Identify which Loss Model profile is seen here by describing the man's verbal and nonverbal behaviors that support your conclusion.

_____

_____

_____

What, if any, key assessment information has been provided to you by the mother?

_____

_____

_____

What characteristics of mental illness are you seeing?

_____

_____

_____

WORKSHEET #3 – SPECIAL POPULATIONS ENCOUNTERS GROUP ONE (cont.)

Is Mom's role escalating the situation? Why or why not?

Are there any safety issues?

What do you do?

If you believe a mental health evaluation is appropriate, write a statement of belief below.

WORKSHEET #3 – SPECIAL POPULATIONS ENCOUNTERS GROUP ONE (cont.)

Scenario Two:

One evening, you are dispatched to a city park. About 30 feet away, you see a 40-year-old male holding what appears to be a large stick. The man is yelling obscenities and swinging the stick around wildly at no one in particular.

What do you do?

_____

_____

_____

_____

As you approach, you notice that it is in fact a stick that is sharply pointed at each end. The man again yells and swings the stick at a citizen who is walking by. "Hey stop that," you call out, and the man stops, makes eye contact with you, and begins walking toward you while yelling. You command, "Drop the stick." The man does not let go of the stick. You back up and yell "Freeze." The man stops walking toward you but continues yelling.

Identify which Loss Model profile is seen here by describing the man's verbal and nonverbal behaviors that support your conclusion.

_____

_____

_____

Are there any safety issues?

_____

_____

What do you do?

_____

_____

WORKSHEET #4 – SPECIAL POPULATIONS ENCOUNTERS GROUP TWO

Scenario One:

While on patrol, you and your partner notice a frail, 54-year-old homeless woman pushing her belongings in a shopping cart along the street. After parking your vehicle, you approach her. You notice her shoes are untied and she is wearing a long winter overcoat, even though it is July. You ask her what her name is, but she keeps pushing the cart. Concerned that the cart was stolen from the nearby chain store, you ask her to stop pushing the cart. She stops and your partner asks, "Is this your cart, Ma'am?" The woman suddenly pulls a 13 inch screwdriver from an inside coat pocket and threatens your partner.

Identify which Loss Model profile is seen here by describing the woman's verbal and nonverbal behaviors that support your conclusion.

_____

_____

_____

Are there any safety issues?

_____

_____

What do you do?

_____

_____

_____

_____

Despite your best efforts to connect, she becomes agitated and threatens to harm you every time you physically move toward her. What do you do? If you believe a mental health evaluation is appropriate, write a statement of belief below.

_____

_____

_____

WORKSHEET #4 – SPECIAL POPULATIONS ENCOUNTERS GROUP TWO (cont.)

Scenario Two:

You receive a call and dispatch informs you that the man is very depressed. You meet John, a 33-year-old who has a 16-year-old son that he is raising on his own. Upon entering the home, you notice the house is a mess and John is unshaven and in a bathrobe. You ask John what is wrong and he tells you he is distressed about his business, a gun shop, going into bankruptcy. He has started drinking alcohol in the evenings to "unwind." John states that he has no friends and has been having heated arguments with his son about everything. John tells you he is tired of living with these problems and that things are not going to get any better. He states that everyone would be "better" if he were "not around" anymore.

Identify which Loss Model profile is seen here by describing the man's verbal and nonverbal behaviors that support your conclusion.

_____

_____

_____

Are there any safety issues?

_____

_____

What should you do?

_____

_____

_____

If, by using the LAST Model, you determine that there is a suicidal intent, what do you do next?

_____

_____

If, by using the LAST Model, you determine that there is a no suicidal intent, what do you do next?

_____

WORKSHEET #5 – LOSS MODEL PROFILES

Video #1: "Mark the Street Preacher (Part 2)"

Which Loss Model profile do you think is represented? Why?

_____

_____

_____

What do the officers do well?

_____

_____

_____

Is there anything that the officers could have done differently?

_____

_____

_____

Why does the officer keep repeating Mark's name?

_____

_____

Thinking back to the first video using command and control tactics with Mark, evaluate each resolution. Which was better for the officers? Which was better for Mark? Which one looked better for bystanders?

_____

_____

_____

_____

WORKSHEET #5 – LOSS MODEL PROFILES (cont.)

Video #2: "Dwayne (bridge)"

Which Loss Model profile do you think is represented? Why?

_____

_____

What did the officer do well?

_____

_____

_____

_____

Is there anything that the officer could have done differently?

_____

_____

_____

_____

What are some de-escalation techniques you might have tried when working with this individual?

_____

_____

_____

_____

WORKSHEET #5 – LOSS MODEL PROFILES (cont.)

Video #3: "Baseball Bat"

Which Loss Model profile do you think is represented? Why?

_____

_____

Are there any officer safety issues?

_____

_____

What did the officers do well?

_____

_____

_____

_____

Is there anything that the officers could have done differently?

_____

_____

_____

_____

What are some de-escalation techniques you might have tried when working with this individual?

_____

_____

_____

_____

WORKSHEET #5 – LOSS MODEL PROFILES (cont.)

Video #4: "Sally in the Kitchen"

Which Loss Model profile do you think is represented? Why?

Are there any officer safety issues?

What did the officer do well?

Is there anything that the officer could have done differently?

What are some de-escalation techniques you might have tried when working with this individual?

WORKSHEET #6 – DISPOSITION EXERCISE

Directions:
Determine the appropriate disposition for your assigned scenario and be prepared to discuss the rationale for your decision.

Scenario 1:

While patrolling in an isolated industrial area, you observe an elderly man run two stop signs. You signal for him to pull over and then approach the car. Despite it snowing outside, you notice the man is wearing only a thin pair of pajamas (i.e., no shoes or coat). He appears confused as to why he was pulled over even after you explain it to him twice that it was for running stop signs. He is not able to produce any identification, and grows increasingly agitated when you ask him where he lives, stating "I don't know. And it's none of your business, anyway!" He is unable to tell you where he is going. You tell him that you would like him to come with you so that you can find out where he lives and get him home safely, but he becomes argumentative and states that he is leaving. He turns in his seat as if to start his car, but is at an obvious loss on how to start it. You ask him again if he would like to come with you, to which he loudly yells in a frightened voice, "Who are you? What do you want? Leave me alone!"

Scenario 2:

You respond to a call of a distressed woman with a knife in a cemetery. When you arrive at the scene, you observe her sitting on a blanket, with pictures around her on the ground and a large kitchen knife in her hand, sobbing. You get her to respond to you and learn that her husband was killed three months ago, leaving her with two young school-aged children – this is her husband's grave. She is overwhelmed with grief and the responsibilities that she has to shoulder on her own – she has no family to speak of, and now her husband is dead. She is threatening suicide. You tell her that you have worked with other people who have also suffered the loss of a loved one and experienced profound sadness, but you were able to connect them with services that helped them regain their footing and be able to enjoy life again. You let her know there are services available to help her, too. You persuade her to put down the knife and, as you continue to talk, it appears as though she is listening more closely to what you are saying. You ask her if she would like to go talk to someone about helping her. While she appears somewhat ambivalent at first, she does not reject the idea. Her crying begins to slow and she appears to contemplate your words. You ask her again if she would like to talk with someone about helping her. She starts to nod her head.

WORKSHEET #6 – DISPOSITION EXERCISE (cont.)

Scenario 3:

You are on foot patrol at a street festival when you notice a young adult male pick up a pocket mirror off of a vendor's table and start to walk away. The young man is staring at the mirror as he walks. As you are approaching the young man, the vendor is yelling at him to stop. When you ask the young man what he is doing, he stares at you blankly. When you ask him what he's doing with the mirror, he holds it closer to his chest and starts to rock back and forth. When you ask him his name, he starts to aggressively rub and hit his head and makes low moaning noises. The vendor is still yelling for him to return the mirror or pay for it, and the young man is growing increasingly agitated. Within moments, a woman comes running over. She explains that she is the young man's mother, that he has autism, and that she had just gone over to another booth to make a purchase. She says in passing how hard it is to get anything done because she can't leave him at home alone and she can't turn her back for a minute. She quickly pays for the mirror and tries to sooth the young man who continues to rock back and forth and rub and hit his head, although less aggressively so.

Scenario 4:

You are called to the city pool on a report of an attempted drowning. When you arrive on the scene you discover that a mother attempted to drown her 3-year-old child by repeatedly pushing the child under the water and saying the child must die and "go to the angels." A lifeguard and the child's father, who was at the pool with his wife and child, were able to get the child away from the mother and start rescue breathing. The child is now being tended to by medics, while the woman is being held down by her husband and several others. The woman appears to be in a state of distress, sobbing and screaming that the child must die and "go to the angels."

WORKSHEET #1A – COMMAND AND CONTROL VIDEO – INSTRUCTOR KEY

After watching the *"Mark the Street Preacher (Part 1)" (command and control)* video, students will answer the following questions in their small group.

1. Describe why command and control approaches may escalate a situation.

   Answers will vary, but may include that the overreliance on commands increased Mark's paranoia and agitation, and his observable behaviors (e.g., pointing, waving Bible) escalated.

2. Think about how the officers physically approached the man. What did the officers do to calm or escalate the citizen's behavior?

   Answers will vary, but may include the officers physically crowded him; having an officer come up behind Mark distracted him and increased his agitation.

3. Describe the dangers the officers faced over the course of the encounter?

   Answers will vary, but may include the officers did not get voluntary compliance and quickly went hands on without knowing if Mark had a weapon on him and/or whether he would fight back.

4. What could the officers have done differently?

   Answers will vary, but may include the officers could have exercised patience and empathy; they could have asked more questions; they could have used less of a command presence.

WORKSHEET #2A – DISTINGUISHING COMMUNICATION STYLES – INSTRUCTOR KEY

Directions:
Using the abbreviations provided, identify the communication style in each statement as: Passive **(P)**, Passive-Aggressive **(PA)**, Aggressive **(AG)**, or Assertive **(AS)**

Statements that do not reflect the Assertive communication style should be rewritten to be Assertive.

AG 1. "Shut up before I shut you up!"

Sentence rewrites will vary. Sample: "I need you to stop talking. Now."

PA 2. "Thanks for that information, because it really didn't help me at all but, whatever. That's fine."

Sentence rewrites will vary. Sample: "That is more information than I need, but I appreciate your willingness to cooperate."

AS 3. "Thank you for your cooperation."

No change required.

P 4. "Would you, um, could you please, if you don't mind, I need you to, um, step outside, please."

Sentence rewrites will vary. Sample: "I need you to step outside, please."

AS 5. "I need you to listen to me now."

No change required.

PA 6. "I think that maybe, just once, we could go with my suggestion because, I know you think they're never as good as yours, but, you know, maybe we could try it."

Sentence rewrites will vary. Sample: "I think my suggestion is the better one here."

P 7. "This may just be me, but, um, and I don't know what you think, but I think, maybe, um, we should, you know, wait for backup. I mean, if you think we should wait for backup."

Sentence rewrites will vary. Sample: "We need to wait for backup."

AG 8. "You need to get your shit together so I can talk to you because I can't understand anything you are trying to say."

Sentence rewrites will vary. Sample: "I need you to take some deep breaths and try to talk to me calmly so I can understand what it is you're trying to tell me."

WORKSHEET #3A – SPECIAL POPULATIONS ENCOUNTERS GROUP ONE – INSTRUCTOR KEY

Scenario One:

The manager of a fast food restaurant calls you to the scene because a young man has been occupying a booth for over two hours. When you arrive, a woman comes to you and pleads with you not to hurt her son, who she says has a mental illness. Then she yells over to the 34-year-old male, "Let's Go! Get up and let's go!" The man is mumbling to himself and periodically yells out obscenities. The mother tells you that her son hears voices.

What do you do? *Students should discuss various engagement skills.*

You approach the man and say, "How are you today?" The mother yells even louder at the man, "Get your ass up and move!" This whole time, the man is staring, unblinking at you. Finally, he slowly gets to his feet and begins backpedaling towards the door of the restaurant keeping his gaze fixed on you.

Identify which Loss Model profile is seen by describing the man's verbal and nonverbal behaviors that support your conclusion.
Students should identify the profile and articulate why it was chosen. Verbal behaviors include basic non-responsiveness and unintelligible speech. Nonverbal behavior includes fixed gaze, maybe paranoia or untrusting of law enforcement, non-compliant, may not understand officer.

What, if any, key assessment information that has been provided to you by the mother?
The voices, worried about officers hurting her son, maybe the man has had past run-ins with law enforcement.

What characteristics of mental illness are you seeing? *Answers will vary.*

Is Mom's role escalating the situation? Why or why not? *Answers will vary.*

Are there any safety issues?
Other patrons in the restaurant, possibly the mother's escalation, unpredictability of man's behavior, touching the man's shoulder may escalate the situation. (Assess phase)

What do you do?
Answers will vary, but should include …

- *Learn the person's first name and use it. (Engage phase)*
- *Have the officer keep trying to get the man's attention by saying, "I'm sorry, I do not understand what you are saying. Do you hear voices? What are they saying?" Help the person deal with the voices by asking him if he can quiet them enough to talk to the officer. (Engage phase)*
- *Ask the mother more questions about "the voices." You need to distinguish between command voices with violent themes versus other types of less potentially violent voices. Ask the mother if her son has a mental illness? Has he been taking medications? Has this ever happened before? (Assess phase)*
- *If repeated attempts to get the man's attention fail, set firm limits. Tell him you are worried about his safety and you want to help him. (Resolve phase)*
- *Students should discuss if it is appropriate to call for a mental health assessment.*

WORKSHEET #3A – SPECIAL POPULATIONS ENCOUNTERS GROUP ONE – INSTRUCTOR KEY (cont.)

Scenario Two:

One evening, you are dispatched to a city park. About 30 feet away, you see a 40-year-old male holding what appears to be a large stick. The man is yelling obscenities and swinging the stick around wildly at no one in particular.

What do you do?
Answers will vary, but should include you should attempt to engage the man.

As you approach, you notice that it is in fact a stick that is sharply pointed at each end. The man again yells and swings the stick at a citizen who is walking by. "Hey stop that," you call out and the man stops, makes eye contact with you, and begins walking toward you while yelling. You command, "Drop the stick." The man does not let go of the stick. You back up and yell "Freeze." The man stops walking toward you but continues yelling.

Identify which Loss Model profile is seen by describing the man's verbal and nonverbal behaviors that support your conclusion.
Students should identify the profile and articulate why it was chosen. Verbal behaviors include aggressive verbal behavior, not talking directly to the officer. Nonverbal behaviors include that although he is aware of the officer's presence, he is not responding to the commands. The man stopped when asked to stop, but it is obvious that he is agitated about something.

Are there any safety issues?
Stick, other possible weapons, officer's safety, citizen safety. (Assess phase)

What do you do?
Answers will vary, but should include …
If the man is not presently lunging at you, back off while trying to make personal contact with him: Ask his name and/or where he is from. Ask if he has a friend or a family member nearby. (Engage phase)

If repeated attempts to get his attention fail, set firm limits on destructive or impulsive behavior. In a calm manner, say what will and what will not be tolerated (e.g., "We cannot allow you to hurt yourself or others"). Tell him that you are worried about his safety and your job is to make sure no one gets hurt. (Resolve phase)

WORKSHEET #4A – SPECIAL POPULATIONS ENCOUNTERS GROUP TWO – INSTRUCTOR KEY

Scenario One:

While on patrol, you and your partner notice a frail, 54-year-old homeless woman pushing her belongings in a shopping cart along the street. After parking your vehicle, you approach her. You notice her shoes are untied and she is wearing a long winter overcoat, even though it is July. You ask her what her name is, but she keeps pushing the cart. Concerned that the cart was stolen from the nearby chain store, you ask her to stop pushing the cart. She stops and your partner asks, "Is this your cart, Ma'am?" The woman suddenly pulls a 13 inch screwdriver from an inside coat pocket and threatens your partner.

Identify which Loss Model profile is seen by describing the woman's verbal and nonverbal behaviors that support your conclusion.
Students should identify the profile and articulate why it was chosen. Verbal behaviors are not present, as she has not spoken. Nonverbal behaviors include being aware of the officer's presence, responsive, stopped pushing the cart when asked to stop, inappropriate clothing choice for the season, more agitated as you approach.

Are there any safety issues?
Screwdriver, threatening the officer, unpredictability of the woman, possibility of other weapons being present, traffic. (Assess phase)

What do you do?
Answers will vary, but should include …
Back off to provide a safe distance between you and the woman. Tell her to put the screwdriver down. Set limits in a calm manner. Acknowledge that no one wants to see anyone get hurt. Keep trying to make a connection by asking what her name is. Ask if you can help her.

Despite your best efforts to connect, she becomes agitated and threatens to harm you every time you physically move toward her. What do you do? If you believe a mental health evaluation is appropriate, write a statement of belief below. *Answers will vary.*

WORKSHEET #4A – SPECIAL POPULATIONS ENCOUNTERS GROUP TWO – INSTRUCTOR KEY (cont.)

Scenario Two:

You receive a call and dispatch informs you that the man is very depressed. You meet John, a 33-year-old who has a 16-year-old son that he is raising on his own. Upon entering the home, you notice the house is a mess and John is unshaven and in a bathrobe. You ask John what is wrong and he tells you he is distressed about his business, a gun shop, going into bankruptcy. He has started drinking alcohol in the evenings to "unwind." John states that he has no friends and has been having heated arguments with his son about everything. John tells you he is tired of living with these problems and that things are not going to get any better. He states that everyone would be "better" if he were "not around" anymore.

Identify which Loss Model profile is seen here by describing the man's verbal and nonverbal behaviors that support your conclusion.
Students should identify the profile and articulate why it was chosen. Verbal behaviors include telling you that life is stressful and he is distressed. Nonverbal behaviors include a lack of personal care and hygiene. This may signal the depth of his depression.

Are there any safety issues?
Possibility of guns in the house, combined with alcohol use and depression; where is his son? (Assess phase)

What should you do?
Use the LAST Model to assess seriousness of risk:

- *Does he have a plan?*
- *A chosen method?*
- *A chosen time?*
- *Has he been depressed or attempted suicide before?*
- *Ask about the existence of firearms in the home.*
- *Ask about the whereabouts of his son.*
- *Is his judgment impaired now due to alcohol abuse?*

If, by using the LAST Model, you determine that there is a suicidal intent, what do you do next? *Answers will vary.*

If, by using the LAST Model, you determine that there is no suicidal intent, what do you do next? *Answers will vary.*

WORKSHEET #5A – LOSS MODEL PROFILES – INSTRUCTOR KEY

Video #1: "Mark the Street Preacher (Part 2)"

Which Loss Model profile do you think is represented? Why?

Loss of Reality; Observable behaviors include delusions, paranoia, confusion.

What do the officers do well?

Answers will vary, but should include the following:

The officers used non-commands early in the interaction and began to inquire about the man's medical state; when positioning themselves, they recognized Mark becoming more agitated, and adjusted their positions; they forecast their intentions and let Mark know what they were going to do next and why.

Is there anything that the officers could have done differently?

Answers will vary, but should include a discussion on the length of time that it took to resolve the situation and the public setting of the interaction.

Why does the officer keep repeating Mark's name?

To ground Mark in reality; it is a method that aids in controlling the subject.

Thinking back to the first video using command and control tactics with Mark, evaluate each resolution. Which was better for the officers? Which was better for Mark? Which one looked better for bystanders?

The second encounter was better for everyone. The officers practiced patience, empathy, and compassion. As a result, officer safety was improved (i.e., they avoided having to go hands-on with Mark). This resolution was also better for Mark, because the focus was on him receiving help as opposed to jail time. The overall approach and outcome in the second Mark video is one more likely to be well received by the public viewing the encounter.

WORKSHEET #5A – LOSS MODEL PROFILES – INSTRUCTOR KEY (cont.)

Video #2: "Dwayne (bridge)"

Which Loss Model profile do you think is represented? Why?

Loss of Hope; Observable behaviors include threatening suicide and being in a position to carry out threat.

What did the officer do well?

Answers will vary, but should include the following:

Within the first 20 seconds, the officer asked Dwayne if Dwayne was okay (showing empathy), "what's going on" (non-authoritative), and Dwayne's name (Engagement); the officer tried to negotiate early safety by asking Dwayne to swing his leg over; as the scenario progresses, the officer continually tries to indicate empathy by expressing concern over the subject's predicament.

Is there anything that the officer could have done differently?

When Dwayne first states what put him in a depressed state (i.e., served divorce papers), the officer's first response was "…so you came out to the bridge because you're planning to kill yourself?"

Generally those who want to commit suicide want the pain to stop and they are not thinking rationally. The officer's first response may have made the individual feel even worse. It would have been better for the officer to reflect back to the person, "So, that is terrible news you got today. It must really hurt, but I'm here to help and I want you to be safe."

What are some de-escalation techniques you might have tried when working with this individual?

Answers will vary, but should include those items listed under "what did the officer do well," if not previously mentioned.

***Ask the class:** In this scenario, the officer chose to use Dwayne's son, Freddie, as one way to keep him from jumping. Discuss the pros and cons of sticking with such a tactic.*

Pros: It can make him think about what he has to live for.
Cons: It can make him feel even guiltier for being a bad father; it could increase his feelings of worthlessness.

WORKSHEET #5A – LOSS MODEL PROFILES – INSTRUCTOR KEY (cont.)

Video #3: "Baseball Bat"

Which Loss Model profile do you think is represented? Why?

Loss of Control; Observable characteristics include anger, yelling, threatening with baseball bat.

Are there any officer safety issues?

The woman is holding a bat; the officers are in the woman's house, which the woman is familiar with but they are not; there are other potential weapons (e.g., knives) nearby (i.e., in the kitchen).

What did the officers do well?

Answers will vary, but should include that the officers separated the adolescent by asking him to stay outside; officers stayed vigilant until they knew what they were dealing with (i.e., guns were drawn as they entered the house); officers tried to negotiate having the woman put down the baseball bat.

Is there anything that the officers could have done differently?

Answers will vary, but should include that, rather than asking the woman several times to calm down, which only escalated the situation, they should have let her vent and tried to draw her away from the door.

What are some de-escalation techniques you might have tried when working with this individual?

Answers will vary, but should include those items listed under "what did the officers do well," if not previously mentioned. In addition, answers may include acknowledging the woman's anger ("Ma'am, I can see that you are very upset and I can see why based on what you told us, but I need you to remain calm and lower the bat so that we can solve this together").

WORKSHEET #5A – LOSS MODEL PROFILES – INSTRUCTOR KEY (cont.)

Video #4: "Sally in the Kitchen"

Which Loss Model profile do you think is represented? Why?

Loss of Perspective; Observable behaviors include anxiousness, high-energy behaviors (e.g., rushed language).

Note that some students may state the answer is Loss of Reality because Sally indicated that her brother was trying to poison her. Have the students compare the profile descriptions of both Loss Model profiles. Have them also compare Sally's observable behaviors to those of Mark in the previous video, and discuss which profile is more likely presenting here (i.e., Loss of Perspective).

Are there any officer safety issues?

Answers will vary, but should include getting Sally out of the kitchen sooner for safety reasons (i.e., Sally was in an agitated state, she is familiar with her house while the officer is not, there are knives in a kitchen).

What did the officer do well?

The officer introduced himself; he used "I" statements; he empathized; he stayed calm and focused; he used paraphrasing, mirroring, and reflection techniques.

Is there anything that the officer could have done differently?

Answers will vary, but may include getting Sally out of the kitchen sooner for safety reasons.

What are some de-escalation techniques you might have tried when working with this individual?

Answers will vary, but should include those items listed under "what did the officer do well," if not previously mentioned.

WORKSHEET #6A – DISPOSITION EXERCISE – INSTRUCTOR KEY

Directions:
Determine the appropriate disposition for your assigned scenario and be prepared to discuss the rationale for your decision.

Scenario 1:

While patrolling in an isolated industrial area, you observe an elderly man run two stop signs. You signal for him to pull over and then approach the car. Despite it snowing outside, you notice the man is wearing only a thin pair of pajamas (i.e., no shoes or coat). He appears confused as to why he was pulled over even after you explain it to him twice that it was for running stop signs. He is not able to produce any identification, and grows increasingly agitated when you ask him where he lives, stating "I don't know. And it's none of your business, anyway!" He is unable to tell you where he is going. You tell him that you would like him to come with you so that you can find out where he lives and get him home safely, but he becomes argumentative and states that he is leaving. He turns in his seat as if to start his car, but is at an obvious loss on how to start it. You ask him again if he would like to come with you, to which he loudly yells in a frightened voice, "Who are you? What do you want? Leave me alone!"

Appropriate disposition:
Emergency custody

Reasoning:
The offense committed by the man was minor. Given the weather conditions and his inappropriate dress, his obvious confusion, the absence of a family member, friend, or caregiver to assume responsibility for his wellbeing, and the man's unwillingness to be transported to a community mental health services provider or hospital, involuntary transport is appropriate.

WORKSHEET #6A – DISPOSITION EXERCISE – INSTRUCTOR KEY (cont.)

Scenario 2:

You respond to a call of a distressed woman with a knife in a cemetery. When you arrive at the scene, you observe her sitting on blanket, with pictures around her on the ground and a large kitchen knife in her hand, sobbing. You get her to respond to you and learn that her husband was killed three months ago, leaving her with two young school-aged children – this is her husband's grave. She is overwhelmed with grief and the responsibilities that she has to shoulder on her own – she has no family to speak of, and now her husband is dead. She is threatening suicide. You tell her that you have worked with other people who have also suffered a loss of a loved one and experienced profound sadness, but you were able to connect them with services that helped them regain their footing and be able to enjoy life again. You let her know there are services available to help her, too. You persuade her to put down the knife and, as you continue to talk, it appears as though she is listening more closely to what you are saying. You ask her if she would like to go talk to someone about helping her. While she appears somewhat ambivalent at first, she does not reject the idea. Her crying begins to slow and she appears to contemplate your words. You ask her again if she would like to talk with someone about helping her. She starts to nod her head.

Appropriate disposition:
Voluntary transport to a community mental health services provider or hospital.

Reasoning:
The woman has not committed any offense, so arrest is not appropriate. She does not have family members to whom she can be released and assume responsibility for her wellbeing, making de-escalation and referral a less optimal disposition. She has not rejected the idea of receiving treatment, so it is appropriate to encourage her to agree to voluntary transport for services.

Note that students may answer that involuntary transport is the appropriate disposition since the woman has threatened suicide. If this is the case, have the class discuss the rationale for choosing voluntary transport over involuntary transport, and compare the pros and cons of each in this situation.

WORKSHEET #6A – DISPOSITION EXERCISE – INSTRUCTOR KEY (cont.)

Scenario 3:

You are on foot patrol at a street festival when you notice a young adult male pick up a pocket mirror off of a vendor's table and start to walk away. The young man is staring at the mirror as he walks. As you are approaching the young man, the vendor is yelling at him to stop. When you ask the young man what he is doing, he stares at you blankly. When you ask him what he's doing with the mirror, he holds is closer to his chest and starts to rock back and forth. When you ask him his name, he starts to aggressively rub and hit his head and makes low moaning noises. The vendor is still yelling for him to return the mirror or pay for it, and the young man is growing increasingly agitated. Within moments, a woman comes running over. She explains that she is the young man's mother, that he has autism, and that she had just gone over to another booth to make a purchase. She says in passing how hard it is to get anything done because she can't leave him at home alone and she can't turn her back for a minute. She quickly pays for the mirror and tries to sooth the young man who continues to rock back and forth and rub and hit his head, although less aggressively so.

Appropriate disposition:
De-escalate and refer for services.

Reasoning:
No substantial risk of physical harm to the young man or others is indicated and his mother is on hand to care for him and assume responsibility for his wellbeing.

Scenario 4:

You are called to the city pool on a report of an attempted drowning. When you arrive on the scene you discover that a mother attempted to drown her 3-year-old child by repeatedly pushing the child under the water and saying the child must die and "go to the angels". A lifeguard and the child's father, who was at the pool with his wife and child, were able to get the child away from the mother and start rescue breathing. The child is now being tended to by medics, while the woman is being held down by her husband and several others. The woman appears to be in a state of distress, sobbing and screaming that the child must die and "go to the angels."

Appropriate disposition:
Arrest

Reasoning:
The woman has committed a felony of violence.

FACILITATOR GUIDE #1 – SPEAKER PRESENTATIONS

Requirements

Speakers:

- At a **minimum**, two outside speakers are to present during this course. (For purposes of time, it is recommended than no more than four speakers present.)

- At a **minimum**, the speakers are to include:

    - One mental health consumer (preferably one who has had an encounter with law enforcement) **and**
    - One family member of a mental health consumer (preferably one whose family experience includes a related encounter with law enforcement)

Approved referrals:

Because of the different stages of recovery and the fragileness of some consumers and their family members, **Commanders and their designees may only seek speaker referrals through one of the following agencies:**

- County alcohol, drug addiction mental health (ADM) board (http://mha.ohio.gov/Treatment/Where-to-Get-Help/Mental-Health-Provider-Search)
- National Alliance on Mental Health (NAMI)
    - Local NAMI affiliate (http://www.namiohio.org/mental_health_affiliates/mental_health_contacts)
    - NAMI Ohio (http://www.namiohio.org/contact_nami_ohio_mental_health)
    - NAMI "In Our Own Voice" (https://www.nami.org/Find-Support/NAMI-Programs/NAMI-In-Our-Own-Voice)
- Mental Health America (MHA) (http://www.mentalhealthamerica.net/find-affiliate)
- Ohio Department of Mental Health and Addiction Services (Ohio MHAS) (http://mha.ohio.gov/)

Commanders and their designees are **not** to solicit speakers outside of these avenues.

FACILITATOR GUIDE #1 – SPEAKER PRESENTATIONS (cont.)

Requirements (cont.)

In-person / video-conferencing:

If there is an articulated hardship that prevents the speaker from presenting to the class in person, the presentation may be given via video conferencing provided that:

- The means used permits real-time, two-way verbal dialogue between the class and the speaker **and**
- Approval has been received in advance from the Compliance Officer and noted as such on the SF146bas – Crisis Intervention Speaker Presentation Certification Sheet.

SF146bas form:

Commanders, instructors, and speakers *(whether speakers are participating in person or via video conferencing)* must complete and sign the SF146bas – Crisis Intervention Speaker Presentation Certification Sheet. (Speakers presenting via video conferencing can be sent a blank copy of SF146bas to complete and sign. Once returned, all related SF146bas paperwork should be bundled and numbered at the bottom of each page, with the total number of pages indicated.) All SF146bas pages must be presented to the Compliance Officer at the closing audit.

Presentation time:

At a ***minimum***, each speaker should be allotted 25 minutes to speak and field questions. When determining the maximum time for each speaker presentation, consider the total number of speakers scheduled and the length of time needed to cover the remaining material and activities included in the lesson plan.

Talking Points

□ ***For Mental Health Consumer:***

1. *Tell us about your illness and how/when you first learned about the diagnosis.*
2. *Describe what it is like living with the illness (e.g., how it affects you, medications you take and their side effects).*
3. *(If applicable) Describe the events that led to your law enforcement encounter and, if you were incarcerated, for how long and how this experience impacted you.*
4. *(If applicable) During the encounter and/or incarceration, did the officers do anything that calmed you or aggravated you? What constructive suggestions might you have for officers?*
5. *What does recovery mean to you? What do you hope for when you think about your future?*

□ ***For Mental Health Consumer Family Member:***

1. *Tell us about your family member's illness and when/how you first learned or suspected the diagnosis.*
2. *Describe what it is like living with a family member with the illness (e.g., how it affects family dynamics, responsibilities, and concerns that arise for your family member).*
3. *(If applicable) Describe the events that led to your family member's encounter with law enforcement and how you learned of it. If you were present during the encounter, what did you think the officer(s) did well/what could he/she/they have improved upon?*
4. *If your family member is an adult, what roles, if any, do you have in your family member's treatment? What are the challenges associated with these roles?*
5. *What do you think is important for officers to know when encountering a person with the same diagnosis as your family member?*

FACILITATOR GUIDE #1 – SPEAKER PRESENTATIONS (cont.)

Facilitator Responsibilities

1. Outside the presence of speakers, emphasize to students the importance of confidentiality, particularly since there is a possibility of the speakers and students living in the same or neighboring communities. Remind students that, although the speakers are voluntarily sharing their stories, their stories are being shared for purposes of law enforcement training only.
2. Introduce the speakers.
3. Explain to the class the rules regarding the question and answer format and time, as agreed upon in advance with the speakers.
4. Facilitate questions and answers.
5. Be conscientious of any insensitive or inflammatory remarks made by speakers or students and address them appropriately (e.g., use as a learning/discussion point).
6. Monitor time.
7. Thank the speakers for their participation.

FACILITATOR GUIDE #2 – COMMUNICATION (INSTRUCTOR) DEMONSTRATION

Objective:
Have students correctly identify the four communication styles.

Set-up:
Four desks and chairs or one table with four chairs at the front of the classroom; 2-3 pens or pencils at each seat.

Participants:
Ask four students to sit at the desks.

Directions:
Following the scripts below, ask each student for a pen. After each request, ask the class which communication style was demonstrated; ask the participating students how he/she felt by the way the request was communicated.

Scripts:

Aggressive Communication Style:

(Impatient look on face; standing close to and over the person; speaking in slightly louder voice) *"Give me your pen."* (Snap fingers and hold out hand) *"I don't have one and I need one."* (Flick fingers up) *"Come on. Give it to me."*

Passive Communication Style:

(Hunched shoulders; stand slightly farther away; look down frequently, speak softly, pick at fingernails) *"Could you, uh, could I please, um, would you mind if I borrowed your pen, please?"* (Smile nervously)

Passive Aggressive Communication Style:

(Shoulders somewhat slumped; head tilted to side; eye brows raised; point at pen on table) (Sigh) *"Seeing as you have your own pen today, and you still have three of mine that you've borrowed before and you haven't given back to me"* [(under breath) *"(even though you promised me you would)*], *if you don't mind, I'd like to borrow one of my pens since I don't have one. Okay? Please?"* (Tight-lipped smile)

Assertive Communication Style:

(Stand straight; look directly at other person; smile) *"I don't have a pen and need one for the assignment. I'd like to borrow one of your extra pens, if it's alright with you."* (Relaxed smile)

FACILITATOR GUIDE #3 – COMMUNICATION (STUDENT) DEMONSTRATION

Objective:
Have students correctly distinguish communication styles

Set-up:
No special set-up required

Participants:
Three student volunteers

Directions:
Assign each of the volunteers a pair of statements to present to the class. Have the student first present the non-Assertive statement and ask the class to identify the communication style (i.e., Aggressive, Passive-Aggressive, Passive); then have the student present the statement using an Assertive style. Discuss the differences in how the communication comes across to the receivers (i.e., those hearing the message) and the potential effect the communication style may have on how a receiver might respond.

Scripts:

Set #1
Passive-Aggressive Communication Style:

(Tight lips; raised eyebrows) *"Sure, Joe."* (Extend hand out, palm up) *"You take the lead on this one."* (Let hand drop to the side; sigh) (Under breath) *"I mean, why would I want to take the lead on it? Because, you know, I am the one who was sent to receive special training for these types of calls and the sergeant said he wants me to take the lead on them; but, whatever."*

Assertive Communication Style:

(Stand straight; make eye contact; looked relaxed, but confident) *"Actually Joe, I will take the lead on this one."*

Set #2:
Passive Communication Style:

(Look down and blink frequently; slightly softer voice that occasionally try to make louder) *"Sir, I, um, well, if you don't mind, you know, I need, um, can I please see your license, registration, and, if you have it and you don't mind, your proof of insurance, please?"*

Assertive Communication Style:

(Stand straight; make eye contact; looked relaxed, but confident) *"Sir, I will need to see your license, registration, and proof of insurance, please."*

FACILITATOR GUIDE #3 – COMMUNICATION (STUDENT) DEMONSTRATION (cont.)

Set #3:
Aggressive Communication Style:

(Speaking loudly, impatient look on face, hands out with palms up) *"Are you deaf or what?! I said stand over there."* (Point aggressively) *"Move it!"* (Roll eyes; shake head) *"Geesh!"* (Throw hands up in air) (Under breath) *"Idiot."*

Assertive Communication Style:

(Stand straight; make eye contact; looked relaxed, but confident) *"I don't know if you were able to hear me over the noise, but I need you to please stand over there."* (Point) *"Now. Thank you."* (Acknowledge compliance with a nod)

PRACTICE EXERCISE

1. Identify the characteristics of a crisis state.

2. List the causes of compromised coping capacity.

3. List the factors that coupled with mental illness produce the greatest increase in the potential for violence.

PRACTICE EXERCISE (cont.)

4. Describe the difference between traditional encounters and special populations encounters.

PRACTICE EXERCISE (cont.)

5. Describe eight techniques of active listening.

PRACTICE EXERCISE (cont.)

6. Use LEAPS and its five basic communication tools that assist in generating compliance.

PRACTICE EXERCISE (cont.)

7. Distinguish the EAR Model's three phases of a crisis encounter.

PRACTICE EXERCISE (cont.)

8. Identify the tactics and behaviors to avoid while engaging in de-escalation.

PRACTICE EXERCISE (cont.)

9. Use the Loss Model to recognize the nature of a person's crisis.

PRACTICE EXERCISE (cont.)

10. Describe the lethality assessment to determine a person's suicidal intent.

PRACTICE EXERCISE (cont.)

11. Determine when each of the typical dispositions for resolving a crisis intervention incident is appropriate.

PRACTICE EXERCISE (cont.)

12. Identify the practical and legal considerations when taking a person into emergency custody.

Submit to OPOTC

OPOTC BASIC TRAINING
LESSON PLAN MODIFICATION FORM

PLEASE USE THIS FORM TO INDICATE ANY PROPOSED CHANGES OR ERRORS WHICH REQUIRE MODIFICATION TO THE LESSON PLAN FOR THE COMMISSION-APPROVED PROGRAM IN WHICH YOU ARE TEACHING.

PROGRAM/CURRICULUM NAME:	UNIT NUMBER:	TOPIC NUMBER:
LESSON PLAN EFFECTIVE DATE:	PAGE NUMBER TO BE MODIFIED:	COPY OF MODIFIED PAGE ATTACHED: (CHECK ONE) YES NO

REASON(S) FOR MODIFICATION:

CONTENT ISSUE: _____

GRAMMATICAL ERROR: _____

LAW CHANGE: _____

TYPOGRAPHICAL ERROR: _____

OTHER (PLEASE SPECIFY): _____

RATIONALE FOR MODIFICATION (ATTACH DOCUMENTATION IF NEEDED):

_____ _____

Commander or Instructor Name *Date*

Contact Phone Number: _____

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