Criminal Justice

RESPONSE

To People with Mental Illness Arrested or Incarcerated in Tennessee

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Tennessee Department of Mental Health and Developmental Disabilities
2004

Instructor Guidelines

Instructor Guidelines

Purpose

This curriculum is designed for Tennessee criminal justice personnel to increase knowledge of mental illness and mental health treatment, and to improve skills in working with individuals with serious mental illness who are, or are at risk of, arrest or incarceration in Tennessee. Appropriate audiences include law enforcement officers (sheriff's department officers and police), correctional officers, court personnel, and probation and parole officers. The intent is to fulfill requirements for mental health crisis management training specified in Title 33, the Tennessee Mental Health Code. Portions of this curriculum may also be used for mental health training through the Tennessee Corrections Institute, or for Peace Officer Standards and Training (POST) sessions.

This curriculum is intended to provide general information and opportunities to improve skills. None of the material should be construed to override existing policies of organizations from which trainees come.

Training Methods

Complete instructional materials are supplied in the Response curriculum, including a digital slide presentation (available in overhead transparencies) and an instructor's manual with a lecture script, suggested discussion questions, motivational activities, educational exercises and handouts.

Digital slides or overhead transparencies: The training session will flow more naturally if the instructor bases the lecture on presentation slides rather than the script in the manual, but a lecture script is provided in the manual for reference.
Make sure:

- The appropriate equipment is available at the training site,
- The equipment is compatible with your material,
- The equipment is in working order; and
- You know how to use the equipment;
- Someone is available to help if something goes wrong.

Customize for the audience: The curriculum contains more material than can be comfortably presented in a one-day session. Sample agendas are included to guide instructors in customizing for the audience. Curriculum modules can be used consecutively or rearranged. Instructors are encouraged to choose modules or parts of modules that will cover topics of most interest to the audience using methods the audience is most likely to appreciate.

Emphasize participation: Because most trainees come to the session with professional experience, instructors will engage the attention of trainees more effectively by emphasizing discussions and Response exercises. Trainees who are encouraged to relate presented material to their own experience will be more likely to incorporate what they have learned into their work life after the session. Participants will feel respected and valued when instructors incorporate information from trainee questions and comments into their presentation of course information.

Use motivational incentives when appropriate: Optional motivational activities are

suggested with the goal of establishing a relaxed, enjoyable learning environment. Some instructors will be comfortable using motivators while others will not. *These activities are entirely optional.*

Some audiences will be more responsive to motivational activities than others. In general, the more formally educated the audience (court personnel, administrators, etc.) the less likely they are to appreciate motivational activities. Front line officers (law enforcement, corrections, probation/parole) are more likely to respond positively to the motivational activities and to engage in course information in a spirit of friendly competition.

Videos: Optional videos are suggested at several points in the curriculum. Videos can be valuable learning tools that make a lasting impression, but they must be chosen carefully to ensure that the desired message is communicated. Choose an appropriate segment of the video and ensure that the tape is set at the starting point of the chosen segment. Do not show more than 15 minutes of video at any one point in the presentation. After each segment facilitate trainee discussion of impressions and what they learned from the video.

Make sure:

- The videotape is set at the beginning of your chosen segment;
- You can identify when the segment ends and stop the tape;
- The equipment is available and in working order;
- You know how to use the equipment;
- Someone is available to help if something goes wrong.

Pre/post tests: Optional pre and post-tests are provided for each module. Use the tests that correspond with information you will include in the presentation. Pre-tests measure how much the audience knows before you begin to present, while post-tests measure how much was learned in the training. Do not include tests in the training packet. Pass them out directly before administration and collect them right after everyone is done.

Do not review responses to the pretest right after you administer it. If the audience wonders about items on the pretest they will pay more attention to your presentation…especially if they know there will be a post-test.

Post-tests can be administered at the end of each module, or at the end of the training session. Be sure you know which personnel have criteria that require post-test grades to be submitted to a certification authority. Unless required to do so, post-tests do not need to be graded. They can be valuable tools to help you evaluate your training skills.

Adjunct Presenters: If other instructors present part of the training, give them the Response Curriculum materials well ahead of time, including the slide presentation and clearly state the length of their presentation, the expected number of participants and what the audience will want to know. They may convey information over and above what is included in the curriculum if time allows.

Instructor Manual Format

Length of presentation: Briefer length is estimated based on presenting only general information or a portion of the information. Longer lengths are estimated for presenting the entire module.

List of Handouts/Supplies: The list of handouts and supplies should be checked *before each training* to ensure that necessary materials are available.

Instructor Notes: The instructor should pay particular attention to the *[Instructor notes]* in italic print and square brackets throughout the manual. Instructor notes provide recommendations regarding presentation procedures and use of handouts.

Objectives for each module are contained in the manual and the slide presentation. They can be used as a basis for a brief discussion of material the instructor will present and may be compared with what trainees hope to learn.

Discussion: The lecture script is contained in the discussion section and is interspersed with discussion questions, learning activities and handout instructions. To ensure a smooth training session the instructor should take time to become familiar with the information and rehearse procedures described in the discussion section. An instructor who knows the material will be able to use the slide presentation as a basis for lecturing and will know when to facilitate group discussion and learning activities and when to review handouts. When referring trainees to a handout, make sure to tell them the handout number and title and give them a moment to find the appropriate handout before discussing it.

Handouts: The instructor should provide a packet of handouts for each trainee. All handouts referred to in the discussion section are included at the end of each module. The instructor should choose handouts based on the length of the presentation and appropriateness of the information for the audience. *It is not necessary to use every handout*. Additional local information or program brochures may be included in the handout packet.

If you will be reviewing a handout in the session, make sure to refer to the number and title before you discuss each handout. If you are simply referring to a handout, give the number and title, then tell trainees you will not be reviewing the handout, that it has been supplied for their reference.

Training Preparation

Find your audience: The training session should be arranged with the individual who coordinates training for the personnel you wish to involve. Larger organizations may have a designated training coordinator while smaller organizations delegate training coordination to administrative staff. Establishing good working relationships with training coordinators will result in reaching your audience with the right information at the right time in the right place. Targeting particular organizations in a specified geographic area is usually more effective than sending out general announcements for training in a central location.

Notify your audience: Ask the training coordinator to recommend the most effective methods to recruit and enroll their personnel in the training. It may be best for the training coordinator to send out information and specify which training requirements it will fulfill. Some organizations have a staff bulletin board or email message system that is a reliable means to get information to potential participants.

Meet the needs of your audience:
Content: Most types of criminal justice personnel have training requirements that can be fulfilled by this curriculum. Find out what those requirements are and develop the agenda accordingly.

Location: Trainees are more likely to attend training sessions in a familiar location. If adequate training facilities are available, locate the session at the workplace of the target personnel. If the training must be held at another place, find out from the training coordinator where training sessions are usually held.

Date: Work with the training coordinator to select a date that will be convenient to the largest number of trainees. Make sure there are no conflicting meetings or training sessions on that day. Because law enforcement and correctional facilities run a 24/7 operation, training may have to be scheduled for two or more different dates and times to accommodate staff schedules.

Length: Work with the training coordinator to establish a session length that will accommodate both the informational and scheduling needs of the staff. Selected material may be covered in an all day workshop or in shorter sessions.

Attendance Roster

Training Title: _____ Date: ___/___/_____
Instructor(s): _____ City/County: _____

#	Name & Position	Organization & Address	Telephone	Email
		City **ZIP**		
		City **ZIP**		
		City **ZIP**		
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Suggested Agenda and Handout Options

Title 33 Mental Health Crisis Management Training

Full Day Schedule, Morning

Time	Module	Handouts	Optional
9:00	**Introduction**	Pre-Test 1-1 Criminalization of Mental Illness: The Problem 1-2 CJ Liaison Project Description 1-5 The Law: Title 33	Video: ABC News, Jailed, But Mentally Ill
9:30	**Mental Health and Mental Illness**	2-1 Mental Health and Mental Illness 2-2 Mental Illness: Facts and Figures 2-3 Myths and Facts of Mental Illness 2-4 Common Psychiatric Diagnoses 2-5 Mental Illness and Effective Communication 2-6 Response: Crisis Communication (Can be done in small group role play or whole group discussion) 2-17 Crossword Quiz	**Choose 2 of the following:** 2-7 Schizophrenia and Psychotic Disorders 2-8 Depression 2-9 Bipolar Disorder 2-10 Panic Attack 2-11 Post Traumatic Stress Disorder 2-12 Obsessive Compulsive Disorder 2-13a Personality Disorder/ Borderline 2-13b Personality Disorder/ Antisocial 2-14 Childhood Behavioral Disorders 2-15 Dementia & Alzheimer's Disease 2-16 Malingering
10:30	**Break**		
10:45	**Mental Health Services**	4-1 Tennessee Public Mental Health System 4-2 Criminal Justice/ Mental Health Liaison Services 4-11 Confidentiality and Privacy of Information Choose one: 4-12a Linking to Services, L 4-12b Linking to Services, C 4-12c Linking to Services, J 4-12d Linking to Services, P **L=Law Enforcement** **C=Corrections** **J=Judicial** **P=Probation/Parole**	4-3 Crisis Response Services L, C, P 4-4 Inpatient Treatment L, J, P 4-5 Medication Management L, C, J, P 4-6 Case Management L, C, J, P 4-7 Counseling & Psychotherapy, J, P 4-8 Psychosocial Rehabilitation, J, P 4-9 Peer Run Services L, J, P 4-10 Housing & Residential J, P
11:45	**Questions/Comments**		
12:00	**Lunch**		

Suggested Agenda and Handout Options

Title 33 Mental Health Crisis Management Training

Full Day Schedule, Afternoon

Time	Module	Handouts	Optional
1:00	**Co-Occurring Disorders**	3-1 Substance Abuse and Mental Illness 3-2 Signs and Symptoms: Mental Illness vs. Substance Abuse 3-5 Mental Retardation 3-6 Mental Retardation and Crime 3-7 Mental Retardation and Mental Illness 3-9 Other Disabilities and Mental Illness	3-3 Integrated Treatment of Mental Illness and Substance Abuse 3-4 Integrated Treatment Programs in Tennessee (Add brochures, etc. for local MI & SA treatment programs) 3-8 Resources: Mental Retardation/ Developmental Disability 3-10 Criminal Justice Procedures for Individuals with Disabilities 3-11 Resources: Other Disabilities 3-12 Response: Service Linkage for People with Co-Occurring Disorders
1:30	**Suicide Intervention**	5-1 Suicide, the Problem 5-2 Myths and Facts of Suicide 5-3 Suicide Signs and Symptoms 5-6 Intervention: Suicide Counseling 5-8 Response: Suicide Assessment and Intervention (choose scenarios most appropriate for audience or use situations from trainee anecdotes)	**Law Enforcement:** 5-4 Suicide Assessment **Corrections:** 5-5 Suicide Assessment 5-7 Suicide Prevention in Correctional Facilities
2:30	**Break**		
2:45	**Speaker, Videos or Closing Activity** **OR** CAMI videos: Community Encounters or	**Potential Speakers:** Consumer Family Member Service Provider **Videos:** CAMI IV: Community Encounters or CAMI V: In Custody **Closing Activity:** Post Test, OR MH/CJ Bingo	
3:45	**Questions/ Comments**	Evaluation	

Suggested Agenda and Handout Options

Title 33 Mental Health Crisis Management Training

Series of Brief Workshops

Workshop 1

Length	Modules	Handouts	Comments
30 minutes	**Introduction**	1-3 Criminalization of Mental Illness: The Problem 1-4 CJ Liaison Project Description 1-5 The Law: Title 33	
30 minutes	**Mental Health and Mental Illness**	2-1 Mental Health and Mental Illness 2-2 Mental Illness: Facts and Figures 2-3 Myths and Facts of Mental Illness 2-4 Common Psychiatric Diagnoses 2-5 Mental Illness and Effective Communication 2-6 Response: Crisis Communication Can be done in small group role play or whole group discussion.	Do not discuss specific disorders. Emphasize communication skills and group discussion of Response scenarios. If more time is available, insert CAMI videos followed by discussion; OR Invite consumer or family member for a brief (15 minute) presentation: * What it is like for them; * What hurts, what helps.

Workshop 2

Length	Modules	Handouts	Comments
1 hour	**Mental Health Services**	4-1 Tennessee Public Mental Health System 4-2 Criminal Justice/ Mental Health Liaison Services 4-11 Confidentiality and Privacy of Information Choose one: 4-12a Linking to Services, L 4-12b Linking to Services, C 4-12c Linking to Services, J 4-12d Linking to Services, P Invite a service provider for a brief (15 minute) presentation: o What they do; o Eligibility criteria; o Procedures for access; o Questions and comments. Encourage speaker to bring business cards, brochures, etc.	**Optional Handouts:** 4-3 Crisis Response Services L, C, P 4-4 Inpatient Treatment L, J, P 4-5 Medication Management L, C, J, P 4-6 Case Management L, C, J, P 4-7 Counseling & Psychotherapy, J, P 4-8 Psychosocial Rehabilitation, J, P 4-9 Peer Run Services L, J, P 4-10 Housing & Residential J, P L=Law Enforcement C=Corrections J=Judicial P=Probation/Parole

Suggested Agenda and Handout Options

Title 33 Mental Health Crisis Management Training

Series of Brief Workshops

Workshop 3

Length	Modules	Handouts	Comments
One hour	**Suicide Intervention**	5-1 Suicide, the Problem 5-2 Myths and Facts of Suicide 5-3 Suicide Signs and Symptoms 5-6 Intervention: Suicide Counseling **Emphasize Discussion** 5-8 Response: Suicide Assessment and Intervention Review scenarios in group discussion or small group role play. OR Ask Trainees for anecdotes from their own experience. Debrief situations with the group OR with the individual alone if there appear to be serious unresolved issues.	**Law Enforcement:** 5-4 Suicide Assessment **Corrections:** **5-5** Suicide Assessment 5-7 Suicide Prevention in Correctional Facilities

Workshop 4

Length	Modules	Handouts	Comments
1 hour	**Co-Occurring Disorders**	3-1 Substance Abuse and Mental Illness 3-2 Signs and Symptoms: Mental Illness vs. Substance Abuse 3-5 Mental Retardation 3-6 Mental Retardation and Crime 3-7 Mental Retardation and Mental Illness 3-9 Other Disabilities and Mental Illness Invite Speaker for 15 minute presentation: Consumer with Co-Occurring Disorder, or family member o What it is like for them o What hurts, what helps. OR Service Provider o What they do; o Eligibility criteria; o Procedures for access; o Questions and comments. Encourage speaker to bring business cards, brochures, etc.	Optional: 3-12 Response: Service Linkage for People with Co-Occurring Disorders

Suggested Agenda

Tennessee Corrections Institute

Length	Modules	Handouts	Comments
10 minutes	**Introduction**	Optional: Pre-test 1-1 Criminalization of Mental Illness: The Problem 1-2 CJ Liaison Project Description	
45 minutes	**Mental Health and Mental Illness**	2-1 Mental Health and Mental Illness 2-2 Mental Illness: Facts and Figures 2-3 Myths and Facts of Mental Illness 1-3 Common Psychiatric Diagnoses 1-4 Mental Illness and Effective Communication 1-5 Response: Crisis Communication Discuss scenarios with whole group. "What would you say/do?"	Do not discuss specific disorders. Emphasize communication skills and group discussion of Response scenarios. If more time is available, insert CAMI videos followed by discussion; OR Invite consumer or family member for a 15 minute presentation: * What it is like for them; * What hurts, what helps.
30 minutes	**Suicide Intervention**	5-1 Suicide, The Problem 5-2 Suicide, Myths and Facts 5-3 Suicide: Signs and Symptoms 5-5 Suicide Assessment: Corrections 5-6 Intervention: Suicide Counseling 5-7 Suicide Prevention in Correctional Facilities	Encourage trainees to discuss situations they have been involved with.
30 minutes	**Mental Health Services**	4-1 Tennessee Public Mental Health System 4-2 Criminal Justice/ Mental Health Liaison Services 4-5 Medication Management 4-11 Confidentiality and Privacy of Information 4-12b Linking to Services, C	**Optional Handouts:** 4-3 Crisis Response Services 4-6 Case Management **Optional:** If more time is available, invite a service provider for a brief (15 minute) presentation: * What they do; * Eligibility criteria; * Procedures for access; * Questions and comments. Encourage speaker to bring business cards, brochures, etc.
10 minutes	**Conclusion**	Optional: Post Test Training Evaluation	

Suggested Agenda

Peace Officer Standards and Training (POST)

Length	Modules	Handouts	Comments
30 minutes	**Introduction**	Pre-Test 1-1 Criminalization of Mental Illness: The Problem 1-2 CJ Liaison Project Description	
45 minutes	**Mental Health and Mental Illness**	2-1 Mental Health and Mental Illness 2-2 Mental Illness: Facts and Figures 2-3 Myths and Facts of Mental Illness 2-4 Common Psychiatric Diagnoses 2-5 Mental Illness and Effective Communication 2-6 Response: Crisis Communication Can be done in small group role play or whole group discussion.	Do not discuss specific disorders. Emphasize communication skills and group discussion of Response scenarios. If more time is available, insert CAMI videos followed by discussion; OR Invite consumer or family member for a brief (15 minute) presentation: * What it is like for them; * What hurts, what helps.
15 minutes	**Break**		
1 hour	**Suicide Intervention**	5-1 Suicide, the Problem 5-2 Myths and Facts of Suicide 5-3 Suicide Signs and Symptoms 5-4 Suicide Assessment 5-6 Intervention: Suicide Counseling **Emphasize Discussion** 5-8 Response: Suicide Assessment and Intervention Review scenarios in group discussion or small group role play; OR Ask Trainees for anecdotes from their own experience. Debrief situations as a group.	Be sensitive to the trauma officers may have suffered in working with suicide cases. If you have concerns, follow organizational procedures for referral and counseling.
45 minutes	**Mental Health Services**	4-1 Tennessee Public Mental Health System 4-2 Criminal Justice/ Mental Health Liaison Services 4-3 Crisis Response Services 4-4 Inpatient Treatment 4-5 Medication Management 4-6 Case Management 4-9 Peer Run Services 4-11 Confidentiality and Privacy of Information 4-12a Linking to Services	If more time is available Invite a service provider for a 15 minute presentation: * What they do; * Eligibility criteria; * Procedures for access; * Questions and comments. Encourage speaker to bring business cards, brochures, etc.
15 minutes	**Conclusion**	Post Test Training Evaluation	

Module 1: Introduction

Test

❑ Pre-Test Name: _____
❑ Post-Test Grade: ___/6 = _____% Date: ____/____/_____

True or False?

1. There is an equal percentage of people with mental illness in Tennessee county jails as in the general population.

   ❑ True ❑ False

2. Criminal Justice/Mental Health Liaisons provide the following services jail inmates with serious mental illness:
   a. Early identification and continuity of care;
   b. Release planning and follow-up;
   c. Consultation with court officials;
   d. Training and education.

   ❑ True ❑ False

3. Incarcerating individuals with mental illness in jail has only become an issue recently.

   ❑ True ❑ False

4. Class action lawsuits resulted in development of patients' rights protections in the 1940's.

   ❑ True ❑ False

5. Advent of psychotropic medication contributed to deinstitutionalization.

   ❑ True ❑ False

Optional, Title 33 Training:

6. Title 33, the Tennessee Mental Health code, stipulates that the county sheriff is responsible for transportation of individuals for emergency involuntary commitment.

   ❑ True ❑ False

Module 2: Mental Health and Mental Illness

Test

❑ Pre-Test Name: _____
❑ Post-Test Grade: ___/6 = _____% Date: ____/____/_____

True or False?

1. Temporary impairment of judgment is different from serious mental illness.

   ❑ True ❑ False

2. Positive symptoms of psychosis are excited, inflated delusions and hallucinations, while negative symptoms are depressing, horrifying delusions and hallucinations.

   ❑ True ❑ False

3. Mental illnesses are rare conditions.

   ❑ True ❑ False

Choose the one best answer:

4. Serious mental illness can be caused or triggered by:

   a. Genetic transmission;
   b. Prolonged, intense stress;
   c. Recreational drug use;
   d. All of the above;

5. Mental illness *usually* impairs:

   a. Thought, mood and behavior;
   b. Ability to comply with the law;
   c. Intelligence;
   d. All of the above.

6. If you suspect an individual has mental illness you should not:

   a. Speak more slowly and calmly;
   b. Stare consistently into the individual's eyes;
   c. Continually assess the situation for dangerousness;
   d. Redirect the individual with poor judgment to other choices.

Module 3: Co-Occurring Disorders

Test

❑ Pre-Test Name: _____
❑ Post-Test Grade: ___/7 = _____% Date: ____/____/_____

True or False?

1. It is uncommon for individuals with mental illnesses to abuse substances.

   ❑ True ❑ False

2. People with mental retardation are no more likely to commit a crime than the average person.

   ❑ True ❑ False

3. Some thyroid deficiencies have symptoms that are often mistaken for mental illness.

   ❑ True ❑ False

4. Screening and assessment for co-occurring disorders is completed when the individual first presents for treatment.

   ❑ True ❑ False

Choose the one best answer:

5. Factors in successful treatment of co-occurring mental illness and substance abuse include:

   a. Treatment should always be voluntary;
   b. Treatment should first address one condition, then the other;
   c. Probation officers should monitor the treatment process of probationers;
   d. All of the above;

6. Which is not true of individuals with mental retardation who are confronted by police?

   a. Feel overwhelmed by police presence;
   b. Almost always tell the truth;
   c. Are the last to leave the scene of the crime and the first to get caught;
   d. Have difficulty describing the facts or details of the offense;

7. Thorough physical exam of inmates with psychiatric symptoms at booking will:

   a. Help rule out other conditions;
   b. Facilitate effective treatment of psychiatric disorder;
   c. Save time and treatment costs;
   d. All of the above.

Module 4: Mental Health Services

Test

❑ Pre-Test Name: _____
❑ Post-Test Grade: ___/7 = _____% Date: ____/____/_____

True or False?

1. People with mental illness are most effectively treated in an intensive inpatient setting.

   ❑ True ❑ False

2. Most public mental health services in Tennessee are funded through TennCare.

   ❑ True ❑ False

3. Community mental health agencies are required to provide crisis response services to the public regardless of TennCare eligibility.

   ❑ True ❑ False

4. Changing medication from what an inmate was taking in the community is fine as long as the newly prescribed drug is in the same class as the previous one.

   ❑ True ❑ False

Choose the one best answer:

5. The following is *not* part of medical necessity criteria:

   a. Appropriate with regard to good medical practice;
   b. Provided in the most intensive setting possible;
   c. Consistent with symptoms, diagnosis and treatment of the illness;
   d. Not solely for the convenience of the enrollee.

6. TennCare mental health case managers mainly provide:

   a. Cognitive behavioral therapy;
   b. Linkage to services and supports;
   c. Transportation for emergency involuntary commitment;
   d. None of the above.

7. An 'Authorization to Release Information' is required to obtain treatment information from a mental health provider when:

   a. The inmate is newly booked into jail;
   b. The inmate is causing a disturbance in the jail;
   c. The inmate has made a suicide attempt;
   d. All of the above.

Module 5: Suicide Prevention

Test

❑ Pre-Test Name: _____
❑ Post-Test Grade: ___/7 = _____% Date: ____/____/_____

True or False?

1. Talking about suicide gives people the idea.

   ❑ True ❑ False

2. Inmates are at highest risk of suicide within the first 24 hours of booking.

   ❑ True ❑ False

3. Offenders who are convicted of serious felonies are more likely to become suicidal than those who are convicted of minor crimes.

   ❑ True ❑ False

4. Screening and assessment for co-occurring disorders is completed when the individual first presents for treatment.

   ❑ True ❑ False

Choose the one best answer:

5. The following is not a suicide risk factor for an inmate:

   a. Being African American;
   b. Fear of the legal process;
   c. Authoritarian environment;
   d. High status prior to incarceration.

6. An officer who observes the following should be concerned about an offender or inmate attempting suicide:

   a. Slowed movements, slowed verbal response, unkempt appearance;
   b. Evasive answer when asked if he or she was thinking of self-harm;
   c. Statements like, “I won’t be here long;”
   d. All of the above.

7. The most effective means of suicide prevention in jails is:

   a. Suicide cell with observation camera, checked at 15 minute intervals;
   b. Paper garments;
   c. Multi-bed cell in full view of security station;
   d. Restraint and seclusion.

Module 1: Introduction

Answer Key

True or False?

1. There is an equal percentage of people with mental illness in Tennessee county jails as in the general population.

   ❑ True ❑ **False**

2. Criminal Justice/Mental Health Liaisons provide the following services jail inmates with serious mental illness:
   a. Early identification and continuity of care;
   b. Release planning and follow-up;
   c. Consultation with court officials;
   d. Training and education.

   ❑ **True** ❑ False

3. Incarcerating individuals with mental illness in jail has only become an issue recently.

   ❑ True ❑ **False**

4. Class action lawsuits resulted in development of patients' rights protections in the 1940's.

   ❑ True ❑ **False**

5. Advent of psychotropic medication contributed to deinstitutionalization.

   ❑ **True** ❑ False

Optional, Title 33 Training:

6. Title 33, the Tennessee Mental Health code, stipulates that the county sheriff is responsible for transportation of individuals for emergency involuntary commitment.

   ❑ **True** ❑ False

Module 2: Mental Health and Mental Illness

Answer Key

True or False?

1. Temporary impairment of judgment is different from serious mental illness.

   ❑ **True** ❑ False

2. Positive symptoms of psychosis are excited, inflated delusions and hallucinations, while negative symptoms are depressing, horrifying delusions and hallucinations.

   ❑ True ❑ **False**

3. Mental illnesses are rare conditions.

   ❑ True ❑ **False**

Choose the one best answer:

4. Serious mental illness can be caused or triggered by:

   a. Genetic transmission;
   b. Prolonged, intense stress;
   c. Recreational drug use;
   d. **All of the above;**

5. Mental illness usually impairs:

   a. **Thought, mood and behavior;**
   b. Ability to comply with the law;
   c. Intelligence;
   d. All of the above.

6. If you suspect an individual has mental illness you should not:

   a. Speak more slowly and calmly;
   b. **Stare consistently into the individual's eyes;**
   c. Continually assess the situation for dangerousness;
   d. Redirect the individual with poor judgment to other choices.

Module 3: Co-Occurring Disorders

Answer Key

True or False?

1. It is uncommon for individuals with mental illnesses to abuse substances.

   ❑ True ❑ **False**

2. People with mental retardation are no more likely to commit a crime than the average person.

   ❑ **True** ❑ False

3. Some thyroid deficiencies have symptoms that are often mistaken for mental illness.

   ❑ **True** ❑ False

4. Screening and assessment for co-occurring disorders is completed when the individual first presents for treatment.

   ❑ True ❑ **False**

Choose the one best answer:

5. Factors in successful treatment of co-occurring mental illness and substance abuse include:

   a. Treatment should always be voluntary;
   b. Treatment should first address one condition, then the other;
   c. **Probation officers should monitor the treatment process of probationers;**
   d. All of the above;

6. Which is not true of individuals with mental retardation who are confronted by police?

   a. Feel overwhelmed by police presence;
   b. **Almost always tell the truth;**
   c. Are the last to leave the scene of the crime and the first to get caught;
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7. Thorough physical exam of inmates with psychiatric symptoms at booking will:

   a. Help rule out other conditions;
   b. Facilitate effective treatment of psychiatric disorder;
   c. Save time and treatment costs;
   d. **All of the above.**

Module 4: Mental Health Services

Answer Key

True or False?

1. People with mental illness are most effectively treated in an intensive inpatient setting.

   ❑ True ❑ **False**

2. Most public mental health services in Tennessee are funded through TennCare.

   ❑ **True** ❑ False

3. Community mental health agencies are required to provide crisis response services to the public regardless of TennCare eligibility.

   ❑ **True** ❑ False

4. Changing medication from what an inmate was taking in the community is fine as long as the newly prescribed drug is in the same class as the previous one.

   ❑ True ❑ **False**

Choose the one best answer:

5. The following is not part of medical necessity criteria:

   a. Appropriate with regard to good medical practice;
   b. **Provided in the most intensive setting possible;**
   c. Consistent with symptoms, diagnosis and treatment of the illness;
   d. Not solely for the convenience of the enrollee.

6. TennCare mental health case managers mainly provide:

   a. Cognitive behavioral therapy;
   b. **Linkage to services and supports;**
   c. Transportation for emergency involuntary commitment;
   d. None of the above.

7. An 'Authorization to Release Information' is required to obtain treatment information from a mental health provider when:

   a. **The inmate is newly booked into jail;**
   b. The inmate is causing a disturbance in the jail;
   c. The inmate has made a suicide attempt;
   d. All of the above.

Module 5: Suicide Prevention

Answer Key

True or False?

1. Talking about suicide gives people the idea.

   ❑ True ❑ **False**

2. Inmates are at highest risk of suicide within the first 24 hours of booking.

   ❑ **True** ❑ False

3. Offenders who are convicted of serious felonies are more likely to become suicidal than those who are convicted of minor crimes.

   ❑ True ❑ **False**

4. Screening and assessment for co-occurring disorders is completed when the individual first presents for treatment.

   ❑ True ❑ **False**

Choose the one best answer:

5. The following is not a suicide risk factor for an inmate:

   a. **Being African American;**
   b. Fear of the legal process;
   c. Authoritarian environment;
   d. High status prior to incarceration.

6. An officer who observes the following should be concerned about an offender or inmate attempting suicide:

   a. Slowed movements, slowed verbal response, unkempt appearance;
   b. Evasive answer when asked if he or she was thinking of self-harm;
   c. Statements like, “I won’t be here long;”
   d. **All of the above.**

7. The most effective means of suicide prevention in jails is:

   a. Suicide cell with observation camera, checked at 15 minute intervals;
   b. Paper garments;
   c. **Multi-bed cell in full view of security station;**
   d. Restraint and seclusion.

Training Evaluation

Training Title: _____ Date: ___/___/____
Instructor(s): _____ City/County: _____

	Very Poor	Poor	Average	Good	Excellent
1. **Content:** How well did the workshop cover the information you anticipated learning?	1	2	3	4	5
2. **Content:** How well did the workshop provide information that is useable in your current work environment?	1	2	3	4	5
3. **Effectiveness:** How well did the workshop actually enhance your attitudes and knowledge?	1	2	3	4	5
4. **Effectiveness:** How well did the workshop actually enhance your skill level?	1	2	3	4	5
5. **Quality:** How well did the instructor(s) present the content of the workshop?	1	2	3	4	5
6. **Quality:** How well did the instructor(s) respond to your questions?	1	2	3	4	5
7. **Efficiency:** How well did the instructor(s) make use of the time devoted to the workshop?	1	2	3	4	5
8. **Materials:** How well did the materials used enhance or facilitate the effectiveness of the workshop?	1	2	3	4	5
9. **Facilities:** How comfortable were the physical facilities?	1	2	3	4	5
10. **Overall:** Please provide an overall rating of this workshop.	1	2	3	4	5

11. **On what other mental health topics would you want further training?**

_____

12. **How could the training have been made more effective and/or efficient?**

_____

13. **Your profession: (check one)**

_ Corrections _ Judiciary _ Transporting Agent _ Family Member
_ Administrator _ Attorney _ Nurse/ Medical _ Consumer
_ Law Enforcement _ Mental Health _ Probation/parole _ Other _____

Thank you for completing the evaluation!

Module 1
Introduction

Module One

Introduction

Length of Presentation: 30 minutes

Handouts and Materials

1-1 Criminalization of Mental Illness: The Problem
1-V Optional Video: ABC News: Jailed, but Mentally Ill
1-2 Criminal Justice/Mental Health Liaison Project Description
1-3 Optional: Criminal Justice Task Force Report: Mental Health and Criminal Justice in Tennessee, June 2000
1-4 Optional: A Survey of County Jails in Tennessee: Four Years Later
1-5 Title 33 Special Provisions for Mental Health Transportation

[Note to Instructor: *The purpose of this module is to give participants confidence that this training will help them in their work. This module is essential to lay a good foundation for the rest of the training session, but do not spend more than the specified time.]*

Objectives

- To discuss reasons for training;
- To give an overview of the history of mental health treatment,
- To learn about the Criminal Justice/ Mental Health Liaison project;
- To create an enjoyable learning setting;
- To find out what participants want to learn.

DISCUSSION

Introduction

Who We Are: Instructor Introductions

- Name, background, education, work history, employer
- Roles and responsibilities
  - Duties;
  - Limitations.

Who Are You? Participant Introduction (omit if group is large)

- Name, position (rank if applicable),
- Length of time you have been on the job

Why Are We Doing This Training?

- Because people with mental illness are too often arrested and incarcerated due to untreated mental illness; and
- Because it's the law.

The Problem

[Refer to Handout 1-1: Criminalization of Mental Illness: The Problem]

- There are more than three times as many people with mental illness in the Tennessee county jails (18%) as in the general population (5%).
- Nationally almost a quarter (23.2%) of the jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of untreated mental illness.

Historical Background:

- 1700's to 1830's: Individuals with mental illness incarcerated in jails/ workhouses,
- Mid 1800's Dorothea Dix advocated for humane treatment of people with mental illness in asylums,
- 1950's peak of institutionalization, lives ruined, great expense to society.
- 1950's psychotropic medications became available to allow people with serious mental illness to function outside a hospital setting;
- 1960's community mental health centers established, only 25% of what was needed.
- 1970's consumer rights movement due to gross human rights violations in institutions (class action lawsuits resulting in patient/consumer rights),
- 1980's Community Support Services developed to help individuals with SPMI live and work in the community (case management and psychosocial rehabilitation that helps people with mental illness live independently through social skills training, and assistance with employment and housing);
- Federal budget tightening resulted in lack of affordable housing, homelessness.
- 1990's Managed care/ cost containment, outcome emphasis. and 'Decade of the Brain,' increased research into new medications and effectiveness of community-based treatment.
- 2000's Increased knowledge base of evidence-based treatment.
- Newer, more effective medications,
- Economic downturn increases barriers to community mental health services,
- Inadequate community services + barriers to rapid assessment + hospitalization too expensive = increased incarceration.

Terms commonly used to refer to individuals with mental illness are consumers, clients, patients, service recipients. Children are referred to as children with SED (serious emotional disturbance).

[Optional Video: NBC News: Jailed, But Mentally Ill]

Strategies and Solutions

Solution 1: Criminal Justice/Mental Health Liaison Project
[Refer to Handout 1-2: Criminal Justice/ Mental Health Liaison Project]

- Mission: To work collaboratively to improve the functioning of the criminal justice and mental health service delivery systems on behalf of individuals with mental illness who interact with the criminal justice system. The target population is adults with serious mental illness who are incarcerated, or at risk of incarceration.
- Staff: 16 liaisons covering 21 counties;
- CJ/MH liaison duties:
  - Decriminalize mental illness by fostering collaboration between criminal justice and mental health organizations;
  - Divert people with mental illness from arrest and incarceration to treatment and rehabilitation, where appropriate;
  - Assess service needs of offenders/inmates suspected of having mental illness;
  - Intervene when issues arise concerning inmates with mental illness;
  - Link jail inmates to family, friends and other supports where appropriate;
  - Link inmates with mental illness scheduled for release to community services and supports.

Solution 2: Consumer Advocacy
- Assistance to consumers who are incarcerated;
- Education of consumers regarding the criminal justice system.

Solution 3: System Changes;
[Optional: Refer to Handout 1-3: Criminal Justice Task Force Report; and Handout 1-4: A Survey of County Jails in Tennessee, Four Years Later]

- Change TennCare eligibility policy: suspension rather than termination upon incarceration, expedited enrollment upon release;
- Develop more appropriate modes of transportation;
- Facilitate use of best practices for criminal justice intervention with people who have mental illness;
- Facilitate use of best practices for prescription and maintenance of psychiatric medication for jail inmates;
- Facilitate better working relationships between crisis response services, law enforcement and jails;

Solution 4: Increase knowledge and skill of criminal justice personnel
- How to recognize mental illness;
- How to recognize malingering;
- How to respond to people whose behavior is disordered:
  - Confused;
  - Fearful;

    - Manipulative;
    - Aggressive;
    - Suicidal;
- How to get help for people with serious mental illness; and
    - Co-occurring disorders of substance abuse or mental retardation

Solution 5: Increase knowledge and skill of mental health personnel
- The criminal justice process;
    - Arrest;
    - Adjudication;
    - Incarceration;
    - Probation/parole;
- Suggested best practices for individuals at risk of arrest and incarceration;
- Continuity of care for individuals with mental illness who are incarcerated.

The Law

Tennessee Code Annotated, Title 33, the mental health code, requires the Tennessee Department of Mental Health and Developmental Disabilities to offer training on mental illness and crisis management to law enforcement officers who provide transportation for involuntary emergency commitment. Criminal justice/ mental health liaisons conduct training on a quarterly basis, also inviting police, correctional officers, probation officers and other criminal justice personnel.
[Refer to Handout 1-5: The Law, Title 33]

Response: What Do You Need to Know?
[Time allotment: 10 minutes]

[Instructor note: *Ask participants what they would like to gain from the training. Write responses on a marker board or flip chart.*

[If participants mention a topic that will not be covered, tell them so and the reasons why. Distribute handout or resource contact information on topic if available.]

References
Council of State Governments (2002) *The Consensus Project.* Washington, DC: Council of State Governments.

Diehl and Hiland, (2003) *Survey of County Jails in Tennessee: Four Years Later,* Nashville, TN: Tennessee Department of Mental Health and Developmental Disabilities.
Tennessee Department of Mental Health and Developmental Disabilities (June, 2000) Mental Health and Criminal Justice in Tennessee. Nashville: TDMHDD.

(2001) Tennessee Code Annotated: Title 33, Section 33-6-901, special provisions for mental health transportation.

Handout 1-1

Criminalization of Mental Illness: The Problem

There are more than three times as many people with mental illness in the Tennessee county jails (18%)[1] as in the general population (5%)[2] (Kessler et al, 1999). Nationally almost a quarter (23.2%) of the jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of untreated mental illness (Ditton, 1999)[3].

Reprinted from The Criminal Justice/Mental Health Consensus Project: (www.consensusproject.org. June 2002)

Of the 10 million people booked into U.S. jails in 1997, at least 700,000 had a serious mental illness; approximately three-quarters of those individuals had a co-occurring substance abuse disorder.[3] A study conducted in New York State found that men involved in the public mental health system over a five-year period were four times as likely to be incarcerated as men in the general population; for women, the ratio was six to one.[4]

Impact of the Problem on People and Systems

How elected officials and the public understand mental illness as it relates to the criminal justice system often is informed by newspaper and television headlines, which typically focus only on the most egregious manifestations of the problem: a screwdriver-wielding woman with mental illness shot dead by officers who subsequently tell of being frightened and confused themselves; a crime victim outraged that, before assaulting her, a person with a history of untreated mental illness bounced between community mental health centers, state hospitals, and the local jail.

Although these tragedies sometimes drive policymaking, they are not the cases involving mental illness most familiar to police officers, prosecutors, defense attorneys, judges, corrections administrators, parole and probation officers, and other criminal justice personnel. These criminal justice practitioners are all too familiar with the following scenarios:

- A police officer returns countless times to a house or street corner in response to a call for assistance involving the same person with a history of mental illness; each time, the officer is unable to link the person to treatment.

- Month after month, a prosecutor charges the same person with committing a different public nuisance crime, and, each time, the defendant with mental illness pleads guilty to time served.

- Jail and prison administrators watch their systems swell with these individuals, who spin through the revolving door of the institution. Corrections officials' job is to keep these inmates alive, even if that means isolating them in administrative segregation with no outside contact for weeks on end. When the release date comes around, freedom for many prisoners is only temporary, unless they are among the few for whom reentry has meant planning and linkage with community supports.

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[1]Diehl, S. & Hiland, E. (2003) *A Survey of County Jails in Tennessee: Four Years Later.* Nashville: Tennessee Department of Mental Health and Developmental Disabilities.

[2]Kessler, RC (1999) *A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness,* In Mental Health United States 1999, Manderscheid, RW and Henderson MJ eds., Rockville, MD, Center for Mental Health Services.

[3]Ditton, PM (1999) Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers. *Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.*

- A parole officer already struggling with an overwhelming caseload is assigned an individual with mental illness released from prison; the officer receives only limited support from the community-based mental health program. The parolee is rearrested and returned to prison when he commits a new crime - urinating on a street corner and making lewd gestures to frightened people passing by - displaying in public the symptoms of his untreated mental illness.

Each of these situations frustrates criminal justice officials; they know they are failing the person who suffers from mental illness and his or her loved ones. Encounters between people with mental illness and law enforcement sometimes end in violence, jeopardizing the safety of consumers and officers. Once incarcerated, people with mental illness become especially vulnerable to assault or other forms of intimidation by predatory inmates.[5] People with mental illness also tend to decompensate in prisons and jails - environments that exacerbate the symptoms of mental illness - and there they are at especial risk of harming themselves or others. Upon their return to the communities they left behind during their incarceration, they discover that their criminal records have, in many cases, made it even harder to obtain access to treatment.

Criminal justice officials may lose sight, however, of the lives these individuals lead. These are sons and daughters, fathers and mothers, who struggle daily to fend off symptoms of mental illness. Without adequate treatment, their disease may disable them significantly. Some experience delusions and may be convinced that strangers are planning to attack them. In other cases, depression immobilizes them; overcome with a sense of hopelessness, their physical strength deteriorates. Many of them are people who've spent years trying to mask torments or hallucinations with alcohol or any street drug they could scrape together enough money to buy and now are dependent on these substances to avoid withdrawal states and further decompensation. Often, their exhausted families have run out of the funds and emotional resources to take care of them.

Sometimes, when the criminal justice and mental health systems let someone with mental illness fall through the cracks, a stranger is harmed and justifiably motivated to demand accountability from the person with the mental illness and the public health system that failed. More often, when a person with a mental illness does assault someone, the victim is a family member, friend, or acquaintance.[6] Whether relatives or strangers, the victims are usually left to make sense of the baffling interface between the criminal justice system and the mental health system.[7]

The current situation not only exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system. Police departments dedicate thousands of hours each year transporting people with mental illness to hospitals and community mental health centers where staff often are unable to admit the individual or quickly return him to the streets. Judges, prosecutors, and defense attorneys race through backlogged dockets, disposing of most cases in minutes, but find that the symptoms and behaviors of the growing numbers of defendants with mental illness who appear in their courtrooms cannot be processed as quickly. On any given day, the Los Angeles County Jail holds as many as 3,300 individuals with mental illness - more than any state hospital or mental health institution in the United States.[8] Without adequate planning to transition inmates with mental illness back into the community, many will quickly return to jail or prison; recidivism rates for inmates with mental illness can reach over 70 percent in some jurisdictions.[9]

Every criminal justice professional would agree that the system has inherited a problem of enormous scope and complexity. Police, courts, and corrections officials feel they're boxed in. Resources are stretched to the limit: they're tight on money and even tighter on time. Under the circumstances, many have tried to find a way to serve people with mental illness more efficiently. But with limited options and resources, especially in rural areas, many criminal justice practitioners are frustrated because they know what they're doing isn't enough.

Origins of the Problem
Understanding why this problem has become so acute in recent years requires some familiarity with the dramatic shifts in mental health and criminal justice policy over the course of recent decades.

Few institutions have attempted so complete a change over the previous 35 years as has the nation's public mental health system. Once based exclusively on institutional care and isolation, the system has shifted its emphasis almost entirely to the provision of community-based support for individuals with mental illness. In 1955, state mental hospital populations peaked at a combined 559,000 people; in 1999 this number totaled fewer than 80,000.[10] There are many reasons for this change; fiscal reality, political realignment, philosophical shifts, and medical advances, in no particular order, have all played a part. These forces and others have converged to create a reality that few could have envisioned when the Community Mental Health Centers Act was signed into law in 1964.[11]

For many clients who utilize this system, successful community integration has indeed been achieved. Reliable data on the success of community mental health are difficult to find, but anecdotal experience shows that many people with active or past diagnoses of mental illness live and work "normally" in communities across the country. Their very success in achieving recovery helps them to mix unremarkably with their families, neighbors, and coworkers.

The mental health system today has powerful and effective medications and rehabilitation models with which to work. The professionals in the system know much about how to meet the needs of the people it is meant to serve. The problem comes, however, in the ability of the system's intended clientele to access its services and, often, in the system's ability to make these services accessible. The existing mental health system bypasses, overlooks, or turns away far too many potential clients. Many people the system might serve are too disabled, fearful, or deluded to make and keep appointments at mental health centers. Others simply never make contact and are camped under highway overpasses, huddled on heating grates, or shuffling with grocery carts on city streets.

The lack of affordable, practicable housing options for individuals with mental illness compounds the difficulty of providing successful treatment. Without housing that is integrated with mental health, substance abuse, employment, and other services, many people with mental illness end up homeless, disconnected from community supports, and thus more likely to decompensate and become involved with the criminal justice system. Most studies estimate that at least 20 to 25 percent of the single adult homeless population suffers from some severe and persistent mental illness.[12]

It is against this backdrop that officials in the criminal justice system have in recent years encountered people with mental illness with increasing frequency. Because of sensational news headlines or other sources that stigmatize mental illness, some criminal justice professionals may be prone to making the incorrect assumption - which most of the public makes - that mental illness by definition incorporates violent behavior.[13] They may respond to situations on the street, in a courtroom, or at a parole board hearing on the basis of common but erroneous perceptions. In such instances, police, judges, and releasing authorities may be especially wary about releasing people with mental illness into the community.

Violence and Mental Illness
Popular beliefs about violence and mental illness do not jibe with reality. The results of several recent, large-scale research projects conclude that only a weak statistical association between mental disorder and violence exists.[14] Serious violence by people with major mental disorders appears concentrated in a small fraction of the total number, and especially among those who use alcohol and other drugs and those without access to effective services.[15] Indeed, the vast majority of people with mental illness are not violent; they are more likely to be victims of crime than they are likely to harm others.[16]

Compounding the problems stemming from the stigma associated with mental illness, changes to criminal justice policies during the course of the last two decades have prolonged the involvement of people with mental illness in the criminal justice system. For example, in response to community or government leaders' demands to increase quality of life and to reduce crime and fear of crime, many police departments have instituted “zero tolerance” policies, arresting people committing offenses such as loitering, urinating in public, and disturbing the peace.[17] Many individuals netted as a result of these tactics were people demonstrating in public the symptoms of untreated mental illness. The majority of these people also have a co-occurring substance abuse problem. As legislatures have increased the length of prison sentences (and frequently made them mandatory) for the possession or sale of some illegal substances, growing numbers of people with mental illness have been incarcerated - and for longer periods of time.

Already overcrowded and overburdened, prisons and jails typically are without the resources to ensure the availability of effective mental health treatment and appropriate medications. In these cases, a person with mental illness is likely to decompensate, exacerbating the symptoms of his or her mental illness. As a result, the person may act out and fail to follow prison rules, which in turn extends the period of incarceration for the individual. For these reasons, people with mental illness tend to stay in jail or prison considerably longer than other general population inmates. For example, on Riker’s Island, New York City’s largest jail, the average stay for all inmates is 42 days, but it is 215 days for people with mental illness.[18]

Inmates with a mental illness who leave prison or jail are typically provided with just a short (two weeks or less) supply of medications and enough money to take a one-way trip on public transportation. Without housing, linkage to a community-based mental health treatment program, or other much-needed services, the person typically returns to the type of behavior that originally contributed to his or her incarceration.

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[1] R. C. Kessler, et al., “A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness,” In *Mental Health United States 1999,* edited by R.W. Manderscheid and M.J. Henderson, Rockville, MD, Center for Mental Health Services.

[2] Paula. M. Ditton, *Mental Health Treatment of Inmates and Probationers,* Bureau of Justice Statistics, U.S. Department of Justice, July 1999. The prevalence statistic for mental illness in U.S. jails and prisons was gathered through a combination of inmate self-reporting and past mental health treatment history. Inmates in the sample qualified as having a mental illness if they met one of the following two criteria: “They reported a current mental or emotional condition, or they reported an overnight stay in a mental hospital or treatment program.” To account for inmate underreporting of their mental health problems, admission to a mental hospital was included as a measure of mental illness. Ten percent of inmates reported a current mental condition and an additional six percent did not report a condition but had stayed overnight in a mental hospital or treatment program.

[3] Linda Teplin and Karen Abram, “Co-Occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy,” *American Psychologist* 46:10, 1036-45.

[4] Judith F. Cox, Pamela C. Morschauser, Steven Banks, James L. Stone, “A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems,” *Journal of Behavioral Health Services & Research* 28:2 May 2001, 177-87. This study used data from the mental health and criminal justice systems of 25 upstate New York counties. The study defines individuals who have been in the public mental health system as having been in a state-run psychiatric inpatient facility or a local psychiatric inpatient facility, or having received mental health services from a local, general hospital using Medicaid coverage. Incarceration was defined as having spent at least one night in jail during the five-year study period.

[5] See testimony of Reginald Wilkinson, then vice president, Association of State Correctional Administrators and director, Ohio Department of Rehabilitation and Correction, before the House Judiciary Committee, Subcommittee on Crime, Terrorism and Homeland Security, oversight hearing on “The Impact of the Mentally Ill on the Criminal Justice System,” September 21, 2000, available at: www.house.gov/judiciary/wilk0921.htm.

[6] Ditton, *Mental Health and Treatment*, 4. More than 60 percent of the victims of violent crimes committed by state prisoners with mental illness were known to the offenders.

[7] People with mental illness who themselves are the victims of a crime are a notable subset of this population. While especially in need of support services, they in particular suffer from insufficient coordination between criminal justice and mental health systems. Although some recommendations in this report address this population, the issue of victims with mental illness is generally beyond the scope of this report.

[8] *Sacramento Bee*, “Treatment Not Jail: A Plan to Rebuild Community Mental Health,” March 17, 1999.

[9] Lois A. Ventura, Charlene A. Cassel, Joseph E. Jacoby, Bu Huang, “Case Management and Recidivism of Mentally Ill Persons Released From Jail,” *Psychiatric Services* 49:10, Oct. 1998, 1330-37. This study

examined the effect of community case management on recidivism for jail detainees who have mental illness. The study followed releasees for 36 months. Within the 36 months, 188 of 261 subjects (72 percent) were rearrested.

[10] T.A. Kupers, *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, San Francisco, Jossey-Bass Publishers, 1999.

[11] The public, the media, and even some in the criminal justice and mental health system, suggest that there is a causal connection between the dramatic reduction in the number of people in mental health institutions and the extraordinary growth of the prison and jail population. Some present two straight-line graphs to illustrate the point, implying that the very same people who used to be in mental health institutions are now in prison or jail. In fact, no study has proven that there has been a transition of this population from one institution to another. Indeed, while the gross number of people with mental illness incarcerated has increased significantly in recent years, there is no evidence that the percentage of people in prison or jail who have a mental illness is any greater than it was 35 years ago when the *Community Mental Health Centers Act* was passed. See Henry J. Steadman, et al., "The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968-1978," *Journal of Criminal Law & Criminology*, 75:2, 1984, pp. 474-90.

[12] Paul Koegel, et al., "The Causes of Homelessness," in *Homelessness in America*, 1996, Oryx Press.However, according to the Federal Task Force on Homelessness and Severe Mental Illness, only approximately 5 percent of people with severe mental illness are homeless on a given day. Federal Task Force on Homelessness and Severe Mental Illness, 1992, *Outcasts On Main Street: A Report of the Federal Task Force on Homelessness and Severe Mental Illness*, Washington, D.C., GPO. For more information on homelessness and mental illness see A.D. Lezak and E. Edgar, *Preventing Homelessness Among People with Severe Mental Illness*, Rockville, MD, Center for Mental Health Services, 1999 and The National Resource Center on Homelessness and Mental Illness, *National Organizations Concerned with Mental Health, Housing, and Homelessness*, Delmar, NY, 2001, available at: www.nrchmi.com

[13] U.S. Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, Available at: www.surgeongeneral.gov.

[14] Ibid.

[15] H. Steadman, E. Mulvey, J. Monahan, P Robbins, P. Applebaum,, T. Grisso, L. Roth, and E. Silver, "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods. *Archives of General Psychiatry* 55, 1998, 393-401. See also K.T. Meuser, et. al., "Trauma and Post-Traumatic Stress Disorder in Severe Mental Illness," *Journal of Consulting and Clinical Psychology* 66:3, 1998, 493-99.

[16] Virginia Hiday, Marvin S. Swartz, Jeffery W. Swanson, Randy Borum, and H. Ryan Wagner, "Criminal Victimization of Persons with Severe Mental Illness," *Psychiatric Services* 50, 1998, pp. 62-68. This study tracked 331 involuntary mental health outpatients. The rate of nonviolent victimization for the study cohort (22.4 percent) was similar to that in the general population (22.1 percent). The rate of violent criminal victimization, however, was two and a half times greater than in the general population - 8.1 percent compared to 3.1 percent. In multivariate analysis, substance use and transient living conditions were strong predictors of criminal victimization.

[17] Ditton, *Mental Health and Treatment*, 4. According to the Bureau of Justice Statistics, over one-quarter of the inmates with mental illness in local jails were incarcerated for a public order offense.

[18] Fox Butterfield, "Prisons Replace Hospitals fro the Nation's Mentally Ill," *New York Times*, March 5, 1998, A1. Refers to testimony of Dr. Arthur Lynch, director of Mental Health Services for the NYC Health and Hospitals Corporation, before the Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse Service (April 22, 1998).

Handout 1-2

Criminal Justice/Mental Health Liaison Project

Overview

The CJ/MH Liaison Project is a community project that examines the issues affecting adults with serious mental illness who are involved in the criminal justice system. The purpose of the project is to facilitate communication/coordination between the community, the criminal justice and the mental health systems to achieve common goals; to support the establishment of services that would promote diversion activities; and provide liaison activities for adults with serious mental illness who are incarcerated or at risk of incarceration.

System Issues

The CJ/MH Liaison projects are charged with examining the issues affecting adults with serious mental illness who are involved in the criminal justice system or at risk of involvement and to facilitate communication and coordination of activities between the community, criminal justice and mental health systems. The success of the projects depends greatly on community support and the willingness of communities to work collaboratively to improve the functioning of the criminal justice and mental health service delivery systems.

The intent is for the CJ/MH liaison to provide services or facilitate the provision of services at all levels of the criminal justice process from arrest to probation.
These services may include:

Early Identification and Continuity of Care: daily/regular contact with arresting agency or jail to identify mental health consumers known to the mental health system and those who may be exhibiting symptoms and require further assessment. Assist jail personnel in establishing viable mental health care for the consumer.

Release Planning and Follow-up: develop and coordinate release planning with the consumer and mental health provider. Follow-up to assure service plan was executed.

Consultation with Court Officials: provide recommendations concerning the mental health needs of a consumer, assist with the development of a release or sentencing plan, make recommendations on when and what mental health assessments may be appropriate, work with probation/parole to establish an appropriate community mental health plan.

Training and Education: provide specific training opportunities for criminal justice personnel and mental health personnel and be available to provide or facilitate information and training activities when requested by either system.

Handout 1-3

Criminal Justice Task Force Report

Mental Health and Criminal Justice in Tennessee
Summary, June 2000

The Criminal Justice Task Force provided an opportunity for key stakeholders to examine issues involved when a person with mental illness interacts with the criminal justice system. Members of the Task Force worked together to promote a better understanding of the needs and rights of persons with mental illness when they interface with the Criminal Justice System.

The members of the Task Force recognize that each Tennessee community, urban and non-urban, is unique and has varied characteristics that need to be addressed. It was determined that the most effective manner in which to begin work on the problem was to facilitate the education of and communication between key statewide and community stakeholders.

The programs that the Task Force reviewed and that have been successfully implemented are those that have leaders who view mental illness as a community issue and who work together by devoting time, energy, and pooling of resources to develop services appropriate for each community.

The Task Force identified components that can be developed and implemented to meet the needs of local communities throughout the state. The components include facilitation, education and training, and community support.

- Facilitation is the process of developing and maintaining relationships between the criminal justice and mental health service systems to ensure they work together to achieve common goals. This process can be accomplished through a designated facilitator, sometimes referred to as a “boundary spanner”.
- Education and training are the necessary building blocks to develop working relationships. Education provides the foundation from which communication and understanding are built; training activities must be relevant and ongoing.
- Community support is the willingness of communities to accept responsibility and work collaboratively to improve the functioning of the criminal justice and mental health service delivery systems on behalf of individuals with mental illness who interact with the Tennessee criminal justice system.

The Criminal Justice Task Force hereby submits the following report with recommendations about the needs of offenders with mental illness in the Tennessee Criminal Justice System.

Task Force Process
During a series of monthly meetings, members of the Task Force were provided individual presentations about programs that have been implemented in Tennessee and other states. The members also shared with one another numerous articles, periodicals, and other written material about programs and models of programs that address the criminal justice system and mental health issues.

The members then reviewed the Tennessee system and how the criminal justice and mental health systems are currently interacting as well as the inadequacies of the system. The recommendations were developed from this extensive review of the mental health and criminal justice systems in Tennessee and other states.

Elements

Themes and elements emerged from the presentations that are characteristic of model programs.

I. Boundary Spanner

The first element is the need for each defined geographical area to have an individual who is responsible for coordinating and facilitating relationships between judicial, correctional and mental health providers. This was presented as an essential component for bringing the appropriate people together to develop a program to benefit the community and its needs for persons with mental illness involved in the criminal justice system. This individual, who is referred to as a "boundary spanner", is defined as someone who navigates between the different systems and agencies to achieve common goals.

II. Diversion Services

The second element is providing diversion services in communities. Many different types of diversion programs provide alternatives to individuals with mental illness from enduring unnecessary incarceration. Diversion services may be designed for both pre-booking and post-booking phases.

A. Pre-booking

The following pre-booking services are examples from the Task Force presentations and review of the literature.

1. Single Port of Entry

   A single port of entry provides an alternative for individuals who are suspected of having a mental health problem, but who have engaged in, or have propensity to engage in inappropriate or criminal behaviors as defined by state law and implemented by the local law enforcement agency. This type of diversion allows the law enforcement agency to immediately access (7 days a week, 24 hours a day) a mental health evaluation to determine the most appropriate treatment resource and avoid booking the individual to a jail. A single port of entry can divert an individual from the criminal justice system and, therefore, promote the decriminalization of mental illness.

2. Specialized Team Approach

   A specialized team is comprised of trained law enforcement agents who are able to address mental health issues in the community. The officers are trained to determine when diversion is appropriate and have the option to divert individuals for mental health evaluation and referral to community resources before booking.

B. Post-booking

Post-booking is offered once the individual is incarcerated. The following are examples of post-booking diversion services.

1. Mental Health Court
   The first mental health court was developed in Broward County, Florida, in an effort to reduce the number of people with mental illnesses in jail and reduce the amount of time they spent in jail. This service model was created by a task force that used a community-based approach to address a broad set of issues involving persons with mental illness in the justice system with non-violent misdemeanor offenses. The Broward County Mental Health Court model has gained national attention for its success and is being replicated in other states.

2. Pre-trial Services
   Pre-trial services are an alternative to bonding and incarceration in which individuals are released on their own recognizance and diverted to appropriate treatment services rather than held in jail. Pre-trial services can be delivered by case managers with diverse skills who obtain mental health evaluations, negotiate treatment plans, link with community resources, and consult with the courts for rapid release to community services, rather than incarcerate an individual who has serious mental illness.

III. Mental Health Services During Incarceration

The third element is the provision of mental health services during incarceration. A successful model must emphasize early identification, evaluation and stabilization of mental health symptoms and coordination of treatment services. Model jail programs demonstrate that case management is an effective means for implementing these activities. An individual with mental health skills and knowledge of criminal justice systems can also provide valuable training for jail personnel. As noted in one presentation, having this type of mental health worker available in the jail is a win-win situation for all parties involved.

The Task Force identified the following additional components as important for jail programs.

- Contracting with or employing a psychiatrist or physician with psychiatric expertise, a physician assistant with psychiatric expertise, or an advanced practice psychiatric nurse to perform assessments for medication and treatment needs.
- Written policies and standards that address suicide prevention.
- Separate holding areas or facilities for individuals with mental illness who are vulnerable and/or experiencing acute symptoms.
- Treatment programs for convicted individuals with substance abuse disorders or other co-occurring disorders.
- A process for quick identification of individuals needing forensic evaluations and expedited court orders to prevent delays and possible deterioration in mental status.

IV. Release Planning

The fourth element is linking offenders to mental health and community services on release from jail or prison. Strong evidence in the literature indicates that many offenders with mental illness continue to offend and return to jail because of lack of participation in community services on release. Release planning is the assessment and planning for services required to assist the individual with successful community living. Community resources that should be in place before release are adequate housing, mental health services, assertive case management, availability of medication, income or insurance to pay for medications and treatment, psychosocial services, and needed social supports and assistance.

Strong collaboration among the criminal justice system, mental health providers, probation and parole, and community services can reduce the revolving door syndrome and decrease the number of individuals with mental illnesses in jails.

Criminal Justice Task Force Recommendations

Mental Health Recommendations

- The Task Force recommends that the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) establish a priority statement recognizing that persons with serious mental illnesses who are involved in the criminal justice system have equal access to mental health services.
- The Task Force recommends that the Tennessee Mental Health Planning Council develop a position statement which promotes access to treatment for persons with serious mental illnesses who are involved in the criminal justice system.
- The Task Force recommends that TDMHDD seek funding for the development, implementation, and monitoring of pilot projects that can be replicated to meet the needs of local communities statewide. The pilot projects should include, but not be limited to, the following: Single Port of Entry, Boundary Spanners, Pre-trial and Post-trial Case Management services, and Mental Health Courts.
- The Task Force recommends that Crisis Response Services develop a policy requiring crisis responders to provide the same level of service to persons with mental illnesses who are involved with law enforcement or correctional personnel as it provides to all other persons who are experiencing mental health crises.
- The Task Force recommends that TDMHDD through office of Housing, Planning and Development work toward increasing appropriate housing options for persons with mental illnesses who have had involvement with the criminal justice system.

Criminal Justice Recommendations

- The Task Force recommends legislation to give an appropriate agency the authority to develop and enforce standards that would ensure that persons with serious mental illnesses as well as co-occurring disorders are provided care and treatment resources while incarcerated.

  The Task Force makes note that the Tennessee Corrections Institute is the only entity in the state that is responsible for certifying jails. If a jail is decertified, there are virtually no consequences or corrective actions that can be taken to improve the jail. Additionally, the standards do not adequately address mental health issues that should be specified as other chronic mental illnesses.

- The Task Force recommends that regardless of legislation, the Tennessee Correctional Institute in conjunction with the Division of Mental Health Services and the Department of Correction, develop and monitor standards that require documentation of release planning for person with serious mental illnesses or co-occurring disorders who are released or transferred from jails to the Department of Correction, probation and parole, or community based corrections. Release planning standards should include information to ensure continuity of care and treatment.
- The Task Force recommends that community correctional facilities use a standardized mental health assessment and screening tool, which includes

procedures for suicide assessment and prevention and provides appropriate housing for special needs detainees.

Training Recommendations

- The Task Force recommends that members from each of the following entities receive specialized multidisciplinary training:
  - Criminal Justice System as defined in this report.
  - Case management and mental health treatment providers.

The multidisciplinary training curriculum should encompass at a minimum the following basic areas:

- Basics of psychopharmacology,
- Mental Health crisis non-violent and de-escalation interventions,
- Symptom recognition and differentiation of mental illness and mental retardation,
- Judicial process,
- Substance abuse disorders,
- Confidentiality,
- Mental health resource identification, service eligibility standards, commitment standards, and mandatory outpatient treatment.

It is further recommended that the multidisciplinary training curriculum be provided as a part of the core training and reinforced through in-service training.

- The Task Force recommends that resources are made available to coordinate and approve the development and delivery of specialized training for the Tennessee Peace Officers Standards and Training (POST) commission and the Tennessee Correctional Institute (TCI).

- The Task Force recommends that community mental health agencies identify personnel who can receive specialized training and education on the criminal justice system.

System Recommendations

- The Task Force recommends that individuals receiving TennCare benefits who enter the criminal justice system be identified and not disenrolled from TennCare. A mechanism for suspending and then reinstating benefits upon release to the community should be implemented.

- The Task Force recommends that the Bureau of TennCare develop an expedited application process for eligible persons with serious mental illness who are incarcerated to ensure benefits may be accessed quickly upon release.

- The Task Force recommends that the Title 33 Commission recommendations be accepted and signed into law. The Commission was appointed by Governor Sundquist to conduct a thorough review of Title 33 and give recommendations for revision of the law. Many of the recommendations are pertinent to the issues and discussions of the Task Force. Recommendations include: a philosophy that promotes community based services for persons with mental illness and accountability to the public; a 24 –72 hour observation service for individuals with mental illness who are experiencing severe impairment; the permission to transport people for involuntary hospitalization by alternative transporting agents; a requirement that the Department of Mental Health and Developmental Disabilities set basic quality standards to people with mental illness.

Handout 1-4

A Survey of County Jails in Tennessee, Four Years Later

A Descriptive Study of Services to People with Mental Illness and Substance Abuse Problems, 2004

Executive Summary

There are more than three times as many people with mental illness in the Tennessee county jails (18%) as in the general population (5%) (Kessler et al, 1999). Nationally almost a quarter (23.2%) of the jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of untreated mental illness (Ditton, 1999). This study, sponsored by the Tennessee Mental Health Planning and Planning Council, examines the number of county jail inmates with serious mental illness and substance abuse issues, services provided in the jails and in the community, and training of correctional personnel that interact with mentally ill inmates. The purpose is to determine what services and supports exist and what can be done through training and coordination to make better use of those resources.

The 2002 "Survey of County Jails" questionnaire was modeled on a previous study sponsored by the TennCare Partners Roundtable. Questionnaires were mailed to individuals designated by the sheriff's with instructions to review the questions and collect information. Telephone interviews were conducted over a two-month period with 179 respondents including sheriff's, jail administrators, correctional medical personnel and others representing jail systems from all of the 95 counties in Tennessee.

At the time of the survey an estimated 2509 inmates were diagnosed with mental illness representing 17.8% of the total inmate population, a slight decrease from 1998 but higher than national rates of mental illness in the jail and prison populations. One fifth (22%) of the total inmate population received psychiatric medication, 2% demonstrated suicidal thoughts, and 55% were estimated to have serious substance abuse problems.

More than two-thirds of the county jails offered mental health assessment, pastoral counseling and psychiatric medications. However, less than one quarter of the jails offered substance abuse counseling even though more than half of the inmates were thought to have serious substance use disorders.

The most common jail diversion and service linkage programs offered in the community included mobile crisis response teams, screening and evaluation clinicians medication evaluation, and post-booking diversion to mental health agencies. However, the services that received the highest satisfaction ratings were only available to a few communities. Those services included mental health court, specially trained police, 24-hour crisis triage centers, criminal justice/mental health liaison personnel and pre-trial diversion services. Cost of psychiatric medication was a major concern to jail administrators, who employed various strategies to control expenditures. Correctional staff from three fourths of the jails attended training programs on mental health topics. Training was conducted by the Tennessee Corrections Institute, criminal justice/mental health liaisons and mental health center staff.

Recommendations concern provision of prevention and early intervention services by mental health and criminal justice personnel, establishing best practices in more Tennessee communities and bringing mental health and substance abuse services to

correctional facilities rather than transporting inmates to community agencies. Training programs should be developed and disseminated to mental health providers, criminal justice personnel, consumers and family members. The Criminal Justice/ Mental Health Task Force made recommendations in FY2000 for closing inter-system gaps that are still pertinent such as, implementing standards of care for incarcerated persons with mental illness, using collective bargaining to control medication costs, suspending rather than disenrolling TennCare beneficiaries with serious mental illness who enter the jails, expediting TennCare benefits upon release, and establishing transportation alternatives to sheriff's' personnel when evaluating persons for civil commitment to Regional Mental Health Institutes.

Collaboration between the Tennessee criminal justice and mental health systems appears to be making headway. Previous efforts by the TennCare Partners Roundtable, the Criminal Justice/Mental Health Task Force and the Tennessee Mental Health Policy and Planning Council have illuminated the problem and established initiatives to resolve the problem of the criminalization of mental illness in Tennessee.

Handout 1-5: The Law, Title 33

Special Provisions for Mental Health Transportation

The county sheriff provides transportation unless:

- A secondary transportation agent is named;
- A municipal law enforcement agency is designated by the sheriff;
- A person authorized under other provisions of the law is designated,
- One or more friends, neighbors, other mental health professionals familiar with the person, relatives of the person or a member of the clergy are willing to transport at their own expense.

However, to use transportation other than law enforcement, a physician or mandatory prescreening authority must evaluate and determine that the individual does not require physical restraint or vehicle security.

Secondary transportation agent shall be available 24/7.

Sheriff should consult with county executive or mayor before designating a secondary transportation agency.
Transportation of persons to be involuntarily hospitalized is the responsibility of the county in which the person is initially detained. The county of residence may be billed for transportation costs.

The Department of Mental Health and Developmental Disabilities shall provide training on mental health crisis management for transportation agents and sheriff s personnel.

If a mandatory prescreening agent, physician, or licensed psychologist determines that the person does not require physical restraint or vehicular security,

Then one or more reputable and trustworthy relatives or friends of the person who will assume responsibility for the person's safe deliverance may be allowed to transport the person to the hospital and do so at their own expense.

A person may be detained pending hospitalization in their home or in some suitable facility; however, not in a non-medical facility used for detention of persons charged with or convicted of criminal offenses.

A protocol is needed for each county to establish criteria to determine which individuals are transported by sheriff's personnel and which by a designated alternate agent.

Summarized from Chapter 6, Part 9: 33-6-901,

Module 2
Mental Health and Mental Illness

Module Two:

Mental Health and Mental Illness

Length of Presentation: 30 minutes (brief version)
1 hour (full version)

Handouts and Materials:

2-1 Mental Health and Mental Illness
2-2 Mental Illness: Facts and Figures
2-3 Myths and Facts of Mental Illness
2-4 Common Psychiatric Diagnoses
2-4a Signs and Symptoms of Mental Illness
2-5 Mental Illness and Effective Communication
2-6 Response: Crisis Communication
2-7 Schizophrenia and Psychotic Disorders
2-V Optional Video: Training the M.E.T. Part IV: Community Encounters, California Alliance for the Mentally Ill (CAMI)
2-V Optional Video: Training the M.E.T. Part V: In Custody, (CAMI)
2-8 Depression
2-9 Bipolar Disorder
2-10 Panic Attack
2-11 Posttraumatic Stress Disorder, PTSD
2-12 Obsessive Compulsive Disorder
2-13a Personality Disorder/ Borderline Personality Disorder
2-13b Personality Disorder/ Antisocial Personality Disorder
2-14 Childhood Behavioral Disorders
2-15 Dementia and Alzheimer's Disease
2-16 Malingering
2-17 Crossword Quiz

Motivational supplies:

Candy: pieces of hard candy;
Several small candy bars; and
One large chocolate bar;
Raffle tickets, a jar or hat for tickets and 3 small prizes for winners.

[Notes to Instructor:
There are more handouts on specific mental illnesses than you can cover in the presentation.

- *Full version: Cover two diagnoses that are of most interest to participants.*
- *Brief version: Cover general information on handouts 2-1 through 2-6. Handouts on specific diagnoses can be distributed as reference material.*

Response exercises are required if participants work directly with offenders or inmates. It is important for participants to connect information on mental illness to their work.]

[At the end of the session, make sure participants complete Handout 2-17: Crossword Quiz.]

[Optional activity: To encourage participation and to instill a sense of fun you can award raffle tickets to those who contribute to the discussion. Show the prize(s) to participants at the beginning of the session. At the end of the session, draw for a prize. To

encourage attendance, draw for prizes after breaks, after lunch and/or at the end of the day. Do not spend much time on the drawings. They should be quick and fun. Prizes should be small, but useful (e.g. a flashlight rather than a knick-knack.)]

Objectives

- Learn about mental health;
- Learn about mental illness;
- Learn to distinguish behaviors associated with types of mental illness;
- Learn to respond effectively to people displaying symptoms of mental illness;
- Learn about recovery from serious mental illness.

DISCUSSION

Mental Health and Mental Illness

Mental Health

[Refer to Handout 2-1: Mental Health and Mental Illness. Refer trainees to Mental Health column.]

"Mental health is a relative term. It can mean many things to many people. Generally, mentally healthy people have a positive self-image and can relate successfully to others. Mental health is the ability to integrated one's self with one's environment. Good mental health is reflected in:

- Solid interpersonal relationships;
- Satisfaction in living;
- Success in achievements;
- Flexibility and coping skills, and
- Maturity.

"In dealing with life's challenges, changes and traumas each person develops methods that enable him or her to function effectively despite these distractions. At times, the pressures may impair one's ability to fulfill responsibilities effectively. The person often deals quickly with the condition, soon restoring effectiveness. It is when the person's methods for dealing with those pressures fail that one begins to experience a disorder in functioning." (PERF, 1997)

Law enforcement may become involved when people who are otherwise mentally healthy make bad decisions. Legal penalties alone or combined with short-term mental health counseling can be expected to restore such people to normal functioning.

Temporary impairment of judgment is different from serious mental illness.

Optional Discussion:

[5-minute limit]

- Describe a situation you have worked with where the offender, inmate or probationer appeared to be a mentally healthy person under stress that had committed a crime, because of bad judgement.

Mental Illness

Serious mental illnesses are brain disorders that:

- Impair thinking, feeling, and behavior; and
- Disrupt ability to function in activities of daily living such as:
  - Social interaction;
  - Employment;

- Education; and
- Self-care.

Mental illness can be caused or triggered by:

- Genetic transmission;
- Biochemical disorder;
- Prolonged or very intense social stress;
- Recreational drugs; and
- Other environmental toxins.

[Review remainder of Handout 2-1: Mental Health and Mental Illness.]

[Review Handout 2-2: Mental Illness: Facts and Figures. Emphasize the points concerning employment, co-occurring substance abuse, homelessness, and incarceration.]

Myths and Facts of Mental Illness

[Review Handout 2-3: Myths and Facts of Mental Illness.]

People with mental illness frequently become victims of discrimination because of commonly held, but false beliefs about mental illness. Just as with the rest of society, these myths influence the actions of law enforcement, correctional staff, court staff and probation and parole officers.

Optional Discussion:

[5-minute limit]

- How have these myths influenced your work with offenders or inmates who have mental illness?

Psychiatric Diagnoses

There are no current laboratory methods or blood tests for diagnosing mental illness. Psychiatric diagnoses are made by asking the individual what he or she is thinking and feeling, and by observing behavior. Symptoms of thought, mood and behavior are grouped into common patterns called diagnoses. Initial diagnoses are usually changed as patterns are clarified over time.

The purpose of psychiatric diagnosis is to guide treatment, not to dictate what the person can or cannot do. Although some mental illnesses are considered to be more disabling than others, individuals across the psychiatric diagnosis spectrum are capable of living and working in a manner indistinguishable from the average person.

Common psychiatric diagnoses are shown in Handout 2-4 along with symptoms and recommended mental health treatments and supports.

[Review Handout 2-4: Common Psychiatric Diagnoses, emphasizing those diagnoses most common in the criminal justice system: psychotic disorders, mood disorders, PTSD and personality disorders.]

[Refer to Handout 2-4a. Only discuss it if you have time.]

Mental Illness and Effective Communication

Psychiatric symptoms often interfere with communication. When an individual is experiencing an episode of mental illness it may be necessary to change your way of communicating to increase the chances of being understood and to get an effective response.

Handout 2-5 shows a few basic techniques for communicating with individuals who are in a psychiatric crisis. The most important point is to remain calm, clear and caring. You will have a much greater chance of resolving the situation peacefully if you keep in mind that the individual is trying to cope with a confusing, overwhelming situation. Giving the individual an opportunity to be heard will often defuse potential violence. Of course it is vital to continuously assess for dangerousness and maintain safety.

[Review Handout 2-5: Mental Illness and Effective Communication.]

Response: Communicating with Individuals in Psychiatric Crisis

[Notes to Instructor:
Refer to Handout 2-6: Response: Crisis Communication.

- *Read client scenarios to the class. (Choose those most appropriate to the audience.)*
- *After each scenario is read, ask participants to suggest the best approach to effective communication.*
- *Then ask participant who suggested approach to role-play what s/he would say and do to facilitate effective communication:*
    a. *What symptoms is this client displaying?*
    b. *What would you say to me, the client?*
    c. *Show me what you would do.*
- *Optional: Reward participation by giving a small piece of candy to each participant who suggests approaches, and a larger piece to those who role-play. As the exercise progresses, place a large candy bar in view of the audience. At the end of the exercise, give the candy bar to the student whose participation was most helpful.*

Alternative: Distribute raffle tickets to each person who responds. See instructor notes at beginning of module.]

[If doing the brief section, skip to the ***Conclusion*** *on page 13. Complete quiz.]*

[If doing the full version cover two or more handouts on particular diagnoses. Choose those that are of most interest to participants. Each segment on mental disorders takes about 20 minutes with discussion.]

Optional segment: Schizophrenia and Psychotic Disorders
Schizophrenia is one of the most disabling mental disorders. In the past, it was thought that people with schizophrenia and other psychotic disorders could not function normally in their families or communities. With new, effective medications and services, many people with psychotic disorders are now living and working productively in the community. The problem is that many people who need the new medications and services don't get them because of lack of funding and other policy barriers. Some of those people end up in the criminal justice system for behaviors that could be attributed to untreated psychosis.

[Review Handout 2-7: Schizophrenia and Psychotic Disorders]

[Optional: *View CAMI video:*
For law enforcement, show Part IV: Community Encounters, the section on the delusional man in the park.
For corrections, show Part V: In Custody, the sections on inmates with psychotic behavior.]

Discussion:
[10-minute limit.
Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed psychotic symptoms such as delusions or hallucinations?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Depression
Depression is a serious medical illness. In contrast to the normal emotional experience of sadness, loss or passing mood states, depression lasts for a period of months or years and can greatly interfere with an individual's ability to function. Depression is the most common mental illness. It is estimated that one in five Americans will suffer serious depression at some time in their lives. Many people with depression believe that symptoms of depression are "not real," that a person should be able to get through it by just trying harder. Because of these beliefs and the stigma associated with mental illness, many depressed people do not seek treatment.

Untreated depression may lead to suicide. It is estimated that 2% of Americans who have ever been treated for depression will end their lives by suicide[1] as compared to .01% of the general population. Law enforcement is frequently called when an individual has made a suicide attempt. Risk of suicide is also higher for persons who are incarcerated, estimated at nine times that of the general population. Therefore it is essential that you know how to recognize symptoms of depression as well as signs of suicide risk. More specific information on suicide will be presented later, but we will begin with a discussion of depression.

[Review Handout 2-8: Depression.]

[Optional: *View CAMI video:*
For law enforcement, show Part IV: Community Encounters, the section on the suicidal woman.
For corrections, show Part V: In Custody, the section on inmate with suicidal ideation.]

Discussion:
[10-minute limit.
Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of depression?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Bipolar Disorder
Also known as manic depression, bipolar disorder is a biologically-based, hereditary mental illness. Moods swing from an intense high of excitement, irritability and inflated sense of self-importance to intense lows of sadness, hopelessness and lethargy. At least two million Americans (1.6% of the population) have bipolar disorder with average onset in early adulthood. Bipolar disorder can vary from mild to severe and can involve only a few episodes of mania, alternating mania and depression, or mood swings associated with seasons.

There is an increased risk of suicide in individuals with bipolar disorder who are in the depressive cycle. Studies show that 10 – 15% of individuals with bipolar disorder complete suicide. In a manic phase, the individual is more likely to engage in violence or high-risk behavior such as truancy or occupational absenteeism, substance abuse, spending sprees or sexual promiscuity. At either of these extremes, individuals' behavior may bring them into contact with the criminal justice system.

[Review Handout 2-9: Bipolar Disorder.]

[Optional: *View CAMI video:*
For law enforcement, show Part IV: Community Encounters, the section on the manic woman in the marketplace.
For corrections, show Part V: In Custody, the section on inmate with delusions of grandeur (God).]

Discussion:
[10-minute limit.
Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of mania?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Panic Attack
A panic attack is a severe episode of anxiety involving intense fear and physical symptoms. Physical symptoms often mimic a heart attack or other life-threatening condition. An individual who has experienced repeated panic attacks, called "panic disorder," often develops intense anxiety between episodes, avoiding situations where they believe another panic attack may occur or where help would not be immediately available. Panic disorder affects an estimated 1.6% of American adults ages 18 to 54 and usually develops in early adulthood.

While behaviors associated with panic attacks do not normally lead people into the criminal justice system, an individual may experience a panic attack as a *result* of an encounter with law enforcement or corrections.

[Review Handout 2-10: Panic Attack.]

Discussion:
[10-minute limit.
Optional: Award a raffle ticket to participants who talk about their experience.]

- In your work, what situations have you encountered where the individual displayed symptoms of a panic attack?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Posttraumatic Stress Disorder, PTSD
Individuals with PTSD may have experienced a single, traumatic event such as a natural disaster, fire, airline accident or rape, or may have been subject to ongoing, overwhelming suffering such as child abuse, domestic abuse, war or political oppression. The individual has intense feelings (to the point of hallucination) of reliving a traumatic

event, is easily startled, may have insomnia, or inability to remember events accompanied by a feeling of numbness, disconnected from others, no future, a “loner”. PTSD can occur at any age. Symptoms usually begin within the first three months after the trauma, although there can be a delay of months or even years. An estimated 8% of Americans experience PTSD at some point in their lives.

While reliving a trauma, persons with PTSD may engage in violent or self-destructive behavior. They may be unaware of their actual surroundings and respond only to threats perceived in a flashback. Law enforcement may be contacted if the person becomes violent or out-of-control behavior occurs in a public setting. Individuals who are incarcerated may experience a flashback and behave aggressively.

[Review Handout 2-11: Posttraumatic Stress Disorder.]

Discussion:
[10-minute limit.
Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of PTSD?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Obsessive Compulsive Disorder (OCD)
Obsessive Compulsive Disorder (OCD) is thought to be the most disabling anxiety disorder. Biological and possible hereditary in nature, symptoms interfere with basic daily activities. The person with OCD becomes trapped in a cycle of obsessions and compulsions spending at least one hour per day going over and over an upsetting, unwanted thought (obsession) or doing something to prevent what is feared (compulsion). OCD affects about 2% of the population, with age of onset from early childhood to adolescence.

Despite the fact that the person recognizes that thoughts and actions are unreasonable, he or she cannot control them. A sense of desperation may lead the individual to become suicidal. In a correctional setting, an individual with OCD may become agitated when attempts at compulsive behavior are thwarted. The individual may also be at risk of mistreatment from other inmates who do not like the individual’s odd, compulsive behavior.

[Review Handout 2-12: Obsessive Compulsive Disorder.]

Discussion:
[10-minute limit.
Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of OCD?
- What did you do and how well did it work?
- Based on the information you have heard today, what else could you have done?

Optional segment: Personality Disorder
Personality disorders are groups of personality “traits” resulting in ongoing, troublesome patterns of thought, feeling and behavior. To be considered a personality disorder, these patterns must cause major problems in self-care, social relationships, work or

school. Personality disorders usually become apparent in late adolescence or early adulthood and continue throughout life unless treated. Personality disorders are usually associated with a difficult childhood or early environment. Women tend more toward dependent, borderline traits while men tend more toward aggressive, antisocial traits.

Borderline Personality Disorder
Individuals with borderline personality disorder tend to look upon themselves and others as “all good” or “all bad”. Because of that they have a pattern of unstable relationships, poor self-image, emotional ups and downs, and impulsive behavior. They make frantic efforts to avoid being abandoned or rejected. Borderline personality disorder is most common among young women, affecting about 2% of the general population.

[Review Handout 2-13a: Personality Disorders, including Borderline Personality Disorder.]

Antisocial Personality Disorder
Antisocial personality disorder is common among male offenders and inmates because the characteristics of disregard for the rights of others, deceit and manipulation lay the foundation for criminal activity. In the general population, about 3% of males and 1% of females have antisocial personality disorder, compared with 25-30% of the American inmate population. Effective treatment involves extremely structured residential therapy in a controlled setting. Most mental health agencies are not equipped to treat antisocial personality disorder, but special needs prisons do offer structured, effective programs.

[Review Handout 2-13b: Antisocial Personality Disorder.]

Discussion:
[10-minute limit.
Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual displayed symptoms of antisocial or borderline personality disorder?
- How did you handle the situation?
- Based on the information you have heard today, what else could you have done?

Optional segment: Behavioral Disorders of Childhood

Oppositional Defiant Disorder
Oppositional defiant disorder is a childhood behavioral disorder involving ongoing patterns of defiant attitudes; and disobedient, hostile behavior toward authority figures. Serious marital discord, parental mood disorders, and parental substance abuse are common in families of children with this disorder. The diagnosis is not usually made before the age of eight or after the onset of adolescence. Children with oppositional defiant disorder do not usually come to the attention of law enforcement or juvenile justice authorities.

[Review Handout 2-14: Childhood Behavioral Disorders, section on Behaviors Associated with Oppositional Defiant Disorder.]

Conduct Disorder
Conduct disorder is a childhood behavioral disorder consisting of a persistent pattern of violating the basic rights of others or major age-appropriate societal norms or rules. Estimated at 1% - 10% of the population, conduct disorder has increased over the last decades. Research shows that conduct disorder has both genetic and environmental influences. Conduct disorder is often preceded by oppositional defiant disorder. Conduct disorder usually goes away by adulthood, but may develop into antisocial personality disorder if left untreated. Acts committed by children and youth with conduct disorder frequently require intervention from law enforcement and juvenile justice authorities.

[Review remainder of Handout 2-14: Childhood Behavioral Disorders.]

Discussion:
[10-minute limit.
Optional: *Award a raffle ticket to participants who talk about their experience.]*
- In what situations have you encountered youth that appeared to have conduct disorders?
- What did you do that got the result you desired?
- What did you do that did not get the result you desired?
- What else could you have done?

Optional segment: Dementia and Alzheimer s Disease
Dementias are mental disorders that are more common later in life, and involve the loss of the ability to think and remember. Despite popular misconceptions, dementias are not inevitable, striking less than 15% of those over the age of 65. Alzheimer's disease is the best-known type of dementia but vascular disease, HIV, head trauma and Parkinson's disease can all lead to dementia.

[Review Handout 2-15: Dementia and Alzheimer s Disease.]

Alzheimer s Disease
Alzheimer's disease is a biological dementia that most typically strikes after age 65. It is possibly genetic, but may be triggered by other diseases and environmental toxins. The person gradually loses memory and the ability to think and respond to the environment, eventually becoming mute and bedridden. At some stages of the disease, individuals may develop paranoia and bizarre behaviors, and could cause enough disturbance to come to the attention of law enforcement.

Law enforcement may also be alerted to abuse of persons who have dementia. Elder abuse is common when caregivers become stressed to the point of aggression.

[Optional: *View video: Unheard Cries (TBI and Tennessee Commission on Aging and Disability.)]*
Discussion:
[10-minute limit.]
Optional: *Award a raffle ticket to participants who talk about their experience.]*
- In what situations have you encountered offenders that appear to have dementia?
- What did you do that got the result you desired?
- What did you do that did not get the result you desired?
- What else could you have done?

Optional segment: Malingering
Malingering is not a mental illness. It is behavior that involves intentionally feigning physical or psychological symptoms, motivated by external incentives such as evading criminal prosecution, avoiding military duty, avoiding work, obtaining financial compensation, or obtaining drugs.

[Review Handout 2-16: Malingering]

Discussion:
[10-minute limit.
Optional: *Award a raffle ticket to participants who talk about their experience.]*

- In what situations have you encountered offenders that appear to be malingering?
- What did you do to detect malingering?
- How well did it work?
- What else could you have done?

Conclusion
[Instructor: *Ask for questions.*

Distribute Crossword Quiz (see Forms section)
Tell participants that this is not a graded quiz; it is just to help them reinforce some points from the session. When they have completed the crossword, they can take a break. Review correct responses after the break.]

Recommended Reading

Police Executive Research Forum (1997) The Police Response to People with *Mental Illness*, Washington DC: PERF.

Handout 2-1

Mental Health and Mental Illness

Mental Health	Mental Illness
Mental health is the ability to integrate one's self with one's environment. Mentally healthy people: • Have a positive self-image; and • Can relate successfully to others. Good mental health is reflected in: • Solid interpersonal relationships; • Satisfaction in living; • Success in achievements; • Flexibility and coping skills; and • Maturity. **Mental Health and Stress** • Each person develops methods to continue functioning effectively when pressure impairs the ability to fulfill responsibilities effectively. • The person often deals with pressures quickly and effectiveness is restored. • When coping methods fail, one begins to experience a disorder in functioning and may make unwise decisions. • Temporary impaired judgment is different from serious mental illness.	Brain disorders that: • Impair thinking, feeling, and behavior; and • Disrupt ability to function in activities of daily living: ◦ Social interaction; ◦ Employment; ◦ Education; and ◦ Self-care. Causes or triggers: ◦ Genetic transmission; ◦ Biochemical disorder; ◦ Prolonged/very intense social stress; ◦ Recreational drugs; and ◦ Other environmental toxins. **Impaired Thoughts** Positive symptoms are unusual perceptions: • Delusions: fixed false beliefs such as Paranoia, delusion of grandeur or guilt, obsession • Hallucinations: auditory, visual, tactile Negative symptoms: Reduced ability to think: ◦ Confusion; ◦ Lack of concentration; ◦ Indecision. **Feelings** Mental illness: • Damages self-concept and social relationships; and • Alters or numbs emotions. Painful, intense emotions may be <u>normal responses</u> to the trauma of mental illness. Normal responses are combined with emotional reactions caused by mental illness. **Behaviors** Behavior changes as a result of impaired thoughts or feelings: • Person responding to voices, delusions, hyper-stimuli or manic feelings may appear strange, agitated and irrational. • Person responding to negative symptoms, depression, apathy, withdrawal or confusion may appear lethargic, disconnected, confused.

Handout 2-2

Mental Illness: Facts and Figures

(From: National Alliance for the Mentally Ill, NAMI Advocate , Spring, 2001)

- Mental illnesses are health conditions characterized by alterations in thought, mood and behavior (or a combination) associated with distress and impaired functioning.

- Of American adults, 5.4 percent have a serious mental illness.

- In any given year, 23 percent of American adults (age 18 or older) have a diagnosable mental disorder, but only half report impairment of their daily functioning due to the mental disorder. Six percent of adults have addictive disorders alone, and three percent have both mental and addictive disorders.

- Almost half of the adults with serious and persistent mental illnesses are between the ages of 25 and 44.

- Approximately nine percent to thirteen percent of children ages nine to seventeen have a serious emotional disturbance with substantial functional impairment, and five percent to nine percent have a serious emotional disturbance with the extreme functional impairment caused by mental illness.

- Not all mental disorders identified in childhood and adolescence persist into adulthood, even though the prevalence of mental disorders is almost the same percentage for both age groups. A substantial number of children and adolescents recover from mental illness.

- Four of ten leading causes of disability in the United States and other developed countries are mental disorders, which include major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder.

- The treatment success rate for a first episode of schizophrenia is 60 percent. It is 65 percent to 70 percent for major depression and 80 percent for bipolar disorder. The treatment success rate for a first episode of schizophrenia is 60 percent. It is 65 percent to 70 percent for major depression and 80 percent for bipolar disorder.

- In 1998, 283,800 people with mental illnesses were incarcerated in American prisons and jails. This is four times the number of people in state mental hospitals throughout the country.

- Sixteen percent of state prison inmates (179,200), seven percent of federal inmates (7,900), 16 percent of jail inmates (97,600) and 16 percent of probationers (547,800) have reported a mental illness.

- Mentally ill offenders are more likely than other offenders to have a history of substance abuse/ dependency and a higher rate of homelessness and unemployment prior to incarceration.

- Of the 1,012, 582 total hospital admissions in the U.S. in 1998, 261, 903 (25.8%) were psychiatric admissions.

- The total cost of mental health services in the U.S. was $148 billion in 1990. The direct cost of mental health services (treatment and rehabilitation costs) totaled $69 billion, and the indirect costs (lost productivity at work, school or home due to disability or death) were estimated at $78.6 billion.

- Serious mental illnesses interfere with employment. An estimated 57% of adults with these illnesses were not employed in 1990. compared to 29 percent of the general population.

- Approximately one-third of the estimated 600,000 homeless people in the U.S. have a severe mental illness, however, only one in 20 persons with severe mental illness are homeless.

- Only five percent to seven percent of homeless persons with mental illness need to be institutionalized. Most can live in the community with appropriate, supportive housing.

Handout 2-3

Myths and Facts of Mental Illness

Myths: People with Mental Illness	Facts: People with Mental Illness
- Have a rare condition	One in five Americans will have a mental illness at some point in their lives.
- Are not smart	People with mental illness have the same range of intelligence as the general population.
- Look different from the average person	Most mental illnesses come and go. A person whose mental illness is in remission may look like any average person. Some older psychiatric medications have side effects that may cause odd mannerisms.
- Are violent and unpredictable	People with mental illness are no more likely to be violent than the general population. BUT, people with mental illness who abuse alcohol or drugs ARE more likely to be violent if not receiving consistent treatment.
- Are a drain on society	Many people with mental illness have contributed to society, including: Abraham Lincoln (16th US president), Ludwig Von Beethoven (composer), Isaac Newton (scientist), Virginia Wolf (author), Winston Churchill (British Prime Minister), Lionel Aldridge (football player), Patty Duke (actress).

Handout 2-4

Common Psychiatric Diagnoses

Diagnosis	Symptoms & Characteristics	Treatments
Psychotic Disorders		
Schizophrenia	Distorted sense of reality: Hallucinations, Delusions, Confusion, Blunted emotional expression, Unusual speech & behavior, Social withdrawal.	Medication: anti-psychotic, Case management Therapy: cognitive-behavioral or supportive, Psychosocial rehabilitation.
Schizoaffective Disorder	Psychotic symptoms, plus Mood swings	Medication: anti-psychotic and mood stabilizer, Case management, Therapy: cognitive-behavioral or supportive, Psychosocial rehabilitation.
Substance Induced Psychotic Disorder	Psychotic symptoms associated with substance abuse	Detoxification, Addiction treatment, Assessment for underlying mental disorder.
Mood Disorders		
Depression	Persistent sadness, Loss of interest, Change in appetite/weight, Sleep problems, Physical slowing or agitation, Energy loss, Feelings of worthlessness, Concentration problems, Suicidal thoughts.	Medication, antidepressant, sedatives-hypnotics (for sleep), Case management if severely impaired, Therapy: cognitive-behavioral or interpersonal.
Bipolar Disorder	Depressive symptoms alternating with mania: Increased energy, racing thoughts, rapid speech, Denial that anything is wrong, Irritability, distractibility, Decreased need for sleep, Unrealistic belief in one's ability, Poor judgment, Impulsive behavior: sexual drive, substance abuse, spending sprees, aggression.	Medication: mood stabilizers, sedatives-hypnotics (for sleep), Case management if severely impaired, Therapy: cognitive-behavioral or interpersonal, Psychosocial rehabilitation.

Handout 2-4

Common Psychiatric Diagnoses (cont.)

Diagnosis	Symptoms & Characteristics	Treatments
Anxiety Disorders		
Generalized Anxiety Disorder	Ongoing, unrealistic sense of impending doom, Strenuous avoidance of feared situations, May involve panic attacks: Episode of intense fear, Chest pain, Rapid heartbeat, Shortness of breath, Dizziness, Abdominal distress.	Medications: anti-anxiety* and anti-depressants, sedatives-hypnotics (for sleep), Therapy: Cognitive-behavioral. * Caution: some anti-anxiety medications are habit-forming.
Posttraumatic Stress Disorder	Following a traumatic event or ongoing situation: Reliving the event through flashbacks or nightmares, Avoiding trauma reminders, Amnesia regarding trauma, Social isolation, Sense of limited future, Wary, Irritable, Insomnia, Lack of concentration.	Psychotherapy: Stress Inoculation Training, relaxation and role playing Medication: Short-term anti-depressant or anti-anxiety, Support groups, group therapy, Case management if severely impaired.
Obsessive Compulsive Disorder	Persistent, unwanted, upsetting thoughts, Repeated actions to prevent what is feared.	Medication: SSRI antidepressants, Therapy: Exposure Response Prevention. Case management if severely impaired.
Personality Disorders Most common: **Women:** Borderline Personality Disorder **Men:** Antisocial Personality Disorder	Group of personality "traits" resulting in ongoing, troublesome patterns of thought, feeling & behavior. Women more commonly have dependent, emotionally unstable traits, Men more commonly have aggressive, antisocial traits.	Borderline: Therapy: cognitive-behavioral or insight-oriented, Psychosocial rehabilitation Short term medication: antidepressant, anti-anxiety Antisocial: Therapy: Behavioral, conducted in a controlled residential setting.
Dementias		
Most Common: Alzheimer's Disease	Memory loss, Trouble speaking, Trouble moving around, Difficulty recognizing objects, Inability to plan & organize, As condition worsens: Psychosis, Depression, Agitation.	Memory training (for early stages) Medications: Anti-depressant, anti-psychotic Day treatment, Caregiver respite

Handout 2-4a

Signs and Symptoms of Mental Illness

Appearance
Dress and hygiene:
Appropriate
Unkempt
Smells of alcohol
Body odor
Unusual dress
Inappropriate dress

Mannerisms
Tics
Tremors
Peculiar or bizarre
Unusual gait
Repeated acts
Lack of coordination
Eye movements

Pace of movement
Hyperactive
Restless
Agitated
Lethargic
Fatigue
Stupor

Speech
Normal
Pressured
Singing
Constant
Poverty of content
Slowed
Mute
Occasional

Attitude
Withdrawn
Evasive
Passive eye contact
Threatening
Impulsive
Aggressive
Manipulative
Demanding
Distractible
Overly dramatic
Distrustful
Accusing
Entitled

Thought Process
Loose associations
Disorganized
Poverty of thoughts
No response
Incoherent
Clanging/rhyming
Flight of ideas

Thought Content

Somatic
Physical complaints
Hypochondriasis
Obsession with body

Guilt feelings
Worthlessness
Feels punished
Guilt
Shame
Suicidal thoughts
Suicidal plans
Past suicide attempts
Homicidal thoughts

Unusual thoughts
Magical thinking
Sexual preoccupation
Bizarre thoughts
Obsessions
Excessive religious talk

Suspicions
Misinterpretation
Delusions of persecution
Delusions of reference
Delusions of control
Paranoid

Grandiose thoughts
Delusions of grandeur
Inflated self-esteem
Thought broadcasting
Extraordinary abilities

Perception
Hallucinations
Visual illusions
Auditory commenting
Auditory command
Visual tactile
Olfactory
Gustatory

Emotions

Mood
Sad
Expressionless
Pessimistic
Tearful
Helpless/hopeless
Euphoric

Affect
Emotionless
Blunted/flat/restricted
Inappropriate
Angry

Orientation
Place
Time
Person
Situation

Cognitive functioning
Inability to concentrate
Short term memory loss

Insight and Judgment
Poor insight
Poor memory

Handout 2-5

Mental Illness and Effective Communication

Psychiatric symptoms often interfere with communication. When an individual is experiencing an episode of mental illness it may be necessary to change your way of communicating.

Situation/ symptom	Do	Don t
If you suspect the person has mental illness: If the person is causing a disturbance:	Speak in a calm, patient, reassuring tone of voice. Be truthful. Maintain personal space, at least arm's length. Be helpful (what would make you feel safer/calmer, etc.?) Continually assess the situation for dangerousness. BUT, remember people with mental illness have rights to fair treatment just like anyone else.	Don't shout or threaten. Don't stare at the person. It may be interpreted as a threat. Don't deceive the person. Don't touch the person unless taking him/her into custody. Only use your weapons as a last resort. Don't arrest the individual for behavioral manifestations of mental illness that are not criminal in nature.
Confusion about what is real, Belief in delusions or hallucinations.	Be simple and straight-forward. Respond to person's needs and apparent feelings.	Neither agree, nor disagree with delusional statements. Don't whisper, laugh or roll your eyes.
Difficulty in concentrating.	Be brief, repeat if needed.	Don't give long, complicated instructions.
Difficulty making decisions.	Give firm, clear directions.	Don't give open-ended or multiple choices.
Over-stimulation.	Limit input. The person may be responding to stimuli you are not aware of. Have one person talk to the individual	Don't force discussion.
Pre-occupation with internal world.	Get the person's attention before asking questions or giving instructions.	Don't assume the person is intentionally ignoring you.
Poor judgment.	Redirect person to other choices.	Don't try to reason with person. Don't expect rational discussion.
Agitation.	Recognize agitation. Try to allow person an exit, a way to save face. Continuously assess for danger.	Don't corner the person.
Fear/paranoia.	Speak and act in a calm manner. Keep communication clear and consistent. Explain what you are going to do before you do it, whenever possible.	Don't challenge or threaten. Don't stare. It may seem threatening.
Fluctuating emotions.	Speak calmly and consistently.	Don't take words or actions personally.

Handout 2-6

Response: Crisis Communication

Instructions:

1. The instructor reads the client scenario.
2. Trainees suggest possible approaches to resolve the situation peacefully.
3. Role-play what you would say and do to get a desired response from the client.

Scenario 1: A 44-year-old male that is well known to law enforcement is causing a disturbance in a downtown shopping area by shouting obscenities at the air.

Scenario 2: A 28-year-old female is pulled over for driving 93 mile per hour on the interstate. She has been chased for 10 miles. When asked why she is going so fast she states that Oprah needs her.

Scenario 3: A 22-year-old male has barricaded himself in his parent's home (not his usual residence) and will not let anyone into the house. The parents report that he believes aliens are preparing to attack and he is responsible to defend the world. When law enforcement gains access to the residence, the young man does not make eye contact and does not respond to questions.

Scenario 4: A 35-year-old female is booked into the county jail on charges of criminal trespassing. During the intake process she responds to questions in nonsense sentence fragments.

Scenario 5: A 50-year-old male inmate is in a cell with six other inmates. In the middle of the night he springs out of his bed, apparently in a nightmare, and begins throwing things around the room. The safety of the other inmates is in jeopardy.

Scenario 6: A 20-year-old female inmate has refused meals for the past three days. The other inmates report that she says the food is poisoned.

Scenario 7: A 23-year-old male probationer on your caseload reports that he has been evicted from his apartment. When you attempt to find out why, he is unable to tell you and seems confused.

Scenario 8: A 25-year-old female probationer comes late to an appointment. She paces the office speaking very rapidly about several unrealistic projects. When asked if she has been fulfilling the terms of probation, she becomes very angry and states that you are not listening to her, that she is trying to tell you about getting back on her feet again.

Handout 2-7

Schizophrenia and Psychotic Disorders

Psychotic Disorders

Psychotic disorders are biologically-based mental disorders that cause a person to experience:

- Delusions, fixed false beliefs such as:
  - Unreasonable fears (paranoia);
  - Exaggerated sense of self-importance;
- Hallucinations, false sensations that cause the person to hear, see or feel things that are not perceived by others.

Delusions and hallucinations are symptoms of psychosis;

- A condition where malfunctions in the brain cause the person to be so overwhelmed by inner perceptions and thoughts that they lose contact with reality.

Schizophrenia

- Long-term, serious psychotic disorder,
- Biological origins,
- Causes impairment in self-care, social and job skills,
- Usual onset in early adulthood.

Symptoms *(from the DSM IV[3])*

Positive Symptoms: Delusions;
Hallucinations;
Disorganized speech;
Grossly disorganized or catatonic behavior (odd movements);

Negative symptoms: Reduced expression of emotion;
Reduced speech and slowed thoughts; or
Difficulty with goal-directed activities.

Treatment

Medication:

Newer, atypical anti-psychotic drugs:

Much more effective, treat positive and negative symptoms,
Help the person think better, have more motivation,
Fewer troublesome side effects,
More expensive; generic only available for clozapine.

Older medications:

Treat only positive symptoms;
Side effects: non-compliance common due to discomfort;
Less expensive; generics available.

Case management:

Help getting needed treatment, rehabilitation services and resources such as income, housing, food, transportation, etc;
Help getting to appointments;
Help resolving social problems with family, neighbors, etc.;
Early intervention to prevent hospitalization or incarceration.

[3]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Psychosocial rehabilitation:

Supportive day program;
Instruction in social and prevocational skills;
Assistance obtaining employment, and on-the-job support;
Assistance obtaining decent, affordable housing in the least restrictive environment.

Cognitive-behavioral therapy:

Recognition of thought processes leading to problematic behaviors;
Rehearsal of alternative strategies.

Supportive therapy:

Empathy and problem-solving.

Schizoaffective Disorder

- Long-term, serious thought and mood disorder
- Symptoms of schizophrenia as well as mood swings or major depression
- Mood symptoms are present even when person is not actively psychotic
- Course and treatment are similar to schizophrenia, although prognosis is somewhat better.

Symptoms: *(from the DSM IV[4])*
A period of illness during which there is a Major Depressive Episode, a Manic Episode, or a Mixed Episode *at the same time as:*

(1) Delusions
(2) Hallucinations
(3) Disorganized speech (losing track, or not making sense)
(4) Very disorganized or catatonic behavior
(5) Negative symptoms (can't express emotion, less talk, low motivation)

During the same period of illness, there have also been delusions or hallucinations for at least two weeks *without* major mood symptoms. Symptoms of mood disorder are present during most of the period of illness, whether actively experiencing psychosis or not.

Substance-Induced Psychotic Disorder

Thought disorder produced by substance abuse. The person experiences psychotic symptoms of delusions (paranoia) or hallucinations that may or may not subside if substance use is stopped. Onset varies with type of substance used. It can occur in minutes if a high dose of cocaine is ingested, or it can take years. Substance induced psychosis may occur sooner and more intensely in persons prone to mental illness.

Treatment for substance-induced psychosis should integrate substance abuse treatment (detoxification, counseling and self-help group attendance) with treatment for psychotic disorders.

[4]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-8

Depression

Depression involves intense sadness, lethargy and irritability or alternating moods of sadness and excitement that are out of proportion to the person's life situation. The moods must continue for more than two weeks to be considered a mental disorder,

- Not part of grief;
- Not short-term reaction to life event or situation;
- Interferes markedly with self-care, social interaction or employment.

Depression can be caused by biological factors such as heredity or physical illness, or by stress due to over-work, poverty or oppression. It is more common in women and the elderly, but recent studies show that up to 2.5 percent of children and up to 8.3 percent of adolescents in the U.S. suffer from depression.

Symptoms of Depression (From DSM-IV[5])

Emotional symptoms:

Sadness,
Despair,
Lack of ability to experience pleasure,
In children depression may appear as irritability and sensitivity.

Physical symptoms:

Slowed movements,
Changes in eating habits,
Changes in sleeping patterns,

Thought symptoms:

Lack of interest,
Lack of concentration,
Intense and unrealistic thoughts of guilt,
Suicidal thoughts or gestures;

Treatment

Anti-depressant medication

There are several different types of anti-depressant medication;
If one type does not work, another type will be prescribed.

Psychotherapy

To resolve social stress;
To distinguish realistic from unrealistic thoughts;
To learn to think of self and others in a more positive light;
To strategize life style changes.

Psychosocial rehabilitation

To relearn job skills;
To interact with others in a positive social environment.

[5]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-9 rv110503

Bipolar Disorder

Formerly known as manic depression, bipolar disorder is a biologically-based, often hereditary mental illness. Moods swing from an intense high of excitement, irritability and inflated sense of self-importance, to intense lows of sadness, hopelessness and lack of energy. At least two million Americans (1.6% of the population) have bipolar disorder with average onset in early adulthood. Bipolar disorder can vary from mild to severe and can involve only a few episodes of mania, alternating mania and depression, or mood swings associated with seasons.

Symptoms of Mania (From DSM-IV[6])
Abnormally excited or irritable mood lasting at least 1 week, and:
Inflated sense of self-importance;
Decreased need for sleep;
Pressure of speech;
Flight of ideas;
Distractibility;
Involvement in many goal-directed activities;
Poor judgment;
Excessive involvement in pleasurable activities with a high risk of painful consequences.

Treatment

Medication:

Mood stabilizers: lithium, a salt found naturally in the environment
Anti-convulsant medications that are also used for seizure disorders like epilepsy.

Full-spectrum light:

For Seasonal Affective Disorder. In addition to getting enough exposure to daylight, full spectrum light fixtures help the person absorb a sufficient amount of light.

Individual Counseling/therapy:

Help resolving social problems caused by mood swings. Counseling does not address the underlying biological cause of the illness, but can help the person develop healthy self-esteem and strategies for coping with problems caused by behavior during mood swings.

Case management:

Help with income, housing, basic needs, medications.

Psychosocial Rehabilitation:

Help regaining social and employment skills.

[6]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-10

Panic Attack

A panic attack is a severe episode of anxiety involving intense fear and physical symptoms. Physical symptoms often mimic a heart attack or other life-threatening condition. An individual who has experienced repeated panic attacks, called "panic disorder," often develops intense anxiety between episodes, avoiding situations where they believe another panic attack may occur or where help would not be immediately available. Panic disorder affects an estimated 1.6% of American adults ages 18 to 54 and usually develops in early adulthood. Panic attacks can be associated with anxiety disorders, mood disorders, psychotic disorders or substance abuse.

Symptoms of Panic Attack *(From DSM-IV[7])*

Discrete period of intense fear or discomfort in the absence of real danger, and

Physical symptoms:

- Rapid or irregular heartbeat;
- Sweating;
- Trembling or shaking;
- Shortness of breath;
- Feeling of choking;
- Chest pain;
- Nausea or abdominal discomfort;
- Dizziness;
- Chills or hot flashes.

Thoughts:

- Sense of depersonalization, being outside of oneself;
- Feeling of "going crazy";
- Fear of dying.

Treatment

Medications (short-term):

- SSRI antidepressant medication,
- Benzodiazepine anti-anxiety medication.

Cognitive-Behavioral Therapy:

- Goals:
- To identify and challenge thoughts/assumptions contributing to anxiety;
- To resolve fears; and
- To develop lifestyle changes that will reduce stress and anxiety.

[7]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-11

Posttraumatic Stress Disorder, PTSD

Individuals with PTSD may have experienced a single, traumatic event such as a natural disaster, fire, airline accident or rape, or may have been subject to ongoing, overwhelming suffering such as child abuse, domestic abuse, war or political oppression. The individual has intense feelings (to the point of hallucination) of reliving a traumatic event, is easily startled, may have insomnia, or inability to remember event accompanied by a feeling of numbness, disconnected from others, no future, a "loner".

Symptoms of PTSD *(From DSM-IV[8])*
The traumatic event is re-lived in one or more of the following ways:

- Upsetting memories or dreams of the event that keep coming back;
- Acting or feeling as if the event were happening again;
- Feeling upset or panic reaction (sweating, pounding heart) when reminded of event.

Avoiding things that remind the person of the trauma and being less able to respond than before the trauma, shown by at least three of the following:

- Avoiding thoughts, feelings or activities that remind them of the trauma;
- Feeling separated from others, less interest in important activities;
- Sense of a limited future, not expecting to have a career, marriage, etc.

Ongoing symptoms of increased excitement such as:

- Difficulty falling or staying asleep;
- Irritability or outbursts of anger;
- Difficulty concentrating;
- Extremely wary and watchful.

Treatment
Psychotherapy:

- To bring events and dysfunctional responses to conscious thought;
- To process the fear and horror, and develop coping mechanisms.

Eye Movement Desensitization and Reprocessing (EMDR):

- A type of therapy in which the therapist helps the client produce rhythmic eye movements to help the brain reprocess information and resolve traumatic thoughts.

Medication:

- Short-term anti-depressant or anti-anxiety medication,

Support groups or group therapy:

- To reduce sense of being alone,
- To work through trauma;
- To develop strategies for recovery.

[8]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-12

Obsessive Compulsive Disorder, OCD

Obsessive Compulsive Disorder (OCD) is thought to be the most disabling anxiety disorder. Biological and possible hereditary in nature, symptoms interfere with basic daily activities. The person with OCD becomes trapped in a cycle of obsessions and compulsions spending at least one hour per day going over and over an upsetting, unwanted thought (obsession) and/or doing something to prevent what is feared (compulsion). OCD affects about 2% of the population, with age of onset from early childhood to adolescence.

Symptoms of Obsessive Compulsive Disorders *(From DSM-IV[9])*

Obsessions:

- Persistent thoughts, impulses or images that are experienced as unwanted and inappropriate, and cause distress and anxiety;
- Not simply excessive worries about real-life problems;
- The person attempts to ignore the thoughts or neutralize them with some other thought or action;
- The person recognizes that the thoughts are a product of his/her own mind, not imposed from without.

Compulsions:

- Repetitive behaviors (hand-washing, checking, counting) that the person feels driven to perform in response to an obsession and according to rigid rules,
- Behaviors are aimed at preventing distress or some dreaded event, but the acts are not connected with the goal in a realistic way, or are excessive.

Treatment for Obsessive Compulsive Disorder

Medication:

Antidepressant medication

Behavioral therapy, Exposure and Response Prevention:

The goal is to learn to explore obsessions rather than avoiding them, and
To develop less disruptive array of responses.

[9]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-13a

Personality Disorder

Personality disorders are groups of personality "traits" resulting in ongoing, troublesome patterns of thought, feeling and behavior. To be considered a personality disorder, these patterns must cause major problems in self-care, social relationships, work or school. Personality disorders usually become apparent in late adolescence or early adulthood and continue throughout life unless treated. Personality disorders are usually associated with a difficult childhood or early environment. Women tend more toward dependent, borderline traits while men tend more toward aggressive, antisocial traits.

Borderline Personality Disorder
Individuals with borderline personality disorder tend to look upon themselves and others as "all good" or "all bad". Because of that they have a pattern of unstable relationships, poor self-image, emotional ups and downs, and impulsive behavior. They make frantic efforts to avoid being abandoned or rejected. Borderline personality disorder is most common among young women, affecting about 2% of the general population.

Behaviors Associated with Borderline Personality Disorders
(From DSM-IV[10])

- Frantic efforts to avoid abandonment;
- Unstable, intense relationships;
- Unstable self-image;
- Impulsive and self-damaging behavior;
- Recurrent suicidal behavior or self-mutilation;
- Unstable moods;
- Chronic feelings of emptiness;
- Intense, inappropriate anger;
- Paranoia when under stress.

Treatment for Borderline Personality Disorder
Counseling/Psychotherapy:

Goals: To gain insight into life situations that produced dysfunctional patterns, and
To develop healthy adult patterns of thought, feeling and behavior.

Often involves setting limits on expectations between the client and authority figures.

Medication:

Short-term only: anti-anxiety or anti-depressant medication to reduce distress during periods of change.

Psychosocial Rehabilitation:

To develop patterns of healthy social interaction in a supervised setting.

[10]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-13b

Personality Disorder

Antisocial Personality Disorder

Individuals with antisocial personality disorder display a consistent pattern of disregard for and violation of the rights of others. This pattern begins in childhood (see oppositional and conduct disorders) and continues into adulthood, although the diagnosis is only given to individuals who are at least 18 years of age. This pattern is also called psychopathy or sociopathy.

Behaviors Associated with Antisocial Personality Disorder

(From DSM-IV[11])

There is a pervasive pattern of disregard for and violation of the rights of others:

- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest;
- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure;
- Impulsivity or failure to plan ahead;
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults;
- Reckless disregard for safety of self or others;
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations;
- Lack of remorse, as indicated by being indifferent or rationalizing having hurt, mistreated, or stolen from another.

Treatment

Forensic residential treatment:

Usually in a prison setting, the individual must earn privileges by demonstrating motivation to change, impulse control, consideration for others, and conformity to expected conduct.

Self-help groups:

Peer influence has been effective in creating motivation for change.

Family therapy:

To help family members understand and cope with the individual's behaviors.

Medication is <u>not</u> helpful in treatment of antisocial personality disorder.

[11]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-14

Childhood Behavior Disorders

Oppositional Defiant Disorder

Oppositional defiant disorder is a childhood behavioral disorder involving ongoing patterns of defiant attitudes; and disobedient, hostile behavior toward authority figures. Serious marital discord, parental mood disorders, and parental substance abuse are common in families of children with this disorder. The diagnosis is not usually made before the age of 8 or after the onset of adolescence.

Behaviors Associated with Oppositional Defiant Disorder *(From DSM-IV[12])*

- Often loses temper;
- Often argues with adults;
- Often refuses to comply with rules or adults' requests;
- Often deliberately annoys people;
- Easily annoyed by others;
- Often blames others for his or her mistakes or behavior;
- Often spiteful and vindictive.

Conduct Disorder

Conduct disorder is a childhood behavioral disorder consisting of a persistent pattern of violating the rights of others or basic age-appropriate societal norms or rules. Estimated at 1% - 10% of the population, conduct disorder has increased over the last decades perhaps due to higher populations in urban settings. Research shows that conduct disorder has both genetic and environmental influences. It is often preceded by oppositional defiant disorder. Conduct disorder usually remits by adulthood, but may develop into antisocial personality disorder.

Behaviors Associated with Conduct Disorder *(From DSM-IV[13])*

- Aggression to people and animals;
- Destruction of property;
- Deceitfulness or theft; and
- Serious violations of rules.

Treatment for Childhood Behavior Disorders

Parent Training: Parents learn methods of effective parenting and discipline

Residential Programs: Treatment residence where children live and learn social skills

School Based Interventions: Mental health providers advise teachers, and provide individual or group counseling to children.

Interpersonal and Skills Training: Mental health providers teach children how get along with others.

Medication: May be prescribed for a child with underlying depression or anxiety disorder.

Wilderness Program: Highly structured, rural setting where children learn new attitudes, behaviors and skills.

[12]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-15

Dementia and Alzheimer's Disease

Dementia

Dementias are mental disorders that are more common later in life, and involve the loss of the ability to think and remember. Despite popular misconceptions, dementias are not inevitable, and strike less than 15% of those over the age of 65. Alzheimer's disease is the best-known type of dementia but vascular disease, HIV, head trauma and Parkinson's disease can all lead to dementia.

Alzheimer s Disease

Alzheimer's disease is a biological dementia that strikes most typically after age 65. It is possibly genetic, but may be triggered by other diseases or environmental toxins. The person gradually loses memory and the ability to think and respond to the environment, eventually becoming mute and bedridden. At some stages of the disease, individuals may develop paranoia and bizarre behaviors, and could cause enough disturbance to come to the attention of law enforcement.

Symptoms and Behaviors of Alzheimer s Disease *(From DSM-IV[14])*

Symptoms

- Memory loss;
- Trouble speaking;
- Trouble moving around;
- Difficulty recognizing objects;
- Inability to plan and organize.

As condition worsens:

- Psychosis;
- Depression;
- Agitation.

Behavioral problems:

- Wandering;
- Insomnia;
- Incontinence;
- Verbal or physical outbursts;
- Sexual disorders;
- Weight loss.

Treatment

Medications: Anti-depressants
Anti-psychotic medications

Memory training: (for early stages)

Day treatment, caregiver respite:
Offers structured activities and meals to affected person(s);
Caregivers receive respite from stress of constant care;
Helps prolong individual's ability to live at home.

[13]American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: APA.

Handout 2-16

Malingering

Malingering is not a mental illness. It is behavior that involves intentionally feigning physical or psychological symptoms, motivated by external incentives such as evading criminal prosecution, avoiding military duty, avoiding work, obtaining financial compensation, or obtaining drugs.

Malingering should be strongly suspected if:

- There is a marked discrepancy between the person's claimed distress or disability and the objective findings;
- Treatment providers report a lack of cooperation during diagnostic evaluation;
- There is lack of cooperation in complying with prescribed treatment regimen;
- The person has antisocial personality disorder.

Malingering is common among jail and prison inmates, but remains controversial.

- On one hand, malingering often goes undetected because staff do not adequately question inmates when they complain of symptoms such as "hearing voices, seeing things, or feeling suicidal".
- On the other hand, when an inmate is suspected of malingering, correctional officers are likely to dismiss threats of suicide or requests for help. All too often, the result is tragic.

Training correctional health care staff to recognize legitimate psychiatric or physical conditions can save inmate's lives while also reducing safety risks and costs due to unnecessary treatment and inappropriate use of psychiatric medication.

There are several effective approaches to detecting malingering:

- Do not automatically assume that prior psychiatric diagnoses are valid. If malingering is suspected, refer inmate for a psychiatric evaluation.
- Train correctional officers and medical staff to recognize signs and symptoms of mental illness. When an inmate complains of psychiatric symptoms, but is suspected of malingering, observe the inmate closely for 24-72 hours to see if the inmate's behaviors are consistent with alleged symptoms. Document observations. For instance, if an inmate complains of depression, but is observed talking animatedly with friends, it is likely that he is malingering.
- If uncertainty remains, submit documentation to a psychiatric professional for review.
- Malingering is often linked with drug-seeking. To determine if the inmate is attempting to obtain prescriptions for inappropriate use, inquire with the inmate's community service providers about prior substance abuse, or substance abuse treatment. The inmate will need to sign information releases to give facility staff permission to talk with his/her mental health or substance abuse providers.
- It is also helpful to corroborate details of the inmate's psychiatric history with the inmate's relatives. If the inmate's version of events leading up to psychiatric symptoms is not verified by kin, malingering should be suspected.
- To reduce misuse of psychiatric medication on a facility-wide basis, it may be cost effective to contract with a psychiatrist with expertise in addictions to conduct psychiatric examinations and substance abuse assessments.
- Behaviors associated with psychiatric symptoms differ across cultures. When malingering is suspected it is important to have observations and evaluations conducted by a professional from the inmate's culture, or one who knows the culture.

Caution: Assume psychiatric symptoms are valid unless there is convincing evidence of malingering.

Handout 2-17

Crossword Quiz: Mental Health and Mental Illness

2.						3.			4.					
		5.		2.										
									4.					
4.														
										6.				
												1.		
				1.										
			5.											
						3.								

Clues

Across:

1. A sign of mental health.
2. Mental illness disrupts thinking, feeling and _____.
3. 1999 national statistic on the percentage of jail inmates with a diagnosis of mental illness._____%
4. A positive symptom of schizophrenia.
5. Episode of mental illness often mistaken for a heart attack.
6. If an individual displays this emotion, you should speak and act calmly.

Down:

1. A US president who had mental illness.
2. The greatest danger in depression.
3. A serious, biologically-based mental illness.
4. When communicating with an individual who appears to have difficulty concentrating, your messages should be _____.
5. Common social situation for individuals with PTSD.
6. A symptom of depression is a sense of excessive _____.

Handout 2-17

Answers to Crossword Quiz: Mental Health and Mental Illness

2.S						3.S			4.B					
U						C			R					
I		5. I		2.B	E	H	A	V	I	O	R			
C		S				I			E					
I		O				Z			4.F	E	A	R		
4.D	E	L	U	S	I	O	N							
E		A				P								
		T				H				6.G				
		I				R				U		1.L		
		O		1. F	L	E	X	I	B	I	L	I	T	Y
		N				N				L		N		
			5.P	A	N	I	C			T		C		
						A						O		
												L		
						3.S	I	X	T	E	E	N		

Clues

Across:

1. A sign of mental health.
2. Mental illness disrupts thinking, feeling and _____.
3. 1999 national statistic on the percentage of jail inmates with a diagnosis of mental illness. _____%
4. A positive symptom of schizophrenia.
5. Episode of mental illness often mistaken for a heart attack
6. If an individual displays this emotion, you should speak and act calmly.

Down:

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2. The greatest danger in depression.
3. A serious, biologically-based mental illness.
4. When communicating with an individual who appears to have difficulty concentrating, your messages should be _____.
5. Common social situation for individuals with PTSD.
6. A symptom of depression is a sense of excessive _____.

Raffle Tickets

#_____ **GOOD POINT!** This ticket entitles the bearer to a chance at the FABULOUS PRIZES awarded for participation in the mental health/criminal justice training program. YOU MUST BE PRESENT TO WIN!	#_____ **GOOD POINT!** This ticket entitles the bearer to a chance at the FABULOUS PRIZES awarded for participation in the mental health/criminal justice training program. YOU MUST BE PRESENT TO WIN!
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Module 3
Co-Occurring Disorders

Module Three:

Co-Occurring Disorders

Length of Presentation: 30 minutes – 1 hour

Handouts and Materials:

3-1 Substance Abuse and Mental Illness
3-2 Signs and Symptoms: Mental Illness vs. Substance Abuse
3-3 Integrated Treatment of Mental Illness & Substance Abuse
3-4 Dual Diagnosis Programs in Tennessee: Mental Illness & Substance Abuse
3-5 Mental Retardation
3-6 Mental Retardation and Crime
3-7 Mental Retardation and Mental Illness
3-8 Resources: Mental Retardation/Developmental Disability
3-9 Other Disabilities and Mental Illness
3-10 Criminal Justice Procedures for Individuals with Disabilities
3-11 Resources: Other Disabilities
3-12: Instructor Version,Response

Motivational rewards:

- *Small candies; or*
- *Raffle Tickets.*

[Instructor note:
When teaching law enforcement officers, emphasize recognizing co-occurring disorders and referral to services.
When teaching correctional officers emphasize recognition, assessment and facility-based treatment.
When teaching probation and parole, emphasize recognition, ongoing assessment and community-based treatment, housing supports and services.
For brief version only cover the section on mental illness and substance abuse. Do only one scenario from the Response exercise.]

Objectives

- To understand co-occurring substance abuse and mental illness;
- To identify behaviors that would suggest substance abuse and/or mental illness;
- To understand co-occurring mental retardation and mental illness;
- To distinguish between mental illness, and mental retardation.
- To understand other co-occurring conditions;
- To identify signs and symptoms that might indicate conditions co-occurring in an individual with mental illness.

DISCUSSION
Co-Occurring Disorders

Individuals with mental illness frequently have additional disorders that “co-occur”. The most common co-occurring conditions are:

- Substance abuse disorders,
- Mental retardation; and
- Physical disabilities such as traumatic brain injury.

Because the behavioral problems associated with mental illness are compounded and complicated by these other conditions, people with co-occurring disorders have:

- More frequent contact with the criminal justice system;
- More behavior problems when incarcerated;
- More difficulty connecting to effective services in the community upon release; and
- Are more likely to be re-arrested.

There are too few services or supports for these individuals. Most professional agencies are ill-equipped to handle their multiple challenges. Few landlords will rent to them, especially if they have criminal records. The sad fact is that many individuals with co-occurring disorders become repeat offenders, sometimes because there is nowhere else for them to go. Criminal justice personnel can play a role in reducing this problem.

Co-Occurring Mental Illness and Substance Abuse

The Problem

Mental illness and substance abuse often go together. It's a big problem. Studies have shown that 7 to 10 million Americans have at least one mental disorder and at least one substance-related disorder in any given year.

*[**Instructor:** Review Handout 3-1: Substance Abuse and Mental Illness, ONLY section on The Problem .]*

A significant number of individuals with co-occurring disorders are involved in the criminal justice system, but many are not recognized due to lack of effective screening and assessment. Offenders and inmates with untreated co-occurring disorders are more likely:

- To cycle frequently through the criminal justice system;
- To be sentenced to more time in correctional facilities;
- To have more behavior problems;
- To be at increased risk for suicide;
- To drop out of treatment or have less successful treatment outcomes; and
- To violate conditions of probation and parole.[1]

What to Do

Screening and assessment are the keys.

*[**Instructor:** Review Handout 3-1: Substance Abuse and Mental Illness, section on What to Do: Assessment.]*

Screening and assessment for mental illness and substance use disorders should be available in all justice settings:

- Arrest,
- Pre-trial detention,
- Courts,
- Jails,
- Prisons, and
- Probation/ parole.

[1]Ibid.

Assessment should be a cooperative effort between criminal justice facilities, mental health agencies and substance abuse treatment providers using standardized screening and assessment protocols.

Assessment is a continuing process, some parts (such as blood alcohol level tests) are done while the person is intoxicated. Other parts are best delayed for 4 – 6 weeks until the individual is clean and sober, in order that psychiatric symptoms may be distinguished from those that are substance-induced.

*[**Instructor note:** Suggested screening instruments are included in Module 7 of this curriculum. If there are questions about it you can either hand it out and review it at the end of the session or ask participants to wait until that session is scheduled.]*

Treatment
*[**Instructor:** Review Handout 3-1: Substance Abuse and Mental Illness, section on What to Do: Treatment.]*

The criminal justice system can play a vital role in increasing treatment success for individuals with co-occurring disorders. Assessment can be a part of every phase of the offender's interaction with the criminal justice system. Treatment should be provided in correctional settings and during probation or parole.

*[**Instructor:** Review Handout 3-1: Substance Abuse and Mental Illness, section on Criminal Justice Response.]*

Discussion:
[10-minute limit.
***Optional:** Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual appeared to have co-occurring mental illness and substance abuse?
- What challenges did that individual present to your work or your facility?
- Were you able to resolve those challenges? If so, how?
- Was one or the other condition ruled out in assessment?
- Based on the information you have heard today, what else could you have done?

Signs and Symptoms: Mental Illness vs. Substance Abuse

Individuals with mental illness are often mistakenly thought to be abusing substances and vice versa, because signs of one condition may mask or mimic signs of another condition. Drug tests are available to help clarify the picture, but symptoms of mental illness may be present while the person is detoxifying and may or may not go away when the person is clean and sober.

Handout 3-2 is for your reference and compares some of the signs and symptoms of common psychiatric disorders and commonly abused drugs.

*[**Instructor:** Refer to Handout 3-2: Signs and Symptoms: Substance Abuse vs. Mental Illness. Do not review it in class unless participants have specific questions.]*

Integrated Treatment

*[**Instructor:** Refer to Handout 3-3: Integrated Treatment of Substance Abuse and Mental Illness.]*

Integrated treatment for co-occurring mental illness and substance abuse involves several stages and often takes place in several agencies and settings. Handout 3-3 shows the phases of:

- Assessment and diagnosis;
  - Can be in an inpatient or outpatient setting or a correctional setting;
  - Usually takes place in several stages as the individual is detoxified;
  - May require contacting kin to get some of the information;
- Stabilization;
  - Medication for substance abuse stabilization is to alleviate serious physical symptoms of withdrawal;
  - Psychiatric medication is to alleviate symptoms of mental illness;
  - Medication must be monitored carefully to avoid drug interactions;
  - Stabilization of mental illness takes longer, but hospital may return the individual to the correctional facility before psychiatric stabilization is complete;
- Engagement;
  - Treatment usually takes place in a community setting (or correctional facility);
  - Confrontation consists of empathic, but straightforward questions and observations of the effects of substance abuse on the individual's life;
- Prolonged Stabilization;
  - Very important that prolonged stabilization of a probationer be monitored by the probation officer;
- Recovery;
  - Criminal justice personnel should encourage the individual to maintain recovery through self-help attendance and active participation in treatment.

Note that the family, or whoever is close to the individual, is involved in most phases of treatment. This is to reinforce the individual's recovery and to reduce family behaviors that would "enable" the individual's addiction.

Integrated treatment is not widely available in Tennessee, but Handout 3-4 contains contact information for some of the programs that do exist.

*[**Instructor:** Refer to Handout 3-4, Dual Diagnosis Programs in Tennessee.]*

Optional Presentation: Ask a provider from an integrated treatment program to briefly address participants on what the agency does, eligibility criteria and how to access the program on behalf of offenders and inmates. This informs participants and also raises the awareness of the provider of the needs of the criminal justice population. It can help facilitate good working relationships.

Ask the provider to speak for *20 minutes*. Allow *5 — 10 minutes* for questions.

Dual Diagnosis: Mental Retardation and Mental Illness

Mental retardation is often confused with mental illness, but the two conditions are very different. Some people with mental retardation also have a mental illness. People with dually-diagnosed mental retardation and mental illness become involved in crime, often through misunderstanding. In an effort to sort out some of this misunderstanding we will begin by looking at mental retardation.

*[**Instructor:** Review Handout 3-5: Mental Retardation.]*

Mental Retardation and Crime[2]

- Studies show that Individuals with mental retardation are no more likely to commit crimes than the average person .
- Data from programs for offenders with mental retardation found:
    - Most offenders with mental retardation were arrested for committing misdemeanors and less serious felonies (White & Wood, 1986) . (Illinois Mentally Retarded and Mentally Ill Task Force, 1988) .

As more people with mental retardation move out of institutions and into the community, they are becoming involved in the criminal justice system as:

- Victims,
- Witnesses, or
- Suspects.

*[**Instructor:** Review Handout 3-6: Mental Retardation and Crime, beginning with the second paragraph.]*

Mental Retardation and Mental Illness,

Many people, including criminal justice personnel, make the mistake of confusing mental retardation with mental illness. It is important to understand that these disorders are separate and distinct conditions.

*[**Instructor:** Review Handout 3-7: Mental Retardation and Mental Illness, ONLY the chart: Mental Retardation/ Mental Illness.]*

[2]Davis, Leigh Ann (2000) People with Mental Retardation in the Criminal Justice System. Retrieved from: http://www.thearc.org/faqs/crimqa.html: August 1, 2000.

[3]Ellis, J., & Luckasson, R. (1985). Mentally retarded criminal defendants. George Washington Law Review, 53 (3-4), 414-493.

[4]White, D. & Wood, H. (1986). The Lancaster County, Pennsylvania, Mentally Retarded Offenders Program. Prison Journal, 65 (1), 77-84.

[5]Illinois Mentally Retarded and Mentally Ill Offender Task Force. (1988, July). Mentally retarded and mentally ill offender task force report. Springfield: Author.

Dual Diagnosis: Mental Retardation and Mental Illness

- Studies estimate that 10 to 20 percent of the people with mental retardation have a co-occurring mental illness.
- The significant advances in mental health treatment made over the last 20 years are rarely adapted for use with people who also have mental retardation.
- There are still many areas where resources are very hard to find.

*[**Instructor:** Review Handout 3-7: Mental Retardation and Mental Illness: section on Treatment.]*

Treatment for dual diagnosis is in its infancy in Tennessee. There are few models of best practice nationally and few agencies that have adopted those best practices. Correctional release planners and probation/parole officers may have a hard time finding housing, treatment and rehabilitation programs for probationers and parolees.

*[**Instructor:** Refer to Handout 3-8: Resources: Mental Retardation/ Developmental Disabilities.]*

Discussion:
[10-minute limit.
***Optional:** Award a raffle ticket to participants who talk about their experience.]*

- In your work, what situations have you encountered where the individual appeared to have a dual diagnosis of mental illness and mental retardation?
- What challenges did that individual present to your work or your facility?
- Were you able to resolve those challenges? If so, how?
- Was one or the other condition ruled out in assessment?
- Based on the information you have heard today, what else could you have done?

Mental Illness and Other Conditions

There are several more diseases or disabilities that commonly occur along with mental illness.

- Some, like traumatic brain injury (TBI), result in mental illness because the primary condition affects the brain.
- In others, like HIV/AIDS, behavior associated with mental illness increases risk of infection.
- Others, like hearing or visual impairment, produce conditions of daily living that may trigger mental illness such as major depression or anxiety disorder.
- Others, such as autism, may have characteristics that are similar to mental illness. Treatment for those characteristics is the same, but there are differences in the course of treatment, rehabilitation and recovery.
- Still others, such as thyroid deficiency, have symptoms that are often mistaken for mental illness, but treatment for the primary condition removes the symptoms of mental illness without psychiatric treatment. Symptoms of the disease “mimic” mental illness.

The difference between mental illness and most other disabilities with similar characteristics , is that symptoms of mental illness are intermittent, whereas most of the others either stay the same or have a gradual deteriorating course that may or may not be halted with treatment.

The main point: When offenders are incarcerated with behavioral and emotional symptoms, it is advisable to conduct a thorough physical examination to rule out other conditions. If the other conditions are treated, psychiatric symptoms may either go away, or become clear. If mental illness is still apparent, it can be diagnosed and treated correctly. Correct diagnosis will prevent human suffering as well as time and costs in treatment.

*[**Instructor:** Review Handout 3-9: Mental Illness and Other Disabilities]*

Individuals with mental illness co-occurring with other disabilities present special challenges to the criminal justice system. People with disabilities have the same rights as anyone else, but in order to communicate effectively, criminal justice personnel may have to make accommodations.

*[**Instructor:** Review Handout 3-10: Criminal Justice Procedures for Individuals with Disabilities.]*

Referral can be difficult for individuals with mental illness and co-occurring disabilities. A few resources are listed on Handout 3-11.

*[**Instructor:** Refer to Handout 3-11: Resources: Other Disabilities.]*

***Response:* Service Linkage for People with Co-Occurring Disorders**

[Notes to Instructor:
Refer to Handout 3-12: Response: Service linkage for people with co-occurring disorders.

- *Read client scenarios to the class. Choose those most appropriate to the audience.*
- *After each scenario is read, ask participants to suggest the best approach to linking the individual to supports and services.*
- *After participants respond, read the solution segment from the instructor handout.*
- *Ask participants to discuss how that solution would or would not have worked in their local area.*
- *Optional: Reward participation by giving a small piece of candy to each participant who suggests approaches, As the exercise progresses, place a large candy bar in view of the audience. At the end of the exercise, give the candy bar to the student whose participation was most helpful.*

Alternative: Distribute raffle tickets to each person who responds. See instructor notes at beginning of module 2.]

Handout 3-1

Substance Abuse and Mental Illness

The Problem

7 – 10 million Americans have at least one mental illness and abuse at least one substance in any given year. Abuse of one or more substances occurs in:

- 56% of individuals with bipolar disorder;
- 47% of individuals with a psychotic disorder (schizophrenia, schizoaffective disorder);
- 32% of individuals with depression; and
- 27% of individuals with anxiety disorders.

Individuals with mental illness who abuse substances are:

- More likely to have marital and social problems;
- More likely to have employment problems;
- More likely to commit aggressive, violent acts;
- More likely to have legal problems;
- More likely to be arrested and incarcerated;
- Less likely to engage in treatment; and
- Less likely to successfully complete treatment.

Why do individuals with mental disorders abuse substances?

- To experience a new mental/emotional state;
- To manage or reduce psychiatric symptoms;
- To kill time, avoid boredom;
- To make friends;
- To shed the label of "mental patient";
- To avoid withdrawal symptoms (when addicted).[7]

What to Do

Assessment

Screening and assessment for mental illness and substance use disorders should be available in all justice settings: arrest, pre-trial detention, courts, jails, prisons, and probation/ parole. Assessment should be undertaken collaboratively between criminal justice facilities, mental health agencies and substance abuse treatment providers using standardized screening and assessment protocols. Assessment is a continuing process, some portions best delayed for 4 – 6 weeks until the individual attains sobriety, in order that psychiatric symptoms may be distinguished from those that are substance-induced.

Treatment

Factors in successful treatment of offenders with co-occurring disorders:

- Treatment addresses both mental illness and substance abuse,
- One provider (either mental health or substance abuse) is designated as the responsible party, but collaboration with the other provider is required,
- Criminal justice personnel, usually probation/parole, monitor the process.[8]

[6]Regier, D., Farmer, M., Rea, D. et al (1990) Comorbidity of mental disorders with alcohol and other drug abuse: Results from the epidemiological catchment area study. Journal of the American Medical Association 264: 2511-2518.

[7]Pepper, B., Hendrickson, E. (199_) Working with Seriously Mentally Ill Substance Abusers, Arlington County Mental Health Department.

Mandatory treatment is usually necessary because the majority of individuals with co-occurring disorders will not voluntarily participate in either substance abuse programs or mental health treatment.

The best approach is to treat co-occurring disorders in a program that integrates substance abuse and mental health treatment. If that is not available, one agency should be assigned to be responsible for treatment coordination and communication between the mental health and the substance abuse programs. When the offender realizes that both provider agencies and the courts are communicating, he or she is more likely to follow through with treatment.

Treatment professionals often notice that after treatment has begun to improve mood, social relationships and quality of life, the client becomes more motivated to continue with treatment after court order or probation/parole expires.

Criminal Justice Response

Law Enforcement

- Ensure that offenders suspected of substance use are tested;
- If using substances, place offenders in detoxification unit;
- If not, refer for psychiatric assessment.

Corrections

- Ensure that offenders/inmates are detoxified prior to referral for assessment;
- Refer offenders/inmates to mental health and substance abuse programs for assessment and treatment;
  Contract with community providers to provide individual and group counseling in the correctional facility;
  Train correctional medical staff to provide facility-based mental health and substance abuse treatment;
- Establish self-help groups in jail. Co-occurring group is best (DRA, Double Trouble): participants are less likely to be pressured by peers to stop taking psychiatric medication.

Probation/ Parole/ Community Corrections

- Ensure that probationers participate in treatment,
  - For both mental illness and substance abuse;
- Lack of participation constitutes violation or parole;
- Integrated treatment program is best;
- Negotiate with one agency to be in charge of treatment plan;
  - Coordinating with other agency,
  - Monitor inter-program collaboration;
- When probationer knows of collaboration, treatment participation increases.

Courts

- Ensure that defendants are connected to treatment;
- Include mental health and substance abuse treatment as conditions of probation;
- Refer offender to mental health treatment and substance abuse treatment;
- Mandate one agency to be responsible for treatment plan; and
  - Charged with coordinating with program from other system.

[8]GAINS Center (1997). Screening and assessment of Co-Occurring Disorders in the Justice System, New Your: Policy Research.

Handout 3-2

Signs and Symptoms: Mental Illness vs. Substance Abuse

Mental illness/ Substance	Signs and Symptoms
depression	Sleep disturbance, sad mood, low energy, suicidality, guilt, hopelessness, inability to experience pleasure
alcohol	Euphoria, slurred speech, loose muscle tone, loss of fine motor coordination, staggering gait, loss of judgment. Impairment of balance, vision, hearing and reaction time. At higher BAC: dysphoria, anxiety, restlessness. **Withdrawal:** nausea, sweating, shakiness, anxiety, delirium tremens, hallucinations, seizures.
heroin (smack, H, skag, junk)	Euphoria, warm skin flush, dry mouth, heavy extremities, alternately wakeful and drowsy state. **Withdrawal:** drug craving, restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes ("cold turkey"), kicking movements ("kicking the habit").
inhalants (glue, gas, solvents: poppers, bold, rush)	Euphoria, loss of inhibition and control. Complications: hearing loss, limb spasms, heart attack, sudden death. Damage to brain, liver and kidney, bone marrow,
mania	Insomnia, hyperactivity, hypersociability, expansiveness, grandiosity, elation
cocaine (crack, C, snow, flake, blow)	Euphoria, rapid speech, reduced need for sleep or food, mentally alert, restlessness, irritability, anxiety, paranoia, headache, constricted blood vessels, dilated pupils, nosebleeds, intestinal problems, “tracks”. Increased temperature, heart rate, and blood pressure. **Complications:** intense craving, heart attack, stroke, seizure, respiratory failure. Combined with alcohol can cause sudden death.
methamphetamine (speed, meth, chalk, ice, crystal, glass)	Euphoria, wakefulness, increased physical activity, decreased appetite, **Complications:** shortness of breath, hyperthermia, irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, aggressiveness
Prescription drug abuse: stimulants	Increased alertness, attention, increased blood pressure, heart rate, respiration. High doses: irregular heartbeat, fever, heart attack, lethal seizures, hostility, paranoia.
anxiety and panic	Sense of impending doom, intense fear, chest pain, rapid heartbeat, shortness of breath, dizziness, sweating, abdominal distress
Prescription drug abuse: benzodiazepines, barbiturates	Calmness, drowsiness, drug dependence. Combined with other medications can cause: heart attach, respiratory problems Sudden withdrawal: seizures
Marijuana (pot, herb, weed, grass, widow, ganja, and hash)	Euphoria, relaxation, dry mouth, rapid heartbeat, loss of coordination and balance, slower reaction times, “red eyes”. Long-term effects: impairment in memory, thinking, learning and problem solving; distorted perception.
psychosis	Hallucinations (auditory or visual), delusions, paranoia, social withdrawal, confusion, incoherent or reduced speech, odd movements
LSD (acid)	Intense emotions, delusions, visual hallucinations. Changed sense of time and self, “cross over" sensations, hearing colors, seeing sounds. Physical signs: dilated pupils, fever, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, tremors. Long term effects: flashbacks, schizophrenia, depression.
PCP (angel dust, ozone, wack, rocket fuel. Combined with marijuana: Killer joints, crystal supergrass)	Feeling of strength, power, invulnerability, numbing of the mind, drop in breathing, blood pressure, heart rate, nausea, vomiting, blurred vision, flicking up and down of the eyes, drooling, loss of balance, dizziness, seizures, coma. Psychological effects: craving, hallucinations, delusions, paranoia, disordered thinking, catatonia. Behavior: Violence, suicide attempts. Long term use: memory loss, depression, weight loss.

Handout 3-3

Integrated Treatment of Mental Illness & Substance Abuse[9]

Substance Abuse Treatment	Mental Health Treatment
ASSESSMENT AND DIAGNOSIS	
Substance abuse history	Psychiatric history
Drug screening	Medical and physical history
Previous treatment history	Previous treatment history
Family background	Family background
Strength of support system	Strength of support system
Vocational background	Vocational background
Self-help group participation	Peer-run program participation
TREATMENT: STABILIZATION	
Detoxification	Stabilize Acute Psychiatric Illness
Usually inpatient	Usually inpatient
Usually need medication	Medication
3-5 days (alcohol)	2 weeks to 6 months
Assessment for other diagnoses	Assessment for substance use
TREATMENT: ENGAGEMENT	
Begins with empathy from therapist and peers. Work on forgiving selves and others; Education about addiction; Introduction to 12-step approach. Empathic confrontation by therapist and/or peers is almost always necessary.	Medication monitored to manage symptoms, Empathy from therapists and peers, Education about mental illness. Empathic confrontation sometimes necessary.
2 – 12 weeks	1-6 months
Multiple relapses often occur before client commits to active, ongoing treatment.	Multiple relapses often occur before client commits to ongoing treatment.
Education of the family facilitates treatment. Involve them in confronting client's denial and supporting recovery.	Education of the family facilitates treatment. Involve them in helping client participate in treatment and supporting recovery.

[9]Hamilton, Timothy (1998) Dual Diagnosis Resource Network: Prepared for the BRIDGES Curriculum, Tennessee Mental Health Consumers' Association, Nashville, TN.

Substance Abuse Treatment	Mental Health Treatment
TREATMENT: PROLONGED STABILIZATION **Active treatment, maintenance, relapse prevention**	
Goal: Continued abstinence (one year)	Goal: Continued stability (one year) rebuilding social and vocational skills
Client consistently attends abstinence support meetings (AA,NA, DRA) usually 3-5 times per week.	Client consistently takes prescribed medications and attends treatment sessions. Individuals with serious mental illness often benefit from peer programs such as a drop-in centers, and from psychosocial rehabilitation programs.
Need to focus on asking for help to cope with urges to use substances and drop out of treatment	Need to focus on asking for help to cope with continuing symptoms and urges to drop out of treatment, or with urge to discontinue medication because symptoms have subsided.
Family needs ongoing involvement in its own recovery support program (ALANON, etc.) to learn empathic detachment and how to set caring limits.	Family needs ongoing involvement in its own recovery support program (NAMI, Journey of Hope) to learn empathic detachment and how to set caring limits.
Continuing assessment	Continuing assessment
RECOVERY: ONGOING	
Stability precedes growth; no growth is possible unless sobriety is fairly secure. Growth occurs slowly, One Day At A Time	Stability precedes growth; no growth is possible unless illness is stable. May be symptomatic, but able to resume social and vocational roles.
Continued work in the self-help program on growing, changing, dealing with feelings (12-steps)	Continued medication, reduced to maintenance level. Participation in psychosocial rehabilitation, work, school, family, community.
Goal is peace of mind and serenity.	Goal is wellness and quality of life.

Handout 3-4

Dual Diagnosis Programs in Tennessee
Mental Illness & Substance Abuse

Program	Address	City/ZIP	Telephone
West Tennessee			
Charter Lakeside Behavioral Health System	2911 Brunswick Rd.	Memphis 38133	901-377-4733
Foundations Associates	2009 Lamar Ave	Memphis 38114	901-726 6053
Power Center, Drop-in Center, Foundations Associates	1048 S. Bellevue	Memphis 38106	901-946-4678
Full Circle Community Mental Health Center	1384 Madison Ave.	Memphis 38104	901-274 5991
Genesis House	300 N. Bellevue	Memphis 38105	901-726-9786
Methodist Hospital	1265 Union	Memphis 38104	901-726-8025
Southeast Mental Health Center	3810 Winchester	Memphis 38118	901-369-1400
Whitehaven Southwest Mental Health Center	1087 Alice	Memphis 38116	901-774-7811
Middle Tennessee			
Centennial Parthenon Pavilion	2401 Parman Place	Nashville 37203	615-342-1400
Centerstone Community Mental Health Centers, A&D Treatment	620 South Gallatin Road	Madison 37115	615-460-4300
Foundations Associates	220 Venture Circle	Nashville 37228	615-256-9002
MIDAS Program Downtown Clinic	526 8th Avenue South	Nashville 37203	615-862-7900
Park Center East	948 Woodland Street	Nashville 37202	615-650-2900
Tennessee Christian Medical Center: Addictions Unit	500 Hospital Drive	Madison 37115	615-860-0426 800-467-8262
VITA, Psychiatric Hospital at Vanderbilt	1001 23rd Avenue South	Nashville 37212	615-327-7078
East Tennessee			
AIM Center	1903 McCallie Avenue	Chattanooga 37404	423-624-4800
CADAS	207 Spears Avenue	Chattanooga 37405	423-756-7644
Columbia Valley Hospital	2200 Morris Hill Road	Chattanooga 37421	423-894-4220
Florence Crittenton Agency	1531 Dick Lonas Road	Knoxville 37909	865-602-2021
Comprehensive Community Cares	1914 McCallie Avenue.	Chattanooga, 37404	423-622-9311
Comprehensive Community Cares	1127 North Broadway	Knoxville, 37909	
Fortwood Center	601 Cumberland, Suite A	Chattanooga 37404	423-266-6751
Helen Ross McNabb Center	1520 Cherokee Trail	Knoxville 37920	423- 524-5757
Peninsula Behavioral Health Lighthouse Treatment Center	6800 Baum Drive	Knoxville 37917	865-558-8880
Overlook Center	100 Main Street	Madisonville 37354	865-442-2425
Peninsula/Ft. Sanders Hospital	PO Box 2000 Jones Bend Rd.	Louisville 37777	865-970-9800
Positively Living	1501 East 5th Ave.	Knoxville, 37917	865-525-1540
Woodridge Hospital	403 N State of Franklin Road	Johnson City 37604	423-928-7111
Self-Help			
Dual Recovery Anonymous	http://draonline.org/meetings_dra/usa/tennessee.html	Statewide	615-742-1000

Handout 3-5

Mental Retardation

Mental retardation is:

- A Lifelong disability consisting of impaired intellectual functioning;
- Affects 3% of the population, or 6.5 million Americans as of the 1990 census;
- Caused by any condition that impairs development of the brain before birth, during birth or in the childhood years, including:
    - Genetic conditions,
    - Problems during pregnancy and birth,
    - Childhood diseases and exposure to environmental toxins, and
    - Other conditions associated with poverty such as:
        - Malnutrition, and
        - Inadequate medical care.

There is a wide range in level of disability among individuals with mental retardation.

- About 87% are mildly affected and will be only a little slower than average in learning new information and skills. As adults, many will live independent lives and no longer be viewed as having mental retardation.
- 13%, those with IQs under 50, have serious limitations in functioning. However, with early intervention, a functional education and appropriate supports as an adult, all can lead satisfying lives in the community.

Definition of Mental Retardation

- IQ below 70-75;
- The condition is present from childhood; AND
- Significant limitations exist in two or more skill areas:
    - Communication
    - Self-care;
    - Home living;
    - Social skills;
    - Leisure;
    - Health and safety;
    - Learning (reading, writing, basic math);
    - Capacity for independent living;
    - Economic self-sufficiency.

Handout 3-6

Mental Retardation and Crime[10]

Individuals with mental retardation are no more likely to commit crimes than the average person[11]. As more people with mental retardation move into the community from institutions, they are becoming involved in the criminal justice system as victims, witnesses, or suspects.

Other criminals often use individuals with mental retardation as accomplices. The person with mental retardation may not understand:

- That he or she is involved in a crime; or
- The consequences of his/her involvement.

He or she may also have a deep need to be accepted and may agree to help with criminal activities in order to gain friendship.

Many individuals unintentionally give "misunderstood responses" to officers, which increases their vulnerability to:

- Arrest,
- Incarceration, and possibly
- Execution, even if they committed no crime (Perske, 1991)[12].

When confronted by police the individual with mental retardation may:

- Not want disability to be recognized (try to cover it up);
- Not understand rights (but pretend to understand);
- Not understand commands;
- Be overwhelmed by police presence;
- Act upset at being detained and/or try to run away;
- Say what he or she thinks others want to hear;
- Have difficulty describing facts or details of offense;
- Be the last to leave the scene of the crime, and the first to get caught;
- Be confused about responsibility for the crime and "confess" when innocent.

Upon arrest, individuals with mental retardation usually answer affirmatively when asked if they understand their rights, even when they do not understand. They are trying to:

- Gain approval, or
- Hide their disability.

[10]Leigh Ann (2000) People with Mental Retardation in the Criminal Justice System. Retrieved from: http://www.thearc.org/faqs/crimqa.html: August 1, 2000.

[11]Ellis, J., & Luckasson, R. (1985). Mentally retarded criminal defendants. George Washington Law Review, 53 (3-4), 414-493.

[12]Perske, R. (1991). Unequal justice? What can happen when persons with retardation or other developmental disabilities encounter the criminal justice system. Nashville: Abingdon Press.

Because of these factors, people with mental retardation are more likely to be:

- Arrested,
- Convicted,
- Sentenced to prison, and
- Victimized in prison (Santamour, 1986)[13].

Once in the criminal justice system, these individuals are less likely to

- Receive probation or parole, and
- Tend to serve longer sentences due to an inability to understand or adapt to prison rules.

Studies show that 2 to 10 percent of the prison population has mental retardation.

Crime Victims with Mental Retardation

Studies show that people with disabilities are about twice as likely as others to be victimized (Sobsey & Doe, 1991)[14]. Some factors in victimization of persons with mental retardation:

- Victims may not report crimes because they depend on the abuser for basic survival needs.
- When victims do report crimes, police and court officials may not take the person's allegations seriously or be reluctant to get involved.
- People with mental retardation often lack the resources necessary to prosecute (Sobsey, 1994)[15].

[13]Santamour, M. (1986, Spring-Summer). The offender with mental retardation. The Prison Journal, 66 (7), 3-1

[14]Sobsey, D., & Doe, T. (1991). Patterns of sexual abuse and assault. Journal of Sexuality and Disability, 9 (3), 243-259.

[15]Sobsey, D. (1994). Violence and abuse in the lives of people with disabilities. Baltimore: Paul H. Brookes Publishing Co.

Handout 3-7

Mental Retardation and Mental Illness

Mental retardation and mental illness are separate and distinct conditions.

Mental Retardation	Mental Illness
A. Refers to significantly below average intellectual functioning.	A. Has nothing to do with intelligence.
B. Refers to impairment in social adaptation.	B. Characterized by disturbances in thinking, feeling and relating to others or the environment.
C. Usually occurs during early development or is present at birth. However, a brain injury or toxemia may cause retardation at any age.	C. Can strike anyone at any time.
D. Mental retardation is permanent, but can be compensated for through education and development.	D. Mental illness may be temporary or chronic. People with mental illness may relapse and recover once or many times.
E. A person with mental retardation can usually be expected to behave rationally at his operational level.	E. A person with a mental illness may vacillate between normal and irrational behavior. Some people with a mental illness may be erratic, especially when not undergoing treatment.

Dual Diagnosis: Mental Retardation and Mental Illness

Studies estimate that 10 to 20 percent of the people with mental retardation have a co-occurring mental illness. The significant advances in mental health treatment made over the last 20 years have been slow to be adapted for use with people with mental retardation. There are still many areas where consumers and families have great difficulty locating appropriate services.

Treatment for Dual Diagnosis

Psychopharmacology. There has been a tendency in the past to over-medicate people with mental retardation and not to carefully monitor the behavioral effects of medications.

Counseling/Psychotherapy. People with mild mental retardation can benefit from counseling. Many individuals cope better when another person listens to their problems and provides social support and understanding.

Cognitive Therapy. This treatment teaches people with mild mental retardation to recognize the situations in which they get into trouble and to develop alternative behavior and solutions to their problems. Although widely used with the general population, cognitive therapy has been adapted only recently for use with people with mental retardation.

Behavior Management. This approach is widely used with people with mental retardation, especially to control behavior problems. The approach often leads to significant behavioral improvements, at least during the time period when the treatment is in effect. Advocates have called for the complete elimination of aversive (punishment) behavior management techniques and the reliance instead on positive behavioral techniques.

Social Skills Training. This is a cost-effective, time-limited approach that often produces noticeable improvements in quality of life and interpersonal behavior. Individuals are gradually taught effective social interactions and appropriate social behavior.

Handout 3-8

Resources: Mental Retardation/Developmental Disability

Program	Address	City/ZIP	Telephone
Statewide			
The Arc of Tennessee	44 Vantage Way, Suite 550 www.thearctn.org	Nashville, 37228	800-835-7077
TN Disability Coalition	480 Craighead St., Suite 200	Nashville, 37204	615-383-9442
TN Family Pathfinder Internet resource directory	http://kc.vanderbilt.edu/ kennedy/pathfinder/		
TN Protection and Advocacy	2416 21st Avenue South http://www.tpainc.org	Nashville 37212 Knoxville & Memphis	615-298-1080 800-287-9636
West Tennessee			
Buffalo River Services	PO Box 847	Waynesboro 38485	931-762-3203
CS Patterson Training Center	PO Box 229	Trenton 38382	731-855-2316
Madison/Haywood Developmental Services	PO Box 11205	Jackson 38308	731-664-0855
TN Division of MR Services: West TN Office			800-308-2586
Division of Rehabilitation Services		Memphis Jackson	901-423-5620 731-423-5620
Middle Tennessee			
Community Development Center	111 Eaglette Way	Shelbyville 37160	931-684-8681
Division of Rehabilitation Services		Nashville Columbia	615 741-1606 931-380-2563
New Horizons Inc.	5221 Harding Place	Nashville 37217	615-360-8595
Pacesetters	2511 Highway 111 North	Algood 38506	931-537-9100
Rochelle Center	1020 Southside Court	Nashville, 37203	615-254-0673
Sunrise Community	171 W. Dunbar Cave Road	Clarksville 37043	931-648-3011
Team Evaluation Center	PO Box 140500	Nashville 37214	615-231-5094
TN Division of MR Services: Middle TN Office			800-654-4839
TN Rehabilitation Center	460 9th Avenue	Smyrna, 37167	
TOP Rehabilitation Services	2110 N. Jackson Street	Tullahoma 37388	931-455-5189
East Tennessee			
Greene County Skills	490 Sunnyside Road	Greeneville 37743	423-639-5351
Scott Appalachian Industries	591 East Montecello Pike	Huntsville 37756	423-663-9300
Team Evaluation Center	600 North Holtzclaw Ave., Suite 100	Chattanooga 37404	423-622 0500
TN Division of MR Services: East TN Office			888-310-4613
Division of Rehabilitation Services		Johnson City Knoxville	423-434-6934 865-594-6054

Handout 3-9

Other Disabilities and Mental Illness

Disease/ Disability	Definition	Signs & Symptoms
Traumatic Brain Injury (TBI)	Impairment of normal brain function due to a neurological insult, such as open or closed head injury	**Perceptual:** Change in vision, hearing, smell, taste or touch, disorientation altered sense of balance. **Physical:** Headache, fatigue, disorders of movement, seizures, sensitivity to light, sleep disorders, paralysis, unclear speech. **Behavioral/Emotional:** Irritability, low stress tolerance, apathy, dependence, denial of disability, inflexibility, suicidality, lack of inhibition (may result in aggression, cursing, inappropriate sexual behavior), flattened/ heightened emotions.
HIV/ AIDS	**HIV:** Virus that causes AIDS. HIV attacks white blood cells that fight off disease. **AIDS:** Most advanced form of HIV infection; immune system cannot fight off infections or cancer. **Transmission by:** Sexual intercourse, Shared needles, syringes, Birth to infected mother.	**HIV Early stages:** Person looks & feels healthy, but white blood cell count decreases. **HIV Intermediate stage:** Swollen lymph glands, fatigue, weight loss, unusual rashes. **AIDS:** Cancers, viruses, fungi and bacteria attack the brain (dementia), nervous system, kidneys, lungs **Mental Illness & AIDS:** Impaired judgment associated with mental illness increases risk of unsafe sex and IV drug use. People with mental illness have a much higher rate of HIV/AIDS than the general population.
Sensory Disability: Deafness, hearing impairment, Blindness, visual impairment	Impairment or loss of hearing or sight. Can be a condition at birth, or caused by accident or disease.	**Mental Illness and sensory disability:** People with sensory disabilities may develop major depression or anxiety as a result of isolation, loneliness, frustration and stresses of poverty. Otherwise, rates of mental illness are the same as for the general population.
Autism	A developmental disability that affects the brain, autism impairs social interaction and communication skills. Impairs verbal and non-verbal communication, social interactions, and leisure or play activities. Autism is neither mental retardation nor mental illness.	**Emotional/ Behavioral Symptoms** Insistence on sameness; resistance to change, difficulty expressing needs; laughing, crying, showing distress for reasons not apparent to others, prefers to be alone; aloof manner, tantrums, difficulty in mixing with others, resists physical contact, little or no eye contact, inappropriate attachments to objects, apparent over-sensitivity or under-sensitivity to pain, no real fears of danger, not responsive to verbal cues; acts as if deaf although hearing tests in normal range.
Thyroid disorders	Under or over-active thyroid can produce symptoms that mimic mental illness. Individuals have been wrongly diagnosed, hospitalized for months, and treated unsuccessfully for psychosis. When treated for a thyroid condition, symptoms of mental illness usually go away.	**Emotional/ Behavioral Symptoms** **Hyperthyroidism:** anxiety, tension, mood swings, irritability, distractible over-activity, noise sensitivity, fluctuating depression, sleep and appetite problems, delirium, hallucination. **Hypothyroidism:** loss of interest and initiative, slowing of mental processes, poor memory, intellectual deterioration, anhedonia, depression, paranoia, dementia

Handout 3-10

Criminal Justice Procedures for Individuals with Disabilities[16]

Disability	Guidelines
	Communication
Mental Retardation	When speaking, enunciate clearly and slowly to ensure that the individual understands what is being said. (note 1)
	Keep sentences short. Use simple language, speak slowly and clearly. Ask for concrete descriptions, colors, clothing, etc. Break complicated series of instructions or information into smaller parts. Whenever possible use pictures, symbols, and actions to help convey meaning. (note 2)
	Don't assume a person with intellectual disability is incapable of understanding or communicating. (note 2) Treat adults as adults; don't treat adults who have mental retardation as children. Give people with intellectual disability the same respect you would show any other individual. (note 3)
Hearing Impairment	Officers are required by the ADA to ensure effective communication with individuals who are deaf or hard of hearing. Whether a qualified sign language interpreter or other communication aid is required will depend on the nature of the communication and the needs of the requesting individual. In one-on-one communication with an individual who lip-reads, an officer should face the individual directly, and should ensure that the communication takes place in a well-lighted area. (note 1)
	Remove barriers to effective communication – There are physical and environmental obstacles that officers should avoid, reduce or eliminate when communicating with people who have communication disabilities. Obstacles include: noise; rooms that echo; distance between the speaker and the listener; multiple speakers; and movement of people through the room, etc. (note 4)
Speech Impairment	Be patient, allowing the individual to complete statements at his/her own pace. Avoid cutting off a person's statement, unless required in an emergency or crisis. Do not anticipate or project the individual's thoughts by "cutting in" and attempting to complete his/her statements. (note 4)
	Documentation
Visual impairment	Officers must read out loud in full any documents that a person who is blind or visually impaired needs to sign. Providing a copy of the large print will make the form accessible to many individual with moderate vision disabilities.(note 1)
Learning Disability	The simplest solution is to have an officer or clerk assist the person in reading and filling out the form. … The form itself could also be provided in an alternative format. (note 1)

[16]A Collection of Overseas Materials Relevant to the Handling of Persons with Disabilities by Law Enforcement Officers. http://www.eoc.org.hk:8080/CE/investigation/immigration/AnnexE_e.doc. Retrieved 8/12/2003.

Disability	Guidelines
	Oath Taking
Intellectual/ Physical disability	Adjudicators must make reasonable accommodations to allow applicants with disabilities to demonstrate that they understand the nature of the oath and agree to it. Such accommodations can include simplifying questions or allowing the applicant to use predetermined physical motions or signals (such as blinks). (note 5)
	Arrest and Detention
Mental retardation	If officers are not sure that a suspect understands his or her rights, they should ask the suspect to explain each phrase of the rights statement in his or her own words. (note 3)
Hearing impairment	During interrogations and arrests, a sign language interpreter will often be necessary to effectively communicate with an individual who uses sign language. (note 1)
	Deaf individuals may be handcuffed in front in order for the person to sign or write notes. (note 1)
Chronic illness (diabetes)	As an example of reasonable accommodation, a rule that prisoners or detainees are not permitted to have food in a cell except at scheduled intervals may be modified to accommodate an individual with diabetes who uses medication and needs access to carbohydrates or sugar to keep blood sugar at an appropriate level. (note 1)
	Transporting
Physical disability	Safe transport of individuals who use manual or power wheelchairs might require departments to make minor modifications to existing cars or vans, or to use lift-equipped vans or buses. Departments may consider other community resources, e.g., accessible taxi services. (note 6)
	Seeking Help from Third Parties
Hearing Impairment	Officers should generally not rely on deaf individual's family members to provide sign language interpreting. But in some limited circumstances, their help may be essential, for example, in an emergency, when the safety or welfare of the public or the deaf individual is of paramount importance, or in a situation when a deaf individual has been robbed and an officer in hot pursuit needs information about the suspect. (note 1)

Note 1	"Commonly Asked Questions about the Americans with Disabilities Act and Law Enforcement" - Disability Rights Section, Civil Rights Division, U.S. Department of Justice.
Note 2	"A Police Officer's Guide – when in contact with people who have mental retardation." – The ARC (http://www.thearc.org/ada/police.html).
Note 3	"The Police Response to People with Mental Retardation: Trainers Guide", Police Executive Research Forum (PERF).
Note 4	"The Police Response to People with Hearing and Speech Disabilities: Trainers Guide" – PERF
Note 5	Immigration and Naturalization Service (INS) News Release April 14, 1999 - INS Implements New Guidance to Improve the Review of Naturalization Cases of Applicants with Disabilities. http://www.ins.usdoj.gov/graphics/publicaffairs/newsrels/natz-dis.htm
Note 6	Police Response to Seizures & Epilepsy: A Curriculum Guide for Law Enforcement Trainers" – PERF, Epilepsy Foundation.

Handout 3-11

Resources: Other Disabilities

Program			
Traumatic Brain Injury			
Brain Injury Association of Tennessee (BIAT)	699 West Main St., Suite 112-B mail@tnbiat.org	Hendersonville, TN 37075	615-264-3052
HIV/AIDS			
Tennessee HIV/AIDS Resource Directory	http://coetenn.bizland.com/ ResDirectory		
AIDS/HIV/STD Hotline:		Tennessee only	800-525-2437
Tennessee HIV AIDS facts	http://www.aidsaction.org/ communications/publications/ statefactsheets/pdfs/tennessee		
Hearing Impairment			
League for the Deaf & Hard of Hearing	415 4th Avenue South http://www.leagueforthedeaf.com	Nashville, TN 37201	615-248-8828 (voice/TTY).
Mental Health Services for Deaf People: Directory By Diane Morton # DY99-1; $12.95	Gallaudet Research Institute Dissemination Office Gallaudet University 800 Florida Avenue, N.E. http://gri.gallaudet.edu	Washington, DC 20002	
Visual Impairment			
National Federation of the Blind	1226 Goodman Circle West http://www.nfb.org/states/tn.htm	Memphis 38111-6524	901-324-7056
Services for the Blind and Visually Impaired, Tennessee Division of Rehabilitation Services	Citizens Plaza Building, 11th Fl. 400 Deaderick Street	Nashville 37248-6200	615-313-4914
Autism			
Autism Solutions Center		Memphis	901-758-8248
Autism Society of Middle TN	480 Craighead St., Suite 200	Nashville 37204	615-385-2077
Autism Society of Southeast TN, Tim Pitchford	ASAchat@AOL.com	Chattanooga	423-485-1272
Autism Society of East TN		Knoxville	865-637-3914
Breakthrough Corporation	P.O. Box 52111 http://www.breakthroughknoxville.com	Knoxville 37950	865-335-3298

Handout 3-12

Response

Service Linkage for People with Co-Occurring Disorders

Individuals who have mental illness in addition to other disabilities present challenges to the criminal justice system. Few community agencies are prepared to offer effective services and supports. Linkages that are successful are often forged through networking and creative approaches to meeting the individual's needs. The following are scenarios of actual individuals. Names have been changed to protect identity.

- Brainstorm with the group about services and supports in your area that could meet the individual's needs;
- After your discussion, the instructor will read what actually happened;
- Discuss your reaction.

Scenario 1:

A woman, age 35, African American, homeless, with Schizoaffective disorder, cocaine dependency and mild mental retardation has been arrested 43 times for charges such as possession of drug paraphernalia, criminal trespassing, pedestrian solicitation and assault charges. Most of the charges over the years have been misdemeanors. Several years ago she and her children were in a house fire in which one of her children died.

She was recently arrested on robbery charges after accosting a woman on the street. The most recent forensic evaluation found that she was competent to stand trial. Upon returning from the evaluation, she struck her public defender and was sent back to the jail cell where she punched a pregnant inmate. Six weeks passed until the preliminary hearing where charges were dismissed because the victim did not come to court.

Scenario 2:

A man, age 40, Native American, homeless, with Schizoaffective disorder, posttraumatic stress disorder (PTSD) and alcohol dependence. He has been arrested numerous times mostly for public disturbance and disorderly conduct, and is constantly in an out of jail. He has been referred to case management several times, but because he does not arrive at appointments and the case manager cannot find him, he is dropped from the caseload.

He was recently arrested for disorderly conduct when he jumped off the bridge into the river in a suicide attempt. Once in the river he decided he didn't want to die and began throwing things at passing cars to attract attention.

The court offered him the options of doing 41 days in jail, or going before the mental health court. He was hearing voices and the mental health court would not see him until he was stabilized.

Scenario 3:

A man, age 50, African American, with bipolar disorder and alcohol dependence. He has a history of violence and was imprisoned for attempted murder ten years ago when he found his wife with another man. He always appears drunk and has been arrested repeatedly for nuisance crimes such as public intoxication and disorderly conduct. He suffered a stroke several years ago due to toxicity from an accidental overdose of lithium. He is partially paralyzed and has spasmodic movements. His

landlady nursed him back to health and continues to care for him. When he was placed in intensive integrated community treatment, arrests slowed to once a month.

Recently he was incarcerated on charges of assaulting an officer during an arrest for public intoxication. He was accused of reaching for the officer's gun, but witnesses thought he might have made a spasmodic movement that was misinterpreted. Preparation of his case was not proceeding well because he was not able to communicate with his defense attorney and was not able to sign papers due to tremors.

Scenario 4:

A man, age 23, Caucasian, with moderate mental retardation, pervasive developmental disorder (autism spectrum disorder) and Impulse Control Disorder. He had a history of impulse control and violence dating from childhood and was frequently delusional.

He lived with his family home until he attacked his mother. She called the police and pressed charges of assault in an effort to get services for him. He was arrested and detained in the county jail. A forensic evaluation found him incompetent to stand trial. The family was willing to drop charges if the individual were placed in an appropriate setting. The judge did not want to release him to the streets and required that he remain in jail until a suitable residential placement was arranged. The Howard Jordan Center in Nashville is the only facility in the state equipped to house individuals with mental retardation who are found incompetent to stand trial. Three beds were available, but there were a number of individuals from various regions of the state who needed those beds.

Scenario 5:

A woman, age 43, Caucasian, with moderate mental retardation (I.Q. 53), Impulse Control Disorder and Mood Disorder NOS. She had a history of impulsive behaviors including vandalism and self-mutilation and has been banned from local mental health facilities due to her behavior.

She recently threw a tantrum at her group home, and broke several windows. This was the latest in a series of episodes of vandalism. She was arrested, given a felony charge of unlawful destruction of property and probation violation from a previous charge. She has been detained in the county jail for the past 60 days. A forensic evaluation found her incompetent to stand trial and stated that she would probably never gain competency. The judge would only release her to a suitable residential facility. Her family would not and could not take her. There is no facility for women in Tennessee that corresponds to the Howard Jordan Center.

Scenario 6:

A man, 48 years old, Caucasian, a homeless veteran with schizophrenia and alcohol dependence. He was recently hit by a car, broke his leg, and has a cast and a walker. When stable, he is intelligent and sweet. He has a fixed delusion of being unworthy and frequently argues with a voice that he identifies as the devil. He is habitually arrested several times a week for public intoxication or criminal trespassing, but is usually released on his own recognizance. Sometimes the judge puts him in jail for 30 days where he becomes stable on Haldol, an antipsychotic medication.

Scenario 7:

A woman, age 48, African American, educated, formerly homeless, who has schizophrenia, polysubstance abuse and AIDS with symptoms of dementia. She has been arrested multiple times for criminal trespassing due to her delusional system. She frequently knocked on doors and announced that she was married to the man of the house. When incarcerated at the county jail she became aggressive, bit herself, and tried to spit blood at others.

Most recently she was arrested for criminal trespassing several times in a row. Three times in three weeks, law enforcement officers transported her a considerable distance to the Regional Mental Health Institute. Institute admissions staff stated that they would not accept her because they did not deem that she met commitment criteria of imminent likelihood of danger to self or others.

Scenario 8:

A man, age 80, Caucasian, a veteran with posttraumatic stress disorder and Alzheimer's disease. He lives with his ex-wife, but claims he does not know her and has no family. He is often belligerent and has been arrested on public disturbance or disorderly conduct charges about twice a year for the past several years.

He was recently arrested for causing an accident with property damage when he drove his car into the wall of a gas station. He was released on his own recognizance. Because he was not detained and would not be appearing before the court, no forensic evaluation was ordered, so there was no decision about competency.

Scenario 9:

A man, age 20, African American, with severe mental retardation and a diagnosis of Impulse Control Disorder. He attacked his father after being told he could not turn on the television, "or else". Police were called; he was charged with assault and detained in the county jail. A forensic evaluation found him incompetent to stand trial. The man was only classified as mentally ill and had not received an assessment for his mental retardation. The man lost his TennCare coverage and his SSI benefits, because he had been in jail several months until bonded out by his family.

Handout 3-12i: Instructor Version

Response

Service Linkage for People with Co-Occurring Disorders

Individuals who have mental illness in addition to other disabilities present challenges to the criminal justice system. Few community agencies are prepared to offer effective services and supports. Linkages that are successful are often forged through networking and creative approaches to meeting the individual's needs. The following are scenarios of actual individuals. Names have been changed to protect identity.

- Brainstorm with the group about services and supports in your area that could meet the individual's needs;
- After your discussion, the instructor will read what actually happened;
- Discuss your reaction.

Scenario 1:

A woman, age 35, African American, homeless, with Schizoaffective disorder, cocaine dependency and mild mental retardation has been arrested 43 times for charges such as possession of drug paraphernalia, criminal trespassing, pedestrian solicitation and assault charges. Most of the charges over the years have been misdemeanors. Several years ago she and her children were in a house fire in which one of her children died.

She was recently arrested on robbery charges after accosting a woman on the street. The most recent forensic evaluation found that she was competent to stand trial. Upon returning from the evaluation, she struck her public defender and was sent back to the jail cell where she punched a pregnant inmate. Six weeks passed until the preliminary hearing where charges were dismissed because the victim did not come to court.

Solution 1:

The criminal justice/ mental health liaison learned that the woman was to be released that day. When the liaison attempted to interview the woman, she was aggressive and violent. She attempted to strike and kick the liaison through the small hole in the cell door.

The liaison took the following steps:

- Called the crisis response team, who assessed the woman as dangerous to others and sent her to the regional mental health institute (RMHI) directly from jail.
- Contacted the RMHI attorney to initiate a mandatory outpatient treatment (MOT) order.
- Contacted the Tennessee Division of Mental Retardation services who conducted a psychological evaluation. The evaluator's opinion was that the woman required one-on-one care if she were to live in the community. Those resources were not available.
- The woman remained in the RMHI for six weeks receiving regular medication and care, and eventually stabilized.
- Upon release, she was linked to specialized residential housing and intensive outpatient treatment.

Sad Ending: The arrangement lasted four days. The woman has been in and out of jail for the past four months. The treatment provider has not filed an affidavit to revoke the MOT order and send her back to the mental health institute.

Scenario 2:

A man, age 40, Native American, homeless, with Schizoaffective disorder, posttraumatic stress disorder (PTSD) and alcohol dependence. He has been arrested numerous times mostly for public disturbance and disorderly conduct, and is constantly in an out of jail. He has been referred to case management several times, but because he does not arrive at appointments and the case manager cannot find him, he is dropped from the caseload.

He was recently arrested for disorderly conduct when he jumped off the bridge into the river in a suicide attempt. Once in the river he decided he didn't want to die and began throwing things at passing cars to attract attention.

The court offered him the options of doing 41 days in jail, or going before the mental health court. He was hearing voices and the mental health court would not see him until he was stabilized.

Solution 2:

The criminal justice/ mental health liaison knew this man from previous episodes and developed trust with him by:

- Listening to his perspective,
- Making recommendations he could be expected to achieve, and
- Following through on her commitments to him,
- Continuing to work with him whether or not he followed through on her referrals.

The liaison met with the man at the conclusion of the court hearing and convinced him to go back to the jail cell. She arranged medication management to help him stabilize and become eligible for the mental health court. He was initially reluctant, but the liaison reminded him that she had always followed through in the past and she would help him now. The man stabilized and was allowed to appear before the mental health court.

- The man was allowed to return to a motel where he felt comfortable.
- He was referred to case management.
- He was referred to an intensive outpatient program that offered integrated treatment.
- The case manager was charged with responsibility for monitoring his participation in treatment.
- The man telephoned the case manager and the intensive outpatient program himself to arrange initial appointments.
- He arrived at both initial appointments.

Happy ending: The liaison rewarded the man with a bus pass for following through on the referrals. She reminded him that she was always there as a point of contact if he needed help.

Scenario 3:

A man, age 50, African American, with bipolar disorder and alcohol dependence. He has a history of violence and was imprisoned for attempted murder ten years ago when he found his wife with another man. He always appears drunk and has been arrested repeatedly for nuisance crimes such as public intoxication and disorderly conduct. He suffered a stroke several years ago due to toxicity from an accidental overdose of lithium. He is partially paralyzed and has spasmodic movements. His landlady nursed him back to health and continues to care for him. When he was placed in intensive integrated community treatment, arrests slowed to once a month.

Recently he was incarcerated on charges of assaulting an officer during an arrest for public intoxication. He was accused of reaching for the officer's gun, but witnesses thought he might have made a spasmodic movement that was misinterpreted. Preparation of his case was not proceeding well because he was not able to communicate with his defense attorney and was not able to sign papers due to tremors.

Solution 3: The criminal justice/ mental health liaison knew the man and understood his speech. The liaison:

- Listened carefully to the man's account of events surrounding the arrest;
- Interpreted for the attorney who was then able to build the case;
- Testified on his behalf in court;
- Arranged for his return to integrated community treatment;
- Arranged with the landlady to accept him back; and
- Referred him to a psychosocial center to participate in social and vocational activities during the day.

Happy ending: The man got 5 years probation with participation in treatment as a condition of probation. The man comes in to visit with the liaison after his treatment appointments. Has not been re-arrested for several months.

Scenario 4:

A man, age 23, Caucasian, with moderate mental retardation, pervasive developmental disorder (autism spectrum disorder) and Impulse Control Disorder. He had a history of impulse control and violence dating from childhood and was frequently delusional.

He lived with his family home until he attacked his mother. She called the police and pressed charges of assault in an effort to get services for him. He was arrested and detained in the county jail. A forensic evaluation found him incompetent to stand trial. The family was willing to drop charges if the individual were placed in an appropriate setting. The judge did not want to release him to the streets and required that he remain in jail until a suitable residential placement was arranged. The Howard Jordan Center in Nashville is the only facility in the state equipped to house individuals with mental retardation who are found incompetent to stand trial. Three beds were available, but there were a number of individuals from various regions of the state who needed those beds.

Solution 4:

- The judge appointed a guardian ad litem for the man to enable the criminal justice/ mental health liaison to obtain the consents to release information that would move the transfer forward,
- The liaison, the defense attorney and the judge worked together to resolve funding difficulties,
- The family, the judge and the criminal justice/ mental health liaison contacted the Jordan Center repeatedly to advocate for expedited admission of this man. He was admitted after three months.

Happy ending: The man was placed at the Howard Jordan Center, has stabilized and will continue to reside there as long as it is necessary.

Scenario 5:

A woman, age 43, Caucasian, with moderate mental retardation (I.Q. 53), Impulse Control Disorder and Mood Disorder NOS. She had a history of impulsive behaviors including vandalism and self-mutilation and has been banned from local mental health facilities due to her behavior.

She recently threw a tantrum at her group home, and broke several windows. This was the latest in a series of episodes of vandalism. She was arrested, given a felony charge of unlawful destruction of property and probation violation from a previous charge. She has been detained in the county jail for the past 60 days. A forensic evaluation found her incompetent to stand trial and stated that she would probably never gain competency. The judge would only release her to a suitable residential facility. Her family would not and could not take her. There is no facility for women in Tennessee that corresponds to the Howard Jordan Center.

Solution 5:

- The judge appointed a guardian ad litem for the woman.
- The criminal justice/ mental health liaison tried to find placement in an assisted living facility or a nursing home, but few facilities had lock-downs or behavioral programs,
- Those facilities that did have behavioral programs would not admit until her TennCare and SSI was reinstated,
- The TennCare Bureau estimated that reinstatement could take six months or more, because of the complexities of the case,
- The Tennessee Division of Developmental Disabilities or the Division of Mental Health were unable to find a placement that would take her once her SSI was reinstated,
- The family assisted with arrangements for a placement in a neighboring state,
- The liaison arranged for the woman to be escorted to the necessary appointments for her SSI to be reinstated, and filed the applications.
- The liaison arranged funding for a psychological evaluation that confirmed the woman's mental retardation and IQ, and stated that the condition was "indefinite" due to its severity.

Sad Ending: The woman was placed in a secure facility in another state. Her family must drive a considerable distance to visit her, which is hard for them due to their financial and health problems. The woman is self-mutilating on a regular basis and the facility is indicating that she may have to be sent back to Tennessee.

Scenario 6:

A man, 48 years old, Caucasian, a homeless veteran with schizophrenia and alcohol dependence. He was recently hit by a car, broke his leg, and has a cast and a walker. When stable, he is intelligent and sweet. He has a fixed delusion of being unworthy and frequently argues with a voice that he identifies as the devil. He is habitually arrested several times a week for public intoxication or criminal trespassing, but is usually released on his own recognizance. Sometimes the judge puts him in jail for 30 days where he becomes stable on Haldol, an antipsychotic medication.

Solution 6:

Upon release, the following arrangements are usually made:

- He is either placed with his sister, who is willing to house him,
- Or a halfway house for recovering alcoholics.
- His veteran's benefit check goes to a representative payee at the downtown clinic.
- He receives his medication at the downtown clinic.

Sad ending: Invariably, the man is back on the streets drinking within a week. When the weather turns rainy he begins to drink. He reports that the medication does not make him feel good and does not make the voices go away. He states, "At least with beer, I get a buzz." He gets beat up by another homeless person or gets arrested for a nuisance crime and the cycle begins again.

Hope for the future: The local homeless program has applied for a large grant for assisted living rooms for chronically homeless people. He is on the list of intended residents. When the program is in operational he will get a room, assistance taking his medications, and other supports.

Scenario 7:

A woman, age 48, African American, educated, formerly homeless, who has schizophrenia, polysubstance abuse and AIDS with symptoms of dementia. She has been arrested multiple times for criminal trespassing due to her delusional system. She frequently knocked on doors and announced that she was married to the man of the house. When incarcerated at the county jail she became aggressive, bit herself, and tried to spit blood at others.

Most recently she was arrested for criminal trespassing several times in a row. Three times in three weeks, law enforcement officers transported her a considerable distance to the Regional Mental Health Institute. Institute admissions staff stated that they would not accept her because they did not deem that she met commitment criteria of imminent likelihood of danger to self or others.

Solution 7:

- On the third trip the police officer asked Institute personnel to sign a document stating that they would bear responsibility if the woman injured or killed someone in the community;
- The Institute accepted her for evaluation,
- The evaluation concluded that she needed to stay at the Institute for a considerable period of time and would probable never be discharged to the community,
- The plan is to discharge her to a secure nursing home eventually when she is stabilized.

Scenario 8:

A man, age 80, Caucasian, a veteran with posttraumatic stress disorder and Alzheimer's disease. He lives with his ex-wife, but claims he does not know her and has no family. He is often belligerent and has been arrested on public disturbance or disorderly conduct charges about twice a year for the past several years.

He was recently arrested for causing an accident with property damage when he drove his car into the wall of a gas station. He was released on his own recognizance. Because he was not detained and would not be appearing before the court, no forensic evaluation was ordered, so there was no decision about competency.

Solution 8:

- The family obtain legal guardianship following an evaluation conducted at the local mental health center,
- The man's driver's license was removed,
- He was enrolled in the local Veteran's administration day program,
- He continued to behave belligerently at home and was admitted to the Veteran's nursing home.

Happy ending: The man has stabilized on antipsychotic medication. He has peers to socialize with at the nursing home. They spend time trading stories about the Korean War.

Scenario 9:

A man, age 20, African American, with severe mental retardation and a diagnosis of Impulse Control Disorder. He attacked his father after being told he could not turn on the television, "or else". Police were called; he was charged with assault and detained in the county jail. A forensic evaluation found him incompetent to stand trial. The man was only classified as mentally ill and had not received an assessment for his mental retardation. The man lost his TennCare coverage and his SSI benefits, because he had been in jail several months until bonded out by his family.

Solution 9:

The criminal justice/ mental health liaison arranged for a psychological evaluation that found him to have severe mental retardation,

- Because he was under 22, the educational system was responsible to fund services for him under the Individuals with Disabilities Education Act.

Happy ending: The man is living with his family and is participating daily in vocational and educational training. Things are going well in the home because the family has respite while he is at the day programs. The young man is calmer at home after returning from his daily activities.

Module 4
Mental Health Services

Module 4

Mental Health Services

Length of Presentation: 30 minutes to 1 hour

Handouts and Materials

4-1 Tennessee Public Mental Health System
4-2 Criminal Justice/ Mental Health Liaison Services
4-3 Crisis Response Services
4-4 Inpatient Psychiatric Treatment
4-5 Medication Management
4-5a Psychiatric Medication
4-6 Case Management
4-7 Psychotherapy & Counseling
4-8 Psychosocial Rehabilitation
4-9 Peer-Run Services, Drop-In Centers and Support Groups
4-10 Housing and Residential Services
4-11 Confidentiality and Privacy of Medical Information
4-12a Linking to Mental Health Services, Law Enforcement
4-12b Linking to Mental Health Services, Corrections
4-12c Linking to Mental Health Services, Courts
4-12d Linking to Mental Health Services, Probation/Parole
4-13 Response: Service Access
Speaker: See note below
Optional stickers: Gold stars
Red dots

[Note to Instructor: *The purpose of this module is to introduce participants to public mental health services for adults in Tennessee, including the structure of the Tennessee public managed behavioral health care system, service types, and access procedures.]*

[Note to Instructor: *Discuss only handouts on services that interact most frequently with trainees: Law Enforcement: Skip 4-6, 4-7, 4-8, 4-10, 4-12 b - d*
Corrections: Skip 4-4, 4-7, 4-8, 4-9, 4-12 a, c & d
Probation/Parole: Skip 4-12 a, b & d
Courts: Skip 4-3, 4-12 a, b & c]

[Recommendation: *Invite a mental health service provider to give a 15-minute talk describing service type and eligibility criteria and how to access the service.*
Facilitate a brief discussion between trainees and presenter on how to establish effective collaboration when mental health clients are in the justice system.

Possible speaker types and topics:

- *Crisis Response Specialist: Roles of crisis team in community crisis calls, assessment in detention, crisis response to jail inmates;*
- *Case Manager: Maintaining continuity of care for incarcerated clients. Release planning and service referral follow up for released inmates. Communication methods with probation officer regarding treatment compliance for probationers sentenced to treatment as a condition of probation;*
- *Psychiatrist/nurse practitioner: Psychiatric medications, what they do, how they make prescription decisions for incarcerated clients;*

- *Housing specialist: Obtaining housing for individuals due for release from long-term incarceration in jail;*
- *TennCare/BHO representative: Regulations/procedures for enrolling inmates due for release.]*

[Optional motivational exercise: ***Gold Stars and Red Dots:***
Among criminal justice personnel, feelings run high regarding some types of mental health services. This exercise encourages participants to ask good questions in a positive manner. Caution: ONLY do this exercise if you feel comfortable facilitating a sense of friendly kidding and good humor among participants.

At the beginning of the class, acknowledge that participants may have opinions regarding mental health service delivery. Encourage them to ask questions during the class, WITH THE FOLLOWING CONDITIONS:
Every time a participant asks a question or makes a comment in a positive, constructive manner the instructor will award a GOLD STAR.

- *Every time a participant asks a question or makes a comment in a negative, critical manner the instructor will award a RED DOT.*

Encourage participants to ask questions, but ask them to be constructive.

- *The participant with the most gold stars at the end of the session will receive a prize from the collection of small prizes gathered for the training.*
- *The participant with the greatest number of red dots will be at the mercy of the class to decide a penalty. If the class seems merciless the instructor can decide a minor penalty such as a fake traffic ticket for being a motor mouth .]*

Objectives

- To learn about types of mental health services for adults, their purpose and methods;
- To learn criteria for acceptance into mental health services;
- To learn about psychiatric medications;
- To build positive working relationships between criminal justice and mental health personnel.

DISCUSSION
Mental Health Services

This session will describe mental health services in Tennessee, what they do and don't do, and how personnel from law enforcement, corrections, the courts and probation and parole can access services and supports for individuals with severe mental illness.

- Good working relations between mental health and criminal justice personnel are key to getting people with mental illness into treatment rather than the criminal justice system when no serious crime has been committed.
- Understanding the mandates and limitations of our respective duties will help everyone work more flexibly and effectively for these individuals.

Tennessee Mental Health Service System

Most individuals with mental illness live in the community and participate in treatment with community mental health providers.
Some are admitted to the psychiatric hospital for brief periods to:

- Resolve psychotic, suicidal or manic episodes; or
- Adjust medications in a controlled environment.

Very few require long-term hospitalization or residential treatment.
However, a 1999 national study by the Bureau of Justice Statistics shows that 23% of jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of mental illness.

Most public mental health services in Tennessee are funded through TennCare Partners, a managed care program using federal Medicaid funds and state funds.

[Refer to Handout 4-1, Tennessee Public Mental Health System, only the first section: list of TennCare Partners Services.]

Eligibility criteria for TennCare Partners is based on being a:

- Medicaid recipient (TANF or SSI), OR
- Medically eligible:
- Current assessment of severe and persistent mental illness;
- Qualifying medical diagnosis;
- Health insurance denial option (uninsurable);
- Income no greater than 100% of poverty.

The state of Tennessee contracts with private "behavioral health organizations" (BHOs), to monitor and pay for mental health and substance abuse treatment services under TennCare Partners. Individuals may apply for TennCare Partners through the Department of Human Services (DHS).
[Review remainder of Handout 4-1.]
TennCare services to individuals are authorized based on "medical necessity".

When a TennCare enrollee is referred for services, assessment personnel must go by medical necessity criteria. If criteria are not met, the provider will not be paid for service.

Service is often interrupted when individuals are incarcerated.

- Partly due to difference between TennCare services provided to individuals in the community and service provided in correctional facilities;
- Disruption in care (especially medication) may exacerbate symptoms of mental

illness and increase the individual's likelihood of misbehavior while incarcerated;
- When stabilized prior to release from jail, but not successfully linked to mental health services, symptoms may re-appear and the individual may cause a disturbance in the community, and be re-arrested.

Recommendations:
- Make every effort to continue the care provided prior to incarceration;
- Contact the individual's mental health provider before the individual's release to establish service linkage.

Types of Mental Health Services

Handouts 4 —2 through 4-10 describe major types of mental health services provided to adults with severe mental illness.
- There will be a brief discussion of each service in class,
- Questions are encouraged,
- Handouts are provided for later reference.

[If speaker is available:]
Following the discussion, ***[name of speaker]*** is here to discuss ***[type of service]*** provided by ***[agency]*** to give a better understanding of what is provided and how to access service.

After the speaker there will be information on:
- How to access mental health services; and
- Confidentiality of medical and mental health information under the Health Insurance Portability and Accountability Act (HIPAA) and Title 33.

Criminal Justice/ Mental Health Liaisons

[Refer to Handout 4-2, Criminal Justice/Mental Health Liaison Services.]

- Boundary spanners available to criminal justice and mental health systems in 21 counties.

Community Activities:
- Identify system breakdowns that contribute to criminalization of mental illness;
- Develop resources that promote diversion of persons with mental illness.

Services:
- Identification of adults with mental illness in the criminal justice system;
- Jail diversion:
- Continuity of care:
- Release planning and follow-up:
- Consultation with court officials:
- Training/ education.

[Ask for questions regarding criminal justice/mental health liaison services. Give brief responses to the whole class. More in-depth questioning should be deferred to the break or after the presentation, when you can respond to the individual.]

[Optional: Award gold stars and red dots as deserved.]

Crisis Response Services

[Refer to Handout 4-3, Crisis Response Services.]

Statewide 24 hour, 7 day per week response to psychiatric emergencies:
- Serves the general population, not just TennCare enrollees;
- Crisis telephone line is managed through a central location;
- Information is relayed to local crisis teams as appropriate;
- There is one statewide provider for children's mental health crisis teams.

In rural areas crisis response teams may take time because of travel time. In large urban areas crisis response may take time because of an overwhelming call load.

Some counties have provided mental health training to some or all of their police force to equip them to respond adequately to calls involving people with mental illness.
- Reduces the need to call crisis services.
- Allows prioritization so crisis response teams can go where most needed.

Some areas have a non-mobile crisis team where law enforcement officers can drop individuals off for assessment without having to wait until the evaluation is complete.

[Ask for questions regarding crisis response services. Give brief responses to the whole class. More in-depth questioning should be deferred to the break or after the presentation, when you can respond to the individual.]

[Optional: Award gold stars and red dots as deserved.]

In-Patient Psychiatric Treatment

[Refer to Handout 4-4, Inpatient Psychiatric Treatment.]

TennCare covers admission to 29 in-patient facilities across the state, five of which are Regional Mental Health Institutes operated by the Tennessee Department of Mental Health and Developmental Disabilities.
RMHIs are at or over capacity, so beds are reserved for involuntary admissions.
Most in-patient admissions are brief and may offer:
- Crisis stabilization,
- Observation for suicidal, self-injurious or aggressive behavior,
- Assessment and diagnosis,
- Medication management,
- Individual and group therapy and
- Release planning.
- Psychiatric hospitalization is NOT a long-term solution to inadequate housing.
- Psychiatric hospitalization RARELY offers a complete solution to the individual's needs. It is part of a continuum of services. No one is committed for life.

[Ask for questions regarding in-patient treatment. Give brief responses to the whole class. More in-depth questioning should be deferred to the break or after the presentation, when you can respond to the individual.]
[Optional: Award gold stars and red dots as deserved.]

Medication Management

[Refer to Handout 4-5, Medication Management.]

Psychiatric medication may be prescribed by:
- Psychiatrist;
- Other medical doctor,
- Physician's assistant, or
- Nurse practitioner.
- Best if the prescribing professional has psychiatric training and expertise because these medications are powerful and must be monitored carefully.

TennCare covers costs for enrollees in the community:
- Diagnosis,
- Prescription,
- Pharmacy services,
- Administration of medication,
- Lab work.

For jail inmates medication costs are usually paid by the county of incarceration and/or by the individual, family or private insurance.
- Because of high medication costs, correctional facilities may not pay for some of the newer, more effective medications covered by TennCare. An abrupt change in medication may lead to increased symptoms and behavioral outbursts.
- The state of Tennessee has provisions by which county jails may purchase medications at reduced cost through the state contract. For further information call the State of Tennessee General Services: (615)-532-9857;
- Correctional facilities may be able to work with prescribing professionals to obtain samples or reduce costs in other ways.

[Refer to Handout 4-5a, Psychiatric Medication.]

Psychiatric medications are grouped by the symptoms they address. Those that alleviate symptoms of major mental illness are:
- Anti-depressant;
- Anti-anxiety;
- Mood stabilizing;
- Anti-psychotic.

Most psychiatric medications are powerful drugs that must be monitored:
- To ensure that they are actually improving the desired symptoms;
- To reduce side effects, many of which are uncomfortable and a few, harmful.

Some psychiatric medications, such as benzodiazepines and stimulants, can be abused, but most do not produce pleasant enough sensations to become street drugs. Because these drugs are powerful, switching from one to another, or changing dosage should be done carefully to avoid adverse reactions.

[Ask for questions regarding medication management. Give brief responses to the whole class. More in-depth question should be deferred to a medical professional.]

Case Management

[Refer to Handout 4-6, Case Management.]

Mental health case managers link individuals with severe mental illness to needed services and resources such as SSI/SSDI, housing and employment programs. TennCare case managers will have to terminate cases where the individual is incarcerated for more than 30 days.
Mental health agencies vary in their policies regarding continuity of care to incarcerated clients. However, with a signed consent to release information from the client, case managers can assist with:

- Jail diversion,
- Communicating treatment information to the correctional facility,
- Encouraging clients to participate in treatment while incarcerated, and
- Release planning and service linkage.

Other services provided by case managers include:

- Assessment and prioritization of needs;
- Service planning;
- Crisis response;
- Assistance in daily living;
- Linkage, referral, and advocacy to other community services; and
- Monitoring the overall service delivery plan.

[Ask for questions regarding case management. Give brief responses to the whole class. More in-depth questioning should be deferred to the break or after the presentation, when you can respond to the individual.]

[Optional: Award gold stars and red dots as deserved.]

Psychotherapy and Counseling

[Refer to Handout 4-7, Psychotherapy and Counseling.]

Psychotherapy and counseling, sometimes referred to as “talk therapy,” helps individuals examine thoughts and feelings, and adopt more healthy modes of behavior.
Psychotherapy is used in certain aspects of treatment for severe psychiatric disorders. It is also used in:

- Substance abuse treatment;
- Child and adolescent treatment;
- Resolution of situational issues, marital issues or family problems.

Most psychotherapy delivered in the TennCare Partners Program is brief, and solution-focused for individuals or families, and is conducted by masters level clinicians. Case managers provide supportive counseling to individuals with severe mental illness.

Types of psychotherapy are described on the handout.

Because of the high prevalence of serious substance use disorders among the jail population, correctional facilities may choose to offer addiction counseling.

Prison-based sex offender treatment is the other major type of counseling offered in correctional facilities.

[Ask for questions regarding psychotherapy and counseling. Give brief responses to the whole class. More in-depth questioning should be deferred to the break or after the presentation, when you can respond to the individual.]

[Optional: Award gold stars and red dots as deserved.]

Psychosocial Rehabilitation

[Refer to Handout 4-8, Psychosocial Rehabilitation.]

Psychosocial rehabilitation is a group of services that use a strengths-based approach to help individuals with psychiatric disabilities gain skills necessary to successfully integrate into the community. Psychosocial rehabilitation helps the individual build on vocational, educational and interpersonal and living skills.

Psychosocial clubhouses provide a daily environment in which individuals learn entry-level employment skills in clerical, maintenance and food preparation fields. The clubhouse becomes a community and social support system for members.

Transitional employment provides entry-level employment opportunities in real job settings to individuals with severe mental illness. The psychosocial agency contracts for the position, then trains and places individual members in the position for several months. If the individual is not able to fill the job, another client is placed in the position.

Supported employment offers individuals the opportunity to work with a job coach to formulate employment goals and seek desired employment. Once the individual is employed, the job coach offers assistance to help the employee perform the work as expected.
Many psychosocial programs offer supported housing in the community with various levels of assistance to help the individual progress to stable, independent housing.

[Ask for questions regarding psychosocial rehabilitation. Give brief responses to the whole class. More in-depth questioning should be deferred to the break or after the presentation, when you can respond to the individual.]

[Optional: Award gold stars and red dots as deserved.]

Peer Run Services

[Refer to Handout 4-9, Peer-Run Services.]

Several types of services are staffed by people with mental illnesses or family members, and offer peer-support, role modeling, peer-education and advocacy.

Drop-in centers exist across the state and offer gathering places for adults with mental illness during the day, evenings and weekends. Members plan and participate in activities and service projects. Food and transportation are usually provided by the center. Law enforcement may be called to a drop-in center if one of the members becomes aggressive or suicidal. Drop-in center staff have training in crisis de-escalation, but they are peers, not professionals, and will call for assistance from crisis response services or law enforcement when needed.

Support groups and peer-taught classes are offered to consumers by the Tennessee Mental Health Consumers Association (TMHCA), and to family members by the National Alliance for the Mentally Ill of Tennessee (NAMI-TN). Classes and support groups occur on a regular basis in most communities.

Peer taught classes have been successfully offered to probationers with mental illness and to drug court defendants who have co-occurring mental illness and substance use disorders. NAMI –TN has successfully offered social support and education to family members of individuals with mental illness who have been arrested and incarcerated.

[Ask for questions regarding peer-run services. Give brief responses to the whole class. More in-depth questioning should be deferred to the break or after the presentation, when you can respond to the individual.]

[Optional: Award gold stars and red dots as deserved.]

Housing and Residential Services

[Refer to Handout 4-10, Housing and Residential Services.]

People with mental illness can and do live successfully in the community. A continuum of decent, affordable housing options is under continual development through the Tennessee Department of Mental Health and Developmental Disabilities in cooperation with mental health agencies across the state. Eligibility for the various types of housing is based on the individual's need for supervision and assistance with living skills. Independent Living Assistance funds are available to supplement rent and utility costs.

From least to most independent, housing options include:

- Supervised group housing with on-site staff and 24-hour care;
- Partially supervised group housing with staff on-site as needed;
- Independent congregate housing;
- Rental housing with minimal staff support; and
- Home ownership.

Housing specialists can assist individuals with criminal records to access subsidized housing through specific programs. Contact information is listed on the handout.

[Ask for questions regarding housing and residential services. Give brief responses to the whole class. More in-depth questioning should be deferred to the break or after the presentation, when you can respond to the individual.]

[Optional: Award gold stars and red dots as deserved.]

Speaker

[15 — 20 minute limit.]

[Introduce the speaker, agency and service type. Ask the speaker to briefly describe:

- *What they offer,*
- *Who is eligible,*
- *Situations in which criminal justice personnel call upon the service; and*
- *Information on what the audience should know to access the service.*

Facilitate a brief discussion between trainees and presenter on how to establish effective collaboration when mental health clients are in the justice system. If there is a discussion seems likely to go overtime, make sure contact information is exchanged and arrangements are made to continue at another time.]

Confidentiality

[Refer to Handout 4-11 Confidentiality and Privacy of Medical Information.]

Mental health providers are bound by professional ethics and the law to protect confidentiality of information disclosed, and records maintained, in mental health treatment. Generally, mental health providers do not disclose whether the individual is a client of the agency, or anything about treatment unless the individual has signed a "Authorization to Release Information" document.

Privacy standards have become even more rigorous with the recent implementation of a federal law: The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Exceptions to privacy standards do exist under HIPAA, some of which concern criminal justice situations. Because HIPAA is so new, mental health providers may be unsure of their duties and responsibilities when a client is involved in the criminal justice system. Handout 4-11 gives basic information, but each situation is different and should be subject to legal opinion.

Linking to Mental Health Services

[Read Handout 12a, 12b, 12c OR 12d: Linking to Mental Health Services. Each handout address linkage for different types of criminal justice personnel.]
Response: Service Access

[Notes to Instructor:
Refer to Handout 4-13: ***Response:*** *Service Access*
Read two or three client scenarios to the class
(Choose those most appropriate to the audience.)

- *After each scenario is read, ask participants to suggest the best approach to linking the individual to supports and services.*
- *Discuss what services would be appropriate and what information should be given to the mental health providers.*
- *Ask participants to discuss alternative solutions. More than one approach usually exists.*
- *Distribute gold stars to each person who responds. See instructor notes at beginning of Module 4.]*

Conclusion

The goal of the public mental health system is to promote recovery of individuals with mental illness and their successful integration into the community as contributing members of society. The goal of the criminal justice system is to protect the safety of the community and promote justice within society. Goals of both systems are served when people with serious mental illness who have not committed serious crimes are re-directed to mental health services instead of arrest and incarceration. Cross training will promote understanding and good working relationships between criminal justice and

mental health personnel, which, in turn, will increase re-direction of people with serious mental illness to the mental health system.

References

Tennessee Department of Mental Health and Developmental Disabilities (2003); Application for 2004 Community Mental Health Services Block Grant, Adult Services Plan, Criterion 1, Comprehensive community-based system of care, p.41.

Tennessee Department of Mental Health and Developmental Disabilities (2002); Criminal Justice/Mental Health Liaison Project Overview.

Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 104th Congress.

Handout 4-1

Tennessee Public Mental Health System

What is TennCare Partners?
TennCare Partners is the public managed behavioral health care program that provides medically necessary services to the 1.3 million enrollees in TennCare.

TennCare Partners Services:

- Inpatient psychiatric treatment;
- Outpatient mental health services;
- Inpatient and outpatient substance abuse treatment services;
- Pharmacy and laboratory services;
- Transportation to covered services;
- Mental health case management;
- 24-hour residential treatment;
- Housing/ residential care;
- Specialized outpatient and symptom management;
- Psychiatric rehabilitation.

Services are provided to TennCare enrollees based on **Medical Necessity.**
That means TennCare will only pay for services that are:

- Consistent with symptoms, diagnosis, treatment of the enrollee's illness;
- Appropriate with regards to good medical practice;
- Not solely for the convenience of an enrollee, physician, institution or other provider; and
- The most appropriate level of service that can safely be provided to the enrollee. For inpatients, this means that symptoms require that the services cannot be safely provided to the enrollee as an outpatient.
- When a TennCare enrollee is referred for services, assessment personnel must follow medical necessity criteria. If criteria are not met, the provider will not be paid for the service.

Problem: Health Coverage for Jail Inmates

- Federal law prohibits Medicaid funds from covering individuals incarcerated in jails, workhouses or prisons;
- Community mental health agencies are required to provide crisis response services to the public regardless of TennCare eligibility, but insurance coverage or payment is required for most other services;
- Most mental health services to inmates of county jails are the financial responsibility of the county;
- Differences between TennCare services and correctional facility services may disrupt the individual's care during booking and intake, exacerbating symptoms and the likelihood that the individual will misbehave;
- When stabilized prior to release from jail, but not successfully linked to community mental health services, symptoms may re-appear, the individual may cause a disturbance in the community, and be re-arrested.

Handout 4-2

Criminal Justice/Mental Health Liaison Services

Criminal Justice/Mental Health Liaison personnel are available in some judicial districts to facilitate coordination between the community, criminal justice and mental health systems; to promote diversion activities; and provide service linkage to adults with serious mental illness who are incarcerated or at risk of incarceration.

Community Activities

- Maintain contact with the various agencies and persons who are part of the criminal justice, mental health, community, family and consumer systems to assure collaborative efforts are effective;
- Identify barriers to continuity of care and developing action plans;
- Identify system gaps that prevent diversion from the criminal justice system;
- Develop resources that promote diversion of persons with mental illness;
- Monitor system interaction, provide solutions to system breakdowns;
- Identify system breakdowns that contribute to criminalization of mental illness.

Services

Identification:

- Daily contacts with arresting agency to identify arrested individuals with mental illness;
- Assess defendants exhibiting symptoms of mental illness as identified by criminal justice personnel.

Jail Diversion:

- Provide arresting agencies with viable diversion strategies such as hospitalization, respite, alternative housing, re-engaging with mental health services/case management, etc.;
- If diversion options are limited or not available, work with the community and mental health system to develop or improve diversion options.

Continuity of Care:

- Rapidly identify persons with mental illness who are arrested;
- Provide information on treatment needs to arresting agency;
- Contact mental health provider regarding defendant's legal status, gather information, encourage contact between mental health and criminal justice agencies;
- Assist jail to establish viable mental health care for inmates with mental illness.

Release Planning and Follow-up:

- Develop/ coordinate release plan with the defendant and mental health provider to ensure that services are in place;
- Contact the defendant and/or the mental health provider to ensure the services were accessed on release, to assist with barriers that may have occurred.

Consultation with Court Officials:

- Make recommendations concerning mental health needs of defendants with mental illness;
- Assist with release or sentencing plan that includes mental health services and community support;
- Aid defense counsel in recommending appropriate mental health assessments for an individual.

Training/ Education:

- Offer regular training sessions for criminal justice and mental health personnel.

Handout 4-3

Crisis Response Services

Crisis response services consist of a statewide 24/7 response to psychiatric crises in the general population. Crisis response services function as the portal of entry into the mental health system, particularly for individuals who have not yet been identified as needing services.

- The crisis response telephone line is managed through a central location. Information is relayed to crisis response teams.
- Crisis response teams:
- Go to the scene of the crisis, OR
- Meet the individual at an emergency room to provide counseling and evaluation, OR
- Meet the individual at a 24-hour walk in assessment facility or crisis stabilization unit.

If the individual with mental illness appears to need emergency involuntary hospitalization, generally, a mandatory pre-screening agent (MPA) designated by the Commissioner of TDMHDD (crisis response teams have one or more MPAs) must conduct an assessment to determine if the individual meets the criteria for emergency involuntary admission to an inpatient psychiatric facility or if other less restrictive services would be more appropriate.

To be eligible for emergency hospitalization, the individual must meet the following criteria (T.C.A. § 33-6-403):

(1) The person has a mental illness or serious emotional disturbance, AND
(2) The person poses an immediate substantial likelihood of serious harm** because of the mental illness or serious emotional disturbance, AND
(3) The person needs care, training, or treatment because of the mental illness or serious emotional disturbance, AND
(4) All available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person.

**"Substantial likelihood of serious harm" means:

(1) A person has threatened or attempted suicide or to inflict serious bodily harm on such person, OR
(2) The person has threatened or attempted homicide or other violent behavior; OR
(3) The person has placed others in reasonable fear of violent behavior and serious physical harm to them, OR
(4) The person is unable to avoid severe impairment or injury from specific risk, AND
(5) There is substantial likelihood that such harm will occur unless the person is placed under involuntary treatment. (T.C.A. § 33-6-501)

Emergency involuntary admission is a serious process in which an individual s right to refuse treatment is temporarily suspended. The law mandates pre-screening and due process procedures to protect the individual s liberty.

If a crisis team determines that an individual does not meet emergency involuntary admission criteria, they must offer an alternative service. The crisis team must follow-up within 12 hours to find out what happened and take further steps if necessary.

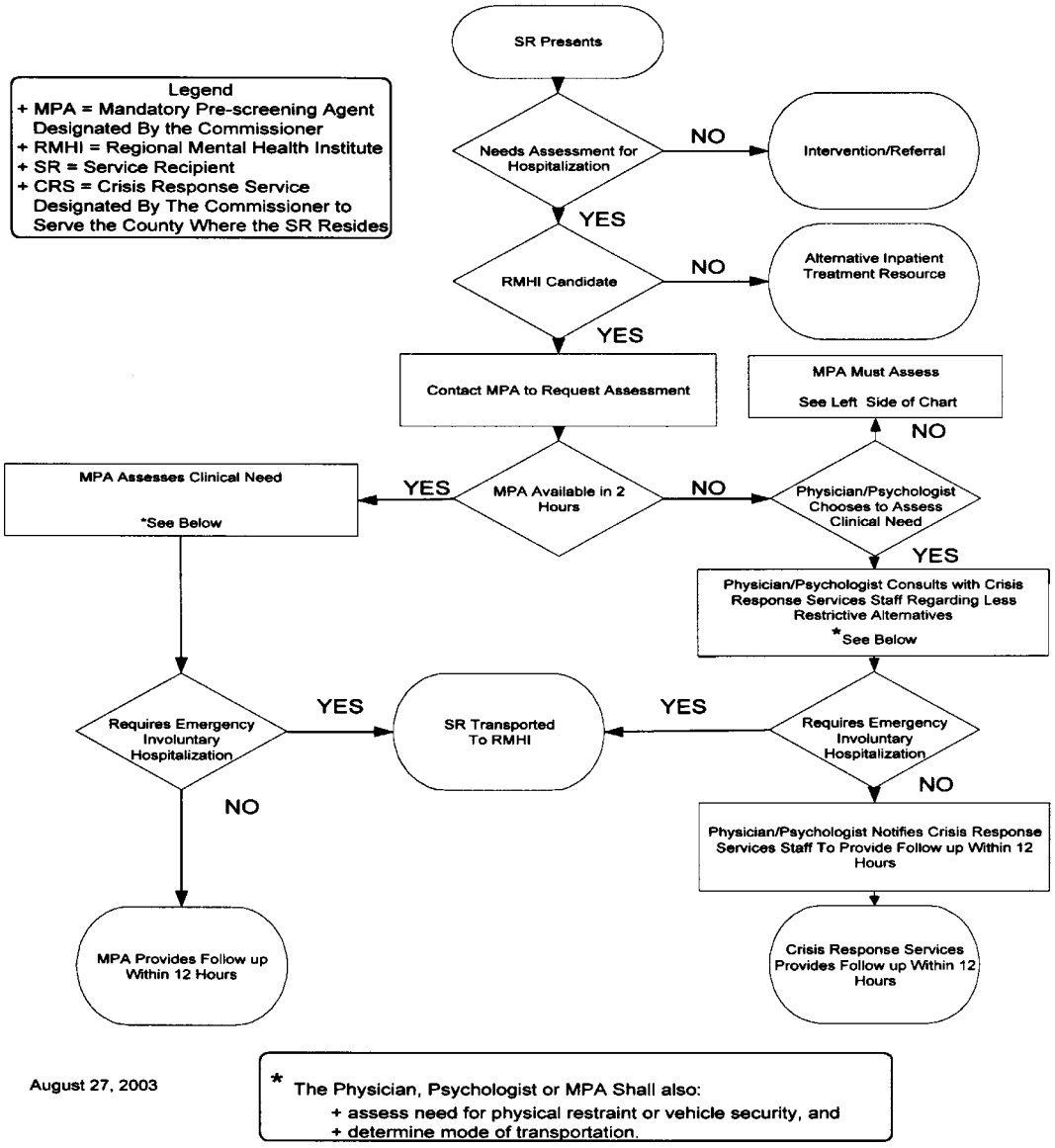
If a crisis team determines that an individual meets criteria for emergency involuntary admission, the team will complete an initial certificate of need.

- The individual would be transported to the admitting facility where a physician conducts another evaluation to determine whether the individual meets criteria for

emergency involuntary admission. If the individual still meets criteria the evaluator completes a second certificate of need. [TCA 33-6-407].

- If the second evaluator deems that the individual does not meet emergency involuntary admission criteria, the individual should be referred to a more appropriate service.
- Services that help individuals stabilize in the community include:
  - Crisis response services;
  - Respite care (accessed through crisis response services);
  - Crisis stabilization unit (Chattanooga);
  - 24 hour walk-in assessment (Knoxville, Nashville, Memphis);
  - Targeted Transitional Support Program (financial assistance with supports and services to effect timely discharge).

COMMUNITY BASED SCREENING PROCESS FOR EMERGENCY INVOLUNTARY HOSPITALIZATION RMHI



Handout 4-4

Inpatient Psychiatric Treatment

TennCare Partners admits adults to 29 in-patient facilities across the state, five of which are Regional Mental Health Institutes operated by the Tennessee Department of Mental Health and Developmental Disabilities.

In-patient services include crisis stabilization, observation for suicidal, self-injurious or aggressive behavior, assessment and diagnosis, medication management, individual and group therapy and release planning. Individuals should only be released from inpatient treatment when the following needs are addressed: treatment (including medication management), case management, and if appropriate; housing, support groups, and consumer and family education.

Problem:

- The overall percentage of inpatient admissions increased by nearly 7% in 2002 - 2003.
- Adult admissions to the Regional Mental Health Institutes increased by 15% in 2002-2003. The RMHIs are a point of entry into the system for many persons who do not have TennCare or other insurance.
- Hospitalization is expensive and often more restrictive than necessary to meet the individual's needs.
- Because most of the RMHIs are at or over capacity, the vast majority of RMHI admissions are on an involuntary emergency basis.
- TennCare does cover voluntary admission to private psychiatric hospitals in the BHO network, however the RMHIs definitely admit jail inmates while private hospitals may choose whether or not to admit.
- In an effort to reduce hospitalization rates, RMHIs must scrutinize every admission closely, and must verify that the certificate of need still describes the individual accurately [TCA 33-6-404].
- Law enforcement officers transport individuals for admission to RMHIs only to have the RMHI refuse to admit the person because harm to self or others and need for inpatient treatment are no longer deemed to be an issue. Then law enforcement must transport the individual back to the community, a treatment agency or jail.

What psychiatric hospitalization is NOT

- Psychiatric hospitalization is NOT a long-term solution to inadequate housing. The Tennessee Department of Mental Health and Developmental Disabilities is currently developing a range of housing options across the state. Individuals with mental illness, even very serious and disabling mental illness, can and do live fulfilling lives in the community with a range of supports and services.
- Psychiatric hospitalization is rarely a complete solution to the individual's needs. It is part of a continuum of services and supports, most of which are best delivered in the community.

Handout 4-5

Medication Management

Psychiatric medication is one of the most effective tools used to treat serious mental illness. In the past, psychiatric medications have involved uncomfortable and sometimes harmful side effects and it was common for individuals to refuse to take medication or not to take it as prescribed. Modern psychiatric medications are much more effective and comfortable, but most are very expensive.

Psychiatric medication may be prescribed by a psychiatrist, other medical doctor, physician's assistant, or nurse practitioner. Best practices indicate that the prescribing professional should have psychiatric training and expertise. TennCare covers cost of diagnosis, prescription, pharmacy services, administration and lab tests for enrollees. For individuals who are incarcerated, medication costs are usually paid by the county of incarceration and/or by the individual. Medication management involves the following personnel types:

Prescribing professional; psychiatrist, other medical doctor, physician's assistant, nurse practitioner: The prescribing professional must diagnose the individual through psychiatric interview, observation of behavior, and consideration of medical history. Medications are used to treat symptoms of psychiatric disorder. Therefore, more than one medication may be prescribed to an individual based on the pattern of symptoms presented. Diagnosis and prescription are part of an ongoing process. Changes in prescription may be due to factors such as changes in symptoms, changes in the effects of medication on the individual, or lack of tolerance for side effects.

Pharmacy: Medications may be purchased from a locally owned pharmacy, pharmacy franchise, wholesale pharmaceutical supplier, or a firm delivering a broader array of health services. The state of Tennessee also provides the option for county governments to utilize the state pharmaceutical contract at greatly reduced cost. (For more information contact General Services: 615-532-9857)

Medication administration: The vast majority of individuals with mental illness self-administer their medication. Some receive medications from a nurse. A nurse or other qualified professional must administer injections.

Medication monitoring: Medication for severe mental illness requires periodic monitoring by a nurse or prescribing professional to identify effects on symptoms, side effects, and compliance with prescription regimen. Part of medication monitoring may involve laboratory tests for level of medication in the individual's system, and presence of complicating biological factors.

Handout 4-5a:

Psychiatric Medication

Anti-Depressant Medication

Generic Name	Brand Name	Usual Dose (mg.)	Side Effects
SSRI: Most frequently prescribed type of anti-depressant			
fluoxetine	Prozac	20 - 40	Anxiety Nausea Headaches Weight Loss Activating rather than sedating; may trigger mania or psychosis. **All non-toxic.**
sertraline	Zoloft	50 - 200	
paroxetine	Paxil	10 - 50	
citalopram	Celexa	20 - 40	
escitalopram	Lexapro	10 –20	
Tri-cyclic			
desipramine	Norpramin Pertofrane	150 - 300	Dry mouth, tremors, blurred vision Bloating and weight gain,Urinary retention,lightheadedness on standing upsuddenly, sweating Constipation, Change in sexual High dose: irregular heartbeat desire **Can be lethal: Use with caution**
imipramine	Tofranil	150 - 300	
nortriptyline	Aventyl Pamelor	75 - 100	
doxepin	Sinequan Adapin	150 - 300	
amitriptyline	Elavil	150 - 300	
MAOI: Stringent dietary restrictions, Use with caution!			
phenelzine	Nardil	45 - 90	Weight Gain Dizziness Sleep disturbances Impaired sexual functioning Swelling of legs and ankles
tranylcypromine	Parnate	20 - 60	
L-deprenyl	Eldepryl	10	
Other Anti-depressants			
buproprion	Welbutrin	150 - 450	Weight loss, agitation, risk of seizures.
trazodone	Desyrel	50 - 400	Very sedating; used in lower doses for insomnia.
venlafaxine	Effexor	37.5 - 300	Activating, headache,, sleepiness, nausea, constipation
nefazodone	Serzone	200 - 600	Headache, sleepiness, agitation, nausea, tremor, constipation
mirtazapine	Remeron	15 - 45	Increased appetite, weight gain, sleepiness, dizziness

Anti-Anxiety Medication

Generic Name	Brand Name	Usual Dose (mg.)	Side Effects
Benzodiazepines			
lorazepam	Ativan	2 - 6 mg. effective for 15 hrs.	Tolerance, Withdrawal syndrome, Does not mix with alcohol
alprazolam	Xanax	0.5 - 6 mg. effective for 12 hrs.	
diazepam	Valium	2 - 60 effective for 100 hrs.	
clonazepam	Klonopin	0.5 - 10 mg. effective 34 hrs.	
Other Anti-Anxiety Medications			
buspirone	BuSpar	15 to 60	Dizziness, headache, sleepiness, nausea
zolpidem	Ambien	10	
diphenhydramine	Benadryl	25 – 150	

Handout 4-5b:

Psychiatric Medication

Mood Stabilizing Medication

Generic Name	Brand Name	Usual Dose (mg.)	Side Effects
lithium carbonate	Eskalith Lithane Lithonate Lithobid Lithotabs	450 to 1500	Nausea, lethargy, thirst, hand tremors, weight gain, acne, increased urination hypothyroidism risk of toxicity: blood level monitoring required
Anti-Convulsant Medication: Effective for stabilizing moods			
divalproex sodium valproic acid	Depakote Depakene	500 -1500	Weight gain, nausea, indigestion, sedation; Liver damage (rare)
gabapentin	Neurontin	300 - 2400	Tiredness, dizziness, fatigue
lamotrigene	Lamictal	50 - 400	Dizziness, sleepiness, hazardous rash
carbemazepine	Tegretol	400 - 800	Nausea, clumsiness, Aplastic anemia (rare)
topiramate	Topimax	50 - 200	Fatigue, dizziness, sleepiness, tremor

Anti-Psychotic Medication

Generic Name	Brand Name	Usual Dose (mg.)	Side Effects
Typical Neuroleptics			
fluphenazine (Injectable)	Prolixin	10	Drowsiness, shakiness, increased stiffness, dizziness, sensitivity to sunburn, muscular spasms, mouth movements, sexual difficulties **SERIOUS:** Tardive dyskinesia, neuroleptic malignant syndrome
haloperidol (Injectable)	Haldol	10	
thiothixene	Navane	20 X 2	
thioridazine	Mellaril	500 X50	
chlorpromazine	Thorazine	500 X50	
Atypical Antipsychotics			
clozapine	Clozaril	300 - 900	Weight gain, sedation salivation, seizures **SERIOUS:** low white blood cell count. Need blood tests.
risperdone	Risperdal	1 - 10	Weight gain, headache sedation, dizziness, low blood pressure, Parkinsonism, restlessness.
quetiapine	Seroquel	150 - 800	Sleepiness, low blood pressure.
olanzapine	Zyprexa Zidas	5 - 20	Sedation, weight gain, minimal anti-cholinergic effects.
ziprasidone	Geodon	20 - 80	Headache, sleepiness, irregular heartbeat, abnormal movements
aripiprazole	Abilify	20 – 30 mg.	Headache, insomnia, anxiety

Handout 4-6

Case Management

TennCare mental health case managers link individuals with severe mental illness to mental health, primary health care, and other needed services. Individuals can be referred to case management by hospitals, crisis response services, community-based service providers, and can self-refer. Mental health case management services consist of the following components:

Assessment and prioritization of needs: Includes examination of the individual's strengths, current situation, aspirations, needs and prioritized goals in the life domains of behavioral health, physical health, living arrangements, financial and social support, vocation/education and recreation. Case managers use state standards to classify adult clients into clinically related groups (CRG) prioritizing those with the greatest need:

- *CRG 1:* Individuals diagnosed with a psychiatric disorder whose functioning is currently, or in the last 6 months has been severely impaired. The duration of their impairment totals six months or longer in the past year.
- *CRG 2:* Individuals diagnosed with a psychiatric disorder whose functioning is currently, or in the last six months has been severely impaired. The duration of their impairment totals less than six months in the past year.
- *CRG 3:* Individuals diagnosed with a psychiatric disorder whose functioning has not been severely impaired within the last 6 months, but has been severely impaired in the past. Services are needed to prevent relapse. The individual meets medical necessity criteria defined by the Behavioral Health Organizations.
- *CRG 4 & 5:* These individuals are not eligible for case management services.

Service planning: The case management service plan is a written action plan mutually developed by the case manager and the individual, and is part of an ongoing assessment/monitoring/evaluation process. It includes prioritized areas of service, needs and skill development; short and long term measurable goals; strategies to meet defined goals; identification of agencies and contacts necessary to accomplish strategies; and examination of barriers to service delivery.

Crisis response: Case managers provide direct crisis assistance during working hours, but are also available to work with crisis services to meet the individual's needs. Case managers help the individual develop skills that will enable them to deal effectively with crisis and prevent the need for more restrictive services.

Assistance in daily living: Assistance in daily living includes ongoing support and development of individual skills needed to enhance the individual's ability to live independently.

Linkage, referral, and advocacy to other community services: The case manager assesses and mobilizes resources to meet needs of the individual, including referring and insuring that needed services are provided. All types of resources and services are included such as income, housing, primary health care, social support and legal/criminal justice services.

Monitoring overall service delivery plan: The case manager is responsible for monitoring delivery of all services in the plan and assessing the extent to which services delivered are helping the individual achieve goals.

Handout 4-7

Psychotherapy and Counseling

Most "talk therapy" delivered in the TennCare Partners Program is brief, solution-focused therapy for individuals or families conducted by masters level clinicians. Case managers provide supportive counseling to individuals with severe mental illness.

Supportive Psychotherapy:
Goal: To improve the client's self-acceptance and ability to perceive social situations accurately, to develop coping skills.
Methods: The therapist is a mentor. The therapist does not judge the client negatively for feelings or thoughts, but advises the client how to develop a healthy lifestyle.

Cognitive Therapy:
Goal: To uncover and change negative thinking patterns. Feelings and behavior are then much easier to change.
Methods: The cognitive therapist serves as a teacher and advisor who helps the client:

1) Uncover negative self-talk;
2) Explore whether the extent to which thought patterns reflect reality;
3) Consider reactions that follow negative self-talk;
4) Test the truth of assumptions that underlie negative thoughts.

Cognitive therapy is often combined with behavioral therapy.

Behavioral Therapy:
Goal: To help the client change dysfunctional behavior. This type of therapy focuses on changing behavior rather than deeply exploring motivation.
Methods: The therapist is a researcher and teacher. Initial assessment seeks to learn:

1) What are the problems and goals?
2) How can progress be measured and monitored?
3) What factors in the person's life are maintaining the problem?
4) Which interventions are likely to be effective?

Techniques used to help the client change behavior include systematic desensitization, flooding, behavior rehearsal, positive reinforcement, aversion therapy and social skills training.

Insight-Oriented Psychoanalytic Therapy:
Goal: The therapist helps the client realize what motivates problem thoughts, feelings and behaviors, reach self-acceptance, and achieve potential.
Methods: The therapist is an understanding listener and an authority figure. The client's response to the therapist brings insight about relationships, thoughts, feelings and behaviors. The therapist's acceptance helps the client grow toward self-acceptance and maturity. Psychoanalytic therapy usually takes a long time and is not commonly used in public managed care services.

Family Therapy
Goal: To help family members change unhealthy relationships and behavior patterns.
Methods: The therapist is an understanding listener and an advisor. Motivations, thoughts and feelings associated with family interactions are explored. The therapist teaches the family how to interact in a healthy manner.

Handout 4-8

Psychosocial Rehabilitation

Psychosocial rehabilitation uses a client-centered, strengths-based approach to help individuals with severe mental illness gain or regain skills necessary to live independently in the community. In partnership with program staff, individuals form goals for skill development in the areas of vocational, educational and interpersonal growth that facilitate opportunities for employment and successful community integration.

Psychosocial clubhouses provide a daily environment in which individuals learn entry-level employment skills in clerical, maintenance and food preparation fields. Many functions of the clubhouse are client-operated, providing realistic opportunities to learn and use employment skills and to develop good work habits. Psychosocial clubhouses sponsor pre-vocational social and support activities as well as social and educational opportunities for working clients. The clubhouse becomes a community and natural support system. Clients are welcomed back for social events even after they have ceased to use formal services.

Transitional employment is an approach to vocational rehabilitation in which the agency negotiates with local businesses for paid entry-level positions to be filled by clients of the agency. Agency personnel work with the business to facilitate on-the-job training for clients who agree to fill the position for a pre-established period of time, usually 3 – 6 months. If an individual client/employee is not able to work on any particular day, another client or staff member of the agency does the job.

Supported employment is another approach to vocational rehabilitation in which individuals work with agency job coaches to form employment goals, obtain necessary training and/or education, and obtain and maintain employment in a chosen field. The individual continues in a supported employment placement as a regular employee without a specified time limit.

Many psychosocial programs sponsor **supported housing** to meet the need for a continuum of housing options as individuals gain the ability to live independently. For individuals who require services and supports in order to maintain housing the psychosocial program functions as the landlord. Agency residential personnel help individuals develop housekeeping skills, social interaction skills and financial responsibility. Most supported housing units are subsidized apartments where two or more individuals live as roommates.

Handout 4-9

Peer-Run Services, Drop-In Centers and Support Groups

Drop-in centers offer gathering places for adults with severe and persistent mental illness. Members plan activities that provide opportunities for socialization, personal and educational enhancement, and emotional peer support. Drop-in center personnel are people with severe mental illness who have recovered to the point where they can function as role models to other members.

Drop-in centers usually have daytime, evening and weekend hours and offer:

- Leisure and recreational activities and outings;
- Peer counseling and support groups;
- Educational presentations on topics of interest to the membership;
- Assistance with advocating for services and supports;
- Meals and/or snacks;
- Transportation for those who need it.

Members of drop-in centers are encouraged and prepared to assume as much responsibility as possible for center activities and functions. Members frequently progress to employment as peer counselors when positions become available.

Consumer Education and Support

The Tennessee Mental Health Consumers Association (TMHCA) is a statewide advocacy organization run by and for people with severe mental illness. TMHCA offers the BRIDGES program consisting of a peer-taught course and ongoing peer-facilitated support group method. BRIDGES groups often occur in drop-in centers, but are also established in hospitals, churches, community centers and other locations.

Family Education and Support

The National Alliance for the Mentally Ill, Tennessee chapter, is a statewide advocacy organization of family members and individuals with severe mental illness. NAMI-TN offers educational presentations and support group meetings in communities across the state. The Journey of Hope program, sponsored by NAMI, consists of a family-taught course and support group method, and often occurs in conjunction with local NAMI affiliate activities.

Handout 4-10

Housing and Residential Services

People with mental illness live successfully in the community when provided decent, affordable housing and appropriate services. Unfortunately, because these individuals are often impoverished by their disability, there is insufficient housing for individuals diagnosed with mental illness. Questionable conditions in low-income housing often exacerbate symptoms for individuals with mental illness.

In response to this need, the Tennessee Department of Mental Health and Developmental Disabilities supports the development of a flexible array of housing options through the Creating Homes Initiative (CHI). Through assertive and strategic partnerships with local communities funds are leveraged to create a continuum of housing options for people with mental illness. This continuum (listed below) provides a variety of housing options to meet the needs of people with mental illness depending upon their individual ability to live independently.

Since FY 2000/01, the CHI has developed more than 3,300 housing options of various levels on the continuum, across the state. For more information regarding CHI activities or for additional information on how to access housing information, contact the state office by telephone (615) 253-3051 or on the web at http://www.housingwithinreach.org.

Supervised group housing with on-site staff and 24-hour care: With on-site awake 24 hour care. Also often referred to as a Supportive Living Facility (SLF), Boarding House or Halfway House. These homes are licensed by the State of Tennessee, Office of Licensure and will have staff people on-site 24 hours a day, every day to assist residents with living needs. The number of people living in this type of home and the number occupying each bedroom may vary depending on a number of factors.

Partially supervised group housing with staff on-site as needed: Staff On-Site as needed. Also often referred to as a Supportive Living Facility (SLF), Boarding House or Halfway House. These homes have staff on-site, as needed by the residents. The number of people living in this type of home and the number occupying each bedroom may vary depending on a number of factors.

Independent congregate housing: No staff support is provided on site, but many residents have case management support. Individuals rent a room in a cooperative house or an apartment in a housing complex where other residents receive mental health services. These homes are not licensed by the State of Tennessee. The number of people living in each housing unit may vary depending on a number of factors.

Rental and subsidized housing with minimal staff support: This is typical rental housing where individuals with mental illness are fully integrated into the community. Few people who live in this type of housing receive case management services. No staff support is available on site and no licensing is required. The number of people living in the room or apartment varies according to the financial resources of the individual.

Home ownership: A number of resources are available to financially assist people with mental illness who are able to purchase a condominium or home. The goal is to locate decent, affordable housing that will contribute to the well being of the individual.

Independent Living Assistance: These funds provide initial/supplementary utility and rent deposits, enabling individuals with mental illness to maintain housing of their choice.

Handout 4-11

Confidentiality and Privacy of Medical Information

Mental health care providers are legally and ethically bound to protect privacy of medical information about clients. In general, mental health providers must have a signed "Authorization to Release Information" document from clients that specifies the type of information to be disclosed, and time period in which information will be given, before disclosing:

- Whether an individual is, or has been, a client;
- Diagnosis;
- Medications prescribed;
- Other treatments provided;
- History of treatment compliance;
- Any other information about treatment.

There are a few uses and disclosures of medical and health information that do not require the client's consent or authorization [HIPAA, 1996]:

As required by law: Mental health care providers will disclose health information when required to do so by federal or state law. Interpretation of how to fulfill the intent of the law may vary between agencies.

Emergency situations: Health information may be disclosed in an emergency situation. If this happens, the provider will try to obtain the client's consent as soon as possible after the delivery of treatment.

Corrections and law enforcement:

- Health information may be released to the correctional institution or law enforcement official if the client is an inmate of a correctional institution or under the custody of a law enforcement official; AND
- If the release is necessary to provide health care, to protect the client's health and safety or the health and safety of others; OR
- For the safety and security of the correctional institution.

Health information may be released to a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements. Disclosure situations require specific types of authorization, so it is always advisable to obtain a legal opinion.

To avert a serious threat to health or safety: Health information may be used and disclosed when necessary to prevent a serious threat to health of the individual or safety of the public or another person.

Public health risks: Health information may be disclosed for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Lawsuits and disputes: Health information may be disclosed in response to a court order or administrative order if the individual is involved in a lawsuit or a legal dispute.

Handout 4-12a
Linking to Mental Health Services

Law Enforcement

Mental health calls to law enforcement officers most frequently involve:

- Individuals who are in crisis; or
- Frequent users of multiple services.

Crisis calls: Mobile crisis teams must triage response to community crisis calls based on urgency. Situations where no assistance is available at the scene may take priority over situations where law enforcement officers are attending to the safety of the individual and others.

Law enforcement departments have minimized the need to call mobile crisis response services by:

- Establishing units of intensively trained officers to respond to mental health calls; or
- Providing mental health training to the general force.

It is a good idea to collaborate with local crisis response services when establishing dispatch, on-scene assessment, on-scene response, incident documentation procedures and transportation to mental health facilities for emergency assessment. Time spent at the front end in procedure development and cross-training of law enforcement and crisis response personnel pays off in rapid response when law enforcement does call crisis response to the scene.

Frequent system users: A small percentage of individuals with mental illness have a history of frequent minor crimes. They use an inordinate amount of criminal justice and mental health resources, while not progressing toward recovery. Collaborative service planning by law enforcement, probation/parole, mental health and addiction treatment personnel can establish a unified plan of action to steer the individual from unhealthy, wasteful patterns of service use to stable, independent community tenure. The individual should be brought into the planning process when stable enough to do so. Once again, time spent in advanced planning pays off in quality of life for the individual, safety for the community and saved resources for service systems. Some mental health agencies have established intensive multi-disciplinary teams to provide service to individuals with mental illness who are frequently involved in the criminal justice system.

Handout 4-12b
Linking to Mental Health Services

Correctional Facilities

Because TennCare does not cover services to incarcerated individuals, most jails either develop contracts with community mental health service agencies and private practitioners, or hire medical staff with psychiatric expertise. Jails establish standards and formularies for mental health services that may or may not conform to TennCare standards.

- **Psychiatric assessment:** Crisis response specialists, criminal justice/ mental health liaisons, or in-house mental health clinicians can assess individual's need for mental health services. For all but the smallest jails, it is efficient to establish regular assessment times in the facility rather than escorting inmates to community agencies for individual appointments. Treatment recommendations arising from assessments should be followed as closely as possible. Correctional staff should indicate where recommendations are not feasible and negotiate acceptable alternatives.

- **Crisis response:** As first responders to any inmate crisis, correctional personnel should take part in basic training on psychiatric emergencies. Crisis teams can provide follow up response, but there may be a considerable delay because calls from facilities are prioritized lower than crisis calls from the community. Correctional staff may obtain advice from crisis response services over the telephone before the crisis team arrives. Mental health/criminal justice liaisons can respond to inmate psychiatric crises in jails they serve.

- **Medication management:** During intake and screening, correctional personnel should attempt to find out if inmates have been taking psychiatric medication, what types they have been taking and who prescribed the medication. Unless there is a compelling reason not to, prescriptions should be continued while the individual is incarcerated. Unnecessary changes or delays in obtaining medication may disrupt the individual's response and cause decompensation.

- **Substance abuse treatment:** Substance abuse counseling is not commonly provided in jails. Where substance abuse counseling is available, jails either employ medical staff trained in addiction treatment or contract with substance abuse treatment providers from the community. Twelve-step groups are an effective adjunct to professional treatment.

Release planning and service linkage: Release planning for inmates with mental illness should begin with the first day of incarceration. If the inmate had a case manager or other provider prior to incarceration, the provider can contact the inmate regularly, at least by telephone, to encourage good behavior and compliance with treatment. Jail staff can get information from the provider on treatment history in order to maintain continuity of care. If lines of communication are open service linkage upon release is more likely even if notification of release was short.

Obtaining Mental Health Treatment for Defendants
If judicial or legal personnel want to find out if someone has a mental illness and get him or her in treatment, the best procedure is to obtain an "Authorization to Release Information" from the defendant to allow the mental health agency, psychiatrist, or other mental health professional to provide information about:

- Diagnosis; medications, treatment;
- Defendant's stability when taking medications as prescribed; and
- Reasons why the defendant might not be in treatment any more.

The court can require treatment as a condition of probation.

If the individual with mental illness appears to need emergency involuntary hospitalization, generally, a mandatory pre-screening agent (MPA) designated by the Commissioner of TDMHDD (crisis response teams have one or more MPAs) must conduct an assessment to determine if the individual meets the criteria for emergency involuntary admission to an inpatient psychiatric facility or if other less restrictive services would be more appropriate.

To be eligible for emergency hospitalization, the individual must meet the following criteria (T.C.A. § 33-6-403):

(1) The person has a mental illness or serious emotional disturbance, AND
(2) The person poses an immediate substantial likelihood of serious harm** because of the mental illness or serious emotional disturbance, AND
(3) The person needs care, training, or treatment because of the mental illness or serious emotional disturbance, AND
(4) All available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person.

**"Substantial likelihood of serious harm" means:

(1) A person has threatened or attempted suicide or to inflict serious bodily harm on such person, OR
(2) The person has threatened or attempted homicide or other violent behavior; OR
(3) The person has placed others in reasonable fear of violent behavior and serious physical harm to them, OR
(4) The person is unable to avoid severe impairment or injury from specific risk, AND
(5) There is substantial likelihood that such harm will occur unless the person is placed under involuntary treatment. (T.C.A. § 33-6-501)

To be involuntarily committed to a hospital, a second designated mandatory pre-screening agent must certify that the defendant meets criteria for emergency involuntary hospitalization.

If the person is in a Tennessee Department of Correction (DOC) prison and is due for release, or is in DOC custody in Community Corrections, the crisis team or a mandatory pre-screening agent authorized by TDMHDD can assess whether the individual meets involuntary commitment criteria.

Most people are not committed to hospital for a long period of time, but they may get stabilized on medications and connected to services prior to release.

Forensic Evaluation:

Forensic evaluation is not a short-cut to mental health treatment. There is a long waiting list for forensic evaluations, which lengthens the defendant's jail term. Two valid reasons to order a forensic evaluation:

- To find out if the defendant's current mental illness prevents him/her from being competent to stand trial,
- To find out if the defendant was "not guilty by reason of insanity" (NGRI):
    - The defendant must be found by the court to have a severe mental disease or defect at the time of the crime; AND
    - Because of severe mental disease or defect, the defendant did not appreciate the "nature or wrongfulness" of the crime;

For the very few cases adjudicated NGRI, the defendant is evaluated for treatment in a state psychiatric institute for 60 – 90 days. After evaluation, the defendant may be:

- Committed indefinitely to the state hospital,
- Released to seek out-patient treatment,
- Released on "mandatory outpatient treatment" (MOT), meaning that the defendant must comply with a treatment plan or risk re-arrest.

Forensic evaluation is only useful for its intended purpose!

Handout 4-12d
Linking to Mental Health Services

Probation/Parole

Case managers from community mental health agencies can be a vital resource for working with probationers or parolees who have severe mental illness. TennCare enrollees with severe mental illness are entitled to case management as part of treatment.

- Find out if the probationer/parolee is/was a community mental health agency client;
  - If not, refer the individual to the nearest community mental health center or case management agency;
- Obtain a signed Authorization to Release Information,
  - From the probationer/parolee,
  - To get information from the mental health agency or provider;
- When release is obtained, contact the mental health agency to find out if the client has a case manager;
  - If not, request that the probationer be assessed for case management;
- With permission from the probationer/parolee, invite the case manager to an appointment as early in the process as possible;
- Meet with the probationer/parolee and case manager to develop a plan for complying with conditions of probation;
  - Find out which expectations are realistic and how to modify unrealistic expectations while still fulfilling conditions of probation/parole;
  - Find out what types of assistance the case manager can offer;
  - Ask the case manager for information on community resources that would help the probationer/parolee fulfill conditions of probation/parole;
  - Inquire about early warning signs of a psychiatric episode and what sort of steps need to be taken to prevent de-compensation;
  - Make sure the probationer/parolee's mental health crisis plan includes:
    - Probation/parole officer contact information; and
    - Action steps necessary to maintain probation conditions if the individual does de-compensate.

Needs for additional mental health treatment or assistance obtaining resources can be communicated through the case manager, or directly to the mental health agency.

Handout 4-13

Response: Service Access

Instructions:

1. The instructor reads the client scenario.
2. Trainees suggest:
   a. Which services are needed; and
   b. Possible approaches to accessing the services.
3. Discuss alternative approaches as a group.

Scenario 1:
Law enforcement has been called to a local shopping mall where an individual is causing a public disturbance, yelling bazaar phrases and waving an umbrella around. The individual is arrested and a search reveals a TennCare card and an appointment card for the local mental health center.

Scenario 2:
An offender is being booked into the local detention facility having been arrested for criminal trespassing. A family member calls to report that the individual has mental illness and has not been taking his medication for the past several weeks. The family member gives the name of the mental health agency, the psychiatrist, and the name of the medications, but not dosages.

Scenario 3:
An offender is released on bond, paid by a bonding company, and is ordered to appear in court in three weeks. She reports having a case manager through the local mental health center.

Scenario 4:
A defendant who is detained in jail appears before the court on charges of assault having attacked his roommate. At intake the defendant says his roommate works for the FBI and is trying to frame him. Family members report that he is a client of the local mental health agency, but has not been going to treatment recently. The court wants to order mental health assessment and services for the individual.

Scenario 5:
An inmate is due for release in two weeks after serving 9 months in the county jail. Prior to incarceration she was a client at the local mental health center, had a case manager, medications and attended a psychosocial rehabilitation program during the day.

Scenario 6:
An individual with mental illness has been released on probation. He is a client of the local mental health agency, has case management and is prescribed medication. When he fails to report for an appointment the probation officer telephones his residence and finds that the telephone is no longer in service. The warrant officer reports that the individual has been evicted from his apartment.

Module 5
Suicide Intervention

Module 5

Suicide Intervention

Module Five: Methods and Procedures, Suicide intervention

Length of Presentation: 1 hour

Handouts and Materials:
Handout 5-1,Suicide, the Problem
Handout 5-2, Myths and Facts of Suicide
Handout 5-3, Suicide: Signs and Symptoms
Handout 5-4, Suicide Assessment: Law Enforcement
Handout 5-5, Suicide Assessment: Corrections
Handout 5-6, Intervention: Suicide Counseling
Handout 5-7, Suicide Management in Correctional Facilities
Handout 5-8, Suicide Prevention in Correctional Facilities
Handout 5-9, Response: Suicide Assessment and Intervention

Objectives

- Understand suicide;
- Identify signs and symptoms of suicidal intent;
- Identify risk factors for suicide, especially in criminal justice situations;
- Learn methods for assessing suicidal intent;
- Learn procedures for suicide intervention in law enforcement and correctional settings.

[Instructor note: *Optional discussions are included throughout the discussion section. Use examples and concerns voiced by trainees to emphasize points in the handouts. Particularly apt situations can be substituted for or added to scenarios in the Response exercise with permission from the trainee. Use the experience and expertise of the group to work through the scenarios to an appropriate and practical approach.]*

[Participants may bring up traumatic experience with suicide intervention. Allow group discussion and feedback with the trainee's permission, but be sensitive to verbal and non-verbal reluctance to discuss the situation publicly. If necessary, set aside time to discuss the situation with the individual after the training session. If you have concerns, refer the trainee for further counseling.]

DISCUSSION
Suicide Intervention

Law enforcement, corrections and probation officers will encounter suicidal individuals in the course of their work. The purpose of this section is to give a basic understanding of suicide, to identify signs of suicidal intent, to identify and reduce risk factors in criminal justice settings, and to learn methods for assessing and intervening to prevent suicide.

Optional Discussion:
[Time limit, 5 minutes.]
- How many here have dealt with suicidal individuals in your work?
- What are your main questions and concerns regarding your role in suicide intervention?

The Problem of Suicide

Suicide is a complex behavior usually caused by a combination of factors. Research shows that almost all people who kill themselves have a diagnosable mental or substance abuse disorder or both, and that the majority have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other psychiatric illnesses.

[Instructor: *Review Handout 5-1, Suicide, the Problem.]*

The Surgeon General's 1999 *Call to Action to Prevent Suicide* recommends a national strategy including:
- Promote public awareness of suicide as a preventable national problem;
- Increased resources to alleviate distress leading to suicide, including crisis lines, mental health and substance abuse services and support groups;
- Increase training of all mental health, health and human service professionals (including law enforcement and corrections) concerning suicide risk assessment, treatment, management and after care regimens;
- Increased monitoring and reporting of suicides and evaluation of suicide prevention programs.

The Tennessee Suicide Prevention Network *[see handout for contact information]* is part of that national strategy. The Network offers a number of services including:
- A statewide suicide hotline that is available 24/7;
- A web site with information on suicide and suicide prevention;
- Suicide prevention training conducted across the state with multiple stakeholder groups, using consistent, effective programs.

Suicide prevention and intervention are often hampered by commonly held misconceptions. Handout 5-2, Myths and Facts of Suicide, describes the most common myths, and the facts.

[Instructor: Refer to Handout 5-2, Myths and Facts of Suicide. Only review handout if class is inexperienced with suicide.]

Most people are severely depressed at the time of a suicide attempt. The first section of Handout 5-3 shows signs of depression associated with suicide.

*[**Instructor:** Review **first section** of Handout 5-3, Suicide: signs and symptoms.]*

Studies indicate that suicide is nine times as common among correctional inmates as in the general population[1]. The remainder of Handout 5-3 lists signs and risk factors in the correctional environment.

*[**Instructor:** Review remainder of Handout 5-3.]*

Jail Environment Risk Factors (Adapted from L.M. Hayes, Jail Suicide/ Mental Health Update, Fall 2000)

The experience of being arrested and jailed can traumatize an individual who has little or no criminal background, especially if the person has severe mental illness, is young, is pregnant, is withdrawing from intoxication, or is a public figure. Law enforcement and corrections personnel who respond sensitively to those individuals can alleviate the emotional trauma that can lead to suicidal behavior. The last section of Handout 5-3 lists some correctional risk factors.

Authoritarian environment: Inmates who are not used to regimentation may be traumatized by the correctional environment, especially if they have delusions, hallucinations or symptoms of severe depression. Mounting stress levels combined with inadequate coping skills increase the likelihood of suicidal behavior.

Fear of what the future holds: Following incarceration, many jail inmates feel powerless over their future. They may have a sense of impending doom about the legal process. Feeling helpless and hopeless increases the suicide risk.

Fears: Stereotypes of jails from the media may heighten anxiety about other inmates and the staff. Individuals who are prone to paranoia or anxiety may be more vulnerable to suicidal behavior induced by terror.

Social isolation: Inmates may feel cut off from family, friends especially with restricted telephone and visiting privileges. Inability to obtain support and encouragement increases risk of suicide.

Shame: Feelings of shame are common in misdemeanants. Often, those charged with minor crimes feel more ashamed than those charged with more serious offenses. Inmates with little or no criminal history also feel more shame. Humiliation is a common factor in suicide.

Dehumanizing aspects of Incarceration: From the inmate's perspective, confinement, even in the best of jails, is dehumanizing. Lack of privacy, association with poorly behaved individuals, lack of opportunity to make choices, strange noises and odors, and overcrowding can all have a devastating effect.

[1]Hayes L., Rowan, R. (1988) National Study of Jail Suicides: Seven Years Later, Alexandria, VA. National Cener on Institutions and Alternatives. National Institute of Corrections, U.S. Department of Justice.

Officer insensitivity to arrest and incarceration: Most professionals working in the criminal justice environment have never personally experienced the trauma of arrest and incarceration. Experience has shown that, in many instances, the longer people work in the criminal justice field, the more insensitive they can become to the emotional effects of arrest and incarceration, particularly for the first-time offender.

Optional Discussion:
[Time limit, 5 minutes.]

- How many here have dealt with individuals who seemed traumatized by arrest or incarceration?
- How did those individuals behave?
- What did you and other officers do that either improved or worsened the situation?
- If you or others did something that made the situation worse, what would you do differently?

Suicide Assessment

Suicide Assessment: Law Enforcement
Law enforcement is commonly called to the scene of an attempted or completed suicide. Officers may refer individuals who have attempted suicide to crisis intervention or mental health services, but as the first officials to arrive, their observation of signs, symptoms, and the physical environment to are essential to begin the assessment and intervention process.

*[**Instructor:** Review Handout 5-4, Suicide Assessment: Law Enforcement.]*

Individuals arrested for crimes may also pose an increased risk of suicide. Often those with the least criminal history arrested for minor offenses are at greater risk of becoming suicidal. Another high-risk group are arrestees with psychotic disorders who may hear voices telling them to kill themselves.

To detect possible suicidal intent law enforcement officers must observe the individual's behavior:

- During arrest;
- During transport to the jail;
- At booking/intake.

Law enforcement officers should alert booking and/or correctional staff when there is a suspicion of suicidality. Many officers help prevent jail suicides by transmitting observations and information indicating danger of self-harm. On the other hand, some have been named in lawsuits for failing "duty of care," or for deliberate indifference for failing to transmit information or ignoring threats of suicide.

Suicide Assessment in Correctional Facilities
Intake screening should occur immediately after a new inmate arrives at the jail, and should assess risk of suicide or self-harm. Screening should be conducted by trained booking or corrections officers, or by medical personnel. Failure to conduct an immediate screening increases the chance that an inmate will kill or harm himself or herself. The facility will probably be subject to a lawsuit if there is an accidental inmate death.

The following are some pointers for effective intake interviewing:

- Explain the purpose of the intake interview to the inmate, especially if the inmate has no previous experience with incarceration or appears frightened, withdrawn or aggressive.
- Use the screening questionnaire as a beginning. Follow-up on any verbal or behavioral responses that suggest the inmate may intend self-harm.
- Ask questions in a straightforward manner speaking in a quiet, matter-of-fact tone. Do not use an abrupt, confrontive tone. You will not get truthful responses and may increase the risk of suicide.
- If the inmate does not understand you, repeat the question.
- Use as private a setting as possible.

If there is any indication of suicidality or mental illness, the inmate should be referred for a more thorough mental health assessment and should be closely monitored.

Warning

More than 50% of all jail suicides occur within the **first 24 hours** of arrival at the jail.

*[**Instructor:** Review Handout 5-5, Suicide Assessment: Corrections.]*

Suicide Attempts vs. Manipulation

It is common for officers to view suicide attempts as manipulative behavior. Studies show that self-mutilation should be taken seriously, because an eventual completed suicide is likely if the individual is not monitored (Liebling,1996). While not all suicide attempts are self-mutilation, it is not useful to try to distinguish self-injury from manipulation. It is more useful to ask, “Why is this person trying to injure himself or herself? (Danto and Lester,1993).

Suicide Counseling

*[**Instructor:** If you only have law enforcement trainees or corrections trainees, use the appropriate discussion script. The handout is the same. If you have both in the audience review the handout during the law enforcement section of the script, but then proceed to corrections.]*

Law Enforcement: Suicide Counseling

Once an assessment has been done, whatever the level of risk, law enforcement officers should begin the suicide counseling process. The objective is to assist the individual to resolve desperate, all-or-nothing thinking and consider healthy alternatives.

If the individual has not committed a crime, the guidelines are as follows:

- **Low risk of self-harm:** Individual can be counseled and released if suicidal ideation was resolved. The chosen method of self harm may need to be confiscated or neutralized. Contact information for local mental health treatment providers should be supplied to the individual;

- **Moderate risk:** Individual should be transported or referred to a mental health agency after initial suicide counseling. Chosen method of self-harm should be confiscated or neutralized and other suicide precautions should be activated;

- **High risk:** Individual should be escorted to an emergency room or psychiatric inpatient facility. Chosen method of self-harm should be confiscated or neutralized and other suicide precautions should be activated. Due to liability concerns, the individual may need to be restrained;

Individuals who are under arrest should be monitored closely at all times during arrest, transport and booking if there is risk of self-harm. This not only keeps the individual safe, but also affords an opportunity to counsel the individual and gather information that is needed by correctional officers.

Whether the individual has committed a crime or not, the officer that asks about self-harm and demonstrates caring attention can save a life. It may not be appropriate for the officer to follow the counseling process through to the action planning stage, but initial steps should be taken to minimize the risk of self-harm in the immediate future.

*[**Instructor:** Review Handout 5-6, Suicide Counseling.]*

Suicide Counseling In Correctional Facilities
The inmate who presents an increased risk of suicide should be placed on suicide watch and counseled by mental health or medical personnel. However, correctional security officers may spend much more time around the inmate and will be in a position to notice signals from the inmate that distress is increasing and self-harm is a possibility. As with law enforcement, it may not be appropriate for the officer to follow the counseling process through to the action planning stage, but initial steps should be taken to minimize the risk of self-harm in the immediate future.

*[**Instructor:** Review Handout 5-6, Suicide Counseling if you haven t already done so.]*

Managing Suicidal Individuals In Correctional Facilities
In general, correctional security officers are more involved in managing suicidal inmates than suicide counseling. Handout 5-7 describes principles and procedures for maintaining the safety of suicidal inmates while reducing risk of suicide attempts. Individuals at risk of self-harm must be monitored at all times and must be treated with care to reduce traumatizing factors in the correctional environment.

*[**Instructor:** Review Handout 5-7: Suicide Management in Correctional Facilities.]*

Suicide Proofing
Increased suicide risk is a fact of life in incarceration. Correctional administrators and staff that take an ongoing, proactive approach to suicide proofing will reduce the chances of having to make drastic changes after the fact. In addition to thorough, systematic screening at intake, there are a few relatively simple, inexpensive approaches to correctional suicide prevention.

- Training of security and medical personnel, initial and on-going;
- Specific physical plant changes;
- Policy and procedure changes;
- “Last resort” approach to use of restraints and forced medication;
- Morbidity and mortality review procedures, critical incident debriefing;
- Good communication between inmates and staff.

*[**Instructor:** Review Handout 5-8, Suicide Prevention in Correctional Facilities.]*

***Response* Exercise:**

*[**Instructor:** Particularly apt situations voiced by trainees in discussions can be substituted for scenarios in the Response exercise with permission from the trainee. Use the experience and expertise of the group to work through the scenarios to an appropriate and practical approach.]*

*[**Instructor:** Proceed through exercise on Handout 5-9, **Response:** Suicide Assessment and Intervention.*

Option 1: Work through scenarios as a group.]

Option 2: Divide the class into small groups (up to 6 trainees) assigned to work through two or more scenarios. Facilitate a whole-group discussion to share what small groups developed.

Write responses on flip chart or marker board.]

References

Hayes, L.M. (2000) Suicide Despite Denial: When Actions speak louder than words, Jail Suicide/ Mental Health Update, Fall, (10) 1, 1 – 6.

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Levitt, G. (2000) Practical Suicide Prevention, *Corrections Today*, December, 110-117.

Texas Commission on Law Enforcement; (2000); *Suicide Detection and Prevention in Jails*. # 3501(Revised).

Handout 5-1

Suicide, the Problem

Suicide is a complex behavior usually caused by a combination of factors. Research shows that almost all people who kill themselves have a diagnosable mental or substance abuse disorder or both, and that the majority have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of depression and other psychiatric illnesses.

- Suicide was the eighth leading cause of death for all Americans (up from ninth in 1996) and the third leading cause of death for young people aged 15-24.
- Suicide took the lives of 30,903 Americans in 1996 (10.8 per 100,000 population). Suicides in that year accounted for only 1% of all deaths, compared with 32% from heart disease, 23% from cancer, and 7% from stroke, the top three causes of death in the U.S.
- More people die of suicide than from homicide. In 1996, there were three suicides in the U.S. for every two homicides committed.
- Up to 80% of all suicides are completed by people who are severely depressed.
- The highest suicide rates were for white men over 85, who had a rate of 65 per 100,000 individuals. However, suicide was not the leading cause of death for this age group.
- Males are four times more likely to die of suicide than are females. However, females are more likely to attempt suicide than are males.
- In 1996, white males accounted for 73% of all suicides. Together, white males and white females accounted for more than 90% of all suicides in the United States. However, during the period from 1979-1992, suicide rates for Native Americans were about 1.5 times the rates for the general population. There were a disproportionate number of suicides among young male Native Americans during this period, as males 15-24 accounted for 64% of all suicides by Native Americans.
- Nearly 3 of every 5 suicides in 1996 (59%) were committed with a firearm, while 79% of all firearm suicides are committed by white men.
- There are an estimated 16 attempted suicides for each completed suicide. The ratio is lower in women and youth and higher in men and the elderly. Suicide attempts are expressions of extreme distress that need to be addressed, and not just a harmless bid for attention. A suicidal person should not be left alone and needs immediate mental health treatment.

From: The Surgeon General's Call To Action to Prevent Suicide, 1999, http://www.surgeongeneral.gov/library/calltoaction/fact1.htm

In Tennessee: Statewide Suicide Hotline, (800) SUICIDE (784-2433)

For more information on suicide prevention: Tennessee Suicide Prevention Network
http://www.state.tn.us/mental/suicidePrev/suicide.html new web address

Scott Ridgway, Director
P. O. Box 40752
Nashville, TN 37204

(615) 298-3359
E-mail: sridgwaytn@aol.com

Handout 5-2

Myths and Facts of Suicide

1) **Myth:** Once someone decides on suicide, he or she cannot be stopped.

   Fact: Most suicidal people have mixed feelings. Most do not want death; they want to end the pain: physical and psychological. They may be miserable, but they wish to be saved.

2) **Myth:** Most suicides are caused by one sudden traumatic event.

   Fact: Most people communicate warning signs of how they are reacting to events that are drawing them toward suicide. There are often a number of opportunities to assist the individual.

3) **Myth:** Talking about suicide gives people the idea.

   Fact: Asking someone about their suicidal feelings may actually make them feel relieved that someone finally recognizes their emotional pain.

4) **Myth:** People who talk about suicide never actually do it.

   Fact: Almost everyone who has attempted suicide has given some warning or clue. When someone talks about committing suicide, he or she may be giving a warning that should not be ignored by others who hear such comments.

5) **Myth:** Suicide occurs without warning.

   Fact: Research has consistently shown that at least two thirds of all suicide victims, including adolescents, communicate their intent some time before death.

6) **Myth:** The suicidal act is a well-thought-out expression of an attempt to cope with serious personal problems.

   Fact: Most people are irrational at the time of a suicidal crisis. They have very strong mixed feelings. They want to live, but are overwhelmed with despair, anxiety and hopelessness. They cannot see any other solution.

7) **Myth:** People who have tried suicide and did not succeed are less likely to try it again because they have gotten it out of their system.

   Fact: Eighty percent of those people who die by suicide have made at least one previous attempt.

8) **Myth:** Inmates who are really suicidal can be distinguished from those who hurt themselves just to be manipulative.

   Fact: Manipulative goals in self-injury are not useful in distinguishing more lethal attempts from less lethal attempts.

9) **Myth:** There is a "typical" type of person who commits suicide.

   Fact: The potential for suicide exists in all of us. There is no typical type of suicidal person.

Handout 5-3

Suicide: Signs and Symptoms

Most people are severely depressed at the time of a suicide attempt. Narrow, all-or-nothing thinking leads them to view suicide as the solution to an intolerable situation. Assessment and counseling can assist suicidal individuals to pursue healthier approaches to problems.

Depressive symptoms

- Expression of an inability to go on (hopelessness, helplessness);
- Extreme sadness, crying;
- Withdrawal, silence;
- Marked changes in appetite and/or weight;
- Changes in sleep: insomnia or over-sleeping;
- No sense of the future, or hopeless attitude toward the future;
- Marked mood changes;
- Tenseness, agitation, aggression;
- Lethargy, slowed movements;
- Loss of self-esteem;
- Self-blaming, strong guilt feelings about offense;
- Loss of interest in people, appearance, activities;
- Difficulty concentrating.

Other signs of suicidality

- Talking about, threatening suicide;
- Intoxication, alcohol/drug withdrawal;
- Previous suicide attempts, history of mental illness;
- Paranoid delusions or hallucinations;
- Does not deal with the present, is preoccupied with the past;
- Poor health or terminal illness;
- Increased difficulty relating to others;
- Engaging in non-lethal self-injury.

In correctional facilities:

- Speaking unrealistically about getting out of jail or “being free”;
- Begins packing or giving belongings away when release is not imminent.

Risk factors in criminal justice settings

Suicide rates in correctional facilities are nine times greater than in the general population.

- Arrestee with little or insignificant criminal history;
- Previous imprisonment and facing new serious charges and long prison term;
- Previous painful alcohol/drug withdrawal, unwilling to go through it again;
- Juvenile, whether or not waived to adult court;
- High status in the community;
- Prior suicide by close friend or family member;
- Recent suicide attempt by another inmate (copycat syndrome);
- Harsh, condemning, rejecting attitudes of officers, e.g. “We’ll give you the rope…”
- Same sex rape, or threat of it.

Risk influences in jail environments:

- Authoritarian environment;
- No apparent control over the future, fear of legal process;
- Isolation from family, friends and community;
- Shame about incarceration;
- Dehumanizing aspects of incarceration;
- Fears of inmates and staff;
- Officer insensitivity to inmates’ experience of arrest and incarceration.

Source: Hayes, L.M. (2000) Suicide Despite Denial: When Actions speak louder than words, Jail Suicide/ Mental Health Update, Fall, (10) 1, 1 – 6.

Handout 5-4

Suicide Assessment: Law Enforcement

Situation	Questions
Attempt has occurred.	Suicide paraphernalia evident? Is individual bleeding? Is individual conscious? What are the vital signs?
	Is anyone else present? If so… Did they see what happened? If not…. How soon after the even did they arrive? Exactly what did they see/hear /when they arrived?
	If conscious ask: Have you already attempted to kill or harm yourself? What did you do? When did you do it? Response time is critical. Seconds might count.
Attempt has not yet occurred.	
Assess **immediate risk:**	**Observe: Physical signs of depression?** Slowed movements; Slowed verbal response; Unkempt appearance; Untidy living place.
	Ask: Have you thought about harming or killing yourself? Affirmative answer or perceived evasiveness = higher risk.
	Ask: Have you thought about how you would do it? More lethal methods = higher risk.
	Have you thought about when you would do it? The more immediate/specific time frame = higher risk.
	What have you done already to prepare to harm yourself? More available methods = higher suicide risk Confiscate weapons, sharp object, medications, other means to suicide
Assess **prior behavior:**	**Have your tried to harm yourself before?** How many times? How did you do it? More lethal methods = higher risk What happened?
Assess **social support:**	**Are you feeling alone with these thoughts of suicide?** Who have you turned to for help? What happened? Who else has helped you in the past? Fewer, more distant persons = higher risk
Assess **behavioral cues:**	Combative, challenging toward law enforcement: “suicide by cop” Depressed, withdrawn, expresses hopelessness, helplessness, Expresses no sense of future: “I won’t be here.” If incarcerated, speaks unrealistically about release. Packs/gives away belongings.
Assess **other risk factors:**	Recent loss of family member, close friend; family history of suicide; loss of: job, financial security, relationship, pet; history of mental illness; public humiliation: especially for public figures; pregnant inmates; inmates needing psychiatric medications, who do not have them.

Handout 5-5

Suicide Assessment: Corrections

Intake:	If there is ANY doubt about suicide, refer the inmate for mental health assessment.
Information about arrest:	Does the arresting and/or transporting officer have any information to indicate that the inmate is a medical, mental health or suicide risk now? If yes, explain.
Prior/collateral information:	• Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility? If yes, explain. • Does the inmate display symptoms of depression, aggression or intoxication that increase suicide risk? If so, what? • Is there any notification/documentation from sending agency to indicate possible suicide risk? If so, what? • Is there any information from relatives or friends that might indicate suicide risk? • Is the inmate in treatment through a mental health agency? • If so, request signed consent to release information from inmate; • Contact agency to notify of incarceration and obtain diagnosis, medication list, history of danger to self or others.
Intake questions:	• Have you ever attempted suicide? If yes, when, why and how? • Have you ever considered suicide? If yes, when and why? • Are you now, or have you ever been treated for mental health or emotional problems? If yes, when and where? • Have you recently experienced a significant loss, such as a relationship, death of a family member or close friend, or job loss? If yes, explain. • Has a family member or close friend ever attempted or committed suicide? If yes, explain. • Do you feel there is nothing to look forward to in the near future? If yes, explain. • Are you thinking of hurting or killing yourself? If yes, explain.
Answers will not necessarily indicate that the individual is suicidal, but the screener should always refer the inmate for assessment if self-harm is suggested by: _ Verbal responses; _ Behavior; _ Demeanor; _ Background; _ Scars from previous suicide attempts; _ Bruises, skin condition and color; _ Visible signs of intoxication, drug withdrawal.	
Observation in jail:	
High risk periods:	More than 50% of jail suicides occur in the **First 24 Hours**; Many within the first **3 hours**. Other high-risk periods: • Darkness; • Times of decreased staff supervision; • When an inmate first starts taking psychiatric medication; • When bad news is received; • Holidays; • During sentencing; • As release date nears.

Handout 5-6

Intervention: Suicide Counseling

The first officer at the scene of a suicide attempt should use basic suicide counseling techniques to calm the individual and begin exploration of healthy alternatives to suicide. The role of an officer is to administer "emotional first aid". Suicidal individuals should be referred or escorted to professional services at the earliest opportunity.

Steps in suicide counseling:
Engage the individual

- Show compassion. Your calm, caring, confident, firm demeanor provides a model. It will encourage trust and will help the individual calm down and begin thinking rationally.
    - Paraphrase implied feelings then invite the individual to discuss them:
      "You seem desperate to relieve the pain you are feeling. Tell me how it feels."
    - Encourage the person to talk about what is happening from his/her point of view.
    - Do not show condemnation or shock.
- Convey that suicidal thoughts are normal part of severe depression. Allows individual to feel less guilty and isolated.

Ask direct questions about suicide

- If the individual has not already spoken of it, ask directly about suicidal intent or attempt:
  "It sounds like you were planning to kill yourself. Is that true?"
  "How were you planning to do it?" (The more specific, immediate and lethal the higher the risk)
- Keep asking questions until you and the individual understand events and feelings in the recent past that led to this point.
- Stay in the here and now, in the recent past and immediate future.
  Do not dwell on early childhood or the distant future.
- Keep the focus on the individual, not family, spouse, etc.
- Focus on the individual's ambivalence about suicide.
  "You want to die, but I think another part of you wants to live. Tell me about that part."
- Begin problem solving only AFTER feelings have been identified and you understand the person's situation.

Redirect the individual away from the act toward alternatives.

"What else could you do right now to make yourself feel better?"

- If emergency procedures have been initiated, explain how you see the situation, what is being done, and the intended outcome.
- Help the individual realize that the crisis is just temporary and things can work out.
- Assure the individual that help is available.

Help the individual develop an action plan

- The plan should be specific: what, where, when, who, how?
- The plan should be achievable: a modest plan that can be carried out will encourage the person. An ambitious plan that does not work is dangerous.
- The person should commit to the plan. Get the person to repeat the agreement out loud.
    - A voiced commitment is more likely to be kept.
- Plan for crisis support. Plan what the person will do if desperate, suicidal feelings return. The plan can include other inmates, staff, contacting clergy, family, etc.
- Suicide-proof the environment: Remove all hazards, particularly those that were used in previous suicide attempts.

Handout 5-7

Suicide Management in Correctional Facilities

Individuals at risk of self-harm must be monitored at all times, with more intensive monitoring during high-risk periods. At the same time, inmates on suicide watch should be treated with care to reduce further trauma. The following procedures will reduce risk of inmate self-harm or suicide:

- Officers who have regular, fair, non-judgmental communication with inmates will be more likely to spot verbal and behavioral cues as an inmate prepares a suicide or self-harm attempt:
  - Inmate is withdrawn, does not respond to greetings or questions;
  - Inmate who has been withdrawn is suddenly cheerful or relieved (indicating that a decision to suicide has been made);
  - Inmate hides something as officer approaches;
    - May have secured means of suicide including bedding, braided toilet paper, wadded toilet paper used for suffocation, sharp object to be used in laceration, pills for overdose.
    - Search inmate and inspect cell thoroughly for evidence of suicide preparation. Remove all possible means.
  - Inmate is packing belongings or giving them away;
  - Other inmates notify officer that inmate is up to something or has said something that raises concerns about suicide;
  - Inmate speaks unrealistically about “release” or “Soon I won’t be here.”

- Procedures for medication administration should include “watch and swallow” techniques and secure storage of disposal of syringes and instruments.

- When inmate is on suicide watch, frequent contact with correctional officers is essential: at least every 15 minutes at staggered intervals, round the clock. Adopt a caring approach to minimize the sense of isolation that increases suicide risk.

- Monitoring by on-call suicide watch personnel may be necessary in high-risk situations. Specially trained security officers, nursing assistants or psychiatric technicians have been used effectively in county jails.

- Removal of clothing and bedding may be necessary. Use of paper garments or suicide proof garments is another option, but suicide garments are not hazard-free, and should not be considered a substitute for close monitoring.

- Use of transitional cells in full view of the security office is a better option than relying on video cameras and monitors.
  - Transitional cells, or suicide watch cells should be free of protrusions, large bore grates and other hazards that can be used in hanging.
  - Plastic bunks are available to reduce possibility of the bed frame being used.
  - Resources used to establish transitional cells can be considered insurance against considerable financial outlay that will be necessary if the jail is sued after an inmate suicide.

Handout 5-8

Suicide Prevention in Correctional Facilities

Increased risk of inmate suicide is a fact of life in correctional facilities. A proactive approach will save lives and will reduce the chance of being forced to make drastic changes after the fact. In addition to thorough and consistent screening at intake, there are a few relatively simple, inexpensive approaches to correctional suicide prevention.

Common Means of Suicide	Suicide Proofing
Hanging: 93.5% of correctional suicides • Using bedding 47.9% • Using clothing 33.7%	• Paper garments Can still be shredded & used for suffocation, or Braided and used for hanging. • Suicide blankets (must be dated, replaced every 6 months) • Plastic bunks
Overdose 1.2%	• Perform watch and swallow techniques; • Periodic observation of staff during medication administration.
Lacerations 1.2%	• Secure disposal procedures to track and dispose of razors and other sharp instruments. • Periodic observation of staff procedures during inmate shaving;
Other methods	• Determine facility weak spots: review incident reports to list means and ways previously used in suicide attempts.

Facility tour: Necessary even in new facilities
Use multi-disciplinary team: include security and mental health staff. Examine facility for potential means of suicide. Include medical/mental health units. Put yourself in the shoes of a desperate inmate.
Look for potentially lethal items: vents with large bore grating, light fixtures that can be bent, open railings, window bars, bunk supports, shower heads, protruding objects, accessible electrical or telephone cords.
Look for poorly visible areas: stairwells, shower stalls, dark corners, sections of cells not visible through door.
Survey inmates: about their observations regarding the institution's vulnerabilities toward suicide
Remove hazardous conditions: Commit resources and change policies.

Observation cameras: Limitations and solutions
Limitations: _ TV monitor must be watched constantly. Staff in the security office are usually answering the phone, responding to radio messages, observing other activities, completing paperwork; _ Poor picture quality: rooms not well lit, pictures may be grainy, distorted; _ Blind spots: Areas of the facility may not be within camera range; difficult to install cameras into existing structures without leaving exposed wiring. **Solutions:** _ Place inmate under constant observation. Hire trained on-call nursing assistants or psych techs; _ Build transition cells that are in full view of the security tower. Equip with plastic bunks.

Policies and procedures:
See examples in: National Commission on Correctional Health Care: *Standards for Health Services*. Compare with federal, state and local mandates. Review annually. Make sure medical and security policies are coordinated and consistent.
Should be detailed, objective and easy to understand.
Regular staff training to ensure familiarity.
Topics:
Emergency psychiatric interventions: Include triage system, expected staff responses and outcomes. Train medical and security officers to respond to psychiatric crises.
Suicide prevention and response: • Must have round the clock observation/intervention plan for suicidal inmate. • Double bunking with a responsible peer inmate; • Consultation with mental health specialist; • Transfer to local hospital if necessary. • Risk levels with required response.
Forced medications: Should be used only • After other measures have been tried unsuccessfully, AND • If the psychiatrist or other qualified psychiatric professional determines that the inmate meets criteria for involuntary administration of medication.
Restraint and seclusion procedures: May be overly restrictive and traumatic for the individual. Must be written with the inmate's constitutional rights in mind. Very detailed and objective, concrete decisions and procedures. Staff accountability measures should be included. Use only as last resort. Document procedure with videotape.

Morbidity and mortality review/ Critical incident debriefing
When inmate completes suicide, analyze events leading up to suicide.
Identify mistakes, to assist in procedure performance improvement.
Develop plan for improvement.
Common issues: response time, disorganized medical intervention, paramedics or crisis team having difficulty entering the facility, failed communication between inmate and staff before the event.
Medical and security staff should participate.
Debriefing should address trauma in staff and inmates (to prevent "copy cat" syndrome).
Report suicide to the appropriate authority.

Source: Levitt, G. (2000) Practical Suicide Prevention, Corrections Today, December, 110-117.

Handout 5-9

Response: Suicide Assessment and Intervention

Scenario 1: A 22-year-old woman calls 911 to report that she has taken an overdose of her medication. When law enforcement officers arrive she is still conscious, but is slumped in the corner of her living room and gives minimal verbal responses. Her speech is slurred.

- What steps do you take to assess level of risk?
- What steps do you take to assist the woman?

Scenario 2: A 35-year-old male, employed as a teacher at the local elementary school, is arrested for sexual assault on a 10 year-old girl. The man has no previous criminal record. During transport to the booking facility he appears withdrawn and murmurs, "There is no point in going on."

- What steps do you take to maintain the safety of the individual?
- What steps do you take to assess level of suicidality?

Scenario 3: A 25-year-old male inmate is discovered hanging from a grate in his cell. He is still breathing, but his skin is blue.

- What steps do you take to maintain safety?
- What steps do you take to assist the individual after the initial crisis has been resolved?

Scenario 4: Workers in an office building call to report that a man is poised on the fifth floor of a parking ramp across the street. When law enforcement officers arrive, the man is shouting angrily at the air and waving a length of metal pipe to ward off onlookers.

- What steps do you take to maintain safety of the individual, law enforcement personnel and onlookers?
- After getting the individual back from the ledge, what steps do you take to further assist the individual?

Scenario 5: A 32-year-old female inmate, diagnosed with schizoaffective disorder and borderline personality disorder, is discovered in her cell having slashed her wrists with a piece of plastic soda bottle. She is bleeding profusely, but is still conscious.

- What steps do you take to maintain the safety of the individual?
- What steps do you take to assess the suicidality of the individual?
- What steps do you take to maintain safety of other inmates?

Scenario 6: After a serious suicide attempt, your sheriff orders a thorough inspection of the correctional facility to remove hazards. Your county is in a budget crisis and the jail has a number of unfilled security officer positions.

- What steps would you take to inspect the facility? Who would be involved?
- What potentially hazardous conditions and items might you look for in the facility?
- What steps can you take to make the facility safer, given budget constraints?

Scenario 7: A 21-year-old male has been placed on your probation caseload. He is a client of the local mental health center where he has been treated for schizophrenia prior to 6 months of incarceration in the jail. He reports that he was refused services when he went to the mental health center yesterday because he does not have TennCare yet. The voices are saying bad things to him.

- What steps would you take to assess his level of suicidality?
- What steps would you take to maintain the safety of the individual in the community?

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Tennessee Department of mental Health and Developmental Disabilities, Authorization Number 331462, 100 copies, April 2003, This public document was promulgated at a cost of $14.79 per copy.

Criminal Justice

Response

To people with mental illness
Arrested or incarcerated in Tennessee

Module 6
Transportation

By Sita Diehl, MA, MSSW
Tennessee Department of Mental Health and Developmental Disabilities
March 2004

Module Six:

Transportation

Length of Presentation: 30 - 60 minutes

Handouts and Materials:

1-1 Title 33: Transportation Requirements
1-2 Alternative Transportation: Criteria and Procedures
1-3 Transportation to Involuntary Commitment: The Process
1-4 Certificate of Need
1-5 Communication During Transportation
1-6 Response: Transportation to Involuntary Commitment

Motivational Supplies:

Raffle tickets,
Jar or hat for tickets
2 small prizes (pens

*[**Notes to Instructor:** If this module is taught as a stand-alone workshop, emphasize communication techniques and role-play. If more time is available, this module can be taught after module 2 on mental health and mental illness. Transportation officers often want information on symptoms and behaviors and how to handle them.]*

*[**Optional activity:** To encourage participation and to instill a sense of fun you can award raffle tickets to those who contribute to the discussion. Show the prize(s) to participants at the beginning of the session. At the end of the session, draw for a prize. Do not spend much time on the drawings. They should be quick and fun. Prizes should be small, but useful (e.g. a pen rather than a knick-knack).]*

Objectives:

- To understand legal responsibilities for transporting to involuntary psychiatric commitment,
- To understand alternative transportation options,
- To learn recommended procedures for transporting individuals to facilities for involuntary commitment,
- To understand special considerations for individuals who are subject to arrest,
- To practice skills for communicating with individuals during transport.

DISCUSSION
Transportation to Involuntary Commitment

Introduction

Transportation to emergency hospitalization is a case where law follows practice. Historically, there are two reasons counties have used sheriff's deputies to transport involuntarily committed psychiatric patients:

1) People with mental illness are assumed to present safety risks to self or others, and therefore to require the security surveillance of law enforcement;

2) Sheriff departments are the only common jurisdiction among all counties in Tennessee that have transportation capability. Not every county has an emergency medical service, but every county has a sheriff's department.

Although transportation by sheriff's officers is the most consistent and reliable solution available, there are several problems with the arrangement:

- The individual in psychiatric crisis may be further traumatized and humiliated by being placed in a law enforcement vehicle;
- The problem may be intensified by use of handcuffs or shackles that can be physically painful if the person struggles or moves around;
- Individuals who were not actively violent toward others may become belligerent as a defense mechanism;
- The practice criminalizes mental illness in the eyes of the individual. When asked why they were brought to the psychiatric facility individuals with mental illness sometimes report that they were arrested, but do not know what crime they have committed [Jolly, McReynolds, Rice & Ross, 2003][1];
- The practice criminalizes mental illness in the community. Neighbors who see the individual in the vehicle may assume that a crime has been committed. They may draw the conclusion that individuals with mental illness are more likely to commit crimes [Jolly, McReynolds, Rice & Ross, 2003][2];
- Criminal justice personnel are used for a medical problem. The practice takes law enforcement officers away from their task of protecting the community from crime, often for many hours;
- Criminal justice resources are used for a medical problem. County funds for sheriff's departments are diverted from addressing crime to alleviating psychiatric crises.

This session is designed to help transportation officers minimize the negative effects of this process by:

- Learning about the requirements of the law,
- Ensuring that appropriate procedures are followed,

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[1] Jolly, L; McReynolds, K, Rice, E; Ross, A; (2003) Transportation of Involuntary Psychiatric Patients, Unpublished, University of Tennessee College of Social Work.
[2] Ibid.

- Referring to alternative transportation agents when appropriate, and
- Using effective communication skills when interacting with the individual, with those who refer the individual for involuntary commitment and with the psychiatric facility to which the individual is transported.

Discussion:
[5-minute limit.]

- What situations have you encountered where transportation of an individual to involuntary commitment has created problems?
    - What sort of problems occurred?
    - What was done about the problems and how well did it work?
    - What questions do you have about this process as a result of that experience?

*[**Instructor:** Note responses on a board or flip chart. Refer to those situations as appropriate during the training.]*

The Law

Tennessee law requiring sheriffs to provide transportation to involuntary commitment was first enacted in 1965[3]. The law was amended in 1993 to allow a secondary transporting agent designated by the sheriff[4]. Secondary transporting agents, such as police departments or emergency medical services must have the same 24/7 capabilities as the sheriff. In 2003, Title 33, the Tennessee mental health code, was amended again to allow "any reputable and trustworthy relative or friend" to transport the person to hospital at their own expense *[T.C.A. §33-6-901]*.

*[**Instructor:** Review Handout 6-1, Tennessee Code Annotated Title 33: Transportation Requirements. Encourage questions and discussion. Make sure to carefully cover 'Waiting Time at the Admitting Facility." It is a recurrent source of misunderstanding between transporting agents and RMHI's.]*

Alternative Transportation

Several types of alternative transporting agent arrangements are used in various counties. It is recommended that counties develop a protocol describing which organization transports under what conditions.

The goal of alternative transportation arrangements is to have round-the-clock, cost effective coverage that does not rely on sheriff's department personnel and does not give the impression that the person is being taken into custody for a crime.

[3] Tennessee Code Annotated, Title 33, Mentally Ill and Mentally Retarded Persons.
[4] Ibid.

*[**Instructor:** Review Handout 6-2, Alternative Transportation.*

- *Describe local arrangements for alternative transportation to involuntary commitment. Not all counties have alternative transporting agents.*
- *Transportation by family, friends and other trustworthy individuals is an option for ALL Tennessee counties under appropriate conditions.]*

Roles:

- The sheriff designates alternative transporting agents and establishes procedures.
- Mandatory Prescreening Agents are responsible for assessing whether the individual requires physical restraints or vehicular security during transportation.
- Alternative transporting agents are responsible for transporting the individual safely to the designated facility, according to local sheriff's policy. Usually, if the transporting agent deems that additional security is necessary, the transporting agent requests assistance from the designated law enforcement agency.

Discussion:
[5-minute limit.]

- What questions do you have about this process?
- What has your experience been with alternative transporting agents?
- In your opinion, what are the pros and cons of using alternative transportation for involuntary commitment?

Transportation Procedures

When an alternative is not available, sheriff's deputies provide transportation. Transportation procedures vary between counties. This discussion provides only a general description and does not supercede local policy. **Always follow the policy established by your department.**

*[**Instructor:** Review Handout 6-3, Procedures: Transportation to Emergency Involuntary Commitment]*

When you are called to transport an individual make sure you get pertinent information from the dispatcher, the Mandatory Prescreening Agent, the individual and others on the scene. The officer has a right and a duty to inspect the certificate of need to ensure that it is completed and signed by an authorized Mandatory Prescreening Agent if the individual is being transported to a Regional Mental Health Institute (RMHI), or the physician, licensed psychologist or other designated mental health professional at a private hospital. The factual foundation for detaining the individual for evaluation must be properly documented. In no event should an individual be transported to involuntarily commitment on a mere referral or oral request.

*[**Instructor:** Review Handout 6-4, Certificate of Need.]*

When restraining an individual, **always** follow procedures established by your department. That said, it is a good idea to calmly inform the person in advance what

actions you will take. This reduces stress which will reduce symptoms that could lead to self-harm or aggression.
*[**Instructor:** Refer to the "Restraint" section of Handout 6-3, Procedures: Transportation to Emergency Involuntary Commitment.]*

Discussion:
[5-minute limit.]

- What questions do you have about this process?
- What has your experience been with accepting custody from a Mandatory Prescreening Agent or calling in an MPA when you were on a mental-illness related case in the community? If there were problems, how did you resolve them?
- What has your experience been with getting individuals in and out of the patrol car and using restraints during transport?
- What has your experience been with the evaluation process at the admitting facility? If there were problems, how did you resolve them?

Communication

The involuntary commitment procedure is often upsetting, frightening and frustrating for the individual. Negative reaction is understandable considering that the person is being transported involuntarily to a place where help may or may not be forthcoming. Your approach to communicating with the person, the family or others on the scene may defuse potential aggression or self-harm during transport.

*[**Instructor:** Review Handout 6-5, Communication During Transportation.]*

Communicating with the individual in a calm, direct, straightforward manner will prevent a great deal of escalating behavior. When the individual is psychotic, agitated and irrational, he or she may not respond to what you say, but will probably respond to the way you say it.

Discussion:
[5-minute limit.]

- What questions do you have about communicating with individuals during transport?

Response: Communicating with Individuals in During Transportation

*[**Notes to Instructor:***
Refer to Handout 6-7: Response: Communication During Transport.

- *Read client scenarios to the class.*
  (Choose those most appropriate to the audience.)

- *After each scenario is read, ask participants to suggest the best approach to effective communication.*
- *Then ask participant who suggested approach to role-play what s/he would say and do to facilitate effective communication:*
    - *"What would you say to me, the client?"*
    - *"Show me what you would do."*

Optional: Distribute raffle tickets to each person who responds. See instructor notes at beginning of module.]

Emergency Involuntary Commitment and Arrest Warrants

When there is an arrest warrant for an individual who is being transported to emergency involuntary commitment the law enforcement agency will need to take custody of the individual:

- At the end of the assessment if the person is not committed, or
- Prior to release if the person is committed to hospitalization.

Always follow your departmental policy. The recommended practice is for law enforcement agencies to negotiate general procedures with admitting facilities and hospitals. A detainer or an authorization to release information should be signed at the point of admission stating that law enforcement will be contacted to serve the warrant before the individual is released by the mental health facility. Confidentiality concerns will not interfere with transfer when there is an established procedure and a signed detainer or release.

Discussion:
[5-minute limit.]

- What has been your experience of transferring and regaining custody of individuals with arrest warrants in cases of involuntary commitment?
- If there were problems, how did you resolve them?
- What other questions do you have about the process?

Conclusion

Transportation of individuals to involuntary commitment is the responsibility of the sheriff in each county. The process can be less traumatic for the individual and use resources more effectively when sheriff's departments, police departments, mental health agencies and hospitals work together to resolve procedural issues.

At the direct service level, transporting officers who make a special effort to develop positive working relationships with crisis response teams have more success with providing efficient transportation to emergency involuntary commitment. Criminal justice/ mental health liaisons, in areas where they are available, can facilitate those working relationships.

Handout 6-1
Tennessee Code Annotated Title 33: Transportation Requirements

Abridged summary of transportation requirements under Title 33, Tennessee Code Annotated

Certificate of Need

Transportation to and involuntary admission of a person to a hospital or treatment resource shall not begin until a mandatory pre-screening agent, physician or psychologist completes a certificate of need *[T.C.A. §33-6-106].* The designated professional who completes the certificate of need shall give the sheriff or transporting agent the original of the certificate and turn the person immediately over the custody of the sheriff or transporting agent, who shall transport the person to a hospital or treatment resource that has available accommodations for involuntary commitment *[T.C.A. §33-6-406(a)].*

Determination for Transportation Mode

(ii) The physician, psychologist or designated professional shall complete a certificate of need for such emergency diagnosis, evaluation and treatment showing the factual foundation for the conclusions, AND

(iii) The physician, psychologist or designated professional shall assess the person's clinical needs and need for physical restraint or vehicular security and determine the mode of transportation to the hospital in consultation with the mandatory prescreening agent, other mental health professional familiar with the person, or a knowledgeable family member *[T.C.A. §33-6-404 (3) (B)].* Anyone transported in a law enforcement vehicle will be restrained.

Notification to the Admitting Facility

Before transportation begins, the sheriff or transportation agent shall notify the hospital or treatment resource at which the person is proposed to be admitted as to, 1) where the person is, and 2) the best estimate of anticipated time of arrival *[T.C.A. §33-6-406 (b) (1)].*

Waiting Time at Admitting Facility

(1) If the transporting agent has given notice and arrives at the treatment resource within the anticipated time of arrival, then the transporting agent is required to remain at the hospital or treatment resource only long enough for the person to be evaluated for admission, but no longer than one hour and forty-five minutes. At the end of that time, the person is the responsibility of the treatment resource and the transporting agent may leave *[T.C.A. §33-6-406(b)(2)].*

(2) If the transporting agent has not given notice or has not arrived within the anticipated time of arrival, the transporting agent shall remain at the treatment resource as long as it takes to complete the evaluation *[T.C.A. §33-6-406 (b) (3)]*

(3) In counties having a population of 600,000 or more the transporting agent is relieved of further transportation duties after the person has been delivered to the treatment resource. Transportation duties shall be assumed by appropriate personnel of the treatment resource *[T.C.A. §33-6-406 (b) (4)].*

Handout 6-1, continued
Title 33: Transportation Requirements

Admission/ Non-Admission

(1) If the person IS subject to admission, the physician shall complete a certificate of need and the person who took the service recipient to the treatment resource may then apply for the admission for the purpose of emergency diagnosis, evaluation and treatment *[T.C.A. §33-6-407 (b)].*

(2) If the person IS NOT subject to admission and the transporting agent is under a duty to remain at the treatment resource, the transporting agent shall return the person to the county [*T.C.A. §33-6-407 (c)].*

(3) If the person IS NOT subject to admission and the transporting agent is not under a duty to remain at the treatment resource, the treatment resource shall return the person to the county *[T.C.A. §33-6-407 (d)].*

Secondary Transporting Agents

The sheriff in a county in which a person with mental illness or serious emotional disturbance is to be transported, shall transport the person except for persons who are transported by:

(1) A secondary transporting agent designated by the sheriff if a physician or mandatory prescreening agent has evaluated and determined the person does not require physical restraint or vehicle security. A secondary transporting agent shall be available 24 hours per day, provide adequately for the safety and security of persons being transported, and provide appropriate medical conditions for transporting person for involuntary hospitalization.

(2) A municipal law enforcement agency that meets the requirements for a secondary transporting agent and is designated by the sheriff;

The sheriff shall take into account in designating a secondary transporting agent or municipal law enforcement agency both its funding and the characteristics of the persons who will be transported. The sheriff shall consult with the county executive or county mayor before designating a secondary transporting agent. A secondary transporting agent has the same duties and authority in detention or transportation of such persons as the sheriff.

Transportation of persons to be involuntarily committed is the responsibility of the county in which the person is initially detained. The sheriff or secondary transporting agent may bill the county of residence for transportation costs *[T.C.A. §33-6-901].*

Handout 6-1, continued
Title 33: Transportation Requirements

Transportation by Friends or Relatives

2003 Amendment: If a mandatory prescreening agent has completed a certificate of need to assess the individual for emergency involuntary commitment AND determines that the person does not require restraint or vehicular security, THEN

(1) One or more reputable and trustworthy relatives or friends of the person, or clergy or mental health professionals who are familiar with the person,

(2) Who will assume responsibility for the person's safe deliverance

(3) May be allowed to transport the person to the hospital if such relative or friend will do so at the transporter's own expense. *[T.C.A. §33-6-901 (4)]*

Transportation to Judicial Commitment

Whenever a person is about to be admitted to a treatment resource under Non-Emergency Involuntary Admission to inpatient treatment (Part 5 of Title 33), the court shall arrange for the transportation of the person to the hospital. Whenever practical, the person to be hospitalized shall be permitted to be accompanied by one or more friends or relatives, who shall travel at their own expense. Any reputable and trustworthy relative or friend of the person who will assume responsibility for the person's safe deliverance may be allowed to transport the person to the hospital if such relative or friend will do so at the transporter's own expense. *[T.C.A. §33-6-902 (a)].*

Transportation from Mandatory Outpatient Treatment Hearing

If an individual subject to Mandatory Outpatient Treatment (MOT) and the person's qualified mental health professional determines that the person is out of compliance with the treatment plan without good cause and:

(1) The person cannot be put immediately in compliance with the treatment plan, or
(2) The person cannot be expected to stay in compliance without further hospitalization, or
(3) The person does not comply immediately with the treatment plan,

The qualified mental health professional shall contact the sheriff and the sheriff shall immediately transport the person to the hospital from which the person was discharged, and the hospital shall admit the person…*[T.C.A. §33-6-615(d)]*

If the person is under Mandatory Outpatient Treatment, and the court or a qualified mental health professional determines that the person is out of compliance with the treatment plan without good cause and:

(1) The person cannot be put in compliance with the treatment plan immediately or
(2) The person cannot be expected to stay in compliance without further hospitalization,

The court shall make written findings of fact and conclusions of law on the issues and order the person re-committed to the hospital from which the person was released. The sheriff shall immediately transport the person as ordered by the court and the hospital shall admit the person *[T.C.A. §33-6-610, and §33-6-204(e)]*.

Handout 6-2
Alternative Transportation

Transportation by kin, friend, clergy or mental health professional:
(Contact local mandatory prescreening agency or hospital to determine if protocols exist in local area.)

- If the Mandatory Prescreening Agent, psychiatrist, licensed psychologist or other designated mental health professional deems that the individual does not require restraints or vehicular security, AND
- If a reliable, trustworthy person who knows the individual is available,
- Then that person may transport the individual to the facility and wait during assessment for emergency involuntary commitment procedures.
- If the individual is not deemed committable, the person that transported the individual to the facility will be responsible for providing transportation home.

Innovative Options for Secondary Transporting Agents:

1. Off-duty EMS personnel:
   - Emergency Medical Service (EMS) workers are paid overtime to provide transportation while off duty, using an unmarked sheriff's department vehicle.
   - Sheriff's deputies still provide transportation in cases where no EMS worker is available or if person needs restraint or vehicular security.

2. Emergency Medical Service as first choice transportation provider:
   - Emergency Medical Service (EMS) provides transportation to the hospital for emergency involuntary commitment.
   - If the Emergency Medical Technician arrives at the scene and deems that restraint or security is needed, a sheriff's deputy is called to ride along in the EMS vehicle.

3. Municipal Police Department as first choice provider (urban areas):
   - Police officers provide transportation to the hospital. In some communities, officers must wait during the assessment period and transport the individual away from the facility if commitment criteria are not met;
   - Some communities use the Crisis Intervention Team (CIT) model of law enforcement intervention,
     - Officers voluntarily agree to receive intensive mental health training, and are designated to respond to calls involving mental health issues;
     - Officers transfer custody to the assessment facility security personnel upon arrival, and return to their other duties.

For further information on these transporting options, contact Liz Ledbetter at the Tennessee Department of Mental Health and Developmental Disabilities (615) 532-6767.

Handout 6-3
Transportation to Emergency Involuntary Commitment: The Process

Gather Information:
From dispatch:

- Circumstances;
- Indications of suspected mental illness,
- Indications of actual or potential violence,
- Prior interaction with law enforcement.

From the Mandatory Prescreening Agent or other designated mental health professional:

- Certificate of need;
- Circumstances of the individual's conduct;
- Security needs during transport;
- Whether admitting facility has agreed to conduct an assessment;
- Destination for detoxification prior to assessment at psychiatric facility;
- Any other medical concerns that pertain to transport or transferal of custody to the admitting facility.

Emergency Involuntary Commitment Procedure:

- A mandatory prescreening agent (MPA), or other designated mental health professional completes a certificate of need.
    - MPA or mental health professional determines need for restraint or vehicular security,
    - If restraint is required, the MPA or mental health professional contacts law enforcement to transport individual,
    - Family members or friends may follow behind to supply information to the admitting facility.
- Transporting officer accepts the completed certificate of need. The officer has a right and a duty to inspect the certificate to ensure that it is fully completed and signed by the appropriate authority prior to accepting custody of the individual.
- If not already done, transporting officer contacts the admitting facility to notify of transport and verify that the facility will assess for involuntary emergency commitment. Other pertinent information:
    - Need for extra security personnel if the individual is violent;
    - Need for medical equipment such as a wheelchair;
- Transporting officer places the individual in the vehicle;
- The service recipient is transported to the facility;
- Individual is transferred to custody of the admitting facility,
- If the officer has given advanced notification:
    - The individual must be evaluated within 1 hour and 45 minutes of arrival at the hospital,
    - If the officer has not given advanced notification, time limits do not apply,
    - If more than one individual has been transported in one vehicle, the process may take longer than 1 hour and 45 minutes.
- Unless departmental policy states otherwise, the officer must wait until the assessment is complete;

Handout 6-3, continued
Transportation to Emergency Involuntary Commitment: The Process

Excerpt from Metropolitan Police Department, Nashville

- The officer should be prepared to relate facts and circumstances known to them to admitting personnel. Information may include, but not be limited to:
    - Observations of the scene when the officer arrived,
    - Indications of mental illness drawn from interviews and observations of the individual;
    - Self-harm or aggressive attempts or threats during transport,
    - Other individuals on the scene who may have pertinent information;
- If the individual is admitted, the officer will return to other duties;
- If the individual is not admitted, the officer will transport the individual to the point of pick-up or to a location away from the facility but within the individual's county of residence;
- Requests from a treatment facility to transport to another treatment facility shall be directed to the designated sheriff's department authority unless otherwise specified by policy. [5]

Restraints:

- Explain what you are going to do before you do it. In direct but simple statements, tell the individual what actions you are preparing to take and the reason why. Make sure you explain that the person has not committed a crime (unless he or she has); but restraint is used for the person's safety and yours.
- Speak slowly. Use a calm, but clear tone of voice. The individual may be distracted by hallucinations and may have difficulty understanding you.
- Use only necessary restraint. Unless you feel it is necessary to use shackles, use only handcuffs.
- Apply restraint with as little force as possible. If the individual is willing to cooperate, give verbal instructions such as, "Place your hands together behind your back," rather than forcing restraints by physical means.
- Search individual for potential means of harm to self or others. If the individual presents immediate substantial risk of harm, remove medications, sharp objects, potential means of strangling and any other object that could be used for self-harm or aggression.
- Place and remove the individual from the vehicle with as little use of force as possible. Do not use physical force if the person responds to verbal instructions.

No Incarceration without Criminal Charges

Pending removal to the hospital, a person with mental illness or serious emotional disturbance taken into custody or ordered to be hospitalized under chapter 6, part 5 of Title 33 may be detained in the person's home or in some suitable facility under such reasonable conditions as the court may order, but the person shall not be detained in a non-medical facility used for the detention of persons charged with or convicted of criminal offenses *[T.C.A. 33-6-902 (b)].*

[5] Metropolitan Police Department, (July, 1999) General Order 99-10 Interviewing and Transporting Mentally Ill Persons, Nashville, Tennessee.

Handout 6-4
Certificate of Need

[Scan]

Handout 6-4
Certificate of Need

Handout 6-5
Communication During Transportation

Individuals	Special Populations

Giving Instructions
o Use short sentences.
o Speak slowly, calmly, reassuringly.
o Give clear instructions when necessary.
o Give only one instruction at a time.
o Check to make sure the individual understands the instruction.
  o Do not assume willful non-compliance.
 	
Giving Information
o Using discretion: Inform the individual of what is about to happen;
  o During transport;
  o At the admitting facility;
  o Will be assessed by doctor;
  o May or may not be admitted;
  o If not admitted, will be transported back home, or county of residence;
 	
Gathering Information
o Listen to the individual during transport,
o Note information that may be pertinent to psychiatric assessment:
  o Verbal threats of harm to self or others;
  o Statements that do not seem to make sense;
  ▪ Possible delusional thinking;
  ▪ Responses to voices or other hallucinations;
  o Other statements that indicate impaired judgment,
  o Inability to take care of himself/herself.
	Children
	o Speak calmly, do not raise your voice;
	o Acknowledge to the child that he or she is in a difficult, scary situation;
	o Reassure the child that you are there to keep him or her safe;
	o Explain briefly what will happen at the hospital;
	o Listen to the child and offer calm reassurance.
	
	Women:
	o Women are more likely than men to have suffered prior physical or sexual trauma, and to have a posttraumatic stress reaction to events;
	  o Acknowledge that the individual may be frightened by the situation;
	o Women tend to seek more information and reassurance during transport. A female may want to talk more than a male service recipient;
	  o Listen to the individual;
	  o Respond in a calm, reassuring tone;
	o Communicate in a matter-of-fact tone,
	  o Neither intimidating, which may be perceived as a threat;
	  o Nor friendly, which may be interpreted as an invitation.
	
	People with Limited English Proficiency (LEP)
	o Speak slowly,
	o Do not speak louder than usual,
	o Give written information in the individual's language, if available,
	o Use caution when relying on family members or friends to interpret:
	  o Watch for inconsistent non-verbal cues that may indicate mistranslation.

Handout 6-6

Response: Communication During Transport

Instructions:

- *Instructor reads client scenarios,*
- *Discuss the best approach the situation.*
- *Optional Role Play:*
    - *Take parts of individuals in the scenario. Demonstrate:*
        a. *What would you say?*
        b. *What would you do?*

Scenario 1: Law enforcement has been called to the home of a woman who reports being assaulted by her 28-year-old son. The woman reports that her son accused her of working for the FBI and struck her with a telephone head set. The subject has a prior history of arrest for assault, but the mother says she does not want to press charges. She just wants to get him to the hospital and get him back on his medicine. Mobile Crisis Response has been notified by dispatch and is due to arrive within 20 minutes.

Scenario 2: Law enforcement has been contacted by the Crisis Response Team to transport a 12-year-old female for involuntary commitment at the psychiatric hospital. The subject overdosed on her anti-depressant medication in a suicide attempt. She has been medically cleared for transport, the hospital has been notified and has agreed to examine the subject.
Option 1: The hospital is a two-hour drive away from the scene.
Option 2: The hospital is a 30-minute drive from the scene.

Scenario 3: Law enforcement has been called to a restaurant where a man was shouting in Spanish at one of the waitresses. The restaurant owner reports that he was "talking crazy". The waitress reports that she is acquainted with the subject, but does not know him well. He has been stalking her for the past week and she is afraid he will do something. Mobile Crisis Response has not yet been notified.

Scenario 4: Law enforcement has been contacted by the Crisis Response Team to transport an intoxicated 48-year-old male to the local emergency room. The subject was found with an empty bottle of whiskey and a partial bottle of anti-anxiety medication. He has a lengthy history of mental health treatment at the local mental health agency. The Mandatory Prescreening Agent has completed a certificate of need for commitment to the psychiatric hospital after the subject's medical condition is stable and the blood alcohol level is acceptable.

Scenario 5: Law enforcement has been contacted by a hospital to transfer a 73-year-old male to the psychiatric hospital for emergency involuntary commitment after his blood alcohol level has reached an acceptable point. A certificate of need has been completed by the Mandatory Prescreening Agent from the crisis team.

Scenario 6: An 80-year-old woman has been assessed as not committable by the psychiatrist at the Regional Mental Health Institute. The law enforcement officer has been contacted to transport the individual away from the hospital, but the woman does not appear to know where she lives.

Criminal Justice

Response

To people with mental illness in arrested or incarcerated in Tennessee

Module 7
Law Enforcement Interaction

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Module Seven

Law Enforcement Interaction

Length of Presentation: 30 - 60 minutes
60 - 90 minutes with Role Play

Handouts and Materials:

7-1 Discretion and Officer Objectiveness
7-2 Police Response to People with Mental Illness
7-3 Expectations of Call-Takers/Dispatchers and Officers
7-4 Response: Law Enforcement Scenarios
7-5 Commonly Asked Questions about the Americans with Disabilities Act and Law Enforcement. (US Dept of Justice, Civil Rights Division, Disability Rights Section) Excerpted as related to Mental Illness.
7-6 Marrero-New Haven Incident
7-7 [Optional] Marrero-New Haven Role Play Training Model
7-8 Arrest Sampling of Mental Health Consumers, January 2005, Nashville Tennessee, from a single mental health services organization

Materials: Needed for Optional Role Play Item 7-7: Headphones and tape player, audio cassette of simulated auditory hallucination, two ink pens or rulers to simulate knives.

Optional Activity: Video Presentation: A Co-Training Effort: Families and Law Enforcement -- Community Encounters Part IV (California Alliance for the Mentally Ill 1995) Can be presented in seven short segments.

*[**Notes to Instructor:** This module can be taught as a stand-alone workshop. Emphasize communication techniques and role-play. Emphasize the real world scenarios and open communication with the trainees regarding the proper methods to approach the individual situations.]*

Objectives:

- To understand officer responsibilities when interacting with persons with mental illness.
- To understand law enforcement interaction options,
- To learn recommended procedures for approaching and interacting with persons with mental illness,
- To understand special considerations relating to arrest and officer discretion,
- To practice skills for effective interaction and positive resolution of encounters.

Discussion
Law Enforcement Interaction

Outside of learning to recognize the indications of mental illness, the most important part of Law Enforcement response to people with mental illness is the actual verbal and physical interaction. People with mental illness are just that: People. Their safety and well-being is just as much of a priority to law enforcement as anyone else. Keeping this in mind, Officers can better respond to their interactions.

Interaction with people with mental illness does not always indicate that the confrontation is with that person. Law enforcement officers interact with them in a variety of ways, including: being the victim of a crime; being a witness to a crime; needing simple assistance; involvement in a community crime prevention project; or being attached to an incident by virtue of living in the same household as a perpetrator or victim. Criminal suspicion is just one type of interaction but is often the most assumed.

There are many schools of thought and training that approach the issues of appropriate and positive police response and interaction with people with mental illness. There is no single method that will render favorable results every time. Keeping this in mind, officers should always defer to their departmental guidelines and policy, as well as their regimented and approved training.

Historically, when a law enforcement officer responds to a call or a report of a disturbance, he/she is expecting a confrontation. The level of anxiety and stress for the officer is ordinarily high until the officer determines that the need for that level of alertness is unnecessary. This does not suggest that the officer drops his/her “guard” during the resolution of the tasks at hand but suggests that the level of alertness is adjusted to meet the situation. Officers’ awareness of signs and symptoms of mental illness will assist them in not getting caught in a possibly dangerous situation where their guard is reduced but the person they are interacting with is in a state that may create a level of unanticipated danger.

Mental Illness does not immediately indicate that a person is dangerous or is a threat to those around him/her. People with mental illness pose no greater threat of danger than the remainder of the populace than anyone else; however, those who have a mental illness who are unmedicated may pose a higher perceived hazard due primarily to their unpredictability. Officers having the appropriate attitude, training, and application of learned skills will be well suited to interaction with these People.

Many options and tools exist for Officers responding to people with mental illness. Communication and training are the best tools available to officers. Arrest is historically the most used tool, which is not always the most appropriate.

Usually arrest is used as a first resort rather than a last resort. This training will help to decriminalize mental illness in allowing law enforcement to make use of their discretion and use arrest as a tool of last resort.

[Instructor Note: while emphasizing the ever present need to preserve the safety of all involved, make sure the trainees understand that mental illness does not equate to an active threat. Mental illness is a condition like any other such as someone who is under the influence of a narcotic or alcohol, or who has sustained an injury. It allows for a degree of unpredictability, not automatic hostility.]

[Policy Issues: Officers and law enforcement personnel should always defer to their department or office guidelines and established policies. It is not always possible to use discretion to prevent an arrest and the misuse of that discretion will cause significant difficulties for the officer and the department.]

Communication of Information

The most valuable **tool** any Law Enforcement Officer can have is effective and productive communication skills accompanied with adequate training. The most valuable **asset** that any Law Enforcement Officer can have is an effective and productive flow of information to him/her from a dispatcher, communications personnel, or other officers. This information may also come directly from this involved in the situation or having special knowledge of the situation and those involved. Coining an old phrase, “Knowledge is power.”

[Instructor note: Communications officers, dispatchers and similar positions can benefit from this training to aid in the appropriate relay of information to officers in the field. More often than not, ineffective information gathering from complaints or reports places officers and those around them in dangerous and stressful situations that would otherwise be unnecessary. This aspect of the training will save lives if applied appropriately.]

Another aspect of effective communication involving the criminal justice systems and the interactions with mental health consumers is the transfer of information between arresting/transporting officers and the hospitals, jails, and treatment centers that they Consumers are transported to. A critical part of treating any mental illness is communication from the Consumer, and the smallest tidbit of information could be the most crucial in diagnosing and treating a debilitating mental illness. It is imperative that the officer transporting the Consumer make note or pass along this information when he/she hands off the Consumer to the facility.

Handout 7-1
Police Officer Arrest Discretion

To arrest or not to arrest, that seems to be the ever-present question when police are involved with persons with mental illness. Law enforcement and police around the world are established, chartered and certified by laws, statutes, ordinances, and codes. There is no absolute law that can cover every conceivable situation that may arise or the police officer may encounter in the field.

Laws are ordinarily created in a political or bureaucratic vacuum without very much influence from outside sources beyond that which instigates the legislation. Law enforcement, on the other hand, experiences the law under a very broad scope of applications. Officers are required to use their education, experience, training, and common sense many times, to make decisions regarding the outcome of situations, positive or negative. This concept is *Officer Discretion*.

Officers of the law are given some incredibly powerful tools to enact justice and enforce the laws as given down to them. Force, even deadly force, is authorized as necessary as well as the seizure of your person and property, should the right circumstance exist. Just as powerful and just as important is the power of police discretion -- to arrest or not to arrest. Granted, some situations mandate that an arrest is made, many occasions involving people with mental illness allow for alternatives to arrest, detention and incarceration.

Police involvement with mentally ill persons is grounded in two common law principles:

(1) The power and responsibility of the police to protect the safety and welfare of the public, and
(2) *Parens patriae,* which dictates protection for disabled citizens such as mentally ill persons.

Most mental health codes specify parameters of police involvement with mentally ill persons and instruct police to initiate a psychiatric emergency apprehension whenever the person is either dangerous to self or others or is unable to provide for basic needs so as to protect him/herself from serious harm.

Although the law legitimizes the police officers power to intervene, it does not— and cannot – dictate the officer's response in any given situation. As with any law enforcement situation, the police must exercise discretion in choosing the most appropriate disposition. Officers who encounter an irrational person or person behaving in such a way as to suggest a mental illness, creating a disturbance have three choices:

(1) Transport the person to a community mental health agency or local hospital emergency room.

(2) Arrest the person [Most commonly used because officers lack the training and knowledge of available resources to pursue alternative placements.] and,

(3) Resolve the matter informally.

Through the use of hospital facilities and the informal process, the idea that mental illness can be decriminalized can become a reality. When an alternative to arrest is pursued, the officer becomes a part of the community in helping to solve the problem as opposed to being strictly an instrument of the law handing out justice with a blind stroke of the sword. It is also understood that situations and circumstances exist that dictate that an arrest and criminal charges are the only option. Discretion is not a mechanism to avoid or circumvent justice. Department policy must be followed in employing arrest discretion.

Having an understanding of mental illness and also understanding that the perceived criminal behavior is clearly and solely the result of mental illness, an officer is permitted to utilize his/her discretion and seek alternatives. The productive and effective use of discretion may change the mode of thinking which suggests that the criminal justice system is the default mechanism for dealing with mental illness.

Discretion can backfire. The legal term is *Deliberate Indifference*. The casual terms are negligence and dereliction of duty. This occurs when an officer utilizes the discretion, not for the positive, productive and safe interaction with someone, but to the contrary. Deliberate indifference is harmful and can lead to serious damage, injury, or loss of life of an individual. This occurs when an officer is directly or indirectly aware of a situation causing extreme danger to individuals or groups of people and the officer is indifferent and takes no action to remedy the situation. This is a source of often-indefensible litigation and criminal sanctions. Beware indifference.

"Keeping the Peace: Police Discretion and Mentally Ill Persons." Linda A. Telpin. National Institute of Justice Journal, July 2000.

"Professional Objectiveness and Personal Development." Enhancing Police Response to the Mentally Disabled. The Center for Health Care Services. No additional information available.

Handout 7-2
Police Response to People with Mental Illness

Officers may encounter people with mental illnesses in various ways. They may encounter them in calls for police assistance, as a victim of a crime or accident, as a witness, as the subject of a call, in community crime prevention program, or in any of the other situations in which police personnel encounter other citizens.

Information

When an officer takes a call, he/she should gather as much relevant information from dispatch as possible to identify the nature and urgency of the situation, and specifically request information on:

- The nature of the atypical or problem behavior,
- Events that may have precipitated the person's behavior, and
- The presence of weapons

The dispatch may have been voluntarily informed of additional relevant information such as:

- Past occurrences of this or other atypical behaviors;
- Past incidents involving injury or harm to the individual or others;
- Prior suicide threats;
- A brief diagnosis, if any;
- Reliance on medication or failure to take medication;
- Relatives, friends or neighbors available to assist officers; and
- Physicians or mental health professionals available to assist officers

Response

When responding to an emergency call that involves a person who has, or exhibits symptoms of mental illness, officers should obtain as much information as possible to assess and stabilize the situation. In particular, officers should gather information regarding the nature of the problem or atypical behavior, events that may have precipitated the behavior in question, and the presence of weapons.

When approaching and interacting with individuals suspected of having mental illnesses, officers must protect the safety of all involved. To maintain this safety and positively resolve the situation officers must:

<u>Do the following</u>:

- Remain calm and avoid overreacting
- Be helpful and professional

- Provide or obtain on-scene emergency aid when treatment of an injury is urgent
- Follow procedures on medical alert bracelets or necklaces
- Indicate a willingness to understand and to help
- Speak simply, briefly, and move slowly
- Remove distractions, upsetting influences and disruptive people from the scene
- *Understand that a rational discussion may not take place*
- Recognize that the person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds (voices) or the environment
- Be friendly, patient, accepting and encouraging, but be firm and professional.
- Be aware that the uniform, gun, handcuffs, and baton may frighten the person with mental illness, and reassure the person that no harm is intended
- Recognize and acknowledge that a person's delusional or hallucinatory experience is real to him or her.
- Announce actions before initiating them
- Gather information from family or bystanders
- If the person is experiencing a psychiatric crisis, ask that a representative of the local mental health organization respond to the scene. *(This may not be possible so transport to the local Emergency Room may be necessary)*

<u>Officers should NOT do the following</u>:

- Move suddenly, giving rapid orders or shouting
- Force discussion
- Maintain direct, continuous eye contact
- Touch the person (unless essential for safety)
- Crowd the person or move into his or her zone of comfort. (usually arms reach, 3-4 feet)
- Express anger, impatience, or irritation
- Assume that a person who does not respond cannot hear
- Use inflammatory language such as "crazy," "psycho," "mental," or "mental subject."
- Challenge delusional or hallucinatory statements
- Mislead the person to believe that officers on the scene think or feel the way the person does.

If the person is acting dangerously, but not directly threatening any other person or him or herself, the person should be given time to calm down. Violent outbursts are usually of short duration. It is better that the officer spend 15-20 minutes waiting and talking than to spend five minutes struggling to subdue the person.

If the person acts dangerously and is an immediate threat to him/herself or others, then follow your established departmental policy. When the threat level is determined, discretionary issues come into play provided there isn't departmental policy dictating required responses to the situation.

Be alert to the medication needs of people with mental illness. A lengthy detention may require the person to have access to their medications. Follow your department policy regarding dispensing medications, verifying prescriptions, and possession of medication by detainees.

It is advisable for officers, either arresting or detaining, to make note in the arrest/detention narrative of any medications discovered in the possession of the arrestee/detainee.

This will accomplish several goals:

- Identifies the validity of the possession of the medication by the detainee through identifying information on prescription containers
- Alerts jail/detention staff to the potential need for these medications
- Further establishes the chain of custody of the medications should they be necessary in a prosecution or simply for tracking of personal medically necessary possessions

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The Police Response to People with Mental Illnesses including information on The Americans with Disabilities Act Requirements and Community Policing Approaches. Police Executive Research Forum, 1997

Handout 7-3
Expectations of Call-Takers and Officers

The quality of information gathered and shared by call-takers/Dispatchers affects the way officers respond to and resolve a call for service. This applies to all calls, including those involving a person who may have a mental illness. Gathering information is critical at all stages in assessing situations involving people who have mental illnesses, but is particularly critical at the onset.

When the department receives a call concerning the actions or behavior of someone who is acting atypically or erratically, it is essential that the call-taker collect information that will prepare an officer to respond to the scene.

As with all calls, call-takers should first assess the urgency of the situation and then collect other relevant information such as:

- The nature of the atypical or problem behavior,
- Events that may have precipitated the person's behavior, and
- The presence of weapons.

A family member, friend or concerned party calling about someone who needs help in accessing mental health or other services may volunteer additional information such as:

- Past occurrences of this or other types of atypical behaviors;
- Past incidents involving injury or harm to the individual or others;
- Prior suicide threats;
- A brief diagnosis, if any;
- Reliance on medication or failure to take medication;
- Relatives, friends or neighbors available to assist officers, and
- Physicians or mental health professionals available to assist officers.

When dispatching calls for service involving people who may have mental illnesses, call-takers should provide all relevant background information to the responding officers.

The use of slang or pejorative terms to describe a person with mental illness is improper and unacceptable (Terms such as: nuts, loony, crazy, loco, etc.).

When a person calls the police to report that he or she has been a crime victim or witness and indicates that he or she has a mental illness or exhibits symptoms, the call-taker should, as with all victims/witnesses of crimes, assist the person in relating the details of the crime and its location, so that officers can be efficiently dispatched to the scene.

Knowledge of department's guidelines for responding to people with mental illnesses and knowledge of the variety of services available for people with mental illnesses equips the department employees to handle a wide range of interactions that may occur. Efforts to assist people who have mental illnesses and their families in obtaining appropriate support services may result in reduced trauma, rapid care for an individual in need, fewer repeat calls for service, and improved officer safety.

The Police Response to People with Mental Illnesses including information on The Americans with Disabilities Act Requirements and Community Policing Approaches. Police Executive Research Forum, 1997

Handout 7-4
Law Enforcement Scenarios: Interaction with Potential Mental Health Consumers

[Instructor note: Allow the participants to fully discuss each scenario. Many of the trainees may have experienced similar calls in the past and can relate that information to the scenario. Please keep in mind that these scenarios may provoke emotion in the trainees as they may have family members or acquaintances that experience these or have experienced similar situations themselves, which may have ended in less than desirable results. What may appear as inappropriate joking during this exercise may in fact be a coping mechanism for the trainee.]

- Middle-aged man, wearing only a t-shirt, is standing by the edge of the road with a shopping bag full of leaves in his hands.

- Lady in grocery store is yelling at the produce saying that it isn't ripe enough, throwing unripe produce in a trashcan despite protests of store employees.

- Woman gets out of a car at a gas station. The car is packed to the windows with her possessions. She's asking directions to the beach hotels. She's in Tennessee. When told by the clerk that there are no beaches, she gets agitated and insists that the beaches are close by.

- Woman is buying cigarettes at a gas station, remarking that she's traveling with her children, who she's left in the car, to an amusement park. The child safety seats in the back seat are empty. She's chain-smoking the cigarettes she just purchased.

- Man and woman are heatedly arguing on the sidewalk. Woman keeps saying that he's off of his medication. She can't control him when he's off of his meds.

- Prostitute you just arrested says she was assaulted and wants to go to the hospital, but first she wants you to stop by her apartment and get her medication claiming she's bi-polar.

- You are dispatched to a house yard where a family pet has been killed. A man stands nearby talking to himself and swaying back and forth.

- A man urinates on a sidewalk newspaper box during midday in full view.

- A man, who you wish to speak to, won't let you approach him too closely. As you approach he always backs away a few feet, weeping, saying, "please don't hurt me."

- A young woman, mid 20's, approaches men, laughing, saying she has a secret to tell them. She pulls them to her by the shoulders and then licks their cheek before running off.

- A man in a shopping mall is stomping women's feet.

- An elderly woman, on her knees in a shopping mall behind a large planter is playing "peek-a-boo" with a number of children, obviously not hers. She tries to entice them to hold her hand and take a walk with her.

- A recognizable country music celebrity is being very vocal on a sidewalk, yelling at pedestrians they'll never get her.

- A homeless man stares at people eating in a restaurant through a window on the sidewalk. He makes faces at them and pulls up his shirt and shows them his stomach, doing a dance.

- A woman sits beside a storefront, stroking and cuddling an obviously long-dead cat.

- A young man dressed as a woman, is weeping, at a fast food restaurant, ripping his fingernails out.

- A man stands on the bridge over the river; his position is so dangerous that you're wary of approaching him. You fear that if you break his concentration by your approach he'll fall. He is fixated on the water below.

- Woman kneeling in busy lane of traffic, arms outstretched waiting to be struck by a car.

Handout 7-5
American's with Disabilities Act, Frequently Asked Questions –Law Enforcement

Section IV – Architectural Access is primarily for Detention and Jail training

[This document contains excerpts of the Q&A, published by the Department of Justice, relating to mental illness and similar issues. Numerical sequence is not an indication of missing materials.]

COMMONLY ASKED QUESTIONS ABOUT THE AMERICANS WITH DISABILITIES ACT AND LAW ENFORCEMENT

I. Introduction

Police officers, sheriff's deputies, and other law enforcement personnel have always interacted with persons with disabilities and, for many officers and deputies, the Americans with Disabilities Act (ADA) may mean few changes in the way they respond to the public. To respond to questions that may arise, this document offers common sense suggestions to assist law enforcement agencies in complying with the ADA. The examples presented are drawn from real-life situations as described by police officers or encountered by the Department of Justice in its enforcement of the ADA.

1. Q: What is the ADA?

A: The Americans with Disabilities Act (ADA) is a Federal civil rights law. It gives Federal civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in State and local government services, public accommodations, employment, transportation, and telecommunications.

2. Q: How does the ADA affect my law enforcement duties?

A: Title II of the ADA prohibits discrimination against people with disabilities in State and local government's services, programs, and employment. Law enforcement agencies are covered because they are programs of State or local governments, regardless of whether they receive Federal grants or other Federal funds. The ADA affects virtually everything that officers and deputies do, for example:

- receiving citizen complaints;

- interrogating witnesses;
- arresting, booking, and holding suspects;
- operating telephone (*911*) emergency centers;
- providing emergency medical services;
- enforcing laws;
- and other duties.

3. Q: Whom does the ADA protect?

A: The ADA covers a wide range of individuals with disabilities. An individual is considered to have a "disability" if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

Major life activities include such things as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. To be substantially limited means that such activities are restricted in the manner, condition, or duration in which they are performed in comparison with most people.

- The ADA also protects people who are discriminated against because of their association with a person with a disability.

Example: Police receive a call from a woman who complains that someone has broken into her residence. The police department keeps a list of dwellings where people with AIDS are known to reside. The woman's residence is on the list because her son has AIDS. Police fail to respond to her call, because they fear catching the HIV virus. The officers have discriminated against the woman on the basis of her association with an individual who has AIDS.

4. Q: What about someone who uses illegal drugs?

A: Nothing in the ADA prevents officers and deputies from enforcing criminal laws relating to an individuals current use or possession of illegal drugs.

II. Interacting with People with Disabilities

5. Q: What are some common problems that people with disabilities have with law enforcement?

A: Unexpected actions taken by some individuals with disabilities may be misconstrued by officers or deputies as suspicious or illegal activity or uncooperative behavior.

Example: An officer approaches a vehicle and asks the driver to step out of the car. The driver, who has a mobility disability, reaches behind the seat to retrieve her assistive device for walking. This appears suspicious to the officer.

- Individuals who are deaf or hard of hearing, or who have speech disabilities or mental retardation, or who are blind or visually impaired may not recognize or be able to respond to police directions. These individuals may erroneously be perceived as uncooperative.

Example: An officer yells "freeze" to an individual who is running from an area in which a crime has been reported. The individual, who is deaf, cannot hear the officer and continues to run. The officer mistakenly believes that the individual is fleeing from the scene. Similarly, ordering a suspect who is visually impaired to get over "there" is likely to lead to confusion and misunderstanding, because the suspect may have no idea where the officer is pointing.

- Some people with disabilities may have a staggering gait or slurred speech related to their disabilities or the medications they take. These characteristics, which can be associated with neurological disabilities, mental/emotional disturbance, or hypoglycemia, may be misperceived as intoxication.

Example: An officer observes a vehicle with one working headlight and pulls the vehicle over. When the driver hands the registration to the officer, the officer notices that the driver's hand is trembling and her speech is slurred. The officer concludes that the individual is under the influence of alcohol, when in fact the symptoms are caused by a neurological disability.

Example: A call comes in from a local restaurant that a customer is causing a disturbance. When the responding officer arrives at the scene, she discovers a 25-year-old man swaying on his feet and grimacing. He has pulled the tablecloth from the table. The officer believes that the man has had too much to drink and is behaving aggressively, when in fact he is having a seizure.

What can be done to avoid these situations?

Training, sensitivity, and awareness will help to ensure equitable treatment of individuals with disabilities as well as effective law enforcement. For example:

- When approaching a car with visible signs that a person with a disability may be driving (such as a designated license

plate or a hand control) , the police officer should be aware that the driver may reach for a mobility device.

- Using hand signals, or calling to people in a crowd to signal for a person to stop, may be effective ways for an officer to get the attention of a deaf individual.

- When speaking, enunciate clearly and slowly to ensure that the individual understands what is being said.

- Finally, typical tests for intoxication, such as walking a straight line, will be ineffective for individuals whose disabilities cause unsteady gait. Other tests, like breathalyzers, will provide more accurate results and reduce the possibility of false arrest.

6. Q: What if someone is demonstrating threatening behavior because of his or her disability?

A: Police officers may, of course, respond appropriately to real threats to health or safety, even if individual's actions are a result of her or his disability. But it is important that police officers are trained to distinguish behaviors that pose a real risk from behaviors that do not, and to recognize when an individual, such as someone who is having a seizure or exhibiting signs of psychotic crisis, needs medical attention. It is also important that behaviors resulting from a disability not be criminalized where no crime has been committed. Avoid these scenarios:

- A storeowner calls to report that an apparently homeless person has been in front of the store for an hour, and customers are complaining that he appears to be talking to himself. The individual, who has mental illness, is violating no loitering or panhandling laws. Officers arriving on the scene arrest him even though he is violating no laws.

- Police receive a call in the middle of the night about a teenager with mental illness who is beyond the control of her parents. All attempts to get services for the teenager at that hour fail, so the responding officer arrests her until he can get her into treatment. She ends up with a record, even though she committed no offense.

III. Effective Communication

14. Q: Is there any legal limit to how much my department must spend on communication aids like interpreters? *(This relates to deaf but may also apply to language barriers and someone with mental illness)*

A: Yes. Your department is not required to take any step that would impose undue financial and administrative burdens. The "undue burden" standard is a high one. For example, whether an action would be an undue financial burden is determined by considering all of the resources available to the department. If providing a particular auxiliary aid or service would impose an undue burden, the department must seek alternatives that ensure effective communication to the maximum extent feasible.

18. Q: Procedures at my office require citizens to fill out forms when reporting crimes. What if the person has a vision disability, a learning disability, mental retardation or some other disability that may prevent the person from filling out a form?

A: The simplest solution is to have an officer or clerk assist the person in reading and filling out the form. Police officers have probably been doing this for years. The form itself could also be provided in an alternative format. Providing a copy of the form in large print (which is usually as simple as using a copy machine or computer to increase type size) will make the form accessible to many individuals with moderate vision disabilities.

IV. Architectural Access

19. Q: Does the ADA require all police stations to be accessible to people with disabilities?

A: No. Individuals with disabilities must have equal access to law enforcement services, but the ADA is flexible in how to achieve that goal. The ADA requires programs to be accessible to individuals with disabilities, not necessarily each and every facility. Often, structural alterations to an existing police station or sheriff's office will be necessary to create effective access. In some situations, however, it may be as effective to use alternative methods, such as relocating a service to an accessible building, or providing an officer who goes directly to the individual with the disability. Whatever approach to achieving "program access" is taken, training of

officers and deputies, well-developed policies, and clear public notice of the approach will be critical to ensuring successful ADA compliance.

Example: A police station in a small town is inaccessible to individuals with mobility disabilities. The department decides that it cannot alter all areas of the station because of insufficient funds. It decides to alter the lobby and restrooms so that the areas the public uses -- for filling out crime reports, obtaining copies of investigative reports for insurance purposes, or seeking referrals to shelter care -- are accessible. Arrangements are made to conduct victim and witness interviews with individuals with disabilities in a private conference room in the local library or other government building, and to use a neighboring department's accessible lock-up for detaining suspects with disabilities. These measures are consistent with the ADA's program accessibility requirements.

Example: An individual who uses a wheelchair calls to report a crime, and is told that the police station is inaccessible, but that the police department has a policy whereby a police officer will meet individuals with disabilities in the parking lot. The individual arrives at the parking lot, waits there for three hours, becomes frustrated, and leaves. By neglecting to adequately train officers about its policy, the police department has failed in its obligation to provide equal access to police services, and has lost valuable information necessary for effective law enforcement.

20. Q: What about holding cells and jails that are not accessible?

A: An arrestee with a mobility disability must have access to the toilet facilities and other amenities provided at the lock-up or jail. A law enforcement agency must make structural changes, if necessary, or arrange to use a nearby accessible facility.

- Structural changes can be undertaken in a manner that ensures officer safety and general security. For example, grab bars in accessible restrooms can be secured so that they are not removable.

- If meeting and/or interrogation rooms are provided, those areas should also be accessible for use by arrestees, family members, or legal counsel who have mobility disabilities.

21. Q: Is there a limit to the amount of money my agency must spend to alter an existing police facility?

A: Yes. It is the same legal standard of "undue burden" discussed earlier with regard to the provision of communication aids. Your agency is not required to undertake alterations that would impose

undue financial and administrative burdens. If an alteration would impose an "undue burden", the agency must chose an alternative that ensures access to its programs and services.

22. Q. We are building a new prison. Do we need to make it accessible?

A: Yes. All new buildings must be made fully accessible to, and usable by, individuals with disabilities. The ADA provides architectural standards that specify what must be done to create access.

- Either the Uniform Federal Accessibility Standards (UFAS) or the ADA Standards for Accessible Design (without the elevator exemption) (ADA Standards) may be used. UFAS has specific scoping requirements for prisons that require, among other things, that 5% of all cells be made accessible to individuals with mobility disabilities.

- Unlike modifications of existing facilities, there is no undue burden limitation for new construction.

- In addition, if an agency alters an existing facility for any reason -- including reasons unrelated to accessibility -- the altered areas must be made accessible to individuals with disabilities.

V. Modifications of Policies, Practices, and Procedures

23. Q: What types of modifications in law enforcement policies, practices, and procedures does the ADA require?

A: The ADA requires law enforcement agencies to make reasonable modifications in their policies, practices, and procedures that are necessary to ensure accessibility for individuals with disabilities, unless making such modifications would fundamentally alter the program or service involved. There are many ways in which a police or sheriff's department might need to modify its normal practices to accommodate a person with a disability.

Example: A department modifies a rule that prisoners or detainees are not permitted to have food in their cells except at scheduled intervals, in order to accommodate an individual with diabetes who

uses medication and needs access to carbohydrates or sugar to keep blood sugar at an appropriate level.

Example: A department modifies its enforcement of a law requiring a license to use motorized vehicles on the streets, in order to accommodate individuals who use scooters or motorized wheelchairs. Such individuals are pedestrians, but may need to use streets where curb cuts are unavailable.

E**xample:** A department modifies its regular practice of handcuffing arrestees behind their backs, and instead handcuffs deaf individuals in front in order for the person to sign or write notes.

E**xample:** A department modifies its practice of confiscating medications for the period of confinement, in order to permit inmates who have disabilities that require self-medication, such as cardiac conditions or epilepsy, to self-administer medications that do not have abuse potential.

Example: A department modifies the procedures for giving Miranda warnings when arresting an individual who has mental retardation. Law enforcement personnel use simple words and ask the individual to repeat each phrase of the warnings in her or his own words. The personnel also check for understanding, by asking the individual such questions as what a lawyer is and how a lawyer might help the individual, or asking the individual for an example of what a right is. Using simple language or pictures and symbols, speaking slowly and clearly, and asking concrete questions, are all ways to communicate with individuals who have mental retardation.

- Informal practices may also need to be modified. Sometimes, because of the demand for police services, third party calls are treated less seriously. Police officers should keep in mind that calling through a third party may be the only option for individuals with certain types of disabilities.

VI. Resources

24. Q: It sounds like awareness and training are critical for effective interaction with individuals with disabilities. How can I find out more about the needs of my local disability community?

A: State and local government entities were required, by January 26, 1993, to conduct a "self-evaluation" reviewing their current services, policies, and practices for compliance with the ADA. Entities employing 50 or more persons were also to develop a

"transition plan" identifying structural changes that needed to be made. As part of that process, the ADA encouraged entities to involve individuals with disabilities from their local communities. Continuing this process will promote access solutions that are reasonable and effective. Even though the deadlines for the self-evaluation, transition plan, and completion of structural changes have passed, compliance with the ADA is an ongoing obligation.

25. Q: Where can I turn for answers to other questions about the ADA?

A: The Department of Justice's toll-free ADA Information Line answers questions and offers free publications about the ADA. The telephone numbers are: 800-514-0301 (voice) or 800-514-0383 (TTY). Publications are also available from the ADA Website www.ADA.gov.

Handout / Training Activity 7-6

The Marrero New Haven Incident

The Incident: December 16, 2004 Hiram Marrero, a mental health patient in the process of decompensation for a period of approximately five days, attacked his caregiver (provocation unknown) with kitchen knives. Caregiver received superficial wounds and called 911. Fire Department Paramedics arrived on scene with Mr. Marrero still armed and in the home. Paramedics refused to enter the residence and called for Police backup.

Communications: 1. Care giver called 911 to get help. Call went to central 911 service and was routed to Fire Department for medical call. 2. Fire Department Paramedics on scene contacted their Dispatcher who in turn contacted Law Enforcement Dispatcher who dispatched Officers to the scene. Caregiver tells Paramedics that person in home is an EDP (emotionally disturbed person). It is unknown as to the importance the caregiver places on that information to the Paramedics. Information is never passed on to responding officers for one or more of the following reasons:

a. Information never reached Fire Department Dispatcher from Paramedics due to omission or not realizing the importance of the EDP information;
b. Information never flowed from Fire Department Dispatcher to Law Enforcement Dispatcher, or
c. Information never flowed from Law Enforcement Dispatcher to responding officers.
d.

The Crisis: Three Police Officers, all well trained, arrive on scene, dispatched as "Man with knife, back up Paramedics on scene with injured citizen," and encounter Mr. Marrero outside of the residence. The Officers are presumably within a zone of danger where aggression from Mr. Marrero could result in serious harm or death of an Officer. Mr. Marrero is in visible possession of two large knives, presumably butcher knives. Police begin to take control of the situation by shouted commands to Mr. Marrero to drop his weapons and submit to their authority. Mr. Marrero complies and drops one knife. Mr. Marrero then crouches and moves toward an officer, still holding the other knife. Officers open fire, firing at least six times. Mr. Marrero dies of gunshot wounds sustained in the exchange.

Description: Mr. Hiram Marrero was a 35-year-old Puerto Rican with Mental Illness living in a sponsored and supported housing situation. He was in the process of a decompensation, which had previously resulted in a visit to the local hospital. He was known to his caregiver to suffer from auditory hallucinations (hearing voices) and was on medication to control his mental illness. Neighbors admit that violent actions weren't unexpected. Mr. Marrero was a successful athlete. Mr. Marrero had a history of being in possession of or selling dangerous weapons. Mr. Marrero was not a small, unimposing figure of a man.

Training Activity 7-7

Marrero New Haven Model Role-Play Training

Through the use of a real world contemporary event that led to the death of an individual with mental illness, the severity and importance of appropriate training, effective communications and observation skills, in addition to basic law enforcement skills, are impressed on the trainees.

1. Role Play the incident from the point of Officer arrival on scene.
    a. Officers will have no knowledge of what actually happened. They are to role-play, as they would respond on the street. See Role Play A. Provide information in "dispatch" as provided to actual officers. Refer to Attachment 1.

    b. Question and Answer – Difficulties of responding to ***angry*** person with knife.

2. Role Play the incident from the point of Officer arrival on the scene:
    a. Officers will have no knowledge of what actually happened. They are to role-play, as they would respond on the street. See Role Play B. Provide information in "dispatch" as provided to actual officers. Refer to Attachment 1.

    b. Question and Answer – Difficulties of responding to Person with ***Mental Illness*** with a knife.

3. Allow the training group to listen to the simulated auditory hallucination utilized in Role Play B. Have trainees comment on how they perceive it would affect them if they were in the grip of mental illness.

4. Discussion: Describe tasks assigned to the trainee volunteer victim while under the influence of the simulated auditory hallucination and get his/her feedback as to the difficulty in following tasks assigned while responding to the commands of the officers.

5. Advise the Trainees that this incident took place in December of 2004. Stress that a man was really killed, a city was shaken, mental health consumers now fear for their lives from police, and political/media pressure came into play.

6. Do not neglect to comment on the fact that despite the shooting incident, an especially aggravated battery did occur, a wounded person and paramedics were on scene, and numerous people were witness to the events. Do not let this be treated as unimportant. It all is relative to the incident as a whole and presents numerous issues that can be addressed over a wide variety of topics.

7. Had the officers known what to expect, were trained in dealing with mental health issues, and used that training, this incident would have resulted much differently.

8. What if the assailant had been a woman, 65 years old? An attractive 25-year-old woman? A 15-year-old child? A feeble looking older man? Think about how an officer would react differently to each situation.

Simulated scenario lay out for classroom purposes: **A** = Assailant/Victim
1,2,3 = Officers on Scene

[Residence (front wall of classroom)]

A

10’

16’ 15’

1

3

2

Simulated Police Dispatch Communication

"Central Dispatch to Car 302"

"302 go ahead"

"302 we have an assault. 2201 Macland Street, paramedics are on scene with victim and need backup. The assailant is still on scene."

"302 Central -- any weapons?"

"302, Paramedics report knives. No known firearms."

"10-4 Central I'm in route"

"305 to 302 I'm a 2 man unit. I'll be in route to back you up."

"10-4 305"

"Central copies 305"

Both cars arrive on scene approximately the same time. Officers see Paramedic emergency vehicle, the Paramedics and a bleeding victim. The seriousness of the victim's wounding is not evident. Blood is visible. Paramedic gestures toward the residence as the Assailant steps onto the front step, near the officers.

This communication is simulated for the sake of the teaching experience.

Role Play A – Angry Man with a Knife

Materials: two pens or similar items that may be used to simulate knives. (Officers will use their hands and fingers to simulate their sidearm.)

Using the diagram on the previous page, arrange the officers and assailant in the same relative positions.

Read the simulated dispatch, asking all trainees to pay close attention to the information given.

Instructions for Assailant: Assailant will hold the two pens in hand to simulate knives. Be angry about something. Say whatever you want but do not be immediately submissive. Most importantly **do not be** aggressive. Do not force the officers to escalate the situation to disarm you. Act as a reasonable person on the street would act when confronted by armed polices officers shouting commands under similar circumstances.

Instructions for Officers: Act as a reasonable and trained police officer would act when confronted by a person armed with two knives, near to the officer's zone of danger.

Expectations: Officers, when confronted will immediately take a defensive posture, drawing their weapons. They will shout commands to drop the weapons, and possibly including commands for assailant to "get on the ground." Assailant, will vocalize his anger, but will comply with the commands of the officers, even if hesitantly.

Results: Situation will be defused because assailant will be disarmed and taken into custody. The threat to Assailant, Officers and immediate environment will be eliminated without need for violence.

Role Play B – Man with knife suffering from unidentified mental illness

Materials:

1. Two pens or similar items that may be used to simulate knives. (Officers shall use their hands to simulate their sidearm.)
2. Portable cassette player with headphones.
3. Cassette of Simulated Auditory Hallucinations. **Trainees will not be made aware of the nature of this tape prior to the exercise.**

Using the diagram on the previous page, arrange the officers and assailant in the same relative positions.

Read the simulated dispatch, asking all trainees to pay close attention to the information given.

Assailant will wear the cassette player and headphones, listening to the simulated auditory hallucinations simulating a person suffering with mental illness and in the process of experiencing auditory hallucinations.

Instructions for Assailant:

- Assailant will **not reveal** the contents or nature of the audiotape to the trainees or other officers participating in the exercise.
- Assailant is tasked to listen closely to the tape and be prepared at the end of the exercise to answer questions regarding how many people were speaking to him, male or female, and what their messages are.
- Assailant must give as much attention to the audiotape task as he does to the commands of the officers confronting him.
- Assailant will eventually only drop one "knife." Do not drop the second "knife" but do not make any aggressive moves.
- Assailant will wait ten seconds, look each officer in the eye, without speaking, and then take a step toward officer #1 ignoring all Officers' commands.
- Assailant must be prepared to later identify the voice speaking to him from the cassette as he takes the step.
- If officers do not "fire" on the Assailant, the Assailant shall make a menacing gesture and draw their fire (think "Suicide by Cop").

Instructions for Officers: Act as a reasonable and trained police officer would act when confronted by a person armed with two knives, near to the officer's zone of danger.

Expectations: Officers, when confronted will immediately take a defensive posture, drawing their weapons. They will shout commands to drop the weapons, and possibly including commands for assailant to "get on the ground." When the Assailant refuses to comply with their commands, in a real world situation, their anxiety and stress will escalate significantly, adding to the danger

factor. Once the Assailant moves toward the officers with knife in hand, Officers will probably "fire" on the Assailant.

Exception: If the Officers do not fire on the Assailant and the Assailant is forced to make a menacing gesture and approach Officers in order to draw their fire, the trainees need to be asked why they didn't fire and the class should discuss their decision.

Results:

- Immediate threat from Assailant is neutralized.
- Assailant will most likely be deceased.
- Danger to Officers and immediate environment is neutralized.
- Begin preparation for **immediate extraordinary attention** from the media, action groups and litigation attorneys.

Trainers Note: This model is in no way meant to be critical of the New Haven Police Department, the Officers involved, the victim's caregivers or the victim. The issues presented are not new or unknown to the Criminal Justice Community. This is a teaching tool not a critique.

Special appreciation goes to the New Haven Connecticut Police Department and Assistant Chief Brian Norwood for their participation in contributing accurate and constructive information as well as to the National Alliance for the Mentally Ill (NAMI) of Connecticut and Executive Director Sheila King for their insight.

Media excerpts are from the New Haven Register newspaper at www.newhavenregister.com that according to those involved reported on a fair, accurate and non-sensational basis.

Handout 7-8
Sampling of Arrests of Mental Health Consumers in January 2005

The following are charges in arrests of mental health Consumers of just one mental health agency in Nashville, Tennessee for the month of January 2005.

1. Obstructing a Passageway (3)
2. Probation Violation (8)
3. Theft of Merchandise (2)
4. Theft of Property
5. Theft under $500
6. Theft – Felony
7. Theft of Vehicle
8. Theft of Services
9. Burglary of a Motor Vehicle
10. Credit Card Fraud
11. Fraud (2)
12. Criminal Impersonation
13. Driving on Revoked License (6)
14. Driving on Suspended License (5)
15. Driving without a License (3)
16. Possession of a Controlled Substance (8)
17. Possession with Intent to resell
18. Possession of Drug Paraphernalia (11)
19. Public Intoxication (9)
20. Driving Under the Influence (4)
21. Open Container Violation (2)
22. Implied Consent Violation
23. Leaving the Scene of an Accident
24. Disorderly Conduct (6)
25. Indecent Exposure
26. Criminal Trespass (12)
27. Domestic Assault (4)
28. Assault (3)
29. Harassment
30. Contempt of Court
31. Resisting Arrest

Each listing indicates one arrest unless a number indicates multiple arrests for the same offense. Misdemeanor and felony charges have been combined. This listing is complete as brought to the attention of the CJ/MH Liaison.

Information complied by Dawn Ducote, LCSW, CJ/MH Liaison, Mental Health Cooperative, Inc. Nashville, Tennessee.

Criminal Justice

Response

To People with Mental Illness
Arrested or Incarcerated in Tennessee

Module 8
Criminal Justice Release Planning

Dawn Ducote, LCSW and
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Mental Health Cooperative, Inc.
A training-group specific continuation of the Criminal Justice Response to People with Mental Illness

Module 8
Criminal Justice Release Planning

Length of Presentation: 30-60 minutes

Handouts and Materials:
8-1 APIC Model of Release Planning
8-2 APIC Model – Assess
8-3 APIC Model – Plan
8-4 APIC Model – Identify
8-5 APIC Model – Coordinate
8-6 Consensus Project – Re-entry and Release

- Policy Statement #21 Development of Transition Plan
- Policy Statement #22 Modification of Conditions of Supervised Release
- Policy Statement #23 Maintaining Contact Between Individual and Mental Health System

Objectives:

- To understand the necessity of identification of Consumers and mental illness in other inmates upon their entry into detention and corrections.
- To understand the best practices in treatment and service planning during the corrections/detention event.
- To understand the best practices for treatment and planning post corrections/detention event.
- To understand the need for accurate and appropriate release planning and linking to services post release.
- To facilitate an understanding for the need for release/re-entry planning in those facilities, or systems, where it is not currently available.

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Discussion
Criminal Justice Release Planning

It is well established that continuity and consistency of care and treatment is necessary in the successful and productive release of mental health Consumers from facilities such as group homes, treatment centers and shelters. This also applies, just as importantly, to those Consumers being released from the criminal justice system. The ambition of post-conviction/detention release planning is to prevent the Consumer from re-offending, if possible, and becoming part of the "revolving door" found in most community jails and larger correctional institutions.

Many of the individuals most in need of mental health and dual diagnosis services become involved in the criminal justice system. They may be in treatment at the time if their arrest, but it is more likely that they have previously been untreated, or have discontinued treatment. They may be arrested because of behaviors that result from their deteriorated psychiatric condition. They often have many cycles of arrest, release, deterioration, and re-arrest. Even though significant improvements in treating and serving persons with mental illness have been developed, in most communities persons with serious mental illness do not have sufficient access to the services they need. There is resistance among community mental health providers to working with individuals with criminal histories, and in corrections there is resistance to working with persons with serious mental illness. Consequently, any effective solutions to the problems addressed here will require an integrated effort spanning the boundary between the criminal justice system and the behavioral health system.

For some individuals, their mental illness may first be identified and treated during incarceration. The onset of many psychiatric disorders is early adulthood and last adolescence. This corresponds to the average ages of persons arrested or incarcerated for the first time. Many of these arrests, if examined closely, could be behavior derived form the new arising symptoms of mental illness. Appropriate treatment and aftercare could change the course of these individual's lives.

Since continuity of care is as essential and integral component of effective mental health treatment, it is imperative that any psychiatric treatment provided during a period of incarceration include planning for post-release follow-up care in the community.[1]

The extraordinary growth of the prison and jail systems has presented enormous challenges to corrections administrators. Of these challenges, few, if any, are more formidable than operating a comprehensive mental health service delivery system for inmates. Increasing budgetary pressures on corrections

[1] Position Statement on Post-Release Planning by the Committee on Persons with Mental Illness Behind Bars and the Committee on Continuity of Care and Discharge Planning of the American Association of Community Psychiatrists; American Association of Community Psychiatrists, 2001.

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systems make this challenge especially daunting. Estimates regarding the number of people with mental illness in prison or jail vary. The US Department of Justice reported in 1999 that about 16 percent have been diagnosed with a mental illness, either prior to or during incarceration.

The vast majority of people in prison or jail will ultimately re-enter the community. Screening inmates for signs and symptoms of mental illness, delivering effective services, providing appropriate housing, and developing a comprehensive treatment plan improve the likelihood that an inmate with mental illness will return to the community (and to his or her loved ones) healthy and safely.[2]

Dr. Fred Osher of the National GAINS Center, in a presentation titled Establishing Links for Successful Reintegration of Offenders with Mental Illness, presented at the NCCHC Conference in July 2004, identified some pertinent and realistic points. The potential outcomes for inadequate or nonexistent transition/release planning are many. A few of these stand out the most:

- Compromised Public Safety
- Increased Psychiatric Disability
- Relapses to Substance Abuse
- Hospitalization
- Suicide
- Homelessness
- Re-arrest

Another point raised by Dr. Osher in his presentation is the significant difference between jails and prisons. Recognition of these differences when planning for release is imperative in working toward the successful reintegration of the Consumer.

- Jails hold a variety of detainees, not just convicted criminals. There are detainees awaiting court appearances, persons awaiting sentences, inmates serving short-term sentences, and persons awaiting deportation.
- Episodes of incarceration may be short in jails versus prisons and release in jails can often be an unpredictable.
- Inmates in jails will be less likely to have lost contact with community supports than prison inmates, due to the relatively shorter stays in jails.[3]

The Criminal Justice Mental Health Consensus Project offers some policy statements and recommendations, founded on sound mental health principles, as they relate to the contemporary criminal justice system. These

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[2] Criminal Justice Mental Health Consensus Project, 2002, Council of State Governments. 126-127.

[3] Establishing Links for Successful Reintegration of Offenders with Mental Illness, Dr. Fred Osher, The National GAINS Center, NCCHC National Conference, July 12, 2004.

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recommendations are offered to stimulate local and state governmental entities in developing new or improving existing systems. The entire Project and recommendations are available for viewing on the Internet at www.consensusproject.org.

A model for criminal justice release and reentry planning that has been determined to be the "best practices" is the A.P.I.C. model. It is understood that failure to adequately and appropriately plan for the release of a mental health consumer back into society has a certain element of the unknown and unpredictability both for the Consumer and for the society into which he/she is being released. Realizing this the A.P.I.C. model lends assistance to the agencies and to the consumers in providing a smooth, efficient and productive transition between corrections/detention and freedom.

The APIC model is a set of critical elements that, if implemented in whole or in part, are likely to improve outcomes for people with co-occurring disorders [or other mental health disorders] who are released from jail. The National Coalition for Mental and Substance Abuse Health Care in the Justice System noted that any comprehensive vision of care for people … re-entering community must "build lasting bridges between mental health and criminal justice systems, leading to coordinated and continual health care for clients in both systems." Successful development of these "bridges," jurisdiction by jurisdiction, will ultimately create an environment where ex-inmates [with mental health disorders] have a real opportunity for successful transition.[4]

For the purpose of utilizing the A.P.I.C. model of release planning a few differences in vocabulary exist. The A.P.I.C. model makes use of the word *transition* instead of release, re-entry, or post conviction planning.

Transition planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together…The results … will only be as good as the … partnership in the community.[5]

It is the responsibility of jails, detention centers, and prisons to provide discharge planning for those held in their facilities. The facility should hold the primary responsibility of establishing and providing linkages between the detainees and those available community services. The primary goal of these linkages is to prevent the detainee from being re-admitted into the criminal justice system due to re-offending. Through provision of adequate services, it is

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[4] A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model. Osher, Steadman and Barr, published by the National GAINS Center, September 2002, page 18

[5] A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model. Osher, Steadman and Barr, published by the National GAINS Center, September 2002

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expected that recidivism by mental health Consumers will be significantly reduced.

[Review Handout 8-1:APIC Model of Release Planning]

Assess

The first requirement of the APIC model is the assessment of the clinical and social needs, and the public safety risks of the inmate. Assessment catalogs the inmate's psychosocial, medical, and behavioral needs and strengths. The nature of behavioral health problems is described, their impact on level of functioning is reviewed, and the inmate's motivation for treatment and capacity for change is evaluated.

Dr. Osher states that assessment begins with the identification of the inmates with mental illness through screening and referral. He demonstrates the need for valid and reliable screening measures, which should be applied to every newly admitted inmate during the routine intake process.

[Review Handout 8-2: APIC Model —Assess]

Plan

The second requirement of the APIC model is the planning for the treatment and services required to address the inmate's needs. Transition planning must address both the inmate's short-term and long-term needs. Special consideration must be given to the critical period immediately following release to the community – the first hour, day and week after leaving jail. High Intensity, time-limited interventions that provide support as the inmate leaves the jail should be developed.[6]

[Review Handout 8-3: APIC Model – Plan]

Identify

The third requirement of the APIC model is identifying the required community and correctional programs responsible for post-release services. A transitional plan must identify specific community referrals that are appropriate to the inmate based on the underlying clinical diagnosis, cultural and demographic factors, financial arrangements, geographic location, and his or her legal circumstances. If correctional mental health staff members do not double as community

[6] A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model. Osher, Steadman and Barr, published by the National GAINS Center, September 2002, page 8

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providers, they should participate in the development of service contacts with community providers to assure appropriateness of community-based care.

The appropriateness of specific placements should be determined in consultation with the community providers. A complete discharge summary, including diagnosis, medications and dosages, legal status, transition plan, and any other relevant information should be faxed to the community provider at or close to the time of release.

Conditions of release and intensity of community corrections supervision should be matched to the severity of the inmate's criminal behavior, and this is determined by the criminal justice system. Intensity of treatment and support services should be matched to the inmate's level of disability, criminal history, motivation for change, and the availability of community resources. Treatment recommendations should be made by mental health professionals, customizing and individualizing the plan to each consumer and his/her needs specifically.

Issues of confidentiality and information sharing need to be addressed as part of any re-entry/transition process. Responsibility to discuss and clarify issues of confidentiality and information sharing should be jointly assumed by staff within the jail and the treatment provider/case manager in the community.

The transition treatment plan must be included in the chart of the correctional mental health service as well as the chart at the community mental health agency.[7]

[Review Handout 8-4: APIC Model – Identify]

Coordinate

The final requirement of the APIC model is to coordinate the transition plan to ensure implementation and avoid gaps in care. Due to the complex and multiple needs of many inmates with co-occurring disorders [and other mental health disorders], the use of case managers is strongly encouraged. In spite of the face validity of this concept, few jails provide case management services for inmates…

For inmates needing case management services, a specific entity that will provide those services should be clearly identified in the transition plan. The development of Assertive Community Treatment (ACT) teams focused on people with serious mental illness coming out of jail has demonstrated effectiveness in reducing recidivism.[8]

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[7] Ibid, pages 13-14

[8] A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model. Osher, Steadman and Barr, published by the National GAINS Center, September 2002, page 15

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[Review Handout 8-5: APIC Model – Coordinate]

Optional Discussion – *5 min limit* – Review and discuss handout 8-6: Consensus Project – Re-entry and Release Planning, how this is applicable in the participant's jurisdiction and brainstorm how some of these ideas could be implemented in their area.

Conclusion
Summarize information presented and allow time for questions.

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Handout 8-1
A.P.I.C. Model of Release Planning

The title of the model, **APIC**, is an acronym standing for **A**ssess, **P**lan, **I**dentify, and **C**oordinate. The detention facility must *assess* the inmate's clinical and social needs and public safety risk. It must *plan* for treatment and services required to address the inmate's needs. It must *identify* required community and correctional programs responsible for post-release services and it must *coordinate* the transition plan to ensure implementation and avoid gaps in care with community-based services.[9]

Assess
Plan
Identify
Coordinate

The publication *A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model* is available online from The National GAINS Center at www.gainsctr.com.

[9] Ibid, page 4, table 1

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Handout 8-2
APIC Model – Assess

A hierarchy of assessment strategies should be employed to ensure, even for short-stay inmates, basic needs are identified and linkage to resources is achieved. This planning is essential and should be initiated as soon as a psychiatric disorder is discovered in the inmate.

Assessment involves:

- Cataloging the inmate's psychosocial, medical, and behavioral needs and strengths
- Gathering information – from law enforcement, court, corrections, correctional health, families and community provider systems – necessary to create a fully informed transition plan
- Incorporating a cultural formulation in the transition plan to ensure a culturally sensitive response
- Engaging the inmate in assessing his or her own personal needs
- Ensuring that the inmate has access to and means to pay for treatment and services in the community

An important part of the assessment process is engaging the inmate in assessing his or her own needs as transition planning must consider the special needs related to cultural identity, language barriers, gender and age related issues to ensure that the inmate is linked with appropriate services.[10]

Valid and reliable screening measures are essential and should be used with all inmates during the routine intake process. The correctional staff should institute these measures and any "red flags" which the screening measures produce should alert that correctional staff member administering the screen to begin the discharge planning process when appropriate. Old records, if available should be obtained and the Consumer must be engaged in the process.[11]

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[10] Ibid, pages 6-7

[11] Establishing Links for successful Reintegration of Offenders with Mental Illness, Presentation, Dr. Fred Osher, M.D., The National GAINS Center, NCCHC Conference, July 2004

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Handout 8-3
APIC Model – Plan

Planning involves many people, agencies and systems but the most important involvement is that of the inmate. Engaging the inmate in his/her own planning can heighten success. This planning involves:

- Addressing the critical period immediately following release -- the first hour, day and week after leaving jail – as well as long term needs
- Learning from the inmate what has worked or not worked during past transitions – Many inmates have been in jail before, and some have passed through the same jail and same transition back to the community several times; the single most important thing a transition planner can do during the planning process is learn from the inmate and plan accordingly.
- Seeking family input – Family input into the release plan should occur to the extent the inmate identifies and wishes for a family member(s) to be involved. The family or other primary support system should be notified of the inmate's release in advance, with inmate consent.
- Address housing needs – Housing providers are understandably reluctant to take in tenants with histories of violence and histories of arson and sex offenses make it nearly impossible to find an individual housing upon release. Luckily, the vast majority of persons with mental illness who are transitioning from jails are not in this category. Mechanisms for sharing the liability of housing high-risk ex-inmates should be developed among housing providers, public behavioral health agencies and correctional authorities. Homelessness more often than not will lead to re-offending and recidivism.
- Arranging an integrated treatment approach for the inmate with co-occurring disorders – an approach that meets his/her multiple needs when in the community.
- Ensuring that the inmate… is on an optimal medication regimen and has sufficient medication to last at least until a follow-up appointment
- Connecting inmates who have acute and chronic medical conditions with community providers

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- Initiating benefit applications/reinstatements for eligible inmates – for Medicaid, SSI/SSDI, Veterans assistance, food stamps and TANF – during incarceration
- Ensuring that the inmate has… adequate clothing, resources to obtain adequate nutrition, transportation from jail to place of residence and from residence to appointments, and a plan for childcare if needed that will allow him or her to keep appointments.[12]

[12] Ibid, pages 8-12

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Handout 8-4
APIC Model – Identify

Dr. Osher, in his presentation, Establishing Links for Successful Reintegration of Offenders with Mental Illness, at the NCCHC Conference in 2004, outlined this identification process with a few specific points.

- Identify community providers that are appropriate to the inmate based on:
    1. Clinical diagnosis
    2. Demographic factors
    3. Financial arrangements
    4. Geographic location
    5. Legal circumstances

- Clarify confidentiality and information sharing processes and communication expectations
- Match conditions of release to severity of criminal offense(s)
- Match intensity of community care to severity of disability and motivational state
- Ensure that every inmate's belongings are returned upon release to include identification, benefit cards and medications

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Handout 8-5
APIC Model – Coordinate

Coordinating involves:

- Supporting the case manager entity – in coordinating the timing and delivery of services and helping the client span the jail-community boundary after release
- Case assignment to a community treatment agency must be made cooperatively – by the inmate, jail providers and the community agency itself
- Explicitly communicating – to the individual, the family, the releasing facility, and the community treatment agency – the name(s) and contact information of the person(s) who will be responsible for care of the consumer between the time of release and the first follow-up appointment
- Confirming that the inmate/consumer…
    1. Knows the details regarding the first follow-up visit
    2. Has adequate medications
    3. Knows who to contact if there are problems with medication, there are medical or social service-related problems, or it is necessary to change the follow-up appointment
- Establishing a mechanism to track consumers who do not keep the first follow-up appointment (appointment should be rescheduled or the plan renegotiated with the consumer)[13]

The jail and community providers should collaborate in establishing standards for post-release treatment planning and documentation and a mechanism to monitor implementation of the plan. A joint committee of representative jail providers and community mental health providers should meet regularly to monitor process, resolve problems, and hold staff to the standards established by the committee.[14]

[13] Ibid, pages 15-16

[14] Ibid, page 17

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Handout 8-6
Consensus Project – Re-entry and Release Planning

The policy statements provided here by the Consensus project review the pivotal role of the mental health system in maintaining a person on a path toward recovery once the person is released. These policy statements go beyond what should happen when a person with mental illness is incarcerated.[15]

Policy Statement #21
Facilitate collaboration among corrections, community corrections, and mental health officials to effect the safe and seamless transition of people with mental illness from prison to the community.

- Identify transition planners in each institution and charge them with coordinating a case management process, which incorporates representatives of institutional corrections, community corrections, social service agencies, and community-based mental health providers.
- Involve all relevant agents and individuals who will assist in carrying out the transition plan, including family members, in its development.
- Take steps to ensure that the inmate's release from secure hosing to community progresses in a gradual sequence of planned steps.
- Develop a transition plan that includes the inmate's assignment to a community-based provider whose resources and assets are consistent with the needs and strengths of the inmate.
- Integrate housing support services into the transition plan and provide releasees with mental illness an arrangement for safe housing or at a minimum, shelter.
- Make arrangements for at least a week's supply of important medications, along with refillable prescriptions, to be provided to inmates at the point of release.
- Develop a process to ensure that inmates eligible for public benefits receive them immediately upon their release.

[15] Criminal Justice Mental Health Consensus Project, 2002, Council of State Governments, 126-127

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- Notify the victim before the offender is release from prison, consistent with the requirements of the state's law or constitution, prior to release.
- Monitor the inmate closely in the days approaching release and modify the discharge plan when appropriate.
- Provide enhanced discharge planning, including extensive coordination with the community treatment provider, to ensure continued case management for inmates with mental illness who will complete their sentence in prison.

Policy Statement #22
Monitor and facilitate compliance with conditions of release and respond swiftly and appropriately to violations of conditions of release.

- Assign small, specialized caseloads of parolees with mental illness to parole officers who have received advanced training in mental health issues.
- Encourage community corrections staff to conduct field supervision and other monitoring responsibilities within the communities, homes, and community-based service programs where the releasee spends most of his or her time.
- Work closely with mental health administrators and providers to ensure that parolees receive services and resources specified in community reintegration and supervision plans.
- Ensure that released offenders are connected to a 24-hour crisis service.
- Establish protocols to share information between community supervision agencies and community mental health providers regarding compliance with conditions of release.
- Develop a range of graduated sanctions to compel (and incentives to encourage) compliance with conditions of release.

Policy Statement #23
Ensure that people with mental illness who are no longer under supervision of the criminal justice system maintain contact with mental health services and supports for as long as is necessary.

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- Develop mechanisms to engage ex-offenders with mental illness who have been released to the community.
- Develop programs to provide appropriate levels of services and supports to ex-offenders with mental illness who have re-entered the community.
- Develop an understanding of the factors leading to community reintegration success or failure for clients with mental illness that have been released from prison.[16]

[16] Criminal Justice Mental Health Consensus Project, 2002, Council of State Governments, 162-184

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Criminal Justice

Response

To People with Mental Illness
Arrested or Incarcerated in Tennessee

Module 9
Communications Personnel

Dawn Ducote, LCSW and
Jonathan C. Jackson, M.A.
Mental Health Cooperative, Inc.
A training-group specific continuation of the Criminal Justice Response to People with Mental Illness

Module 9
Communications Personnel

Length of Presentation: 60-90 minutes

Handouts and Materials:
9-1 Prevalence of Mental Illness in US Society
9-2 Mental Health vs. Mental Illness
9-3 Common Psychiatric Diagnoses
9-4 Signs and Symptoms of Mental Illness
9-5 Suicidal Behavior and Indicators
9-6 Mental Health Call Taking

Objectives:
- To provide understanding of mental illness to call takers of emergency services.
- To assist in effective communication with persons with mental illness.
- To understand the need for complete and accurate information gathering when in communication with persons with mental illness.
- To assist in implementing procedures in call taking and dispatching, which will accommodate appropriate response personnel utilization.

[Instructor Note: This module of training may be utilized as a stand-alone training or in-service module.]

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Discussion
Communications Personnel

Optional Exercise: Ask for volunteers, make 2 copies of the handout and highlight each speaker's portion on the individual copies. Have the volunteers role pay/read this script. This is a good icebreaker and provides an "attention grabber" at the on-set of the training. Another options would be to audiotape the script and play it for the training participants at the beginning of the training.

Exercise:

The telephone rings and the communications officer / call taker lifts the receiver to be met by a scream and a panicked voice:

"911 what is your emergency?"

"Help! Help! He won't let me in!"

"Ma'am please calm down and tell me what's going on."

"He's going to hurt himself…<garbled>...knife…<shout>… mentally ill"

"Who is going to hurt himself? Are you sure he has a knife?"

"He says he has a knife. He's locked the door!"

"Please calm down! I can't help if you don't tell me what's going on."

"My son's locked in the bathroom saying he's going to hurt himself!"

"I have your address, units are being dispatched to you now."

"Hurry!"

"Ma'am please stay on the line with me. Has he done this before?"

"Yes!"

This is an example of a call involving a man who is a mental health consumer who has locked himself in the bathroom at his home, threatening to harm himself. He has told his mother that he has a knife. He has a history of mental illness and of attempting suicide. His motivation is unknown. The mother dials 911.

This is a frightening situation for anyone involved, call taker or the officer dispatched. It is apparent that some degree of injury may soon take place. In this situation, it is easier for the call taker to provide responding officers with the

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information they need to effectively eliminate the threatening situation because of its accuracy and reliability.

Contrasted to this is the call that comes in with a lack of useful information, as it relates to mental health. The caller is not forthcoming with information due to being unable to provide more, unwilling to do so, or is experiencing a threat and simply can't, or does not have the information to provide.

What may begin as a call from a business owner to "do something" about an unkempt young man pacing in front of his store or community demands to keep individuals from sleeping on park benches…will prompt a police response that can result in myriad outcomes.[1]

Police response at this critical first encounter will be shaped by whether they perceive a person's mental illness as a factor in the call for service; their knowledge of de-escalation techniques at the scene; and their understanding of when the nature of the call necessitates criminal justice action or whether it is better to engage in appropriate alternative resources.[2] Before any of this can be employed for positive and successful intervention, the accurate and complete information must first be relayed to the responding officers.

Discussion – *5 min limit* – Ask the questions "Is this realistic?", "Will you get call like the one present here?", "Do calls regarding only mental illness really come in?", " Are they common?"

[Review Handout 9-1: Prevalence of Mental Illness in Modern U.S. Society]

Mental Health vs. Mental Illness

[Instructor Note: When discussing people who have mental illness, the correct term to use is Consumer. This has become the standard for this reference. Please encourage your trainees to utilize this term.]

"Mental health is a relative term. It can mean many things to many people. Generally, mentally healthy people have a positive self-image and can relate successfully to others. Mental health is the ability to integrated one's self with one's environment. Good mental health is reflected in:

- Solid interpersonal relationships;
- Satisfaction in living;
- Success in achievements;
- Flexibility and coping skills, and
- Maturity.

[1] Criminal Justice Mental Health Consensus Project, 2002, Council of State Governments, 34

[2] Ibid, 34-35

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"In dealing with life's challenges, changes and traumas each person develops methods that enable him or her to function effectively despite these distractions. At times, the pressures may impair one's ability to fulfill responsibilities effectively. The person often deals quickly with the condition, soon restoring effectiveness. It is when the person's methods for dealing with those pressures fail that one begins to experience a disorder in functioning." (PERF, 1997)

[Review Handout 9-2: Mental Health vs. Mental Illness, portion on mental health]

*Note: Success in achievements doesn't signify that someone who isn't very successful is mentally ill. This indicates that a mentally healthy person is able to set goals for him/herself and attain those goals. A mentally healthy person can also adjust those goals to be more reasonable and attainable as the situation dictates.

[Review Handout 9-2: Mental Health vs. Mental illness, portion on mental illness]

Optional Discussion: As a large group, discuss past experiences/calls and specific statements made by a caller that gave you an indication that a person may be mentally ill.

Signs and Symptoms of Mental Illness

Instructor's notes: Briefly describe the different classes of disorders (psychotic disorders, mood disorders, anxiety disorders, etc. – See Module 2 for a more indepth description).

[Review Handout 9-3: Common Psychiatric Disorders, and Handout 9-4: Signs and Symptoms of Mental Illness]. Allow time for questions.

Suicide

[Instructor Note: This is an informational segment and is not recommended to replace more thorough and detailed training in reporting and intervention in suicide.]

Suicide can be the result of untreated depression, traumatic experiences, health problems, an injury, or a subtle buildup of events that are stressful or tragic. Suicidal feelings, thoughts, and behavior are very often associated with symptoms of depression, anxiety or the result of medical problems involving a chemical imbalance.

[Review Handout 9-5: Suicidal Behavior and Indicators]

Mental Health Call Taking

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[An important aspect of being an Emergency Services Call Taker is the adherence to department policy. Most established policies and procedures are based on reason with positive results and expectations of those results leading to the establishment of the policy.]

According to Dr. Michael G. Conner in Use of Police and 911 for Mental Health and Psychological Emergencies, there is a tremendous variability between police agencies, their training, their professionalism, and their general orders when handling a call that involves angry, aggressive, violent, suicidal, self harming, dangerous or severely disturbed behavior. There is also tremendous variability within 911 and law enforcement regarding their attitudes, skills, patience and the degree to which they are willing to be thorough when handling a call.

[Review Handout 9-6: Mental Health Call Taking]

When a person calls the police to report that he or she has been a crime victim or witness and indicates that he or she has a mental illness or exhibits symptoms, the call-taker should, as with all victims/witnesses of crimes, assist the person in relating the details of the crime and its location, so that officers can be efficiently dispatched to the scene.

Knowledge of department's guidelines for responding to people with mental illnesses and knowledge of the variety of services available for people with mental illnesses equips the department employees to handle a wide range of interactions that may occur. Efforts to assist people who have mental illnesses and their families in obtaining appropriate support services may result in reduced trauma, rapid care for an individual in need, fewer repeat calls for service, and improved officer safety.[3]

Conclusion

Summarize information discussed. Provide time for questions.

Recommended Reading

Police Executive Research Forum (1997) *The Police Response to People with Mental Illness,* Washington DC: PERF.

[3] The Police Response to People with Mental Illnesses including information on The Americans with Disabilities Act Requirements and Community Policing Approaches. Police Executive Research Forum, 1997

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Handout 9-1
Prevalence of Mental Illness in Modern US Society

[Instructor note: These facts and figures were generated by the Criminal Justice / Mental Health Consensus Project, 2002 and the NAMI Advocate, spring, 2001.]

- Approximately 5% of the total US population has a serious mental illness.
- Over the course of a lifetime, it is anticipated that 1 in 5 people with develop a diagnosable mental illness.
- Nearly one half of the inmates in prison with mental illness were incarcerated for committing a nonviolent crime.
- Inmates with mental illness in a state prison were 2 to 5 times as likely to have been homeless in the year preceding their arrest than inmates without a mental illness.
- The Los Angeles County Jail, Cook County Jail (Chicago) and Riker's Island (New York City) each hold more people with mental illness on any given day than any psychiatric facility in the United States.
- The Miami-Dade Department of Corrections spends almost $4 million annually on overtime to manage inmates with mental illness.
- When a person with mental illness commits a violent crime, more than half of the time, the victim is a family member, a friend, or an acquaintance.
- A North Carolina study found that persons with mental illness are almost three times as likely to be the victim of violent crime than persons without mental illness.
- Almost half of the adults with serious and persistent mental illness are between the ages of 25 and 44.
- Four of ten leading causes of disability in the United States…are mental disorders, which include major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder.
- Approximately one-third of the estimated 600,000 homeless people in the U.S. have severe mental illness, however, only 1 in 20 people with severe mental illness is homeless.

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Handout 9-2
Mental Health vs. Mental Illness

There is some confusion as to what constitutes "mentally healthy" and "mentally ill." The following information is borrowed from the Criminal Justice / Mental Health Consensus Project, 2002.

Mental Health is the ability to integrate one's self with one's environment. Mentally healthy people have a positive self-image and can relate successfully to others.

This is reflected in

- Solid interpersonal relationships,
- Satisfaction in living,
- Success in achievements, *
- Flexibility and coping skills, and
- Maturity

Mental Illness consists of brain disorders that impair thinking, feeling and behavior **and** disrupt ability to function in activities of daily living. Mental illness is caused or triggered by a number of different circumstances:

- Genetic transmission,
- Biochemical disorder,
- Prolonged or very intense social stress
- Recreational drug use, and
- Environmental toxins

Unusual Perceptions
Delusions and hallucinations are examples of unusual perceptions.

- *Delusions* are false beliefs such as paranoia, delusions of grandeur or guilt, or jealousy.
- *Hallucinations* are stimulus passed in perception. Hearing voices is an example of auditory hallucinations. Seeing items or people who aren't there are examples of visual hallucinations. Feeling something that doesn't exist caress your hand is an example of a tactile hallucination. Hallucinations exist in all of the five senses.

Thought Impairment
Thought impairment is characterized by confusion, difficulty concentrating, indecision, and impaired insight and judgment. Thought impairment can also include a change in the amount/frequency of thoughts and the content of thoughts.

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Impaired or Affected Emotions

Mental illness damages self-concept and social relationships as well as alters emotions. Painful and/or intense emotions may be the normal response to the trauma of mental illness. Emotions can be magnified or intensified, be uncharacteristic for the individual, shift frequently and have an ____? Instability. The opposite is possible as well, and the individual can experience a lack of emotional stimulation, a "numbness," or affective withdrawal.

Behaviors

Behavior changes as a result of impaired thoughts or feelings.

- Persons responding to voices, delusions, hyper-stimuli or manic feelings may appear strange/bizarre in their appearance or actions, agitated and irrational.
- Persons responding to the negative symptoms of the mental illness, depression, apathy, withdrawal or confusion may appear lethargic, disconnected and confused.

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Handout 9-3
Common Psychiatric Diagnoses

Diagnosis	Symptoms & Characteristics	Treatments
Psychotic Disorders		
Schizophrenia	Distorted sense of reality: Hallucinations, Delusions, Confusion, Blunted emotional expression, Unusual speech & behavior, Social withdrawal.	Medication: anti-psychotic, Case management Therapy: cognitive-behavioral or supportive, Psychosocial rehabilitation.
Schizoaffective Disorder	Psychotic symptoms, plus Mood swings	Medication: anti-psychotic and mood stabilizer, Case management, Therapy: cognitive-behavioral or supportive, Psychosocial rehabilitation.
Substance Induced Psychotic Disorder	Psychotic symptoms associated with substance abuse	Detoxification, Addiction treatment, Assessment for underlying mental disorder.
Mood Disorders		
Depression	Persistent sadness, Loss of interest, Change in appetite/weight, Sleep problems, Physical slowing or agitation, Energy loss, Feelings of worthlessness, Concentration problems, Suicidal thoughts.	Medication, antidepressant, sedatives-hypnotics (for sleep), Case management if severely impaired, Therapy: cognitive-behavioral or interpersonal.
Bipolar Disorder	Depressive symptoms alternating with mania: Increased energy, racing thoughts, rapid speech, Denial that anything is wrong, Irritability, distractibility, Decreased need for sleep, Unrealistic belief in one's ability, Poor judgment, Impulsive behavior: sexual drive, substance abuse, spending sprees, aggression.	Medication: mood stabilizers, sedatives-hypnotics (for sleep), Case management if severely impaired, Therapy: cognitive-behavioral or interpersonal, Psychosocial rehabilitation.

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Diagnosis	Symptoms & Characteristics	Treatments
Anxiety Disorders		
Generalized Anxiety Disorder	Ongoing, unrealistic sense of impending doom, Strenuous avoidance of feared situations, May involve panic attacks: Episode of intense fear, Chest pain, Rapid heartbeat, Shortness of breath, Dizziness, Abdominal distress.	Medications: anti-anxiety* and anti-depressants, sedatives-hypnotics (for sleep), Therapy: Cognitive-behavioral. * Caution: some anti-anxiety medications are habit-forming.
Posttraumatic Stress Disorder	Following a traumatic event or ongoing situation: Reliving the event through flashbacks or nightmares, Avoiding trauma reminders, Amnesia regarding trauma, Social isolation, Sense of limited future, Wary, Irritable, Insomnia, Lack of concentration.	Psychotherapy: Stress Inoculation Training, relaxation and role playing Medication: Short-term anti-depressant or anti-anxiety, Support groups, group therapy, Case management if severely impaired.
Obsessive Compulsive Disorder	Persistent, unwanted, upsetting thoughts, Repeated actions to prevent what is feared.	Medication: SSRI antidepressants, Therapy: Exposure Response Prevention. Case management if severely impaired.
Personality Disorders Most common: **Women:** Borderline Personality Disorder **Men:** Antisocial Personality Disorder	Group of personality "traits" resulting in ongoing, troublesome patterns of thought, feeling & behavior. Women more commonly have dependent, emotionally unstable traits, Men more commonly have aggressive, antisocial traits.	Borderline: Therapy: cognitive-behavioral or insight-oriented, Psychosocial rehabilitation Short term medication: antidepressant, anti-anxiety Antisocial: Therapy: Behavioral, conducted in a controlled residential setting.
Dementias		
Most Common: Alzheimer's Disease	Memory loss, Trouble speaking, Trouble moving around, Difficulty recognizing objects, Inability to plan & organize, As condition worsens: Psychosis, Depression, Agitation.	Memory training (for early stages) Medications: Anti-depressant, anti-psychotic Day treatment, Caregiver respite

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Handout 9-4
Signs and Symptoms of Mental Illness

Appearance Dress and hygiene: Appropriate Unkempt Smells of alcohol Body odor Unusual dress Inappropriate dress	**Thought Process** Loose associations Disorganized Poverty of thoughts No response Incoherent Clanging/rhyming Flight of ideas	**Perception** Hallucinations Visual illusions Auditory commenting Auditory command Visual tactile Olfactory Gustatory
Mannerisms Tics Tremors Peculiar or bizarre Unusual gait Repeated acts Lack of coordination Eye movements **Pace of movement** Hyperactive Restless Agitated Lethargic Fatigue Stupor	**Thought Content** **Somatic** Physical complaints Hypochondriasis Obsession with body **Guilt feelings** Worthlessness Feels punished Guilt Shame Suicidal thoughts Suicidal plans Past suicide attempts Homicidal thoughts	**Emotions** **Mood** Sad Expressionless Pessimistic Tearful Helpless/hopeless Euphoric **Affect** Emotionless Blunted/flat/restricted Inappropriate Angry
Speech Normal Pressured Singing Constant Poverty of content Slowed Mute Occasional	**Unusual thoughts** Magical thinking Sexual preoccupation Bizarre thoughts Obsessions Excessive religious talk	**Orientation** Place Time Person Situation **Cognitive functioning** Inability to concentrate Short term memory loss
Attitude Withdrawn Evasive Passive eye contact Threatening Impulsive Aggressive Manipulative Demanding Distractible Overly dramatic Distrustful Accusing Entitled	**Suspicions** Misinterpretation Delusions of persecution Delusions of reference Delusions of control Paranoid **Grandiose thoughts** Delusions of grandeur Inflated self-esteem Thought broadcasting Extraordinary abilities	**Insight and Judgment** Poor insight Poor memory

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Handout 9-5
Suicidal Behavior and Indicators

Several thousand articles and books have been written about the cause and prevention of suicide. For the purpose of understanding…there are essentially six reasons why people attempt suicide. Understanding these reasons can help you recognize the risk of suicide:

- Change: Suicide is a way to change how the person feels or what is happening in their life or at that moment.
- Choice: To assert or make a choice during circumstances in which there is perceived to be no choices or where important choices are being taken away.
- Control: The suicidal behavior is a means to relieve guilt or attempt to assert control on an overwhelming situation.
- Self-Punishment: Suicidal behavior is a means to relieve guilt or punish the person for their actions.
- Punish Others: The suicidal act is intended to inflict harm or punishment on others.
- Psychotic Illness: The suicidal act is the result of strange and bizarre beliefs that are caused by a mental illness or a severe medical problem.[4]

There are a number of risk factors associated with suicide that can be verbalized and are signals to the person taking the call that a potential threat of suicide is there. Some of these risk factors are commonly heard but often not recognized for what they are. These include:

- Wishing you didn't exist
- Thinking you would like to go to sleep and not wake up
- Dwelling on death
- Thinking or feeling you're better off dead
- Making plans or thinking about plans to commit suicide
- And recent behaviors that may be suicidal, dangerous or self-harming.

As communications personnel or dispatchers if you receive a call where you suspect that a person may be in the mindset of self-injurious behavior or suicide there are significant items of information that you need to try and obtain.

Ask: Don't be afraid to ask the obvious, "Do you want to kill yourself?"

Plan: Does the person have a plan to harm him/herself? What is that plan? Don't be afraid to ask the obvious, "Have you already begun to carry out this plan? (Taken the pills, started gas, lacerations, etc.) If so, what has been done? This will help you determine which emergency responders to dispatch.

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[4] Conner, Michael G, Psy.D., Understanding and Dealing with the Risk of Suicide

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Time Frame: Does the person have a time frame in which it's intended to begin the harm? What is the time frame?

Location: Where is the person located?

Method: How do you plan on carrying out your plan? Do you have the capability/materials to do it?

Others: Is anyone else there? Have they been injured? Who are they? Can they help you? Do you have any mental health professionals involved in your care?

Once you have this information, you have more than enough to pass along to responding officers or paramedics that can help them to de-escalate the situation and hopefully save the caller from serious injury or death.

As a Dispatcher/Call Taker/Communications Professional, once you have the information that you need, you *must* stay in constant contact with the person you believe to be suicidal. Do not break the connection until dispatched units are on the scene. Continue communication and engage the person in conversation as much as possible.

The more you engage them, the less likely they are to be able to implement their plan for injury. Also, the constant engagement allows you to monitor the Caller's progress (positive or negative) to relay to responding units.

You can ask the person what made them feel the way they do, or you can talk about the weather and the flowers growing in the yard. Do anything you have to; to keep that person engaged with you.

Mobile Crisis for your area should be notified as soon as possible.

As a department, you may have procedures for transferring non-lifethreatening calls to a talk line or to MCRT. Please be aware of these procedures and resources in your area.

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Handout 9-6
Mental Health Call Taking

Communication breakdown and loss of information is the biggest problem when calling 911. A dispatcher is trained to summarize a call and to use an abbreviated communication format. This is difficult when you have persons calling in who are in stressful, emergency situations. They may be scared, injured, or disturbed themselves. Gathering information and making a judgment about what of that information is pertinent to responders can be even more trying. Even when the dispatcher relays your content in the most accurate manner possible, the officer may disregard a great deal of what a dispatcher has to say about the call due several reasons (attempting to juggle the various types of stimulation as well as assessing the situation for dangerousness).

The Improvement Plan

The quality of information gathered and shared by call-takers/dispatchers affects the way officers respond to and resolve a call for service. This applies to all calls, including those involving a person who may have a mental illness. Gathering information is critical at all stages in assessing situations involving people who have mental illnesses, but is particularly critical at the onset.

When the department receives a call concerning the actions or behavior of someone who is acting atypically or erratically, it is essential that the call-taker collect information that will prepare an officer to respond to the scene.

As with all calls, call-takers should first assess the urgency of the situation and then collect other relevant information such as:

- The nature of the atypical or problem behavior,
- Events that may have precipitated the person's behavior, and
- The presence of weapons.

A family member, friend or concerned party calling about someone who needs help in accessing mental health or other services may volunteer additional information such as:

- Past occurrences of this or other types of atypical behaviors;
- Past incidents involving injury or harm to the individual or others;
- Prior suicide threats;
- A brief diagnosis, if any;
- Reliance on medication or failure to take medication;
- Relatives, friends or neighbors available to assist officers, and
- Physicians or mental health professionals available to assist officers.

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When dispatching calls for service involving people who may have mental illnesses, call-takers should provide all relevant background information to the responding officers.

The use of slang or pejorative terms to describe a person with mental illness is improper and unacceptable (Terms such as: nuts, loony, crazy, loco, etc.). It is helpful to have established common language between departments to expedite communication that is accurate, of good quality and reliability and is not offensive to any particular person/entity.

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Handout 9-7
Consensus Project – Contact with Law Enforcement

Requests for police service generally come in one of two ways: through a personal contact with an officer who happens to be near the scene or through a call to the department. The dispatcher is responsible for gathering information about the situation and dispatching the call to a patrol officer.

Policy Statement #2
Provide dispatchers with tools to determine whether mental illness may be a factor in a call for service and to use that information to dispatch the call to the appropriate responder.

- Provide dispatchers with questions that help determine whether mental illness is relevant to the call for services.
- Provide dispatchers with tools that determine whether the situation involves violence or weapons.
- Provide dispatchers with a flowchart to facilitate dispatch of the call to designated personnel.
- Use designated codes and appropriate language when dispatching the call.[5]

[5] Criminal Justice Mental Health Consensus Project, 2002, Council of State Governments

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