BASIC COURSE UNIT GUIDE

45

MENTALLY ILL AND DEVELOPMENTALLY DISABLED

This unit guide covers the following learning goals contained in the POST Basic Course performance objective document:

8.36.0 Mentally Ill and Developmentally Disabled

Revised October 1990

THE COMMISSION
ON PEACE OFFICER STANDARDS AND TRAINING

STATE OF CALIFORNIA

This unit of instruction is designed as a *guideline* for Performance Objective-based law enforcement basic training. This unit is part of the POST Basic Course Guidelines system developed by the California Commission on Peace Officer Standards and Training with the assistance of the law enforcement training community.

This Guide is designed to assist the instructor in developing an appropriate lesson plan to cover the performance objectives, which are required as minimum content of the Basic Course.

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Learning Goals and Performance Objectives

8.36.0: MENTALLY ILL AND DEVELOPMENTALLY DISABLED

Learning Goal: The student will gain the ability to appropriately respond to persons with developmental disabilities or mental illness, understanding the general nature and causes of these afflictions, and the community resources available for referral.

8.36.2 Given a description of a situation involving a person exhibiting unusual behavior, the student will identify whether the person can be lawfully detained under the provisions of Section 5150 of the Welfare and Institutions Code. The student will be minimally required to respond to the descriptions of situations where the following conditions exist:

A. A person is mentally ill and a danger to himself
B. A person is mentally ill and a danger to others
C. A person is mentally ill and incapable of providing for his own needs
D. A person is not mentally ill but is a danger to others
E. A person is mentally ill but is not a danger to himself, a danger to others, or incapable of providing for himself

8.36.4 Given a word picture or audio-visual presentation of a situation involving a person who is mentally disordered or developmentally disabled, the student will identify the appropriate mental health facility or regional center within the agency's jurisdiction to be used for evaluation, treatment, counseling, or referral.

8.36.5 Given an exercise, the student will safely and properly handle a person simulating mental illness.

8.36.6 Given a description of a person exhibiting unusual behavior or appearance, the student will identify the most likely primary disability or problem. These include:

A. Autism
B. Mental retardation
C. Epilepsy
D. Cerebral palsy
E. Thought disorder
F. Mood disorder
G. Substance abuse
H. Other neurologic conditions

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8.36.7 Given a description of a person exhibiting any of the symptoms listed below, the student will identify them as symptomatic of mental illness:

A. Delusions
B. Hallucinations
C. Disorganized speech patterns
D. Irrational fear or sense of panic
E. Depression
F. Thoughts of death and suicide
G. Impaired self care
H. Impulsive, erratic, and bizarre behavior
I. Disorientation

8.36.8 Given a description of a person exhibiting any of the symptoms listed below, the student will identify them as symptomatic of a developmental disability:

A. Receptive or expressive communication difficulty
B. Seizure disorder
C. Muscle control difficulty
D. Slurred speech
E. Confused or disoriented
F. Lethargic
G. Self-endangering behavior
H. Inappropriate response to situation
I. Purposeless repetitive behavior
J. Deficits in common language

8.36.9 The student will identify the following procedures required of officers for safeguarding the rights of a person detained under the authority of Section 5150 of the Welfare and Institutions Code:

A. The circumstance under which the person's condition was called to the officer's attention and the observation constituting probable cause for detention must be recorded on the Application for 72-Hour Detention For Evaluation and Treatment
B. Advisement of Miranda rights, as appropriate, when criminal action is involved
C. Reasonable precaution must be made to safeguard personal property in the possession of or on the premises occupied by the person
D. The person must be informed of the officer's name and agency, and the reason the person is being detained

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E. If taken into custody at a residence, inform person of personal items that may be brought along, right to a telephone call, and right to leave a note to friends or family

8.36.10 Given a description of a situation in which involuntary detention for evaluation and treatment is NOT appropriate, the student will identify appropriate alternative methods for handling the situation. These include:

A. Urgent medical attention
B. Arrest
C. Referral for mental health services
D. Referral to local developmental disabilities agency
E. No police action required

* 8.36.11 Given a description of a situation involving a woman who has given birth within the last 12 months and who displays one or more of the following risk factors, the student will identify that the woman may be suffering from postpartum psychosis. Risk factors:

A. Insomnia
B. Agitation
C. Hyperactivity
D. Stupor
E. Confusion
F. Hallucinations
G. Delusions
H. Violent or bizzare behavior
I. Fearful thoughts (childs's safety)

* 8.36.12 Given a description of a situation involving a woman who might be suffering from postpartum psychosis, the student will select an appropriate cause of action from the following options:

A. Involuntary detention under 5150 of the Welfare and Institutions Code
B. Referral for mental health services, and notify family members or other concerned parties
C. Arrest
D. Emergency medical care
E. No police action required

*Added July 1, 1990

Material/Equipment

Each training institution should develop its own list of equipment and materials for each unit. This list is dependent upon the instructional strategies methods/media considerations.

Refer to Scenario Manual for material or equipment needed for Performance Objective 8.36.5.

Learning Goal 8.36.0 : The student will gain the ability to appropriately respond to persons with developmental disabilities or mental illness, understanding the general nature and causes of these afflictions, and the community resources available for referral.

Unit Outline & Presentation	Objectives & Instructional Cues
I. LEGAL ISSUES	Note: Review LPS handout material and provisions of Section 5150 of W.I.C. Provide copies to class for reference.
A. Lanterman-Petris-Short Act (LPS)	(Handout #1)
1. Established in 1968, reformed commitment laws pertaining to mental health treatment.	8.36.2 Given a description of a situation involving a person exhibiting unusual behavior, the student will identify whether the person can be lawfully detained under the provisions of Section 5150 of the Welfare and Institutions Code. The student will be minimally required to respond to descriptions of situations where the following conditions exist:
a. California W. I. Code Section 5150 sets out civil procedures for mental evaluation/treatment.	A. A person is mentally ill and a danger to himself
b. Establishes procedures and locations for placing a person into an approved mental health facility.	B. A person is mentally ill and a danger to others
2. Intended to balance rights of the community with rights of person to freedom and due process.	C. A person is mentally ill and incapable of providing for his own needs
a. Important to note that civil commitment or emergency involuntary detention constitutes a serious deprivation of personal liberty.	D. A person is not mentally ill but is a danger to others
3. Permits, under specific conditions, peace officer to take into custody a person for transportation to a designated mental health facility for 72-hour treatment and evaluation.	
a. Officer has probable cause to detain a person when:	
(1) Person, as a result of mental disorder, is:	
(a) danger to others, or	
(b) danger to self, or	
(c) gravely disabled.	

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Unit Outline & Presentation	Objectives & Instructional Cues
A combination of one or more of the above constitutes a condition warranting treatment and evaluation.	E. A person is mentally ill but is not a danger to himself, a danger to others, or incapable of providing for himself
b. Requires an application in writing stating the circumstances and probable cause conditions.	
B. Lanterman Development Disabilities Services Act	Note: People vs. Triplett case sets forth explicitly the elements of probable cause in these matters. People vs. Triplett 1983, 192 Cal Rptr 537, 144 CA 3D 283.
1. Establishes State responsibility and coordination services for developmentally disabled citizens.	
2. Ensures protection of same legal rights and responsibilities.	
3. Defines a "developmental disability" to include:	Note: Review student handout on Lanterman Developmental Disabilities Services Act. Provide copies to students.
a. Mental retardation	
b. Cerebral palsy	
c. Epilepsy	(Handout #2)
d. Autism	
e. Other related handicapping conditions	Note: Review student handout materials on Mental Disorders and provide students with copy for reference.
II. PRIMARY TYPES OF MENTAL DISORDER OR DEVELOPMENTAL DISABILITIES	
A. The term "mental disorder" includes mental disorders of either organic or non-organic origin.	(Handout #3)
1. The Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III R) is the accepted standard for describing mental disorders in behavioral terms.	8.36.6 Given a description of a person exhibiting unusual behavior or appearance, the student will identify the most likely primary disability or problem. These include:

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B. The major categories of mental disorders include: 1. Thought Disorders - a condition where disruption of thought process is primary. Major thought disorders include schizophrenia and delusional conditions. 2. Mood Disorders - primarily affect an individual's mood. Major mood disorders include depression and mania. 3. Substance Abuse - alcohol and drug influence may resemble a thought or mood disorder. Addictive disorders represents disorders of self-control, resulting in organic impairment due to ingestion of a psychoactive substance or maladaptive behavior resulting from regular and consistent use of the substance involved - called dependence disorder. 4. Other Neurologic Conditions - brain injury or disease, and certain medical conditions, may resemble thought or mood disorders. Examples include Alzheimer, AIDS dementia, and stroke.	A. Autism B. Mental Retardation C. Epilepsy D. Cerebral Palsy E. Thought Disorder F. Mood Disorder G. Substance Abuse H. Other Neurologic Conditions
C. The major categories of developmental disabilities include: 1. Autism - manifested by one or more of the following: a. Severe disorders of communication and behavior which begins in early childhood, usually prior to age 3. b. Inability to communicate or relate to other persons in a normal way. c. Non-responsive to sound and appearing deaf. d. Total lack of interest in nearby persons or objects. e. Lack of meaningful speech or echoing others' words.	Note: Handout #3 lists and defines the developmental disabilities.

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Unit Outline & Presentation	Objectives & Instructional Cues
2. Mental Retardation - subaverage intellectual functioning with deficits in adaptive behavior and self-care.	
3. Epilepsy - various disorders marked by disturbed electrical rhythms of the brain which may result in seizures. Types of seizures include: a. Grand Mal b. Petit Mal c. Psychomotor	
4. Cerebral Palsy - a disorder of posture and movement due to a dysfunction of the brain. Persons may have difficulty in muscle control or coordination which may affect speech, hearing, and/or vision.	
III BEHAVIOR CUES ASSOCIATED WITH MENTAL DISORDER AND DEVELOPMENTAL DISABILITIES To better differentiate between mental disorders and developmental disabilities, specific behaviors must be recognized and articulated in reports and to other individuals involved in the evaluation and treatment process in order to provide proper disposition of the incident.	8.36.7 Given a description of a person exhibiting any of the symptoms listed below, the student will identify them as symptomatic of mental illness:
A.Behavior Cues Associated with Mental Disorders Behaviors associated with mental disorder will depend on the severity of the affliction. With the onset of the disorder, the individual will generally exhibit three general characteristics symptomatic with a mental disorder: the behaviors and mood of the person are inappropriate to the setting; the behavior of the person tends to be inflexible; and the behavior of the person tends to be impulsive. The common behavior includes:	A. Delusions B. Hallucinations C. Disorganized Speech Patterns D. Irrational Fear or Sense of Panic E. Depression F. Thoughts of death and suicide G. Impaired self-care H. Impulsive, erratic, and bizarre behavior I. Disorientation
1. Delusions - persistent false beliefs. Examples include: a. The false belief that the person is being persecuted, attacked, harassed, cheated, or conspired against.	

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b. The false belief of one's own self-importance such as belief that they are Jesus Christ or the devil, or that they possess special powers. Delusions can be associated with thought disorder, mood disorder, substance abuse, and neurological conditions. The individual's thoughts and actions are not based on reality and their ability to think clearly is impaired. This level of impairment can vary tremendously not only from person to person but also over time with each person.	
2. Hallucinations - A hallucination is a false perception through any one of the five senses. Most hallucinations involve hearing voices or seeing visions that are not there. Hallucinations are most often associated with thought disorders, substance abuse, and neurological conditions.	Note: See Table on Types of Behavior Encountered by Police, Addendum #1. See Table on Behavioral Elements Attracting Police Attention, Addendum #2.
3. Disorganized Speech Patterns - Disordered thinking is the inability to concentrate or to make logical thought connections and is often reflected in the speech of the person. The behaviors may include:	
a. Rapid flow of unrelated thoughts.	
b. Unclear speech that does not communicate an idea.	
c. Speech which is incoherent - words that do not fit together.	
d. Individual makes up new words.	
e. Individual talks in rhymes without regard to meaning.	
f. Repeats same words and phrases.	
g. Fails to or is slow to respond to simple questions, or has blank stares.	

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4. Irrational Fear or Sense of Panic - severe personality disorganization involving intense anxiety and usually either blind flight or paralyzed immobility. These are transient episodes of overwhelming fear with no apparent cause, often referred to as panic attacks.

5. Depression - an emotional state characterized by extreme dejection, gloomy ruminations, loss of hope, and often apprehension. Individuals may feel overwhelmingly hopeless, guilty, in despair, or worthless. They may have little energy and may have thoughts of death or suicide.

6. Thoughts of Death, Suicide - the risk of suicide is a significant factor in depressive state. Events, circumstances, and mental state found to be related to the onset of depression are also generally linked to suicide.

   Current stressors, depressed and angry feelings, interpersonal crises of various sorts, failure and consequent self-devaluation, inner conflict, and the loss of a sense of meaning and hope can produce, independently or in combination, a mental sta te that looks to suicide as a possible way out.

   Threats, suggestions, attempts of suicide should always be taken seriously even though the person may deny any intent. The person may or may not demonstrate any other symptoms.

7. Impaired Self Care - inability to feed, clothe, or shelter self (due to mental disorder).

8. Impulsive, Erratic, and Bizarre Behavior - examples may include head banging, self-mutilation, rigid and unusual postures, inappropriate nudity or sexual behavior, directing traffic, or running in or lying down in traffic.

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9. Disorientation - not always aware of time, place or identity of self or others. B. Behavior Cues Associated With Developmental Disabilities Behaviors associated with mental retardation, autism, epilepsy, and cerebral palsy range in severity from mildly affected to severely affected. Persons with these disabilities may display the following symptoms in any or all combinations: 1. Receptive or expressive communication difficulty commonly found in mental retardation, autism, cerebral palsy areas. 2. Seizure disorder. Most often found in people with epilepsy. 3. Muscle control difficulty. Found in individuals with cerebral palsy, epileptic seizures, and severe mental retardation. 4. Slurred speech. Found in individuals afflicted with cerebral palsy, and those with epilepsy immediately after seizure. 5. Confused and/or disoriented. Applies to individuals afflicted with autism, moderate to severe mental retardation and post seizure epilepsy. 6. Lethargic. Found in the post seizure epilepsy situation. 7. Self-endangering behavior. Individuals afflicted with moderate to severe mental retardation, and autism. 8. Inappropriate response to situation. Includes autism, mental retardation, psychomotor seizure of epilepsy. 9. Purposeless repetitive behavior. This includes autism and mental retardation. 10. Deficits in common knowledge. Includes mental retardation, autism. Tests for this include coin counting and time telling.	8.36.8 Given a description of a person exhibiting any of the symptoms listed below, the student will identify them as symptomatic of a developmental disability: A. Receptive or expressive communication difficulty B. Seizure disorder C. Muscle control difficulty D. Slurred speech E. Confused or disoriented F. Lethargic G. Self-endangering behavior H. Inappropriate response to situation I. Purposeless repetitive behavior J. Deficits in common language

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Unit Outline & Presentation	Objectives & Instructional Cues
IV. DETENTION PROCEDURES	8.36.9 Please refer to Page ii for this Performance Objective
A. Safeguard of legal rights	
1. Mentally disordered individuals are entitled to the basic federal and state constitutional rights.	
2. LPS Act established (in part) to safeguard individual rights through judicial review.	
3. Requires advisement of 5150 rights by officer when person is taken into custody in home.	
4. Professional in charge of mental health facility must evaluate and may release individual from custody.	
B. Documentation of Probable Cause to Detain and Circumstances of Incident	
1. LPS Act requires application in writing on a standard form.	See Application for 72-hour Detention for Evaluation and Treatment, Addendum #3
2. Application must state circumstance upon which officer was called/brought to attention.	
3. Application must state probable cause to believe person is, as the result of mental disorder, a:	Note: Officer must be able to point to articulative and specific facts which, taken together with rational inferences from these facts, reasonably warrant belief or suspicion. (Triplett Case)
a. danger to self, or	
b. danger to others, or	
c. gravely disabled.	
A combination of one or more of the above constitutes a condition warranting detention for evaluation and treatment.	Example of application in Resource Documents.
C. Safeguard of Personal Property	
1. Section 5156 W.I.C. requires person taking individual into custody to:	Addendum #3

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a. take reasonable precaution to preserve and safeguard personal property in possession of or on premises occupied by person, b. provide court with report describing property so preserved and its disposition. D. Mental Health Facilities and Regional Centers 1. Each county may designate facilities as 72-hour evaluation and treatment centers if such facilities meet the requirements established by Department of Mental Health. 2. State Department of Developmental Services administers seven developmental centers and contracts with 21 regional centers throughout the state to provide services locally. V. ALTERNATE METHODS FOR DISPOSITION The official mandate of the law enforcement officer encompasses dealing with the mentally disordered and/or developmentally disabled from a law enforcement, civil, and social order perspective: law enforcement in that public order may have been disturbed or a crime committed; civil in that an emergency detention for examination may have to be initiated; and social service in that referral to a community service agency may be required. It is estimated that 60-70 percent of law enforcement efforts involve social order maintenance activities. Law enforcement is in many cases the first, last, and only resource available when other agencies are closed. Alternate methods for appropriately handling the mentally disordered and/or developmentally disabled include:	8.36.4 Given a word picture or audio-visual presentation of a situation involving a person who is mentally disordered or developmentally disabled, the student will identify the appropriate mental health facility or regional center within the agency's jurisdiction to be used for evaluation, treatment, counseling or referral. Note: Refer to Handout #5 8.36.10 Given a description of a situation in which involuntary detention for evaluation and treatment is NOT appropriate, the student will identify appropriate alternative methods for handling the situation. These include: A. Urgent medical attention B. Arrest C. Referral for mental health services

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Unit Outline & Presentation	Objectives & Instructional Cues
A. Urgent Medical Attention 1. First concern, after control of the situation is obtained, is rendering or obtaining urgent medical care. 2. Emergency medical personnel should be summoned if not on scene. 3. Determination of final disposition can be made after medical care is rendered.	D. Referral to local developmental disabilities agency E. No police action required
B. Arrest of Individual 1. A person who is mentally disordered and/or developmentally disabled is not relieved from legal obligations. 2. Questions of mitigation are for prosecuting authority and judicial review system. 3. Agency policies/procedures must be considered. 4. Officers have discretionary authority to arrest, cite and release, file a complaint, or release from custody. 5. Considerations for officer safety must be constantly evaluated, along with safety of community.	
C. Referral for Mental Health Services Individuals and families who may be in need of treatment can be referred to available mental health services.	Note: Provide listing of local mental health service agencies.
D. Referral to Local Developmental Disability Agency 1. State has established 21 Regional Centers throughout the state. 2. Regional Centers are a resource system for persons with developmental disabilities.	Note: Provide a listing of the Regional Centers (Handout #5)

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Unit Outline & Presentation	Objectives & Instructional Cues
3. Availability of service of Regional Centers - time, service levels, etc. - varies throughout the state.	
E. No Police Action Required	
1. Some situations will not fall into alternatives listed above - no crime committed, no urgent medical care necessary, referral not needed.	
2. Release from custody.	
3. Consider appropriate assistance pursuant to agency policy and procedures, officer discretion, and available resources.	
VI. HANDLING PERSONS WITH MENTAL DISORDERS	8.36.5 Given an exercise, the student will safely and properly handle a person simulating mental illness.
The response to a call involving a mentally or emotionally ill person requires a cautious approach. In order to determine whether a person is mentally disordered, an officer will usually have to interact with the person.	
1. The first step is to gain on-scene control before interacting with the individual.	Note: These techniques may also be applicable to handling a person afflicted with a developmental disability.
2. By first getting the situation under control, the officer will be in a position to interact with the person and effect a disposition with a minimum of distractions.	
a. Gather as much information as possible before arriving on scene.	
b. Be calm, avoid excitement, and portray a take charge attitude.	
c. Remove as many distractions or upsetting influences from the scene as possible, including bystanders, disruptive friends or family members.	
d. Contact the complaining party and elicit as much information as possible about the disordered individual.	

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e. Gather information from family, friends, onlookers. 3. Be aware of potential for violence. a. Constant safety awareness is essential. b. Maintain proper safety precautions for officer/public safety needs. c. Many situations involving a person with a mental disorder are not overtly dangerous; however, officers should be alert to changing conditions. d. Often the exaggerated behavior displayed by a disturbed person is of short duration. e. Take enough time to ensure safety for all concerned. f. Have sufficient police personnel on-scene. Before approaching a disturbed person, a back-up officer should be summoned. g. Given a chance to calm down, a disturbed person can often be handled very easily. 4. Interaction Techniques a. Establish initial communications, using appropriate voice tones and levels. b. Use firm, calm approach. c. Avoid excitement; do not allow person or situation to anger or rile officer. d. Be truthful - deception acerbates the situation. Deceit by those who are expected to be helpful (officers) will make it very difficult to regain the disturbed person's confidence.	

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e. Officers should never threaten or intimidate a disturbed person. Generally, understanding and empathy are far more productive than threats or fear.

f. Avoid controversial comments, issues, and use of terms likely to agitate. Officer must ignore insults and verbal abuse. It is not unusual for a disturbed person, acting out of fear and anger, to use verbal abuse toward an officer.

g. Use interview techniques to determine background data and present condition.

Communication allows the officer to gain valuable information regarding the problem. It also should be used to enable the officer and the subject to understand each other, and, in turn, reduce the tension that accompanies these encounters.

5. Use of Force

a. A quick response is seldom necessary, unless the person is committing a violent act.

b. In a situation in which physical restraint or force is needed, the officer should not hesitate to take the necessary action.

c. Use the least amount of force necessary to accomplish the task for stopping the outburst.

d. Restraint should be accomplished quickly. If it becomes necessary to physically restrain a mentally disordered person, the officers should gradually maneuver the person into a position where the person can be overtaken without undue risk of injury to the person or to the officers.

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e. Pain-producing restraining holds and techniques may have little or no effect because the person may not be aware of the pain; permanent injury may result. f. Due to their excited state of mind, occasionally mentally disordered persons may exhibit extraordinary strength. However, most truly mentally ill persons are frightened, confused, and apprehensive when in a crisis situation. g. Requests for back-up assistance are appropriate to ensure adequate control procedures.	
6. Evaluation of Individual Evaluation is a continuous process. a. The officer's first obligation, absence a violent act, is to determine whether or not the situation warrants police involvement. b. Attempts should be made to determine what caused the person to be upset. c. The person's background, support network in community, present condition, involvement in a crime, and other factors must be evaluated.	Note: Handout #4 outlines an assessment format that can be used in the evaluation of a potentially mentally disordered person.
7. Disposition a. Appropriate to relevant statute, case decisions, agency policy, officer discretion, and resources available.	

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Unit Outline & Presentation	Objectives & Instructional Cues
VII. POSTPARTUM PSYCHOSIS	
A. Postpartum Psychosis is a severe mental disorder generally occurring within one year after childbirth which is related to the extensive chemical and hormonal changes which take place when the mother's body readjusts from the pregnant to the non-pregnant state. Postpartum illness presents three major hazards: 1. The mother may harm herself. 2. The mother may harm (injure or even kill) her baby. 3. The mother's condition may evolve into a chronic depressive state.	
B. Number of Incidents It has been estimated that there are 3,700 severe cases per year in the United States. The term "severe" is defined as sufficiently ill for prudent individuals to believe that the individual should be hospitalized in a facility with psychiatric services. 1. Incidence of infanticide cases in California. It is estimated that there are twenty to thirty infanticide cases in California yearly. 2. The number of serious injuries to infants has not been estimated.	
C. Behavior Cues Associated With Postpartum Psychosis 1. An early, agitated syndrome, called puerperal psychosis by some, can arise from the third day to the 20th day after childbearing. It is characterized by: (a) confusion (b) agitation (c) severe disturbance of sleep (d) sometimes delirium	8.36.11 Given a description of a situation involving a woman who has given birth within the last 12 months and who displays one or more of the following risk factors, the student will identify that the woman may be suffering from postpartumpsychosis.

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Unit Outline & Presentation	Objectives & Instructional Cues
(e) transitory hallucinations (f) delusions	A. Insomnia B. Agitation C. Hyperactivity D. Stupor E. Confusion F. Hallucinations G. Delusions H. Violent or bizarre behavior I. Fearful thoughts (child's safety)
2. After the third week depression may develop in the mother. It has real suicidal risk. The person may exhibit behaviors of: (a) depression (b) hair loss (c) edema (d) excessive fatigability	
3. A long-lasting, mild to moderate depression may develop after the 20th day or arise after other syndromes. It is characterized by: (a) lack of energy (b) anxiety (c) subtle changes of personality (d) depression The mother may seem to be functioning at a marginal level, in a slow, dull, confused and moderately depressed manner. However, this state is interrupted occasionally by episodes of severe psychosis, during which the person's behavior may be totally out of control and under the domination of delusions or "voices" which may lead to unusual and bizarre behavior, suicide, or violence toward others, including violence against her own child.	8.36.12 Given a description of a situation involving a woman who might be suffering from postpartum psychosis, the student will select an appropriate course of action from the following options: A. Involuntary detention under 5150 of the Welfare and Institutions Code B. Referral for mental health services, and notify family members or other concerned parties C. Arrest D. Emergency medical care E. No police action required
D. Methods for Disposition Peace officers are often the first individuals to come into contact with women who may be suffering from postpartum psychosis and have exhibited behaviors that requires appropriate action. The following are appropriate courses of action.	
1. Detention for Mental Evaluation When the exhibited conduct presents a threat to the person, or another person within the requirements of 5150 of Welfare and Institution Code, the person may be taken in for mental evaluation.	Refer to page 45-8 of this Unit Guide See Addendum #4

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Unit Outline & Presentation	Objectives & Instructional Cues
2. Referral for Mental Health Services Where there is evidence of depression, anxiety and other symptoms but the behaviors are such as to not justify a 5150 detention, officers may refer for mental health services. Members of the family and other concerned parties should be notified, and assist in this approach.	
3. Report to Child Protective Services Peace officers are required to report conditions of child abuse to local child protective agencies.	Refer to: PC Sec. 11166
4. Arrest In some cases of injury to the child or another, the person may be arrested. The follow-up investigation and court procedures will determine adjudication of the incident.	
E. Emergency Medical Care Appropriate medical care should be obtained when there is injury to the mother. If injury is result of self-inflicted action (suicide attempt) and after medical treatment has been secured, the person should be evaluated under 5150 WIC.	
F. No Police Action Required In many instances, the episode may be handled within the confines of the family and local health services. If no crime has been committed, and no present conditions for mental evaluation, an appropriate action would be to document the event, make appropriate notifications, and depart from location.	

SUPPORTING MATERIAL

AND

REFERENCES

LANTERMAN-PETRIS-SHORT ACT

The Lanterman-Petris-Short (LPS) Act was placed into law as the California Community Mental Health Services Act of 1968 in order to reform the commitment laws pertaining to mental health treatment. This Act has undergone some modification during the subsequent years, in continuing efforts to balance the rights of the community with the rights of a person to freedom and due process. The laws have been listed in the State of California's Welfare and Institutions Codes, commencing with section 5150 which describes the initial involuntary commitment - the 72-hour hold.

The 5150 law functions in two manners: it allows a peace officer to take a citizen to an officially designated 5150 facility and if admitted to its Mental Health Unit, serves as the legal authority for evaluation and treatment which may not exceed 72 hours. The law specifies the three categories of conditions (danger to self, others, and gravely disabled) which appear to result from a mental disorder and requires that the person be incapable or unwilling to accept voluntary treatment. The law further states that the person who is admitted shall receive an evaluation as soon after admission as possible and shall receive such treatment and care as his/her condition requires for the full period that the person is held. The person is to be released before the 72 hours have elapsed if the treating staff believes that the person no longer requires treatment and evaluation.

It is important to note that civil commitment or emergency involuntary detention constitutes the serious deprivation of personal liberty. The 5150 process has no legal redress until after 72 hours, even if detaining parties acted improperly without probable cause being present for the necessary condition. Once a person is admitted involuntarily, the individual is deprived of friends and family, may be subject to the forced administration of medications, and may be stigmatized by some as sick and abnormal during confinement. Because of these issues, it is very important that the initiators of a 5150 be aware of the responsibility involved.

A Detention Facility will require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, and stating that the officer has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled. Because deprivation of liberty is involved in a 5150 action, there has been a great deal of judicial review of the 72-hour hold and the courts have, in one case (People vs. Triplett), made explicit the elements of probable cause in these matters:

> "To constitute probable cause to detain a person pursuant to Section 5150, a state of facts must be known to the peace officer that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion, that the person detained is mentally disordered and is a danger to himself or herself or is gravely

disabled. In justifying the particular intrusion, the officer must be able to point to specific and articulable facts which if taken together with rational inferences from those facts, reasonably warrant his or her belief or suspicion."

Section 5150.2 of the Welfare and Institutions Code lists the requirement that in each county whenever a peace officer has transported a person to a designated facility for assessment under Section 5150, that officer shall be detained no longer than the time necessary to complete documentation of the factual basis of the detention under Section 5150 and a safe and orderly transfer to physical custody of the person. The documentation shall include detailed information regarding the factual circumstances and observations constituting probable cause for the peace officer to believe that the individual required psychiatric evaluation under the standards of Section 5150.

43.92 of the California Civil Code establishes a duty for psychotherapists to warn and protect a person from a patient's threatened violent behavior where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims. This duty is discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim and to a law enforcement agency. This information should be recorded on a police report for appropriate follow-up activity.

Identification of Mentally Ill: Since qualification for 5150 requires that a person must be suffering from a mental disorder, it is important to know how to identify these conditions. Overall, in the assessment of mental illness the most important concern is the person's contact with reality. Mental illness is present when reality contact is seriously disturbed.

While "danger to self" is not explicitly defined in Section 5150, it typically means the presence of suicidal thoughts, statements, and behaviors - the suicide attempts or gestures. Self-endangering activities, such as sky-diving, are not, per se, associated with a mental disorder, but clearly persons who are wandering in traffic present a danger to themselves and would be suspected of having disordered thinking. The general criteria for dangerousness to self, again often associated with depression, intoxication or global confusion as the mental disorder include:

1. An individual has indicated by words or actions an intent to commit suicide or inflict bodily harm on self.

2. The individuals exhibit such gross neglect for their personal safety that they receive or are at risk of receiving serious injury.

3. The individual's statements or actions indicate a specific plan by which to commit suicide or inflict harm on self.

4. The individual's plans or means are available or within the individual's ability to carry out.

The concept of dangerousness to others often involves verbalizations or actions that are easily interpreted as aggressive and usually involve poor impulse control. Frequently, it is associated with emotional distress of a situational nature, but occasionally there is a long-standing thought disorder of a persecutory nature. For those felt to be a danger to others, while evidencing disordered thinking, and appropriate for involuntary commitment at a mental health unit for evaluation and treatment, the following are typical situations:

1. An individual has indicated by words or actions an intent to cause bodily harm to another person.

2. The individual's threats or intentions are specific as to the particular person to whom harm would be done.

3. The individual, though not focused on a particular person, is agitated, angry, and appears explosive.

4. The individual is engaging in or intends to engage in acts or behavior of such an irrational, impulsive or reckless nature, such as destruction of property or misuse of a vehicle, as to put others directly in danger of harm.

5. The individual's acts or words regarding an intent to cause harm to another person are based on, or caused by the individual's mental state which indicates the need for psychiatric evaluation and treatment.

The law defines "gravely disabled" as a condition in which a person, as a result of a mental disorder, is unable to provide for basic personal needs of food, clothing, or shelter. Evidence of inability to provide for food, clothing or shelter may include the following examples which should be verified by personal observations:

1. Food - person is malnourished and dehydrated; little or no food in the house and the person is unable to establish where or how meals are obtained; person has no realistic plan for obtaining food; person has repeatedly indicated intention to no longer eat or believes food is poisoned; person frequently obtains food from garbage cans or similar sources; person has been losing substantial weight without reasonable explanation; person repeatedly eats items not ordinarily considered fit for human consumption.

2. Clothing - the person repeatedly destroys personal clothing; person regularly fails to wear clothing in keeping with prevailing climatic conditions; clothing repeatedly is grossly torn or dirty; person has no realistic plan for obtaining needed clothing.

3. Shelter - the person is observed to frequently sleep in abandoned buildings, doorways of buildings, near public thoroughfares, in prohibited areas or in other than ordinary shelter; person is repeatedly ejected from living quarters by landlords because of

LANTERMAN DEVELOPMENTAL DISABILITIES SERVICES ACT

The Lanterman Developmental Disabilities Services Act contains the following information regarding the developmental disabled.

The State of California accepts a responsibility for its developmentally disabled citizens and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors, and whole communities, developmental disabilities present social, medical, economic, and legal problems of extreme importance. To the maximum extent feasible, services should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

Persons with developmental disabilities have the same legal rights and responsibilities guaranteed all other individuals by the Federal Constitution and laws and the Constitution and laws of the State of California. No otherwise qualified person by reason of having a developmental disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity, which receives public funds.

It is the intent of the Legislature that persons with developmental disabilities shall have rights including, but not limited to, the following:

a. A right to treatment and habilitation services. Treatment and habilitation services should foster the developmental potential of the person. Such services shall protect the personal liberty of the individual and shall be provided with the least restrictive conditions necessary to achieve the purpose of treatment.

b. A right to dignity, privacy, and humane care.

c. A right to participate in an appropriate program of publicly supported education, regardless of degree of handicap.

d. A right to prompt medical care and treatment.

e. A right to religious freedom and practice.

f. A right to social interaction and participation in community activities.

g. A right to physical exercise and recreational opportunity.

h. A right to be free from harm, including unnecessary physical restraint, or isolation, excessive medication, abuse, or neglect.

i. A right to be free from hazardous procedures.

The State Department of Developmental Services has jurisdiction over the execution of the laws relating to the care, custody, and treatment of developmentally disabled persons, including every hospital, sanitarium, boarding home, or other place receiving or caring for developmentally disabled persons.

The State Department of Developmental Services, one of eleven departments within the Health and Welfare Agency, was founded in 1978 to provide services to Californians with developmental disabilities. DDS administers seven developmental centers (formerly called state hospitals) and contracts with 21 regional centers throughout the state to provide such services in local communities.

The State Department of Developmental Services administers and coordinates programs for approximately 75,000 people with developmental disabilities. Of these, 34% live in out-of-home placement in community-based residential facilities. Licensed health facilities, residential schools, and in semi-independent or independent living arrangement. Twelve percent (12%) reside in state hospitals and the remaining 54% live in their own homes or with their families, with primary programs and services provided through the public schools and day-training programs. The most severely disabled people are served in California's seven developmental centers. Health care and treatment are provided to 7,000 people by a professional staff, including around-the-clock therapists, psychiatric technicians, nurses, and physicians.

REGIONAL CENTERS

In order for the state to carry out many of its responsibilities, the state contracts with appropriate agencies to provide fixed points of contact in the community for persons with developmental disabilities and their families, to the end that such persons may have access to the facilities and services best suited to them throughout their lifetime. It is the intent of this process that a network of regional centers for persons with developmental disabilities and their families be accessible to every family in need of regional center services.

The regional centers in California -- private, nonprofit organizations which contract with DDS -- serve as the point of entry into the State's developmental services system. Each of the 21 centers determines eligibility, makes diagnoses, and develops individual program plans. The regional centers have primary responsibility for coordinating and providing the necessary services.

Any person believed to have a developmental disability, and any person believed to have a high risk of parenting a developmentally disabled infant is eligible for initial intake and assessment services in the regional centers.

WHAT IS A DEVELOPMENTAL DISABILITY?

A developmental disability, as defined by California law, can refer to mental retardation, cerebral palsy, epilepsy, autism or other neurological disorders that require services similar to mental retardation. Developmental disability is not a diagnostic term, but a concept that assumes people can learn and grow at any age, regardless of handicap. Developmental disabilities are further defined as having their origin in the developmental period, that is prior to age 18, being substantially handicapping and expected to continue over the lifetime of the individual.

Mental retardation, cerebral palsy, epilepsy and autism are physical conditions, the origin of which may be genetic, traumatic, or from certain illnesses or unknown causes, and the residual damage is usually irreversible.

Mental Retardation -- As stated in California law, mentally retarded means a condition of significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Classifications of Degrees of Retardation: There are traditionally considered to be 4 levels of mental retardation:

1. Mildly Retarded: The vast majority are classified as mildly retarded. They differ from non-retarded people only in the rate and degree of intellectual development, and usually display no physical disability. Many mildly retarded persons hold regular jobs and are self-supporting, but may need guidance and assistance when faced with unusual social or economic problems. Peace officers are more likely to come in contact with mildly retarded persons, as they are commonly members of the general community.

   Because of their difficulty in finding friends, and their eagerness to be liked and make friends, mildly retarded people generally tend to be followers and to be easily led.

2. Moderately Retarded: Persons who are moderately retarded may be more easily recognizable since many have physical characteristics which accompany the retardation. Moderately retarded persons have greater difficulty in intellectual functioning than the mildly retarded person. The moderately retarded person is usually capable of traveling alone in familiar places, and may live in an independent or semi-independent manner. Most moderately retarded people live in a family or group setting, and many attend sheltered work, or adult community programs. Many persons with Down's Syndrome (formally called "mongolism") can be described as moderately retarded.

3. Severely Retarded and Profoundly Retarded: Severely retarded and profoundly retarded persons are generally not able to use sophisticated abstract reasoning which would demonstrate the

consequences of acts. Severe physical handicaps may accompany these degrees of retardation, including major speech impediments, vision and auditory problems, lack of coordination, orthopedic impairments, etc. The severely retarded and the profoundly retarded are easy targets, and thus may be the victims of deviates. Many tend to watch or play with younger children functioning at their mental level.

Missing person cases are common situations in which a peace officer may encounter a mentally retarded individual. Retarded adults are as likely to become lost as retarded children, but this is not to imply that this is true of all retarded persons. The degree of disability will determine the level of intellectual functioning. Retarded persons can learn their way to many different places; many travel unescorted daily. However, in an unfamiliar location they are sometimes unable to find their way, and may need assistance.

Cerebral Palsy -- A persistent but not unchanging disorder of posture and movement due to a dysfunction of the brain occurring in its developing period. It may be attributable to heredity, physical or biochemical damage in the prenatal or postnatal period, or later physical damage. Persons may have difficulty in muscle control or coordination which may affect speech, hearing, and/or vision.

Cerebral palsy is characterized by an inability to control motor function. Depending on which part of the brain has been damaged and the degree of involvement of the central nervous system, one or more of the following may occur: seizures, spasms, mental retardation, abnormal sensation and perception, disturbance in gait and mobility, and impairment of sight, hearing, or speech. The severity of cerebral palsy may vary from slight to severe, depending on the regions of the brain affected and the amount affected. The problem common to most persons with cerebral palsy is the lack of muscle control affecting both posture and walking to some degree.

Types of Cerebral Palsy: There are three main type of cerebral palsy:

1. The spastic individual moves stiffly and with difficulty.

2. The antetoid has involuntary and uncontrolled movements.

3. The ataxic has a disturbed sense of balance and depth perception.

There may be a mixture of these types for any one individual.

Epilepsy -- Various disorders marked by disturbed electrical rhythms of the central nervous system and sometimes manifested by seizures. A seizure is an unpredictable, involuntary, temporary sudden active disturbance of brain functions.

Types of Epilepsy: The symptoms of epilepsy vary.

1. A grand mal seizure is a convulsion that comes on suddenly. The person will fall to the ground, may not be conscious, may have uncontrolled movements, may be confused and may be extremely fatigued or sleepy after consciousness returns. It is possible to mistake some of the symptoms of epilepsy with drug or alcohol abuse, or with heart attack.

2. A petit mal seizure may simply be unconscious repetition of sound with blinking or vacant staring for a few seconds or minutes. Sometimes mistaken for daydreaming, petit mal seizures are often marked by small twitching movement.

3. Psychomotor seizures are those which are limited to one part of the brain. Usually occurring in the temporal lobe, the seizure takes the form of automatic behavior. Individuals experiencing psychomotor seizures appear to be in a dreamlike state and will not respond to outside stimuli.

Autism -- This condition is manifested by one or more of the following: severe disorders of communication and behavior which begins in early childhood usually prior to age three; inability to communicate or relate to other persons in a normal way; nonresponse to sound and appearing deaf; total lack of interest in nearby persons or objects; and lack of meaningful speech or echoing others' words.

MENTAL DISORDER

Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and relating. They result in substantially diminished capacity for coping with the ordinary demands of life. Mental illnesses can affect persons of any age - children, adolescents, adults, and the elderly - and they can occur in any family. Several million people in this country suffer from a serious, long term mental disorder.

The term "mental disorder" is not defined by the Lanterman-Petris-Short (LPS) law but its practical definition may range from florid psychotic states to situational adjustment reactions of differing types. While common problems of marital strife or responses to loss are not necessarily pathologic states, in some individuals these reactions may escalate to points of involving dangerousness to self or others. For other persons, drug use or abuse may produce bizarre and unpredictable states, or alcoholic intoxication may provide the "fortitude" to proceed with self-destruction by drug overdose or other means.

According to Nancy C. Anderson, M.D. in her book The Broken Brain:

> "Psychiatry now recognizes that the serious mental illnesses are diseases in the same sense that cancer or high blood pressure are diseases. Mental illnesses are diseases that affect the brain....People who suffer from mental illness suffer from a sick or broken brain, not from weak will, laziness, bad character or bad upbringing. The mind and the body are in fact inseparable. When we talk, feel, sleep, or dream each of these mental functions is due to electrical impulses passing through the complicated and highly specialized circuits that make up the human brain. The messages are transmitted and modulated through chemical processes....Mental illnesses are due to disruptions in flow of messages through this circuitry, and these 'breaks'in the brain can occur in many different ways. They are breaks in the biology of the body, breaks that have usually passed beyond a person's capacity to heal himself. The victim of mental illness has not brought it on himself, and he cannot cure it through his own free will."

Below is a list of symptoms that may indicate the presence of the mental illnesses described in this handout:

a. Changes in personality or mood

b. Withdrawn from others; abnormal self-centeredness

c. Confused or delusional thinking: strange or grandiose ideas

d. Persistent depression, apathy or extreme mood swings

e. Excessive anxiety, worries or fears

f. Changes in eating or sleeping patterns

g. Difficulty coping with daily activities

h. Inappropriate emotions

i. Denial of obvious problems

j. Increases use of alcohol; use of drugs

k. Anger or hostility out of proportion to the situation

l. Hallucinations or auditory voices

m. Violent or suicidal thoughts or actions

The commonest clinical condition which underlies the admission to most psychiatric units is that of recurrent or chronic schizophrenia. This major mental disorder, affecting some 1-2% of the population, is evidenced primarily by auditory hallucinations (hearing voices) and delusional thinking, such as having peculiar ideas or beliefs with no basis in reality.

This chronic illness often features illogical or incoherent speech, elements of persecution complexes and deteriorated self-care. Paranoid and angry/agitated patients may be at some risk for violence. Most persons with schizophrenia present no serious risks to themselves or others and they can respond to anti-psychotic medications. Many do not understand the extent of their illness and refuse voluntary treatment, such that episodic involuntary hospitalization is for some a routine part of their care.

Another common major mental disorder is manic-depressive illness, generally seen as a "chemical imbalance" that affects a person's mood, often leading to days or weeks of hyperactivity, elation or anger sometimes combined with grandiose thoughts of fame or fortune. In this manic phase of this illness, patients occasionally escalate in their behaviors to the point that family or friends can no longer tolerate their intensity, anger or demands and then request police assistance.

Depression itself is a common human condition that is extremely painful, occasionally the cause of death by suicide, usually very treatable, and requires short-term hospital care when self-destruction has been threatened, attempted, or is likely. It is typically characterized by hopelessness, helplessness, poor sleep, appetite changes, inability to concentrate, thoughts of death, lack of pleasure in life and crying episodes. The causes of depression may be quite variable, ranging from an obvious significant loss, to the lack of any identifiable stressor. Whatever the cause, many patients require the safety of a hospital for evaluation and treatment. It is not the intent of this material to make diagnosticians out of law enforcement personnel but to provide some indication of common mental

conditions which lead to admission at a psychiatric facility. For purposes of understanding, the mental disorders are divided into two major categories and described as follows:

A. Thought Disorders -- A condition where disruption of thought process is primary, particularly in schizophrenic and delusional disorders.

1. Schizophrenia is a disease that causes disordered thinking and perceptions. It is a thought, rather than a mood, disorder. Schizophrenia is the label given to a group of symptoms and behaviors in which deterioration of functioning is marked by severe distortion of thought, perception, feelings and by bizarre behavior.

Schizophrenia is now thought to be not a single disease, but a group of related illnesses that cause disordered thinking and perceptions. Although it sometimes develops in childhood, 75% of the time schizophrenia develops in young adults aged 16 to 25. Occurrence after age 30 is uncommon and very rare later in life.

Schizophrenia is characterized by deterioration in the ability to work, relate to other people, and take care of oneself. Most people with schizophrenia lose some of their previously developed social or life skills with the onset of the illness. As the illness progresses, the symptoms become more bizarre. The individual develops peculiar behavior, begins talking nonsense, and has unusual perceptions. This is the beginning of psychosis.

Symptoms of schizophrenia are usually classified as positive and negative. Positive or "active" symptoms include: bizarre delusion (perhaps of persecution); hallucinatory voices; incoherent, disconnected thought; irrational fear; poor reasoning; strange and erratic behavior.

Negative or "deficit" symptoms include a lack of motivation, drive, initiative. People experiencing these negative symptoms have toneless voices, expressionless faces. They may speak infrequently, slowly and hesitantly; they may lose a thought in the middle of a sentence. They have great difficulty concentrating and taking pleasure in anything. Many researchers believe the negative symptoms are the most fundamental and, in many cases, are the background against which positive symptoms periodically emerge.

It is likely that an officer may observe agitation of the body in this disorder. Sometimes the agitation is the result of medication the person is taking. Also the agitation can be the buildup of tension, anxiety, or panic, which may be dangerous. Taken alone this physical symptom must be taken in context to properly assess its importance to the officer. Schizophrenics are not typically violent. Most individuals with this disease prefer to withdraw and be left alone.

When frightened, a person with this disorder may act out that fear in a way that not only distances others but controls the environment. That act out can take the form of bizarre or paranoid behavior. This may take many pathways such as an escalation of behavior already exhibited: barking like a dog, or speaking in "word salad," or any sort of behavior that distances others and provides safety for the person. Remember, they are the ones afraid. However most schizophrenics will recognize a police officer's uniform and the authority it represents and by setting the example of maintaining self-control and control of the situation, the officer will find it easy to handle a situation with a schizophrenic involved.

B. Mood Disorders -- Major mood disorders, also called affective disorders, depression, manic depression, unipolar or bipolar disorder, primarily affect an individual's mood. Affective disorders are the most common of psychiatric disorders. They are generally less persistently disabling than schizophrenia. The primary disturbance in these disorders is that of affect or mood. About six percent of the population suffers from an affective disorder -- a major cause of suicide.

They involve periodic disturbances in mood, concentration, sleep, activity, appetite, and social behavior. Unlike schizophrenia, mood disorders tend to be episodic. Between episodes an individual may have no remarkable symptoms or difficulties.

The term "affect" refers to one's mood or "spirits". The term affective disorder refers to changes in mood that occur during an episode or illness marked by extreme sadness (depression) or excitement (mania), or both. Mania is a term used to describe periods of abnormal elation and increased activity, and depression is used to describe an abnormal degree of sadness and melancholy. The same person may have periods of mania and depression. Occasionally, the disease presents a combination of manic and depressive symptoms. These episodes tend to recur or persist throughout life if untreated.

Major depression is the most common of the mood disorders affecting over 10 million Americans according to the National Institute of Mental Health. Although some people have only a single episode of clinical depression in a lifetime, it is more commonly a recurrent disorder. Mood disorders can be life-threatening. While the risk of suicide for the general population is 1 percent, the lifetime risk of suicide for someone with major depression is 18 percent. For someone with manic-depression, the risk rises to 24 percent.

The symptoms of depression are:

a. Persistent sad, anxious, or "empty" mood

b. Feelings of hopelessness, pessimism

c. Feelings of guilt, worthlessness, helplessness

d. Loss of interest or pleasure in ordinary activities, including sex

e. Sleep disturbances, (insomnia, early morning waking, oversleeping)

f. Eating disturbances (changes in appetite and/or weight loss or gain)

g. Decreased energy, fatigue, being "slowed down"

h. Thoughts of death or suicide, suicide attempts

i. Restlessness, irritability

j. Difficulty in concentrating, remembering, making decisions

k. At times, depressive disorders masquerade as persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain.

The symptoms of mania include:

a. Boundless energy, enthusiasm, and need for activity

b. Decreased need for sleep

c. Rapid, loud, disorganized speech

d. Short temper and argumentiveness

e. Impulsive and erratic behavior

f. Possible delusional thinking

g. Rapid switch to severe depression

C. Suicide -- The risk of suicide is a significant factor in depressive states, all depressive states. While it is obvious that people on occasion commit suicide for other reasons, the vast majority of those who complete

the act do so during or in the recovery phase of a depressive episode. Paradoxically, the act often occurs at a point when the individual appears to be emerging for the deepest phase of the depressive attack. The risk of suicide is about one percent during the year in which a depressive episode occurs, and it rises to 15 percent over the lifetime of an individual who has recurrent episodes.

At the present time, suicide ranks among the first ten causes of death in most Western countries. In the United States, estimates show that over 200,000 persons attempt suicide each year and that over 5 million living Americans have made suicide attempts at some time in their lives.

In the United States, the peak age for suicide attempts is between 24 and 44. Most attempts occur in the context of inter-personal discord or other severe life stress. For females, the most commonly used method is drug ingestion, usually barbiturates; males tend to use methods more likely to be lethal, particularly gunshot, which is probably the main reason that successful suicides are higher among men.

Events, circumstances, and mental states found to be related to the onset of depression are also generally linked to suicidal behavior. Studies have disclosed that current stressors, such as depressed and angry feelings, interpersonal crises of various sorts, failure and consequent self-devaluation, inner conflict, and the loss of a sense of meaning and hope all can produce, independently or in combination, a mental state that looks to suicide as a possible way out. Should a person also happen to be drinking excessively at the time, or using drugs with similar effects, the danger of successful suicide is markedly increased.

ASSESSMENT EVALUATION TECHNIQUES

I. Use of Mental Status Evaluation Questions

From the officer's perspective, it is not essential that specific types of mental disorders or developmental disabilities be identified. Rather, the officer must be able to recognize general indicators of mental disorder so that appropriate action can be taken. The attached questionnaire can be used to help in assessing the mental status of individuals exhibiting unusual behavior. Usage may simply assist an officer in making field decisions.

Many times, the mental status of the person and the subsequent police actions will be evident due to the immediate circumstances, such as an attempted or threatened suicide, or the person behaving in a life threatening manner. It may be determined that the questionable behavior is the result of the influence of alcohol and/or drugs and the appropriate action is arrest or medical attention. Other times, there will be a need to question the person in order to decide whether to take the person into custody for a 72-hour mental evaluation, obtain other assistance for the person, refer the person to a specific resource, or release the person with no action whatsoever.

Based upon the answers received, observations of the person's behavior, and statements of other witnesses when available, an officer should be able to better differentiate between persons displaying a developmental disability, mental illness, or mental disorder which places them under the provisions of 5150 of the Welfare and Institutions Code. It is important to remember that the mere existence of a mental disorder or illness does not mean that the person comes within the purview of 5150 W.I.C. The Section 5150 W.I.C. requires that the person be a danger to self or others or be gravely disabled.

The questions are designed to help make that determination. The order in which these questions are asked is subject to the appraisal of the situation, including the cooperative nature of the person, family members, and physical hazards. As in any interview, there will be varying levels of co-operation and honesty. It is up to the officer to establish rapport with the person in order to obtain the best results.

It is the consideration of the totality of the situation, including observations, interview, statements of others, which will enable an officer to make the proper decisions. The information collected by an officer on the scene will be beneficial to obtaining a psychiatric examination for the individual, if needed. The use of an assessment instrument can help an officer present valid evidence of the need for an examination.

II. Questions for complaining party, family members, or witnesses:

1. Has the individual threatened or attempted to use violence, or acted dangerously towards self or others?
2. Has the individual threatened or attempted suicide?
3. Has the individual been neglecting personal care or bodily functions?
4. Has the individual recently suffered a traumatic experience?
5. Does the individual have a history of mental illness?
6. Does the individual take medication or have any physical handicapping condition?

III. Questions for concerned individual:

1. What is your name?
2. Where do you live or sleep?
3. Where are you right now?
4. What date/day/time is it?
5. When did you last eat?
6. When did you last sleep, and for how long?
7. Are you going to hurt yourself?
8. Are you going to hurt someone?
9. Are you supposed to take any medication(s) and are you taking your medication(s)?
10. Do you have a doctor and for what is your treatment?
11. What types of fears do you have and what is causing those fears?
12. What are your plans, what are you going to do now?

The questions should be asked in a manner to elicit more than a simple yes or no answer. The person should be asked in a manner that allows for the individual to explain the problem or situation, and will provide specific information that will assist in evaluating the individual.

CALIFORNIA REGIONAL CENTERS

Alta California Regional Center
2031 Howe Avenue, Suite 100
Sacramento, CA 95825
(916) 924-0400

Central Valley Regional Center
4747 North First Street,
Suite 195
Fresno, CA 93726
(209) 228-3000

Developmental Disabilities Center
Central Tower, Union Bank Square
500 South Main
Orange, CA 92668
(714) 973-1999

Eastern Los Angeles Regional Center
3845 Selig Place
Los Angeles, CA 90031
(213) 224-4700

Far Northern Regional Center
P.O. Box 1848
Redding, CA 96099
2400 Washington Avenue, Suite 301
Redding, CA 96099
(916) 222-4791

Golden Gate Regional Center
120 Howard Street, Third Floor
San Francisco, CA 94105-1848
(415) 546-9222

Harbor Regional Center
P.O. Box 2930
Torrance, CA 90509
Del Amo Business Plaza
21231 Hawthorne Boulevard
Torrance, CA 90509
(213) 540-1711

Inland Regional Center
P.O. Box 6127
San Bernardino, CA 92412-6127
1020 Cooley Drive
Colton, CA 92324
(714) 370-0902

Kern Regional Center
P.O. Box 2536
501 40th Street
Bakersfield, CA 93303
(805) 327-8531

Frank D. Lanterman Regional Center
3440 Wilshire Boulevard,
Suite 400
Los Angeles, CA 90010
(213) 383-1300

North Bay Regional Center
1710 Soscol Avenue, Suite 1
Napa, CA 94559-1387
(707) 252-0444

North Los Angeles Regional Center
14550 Lanark Street
Panorama City, CA 91402
(818) 997-1311

Redwood Coast Regional Center
808 "E" Street
Eureka, CA 95501
(707) 445-0893

Regional Center of the East Bay
2201 Broadway, Fifth Floor
Oakland, CA 94612
(415) 451-7232

San Andreas Regional Center
P.O. Box 50002
San Jose, CA 95150
300 Orchard City Drive,
Suite 170
Campbell, CA 95008
(408) 374-9960

San Diego Regional Center
4355 Ruffin Road, Suite 205
San Diego, CA 92123-1648
(619) 576-2996

San Gabriel/Pomona Regional Center
P.O. Box 2280
West Covina, CA 91793-2280
1521 West Cameron Avenue,
Building A
West Covina, CA 91793
(818) 814-8811

CALIFORNIA REGIONAL CENTERS
(Continued)

South Central Los Angeles Regional Center
2160 West Adams Boulevard
Los Angeles, CA 90018
(213) 734-1884

Tri-Counties Regional Center
222 East Canon Perdido
Santa Barbara, CA 93101
(805) 963-6717

Valley Mountain Regional Center
7210 Murray Drive
Stockton, CA 95210
(209) 473-0951

Westside Regional Center
5901 Valley Circle, Suite 390
Culver City, CA 90230
(213) 337-1155

Types of Behavior Encountered by Police

Category	Frequency	Percentage
Emotional State	78	39.8
Bizarre Behavior	75	38.3
Public Nuisance	72	36.7
Acts Against Self	70	35.7
Psychiatric History	66	33.7
Confused Behavior	55	28.0
Uncooperative	48	24.5
Acts Against Others	42	21.4
Law Violation	28	14.3
Destruction of Property	23	11.7
Omission in Care	10	5.0

Source: D.S. Schag, Predicting Dangerousness - An Analysis of Procedures in a Medical Center and Two Police Agencies. An Arbor, Michigan: University Microfilms, 1977.

Behavioral Elements Attracting Police Attention

Behavioral Element	Frequency	Percentage
1. Prior mental illness.	116	22.3
2. Aggressive behavior against <u>others</u>: overt - actual or attempted.	50	9.6
3. Transportation under warrant or committal papers already signed by a doctor.	38	7.3
4. Bizarre, <u>extremely</u> unusual behavior.	38	7.3
5. Report of hallucinations and/or delusions.	34	6.5
6. Drug or alcohol intoxication - apparent or reported.	32	6.2
7. In an emotional state (hysterical, incoherent, agitated).	31	6.0
8. Unusual <u>active</u> behavior (annoyance, yelling, running around, bothering people, disorderly).	30	5.8
9. Unusual <u>passive</u> behavior (disoriented, disheveled, vagueness, unable to account for self).	27	5.2
10. Aggressive behavior against <u>self</u> - overt - actual or attempted.	26	5.0
11. Aggressive behavior against <u>self</u> - potential - verbal mention only.	25	4.8
12. Destruction or theft of property.	23	4.4
13. Aggressive behavior against <u>others</u> - potential - verbal mention only.	15	2.9
14. Voluntary request for hospitalization or assistance by patient.	15	2.9
15. Other (any residual uncategorizable information).	20	3.8
<u>Totals</u>	520	100.0

Source: Richard G. Fox, Patricia G. Erickson, and Lorne M. Salutin. <u>Apparently Suffering from Mental Disorder</u>. Canada: University of Toronto, Centre of Criminology, 1972, P.93.

Addendum #2

State of California—Health and Welfare Agency

Department of Mental Health

APPLICATION FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT

Confidential Client/Patient Information
See California W & I Code Section 5328

MH 302 (10/81)
(Formerly MH 1533)

ORIGINAL
&
TWO COPIES TO FACILITY
ONE COPY TO MEU

W & I Code, Section 5157, requires that each person when first detained for psychiatric evaluation be given certain specific information orally, and a record be kept of the advisement by the evaluating facility.

☐ Advisement Complete (CHECK ONE) ☐ Advisement Incomplete

Good Cause for Incomplete Advisement
(IF APPLICABLE)

Advisement Completed By: John Doe

Position: Police Officer

Date: 01-01-89

DETAINMENT ADVISEMENT

My name is Officer John Doe

I am a (Peace Officer, etc.) with (Name of Agency).

You are not under criminal arrest, but I am taking you for examination by mental health professionals at (Name of Facility).

You will be told your rights by the mental health staff.

If taken into custody at his or her residence, the person shall also be told the following information in substantially the following form:

You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

To Olive View Hospital

Application is hereby made for the admission of Joseph Q. Public (DOB: 02-16-40)

residing at 123 West Ball Road, Los ANgeles 90012, California, for

72-hour treatment and evaluation pursuant to Section 5150, et seq., of the Welfare and Institutions Code.

* * * * * * * * * * *

The circumstances under which said person's condition was called to my attention are as follows:

How as situation brought to your attention (i.e. Radio Call, Citizen Call etc.)

Description of alleged behaviors or situation

Relevent historical factors (i.e. prior hospitalization, dangerous destructive behaviors etc.)

SEE REVERSE SIDE FOR DEFINITIONS

* * * * * * * * * * *

The following information has been established: (Please state with sufficient detail information to warrant the belief that the person for whom evaluation and treatment is sought is in fact a danger to others, a danger to himself, or gravely disabled.)

Brief description of subject
Observable behaviors or "quotes" of subject's statements
Justification for the 5150 WIC

NOTE: THIS FORM DOES NOT HAVE TO BE FILLED OUT FOR A REJECT OR IF SUBJECT INFO IS PHONED INTO MEU BY OUTLYING DIVISION

Based upon the above information it appears that there is probable cause to believe that said person is, as a result of mental disorder:

☐ A danger to himself. (Appropriate box or boxes) ☐ A danger to others. ☐ Gravely disabled.

Signature and title of peace officer, member of attending staff of evaluation facility or person designated by county.
SIGNATURE AND SERIAL #

Date 01-01-89
Time 1200

Phone: PHONE

Address of Law Enforcement Agency or Facility

ADDRESS :

THIS SECTION USED IF NOTIFICATION SHOULD BE MADE PRIOR TO RELEASE FROM FACILITY PENDING CRIMINAL CHARGES

Certication of Criminal Charges (W & I) Code 5152.1, also 5152.2)

CALL MEU FOR ADVICE ON THIS SECTION

If person is not accepted for admission or is detained for less than 72 hours, notification shall be made pursuant to W & I Code, Section 5152.1.

☑ Notification is requested as person has been referred under circumstances in which criminal charges might be filed.

Signature of Peace Officer

SEE REVERSE SIDE FOR INSTRUCTIONS

Addendum #3

DEFINITIONS

GRAVELY DISABLED

A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter. (Section 5008 (h) WIC)

The term "gravely disabled" does not include mentally retarded persons by reason of being mentally retarded alone. (Section 5008 (h) WIC)

A gravely disabled minor is a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. (Section 5008 (l) WIC)

PEACE OFFICER

"Peace officer" means each of the persons specified in Sections 830.1 and 830.2 of the Penal Code and any peace officer of the Department of Parks and Recreation or any regional park district. Peace officer also means any parole officer or probation officer specified in subdivision (a) of Section 830.5 of the Penal Code when acting in relation to cases for which they have a legally mandated responsibility. (Section 5008 (i) WIC)

INSTRUCTIONS FOR SECTIONS 5152.1 and 5152.2 WIC

Section 5152.1 WIC

The professional person in charge of the facility providing 72-hour evaluation and treatment, or his designee, shall notify the county mental health director or his designee and the peace officer who makes the written application pursuant to Section 5150 if both of the following conditions apply:

(a) The peace officer requests such notification at the time he makes the application and he certifies in writing that the person has been referred to the facility under circumstances in which a criminal charge might be filed.

(b) The person admitted pursuant to such application is not detained by the facility or is detained for a period less than the full period of allowable detention in the 72-hour facility.

Section 5152.2 WIC

Each law enforcement agency within a county shall arrange with the county mental health director a method for giving prompt notification to peace officers pursuant to Section 5152.1.

COUNTY DESIGNATED FACILITIES ROSTER FOR 5150 ACTION

ALAMEDA COUNTY

Herrick Hospital & Health Center
2001 Dwight Way
Berkeley (415) 845-0130

Eden Hospital & Medical Center
20103 Lake Chabot Road
Castro Valley (415) 537-1234

Washington Hospital
2000 Mowry Avenue
Fremont (415) 797-1111

Valley Memorial Hospital
1111 East Stanley Blvd.
Livermore (415) 447-7000

Highland General Hospital*
1411 East 31st Street
Oakland (415) 534-8055

Gladman Hospital
2633 East 27th Street
Oakland (415) 536-8111

Villa Fairmont*
15200 Foothill Blvd.
San Leandro (415) 532-0820

ALPINE AND AMADOR COUNTY

El Dorado PHF*
931 Spring Street
Placerville

BUTTE COUNTY

Butte PHF*
592 Rio Lindo Avenue
Chico

CALAVERAS COUNTY

San Joaquin County*
1212 North California Street
Stockton

El Dorado County*
931 Spring Street
Placerville

COLUSA COUNTY

Woodland Memorial
1325 Cottonwood
Woodland

Yolo General Hospital*
170 West Cottonwood
Woodland

Tehama PHF*
1860 Walnut Street
Red Bluff

CONTRA COSTA COUNTY

Walnut Creek Hospital
175 La Casa Via
Walnut Creek (415) 933-7990

Merrithew Memorial Hospital*
2500 Alhambra Avenue
Martinez (415) 646-4200

East Bay Hospital
1820 - 23rd Street
Richmond

Napa State Hospital*
2100 Napa-Vallejo Highway
Napa

John Muir Medical Center
1601 Ignacio Valley Road
Walnut Creek (415) 939-3000

Kaiser Foundation Hospital*
200 Muir Road
Martinez (415) 372-1370

DEL NORTE COUNTY

No designated facility. Services are on an as needed basis, per contract with the Tehama PHF.

*Indicates public agency

EL DORADO COUNTY

El Dorado PHF*
931 Spring Street
Placerville

FRESNO COUNTY

Valley Medical Center*
445 South Cedar
Fresno

Kingsview Hospital
Reedley

Cedar Vista
7171 North Cedar
Fresno

Fresno Care & Guidance
1715 South Cedar
Fresno

Sierra Gateway Hospital
2025 E. Dakota Avenue
Fresno

Veterans Administration Hospital
2615 E. Clinton Avenue
Fresno

GLENN COUNTY

Butte PHF*
592 Rio Lindo Avenue
Chico

Tehama PHF*
1860 Walnut Street
Red Bluff

Woodland Memorial Hospital*
1325 Cottonwood
Woodland

HUMBOLDT COUNTY

Humboldt PHF*
720 Wood Street
Eureka

IMPERIAL COUNTY

Harbor View Hospital
120 Elm Street
San Diego

San Luis Rey Hospital
1015 Devonshire Drive
Encinitas

INYO COUNTY

Northern Inyo Hospital
150 Pioneer Lane
Bishop

KERN COUNTY

Kern Medical Center*
1830 Flower Street
Bakersfield

Kernview Hospital
3600 San Dimas Street
Bakersfield

KINGS COUNTY

Fresno Community Hospital
Fresno & R Streets
Fresno

Kingsview Hospital
42675 Road 44
Reedley

Kingsburg Hospital
1200 Smith Street
Kingsburg

LAKE COUNTY

Mendocino PHF*
860-A North Bush Street
Ukiah

St. Helena Hospital
Deer Park

Napa State Hospital*
2100 Napa-Vallejo Highway
Napa

*Indicates public agency

LASSEN COUNTY

No designated facility. Services are on an as needed basis, per contract with the Tehama PHF.

LOS ANGELES COUNTY

Alhambra Hospital
4619 N. Rosemead
Rosemead

Alondra Crest Hospital
9246 E. Alondra Blvd.
Bellflower

Antelope Valley Medical Center
Mental Health Unit
1600 West Avenue J
Lancaster

Brotman Medical Center
Mental Health Unit
3828 Delmas Terrace
Culver City

Cedar-Sinai Medical Center
Thalians CMHC
8730 Alden Drive
Los Angeles

Century City Hospital
2070 Century Park East
Los Angeles

Charter Hospital of Long Beach
6060 Paramount Blvd.
Long Beach

Charter Oak Hospital
1161 E. Covina Blvd.
Covina

Coldwater Canyon Hospital
6421 Coldwater Canyon
North Hollywood

College Hospital
10802 College Place
Cerritos

Crisis Evaluation Unit*
Metropolitan State Hospital
11400 Norwalk Blvd.
Norwalk

Crossroads Hospital
6323 Woodman Avenue
Van Nuys

Del Amo Hospital
23700 Camino Del Sol
Torrance

Dominguez Medical Center
(New Horizons)
171 West Bort Street
Long Beach

Edgemont Hospital
4841 Hollywood Blvd.
Los Angeles

Forensic Inpatient Program*
441 Bauchet Street
Los Angeles

Gateways Hospital
1891 Effie Street
Los Angeles

Glendale Adventist Medical Center
Mental Health Unit
1509 Wilson Terrace
Glendale

Harbor-UCLA Medical Center*
1000 W. Carson Street
Torrance

Hawkins CMHC*
1720 E. 120th Street
Los Angeles

Hawkins Psychiatric Emergency
Services (PES)*
1720 E. 120th Street
Los Angeles

Horizon Hospital
566 N. Gordon Street
Ponoma

*Indicates public agency

LOS ANGELES COUNTY (Cont)

Ingleside Hospital
7500 W. Heilman Avenue
Rosemead

Inter-Community Medical Center
(Parkside-West)
330 N. Third Street
Covina

Kaiser Mental Health Center
765 College Street
Los Angeles

Kedren CMHC
4211 S. Avalon Blvd.
Los Angeles

Kennedy, R.F. Medical Center
4500 West 116th Street
Hawthorne

La Casa
11400 Norwalk
Norwalk

La Paz Gero-Psych Center
8835 Vans Avenue
Paramount

LAC/USC Medical Center*
Psychiatric Hospital
1934 Hospital Place
Los Angeles

Las Encinas Hospital
2900 E. Del Mar Blvd.
Pasadena

Long Beach Community
1720 Termino Avenue
Long Beach

Los Altos Hospital & Medical Center
3340 Los Coyotes Diag.
Long Beach

Memorial Medical Center
(Memorial Coastview)
455 Columbia Avenue
Long Beach

Methodist Hospital of
Southern California
300 W. Huntington Drive
Arcadia

Northridge Hospital
(Pavilion East)
19300 Roscoe Blvd.
Northridge

Olive View Medical Center*
14445 Olive View Drive
Cottage 3
Sylmar

Pasadena Community Hospital
1845 N. Fair Oaks Avenue
Pasadena

Pen Mar Therapeutic Center
3938 Cogswell Road
El Monte

Presbyterian Intercommunity
12401 E. Washington Blvd.
Whittier

San Fernando Community Hospital
Psych Institute
700 Chatsworth Drive
San Fernando

San Pedro Peninsula Hospital
1300 W. 7th Street
San Pedro

St. John's Hospital
1311 - 22nd Street
Santa Monica

Therapeutic Residential Center*
3825 N. Durfee Road
El Monte

Torrance Memorial Hospital
3330 Lomita Blvd.
Torrance

Treatment Centers of America
9540 Van Nuys Blvd.
Panorama City

*Indicates public agency

LOS ANGELES COUNTY (Cont)

UCLA Neuropsychiatric Hospital
(UCLA-NPH)
760 Westwood Plaza
Los Angeles

Valley Hospital Medical Center
14500 Sherman Circle
Van Nuys

Van Nuys Hospital
15220 Vanowen Street
Van Nuys

Veterans Administration*
Medical Center-Brentwood
11301 Wilshire Blvd.
Los Angeles

Veterans Administration*
Medical Center-Sepulveda
16111 Plummer Street
Sepulveda

Westwood Hospital
2112 W. Barrington
Los Angeles

Woodview-Calabasas Hospital
25100 Calabasas Road
Calabasas

MADERA COUNTY

Fresno Community Hospital
Fresno & R Streets
Fresno

Sierra Gateway
650 W. Alluvial
Fresno

Kingsview Hospital
42675 Road 44
Reedley

Kingsburg Hospital
1200 Smith Street
Kingsburg

*Indicates public agency

MARIN COUNTY

Crisis Unit*
250 Bon Air Road
Greenbrae (415) 499-6819

Marin General Hospital*
Unit A
250 Bon Air Road
Greenbrae (415) 925-7000

Ross Psychiatric Hospital
1111 Sir Francis Drake Blvd.
Kentfield

MARIPOSA COUNTY

Fresno Community Hospital
Fresno & R Streets
Fresno

MENDOCINO COUNTY

Mendocino PHF*
860-A North Bush Street
Ukiah

MERCED COUNTY

BRITE*
1275 B Street
Merced

Fresno Community Hospital
Fresno & R Streets
Fresno

Crossroads Psychiatric
Health Center
1905 Memorial Drive
Ceres

MODOC COUNTY

No designated facility. Services are on an as needed basis, per contract with the Tehama PHF.

MONO COUNTY

Designation of Northern Inyo Hospital pending. See Inyo county.

MONTEREY COUNTY

Natividad Medical Center*
1370 Natividad Road
Salinas

Community Hospital of
Monterey Peninsula
PO Box HH
Monterey (415) 624-5311

St. Helena Hospital
Deer Park

Napa State Hospital*
2100 Napa-Vallejo Highway
Napa

Veteran's Home & Hospital*
Ward 1A
Yountville

NEVADA COUNTY

Placer PHF*
11512 B Avenue
DeWitt Center
Auburn

ORANGE COUNTY

Anaheim Therapeutic
Residential Center
501 S. Beach Blvd.
Anaheim

Brea Hospital
Neuropsychiatric Center
875 N. Brea Blvd.
Brea

Capistrano by the Sea Hospital
Care Unit
33915 Del Obispo
Dana Point

Care Unit Hospital of Orange
401 S. Tustin
Orange

Guidance Center Sanitarium
1135 N. Leisure Court
Anaheim

Evaluation Treatment Services
1030 W. Warner
Santa Ana

Hoag Memorial Hospital
Presbyterian
301 Newport Blvd. (Box Y)
Newport Beach

Humana Hospital-Huntington Beach
17772 Beach Blvd.
Huntington Beach

La Habra Community Hospital
Mental health Unit
1251 W. Lambert Road
La Habra

Los Alamitos Medical Center
3751 Katella Avenue
Los Alamitos

Newport Harbor Psychiatric
Institute
1501 E. 16th Street
Newport Beach

Orange County Mental Health*
Jail Team
550 N. flower
Santa Ana

Royale Therapeutic Residential
Center
1030 W. Warner
Santa Ana

CPC Santa Ana Psychiatric Hospital
2212 E. Fourth Street
Santa Ana

South Coast Medical Center
Stress Unit
31872 South Coast Highway
South Laguna

*Indicates public agency

ORANGE COUNTY (Cont)

St. Joseph Hospital-Rush Center
1100 W. Stewart Drive
Orange

UCI Medical Center*
Psychiatry Department
101 City Drive South
Orange

Western Medical Center-Orange
1205 S. Anaheim Blvd.
Anaheim

PLACER COUNTY

START-Placer County Psychiatric
Health Facility*
11512 B Avenue
DeWitt Center
Auburn

PLUMAS COUNTY

No designated facility. Services are on an as needed basis, per contract with the Tehama PHF.

RIVERSIDE COUNTY

Riverside General Hospital*
9851 Magnolia Avenue
Riverside

Charter Grove Hospital
2005 Kellogg Avenue
Corona

Loma Linda University Medical Center
11234 Anderson Street
Loma Linda

Hemet Valley Hospital
1116 East Latham Street
Hemet

Desert Hospital
1150 North Indian Avenue
Palm Springs

SACRAMENTO COUNTY

Fair Oaks Hospital
11228 Fair Oaks Blvd.
Fair Oaks

Sutter Center for Psychiatry*
7700 Folsom Blvd.
Sacramento

Sacramento PHF*
2150 Stockton Blvd.
Sacramento

UC Davis Medical Center*
2215 Stockton Blvd.
Sacramento

CPC-Sierra Vista
8001 Bruceville Road
Sacramento

CPC-Heritage Oaks
4250 Auburn Blvd.
Sacramento

Sacramento County Jail*
620 H Street
Sacramento

SAN BENITO COUNTY

Dominican Mental Health Unit
1555 Soquel Drive
Santa Cruz (408) 462-7700

SAN BERNARDINO COUNTY

Jerry L. Pettis Memorial
VA Hospital*
12001 Benton Street
Loma Linda

Loma Linda University
Medical Center
11234 Anderson Street
Loma Linda

San Antonio Community Hospital
999 San Bernardino Road
Upland

*Indicates public agency

SAN BERNARDINO COUNTY (Cont)

San Bernardino County Mental Health Inpatient*
700 East Gilbert Street
San Bernardino

CPC-Horizon Hospital
566 N. Gordon Street
Ponoma

SAN DIEGO COUNTY

Alvarado Parkway Institute
6655 Alvarado Road
San Diego

Grossmont Hospital*
5555 Grossmont Center Drive
La Mesa

Harbor View Hospital
120 Elm Street
San Diego

Mercy Hospital
4011 - 5th Avenue
San Diego

Mesa Vista Hospital
7850 Vista Hill Avenue
San Diego

Palomar Memorial Hospital*
550 East Grand Avenue
Escondido

Paradise Valley Hospital
2400 East Fourth Avenue
National City

Rancho Park Hospital
109 East Chase Avenue
El Cajon

San Luis Rey Hospital
1015 Devonshire Drive
Encinitas

Southwood Mental Health Center
950 - 3rd Avenue
Chula Vista

Tri-City Hospital*
4002 Vista Way
Oceanside

UCSD Medical Center*
225 Dickinson Street
San Diego

Veterans Administration Hospital*
3350 La Jolla Village Drive
San Diego

Vista Hill Hospital
730 Medical Center Court
Chula Vista

Villa View Community Hospital
5550 University Avenue
San Diego

Hillcrest Mental Health Facility*
345 Dickinson Street
San Diego

Loma Portal Mental Health Facility*
3485 Kenyon Street
San Diego

Psychiatric Security Unit*
County Jail
222 West C Street
San Diego

SAN FRANCISCO COUNTY

Mt. Zion Hospital
1600 Divisadero
San Francisco (415) 567-9600

Pacific Presbyterian Medical Ctr
2333 Buchanan
San Francisco (415) 923-3435

St. Francis Hospital
900 Hyde
San Francisco (415) 775-4321

San Francisco General Hospital*
1001 Potrero Avenue
San Francisco

*Indicates public agency

SAN FRANCISCO COUNTY (Cont)

Langley Porter Hospital*
401 Parnassus Avenue
San Francisco

St. Luke's Hospital
3555 Army Street
San Francisco

St Mary's Hospital
450 Stanton Street
San Francisco

Seaton Medical Center
1900 Sullivan Avenue
Daly City

French Hospital
NO LONGER A 5150 FACILITY

SAN JOAQUIN COUNTY

San Joaquin County Psychiatric
Health Facility*
1212 N. California Street
Stockton

St. Joseph's Parkside Hospital*
2510 N. California Street
Stockton

SAN LUIS OBISPO COUNTY

San Luis Obispo County
Mental Health Facility*
2180 Johnson Avenue
San Luis Obispo

SAN MATEO COUNTY

Belmont Hills
1301 Ralston Avenue
Belmont (415) 593-2143

H.D. Chope Hospital*
222 W. 39th Avenue
San Mateo (415) 573-2222

Menlo Park VA Hospital
3801 Miranda Avenue
Palo Alto (415) 493-5000

*Indicates public agency

Mills Peninsula*
1783 El Camino Real
Burlingame (415) 696-5400

Sequoia Hospital*
Whipple & Alameda
Redwood City (415) 369-5811

Seaton Medical Center
1900 Sullivan Avenue
Daly City

SANTA BARBARA COUNTY

Psychiatric Health Facility*
315 Camino Del Remedio
Santa Barbara

SANTA CLARA COUNTY

Santa Clara Valley Medical Center*
751 South B Street
San Jose

Good Samaritan Hospital*
2425 Samaritan Drive
San Jose (408) 559-2011

El Camino Hospital*
2500 Grant Road
Mountain View (415) 940-7000

San Jose Medical Center
675 East Santa Clara Street
San Jose (408) 998-3212

Stanford Palo Alto Hospital
Stanford University Hospital
Stanford (415) 723-4000

Monte Villa Hospital
17925 Hale Avenue
Morgan Hill (408) 226-3020

Napa State Hospital*
2100 Napa-Vallejo Highway
Napa

VA Hospital
3801 Miranda Avenue
Palo Alto (415) 593-2143

SANTA CLARA COUNTY (Cont)

Kingsview Hospital
42675 Road 44
Reedley

Santa Clara County Main Jail
180 West Hedding
San Jose

SANTA CRUZ COUNTY

Dominican Mental Health Unit
1555 Soquel Drive
Santa Cruz (408) 462-7700

SHASTA COUNTY

Shasta PHF*
2430 Hospital Lane
Redding

SIERRA COUNTY

START-Placer County Psychiatric
Health Facility*
11512 B Avenue
DeWitt Center
Auburn

SISKIYOU COUNTY

Siskiyou General Hospital
818 South Main
Yreka

Mercy Medical Center
914 Pine Street
Mt. Shasta

SOLANO COUNTY

St. Helena Hospital
Deer Park

Marin General Hospital*
Unit A
250 Bon Air Road
Greenbrae (415) 925-7000

East Bay Hospital
1820 - 23rd Street
Richmond

Woodland Memorial Hospital*
1325 Cottonwood
Woodland

Herrick Hospital & Health Center
2001 Dwight Way
Berkeley (415) 845-0130

Oakcrest*
3322 Chanate Road
Santa Rosa

First Hospital of Vallejo
525 Oregon Street
Vallejo

Gladman Hospital
2633 East 27th Street
Oakland (415) 536-8111

Napa State Hospital*
2100 Napa-Vallejo Highway
Napa

VA Hospital-Palo Alto*
3801 Miranda Avenue
Palo Alto (415) 593-2143

Crestwood-Vallejo
2201 Tuolumne
Vallejo

CPC-Sierra Vista
8001 Bruceville Road
Sacramento

SONOMA COUNTY

Napa State Hospital*
2100 Napa-Vallejo Highway
Napa

Oakcrest*
3322 Chanate Road
Santa Rosa

*Indicates public agency

SONOMA COUNTY (Cont)

First Hospital of Vallejo
525 Oregon Street
Vallejo

Ross General Hospital
1150 Sir Francis Drake Blvd.
Ross

STANISLAUS COUNTY

Stanislaus County MHS*
800 Scenic Drive
Modesto

Crossroads Psychiatric
Health Center
1905 Memorial Drive
Ceres

Modesto Psychiatric Center
1501 Claus Road
Modesto

Sutter/Yuba PHF*
1965 Live Oak Highway
Yuba City

TEHAMA COUNTY

Tehama PHF*
1860 Walnut Street
Red Bluff

TRI-CITY

See Los Angeles County

TRINITY COUNTY

No designated facility. Services are on an as needed basis, per contract with the Tehama PHF.

TULARE COUNTY

Kingsview Hospital
42675 Road 44
Reedley

Kingsburg Hospital
1200 Smith Street
Kingsburg

TUOLUMNE COUNTY

BRITE*
1275 B Street
Merced

Crossroads Psychiatric
Health Center
1905 Memorial Drive
Ceres

VENTURA COUNTY

Ventura County Medical Center
Psychiatric Inpatient Unit
300 N. Hillmont Avenue
Ventura

CPC Vista Del Mar Hospital
801 Seneca Street
Ventura

Jail Infirmary*
County of Ventura
800 S. Victoria Avenue
Ventura

YOLO COUNTY

Woodland Memorial
1325 Cottonwood
Woodland

Yolo General Hospital*
170 West Cottonwood
Woodland

*Indicates public agency

CALIFORNIA REGIONAL CENTERS

REGIONAL CENTER	DIRECTOR	COUNTIES SERVED
ALTA CALIFORNIA REGIONAL CENTER 2031 Howe Avenue, Suite 100 Sacramento, CA 95825	**RALPH D. LEVY** Director (916) 924-0400	Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, Yuba
CENTRAL VALLEY REGIONAL CENTER 5168 North Blythe Fresno, CA 93722	**DAVID RIESTER** Director (209) 276-4300	Fresno, Kings, Madera, Mariposa, Merced, Tulare
DEVELOPMENTAL DISABILITIES CENTER Central Tower, Union Bank Square 500 South Main Street Orange, CA 92668-4579	**ELAINE E. BAMBERG** Director (714) 973-1999	Orange
FAR NORTHERN REGIONAL CENTER 1900 Churn Creek Road, Suite 319 * P.O. Box 492418 (96049-2418) Redding, CA 96002	**ROBERT J. BALDO** Director (916) 222-4791	Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, Trinity
GOLDEN GATE REGIONAL CENTER 120 Howard Street, Third Floor San Francisco, CA 94105-1848	**J. F. GAILLARD** Director (415) 546-9222	Marin, San Francisco, San Mateo
INLAND REGIONAL CENTER 1020 Cooley Drive Colton, CA 92324 * P.O. Box 6127 San Bernardino, CA 92412-6127	**VERLIN WOOLLEY** Director (714) 370-0902	Inyo, Mono, Riverside, San Bernardino
KERN REGIONAL CENTER 501 40th Street * P.O. Box 2536 (93303) Bakersfield, CA 93301	**MICHAL C. CLARK, Ph.D.** Director (805) 327-8531	Kern
NORTH BAY REGIONAL CENTER 1710 Soscol Avenue, Suite 1 Napa, CA 94559-1387	**GARY NAKAO, Ph.D.** Director (707) 252-0444	Napa, Solano, Sonoma
REDWOOD COAST REGIONAL CENTER 808 E Street Eureka, CA 95501	**DAVID A. ISOM** Director (707) 445-0893	Del Norte, Humboldt, Mendocino, Lake
REGIONAL CENTER OF THE EAST BAY 2201 Broadway, Fifth Floor Oakland, CA 94612-3402	**KATHRYN M. FENNELL** Director (415) 451-7232	Alameda, Contra Costa
SAN ANDREAS REGIONAL CENTER 300 Orchard City Drive, Suite 170 Campbell, CA 95008 * P.O. Box 50002 San Jose, CA 95150-0002	**G. DAVID PEACH** Director (408) 374-9960	Monterey, San Benito, Santa Clara, Santa Cruz
SAN DIEGO REGIONAL CENTER 4355 Ruffin Road, Suite 205 San Diego, CA 92123-1648	**RAYMOND M. PETERSON, M.D.** Director (619) 576-2996	Imperial, San Diego

REGIONAL CENTER	DIRECTOR	COUNTIES SERVED
TRI-COUNTIES REGIONAL CENTER 5464 Carpinteria Avenue, Ste. B Carpinteria, CA 93013	**ALLEN G. EVANS** Director (805) 684-1204	San Luis Obispo, Santa Barbara, Ventura
VALLEY MOUNTAIN REGIONAL CENTER 7210 Murray Drive * P.O. Box 692290 (95269-2290) Stockton, CA 95210	**RICHARD JACOBS** Director (209) 473-0951	Amador, Calaveras, San Joaquin, Stanislaus, Tuolumne

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REGIONAL CENTER	DIRECTOR	HEALTH DISTRICTS SERVED
EASTERN LOS ANGELES REG. CENTER 3845 Selig Place * P.O. Box 31909 Los Angeles, CA 90031-0909	**HERMAN FOGATA** Director (213) 224-4700	Alhambra, East Los Angeles, Northeast, Whittier
FRANK D. LANTERMAN REGIONAL CENTER 3440 Wilshire Boulevard, Suite 400 Los Angeles, CA 90010	**DIANE CAMPBELL ANAND, M.P.H.** Director (213) 383-1300	Central, Glendale, Hollywood-Wilshire, Pasadena
HARBOR REGIONAL CENTER Del Amo Business Plaza 21231 Hawthorne Boulevard * P.O. Box 2930 (90509) Torrance, CA 90503	**MS. PAT DEL MONICO** Director (213) 540-1711	Bellflower, Harbor, Long Beach, Torrance
NORTH L.A. COUNTY REGIONAL CENTER 8353 Sepulveda Boulevard Sepulveda, CA 91343	**WILLIAM C. DONOVAN, Ph.D.** Director (818) 891-0920	East Valley, San Fernando, West Valley
SAN GABRIEL/POMONA REGIONAL CENTER 1521 West Cameron Avenue, Bldg. A * P.O. Box 2280 West Covina, CA 91793-2280	**JUDITH POINDEXTER** Director (818) 814-8811	El Monte, Monrovia, Pomona, Glendora
SOUTH CENTRAL L.A. REGIONAL CENTER 2160 West Adams Boulevard Los Angeles, CA 90018	**DEXTER A. HENDERSON** Director (213) 734-1884	Compton, San Antonio, South, Southeast, Southwest
WESTSIDE REGIONAL CENTER 5901 Green Valley Circle, Suite 320 Culver City, CA 90230-6902	**MICHAEL DANNEKER** Director (213) 337-1155	Inglewood, Santa Monica-West

DEPARTMENT OF DEVELOPMENTAL SERVICES Community Services Division 1600 Ninth Street, Room 322 * P.O. Box 944202 (94244-2020) Sacramento, CA 95814	**KENNETH H. NELSEN** Deputy Director (916) 323-4828	

* Mailing Address

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Reference Materials

This section is set up as reference information for use by training institutions. These materials can be utilized for prime instruction; remediation, additional reading, viewing or for planning local units of instruction. They are presented here as instructional materials that may assist the learner or the academy staff in the teaching-learning process. Each training institution is encouraged to expand this list but only after careful viewing and reading to determine its acceptability.

"Dangerous Behavior: A Problem in Law and Mental Health" by Calvin J. Frederick. U.S. Government Printing Office: 1978.

Texts:

"The Broken Brain: The Biological Revolution in Psychiatry" by Nancy Anderson; Harper & Row: 1984.

"Nowhere To Go" by E. Fuller Torrey; Harper & Row: 1988.

"Overcoming Depression" by D. and Janice Papolos; Harper & Row: 1987.

"Surviving Schizophrenia: A Family Manual" by E. Fuller Torrey; Harper & Row: 1988.

"Mental Illness: Law and Public Policy" by Barush A. Brody and H. Tristram Englehardt, Jr., ed.s., D. Reidel Publishing Co.: 1986.

Journals:

Mental Disability Law Reporter
Biological Sciences and the Law

Pamphlets:

"Developmental Disabilities," - A Training Handbook for Law Enforcement Officers, written by the Committee for the Developmentally Disabled Alleged Offender, under the auspices of the Los Angeles County Regional Centers.

"Families Know About Coping With Serious Mental Illness," California Department of Mental Health.

In no way is this list an endorsement of any author, publisher, producer, or presentation. Each training institution must read or view these materials, and others to establish their own list of reference materials.

Films/Video Tapes:

"Mental Illness: New Directions" by California Department of Mental Health.

"Developmentally Disabled" by LAPD, 16 minute video tape.

"Interacting with the Disabled" by Newport Beach Police Department, video tape.

"Police Interaction with People Who Have Disabilities" by San Diego Police Department, 30 minute video tape.

Articles/Bulletins:

"Civil Liberties and Mental Illness," by Bruce J. Ennis. Criminal Law Bulletin, March 1971.

"Managing the Potentially Violent Patient: A Protocol for Training EMTs and Paramedics," by Terence T. Gorski and Michael E. Carbine. Emergency Medical Services, September/October 1981.

"Dealing With the Mentally Ill." Police Product News, September 1983.

"Thousands Released; Few Treatment Facilities," by Walter Truett Anderson. California Journal, June 1984.

"State Leaders Face the Treatment Problem," by Bruce Bronzan. California Journal, June 1984.

"Controlling Violent Patients," by Joseph A. Infantino, Jr. Emergency Medical Services, September/October 1984.

"Dealing With The Mentally Disturbed," by Barbara J. Price. Police Product News, November 1984.

"How Police Deal With Mentally Unbalanced--Very Carefully," by Brian Hamlin. Reporter, March 10, 1985.