BASIC COURSE INSTRUCTOR UNIT GUIDE

37

PERSONS WITH DISABILITIES

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THE COMMISSION
ON PEACE OFFICER STANDARDS AND TRAINING

STATE OF CALIFORNIA

The curricula contained in this document is designed as a *guideline* for the delivery of performance-based law enforcement training. It is part of the POST Basic Course guidelines system developed by California law enforcement trainers and criminal justice educators in cooperation with the California Commission on Peace Officer Standards and Training.

UNIT GUIDE

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COMMUNICATING WITH DEAF OR HEARING IMPAIRED PERSONS

Given a word picture depicting a person who may be deaf or hearing impaired (see list of cues), the student will identify an appropriate response (see list of appropriate responses for communicating with deaf or hearing impaired persons).

A. The following cues signal that a person may be deaf or hearing impaired:
   1. Signing
   2. Speaking with difficulty
   3. Reaching for a pad and pencil
   4. Pointing to the ear and then the lips
   5. Pointing to the ear and shaking the head negatively
   6. Failing to answer questions or failing to obey instructions
   7. Using prosthetic devices such as hearing aids or artificial speech synthesizers
   8. Attempting to gain attention by touching, foot stomping, hand waving, or other body movements

B. The following responses are appropriate for communicating with the deaf or hearing impaired persons:
   1. Use the sign for driver license (palms out, tips of thumbs touching, index fingers extended upward) to request identification
   2. Make a "C" with your right hand over your heart to identify yourself as an officer if you are not in uniform
   3. Use a pad and pencil to ask questions and receive answers (use common words and simple sentences)
   4. Give Miranda warnings and interrogate only with the assistance of a qualified sign language interpreter
   5. Arrange for the use of a TTY or TDD device if an arrested person cannot use a standard telephone due to a hearing impairment. (Note: A TTY or TDD device allows deaf persons to transmit typewritten messages over standard telephone lines.)

Performance Objective 5.7.1

CURRICULUM

A. Recognition

1. Deafness--Hearing impairment significantly affects communication skills. The inability to hear normally results in varying degrees of speech and language deficits. This may include reading and writing difficulties.

   a. Approximately 15% of the population of the United States is deaf or hearing impaired which causes communication problems.

   b. In California, approximately 2.5 million persons are deaf or hearing impaired.

c. It affects all levels of society regardless of age, race, education level or occupation.

d. Hearing impairments may cause speech defects for some, and for others none at all.

e. American sign language is not universal because each country has its own sign language.

2. Terms

a. "Deaf and dumb" and "deaf mute" do not properly describe this impairment and are considered offensive.

b. Acceptable terms - "deaf," and/or "hearing impaired."

3. Police Contacts With deaf persons

a. The ability to rapidly identify and give proper treatment to persons with hearing disabilities will enhance officers' abilities to accomplish their field duties in a professional manner.

b. Routine traffic stops--most frequent contact with deaf persons

c. Other contacts--victims, witnesses, suspects, or traffic accidents

d. A person who does not answer or obey your instructions may not be refusing to cooperate; they may not have heard you.

e. Deaf person's fears about being misunderstood by the police:

(1) May be mistakenly arrested or shot

(2) May be mistaken for a person who is drunk or under the influence of drugs

(3) May be mistaken for being uncooperative or disrespectful

(4) Anxiety because of deaf person's inability to communicate

(5) Concern that officer will be impatient

4. Indicators

a. Person is signing

b. Pointing to the ear and shaking the head negatively

c. Use of the common sign for deaf

d. Reaching for a pad and pencil.

NOTE: When a person indicates by gesture that he/she is deaf, offer that person a paper and pencil. This precludes the person from reaching for an unseen object and it shows understanding, thus easing fears.

e. Use of prosthetic devices (hearing aid or artificial speech device) may be located in a pocket, under clothing, in a purse, or behind the ear. Other materials the person may reach for could include pencil and paper, an identification card, or a medic-alert tag to identify their communication handicap. Any movements for such a device may be misinterpreted.

f. Attempts to gain attention, through exaggerated body movements and touching, i.e., tapping on the officer's shoulder, foot stomping, waving, and clapping hands

B. Approach

1. Deaf persons should receive the same courtesy and consideration as those with normal hearing. (BE PATIENT)

2. Traffic stops with the deaf may be more difficult and time consuming.

3. The success of the contact is often determined by the officer's conduct during the first moments of the encounter.

4. A traffic stop should be made in a position that allows the driver to see the lights.

5. Learn the commonly accepted sign which indicates "drivers license" to deaf people and use when requesting identification. Using this sign will place deaf persons at ease, because they know the officer recognize their impairment.

6. One common sign that is recognized throughout the United States to identify an officer in plain -clothes to a deaf person is to make a "C" with the right hand over where the badge is normally worn when in uniform.

C. Communication

1. Deaf and hearing impaired people communicate in different ways. Some use only speech; others will use a combination of speech, sign language, and finger spelling. Many write and use body language or facial expressions to supplement their statements. In any case, a deaf person will use every possible way to convey an

idea to another person. In communicating with a deaf person, remember that intelligence, personality, age at the onset of deafness, language background, listening skills, lip reading, writing, reading, and speech abilities vary with each person.

2. The most commonly used form of communication with the deaf is through writing. Due to the fact many hearing impaired cannot hear words, they may have poor reading and writing skills. It is important that simple and concise language be used to inform them of the reason for being stopped, questioned, detained, or arrested.

3. When issuing a traffic citation to a hearing impaired person make every effort to fully and clearly explain the violation and the obligation of the driver in resolving the citation.

4. The best means of communication with the deaf is through a skilled sign language interpreter. It is recommended that a qualified/certified interpreter be obtained in more serious circumstances such as an interrogation or advising of "Miranda" warnings.

5. General communicating tips

   a. It is important to have the deaf person's attention before speaking. Since deaf people cannot hear usual calls for attention, they may need a tap on the shoulder or other visual signals to gain their attention.

   b. Try to maintain eye contact with the deaf person. This helps convey the feeling of direct communication.

   c. Look directly at the person when speaking. Even a slight turning of the head can impair ability to lip read. It is a myth that all deaf people can lip read. Only a few can lip read. Even the most skilled lip reader can only understand a minimal amount of spoken language.

   d. Speak slowly and clearly. Don't shout. Avoid exaggeration and overemphasis of words. This distorts your lip movements and makes lip reading more difficult.

   e. Pantomime, body language, and facial expressions are important factors in communications. Be sure to use all of them.

   f. Try to rephrase a thought rather than repeat the same words. Keep sentences short.

   g. Be aware that bright spotlights or insufficient light can be a barrier to communications.

h. Don't be embarrassed about communication via pencil and paper.

i. Most deaf people have in their home or business a device known as a TTY/TDD system.
This enables them to transmit typewritten messages over the telephone which are received at locations with similar equipment.

D. Safety

1. Deaf and hearing impaired people are no less dangerous because of their impairment. Do not jeopardize your safety by forming an overly sympathetic attitude toward them.

2. If you are unable to obtain information necessary to complete your investigation, take the deaf person to where he/she can be questioned through an interpreter.

3. Conduct investigations with an open mind, being alert for any eventuality.

4. If the situation warrants, do not be reluctant to place the person in handcuffs.

E. Legal

1. Deaf and hearing impaired people have the same rights as any other persons to make telephone calls. Therefore, if they cannot make the calls, officers should assist them by providing access to TTY or TDD device or by notifying parties of the arrestee's desire to communicate with them.

2. The arrestee's right to privileged communications with family and attorney cannot be denied because of deafness or hearing impairment.

3. Miranda Rights

a. It is an officer's responsibility when interrogating arrested deaf people to make certain that they understand their "Miranda" rights. If you have doubt about their understanding the "Miranda" rights, obtain a certified interpreter.

b. Several court cases involving deaf people charged with criminal offenses were reversed when it was shown that they did not, or could not, understand the admonition of rights as read to them.

4. Interpreters

a. Interrogation of a deaf suspect performed through an interpreter is most likely to be reliable.

b. Officers should understand the difference between a person who signs and an interpreter. Interpreters have completed formal training and are certified.

5. Deaf persons have a right to be accompanied by a Signal Dog (Hearing Ear). (Civil Code Section 54.2)

COMMUNICATING WITH BLIND OR VISUALLY IMPAIRED PERSONS

Given a word picture depicting a person who may be blind or visually impaired (see list of cues), the student will identify an appropriate response (see list of appropriate responses) for communicating with blind or visually impaired persons.

A. The following cues signal that a person may be blind or visually impaired:
   1. Using seeing eye dog and/or cane (all white or metallic color - with or without red tip, collapsible or noncollapsible)
   2. Jerky motion of the eyes
   3. Milky coloration of the eyes
   4. Person appears to be tracking the sound of someone's voice or is unable to maintain eye contact
   5. Rocking motion of body
   6. Unusual head motion or position of head
   7. Getting unusually close to printed material or objects
   8. Using bioptic lens and/or thick clear lenses or sunglasses
   9. Holding onto arm of sighted guide

   (NOTE: Eighty percent of the "blind" population have partial vision and may not be identifiable using these cues.)

B. The following responses are appropriate for communicating with blind or visually impaired persons:
   1. Identify yourself by saying "I'm a police officer. My badge number is __. Are you blind ?"
   2. Allow the blind person to feel your badge or handcuffs if he/she seeks confirmation of your identity
   3. Help a blind person cross an intersection by introducing yourself and asking if he/she needs assistance
   4. When guiding a blind person, let that person hold your elbow or shoulder so that he/she can more easily follow your body movements
   5. Walk normally when guiding a blind person; don't pull or push the person along
   6. Talk directly to the blind person in a normal manner (they are blind, not deaf)

Performance Objective 5.7.2

CURRICULUM

A. Introduction

   1. Blind persons are perhaps the most patronized members of society.

      a. The historical misconception of blind persons is that they are inferior and helpless.

      b. Because they cannot see, people often make false assumptions (e.g., they are not intelligent, unable to care for themselves or not creditable witnesses to accidents or crimes)

      c. The real handicaps of blindness are:

a. mobility (independence and confidence are direct results of mobility), and

b. negative public attitude toward the blind.

2. A peace officer's responsibility is to treat all citizens with equal consideration under the law.

B. Characteristics

1. Cues that signal a person may be blind or visually impaired

a. Using a seeing eye dog and/or cane (all white or metallic color - with or without red tip, collapsible or noncollapsible)

(1) Guide dog

(a) A visually impaired person using a guide dog is **usually** totally blind.

(b) Used by approximately one percent of the visually impaired population, and of that one percent, 70 percent of guide dog users are totally blind.

(2) Long cane

(a) Most commonly used mobility tool

(b) Mobility training is required to acquaint the visually impaired person with capabilities of the long cane

b. Jerky motion of the eyes

c. Milky coloration of the eyes

d. Person appears to be tracking the sound of someone's voice or is unable to maintain eye contact

e. Rocking motion of body

f. Unusual head motion or position of head

g. Getting unusually close to printed material or objects

h. Using bioptic lens and/or thick clear lenses or sunglasses

i. Holding onto arm of sighted guide

2. Not all blind persons are **totally** blind.

a. 80% have some remaining vision.

b. The degree to which vision impairment may affect mobility depends on the person.

c. The peace officer should ask the blind person about the extent of their visual impairment.

3. Age is a significant contributing factor to the incidence of blindness, unlike most disabilities.

a. 60 percent of the blind are over 65.

b. A person who has become visually impaired late in life may not be trained to deal with their handicap.

C. Appropriate responses for communicating with blind and visually impaired persons

1. Identify yourself by saying "I'm a police officer. My badge number is__. Are you blind?"

2. Allow the blind person to feel your badge or handcuffs if they seek confirmation of your identify.

NOTE: Blind persons who assisted in the development of this curriculum unanimously agreed that mentioning a badge number would be a way for them to sense that the person approaching them is indeed a police officer and that further reassurance could be provided by feeling the badge or handcuffs.

3. When guiding a blind person, let them hold your hand or elbow rather than taking that person's hand or elbow; in so doing, the blind person is able to feel your body movements more readily.

4. When guiding a blind person, walk normally; don't pull them along

5. Talk directly to the person, not through an intermediary. Speak clearly in a normal voice. Do not raise your voice or rush through sentences. Blind persons are frequently spoken to in extremely loud voices; they are probably not deaf.

6. Don't avoid words such as "look" "see" and "read".

7. Blind persons are interested in detailed descriptions so try to describe visual scenes vividly.

8. End your conversation in such a manner that the blind person knows you are leaving.

9. When getting into a car, indicate whether the car is four-door or two-door. When you reach the car, open the door. Place one of his/her hands on top of the roof and the other on the door, thus

allowing the person to sit by his/her own efforts. When closing the door for a blind passenger, make sure that they are sitting far enough away from the door so that when you close it, it will not bump them in any way.

10. If helping with money, identify each type of money. Blind persons usually have their own system of identification once they are told what the bills are.

D. General public contacts/witnesses

1. Blind persons cannot read or fill out police forms and other printed documents. They will need your assistance.

2. Sight is an important means of identifying people, the environment, and objects. Still, visually impaired persons can compensate for not seeing. They can rely on hearing, touch and other senses to relate to their surroundings.

3. Blind people are likely to remember voices that they have heard before. If a voice is especially outstanding, it will leave an auditory imprint. Voices and sounds can be analyzed and used for the following purposes:

   a. Identification

   b. Direction

   c. Distance

   d. Size and structure

   e. Localization (using sound reflection and echo location)

LAWS PROTECTING PERSONS WITH DISABILITIES

Given a direct question, the student will identify the following provisions of law which apply to the deaf and hearing impaired and the blind and visually impaired.

A. Vehicle Code Section 21963 entitles total or partially blind pedestrians carrying white canes or using a guide dog to the right-of-way
B. Civil Code Section 54.1 ("White Cane Law") entitles total or partially blind persons and deaf persons to full and equal access to public streets and byways, buildings, facilities, modes of transportation, lodging, amusement and other places to which the public is invited
C. Civil Code Section 54.2 ("White Cane Law") entitles total or partially blind persons and deaf or hearing impaired persons to be accompanied by a guide dog, signal dog, or service dog in any of the places specified in Section 54.1
D. Civil Code Section 54.4 ("White Cane Law") entitles total or partially blind persons to the same rights and privileges conferred by law upon other persons in any of the places, accommodations, or conveyances specified in Sections 54 and 54.1 with or without white cane or guide dog
E. Penal Code Section 365.5 provides that physically disabled persons who are passengers on public conveyances have a right to have specially trained guide, signal, or service dogs, and to be admitted to places of public accommodation. Guide dogs are not permitted in zoos. Anyone who prevents a physically disabled person from exercising these rights is guilty of an infraction

Performance Objective 5.7.3

CURRICULUM

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public accommodation. Dog guides are not permitted in zoos. Anyone who prevents a physically disabled person from exercising these rights is guilty of an infraction.

F. Lanterman Development Disabilities Services Act

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:

   a. Mental retardation

   b. Cerebral palsy

   c. Epilepsy

   d. Autism

   e. Other related handicapping conditions

REQUIREMENTS FOR DETENTION UNDER 5150 WIC

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. 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

Performance Objective 8.36.2

CURRICULUM

A. Lanterman-Petris-Short Act (LPS)

1. Established in 1968, reformed commitment laws pertaining to mental health treatment.

   a. California Welfare and Institutions Code Section 5150 sets out civil procedures for mental evaluation/treatment.

   b. Establishes procedures and locations for placing a person into an approved mental health facility

2. Intended to balance rights of the community with rights of person to freedom and due process.

   a. Important to note that civil commitment or emergency involuntary detention constitutes a serious deprivation of personal liberty

3. Permits, under specific conditions, the 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 the person , as a result of a mental disorder, is a

      (1) danger to others, or;

      (2) danger to self, or;

      (3) gravely disabled.

A combination of one or more of the above constitutes a condition warranting treatment and evaluation.

b. Requires an application in writing stating the circumstances and probable cause conditions

UNUSUAL BEHAVIOR OR APPEARANCE

Given a description of a person exhibiting unusual behavior or appearance, the student will identify whether the behavior is most likely to be related to mental illness, a developmental disability or a neurologic disorder. (3-1-94)

A. Mental illnesses
   1. Thought disorders (the behaviors may include hallucinations, delusions, disorganized speech patterns, impaired self-care, bizarre behavior, disorientation)
   2. Mood disorder (the behaviors may include impaired self-care, depression and thoughts of death and suicide, anxiety, excitability, impulsive, erratic actions)

B. Developmental disabilities
   1. Autism (the behaviors may include interpersonal communication difficulties, inability to relate well with people, nonresponsiveness to sounds, lack of interest in nearby persons, fixation on objects, lack of meaningful speech, echoing another person's words, self-endangering actions, purposeless repetitive movements)
   2. Mental retardation (the behaviors may include actions which are notage propriate, child-like behavior, difficulty understanding complex instructions)
   3. Cerebral palsy (the behaviors may include a loss of motor/muscle control, somewhat spasmodic but repetitive movements, slurred speech, but usually no impairment of mental ability)
   4. Epilepsy (the behaviors may include obvious or subtle seizures followed by disorientation, confusion, lethargy, slurred speech and staggering which collectively resemble intoxication or substance abuse)

C. Neurologic disorders
   1. Alzheimer's Disease (the behaviors usually include confusion and loss of memory - the disease usually affects persons over 40 but more commonly over 60)
   2. Traumatic or acquired brain injury (These include stroke as well as accidental injuries. Behaviors may resemble developmental disabilities or substance abuse)

Performance Objective 8.36.6

CURRICULUM

A. The term "mental disorder" includes mental disorders of either organic or nonorganic origin.

   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.

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. Other neurologic conditions - brain injury or disease, and certain medical conditions, may resemble thought or mood disorders. Examples include Alzheimer, AIDS dementia, and stroke.

C. 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:

1. Delusions - persistent false beliefs. Examples include:

   a. The false belief that the person is being persecuted, attacked, harassed, cheated, or conspired against

   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.

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. Makes up new words

e. 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

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 state 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.

9. Disorientation - not always aware of time, place or identity of self or others

D. 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 three

b. Inability to communicate or relate to other persons in a normal way

c. Nonresponsive to sound and appear deaf

d. Total lack of interest in nearby persons or objects

e. Lack of meaningful speech or echoing others' words

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 - full seizure, usually prone, spasmodic movements, loss of consciousness, loss of bowel and bladder control

b. Psychomotor - usually starts in part of persons body, doesn't usually appear to be a seizure initially, person may throw items and destroy things, often ends in a complete seizure

c. Petit Mal - brief lapses of attention, difficult to detect. Less of a concern to peace officer

NOTE: Refer to topical references in this unit guide.

4. Cerebral Palsy - a disorder of posture and movement due to a dysfunction of a portion of the brain. Persons may have difficulty in muscle control or coordination which may affect speech, hearing, and/or vision.

E. 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.

F. Neurological disorders

1. Alzheimer's Disease - characterized by confusion, loss of memory, disorientation, primarily in an aging population. Often found wandering away from place of residence

2. Strokes - sometimes slurred speech, loss of physical movement - result of oxygen deprivation to part of the brain

3. Brain injury - result of accidental injury to the brain - may be highly irritable or impulsive

4. AIDS dementia - confused, loss of expression, disorientation - person may appear physically ill

RIGHTS OF PERSON DETAILED UNDER 5150 WIC

Given a description of a detention under Section 5150 of the Welfare and Institutions Code, the student will identify if the detaining officer(s) followed the appropriate procedures to safeguard the rights of the person detained.

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 Reasonable precaution must be made to safeguard personal property in the possession of or on the premises occupied by the person
C. The person must be informed of the officer's name and agency, and the reason the person is being detained
D. 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

Performance Objective 8.36.9

CURRICULUM

A. Safeguard of legal rights

1. Mentally disordered individuals are entitled to the basic federal and state constitutional rights.

2. Lanterman-Petris-Short Act (LPS) 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.

a. The person must be informed of the officer's name and agency, and the reason the person is being detained

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

B. Documentation of probable cause to detain and circumstances of incident

1. LPS Act requires application in writing on a standard form.

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

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.

NOTE: Officer must be able to articulate specific facts which, taken together with rational inferences from these facts, reasonably warrant belief or suspicion. (Triplett Case)

C. Safeguard of personal property

1. Section 5156 of the Welfare and Institutions Code requires person taking an individual into custody to

a. take reasonable precaution to preserve and safeguard personal property in possession of or on premises occupied by person, and;

NOTE: Possessions of homeless, mentally ill persons must be safeguarded.

b. provide the court with a report describing property so preserved and its disposition.

D. Mental health facilities and regional centers

1. Professional in charge of mental health facility must evaluate and may release individual from custody.

2. Each county may designate facilities as 72-hour evaluation and treatment centers if such facilities meet the requirements established by Department of Mental Health.

3. State Department of Developmental Services administers seven developmental centers and contracts with 21 regional centers throughout the state to provide services locally.

ALTERNATIVE METHODS OF EVALUATION AND TREATMENT

Given a word picture depicting behavior which does NOT qualify for involuntary detention under Section 5150 of the Welfare and Institutions Code, the student will identify appropriate alternative response for handling the situation. These responses are:

A. Urgent medical attention
B. Arrest
C. Referral for mental health services
D. Referral to local developmental disabilities agency
E. No arrest action required
F. Appropriate social resource referral

Performance Objective 8.36.10

CURRICULUM

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.

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

1. Individuals and families who may be in need of treatment can be referred to available mental health services.

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.

3. Availability of service of Regional Centers - time, service levels, etc. - varies throughout the state.

E. No arrest 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. (i.e., such as appropriate social service referrals)

RISK FACTORS OF POSTPARTUM PSYCHOSIS

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. Severe depression
E. Confusion
F. Hallucinations
G. Delusions
H. Violent or bizarre behavior (directed toward child or self)
I. Fearful thoughts concerning child's safety
J. Physical appearance and behavior appear to be normal (moods may rapidly change)

Performance Objective 8.36.11

CURRICULUM

A. Three patterns of behavior associated with postpartum women

NOTE: The physiological/psychological root causes of postpartum behaviors are uncertain. Postpartum reactions are a process rather than a specific event. Many women will experience some form of normal depression after giving birth. In rare instances, the reactions may progress to a more severe depression or into a postpartum psychosis.

1. Maternity (baby) blues:

   a. For women to go through the "baby" blues is normal

   b. It occurs in 50-80% of new mothers.

   c. Symptoms usually appear about three days after a woman gives birth and involve brief, self-limited episodes of sadness, weeping, anxiety, headache, sleep disorders, or irritability

2. Postpartum depression (Postnatal Depression):

   a. May be mildly to severely despondent

   b. May experience mood swings, feelings of guilt

   c. May experience sleep disturbances and occasional hostility

d. Occurs in about 10% of new mothers developing two weeks to four months after delivery

3. Postpartum psychosis

a. Occurs to one in every 1,000 mothers

b. Women who seem to be functioning normally or feeling only mildly depressed may exhibit episodes of paranoia, confusion, incoherence, hyperactivity, agitation, hallucinations, delusions

c. May experience nightmares and insomnia

d. May make irrational statements or have thoughts of harming themselves or their infants

e. May experience feelings of inadequacy and believe they are inept mothers and are morally failing their child

d. May kill themselves or their infants

NOTE: Instructor may wish to have a nurse or another person associated with a maternity ward make a presentation to class.

ACTION TO ASSIST SUFFERER OF POSTPARTUM PSYCHOSIS

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

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

Performance Objective 8.36.12

CURRICULUM

A. 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.

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.

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.

B. 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.

C. 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.

SCENARIOS

HANDLING PERSONS MENTALLY ILL

Given a scenario, the student will safely and properly handle a person simulating mental illness.

Performance Objective 8.36.5

CURRICULUM

SUPPORTING MATERIAL

AND

REFERENCES

This section is set up as reference information for use by training institutions. These materials can be used for instruction, remediation, additional reading, viewing, or for planning local blocks of instruction. This list is not an endorsement of any author, publisher, producer, or presentation. Each training institution should establish its own list of reference materials.

TOPICAL LIST OF SUPPORTING MATERIALS AND REFERENCES INCLUDED IN THIS SECTION

Lanterman-Petris-Short Act

Lanterman Developmental Disabilities Services Act

What is a Developmental Disability?

Mental Disorder

Assessment Evaluation Techniques

California Regional Centers

Types of Behavior Encountered by Police

Behavioral Elements Attracting Police Attention

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 v. 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 behavioral problems; person has no realistic plan for obtaining shelter due to present mental state and does not appear to be able to care for self.

It should be noted that the danger within these statutes must be specific and imminent and that mentally ill individuals cannot be treated involuntarily because of vague, ambiguous and unspecific or potentially dangerous behavior.

All such examples must be shown to be the result of a mental disorder and not merely the result of a lifestyle or attitude choice, including chronic alcoholism.

In the assessment of a person in the field, it is important to make accurate observations, to document what was said and/or done, to determine if the person makes sense and to evaluate the incident for the degree of seriousness. In reflecting on these, it may be helpful to consider factors which may connect the behavior and thinking to emotional problems, such as a known psychiatric history, recent drug use, information from family or bystanders, personal observations, etc.

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; non-response 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

CALIFORNIA REGIONAL CENTERS
(Continued)

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

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.

Addendum #1

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.

Apparently Suffering from Mental Disorder. Canada: University of Toronto, Centre of Criminology, 1972, P.93.

Addendum #2

ADDITIONAL REFERENCE MATERIALS

"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.

Films/Video Tapes:

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

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

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

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

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