CRISIS MANAGEMENT

A Training Guide for Law Enforcement Officers

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TABLE OF CONTENTS

INTRODUCTION

As a law enforcement officer, the nature of your job means that you will deal with many people who, for one reason or another, are in a state of crisis. The term *crisis* means a situation—real or perceived—that significantly reduces a person's ability to cope. Part of your job is to recognize when people are in crisis and to do what you can to effectively manage the situation.

Your goals in managing crisis situations are to:

- try to ensure safety for yourself, other officers, subjects, and other citizens
- establish and maintain control
- resolve the situation positively
- when appropriate, help arrange follow-up care for people undergoing crises

Accomplishing these goals requires both *knowledge* and *skills*. The key areas *of knowledge* that you will learn about in this course include:

- categories of emotionally-disturbed persons (EDP's)
- reasons for crisis incidents and basic indicators of crises
- types of serious mental illness, and indicators that a person may have a mental illness
- indicators that a person may be under the influence of alcohol or another drug
- indicators that a person may have a developmental disability
- indicators that a person may have Alzheimer's Disease or another dementia disorder
- provisions of Wisconsin law regarding people in crisis situations.

The key crisis management *skills* you will learn about include:

- pre-intervention preparation
- basic crisis-response techniques
- crisis intervention tactics and techniques
- articulation (oral and written) of situations and actions taken
- initiating emergency detentions and emergency protective placements

THE CONTEXT OF CRISIS MANAGEMENT

CRISIS MANAGEMENT AND PROFESSIONAL COMMUNICATION

Crisis management skills are closely related to the communication skills that you learned about in Professional Communication. In that course, in addition to communication skills applicable in many contexts, you learned guidelines and techniques for effectively communicating with subjects on the street, including crisis intervention skills.

The section of Professional Communication that deals with crisis intervention contains the basic guidelines and techniques that are a key focus of crisis management. This course, while re-emphasizing those guidelines and techniques, addresses crisis intervention and management in more depth. What you will learn here is a continuation and expansion of what you have learned previously.

EMOTIONALLY DISTURBED PERSONS: AN OVERVIEW

In Professional Communication, you learned the term *emotionally-disturbed person*, or *EDP*. People who are emotionally disturbed do not think clearly and rationally, making it difficult to use reasoning and logic to gain compliance from them.

EDP's fall into three basic categories:

- Long-Term EDP's
- Short-Term EDP's
- Chemical Abusers

Long-Term EDP's include people who are chronically mentally ill, meaning that they have a mental disorder all the time. This does not mean that the symptoms of their illness are the same at all times, or that the illness is problematic to the same degree at all times—only that it is a long-term disorder that can be treated but not cured.

Short-Term EDPs include people who are going through an acute mental or emotional crisis, or who are simply very upset for some reason. Such people may normally be rational, but they have been pushed to the limits of their coping abilities by events or circumstances. Generally, the crisis period only lasts for a relatively short time.

Chemical Abusers include people who abuse alcohol or other drugs, or both. This category includes chronic abusers as well as those who are temporarily under the influence of alcohol or another drug, but who are not necessarily long-term substance abusers. This category also includes people who are withdrawing from alcohol or other drugs.

In short, a person can be "emotionally disturbed"—going through a crisis period—for any of a number of reasons. When you are dealing with an EDP, of course, you may not know what caused the crisis and you may not know which category the person falls into. For example, when you respond to a call about a person creating a disturbance, you probably wouldn't know whether the person is mentally ill, under the influence of alcohol, or is just upset about some life situation. Fortunately, you don't need to know the reason for a crisis in order to respond to it effectively. Your job is to intervene in and manage the crisis situation as best you can, not to diagnose a person's problem or to provide therapy. While in some cases it might be helpful or useful for you to know the reason behind the crisis, you will apply the same basic crisis management skills.

Yet even though you do not *have* to know the reason that a person is in crisis, it is very much to your advantage to have a basic understanding of some of the more common conditions that can cause a crisis. Such knowledge is helpful for several reasons:

- It may help you better understand the reasons for a person's behavior

- It may help you determine *specific* actions to take in response to the person, in addition to the *general* crisis intervention techniques that you will learn in this course. For example, if you are dealing with a person whom you know to be mentally ill and who is "manic," you can apply guidelines specific to dealing with a manic individual

- It may help you better determine appropriate follow-up care for a person, such as taking an intoxicated person to a detoxification facility or initiating an emergency detention of a person with a serious mental illness

This course includes detailed information about several of the more common conditions that can cause people to be in crisis. These include

- Mental disorders, including serious and persistent mental illnesses (depression, bipolar disorder, schizophrenia, and anxiety disorders) as well as personality disorders
- Alcohol and/or drug abuse
- Developmental disabilities
- Alzheimer's disease or other dementia disorders

Remember, it is not your job to diagnose or treat any of these conditions. However, you need to be familiar with them so that you can respond effectively to people who have one or more of them. Over time, you will encounter all of these conditions—sometimes in combination.

CRISIS SITUATIONS: AN OVERVIEW

Crisis situations (usually short-term situations) are often related to events in a person's life. Some examples include:

- *Situational crisis*, such as an injury, accident, a sudden illness, a natural disaster, a fire, a vehicle breakdown, a serious traffic violation

- *Normal life changes perceived as a crisis*, such as graduation, pregnancy, a new job, marriage, moving in with someone, or recovering from an illness

- *A loss or deprivation or some kind*, such as the breakup of a relationship, separation or divorce, death of a loved one, loss of employment, a serious financial setback, a health crisis, or lost opportunities

These factors may be what triggers a crisis, but it is a person's *perception* about the situation and his or her *coping ability to deal with the situation* that determines how any particular person will react. Faced with the same fact situation, different people may react very differently. Whereas one person might get upset, angry, or depressed, or even become out-of-control, another person in the same situation might not even experience the event as a significant problem. The way in which someone reacts to a problematic situation very much depends on such factors as the individual's genetic makeup, upbringing, past experience, personality, and learned coping strategies.

Also, a person may experience a crisis in reaction to a *series* of things that happen, rather than a single event. A person may be able to cope well enough with a single troubling event or situation, but may not be able to cope as well when several troubling things happen within a relatively short time. For example, if a man has a fight with his wife he may be upset for a while, but it is not necessarily a significant crisis for him. But if has to deal with a sick child and a problem with his boss at work, and then has a fight with his wife, the combination of these three circumstances may be so disturbing to him that he experiences an emotional crisis.

Another important factor in crisis situations is the effect of alcohol and drugs. A person who is under the influence of such substances is generally less capable of coping with real-life difficult situations, and usually reacts to such situations in an inappropriate way. People who are under the influence of alcohol and/or drugs are people in crisis.

In responding to people in crisis, never assume that a person ought or ought not to feel as he or she does in a given situation. A person may be in a state of crisis for a reason that does not seem significant to you, and which might not cause you to be upset if you were in that situation. However, crisis is a matter of *perception*, and the

other person's perception—not yours—is what matters. A seemingly minor matter or issue may be very significant to a person. A good example is a minor fender-bender accident. As a law enforcement officer, you may respond to several such crashes each shift. They become routine and trivial to you. But for the person whose car just got hit, such an accident is anything but routine.

People who are undergoing a crisis do not always act the same way. Sometimes a person in crisis is visibly upset or even out-of-control. In other cases, a person may not display obvious behaviors that indicate he or she is in a state of crisis. In general, however, the following behaviors suggest that a person is undergoing a crisis—and that he or she should be considered an EDP:

- Appears very upset or angry
- Is crying
- Seems very confused and/or disoriented
- Is withdrawn; is not interacting with or responding to other people
- Acts depressed
- Seems to be out-of-touch with reality

Some people who display such indicators are people undergoing an *acute* crisis episode—that is, a distinct, short-term crisis situation that is usually related to a specific cause. Others may have ongoing crisis episodes and normally be in a continuing, or *chronic*, crisis state. People who undergo chronic crisis situations are usually candidates for a mental health system response rather than a criminal justice system response. To respond effectively to such people, you must know and be able to access the mental health resources available in your community.

THE CRISIS CYCLE

A crisis situation does not last forever. It is time-limited. When a person is experiencing a crisis, he or she generally goes through what is often referred to as a *crisis cycle*. This refers to a typical progression of stages of a crisis. The *crisis cycle* includes the following stages:

1. **Normal state**

   There is no crisis yet. The person's emotional state and mental abilities are at normal levels.

2. **Stimulation**

   Something happens to cause the person to become excited, upset, active or physically uncomfortable. The cause can be *external* (something someone said or did, or an environmental factor such as heat, cold, or crowded conditions) or *internal* (physical illness or injury, pain, emotional reaction, or mental illness).

3. **Escalation**

   The person shows obvious signs of distress, including observable physical changes and changes in behavior. Some examples of these include

   - Reddening of the face
   - Tensing of muscles (clenched jaw, clenched fists)
   - Talking more or louder
   - Sometimes becoming quieter or more withdrawn
   - Increased activity, such as pacing or rocking

4. **Crisis State**

   The person becomes temporarily out-of-control. He or she may scream, yell or curse, or may wave arms or stamp feet. In the crisis state, a person may become assaultive.

5. **De-escalation**

   In this phase, there is a gradual decrease in the crisis behaviors. The person remains tense, but is more in control. If provoked, however, the person can go back into crisis.

6. **Stabilization (return to normalcy)**

   During stabilization, the person is back to normal behavior and is once again under control.

7. **Post-Crisis Drain, or Depletion**

   Following the crisis, the person may drop below their normal level of stimulation. This drop is more likely if the crisis phase was prolonged and/or physical. Typically a person in this stage is quiet, tired and/or withdrawn, and may express regret about his or her actions, including by crying.

Everyone goes through some sort of cycle when upset, and that cycle may include these phases. Cycles vary in length, intensity and in how different people react. Not everyone, for example, goes all the way up to the *crisis state*.

You may come into a person's crisis cycle at any phase. Depending on where the person is in the cycle, his or her ability to understand what you are saying and to respond appropriately will vary greatly. For example, when a person is in a normal state, he or she may be very focused and able to understand you. But when he or she is in the *escalation phase*, understanding and comprehension are much

diminished. And when a person is in a full *crisis state* phase, the ability to listen and comprehend and focus may be as little as 5% of normal.

For this reason, you may have to vary your crisis intervention strategies and techniques depending on your assessment of the crisis cycle phase that a person is in. Such strategies and techniques are discussed in the section of this text entitled *Crisis Intervention Techniques.*

TACTICAL CONSIDERATIONS/OFFICER SAFETY ISSUES

Remember that two of your goals in managing crisis situations are:

- To try to ensure safety for yourself, other officers, subjects, and other citizens
- To establish and maintain control

To accomplish these goals, you must apply the concepts and skills learned during Defense and Arrest Tactics (DAAT) training. This is important, because when you are dealing with *any* EDP, you are dealing with someone who is potentially dangerous, at least for a short period of time. The person may be angry, upset, even out-of-control, and may not be thinking clearly or rationally. Some EDP's may have a mental disorder. Certainly, most people with mental illness are not violent or dangerous, but some are—particularly when they are under the influence of alcohol or drugs.

Specifically, remember and follow the two basic concepts that are the basis of the DAAT system:

- Incident Response
- Disturbance Resolution

Incident Response

Incident Response sets forth a seven-step "road map" or framework for handling a variety of situations to which law enforcement officers respond. Based on the acronym **RESPOND**, this model appears on the following page. In addition, each of the seven steps under **RESPOND** is described in the DAAT text.

INCIDENT RESPONSE

(Approved by the DAAT Committee January 16, 2002)

R ***Report***

Become aware
Plan response
Arrive / Assess
Alarm / Inform

E ***Evaluate***

Look for dangers
Determine backup needs
Enter when appropriate / tactically sound

S ***Stabilize***

Subject(s)
Scene

P ***Preserve***

Life
- Conduct an initial medical assessment (as trained)
- Treat to level of training
- Continue to monitor the subject(s)

Evidence

O ***Organize***

Coordinate additional responding units (if necessary)
Communicate with dispatch and others
Organize the collection of evidence (if appropriate)

N ***Normalize***

Provide long-term monitoring (as appropriate)
Restore scene to normal
Return radio communications to normal

D ***Document / Debrief***

Debrief self, other responding personnel, subject(s), and other persons
Document incident appropriately

Disturbance Resolution

Disturbance Resolution is a model for proper response to any sort of disturbance or potential emergency. This model consists of three phases:

1. **Approach Considerations**

   This sets forth your initial approach to a disturbance. In this stage, you will decide whether or not to make contact, decide how to deploy your resources, and evaluate the threat level. The fact that you are dealing with a subject who is an EDP is certainly a significant factor in your threat assessment, because an EDP can be unpredictable.

2. **Intervention Options**

   This phase describes the specific trained force intervention options, if you decide to intervene. It lists the trained modes and tactics, and their purposes.

3. **Follow-Through Considerations**

   The third part of Disturbance Resolution describes the actions an officer should take following use of force. It includes the steps taken to ensure proper care, custody and control of a subject or subjects. The six steps included are:

   - Stabilize
   - Monitor/Debrief
   - Search
   - Escort
   - Transport
   - Turnover/Release

Each of the steps in Disturbance Resolution is described in detail in the DAAT text.

When dealing with an EDP, conducting a good threat assessment is very important. Before rushing into a situation, take time, if possible, to look it over and try to determine what is really going on with the subject(s). Ask questions and listen carefully and non-judgmentally, so that you have a better chance of accurately assessing what is happening. This is very important: whenever you have the time to do so, *listen* to people's concerns and try to identify the person's problem, or perceived problem, as best you can. Do not get focused on finding solutions; just listen and see if you can learn what is going on for that person.

In doing so, remember that a crisis situation is always a matter of *perception*. It is not the apparent facts of a situation that causes a person to feel that he or she is in crisis, but instead, the person's perception of the situation and what it means to him or her. Something that may not seem meaningful or significant to you or another observer may be central to the person undergoing the crisis. Never assume that because something seems meaningless or insignificant to you, it is also meaningless or insignificant to a subject. Something that seems trivial to you may be the triggering even that put the person into a serious emotional or mental crisis, making the person an EDP.

EDP's are potentially dangerous. Even if the subject is someone you have dealt with in the past, the fact that he or she is in crisis can radically change the equation. Always assume that an EDP may be dangerous, and make your threat assessment accordingly. Remember the key indicators for threat potential that you learned in DAAT. In particular, watch out for *early warning signs* and *pre-attack postures.*

Early warning signs include when a subject:

- Conspicuously ignores you
- Gives you excessive emotional attention
- Moves in an exaggerated way
- Ceases all movement
- Has a known violent history

Specific pre-attack postures include:

- Boxer stance
- Hand set/clenched fists
- Shoulder shift
- Target glance
- The "thousand-yard" stare

With people in crisis, including those who are mentally ill, you may not see any indicators of escalating tension before an attack.

Also, remember the *presumed compliance* concept that you learned in Professional Communication and in DAAT. This is the belief that a subject will comply with your verbal directions just because you are a law enforcement officer giving such directions. Even if a subject that you know has complied in the past when so directed, do not assume that he or she will comply the next time you have contact. Presumed compliance is a form of complacency that puts officers at risk. Remember this concept when dealing with any subject, and especially when dealing with a person in crisis. When you are dealing with an EDP, you potentially wear a number of hats: medical first responder, therapist, and so on. But you are always a law enforcement officer first, and officer safety and the safety of others are always critical. This means *always* staying alert, and *never* becoming complacent.

It is easy to become complacent in your threat assessment when dealing with a subject who seems to be a low risk, or low threat. For example, you may respond to a situation involving an elderly man or woman, who although upset about something does not physically seem like much of a threat. Yet that person may suddenly lash out at you or another person, and show great strength. To presume that any person in crisis—no matter how frail or how disturbed—is not a potential threat is to set yourself up for trouble.

Remember too, that a key DAAT concept is that an officer always has the option to disengage and/or escalate, in order to take proper police action so as to achieve and maintain control. This is an important element of officer safety as well. You always have the option of disengaging from a situation, temporarily or permanently (if appropriate), and to escalate to a higher mode or tactic under "Intervention Options," based upon your assessment of the threat in a particular situation.

The third part of Disturbance Resolution is "Follow-Through Considerations." These are the steps you take once control has been achieved in order to try to ensure proper custody and care of subjects. Your actions during this phase are important when dealing with any subject, and are critical when dealing with an EDP. In this phase, you talk to the subject, try to calm him or her and provide for medical needs. The way in which you act with subjects during this phase will affect the subject's attitude and feelings toward you and other officers, both now and in the future. Careful attention to follow-through may save another officer from a fight or injury the next time the subject has contact with law enforcement—and EDP's often have multiple contacts with police.

An important step under "Follow-Through Considerations" is *stabilize*. As you learned in DAAT, this often involves applying restraints, generally handcuffs. With some people in crisis, including some EDP's, being handcuffed can be a frightening experience and can make their crisis worse. Some agencies allow officers discretion in deciding what kind of restraints to use and even whether to restrain a person at all. For example, a policy may direct or allow an officer to use soft restraints rather than handcuffs and/or leg shackles with certain categories of people. Know your policies in this regard.

Contact Officer Override

Another concept important to proper tactics and safety of both officers and subjects is *contact officer override*, which you learned about in Professional Communication. This concept is a corollary of the concept of *shared responsibility* by law enforcement officers during contacts with subjects. It means that if the officer who is making actual contact with a subject behaves inappropriately or is somehow not handling the situation effectively, then the cover officer (officer observing to ensure that all goes well) has the proactive responsibility to intervene and to override the contact officer.

This concept is important in general, but is particularly important in regard to contacts with people who are or may be in a crisis. Crisis management is not always easy. You are often dealing with difficult people, many of whom are behaving poorly. If you are working with a partner and are in the position of cover officer, remember that you may need to be ready to apply this concept.

CRISIS INTERVENTION TECHNIQUES

When you are dealing with a person who is apparently in a crisis state (very upset or angry, depressed, irrational, unusually confused, very withdrawn or frightened, possibly mentally ill, or under the influence of alcohol or other drugs, etc.), using the techniques described in this chapter will help you manage the situation effectively.

These tactics fall into two main skill clusters:

1. Pre-Intervention Preparation
2. Crisis Intervention Format

These are discussed below.

PRE-INTERVENTION PREPARATION

Before you actually use crisis management techniques in a situation, it is a good idea to take time to prepare yourself and to formulate a basic plan for the intervention. This is because such situations are often difficult and/or volatile. You may be dealing with subjects who are unpredictable and/or potentially violent, and your usual communication skills may not work well.

As you learned in Professional Communication, the recommended steps to follow in pre-intervention preparation are as follows:

- Calm yourself
- Center yourself and get focused
- Develop a strategy for the intervention

Here is more on each of these steps.

Calm Yourself

For you to help calm someone else down, you yourself need to appear calm. The subject will pick up on your calmness. A good way to calm yourself is with *autogenic breathing*, in which you take slow, deep, full breaths. Here is the technique:

1. Breathe in for a four-count through your nose,
2. Pause for a four-count.
3. Exhale for a four-count through your mouth,
4. Pause for a four-count.

Repeat this several times. Doing this exercise will help supply oxygen to your system, which will help you calm down.

Center Yourself and Get Focused

Do what you can to focus on the task at hand and prepare yourself to deal with a potentially difficult situation. There are certainly different ways to focus, and different officers use techniques that work for them. Some people visualize the coming event and how to respond to it effectively. This is a form of *crisis rehearsal*. Others use *positive self-talk*, which basically involves affirming to yourself (silently or aloud) your abilities and determination to handle the situation effectively. Whatever technique you use, your goal should be to prepare yourself to use your skills effectively in responding to a person or persons in crisis, and to ensure your safety and that of others.

Develop a Strategy for the Intervention

As best you can, plan how you will respond to the situation. Specifically, decide in advance what you will say and do and how you will position yourself, whether backup is required, and so on. Try to decide what level and type of intervention is called for, taking into consideration your safety and the safety of others. Consider all the options. For example, it may be that medical intervention is needed. A person who appears to be in crisis may be behaving oddly because of a physical problem, such as an insulin reaction, a stroke, or Alzheimer's disease or another dementia disorder.

Of course, you will not always have the time to plan your intervention response. There may be time constraints or a situation may develop rapidly, or other reasons may prevent you from taking the time you would like to plan your intervention. But whenever you can, taking a few minutes to plan will usually increase your chances of success. A good guide for planning your response is the RESPOND model.

CRISIS INTERVENTION FORMAT

When you are intervening with a subject in an apparent crisis, for whatever reason, the following process will enhance your chances for a successful intervention. These guidelines were also introduced in Professional Communication.

The guidelines include:

1. Try to get the person's attention.
2. Check on the person's perception of reality.
3. Try to establish rapport with the person.
4. Explain your perception of reality.
5. Move toward resolution of the situation.

When trying to follow these guidelines, remember that you are dealing with a person who is in crisis—a person who may be upset, scared, and feel out-of-control. In responding to such a person, try to think of how you would want to be treated by law

enforcement officials and how you would want one of your family members—a parent, grandparent, child, sibling, etc.—to be treated. Then treat the subject accordingly.

In applying these guidelines and skills, remember that your *professional presence* and your effective use of *dialogue* (verbalization skills—what you say and how you say it) are critically important. Your ability to use presence and dialogue effectively help you achieve the goal of getting voluntary compliance from a person in crisis, and help create as positive an environment as possible. It also helps minimize the likelihood that you will have to use physical force to achieve control.

The following explains these guidelines in more detail.

1. Try to Get the Person's Attention

This is an important first step. You will not be able to make progress with a person in crisis unless he or she is paying adequate attention to you. Keep in mind that a person in crisis is more likely to see you rather than to hear you, at least initially. At first the subject may literally not be able to hear or understand the words you are saying but will see you and will gain an impression of you from what he or she sees.

Guidelines for good positioning and body language include:

- *Move to where the subject can see you and use an open stance.* An open stance, with your body slightly bladed and hands visible with palms up appears non-confrontational to the person in crisis while also allowing you to react quickly if need be. If dealing with a child or a short adult or seated person, you may wish to lower yourself. By kneeling or stooping or sitting, you may appear less threatening. However, only do this if you feel it is safe. Remember that people in crisis are unpredictable.

- *Avoid crowding the subject, to the extent possible.* If you crowd the person, you may appear threatening or may appear as though you are blocking the person's "escape" route. People in crisis are likely to have expanded "intimate" zones, meaning that the "bubble of space" they need around them is larger than for most people. If you get too close, they may feel threatened or upset or lash out. How close is too close varies with the individual and may change during an encounter—increasing if the person becomes more agitated and decreasing as he or she calms down. Always try to pay attention to the person's body language, posturing, facial expressions, and so on. These non-verbal cues can tell you a lot.

- *Control distance and maintain bailout routes.* Because EDP's can be dangerous and unpredictable, maintain an appropriate distance for officer safety. Even if the person in crisis is not bothered by closeness, you must

keep a safe distance away—out of the reach of a punch or kick. Be aware of your escape routes should you suddenly need to disengage.

- *Remain alert, but try not to appear tense*. Instead, try to project that you are calm. Speak in a low, calm tone of voice and keep your body relaxed. Try to maintain a neutral but interested facial expression, and keep your palms open, not closed. Remember that your calm appearance may help the subject to feel safer and calmer, because he or she will perceive that you are in control of the situation.

Once you have positioned yourself effectively, you will need to talk to the subject. This initial interaction is critical. In trying to get the subject's attention, keep in mind that what you say and how you say it are very important. The subject will remember your initial interaction with him or her, particularly if he or she is mentally ill, and that memory will affect future interactions with you and perhaps with other law enforcement officers. Here are some guidelines for good verbal interaction:

- *Use your given name, rather than a title*. This will make the encounter seem less formal, and thus be less frightening to the subject. It makes you seem like a person first.

  Example: *"Good morning, I'm Bill Smith."*

  You can add your title after you've given your name, if you wish to do so.

- *Learn and use the individual's name*. Often using the person's first name helps establish a bond, but it is a good idea to ask permission first, particularly if you are a younger officer dealing with an older subject. In that case, it might be better to use "Mr." Or "Mrs."

  Example: *"Is it okay if I call you Bill?"*

- *Ask the subject to look at you. But do **not** order him or her to do so.* Be polite about this. If needed, wave your hands slowly to get the other person's attention.

  Examples: *"Joe, please look at me."*
  "Susan, can I get you to look at me?"

  If the person does not look at you, keep on trying. It's important to try to get the person's attention.

- *Get the subject to focus **on** you, not **at** you*. Talk softly and slowly. One technique to consider is "reverse yelling," which means that instead of talking loudly when you feel so inclined, you deliberately speak softly and slowly. This unexpected behavior may be effective in getting the subject's attention.

- *Use simple commands, using the subject's first name if you know it.* Remember, a person in crisis has a diminished ability to think rationally. If your orders or commands are too complex or abstract, the subject may not understand them. Nor will the subject necessarily let you know that he or she does not understand what you have said. That can be a problem. Keep your commands as simple as possible and be polite. This is a sign of basic respect, and is likely (though not guaranteed) to make the encounter go more smoothly.

  Examples: *"Joe, please move three steps that way."* (pointing the way)
  "Mary, walk toward me."
  "Bill, show me your hands."

  Avoid using words or phrases that the subject may not understand, or may be frightened or confused by. Do not use ten-codes or other police jargon ("What's your D.O.B.?" "Have you ever been Chapter 51'd?" or "We may have to Chapter you"). Instead, try to use simple words or phrases that the subject is more likely to understand.

  Example: *"When were you born?"* or *"What's your date of birth?"*

  Avoid anything that may unnecessarily escalate the situation, such as:

  - Being overly authoritative if you do not have to do so
  - Talking too loud or too fast, so as to frighten or confuse the subject
  - Pointing at the person with the "parental finger"
  - Laughing at the person or using derogatory words or phrases.

- *Take your time—don't rush the encounter*. If you try to rush, the subject may feel threatened or get upset, and may therefore be less cooperative. Take as much time as you can, so that the subject will calm down, focus on you, and be compliant. Remember that time is your friend. The longer you can keep things in a verbal mode, the less likely it is that you will have to escalate to physical intervention. Wait the person out, if you can do that.

2. Check on the Person's Perception of Reality

A person in crisis may or may not perceive reality accurately. This may be particularly true of someone who is experiencing a mental disorder, but may also be true of a person who is under the influence of alcohol and/or drugs, or is in a temporary crisis for any reason.

Here are some guidelines for checking on a person's perception of reality.

- *Ask the person basic questions to determine his or her orientation to reality.* Ask basic questions like, *"Who are you?"* or *"Where are you?"* See if the person is oriented to time by asking, *"What time is it?"* or *"What is the date today?"*

- *Ask the person what he or she is seeing.* This is a direct question which is very appropriate, particularly if you have reason to believe that the person is not perceiving your identity or the situation correctly. For example, an EDP (particularly a person with a mental illness) may perceive that you are someone other than an officer, or even that you are a devil or a monster, etc. He or she may be experiencing visual hallucinations.

  Example: *"Joe, what are you seeing?"*

  The person may or may not answer you directly, although many will tell you just what they are seeing. The answer may help you to figure out what the person is experiencing.

- *If the person does not answer, tell him or her that you cannot hear what he or she is thinking.* Some EDP's—particularly individuals with mental disorders—may believe that other people can hear or read what they are thinking, and therefore do not verbalize all of their thoughts. This is known as "thought broadcasting." Some may have the delusional belief that others can hear their thoughts, or read their thoughts, or that their brains are controlled by others.

  Example: *"Joe, I can't hear what you're thinking. Please talk to me."*

- *Recognize that the person may feel the need to touch you to determine if you are real.* Some EDP's may not be sure whether you are a real person or a hallucination, and may want to touch you as a sort of "reality check." On the other hand, some mentally disordered individuals may want to touch you for other reasons as well. Your choice of how to respond will depend upon your assessment of the situation. Some options include:

  - Allow it to happen, as a calculated risk—remembering that you are putting your safety at risk. For example, you may feel comfortable allowing the person to touch your extended arm or hand, in a way that you can still control distance. In general, do not allow a subject to hug you—it places the person too close to your weapon.

  - Do not allow the person to touch you. Step back.

  - While verbalizing that you are real, establish the physical contact yourself.

3. Attempt to Establish Rapport with the Person

To try to alleviate the person's fears and to get him or her to trust you, there are certain things that you can and should say to a person in crisis.

- *Tell the person directly that you are here to help and to protect him or her.*

  Use positive words and keep it simple

  For example: *"Joe, I'm here to help you."*

  Avoid words that could have a negative connotation, if those words are misunderstood by the other person. For example, if you say, *"Joe, I'm not here to hurt you,"* the person may only hear the word "hurt" and may conclude that you are going to hurt him or her.

- *Listen to the person, using your active listening skills*. Listening is the best tool you have. It allows you to assess the person's state of mind and intensity of emotions. Additionally, getting a person to talk and listen in a positive way can allow him or her to "talk out" feelings or emotions rather than to "act out" such feelings, perhaps in a negative way.

- *Use the pronoun "I" as frequently as possible*. Just like using your name when you introduce yourself, this helps make the encounter more personal, and helps the subject see you as a human being.

  Examples: *"I understand." "I hear you."*

  The phrase "I understand" can sometimes backfire and provoke a negative response. Some people, particularly those who are angry or depressed may feel that you can't understand them because you are not in their situation. Similarly, avoid saying, "I know how you feel."

- *Acknowledge the person's sensory or emotional experience.* For example, if a person says that he or she is seeing something frightening, such as a devil or a monster, an appropriate response might be, *"Joe that must be terrifying."* Speak in a neutral, even tone of voice, avoiding sarcasm or condescension. And remember that your body language also conveys messages.

- *Acknowledge that you too would feel upset if the same thing were happening to you.* For example, you might say, *"Joe, if I saw what you're seeing, it would be very upsetting to me."* This way, you give the person the message that you empathize with his or her experience, and that he or she is not that different from you.

- *Sometimes, establishing physical contact with a person can help establish rapport.* Even a light touch on a person's arm, for example, can have a significant effect on establishing a connection with another person—particularly a troubled or frightened individual. Use a gentle, firm touch and maintain the contact for a little while. But at the same time, remember that touching can sometimes be threatening to EDP's. For that reason, be cautious and go slowly.

  Always ask for permission before touching a person in crisis: For example: *"Joe, would it be okay for me to touch your arm?"* If the person does not grant permission, do not touch him or her.

- *Explore ways to help the person calm down.* Deep, deliberate breathing helps calm most people, particularly when you help by modeling the behavior. It may be helpful simply to ask the person what would help him or her to calm down—sometimes something as simple as smoking a cigarette, sitting down, or even taking a dose of medication may help. Certain anti-psychotic medications may work fairly quickly to help calm and stabilize an agitated, psychotic person. Unless there is some clear and compelling reason not to do so, it is often okay to let the person take a dose of their prescribed medication. Psychologically, just the idea of taking a medication can help calm a person.

4. Explain Your Perception of Reality

At the same time that it is important for you to try to understand the perception of reality of a person in crisis, it is also important for you to try to make clear your perception of reality to that person. This helps the other person to distinguish between what he or she is experiencing and what you are experiencing. Some people in a crisis—whether based on mental disorder, alcohol or drug abuse, etc.—are uncertain as to what is "real" or not. On the one hand, a person may see or hear something, but on the other hand may know or suspect that what they perceive is not real. For that reason, a "reality check" from another person may be useful.

Tell the other person directly what you are seeing.

Examples: *"Joe, I see you standing there."*
"Bill, we are in your living room and no one else is here. We're safe."

It is also appropriate for you to tell the person that you are *not* seeing, hearing, or smelling what they say they is perceiving. This also serves as a reality check for the other person.

Examples: *"Joe, I don't hear those voices you're talking about."*
"Jane, I don't see that snake you're talking about."

In doing this, you are not denying the other person's reality—because what a person in crisis experiences *is* real to him or her. You are simply stating *your* reality. According to mental health experts, you should avoid telling an EDP that what he or she is experiencing is not real. To do so undermines the person's ability to believe you and trust you.

5. Move toward Resolution of the Situation

Finally, you need to try to move toward achieving a resolution of the situation. What that resolution is depends on the reason that you are there. You may have resolved the immediate crisis, and nothing more needs to be done. Or resolving the crisis may be just the initial step, and something else must follow—such as taking the person to a hospital or other care facility, either voluntarily or via an emergency detention.

To make the right decision and achieve resolution requires that you:

- Keep the subject as calm as possible
- Find out as much as you can about the situation
- Use available resources to help with resolution
- Remain realistic and honest in your dealing with the subject

Let's look at these in more detail.

Keep the subject as calm as possible. Keep in mind the phases of the crisis cycle: when a person is escalating or is in a full crisis state, you may not get very far in resolving the situation. You may have to wait until he or she begins to de-escalate and return to normal. All of the techniques we have discussed are designed to help a person in crisis calm down and remain calm. In working toward a positive resolution, the following may also help:

- *If possible, separate the person in crisis and his or her "audience."* This will help prevent "grandstanding" and embarrassment of the person. It is almost always easier to resolve a situation more effectively when you can work just with the person, rather than with a lot of other people around.

- *Try to allow the person to "save face."* Don't make statements that will embarrass or demean the other person. Remember that there is a stigma about mental illness, and you should not add to that stigma. Do not label someone as mentally ill. For example, you may need to handcuff a person in crisis, but—if possible—do so out of sight of his or her family members or other people. Similarly, if you need to take the person to a mental health facility, it may be better to tell him or her about that when you are alone with that person, rather than in the presence of others. Try to get the person to voluntarily agree to move to a different location.

Find out as much as you can about the situation. The more information you have, the better able you will be to resolve it appropriately. You have already begun this process when you checked on the person's perception of reality and established rapport. Now you can ask more specific questions about the immediate crisis and also about any history of crisis.

Ask open-ended questions like:

- *"What's going on today?"*
- *"Can you tell me why you're upset today?"*
- *"Have you been the recent victim of a crime?"*

If it seems to be a mental health crisis, you should also try to find out information about the person's treatment history and care providers. Ask such questions as:

- *"What kind of illness do you have?"*
- *"Are you under care by a doctor or therapist or other care provider?"*
- *"What's your doctor's name?"*
- *"Do you have a case manager?" "What's his/her name?"*
- *"Are you supposed to be taking any medications?"*

If the person indicates that he or she is supposed to be taking medications, ask:

- *"What are the medications for?"* or *"Why are you on these medications?"*
- *"Do you know the names of the medications?"*
- *"When did you last take your medication?"*
- *"When are you supposed to take it next?"*
- *"Do you have your medications with you?"*

Write down the answers to these questions.

Use available resources to help with resolution. These resources may include:

- Mental health professionals
- The subject, him or herself
- The subject's family or friends

If you can, contact your local crisis intervention or other mental health professionals to seek their advice and/or assistance. They may have had prior contact with the individual or may be able to suggest a course of action based on your description of events. If the person is under the care of a doctor or therapist, you may be able to reach that person. If you are working with a partner, you can have him or her make those contacts while you talk with the subject.

Sometimes the person in crisis may be able to help reach a resolution. An excellent technique is to ask a person directly: *"What would you like me to do?"* or *"What can I do to help you?"* or *"How can I help you?"* or a variation of these questions. This shows that you are concerned about the person, and also gives the person the messages that you want to help them and that you trust them to be able to make decisions about what is in their best interest. That can be powerful and quite reassuring to a person who is feeling upset.

Other examples of good questions to ask to try to achieve resolution include:

- *"Joe, would you like me to take you somewhere? Do you need to go to the hospital?"*
- *"Jill, what can we do to get this matter taken care of?"*
- *"Bill, is there anyone we can contact to help you here? Is there a family member, or care provider, you'd like to talk to?"*
- *"Susan, do you have a case manager we can contact?"*

Sometimes, what the person wishes to do may not be acceptable, and you will have to make the choice for them. Other times, you may need to be non-committal when a subject asks for something to happen to resolve a situation. For example, if a person says, *"I'd like to see my mother,"* you may need to say something like, *"We'll see"* or *"We'll look into that"* rather than giving the person a definite yes or no. Doing that does not commit you to any specific course of action, and may help buy time. Also, it gives the subject some hope that they will get what they have asked for, which is good. However, if you tell a person that you will "look into" something, then you must do so.

Remember that voluntary compliance by subjects is *always* your goal. In many cases, enlisting the subject's help in finding resolution will help achieve voluntary compliance.

Often a subject's family or friends can be very helpful. They know the subject and may know the history behind the current crisis. If so, you may well decide to involve them in resolving the situation. On the other hand, there are times when the opposite is true and family members are more of a hindrance than a help or even make the situation worse by agitating the subject more. In such cases, the best course of action may be to remove them from the scene of the crisis or to not contact them. It is *your* job to control the interaction to achieve the safety and resolution of the crisis situation. You must use your judgment, on a case-by-case basis, about involvement of other people.

Be aware that in some cultures, including Hispanic and Hmong, decisions are often made by family members and/or family leaders rather than just by individuals. In such cases, it may not be good practice to separate a subject from his or her family members.

Remain realistic and honest in your dealing with the subject. You have worked hard to establish rapport and calm the subject. To do so, meant that you had to establish your credibility with the subject and maintaining that credibility is crucial to achieving a positive resolution. Here are some guidelines:

- *Work toward small, concrete goals.* It is unrealistic in most cases to expect immediate resolution of a complex situation. Thus, it is better to try to set small, more workable goals and achieve these one at a time. For example, you might ask a subject to sit down as a first goal, then to calm down and stop yelling as a second goal, then to tell you what happened as a third goal, and so on. Step by step is a workable approach to problem solving.

- *Avoid making promises that you cannot keep, do not intend to keep, or do not have the authority to follow-up on.* Sometimes we have a tendency to make promises just to get someone to cooperate and to bring closure to a situation, but do not always intend to keep those promises. That is a bad idea. Even when a subject is very disturbed or even mentally ill, he or she may well remember your promise. If you cannot or do not keep that promise, you lose credibility with that subject. He or she is likely to remember that. And then that loss of credibility will hurt you, or perhaps other officers, during future contacts with the subject. If a subject asks you to promise to do or not do something, be honest and tell them directly whether or not you can follow through on that issue. If you cannot keep a promise for any reason, do not make it.

- Use the technique of "creative confusion" to move toward resolution. With this technique, you appear as though you do not understand something and ask the other person to help you understand.

  Examples: *"Joe, you just lost me with what you've been saying. Can you try to make it clearer to me?"*

  "Bill, you need to help me understand this."

  This technique does not always work, but it often does, it allows you to ask the other person to slow down in which will seem to be helping you. In so doing, you encourage the other person to work with you to achieve resolution of the problem.

  In some cases, a person may be trying to manipulate you and/or the system, and you can use this technique to try to reveal that manipulation attempt. For example, a person may be talking about seeing "red men from Mars" one moment and "green men from Mars" the next moment. You may call him or her on that contradiction by asking a question such as "Joe, what color were those men from Mars? I thought you said a moment ago that they were red." Even if there are apparent discrepancies and you suspect manipulation,

however, do not call the person a liar. Just take appropriate action, in light of the information you have.

- *When you make a decision about resolution of the crisis incident, let the subject know that.* When you make such a decision, tell the subject directly and clearly. Let him or her know your perception of the situation, and what you think should happen or what you intend to do.

  Examples:

  "Hank, here's how I see this. You say you haven't taken your meds for a few days, and that the voices are upsetting you. I'd like to take you to the clinic so they can work with you on your medications, maybe get that straightened out. Is that okay with you?"

  "Susan, I can see that you're worried that your husband will be mad at you for wrecking the car. Let me call him and talk to him a little bit, and then maybe you can talk to him, and then we'll get you a ride to work somehow. Okay?"

  "Bill, for your own safety I'm going to have to put you in the car and take you to the hospital. They're going to talk to you there, and decide what the best thing to do is. I'm going to have to put these handcuffs on you, and I want you to let me know if you think they're too tight…."

  When you give this information to a person in crisis, it can be helpful because it lets them know that you are in control and are making decisions to help them. A person in crisis may, at least temporarily, be incapable of making such decisions on his or her own. It is also basic courtesy to let people know what to expect, or what will happen.

  Whenever possible, get the person's agreement as to what will happen. That is why it is good to say things like, *"Okay?"* or *"Can I get your cooperation on this?"* That empowers a person, and makes him part of the resolution of the situation rather than just a passive subject. This is a form of voluntary compliance. Sometimes, however, you will not be able to get the person's agreement, and you will just have to take appropriate action anyway.

In subsequent sections of this text, you will learn about people who may be in a crisis in association with a specific condition, such as mental illness, suicidal feelings, alcohol or other drug abuse, developmental disability, or a form of dementia. As you will learn, when dealing with people with these conditions, or a combination of such conditions, you should apply the basic crisis intervention guidelines. In addition to the general guidelines, specific guidelines and techniques applicable to particular conditions are listed and discussed in the subsequent sections of this text.

DEBRIEFING AND DOCUMENTATION

The "D" in the **RESPOND** model stands for "Document/Debrief." Both activities are important in crisis intervention.

Debriefing

You learned about debriefing in Professional Communication. Debriefing refers to general steps taken following an incident to calm those involved; to provide needed medical, psychological and custodial care; and to learn from the incident how best to handle similar situations in the future. The two basic categories of debriefing are incident debriefing and subject debriefing. Both are important as follow-through to dealing with people in crisis.

Incident debriefing refers to a formal or informal process of discussing an incident that happened in order to talk about what happened and to determine if any changes are needed in policies and procedures or training, etc., in order to improve future performance in similar situations.

Subject debriefing is intended to enable the participants to come "full circle"—that is to return to the point at which you started and to provide proper closure to the contact. Proper subject debriefing involves five steps:

1. *Calm yourself and your partner*. As necessary, use autogenic breathing and positive self-talk to calm yourself after an encounter. You may also need to calm your partner if he or she is upset or angry.

2. *Calm the subject*. Helping the subject to calm down is important throughout your contact with a person in crisis. It remains important once you have arrived at a resolution to the person's crisis situation.

3. *Provide initial medical assessment*. If there is any possibility that a subject was injured or became ill during a contact, you must conduct an initial medical assessment to find out if anyone requires medical care.

4. *Reassure subject*. You may have to verbally reassure a subject following a contact situation, particularly if he or she is upset or frightened. You may need to repeat reassuring remarks several times.

5. *Rebuild the subject's self-esteem*. Finally, you may have to take steps to help a subject regain his or her sense of control and dignity. This too is very important as a follow-through with a person who has been in crisis.

Some ways to do this include:

- Help the person sit or stand, or otherwise resume a more normal and comfortable physical position

- Offer a drink of water, if available

- Simply talk to the person, to help him or her calm down and regain a sense of normalcy

- If you have to handcuff a subject, check to see that the cuffs are not too tight or painful

Documentation

As you learned in Report Writing and in other parts of training, proper documentation following incidents and contacts is critically important. This is certainly true of contacts involving crisis management. Remember to use the Incident Response model as your guide as to what to include in a written report. And if it was an incident involving use of physical force, be sure to include information on all components of Disturbance Resolution, including Approach Considerations, Intervention Options, and Follow-through Considerations.

Also, remember that you must also be able to orally explain your actions when asked to do so. You may, for example, be required to do this when explaining an incident to a supervisor or manager, during a meeting within your agency, during a formal or informal debriefing, or even during a legal setting.

In the section of this text entitled Emergency Detentions And Protective Placements you will learn specific guidelines for other forms of documentation involved in crisis management—specifically, filling out forms for initiating two legal procedures; emergency detentions and emergency protective placements of people.

PEOPLE WITH POSSIBLE MENTAL DISORDERS

As you've learned, some EDP's are in crisis as a result of having a mental disorder. Such a disorder may be either an acute (short-term) or chronic (long-term) condition. Either way, you need to know how to respond to people with mental disorders. Mental disorders of one sort or another are very common, and law enforcement officers are often the first called to assist.

The terms *mental disorder* and *mental illness* are widely used in our society, but not necessarily well understood. The term "mental disorders" is a broad term that includes many different types of conditions. When mental health professionals diagnose mental disorders, they usually do so based on a classification system established by the American Psychiatric Association and set forth in that organization's publication entitled *Diagnostic and Statistical Manual of Mental Disorders*—often referred to by the acronym "DSM." According to DSM-IV (the fourth edition of the manual, published in 1994), a mental disorder is defined as:

> …a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significant increased risk of suffering, death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. (page xx-xxii)

This definition is important because it makes clear that normal emotional reactions to stressful life events are *not* mental disorders. That is, when people feel depressed or angry or anxious or fearful (within "normal" expectations) because of a difficult life event or situation, they are not suffering a mental disorder. However, in other circumstances, those same feelings—depression, anger, anxiety, fear, etc.—can be symptoms of a mental disorder.

Wisconsin statutes also include a specific definition of mental illness, which is used in regard to the decision about making an *emergency detention* of a person. An *emergency detention* is a legal procedure by which law enforcement officers are authorized to take a mentally ill person, who presents a danger to himself or others (according to specified statutory criteria), into custody and take that person to a hospital or other treatment facility for evaluation, for up to 72 hours. That definition is as follows:

> ‘Mental illness’, for purposes of involuntary commitment, means substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism. (from §51.01(13)(b), Wis. Stats)

Emergency detentions, are discussed in detail in a later section of this text.

The DSM-IV manual includes chapters describing many categories of mental disorders, such as substance-related disorders, sexual and gender identity disorders, eating disorders, sleeping disorders, adjustment disorders, and personality disorders. Each of these chapters lists and describes a number of specific disorders. For each disorder, the manual lists specific criteria that must be present for a mental health professional to diagnose that particular disorder. This text cannot discuss all of these mental disorders, although as an officer, you may encounter people with disorders in many of these categories.

In general, people with mental disorders are not inherently any more violent or dangerous than anyone else. However, some people with such disorders may be more unpredictable in their reactions, sometimes in violent ways. Others may be potentially dangerous some of the time because of the symptoms of their illness. For example, a person with schizophrenia may be hearing voices telling him to harm or kill another person. Or, a person with a mental illness may perceive that you or another person wants to hurt or kill her.

The text will provide information about general indicators that a person *may* have a mental disorder. You need to be aware of what are often referred to as “serious and persistent” forms of mental illness; what they are, specific indicators of each, and guidelines for responding to people who have or may have such illnesses. The text will also present some basic information about some of the more common “personality disorders” that you will see in people whom you encounter. You will also learn the options you have for disposition of calls involving people with mental disorders.

GENERAL INDICATORS OF POSSIBLE MENTAL DISORDER

The following are the general indicators that a person may have a mental disorder. Not everyone who has a mental disorder will exhibit these behaviors, and not everyone who exhibits the behaviors has a mental disorder. Nevertheless, if you encounter one or more of these behaviors, consider that it might indicate the presence of a mental disorder.

Verbal Indicators (What People Say)

Oftentimes, what people say—or how they say it—can give information about their state of mind. Here are some verbal indicators that the person you are dealing with may have a mental disorder:

- Expressing extreme hostility or excitement
- Expressing thoughts or ideas that seem to be illogical, disconnected, unrelated, or bizarre
- Expressing "paranoid" or extremely suspicious ideas or feelings
- Using unusual speech patterns, such as rapid or forced speech, or rhyming speech, or sometimes, delayed verbal responses.

Behavioral Indicators (What People Do)

As you learned in Professional Communication, body language and other non-verbal expressions can be just as important as verbal indicators of a person's state of mind. Some of the behavioral indicators to watch for include:

- Bizarre or inappropriate clothing, makeup, or accessories
- Unusual body postures or movements
- Lethargic, or sluggish, movements and responses
- Repetitious, ritualistic movements
- Apparent hallucinations, such as seeing things that are not there or seeming to hear voices
- Extreme or unusual or inappropriate agitation or anger
- Expression of or appearance of extreme emotions or emotional reactions, such as fear, happiness, sadness, or anxiety
- Seemingly inappropriate emotional reactions, such as laughing at being told bad news, or giving only limited responses to questions that are asked
- Being very withdrawn
- Unusual or extreme confusion

Environmental Indicators

Finally, a person's surroundings can often tell you something about the person's mental condition. Some indicators of possible mental disorder include:

- Trash or items of little or no worth, sometimes collected in bags (trash bags, etc.)
- Lots of debris in a person's residence
- Strange decorations or ritualistic displays, such as many candles, aluminum foil on televisions or radios, doors and windows, etc.

These are some general indicators that a person *may* have a mental disorder. However, they may also point to something else; alcohol or drug abuse, a medical disorder of some kind, a head injury, a dementia disorder, and so on. You probably will not know which it is. Professional assessment and evaluation of a person is needed to determine mental status with assurance.

SERIOUS AND PERSISTENT MENTAL ILLNESS

Some mental disorders are often referred to as "serious and persistent mental illnesses." These disorders affect many people, and are largely the result of brain chemistry abnormalities. These illnesses are described in "Axis I" disorders in DSM-IV. The serious and persistent mental illnesses include:

- Depression
- Bipolar disorder
- Schizophrenia
- Anxiety disorders

Following is a brief description of each of these disorders along with some basic guidelines for responding to people who have or may have such a disorder.

In your job, it is very likely that you will encounter and respond to people with some form of serious and persistent mental illness. These encounters can take place in a variety of contexts, including:

- A family-related problem or emergency
- A call about a person on the streets or in a public place who seems confused or is behaving strangely or inappropriately
- A response to a person who has called with a seemingly strange complaint, such as messages being beamed into his or her home, aliens, or other ideas or occurrences that may be based on the person's delusional beliefs

- A “disorderly conduct” situation, such as a person in a commercial establishment (store, restaurant, bar, etc.) who is behaving in a loud or obnoxious manner, or perhaps threatening people, or otherwise creating a disturbance

- A response to a homeless person in need of assistance of some kind

- A crime investigation in which the victim is mentally ill

Serious and persistent mental illnesses are primarily disorders of the brain. That is, the symptoms of the illnesses are generally caused by disruptions in normal brain functioning, such as changes in the chemistry of the brain. In that way, mental illness is no different than many common “medical” disorders, such as diabetes, in which a person experiences symptoms resulting from an insulin deficiency. People do not choose to have mental illnesses, and they are not weak or deficient somehow because they have such an illness, any more than a person with diabetes is weak or deficient because of his or her insulin imbalance.

Another key point to remember is that mental illnesses can be treated. There are different forms of treatment, including medications and talk therapy and others. Medications for psychiatric disorders are usually very effective in controlling the symptoms of an illness, although they do not cure the illness. That is why it is very important for people with mental illness to seek professional treatment and to follow treatment regimens. Unfortunately, some people who are prescribed psychiatric medications for their disorders, resist taking the medications, or stop taking them. They may do so for one or more of the following reasons:

- The person feels that he or she is better and no longer needs the medication

- The person dislikes the side effects of the medication. Some medications for thought disorders such as schizophrenia can have very uncomfortable side effects, such as dry mouth and muscle discomfort

- The person with paranoid (highly suspicious) feelings or delusions may think that a medication is really poison, and that people are trying to use it to hurt him or her

- In some cases, the person may just wish to see what he or she is “really like,” without the medications

- The person may not be able to afford to buy the medication

Often a person may be very functional when taking medication, but very symptomatic when not taking it. For this reason, you should try to get information about a person's treatment regimen, treatment providers, and—specifically—medication status. This information may help you better understand the nature of a crisis situation, and may help you make more appropriate decisions as to proper action to take in a situation.

Remember that it is not your job to diagnose a mental disorder. That is, you do not have to observe behaviors or signs to determine that a person has a particular illness. In some cases you may know or suspect that the person has a particular disorder, either from past experience or from some other source, such as a family member; in other cases you will have no information. Either way, knowing a little about some of the specific illnesses which people have and why they cause certain behaviors may be helpful.

Depression

The word *depression* has several meanings. On the one hand, it refers to a feeling that is common to everyone at one time or another; a feeling of sadness, the "blues," feeling down. Usually these feelings are related to some life event, problem, or loss, they don't last very long and don't cause much of a problem for a person who experiences them.

On the other hand, the same word—*depression*—refers to an illness, a disorder of the brain in which a change in the chemical balance of the brain causes serious symptoms. This condition is known by various names—serious depression, clinical depression, severe depression, biological depression, vital depression, and so on. The symptoms of serious depression are not the same for each person. However, common signs and symptoms include:

- Profound feelings of sadness, "blues," which last more than a few days—maybe even weeks
- Deep feelings of helplessness and hopelessness; profound pessimism
- Thoughts and feelings of guilt and self-blaming
- Diminished feelings of self-worth
- Lack of energy or ability to do normal activities, sometimes even including simple and routine activities
- Loss of interest in normal activities, such as family, friends, hobbies, etc., and tendency toward isolation
- Feelings of irritability

- Physical symptoms, which may include some or all of the following:

    - Changes
    - Changes in eating patterns (either more or less than normal)
    - Changes in sleeping patterns (difficulty sleeping, sleeping a lot)
    - Feeling tired a lot
    - Loss of sex drive
    - Constipation
    - Physical complaints such as headaches, stomachaches, back problems, dizziness, and so on

In some cases, a person may experience a "psychotic depression," meaning that the depression is accompanied by hallucinations (seeing or hearing things that are not real) and/or delusions (fixed rigid beliefs that have no basis in reality).

When mental health professionals diagnose serious depression, they pay attention to the duration of the symptoms. If the symptoms are present continually for a period of two weeks or longer, there is a good chance that those symptoms indicate serious depression.

This illness is quite common—the American Psychiatric Association has indicated that 25% of women and 10% of men will suffer from it during their lifetimes. Some people suffer from acute episodes of depression, meaning that they only have occasional serious episodes. Others suffer from chronic depression, meaning that they have continuing problems over the course of their lives.

The good news about serious depression is that it is very treatable. A number of medications—generally known as *anti-depressant medications*—are effective in alleviating the symptoms of the illness. They do so by altering the chemical actions in a person's brain. Yet medications are not the only form of treatment for depression. In fact, mental health professionals have found that a combination of medication and talk therapy (psychotherapy) is the most effective form of treatment for most people with serious depression.

A person who is experiencing an episode of serious depression may be in crisis. Because there is a very high correlation between serious depression and suicidal thoughts and feelings, such a person may in fact be undergoing a suicidal crisis. That is an extremely serious situation. (Note: see the section below on *Responding to Suicidal People* for more information.)

In addition to the general guidelines and techniques for crisis response and crisis management that were listed earlier, here are some specific guidelines for responding to a person who is (or may be) seriously depressed:

- Take time to listen

- Do not argue with a person about the source of his or her depression
- Do not tell a depressed person to "just snap out of it"
- Be aware of medication needs
- Be aware of suicide risk

The following paragraphs explain these in more detail.

***Take the time to listen. Be concerned and supportive*.** This can be very reassuring to someone who is seriously depressed. You do not have to ooze sympathy, but just take some time to listen to what the person says and show that you are concerned. Never respond in a way that is harsh or sarcastic or demeaning, because that will just make it worse.

***Do not argue with a person about the source of his or her depression*.** Sometimes a depressed person will talk about the reason(s) he or she is feeling depressed. Sometimes these reasons will make sense or seem reasonable, but at other times they may not. Remember that depression affects both mood *and* thinking, and many depressed people dwell on negative ideas or thoughts and do not see the positive aspects of their lives. They do not see things in a balanced way while depressed. For that reason, what they say about why they are feeling depressed may seem skewed or may not make much sense. Avoid any tendency to argue about that or to try to convince the person that he or she should not feel depressed. That is not your job, and is probably not going to work anyway. Just listen to the person, and do not argue or judge.

Do not tell a depressed person to "just snap out of it." That is fruitless. A depressed person can no more "snap out of it" than a diabetic can will themselves to stop having an insulin reaction. It is a chemical imbalance that causes the symptoms of the depression, and that cannot be altered by a simple act of will.

***Be aware of medication needs*.** As noted above, many people who suffer from serious depression are on prescribed medications to control the symptoms of the disorder. If you are aware or strongly suspect that a person is undergoing serious depression, ask about their medications. Try to find out if they are on an anti-depressant medication, or other psychiatric medication. If so, ask: What is the name of the medication? What is it for? Have you been taking it? When are you supposed to take it next? And so on.

***Be aware of suicide risk*.** As noted, there is a high correlation between serious depression and suicidal thoughts and feelings. This does not mean that everyone who is seriously depressed is suicidal, but it does mean that it is important to try to find out if someone is having thoughts of suicide if they are depressed. The best way to do so is to ask direct questions. If you are responding to a depressed person in a crisis, ask such questions as:

- *"Are you thinking of killing (or hurting) yourself?"*

- If the person answers yes*: "Have you thought about how you would do it?" "Have you thought about when you would do it?"*

- *"Have you made previous suicide attempts? If so, when? How?"*

You may be surprised at how often people will give you honest and direct answers to these questions. They may not answer honestly, of course, but it is always to your benefit to ask, for two reasons: (1) it may give you valuable information that will help you decide what action to take; and (2) providing a person an opportunity to talk about their difficult feelings, to get it "out in the open," may help them feel better. It is a myth that talking about suicide will put the idea of killing himself or herself into someone's head.

Be sure to ask if there are any weapons in the house. If the person tells you there are firearms in the house, ask where they are, where any ammunition is, and who else has access to the firearms.

It is also important to ask questions the right way. Asking people about their suicidal thoughts and feelings is a very personal and potentially embarrassing subject. Therefore, you should ask questions in a neutral, straightforward tone of voice that simply conveys the message that you are concerned and are seeking information. On the other hand, if you ask people about their suicidal feelings in a way that gives the message that you think they are "crazy" for having such thoughts, they will be less likely to share their real feelings with you.

Bipolar Disorder

The key characteristic of this form of serious and persistent mental illness is mood swings, from depression to mania—from a "low" to a "high." This illness was previously known as "manic-depressive disorder." There is, however, wide variation of symptoms between different people with this disorder. Some people have great mood swings, going from extreme manic periods to the depths of depression. Others may only get somewhat "high" and somewhat depressed, but not to extremes. Some people, during manic episodes, may be psychotic—out of touch with reality—and may experience delusions and/or hallucinations. Other people may only experience "hypomania," meaning mild mania, in which they experience feelings of enhanced energy and creativity, but are not out of touch with reality.

Bipolar disorder is less common than "unipolar" serious depression, in which people feel depressed but do not have mood swings from depression to mania. Bipolar disorder is also thought to have a genetic component, meaning that a predisposition to the disease is passed from one generation to the next in genes. But as with serious depression a predisposition does not automatically mean that a person will suffer much—or even at all—from the disorder during his or her life. That depends also on such factors as life stresses, coping abilities, and basic overall health.

When a person with bipolar disorder is depressed, the signs and symptoms are basically the same as those listed above for serious depression, although persons with this disorder experience different levels of depression.

The manic phase of bipolar disorder also varies among people. In general, however, the following are typical signs and symptoms of manic phases:

- Feelings of great happiness and euphoria
- Sometimes, sudden outbursts or irritability, rage, and/or paranoia
- Grandiose ideas and feelings of inflated self-importance (great plans or ideas for activities, and feeling of being capable of doing great things to realize those plans or ambitions)
- Rapid flights of ideas or thoughts. At the extremes, a person's thoughts may race so that his or her words come out in a nonstop rush and may not make sense because they seem so disconnected
- Sometimes, risky or reckless behavior (driving very fast, buying sprees, indiscreet sexual advances, high-risk recreational activities (e.g. hang-gliding)
- Great energy and enhanced physical activity for long periods of time. Sometimes, a person can go for days with little or no sleep
- Often, feelings of great creativity, insight, and understanding of the world and of connections between things. Sometimes these feelings are associated with religious or spiritual ideas or concepts
- Behavior that is often obnoxious to others (saying or doing things that are often offensive to others, and are outside of normally-accepted social boundaries)
- Great increases in sexual energy and desire
- In extreme cases, ideas or thoughts that are clearly out of touch with reality

Note that some of these behaviors may also be associated with other illnesses or conditions besides bipolar disorder. For example, the effects of some drugs can cause similar behaviors. In other words, these signs may indicate a mental illness, or they may indicate substance abuse or another medical condition.

In addition to the general guidelines and techniques for crisis response and crisis management that were listed earlier, here are some specific guidelines for responding to a person who is (or may be) experiencing a manic episode:

- Be alert to sudden angry, even assaultive, behavior.
- Be aware that you may need to calm the person before you can resolve the situation.
- Be alert to the influence a person in a manic phase can have on other people.
- Do not engage in arguments or prolonged discussions. Simply indicate what you want done, indicate the clear options, and act decisively.
- Be aware that a person who is manic can subsequently become depressed.
- Be aware of medication needs.

Here is more detail on each of these points.

Be alert to sudden angry, even assaultive behavior. Some people in manic phases may become very angry or upset, sometimes with no apparent provocation. You may not see any signs of escalating tension, as you will with most people. Thus, for your safety, it is a good idea to maintain proper distance (proxemics) from such people so that if an assault occurs you will be in a more defensible position.

Be aware that you may need to calm the person before you can resolve the situation. Some people in the midst of a manic episode engage in rapid speech—so rapid that it is almost impossible to get a word in edgewise. In that case, you will need to try to get the person to slow down and repeat what he or she has said. Use the techniques discussed earlier to help the person calm down.

Be alert to the influence a person in a manic phase can have on other people. Often, people in a manic phase are quite charming, very sure of themselves and confident, and verbally persuasive. They can persuade people to do inappropriate things, including engaging in financial schemes or even illegal behavior. They might even foster animosities between people, sometimes just as a form of recreation for themselves. This can be a particular problem if you are dealing with a manic person and there are other people in the vicinity. It is best to remove the subject from his or her audience, if possible, so as to minimize the person's possible influence over others.

Do not engage in arguments or prolonged discussions. Simply indicate what you want done, indicate the clear options, and act decisively. Some people in manic phases like to argue, and can be difficult to deal with. It is to their advantage, not yours, to engage in arguments or long discussions. If you want a person to do something, it is better to simply state what needs to be done, simply and clearly, and then if necessary indicate the consequences for noncompliance. If the person argues, avoid the trap and again state what you want done. Then, if compliance is

not forthcoming, follow through quickly with the consequences which you had set forth—arrest, or other alternative.

Be aware that a person who is manic can subsequently become depressed. Depression is the other side of the coin of bipolar disorder. You may see a person who is clearly very manic, and in a short time—even later that same day—the same person may clearly appear depressed. He or she may be a lot quieter and withdrawn, less energetic, and so on. Sometimes, this change in mood and behavior will seem quite drastic. When a person is depressed, keep in mind the cautions and guidelines discussed above.

Be aware of their medication needs. Medications are a key form of treatment for people with bipolar disorder. Medications have proven effective in reducing the number of manic episodes, and often the intensity of episodes, in most people with this disorder. The long-standing drug-of-choice for bipolar disorder is lithium carbonate, but in recent years physicians have prescribed other medications, including several anti-convulsant medications. Again, if you are aware or strongly suspect that a person has bipolar disorder, ask about medications. Try to find out if the person is on a medication for this disorder, or other psychiatric medication. If so, ask:

- *What is the name of the medication?*
- *What is it for?*
- *Have you been taking it?*
- *When are you supposed to take it next?*
- And so on.

Schizophrenia / Thought Disorders

Another major category of severe and persistent mental illness is thought disorders—diseases in which the predominant factor is a disturbance of thinking, rather than primarily of mood. DSM-IV lists a number of such disorders, which are categorized as “psychotic disorders.” The term *psychotic* means, in a very general way, thinking that is out of touch with reality.

Schizophrenia is probably the most predominant type of thought disorder. It is a complex and difficult disorder. The severity of it varies from person to person, and the symptoms of the disease may change over time. Usually, schizophrenia starts in late adolescence or young adulthood, and the symptoms may then develop gradually. The disease presents differently in different people: some may have a series of acute episodes, during which their symptoms are very significant, but are relatively functional at other times; others may have only one or a few acute episodes; and others may be chronically mentally ill, meaning that they are symptomatic, to some degree, most of the time. A person with chronic schizophrenia does not typically recover normal functioning and usually needs continuing treatment, including medications, to manage the symptoms of the

disease. Schizophrenia can affect people of all socio-economic classes and of all levels of intelligence and ability.

Schizophrenia is a very debilitating disorder. People who suffer from it often have significant problems in major aspects of their lives, and it also causes heartaches for family members and friends of people with the disorder. Support groups and advocacy groups are helpful for people with the disorder and for their families.

As noted, the symptoms of thought disorders vary from person to person. In general, the following are among the common indicators of schizophrenia and other thought disorders:

- *Disordered thinking and speech:* Thoughts may seem random, illogical or irrelevant to the immediate situation or circumstances. Sometimes, a person may make up words or phrases or use rhyming words in a unique and strange manner.

- *Delusions*: These are fixed, rigid beliefs that have no basis in reality, but of which the person who has them is convinced. For example, a person may believe that others can read his thoughts or insert ideas into his brain, or control his actions or feelings. Or a person may believe that she is a famous or well-known person or deity, or feel that she has special powers and abilities. Or a person may feel that others are plotting against him or her or are out to cause harm. Many delusions that people have are quite broad in scope, and some people pretty much incorporate everything in their environments into their delusional systems.

- *Hallucinations:* These are auditory or visual stimuli that have no basis in reality. The most common type of hallucination for people with mental illness is hearing voices. The voices are not the same for each person who experiences these hallucinations. In some cases, the voices are very mocking or accusatory or insulting, and sometimes they give orders to the person ("command hallucinations"). In other cases, the voices are more benign. The voices are quite real to the person who hears them, and sometimes he or she cannot distinguish between the voices and what real people are saying to him or her. Sometimes a person knows, on some level, that the voices are not real; in other cases they do not.

  Visual hallucinations—seeing things that are not there—are a less common form of hallucination for those with schizophrenia. Visual hallucinations are more commonly associated with alcohol or drug abuse. In some cases, visual hallucinations are very frightening; people perceive others to be devils or monsters or frightening animals, etc.

- *Concrete thinking:* Some people with schizophrenia or other thought disorders engage in "concrete thinking," which means that they usually interpret literally

everything that is said to them. They have difficulty processing or understanding abstract thoughts or ideas.

- *Unusual realities:* Many people with schizophrenia have views of the world, or ideas about aspects of the world or of people, that are unique to them and are very different from the views of those who do not have a thought disorder.

- *Other symptoms:* In addition to the symptoms listed above, people with schizophrenia or other thought disorders may exhibit some or all of the following:

    - Confusion
    - Poor hygiene or grooming
    - Inappropriate or muted feelings or emotions
    - Isolation, being withdrawn
    - Strange behaviors or actions, including inappropriate social behaviors, dressing inappropriately for the weather, etc.

Schizophrenia (like other major mental illnesses) is thought to have a genetic component, meaning that a predisposition to the disorder is passed on in genes. But such a predisposition does not automatically predict whether a person will suffer from the disorder or, if it does develop, how severe or problematic the illness will be.

There are several sub-categories of schizophrenia. One of these is "paranoid schizophrenia." A key symptom of this is extreme suspiciousness, delusions that others are persecuting or plotting against a person, and possibly grandiose thinking. Such individuals are frequently also very angry and aloof, and can be argumentative or difficult. They may also be very violent or suicidal, particularly when they feel they are somehow threatened. Thus, people with this particular disorder are probably the greatest potential threats to law enforcement officers and others—particularly when they are under the influence of alcohol or other drugs.

In addition to the general guidelines and techniques for crisis response and crisis management that were listed earlier, here are some specific guidelines for responding to a person who has (or may have) schizophrenia or another form of thought disorder:

- Try to use a passive, friendly, and low-key approach.
- Give simple commands or requests.
- Never demean or make fun of a person who is behaving strangely. If a person seems to be experiencing delusions or hallucinations, do not argue with him or her or tell the person that their perceptions are not real.
- If a person says that he or she is hearing voices, ask directly what the voices are saying.
- Be aware that some people with delusions incorporate everything into their delusional beliefs.

- Maintain proper distances and—if possible—allow people to feel that they have an escape route.
- Be cautious about "buying into" a person's delusions or hallucinations. However, at times doing so may be acceptable.
- Be aware of both suicidal and assaultive potential.
- Be aware of medication needs.
- Be respectful of people's possessions and property.

The following provides more detail on each of these points.

Try to use a passive, friendly and low-key approach. This is important when dealing with anyone in crisis, of course, but it can be particularly important when responding to people with thought disorders. Even when a person is going through a psychotic episode—that is, is experiencing delusions and/or hallucinations, etc.—he or she is still likely to remember how you (or others) treated them. The way you treat a person in one encounter may affect the future interactions with that person, for better or worse. The best approach is to talk softly and slowly, in a calm voice, if you can. Use the person's first name, if you know it.

Give simple commands or requests*.* Many people with thought disorders cannot deal effectively with complex or abstract orders, questions, or expectations. Thus, avoid these. Instead, use simple commands—preferably one for each specific thing you want a person to do. Examples:

- *"Richard, please look at me."*
- *"Hank, take three steps toward my vehicle."*

When giving orders, or asking questions, remember to try to do so in a non-confrontational or challenging manner, when you can. You do not want to frighten or confuse the person if you can avoid doing so. At the same time, try to provide as much structure as you can. Many persons with schizophrenia like to know just what is going to happen. This helps reduce their anxiety. Thus, the more you can structure the experience for them by being directive and by explaining each step you are taking, the better the outcome is likely to be.

Never demean or make fun of a person who is behaving strangely. Some people with schizophrenia talk and act strangely, and/or wear strange clothing. It is completely unprofessional to demean such people or to make nasty, sarcastic or insulting remarks in their presence. Such remarks may hurt their feelings and make them feel worse about themselves. Nor should you allow others, including fellow officers or citizens, to do these things.

If a person seems to be experiencing delusions or hallucinations, do not argue with him or her or tell the person that their perceptions are not real**.** Those perceptions—delusions and hallucinations—are quite real to the person who is experiencing them. A person may be aware on one level that his or her delusions or

hallucinations are not based in reality, but they experience them anyway and cannot will themselves not to do so. So, there is no point in arguing with them as to the reality of their experiences. However, it is okay to say that you do not hear the voices that they say they are hearing *("Susan, I'm not hearing that."*). You are then merely stating your reality, not denying the other person's reality.

If a person says that he or she is hearing voices, ask directly what the voices are saying. This can be useful information for you to have. A person may be experiencing "command hallucinations," which are authoritative voices telling him or her to do something, and that might include doing something inappropriate or dangerous such as hurting or killing themselves or someone else, including you. Many people who hear such voices feel that they have to do what the voices tell them to do. A good way to ask this is, *"Mary, tell me what you're hearing"* or *"What are the voices saying?"* Ask such questions in a neutral, straightforward way. If the person thinks that you are sarcastic or demeaning, he or she may not answer you truthfully or at all.

Sometimes a person will not answer your question on this issue (or other issues) because he or she believes that others can hear his thought responses, and therefore he does not need to verbalize them. This is known as "thought broadcasting." A useful response in such a case is, *"Richard, I can't hear what you're thinking. Please tell me."*

If a person tells you that he is hearing voices commanding him to harm or kill himself or someone else, you should ask follow-up questions to get further useful information. For example, ask*: "How would you do it"* and *"When would you do it?" "Are you going to hurt me or my partner?"* Again, always ask such questions in a neutral, even tone of voice so that the person does not think you are sarcastic or judgmental.

Remember that a person experiencing auditory hallucinations (hearing voices) may have difficulty attending to conversations or following directions, simply because he or she is listening both to the real person speaking and to the hallucination. That is a lot of stimulation—similar to holding a telephone receiver to each ear and trying to listen to people talking through both at the same time. You may need to repeat what you say.

Be aware that some people with delusions incorporate everything into their delusional beliefs. Some people with thought disorders see themselves as being at the center of the world, and all people and events revolve around them and are part of a system involving them. For example, a person may believe that everyone else is part of a conspiracy directed against him, or that everyone else can read his thoughts, or knows about him and is laughing at him. Because of their delusions, such people consistently misinterpret much of reality.

This can be particularly problematic when you are dealing with a person with paranoid schizophrenia. Because of the highly suspicious nature of their delusions, which may include significant feelings of persecution, such a person may perceive himself as being trapped or cornered or otherwise at risk of danger from others and may react violently in his own defense. Some people with this diagnosis are potentially dangerous to others, and sometimes to themselves as well. Because you do not know what is going on in their minds, you cannot accurately predict how they will behave or react to situations.

Maintain proper distances and—if possible—allow people to feel that they have an escape route. It is important to maintain proper distance from any EDP for officer safety. Remember that it is not always possible to predict how an EDP will respond, and that may be particularly true of a person who may be experiencing delusions or hallucinations.

If you can avoid it—and it may not be possible—do not back an EDP into a corner so that he or she perceives that there is no escape route. If a person with delusions, particularly paranoid delusions, feels that he or she is trapped, he or she may lash out violently.

Be cautious about "buying into" a person's delusions or hallucinations. However, at times doing so may be acceptable. As an officer, you will probably respond to people who are experiencing delusions or hallucinations. Sometimes these will include people on the street. You may also respond to people in their homes who have called in with bizarre complaints, such as rays being beamed into the house, messages coming through the television or radio, alien invasions, and so on. As strange as it sounds, the messages are real to the people who make such calls, and may be very frightening.

As noted, it is generally best not to argue with a person about their delusions or hallucinations or to deny their perceived reality. However, there are times when it may be okay to "buy into" a person's delusions or hallucinations so as to help them feel better and get through a crisis situation. For example, if you respond to a person who is upset because he says that rays are being beamed into his house, it may be okay to suggest that he put aluminum foil over his windows to deflect the rays. An even better approach is to ask the person what he or she thinks might help. For example*, "Henry, what do you think would help with these rays being beamed into your house?"* Then if the person mentions aluminum foil as a ray deterrent, you can agree that it might help. Or you may ask if there is a care provider or someone at the hospital or clinic that can help them with the particular issue or concern.

You have to be cautious about "buying into" a person's delusions. It may work with some people, but not with others. It's probably best to use such a tactic with someone whom you know. Use your judgment.

Never pretend to see or hear an EDP's visual or auditory hallucinations. Since you don't actually see or hear them, you will not be able to respond appropriately if the person asks you a question about what the hallucinations are doing or saying—and you will be caught in the lie and lose the person's trust.

Be aware of both suicidal and assaultive potential. Most people with schizophrenia or other thought disorders are not violent or dangerous. But some are, especially if they have been using alcohol or other drugs. In some cases, as noted, a person may be dangerous if their delusions or hallucinations cause them to feel threatened by or at risk from others. A person with a thought disorder may be a suicide risk as well, because he is hearing voices telling him to kill himself, or because of discomfort with his situation, or for some other reason related to the symptoms of the disorder.

***Be aware of medication needs*.** Medications are a key form of treatment for people with schizophrenia or other thought disorders. These medications—generally referred to as "anti-psychotic medications"—have proven effective in alleviating the symptoms of schizophrenia, as well as helping prevent relapses. Again, if you are aware or strongly suspect that a person has schizophrenia or another thought disorder, ask about medications. Try to find out if the person is on a medication for this disorder, or other psychiatric medication. If so ask: *What is the name of the medication? What is it for? Have you been taking it? When are you supposed to take it next?* And so on.

While many anti-psychotic medications are quite effective, some of them have uncomfortable side effects, such as dry mouth, muscle discomfort, restlessness and drowsiness. For that reason, many people also take medications to counter these side effects. Others do not take their anti-psychotic medications as prescribed, leaving the symptoms of their disorder uncontrolled.

As noted earlier, it may be helpful for a person in crisis to take a dose of prescribed medication. Many anti-psychotic or anti-anxiety medications can quickly calm an agitated person. It is okay to ask a person directly if he or she feels that taking some medication would help.

Be respectful of people's possessions and property. You may respond to a person with a mental disorder who has possessions that do not seem important to you, but may be very important to them. For example, you may encounter a homeless person living in a cardboard container or a person with a shopping cart or trash bag or other container filled with seemingly useless items, or a person wearing several layers of tattered and worn clothing. Be respectful of their property and possessions. Do not laugh at it and do not destroy or discard it, even if it seems insignificant to you. It may be all they have.

If you take a person into custody, inventory the person's property just as you would anyone's property, and follow routine procedures to safeguard it.

Schizophrenia and other thought disorders are difficult, problematic forms of mental illness. While you will certainly respond to people with such disorders, you will also respond to people displaying behaviors that seem to be this form of mental illness but which are caused by something else. For example, a person may display paranoia or strange behavior as a result of alcohol or other drug abuse. Or strange behavior, including confusion or disorientation, may be the result of such causes as severe head injury, heart attack or stroke, diabetic reaction, adverse reaction to a medication, thyroid disorder, high blood pressure, severe infection, and so on. Again, you will not necessarily know the cause for a person's behavior, nor is it necessarily your responsibility to find it out—although such information is always helpful. Your key role is to respond to behavior that you see. Nevertheless, you certainly should ask simple questions like, *"Are you a diabetic?"* and *"Do you have any conditions we should know about?"* The person may give you information that will help you decide on appropriate action.

Anxiety Disorders

Anxiety disorders are a very common category of mental disorders. They can be very troubling and uncomfortable for people, and can certainly cause a person to experience a crisis situation.

Anxiety is a normal emotion that everyone experiences at one time or another, usually in response to a realistic situation or concern. Feelings of normal anxiety are, in fact, often a good thing because such feelings motivate us to take positive actions—such as preparing for a test or a presentation or some other event about which we feel anxious.

Sometimes people experience feelings of more than normal anxiety. Often the feelings start as a "normal" response to a realistic situation or concern, but then escalate into an emotional crisis situation that is beyond the scope of "normal anxiety." During such a crisis, a person may feel extremely upset and unable to control feelings and situations. He or she may feel very worried and upset and may exaggerate the significance of an actual or imagined event or situation. The person may "catastrophize," meaning to see things in the most negative or hopeless possible light and expect the worst to happen in any given situation. The person may worry all the time—typically way out of proportion to realistic causes for such worry. A person who is excessively anxious may also have physical symptoms, such as headaches, stomachaches, sleeping problems, difficulty breathing, and so on. It is very uncomfortable for them.

Typically, people who experience episodes of extreme anxiety have continuing episodes. An anxiety episode is rarely just a one-time event, but is instead a pattern of responding to life situations. It is a very uncomfortable way to be, and some seek treatment for it. Such treatment usually involves psychotherapy—talk therapy—in which a therapist may try to help the anxiety sufferer to better understand his or her

patterns of behavior, to think differently about his or her experiences and responses to those experiences, and to develop more effective coping strategies. Medications may be helpful for some such people, but they are usually not the primary therapy.

Neither normal anxiety nor excessive anxiety is necessarily a diagnosable mental disorder. However, if not dealt with appropriately, a person's feelings of excessive anxiety can evolve into a diagnosable anxiety disorder. Often, feelings of normal anxiety and normal depression go hand-in-hand. The main issue in this regard is that such emotional responses, if not noticed and addressed, can escalate into more significant emotional crisis situations for people.

Specific Anxiety Disorders

The category known as "Anxiety Disorders" in DSM-IV includes several specific disorders that are listed and discussed below. A key difference between these disorders and "normal" or "excessive" anxiety is that they usually occur without any connection to a specific life event or circumstance. Also, anxiety disorders are often chronic; a person may have many episodes over the course of his or her life. They can cause great discomfort and can have a significant impact on the ability to function in everyday life. Anxiety disorders are the most commonly-diagnosed psychiatric condition in the United States. They include:

- Generalized Anxiety Disorder
- Panic Disorder
- Phobias
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder

The following presents more information about each.

Generalized Anxiety Disorder. Sometimes referred to as GAD, this disorder may be diagnosed by a clinician if a person displays symptoms for at least six months. The symptoms include fairly constant and excessive anxiety, and feelings of tension and worry. Some people describe their feelings as being "shaky" or "keyed-up" or "on edge." These feelings are accompanied by other symptoms, which may include restlessness, being easily fatigued, difficulty concentrating, muscle tension, disturbed sleep, and irritability. A person may experience pain and discomfort from headaches, stomachaches, backaches, and so on. The feelings of worry and anxiety are pervasive and control a person's life, even when there are no identifiable real-life situations or concerns that would cause the feelings of anxiety or worry. For example, people with this disorder often worry excessively about financial concerns, their jobs, family issues, relationship issues, possible misfortunes to themselves or others, or even minor matters like routine car repairs, and cannot will themselves not to worry about these things.

Many people with this disorder are so troubled by the feelings of anxiety that they self-medicate with alcohol and/or drugs. That is how they may try to calm themselves down and fall asleep. Unfortunately, some then get addicted to the alcohol or drugs, causing further problems for them. Also, some people who suffer from this disorder for a long time develop major depression as well, which then requires treatment. Or, a person may experience chronic low-grade depression, referred to as "dysthmia." Thus, chronic anxiety and depression often are seen in the same person.

Panic Disorders. Panic disorders are another common category of anxiety disorders. The key feature of this is panic attacks, which are very uncomfortable feelings of extreme anxiety that come out of the blue and are not usually associated with any specific event or "trigger." A person experiencing a panic attack may feel flushed, perspire greatly, have a rapid heartbeat, have the "shakes," feel dizzy and light-headed, and feel very out of control. Someone may feel that he or she can't breathe, and may feel that he or she is about to have a heart attack or even die. Such an attack typically lasts for a short time, such as 15-30 minutes, although individual episodes could be longer or shorter. But even that 15-30 minutes can seem like an eternity to a person undergoing a panic attack. The frequency of a person's panic attacks can vary widely. Some people have frequent attacks, such as each week, continuing for months. Other people may have a number of attacks within days, but then not experience any more attacks for many weeks or months. Once a person has experienced panic attacks, they are usually very concerned about having further episodes of such attacks.

Research has shown that 25% to 30% of people with panic disorder have suicidal thoughts at some point. Depression is a common co-occurring disorder.

Research has indicated that the cause of panic attacks is probably partly psychological and partly biological. However, stressful life events are thought to be a factor in the severity of the disorder. Medications have proven effective for many people in blocking the frequency and severity of panic attacks.

Phobias. DSM-IV, the diagnostic manual of the American Psychiatric Association, defines a *phobia* as *"a persistent, irrational fear of a specific object, activity, or situation (the phobic stimulus) that results in a compelling desire to avoid it. This often leads either to avoidance of the phobic stimulus or enduring it with dread.*" To be classified by a clinician as a phobia, the avoidance of the object, activity or situation by a person must seriously interfere with the person's ability to function normally. A person may have a great fear about a certain activity, such as bungee jumping, but if he or she simply avoids engaging in that activity in routine life, it is not a phobia.

A *specific phobia* is a marked and persistent fear of a specific, identifiable situation or object. Examples are fear of heights, fear of flying, fear of snakes, or fear of being in closed-up spaces (claustrophobia). The person may recognize that his or

her fear is unreasonable or excessive, but cannot help responding to the "phobic stimulus" either by avoiding it entirely or by experiencing it with extreme anxiety that is similar to the symptoms of a panic attack.

Social phobia—which is also sometimes known as "social anxiety disorder"—is fear of social situations, including social performance situations such as speaking in public or participating in certain types of events in which other people are present. Some people, for example, have a phobia about eating or drinking in front of other people. A person with this disorder may be petrified of being embarrassed and/or of having to do something with other people watching and maybe judging them, and that fear causes panic-like feelings. Again, a person may realize that his or her fear is unreasonable, but can't help it.

Both specific and social phobias are treatable in most people.

Obsessive-Compulsive Disorder*,* commonly referred to as "OCD," is primarily characterized by recurrent obsessions or compulsions that are severe and that cause significant distress and/or impairment for a person with the disorder. *Obsessions* are defined in DSM-IV as "*persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress."* Some examples of obsessions include: the need to have things or objects in a particular order, such as on a dresser or desktop; repeated thoughts about contamination, such as fear of being contaminated by germs through shaking hands or touching another person; and repeatedly doubting whether one has locked a door or turned off a stove.

Compulsions are defined as "*repetitive behaviors or mental acts the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification.*" Examples include: repeated hand-washing, cleaning things over and over, counting things, repeatedly checking on things (such as whether a door is in fact locked), or demanding assurances about something from other people. An obsession, which is an idea or thought, often leads to a compulsion, which is a behavior based on that idea or thought. For example, a person who has an *obsession* with contamination by germs may then have the *compulsion* to wash his hands fifty times a day. The person feels intense anxiety about contamination until he washes his hands, which temporarily brings relief from the anxiety caused by that obsession, but that relief is usually short-lived, and the person feels compelled to repeat the hand-washing again and again. People with OCD typically experience a lot of distress and discomfort due to the disorder. Such people may or may not recognize the unreasonableness or excessiveness of their obsessions and compulsions. Or, they may recognize that only to some extent

Post-Traumatic Stress Disorder*,* often referred to as PTSD, always develops in response to some real-life event that a person experiences. In that sense, it is unlike the other anxiety disorders, which may or may not be related to real-life experiences. People may develop the symptoms of post-traumatic stress disorder

following direct experience of a highly traumatic event that usually involves serious injury, threatened death, actual death, or a serious threat to physical well-being. Or, a person may simply witness these stress factors rather than directly experience them. The person experiencing or witnessing the terrible event(s) feels intense fear, helplessness, or a sense of horror.

The symptoms of PTSD then develop as a response to the highly traumatic event. Those symptoms involve re-experiencing the traumatic event in some way, including through nightmares or night terrors or flashbacks. For example, a person who has been through a frightening or traumatic war incident may experience feelings of horror upon hearing a car backfire, because the sound reminds him of guns or bombs. Or a woman who was the victim of sexual abuse may relive the horror of that experience when touched by any other man, even when that touch is not meant to be threatening or abusive. The person may have recurrent and distressing memories and/or dreams about the traumatic event, and may experience intense psychological distress when exposed to stimuli—sounds, sights, smells, experiences—that symbolize or resemble something about that event.

Some people with PTSD experience a sense of emotional "blunting," meaning that their emotional responses to people and events are numb or distant. They may be unable to remember important aspects of the traumatic event, may feel detached or estranged from other people, and/or they may be unable to have loving feelings toward other people.

When medical or mental health professionals diagnose anxiety disorders, they do so on-the-basis of specific diagnostic criteria. Some of these criteria were noted above. An important consideration in making such diagnoses is that the clinician must rule out the possibility that the symptoms of anxiety are caused by a medical or substance abuse problem. There are, for example, a number of medical conditions that can cause a person to experience feelings of great anxiety. Some include: cardiac (heart) conditions; thyroid problems, such as hyperthyroidism; seizure disorders; diabetes; respiratory conditions such as pneumonia, pulmonary disease, or hyperventilation; or vitamin deficiencies. Anxiety can also be the result of reactions to prescribed or over-the-counter medications.

Substance abuse can also cause significant anxiety symptoms. Anxiety can result from alcohol intoxication or withdrawal, as well as from abuse of a number of illegal or illicit drugs, including cocaine, methamphetamines, hallucinogens, cannabis (marijuana), and inhalants. Use of the drug Ecstasy can cause feelings of intense anxiety.

In addition to the general guidelines and techniques for crisis response that were listed earlier, here are some specific guidelines for responding to a person who is (or may be) experiencing an episode of one of the above-listed anxiety disorders:

- Be aware of indicators of possibly serious anxiety episodes
- Be concerned and supportive, and try to find out what is going on

- Try to help the person calm down a bit
- Be aware of medication needs
- Be aware of possible emergency situations

Be aware of indicators of possibly serious anxiety episodes. Anxiety disorders, as well as excessive anxiety that a person may experience, are sometimes easy to overlook or to not take seriously. Sometimes there is a tendency to dismiss anxiety symptoms as signs of weakness or silliness. But anxiety can be quite serious, and should not be overlooked or taken lightly. Keep in mind that a person experiencing severe anxiety symptoms is often a person in a state of crisis or one who can escalate into such a state.

Be concerned and supportive, and try to find out what is going on. Some of the key indicators of severe anxiety and anxiety disorders were listed above. Keep in mind that the symptoms of various anxiety disorders are different. The best thing you can do is to take a little time to talk with the person, both in order to help him calm down a bit and to try to find out what is going on and what he is upset or anxious about. Sometimes, a simple opening remark such as, *"Paul, you seem upset today. What's going on?"* can be helpful. It at least gives the other person an opportunity to talk. When responding, you do not have to ooze sympathy or be a therapist. However, if you can show that you are a little concerned for the person and talk in a reassuring way that alone could mean a lot.

Try to help the person calm down a bit. Always speak calmly and reassuringly to the person, and to tell him or her that you would like to help, if possible. Try to be sure that the person is physically comfortable, perhaps sitting down, having a cigarette if they smoke, and so on. It may help to tell the person to take several slow, deep, rhythmic breaths—inhaling through the nose and exhaling through the mouth. It can even be helpful for you to model such breathing: *"Take a deep breath, Mary. Slowly now, let's do it together. Breathe with me…"*

One thing that is *not* helpful is to command a person to calm down, particularly if you do so in a loud voice.

Be aware of medication needs**.** Medications are a key form of treatment for many people with anxiety disorders. These medications—generally referred to as "anti-anxiety medications"—do not cure the disorders, but they cab help alleviate symptoms. Some people with anxiety disorders may be taking anti-depressant medication, either in addition to or instead of an anti-anxiety medication. This depends on the nature of the disorder, and the clinician's preferences. If you are aware or strongly suspect that a person has an anxiety disorder, ask about their medications. Try to find out if they are on a medication for this disorder, or other psychiatric medication. If so, ask: *What is the name of the medication? What is it for? Have you been taking it? When are you supposed to take it next?* And so on.

Be aware of possible emergency situations. A person with an anxiety disorder may experience a crisis so severe that it constitutes an emergency situation. Such a situation may require hospitalization for a time. A person may, for example, experience an uncontrollable series of panic attacks or may have a very serious episode of PTSD that causes extreme symptoms. For example, a former soldier who has been in combat may react violently when he experiences something—such as a backfiring car that sounds like a gunshot—because the sound of the car makes him relive the trauma of combat. Or in some cases, a person with a severe phobia, such as claustrophobia, may have a very severe anxiety reaction in a specific situation that induces the feelings of claustrophobia, such as being "trapped" in an enclosed space like a tunnel or an elevator.

PERSONALITY DISORDERS

Another important category of mental disorders in regard to crisis management is "personality disorders." Personality disorders are listed and described in DSM-IV. Unlike serious and persistent mental illnesses such as serious depression and bipolar disorder and schizophrenia, however, personality disorders are not primarily the result of defective brain chemistry. Instead, they are defined as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." (*from DSM-IV*) Although exact causes are not certain, it is generally thought that many personality disorders result from difficult or negative or traumatic childhood experiences. For example, borderline personality disorder is thought to be associated with abuse or neglect during childhood.

There are eleven specific personality disorders listed and described in DSM-IV. Two of the more commonly-known personality disorders are:

- Antisocial personality disorder
- Borderline personality disorder

Antisocial Personality Disorder. Most people with this disorder are males. Key features include: a continuing pattern of behavior that shows disregard for or abuse of the rights of other people; disregard of the wishes or feelings of others; manipulative and/or deceitful behavior; a pattern of impulsive behavior (acting on the spur of the moment, without thinking ahead to the consequences); irritability or aggressiveness; a pattern of irresponsibility in regard to work, family obligations, and so on; and lack of remorse or guilt for their actions—partly because they tend to always blame other people for their actions rather than take blame or responsibility themselves. Such individuals are often charming and verbally persuasive.

People with antisocial personality disorder are sometimes referred to as "sociopaths," although this is not a specific mental health term.

These can be difficult people to deal with because they act out a lot, do not take responsibility for their actions, and are often argumentative—particularly when challenged. Some can be dangerous people. Many use and abuse alcohol and drugs consistently, and can be even more unpredictable and potentially dangerous when under such influence. People with this disorder often get involved with law enforcement. They often commit crimes such as stealing, destroying property, and drug dealing.

Borderline Personality Disorder. The essential feature of this disorder, as set forth in DSM-IV, is "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins in early adulthood and is present in a variety of contexts." This is a disorder that affects approximately 2% of the population. Most people diagnosed with it are women. Many people with this disorder are victims of trauma—often during childhood or adolescence—including physical, sexual, and/or extreme emotional abuse.

Key symptoms of borderline personality disorder include: emotional instability, with frequent shifts of feelings from depression to irritability to anxiety, etc.; displays of inappropriate and intense anger, with temper tantrums or deep brooding; and intense but stormy relationships with other people. People with this disorder tend to view other people, at any given time, as either all-good or all-bad, depending on whether they think the other person is meeting *their* needs at that particular moment. Their assessments of others shift frequently. Also, they tend to be quite impulsive in all aspects of their lives—behaving on the spur of the moment based on their emotions, rather than rationally thinking ahead to the consequences of their actions.

Such individuals frequently use alcohol and drugs to self-medicate, and are often long-term substance abusers. Many are also prone to episodes of depression, sometimes including suicidal behavior. Their substance abuse and depression are often patterns of response to a personal history of neglect and abuse suffered during the person's formative years.

Many people with this disorder make suicide attempts. Some also engage in self-injurious behavior, including cutting themselves or sometimes burning themselves with cigarettes or matches, but their doing so is not necessarily a suicide attempt. The motivations for such self-injurious behavior can be complicated, and sometimes have to do with experiencing pain in order to feel "real." People who do this often say that hurting themselves gives them a feeling of relief.

They often experience intense emotional crises, usually in response to a perceived problem or disappointment with another person or persons in their life. A person may get extremely upset and volatile in such a circumstance. You may respond to a person during such a crisis, perhaps in the context of a domestic disturbance call, a disturbance in a public place, a suicidal person contact, or other situation. The subject may be intoxicated during such a contact.

As noted, many people with borderline personality disorder are victims of trauma, often including physical and/or sexual abuse. Many such victims of trauma may have difficulties with being placed in restraints, such as handcuffs, or with being required to remove clothing. Being placed in restraints, for example, may cause them to re-live their trauma and thus cause feelings of extreme distress. This does not necessarily mean that you should not place them in restraints, but at least be aware of the possible implications of restraints for them. If it is possible to use an alternative to handcuffs, consider doing so.

Treatment for personality disorders primarily consists of talk therapy to help people better understand their behavior patterns and to develop more constructive behaviors. There are no medications that specifically treat or cure a personality disorder, although people with such disorders frequently take psychiatric medications for conditions associated with their disorder, such as depression and anxiety.

Many people with personality disorders have not, in fact, specifically been diagnosed as having such a disorder. Most will not have sought the help of a medical or mental health professional for a personality disorder, and they do not even usually know about such disorders or recognize that they have a problem based on the disorder.

Thus, during a contact with a subject, you are unlikely to be in a position to be able to identify him or her as a person with a personality disorder, either in general or in regard to a specific disorder. Again, your job is to be aware of behaviors and to respond to people exhibiting such behaviors. Nevertheless, it is useful to know that such disorders are often the basis for the behavior that you will see.

DISPOSITIONS / HELPING PEOPLE WITH MENTAL DISORDERS

When responding to a person who has, or may have, a mental disorder, part of your job is to decide what to do—if anything—to get appropriate professional help for the person. What you decide depends on the nature of the situation to which you are responding and what resources are available. The availability of such resources varies depending on the size of your municipality or county: smaller, more rural areas typically have fewer resources available than larger urban areas. However, every county has agencies and organizations for people with mental disorders.

In some cases, you may simply talk to people, try to calm them down, perhaps counsel or mediate, but take no further actions. How you handle a specific incident depends on many things, including the seriousness of the incident, available support systems, the potential for continued disturbance, and the potential for danger to the subject or others. Remember that your goal is to achieve the best resolution of the situation that you can. You have a wide range of options available to you, including:

- Release the person and refer him or her to a helping agency
- Release the person to the custody of family or friends

- Consult with a mental health professional in your community
- Contact a crisis intervention team, if such a unit is available in your community
- Contact a local mental health crisis center
- Arrest the person for a statutory violation
- If warranted, conduct an emergency detention or an emergency protective placement of a person

Let's look at each of these.

Release the Person and Refer Him or Her to a Helping Agency

If a situation seems to be fairly minor, and the person's behavior does not appear incapacitating or dangerous to himself or others or otherwise overly concerning, you may decide to release him or her and do a referral. A referral means giving the person specific information about a community agency or organization that might provide professional help, including name of the agency, address, and telephone number. If possible, give the subject the name of a specific person to contact. If the person is the victim of a crime, you may refer him or her to a victim's assistance agency.

If you choose this option, be sure to document your contact thoroughly, usually in an incident report. It is usually a good idea to forward a copy of the report to the helping agency, so they can follow up with the subject if appropriate.

If you release a person, you must feel confident that it is safe to do so for all concerned, and that the situation which was the basis for the contact will not recur. If you have reason to believe that the person is mentally ill and potentially dangerous to self or others, this is probably not the best option.

Release the Person to the Custody of Family Members or Friends

If the situation is minor, but the behavior involved seems severe enough to make release of the subject unsafe, or if you think it likely that the incident will recur, an option may be to place the subject in the custody of family members or friends. In some situations, the person to whom you release the subject may be a guardian, caseworker, or mental health service provider who helps with daily living tasks. This can be a good option not just for people with mental disorders, but also with people who appear to be developmentally disabled or have an apparent dementia.

If you decide to release a subject to family or friends, always give the family members or friends a complete account of the situation. It is also good practice to provide such persons with referral information on helping agencies and organizations. If the subject is already connected with a helping agency, be sure to give the agency a copy of the incident report, so that they can initiate a contact with the subject or caregivers.

Consult With a Mental Health Professional

You may have the option of contacting a local mental health center or agency for advice and assistance. This can be done over the telephone, or in person. You may even convey a subject to a mental health center, if he or she is willing, to meet with a mental health professional. The professional can then give you input about appropriate disposition of the situation. However, it is still your decision as to the appropriate action.

Contact a Crisis Intervention Team

Some communities have established multi-disciplinary teams to respond to persons in crisis. Such teams may consist of law enforcement personnel and, in some cases, mental health professionals. Members of these teams have received special training in dealing effectively with troubled people. The members of this unit will respond to the person and will typically decide on an appropriate disposition, based on their contact and assessment of the person.

Contact a Local Mental Health Crisis Center

Every county has a mental health center that is equipped to handle psychiatric emergencies. Additionally, many mental health centers provide ongoing or short-term counseling for persons in crisis. If you encounter someone who seems to be undergoing an extreme crisis or who is having a psychiatric emergency, contact your local mental health crisis center immediately for assistance. Even if the situation does not seem to be extreme, oftentimes personnel at the mental health center can be of assistance, particularly if they have had prior contact with the individual.

Arrest the Person for a Statutory Violation

Arrest is generally the appropriate disposition when a felony offense has been committed. It may also be appropriate if you would normally arrest a person for the behavior at issue who did not exhibit indicators of possible mental disorder, but the person's indicators of possible mental disorder are minor or are unrelated to the violation. That is a judgment call.

Arrest may also be the most appropriate option when the person exhibits behavior indicating that he or she cannot be safely released and the following factors are present:

- The original incident involves an apparent violation of a statute
- No one can be located who can safely take custody of the subject
- The subject will not be admitted to a medical facility voluntarily
- The criteria for emergency detention under § 51.15 of the Wisconsin Statutes are not met

As a result of the arrest, a court may order treatment of a person, or determine other appropriate disposition to try to ensure appropriate care for the person.

If you arrest a person and convey him or her to a jail, be sure to notify jail personnel about the person's medical and mental health status. Provide them with detailed and specific information as to the person's behavior, verbalizations, and any information about medications or other treatment. If the person is in possession of medications, bring those along and give them to jail staff. Also, be very sure to let jail staff know of *any* information that causes you believe that a subject is either a possible suicide risk or a risk to assault others. Failing to provide such information could result in problems while the person is incarcerated and potential legal liability for you.

Conduct an Emergency Detention or an Emergency Protective Placement

Wisconsin law provides these options to ensure care for persons under certain circumstances. Law enforcement officers are legally authorized to implement emergency detentions and emergency protective placements, if specific legal criteria have been met. These are discussed in a later section of this text.

When dealing with persons who have, or may have a mental disorder, your determination of appropriate action to take depends on the particular situation, including your knowledge and familiarity with the subject. In some cases, of course, you will be familiar with the subject's situation because you have dealt with him or her in the past. In other cases, you will not know the person and will have to ask questions to help you assess the situation. Sometimes, a question as simple as, *"Ma'am, what can we do to help you today?"* can be quite useful. It shows that you want to help, gives a person the opportunity to let you know what would be helpful, and promotes voluntary compliance.

Remember that in deciding the best course of action, your goals are:

- to try to ensure safety of the subject and others
- to establish control
- to achieve positive resolutions of situations
- when necessary and appropriate to help arrange follow-up care and intervention for people undergoing crises

You are there to help, not just to enforce the laws.

SUICIDAL PEOPLE

Law enforcement officers often have to deal with suicidal people. You may encounter a suicidal person in a variety of contexts, including:

- A disturbance call at a residence or a public place, in which you subsequently learn that a subject is feeling suicidal
- A call about a person threatening suicide—in some cases, a person who is armed
- A rescue squad call regarding a person who has harmed him or herself—perhaps by taking an overdose of pills or cutting his or her wrists
- A call from a mental health or crisis intervention agency involving a report of a person with suicidal ideation

WHY PEOPLE CONSIDER SUICIDE

People think about, threaten, or attempt suicide for many reasons. Chief among them are the following:

- Emotional pain
- Mental illness
- Alcohol and drug use
- Rational decision
- Manipulation of others

Emotional Pain

A person may be undergoing a severe emotional crisis due to a life situation that is causing a lot of stress, leading to feelings of depression and anxiety. The person's coping abilities are temporarily severely reduced. These very uncomfortable feelings may cause a person to have thoughts of suicide. The person does not usually want to be dead, but instead wants a way out of the psychological and emotional pain they are experiencing, and perceives suicide as the way out of that pain. This is probably the most common situation that you will encounter.

Sometimes a person undergoing such a crisis will think about suicide for a while, but in other cases he or she will make a sudden, impulsive decision to take his or her life. Such an impulsive decision often follows a particularly perturbing event, such as a serious argument with another person, losing a job, hearing very bad news, or being arrested.

Mental Illness

Other suicidal people are mentally ill, and having thoughts of suicide is a result of an aspect of the illness. Serious depression is probably the form of mental illness most commonly associated with suicidal feelings. There is a very high correlation between major depression and suicidal thoughts and behavior. As noted, one reason for this is that deep feelings of helplessness and hopelessness are commonly associated with depression. That is, a seriously depressed person feels that things are terrible, that they will not get better, and that they are powerless to make things better. They are not thinking in a rational or balanced way, of course, and cannot be convinced rationally to see things differently.

In other cases, a person may be having delusional thoughts in which self-harm is predominant. Remember that delusions are ideas or thoughts that are not based in reality, but of which the person is convinced. Or, a person may be experiencing hallucinations, such as voices telling him or her to kill him or herself.

Sometimes a person's illness may cause so much discomfort that the person considers suicide as a way to end that discomfort. For example, a person with severe continuing anxiety may feel that he or she simply can't go on having those feelings, and that ending his or her life is the option to end the discomfort. Or, a person who hears voices that are accusatory or mocking or belittling may see suicide as a way to end the tortured feelings caused by the voices.

Alcohol and Drug Use

Alcohol and drug use can be factors in a person's suicidal thoughts and feelings, in a number of ways. For one thing, alcohol and drugs negatively affect judgment and reasoning, and may cause a person to act in ways that he or she might not act when not affected by the chemical substances. A person may, for example, act much more impulsively when drinking or using drugs.

In some cases, the effects of alcohol or drugs may be so uncomfortable or distressing that a person may want to be dead. Alcohol withdrawal, for example, can be extremely unpleasant, both physically and psychologically, as can withdrawal from some drugs. Some illegal or illicit drugs can cause intoxication effects that may be associated with thoughts or behavior that can result in danger to one's self or to other people.

In rarer cases, a person who is an alcoholic or drug addict may simply be so discouraged by the inability to stop drinking or using drugs as to have thoughts of suicide. Such persons may feel like failures, may feel that they have hurt or let down their loved ones or others, and may feel that others would be better off without them.

Remember that many people have co-occurring disorders, most commonly meaning that they have both a substance abuse disorder *and* a mental disorder. This "double

whammy" is problematic in many ways, because the two disorders can worsen the effects of each other. For example, if a person is having suicidal thoughts or feelings due to a mental disorder, those thoughts and feelings may be compounded when the person is drinking or using drugs.

Rational Decision

Some people will make a rational decision that they want to be dead. *Most* people who think about suicide do not really want to die, but instead just want their psychological or emotional feelings of pain to end and perceive suicide as the way to accomplish that. But some people actually want to end their lives. For example, a person may have a terminal illness and does not wish to suffer longer or be a burden to others.

Manipulation of Others

Some people use suicide threats or suicidal behavior as a way to manipulate others. They do not wish to be dead and are not feeling that suicide is a way to end emotional pain, but instead are using suicide as a way to get something they want. Example: *"If you leave me, I'll kill myself."*

Some people go further than just threatening suicide—they actually make suicide attempts as a way to manipulate others. For example, such persons might attempt suicide to get people to feel sorry for them or to get attention that they think they could not have gotten otherwise. Some such people kill themselves accidentally.

As the officer responding to a person in crisis, you cannot determine whether a suicidal person is being manipulative or really intends to commit suicide. Even if you suspect the person is being manipulative, always treat suicide threats and suicidal behavior as being real.

GUIDELINES FOR RESPONDING TO SUICIDAL PEOPLE

When responding to a person in a suicidal crisis, your key goals are to keep the subject and others safe, to control the situation, and to do what you reasonably can to help arrange follow-up care or intervention.

To help accomplish these goals, follow these steps:

1. Conduct a continuing threat assessment.
2. Try to get the person to talk
3. Show empathy
4. Negotiate solutions
5. Determine what action to take

The following discusses each of these steps in more depth.

1. Conduct a Continuing Threat Assessment.

Remember that people in crisis are unpredictable. Your first priority is to ensure safety. Conduct a threat assessment before you walk into a situation, and continue to assess throughout your contact. If the situation is clearly dangerous—for example, if the subject is armed with a weapon and threatening suicide, good tactics are critical. When dealing with a suicidal person, safety is always an issue. Even when a person seems to be calmer and more in control, he or she can be a threat to his or her own safety and the safety of others.

Always ask about weapons, including edged weapons, and check for weapons. Be aware of the possibility of weapons being brought out, even when you have checked. If you are in a residence, do not allow the subject to go into the kitchen, where there are knives. Even when a person is sitting on a couch or chair, he or she may have a knife or other weapon hidden under a cushion. Suspect that possibility and remain alert, and check for such items as soon as you can.

If the person needs immediate medical care—for example, if the person has cut him or herself or taken poison or an overdose of medication, call EMS and provide whatever immediate care you are trained to do.

If you respond to a suicidal person in a residence and you smell gas, the situation is extremely hazardous. Do not operate anything electric—do not turn on a light switch or activate any electrical appliances. Do not use your flashlight or radio. Any spark—even from static electricity—could cause a gas explosion. Leave the house *immediately* (with the suicidal person, if possible) and request fire to respond.

2. Try to Get the Person to Talk.

Try to get the person to talk and then listen carefully, so you can assess the situation and find out what is going on. Sometimes you will have information in advance that a person is suicidal, and sometimes you will not know that until you arrive at a scene. You may become aware that a person is in a suicidal crisis because of what that person says. Note, however, that often a person will make subtle hints about suicidal feelings rather than talk directly about thoughts of suicide. For example, the person may say, *"She'd be better off without me"* or, *"He'll soon be sorry he treated me this way."*

As always, getting a person to talk and listening carefully is your best way to find out what is going on. First, try to get the subject to calm down and be as physically comfortable as possible. Then, ask questions and get the person to talk, if possible. Suicidal thoughts and feelings can be difficult to talk about, but it is always best to talk about them directly rather than to avoid the subject. As you learned during the

section in this text on serious depression, some questions that are appropriate for you to ask include:

- *"Can you tell me what's going on?"*
- *"Are you thinking of killing (or hurting) yourself?"*
- If the person answers yes*: "Have you thought about how you would do it? Have you thought about when you would do it?"*
- *"Have you made previous suicide attempts?"*

Other very good questions to ask are:

- *"Is there anything that would help you now?*
- *"Is there anything we can do to help you get through this?"*

Ask these questions in a neutral, straightforward manner so that you do not give the subject the message that you consider the person "crazy" or strange for having suicidal feelings.

Listen to what the person says, using your best active listening skills. Ask follow-up questions as necessary. Doing so will not only help you better understand and assess the situation so as to decide on appropriate action, but it may also help the subject. Remember that talking things out is always better than acting things out. So if you can provide an opportunity for the subject to talk about his or her difficult feelings and thoughts, that may help prevent him or her from acting out those feelings by attempting or committing suicide.

By getting the subject to talk and by listening, you also stall for time. ***Time is your ally in a suicidal crisis situation*.** There is rarely a need to resolve such a situation quickly. A good approach is whenever you can take the time to try to defuse a subject's difficult feelings and calm a situation.

Another reason for asking these questions and documenting the answers is that it will help you decide whether to initiate an Emergency Detention of the subject. Dangerousness to self is one of the criteria for Emergency Detention, and the answers to your questions may help to establish dangerousness. You may observe other things that suggest dangerousness, such as supplies of pills, or cuts or burns on a person's arm. As noted, some people who hurt themselves are not actually suicidal, but do so for other psychological reasons. In such a case, a good question to ask is *"Did you feel the need to be dead or just hurt yourself?"* The answer may help you determine an appropriate disposition.

3. Show Empathy.

Show empathy for the person and his or her situation. Remember that your attitude and demeanor during an encounter with a person in crisis makes a big difference in the outcome of that encounter. A person experiencing a suicidal crisis is someone in a lot of pain. If you can show some human empathy for the person, it will probably help them get through the crisis a bit better. One way of showing empathy is to let the person know that you can identify with their feelings. For example, if the person is depressed because of a failed marriage, you might say (if it's true), "*"Yeah, I've been through a divorce myself. It made me feel terrible."* Remember do not say, *"I know how you feel."* You don't.

You can also say things like:

- *"I sense you're really down on yourself right now."*
- *"I know talking about this is really rough, but we can take it slow."*

4. Negotiate Solutions.

Once you have talked to a person who is in a suicidal crisis and tried to assess what is going on with him or her, try to find out what specifically can be done to help the person. As noted, it may be a good idea to ask that directly. What the answer will be depends on the circumstances. In some cases, a person may indicate that he or she needs to go to a hospital or other care facility. In other cases, the person may want to talk to a particular person or entity. If you don't ask, you may not know.

You may have to negotiate with the person. For example, he or she may want something that is not feasible, such as to be left alone or to be allowed to go to a particular location, and you cannot allow those requests. You may then have to keep talking and try to get the person to agree to another option that will ensure safety of the person and control of the situation. ***Never promise anything that you cannot deliver or do not have the authority to follow up on.*** That is never a good idea. Remember that your credibility is critical at all times, and especially so when you are responding to a troubled person.

Use whatever tools or techniques you can, in the time available, to try to get the person through the crisis situation. You are not a therapist, but you are a first responder, and your goal is to do what is possible and feasible to get the person through the suicidal crisis situation (which may last for only a short while) to a point that he or she is better able to make good decisions. Time is your ally. Do what you can in the time that you have, rather than rushing to resolve the situation—and perhaps ending up with a worse situation. Here are some tools or techniques that you can try:

Non-suicide agreement. A useful tool to consider is a non-suicide agreement, or pact. It can be a verbal agreement. It simply means that you specifically ask the subject if he or she will agree not to attempt suicide for a short, specific period of time—such as three hours or six hours. For the agreement to be reasonable the time frame must be short and definite. It is best to indicate what will happen during or by the end of that time—perhaps getting someone to see the person, getting him or her into a hospital, etc.

Example:

"Mary, we're going to try to get some help for you, but it may take a little while. Can I have your agreement that you won't try to kill yourself between now and 8:00 a.m., when we can get you in to the clinic?"

The value of this is that it provides structure for the person, and buys time for the person to get through the crisis. It gives the subject the message that you trust him or her to follow through with an agreement, which is empowering to the person. It may or may not work, but it is often worth trying. It is a tool that many therapists use, and so can you. However, it is a technique that depends on a sense of trust between you and the subject. For that reason, you should generally use it only with people you know and with whom you have a decent relationship.

A non-suicide agreement is not a binding contract, and should not be thought of as such. It is just a potential tool.

Appeal to reality/consequences of behavior. In some cases, you may be able to make a rational appeal to a suicidal person. People in suicidal crises are not usually thinking clearly and rationally, and they do not necessarily think about the possible consequences of their behavior, particularly the long-term consequences. So if you can identify a person's "hooks"—people or things that are important to them, you may be able to use this information. As with the non-suicide agreement, it is generally best to use this technique if you know the person and have a relationship with him or her, but that is not an absolute requirement.

For example, you might say something like, *"Joe, have you thought about how your death will affect others?"* In fact, Joe may not have thought about how his children or wife or others would be affected by his suicide, and your reminding him of that may affect his thinking and actions.

Or, you may say things like:

- *"How do you think your mother and/or father will deal with you killing yourself?"*

- *"You know, if you kill yourself, you'll never see Susie grow up, graduate, and get married. I can tell you care about her a lot."*

- *"You've told me you've made some pretty important breakthroughs on your job. If you killed yourself, you'll never have that satisfaction again."*

This approach may or may not work in a given situation, but it is at least a tool to consider using. In fact, it will simply not work with some people in a suicidal crisis. Some people are so desperate that they believe their loved ones actually *would* be better off without them, and are not subject to logical or reasonable arguments to the contrary. This does not mean that it is not worthwhile to *try* to appeal to a person about possible consequences of suicide, just realize that it will not work with some people.

5. Determine What Action to Take.

Once you have ensured safety and achieved control of a situation, then you should try to determine the next appropriate steps to help a person in a suicidal crisis. What these steps are depends on the circumstances. Some options include:

- Releasing the subject to his or her family and providing the subject and family members with a referral (names and telephone numbers) to local sources of assistance such as local or county crisis intervention or substance abuse agencies, suicide-prevention hotlines, etc.

- Contacting family members or friends of a person. In some cases, you may decide to initiate a contact with a subject's family or friends, to inform them of the situation and to enlist their assistance.

- Contacting local crisis intervention specialists to see the person either immediately or very soon. This may include a law enforcement crisis intervention team if available or local or county mental health/crisis intervention personnel.

- Get the person to agree to a voluntary psychiatric evaluation. You may need the assistance of local crisis intervention specialists or local mental health resources to arrange this.

- Initiating an emergency detention. As a law enforcement officer, you have the legal authority to take a person into custody, without their consent, for an emergency detention if he or she meets the legal criteria of being dangerous (to self or others) and is mentally ill, drug dependent or developmentally disabled. The purpose of an emergency detention is to make it possible for the person to be evaluated to see if he or she meets the criteria for involuntary civil commitment. If you feel you cannot safely leave the person alone or with friends or family, an emergency detention may be the appropriate choice. This option is discussed in detail in a later section of this text.

These are just some of the options available to you. How to determine the most appropriate choice in such a situation is a matter of local policy and procedure. In some cases, you may be required or advised to check with a supervisor or other person in your agency. Or policy may indicate that you are to contact a designated mental health or crisis intervention agency for advice on the best thing to do. As always, know and follow your agency's policies.

RESPONDING TO AN ARMED SUBJECT THREATENING SUICIDE

You might respond to a subject who is armed and threatening suicide. These situations are all extreme, but the specifics may vary: the subject may be armed with a firearm, an edged weapon, or some other form of weapon; the subject may be alone or have others with him or her.

Regardless of the circumstances, the primary issue in such a situation is safety—of the subject, of other citizens involved, and of responding law enforcement personnel. Gaining control of the situation is critical. How you respond depends on your threat assessment and whether anyone is in imminent danger. As always, you will try to gain control of a situation through *Professional Communication* verbalization skills. That may take time, but if you have that time, always try to use it. Do not hurry. If verbalization does not work or would clearly be ineffective under the circumstances, you can escalate to physical force. In some situations, you may need to use deadly force.

A particular concern in this regard is a subject who is apparently trying to commit "suicide by cop"—that is, acting in such a way as to force the police to kill him or her, rather than committing suicide himself or herself. For example, a suicidal man with a gun may ignore orders to drop the weapon, and instead point it at responding officers. Now it is a deadly force situation, and the subject's goal may be to have police respond with deadly force. The person is using the police as the agents of his death rather than pulling the trigger himself.

If the person is simply armed and refusing to drop the weapon, but has not actually threatened anyone with it, the proper response depends on the circumstances. As an officer, you always have the options to disengage and/or escalate in order to take proper police action. In some cases, temporary disengagement may be the appropriate response. For example, if the subject is alone and there are no other people in the vicinity that he or she can harm, it might be appropriate to disengage. In other cases, that may not be possible, and the only option may be to use physical force, perhaps including deadly force.

A specific scenario in this regard is an armed subject who is barricaded in a house and threatening suicide. Such a subject may or may not want the police to kill him. Again, proper response depends on the situation. If the subject has other people with him, perhaps as hostages, then there has to be some response to try to ensure

the safety of those other people. In such a case, hostage negotiators will likely be called to try to resolve the situation. If a subject is apparently alone, however, the tactical response decision may be different. Some law enforcement agencies have adopted a "hands off" policy in such cases. They choose not to respond so as to avoid forcing a possible deadly force "suicide by cop" situation. That is, they simply do not provide the subject with the opportunity that he wants for others to kill him.

Many law enforcement agencies throughout the country are using "less-than-lethal" weapons, such as the Taser® or other devices which stun or shock a subject but are not likely to result in death of the subject. Such devices are used increasingly in situations where firearms might have been used in the past. This includes situations where a subject seems to want to die at the hands of police. Needless to say, this is good because it is a way to avoid using deadly force when avoiding such use is feasible. Be sure you are familiar—*before* a crisis situation—with your agency's policies and procedures for use of less-than-lethal force options.

Remember that deadly force is a last resort to stop a threat, and is *only* to be employed when use of lesser force options has been precluded. As always, your threat assessment in the particular circumstances is the basis for your actions.

PEOPLE UNDER THE INFLUENCE OF ALCOHOL OR OTHER DRUGS

As a law enforcement officer, you will encounter many people under the influence of alcohol or other drugs. Some will be intoxicated when you deal with them, which can cause them to act strangely, foolishly, bizarrely, and even dangerously. Others will be experiencing withdrawal from a substance, which can also cause concerning behaviors. Both intoxication and withdrawal also present potentially serious medical problems and concerns.

Remember that *chemical abusers* constitute one of the three main categories of EDP's. As noted, this group includes people who abuse alcohol or other drugs, or both, and includes chronic abusers as well as those who are currently under the influence of alcohol or another drug, but are not necessarily long-term chemical (substance) abusers. These are people in crisis, due at least in part to the effects of the alcohol and/or drugs. Some people whom you encounter will be addicts, meaning that they are physically and/or psychologically dependent on a habit-forming substance. Alcoholics, for example, are people who are addicted to alcohol. Remember also that people who abuse substances may also have a mental disorder or a developmental disability, which can complicate your response.

ALCOHOL AND DRUG ABUSE

Abuse of alcohol is one of the most significant social problems in the United States. It causes health problems, is the source of a huge amount of personal and family heartache, and results in millions of dollars in lost work time.

Alcohol abuse also creates problems for law enforcement officers. Not only do you often have to deal with drunk drivers, you also must respond to people in a variety of situations—domestic disputes, bar fights, etc.—who have had too much to drink and are therefore difficult to deal with. In addition, Wisconsin law specifically addresses the responsibilities of a law enforcement officer in responding to people who meet the statutory definitions of *intoxication* and *incapacitation* as a result of alcohol use. These provisions are addressed later in this chapter.

Use and abuse of drugs, both legal and illicit, is also a major problem in our society. It is beyond the intent and scope of this text to list all of the various drugs and their potential effects; only general information on drug use and abuse is included.

As with alcohol, both intoxication and withdrawal from drugs are problematic. However, although withdrawal from many drugs is painful and difficult, drug withdrawal is generally not a potentially life-threatening condition as is alcohol withdrawal.

General Indicators of Intoxication

The level and degree of alcohol intoxication depends on such factors as what the person has had to drink, the amount of alcohol consumed, the time frame during which it was consumed, whether or not the person has eaten while drinking, and the person's body weight. A subject may be mildly intoxicated or extremely intoxicated, depending on a combination of these factors.

The effects of use and abuse of drugs vary greatly according to the specific drugs taken. Additionally, many subjects whom you encounter will have used a combination of alcohol and drugs. Furthermore, some subjects will have taken more than one type of drug. Thus, you are not likely to know for sure what substances a person has used.

You do not need to know the specifics to be able to recognize indicators of intoxication and/or drug use. Such general indicators include:

- Slurred speech
- Alcohol odor on breath
- Inability to stand or walk normally
- Confusion or disorientation
- Lethargy (slow, sleepy, uninspired behavior)
- Unusual or severe aggressiveness or agitation, or unusually obnoxious behavior
- Abnormal breathing, such as breathing which is very rapid and/or shallow
- Tremors ("shakes")
- Excessive irritability, being quick to anger
- Unusual restlessness, inability to stand or sit still or stay on task for long
- Feeling of being very hot or very cold
- Strange, unusual, or bizarre behavior

Additionally, you may notice indicators that are specific to possible drug use, some of which include the following:

- Track or needle marks on a person's arms or legs
- Presence of drugs or drug paraphernalia, such as wrapping paper, pipes, needles and syringes, etc.
- Pupils of the eyes either very dilated (large) or pinpoint

You may also notice that a subject seems to be experiencing delusions (ideas or thoughts that are not based in reality) and/or hallucinations (seeing things that are not there, or hearing voices, or sometimes smelling things that are not there). These symptoms may indicate drug intoxication, alcohol withdrawal, mental illness, or some combination. Again, you probably will not know the cause of these symptoms.

Indicators of Possible Alcohol or Drug Withdrawal

Withdrawal is a phenomenon that occurs when a person who has used significant amounts of alcohol or drugs, usually over a long time, stops taking them. The person's body has become used to the substance(s), and reacts in specific ways to the change that occurs when they are no longer provided.

Withdrawal from alcohol is potentially the most serious type of withdrawal. At the extreme, withdrawal can be a medical emergency. People can die from this. Alcohol withdrawal occurs when a person who has been a long-time, regular user of alcohol, in significant amounts, stops drinking. The person's body reacts to this drastic change in ways that can lead to serious complications.

Alcohol withdrawal typically occurs in stages, as follows:

1. Stage 1 occurs in the first day or so after the person has stopped drinking. Initial signs and symptoms may include tremors, profuse sweating, disorientation, and possibly delusions and/or hallucinations.

2. Stage 2 begins within 7 to 48 hours after the person has stopped drinking, and may include seizures.

3. Stage 3 takes place between 12 and 48 hours after the person's last drink. The person may experience auditory hallucinations—that is, hear voices. These voices may be taunting or persecuting.

4. Stage 4 is the final stage, and may occur within 72 to 96 hours after the person's last drink. In this stage, the person may experience delirium tremens, often known as "DTs." These are characterized by some or all of the following:

    - Profound confusion and disorientation
    - Delusions and vivid hallucinations in which the person sees various creatures—usually animals or snakes or bugs—in various postures around him or her, or feels things crawling on his or her skin
    - Shaking
    - Feeling of severe agitation and fright
    - Rapid pulse and breathing
    - Pale skin
    - Sweating
    - High fever, along with possible seizures or convulsions
    - Vomiting
    - Curling into a fetal position

If you observe a person displaying these last signs and symptoms—that is, indicators of possible delirium tremens—consider it a medical emergency and

arrange for immediate emergency medical care. Remember: a person can die from this serious stage of alcohol withdrawal.

Withdrawal from drugs is not the same as alcohol withdrawal. There is no withdrawal at all from some drugs (such as hallucinogens), and the nature of withdrawal varies depending on the particular drug for those drugs that do cause withdrawal symptoms. With some drugs (such as stimulants), withdrawal may mostly result in apathy and long periods of sleep. With others, withdrawal can be more of a medical and psychological problem for the person. Withdrawal from depressants such as barbiturates, for example, can result in convulsions, delirium, and—in rare cases—death.

LEGAL REQUIREMENTS: PEOPLE WHO ARE INTOXICATED OR INCAPACITATED

Wisconsin law addresses care of people who are or may be intoxicated or incapacitated by alcohol. The legal requirements in this regard are contained in §51.45 of the Wisconsin Statutes, **Prevention and Control of Alcoholism**. This section of law makes clear that the goal for dealing with such people is to provide appropriate treatment "in order that they may lead normal lives as productive members of society" (§51.45(1)).

The law distinguishes between people who are *intoxicated* and people who are *incapacitated*, and has different guidelines or requirements for each.

Intoxicated Person

An "intoxicated person" is defined in §51.45(2)(f) as *"…a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol."* In regard to intoxicated persons, the statutory provision is as follows:

> *"An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. Any law enforcement officer, or designated person upon the request of a law enforcement officer, may assist a person who appears to be intoxicated in a public place and to be in need of help to his or her home, an approved treatment facility or other health facility, if such person consents to the proffered help. Section 51.13 shall govern voluntary admission of an adjudicated minor to an inpatient facility under this paragraph*" (§51.45(11)(a) of the Wisconsin Statutes).

In other words, if an intoxicated person agrees, you may assist him or her to get home or to a detoxification facility or other approved treatment facility or health care facility. Or you may request another person to do so. You do not, however, have the authority to make an intoxicated person go to a detoxification facility against his or her will.

Incapacitated Persons

The legal provision is different for people who are *incapacitated* by alcohol. The term "incapacitated by alcohol" is defined in the statute as follows:

> *"'Incapacitated by alcohol' means that a person, as a result of the use of or withdrawal from alcohol, is unconscious or has his or her judgment otherwise so impaired that he or she is incapable of making a rational decision, as evidenced objectively by such indicators as extreme physical debilitation, physical harm or threats of harm to himself or herself or to any other person, or to property"* (§51.45(2)(d) of the Wisconsin Statutes).

In other words, a person meets the statutory definition of an incapacitated person if he or she, as a result of alcohol use:

- Is unconscious, or
- Cannot make rational decisions

The evidence for an inability to make rational decisions is that the person is in very poor physical condition, or has either harmed or threatened to harm himself, or others, or damage property.

If you determine that a person meets either of these criteria, then the statute requires you to take certain action, as follows:

> *"A person who appears to be incapacitated by alcohol shall be placed under protective custody by a law enforcement officer. The law enforcement officer shall either bring such person to an approved public treatment facility for emergency treatment or request a designated person to bring such person to the facility for emergency treatment. If no approved public treatment facility is readily available or if, in the judgment of the law enforcement officer or designated person, the person is in need of medical treatment, the law enforcement officer or designated person upon the request of the law enforcement officer shall take such person to an emergency medical facility. The law enforcement officer or designated person, in detaining such person or in taking him or her to an approved public treatment facility or emergency medical facility, is holding such person under protective custody and shall make every reasonable effort to protect the person's health and safety. In placing the person under protective custody the law enforcement officer may search such person and seize any weapons. Placement under protective custody under this subsection is not an arrest. No entry or other record shall be made to indicate that such person has been arrested or charged with a crime. A person brought to an approved public treatment facility under this paragraph shall be deemed to be under the protective custody of the facility upon arrival" (*§51.45(11)(b) of the Wisconsin Statutes).

This section of statutes *requires* you, as a law enforcement officer, to place a person who meets the above statutory definition of incapacitation into protective custody. Having done so, you (or your designee) must take him or her to an approved public treatment facility—such as a detoxification facility. If you designate someone else to do so, you must determine that the designated person is trustworthy and reliable and sober. The statute then says that if a public treatment facility is not available in your jurisdiction, you (or the designee) are to take the incapacitated person to an emergency medical facility for treatment.

The statute makes clear that in taking these actions, you are placing the person under "protective custody," *not* arresting him or her. That is, you are taking the person into custody, whether or not he or she wishes to cooperate, for the person's own good—primarily to ensure that his or her medical care needs are taken care of.

When you do a protective placement, you will complete a specific form for this purpose.

A subsequent section of the same statute (§51.45((11)(bm)) indicates that if the incapacitated person is a minor, then either a law enforcement officer or a person authorized to take the juvenile into custody under provisions of either Chapter 48 (the Children's Code) or Chapter 938 (the Juvenile Justice Code) may take the minor into custody, as described above. This may, for example, be a juvenile intake worker or a social worker. This statutory provision is narrow; it covers only incapacitation of a minor by alcohol, not other medical situations.

In short, the law differentiates between people who are *intoxicated* and who are *incapacitated*, gives definitions for both conditions, and sets forth different requirements for law enforcement officers to follow in responding to people in these categories.

RESPONDING TO CHEMICAL ABUSERS

Follow the general guidelines for responding to any person in crisis when dealing with a person who has (or may have) used alcohol and/or drugs. In addition, keep in mind these guidelines:

- Always consider a person under the influence of alcohol or drugs a potential threat
- Try to assess the person's physical condition
- Remember that a crisis situation is a matter of perception
- Never argue with a person under the influence of alcohol or drugs
- Remember that the person may have additional problems
- Recognize that apparent intoxication may be caused by other conditions
- Know your options for resolving the situation

Always Consider a Person Under the Influence a Potential Threat

EDP's who have used alcohol and/or drugs are unpredictable and they may be volatile and even dangerous. Such an individual may be quite cooperative one moment, and uncooperative or resistive the next moment. Never be complacent when dealing with such individuals, and always take precautions and actions that best ensure your safety and that of others.

One of the common effects of use of alcohol or other drugs is loss of normal inhibitions or other social controls that a person has when not affected by the chemicals. Thus, a person may behave in a very obnoxious or threatening or even dangerous way when intoxicated and that behavior should affect your threat assessment. A person who is under the influence of alcohol or drugs should *always* be considered a greater potential threat to officers and citizens in any situation.

People who are under the influence of certain drugs can be particularly dangerous. For example, PCP ("angel dust") may cause people to behave in a very bizarre way, experiencing vivid hallucinations and delusions—often paranoid delusions that others are out to hurt or kill them. Such a person may be very strong and violent, believing that you or others want to harm them. Such people can also be suicidal.

Similarly, a person who has taken LSD, a hallucinogenic drug, may experience a "bad trip," in which he or she may experience extreme anxiety and confusion and a feeling of loss of control.

Cocaine users may behave in a "manic" way, or appear quite anxious and restless. They may experience severe mood swings. Cocaine is a stimulant. A person who has overdosed on cocaine may be quite agitated and may experience hallucinations and/or convulsions.

Ecstasy causes users to behave in bizarre ways. People under the influence of this drug can be dangerous.

The key point is that people who have taken drugs are unpredictable and potentially dangerous to you and others. You generally do not know what drugs they have taken, nor do you know what the drugs have been mixed with, nor do you know whether the person is also mentally ill. There are a lot of variables. Always consider people under the influence to be EDPs. Therefore, never presume that you know how a subject will react to your presence and to your verbal directions in a given situation—even when you have dealt with that subject previously. Always maintain proper distancing and continue to assess threat and take proper tactical actions accordingly.

The other side of this coin is that people who behave badly when under the influence of a substance are often very different when they are not under that influence. Thus, a subject whom you encounter may be quite obnoxious and difficult—swearing at

you, being uncooperative, maybe even fighting—and then the next day, when sober, may be normal and perhaps even embarrassed and apologetic about their behavior.

Try to Assess the Person's Physical Condition

You have a responsibility to assess an individual's condition. Under the law, if a person is incapacitated due to alcohol, you have a duty to place that person in protective custody.

If you suspect alcohol or drug use, ask such questions as:

- *"What have you had to drink?"*
- *"How much have you had to drink?"*
- *"When did you take your last drink?"*
- *"Have you used any other substances / drugs? If so, what? How much? When?"*

Try to get the person to voluntarily agree to a preliminary breath test (PBT).

Also try to assess the person's physical condition, in terms of their ability to walk and talk, and so on. Observe the person for indications of deteriorating condition, as the level of alcohol or drugs increases in his or her system. Watch for such signs as:

- Decreasing level of consciousness
- Speech becoming more slurred
- Face getting more slack
- Decreasing ability to understand or respond
- Decreasing ability to walk or stand up straight

Also, be aware of possible serious injuries that may need medical attention. A person who has used alcohol or drugs may have fallen down and hurt himself. He may or may not show that he is in pain, because alcohol and drugs may dull the pain. A person may even have a broken limb and not show much pain, and may not even know that he is seriously injured. So be aware of such possible injuries, and if appropriate provide medical attention for the person.

Remember that a Crisis Situation is a Matter of Perception

Remember that a crisis situation is a matter of *perceptio*n to a person experiencing the crisis. What may seem like a routine non-crisis incident to you may be perceived very differently by a subject. For example, you may stop a man for drunk driving and may issue him a citation. To you, that is a routine procedure. But the subject may perceive this as a very significant event: he will now have this on his driving record, may lose his license, his insurance will increase, his wife may be very upset with him, and so on. To him, it is very much a crisis situation, and he may react accordingly—perhaps by becoming very upset and even confrontational. He

becomes a short-term EDP. At the very least, try to understand the significance of such an event to the subject, and do not minimize the significance of the event to him.

Never Argue with a Person Under the Influence of Alcohol or Drugs

It is not to your advantage to argue with a person who is under the influence of alcohol and/or drugs. Such a person is usually not rational, and may even enjoy or provoke arguments. Arguing can escalate emotions in a situation, and that is not what you want to happen. It is usually better to state your expectations for the subject's compliance clearly and directly and then take appropriate actions, following the **DONE** concept that you have learned about in Professional Communication and DAAT training. According to this concept, you should stop talking and take action under the following conditions:

- **D**anger
- **O**verriding concern
- **N**o progress
- **E**scape

Be prepared for a subject to be challenging and argumentative. You may hear such remarks as, *"Why are you guys hassling me?"* in a belligerent tone. You may need to be more authoritative. You may also need to repeat yourself. Persons under the influence of alcohol have a diminished capacity to process words and information. For that reason, you should speak slowly and give only one command at a time.

Remember That the Person May Have Additional Problems

Many people who abuse alcohol and/or drugs also have other issues: they may also have a mental illness, be developmentally disabled, and so on. People who are substance abusers and are mentally ill are said to have a "dual diagnosis." Dual diagnosis is fairly common. In particular, people who have depressive disorders and/or anxiety disorders often use alcohol or drugs, partly as a way to self-medicate their persistently uncomfortable feelings. Also, people with certain personality disorders—including antisocial personality disorder and borderline personality disorder—are often substance abusers.

The dual diagnosis of mental illness and substance abuse is problematic because the two disorders together make each one worse. A confused person becomes more confused, a hostile person more threatening and assaultive, and a suicidal person more likely to engage in self-harmful behavior, and so on. Thus, the potential threat to you and others from such a person is more than if the person were just a substance abuser or just mentally ill. Also, with some people their mental disorder and their alcohol or drug use may increase the likelihood that they will engage in antisocial and criminal behavior.

Again, you may or may not know that a person has both a mental disorder and a substance abuse problem. You may only be aware of his or her behavior, not the cause of that behavior. However, if you are aware that a subject has a history of mental illness *and is also* a substance abuser, that information should make you aware that this particular EDP is potentially more unpredictable and dangerous.

Recognize That Apparent Intoxication May Be Caused by Other Conditions

Some medical conditions mimic the indicators of substance abuse, as well as of mental illness. For example, a person with diabetes may experience a diabetic coma or insulin shock, and those signs and symptoms may be interpreted as mental illness or substance abuse. They are similar in some ways. Or, a person may have a seizure, which could be due to alcohol withdrawal or could be due to epilepsy. A person may experience visual or auditory hallucinations and/or indicators of paranoia (extreme suspiciousness) as a result of mental illness, or use of certain drugs, or as a result of alcohol withdrawal.

If you smell the odor of an intoxicant (such as beer or whiskey) on a person's breath or clothing, that may tell you that he or she has used alcohol. But it does not mean that alcohol is the only issue; the person may have used other drugs as well, may be mentally ill, and may have another medical condition or problem in addition to the alcohol use. Remember, it is not your job to diagnose a person's condition—that is, to determine the reason for the signs and symptoms you observe. Your job is to assess whether or not a situation seems to be serious enough to require medical attention, including emergency care.

Know Your Options for Resolving the Situation

If a person is intoxicated, but not incapacitated, you have various options for resolving the situation. Depending on the circumstances, these may include:

- Doing nothing, if the person appears to be safe and is not causing a disturbance
- Taking the person home, if he or she consents
- Leaving the person in the care of a sober friend or family member
- Taking the person to a detoxification facility for voluntary admission if the person and the facility staff agree

Your agency may have specific policies for dealing with intoxicated persons. You should know and follow these.

If the person is incapacitated by alcohol, you have no choice: you must place him or her in protective custody and take him or her to a treatment facility.

Of course, if the person needs medical attention for injuries or other conditions, you must provide for that as well.

PEOPLE EXHIBITING MEDICALLY SIGNIFICANT BEHAVIOR

The last chapter discussed people under the influence of alcohol and other drugs and noted that a person who is drunk or high may also have other medical problems. This chapter addresses the broad topic of "medically significant behaviors" that you may encounter in your work as an officer and how best to respond to them.

You are not expected to diagnose and treat medical or psychiatric conditions, and you are not expected to jeopardize your safety or the safety of others when a subject's behavior poses a danger. However, you should be aware of behaviors that may indicate a serious medical condition exists and take steps to ensure that the subject receives appropriate medical care as soon as practical.

WHAT IS MEDICALLY SIGNIFICANT BEHAVIOR?

The term "medically significant behavior" cannot be precisely defined. It includes a variety of behaviors that indicate a serious and potentially life-threatening medical condition is present. Many acute medical conditions can be life-threatening. For example, severe chest pain may indicate that a person is having a heart attack, or mental confusion coupled with flushed, hot, dry skin can indicate heat stroke. These sets of signs and symptoms indicate life-threatening medical emergencies, and you need to recognize their seriousness—but they are not medically significant *behaviors*. This chapter focuses on particular behaviors and signs exhibited by people in crisis that signal a medical emergency.

As we have seen, people in crisis may behave in a variety of ways that are unusual. They may act fearful or paranoid, they may talk to people you can't see, they may make odd or repetitious movements, or they may speak incoherently. While these behaviors can certainly be troublesome, they do not in and of themselves indicate that a life-threatening emergency exists. Certain unusual behaviors, however, particularly when combined with extreme agitation, can indicate physiological imbalances that if untreated often lead to death. This chapter addresses how to recognize and respond to these.

As an officer, you must be aware of medically significant behavior for two reasons:

- You are most likely to be first on the scene
- Medically significant behavior is associated with in-custody deaths

First On Scene

When someone is exhibiting extreme or peculiar behavior, bystanders usually call the police rather than EMS. This is particularly true when the behavior is disruptive or violent. As a consequence, when a person is exhibiting medically significant

behavior, it is likely that officers will be on the scene long before EMS. In fact, unless the subject has obvious injuries—or has caused injury, EMS may not be called at all. Unless the officer recognizes medically significant behavior and requests an EMS response, the individual may not receive treatment in time to prevent death.

In-Custody Death

Medically significant behavior is also associated with in-custody deaths. Here is a typical scenario:[1]

> *A man who is high on meth suddenly begins acting bizarrely. He begins yelling and screaming for no apparent reason. He starts to attack inanimate objects, particularly a plate-glass window. He strips off his clothes. He may be cut by the glass, but acts as if he is not even aware of the injuries. Bystanders call police. The responding officers attempt to calm the individual without success. He does not even acknowledge their presence and continues to behave violently.*
>
> *Officers attempt to take him into custody, but he fights them off, showing "superhuman" strength. More officers arrive and join the fray. Eventually, after an extended struggle, six officers are able to subdue him. They handcuff him and apply leg restraints and place him in the back of a squad car, where he continues to struggle against the restraints. Eventually, he calms down. He does not complain of any injury. The officers arrive at the jail only to discover that the subject is dead. Resuscitation efforts fail.*

What is the likely aftermath of this set of events? The subject's family will accuse the police of causing the death by excessive force or inappropriate restraint procedures. The media will give the incident widespread coverage, and editorials will appear that are critical of the agency's policies and procedures and that question its commitment to upholding arrestees' civil rights. An internal investigation will ensue and lawsuits will be filed. The findings of the investigation may be referred to the District Attorney's office to determine whether charges should be filed. The officers' lives and careers will be disrupted—and possibly permanently damaged.

While some cases of in-custody death no doubt do result from officers' misconduct, many are never satisfactorily explained. Over the years, various theories have been advanced, including that certain restraint procedures, such as "hog-tying" might cause death by positional asphyxia, by placing a prisoner in a position that compromises his or her ability to breathe. As a result, many agencies have

[1] Adapted from a PowerPoint created by Michael D. Curtis, M.D., EMS Medical Director Saint Michael's Hospital, Stevens Point, Wisconsin; St. Clare's Hospital, Weston, Wisconsin; Ministry Health Care. Used by permission.

developed policies regarding restraint options, in the hope of reducing in-custody deaths. While positional asphyxia may be a contributing factor to unexplained in-custody deaths, particularly with obese subjects, it is not the entire answer.

Other theories have suggested that the use of OC spray or electronic control devices is a primary cause of in-custody deaths. Research has so far not substantiated these claims.[2]

A relatively new theory suggests that many in-custody deaths are the result of underlying medical problems, sometimes related to the use of illicit drugs, alcohol withdrawal, or use of psychotropic medications. These medical problems may be exacerbated by prolonged struggles with police, setting in motion a series of changes in the chemistry of the blood and brain that have been referred to as "the freight train to death."[3] Immediate medical intervention may be able to reverse these changes and stop the train. Without prompt medical intervention, a person experiencing these body chemistry changes will almost certainly die.

RECOGNIZING MEDICALLY SIGNIFICANT BEHAVIORS

Law enforcement officers are skilled at observing human behavior. After all, much of police work involves dealing with people. As an officer, you receive training in how to conduct a threat assessment—some of which is guided by your observations of a subject's behavior. In conducting investigations, you look for cues in a subject's behavior to guide your interview and help you try to determine who is lying and who is telling the truth. Just as certain behaviors may indicate a person is threatening to attack, certain behaviors may indicate a serious medical condition. Of course, anytime the police are called because of someone's behavior, the behavior is likely to be out of the ordinary. People don't call the police because their neighbor or friend is acting normal! How can you recognize medically significant behaviors?

Identifying medically significant behaviors in a timely way depends on two skills:

- Developing an accurate field impression
- Recognizing typical behaviors associated with Excited Delirium

Field Impression

One of the first questions that emergency medical technicians (EMT's) learn to ask in initially assessing a patient is "What's my general impression?" They are taught to form a general impression even before taking a blood pressure or checking a pulse.

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[2] See Petty, Charles, S., M.D. *Deaths in Police Confrontations When Oleoresin Capsicum is Used.* Unpublished report funded by the U.S. Department of Justice under Award Number 2001-M7-56. February 2004. Available at http://www.ncjrs.gov/pdffiles1/nij/grants/204029.pdf. See also Manojlovic, Drazen, et al. *Review of Conducted Energy Devices*, Technical Report TR-01-2006 prepared for the Canadian Association of Chiefs of Police.

[3] Michael Curtis, M.D.

The idea behind this is that simply by virtue of growing up around other people, a new EMT already has a good sense of what someone looks like when they are generally well—or not. If the new EMT looks at a patient and thinks to himself, "This guy looks really sick," he's probably right. Of course, as that new EMT gains field experience, his general impressions are likely to become even more reliable.

Similarly, as you gain experience on the street dealing with a variety of people exhibiting various sorts of behavior that prompted a call to 911, you will get a sense of what's "normal" bad behavior and what's out of the ordinary. If you encounter a person whose behavior is extreme in ways you don't normally see, consider the possibility that it might indicate a serious medical problem.

As you arrive on scene, during the Approach Considerations phase of Disturbance Resolution, in addition to assessing the threat potential, make a conscious effort to form a field impression of the person. Ask yourself if the person's behavior is similar to other people you've dealt with in similar circumstances. For example, officers are frequently called to remove an intoxicated person who is refusing to leave a residence. Sometimes these people are combative, or have difficulty processing information, or repeat themselves. Those are all common behaviors associated with alcohol intoxication. If instead, when you respond to the call, you find the subject fighting with his own reflection in a mirror while totally ignoring the fact that you're there, that's *not* typical for an everyday drunk. Something else may be going on.

Typical Behaviors Associated with Excited Delirium

Many medical conditions can cause behavior problems. Head injuries, for example, can often cause behavior that is atypical for the person. Mental disorders and mental illness, as discussed in an earlier chapter, often have associated behaviors. Purely medical conditions, such as hypoglycemia (a type of diabetic emergency) or hyperthyroidism can produce irritable or combative behavior. Of course, ingestion of excessive alcohol or use of stimulant drugs such as cocaine and methamphetamine can cause disruptive behavior as well. Recently, researchers have identified a syndrome called *Excited Delirium* that may explain otherwise inexplicable in-custody deaths.

While the existence of Excited Delirium as a distinct condition is still somewhat controversial in the medical world, autopsies of persons who have died in police custody after violent confrontations have revealed certain abnormalities in the brain and blood chemistry that are unlikely to be the result of police action. Usually, the person has ingested a stimulant drug that may serve as a trigger to set the process in motion. In some cases, psychiatric drugs may also be involved.

In the cases studied, the subjects' behavior at the time of their confrontation with police contained some common elements. Some of these signs and behaviors associated with Excited Delirium are readily observable by a responding officer:

- Confusion and bizarre behavior—out of the realm of "ordinary" bad behavior
- Extreme agitation and excitement
- Hallucinations and paranoia
- Violence directed at objects—especially glass and shiny surfaces
- Superhuman strength and insensitivity to pain
- Hyperthermia—the body temperature may rise as high as *113°F* almost 15 degrees above normal—resulting in profuse sweating and often undressing

Frequently, bystanders will report that the subject "just snapped" or suddenly started acting strange. The subject will not follow your commands and indeed, may not even acknowledge your existence.

If you see these behaviors, you may have a subject who is experiencing an extreme medical emergency. While your first job is always to protect the safety of yourself and others, you should recognize that getting medical help to this individual is also a priority. Without medical intervention, a person experiencing Excited Delirium will almost certainly die—and die quickly. So what should you do? The next section addresses how best to respond to those exhibiting medically significant behavior.

RESPONDING TO MEDICALLY SIGNIFICANT BEHAVIOR

If you are confronted with a subject who is displaying behaviors that suggest the possibility of an underlying medical problem, especially an imminently life-threatening one, managing the situation becomes more complex. Your immediate goals remain the same as always: to stabilize the scene and preserve life and evidence. How you accomplish these goals, however, may change.

An important point to remember is that at the center, what you are seeing is not so much a crime in progress—although criminal acts may be taking place—as it is a medical emergency in progress. If you recognize medically significant behaviors, especially those consistent with Excited Delirium, your priority must be the safety of all involved, *including the suspect.* Criminal prosecution can wait, but the medical emergency won't.[4]

If a person is experiencing Excited Delirium or some other medical problem that is contributing to violent behavior, your response tactics should be geared to accomplish the following:

- Avoid increasing the subject's agitation or excitement
- Minimize physical struggles with the subject
- Minimize the use of restraints
- Get medical care for the subject as quickly as possible

[4] From a PowerPoint by Michael D. Curtis, M.D.

Of course, your first priority is always safety—and your safety, your partner's safety, and the public's safety come first. If, however, circumstances allow, the following procedure may be helpful:

1. Attempt to calm the subject, using verbal techniques from Crisis Management and Professional Communication.
2. Request backup and Advanced Life Support (ALS) EMS response (paramedics).
3. Once EMS is on scene, use an Electronic Control Device to make it possible to approach the subject.
4. Have the paramedics administer a tranquilizer, in accordance with local protocols.
5. Contain the subject without restraints until he or she is calm.
6. Transport the subject to a hospital in an ambulance, using minimal restraints.

Of course, not every situation will allow this procedure. If the subject is posing an imminent threat of injury to someone, you cannot stand by while you wait for EMS to arrive. Nor will this procedure work if an ALS ambulance is not readily available (EMT-Basics and EMT-Intermediates cannot administer tranquilizing drugs). If the subject does not calm down and remains combative, you may need to use restraints. You certainly cannot place a combative patient in an ambulance without restraints—nor should an ambulance transport a restrained subject without an officer along who can remove the restraints if needed.

If the circumstances do not permit this procedure, use other customary practices to gain control of the subject.

When circumstances do make this procedure possible, however, following it can literally save lives. By recognizing medically significant behavior early and acting to allow quick medical intervention, you may be able to provide critical care and derail the "freight train to death."

PEOPLE WITH DEVELOPMENTAL DISABILITIES

As a law enforcement officer, from time to time you will respond to calls involving people who have some form of developmental disability. Such a disability is defined as a severe, chronic (continuing) disability which originated during birth or childhood, is expected to continue indefinitely, and which substantially restricts the person's functioning in several major life activities. It is caused by a mental or physical impairment or some combination of such impairments, and begins before the person reaches the age of 22. The disability results in substantial functional limitations in at least three of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Typically, people with such disabilities require life-long services and supports or other forms of assistance.[5]

Wisconsin statutes define the term <u>developmental disability</u>, as follows:

> *"'Developmental disability' means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the affected individual. 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging."* (§51.01(5))

According to this definition, a developmental disability can be caused by any of several conditions. Sometimes these conditions can occur in combination. For example, a person could have both cerebral palsy and mental retardation.

Also according to the statutory definition, there are two key characteristics of a developmental disability:

- The disability has either continued for a period of time or "can be expected to continue indefinitely."
- The disability results in a significant handicap to the person with the disability.

As a law enforcement officer, you may have occasion to respond to persons with developmental disabilities. It is not uncommon for them to be victims of crimes. In

[5] Federal Developmental Disabilities Assistance and Bill of Rights Act (DD Act) of 2000.

fact, some studies have shown that both children and adults with developmental disabilities are at significantly greater risk of being physically or sexually assaulted than people who do not have such disabilities.

In this chapter, we discuss several of the more common developmental disabilities, including mental retardation, autism, and other conditions that can result from physical injury or brain damage. We also address fetal alcohol syndrome, which is not considered a developmental disability, but which presents some similar challenges for law enforcement.

MENTAL RETARDATION

The most common form of developmental disability you will encounter is probably *mental retardation*. The key characteristic of mental retardation is reduced intellectual functioning. A person with retardation also has diminished ability to adapt to the daily demands of the normal social environment, including communication, academic or vocational skills, and independent living skills. To be diagnosed as retardation, this disability has to originate before the age of 18.[6]

Mental retardation may result from any of several causes. Sometimes mental retardation is caused by prenatal (before birth) problems such as illnesses, viruses or infections, maternal use of alcohol, drugs or tobacco, or exposure to pollutants or chemicals. Other times, difficulties during childbirth that cause the child's brain to be deprived of oxygen or things that happen after a child is born, such as brain injury, malnutrition, infection, or exposure to toxic chemicals can cause retardation. Retardation may also result from genetic or hereditary causes, such as Down syndrome.

Mental retardation is not a form of mental illness, nor is it a disease. It cannot be cured. However, people with mental retardation can also experience different types of mental illness with symptoms such as hallucinations, delusions, and severe depression.

Recognizing People with Mental Retardation

Indicators that a person may have mental retardation include:

- Apparent inability to understand things as well as other people
- Concrete thinking: apparent difficulty in understanding or processing abstract ideas or concepts
- Immature behavior in certain social situations or acting below age level

Most people with mental retardation whom you will encounter will be mildly or moderately mentally retarded. (These distinctions are based on IQ (intelligence

[6] American Association on Mental Retardation.

quotient) levels.) Such people are generally quite capable of holding a job and living independently and caring for themselves, though with some limitations. People with severe retardation or profound retardation are less likely to be able to function independently, but are still often victims of crimes.

A person with mental retardation may experience a crisis situation for any of several reasons. He or she may be traumatized as a victim of a crime, or may have a disturbing argument or confrontation with someone, including a family member, employer, or other person. Sometimes people who are retarded are "scapegoated" or set up by others to do things that they would not otherwise do, which gets them into trouble—including trouble with the criminal justice system.

Responding to People with Mental Retardation

In addition to the basic crisis intervention guidelines, follow these guidelines for responding to a person who has or may have mental retardation or other developmental disability.

Treat the Person With Respect. A person with mental retardation or other developmental disability is as deserving of respect and consideration as anyone else. Avoid any behavior that could be interpreted as demeaning—it is unprofessional.

- Do not talk down to the person or condescend in any way. Treat adults as adults, and don't assume the person can't understand you.

- Never make demeaning or sarcastic comments about the person, especially in his or her hearing.

- Avoid using the words "retardation" or "retarded" in front of people. If you need to refer to a victim's impairment and the person is nearby, use the term "person with a disability." In most cases, the person knows that he or she has a disability, and it is okay to ask politely about it: *"Do you have a disability of some kind?"*

Be Patient. A person with mental retardation or other developmental disability may be frightened or intimidated by the presence of a law enforcement officer, with uniform, badge, gun and so on, in addition to the distress surrounding the circumstances that created the crisis. Be prepared for the fact that these encounters may take more time than others. Some specific suggestions include:

- Always take a moment to explain who you are, and why you are there. Introduce yourself as a law enforcement officer, followed by your agency and your name.

- Be persistent but calm if the person doesn't comply or becomes hostile or aggressive. Remember that he or she may feel confused, may not understand what is going on, and may feel frustrated. Take your time. If necessary, take a break in your interview or discussion to allow the person to calm down.

- Minimize distractions if possible, such as radios or other outside noise sources and try to make the person comfortable. If possible, have him or her sit down.

- Be careful about touching—it may be perceived as threatening.

Keep Things Simple. People with mental retardation or other developmental disabilities may have difficulty communicating. They may find it difficult to organize information, relate events in a coherent time sequence, or understand complicated or abstract questions. In addition, they (including someone who is a victim) may be eager to please or may be easily influenced by you. They may say what they think you want to hear, which may or may not be the truth. Thus it is important to keep your questions very simple and clear. Here are some specific suggestions:

- Speak directly to the person. If he or she is with another person (family member, friend, etc.), do not assume that you need to speak to that other person instead of the person with retardation.

- Speak slowly, and use simple language and vocabulary that the person can understand. If he or she does not seem to comprehend what you are saying, try again, using simpler or more concrete words or phrases. Do not overload the person with too much information.

- Ask only one question at a time. Break complex questions down and simplify them as much as you can. It is usually best to ask open-ended questions that cannot be answered with a "yes" or "no." Examples: *"Tell me what happened?"* In the same way, break instructions or explanations down into small, simple components.

- Keep in mind that *who*, *what*, *where*, *when* or *how* questions can be difficult for people with cognitive disabilities. "When" is probably the most difficult concept, even when people are able to tell what happened and by whom, they may not get the time sequencing right. That difficulty of theirs might lead you to believe that the person is lying, but that is usually not the case. It is just not possible for them to give you an accurate time sequence because that is a bit too abstract a concept.

- You may need to help a person understand your questions by giving him or her concrete points of description or reference. For example:

- *"What color was the man's hair?"*
- *"What color was the jacket he was wearing?"*
- *"Was she driving a car or a truck?"*
- *"What did the woman look like?"*
- *"Did this happen before or after lunch?"*

- Avoid questions that are confusing or require much reasoning, such as these:
  - *"Do you have any idea what was going on?"*
  - *"What made you do that?"*
  - *"Why do you think she did that?"*
- Check frequently to be sure you have understood correctly by paraphrasing what the person has said.
- Explain written information, if appropriate, and offer to help the person fill out paperwork.

If the person is a victim of a crime, he or she may feel very upset and scared. This is especially likely in a situation in which the person has been physically or sexually assaulted. It is then particularly complex if the perpetrator of such an assault was a family member or caregiver or someone else with whom the person is close. In such a case, the person may have difficulty telling what happened, may feel that he or she is to blame, or that if he or she "tells on" the perpetrator, he or she will risk losing the family member or caregiver.

You might ask a person who is a victim if there is anyone they would like you to call to be with them during the interview. But remember that family members, service providers, and others can have a vested interest in the interview. As noted, they could be the offender(s) or may be trying to protect the offender(s).

Again your job is also to do what you can to try to be sure that a person with mental retardation receives appropriate community services, when that is appropriate. You do this by asking questions to determine if such services are needed and if the person knows about them, and if they are currently involved. You need to be aware of available community services and refer people to such services, when appropriate. You may give referrals to people with disabilities as well as to their family members or friends or employers, depending on the circumstances.

AUTISM

Autism is a neurologically-based developmental disability that seriously affects a person's communication, decision-making and socialization skills. It is estimated to affect more than 12 million people in the world, and affects four times as many males as females. Autism is a complex disorder that includes multiple levels of functioning, from mild to severe. Some people with autism have severe mental retardation; others have superior abilities. Cognitive ability will have a significant effect on whether or not a person with autism will be verbal or nonverbal and the extent to which he or she is able to function independently. Almost all people with autism have significant problems responding appropriately in social situations.

There is no known cure for autism, although medications may help some of the symptoms in some cases.

Recognizing People with Autism

It may be difficult to recognize that a person has autism. He or she may have and present an autism information card, may wear a medical-alert bracelet or other piece of jewelry, or may have information sewn or imprinted on clothing or on a non-permanent tattoo. Some other indicators that a person may have autism include:

- Verbal difficulties
- Unusual physical behaviors
- Inappropriate social responses

Verbal difficulties. Approximately 50% of people with autism are entirely non-verbal. Others may only repeat what was said to them, or may communicate with sign language, picture cards, or use gestures and pointing. Those who do speak may do so in a passive, monotone voice, possibly with unusual pronunciations or words. He or she may sound computer-like, and/or may not use an appropriate volume for a given situation.

Persons with autism may not understand verbal directions or commands such as, *"Stop," "Come here," or "Stand here."* He or she may seem not to listen, or may not seem to care about what is being said. Or he or she may not make normal eye contact, which can give the impression that he or she is not listening or has something to hide. The person may not be able to give important information or answer questions. He or she may not respond to a request for clarification, or may not understand or accept statements or answers from officers.

The person may appear argumentative, stubborn or belligerent. He or she may say *"No!"* in response to many questions, or may ask *"Why?"* incessantly. When uncomfortable for any reason, a person with autism may engage in repeated questions (*"What if…? What's your name?…"*); or may continually argue; or may

ramble on about such things as a favorite sports team, train or bus schedules, names of cities, etc. People with autism are usually very honest—sometimes *too* honest. They are often very blunt and not tactful, and do not or cannot tell lies.

Unusual physical behaviors. Often people with autism have physical behaviors that can seem very odd or bizarre. They may walk in an unusual way—such as walking on their toes, or using a pigeon-toed gait or a running style. They may appear drunk, or as though high on drugs, or having a psychotic episode. The person may stare at you or direct a fixed gaze somewhere else.

In the case of a sudden change in routine or unusual sensory input (e.g., lights, sirens, presence of dogs) a person with autism may respond with an escalation of behaviors often associated with autism. These can include repetitive behaviors such as pacing, hand flapping, or twirling hands; hitting oneself; or screaming. Temper tantrums are often a response to fear, confusion or frustration, and represent an effort to stop the disturbing stimulus.

Persons with autism may also have a seizure disorder, although this will not ordinarily be obvious to someone who does not know them.

Inappropriate social responses. People with autism may have difficulty with appropriate personal space, and may stand too close or too far away. He or she may have difficulty interpreting facial expressions (e.g., smiles, frowns, raised eyebrows, etc.) or body language (e.g., command presence or a defensive posture). Similarly, the person may have difficulty recognizing jokes or teasing remarks.

A person with autism may not recognize potentially dangerous situations, and/or may not be able to distinguish between serious problems and minor ones. He or she may not know how or where to get help for problems. Persons with autism may not recognize a police vehicle, badge or uniform, or, even if they do recognize these symbols of authority, they may not understand what is expected of them.

Responding to People with Autism

The following are some general guidelines for proper response to people who you know have autism, or who behave in the ways described above:

- Keep sensory stimuli to a minimum
- Check for injury and medical information
- Use effective communication techniques

Keep sensory stimuli to a minimum. If possible, turn off sirens and flashing lights and remove or limit other sensory stimuli. If feasible, keep dogs from the scene. Even ordinary lights, sounds, touch, and/or verbal directions may not be well tolerated, and the person may react with repetitive behaviors often associated with autism. If the person's behavior escalates, maintain a safe distance until his or her

inappropriate behaviors lessen—but remain alert to the possibility of further outbursts or impulsive acts.

Check for injury and medical information. Check for the presence of medical alert jewelry or tags, or other information indicating that a person has autism. Remember that a person may also have a seizure disorder, and there may be information about that specifically. Evaluate the person for injury. He or she may not ask for help or show any indications of pain, even though injury seems apparent.

If possible, avoid touching the person—especially near the face and shoulders. If touching seems necessary, alert the person first. Try to avoid standing close to or directly behind a person with autism.

If you take an individual you know or suspect has autism into custody and convey him or her to jail, be sure to let jail staff know about the possibility of autism. This is information that is important for the individual's safety. You may suggest to staff that they place the person by himself, rather than in general population, pending an evaluation by a mental health professional. That will help avoid risk of abuse and/or injury to the person with autism.

Use effective communication techniques. When you are dealing with a person with autism, you should talk in a calm voice and repeat things as necessary. Be patient and use a normal tone of voice—talking more loudly will not help the person understand better. Expect delayed responses to questions or commands. Wait for the person to respond and wait for him or her to make eye contact. If the person seems comfortable, you can ask him or her to *"Look at me."* However, do not interpret limited or no eye contact as meaning that the person is being deceitful or disrespectful. Do not force or expect eye contact.

Use short, direct phrases, such as: *"Stand up now."* and *"Go to the car."* Avoid idioms or figurative expressions such as *"What's up your sleeve?"* or *"Are you pulling my leg?"* because the person will probably not understand these phrases. You may want to consider using alternate ways of communicating with the person, through visual techniques such as writing, drawing stick figures, or sign language (if you or someone knows that), or—if available—picture or phrase books.

OTHER DEVELOPMENTAL DISABILITIES

You will sometimes respond to persons with other developmental disabilities, in addition to those with mental retardation. Here are descriptions of some of the more common ones and guidelines to keep in mind.

Cerebral Palsy

Cerebral palsy is a term used to describe a group of chronic conditions affecting body movements and muscle coordination. It is characterized by an inability to fully

control motor function, particularly muscle control and coordination. Some people with this condition experience muscle spasms or other involuntary movements. Some cannot talk or walk; others can. Cerebral palsy is caused by brain damage, usually during fetal development or infancy.

A person with cerebral palsy may experience a crisis situation like anyone else. He or she may, for example, become easily frustrated if something unusual happens, or if unable to communicate with someone or to get around easily.

It is important to be patient with people with this disability. They may have great difficulty communicating verbally, and it can be too easy to become impatient. Take time, and, if necessary, seek the assistance of a person who has experience in communicating with the person. Remember that a person with cerebral palsy may *or may not* have associated mental impairment.

Epilepsy (Seizure Disorder)

Epilepsy is a physical condition that occurs when there is a sudden, brief change in the way that the brain works. When brain cells are not working properly, for any of a variety of reasons, a person's consciousness, movements or actions may be altered for a short time. These altered states are known as epileptic seizures. In some cases, a person can have a convulsion with complete loss of consciousness. In other cases, a person will just have a brief period of fixed staring. Or, a person may engage in brief periods of unconscious "automatic behavior," such as buttoning or unbuttoning a shirt, and may not remember doing so later.

If you observe behaviors such as these, be aware that it could be a seizure. Do not assume that a person is acting "weird" on purpose.

Traumatic Brain Injury

Traumatic brain injury (TBI) occurs when a sudden physical assault on the head causes damage to the brain. This may result from an accident, a fight, or other head trauma. Shaken baby syndrome is a severe form of head injury that occurs when a baby has been shaken forcibly enough to cause extreme brain injury. TBI does not refer to brain injuries that happen during birth.

The signs of brain injury vary, depending on the part of the brain that was injured and the severity of the injury. Signs of injury may include difficulties with:

- Abstract thinking and reasoning or understanding words
- Memory, attention, or problem-solving
- Speech
- Walking or other physical activities
- Seeing and/or hearing
- Learning

Brain injury can also sometimes cause strange behaviors or behavior patterns. If you see a person exhibiting these behaviors, at least keep in mind that brain injury may be the cause. It could be a medical emergency, or at least a situation that calls for medical evaluation to determine the cause of the behavior.

Prader-Willi Syndrome

Prader-Willi Syndrome is a rare genetic (inherited) disorder that is characterized by mental retardation, short stature, small hands and feet, and often an insatiable appetite that commonly leads to obesity.

FETAL ALCOHOL SYNDROME

Fetal alcohol syndrome (FAS) is not specifically a developmental disability, according to the Wisconsin statutory definition. However, it is a condition that is not uncommon and shares certain characteristics with developmental disabilities.

Fetal alcohol syndrome is a pattern of physical and mental defects which develops in some unborn babies when the mother drinks too much alcohol during pregnancy. Symptoms include growth deficiencies, such as small body size and weight, deformed facial features, poor coordination, and mental retardation or problems with learning. Many people with FAS are also hyperactive as children, and may have poor impulse control and poor judgment. Many experience behavior problems throughout their lives, which can lead to involvement with the criminal justice system.

You are unlikely to know that a person has been affected by FAS. The person may not be aware of it. However, such a person is potentially an EDP because of his or her poor judgment, poor impulse control, and other behavior problems, and therefore may be more of a threat risk.

PEOPLE WITH ALZHEIMER'S OR OTHER DEMENTIA

Though not part of the "normal" aging process, some people show signs of changes in their memory and intellectual functions as they age. Most commonly, such changes are associated with Alzheimer's disease and other forms of dementia.

You may respond to situations involving people who have Alzheimer's disease or another form of dementia. Thus, you should know basic facts about dementia, how to recognize it, and how best to respond to a person with dementia.

WHAT IS DEMENTIA?

The term *dementia* refers to the loss of intellectual abilities, such as thinking and memory and reasoning, that is severe enough to interfere with a person's ability to care for himself or herself, socialize, and plan for the future.

Dementia is not a disease in itself, but rather a description of a group of symptoms that can accompany other diseases or physical conditions. These symptoms most commonly include the following:

- Confusion as to time, place or person
- Shortened attention span
- Changes in short term memory
- Changes in language capability or trouble finding words
- Changes in ability to calculate, plan or reason
- Changes in personal care habits
- Changes in personality

Dementia is usually separated into two categories: *reversible* and *irreversible*. Gone untreated, all dementia can lead to progressive decline. However, reversible dementia means that the dementia is caused by a condition that, if treated properly, will cure it or at least slow the rate of decline. Reversible dementia that goes untreated for long periods of time can lead to irreversible changes. Conditions causing reversible and irreversible dementia can include the following:

REVERSIBLE DEMENTIA	IRREVERSIBLE DEMENTIA
Depression	Alzheimer's disease
Malnutrition/dehydration	Vascular disease (small strokes)
Infection	Frontotemporal Dementias
Medication/drug interactions	Lewy Body Disease
Vitamin B-12 deficiency	Parkinson's disease
Hydrocephalus	Huntington's disease
Hypoglycemia/hyperglycemia	Creutzfeld-Jakob Disease
	Alcohol-related dementia

Because some dementia causes can be treated and even cured, it is very important for family members and others to seek and obtain a thorough medical and psychiatric diagnosis of a person so as to identify treatable conditions. Early assessment and intervention in all cases is essential for effective treatment either to reverse the condition, if possible, or to slow the rate of progression in the case of irreversible dementia.

In the case of Alzheimer's disease and most other irreversible dementias, the changes are often subtle and come on over time, not always showing a clear indication of a problem.

Most irreversible dementias such as Alzheimer's disease are most commonly associated with older adults. In fact, research has indicated that almost 10% of people over the age of 65 have Alzheimer's or a related dementia, and that figure doubles every five years beyond 65. The Alzheimer's Association estimates that as many as 50% of persons over the age of 85 have Alzheimer's disease or a related form of irreversible dementia. In more rare instances, persons as young as 35 have been diagnosed with Alzheimer's disease. The progression of the disease in younger people is typically much more aggressive than that seen in older adults.

ALZHEIMER'S DISEASE

Alzheimer's disease is the most common form of dementia. Alzheimer's is a progressive disease that attacks brain cells, eventually causing a person to lose control over language, social awareness, mood, self-care ability, planning, reasoning, and judgment. It is a devastating disease, with huge human and economic burdens. It has been estimated that if the present trend continues, 10 to 15 million Americans will be suffering from it by 2050. Many more, of course, will be involved in caring for those people.

The progression of Alzheimer's disease is highly individualized relative to other health situations a person may experience. The progression can take anywhere

between 5 and 25 years. As the disease advances, a person may not be able to care for him or herself and may not be able to function independently. People in the terminal stages of Alzheimer's disease eventually lose control of all physical function, may no longer feel pain or hunger or thirst, and may be unable to fight off even the most basic of infections. At this point death is imminent.

It is common for people with Alzheimer's disease to be unable to recognize spouses, children and other close family members and friends. People become unable to do familiar tasks that they may have been doing all their lives. In younger people with Alzheimer's disease, keeping a job, driving safely, and participating in familiar hobbies or activities becomes impossible.

Due to its increasing prevalence, research around Alzheimer's disease is rapidly expanding. Some researchers are looking at early signs of the disease so as to better enable early diagnosis and treatment. Others are studying protective and preventive measures, including the role of certain vitamins. Still others are considering the relationship of other diseases and processes, such as high cholesterol, obesity and head trauma to the onset of Alzheimer's disease. Scientists report that there is even hope of preventing or reversing brain deterioration associated with Alzheimer's disease.

Recognizing a Person with Dementia

No two people experience the progression of dementia in the same way or at the same rate. However, the following are general indicators that you may be dealing with a person with Alzheimer's disease or another form of dementia:

- Memory loss and impaired thinking
- Difficulty performing familiar tasks
- Problems with language and communication
- Disorientation to time and place
- Poor or diminished judgment
- Problems following directions
- Misplacing things
- Changes in mood, personality, or behavior
- Impaired visual or spatial skills
- Loss of motivation or initiative
- Changes in normal sleep patterns

The following paragraphs explain these in more detail.

Memory loss and impaired thinking. Even in the early stages of Alzheimer's disease, a person may have difficulty providing an address or telephone number, or may give one that is no longer current. This person may forget that he or she has a spouse or children, and may not be able to remember names of people, even of loved ones. Lacking social awareness and inhibition, a person may expose himself

to others, when he is only trying to communicate a need to go to the bathroom or to remove clothing that is too tight, but is unable to find the right words.

Difficulty performing familiar tasks. Familiar tasks such as cooking, caring for a pet, or taking part in hobbies, may become permanently lost. In some cases, a person's inability to dress appropriately for the weather or to perform routine hygiene is a first warning for others. A person may have difficulty dressing himself or herself. A person with Alzheimer's disease may find herself accused of shoplifting, forgetting that the items placed in her cart at the grocery store must be paid for before leaving.

***Problems with language and communication*.** Especially under stress, a person with Alzheimer's disease may have trouble naming objects and people, or may substitute unusual words or phrases. If anxious or fearful, some people with dementia may respond with profane language, leading others to misinterpret them as becoming violent or aggressive, when in fact these are the only words that will come out. They may have trouble communicating even basic needs such as pain or discomfort, and may have trouble understanding the words of others, especially if trying to communicate abstract thoughts.

***Disorientation to time and place*.** A person may not be able to recognize familiar people, such as family members or friends, or a familiar location, such as their current home. A person may wander away from home or may get lost driving just two blocks to the grocery store, often ending up miles and even cities away from where he or she belongs. In the later stages of the disease, clock and calendar time become meaningless, and some may confuse their days and nights in terms of activity level.

***Poor or diminished judgment*.** A person with Alzheimer's disease may dress inappropriately for the weather. He or she may also take unnecessary or uncharacteristic risks, such as working outside in extreme heat or leaving for a trip in a terrible storm. People with dementia can show poor judgment about spending money, sometimes giving away large sums of money to telemarketers, by mail or to people unknown to them who offer to do home repairs. On the other hand, that same person may exhibit distrust of other family members who may try to assist them in managing their finances or making other decisions.

***Problems with following directions*.** A person with Alzheimer's disease or another dementia may have greater trouble understanding the directions or reasoning of others, especially when under stress. They may often be unable to understand that others are trying to assist them, and may be unable to process more than one step at a time when taking directions. A person with Alzheimer's disease may be able to read aloud words written on paper, but he or she will likely have little or no comprehension of what the words mean.

Misplacing things. A person with dementia may accuse others of having stolen items of value, when in fact the person may have hidden the item or placed it in an

unusual location. For example, a person with dementia, fearing that others are stealing, may hide their money at the bottom of a garbage can, later throwing it away when emptying the garbage.

***Changes in mood, personality and behavior*.** A person with Alzheimer's disease or another form of dementia displays rapid changes in mood or behavior, unexpectedly becoming angry or tearful, depending on the level of stress they are experiencing. Feelings of suspiciousness can be quite common. Another significant change is that people who were once very social may become withdrawn.

***Impaired visual and spatial skills*.** A person may have greater difficulty judging distances or correctly interpreting signs and obstacles. This may, for example, happen while driving, causing accidents. People with a "clean" driving record may have increased traffic altercations and citations, and may have minor traffic accidents with garbage cans and garage doors, etc. Persons with dementia may have difficulty navigating complex intersections or one-way streets, even those that they have long been familiar with.

***Loss of motivation or initiative*.** A person may become very passive, and may need prompting or encouragement to become involved and interact with other people, even in activities that he or she used to enjoy.

***Changes in normal sleep patterns*.** A person may sleep a lot during the day and be awake and more active at night.

These are some of the more common symptoms of Alzheimer's disease and other dementias. Again, the presence of these symptoms (and their severity) varies from person to person. It is a progressive disease, so that the symptoms may develop or become more noticeable as time goes on and the brain deteriorates more.

Responding to People with Dementia

As a law enforcement officer, you may encounter a person with dementia in a number of possible circumstances. Some include:

- A domestic disturbance call, in which a person may be being abused or harassed by a frustrated family member or other caregiver

- A domestic disturbance call in which a family member or other caregiver feels they are being threatened by a person with dementia

- A report of possible abuse of a vulnerable person by family members, caregivers, institution personnel, etc

- An apparently lost or confused person (usually elderly), or a person in a neighborhood or other area where he or she does not seem to belong. In

some cases, the person may seem to be looking for a particular place, like a relative's home, but does not remember exactly where it is

- A report of a missing older adult with memory loss who has wandered off from a residence or a shopping area or a residential care facility

- A request from a residential care facility where a resident has threatened violence to himself or herself or others

As a law enforcement officer, you may not initially be aware of the symptoms of dementia in a subject with whom you are interacting. If you suspect that you are interacting with a person with dementia, you may quickly confirm this by observation and conversation. Remember that a person with Alzheimer's or other form of dementia may become confused and may have difficulty communicating when asked questions. He or she may not be able to find the right words to express a thought.

In many situations, the subject will probably feel a high level of anxiety, and may feel threatened and act defensive. Given the extreme stress of the moment, it would not be unusual for the person to exhibit increased confusion and greater difficulty than normal with communication. However, other people may be able to recognize you as someone trying to assist them and will feel and demonstrate great respect for the authority that your uniform represents. They may be calmed by your presence.

Following are some guidelines to keep in mind when communicating with a person who has (or seems to have) Alzheimer's disease or some other form of dementia:

- Minimize distractions
- Gain the person's attention before touching
- Speak naturally and respectfully
- Be attentive and understanding
- Keep it simple
- Be patient
- Deal with violations appropriately

Let's look at these more closely.

Minimize distractions. Reduce background noise, such as from a TV or radio or other conversations, as much as you can. Also, eliminate crowds or bystanders to the extent possible, and encourage the person to step away from an exit door, car or other setting of possible danger or threat. If possible, have someone else conduct a radio background check away from the person's presence and out of earshot. All of these distractions make it difficult for the person with dementia to focus on your assistance.

Get the person's attention before touching. Try to make eye contact with the person before speaking, and certainly before touching. Only in circumstances where extreme danger is imminent should you touch the person without first getting his or her attention. Approach from the front, identify yourself in a quiet and calm voice (*"Hello, I'm John. I'm with the _____ Police Department"*), smile, and use the person's name if you know it. Ask permission to use the person's first name. If you are a younger officer, older adults may respond better to being addressed as "Mr." or "Mrs." Tell the person directly that you are there to help.

When you do need to touch, initiate it by extending your hand as if for a handshake. This is a social gesture that sends a message of openness and greeting, and is not as threatening as taking someone by the arm or around the waist. This may also help you judge whether the person is willing to follow your directions, or whether he or she may be too angry to cooperate or participate.

Speak naturally and respectfully. Not all older adults are hard of hearing. Speaking in an unnecessarily loud voice may startle or frighten, and can sound like shouting in anger. People with dementia who no longer understand spoken words will probably take their cues from the tone of your voice. Never speak to an older adult, regardless of the person's degree of dementia, as though speaking to a child. Do not "talk down" to them, and avoid using words such as "honey" or "sweetie." Never use baby talk.

In all interactions with a person with Alzheimer's disease and other dementias, always treat the individual with dignity and respect. That is what every person is entitled to, regardless of their condition. Never treat such a person as a child, even though his or her behavior may resemble that of a child.

Be attentive and understanding. Show that you are listening and are trying to understand. Use a gentle, relaxed tone of voice and friendly facial expressions. That can be quite reassuring to someone who may be confused. Keep your hands away from your face so that the person can see your expression. Pay attention to the person's facial expressions and body language as well—you may pick up clues indicating change in mood or behavior.

It is best for the person to be able to see your face as well, so that he or she does not feel threatened. Keep your hands away from your face and avoid making large gestures, such as waving your arms, this could be misperceived as threatening, and may startle or frighten.

Tell the person that you understand what he or she is telling you. Never tell persons with dementia that they are wrong or that they have misunderstood. If you do that, they will perceive that you do not believe them or that you think they are lying and are "ganging up" others against them. Instead, simply state what you heard them say or what you see in their emotions.

Example: "*I can see that you're upset. That would bother me too*."

Never argue with a person who has dementia. A person with dementia may express strange or incorrect ideas and perceptions, and may fully believe that these are real. He or she may verbalize delusional and/or paranoid thoughts about what others are trying to do to them, even those with whom they have a very close relationship. Do not argue or try to convince the person that their beliefs are not accurate. However, do investigate to make sure the person with dementia is not, in fact, being harmed by others. Look to family members, friends or facility staff too assist you with communication techniques to get information. Avoid criticizing him or her, or arguing or correcting.

Check for an identification bracelet or card. Some people with Alzheimer's disease or another form of dementia have a bracelet or card with their name and address and a contact person.

Keep in mind that some people with dementia live more in the past than in the present. Their short-term memory may be affected more than their long-term memory. For example, a person may not know where he lives now but remembers very clearly where he lived twenty years ago. He may even think that he still lives at that location, and is trying to find it. Or, a person may talk about something that happened many years ago as if it happened today or yesterday. Understand that this is part of the disorder, and do not argue with the person or try to convince him that he is wrong. That is not your job, and will likely only frustrate the person more.

Keep it simple. Use short, simple and familiar words. Use words and phrases that are as concrete as possible, because the person may have difficulty understanding and processing abstract ideas or concepts. If you have to give orders or commands or make requests, make them short and simple. It is better to ask or tell someone to do one specific thing at a time, and then go on to the next thing, rather than making a complex, multi-stepped request or order.

Avoid lengthy explanations or trying to reason or rationalize, as this will only further frustrate the person with dementia. The person will likely not be able to accept reality-based approaches, perhaps causing him or her to distrust you even more.

Rephrase rather than repeat. If questions appear to cause further anger or anxiety, try re-phrasing the question into a statement. If the person seems to have difficulty understanding what you are saying, try to find a different way of saying it, perhaps using simpler words and phrases.

Be patient. Helping persons with dementia can take time. Recognize this and be prepared to spend the time necessary without becoming impatient. Sensing your frustration and impatience, the person may become further agitated, may try to leave, or even become aggressive.

Repetitive speech and behavior are typical parts of dementia, so you may be tempted to interrupt or tell the person that they have already said that. Avoid that temptation. Listen as though it is the first time you have heard it, and then try to bring the conversation around to a more helpful focus. If a person does not seem to understand or remember things, be reassuring. Say, *"It's okay if you don't remember."* Never cajole a person to the point that his or her frustration increases.

Deal with violations appropriately. Be aware that some people with dementia disorders commit unintentional violations of the law. For example, a person may take an item from a store and not pay for it. Technically, this seems to be shoplifting. However, the person may have simply forgotten to pay for the item due to his or her dementia, or may not have realized that he had it, and so on. There was no intent to steal the item. Therefore, the person's behavior did not fulfill the elements of the criminal statute and charging him or her with that offense would probably not be the appropriate course of action.

If a person with apparent dementia was driving a vehicle and committed a moving violation or caused an accident, consider ordering a re-testing for his or her driver's license. Doing so is in the public interest as well as the best interests of the person.

As always, part of your job is to try to be sure that a subject (or his or her caregiver) is aware of available community assistance resources. Thus, you must learn about resources in your community for people with Alzheimer's disease or other forms of dementia. The Alzheimer's Association provides information and referral to persons living in every county in Wisconsin, and has available a 24-hour toll-free Helpline (1-800-272-3900). Providing this information to family members or caregivers can assist them with not only the immediate situation, but in planning for future needs to come. Through the Alzheimer's Association, persons may then become linked with other community resources to further assist them.

EMERGENCY DETENTIONS AND PROTECTIVE PLACEMENTS

Wisconsin law covers two issues that are relevant to proper care of people in crisis. Two key statutes are:

- **§ 51.15 *Emergency Detention***
- **§ 55.06, *Protective Placement***

As a law enforcement officer you will have to carry out the provisions and requirements of these parts of state law. This section will explain these statutes and their provisions, define your role in implementing them, and detail the necessary documentation you must complete.

WISCONSIN'S MENTAL HEALTH LAWS: AN OVERVIEW

Wisconsin has very detailed laws regarding proper care and treatment of people with mental disorders. Our mental health system is governed by Chapter 51 of the Wisconsin Statutes, known as the Mental Health Act. This chapter sets forth the roles of the state and counties in providing services to people, as well as the procedures for voluntary admission of people to inpatient mental health facilities. It also specifies the standards and procedures for civil commitment of people, which means placing someone in a mental health facility involuntarily for proper care and treatment. Chapter 51 also sets forth the rights of persons receiving mental health care.

The general philosophy underlying Chapter 51 is that there is to be a range of services available, allowing people to receive treatment in the least restrictive environment that will meet their needs for care and treatment. Therefore, Wisconsin law requires that there be a continuum of mental health services available throughout the state. Every county has the responsibility to ensure provision of such services to county residents, and this is the responsibility of a county department of community programs. Counties can, as an alternative, ensure provision for such services through a community human services department, per § 46.23 of the Wisconsin Statutes. Counties must also provide emergency crisis intervention services.

Another premise is that voluntary treatment is preferable to involuntary treatment. Under Wisconsin law people will only be placed in a facility and/or treated involuntarily as a last resort, and only if they meet strict criteria for such placement and treatment. Respect for the civil rights of people is a critical element of our system.

Another important part of Wisconsin law in this regard is Chapter 55, the Protective Services Law. This chapter addresses long-term care for persons with mental disabilities, and specifies procedures for provision of such care, in a nursing home or other facility, or in the community, for persons who have been declared incompetent under another section of law, Chapter 880. Chapter 880 includes the standards and procedures for guardianship of people who are declared mentally incompetent—that is, unable to make proper decisions regarding their own care and best interests.

Several other sections of state law also contain provisions regarding proper care of people with mental disorders. They are:

- Chapters 48 and 938: These parts of state law have to do with children (Chapter 48) and juveniles (Chapter 938). These statutes may be used as the basis for obtaining court-ordered mental health services for young people. Chapter 51 also applies in this regard.

- Section 971: Several subsections of this statute (971.13 through 971.17) have to do with forensic patients, meaning people who have been charged with crimes and found incompetent to stand trial or who have used the "insanity defense" successfully.

- Chapter 980: This chapter has to do with civil commitment of people who have been found to have committed an illegal sexual offense and have a mental disorder that makes it likely that they will commit further acts of sexual violence. The provisions of this chapter address involuntary commitment of people whose criminal sentence or commitment under the insanity plea for specified sexual offenses is expiring.

Law enforcement personnel have a significant role in the overall provision of mental health services to people in Wisconsin. That role is specified in the various chapters and section of the law, listed above.

EMERGENCY DETENTION

One of the ways in which law enforcement personnel play an important role in obtaining mental health care for people is via *emergency detentions*. If a mentally ill person presents a danger to self or others according to specific statutory standards, a law enforcement officer is authorized to take that person into custody and take him or her to a hospital or other appropriate treatment facility. That is what an emergency detention is. The person can then be held in that hospital or treatment facility for up to 72 hours (excluding weekends and holidays) until a hearing is held to determine whether there is probable cause to believe the person meets the legal standards for civil commitment.

If probable cause is found, the person can be held for fourteen (14) days from the date of detention, at which time a final commitment hearing must be held. Many cases are settled before this time with the person signing a stipulation agreeing to treatment. If a person is actually committed, an initial commitment lasts six (6) months; any subsequent extension of the commitment may be for up to one year.

Civil commitment is a serious thing. It essentially involves taking away a person's freedom and placing him or her in a treatment facility *involuntarily*—regardless of whether the person agrees—for the good of that person and of society in general. In our country, depriving a person of their liberty for any reason is not to be done lightly or carelessly. That is why the civil commitment legal standards, including those for emergency detentions, are so specific and detailed. These standards are based on three general criteria:

- The person is mentally ill
- The person is dangerous
- The person is a candidate for effective treatment

As a law enforcement officer, you may decide that an emergency detention is appropriate either based on your own observation of a subject, or based on reliable information you receive from someone else—family member, friend, or other person—who has observed that subject.

Depending on policies in your agency or jurisdiction, you may be required to consult with a mental health professional before initiating an emergency detention. Such a professional would help determine whether or not the subject meets the legal standards for an emergency detention. This can be a useful approach, because law enforcement officers are not trained mental health professionals. You should be aware of the policies in your jurisdiction and agency in this regard.

Or, your policies may either *allow* you, at your discretion, or *require* you to consult with a designated person or persons within your department, such as a supervisor, as to the decision to do an emergency detention. Some law enforcement agencies have mobile crisis intervention teams, consisting of specially-trained law enforcement personnel and in some cases mental health professionals and they may be the ones who are authorized to evaluate a subject and to decide on emergency detentions. Again, know and follow your policies in this regard.

Standards for Emergency Detention

The standards for conducting an emergency detention are specified in § 51.15 of the Wisconsin Statutes. According to the wording of the statute, a law enforcement officer is authorized to take a person into custody for an emergency detention *"if the officer…has cause to believe that such individual is mentally ill, drug dependent or developmentally disabled, and the individual evidences any of the following:* Five standards are then listed, but only the first four of them apply to emergency

detentions by law enforcement personnel. The four applicable standards are discussed below.

In other words, your *first* decision is whether a subject seems to be mentally ill, developmentally disabled, and/or drug dependent. For this purpose, § 51.01(13)(b) provides a working definition of mental illness:

> *"'Mental illness', for purposes of involuntary commitment, means substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism."*

In many cases, the main categories of serious and persistent mental illness that were listed and discussed earlier—major depression, bipolar disorder and schizophrenia—are "substantial" disorders. Remember, though, that under the statute you must be able to articulate that the person's mental illness has a specific result—it must "grossly impair" the person's judgment, behavior, and so on.

There are also applicable definitions of developmental disabilities and of drug dependency, in other parts of the statutes. Section 51.01(5)(a) & (b) defines a developmental disability, for purposes of civil commitment, as:

> *"…a disability attributable to brain injury, … autism, Prader-Willi Syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual."*

And § 51.01(8) of the Wisconsin Statutes defines a drug dependent person, for this purpose, as:

> *"…a person who uses one or more drugs to the extent that the person's health is substantially impaired or his/her social or economic functioning is substantially disrupted."*

You are not expected to make a professional diagnosis about these things, and are not qualified to do that. Instead, you are expected to make a decision based on your experience, judgment and training—including the training in this course. And remember that that decision may be based on your observations of the subject, on reliable information received from another person or persons, or on a combination of both.

Once you have "cause to believe" that a person is mentally ill, developmentally disabled and/or drug dependent, you must then determine whether the person *also* meets at least one of the other four criteria specified in § 51.15 regarding probable dangerousness, before you can do an emergency detention of that person. These

criteria allow an individual to be committed if he or she evidences any of the following:

1. Danger to self: “a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats or attempts at suicide or serious bodily harm.”

2. Danger to others: “a substantial probability of physical harm to other persons as manifested by evidence of recent homicidal or other behavior on his or her part, or by evidence that others are placed in recent fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt, or threat to do serious physical harm on his or her part.”

3. Inability to care for self: “a substantial probability of physical impairment or injury to himself or herself due to impaired judgment, as evidenced by a recent act or omission.”

4. Inability to satisfy basic needs: “behavior manifested by a recent act or omission that, due to mental illness or drug dependency, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt or adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness or drug dependency.”

Let’s look at these more closely.

***1. Danger to self*.** This standard focuses on a subject’s dangerousness or potential dangerousness to himself or herself. The key point is that you may determine that a person meets this standard if he or she has either *threatened* suicide or self-harm or *attempted* suicide or self-harm. However, the threats or attempts must have been made *recently*. You may make the decision that this standard applies based upon your observation of a scene, including such things as presence of a weapon, pills, a suicide note, the odor of natural gas, and so on.

2. Danger to others. This standard focuses on a subject’s dangerousness or potential dangerousness to other people. It takes into account several possible types of evidence:

- Recent homicidal or other violent behavior—that is, something that the subject has actually done

- A recent act which places other people in reasonable fear of violent behavior and serious physical harm—that is, not necessarily violent behavior *per se*, but some action by a subject that causes others to fear violent behavior and harm by that subject

- A recent attempt at serious physical harm that places others in reasonable fear of violent behavior and serious physical harm

- A recent threat to do serious physical harm which places others in reasonable fear of violent behavior and serious physical harm

In short, to meet this standard a subject does not have to actually carry out a violent act. An attempt or a threat to do something which creates a reasonable fear of future violence could be sufficient. Again, "reasonable" is the key word. A state appellate court ruling indicated that a threat to do harm to another person does not have to be made in the presence of the person threatened. Nor does the person threatened have to be aware of that threat.[7]

3. Inability to care for self. This standard focuses on a person's inability to care for himself or herself due to a mental condition—to the degree that it creates a danger of physical harm. Applying this standard requires evidence of a recent act (something a person has done) or omission (something a person has failed to do) which shows that the person's judgment is seriously impaired. If a person was wandering in traffic and clearly oblivious to the danger to himself, that would fall under this standard.

However, the language of this standard makes clear that there *cannot* be a "substantial probability of physical impairment or injury" if either of the following apply;

- If there is *"reasonable provision for the individual's protection…available in the community and there is a reasonable probability that the individual will avail himself or herself of these services."* In other words, if there are community resources, such as a psychiatric treatment facility, available to help the person and keep him or her safe, and it's likely that the person will take advantage of such services, then he or she cannot be committed. **Provision of care by family members or friends does not count, under the statutory provisions.**

- If the subject is a minor, *"if the individual is appropriate for services or placement under s.48.13(4) or (11) or 938.13(4)."* In other words, if legal protection is available under provisions of either the Children's Code of the Juvenile Justice Code, then the young person cannot be a candidate for civil commitment under this standard.

4. Inability to satisfy basic needs. This standard focuses on a person's inability to satisfy basic needs. It reads in part,

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[7] : *In the Matter of R.J.*, 146 Wis. 2d 431 [Ct. App 1988]

> *"…behavior manifested by a recent act or omission that, due to mental illness or drug dependency, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt or adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness or drug dependency."*

Similarly to the third standard, there must be evidence of recent acts (things a person has done) or omissions (things a person has failed to do) which shows that the person—due to mental illness or drug dependency—cannot provide for his or her basic needs (food, shelter, etc.) without prompt and adequate treatment. However, under this standard as opposed to the third standard, you are basing your decision on the person's *behavior* rather than his or her *judgment*.

A key word in this standard is "imminently," which means "about to happen." This standard makes clear that there is a probability that unless the person receives prompt treatment, he or she will *imminently* die or suffer a serious injury or debilitation or disease. For example, if a person was failing to eat because he was too mentally ill to buy food and prepare it, or thought food was poison, and the lack of eating seemed likely to impair the person's health, an emergency detention might be warranted. Imminence is not at issue for the third standard, but it is for the fourth standard.

As with the third standard, this provision may not apply if reasonable protection and treatment is available in the community, provided by a treatment program, and the person is likely to use such services; or if the person is a minor and is appropriate for services or placement under the same provisions of either the Children's Code or Juvenile Justice Code listed above, under the third standard. Also, it does not apply if the person is a candidate for protective placement, under provisions of s.55.06, which is discussed below.

These are the four standards that you will use in your decision to do an emergency detention. There is also a fifth standard for involuntary commitment, which was added to the statute (s.51.20) later than the first four standards and which went into effect in 1996. The fifth standard does not so much focus on dangerousness *per se* as it does the need for care and treatment and the potential problems that would result from lack of provision of such care and treatment. However, the fifth standard does not apply to emergency detentions by law enforcement, and is therefore not relevant to your work as a law enforcement officer in making a decision as to an emergency detention.

Remember that an emergency detention is *not* a civil commitment. You do not have the legal authority to do that. Instead, you are simply determining that a person meets the statutory requirements for *possible* civil commitment. If so, you are empowered to detain the person for a limited time until the court can decide whether

commitment is appropriate. As a law enforcement officer, the determination as to whether or not to initiate an emergency detention is yours to make. You will make these decisions based on your best judgment and professional evaluation in any particular situation. Of course, as noted, it is good practice to consult with mental health professionals or members of a law enforcement crisis intervention team to help you make the decision.

You may encounter people who want you to do an emergency detention of a person or expect you to do so, and may even try to bully or coerce you to do so. For example, staff at a hospital emergency room or a nursing home or other care facility may call police about a patient or client, and may ask or even demand that you do an emergency detention—either because they believe that it would be in the subject's best interests, or because they simply want to be rid of a person they regard as troublesome. They may just want to pass on their "problem" to someone else, or they may simply not want to take the time and effort to utilize other available legal avenues for possible involuntary commitment of the person.

In other cases, family members may ask for or demand an emergency detention of a person. Or family members or others may want you to *not* conduct an emergency detention of a person. In any event, do not allow yourself to be swayed or bullied by the demands or expectations of others—whatever their motives. Only a law enforcement officer has the authority to make an emergency detention. You must make the decision. If you think, based on the statutory provisions, that an emergency detention is warranted, you have the authority to do it.

Procedure for Emergency Detention

If you believe that an emergency detention seems appropriate, based on the legal standards listed above, then you must take the following four steps:

1. Take the person into custody

2. Complete and sign a Statement of Emergency Detention

3. Transport the person to an approved facility for evaluation

4. File the statement of emergency detention with an appropriate official at the approved facility for evaluation, and another copy with the court

The subject may then be legally detained in the evaluation facility for up to 72 hours, excluding weekends and holidays. During that time, officials of the facility will determine if they believe the person meets the statutory requirement under s.51.20 for civil commitment. A court will then hold a probable cause hearing to decide on the commitment, with the subject being provided specified due process rights. You may have to testify at such a hearing. If the officials of the evaluation facility feel that a person does not meet the standards for commitment, the person is to be released.

A person may also receive treatment during the period of the evaluation, if he or she agrees to such treatment.

Here's a closer look at the above steps.

1. Take the person into custody. The person may or may not be cooperative with you, and may or may not understand what is going on. As noted, a "best practice" is to consult with a mental health professional, crisis intervention team, or similar resource in making your decision. If the person is physically resistive, you will need to follow your DAAT training to decide whether and how much force is necessary. If the person is physically injured, you must of course provide medical treatment before transporting the person for evaluation.

2. Complete and sign a Statement of Emergency Detention. A key part of your role in this process is to properly complete a statement of emergency detention. You will use a State of Wisconsin form called *Statement of Emergency Detention by Law Enforcement Officer* (form number ME-901). This is a legal document, and is critically important in the overall process for civil commitment. The Statement of Emergency Detention must accurately and thoroughly set forth the facts that led you to believe the person may meet the standard for commitment. Note that when you complete this form, you do not state that the subject person *is* mentally ill, developmentally disabled or drug dependent. You are not professionally qualified to make such diagnoses. Instead, you simply indicate that you have "cause to believe" that the subject shows evidence of one or more or these conditions.

Prepare this document as carefully as you would any crime report or report on a criminal investigation, as with an ordinary police report, start by describing how you got involved.

> Example: *"I was on-duty on (date) and was dispatched to (address) for a disorderly conduct call…"*

In completing the form, be as detailed and specific as possible about the subject's recent behavior that causes you to believe that he or she meets the criteria for dangerousness. The form requires you to indicate when and where such behavior occurred, and has a section for you to describe the behavior that you either observed or were made aware of. You must be as specific as possible in completing this section of the form. The information that you provide will help officials in deciding whether or not a civil commitment is warranted, and will assist the office of county corporation counsel to prepare and present the case in court.

When you describe the subject's behavior, keep in mind the statutory criteria for dangerousness—that is, the four standards described above. You do not have to specify which standard you believe the dangerousness falls within, but you must get factual information to support allegations of dangerousness.

A section of the form provides for information on eyewitnesses to the subject's dangerous behavior, including other law enforcement officers. Complete this section carefully and thoroughly as it is vital information. Quote directly what the subject or witnesses said that support your judgment that the subject showed dangerousness. Always include the telephone numbers (home and work) of any witnesses.

If you know of prior law enforcement contacts with the subject, include that information. If necessary, you can attach supplemental information to the form. If you do so, be sure to check the box on the form labeled "See attached page."

Be sure your information is as complete as possible. If you have information on the subject's behavior but do not include such information in the report or a supplemental attachment, that information cannot be brought up later in a legal proceeding regarding a decision as to involuntary commitment of the subject. That is based on the legal concept of "prior notice." Include on the form the name of the facility to which the subject was taken, and the date and time of the detention.

Finally, sign the form. As with other legal forms, your signature is your testament that the information on the form is true. The statute, under §51.15(11), provides that you are immune from liability "for any actions taken in good faith." This basically means that you are doing the best you can with the information that you have. It is presumed that your actions are done in good faith, and if someone alleges otherwise the burden of proof is on that person. However, the statute, under §51.15(12), also indicates that there are criminal penalties for knowingly including false information in a statement of emergency detention.

3. Transport the person to an approved facility for evaluation. Such facilities are listed in the emergency detention statute, in § 51.15(2). They include hospitals approved by the state Department of Health and Family Services or under contract with a county; a state center for the developmentally disabled; a state mental health treatment facility; or an approved private treatment facility, if such facility agrees to detain a person. Your policies and procedures should indicate the possible locations for emergency detentions initiated by personnel of your agency. You should be familiar with the facilities which are under contract for this purpose in your county. In Milwaukee County, the statute specifies that people taken for emergency detentions are to be taken directly to a designated unit of the Milwaukee County Mental Health Complex.

4. File the statement of emergency detention, with an appropriate official, at the approved facility for evaluation and another copy with the court. The copy filed with the court then serves as a petition for commitment of the subject. The exception is that in Milwaukee County, the staff of the facility to which the subject has been taken files the statement of emergency detention with the court, rather than the officer doing so.

EMERGENCY PROTECTIVE PLACEMENTS

Another important way in which law enforcement officers assist in provision of appropriate care for people with mental health or related problems is in regard to protective placements. This issue is covered in § 55.06 of the Wisconsin Statutes. Chapter 55 is entitled "Protective Service System," and it contains the statutory requirements on another option for trying to ensure proper care and treatment of people who are deemed in need of care and, for one reason or another, are unable to make good decisions for themselves. That option is known as *protective services*.

This chapter includes a range of options for provision of protective services to people who are in need of such services because of chronic mental illness, mental retardation or other developmental disabilities, infirmities of aging, or other incapacities.

As with other aspects of the mental health laws, the intent of this chapter is not only to ensure provision of needed services to people but to do so in a way that will *"place the least possible restriction on personal liberty and exercise of constitutional rights consistent with due process and protection from abuse, exploitation and neglect."* (§ 55.001 of the Wisconsin Statutes)

Criteria for Protective Placement

Protective placement, under § 55.06, is an option for people who:

- Have a primary need for residential care and custody
- Are at least age 18 (except that it is an option for people with developmental disabilities who are at least 14)
- Have been determined to be incompetent by a circuit court, or—if a minor—if a petition for guardianship has been submitted to a court
- Are dangerous to self or others, due to their developmental disabilities, chronic mental illness, infirmity of aging, or other incapacities. Specifically, that the person *"is so totally incapable of providing for his or her own care or custody as to create a substantial harm to oneself or others. Serious harm may be occasioned by overt acts or acts of omission"*
- Have a disability which is permanent or likely to be permanent. This would include chronic mental illness, developmental disability and/or a dementia disorder.

The statute contains specific procedures for protective placement of people. The role of law enforcement personnel in protective placement of people is set forth in § 55.06(11)(a) of the statute. This section authorizes law enforcement officers

(and certain other people, including firefighters) to implement emergency protective placements. This section reads as follows:

> *"If from personal observation of a sheriff, police officer…it appears probable that an individual will suffer irreparable injury or death or will present a substantial risk of serious physical harm to others as a result of developmental disabilities, infirmities of aging, chronic mental illness or other like incapacities if not immediately placed, the person making the observation may take into custody and transport the individual to an appropriate medical or protective placement facility."*

In other words, you are authorized to do an emergency protective placement of a person who meets the criteria specified, based on your observation. The key elements are that as an apparent result of the person's chronic mental illness, developmental disability, an infirmity of aging or some other form of incapacity:

- There is an apparent *probability*—not just a *possibility*—that the person will experience a serious, "irreparable" injury or even death;

  or

- There is an apparent probability that the person presents a substantial risk of physically harming others.

Note that your decision to initiate such an emergency protective placement must be based on *your personal observation*. This is different from an emergency detention, under §51.15, in which the law authorizes you to initiate such a detention based either on your observations or upon information received from others.

If you determine that an emergency protective placement is appropriate, based on the statutory criteria, then you will take the person into custody and transport him or her "to an appropriate medical or protective placement facility." This generally means a hospital or nursing home or other care facility. The exact locations for such placements should be specified in your agency policies.

As with emergency detentions, your agency policies may require or suggest that you consult with local professionals (mental health, social services, etc.) to get input or advice for proper decision-making.

Statement of Emergency Protective Placement

The law also requires you to "*prepare a statement at the time of detention providing specific factual information concerning the person's observations and the basis for emergency placement.*" This is generally done on a specific State of Wisconsin form for this purpose, entitled *Statement of Emergency Protective Placement* (form number GN-2040). In preparing this document, it is very important to be specific as

to what you *personally* observed about the person. Include, in the appropriate section of the form, specific information as to:

- The apparent incapacity that the person has—such as chronic mental illness, developmental disability, infirmity of age, etc.—and the reason that you believe him or her to have such an incapacity

- The specific behavior of the person, that you observed, that led you to conclude that he or she meets the criteria for emergency protective placement—that is, that he or she would suffer irreparable injury or death or presents a substantial risk of physically harming others

You may attach supplemental information to the form. You then sign this form and give it to the staff at the facility to which you take the person. It is good practice to give a copy to the person being detained and route a copy to the court for filing.

The staff at the facility has the legal obligation to inform the person being placed of his or her legal rights, including the right to contact an attorney. A hearing will then be held within 72 hours, excluding weekends and holidays, to determine if there is probable cause for the protective placement. You may have to testify at such a hearing.

According to § 55.06(11)(b), a law enforcement agency representative also has to give the subject notice of the time and place of the probable cause hearing, when that has been determined. This must be done both orally and in writing.

The statute [under § 55.06(11)(am)] makes clear that there are criminal penalties for *knowingly* including false information in a statement for emergency protective placement. However, as is true of emergency detentions, the statute (under § 55.06(11)(ar)) also makes clear that you are immune from liability "for any actions performed in good faith"—that is, honestly doing the best you can with the information that you have and believe to be accurate.

PERSPECTIVE ON EMERGENCY DETENTIONS AND PROTECTIVE PLACEMENTS

The information presented in this section so far sets forth your legal responsibilities and duties under Wisconsin statutes, in regard to emergency detentions and emergency protective placements of people. The actions that you take in regard to these two procedures are taken to ensure the best interests both of the subjects and of others.

It is important to try to view these legal procedures and requirements in the context of the human beings with whom you are dealing. Procedures such as emergency detentions and emergency protective placements can be quite frightening for people, even when they are deemed necessary. It is frightening to anyone to be taken into

custody and taken to a place that they do not know about, and it can be even more frightening to a person with a mental illness or other disability. It is a potential crisis situation for a person, and you should recognize that and act accordingly by applying the crisis management guidelines that you have learned.

If you can find a reasonable, safe alternative to doing an emergency detention or emergency protective placement, you should try to do so. The best practice is to work as closely and cooperatively as possible with mental health/crisis intervention professionals in your county to see if a situation can be handled in some other way. Such professionals should be consulted whenever possible to see if they can help calm a person and to assess what is going on. They may be able to provide input and advice as to whether or not a detention or placement is the most appropriate choice.

INDEX