This manual is not a substitute for an informed discussion between a patient and his or her health-care provider about the procedures or medications described in this manual.
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Forward

Who We Are

The Florida Regional Community Policing Institute (RCPI) at St. Petersburg College (SPC) operates under a cooperative agreement from the Department of Justice, Office of Community Oriented Policing Services (COPS). RCPI provides FREE community policing training to law enforcement officers, community residents, city employees, social services agencies, and private sector representatives throughout Florida.

Training Available

- Introduction to Community Policing
- Police-Community Partnerships
- Problem Solving for the Community Policing Officer and Citizen
- Planning a Win for the Good Guys: Crime Prevention/CPTED
- Ethical Issues and Decisions in Law Enforcement
- Reach Your Goals Through Code Compliance
- Managing Encounters with the Mentally Ill
- Changing Roles: Supervising Today’s Community Policing Officer
- Effective Media Skills for Law Enforcement
- Grantsmanship 101
- Landlord/Tenant and Hotel/Motel Train the Trainer
- IPMBA: Police Cyclist Course
- Survival Skills for Community Policing Officers
- Adult Ed Principles/Train the Trainer
- Building Bridges: Community Policing Overview for Citizens
- Sexual Predator and Offender Awareness in Your Neighborhood and on the Internet
- Crisis Response: Creating, Reviewing and Implementing Safety Initiatives for Schools
- A three-part Domestic Violence Series:
  1. Dynamics of Domestic Violence
  2. Legal Aspects of Domestic Violence
  3. Resources for Domestic Violence Teams
- A three-part Managerial Series: (for Lieutenants and above)
  1. Managerial Buy-In
  2. Managerial Advantage
  3. Tool Kit for Managing Organizational Change
- Probation/Police Partnership: Protecting, Serving and Supervising through Community Partnerships

Course Material

Course material is provided at no charge to all participants. We can adapt our training to fit your agency/community/business needs. Evening and weekend classes are available. Most training modules are 8 or 16 hours but may be modified to allow for limited time allotments.
Training Locations

Generally, classes are conducted at our SPC training site. However, we will arrange training at your facility or a training center in your area. Students who travel more than 50 miles may be eligible for lodging reimbursement.

Who Can Attend?

- Any law enforcement officer (community policing patrol, crime prevention, campus police), civilian employees, probation officers, and social service agencies
- Community leaders and citizens
- Chiefs and Sheriffs who are interested in starting and maintaining community policing in their communities
- Business managers, executives and employees
- Mayors, City Managers, Council members, trustees and government leaders

Registration

To register for classes, schedule on-site training or become part of our mailing list, please call:

Eileen LaHaie-RCPI Program Director
Florida Regional Community Policing Institute
3200 34th Street South
St. Petersburg, FL 33711
phone: (727) 341-4581 or (727) 341-4502
fax: (727) 341-4524
e-mail: lahaiie@spcollege.edu

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Acknowledgements

This 16-hour, two day session, focuses on practical solutions and interventions for community police to assess and manage encounters with individuals who are experiencing mental illness. Experiential and interactive activities designed to promote proactive management of situations, in which persons who are mentally ill require assistance, intervention, diversion, or restraint, will be offered. Course content is presented without psychological, medical, or diagnostic terminology, and is intended to provide straightforward information to demystify interactions with the mentally ill.

This textbook was written for the Florida Regional Community Policing Institute (RCPI) at St. Petersburg College (SPC) with the assistance of a multidisciplinary focus group consisting of community police officers and supervisors, psychologists, addictions counselors, mental health counselors, and behavioral health consultants.

The authors/training staff would like to extend heartfelt thanks to members of the group who contributed information, and support.

The authors also wish to thank the following for feedback, information, and support.

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- Dr. Joseph J. Federico

This textbook summarizes the development of encounters with the mentally ill and was supported by the Department of Justice, Office of Community Oriented Policing Services (COPS). The author wishes to acknowledge the staff that envisioned and implemented this textbook for the Florida Regional Community Policing Institute at St. Petersburg College. Finally, the support of COPS personnel who assisted and were committed to the dissemination of this textbook is gratefully acknowledged.
Introduction

Discussion:

Training officers to deal with the mentally ill is not something that is new. The format and scope of this training is new. Until recently the model of mental health training for law enforcement came from Memphis.

Memphis Police Department saw a need to create training to address a growing problem of dealing with the mentally ill. They saw their solution in the creation of specialized units. These units were supposed to handle the calls for service that involved the mentally ill. Memphis had the staffing available to dedicate selected officers to their newly created Crisis Intervention Teams (CIT).

At RCPI we identify that community policing is all encompassing. The basic unit of work is a problem. We want all officers to be able to effectively deal with problems that they encounter with the mentally ill. Think for a moment about those officers in Memphis that were not trained to deal with the mentally ill. What did they do until a CIT was available? If the CIT were unavailable what would the first responder do?

The community policing philosophy dictates that every officer should have the skills available to handle any situation that they may encounter. The creation of specialized units is in and of itself not community policing. Partnerships and problem solving are community policing.
Introduction

Historical Overview of Mental Health Treatment

Following World War II (1939-1945), a movement emerged in the United States to reform the system of psychiatric hospitals, in which hundreds of thousands of mentally ill persons lived in isolation for years or decades. Many mental health professionals—seeing that large state institutions caused as much, if not more, harm to patients than mental illnesses themselves—came to believe that only patients with severe symptoms should be hospitalized. In addition, the development in the 1950s of Antipsychotic drugs, which helped to control bizarre and violent behavior, allowed more patients to be treated in the community. In combination, these factors led to the deinstitutionalization movement: the release, over the next four decades, of hundreds of thousands of patients from state mental hospitals. In 1950, 513,000 patients resided in these institutions. By 1965 there were 475,000, and by 1990 state mental hospitals housed only 92,000 patients on any given night. Many patients who were released returned to their families, although many were transferred to questionable conditions in nursing homes or board-and-care homes. Many patients had no place to go and began to live on the streets.

Instructor Notes:

Introduce her/him, or themselves, including pertinent background qualifying them to train others on mental illness and/or community policing.

Lead the introduction of participants, which includes names, workplaces, and job titles, as well as responses to the following:

- What is one thing you know about mental illness or the mentally ill?
- What is one thing you would like to know about mental illness or the mentally ill?
- Describe one encounter you have had in the line of duty, with an individual who was mentally ill.
The National Mental Health Act of 1946 created the National Institute of Mental Health as a center for research and funding of research on mental illness. In 1955, Congress created a commission to investigate the state of mental health care, treatment, and prevention. In 1963, as a result of the commission’s findings, Congress passed the Community Mental Health Centers Act, which authorized the construction of community mental health centers throughout the country. Implementation of these centers was not as extensive as originally planned, and many people with severe mental illnesses failed to receive care of any kind.

Recent continuation of funding cuts to community mental health services has resulted in increasing numbers of persons with mental disorders who are without medications, homes, food, or jobs, and who often resort to the commission of crimes to survive. Others who experience rage, frustration, and helplessness-hopelessness as a result of this dilemma, become violent, self destructive, or seek refuge in alcohol and/or drugs.

Increasingly, law enforcement officers are placed in the position of managing difficult encounters with these individuals, requiring skills beyond those typically included in school coursework or training. It is the sincere desire of the trainers that participants in these sessions learn about and learn to apply useful and practical methods to facilitate disposition of these encounters. It is our belief that, with applied skill, interventions with disturbed persons can be beneficial to the officer, members of the community, and individuals who are mentally ill.
Principles of Community Policing: A Problem Solving Model to Assist Interventionists and Persons with Mental Illness

Central to all of the techniques and skills listed in this manual are the principles of Community Policing. “Community policing is a philosophy and an organizational strategy that promotes a new partnership between people and their police. It is based on the premise that both the police and the community must work together identify, prioritize, and solve problems such as crime, social and physical disorder, and overall neighborhood decay, with the goal of improving the quality of life in the area.” (Trojanowicz and Bucqueroux, *Community Policing*, 1994). Two major components of community policing that participants will recognize as recurring themes throughout the training are:

- The importance of creating and nurturing Partnerships with members of the community and various community service agencies and…

- Utilization of Problem Solving to work toward durable solutions to community problems.
Chapter One

Perspective on Mental Illness

They are Us

Remember! When you talk about persons with so-called “mental illness,” or who are “crazy,” …except for the… FREQUENCY, DURATION and INTENSITY of their actions and reactions…

“THEY” are “US!”

Persons who are supposedly “mentally ill” (“them”) only demonstrate exaggerated frequency, duration, and intensity of behaviors that we (“us”) consider to be perfectly normal reactions to every-day life.
### Consider These Examples

- Do you ever double check things just to make sure they are done?
  - “Did I turn off the coffee pot?”
  - “Is the door locked?”

<table>
<thead>
<tr>
<th>“US” Normal or sub-clinical “Worry-Wart”</th>
<th>“THEM” Obsessive-Compulsive Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensity: We check the coffee maker 3 times to make sure it is off before we leave home and feel uncomfortable if we don’t!</td>
<td>They panic or become assaultive toward anyone who prevents them from checking, counting, washing, or completing any compulsive act.</td>
</tr>
<tr>
<td>Frequency: This may occur 3-4 days per week for “US.”</td>
<td>This is a daily, constant set of behaviors that are required by the individual to feel safe or complete.</td>
</tr>
<tr>
<td>Duration: Periodic</td>
<td>Prolonged... for years</td>
</tr>
</tbody>
</table>

### Consider These Examples:

- “I hate parties!”
- “I would really rather be alone and not be bothered by people.”
- “I’ll do that later... I just don’t want to face that crowd right now.”

<table>
<thead>
<tr>
<th>“US” Normal or sub-clinical “Withdrawn”</th>
<th>“THEM” Social Phobia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensity: We avoid social interaction at times, even at the expense of managing some responsibility</td>
<td>Refusal to interact with others due to intense feelings of fear/panic; Loss of ability to perform necessary tasks to care for her or himself; extreme self neglect; May become threatening to others to escape social situations</td>
</tr>
<tr>
<td>Frequency: 1 time per month</td>
<td>In response to any event that may require interaction with others</td>
</tr>
<tr>
<td>Duration: Situational or for a brief period</td>
<td>Prolonged... for years</td>
</tr>
</tbody>
</table>
OR . . .

- Have you ever forgotten things that you normally know?
- Do you sometimes forget or stumble on the names of persons you know?
- Have you ever gotten disoriented if not temporarily lost in an area you frequent?

<table>
<thead>
<tr>
<th>OR</th>
<th>“US”</th>
<th>“THEM”</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR</td>
<td>Normal or sub-clinical “Forgetfulness”</td>
<td>Dementia</td>
</tr>
<tr>
<td>Intensity</td>
<td>We experience temporary “mental blocks,” get confused, lose car keys, get lost, or forget things, etc...</td>
<td>S/He wanders, gets lost, and can’t tell anyone who s/he is! Profound memory loss, disorientation, and confusion; sometimes even to the extent that they do not know who or where they are!</td>
</tr>
<tr>
<td>Frequency</td>
<td>Situational or for brief periods, depending on stress levels.</td>
<td>Daily at most extreme level</td>
</tr>
<tr>
<td>Duration</td>
<td>Onset usually at middle to post middle age, but no remarkable duration.</td>
<td>Prolonged... for years</td>
</tr>
</tbody>
</table>

Managing Encounters with the Mentally Ill  Slide # 4

OR . . .

- Have you ever consumed more alcohol than you meant to?
- Have you ever done things that were embarrassing or that you regret under the influence of alcohol?
- Have you ever had a hangover?

<table>
<thead>
<tr>
<th>OR</th>
<th>“US”</th>
<th>“THEM”</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR</td>
<td>Normal or sub-clinical “Social Drinker”</td>
<td>Alcohol Abuse or Dependence</td>
</tr>
<tr>
<td>Intensity</td>
<td>We may go to a party and drink too much, upsetting significant others, embarrassing ourselves, or just causing ourselves a horrific hangover the next day!</td>
<td>They repeat abusive patterns of alcohol intake, despite adverse consequences, progressing to the point that physiological dependence becomes a factor. They commit DUls, assaults, injure themselves, and fight with others!</td>
</tr>
<tr>
<td>Frequency</td>
<td>Episodic, situational</td>
<td>Progresses from situational to daily</td>
</tr>
<tr>
<td>Duration</td>
<td>1-2 times per year</td>
<td>Prolonged... for years</td>
</tr>
</tbody>
</table>

Managing Encounters with the Mentally Ill  Slide # 5
OR . . .

- Have you ever strongly believed something that turned out to be completely untrue?
- Have you ever thought people were talking about you or conspiring to take advantage of you?
- (Think about the last time you bought a car or a mortgage!)

<table>
<thead>
<tr>
<th><strong>“US”</strong></th>
<th><strong>“THEM”</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal or sub-clinical</td>
<td>“Cautious, Territorial”</td>
</tr>
</tbody>
</table>

- Intensity: We may believe and defend ideas that are totally false and even refuse to listen to evidence refuting our point of view. At times, particularly in situations in which our livelihood or economic well being is threatened, we may believe that others are conspiring to take advantage of us. They become fixated on beliefs that are not only untrue, but, at times, bizarre or paranoid. Persons with paranoid delusions believe that persons or organizations are following them, or conspiring to cause them harm. They are extremely dangerous when they feel threatened, as they become assaultive to protect themselves or to escape.

- Frequency: Situational, 2-3 times per year | Daily

- Duration: Usually episodic with no specific duration | Prolonged . . . for years

**Managing Encounters with the Mentally Ill**

- They are US . . . except that it is not happening to us . . .

**Now or Yet**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
<th>Lifetime Prevalence</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>7%</td>
<td>20%</td>
<td>1 in 5</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>1-3%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>2%</td>
<td>10%</td>
<td>1 in 10</td>
</tr>
<tr>
<td>Chemical Abuse</td>
<td>14%</td>
<td>20%</td>
<td>2 in 10</td>
</tr>
</tbody>
</table>

According to Epidemiological Study cited in the *Harvard Mental Health Letter*.
Prevalence in Percent of Mental Illness: General Population

Note: Including schizoaffective, schizophreniform delusional disorder, and atypical psychosis.

### Increasing Prevalence of Police Encounters with Persons with Mental Illness

This chart illustrates the percentage of people in the United States who experience a particular mental illness at some point during their lives. The figures are derived from the National Comorbidity Survey, in which researchers interviewed more than 8000 people aged 15 to 54 years. Homeless people and those living in prisons, nursing homes, or other institutions were not included in the survey.

- **Schizophrenia and Related Disorders**: 3%  
- **Mania**: 2.5%  
- **Panic Disorder**: 4%  
- **Antisocial Personality Disorder**: 4%  
- **Post Traumatic Stress Disorder**: 8%  
- **Simple Phobia**: 11%  
- **Social Phobia**: 12.5%  
- **Major Depression**: 17%

1 Including schizoaffective, schizophreniform delusional disorder, and atypical psychosis.
The Brain, Social Systems, and Stress

Because humans consist of physical, psychological, and social components that can be inherently flawed, damaged, or that can deteriorate, all so-called “normal” persons possess the potential to be dysfunctional or “mentally ill” to some degree.

They are us because we all have a brain…

- Potential to Inherit Mental Illness
- Chemical Disorder (Neurotransmitters)
- Neurological (Circuitry) Disorder
  - Neuronal activity,
  - (Utilization of Neurotransmitters)

and a mind…

<table>
<thead>
<tr>
<th>Thoughts</th>
<th>Emotions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beliefs</td>
<td>Behaviors</td>
</tr>
<tr>
<td>Values</td>
<td></td>
</tr>
</tbody>
</table>

we all live within a Social System…

<table>
<thead>
<tr>
<th>Job</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships</td>
<td>Discrimination</td>
</tr>
<tr>
<td>Poverty</td>
<td>Laws (Justice)</td>
</tr>
<tr>
<td>Injustice</td>
<td></td>
</tr>
</tbody>
</table>

and we all experience Stress

- The Common Denominator!
  - Which can cause, contribute to, or exacerbate mental disorders (or lead to trauma).
Myths about Mental Illness

- Persons we call “mentally ill” are inherently hostile or dangerous
- Persons with Mental Illness or Brain Disorders cannot be helped
- People who are supposedly “mentally ill” are not capable of functioning in mainstream society
- People who are mentally ill often believe they are more than one person or have “multiple identities” (this is an extremely rare condition)
- Individuals with mental illness just need someone to explain to them that they are ill and that the things they are experiencing are not real
- Persons with mental illness are irresponsible, immoral, unintelligent, or somehow inferior to so-called “normal” folks
- People who are called mentally ill do not realize that other people poke fun or often ridicule them
- Treatment for mental illness consists of a bearded man listening to a “sick” person lying on a couch, talking about their problems
- People take psychiatric medicines to get high
- Psychiatric medications are desirable street drugs
- Individuals who are mentally ill are innocuous, zany stereotypes like the guy on Taxi or other television shows or movies
- Individuals with mental illness are dark sociopaths like Robert DeNiro in Taxi Driver or Cape Fear, or paranoid weirdos like Mel Gibson in Conspiracy Theory
- Children do not experience mental illness

Instructor Notes:
Question:
- What are some myths about mental illness that you are aware of?
- Individuals who are mentally ill are easy to pick out of a crowd or are easily identifiable by their appearance.

Think about language that is commonly used in reference to the mentally ill, that promotes stereotypes and misconceptions:

<table>
<thead>
<tr>
<th>Loony Bin</th>
<th>Loony</th>
<th>Nutcase</th>
<th>Crackers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wacko</td>
<td>Funny Farm</td>
<td>Weirdo</td>
<td>Fruitcake</td>
</tr>
<tr>
<td>Crazy</td>
<td>Laughing Academy</td>
<td>Touched</td>
<td></td>
</tr>
</tbody>
</table>

- In Police lingo that’s…
  - Slash-X, a Baker Act, a Code20, Signal 20, Consumer, or…

Instructor Notes:
Show video clip from “Dream Team”
Question:
- What attitude is shaped by the portrayal of mentally ill persons in the film?
The Myth of Schizophrenia and Violence

Schizophrenia is one of the most misunderstood diseases on the planet. Many people think it means having a split personality, a belief that has its roots in old Hollywood movies. Schizophrenia is not splitting of the personality into different parts—as portrayed in Dr. Jekyll and Mr. Hyde, or The Three Faces of Eve. In fact, the thought processes of persons with severe schizophrenia are so disordered that they barely cope with the requirements of daily existence, nevermind multiple existences. The phenomenon of multiple personalities is extremely rare, and is not a form of schizophrenia. Additionally, the picture of a person with schizophrenia as a “violent madman,” is a legacy of popular fiction. Many persons with this condition are extremely timid and afraid, and become hostile only when they are not taking their medicine, or when they feel threatened.
Discussion

The Diagnostic Statistical Manual of Psychiatric Disorders, Fourth Edition

The following sections are intended to present practical guidelines for laypersons to observe the behaviors and listen to statements of persons who may be experiencing problems with mental illness and formulate (a) rapid intervention plan(s). None of the information is meant to be exhaustive, but is comprehensive to the extent that it is useful.

Each set of behaviors and statements include a section entitled “Possible Diagnoses.” This information is consistent with the Diagnostic Statistical Manual of Psychiatric Disorders-Fourth Edition (DSM-IV) criteria for various mental conditions, and is directed toward individuals with some familiarity with the criteria. It is not, however, essential or even helpful to be able to assign a name to a set of behaviors, other than being able to describe the condition to another person. It is for this purpose that this section is included here. A lay person attempting to assist an individual experiencing problems, to access professional help, may find that use of approximate or accurate terminology can facilitate a referral or admission to a psychiatric facility.

Instructor Notes:

Instructor to introduce use of filmed vignettes, during training, to illustrate symptoms of mental illness.

The following film clips, as well as others that will be shown today, are from a series of film vignettes used to train clinicians to recognize symptoms of mental illness. Other clips are from popular films and will be recognizable, but all accurately portray individuals who meet diagnostic criteria for a mental disorder.

These are the questions to consider while watching the film vignettes:

• What do you hear and see?
• Who is the most disturbed?
• Who is most likely to be dangerous and difficult to manage?

Show film clips of:
• Gary-Schizoid Personality Disorder
• Greg-Paranoid Schizophrenia
• Rita-Delusional Disorder

Pose the following questions to participants:

• What do you hear and see?
• Who is the most disturbed?
• Who is most likely to be dangerous and difficult to manage?
A brief (maybe not brief enough) note about the Diagnostic Statistical Manual of Psychiatric Disorders-Fourth Edition more popularly known as the… DSM-IV

The DSM-IV is a comprehensive manual of all psychiatric disorders identified to date, by a governing committee and multiple sub-committees of psychiatrists, working under the sanction of the American Psychiatric Association. The Fourth Edition of the DSM, preceded naturally by the DSM-III-Revised, and DSM-III, etc., contains criteria for all recognized psychiatric illnesses. The book is available in most school book stores and some commercial ones, and can be useful to learn to accurately communicate information about psychiatric symptoms and disorders. In addition this manual includes a limited glossary with many terms used in the DSM-IV.

Instructor Notes:
Provide brief overview of DSM-IV
Cultural, Spiritual, and Religious Considerations

In some non-industrial cultures, anthropologists have discovered that individuals who are known to hear voices, take powerful hallucinogenic drugs, experience visions, and/or foresee future events, are revered as the holy person or spiritual leader of the tribe, group, village, or civilization. A behavior or set of behaviors can only be considered pathological or disordered if it/they has/have some undesirable outcome. It is, therefore, important to consider statements and behaviors by others in the context of culture and religious belief. An individual practicing Santeria, one who espouses paganism, or even someone who participates in forms of Voodoo, should not be judged to be disordered, though parts of their behavior may seem foreign or even bizarre. Use of chicken feathers, bones, icons, special oils and poultices, chanting, meditation or magic, may not be that different than some more traditional practices, in principle.

At times, individuals with religious, cultural, or spiritual beliefs outside the mainstream of so-called orthodoxy, can make statements or engage in practices that may seem bizarre to someone raised in a so-called traditional western culture. It would be a profound mistake to judge these as products of a disorder or confusion, regardless of how strange they may seem at the time.
Persons Who Act Obsessed, and Say-Do Repetitious Things

Common Features

- Repetitious statements
- Compulsive counting
- Compulsive checking
- Compulsive washing
- Refusal (or inability) to talk about any topic except the subject/object of obsession
- Panic reactions when unable to perform repetitious-ritual acts
- Anxiety and panic based on superstitions
- Pressured/rapid speech
- Stuttering
- Speaking in sentence fragments
- Excessive perspiration
- Tremors
- Physical Agitation
- Exaggerated reactions to routine situations or people, e.g., fear, avoidance, etc.

Instructor Notes:
Show film clip *All About Bob*
Pose the following questions to participants:
- What do you hear and see?
- Who is the most disturbed?
- Who is most likely to be dangerous and difficult to manage?

Instructor Notes:
Show film clip *Pat Marcella*
Pose the following questions to participants:
- What do you hear and see?
- Who is the most disturbed?
- Who is most likely to be dangerous and difficult to manage?
**Persons who are obsessed and say-do repetitious things**

**Typical-EXAMPLE STATEMENTS**

- I have to check, find, call, wash, clean, count, etc., *or*...
- I must check, find, call, wash, clean, count, etc., *or*...
- If I don’t check, find, call, wash, clean, count, etc., *then*...
- I will lose ________ if I don’t check, find, call, wash, clean, count, etc.

**Possible Diagnoses-see DSM-IV**

Obsessive Compulsive Disorder; Obsessive Compulsive Personality Disorder; Anxiety Disorders; Panic Attacks; Phobias; Agitated Depression; Psychotic disorders (obsessions may be a product of delusions)

**Considerations/Related Topics**

No matter how trivial the obsessions an individual with this pathology may present, the fear and anxiety they feel when faced with the prospect of being unable to accomplish their particular mission(s), can result in acts of violence or attempts to escape at all cost.
Persons whose speech is disorganized to the extent that they do not make sense

Common Features

- Statements reflecting:
  - Loose Associations
    - Expression of ideas or words that have no relationship, as if they do
  - Flight of Ideas
    - Expression of incomplete ideas, wandering from topic to topic, with vague or no relationships
  - Word Salad
    - Incomprehensible combinations of words at random
  - Clanging
    - Rhyming words with each other and manufactured words

Instructor Notes:
Show film clip TV News Show
Pose the following questions to participants:
- What do you hear and see?
- Who is the most disturbed?
- Who is most likely to be dangerous and difficult to manage?
Perspectives on Mental Illness

Persons whose speech is disorganized to the extent that they do not make sense

- Loose Associations
  - “I had no idea that the people with long sleeved shirts on the porch at the home had all of the aluminum recycling business, in fact Elvis told us that.”

- Flight of Ideas
  - “I have to go to the doctor but of course the bus driver I met yesterday is probably still mad and I have nothing proper to wear.”

- Word Salad
  - “Biscuits with no wheels are not of any proprietary means to me unless Pic tells us to do it!”

- Clanging
  - “The bang on the tang is lang bang hang!”

Possible Diagnoses—see DSM-IV

Schizophrenia; Psychotic Disorders; Bipolar Disorder, Manic Phase, with Psychosis other Psychotic Disorders

Considerations/Related Topics

While it is tempting to try to enter the world of a psychotic person to decipher this mysterious language, attempts to ask about bizarre or confusing language can easily be misinterpreted by the individual. It is usually more productive to sidestep all of this to ask simple questions of the individual. Many persons who appear to be completely psychotic (with exceptions) are capable of making some sense and answering questions at times.
Individuals who make paranoid statements and are extremely suspicious of everyone and everything

Common Features

- Talking—appearing to be involved in conversations with themselves or with entities not visible to others present
- Avoidance of social contact
- Fear of electronic or mechanical objects
- Ritual or routine avoidance of any particular object or person
- Obsession with/about a particular news event or social phenomenon
- Obsession with/about any particular government or other organization
- Changes in personal appearance—use of unusual objects as protective gear, e.g. mirrors, aluminum foil, pieces of paper or cardboard, hats, etc.

Instructor Notes:
Show film clip Conspiracy Theory
Pose the following questions to participants:
- What do you hear and see?
- Who is the most disturbed?
- Who is most likely to be dangerous and difficult to manage?
Individuals who make paranoid statements and are extremely suspicious of everyone and everything

Typical Example Statements

- “They know where I am and what I am doing.”
- “I have to stay on the move.”
- The... CIA, FBI, Secret Service, President, Queen Mother, television networks, Microsoft, UFOs, Disney, etc,... is looking for me.”
- “The food is poisoned here.”
- “There are chemicals in the water that the people at the mall use to make you buy stuff.”
- “There is stuff in the air that controls my thoughts.”
- “I read your thoughts and I know what you are doing.”

Possible Diagnoses - see DSM-IV

Schizophrenia, Paranoid Type; Delusional Disorder; Other Psychotic Disorders; Cocaine Psychosis; Dementia; Paranoid Personality Disorder

Considerations/Related Topics

This is a condition that is characterized by intense fear and suspicion. Individuals who experience these conditions are likely to become violent, attempt to escape, or to completely decompensate i.e., lose physiological balance if confronted heavily. It is not prudent to directly dispute or confront the beliefs of individuals who are paranoid or extremely suspicious.
Common Features

- Appearance of conversation with no one else present
- Walking around-avoiding collision with objects-persons not visible to others
- Gestures, movement indicating attempts to communicate with entities/objects not visible to others present
- Petting, patting, rubbing inanimate objects
- Sudden ducking, jumping, running
- Self destructive or bizarre actions guided by supposed telepathic or mentally broadcasted instructions
- Inability to function due to interference by internal voices

Persons who say they are seeing or hearing (or smelling or feeling physical sensations)
Things that no one else can see or hear (visual and auditory hallucinations)
Perspectives on Mental Illness

Typical Example Statements

- Statements would resemble normal speech patterns for the individual involved, though speech content would most likely be extremely disorganized, paranoid, delusional.
  - “Look out!” “Watch it!” (Avoiding collision or encounter with object/persons not visible to others)
  - Statements that sound like responses to questions when no one has asked anything: ‘No!’ ‘I can’t right now.’ Will you help me do it?”
  - “I told Mr. Harry that I can’t go with him now.” (with no other person present)
  - “Tell Mr. Harry I am busy.” (with no one else present)
  - “Mr. Harry told me I should just kill myself.”
  - “Aliens are broadcasting instructions to me.”
  - “The FBI tells me what to do through voices in my head.”

Persons who say they are seeing or hearing (or smelling or feeling physical sensations)
Things that no one else can see or hear (visual and auditory hallucinations)
Persons who say they are seeing or hearing
(or smelling or feeling physical sensations)
Things that no one else can see or hear
(visual and auditory hallucinations)

Possible Diagnoses—see DSM-IV

Schizophrenia, Post Traumatic Stress Disorder; Other psychotic states or disorders

Considerations/Related Topics

These individuals are clearly the most unpredictable of all. Persons who are hallucinating can rarely be convinced that their experiences are a result of mental illness and rarely respond to attempts by others to talk them out of psychosis. If an individual is experiencing visual or auditory hallucinations and presenting some type of problem, (depending on the seriousness of the situation) it will generally be more productive to acknowledge the experiences they describe, but maintain a separate line of questioning pertinent to conflict or problem resolution. It would be prudent to take one’s time with individuals with this type of problem, making sure to stay very calm, speaking clearly and in an unexcited manner, and avoiding controversy of any kind.

Instructor Notes:
Show film clip Fisher King
Pose the following questions to participants:
- What do you hear and see?
- Who is the most disturbed?
- Who is most likely to be dangerous and difficult to manage?
**Perspectives on Mental Illness**

*Persons who are agitated, angry, and pose a threat of violence*

**Common Features**

- Exaggerated Anger–Excessive Response regarding some problem, injustice, or perceived personal slight
- Rapid, erratic physical movement
- Pacing
- Breathlessness
- Excessive perspiration
- Repetitious statements regarding some injustice or perceived slight
- Rapid, pressured speech
- Topics of speech change rapidly with little or no coherent relationship between topics
- Slapping or hitting her or himself in a frustrated manner
- Hair pulling
- Spitting
- Cursing
**Persons who are agitated, angry, and pose a threat of violence**

**Typical Example Statements**

- “I’m gonna kill somebody if they don’t get outta my way!”

- “He told me I was crazy… I am crazy… I’ll show who is crazy… I mean… That’s who!!”

- “I told them not to let me catch them together and then I saw him wearing my shirt… well… I ran that before… I mean I been there… She can’t come back now… I mean it!”

- “Those are my food stamps and they can’t take em away… I will get my food stamps back if I have to kick some %@#$%^ to do it!”

- “Mr. Harry told me… I mean he told me to kick their %@#$%^& so I am gonna do it.”

**Possible Diagnoses—see DSM-IV**

- Bipolar Affective Disorder, Manic Phase; Schizophrenia, Schizoaffective Disorder; Intermittent Explosive Disorder; Other psychotic states and/or disorders

**Considerations/Related Topics**

This is obviously a situation requiring verbal de-escalation skills. One tip would be to let an individual express her or himself a while, and then ask if they would like to work toward some relief or resolution to the problem.
Persons who appear to be developmentally impaired or challenged

Common Features

- Speech impediment or speech pathology
- Severely limited fund of information, e.g. no awareness regarding surroundings or other people; inability to assess situations for threat or danger
- Confusion about roles and relationships with other people
- Inability to analyze and sequentially, systematically solve simple problems
- Disheveled, unkempt personal appearance at times, particularly food on clothing
- Facial features that indicate retardation or developmental delay, e.g. mongoloids
- Irrelevant, childish statements
- Extreme child like gullibility-vulnerability-easy victim of crime or sexual abuse

Typical Example Statements

- “I walk down the road to the corner by myself, but then I got lost one time and Mrs. Grant got mad. Mrs. Grant is my mommy.”
- “I got twenty dollars and I can get me a milkshake.”
- “They said if I was good, I could have cheese… do you have cheese?”

Instructor Notes:
Show film clip What’s Eating Gilbert Grape
Pose the following questions to participants:
- What do you hear and see?
- Who is the most disturbed?
- Who is most likely to be dangerous and difficult to manage?
**Persons who appear to be developmentally impaired or challenged**

**Possible Diagnoses—see DSM-IV**

Mental Retardation; Organic brain syndrome; Psychosis due to a general medical condition

**Considerations/Related Topics**

Consider the difference between mental retardation and mental illness.

<table>
<thead>
<tr>
<th>Mental Retardation</th>
<th>Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-average intellectual functioning</td>
<td>Intelligence or IQ is irrelevant</td>
</tr>
<tr>
<td>Impaired social adaptation</td>
<td>Problematic behaviors but sometimes socially competent</td>
</tr>
<tr>
<td>Usually occurs during developmental years</td>
<td>Can occur at any time</td>
</tr>
<tr>
<td>Usually not violent</td>
<td>May be unpredictable, erratic or violent</td>
</tr>
<tr>
<td>Learning disability that requires assistance from educators,</td>
<td>Disorder that requires assistance of psychiatrists, psychotherapists, or psychologists</td>
</tr>
<tr>
<td>vocational and rehabilitation specialists, psychologists</td>
<td></td>
</tr>
</tbody>
</table>
Common Features

- Most common amongst the elderly, however, not restricted to that age group
- Extreme confusion about date-time, place, people around them
- Fragmented speech—unable to express complete ideas at times
- Thought-speech content sounds delusional, e.g. false memory, confused identity, grandiose ideas
- Conversations about persons who are deceased (some times for many years) as though still alive

Typical Example Statements

- “I told Helen to come over last night to have that new chicken soup recipe I made.” (Helen is deceased and the speaker lives in a nursing home.)
- “What time does the bus come to pick us up?” (in bed-12:00 midnight)
- “Oh I’ve been here before. This is the place I saw Joe DiMaggio.” (statement made driving to doctor’s appointment)
- “I was the first one to think of using an iron and ironing boards, ya know!”

Instructor Notes:
Show film clip Jim
Pose the following questions to participants:
- What do you hear and see?
- Who is the most disturbed?
- Who is most likely to be dangerous and difficult to manage?
**Persons who are disoriented, lost, and unable to communicate clear and complete ideas**

**Possible Diagnoses—see DSM-IV**

Dementia, Alzheimer’s Type Dementia, Vascular Dementia or dementia due to other medical conditions; Dementia with psychosis; Pseudodementia

**Considerations/Related Topics**

If an individual is lost and cannot say who they are or where they live, it will only be possible to find the individual’s home or family by questioning people other than the person her or himself. There may be clues in the person’s pockets, wallet or purse, but extensive research may be necessary.

Utilize CAD or police report information. If the police are involved now or they may have been involved in the past. Contact your partners in the Behavioral Health Care System. Dept. of Children and Families, County Social Services or other organizations can help. They may be able to provide address or guardian information. If you meet a dead end, they may relieve you of custody of the individual.
A Word about Psychotropic Medications

Dramatic changes in the treatment of the mentally ill in the United States began in the mid-1950s with the introduction of the first effective drugs for treating psychotic symptoms. Along with drug treatment, new, more liberal and humane policies and treatment strategies were introduced into mental hospitals. More and more patients were treated in community settings in the 1960s and 1970s. Support for mental health research led to significant new discoveries, especially in the understanding of genetic and biochemical determinants in mental illness and the functioning of the brain.

The movement toward deinstitutionalization, beginning in 1950 and continuing to present, during which thousands of persons were and have continued to be released from psychiatric hospitals, was made possible by the development of effective psychotropic medications. While psychiatric medication has enabled persons who are mentally ill to reclaim some level of independence and to live in the community, many who do not take the medicine as prescribed for various reasons, or who can’t afford it, begin to deteriorate.

Psychotropic medication and compliance with prescribed medications are then, central to the ability of a person diagnosed with mental illness to function adaptively in the community. Individuals who threaten suicide, who display bizarre behavior, or who disturb those around them are, most likely, not taking prescribed medications as directed by a psychiatrist.
So . . .
Why do people stop taking medications that keep them out of trouble and help them live “normal” lives?

- Side Effects
  - Many psychiatric drugs cause side effects that range from mild and reversible to profound and irreversible!

<table>
<thead>
<tr>
<th>Drowsiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
</tr>
<tr>
<td>Nausea</td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Blurred Vision</td>
</tr>
<tr>
<td>Dry mouth</td>
</tr>
<tr>
<td>Drooling</td>
</tr>
<tr>
<td>Involuntary Movements –tics</td>
</tr>
<tr>
<td>Changes in Sexual Functioning</td>
</tr>
<tr>
<td>Parkinsonism</td>
</tr>
<tr>
<td>Tardive Dyskinesia</td>
</tr>
<tr>
<td>Extrapyramidal Syndrome</td>
</tr>
<tr>
<td>Tremors</td>
</tr>
</tbody>
</table>

- They can’t afford them
  - Without health insurance, the cost of most psychiatric medications is prohibitive. Since many persons with mental illness are unemployed, unless they have been designated as disabled by Social Security, there simply is no funding available.

- They take their medications for a while, feel better, and forget they have a treatable illness.

- The stigma surrounding mental illness and psychiatric medications
  - The “Sorry I forgot to take my Prozac or Thorazine” Joke Syndrome.

- Lack of support from family and/or friends
Medication Non-Compliance

- Return of Symptoms-Decompensation
- Hospitalization
- Arrest
- Homelessness
- Episodes of Violence
- Suicide-Suicide Attempts
- Loss of Previous Stabilization
# Chapter Two

## Suicide

*Persons who appear depressed and are, therefore, potentially suicidal*

<table>
<thead>
<tr>
<th>Common Features</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive sleep</td>
<td>Instructor Notes:</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Show film clips of <em>Jerry</em></td>
</tr>
<tr>
<td>Weight loss</td>
<td>Pose the following questions to participants:</td>
</tr>
<tr>
<td>Loss of energy-Lethargy</td>
<td>- What do you hear and see?</td>
</tr>
<tr>
<td>Lapse in usual self care (appearance-hygiene)</td>
<td>- Who is the most disturbed?</td>
</tr>
<tr>
<td>Giving away personal possessions</td>
<td>- Who is most likely to be dangerous and difficult to manage?</td>
</tr>
<tr>
<td>Writing farewell letters or despondent journal entries</td>
<td></td>
</tr>
<tr>
<td>Refusal to interact with others-social isolation</td>
<td></td>
</tr>
<tr>
<td>Listening to music repetitiously emphasizing suicidality or hopelessness</td>
<td></td>
</tr>
<tr>
<td>Preoccupation with symbols/artistic representations of death</td>
<td></td>
</tr>
<tr>
<td>Hostility toward others without apparent reason</td>
<td></td>
</tr>
</tbody>
</table>
Typical example Statements

“I am so tired of living.” “I can’t seem to do anything.”
“Why can’t I just die?”

“I wish I had never been born” “Why am I alive?”

“I don’t want to kill myself, but I wish something or someone would do it for me.”

“Who cares?” or “I don’t care about anything.”

“I am so . . . ugly, useless, hopeless, helpless, stupid, crazy, worthless, etc.”

Persons who appear depressed and are, therefore, potentially suicidal

Possible Diagnoses—see DSM-IV

- Major Depression; Bipolar Affective Disorder; Schizoaffective Disorder, Depressed Type or Bipolar Type-Depressed;
- Psychotic Disorders; Most Substance Related Disorders

Considerations/Related Topics

- Suicidality
- Baker Act
- Involuntary Admission to a Psychiatric Facility
Suicide: WHO AND WHY...

- Suicide is the eighth leading cause of death in the United States.

- Suicide rates are highest in old age. Forty percent of all suicides are over 60, yet the elderly constitute only 20% of the general population.

- The age group between 15 and 24 now accounts for 20% of all male suicides and 14% of female suicides.

- Suicide attempts are one of the most common causes of admission to hospital emergency rooms, among people under 35.

- Rates are lower in rural areas and among persons with strong religious convictions.

- African Americans commit suicide only half as often as Caucasian people and the rate does not rise with old age.

- Native Americans have a higher suicide rate than Caucasians of all ages.

- Suicide rates are high in people with a history of bad temper, verbal abuse, fighting, domestic and/or sexual violence, and antisocial behavior.

- Losses such as death of loved ones, broken relationships, changes in health status, and unemployment are associated with suicide. Substance abuse and emotional disorders are common factors associated with suicide attempts and successes.
• Adolescent suicides are associated with depression, recklessness, delinquency, and the use of alcohol and other drugs.

• The most common methods of successful suicide include:
  – Firearms 55-60%
  – Hanging 14%
  – Poison 11%
  – Gas 9%
  – Other 8%

*Persons who appear depressed and are, therefore, potentially suicidal*
Use the SLAP Model to Assess an Individual's Suicide Plan

**Specific details of the plan**

- What is the individual planning to do?

**Lethality of the plan**

- If the person executes the plan, how harmful will it be and how immediate does intervention need to take place?

**Availability of the method**

- Does the individual have the proper equipment, weapons, environmental factors, or other objects necessary to execute the plan at her or his disposal?

**Proximity of assistance or help**

- How quickly can the person access assistance/support or are they alone and unwilling to do so?
Suicide Assessment

- Previous attempts are the best predictors of risk for suicide. Up to 40% of all persons attempting suicides have made a prior attempt.

- The risk for successful suicide is greatest during the year following a previous attempt.

- Women make at least three times as many attempts as males to commit suicide. Males complete 75% of all successful suicides.

- The most common disorders associated with suicide are substance related disorders, Schizophrenia, Depression, and Borderline Personality Disorder.

- Do not let gender, age, ethnicity or social status diminish the possibility of suicide. Take all threats as being real.
Developing a Suicide Contract

A suicide contract is an agreement or document, which may provide some concrete safeguards against suicidal behaviors, and encourage a despondent person to postpone self-destructive acts until such time as advice, counsel, or further information may be used to make better decisions. The contract should contain time frames, names of persons who will be contacted immediately before the individual engages in self-harm, activities that can provide diversion to suicidal thoughts and impulses, and a more long-term plan to seek assistance. It is extremely useful to allow the distressed individual to become the author of the contract if possible. A usable contract is provided on the following page. Although a contract may be verbal, a physical reminder of an agreement to seek help (with specifics listed) is more likely to prevent an actual suicide attempt. The most important principle in writing a contract with a consumer, who is suicidal, is the decision to postpone the self-destructive act.
CONTRACT

I, ____________________, promise not to harm myself between today and _____________.

I will call the emergency or crisis mental health line at ________________ and discuss my feelings
if I feel I want to break this contract.

I promise to make and keep an appointment with __________________________ on _____________.

Other Agreements/Conditions

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

Signed: ______________________

Date: ________________________
Chapter Three

Substance Abuse

Basic Facts

- Substance Related Disorders are considered psychiatric illnesses and are listed, along with criteria specific to particular patterns of abuse and dependence, in the DSM-IV.

- Drug and/or alcohol abuse or dependence exacerbate symptoms of mental illness.

- Symptoms of mental illness exacerbate patterns of drug and/or alcohol abuse or dependence.

- Drug and/or alcohol use can cause symptoms that mimic mental illness.

- Symptoms of mental illness can mimic symptoms of alcohol and/or drug abuse or dependence.
Typical behaviors and speech patterns of persons abusing drugs and/or alcohol

“The mashosh dish on the wigering ish nod a barg dull iv ya habben dun id yed!”

Many times, the symptoms of a mental illness and those of a person who is intoxicated or doing drugs, are indistinguishable…

The interventionist gets to play…

Guess the Disorder!

Is the individual mentally ill or is s/he just drunk?

• …Or wired on drugs?

How would you assess a person with the following presentation?

• Slurred speech, stumbling around, repeating angry statements, crying, threatening suicide, sour bar smell.

A. Depression  
B. Alcohol Abuse or Intoxication

2*Answer below

In other words…

• Alcohol and drug abuse/dependence often mimic symptoms of mental illness!

---

2 *The correct answer is A or B, or A and B with other possibilities.
Examples:

- Rapid, pressured speech, hyperactivity, impulsive and self-destructive behaviors, or appearance of mania may be...
  - Bipolar Affective Disorder or...
  - Amphetamine or Cocaine Intoxication

- Slurred speech, flat facial expression, monotonous voice, disorganized speech, and retarded movement may be...
  - Alcohol, Barbiturate, or Sedative Intoxication or...
  - Depression

Instructor Notes:
Show film clip Mel
Bipolar Hypomanic
Pose the following questions to participants:
- What do you hear and see?
- Who is the most disturbed?
- Who is most likely to be dangerous and difficult to manage?
### Table: Relationships between Drug and Alcohol Abuse and Mental Illness

<table>
<thead>
<tr>
<th>Feature/Symptoms</th>
<th>Mental Disorder</th>
<th>Substance Related Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
<td>Major Depression</td>
<td>Alcohol Intoxication, Abuse or Dependence</td>
</tr>
<tr>
<td><strong>Suicidality</strong></td>
<td>Bipolar disorder</td>
<td>Intoxication, Abuse or Dependence on any Depressant Drugs</td>
</tr>
<tr>
<td></td>
<td>Schizoaffective disorder</td>
<td>Drug and/or Alcohol Withdraw</td>
</tr>
<tr>
<td><strong>Mania</strong></td>
<td>Bipolar Affective disorder</td>
<td>Cocaine Intoxication, Abuse or Dependence</td>
</tr>
<tr>
<td></td>
<td>Cyclothymia</td>
<td>Amphetamine Abuse or Dependence</td>
</tr>
<tr>
<td></td>
<td>Schizoaffective disorder</td>
<td></td>
</tr>
<tr>
<td><strong>Psychosis</strong></td>
<td>Schizophrenia</td>
<td>Cocaine Intoxication, Abuse, Dependence, or Psychosis</td>
</tr>
<tr>
<td></td>
<td>Other psychotic disorders</td>
<td>Alcohol Hallucinosis, Delirium Tremens</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Certain Drug withdrawal</td>
</tr>
<tr>
<td><strong>Delusions</strong></td>
<td>Schizophrenia</td>
<td>Cocaine Intoxication, Abuse, Dependence, or Psychosis</td>
</tr>
<tr>
<td></td>
<td>Other psychotic disorders</td>
<td>Amphetamine Intoxication, Abuse, Dependence, or Psychosis</td>
</tr>
<tr>
<td><strong>Hallucinations</strong></td>
<td>Schizophrenia</td>
<td>Delirium Tremens</td>
</tr>
<tr>
<td></td>
<td>Other psychotic disorders</td>
<td>Other forms of drug withdrawal, Hallucinogen intoxication</td>
</tr>
<tr>
<td><strong>Obsessions</strong></td>
<td>Obsessive Compulsive disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obsessive Compulsive personality disorder</td>
<td></td>
</tr>
<tr>
<td><strong>Paranoia</strong></td>
<td>Schizophrenia</td>
<td>Cocaine Intoxication, Abuse, Dependence, or Psychosis</td>
</tr>
<tr>
<td></td>
<td>Other psychotic disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paranoid personality disorder</td>
<td></td>
</tr>
<tr>
<td><strong>Panic</strong></td>
<td>Panic attacks</td>
<td>Drug and/or alcohol withdrawal, Cocaine Intoxication, Abuse, Dependence, or Psychosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amphetamine Intoxication, Abuse, Dependence, or Psychosis</td>
</tr>
</tbody>
</table>
Typical Behaviors and Statements of Persons Experiencing Substance Related Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Signs/Symptoms</th>
<th>Considerations</th>
</tr>
</thead>
</table>
| Alcohol Abuse/Dependence  | Slurred speech, stumbling, inappropriate laughing or crying, uncoordinated movement belligerence, repetitious statements, alcohol smell | Dependence requires medical detoxification  
Serious potential for violence in persons who are intoxicated |
| Amphetamine Abuse/Dependence | Hyper verbal, rapid speech, pressured speech, disorganized thoughts, agitation, irritability, rapid movement, excessive energy-hyperactivity | May be extremely impulsive, potentially violent |
| Barbiturate Abuse/Dependence | Drunken appearance, drowsy, slurred speech, uncoordinated movement, lethargic, unresponsive | Dependence requires medical detoxification  
Potential for violent behavior though these individuals are slowed down to the extent that intervention is possible |
| Cannabis Abuse/Dependence | Detached, bloodshot eyes, slow-retarded movement, preoccupation with trivialities or unimportant details, lethargy, apathy, inappropriate laughter or giggling |  |
| Cocaine Abuse/Dependence | Over stimulation, hyper-activity, hyper-verbal, Disorganized statements and behavior, hyper-sexuality, irritability, agitation | May be over stimulated-introduction of further stimulation may produce violent response |
| Hallucinogen Abuse/Dependence | Inappropriate laughter, preoccupation-fixation on details or trivial things, staring with blank expression, Loss of contact with reality, nonsensical and irrelevant speech | People in this condition are not responding to the same external stimulus as others present who are not under the influence |
| Inhalant Abuse/Dependence | Loss of contact with reality, psychotic type behavior | Potential for violence if approached too rapidly or with heavy initial confrontation |
| Sedative/Hypnotic Abuse | Drowsiness, lethargy, uncoordinated movements, slurred speech, stuporous presentation |  |
| Opioids                  | Lethargic, dreamy behavior, drowsiness, continuously scratching nose and face, extreme detachment, stuporous presentation | Dependence requires medical detoxification |

Instructor Notes:
- Review Table
The Relationship between Substance Related and Other Psychiatric Disorders

The relationship between substance related and other psychiatric disorders is often analyzed in terms of cause and effect, in other words, people use drugs and abuse alcohol because they are depressed, or people are depressed because they use drugs and alcohol.

It is more productive to assess this in terms of specific synergistic, antagonistic, agonistic, and protagonistic relationships, however.

*Synergistic* means that two conditions amplify or increase each other.

- Depressant drug and alcohol related disorders exist in a synergistic relationship with depressive disorders or other mood disorders characterized by depression.

*Antagonistic* means that two conditions are in some sort of opposition or conflict.

- Stimulant drug or cocaine related disorders exist in an antagonistic relationship with depressive disorders.

*Protagonistic* means that one condition compliments the other.

- Some persons who experience mania enjoy the feeling and enhance it by taking cocaine or other stimulant drugs. Therefore, cocaine or stimulant drug related disorders can exist in a protagonistic relationship with mania.

*Agonistic* means that there is little to no relationship between two conditions.
Knowing the cause of a particular pathology in this instance is less helpful than understanding some of the dynamics when planning an intervention.

- An individual who is manic, taking cocaine, and demonstrating threatening behaviors is likely to become calmer as soon as the cocaine is gone from her or his bloodstream.

- A depressed person is going to be less so when the alcohol leaves her or his system; it is not reasonable to think one can intervene verbally with an intoxicated person in an emergency. The interventionist then knows to work toward postponement of dangerous behaviors or to do anything to buy time in this situation.

Instructor Notes
- Marchman Act
Chapter Four

Practical Interventions to Manage Difficult Encounters with the Mentally Ill

Notes:

Priorities for Verbal De-escalation or Intervention

- The safety of all persons present, including YOU!
- The safety of the individual presenting the problem
- Property

Assessing Who is dangerous?

- Persons who are paranoid
- Persons experiencing command hallucinations (voices telling them to do things)
- Individuals who are agitated
- Individuals expressing rage or extreme anger
- People who say they are dangerous
Practical Interventions to Manage Difficult Encounters with the Mentally Ill

Practical Methods to Manage Difficult or Dangerous Encounters with Persons who are Mentally Ill

Always remain calm and use a non-confrontational approach

- Do not
  - Argue
  - Threaten
  - Command

- Do
  - Placate–agree
  - Reassure
  - Distract
  - Detach emotionally
  - Use authority positively
Components of the Assessment

In any confrontation or encounter, there are three elements that need to be assessed and included in decision making:

- **Verbal Characteristics**
  - The content and quality of speech, style, volume, pitch, inflection, mimicry, accent

- **Behavioral Characteristics**
  - Posture, body language, gestures, facial expression, eye movement, hand position, tremors-shaking, clothing

- **Environmental Factors**
  - Those items that the person has surrounded themselves with and used to create their environment, strange decorations or trimmings, the inappropriate use of aluminum foil or any other object, clutter.
General Guidelines for Physical Behavior during Verbal Interventions

• Assess the situation for potential escape routes/exits, and make mental plans to control them if necessary.

• Avoid aggressive or confrontational eye contact-use intermittent contact.

• Move slowly.

• Do not touch the individual until you are ready to take her or him into custody.

• Attempt to remove anything or anyone that is disturbing the individual.

• Allow yourself and the individual an escape route if possible (allow them to save face and give yourself room to keep negotiating.)

• Maintain open body posture.
Essential Verbal Behavior

- Use a calm voice.
- Maintain volume that is less than that of an aggressor.
- Reflect or paraphrase their concerns—
  - “I understand that you are concerned about your wife.”
- Reflect and validate their affect—
  - … “I can see that you are extremely upset.”
- Use descriptive statements with “I” references.
Further Guidelines for Intervention

- Recognize that an individual may be overwhelmed by sensations, thoughts, frightening beliefs, sounds (voices), or other hallucinations.

- Remain firm and professional, but friendly, encouraging, and patient.

- Be aware that a uniform, nightstick, firearm, and handcuffs may be intimidating to persons who do not have mental illnesses, so persons who are disturbed may be overwhelmed. Assure the individual that you mean them no harm. Express your authority in a positive manner. “I’m here to help.”

- Announce all of your actions before initiating them. Answer all “why?” questions.

- A person who is psychotic is experiencing states that are real to them, no matter how bizarre it may sound to others. It is usually impossible to assess the way a disturbed individual may interpret your actions and statements, and it is prudent to assume nothing. Expect the unexpected and you will never be disappointed!

What to Do

- Stay calm... avoid overreacting... be helpful.

- Gather information from all bystanders, family members, significant others.

- Speak slowly and in unambiguous terms.

- Remove distractions, disruptive people, and/or upsetting objects from the scene.

- Understand that it may not be possible to have a rational discussion.
Use the CAF Problem Solving -Conflict Resolution Model

- **Calm**–Try to deescalate the people present and therefore, the situation. It is easy to become a part of the problem by forming a relationship with a person’s disturbance or pathology before forming a relationship with the individual. Use a voice that is even, with a volume that is less than that of the aggressor or troubled individual. Move slowly.

- **Assess**–Formulate a mental picture of what you think is happening. Use what you know about the type of behaviors you observe and the speech patterns and content you hear, to formulate an intervention plan before you do anything!

- **Facilitate**–Make it easy for the individual to solve her or his problem. Facilitate means to make easy or to simplify, so the goal at this step would be to assist an individual to access proper assistance and form a plan to stop whatever troublesome behaviors s/he is demonstrating.

**Instructor Notes:**
CAF does not have to occur in order. Depending on the circumstances you may be doing several things at once.
Questions to ask the troubled Individual

- What is your name?
- Where do you live or sleep?
- Do you know where you are right now?
- Do you know what day it is?
- Do you know what is happening right now?
- What kind of problem are you having?

Questions to ask the Family Members, Bystanders, and other Involved Parties

Has your brother/sister, husband/wife, son/daughter, or (use the individual’s name):

- Acted in a violent manner or threatened anyone recently or in the past?
- Threatened or attempted to hurt her or himself recently or in the past?
- Been using any alcohol or illicit drugs today or has s/he in the past?
- Been taking any medications for a mental disorder or for anything else?
- Ever been in treatment or seen a psychiatrist for a mental disorder?
- Ever been a veteran that has seen active combat duty?
- Ever had a history of unusual behavior?
- Been neglecting her or his personal care or hygiene recently?
Crisis Intervention

- Do not react quickly.
- Take time to assess the situation. Time is a tool.
- Attempt to de-escalate or calm the individual, as well as others involved.
- Urge them to discard any potentially lethal instruments (guns, pills, knives, etc.)
- Do not show surprise or discouragement… stay calm!
- Offer hope without reassurances that may be meaningless.
- Ask them for an agreement not to act on their intentions now… bargain for a delay.
- Urge them to put off the decision or the act until they have discussed all of the options available to them.
- Perform a Baker Act (BA-52) after the situation has been stabilized.

3 It is common for the interventionist to experience emotions when encountering a suicidal person. Sometimes annoyance and resentments are felt. These reactions are normal! Try to put yourself at ease, do the best you can. There is, often, no perfect or ideal method to manage this extremely taxing situation!
The Baker Act
Voluntary or Involuntary Admission to an Inpatient Psychiatric Receiving Facility

Criteria for voluntary admission

Criteria include any person over the age of 18 from whom express and informed consent can be obtained. Persons under the age of 17 must attend a hearing to evaluate the consent.

Mental illness is defined in the Baker Act as:

An impairment of the emotional processes that exercise conscious control of one’s actions or of the ability to perceive or understand reality, which substantially interferes with a person’s ability to meet the ordinary demands of living, regardless of etiology. 4

Voluntary admission

Voluntary admission is achieved only after Express and Informed Consent has been obtained from a consumer-potential patient. Express and Informed consent is written, signed consent from a potential consumer, obtained after sufficient explanation regarding the nature and duration of intervention/treatment, has been provided. Explanation of treatment must be sufficient to allow the person whose consent is necessary to make a “knowing and willful decision without any element of force, fraud, deceit, duress, or other forms of constraint or coercion,” regarding the admission.

4 For the purposes of admission to a psychiatric facility, the Baker Act definition of mental illness does not include developmental disorders or delays, substance related disorders, or disorders characterized solely by antisocial behavior.
Disclosure

• The following information is required to be disclosed to any potential consumer, prior to obtaining informed consent:
  – Reason for admission
  – Proposed treatment
  – Purpose of treatment
  – Common side effects of treatment
  – Alternative treatment modalities
  – Approximate length of care
  – That the consent may be revoked orally or in writing prior to or during the course of treatment by the consumer, legal advocate, or guardian

Incompetent to Consent to Treatment

Incompetent to Consent to Treatment means that a person’s judgment is so impaired that s/he lacks the capacity to make a well-reasoned willful and knowing decision regarding medical/mental health treatment.

Persons, who are incapable of providing express and informed consent may be subject to involuntary admission procedures, based on risk to themselves and others.
The Baker Act

Criteria for Involuntary Examination – Admission to a Receiving Facility

- An individual may be taken to a Baker Act receiving facility for involuntary examination if they are found to be mentally ill and because of that illness:
  - They have refused voluntary examination (after conscientious explanation of the purpose of the examination); or
  - The person is unable to determine for her or himself whether examination is necessary; and
- Without care or treatment, the individual is likely to suffer from neglect or refuse to care for her or himself, and such neglect/refusal poses a real and present threat to her or his well being; or
- There is substantial likelihood that without care or treatment, the person will cause serious bodily harm to her or himself or to others in the near future, as evidenced by recent behavior.
The Baker Act

Initiation of Involuntary Examination

An involuntary examination may be initiated by one of the following methods:

• An ex parte order stating that an individual meets the criteria for involuntary examination, based on sworn testimony, is issued. In this instance, a law enforcement officer transports the person named in the order to the nearest receiving facility.

• A law enforcement officer may take an individual who appears to meet criteria into custody and deliver her or him to the nearest receiving facility.

• A physician, clinical psychologist, psychiatric nurse, or clinical social worker may execute a certificate stating that an individual meets criteria for involuntary examination. A law enforcement officer is required to transport the individual to the nearest receiving facility in this instance. The law enforcement officer is required to prepare a written report, not the BA52, detailing circumstances under which the individual was taken into custody.

The professional certificate, ex parte order, or report of the law enforcement officer becomes a part of the individual’s clinical record.

A receiving facility accepting a patient for involuntary examination without an ex parte order, a professional certificate, or the report of a law enforcement officer, is required to notify the Agency for Health Care Administration or the Human Rights Advocacy Committee on the next working day.
The Baker Act

Selected Procedures

An individual may not be removed from a program or residential placement without an ex parte order, a professional certificate, or the report of a law enforcement officer.

A patient must be examined by a physician or clinical psychologist without unnecessary delay, and can be provided with emergency treatment if that treatment is deemed necessary to maintain the safety of the patient or others.

A patient can be released from a receiving facility with the approval of a physician or clinical psychologist only, but the individual may not be held in the facility longer than 72 hours.

Within the 72-hour examination period, one of the following actions must be taken:

- The patient must be released unless charged with a crime
- The patient must be released for outpatient treatment
- The patient must be asked to provide express and informed consent to placement as a voluntary patient, and if such consent is given, the patient will be admitted as a voluntary patient.
- A petition for involuntary placement must be filed in the appropriate court.

An individual may be evaluated as not meeting criteria for involuntary placement by a professional qualified to perform an involuntary examination, and...

- Offered voluntary placement when indicated, or...
- Released directly from a receiving facility. Documentation of the basis for this conclusion is included as a part of the individual’s clinical record.

Any facility accepting a patient based on an ex parte order or a BA 3052 A or B must send a copy of the document to the Agency for Health Care Administration and the human Rights Advocacy Committee on the next working day.
Further Considerations

The involuntary examination is initiated via an ex parte order, a professional certificate, or when a law enforcement officer takes an individual into custody. In this litigious age, it behooves any and all of these professionals to be absolutely sure that the case adheres to criteria and that it is documented as such.

The criteria, in simple terms, is:

- There is substantial likelihood that the individual's present or recent behavior indicates that s/he will cause harm to her or himself or others in the near future without care or treatment…or…

- Without care or treatment, there is a real and present threat to the individual's well being due to self or other neglect. (Refusal to care for her or himself, or to participate in care). Plus…

- All of the threats for injury or harm must be attributable to mental illness

In making a decision to initiate a BA-52, the definitions of certain words and concepts must be satisfied and documented in the report: substantial likelihood behaviors that indicate presence of potential or actual harm, behaviors and/or statements that indicate that the individual is mentally ill, near future-immediacy or acuity of the presenting problems threat to well being, self neglect refusal to participate in self preservation/care.

Example of a report statement that does not satisfy criteria:
01/01/99-2:00a.m. – 28 y.o. Cauca male, A/V hallucinations, delusional, making bizarre statements indicating potential for self harm, destruction of property, possible injury to others. Acting in an agitated angry manner, the consumer made statements about “revenge,” and a “weapon.” Facial tics observed, as well as unusual head and neck movement.
Practical Interventions to Manage Difficult Encounters with the Mentally Ill

The Baker Act

A more sufficient report would contain most of the following elements, as applicable:

- Initial observations at the scene, including quotes
- Specific descriptions of behaviors
- Specific descriptions of the individual’s stated plans
- Specific description of danger, potential threat, posed by the person’s behavior
- Description of the immediacy of the problem
- Nature of threat to the individual posed by self or other neglect

Example of a report statement that does satisfy criteria:

01/01/99-2:00a.m. – 28 y.o. Cauc., male, stating he will not tolerate the actions of intruders from other dimensions, and that he plans to exact violent revenge with secret weapons, before daybreak. Consumer, on further questioning, describes said weapons as “a 22 I keep in the garage.” Consumer extremely agitated, at times: shouting and kicking at the air in front of him, pointing imaginary weapon at the sky, making noises as if shooting a gun. The individual exhibits signs and makes statements indicating mental illness, e.g., psychotic/delusional statements (see quote); report of prior psychiatric treatment; facial tics—involuntary physical movement (head-neck), indicating possible RX Antipsychotic medicine (past or present); and inability to accurately state the day, date, time, or city of residence (“Arizona”). No evidence of alcohol or drug ingestion at this time, consumer denies any use of alcohol or other drugs ever.

Instructor Notes:
The standard of proof is clear and convincing evidence. This must be plainly stated on the BA-52
Age, gender, cultural, and other influences affect these issues.

There may be special considerations necessary in the cases of:

- Juveniles, particularly adolescents
- The elderly
- Persons with medical problems or injuries requiring treatment
- Persons of certain religious beliefs
- Individuals from certain cultures
The Baker Act

Of the following examples:

**which would be appropriate for initiation of a BA-52?**

A. An elderly person wandering the street who cannot tell you where s/he lives, what her or his name is, or where s/he is.

B. An individual who is extremely confused and admits that s/he has not taken insulin required to manage insulin dependent Diabetes.

C. A combat veteran who says he is hearing choppers and gunfire. He says he must protect himself!

D. An individual who says she feels worthless, has been thinking about swallowing all of her sleeping pills at home, and refuses to discuss her situation with you.

E. An individual who cannot remember his last meal, and who claims he does not need to eat for religious or spiritual reasons.

F. A person who is physically injured to the extent that medical attention is essential, but says she will treat the condition with prayer and herbal remedies.

G. A man who says he is going to kill his brother who has been sleeping with his wife, but admits he does not have access to, or own any kind of weapon.

H. An adolescent with a pocketknife who is truant and obviously under the influence of alcohol, who says he is going to “get even” with his parents ... he is loud, big, and belligerent, but there is no further information offered.
I. A 16-year-old runaway who has been smoking crack and is “working” (as a prostitute) the corner of Central and 19th Street.

J. A middle aged man, walking down the road at midnight, holding a stick, who says he “must reach the ocean before daybreak, to save the irrigation system on Mars before the Germans get there.”

K. An individual who says that unless he is able to persuade “Atomin” the cereal god, otherwise, the world will end by 6:00 a.m.

Questions: Which of these demonstrate...

- Substantial likelihood that there will be injury or harm to the individual or others
- Specific behaviors that indicate presence of potential or actual harm
- Specific behaviors and/or statements that indicate that the individual is mentally ill
- Near future-immediacy or acuity of the presenting problems
- The presence of some form of self neglect
- Refusal to participate in self preservation/care
Assisting Persons with Mental Illness and/or Substance Abuse Problems, to Access Professional Help and Community Resources

**Discussion**

**Goals and Methods**

This topic requires further mention of the Community Policing Philosophy; a model of partnership and systematic, integrated problem solving in which the police, human services providers, health care professionals and all members of the community cooperate to resolve problems that affect everyone. This philosophy is a dramatic departure from old-fashioned territorialism and compartmentalization of community services, to a new model founded on cooperation.

In the case of mental health services and law enforcement officers, the traditional situation has been that the service providers, feeling self protective and territorial due to constant funding cuts, and overwhelming demand for admissions and evaluations, are somewhat jaded and weary/weary. The law enforcement officer, experiencing exactly the same pressures, is concerned with disposition of a case or cases and reinforces the no-win situation initiated by the mental health agency contact. Both parties, though likely to be dedicated and devoted community servants, are participants in an obsolete system that requires re-thinking.
How can law enforcement officers, mental health services providers, and members of the community cooperate to overcome the traditional system?

- To improve services
- To reduce stress
- To minimize or eliminate problems

*All* parties can increase information regarding the responsibilities and parameters of the other’s situation-job.

*All* parties can establish structured agreements.

*All* parties can regularly review agreements for efficacy and appropriateness.

**The SARA Model of Assessment and Decision Making**

The most effective tools an interventionist has at her or his disposal are processes for calm, objective, assessment and decision making/problem solving.

Utilization of the SARA model to collect “just the facts” eliminates or at least minimizes the influence of misperception, misconception, and pre-judgement:

**Scan** the entire situation; take all environmental and human factors into consideration.

**Analyze** the data you collect—interpret the situation in terms of what you know and have learned about mental illness and people in general.

**Respond** by formulating a creative intervention or resolution plan; base responses on your assessment of the facts of the situation.

**Assess** the results or likelihood of success of your plan; return to step one if you are not satisfied with your initial plan or to make adjustments.
## Mental Status Exam Lexicon of Terms and Descriptors

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<tr>
<td>Tattoos</td>
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### Interview Behavior

<table>
<thead>
<tr>
<th>Abusive</th>
<th>Guarded</th>
<th>Naïve</th>
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</thead>
<tbody>
<tr>
<td>Angry</td>
<td>Histrionic</td>
<td>Negative</td>
</tr>
<tr>
<td>Aggressive</td>
<td>Hostile</td>
<td>Passive</td>
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<tr>
<td>Apathetic</td>
<td>Impulsive</td>
<td>Sarcastic</td>
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<tr>
<td>Arrogant</td>
<td>Indifferent</td>
<td>Seductive</td>
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<tr>
<td>Assertive</td>
<td>Initiates</td>
<td>Sensitive</td>
</tr>
<tr>
<td>Cooperative</td>
<td>Interested</td>
<td>Silly</td>
</tr>
<tr>
<td>Dependent</td>
<td>Introverted</td>
<td>Silly</td>
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<tr>
<td>Disinterested</td>
<td>Intrusive</td>
<td>Suspicious</td>
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<tr>
<td>Dramatic</td>
<td>Irritable</td>
<td>Threatening</td>
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<tr>
<td>Evasive</td>
<td>Lethargic</td>
<td>Uncooperative</td>
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<tr>
<td>Extraverted</td>
<td>Manipulative</td>
<td>Unresponsive</td>
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<tr>
<td>Grandiose</td>
<td>Menacing</td>
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### Psychomotor Activity

<table>
<thead>
<tr>
<th>Agitation</th>
<th>Repetitious</th>
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<tr>
<td>Compulsivity</td>
<td>Restless</td>
<td>Tics</td>
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<tr>
<td>Hyperactivity</td>
<td>Retardation</td>
<td>Unusual gait</td>
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<td>Impulsivity</td>
<td>Ritualistic</td>
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### Speech

<table>
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<tr>
<th>Aphasic</th>
<th>Mute</th>
<th>Slurs</th>
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<tr>
<td>Deliberate</td>
<td>Muttering</td>
<td>Spontaneous</td>
</tr>
<tr>
<td>Excessive</td>
<td>Paucity</td>
<td>Stammering</td>
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<td>Halting</td>
<td>Pressured</td>
<td>Stuttering</td>
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<td>Indistinct</td>
<td>Rapid</td>
<td>Talkative</td>
</tr>
<tr>
<td>Loud</td>
<td>Soft</td>
<td></td>
</tr>
<tr>
<td>Mumbling</td>
<td>Slow</td>
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### Mood/Emotions/Affects

<p>| | | |</p>
<table>
<thead>
<tr>
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<td>Angry</td>
<td>Elevated</td>
<td>Labile</td>
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<td>Nervous</td>
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<td>Constricted</td>
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<td>Phobic</td>
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<td>Sad</td>
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<tr>
<td>Despondent</td>
<td>Flat</td>
<td>Rage</td>
</tr>
<tr>
<td>Distressed</td>
<td>Hypomanic</td>
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### Thought Flow

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Blocking</td>
<td>Flight of ideas</td>
<td>Perseveration</td>
</tr>
<tr>
<td>Circumstantial</td>
<td>Fragmentary</td>
<td>Rambling</td>
</tr>
<tr>
<td>Clang</td>
<td>Loose Association</td>
<td>Tangential</td>
</tr>
<tr>
<td>Echolalia</td>
<td>Neologism</td>
<td>Word Salad</td>
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### Thought Content

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<table>
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<tr>
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<tr>
<td>Antisocial</td>
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<td>Paranoid</td>
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<tr>
<td>Assultive</td>
<td>Hopelessness</td>
<td>Religiosity</td>
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<tr>
<td>Delusions:</td>
<td>Hypochondriacal (Somatic)</td>
<td>Sexual preoccupation</td>
</tr>
<tr>
<td>Grandeur</td>
<td>Ideas of reference</td>
<td>Suicidal</td>
</tr>
<tr>
<td>Persecution</td>
<td>Obscene</td>
<td>Suspiciousness</td>
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<td>Religious</td>
<td>Obsessive</td>
<td>Worthlessness</td>
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<tr>
<td>Guilt</td>
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### Sensorium/Perception

<table>
<thead>
<tr>
<th></th>
<th>Amnesia</th>
<th>Confabulation</th>
<th>Delirium</th>
<th>Depersonalization</th>
<th>Derealization</th>
<th>Distracted</th>
<th>Dissociation</th>
<th>Hallucinations:</th>
<th>Memory:</th>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Olfactory</td>
<td>Poor Concentration</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Gustatorial</td>
<td>Sedated</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Impaired orientation to:</td>
<td>Stuporous</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Person, place, time</td>
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### Intellect

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<thead>
<tr>
<th></th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>Paucity of knowledge</th>
<th>Paucity of vocabulary</th>
<th>Poor abstraction</th>
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<tr>
<td></td>
<td>Above Average</td>
<td>Average</td>
<td>Below Average</td>
<td>Paucity of knowledge</td>
<td>Paucity of vocabulary</td>
<td>Poor abstraction</td>
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</table>

### Judgement/Insight

<table>
<thead>
<tr>
<th></th>
<th>Denial of degree / severity of their condition</th>
<th>Judgement is impaired</th>
<th>Doesn’t know why they are here</th>
<th>Unmotivated for treatment</th>
<th>Insight is impaired</th>
<th>Unrealistic expectations for treatment outcome</th>
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## Community Resources for Persons who are Mentally Ill

<table>
<thead>
<tr>
<th>Situation</th>
<th>Police Action</th>
<th>Community Resource</th>
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<tr>
<td>Onset of illness</td>
<td>Usually none</td>
<td>Psychiatric Evaluation</td>
</tr>
<tr>
<td>Initial behavioral disruption</td>
<td>Possible mediation</td>
<td>Medication Management</td>
</tr>
<tr>
<td>Mild psychosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Onset of initial depression</td>
<td></td>
<td></td>
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<tr>
<td>Relapse of symptoms or severe onset of illness</td>
<td>Mediation</td>
<td>Medication Management</td>
</tr>
<tr>
<td></td>
<td>Verbal Intervention</td>
<td>Case Management</td>
</tr>
<tr>
<td></td>
<td>Possible physical intervention</td>
<td></td>
</tr>
<tr>
<td>Progression of Severity</td>
<td>Mediation</td>
<td>Medication Management</td>
</tr>
<tr>
<td>Episodes of disruption, self neglect, medication non-compliance</td>
<td>Verbal Intervention</td>
<td>Case Management</td>
</tr>
<tr>
<td></td>
<td>Possible Physical Intervention</td>
<td>Day Treatment Program</td>
</tr>
<tr>
<td>Beginning of Chronicity</td>
<td>Verbal Intervention</td>
<td>Medication Management</td>
</tr>
<tr>
<td>More severe disruption, medication non compliance, more severe symptoms, misdemeanor criminal acts</td>
<td>Physical Intervention</td>
<td>Case Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient Treatment Program</td>
</tr>
<tr>
<td>Acute Stage</td>
<td>Verbal Intervention</td>
<td>Medication Management</td>
</tr>
<tr>
<td>Criminal Acts, Suicide Attempts, Assaults, Severe Self Neglect</td>
<td>Physical Intervention</td>
<td>Case Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intensive Treatment Program or Partial Hospitalization Program</td>
</tr>
<tr>
<td>Crisis Stage</td>
<td>Verbal Intervention</td>
<td>Psychiatric Hospitalization or Inpatient Program</td>
</tr>
<tr>
<td></td>
<td>Physical Intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baker Act</td>
<td></td>
</tr>
<tr>
<td>Chronic Stage</td>
<td>None</td>
<td>State Hospitalization</td>
</tr>
</tbody>
</table>
### Glossary

*When we talk to God, it is called prayer... When God talks to us, it is called Schizophrenia.*
—Lily Tomlin

---

**Addiction**—patterned intake of prescription or non-prescription, illicit substances and/or ethanol-alcohol, to the extent that *physiological dependence* is established. Individuals, who are said to be addicted to a substance, will experience increased need for greater amounts of a chemical, to achieve the same effect over time. Cessation of use will additionally cause the individual to experience various withdrawal symptoms.

*See Substance related disorders*

**Addictions Professional-Certified Addictions Professional**—(CAP) a standardized state certification for counselors specializing in the assessment and treatment of alcohol and drug related addictions.

**Affect/Affective Disorder**—pertaining to an individual’s mood or disorders related to mood, e.g. depression, bipolar affective disorder, etc.

**Affective States**—

- Full—ability to express range of emotions appropriately, e.g. happiness, anger, fear, etc.

- Restricted—limited or impaired ability to express emotions
• Blunted—minimal expression of emotion; mostly un-changing facial expression/monotonous speech

• Flat—no expression of emotions; blank facial expression and speech devoid of expression

• Labile—rapid changes in emotional expression

• Inappropriate—emotional expression that is contrary to emotional state, e.g. laughing instead of crying at tragedy

Agitation—excessive fidgeting, pacing, hand wringing, or other physical activity with no apparent purpose, resulting from internal tension.

Alcoholism—Term used to describe alcohol dependence.

Alzheimer’s Type Dementia—a degenerative organic mental disease that causes increasing deterioration of memory, ability to organize tasks associated with daily living, and progressive self-neglect.

Amnesia—Pathological memory loss.

Anorexia Nervosa—disorder involving obsessive fear of becoming obese characterized by distorted body image, refusal to eat, and subsequent severe weight loss.

Antidepressant Medications—A type of psychotropic medication designed to treat physiological determinants of depression.

Antipsychotic Medications—A type of psychotropic medication designed to treat physiological determinants of psychosis or detachment from reality.

Anxiety Disorder—Disorder characterized by obsessive, intense worrying with no particular cause, to the extent that the individual has palpitations, increased respiration, hot and cold flashes, increased perspiration, and other physical symptoms.

Anxiolytic Medications—Medications used to treat anxiety and panic; see benzodiazepines.

Auditory Hallucinations—hearing voices or sounds with no particular external source, which is not apparent to other persons present.
**B**

**Baker Act—BA-52**—Statute governing involuntary admission to a designated psychiatric receiving facility when an individual presents an immediate threat to the safety and well being of her or himself, or others.

**Bipolar Affective Disorder**—Mood disorder characterized by cycling moods; individuals who are bipolar, “cycle” from an elevated, euphoric and expansive state (mania) to a more depressive, lethargic one. (See mania and depression)

**Bulimia**—disorder consisting of eating binges, usually followed by intense feelings of guilt and worthlessness, often culminating in self-induced vomiting or purging.

**C**

**Compulsion**—persistent, intrusive urge to perform an act that is inconsistent with an individual’s ordinary wishes or desires. Inability or failure to satisfy the compulsion results in overt anxiety. Examples include urges to repetitiously wash, check, count, to satisfy superstitions, or to make repetitive statements, etc.

**Crisis Stabilization Unit (CSU)**—A community intervention and, sometimes, treatment facility that admits persons who are at risk to injure themselves or others. CSU’s are most commonly (though not always) found at community hospitals, and are authorized to involuntarily admit persons who meet strict legal criteria, as well as others, based on capacity and economic conditions.

**Cyclothymic Disorder**—mild form of bipolar disorder in which cycling mood states are less intense.

**D**

**Decompensation**—deterioration of an individual’s normal system of defense, during which, psychiatric symptoms or problems become more prominent.

**Deinstitutionalization**—Movement during the 1950s to release patients from mental hospitals based on emergence of (then) new anti-psychotic medications
Delusions—false belief(s) held despite obvious proof or evidence to the contrary. Delusional beliefs are typically in conflict with those of the individual’s culture. Delusions are classified by psychiatrists, into categories, e.g. organized, disorganized, religious, paranoid, persecution, grandiose, etc.

Dementia—progressive loss of intellectual and emotional functioning, as well as... uh ... well...

Depression—persistent feelings of sadness; fixation on inability to succeed at future ventures; loss of capacity to experience pleasure; feelings of worthlessness or diminished self worth; and resulting disturbance in sleep and/or appetite, as well as other symptoms are listed as criteria for depression in the DSM-IV. (See Diagnostic Statistical Manual, Fourth Edition)

Detoxification Program—medical program designed to assist individuals with physiological dependence on addictive substances, to “withdraw” or physically eliminate toxic substance from their systems.

Dissociative Disorder—disorder in which consciousness is interrupted to the extent that an individual develops multiple personalities or various types of amnesia. Dissociative disorders are mostly reactions to severe trauma.

Dyslexia—Tendency to reverse letters and words when reading and writing.

Echolalia—pathological repetition of another persons words; pathological repetition of another persons words; pathological repetition of another persons words.

Echopraxia—pathological repetition of another person’s movements/actions.

Euphoria—an exaggerated feeling of emotional and physical well being.

Electroconvulsive Therapy (ECT)—therapy performed in a hospital with patient consent in which electrical current is transmitted into the brain, to reverse symptoms of chronic depression or psychoticism. ECT is an effective form of therapy for some persons, though its results are mostly temporary.
Extra Pyramidal Syndrome (EPS)—physical symptoms that result from long term use of certain anti-psychotic medications. Symptoms include muscular rigidity, tremors, drooling, restlessness, peculiar physical movements and postures.

F

Flight of Ideas—making fragmented unconnected statements without completing an idea.

• “I caught the plane on time, but of course my car has all that hair in the back seat because of the landlord not letting me keep the dogs without any notarization of the signature.”

Fugue—memory loss and flight from immediate environment; an individual who is in a fugue state may move and assume a new identity with no memory of the previous life.

G

H

Hallucination—seeing, hearing, smelling, or physically feeling things in the absence of actual external stimulus.

Homicidal Ideation—thoughts of killing someone.

Hypochondriasis—preoccupation with health accompanied by delusions of disease.

I

Inpatient—treatment facility that offers 24 hour monitoring and supervision.

Involuntary Treatment—treatment in which an individual has not granted or has been adjudicated as being unable to grant express and informed consent to treatment.
**Mania**—behaviors characterized by hyperactivity, excessive elation, agitation, and accelerated thoughts and speech. Mania is usually attributable to bipolar affective disorder.

**Major Depression**—disorder characterized by persistent, intense, sadness; inability to experience pleasure, sleep and appetite disturbance; lethargy-decreased energy; memory and concentration problems, among others.

**Mental Health Counselor-Licensed Mental Health Counselor (LMHC)**—individual licensed by the Department of Professional Regulation in Florida to assess and offer therapeutic services to persons with mental illness. Note: The LMHC is not considered by the state to be qualified to perform an involuntary examination for admission to a psychiatric receiving facility.

**Mood Stabilizers**—class of psychotropic drugs designed to help people who experience extreme mood swings as in bipolar affective disorder. Examples of these drugs are: Tegretol, Depakene, and Lithium.

**Mood Swings**—Dramatic changes in feelings and energy level, sometimes ranging from severe depression and anhedonia to elation and euphoria. This “cycling” is usually attributable to bipolar affective disorder.

**Obsessive Compulsive Disorder**—disorder characterized by persistent, unwanted behaviors (motivated by uncontrollable urges) for example, performing repetitious, ritualistic acts such as washing, counting, checking and re-checking things, etc.

**Olfactory Hallucinations**—experiencing smells with no external stimulus or source of stimulus present.

**Organic Mental Disorders**—disturbance or permanent physiological impairment of brain functioning. These disorders can be caused by injury, exposure to toxic substances, aging, or a variety of medical conditions, e.g. Parkinson’s, Cerebral Palsy, Muscular Dystrophy, long term alcoholism or drug addiction, etc.

**Outpatient Treatment Program**—treatment program at which patient/consumers attend assessment and therapeutic services typically scheduled two-three times per week.
P

Panic Attack—episode in which an individual experiences uncontrollable, intense, and debilitating anxiety or fear.

Paranoia—rare condition characterized by belief that other individuals, groups, or organizations are conspiring or planning some undesirable intrusion or attack on a person. In many cases, paranoia arises from misinterpretation of actual events, but progresses to an illogical, delusional level.

Personality Disorders—disorders characterized by inflexible patterns of relating to others, distorted thinking and perception, poor judgement, and resulting distress, that impair an individual’s ability to function effectively. Personality disorders cited in the DSM-IV are:

- **Dependent**—inability to make independent decisions, and ongoing attempts to induce others to assume responsibility for one’s life or a portion of one’s life.

- **Borderline**—characterized by unstable relationships and mood, chronic feelings of emptiness or boredom, impulsivity, and potential for injury via self-mutilation, among others. This is an extremely complex condition that is the subject of a great deal of literature and debate.

- **Antisocial**—personality disorder marked by repeated conflict with society and others due to total disregard for other people, social and even legal norms.

- **Obsessive-Compulsive Personality Disorder**—distinguished from Obsessive Compulsive Disorder by lack of biological basis for behaviors; Learned pattern of repetitious, unwanted behaviors such as counting, checking things, superstitious behaviors, and/or rituals.

- **Histrionic**—personality disorder characterized by overly dramatic-melodramatic behavior, attention seeking and emotional instability.

- **Narcissistic**—personality disorder marked by elevated ideas of self-importance, grandiose self-concept.
• **Paranoid**—personality disorder characterized by suspiciousness and hypersensitivity. There is an absence of psychotic and delusional ideas in this condition as the individual only mistrusts other people to the extent that s/he believes others are talking about her or him or trying to undermine her or his plans for success.

• **Schizoid**—personality disorder marked by social withdrawal, eccentricity, and avoidance of any contact with others. This disorder is accompanied by impaired ability to express emotions, particularly anger or ordinary aggressive feelings.

• **Schizotypal**—personality disorder marked by various peculiarities of thinking, perception, and communication that are not severe enough to meet criteria for schizophrenia. Persons with this condition may appear to have schizophrenia but are not impaired to the extent that odd or magical thinking, speech, or behavior precludes some level of effective functioning.

**Phobia**—an unrealistic but intense, persistent fear of an object or situation, e.g. insects, heights, bridges, planes, open spaces, crowds, etc.

**Psychiatrist**—A medical doctor with a specialization in disorders of the brain, that diagnoses and treats persons with mental illness. Despite the stereotype of bearded psychiatrists performing psychoanalysis, most psychiatrists today focus on pharmacological interventions. Some psychiatrists, however, do maintain current credentials in, and offer psychotherapy services.

**Psychologist**—an individual with an advanced degree in psychology, who performs psychometric testing, evaluation, and treatment services, depending on experience and credentials/board certification. For the purposes of involuntary examination and admission, only an individual who has been licensed by the state may perform a Baker Act.

**Psychosis-Psychotic**—experiences of thought, perception, and/or senses, with no external source (basis) or stimulus.

**Psychotropic Medications**—medications to treat persons with mental illness.
PTSD—(Post Traumatic Stress Disorder)—a disorder in which past trauma creates disturbance/interference in current functioning. Individuals with PTSD experience flashbacks of traumatizing events in the past, panic, anxiety, depression, and are often prone to substance abuse. PTSD is common amongst veterans of the armed forces who have been involved in combat situations. Other situations that can cause PTSD include rape, sexual abuse, or other types of abuse and victimization.

Q

R

S

Schizoaffective Disorder—A mood disorder (depressive, manic, or mixed) occurring concurrently with psychotic symptoms.

Schizophrenia—a group of mental disorders, characterized by psychosis, in which individuals experience disturbances in perception, thought, speech, affect, and behavior for more than six months.

Subtypes of schizophrenia include:

Catatonic—type of schizophrenia in which an individual is in a stuporous, mute state, often exhibiting extreme rigidity and posturing.

Disorganic (Hebrephenic)—characterized by inappropriate affect, extremely disorganized speech and behavior, regressive and childlike behaviors, non-sensical language, silliness and giggling.

Paranoid—pathological delusional belief by an individual, that others are conspiring to persecute or harm them.

Undifferentiated—condition in which an individual demonstrates various symptoms of schizophrenia that satisfy diagnostic criteria, but are mixed to the extent that they defy clear classification.

Schizoid—see Personality Disorders

Schizotypal—see Personality Disorders

Side Effects—non-therapeutic effects of prescribed medications, typically dry mouth, drowsiness, nausea, tremors, etc.
Social Worker—Licensed Clinical Social Worker—an individual licensed by the Department of Professional Regulation as a Clinical Social Worker (LCSW). An individual with this credential is permitted to perform involuntary examinations and admissions to psychiatric receiving facilities via the Baker Act.

State Mental Hospitals—state funded residential hospitals for severe, chronic mentally ill persons. Some state hospitals or wings of state hospitals are dedicated to the housing and treatment of persons who have committed criminal acts because of mental illness and have been adjudicated as not guilty of criminal charges by way of insanity.

Suicidal Ideation—thoughts of killing oneself.

Substance Abuse—condition in which an individual uses elicit drugs or misuses legal substances to the extent that there is some undesirable biopsychosocial consequence. Persons who have family, work, or legal problems as a result of alcohol or drug use, fulfill diagnostic criteria in the D.S.M. IV for substance abuse.

Substance Dependence—continued, pathological use of drugs and or alcohol, despite multiple adverse consequences, and development of physiological dependence. Physiological dependence is established via drug or alcohol tolerance and the phenomenon of withdrawal syndrome during attempts at abstinence.

Substance Related disorders—The official DSM-IV term for adverse conditions involving illicit drugs, misuse of legal drugs or alcohol ingestion.

T

Tardive Dyskenesia (TD)—condition resulting from long term prescription of certain Antipsychotic medications, characterized by involuntary movement and facial tics, muscle rigidity, tremors, and other physical symptoms.

Thought Disorders—disorders characterized by disorganized or impaired thought processes or content

U-V

Visual Hallucinations—seeing things that are not apparent to others present. Experiencing visual images in the absence of physical, external stimulus.
Withdrawal—Drugs/Alcohol—physical symptoms caused by discontinuance of use of alcohol or certain drugs after establishing a dependent pattern of ingestion; Withdrawal syndrome is a feature of any form of substance dependence, and can be characterized by hallucinations, sleeplessness, nausea, cold sweats, episodes of anxiety or panic, and other symptoms.

Word Salad—Incoherent and incomprehensible mixture of words and phrases. Example: “That cat out of the bag is not in the irrigation plans that President Honey told us about!”
Drug Reference

Cautions!

This drug information is presented with the following precautions:

- First, drug and/or alcohol abuse is common, which confounds the typical reactions of each respective drug.

- Second, the environment or context in which the substances are used often influences the reaction.

- Third, drug reactions are very idiosyncratic, based upon the psychological and/or physical status of the person.

- Fourth, the person will react differently when respectively experiencing the desired effects, the toxic effects or the abstinence syndrome.
ALCOHOL

DEPRESSANT

NAMES:
Beer, Wine, Liquor, Liqueur

DESIRED EFFECTS:
Euphoria, Intoxication, Sedation

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Delirium, disorientation, staggering, disinhibition, drowsiness, impaired judgement and reactions, depressed respiration, slurred speech.

ABSTINENCE SYNDROME:
Hyperexcitability, seizures (peaking 8-12 hours after last drink), tremors, hallucinations, psychomotor agitation, confusion, disorientation.

COMMENTS:
Progressive impairment occurs with the amount ingested. Setting and psychological state of the person determines the behavioral potential, but violence and aggression are strong possibilities.
AMPHETAMINE

STIMULANT

NAMES:
Methamphetamine, Speed, Crystal, Crank, Go, Ice, Meth

DESIRED EFFECT(S):
Euphoria, Psychostimulation, Energy, Antinarcolepsy, Antiobesity, improve task performance (long-lasting effects)

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Impairment of fine motor dexterity, fast breathing, tremors, increased motor activity, insomnia, agitation, repetitive acts.

ABSTINENCE SYNDROME:
Increased need for sleep, increased appetite, decreased energy, depression, paranoia may persist

COMMENTS:
Strong potential for violence and aggression. May become suicidal during abstinence syndrome.
ANTIANXIETY, ANTIEPILEPTIC

DEPRESSANT, TRANQUILIZER, ANTICONVULSANT

NAMES:
Phenobarbital, Tegretol, Depalcote, Valporic Acid, Dilantin, Klonopin, Transene, Valium, Ativan, Zanax, Buspar, Ambien, Rohypnol

DESIRED EFFECT (S):
Sedation, anticonvulsive

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Drowsiness, staggering, lethargy, mental confusion, motor impairment, slowed thinking, disorientation, slurred speech

ABSTINENCE SYNDROME:
Anxiety, agitation, insomnia, restlessness, irritability, unpleasant dreams and occasionally hallucinations and delusions, seizures

COMMENTS:
Physical and/or psychological dependence are possible. Can be lethal when combined with other depressants, such as alcohol. Behavioral potential for violence and aggression are greatest during withdrawal stage.
ANTIDEPRESSANTS

MOOD ELEVATION, ANTI-ANXIETY, ANALGESICS

NAMEs:
Imipramine (Tofranil), Desipramine (Norpramine), Trimipramine (Surmontil), Protriptylene (Vivactil), Nortriptyline (Pamelor, Aventil), Amitriptylene (Elavil), Doxepin (Adapin, Sinequan), Clomipramine (Anafranil), Amoxapine (Asendin), Maprotilene (Ludiomil), Trazadone (Desyrel), Bupropion (Wellbutrin), Fluoxetine (Prozac), Sertraline (Zoloft), Paroxetine (Paxil), Venlafoxin (Effexor), Fluvoramine (Lervox), Nefazadone (Serzone), Mirtazapine (Remeron), Phelazine (Nardil), Isocarborazid (Marplan), Tranylcypromine (Parnate), Moclobemide (Aurorix)

DESIRED EFFECTS:
Mood elevation, anti-anxiety, analgesic, sedation (some of the above)

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Sedation, nausea, light-headedness, dizziness, agitation, confusion, blurred vision

ABSTINENCE SYNDROME:
Return of the depression, anxiety disorder and/or pain (if taking for pain).

COMMENTS:
20%-30% of untreated depressives commit suicide. This class drug is seldom abused, and there is little likelihood of physical or psychological dependence.
ANTIMANIC

MOOD STABILIZER

NAMES:
Lithium, Tegretol, Depakote, Valporic Acid

DESIRED EFFECTS:
Mood stabilization

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Nausea, vomiting, diarrhea, abdominal pain, tremors, lethargy, impaired concentration, dizziness, slurred speech, staggering, muscle weakness, impaired memory

ABSTINENCE SYNDROME:
Return of the mania, depression, agitation, anxiety

COMMENTS:
At high doses it can cause coma, renal failure and death. Some potential for violence and aggression, particularly when the individual is in a manic state. 20% - 30% of untreated bi-polar individuals commit suicide.
ANTIPSYCHOTIC

TRANQUILIZER

NAMES:
Chlorpromazine (Thorazine), Clozapine (Clozaril), Risperidone (Risperdal), Olanzapine (Zyprexa), Haloperidol (Haldol), Molindone (Moban), Prochlorperazine (Compazine), Fluphenazine (Prolixin), Tufluoperazine (Stelazine), Perhenazine (Trilafon), Mesordazine (Serentil), Thioridazine (Mellaril), Thiaxthixene (Navone), Chlorprothixene (Taractin), Loxipine (Loxitane), Pimozide (Orap), Sertindole (Serlect), Acetophenazine (Tindal), Carphenazine (Proketazine), Triflupromazine (Vespron).

DESIRED EFFECTS:
Sedation, removal of psychotic symptoms

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Involuntary movements of the face, tongue, trunk or limbs, sucking and smacking of lips, lateral jaw movements, darting, pushing or twisting of the tongue, extreme sedation, staggering, shuffling.

ABSTINENCE SYNDROME:
Return of mania, hallucinations, delusions and bizarre, illogical and irrational thinking

COMMENTS:
Potential for violence and aggression when the individual is delusional, particularly when receiving command hallucinations to hurt someone or themselves. This class of drug does not produce physical or psychological dependence.
COCAINE

STIMULANT

NAMES:
Coke, Crack, Free Base, Girl, Blow, Snow, Rock, Crank, Crystal

DESIRED EFFECTS:
Euphoria, Psychostimulation, energy, relieve boredom, improve task performance, local anesthetic, suppresses appetite

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Anxiety, insomnia, irritability, hyperactivity, increased blood pressure, racing thoughts and speech, sleep deprivation, hypervigilence, suspiciousness, paranoia, persecutory fears

ABSTINENCE SYNDROME:
Depression, anxiety, decreased energy, increased need for sleep

COMMENTS:
Strong potential for violence and aggression
INHALANTS

DEPRESSANT

NAMES:

DESIRED EFFECTS:
Euphoria, intoxication, sedation, enhance sexual experience (in combination with cocaine or marijuana)

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Resembles alcohol intoxication, disinhibition, drowsiness, light-headedness, dizziness, staggering, delirium, muscle weakness, disorientation, headaches. Hallucinations can occur at high doses, cardiac arrhythmia

ABSTINENCE SYNDROME:
Hyperexcitability, agitation, confusion, disorientation

COMMENTS:
Odor of the gases usually is detectable in the regions of the nose and mouth. Plastic bags may be evident if they were “bagging” or saturated rags may be present if “huffing”. Can be lethal due to overdose or aspiration of vomitus.
HALUCINOGENS

PSYCHEDELIC

NAMES:
LSD, PCP, STP, TIC, TAC, DMT, Psilocybin, Angel Dust, Angel Trumpets, Psychedelic Mushrooms, Mescaline, Ecstasy, Crystal, Sherman, Sticks, Sheets, Hog, Peace Pill

DESIRED EFFECTS:
Sensory distortion, heightened awareness of sensory input, Derealization (disembodiment, observers and participant), euphoria, drowsiness

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Amnesia, fatigue, delirium, confusion, loss of attention, extreme sedation, tachycardia, blurred vision, urinary retention, tremors, disorientation, anxiety, panic, depersonalization, profuse sweating

ABSTINENCE SYNDROME:
Chronic or intermittent psychotic states, depression, anxiety, agitation and excitement, incoordination, blank staring and involuntary movements of the eyeballs, inability to speak, flashbacks

COMMENTS:
With drugs such as STP (DOM) overdose can lead to convulsive movements, unconsciousness and death. Psychological dependence is common, especially with PCP. This class of drug strongly exacerbates existing psychiatric conditions, especially psychosis. Strong potential for violence and aggression and for self-harm.
MARIJUANA

SEDATIVE, EUPHORIANT, PSYCHEDELIC

NAMES:
Cannabis, Hashish, Charas, Bhang, Ganga, Sinsemilla, Pot, Weed, Mary Jane, Reefer, Grass, Herb, Cheebah

DESIRED EFFECTS:
Euphoria, relaxation, heightened sensory sensations

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Sensory distortion, mild hallucinations, panic reactions, mild paranoia, confusion, “munchies”, reddened eyes, disorientation, depersonalization, motor impairment, impaired short-term memory

ABSTINENCE SYNDROME:
Restlessness, irritability, mild agitation, insomnia, sleep disturbances, nausea, cramping

COMMENTS:
Psychological dependence is quite common, and there can be physical dependence as well.
OPIOIDS

ANALGESIC

NAMES:
Heroin, Morphine, Codeine, Meperidine (Demerol)

DESIRED EFFECTS:
Pain relief, euphoria, and sedation

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Respiratory depression, papillary constriction, extreme sedation, confusion, staggering, nodding, cognitive impairment, complacency, apathy, lack of concentration

ABSTINENCE SYNDROME:
Restlessness, Sweating, Extreme Anxiety, Depression, Irritability, Fever, Chills, Vomiting, Panting, Cramping, Insomnia, Diarrhea, Intense Aches and Pains

COMMENTS:
Strong potential for overdose. High degree of co-morbid disorders, such as depression, anxiety disorders and antisocial personality among users of illicit Opioids.
SEDATIVE, HYPNOTIC

DEPRESSANT, TRANQUILIZER, HYPNOTIC

NAMES:
Librium, Miltown, Placidyl, Quaalude, Equinil, Amytal, Nembutal, Chlroral Hydrate, Seconal, Dariden, Restoril, Halcyon

DESIRED EFFECTS:
Sedation, sleep inducement

SIDE EFFECTS AND/OR TOXIC EFFECTS:
Diminished environmental awareness, reduced sensory stimulation, reduced physical activity, lethargy, amnesia, flat affect, slow thinking and responding, impaired judgement, extreme drowsiness, decreased respiration.

ABSTINENCE SYNDROME:
Sleep difficulties, increased dreaming and nightmares, hallucinations, restlessness, disorientation, convulsion

COMMENTS:
Physiological and/or psychological dependence are common. Can be lethal, especially when taken with other depressants, such as alcohol. Little potential for violence or aggression.
### Table of Common Psychotherapeutic Drugs

<table>
<thead>
<tr>
<th>Category</th>
<th>Drug Class</th>
<th>Generic Name</th>
<th>Trade Name</th>
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<td>Chlordiazepoxide</td>
<td>Librium</td>
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<td>Clonazepam</td>
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<td>Diazepam</td>
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<td>Oxazepam</td>
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<td>Azaspirodecanidiones</td>
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<td></td>
<td>Propanediol carbamates</td>
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<td><strong>Antidepressant Drugs</strong></td>
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<td>Clomipramine</td>
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<td>Desipramine</td>
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<td>Imipramine</td>
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<td>Nortriptyline</td>
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<td>Protriptyline</td>
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<td>Tetracyclics</td>
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<td>Monoamine Oxidase (MAO) Inhibitors</td>
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<td>Tranylcypromine</td>
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<td>Paroxetine</td>
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<td>Sertraline</td>
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<td>Dopamine Reuptake Inhibitors</td>
<td>Buproprion</td>
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<td><strong>Antimanic Drugs</strong></td>
<td>Lithium Salts</td>
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<td>Carbamazepine</td>
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<td><strong>Antipsychotic Drugs</strong></td>
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<td>Chlorpromazine</td>
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<td>Thiothixene</td>
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<td>Benzisoxazole derivatives</td>
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<td>Butyrophenones</td>
<td>Haloperidol</td>
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<td>Debenzodiazepines</td>
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<td>Dibenzoxapines</td>
<td>Loxapine</td>
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<td>Dihydroindolines</td>
<td>Molindone</td>
<td>Moban</td>
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<td></td>
<td>Thienbenzodiazepines</td>
<td>Olanzapine</td>
<td>Zephrax</td>
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Case Study

The San Diego Experience

In the City of San Diego, a community police officer checked his repeat calls for service. He noticed that many of the repeats involved EDPs. He decided to check into the problem further to determine if a problem-solving strategy was needed. What he found was that the city experienced almost 85,000 calls annually that involved EDPs. At the time there was no organized strategy in place to reduce such calls.

They determined that in order to understand the problem better they would have to get some training. The course they chose was to train selected officers and supervisors to deal with the mentally ill and those in crisis. These officers would then spearhead the effort to reduce calls. To this point the officers were involved in Scanning.

The officers determined that the problem was of such a magnitude and nature that the police were not able in and of themselves to have a positive impact on the problem. California law is similar to the Florida Mental Health Act in that officers have powers to act in limited circumstances to deal with EDPs. The officers realized that they needed to enlist the aid of others. The officers analyzed the information that they had gained and determined that they needed to form partnerships.

The San Diego County Mental Health Department was the selected partner. They are tasked with all intake and supervision of the mentally ill. The philosophy was that these folks are tasked with aftercare and therefore could assist in initial contacts. The idea was sold to the mental health professionals that contact with EDPs on scene could help them in initial screening. Riding with officers also had the benefit that the mental health professionals could check up on their charges while accompanied by a police officer. The civilians definitely liked this idea because their safety was assured.

Furnished by Pete Cohen of San Diego Police Department. Telephone (619) 552-1700
With this information a response was formed. The specially trained officers would have trained mental health professionals ride with them as a team. These teams would be primarily responsible for making initial contacts with those in crisis and conducting follow up checks. It was hoped that this co-active response would ultimately provide better service to those in need and reduce calls for service. The PERT teams were formed, Psychological Evaluation Response Teams.

Initial deployment was three teams. The PD identified good initial success and increased the teams to 7. These individuals only work 20-hour weeks. The remainder of the week they work in their regular capacity. The City successes were noteworthy. San Diego County S.O. began participating. There are now 15 teams working in the county. A final assessment found that the City of San Diego claims a 24% reduction in calls involving EDPs as a result of PERT.

**The Ithaca Experience**

Ithaca, New York is a small Department. They did a routine analysis of their calls for service. In this check it was determined that the largest number of non-criminal calls for service were involving EDPs. This information alone qualified as a problem that needed attention. Further Scanning found that line officers and dispatch spent a great deal of time dealing with the EDP calls. The calls were researched so that there was information about each one.

Sgt. Beau Saul analyzed the information and found that the outcome of the EDP calls was usually not as good as expected. There was a great deal of frustration on the part of officers and EDPs alike. This anecdotal information rounded out the number stats. Sgt. Saul found that the problems did not follow a pattern. As a result formulating a response might be difficult.

He set out to make Partnerships with the mental health community as part of his Response phase. They decided that they would scan each day for reports involving EDPs. Community Police officers would be the primary problem solvers who would work with the mental health sector. They determined that they would tailor their problem solving efforts to each circumstance.

Sgt. Saul said that dispatch and patrol have experienced a decrease in calls for service, this is assessment. However, they discovered that many of the problems that are suffered by the mentally ill are maintenance problems. He said that the workload has increased as a result of their problem solving efforts.

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6 Furnished by Sgt. Beau Saul of Ithaca Police Department.
References

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Community Policing Strategies, Series: NIJ Research Preview Published: November 1995, 4 pages

cop.spcollege.edu/cop
Florida Regional Community Policing Institute

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