MPTC IN-SERVICE T.Y. 2019

Police Interaction with Persons with Mental Illnesses—Part II

G.A.O. IDENTIFIED 5 CHALLENGES REGARDING INTERACTION BETWEEN POLICE AND PERSONS WITH MENTAL ILLNESSES

1. How to identify whether a person has a mental illness
2. How to effectively communicate with individuals with mental illness
3. How to understand what the individual may be going through
4. Police operating with limited access to mental health resources
5. Police have repeated contacts with the same individual, which is time consuming and takes them away from other duties

US Government Accountability Office (GAO) February 2018

GOALS & OBJECTIVES

- Review Police Interactions with Persons with Mental Illnesses – Part I
- Discuss the Massachusetts MPTC Mental Health Action Plan (MHAP)
- Review Mental Health Symptoms
- SPACER - a tool that provides officers with six intervention strategies

REVIEW OF PART I

- Understanding of MGL Chapter 123, Section 12 (“Pink Paper”)
- Verbal and Non-verbal communication skills to de-escalate situations
- Trauma
- Common types of disorders that affect behavior
- Be respectful to all
- Affects everyone at different levels
- Respect shown in today’s interaction can help with tomorrow’s

REVIEW: §12's

- Understanding of MGL Chapter 123, §12 ("Pink Paper")
- Criteria
- Officers can use §12's; when might a §12 be warranted?
- How to fill it out properly
- Warm handoff – how to optimize communication with ESP's and hospitals/ER's. What about CBL (Community based location) evaluations?
- Difference between §12a and §12b

SCENARIO

- Review §12 scenario: Jeffrey, a 25 year old with a history of bipolar disorder cuts himself and is brought to the ER by the police. He had been yelling at his neighbors, and he had a paranoid edge to his thinking, believing his neighbors were intent on harming him. When police approached him they could smell marijuana.
- Four hours later, the Bigtown police see him walking down Main Street…
- DISCUSSION

REVIEW: VERBAL AND NONVERBAL DE-ESCALATION SKILLS

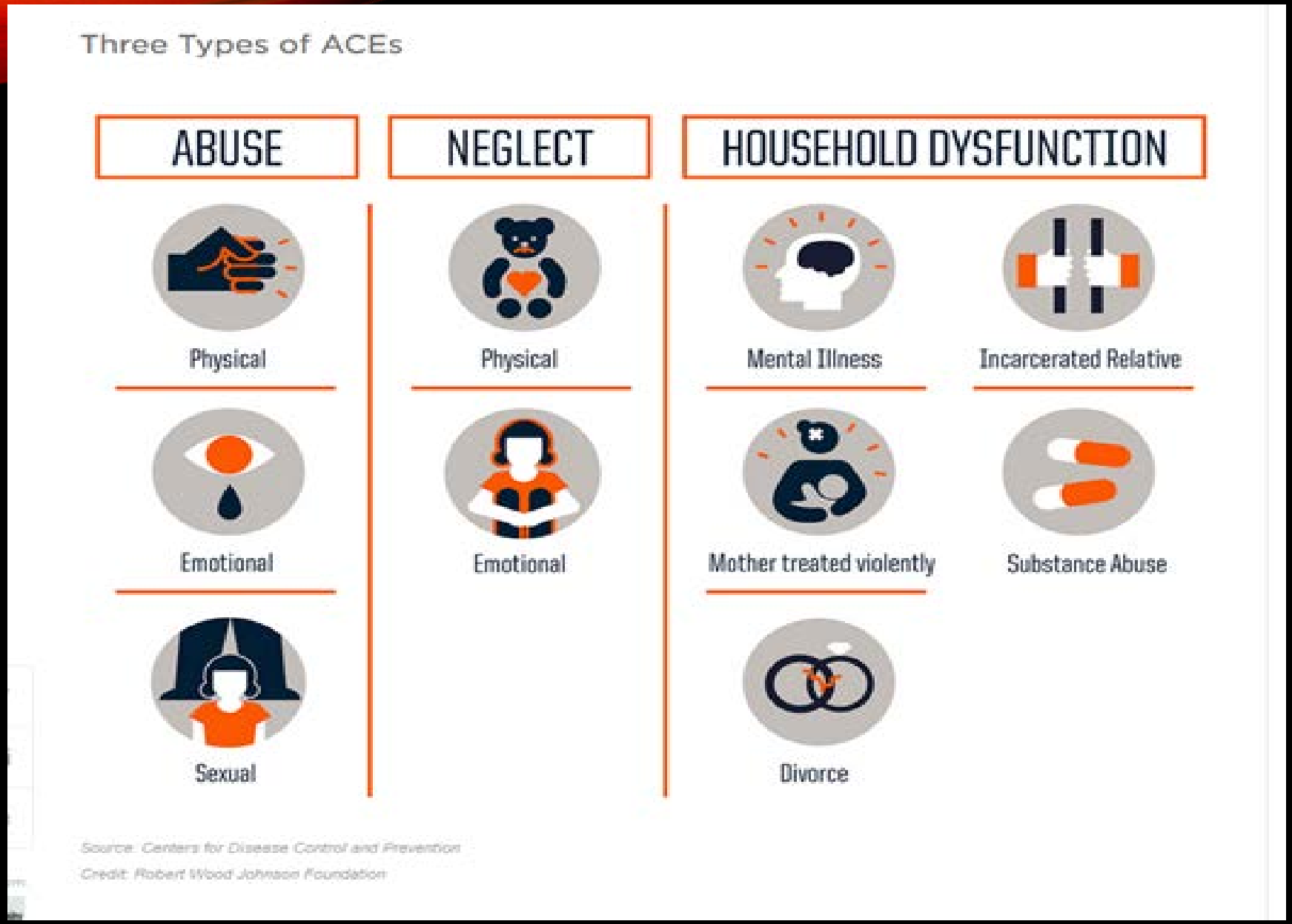
- Verbal: Use active listening and reflective listening skills; Build rapport, paraphrase, be RESPECTFUL

- Nonverbal: Listen, give appropriate space, appropriate eye contact, open stance, do NOT cross arms, be aware of tone and inflection, be patient

REVIEW: TRAUMA

- Trauma –
- Estimates suggest that better than 70% of people with serious mental illness have trauma histories
- Workplaces including criminal justice, mental health, and substance use treatment settings can also have a significant % of staff with trauma histories
- Assume that *trauma has occurred* in all your interactions – use *emotional* universal precautions

ACES


Three Types of ACEs
ABUSE
NEGLECT
HOUSEHOLD DYSFUNCTION
Physical
Emotional
Sexual
Physical
Emotional
Mental Illness
Mother treated violently
Divorce
Incarcerated Relative
Substance Abuse
Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

REVIEW: TYPES OF COMMON DISORDERS THAT AFFECT BEHAVIOR

- Mental Illness
  - Various types
  - Various signs and symptoms
- Developmental and Intellectual Disorder
  - Social communication/interaction difficulties, repetitive behavior patterns
  - Intellectual limitations
- Neurological and Medical:
  - Head injuries
  - Dementia or “neurocognitive disorders”
- Substance-Related Conditions
  - Intoxication
  - Withdrawal
  - Psychosis due to substance use (loss of touch with reality)

MENTAL HEALTH FACTS

18% of adults have a mental health condition

That's over 43 million Americans

9.6 million experienced suicidal ideation

Nearly half have a co-occurring substance use disorder

PEOPLE HAVE CRISES AND BEHAVIORAL HEALTH STRUGGLES

- So it's not THEM, "they" are
  - Your neighbors
  - Your family
  - Your colleagues
  - Us – we are ALL vulnerable to behavioral health difficulties
- *Role of STIGMA*
- Many times, someone will have more than one episode of crisis
- How you interact today can affect tomorrow's interaction
- People have different ways of dealing with emotional distress

QUESTIONS

...about anything from the Part 1 review?

PART II

- The IACP “One Mind” Campaign
- Additional intervention tools for the police officer
- Mental Health Action Plan (MHAP) model: SPACER
- Specific reviews of depression, mania, psychosis, anxiety, personality disorder, and substance misuse
- Scenarios

IACP "ONE MIND" CAMPAIGN PRACTICES

1. Establishing a clearly defined and sustainable partnership with a community mental health organization
2. Developing a model policy to implement police response to persons affected by mental illness
3. Training and certifying sworn officers and selected non-sworn staff in mental health first aid training or other equivalent mental health awareness course
4. Providing CIT training to 20% of an agency's officers

MPTC'S MENTAL HEALTH ACTION PLAN (MHAP)

Assist ALL people with mental health problems, not just those with diagnosable mental disorder

POLICE ENCOUNTERS WITH PERSONS WITH MENTAL ILLNESS

- Police often the first line of response for persons with MI in crisis
- 60-90% of officers reported responding to calls of persons with MI in the last month (Gillig et al 1990 and Borum et al 1998)
- 7-10% of officer contacts involve persons with MI; amount varies locally
- Rates in Massachusetts appear to be much higher when the amount includes crisis and behavioral crisis calls
- CIT and MHFA training help further equip officers in their response to people who are suffering with mental health problems and addiction

WHY SPECIALIZED APPROACHES MATTER

- Overrepresentation of people with mental illnesses in places of incarceration
- People with MI much more likely to be **victims** than perpetrators of violence
- Skillful intervention and finding appropriate options for treatment may be more effective AND require less time
- Use of less force and more focus on effective de-escalation techniques and approaches that manage, not inflame the crisis
- Co-response clinicians can also assist police in follow-ups or crisis response to aid in diverting individuals into treatment

CO-RESPONSE CLINICAL IMPACTS

- Co-response clinicians can evaluate the person in crisis on site in the community with police
- Co-response clinicians model interview skills for law enforcement
- Co-response clinicians work for or liaison with the ESP
- Co-response clinicians provide an opportunity for navigation/service linkage for the person responded to
- Increasingly, officer are being trained in MHFA and CIT and cities/towns/regions are employing licensed social workers to assist them in assisting with police calls or post-intervention responses

CIT RESULTS

- Several studies indicate that CIT Training develops positive perceptions and increased confidence among police officers (1,2)
- Additionally, CIT Officers have very efficient crisis response times
- Increased jail diversion among those with mental illness
- Improves the likelihood of treatment continuity This was all accomplished while significantly decreasing police officer injury rates

1.Compton et al. “A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs”J Am Acad Psychiatry Law 36:1:47-55 (March 2008)

2. http://www.citinternational.org/training-overview/163-memphis-model.html

WHAT IS MENTAL ILLNESS?

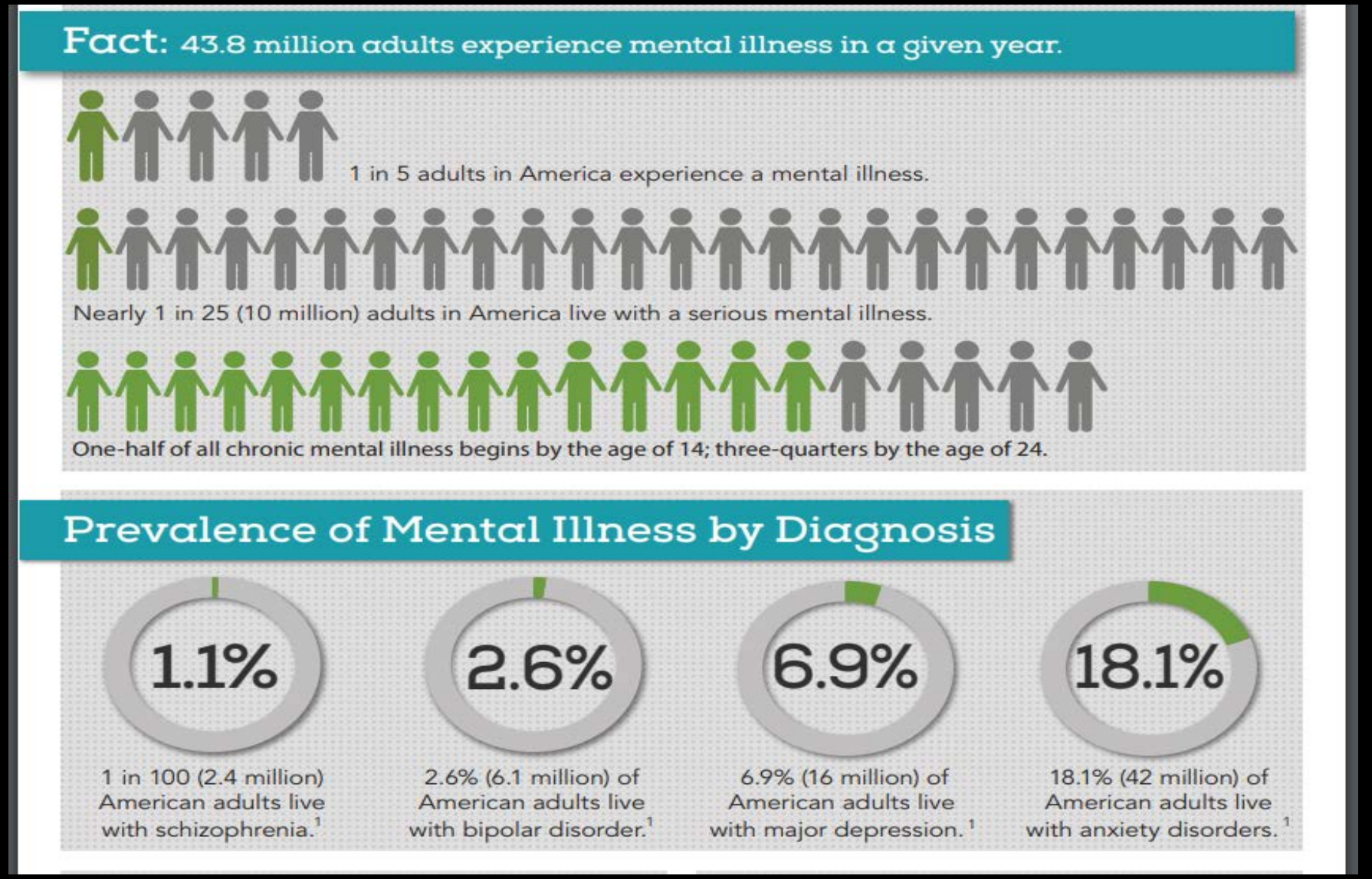
- Definition: A health condition characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning
- Causes still being identified such as:
  - Genetic factors
  - Neurotransmitter (chemicals in the brain) imbalance
  - Brain structure differences
- Social/environmental factors contribute

MENTAL ILLNESS IS COMMON

- Anxiety disorder – 18.1% adults
- Major depressive disorder – 6.9% adults
- Substance Use disorder – 10 to12% adults (2013 NIDA)
- Bipolar disorder – 2.6 % adults
- Eating disorder – 2.1 % adults
- Schizophrenia -- 1.1 % adults
- Any mental disorder – 20% adults

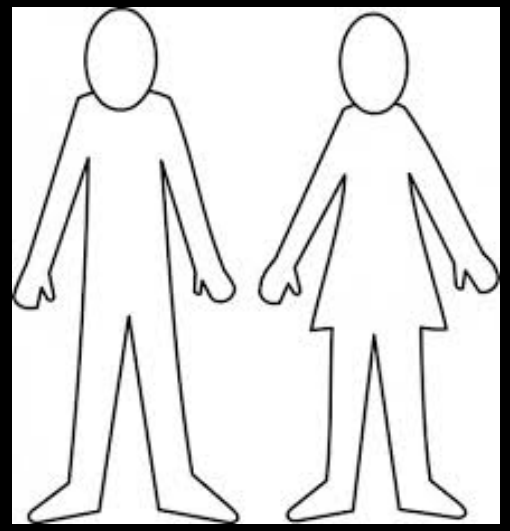
2015 National Institute of Health

MENTAL HEALTH FACTS—ANOTHER LOOK



CHILDREN AND TEENS

Fact: 1 in 5 children between ages 13-18 have or will have a serious mental illness



20% of youths ages 13-18 live with a mental health condition

11% of youth have a mood disorder

10% of youth have a behavior or conduct disorder

8% of youth have an anxiety disorder

POLICE ARE THE FIRST CALL AND THE FIRST RESPONDERS

People rely on you

People don’t know of other resources

People don’t have access to other resources

People have immediate safety concerns

KNOW YOUR ESP

- ESP stands for *Emergency Service Provider*
- Every city / town in Massachusetts has a team
- Know your provider and their contact number
- They respond 24/7 and can partner with police in mental health crisis
- In the meantime, get trained in approaches for responding to mental and behavioral health crises

EFFECTIVE DE-ESCALATION

- What are ways that a person can help talk someone down from a crisis?
- Body language, what you say, and how well you offer a listening ear can have a powerful impact and defuse a crisis.
- The quality of support a police officer offers through listening can enhance a person's self-esteem and coping skills
- Skillful intervention may be more effective AND require less time on the part of the police officer

DURING THE MENTAL HEALTH ACTION PLAN PROCESS, THE OFFICER MUST BE FULLY PRESENT & LISTENING TO THE PERSON IN CRISIS

SUSPEND YOUR JUDGEMENT & BIASES

A MENTAL HEALTH ACTION PLAN

- Allows police to recognize that a disorder may be developing or is present
- Assists police on how to respond properly and safely for all involved
- Gives police a better understanding of the person's mental health problems allowing them to communicate appropriately without escalating situation

MASSACHUSETTS' MENTAL HEALTH ACTION PLAN

SPACER

SPACER

S is for SAFETY

SPACER

P is for PATIENCE

SPACER

A is for ASSESS

SPACER

C is for COMMUNICATION

WHAT IS MEANT BY "COMMUNICATION"

- 55% of our communication is non verbal
  - 38% is *how* you say it
  - 7% is what the words actually mean: the content
- "I statements" are best – "I can see that you are feeling really down"
- Open-ended questions give people the opportunity to vent
- Use a calm, even tone
- Be predictable, **clear** and consistent

COMMUNICATE

- An important part of communication is **LISTENING**
- Be genuine
- Listen nonjudgmentally
- Check your attitude
- Respect what the person is saying even though they do not align to your beliefs or values
- Withhold any judgment that you may have about this person and his or her circumstances
- Repeating or paraphrasing what that person is saying demonstrates to that person that you are listening to them

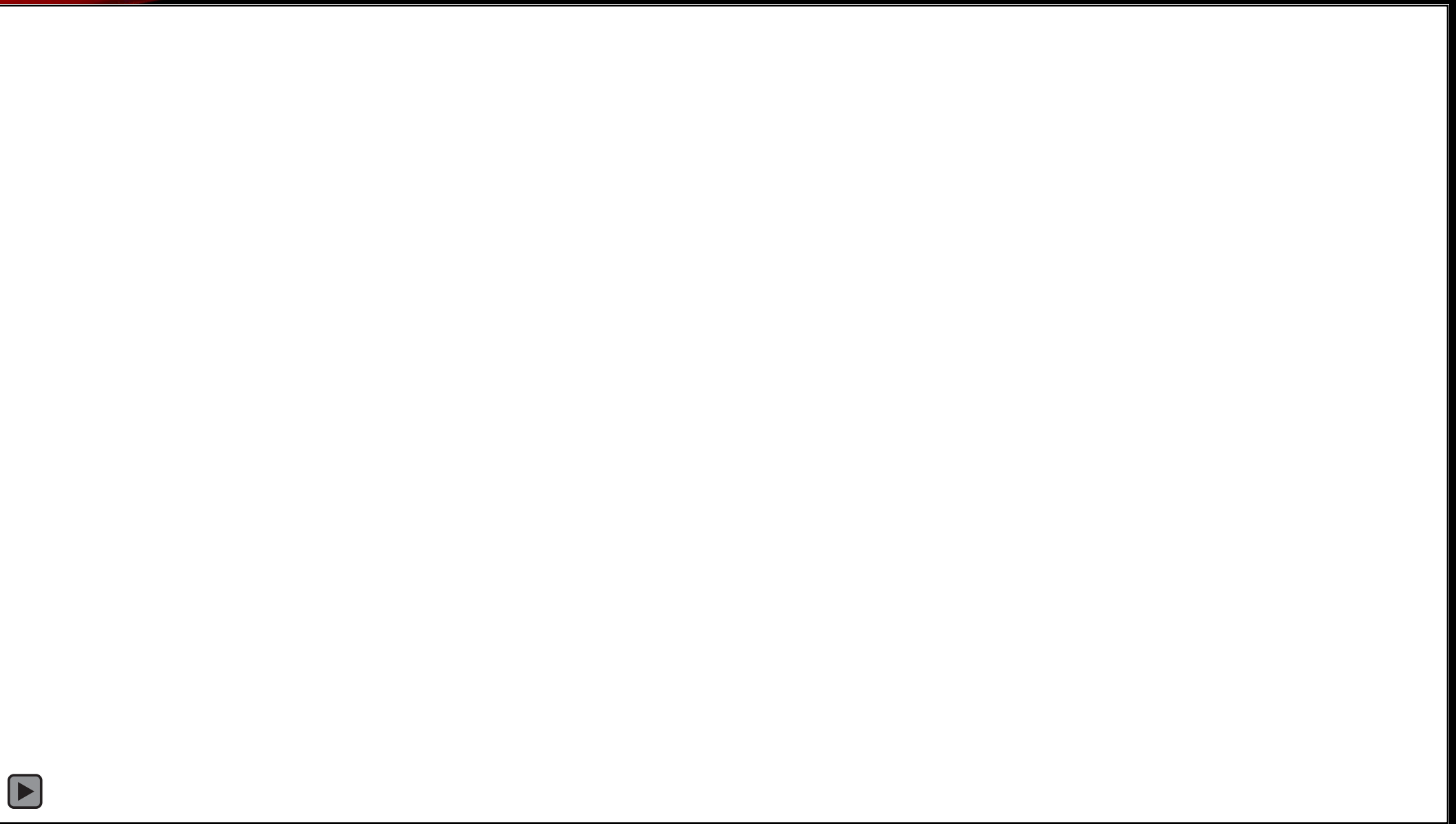
SPACER

E is for EMPATHY

EMPATHY

- What is empathy?
- Empathy vs. Sympathy?
- What makes empathy important?

EMPATHY AND LISTENING VIDEOS



EMPATHY AND LISTENING VIDEOS

SPACER

R is for RESPECT

WHAT DOES RESPECT LOOK LIKE?

- When someone is struggling with a crisis?
- When someone is showing mental health symptoms?
- When someone has another disorder?

TYPES OF DISORDERS THAT AFFECT BEHAVIOR

- ✓Depression
- ✓Mood Disorders: Manic
- ✓Anxiety Disorder
- ✓Psychosis
- ✓Personality Disorders

MOOD DISORDERS: DEPRESSIVE SYMPTOMS

- Sad or irritable mood
- Slow or agitated movements
- Statements of hopelessness
- Impaired thinking
- Tearfulness
- Suicidal behavior and statements (aggression also possible)

SPACER FOR DEPRESSION

- **S – Safety:** yours, those around you, and the person in crisis: Will this person harm you, someone else or themselves including suicide?
- **P – Patience:** People who are depressed speak slowly, their thoughts do not connect well together
- **A – Assess:** What is going on with this person in crisis? Try to understand from their perspective
- **C – Communicate:** Low self-esteem, have given up or feel guilty so may not be talkative ("What's the use…."). May also be blaming themselves. Be encouraging and positive while communicating with them. Find a hopeful path to the future – what do they have as bright spots?
- **E – Empathy:** Put yourself in their shoes. Be cautious not to patronize – "It sounds like you've really tried to work this out," "I know it's difficult but I'm hoping you might stay with me for a bit longer can we give it one more chance to work it out." If they are resistant or are stating that the hospital hasn't helped – validate and say that you can talk with the staff to try to address these concerns. Avoid platitudes.
- **R – RESPECT**

SCENARIO

- A local high school requested the assistance of the police for a student who was found to be watching U Tube videos about guns in the classroom and on the school's I-Pad they use in class.
- Upon arrival, the assistant Principal further elaborated that he was watching videos of how to make cyanide and the effects it has on the skin.
- When you arrive, the student appears sad and it looks as though she has been crying.

MOOD DISORDERS: SYMPTOMS OF MANIA

- Overly cheerful or irritable
- Increased energy
- Rapid speech
- Grand plans or ideas
- Distractible
- Agitation
- Reckless behavior
- Suicidal/aggressive

SPACER FOR MANIA

- **S – Safety**: Risk of suicide or harm (May have to de-escalate). Suicide and violence risks are typically high with someone experiencing Bipolar-related symptoms
- **P– Patience**: Lots of patience needed here; do not internalize verbal abuse. There is a lot of energy going on with them. Can be extremely happy or mad. Easily distracted, so not paying attention to you.
- **A – Assess:** Is there reckless behavior (sexual promiscuity, spending sprees, gambling, substance misuse, criminal behavior?). Grandiose plans/ideas? Watch for escalation.
- **C – Communicate:** Listen nonjudgmentally (Listen patiently and wait out speech that is uninterruptible); Verbal and non-verbal communications will be watched closely ("Are you laughing at me?" "You don't believe me do you…."). Avoid accepting or challenging delusions.
- **E – Empathy**: Offer self-help and other support strategies; Give reassurance and information (Don't personalize. May be verbally aggressive, dismissive, accusatory or narcissistic. The person cannot help it.)
- **R – Respect** for the individual

Typically – the officer will need to have the person assessed by an ESP

SCENARIO

- The Police Department was dispatched to a local motel for a wellbeing check on someone with a history of bipolar disorder and substance use.
- Officers knew that she was recently discharged from a psychiatric facility.
- The call to police was from her case manager, because when her case manager went to pick her up for therapy, she yelled at him in an agitated manner to leave.
- Upon arrival of police, the person was agitated but compliant.
- The room was in complete disarray.
- She reported that smoking “a lot” of marijuana but denied other drug use.

ANXIETY SYMPTOMS

- Physical – Cardiovascular, Respiratory, Neurological Gastrointestinal and Musculoskeletal
- Psychological – Unrealistic and/or excessive fear and worry, mind racing or going blank, decreased concentration and memory, indecisiveness, irritability, impatience, anger, confusion, restlessness or feeling “on edge” or nervous, tiredness, sleep disturbance
- Behavioral – Avoidance of situations, obsessive or compulsive behavior (rituals), extreme fear of social situations, irrational behavior, limited social interactions

- Difference between anxiety and anxiety disorder

SPACER FOR ANXIETY DISORDERS

- **S – Safety**: Assess for risk of harm to self or others or suicide; anxiety surges are a contributing ingredient to suicide
- **P – Patience**: Fear/terror is real to them as well as physical symptoms; they may feel embarrassed and therefore may be resistant to talk
- **A – Assess**: Do they really need an ambulance ? Do they need evaluation?
- **C – Communicate**: Avoid assumptions/judgments. How do they effectively cope with their anxiety? Has this happened before? What has been helpful – do you have a coping plan/provider?
- **E – Empathy**: Again… Put yourself in their shoes
- **R – Respect** for the individual

SYMPTOMS OF PSYCHOSIS

- Loss of touch with reality
- Hearing voices, seeing things (hallucinations)
- False beliefs/delusions
- Not making sense: disordered thinking
- Suspiciousness/paranoia
- Flat emotions
- Gesturing
- Irritable and agitated
- Making remarks about suicide

SPACER FOR PSYCHOSIS

- **S – Safety:** Will they hurt themselves or others because of delusions or voices?
- **P – Patience:** When hearing voices, the person has to sort out who to listen to, like being in a very busy, crowded room with everyone talking. (We did Hearing voices exercise in Part I). Voices are very distracting. It takes time to respond to you so patience is key; remember: the individual is not ignoring you.
- **A – Assess**
- **C – Communicate:** Listen nonjudgmentally (Don't dismiss, minimize or argue with person about their delusions or hallucinations, don't act alarmed, horrified or embarrassed by them, don't laugh or encourage or inflame the person's paranoia. One question at a time
- **E – Empathy:** Again, put yourself in their shoes to understand what is happening to them and out of their control
- **R – Respect** for the individual

SCENARIO

- You are dispatched on scene to an EDP that is walking down Main Street yelling loudly at passersby.
- The subject is overdressed for summertime, has fair hygiene, is speaking very fast, and making gestures with his hand.
- He is making lots of inferences, some accusatory that are hard to follow, but he mentions God and the devil frequently.
- A couple of times, he turns his head entirely and speaks out loud to no one. It becomes clear that he is very upset that someone has taken his bicycle (or so he thinks).

SYMPTOMS OF PERSONALITY DISORDERS

A **personality disorder** is an enduring pattern of experience and behavior that deviates from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

Borderline Personality Disorder:

- A pattern of instability in interpersonal relationships, self-image, emotional presentation, and marked impulsivity. It is correlated with self-injury (cutting), excessive 911 calls and suicide attempts

Antisocial Personality Disorder:

- Repetitive criminal conduct without much empathy
- Social irresponsibility, disregard for others, deceitfulness, and manipulation of others for personal gain

SPACER FOR PERSONALITY DISORDERS

- **S – Safety:** Antisocial – safety of others; Borderline – safety of self.
- **P –Patience**: Listen non judgmentally (Respect their wishes as long as they remain safe for example if they are asking for space; do not react out of anger/pride; avoid arguing/defending actions; maintain space between yourself and the person;
- **A – Assess**: Give reassurance and information (If person not responding and continuing to escalate, remove person from stimulation/area; use phrases like “I want to help you, but it’s difficult for me to understand you when you are yelling,” “I would like to help you, but I need you to…..”; Speak clearly and simply; avoid quick movements; De-escalate and follow academy training as needed.
- **C – Communicate**: Make calm, respectful and firm observations about the person’s behavior so they can identify their emotion. If necessary, set calm, respectful and firm limits on the person’s behavior. Empathize with their emotion BUT remind them that you need to maintain safety))
- **E – Encourage** appropriate boundaries and professional help
- **R – Respect** for the individual

TYPES OF SUBSTANCE USE DISORDERS THAT AFFECT BEHAVIOR

Substance Use Disorders

Alcohol

Drugs

CONCERNS ABOUT SUBSTANCE USE DISORDERS

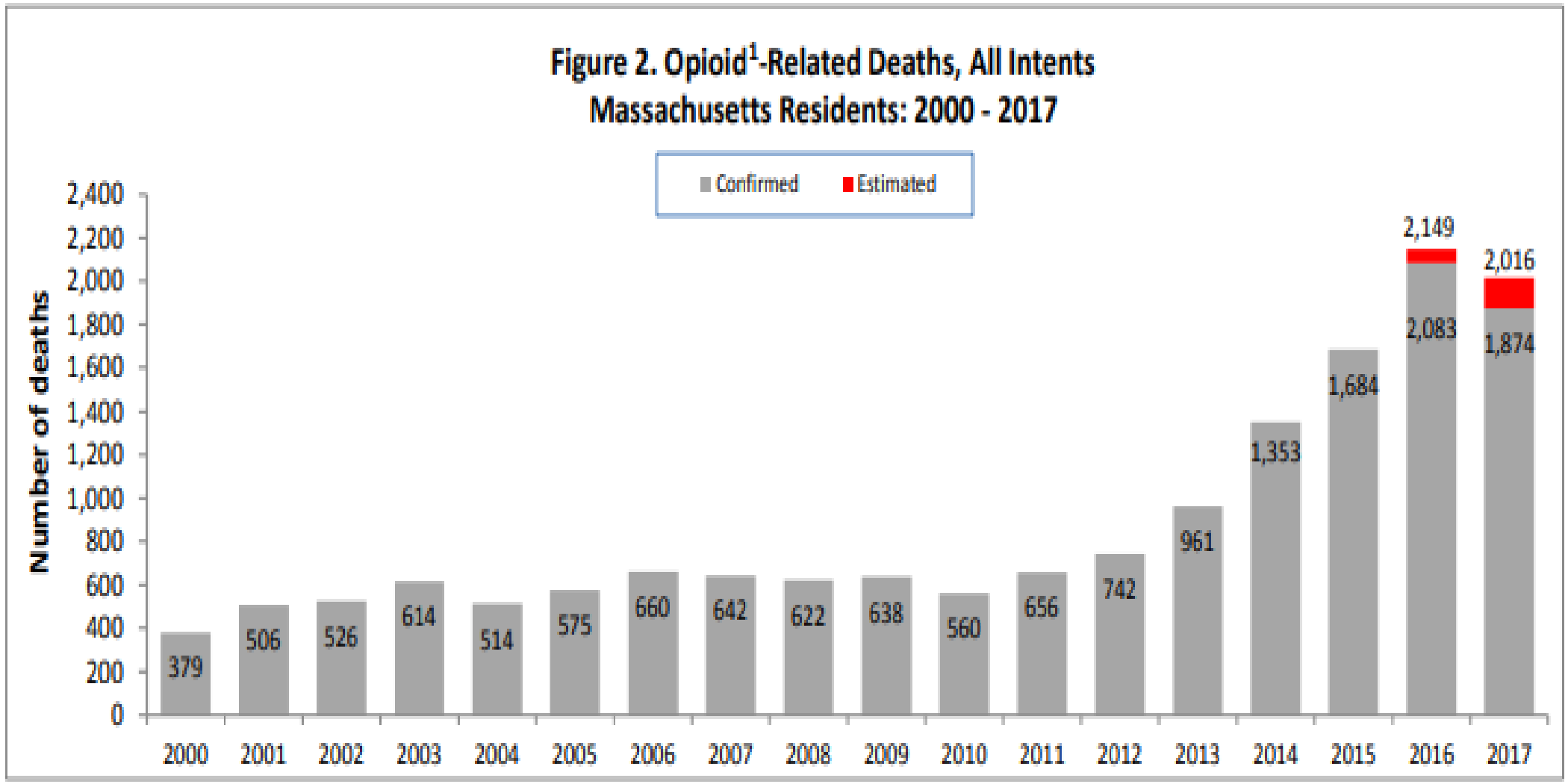
- Abuse of alcohol or other drugs can lead to work, school, home, health, or legal problems
- Addiction is a progressive disease – leading to dependence on alcohol or other drugs and at great cost to an individual's life
- Presentation may mimic any psychiatric disorder
- Increases risk for violence and medical problems
- Risk of suicide is greatly increased when combined with any other psychiatric disorder
- Impulsivity
- Substance-related criminal activity

SYMPTOMS OF SUBSTANCE USE DISORDERS

- Tolerance
- Substance taken in larger amounts than intended.
- Withdrawal
- Persistent desire or attempt to cut down or control use
- Cravings
- Use of larger amounts over longer periods than intended
- A lot of time spent getting the substance, using it, or recovering from its effects
- Person gives up or reduces important social, occupational, or recreational activities because of substance use

SPECIAL EFFORTS BY FIRST RESPONDERS DURING THE OPIOID EPIDEMIC

- Narcan: Training in First Aid in the academy
- Awareness: A low percentage of individuals who are brought back with Narcan may become combative and upset (instantly "dope" sick)
- Being dope sick – "like having the flu, but 100x worse" "you're not going to die, but you just feel like you are."
- Specialized responses: DART team



Source: DPH Opioid Overdose Data Quarterly Report - May 2018

SPACER FOR SUBSTANCE USE DISORDERS

- **S – Safety:** Are they a risk to harm themselves or others?
- **P- Patience**
- **A – Assess**: Are they at risk because of use? Example: DT's (alcohol) or nodding off, pinpoint pupils, can't wake up, slow or irregular breathing – opioid overdose needing Narcan/EMS.
- **C – Communicate**: Be a good listener, nonjudgmental
- **E – Empathy**: People who have a substance use disorder may or may not want to get help or change. When they are ready for help, Give them reassurance and offer than resources/information (i.e., treatment, DPH helpline, and AA/NA meeting books/resources)
- **R – Respect** for the individual

SUICIDE AND SELF-INJURY

- Suicide has reached an epidemic proportion in the US: About 45,000 people died in 2016, or 13 per 100,000 – the highest in 30 years
  - In Massachusetts – a little lower @ 9 per 100,000
- Bipolar Disorder, Major Depressive Disorder, Schizophrenia, and Borderline Personality Disorder all are conditions associated with suicide. However, most people who die by suicide are not diagnosed with a mental health disorder.
- Self-injury is frequently used by some people (often who have a history of trauma) as a means of externalizing and “releasing” intense feelings. When a person superficially cuts, it actually makes them feel emotionally better. It is a maladaptive coping response.

SUICIDAL AND SELF-INJURIOUS BEHAVIORS

10th Leading Cause of death in U.S.

2nd among 15-34 year olds

3rd among 10-14 year olds

Highest suicide rate:

45-64 year olds

MENTAL HEALTH FIRST AID & OTHER RESOURCES

- Mental Health First Aid for Public Safety
  - Resources through DMH have free 8-hour courses
  - Contact your Area Forensic Director for more information
- Suicide Prevention Crisis Line: Samaritans Statewide Hotline
  Call or Text: 1-877-870-HOPE (4673)
- National Suicide Prevention Lifeline
  1-800-273-TALK (8255)
  Press # 1 if you are a Veteran

LIST OF RESOURCES FOR PROGRAM AND CONTACTS

Listed on the MPTC Website And in Today's Handouts:

- ESP's – Emergency Service Programs

https://www.masspartnership.com/pdf/MBHPESPDirectory.pdf

- CIT-TTACs /CR-TTAC– Crisis Intervention Team and Co-Response Training and Technical Assistance Centers (handout)
- DMH Forensic Services:
  - John Barber John.Barber@MassMail.State.MA.US
  - Karin Orr Karin.Orr@MassMail.State.MA.US

WHY IT IS IMPORTANT TO HAVE A PLAN

- Mental health problems are common and you as a first responder will encounter them throughout your career
- An ability to identify whether it is a mental illness or drug/alcohol related is helpful
- Understanding what person is experiencing assists you in determining how to proceed
- Good communication skills & effective listening skills will assist in completing the call more quickly and efficiently
- Having an established partnership with your ESP or a community health organization will generate access to mental health resources
- Providing linkage and resources will bring down the number of frequent encounters

SPACER

Provides officers with additional tools for the challenges they face during their interactions with persons with mental illnesses

QUESTIONS?


QUESTIONS
what
how
when
who
why
where
answers
questions
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