



AMHD
ADULT MENTAL HEALTH DIVISION

CONSUMER/SURVIVOR PANEL PRESENTATION

for

**Assisting in the
Training of Police Officers
in the Handling of Persons
with Mental Health Issues**

**Developed by Sarah Ho, MA, Consumer Advocate
Hawai'i County Jail Diversion Program (HCJDP)**

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OBJECTIVES OF THE CONSUMER/SURVIVOR PANEL

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To broaden understanding and awareness of mental illnesses and stress responses so police officers can:

- recognize when mental health is an issue for an individual;
- calm and de-escalate a crisis situation;
- reduce the likelihood of violence and ensure safety for those involved;
- respond in ways that preserve the individual's dignity and self-respect;
- assist the individual in accessing mental health treatment and/or substance abuse counseling, as appropriate;
- understand the importance of trauma in the development of mental illnesses, and avoid retraumatization during police encounters;
- protect themselves from the consequences of work-related stress;
- gain confidence and competence in dealing with individuals with mental health issues.

MENTAL ILLNESS ATTITUDE TEST
(Adapted from *PERF*, 1999 by S.Ho 12/05)

1.	T F	The best approach for handling a person with mental illness is to be tough and to remain impersonal.
2.	T F	Police officers should treat people with mental illnesses with the same respect as they would any other person.
3.	T F	The first objective in dealing with people with mental illnesses is to control the person with whatever force is necessary.
4.	T F	Trying to talk with a person in a mental health crisis usually isn't possible.
5.	T F	People with mental illnesses are more violent than most people.
6.	T F	The degree of resistance officers receive when dealing with a person with mental illness will greatly depend on the officer's demeanor and attitude.
7.	T F	Police officers are able to begin the process of providing treatment to persons with mental health issues.
8.	T F	Basically, mental illness and mental retardation are the same thing.
9.	T F	A person with mental illness can still be intelligent and perceptive.
10.	T F	Putting an obnoxious person with mental illness in jail for a night is a good way to teach the person a lesson.
11.	T F	Responding to people with mental illnesses is a legitimate role of police.
12.	T F	People with mental illness can control their bizarre behavior, but prefer not to because of the attention they receive when they act weird.
13.	T F	Mental illness is a permanent condition.
14.	T F	Any person who attempts suicide is clearly mentally ill.
15.	T F	Persons with mental illness are still aware of things being said around them.
16.	T F	Mental illness symptoms are often faked.
17.	T F	A person with mental illness may demonstrate illogical thinking or be cognitively impaired.

INTRODUCTION AND BACKGROUND INFORMATION

"People with mental, cognitive and psychiatric disabilities constitute perhaps the single most persecuted and least understood group of individuals in the disability community. The stigma associated with mental illness remains an oppressive obstacle to employment and integration, hampering the efforts of people with mental disabilities to enter the work force, attend schools and contribute their talents and energy to society."

~The President's Committee on
Employment of People with Disabilities, March, 1994

The Americans with Disabilities Act (ADA, 1990) entitles people with disabilities to the same service and protections that police departments provide to anyone else. They may not be excluded or segregated from services, or otherwise provided with lesser services or protection than are provided to others. This law has refocused awareness on police response to people with mental illnesses.

The ADA does not call for a fixed set of rules to be followed in all cases involving a person who has - or exhibits symptoms of - mental illness. Rather, the ADA calls for law enforcement agencies and personnel to make reasonable adjustments and modifications in their policies, practices, or procedures on a case-by-case basis. For example, if a person exhibits symptoms of mental illness, expresses that he or she has a mental illness or requests accommodation for a mental illness (such as access to medication or water), officers and call-takers may need to modify routine practices and procedures, take more time or show more sensitivity to extend the services or protections that would be extended to someone else in a similar circumstance.

Today, the scope of the ADA has been broadened by the 1999 Supreme Court ruling in the case of *Olmstead vs. L.C.* This decision, known as the *Olmstead Act*, states that '...the unjustified institutionalization of persons with disabilities is a form of discrimination under the Americans with Disabilities Act.' Accordingly, the U.S.

Department of Health and Human Services has advised states to promote effective plans and set aside funds to identify institutional residents, to prepare them for release, and to provide residence facilities and supportive treatment for them within the most integrated community settings possible. In compliance with this federal request, State of Hawai'i Olmstead Plan does just that; it is currently awaiting the governor's signature to become law. In addition, Hawai'i's federally mandated Community Plan, which was court-ordered so as to improve mental health services state-wide, is bringing more individuals with mental health issues out into the larger community.

At the local level, Hawai'i County reports the highest levels of child abuse and neglect in the state, and abuse victims are more than twice as likely to receive a psychiatric diagnosis. Hawai'i County is also dealing with a virtual methamphetamine epidemic. Substance abuse, research shows, is very often an attempt at self-medication for an underlying mental illness. A further complication is that federal funding for the Hawai'i County Ice Task force was recently cut (11/05), which may exacerbate what is already a complex, demanding problem.

As a direct result of these federal and state laws, and in consequence of the socioeconomic realities on the Big Island, persons with mental illnesses now live increasingly in houses, apartments, group homes, transition or treatment houses, or on the street without homes or shelter. They may be professionals, laborers, homemakers, or unemployed; they may be children, adolescents, or the elderly. They can be victims of crime, witnesses to it, or themselves the subject of a call. Current best estimates are that 7-10% of police encounters involve a mental illness; inclusion of individuals with substance abuse issues or mental handicaps brings this percentage even higher. Therefore, police officers increasingly need to learn how to respond to such encounters with confidence and comfort. In addition, one in five persons will develop a mental illness in his/her lifetime. Helping people with mental illnesses and their families obtain the services of other government agencies, mental health organizations, hospitals, clinics, and shelter care facilities has become a critical role for police.

Certain working assumptions underlie most Crisis Intervention Training for police officers. These assumptions provide a backbone of understanding for participants, and they directly address some commonly held misconceptions about persons with mental health issues. These are:

1. Mental illness is not a crime.
2. Most people with mental illnesses are fully functioning members of their communities.
3. There is no correlation between mental illness and a person's participation in crime.
4. Involvement in minor infractions (such as traffic violations, loitering, disorderly conduct, disobedience) may be a manifestation of a person's mental illness or failure to receive treatment for that illness, rather than a result of intentional wrongdoing.
5. Persons with mental illnesses may be more vulnerable to crime, abuse, or injury than the general population. For example, 51% of those individuals with a mental illness exhibit at least one substance abuse disorder as well; 92% of homeless mothers have experienced physical and/or sexual assault, and trauma generates emotional/mental disorders.

Adapted from PERF (Police Executive Research Forum), 1999
S. Ho, 12/05

EXCERPTS FROM " Handling the Mentally Ill: There Are No Shortcuts for Officers"

By retired police Chief D.P. Van Blaricom,

Appeared in the March 2000 issue of Police Magazine

Who is called when a mentally ill person starts exhibiting bizarre behavior in public? The police, of course, and one out of every 10 calls is estimated to involve a mentally ill person.

When a problem of that magnitude faces officers on the street, you would expect to see commensurate training provided, right? Wrong. The fact is that officers generally receive very little training in recognizing and appropriately responding to the mentally ill, whom they are certain to encounter.

A recent federal appellate court decision, incidentally, suggests that the Americans with Disabilities Act (ADA) requires such training.

The essential difference between suspect encounter training, that officers traditionally receive, and how to approach the mentally ill is the need to be **non**-confrontational. Such a requirement to, in effect, shift gears is diametrically opposed to the way officers are routinely expected to control conflict. The same command techniques that are employed to take a criminal suspect into custody can only serve to escalate a contact with the mentally ill into violence.

The National Law Enforcement Policy Center (NLEPC) has developed well-reasoned policy for police contact with the mentally ill and suggests that:

- " It is helpful for officers to understand the symptomatic behavior of persons who are afflicted with a form of mental illness. In this way, officers are in a better position to formulate appropriate strategies for gaining the individual's compliance."

- "Officers should first take time, if possible, to survey the situation in order to gather necessary information and avoid hasty and potentially counterproductive decisions and actions."...
- "All attempts should be used to communicate with the person first by allowing him to ventilate."
- "The individual should not be threatened with arrest or other enforcement action as this will only add to the subject's fright and stress and may potentially spark aggression."

PERF has long been a leader in advocating better training for the police response to the mentally ill, and they similarly suggest:

- "Do not rush the person or crowd his personal space. Any attempt to force an issue may quickly backfire in the form of violence."
- "He may be waving his fists, or a knife, or yelling. If the situation is secure, and if no one can be accidentally harmed by the individual, you should adopt a non-threatening, non-confrontative stance with the subject."
- "Excessively emotional or even violent outbursts by the mentally ill are often of short duration. It is better to let the outburst dissipate rather than wrestle with a person who is under extreme emotional stress. Bizarre behavior alone is not reason for use of force."
- "Increased adrenaline causes insensitivity to pain."
- "What works best and what is most beneficial is patience and communication."

Some training that is currently provided to officers may actually exacerbate an encounter with a mentally ill person, particularly if that person has a knife. Since police trainers adopted the so-called "21-foot rule," officers have been taught that anyone within that distance, who is armed with a knife, may be shot in self-defense. Had I been similarly trained, when I was on the street, I might have shot a mentally ill person myself but, fortunately, the outcome was different.

I was dispatched to an apartment where a person was reported to be acting bizarre and when I knocked at the door, it was opening by a woman holding a steak knife. Under today's training scenario I should have immediately drawn my gun and shot her at such close range. Instead, she began using the knife to spread peanut butter on her hair and I responded by asking her what she was doing. She replied that she was making a sandwich and so I next asked her if she was hungry. When she said that she was, I suggested that we go to lunch together and thus became the start of her transport to a mental health facility (in further violation of today's more dogmatic training, I did not handcuff her either).

It is not unusual for the mentally ill to display a knife or a club, when they fearfully and predictably react to an officer's "command presence," but does that justify shooting them? A better understanding of the dynamics of the mentally ill, through training, can help to resolve such encounters with less violent results.

A term for exacerbating danger, for failing to utilize "time, talk and tactics," is "officer-created jeopardy." Some researchers have even suggested that "hasty cops who force confrontations with emotionally disturbed persons and who consequently must shoot them to escape uninjured have used unnecessary force." Whether excessive or not, in the final analysis, no reasonable officer should want to use any force, deadly or otherwise, if there is the alternative of taking the time to talk and exercise other options.

It is well accepted, by trained negotiators, that "trying to resolve any problem or crisis too quickly will have negative results." Accordingly, and despite some delay, the ultimate outcome will consume far less time and expense than yet another shooting caused by inadequately trained officers taking too precipitous an action. There are no shortcuts for safely taking the mentally ill into protective custody.

**EXCERPTS FROM "CRISIS INTERVENTION TEAMS:
CURING POLICE PROBLEMS WITH THE MENTALLY ILL"**

*by Donald G. Turnbaugh, President, National Alliance for the Mentally Ill,
Pinellas County, Florida - from The Police Chief Magazine, Feb. 1999*

No one who is not personally involved with someone with mental illness can understand the depths of worry, fear and despair the family goes through. They remember the healthy, bright, lovable children they raised before the illness struck, and just want them to be like everyone else. Generally, families of the mentally ill are honest, law-abiding, working people who respect and like the police. Once mental illness strikes, however, family members live in constant fear that both the child and the police may over-react if they come into contact with each other - one from paranoia or delusions, the other from fear or ignorance.

Tragically, there is more than a little basis for these fears. The words, "Officer Shoots, Kills Man" recently captured the headlines three times in less than 90 days in the Tampa Bay area. Police responded to calls, were physically attacked and, in turn, shot and killed the attackers.

In all three fatal encounters, the attacker was apparently mentally ill. Situations like these, repeated all too often throughout the United States, occur when a mentally ill person stops taking his medication, becomes violent and is killed by the police. Why do scenarios like this happen? Because mental institutions have been closed, medications are not available or too costly, families are excluded from involvement, community treatment is on overload, budgets are drastically cut and adequate funding legislation is not passed.

If all of this were not enough, the situation is magnified by law enforcement's limited knowledge about how to deal with the mentally ill. Too often, the mentally ill person's contact with the police results in his going to jail for abnormal behavior stemming from his illness.

These tragedies vividly manifest the need for a better, more professional way to handle these most vulnerable and chronically ill of our citizens in volatile situations. One such better way, now available and operational in too few police departments nationwide, where incidents of this type are all but non-existent, is crisis intervention training.

In Memphis, they have learned that there is no appropriate or worthwhile quick-fix solution. The department's comprehensive five-day (CIT) training program consists of four phases. First, officers learn about the many types of mental illnesses and the even more types of drugs used to control them. Then they receive a consumer viewpoint session by visiting their homes, assisted living facilities and group homes for one-on-one and group discussions. Phase three incorporates role-playing and acting out real-life situations of persons in crisis. Here officers learn to listen and develop response skills and crisis intervention strategies. The final component is training the trainers. The mental health trainers ride with police officers to gain an understanding of what officers' face. This removes barriers between officers and trainers and provides a greater appreciation of what each has to contribute to the situation.

This unique partnership of police, mental health providers and advocates is more than just training for the police. It can change the way society looks at and deals with mental illness. It is community policing at its best - an opportunity for police to enhance their image, gain public trust, show professionalism and demonstrate their sensitivity to community needs.

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RECOGNIZING CHARACTERISTICS OF A MENTAL HEALTH CRISIS

REMEMBER: Any behavior at all is possible when someone is in crisis.

1. The subject may be responding to internal sounds, sensations, voices, even commands, which feel completely real to him/her. This is psychosis.
2. The subject may not be rational. His/her primitive brain has taken over. A direction from an officer may not be understood; a paper to be signed may not be comprehended.
3. The person may be reliving a trauma, at the emotional level, and literally isn't 'in the present.'
4. Some part of the individual, however, is probably still aware of how (s)he is being treated and of the emotional tone of what is said to him/her. Practice as much kindness as you can.
5. Emotions may be intense and/or change rapidly; or they may be flat or absent (similar to shock).
6. There may be a lot of forgetfulness and confusion.
7. The subject is probably frightened and needs calm, reassuring words.
8. Some mental illness/psychotic states do hold a higher risk of violence, particularly if the individual is off his/her medications. Special concerns include:
 - mania
 - disinhibition
 - impulsivity
 - delusions
 - command hallucinations

- poor judgment

9. The subject may display erratic, abnormal, or repetitive movements of the body; or (s)he may appear agitated.

10. The subject may demonstrate unusual speech patterns: too slow or too fast, non-linear, or nonsensical messages.

11. The person may be in a state of personal disarray or poor hygiene.

12. The person may not remember later on what happened during the crisis, and may need to see the police report and have everything told to him/her truthfully.

13. The subject may frustrate, dismay, infuriate, taunt, insult, threaten, or otherwise mistreat you. **Please do not take anything personally. The subject is not him/herself, but is operating in an altered reality. You are the only rational person there, so it's up to you to do the best you can.**

S.Ho 12/05

INTERACTING WITH PEOPLE WITH MENTAL ILLNESSES IN CRISIS SITUATIONS

WHAT TO DO:

1. Remain calm and non-threatening; avoid overreacting. Keep the volume of your voice lowered.
2. Continually assess the situation for dangerousness. Stay alert for unpredictable behavior changes. Ask for input from family and witnesses. Obtain medical aid if needed. SAFETY FIRST.
3. Be helpful and patient with the person. Perhaps ask what the person needs right now, and respond as best you can (a glass of water, a medication, etc.). Give the individual time to calm down.
4. Maintain adequate space between you and the subject (ask the person what is comfortable for him/her).
5. Give firm, clear, simple directions, and check for understanding: 'baby steps.' Be tactful and truthful.
6. Announce your actions before initiating them, and then move slowly.
7. Remove distractions, upsetting influences, or disruptive people from the scene.(The person may be overwhelmed by his/her own sensations, thoughts ['voices'] or the environment.)
8. Respond to the apparent feelings, hallucinations, delusions ("That sounds scary. I can see why you are upset/angry...").
9. Be aware that your uniform, firearm, handcuffs, and nightstick may frighten the person. Reassure him/her that you don't intend harm.
10. Understand that you may not have a rational discussion.

Adapted from PERF, USF, and LERC(Law Enforcement Resource Center), 1999 by S.
Ho 12/05

INTERACTING WITH PEOPLE WITH MENTAL ILLNESSES IN CRISIS SITUATIONS

WHAT NOT TO DO:

1. Move suddenly or rapidly, as this can be a trigger for further upset.
2. Stare directly and continually; this may be interpreted as a threat.
3. Crowd the person or move into his/her comfort zone.
4. Express anger, impatience, or irritation. Do not speak loudly or yell.
5. Touch the person (unless essential for safety).
6. Arrest the individual for behavioral manifestations of his/her mental illness that are not intentionally criminal in nature.
7. Laugh at the person, joke or make fun, or whisper. These can all feel frightening and can increase suspiciousness, paranoia, and the likelihood of violence.
8. Give multiple choices, which are confusing.
9. Join into nor challenge the subject's delusions or hallucinations.
10. Assume that a person who does not respond cannot hear.
11. Use inflammatory language, such a 'crazy,' 'mental,' or 'psycho.'
12. Deceive the subject. (Being honest about your concerns and necessary actions will build trust and keep communication happening.)

Adapted from PERF and USF, 1999 by S. Ho 12/05

QUESTIONS TO ASK A PERSON IN CRISIS

WHAT'S YOUR NAME?

WHERE DO YOU LIVE OR SLEEP?

WHERE ARE YOU RIGHT NOW?

WHAT DAY IS IT?

WHAT TIME IS IT?

QUESTIONS TO ASK FAMILY MEMBERS OR WITNESSES: HAS THE PERSON IN QUESTION:

- 1) threatened or attempted to use violence, or acted so as to endanger him/herself or others?
- 2) threatened or attempted suicide?
- 3) been neglecting personal hygiene or bodily care?
- 4) recently experienced a trauma?
- 5) shown any history of mental illness or other abnormal behaviors?
- 6) been prescribed any medications for emotional problems, or stopped taking those medications recently?
- 7) exhibited changes in personality in recent weeks?
- 8) been drinking or using drugs?

Adapted from USF, 1999 by S.Ho, 12/05

TRAUMA AND ITS EFFECTS

Between 50 and 98% (depending on the diagnosis) of people with mental illness have experienced trauma. This strong correlation shows us that, in order to understand how to treat persons with a mental health issue, we have to understand trauma also.

TRAUMA IS A FORM OF PSYCHOLOGICAL SHOCK THAT INVOLVES INTENSE FEAR, HELPLESSNESS, LOSS OF CONTROL, DENIAL OF ONE'S PERSONHOOD, AND THE THREAT OF ANNIHILATION.

Trauma can be mild or horrendous (a full spectrum), and can be caused by:

- natural disasters
- crime - either witnessing or being a victim
- war experiences
- assault/violence of any sort
- rape
- abuse: mental, emotional, verbal or physical

The similarity among all those causes is that the experience involves a threat - often to one's life - that overwhelms one's sense of connection and meaning. It will cause physiological arousal, which includes:

- activation of the sympathetic nervous system, our 'fight or flight' response and its accompanying high adrenaline and cortisol levels;
- forced focusing of the individual's attention on the situation before him/her;
- alteration of ordinary perception, including sometimes overriding pain, hunger, or fatigue;
- evocation of great fear and/or anger.

During the experience of trauma, the individual feels that neither resistance nor escape is possible. One is rendered helpless and violated. One despairs and feels hopeless.

Because one's life can be endangered, the mind/brain remembers the traumatic event and all its surrounding circumstances differently than other events are remembered. It is as though the brain UNDERLINES or HIGHLIGHTS the memories so they will never be forgotten. This is a deep, perhaps permanent, imprinting on the neural pathways.

Trauma is remembered best in the middle brain, a more primitive part of our brains, and the part that handles emotions and drives. This part of the brain is NOT RATIONAL. (Brain model shown here.)

Because the trauma is remembered so deeply and completely, the survivor is reminded of it over and over again. This repetition/recurrence of the experience itself, with all its accompanying terrors, is known as posttraumatic stress disorder, or PTSD.

Because emotions are the gateway to trauma memories, experiencing any strong emotion can trigger the memories. Or, being in a situation in which one again feels threatened can trigger the memories. And when they return, they can return as strongly as they were experienced in the first place. One is actually reliving the terror or the disaster or the atrocity. One is no longer in the present. One is no longer rational.

A confrontation with a police officer or an arrest process can feel frightening or threatening, so it MAY TRIGGER RELIVING/REEXPERIENCING THE TRAUMA.

This is why a police officer who speaks calmly to a person in a mental health crisis can, by his attitude and demeanor, prevent the retraumatization of that person. The officer can provide kindness and reassurance to a terrified human being, and assist him/her in feeling safe again and in getting the psychological help (s)he needs.

POLICE AND SUICIDE

Factors to Consider: Law Enforcement Work Involves High Levels of Stress

Police officers are more likely than many to experience trauma and its aftereffects. According to an article in the Philadelphia Inquirer in Nov. '05, about twice as many police officers die by their own hand than are killed in the line of duty. The rate of suicide among NYPD officers is 29 per 100,000, whereas in the general public, the rate is only 12 per 100,000. Many officers who are emotionally 'down' try to solve their problems quietly. They fear that if they ask for help, they will be labeled 'weak.' But officers are as likely as anyone to have to cope with emotional difficulties; perhaps even more so because of the nature of police work.

Below are some factors that help explain the high suicide risk among police. Being aware of these factors in yourself and others may help avert a suicide or an emotional crisis. The National Police Suicide Foundation (NPSF) seeks to educate fellow officers about these risks.

1. HIGH LEVELS OF STRESS ARE PART OF THE JOB: As an officer, you never know what a call will bring. You may have to transition rapidly from a quiet cruise in your vehicle to a highly charged emotional scene. This sort of quick transition is known as 'burst stress,' and it is particularly hard on the brain and body. You must react quickly, producing high levels of adrenaline in order to cope with the situation before you. Then on the very next call you might have to shift out of the super-charged level at which you were functioning moments ago. Such rapid changes are stressful.

2. OFFICERS SEE THE GRIM SIDES OF LIFE: Officers have to deal with the sad and sordid sides of human life almost on a daily basis: violence, death, loss, trauma, despair. Exposure to these sorts of events can lead to depression, post-traumatic stress disorder (PTSD), or substance/alcohol use to help cope. Officers can become cynical, chronically sad or tense, or emotionally protective of themselves. None of this is easy.

3. MOST OFFICERS ARE MEN, AND MEN ARE TAUGHT TO SURVIVE ON THEIR OWN: In our society, men are not 'supposed' to ask for help or to say that they cannot cope with something that has happened. Men are taught to 'tough it out' and remain 'strong' and 'macho,' even when they are hurting badly inside. Because they believe that emotionalism is weak, they may not get help when they need it. But brain chemistry sometimes needs a boost from an anti-depressant medication to function properly, just as an underfunctioning stomach may require antacids or Prilosec. A man who resists asking for support may be denying his brain medication it needs to stay in balance.

4. DEPRESSION AND STRESS MANIFEST DIFFERENTLY IN MEN: Even well-educated persons may not realize that stress and depression manifest differently in men than in women, much as the symptoms of a heart condition differ in the sexes. There is a strong movement to add another category to the Diagnostic and Statistical Manual (DSM IV) called 'male-based depression.' Instead of the unrelieved crying or excessive sleep that is seen in many women with a mood disorder, in men the disorders are likely to manifest as anger, aggression, bullying or accusatory language; high-risk behaviors (such as driving too fast); extremes of work or physicality (working out two or 3 times a day, keeping long hours at the office); distracting oneself from alone time; using alcohol or other drugs to block feelings and find relief; or seeking confrontation. Recognizing these behaviors in oneself or a friend may help the individual obtain needed help or medication.

5. A POLICE OFFICER IS AN AUTHORITY FIGURE: A police officer wears a uniform, a badge, and carries weapons. Anyone with problems with authority may act out those problems on a uniformed officer. People don't always - or can't - respond to the **person** behind the badge and uniform. Instead, they may yell at the officer, or be abusive or disrespectful. Or, they may merely be intimidated, awkward, or withdrawn. All of this leaves the uniformed officer isolated from his/her fellow human beings, which adds to the emotional burdens and stress levels of the officer.

6. HIGH EXPECTATIONS THAT ARE IMPOSSIBLE TO MEET: A police officer is expected to stay in control, regardless of what is happening around him/her. (S)he is expected to remain calm, even while others around him/her are 'losing their heads.' An officer is taught to stay alert, responsive, careful, aware of the environment; to use force only when necessary; to avoid harming others; and not to make mistakes about disposition, whatever the incident. In short, the officer is expected to be somewhat more than human.

7. BIOLOGICAL STRESSES HAPPEN ALSO: We humans have innate biological rhythms called 'diurnal cycles' or 'circadian rhythms,' and working night shifts or overly long hours upsets those inborn cycles. An officer may lose sleep after a particularly challenging call, but then be expected to function at top performance the very next day. The officer may miss holidays or family events because of the demands of his/her job schedule. All of this adds to the tensions of the officer.

S.Ho, 12/05

SCENARIOS:

REAL-LIFE SITUATIONS TO EXAMINE AND EVALUATE

- READ EACH SITUATION CAREFULLY AND DECIDE WHAT YOU THINK SHOULD BE DONE AND WHY. OR, IF THE SCENARIO DESCRIBES FULLY WHAT HAPPENED IN THE INCIDENT, EVALUATE THE DECISIONS THAT WERE MADE.

- SOME THINGS TO REMEMBER: ASSESS FOR THE POSSIBILITY OF A MENTAL HEALTH ISSUE; LEARN IF ALCOHOL OR DRUGS ARE INVOLVED; EVALUATE THE POTENTIAL FOR VIOLENCE IN EACH SITUATION: SAFETY COMES FIRST.

SCENARIO # 1:

Officer Therman Canton (Houston, TX) was called to a scene because of a possible suicide. He arrived to find a man known to have a drug problem up on the roof of his two-story house with a rope tied around his neck. The man was alternately yelling and talking to himself; and he was threatening suicide.

Notes:

SCENARIO # 2:

Officer Lechelle Brown (Memphis, TN) arrived at a group home for the mentally ill, a place she had visited before. She found 27-year-old Mary, a person known to her,

holding a knife and refusing to take her meds. She was also threatening to cut herself and kill the nurse on duty.

Notes:

SCENARIO # 3:

Two officers in Kealahou were called to a housing complex for the disabled because of an altercation between two residents. One angry female resident had shown up at the door of a neighbor, knocked loudly and persistently, and shouted, "I'm going to kill you!" The woman inside had been badly frightened and has now refused to come out when the officers direct her to do so. The woman outside, who has consumed some alcohol, continues to threaten the woman inside the apartment; the police continue to direct the woman inside to come out so that the two residents can discuss their problems. The officers are frustrated and restate their orders with increasing authority.

Notes:

SCENARIO #4:

A female in bizarre clothing (white long-johns, gloves on her feet for shoes) had been

taken by the security guard to his office at the mall where she was causing a disturbance by her shouting. An officer arrived and asked the woman where she lived. She replied that she had just been kicked out of a group residence for fighting. The officer told the woman that no other home or agency would help her until she agreed to get counseling and medical treatment. At this, the accused began to swear and repeat loudly that she was not a paranoid psycho, but that she just had ESP and had been chosen by the angel Gabriel to give other people certain messages. The officer informed her that she could be arrested because she was a danger to others. The accused came close to the officer and spat in her face.

Notes:

SCENARIO #5:

A Canadian woman was disciplining her 12-year-old son for eating too many cookies and crackers before dinner. Her 'disciplining' was to strike the child about a dozen times with a 14-inch-long wooden stick. The child victim was severely bruised, but not bleeding. When the father attempted to intervene and stop the beating, his wife dropped the stick and picked up a knife, at which point the police arrived. The woman's husband told the officers that beatings like this were becoming more frequent; that she was getting out of control.

Notes:

SCENARIO #6:

A 911 call was placed from a cell phone at approximately 7 PM, and two female officers arrived at a residence in Honaunau to find a young woman within with her infant son. She told the officers that she had no idea about the call, but that her mother, with whom she'd just had a bad argument, was outside in her car. The woman was awakened by one officer while the other officer spoke with the daughter. The woman awoke in a confused, disoriented state, and when she was asked about the call, she didn't remember having made it. The officer could smell alcohol on her breath. The situation escalated when officers asked the woman to leave the premises, per the daughter's request; the woman began to yell. She said she was a mental health consumer and wanted to be taken to the hospital. She became abusive and continued screaming when officers did not comply. One officer gave her a direct order to quit the premises, and to have no further contact with her daughter for 24 hours, either by phone or in person. The officer also asked her to sign a paper which verified that she understood this order. She refused to sign. A few minutes later, while both officers were at the residence with the daughter, the woman placed a call to her daughter's cell phone. One officer confiscated the daughter's phone as evidence that the woman had violated the officer's order. The woman continued to scream angry insults. She was eventually handcuffed and pushed to the ground; then transported to Kealakehe station where she spent the night in jail before being admitted to the Hawai'i County Jail Diversion Program.

Notes:

SCENARIO #7:

In Milwaukee, Officer Tommy Wilson was called to a scene of violence around 8:30 PM. He found Michael Blucher, an 18-year-old schizophrenic with a history of depression since the age of six, in front of a friend's house. The subject was waving 2 kitchen knives and screaming, begging someone to shoot him. Officer Wilson learned that Michael had gotten into an argument with the 14-year-old sister of his friend; knives were pulled by each; and Blucher had hit the girl on the head with a samurai sword he'd pulled from the wall. The girl was lying on the floor, conscious but bleeding profusely and badly frightened. The parents of the girl had recently arrived home and were frantic. The mother had slashed Blucher's hands; the father had a gun and had fired it at the wall. Wilson called for backup. He went outside and repeatedly ordered Blucher to calm down and go back inside, which he refused to do. When Wilson tried to contain Blucher, Blucher lunged toward him. Wilson fired three bullets into the man's chest, killing him. Wilson was so overcome by grief that he collapsed on the ground and had to be helped back to his squad car, when backup finally arrived.

Notes:
