DPSST Basic Class	Instructor
Hlth & Fitness pre test/post test	Sgt Dave Virtue & Sgt Mark Chamberlain
Intro to CJ System	Dep DA Michael Kuykendall
Survival Ethics	Off Robert King
Govt Ethics	Asst Chief Bruce Prunk
Ethics	Asst Chief Bruce Prunk
Cultural Awareness	Ms. Frances Portilla
Law Enforcement Professionalism	Chief Charles Moose
Defensive Tactics	Off Paul Dolby, Ken Gardner
Community Policing	Lt Greg Hendricks
Problem Solving	Lt Greg Hendricks
Report Writing	Sgt Terry Wagner & Sgt Dave Schlegel
Criminal Law I, II, III, IV, V, VI, VII, VIII , Procedural Law, Juvenile Law & Officer in Court	Dep DA's Wayne Pearson, Stacey Heyworth, Tom Cleary, Eric Bergstrom & Jim Hayden
Interviewing Techniques	Sgts Wagner & Schlegal
Federal Civil Rights	SA Cal Penewit
Sexual Harassment	Dep City Atty Marinna Kanwit
Americans With Disabilities	Dep City Atty Kanwit
Dealing With the Mentally Ill	Off Sarah Westbrook
Tactical communications	Off Robert King
Firearms, ConSims, FATS	Sgt Larry Baird, Off John Richards, Off Scott Reasor
Auto Theft	Sgt Bob Gross

INTERGOVERNMENTAL AGREEMENT BETWEEN THE PORTLAND POLICE BUREAU AND THE DEPARTMENT OF PUBLIC SAFETY STANDARDS & TRAINING

This AGREEMENT is made and entered into by and between THE STATE OF OREGON, DEPARTMENT OF PUBIC SAFETY STANDARDS AND TRAINING, hereinafter referred to as "DPSST," and THE PORTLAND POLICE BUREAU, hereinafter referred to as PPB.

Recitals

1. By authority granted in ORD 190.110, state agencies may enter into agreements with units of local governments for the performance of any or all functions and activities that a party to the agreement, its officers, or agents have the authority to perform.

2. By authority granted in City of Portland Charter 2-105 (a)(4), the City of Portland may enter into this agreement.

3. Under such authority, DPSST and PPB wish to cooperate in a joint collaboration to provide the DPSST 10 week basic police course as an experimental pilot program in or near Portland, Oregon.

4. The pilot program is primarily intended to provide efficient delivery of mandated DPSST training to a group of newly hired Portland Police Bureau police officers (students) on a one-time basis.

5. The purpose of this AGREEMENT is to document the curriculum and delivery of training between DPSST and PPB in the selection and certification of instructors, in support of the development and implementation of the pilot program in Portland.

NOW, THEREFORE, the premises being in general as stated in the foregoing recitals, it is agreed by and between the parties as follows:

Management and Pilot Program Guidelines

1. All students will attend the DPSST training in Portland on a commuter basis (a commuter is one who drives from their primary residence to the academy) on a daily basis. Students will be responsible for their own transportation and meals while participating in the program.

2. Instructors for the program will be certified and approved by DPSST, and DPSST form F-9 will be submitted and current for each instructor and received by DPSST no later than January 15, 1999.

3. Up to 80 students will participate in the pilot program.

4. The ratio of instructors for defensive tactics training will be no less than one (1) instructor to ten (10) students. The ratio of instructors for firearms training will be no less than one (1) instructor to five (5) students.

5. The pilot program will commence on or about February 15, 1999, and end on or about August 30, 1999. DPSST and PPB may mutually agree to schedule certain component classes outside the established dates for the course.

6. The pilot program is a 'uniformed' academy. PPB will ensure that students wear an appropriate academy uniform in the classroom, appropriate academy attire at the firing range and while participating in skills and physical fitness training. Each student will wear nametags identifying DPSST and the class number. Students will provide civilian clothing and training wear.

7. PPB will adhere to DPSST standards for instructor and student conduct expectations. PPB will enforce the provisions of the DPSST Instructor Expectations Guide, Student Conduct Guide, Student Leadership Guide and all testing policies and procedures developed by DPSST. All PPB instructors will sign off that they understand and will comply with DPSST Instructor Expectations. The signed 'Instructor Expectations' agreement will be forwarded to the DPSST Regional Basic Academy Coordinator.

8. Representatives from DPSST and PPB will meet as may be needed to manage the joint collaboration of the pilot program.

Curriculum

1. The PPB pilot Basic Police Course curriculum shall be comprised of the DPSST 400 hour Basic Police Course. PPB may provide additional hours of training in the pilot course, but all students shall receive the 400 hour Basic Police Course and successfully pass the DPSST written and demonstrated examinations. DPSST will provide lesson plans to PPB for the 400 hour Basic Police Course.

2. Additional curriculum must be submitted to DPSST Standards and Certification as PPB Advanced Academy Curriculum.

3. Included in the basic academy curriculum are the following 'benchmark' courses that must be delivered in their entirety as developed by DPSST. The below listed

courses have been specifically developed to integrate key components as identified by DPSST. Any deviation from course outlines is prohibited.

Course
Domestic Violence
Community Policing
Problem Solving
Diversity
Professionalism
Government Standards
And Practices
Survival Ethics

4. Standard Operating Procedures (SOP's) from DPSST that pertains to training will be provided to PPB and will be used where applicable.

5. Lawyers, preferably prosecutors, will teach units of legal instruction.

6. Supplemental course material must be submitted to DPSST Standards and Certification for approval no later than January 15, 1999. All supplemental course material will conform to the standards established by DPSST for approval of such courses.

7. Any proposed changes to lesson plans, performance objectives or test questions in the 400 hour DPSST Basic Police Course must be submitted to the DPSST Regional Basic Academy Coordinator for approval prior to implementation.

8. The CD ROM Basic Academy Curriculum provided to PPB by DPSST will be returned to DPSST upon completion of the academy. Copyright remains with DPSST, and copies of the CD ROM may not be made.

Responsibilities of PPB

1. PPB will provide all facilities (classroom, range, EVOC track, gymnasium for defensive tactics). Classroom space will include all utilities, janitorial, parking, restroom, and common areas for breaks. DPSST will have final approval of facilities.

2. DPSST will not pay or reimburse the cost of facilities for the pilot course.

3. PPB will ensure that the classroom space is set up with the following equipment at a minimum:

Table area or desk and chair for each student
Table (3' x 5') and 2 chairs for instructor in front of classroom
Table (3' x 5') for materials in the back or side of classroom

Pencils for all students and sharpener
3 hole punch
Notebook paper and paper cutter
Table (3' x 5') for class coordinator in back of classroom
3 to 5 extra chairs for visitors
2 bulletin boards (4' x 6')
2 dry erase boards
1 flip chart and 3 pads of chart paper
Projection screen
Utility cart with power strip
VCR
Slide Projector
Overhead projector
Cassette or CD player
2 television sets (27" minimum) or video projector
Reasonable sound-proofing of classroom
Computer projector (for Power Point presentations) and PC
Secured area for testing materials
Message board

4. PPB will provide proctors for administering and monitoring testing.

5. DPSST will provide Student Leadership Guide, Instructor Expectation Guide, and Student Conduct Guide to PPB Regional Academy recruits.

6. PPB and DPSST will provide an orientation to the students on the rules and expectations of the Student Conduct Guide. PPB shall enforce the requirements of the Student Conduct Guide and ensure that each student has signed that they understand the expectations and 'zero tolerance' requirements.

Pistol Range

1. PPB will provide a pistol range for the firearms training portion of the basic police curriculum. DPSST will have final approval of this facility.

2. PPB will transport students from the academy classroom to the firearms range.

3. PPB will ensure that the firearms range is equipped, at a minimum, with:

An emergency medical evacuation plan
24 hour Emergency Medical Transport from firing range
An OSHA approved first aid kit
First aid trained instructors on site
Adequate supply of potable water
Air-borne lead safety briefing for instructors and students
Wash up capability (hands and face)

Adequate sanitary facilities (one facility per 25 students)
Adequate shade/shelter from weather conditions during breaks
Wireless communications capability
Suitable public address system
One shotgun per 5 students
Holster – (describe make and model)
Magazines – (quantity)
Magazine pouch
Ear Protection
Safety glasses
Handgun cleaning materials: one rod, one bore brush, one parts brush (tooth brush), 10 flannel patches per student and one bottle of Break-Free per 5 students.
Ammunition Handgun: 500 rounds per student
Shotgun: 10 rounds per student
Dummy rounds: xx per student

Targets: PPB will use own targets.
Target patching tape
Target stands (holders)

4. Handguns will be provided to each student by the employing agency.

5. PPB will ensure that all instructors and students at the firing range wear DPSST approved ear and eye protection.

6. PPB will train using their own course of fire, but will qualify using the DPSST course of fire.

Skills, Defensive Tactics and Physical Training

1. Skills, defensive tactics, and physical fitness training will be conducted in a DPSST approved facility.

2. PPB will ensure that the gymnasium is equipped with approximately 100 square feet per student.

3. PPB will provide the following:

Numbered vests
1 Hitman simulation suit
Handcuffs
Striking Shields
Printing
Stop watches
50 wrestling mats

4. Student will provide a blue t-shirt and sweat pants.

5. All demonstrated defensive tactics performance objectives must be passed at 100 percent proficiency.

Instructors

PPB will provide all instructors for the program unless otherwise requested from DPSST.

Instructor Development

PPB will effectuate agreements and make appropriate arrangements for DPSST to conduct instructor development training in Portland. PPB's responsibilities will include providing a classroom or other suitable facility for instructor development.

Training Coordinators

PPB Training Coordinators will wear PPB uniform designated by academy director.

Testing / Coordination

1. A PPB employee will serve as the full-time, on-site class coordinator during the academy program. The PPB Course Coordinator will have a public safety and training delivery background acceptable to DPSST.

2. The PPB Course Coordinator will be responsible for student attendance records, etc., under the supervision of DPSST.

3. DPSST – Training will compile DPSST written exams based upon the PO's listed in the Course Schedule.

4. DPSST performance objectives will be evaluated through DPSST examination and testing process. Any other testing administered by PPB will be given in addition to, but not in lieu of DPSST exams. PPB will administer skills demonstrations under the oversight of DPSST staff, and shall use DPSST evaluation instruments.

5. The DPSST Regional Basic Academy Coordinator will administer the exams. DPSST will fax the results back to the PPB Course Coordinator, and send separately, student 'reports' for each exam.

6. The passing score on every academic exam is 75%. Students, who fall below a 75% average for the entire course will not graduate.

Scheduling, Student Absences, and Records

1. PPB will ensure that student attendance is in compliance with DPSST student attendance and absence requirements.

2. DPSST's Attendance Forms will be used. Students may not miss more than 10% of the DPSST 400 hour Basic Police Course.

3. All labs (vehicle stops, EVOC, firearms, defensive tactics), will use the same performance objectives, and demonstrated performance criteria as used in the DPSST 400 hour Basic Police Course, except as agreed upon by PPB and DPSST.
4. The PPB Course Coordinator is responsible for maintaining course records and maintaining a master course schedule that captures daily scheduling changes and instructor substitutes. All schedule changes (i.e., postpone a class due to a sick instructor) must be documented.

5. The Course Coordinator will notify DPSST of any change of sequence of units of instruction as soon as possible after it is determined that a change will have to be made.

Graduation

DPSST and PPB will coordinate and provide a graduation ceremony for students at the completion of the program. The graduation ceremony will be conducted at a facility provided by PPB, and will be conducted by PPB and DPSST staff. The graduation ceremony will include the same certificates, professional photography, awards, plaques, and guest speakers as found at the graduation ceremonies at DPSST.

PPB Course Coordinator

1. PPB Course Coordinator will work with DPSST to develop and gather data to measure the effectiveness as well as cost and efficiencies associated with alternative training delivery methods.

2. DPSST will provide PPB with a Weekly Recap Report form designed to help capture this data. Additional narrative may be added for an 'after-action' report.

3. The PPB Course Coordinator will maintain a class file that will contain at a minimum daily attendance records, all class / course instructor changes, the Weekly Recap Report, examinations and results, firearms qualification scores, lab skills and proficiency reports, records of student counseling and discipline, and all other pertinent data. PPB will forward the original class file to DPSST for archiving within 30 days of the completion of the course.

4. The PPB Course Coordinator will use the DPSST class/instructor evaluation form, and forward the completed forms for each class and instructor to the DPSST Regional Academy Program Coordinator.

Responsibilities of DPSST

1. DPSST will participate in the planning and have final approval of program facilities, instructor selection and assignment, and class sequencing and scheduling.

2. DPSST will provide, develop, control and make necessary copies of materials for:

   Instructor development training
   Instructor certification
   All curriculum to include performance objectives, lesson plans, workbooks, exercises, and audio visual material.
   Enrollment liaison with PPB
   Testing services, protocol and policy

3. DPSST will provide a Regional Academy Coordinator who will be responsible for DPSST oversight and coordination of the program. The Regional Academy Coordinator will be available to PPB, but will not be stationed full time in Portland. PPB will provide office space for the DPSST Regional Academy Coordinator at the regional academy.

General Provisions

1. DPSST and PPB are subject employers under the Oregon Workers' Compensation Law and shall comply with ORS 656.017, which requires them to provide workers' compensation coverage for all their subject workers. PPB and DPSST are subject to the provisions contained within the Fair Labor and Standards Act (FLSA).

2. The parties agree that if any term or provision of this Agreement is declared by a court of competent jurisdiction to be invalid, unenforceable, illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular term or provision held to be invalid.

3. Subject to the limitations of the Oregon Constitution and statutes, PPB and DPSST each shall be solely responsible for any loss or injury caused to third parties arising from their own acts or omissions under this Agreement. Each party shall indemnify, defend and hold harmless the other party with respect to any claims, litigation or liability arising from PPB's or DPSST's own acts or omission under this Agreement. The parties to this Agreement are of equal authority. Each party acts independently in the performance of its obligations and functions under this Agreement, and neither party is to be considered the agent of the other

4. This Agreement may be modified by mutual consent of both parties and upon execution of amendments to this Agreement stating said modifications.

5. The terms of this Agreement will commence on the date in which every party has signed the Agreement and end on August 31, 1999. This Agreement may be renewed by both DPSST and PPB.

6. PPB shall keep its premises insured at its own expense against fire and other risks covered by a standard fire insurance policy. The property and equipment used in the program will be covered under PPB's fire insurance policy while the property and equipment is on PPB's premises. DPSST shall bear the expense of additional insurance insuring its property but shall not be required to insure. Neither party shall be liable to the other party for any loss or damage caused by fire or any other risks enumerated in a standard fire insurance policy with an extended coverage endorsement, and in the event of insured loss neither party's insurance company shall have a subrogated claim against the other.

7. Major emergency medical care and treatment will be provided to students by accessing 911.

Dianne L Middle 2-12-99

Dianne L. Middle date
Executive Director DPSST

Charles G. Moose 2-18-99

Charles Moose date
Chief of Police, Portland Police Bureau

APPROVED AS TO LEGAL SUFFICIENCY:

_____

date

DATE: January 13, 1999

TO: Asst Chief Mark Paresi
(Through channels)

FROM: Lt Steve Asp
Training Division
Basic Academy

Bureau of Police
Portland, Oregon
INTER-OFFICE MEMORANDUM

SUBJECT: Student expectations agreement

Attached is our proposed method of establishing the performance expectations of the academy students. It is modeled after a contract of understanding which San Jose Police Academy uses. The standards are those which are now in place in the training disciplines, and the consequences of not meeting the standards are spelled out as termination from employment with the Police Bureau.

San Jose has had very good results using a "contract" such as this. The students know from day one what the expectations are and at what level they must perform. If at some juncture, an expectation is not met, and the student is to be terminated, it is not a surprise to anyone and there are no issues for litigation. The director of the San Jose Academy indicated that they lose 20% of their people for a variety of reasons, much of it performance related. This tool helps in the process.

Based on San Jose's experience, I anticipate we could lose 10-15% of our people as well. This agreement would certainly facilitate the unpleasant task of terminating a recruit who cannot perform up to our standards.

PORTLAND POLICE BUREAU BASIC ACADEMY

STUDENT AGREEMENT

EXAMINATIONS **Initial:____**

Probationary Officers must achieve DPSST and PPB minimum passing scores on all examinations. If you fail a practical exam, we will give you remedial training and one retest, if you fail a written test we will allow you one retest within five days. Failure of the retest will cause termination from the Portland Police Bureau.

75% Grade Point Average **Initial:____**

Probationary Officer must achieve an overall average of no less than 75% to successfully graduate from the academy. This includes all facets of the course. The average is computed at the end of the academy.
One exception to the 75% G.P.A. is the DPSST E.V.O.C. practical evaluation in which performance objectives must be met by a 90% minimum.

ACADEMY SPECIFIC TESTS **Initial:____**

The academy specific tests include; Firearms, Defensive Tactics, Police Vehicle Operation and Patrol Tactics.

FIREARMS: **Initial:____**

After the first two recorded qualification courses, Probationary Officers must qualify with a minimum of 75% each time a qualification course is fired. Probationary Officers who fail to qualify will receive remedial training within five days. Probationary Officers failing to re-qualify will be terminated.

Throughout the Probationary Officers Probation they will qualify cold with a minimum of 75% on their first attempt during tri-annual qualifications. Probationary Officers who fail to cold qualify with a minimum of 75% will be terminated.

All probationary Officers will qualify with the shotgun. After the first two documented qualification courses, Probationary Officers must pass the shotgun qualification course. Probationary Officers who fail to qualify will receive remedial training within five days. Probationary Officers failing to re-qualify will be terminated.

Probationary Officers must pass all of the Firearms performance objectives by the last academy range day. Consistent documented violations of the safety rules will result in termination from the Portland Police Bureau.

DEFENSIVE TACTICS: **Initial:____**

Probationary Officers must pass all Defensive Tactics written tests with a minimum score of 75%. Additionally, all Probationary Officers must pass a Defensive Tactics physical assessment. A total physical assessment score of less than 75% is a failure. A score of one or less in any of the physical assessment categories will result in a failure of the entire physical assessment.
Probationary Officers who fail to pass either the written and/or the physical assessment tests will be given the opportunity for remedial training and be retested within ten days of the original test. Probationary Officers who fail the retest{s} will be terminated from the Portland Police Bureau.

POLICE VEHICLE OPERATIONS: **Initial:____**

Probationary Officers must pass a DPSST E.V.O.C. practical evaluation in which performance objectives must be met with a no less than 90%. Probationary Officers must also pass a DPSST E.V.O.C. written tests with a score no less than 75%. If either of these two tests is failed, remedial training will be provided within five days and the student will be retested. Failures to pass the retest will result in termination from the Portland Police Bureau.

Probationary Officers must pass the practical evaluation in the P.I.T. technique and no less than 75% on the PPB P.V.O. written tests. Failure of either of these two tests will result in remedial training within five days and a retest. Failing the retest will result in termination from the Portland Police Bureau.

PATROL TACTICS: **Initial:____**

All Probationary Officers will pass the Patrol Tactics Scenarios. Scenarios are pass/fail. Probationary Officers who fail any Patrol Tactics scenario will be given remedial training and retested within five days. Any Probationary Officers who fails the retest will be terminated from the Portland Police Bureau.

ATTENDANCE: **Initial:____**

All absences have to be approved by an academy sergeant. Any Probationary Officer who has an unexcused absence will be terminated from the Portland Police Bureau. Any Probationary Officer who has an excused absence of more then forty {40} hours will be required to attend the next Basic Academy.

STANDARDS OF CONDUCT: **Initial:____**

All Probationary Officers are required to follow the rules of the Academy and the general orders of the Portland Police Bureau. Probationary Officers who are found violating Academy Rules or the General Orders will be disciplined up to and including termination from the Portland Police Bureau.

CHEATING: **Initial:____**

Any form of cheating by a Probationary Officer will result in termination from the Portland Police Bureau. Cheating is defined in the student manual.

I have read and understand the requirement of the Academy put on by the Portland Police Bureau.

Print Name: _____

Signature: _____ **Date:_____**

BASIC ACADEMY RECRUIT OBSERVATION FORM

_____

Name BPSST

Observation Period: **From:_____To:_____**

1.	General Appearance	**U IN IO A N.O.**
2.	Attitude: Acceptance of Feedback	**U IN IO A N.O.**
3.	Attitude Towards Police Work	**U IN IO A N.O.**
4.	Relationships with Bureau Members	**U IN IO A N.O.**
5.	Problem Solving - Decision Making	**U IN IO A N.O.**
6.	Punctuality	**U IN IO A N.O.**
7.	Communicating and Interacting With People	**U IN IO A N.O.**
8.	Information Retention	**U IN IO A N.O.**
9.	Writing Skills: Organization/Detail/Grammar/Spelling Neatness/Other	**U IN IO A N.O.**
10.	Adherence to Bureau General Orders and Academy Rules	**U IN IO A N.O.**

1. **GENERAL APPEARANCE**: Evaluates a Recruit's conformity to the uniform and grooming standards of the Academy and the Police Bureau.

(A) **ACCEPTABLE:** Uniform is neat and clean. Uniform fits and is worn properly. Weapon and/or equipment is clean, operative and in good condition. Shoes are clean and shined. Recruit maintains a high level of personal hygiene.

(U) **UNACCEPTABLE:** Uniform is dirty and/or wrinkled. Uniform fits poorly or is worn improperly. Weapon and/or equipment is dirty or inoperative. Equipment is missing. Poor personal hygiene.

2. **ACCEPTANCE OF FEEDBACK:** Evaluated how the Recruit accepts the trainer's criticism/critiques and how that feedback is used to further the learning process and improve performance.

(A) **ACCEPTABLE:** Accepts Criticism in a positive manner and applies it to improve performance and further learning. Recruit self-critiques and closely examines each situation to reinforce proper performance and correct performance when warranted.

(U) **UNACCEPTABLE:** Rationalizes mistakes; denies that errors were made; is argumentative; refuses to, or does not attempt to, make corrections. Considers criticism as a personal attack. Does not self-critique each situation.

3. **ATTITUDE TOWARD POLICE WORK:** Evaluates how the Recruit views new career in terms of personal motivation, goals and acceptance of the responsibilities of a Portland Police Officer.

(A) **ACCEPTABLE:** Demonstrates an active interest in new career and in police responsibilities. Is punctual and reports for duty on time.

(U) **UNACCEPTABLE:** Sees career only as a job; uses job to boost ego; abuses authority; demonstrates little dedication to the principles of the profession. Does not report for duty on time. Is not ready for duty.

4. **RELATIONSHIPS WITH BUREAU MEMBERS:** Evaluates the Recruits ability to effectively interact with other Bureau members of various ranks and in differing capacities.

(A) **ACCEPTABLE:** Adheres to the chain of command and accepts role in the organization; good peer and staff relationships and is accepted as a group member.

(U) **UNACCEPTABLE:** Patronizes Staff/Supervisors/Peers or is antagonistic towards them; gossips; is insubordinate, argumentative, sarcastic; resists instructions; considers self superior, belittles others or engages in sexually harassing conduct; is not a team player.

5. **PROBLEM SOLVING - DECISION MAKER:** Evaluates the Recruit's ability to perceive situations, form valid conclusions, arrive at sound judgements and make proper decisions.

(A) **ACCEPTABLE:** Recruit is able to reason through a problem and come to an acceptable conclusion in routine situations; is aware of, and uses, SARA when appropriate; makes reasonable decisions based on information available; perceives situations as they really are; makes decisions without assistance.

(U) **UNACCEPTABLE:** Recruit acts without thought or good reason; is indecisive, naive; is unable to reason through a problem and come to a conclusion; can't recall previous solutions and apply them in like situations.

6. **PUNCTUALITY:** Evaluates the Recruits ability to arrive on time and ready for the duty day.

(A) **ACCEPTABLE:** Recruit is able to plan ahead and arrive on time to training assignments. Recruit is ready for the training day.

(U) **UNACCEPTABLE:** Recruit is unable to arrive on time to training assignments. Recruit is not ready for the training day.

7. **COMMUNICATING AND INTERACTING WITH PEOPLE:** Evaluates the Recruits ability to communicate and interact with people outside the Police Bureau.

(A) **ACCEPTABLE:** Recruits is able to effectively communicate and interact with persons not associated with the Police Bureau. Recruits treat individuals in a calm professional manner.

(U) **UNACCEPTABLE:** Recruits is unable to effectively interact and communicate with persons not associated with the Police Bureau. Recruits do not respond in a professional manner.

8. **INFORMATION RETENTION:** Evaluates the Recruits ability to retain information provided by the training instructors and staff.

(A) **ACCEPTABLE:** Recruit is able to recall information given to them by the Training instructors or staff members.

(U) **UNACCEPTABLE:** The Recruit is unable to recall information given out by Training instructors or staff members.

9. **WRITING SKILLS:** Evaluates the Recruits ability to communicate in written form; using correct Grammar and Spelling. Evaluates the Recruits ability to organize a document and provide details.

(A) **ACCEPTABLE:** Recruit is able to communicate effectively in written form. Recruit uses proper grammar and spelling. Recruit's written product is neat, Recruits is able to organized and write a detailed document.

(U) **UNACCEPTABLE:** Recruit is unable to communicate effectively in written form. Recruit does not use proper grammar and spelling. Recruit is unable to organize a document or provide detail.

Mybeq : BATFile

DPSST REQUIRED COURSES AND HOURS REQUIRED

	DPSST	PPB
-Intro to the Criminal Justice System	4 hrs	4 hrs
-Health and Fitness	12 hrs	12 hrs
-Ethics	12 hrs	12 hrs
-Cultural Awareness	4 hrs	8 hrs
~~-Defensive Tactics~~ W/hitman simulations	32 hrs	~~63 hrs~~
-Community Policing	8 hrs	9 hrs
-Problem Solving	8 hrs	8 hrs
-Report Writing/Interviewing	8 hrs	13 hrs
-Criminal Law	32 hrs	70 hrs
~~-Firearms W/FATS~~	34 hrs	~~82 hrs~~
-LEDS/NCIC	2 hrs	4 hrs
-Interview Techniques (see report writing)	4 hrs	4 hrs
-Federal Civil Rights	2 hrs	2 hrs
-Sexual Harassment	1 hrs	2 hrs
-American w/Disabilities	1 hrs	1 hrs
-Dealing w/Mentally ill	4 hrs	4 hrs
-Tactical Communications	4 hrs	4 hrs
-Procedural Law	12 hrs	24 hrs
-Auto Theft	4 hrs	2 hrs
~~-EVOC~~	24 hrs	~~40 hrs~~
-Standard Field Sobriety test	24 hrs	24 hrs
~~-Traffic Enforcement/Vehicle stops/Patrol Procedures~~ (includes Deadly Force simulations)	32 hrs	~~80 hrs~~
-Juvenile Law	4 hrs	8 hrs
-Civil Liability	2 hrs	3 hrs
-Courtroom Testimony	2 hrs	7 hrs
-Oregon Vehicle code	6 hrs	9 hrs
-Intoxiyzer	4 hrs	4 hrs
-Major Accident Investigations	4 hrs	4 hrs
-Blood and Air Borne Pathogens	4 hrs	4 hrs
-Hazardous Material	4 hrs	4 hrs
-Preliminary Criminal Investigations	4 hrs	13 hrs
-OSP Forensics	12 hrs	13 hrs
-Domestic Conflict Managements	12 hrs	12 hrs
-Accident Investigation (SFST,Radar, Duii and Intoxilyzer at Traffic Academy)	8 hrs	8 hrs
-Multiple Discipline Investigations	8 hrs	9 hrs
-Sexual Assaults	8 hrs	9 hrs
-Control Substances	6 hrs	9 hrs
-Death Investigations	4 hrs	4 hrs
-Traumatic Incidents	4 hrs	4 hrs
-Elder Abuse	4 hrs	4 hrs

-First aid	8 hrs	9 hrs
-OLCC	2 hrs	2 hrs
-Rural Agency Response	2 hrs	0 hrs
-K-9	2 hrs	2 hrs

Patrol tactics 81 hrs

Firearms 63 hrs

Defensive Tactic 63 hrs

PVO 63 hrs

CIR 11 hrs

In addition to the Basic Curriculum mandated by DPSST, we will also present training on topics covered in the PPB Advanced Academy. Following are the topics included:

PPB Supplemental class	Instructor
Records Div, LEDS, NCIC	Ms Debbie Haugen
Outlaw Motorcycle Gangs	Off Denny Kelly
Internal Affairs Division	Sgt John Smith
Hostage Negotiation Team	Sgt Bill Johnston
Electronic Tracking System (ETS)	Off Scott Elliott
District Attorney	DA Michael Schrunk
Criminal Intelligence Division	Lt Randy Kane, Sgt Norm Sharp, Off Dave Famous, Off Daniel Thompson, Off Karl Sprague, Off Cinda Kazowa, Off Mike Larson
Portland Police Association	Off Greg Pluchos
Radio/MDT use (outline to be sent)	Officer Tim Sessions
Crowd Control/Mounted Patrol Unit	Sgt Virtue, Sgt Chamberlain, Off Elliott, Off Roesser and Sgt Dave Pool
Peer Support	Sgt Jeanne Stevenson
Field Training Officer hour	Off Marv Labsch
Street Gangs	Off Rafael Cancio
SERT	Off Terry Kruger
Explosive Disposal Unit	Sgt Mike Unsworth
Public Information Officer	Sgt John Derek Anderson
Sexual Minorities	Ms. Lori Buchwalter (outline & F9 to be sent)

Lesson Plan Outline and Presentation Page

Criminal Law - Section A2.1

Unit Goals: To develop the necessary knowledge of the Oregon Criminal Code and laws to recognize the majority of the criminal laws police enforce, their elements and classification.

Performance Objectives: (Evaluated by Written Exam) **Plan Updated** : June-98

Performance Objectives and Instructional Cues	Outline and Presentation

B. Purpose of Course

1. Explain Sources of Law
   a. Federal
   b. Oregon
2. Explain Crime Elements
   a. classifications
   b. *actus reus and mens rea*
      1) mental state
      2) examples of assaults
      3) examples of self defense
   c. parties to crime
3. Explain Inchoate Crimes
   a. attempt
   b. conspiracy
   c. solicitation
4. Explain Criminal Trial Procedure

OH #1

II. Sources of Law

A. Federal Constitution
1. enacted in 1787
2. Bill of Rights enacted in 1791

OH #2

3. **First Amendment** - religion, speech, press and assembly.
   a. **Speech**: obscenity, panhandling, disorderly conduct, noise ordinances, political demonstrations, pornography
   b. **Assembly**: loitering, vagrancy, picketing, demonstrations
   c. **Religion**: avoidance of taxes, drug use, medical treatment
   d. **Press**: victims' right to privacy, confidentiality of internal affairs & criminal investigations

OH #3

4. **Second Amendment** - Right to keep and bear arms (possess, carry, use)

OH #4

5. **Third Amendment** - Quartering soldiers in private homes

OH #5

6. **Fourth Amendment** - Prohibition against unreasonable search and seizure, warrants need probable cause, exclusionary rule

OH #6

7. **Fifth Amendment** - Privilege against compulsory self-incrimination, double jeopardy, due process

OH #7

8. **Sixth Amendment** - Speedy public trial, confront witnesses, right to counsel, compulsory process
9. **Seventh Amendment** - right to jury in civil actions

OH #8

10. **Eighth Amendment** - no cruel or unusual punishment, no excessive bail or fines (jail conditions, overcrowding, conjugal visits, libraries, death penalty

OH #9

11. **Ninth Amendment** - limits powers of government; people retain all other powers
12. **Tenth Amendment** - fed v. state rts.; those not designated to govt. retained by people

OH #10

OH #11

13. Other Amendments
    a. **13th** - abolished slavery
    b. **14th** - equal protection; states cannot prohibit activities or restrict rights guaranteed by fed constitution
    c. **15th** - no voting discrim (race)
    d. **16th** - income tax
    e. **18th** - prohibition
    f. **19th** - women vote
    g. **21st** - repealed prohibition
    h. **26th** - voting age to 18

B. **US Supreme Court.** This is the highest appellate court. The Supreme Court hears cases arising under the Constitution, Congressional Acts and treaties (original jurisdiction). The Court also has appellate jurisdiction. Cases come to the Court either on appeal (jurisdiction is mandatory, but very few cases come up this way) or by *certiorari*. A *writ of certiorari* is an appeal from federal appellate courts, or the highest state courts regarding the constitutionality of a federal or state statute, or when a state law allegedly violates federal law. The court has complete discretion regarding cases appealed on certiorari. Four of the nine justices must agree to hear the case before cert. will be granted.

There are nine justices, nominated by the president and approved by the senate for life. They are William Rehnquist (chief justice), Antonin Scalia, Sandra Day O'Connor, Clarence Thomas, David Souter, William Kennedy, John Paul Stevens, Ruth Bader-Ginsberg and Steven Breyer.

Most Supreme Court cases concerning criminal justice deal with procedural law issues (Miranda, Terry v. Ohio, Tennessee v. Garner).

Supreme Court opinions are published in one of three series of books. The official citator is U.S. Supreme Court Reports, published by the Court. The abbreviation is US. The unofficial reporters are Supreme Court Reports (West) which is abbreviated S.Ct. and Lawyer's Edition, abbreviated L.Ed.

C. **Federal Appellate Courts** are divided into Circuits. Oregon and the western US are in the Ninth Circuit (OR, CA, NV, ID, Mont, AZ, WY, NM, AK, HI). The Circuit Courts hear appeals from US District Court opinions and from state courts.

The opinions of the Circuit Courts are published in the Federal Reports (F., F.2d, etc.). The unofficial reporters are regional and published by West (e.g. Pacific Reporter, etc.)

D. **The Federal District Courts** are the trial courts for the federal system. Opinions are infrequently published and appear in the Federal Supplement or F.Supp.

E. Congress is a source of federal law. It enacts legislation, which is signed into law by the President. All federal criminal laws have been codified, or enacted by Congress and approved by the president. Examples are the Assault Weapons Ban, the Brady Bill, the Omnibus Crime Bill, etc. These laws can be found in the US Codes or USC.

F. Oregon Constitution was enacted in 1859. Numerous amendments have been added. The constitution models the federal constitution and provides similar safeguards against unreasonable search and seizure, cruel and unusual punishment, excessive bail, right to jury, freedom of speech and religion, etc.

G. The Oregon Supreme Court is made up of 7 justices. It is the highest appellate court in Oregon and hears appeals from the lower appellate court. It also would rule on the constitutionality of Oregon laws. Opinions are published in Oregon Reports (OR).

H. The Oregon Court of Appeal hears appeals from trial courts. The court sits in 3 judge panels. Opinions are published in Oregon Appellate Reports (OrApp).

I. The Oregon Legislature enacts laws which are then published in the Oregon Revised Statutes (ORS)). The legislature sits every 2 years.

III. Elements of Crimes

A. **Classifications**. Offenses are classified as either crimes (subject to possible imprisonment) or violations or infractions (fine, forfeiture or other civil penalty).

Crimes are further classified as either felonies, where the maximum period of imprisonment possible is greater than one year, or misdemeanors, where the maximum term of imprisonment is less than one year.

Unclassified felonies, such as murder and aggravated murder, include the specific sentence options in the language of the statute. Class A Felonies are punished by a term of imprisonment up to 20 years and a fine up to $300,000. Class B Felonies are punished by a term up to 10 years and a fine up to $200,000. Class C Felonies are punished by a term up to 5 years and a fine up to $100,000. Class A Misdemeanors are punished by a term of imprisonment of 1 year and a fine of $5,000. Class B Misdemeanors are punished by a term of 6 months and a fine of $2,000. Class C Misdemeanors are punished by a term of 1 month and a fine of $1,000. Felony sentences are indeterminate and misdemeanor sentences are definite.

Overhead of Grid / Handouts

There needs to be mention here regarding the sentencing guideline / grid and Measure 11

B. **Requirements for Criminal Culpability**

1. In order to have criminal culpability in Oregon, the state must establish two preliminary elements.

   The state must show that the suspect committed a guilty act (*actus reus*). Bad thoughts alone will not be punished. The act must be voluntary and not reflexive or convulsive.

   In addition, the state must prove that concurrent with the guilty act, the suspect had the requisite mental state, or *mens rea*, as required by the particular statute.

2. There are 4 mental states recognized by Oregon courts.

Intentionally requires that the suspect meant to do the act. The suspect is said to have acted with a conscious objective to cause the result or engage in the particular conduct. For example, acts which involve planning or preparation are intentional.

Knowingly requires proof that the suspect acted with an awareness that his conduct was of a particular nature or that a particular circumstance existed. For example,

Recklessly aware of and consciously disregards a substantial and unjustifiable risk that the result will occur or the circumstance exists.

Criminal Negligent fails to be aware of substantial and unjustifiable risk that the result will occur or the circumstance exists.

#A2-073

C. Use of **OREGON CRIMINAL CODE BOOK** to define terms

1. *Sexual Intercourse* :

2. *Deviate Sexual Intercourse* :

3. *Sexual Contact* :

4. *Forcible Compulsion* :

5. *Building* :

6. *Premises* :

7. *Dwelling* :

8. *Enter or Remain Unlawfully* :

9. *Custody* :

10. *Correctional Facility* :

#A2-001
ORS 161.015(7)

11. *Physical Injury* : An injury that impairs a person's physical condition, **or** causes substantial pain.

#A2-002
ORS 161.015(8)

12. *Serious Physical Injury* :
    a. Creates substantial risk of death, **or**
    b. Causes serious & protracted disfigurement, **or**
    c. Causes protracted impairment of health, **or**
    d. Causes protracted loss or impairment of the function of a bodily organ.

#A2-003
ORS 161.015(1)

13. *Dangerous Weapon* : Any instrument, article or substance which under the circumstances in which it is used, attempted to be used, or threatened to be used, is **readily capable of causing death or serious physical injury**.

#A2-004
ORS 161.015(2)

14. *Deadly Weapon* : Any instrument , article or substance **designed for and presently capable** of causing death or serious physical injury.

#A2-005
ORS 161.015 (3)

15. *Deadly Physical Force* : Physical force that under the circumstances in which it is used is **readily capable** of causing death or serious physical injury.

IV. Crimes Against Persons

A. Homicide

ORS 163.005
OH

1. **Criminal Homicide** occurs if without justification or excuse the person intentionally, knowingly, recklessly or with criminal negligence causes the death of another human being. The victim must be alive and born at time of killing (does not apply to fetuses)

#A2-006
OH
ORS 163.115

2. **Murder** is an intentional homicide.

   Example: Fred has hated Thomas for years and spends all of his free time fantasizing about strangling his "little buddy". Finally, after weeks of planning and preparation, Fred lures Thomas away from their wives with promises of a "night bowling with the boys" at the local bowling alley. Before reaching the bowling alley, Fred has Thomas join him outside the car in a deserted part of town, where Fred says, "Thomas, you no-good little weasel. I should have put myself out of misery years ago by getting rid of you." Whereupon Fred bashes in Thomas' skull with a 14 pound bowling ball.

OH

3. **Felony Murder** is the charge when a death occurs while the suspect is committing, attempting to commit or during immediate flight from commission of a designated felony crime. The death must be of non-participant. The qualifying felonies are: arson 1, criminal mischief 1 by means of an explosive, burglary 1, escape 1, kidnapping 1 or 2, robbery 1, felony sex crimes, or compelling prostitution. Assault in the first degree, as defined in ORS 163.185, and the victim is under 14 years of age, or assault in the second degree as defined in ORS

163.175 (1)(a) or (b) and the victim is under 14 years of age.

It is an affirmative defense if :

a, there is more than one participant, **and**

b. did not commit homicidal act or in any way solicit, request, command, importune, cause or aid in the commission of homicidal act.

c. was not armed with a dangerous or deadly weapon ;

d. Had no reasonable ground to believe that any other participant was armed with a dangerous or deadly weapon; **and**

e. Had no reasonable ground to believe that any other participant intended to engage in conduct likely to result in death.

4. **Murder by Abuse** occurs when the suspect recklessly, under circumstances indicating an extreme indifference to the value of human life, causes the death of child under 14 or a dependent person. **and**

a. The suspect must have previously engaged in a pattern of assault or torture of the victim or another child under 14 yrs. of age or dependent person, **or**

b. the death must have been caused by neglect or maltreatment.

"Assault" means to intentionally knowingly or recklessly cause physical injury to another person.

"Torture" means to intentionally inflict intense physical pain upon an unwilling victim as a separate objective apart from any other purpose.

"Neglect" is defined as failing to provide adequate food, clothing, shelter or medical care that is likely to

endanger the health or welfare of the child or dependent person.

"Pattern or Practice" means one or more previous episodes.

Examples: 1) Disabled person meets a "nurse" and marries her so she will take care of him. He is unable to care for himself and is wheelchair confined. She places him in a reclining chair and leaves him there for months. No medical care, no toileting, no hygiene. Pressure sores become infected, blood becomes toxic, he dies.

2) Oregon family starting a new business becomes so engrossed in project that they "forget" to feed their baby. Older children can barely fend for themselves. Home is squalid. Baby starves to death.

OH
ORS 163.095

5. **Aggravated Murder** occurs when one of the following "special circumstances" is present. The maximum penalty possible for Aggravated Murder is the death penalty. Another possibility is life without parole, or life (minimum 30 years).

Special Circumstances:

a. murder for hire,

b. solicited murder,

c. prior homicide conviction (manslaughter 1 or murder),

d. more than one victim in the same criminal episode,

e. during the course of torture or maiming,

f. the victim of the intentional homicide was a person under the age of 14 years,

g. the victim was one of the following and the murder was related to the performance of the victim's official duties in the justice system ;

1) A police officer

2) A correctional, parole or probation officer or other person charged with the duty of custody, control or supervision of convicted persons.

3) A member of the Oregon State Police

4) A judicial officer as defined in ORS 1.210

5) A juror or witness in a criminal proceeding.

6) An employee or officer of a court of justice **or**

7) A member of the State Board of Parole & Post-Prison supervision.

h. the defendant was confined in a state, county or municipal penal or correctional facility or was otherwise in custody when the murder occurred.

i. caused by explosives,

j. effort to conceal crime or identity of perpetrator.

k. after escape.

6. **Aggravated Felony Murder** is felony murder committed intentionally and personally by the defendant.

#A2-007
OH
ORS 163.118

7. **Manslaughter I** is the charge when there is a criminal homicide which is committed recklessly under circumstances manifesting an extreme indifference to the value of human life, or which is committed intentionally under the influence of an extreme emotional disturbance. **or** murder by abuse recklessly caused but not under circumstances manifesting extreme indifference to the value of life.

Examples: 1) Two teens agree to play "William Tell" with a bow and arrow. Suspect teen shoots arrow at victim teen's head in effort to pierce apple. Misses apple and arrow lodges in victims brain, killing him instantly. 2) Man arrives home during day to find wife in bed with his best friend. In a fit of rage he

grabs shotgun from closet and fires at friend, striking him in the torso, killing him instantly.

#A2-008
OH
ORS 163.125

8. **Manslaughter II** occurs when a death is committed recklessly, or when someone intentionally causes or aids another in committing suicide ; except as authorized by the Assisted Suicide Law. **or** Murder by Abuse when caused with criminal negligence but not under circumstances manifesting extreme indifference to the value of life. This is a B felony.

   Examples: 1) driving under the influence with some indications of bad driving;

(Stacy Heyworth has agreed to develop this section - difference btwn Man 1 and Man 2)

#A2-009
OH
ORS 163.145

9. **Criminally Negligent Homicide** is the charge when someone causes the death of another with criminal negligence. C Felony.

   Criminal negligence is defined as failing to be aware of a substantial and unjustifiable risk that the result will occur or that certain circumstances exist. The risk must be such that to disregard it is a gross deviation of the standard of conduct expected of reasonable persons in the same situation.

   Example: Rod is cleaning his AK-47 and it discharges through his apartment floor killing the occupant in the apartment below him.

B. Assault

#A2-010
OH
ORS 163.160

1. **Assault IV** occurs when someone
   a. intentionally, knowingly or recklessly causes physical injury to another, **or**
   b. when someone with criminal negligence causes physical injury by means of a deadly weapon. This is an A misdemeanor.

Definition :

"Deadly Weapon" means any instrument, article, or substance specifically designed for and presently capable of causing death or serious physical injury.

Examples: 1) Frank hits Steve square in the nose with his closed fist, causing substantial pain, 2 black eyes and a nose bleed; 2) Elroy received a new gun for Christmas. He set the target up in his backyard, against a fence. On the other side of the fence is the Be Safe Day Care. While target shooting, Elroy fires a shot, which travels through the fence, striking Tommy, a three year old, in the foot. The injury caused Tommy substantial pain and required stitches.

2. Assault IV is a Class C Felony when a person commits assault in the 4th degree **and**
   a. person previously convicted of assaulting the same victim, **or**
   b. assault is witnessed by the person's or the victim's minor child or stepchild or a minor child residing within the household of the person or victim.

OH
ORS 163.165

3. **Assault III** is the charge when one of the following occurs:
   a. serious physical injury is caused recklessly with a deadly or dangerous weapon;
   b. serious physical injury is caused recklessly under circumstances manifesting an extreme indifference to the value of human life;
   c. physical injury is caused recklessly with a deadly or dangerous weapon under circumstances manifesting an extreme indifference to the value of human life;
   d. physical injury is intentionally, knowingly or recklessly caused to a public transportation operator while working;
   e. physical injury is caused intentionally or knowingly while aided by another person actually present;
   f. physical injury is caused intentionally or knowingly to a person known to be a staff member of the juvenile facility

g. physical injury is caused intentionally, knowingly or recklessly to a paramedic or EMT while performing official duties;
h. a person at least 18 years old caused physical injury intentionally or knowingly to a child 10 years old or younger.

This is a C Felony.

Examples:
1. A person on a public bus gets mad at the driver and hits him causing physical injury.
2. One individual holds the victim down while the other defendant hits him / her.

ORS 163.175

4. **Assault II** is the correct charge whenever someone:
   a. intentionally or knowingly causes serious physical injury; **or**
   b. intentionally or knowingly causes physical injury with deadly/dangerous weapon; **or**
   c. recklessly causes serious physical injury with a deadly or dangerous weapon under circumstances manifesting an extreme indifference to the value of human life.

This is a B Felony.

Examples:
1. Stab in the arm 2. Baseball bat to the head causing physical injury. 3. Intentionally gauges out eyes.

ORS 163.185

5. **Assault I** is the correct charge whenever someone intentionally causes serious physical injury to another with a deadly or dangerous weapon. This is an A Felony.

Examples: 1) Matt intends to cause serious injury to Larry when he slashes a knife across Larry's face. 2) Curtis stabs Scott in the throat, intending to silence his annoying noises.

6. **Assaulting a Public Safety Officer** requires a person to intentionally or knowingly cause physical

injury to a PSO, knowing the victim to be a PSO, and while the PSO (defined as a peace officer, corrections officer, youth corrections officer, parole and probation officer, emergency medical technician or firefighter) is acting in the course of his or her official duty.
Example: Judy is working patrol in a full uniform one day when Eugene sees her and starts to yell obscenities at her. She approaches him and asks him to quiet down. As she reaches him he punches her in the face causing her a black eye. She is unable to work patrol for a few days while her eye recovers. Her back up officer arrests Eugene for assaulting a public safety officer.

#A2-012
OH
ORS 163.190

7. **Menacing** is the correct charge when a suspect, by word or conduct, intentionally attempts to place a victim in fear of imminent serious physical injury. The victim need not actually be afraid as long as it can be proven that the suspect intended to make victim afraid. Imminent is defined as "near at hand, impending, on the point of happening." The serious physical injury threatened does not have to actually be occurring, but cannot be a threat to cause injury some time in the future. See *Coercion* 163.275 and *Intimidation* 166.155.

   Example: Jeremy encounters Arnold one day and decides that it is time Arnold receive some pay back for all of the aggravation he has caused Jeremy over the years. Intending to frighten Arnold, Jeremy picks up an aluminum baseball bat, raises it over his head and tells Arnold he's going to bash in his skull. Jeremy is standing 2-3 feet from Arnold at this time.

#A2-013
OH
ORS 163.195

8. **Recklessly Endangering Another** occurs when a suspect recklessly engages in conduct which creates a substantial risk of serious physical injury to another person.

   Example: 1) Maria is driving with a BAC of .23. Her baby, Mercedes, is in the car and not secured in an infant restraint seat.

A2.3 – Kidnapping / Custodial Interference / Sex Crimes / Abandonment / Neglect / Endangering Welfare of a Minor.

C. Kidnap

#A2-018
OH
ORS 163.225

1. **Kidnapping II** occurs when a suspect has the intent to substantially interfere with the victim's liberty, and without the victim's consent or any legal authority, the suspect either moves the victim from one place to another, or secretly confines the victim where the victim is unlikely to be found. This requires either asportation or secret confinement. The courts in Oregon have held that any movement of the victim's body from one place to another, no matter how short a distance, is sufficient. Merely moving victim's upper body while the lower body remained seated in a car was not sufficient, however.

   Example:

An example needs to be added here.

   - child under age of 16 who is taken without consent. ORS 163.215(1)
   - Intended Rape

ORS 163.225

2. **Kidnapping I** requires the same intent and activity as Kidnapping II, with the additional requirement that the purpose of the movement or concealment be either to compel payment of ransom, to use the victim as a shield or to cause injury to the victim or to terrorize the victim or someone else.

#A2-019
OH
ORS 163.245

3. **Custodial interference II** is the correct charge when a suspect knows or has good reason to know that she has no legal right to do so and she takes, entices, or keeps a child from the child's lawful custodian. This requires that the suspect intend to hold the child permanently or for an extended period of time. This is a Class C Felony.

   Example: Mom and Dad are divorced. Dad has custody of children and per the court order Mom gets visitation every other weekend from 5 p.m. Friday

until 7 p.m. Sunday. Mom fails to return the children as ordered Sunday night. She knows or has good reason to know that she doesn't have authority to keep them from Dad beyond Sunday at 7 p.m.. If she returns them just a few hours late, this is insufficient to charge. If, however, she keeps the children until Thursday, without court or Dad's permission, she may have violated Custodial Interference statute sufficiently to warrant arrest.

*** Students are also asked to consider that a situation may already be related to a domestic relations case. Is there paperwork?*

4. **Custodial Interference I** is the same as Custodial Interference II except it requires that the suspect remove the child from the state or expose the child to a substantial risk of illness or physical injury. This is a Class B felony.

   Example: Non-custodial parent takes child who lives in Portland across the river to Washington state for lunch. Technical violation, but not sufficient to prosecute. If, however, the non-custodial parent takes the child to Duluth, Minnesota for the summer, without permission from court or custodial parent, there is an actionable violation.

#A2-020
OH
ORS 163.375

D. **Sex Crimes**

1. **Rape I** occurs when the suspect has sexual intercourse with the victim under certain circumstances. Sexual intercourse requires penetration, however slight, by a penis into a vagina. The circumstances in which intercourse will be considered Rape I are:
   a. The victim is subjected to forcible compulsion, which is defined as
      1) physical force that overcomes earnest resistance,
      2) a threat, express or implied, that places victim in fear of immediate or future death or serious physical injury to victim or another person,

3) fear that the victim or another person will be kidnapped immediately or in the future.

b. The victim is **under 12** years of age;

c. The victim is **under 16** and is related to the suspect by blood or marriage (child, stepchild, sibling);

d. The victim is incapable of consent because of mental or physical defect, limitation or helplessness. This is a Class A Felony.

Examples: 1) Suspect has sexual intercourse with victim by threatening to kill her if she refuses; 2) Suspect has sexual intercourse with an 11 year old girl; 3) Suspect has consensual sexual intercourse with his 15 year old stepchild; 4) Suspect has sexual intercourse with the victim, who is comatose and a resident of a nursing facility.

ORS 163.365

2. **Rape II** occurs when a suspect has sexual intercourse with a victim who is under 14 years old. This is a Class B Felony.

Example: Suspect has consensual sexual intercourse with his family's 13 year old baby-sitter.

ORS 163.335

3. **Rape III** is the charge when a suspect has sexual intercourse with a victim who is under 16 years old. This is a Class C Felony.

Example: Twenty year old suspect has consensual sexual intercourse with a 15 year old victim.

#A2-021
OH
ORS 163.405

4. **Sodomy I** is the crime which occurs when a suspect has deviate sexual intercourse with a victim under the same circumstances which were listed in Rape I. **Deviate sexual intercourse** is defined as sexual contact between the sex organs of one person and the mouth or anus of another. **Sexual contact** is defined as any touching of the sexual or intimate parts of a person, or causing such person to touch the sexual or intimate parts of the actor, for the purpose of arousing the sexual desire of either party.

a. The victim is subjected to forcible compulsion, which is defined as
   1) physical force that overcomes earnest resistance,
   2) a threat, express or implied, that places victim in fear of immediate or future death or serious physical injury to victim or another person,
   3) fear that the victim or another person will be kidnapped immediately or in the future.
b. The victim is **under 12** years of age;
c. The victim is **under 16** and is related to the suspect by blood or marriage (child, stepchild, sibling);
d. The victim is incapable of consent because of mental or physical defect, limitation or helplessness. This is a Class A Felony.

Examples: 1) Suspect forces Victim to orally copulate him; 2) Suspect has deviate intercourse with an 11 year old;
3) Suspect orally copulates his 15 year old sister; 4) Suspect has anal sex with a victim who is severely developmentally disabled.

ORS 163.395

5. **Sodomy II** occurs when the Suspect has deviate intercourse with a victim under 14 years old. This is a Class B Felony.

Example: Suspect convinces a 13 year old to orally copulate him.

ORS 163.385

6. **Sodomy III** occurs when the Suspect has deviate intercourse with a victim under 18 years old. This is a Class C Felony.

Example: A twenty year old Suspect has consensual anal intercourse with a 15 year old boy.

#A2--022
OH
ORS 163.427

7. **Sexual Abuse I** occurs when the suspect has sexual contact with a victim who is: under 14 years old; subjected to forcible compulsion or incapable of consenting due to mental or physical limitations. Or, if the suspect intentionally causes a victim under 18

years old to touch or contact the mouth, anus or sex organs of an animal for the purpose of arousing or gratifying the sexual desires of a person.

Example: The suspect fondles the breasts of a 13 year old girl for the purpose of arousing himself sexually.

ORS 163.425

8. **Sexual Abuse II** occurs when the suspect subjects the victim to sexual intercourse, deviate sexual intercourse or penetration of the victim's vagina or anus with a foreign object other than the penis or mouth of the suspect, and the victim does not consent.

Example: Without first obtaining the victim's consent, the suspect inserts a foreign object into the victim's anus.

ORS 163.415

9. **Sexual Abuse III** occurs when the suspect subjects the victim to sexual contact and the victim does not consent or is incapable of consenting because the victim is under 18.

Example: 1)The suspect grabs the victim by the buttocks without the victim's consent. 2) The suspect touches the vagina of a 17 year old

ORS 163.345
OH

10. **Age as a Defense**. For certain offenses, it is a defense if the only basis for non-consent is age of the victim, if the victim and defendant are within 3 years of age of each other.

This defense only applies to **Rape 2, Rape 3, Sodomy 2, Sodomy 3, and Sex Abuse 1,2 or 3**

Example: If a suspect, age 17, and a victim, age 15, engage in consensual sexual intercourse, the suspect will have a defense to any prosecution for Rape 3 based on that conduct.

#A2-023
OH
ORS 163.435

11. **Contributing to the Sexual Delinquency of a Minor** is the correct charge to make when a suspect, 18 or older, has sexual intercourse or deviate sexual

intercourse, with a victim under 18 years old. This applies to same and opposite sex encounters. This is an A Misdemeanor.

Example: 19 year old female has consensual sexual intercourse with a 17 year old male. The age defense does not apply to this offense.

ORS 163.445

12. **Sexual Misconduct** occurs whenever a suspect engages in sexual intercourse or deviate intercourse with an unmarried person under 18 years of age. This is a C Misdemeanor.

Example: An 18 year old male who has deviate intercourse with an unmarried 17 year old male is guilty of Sexual Misconduct. The age defense does not apply.

#A2-024
OH
ORS 163.465

13. **Public Indecency** is the correct charge whenever suspects, while in view of the public or in a public place, engage in sexual or deviate intercourse. This is also the charge whenever a suspect exposes his or her genitals in public with the intent of arousing the sexual desire of the suspect or someone else.

Genitals are defined as the sex organs of a person.

Engaging in sex acts in public does not require proof of an intent to arouse anyone. Exposing genitals does.

Examples: 1) Todd and Susan have intercourse in the living room in front of the picture window, in view of the public, and forget to close the curtains. 2) Willie openly masturbates in front of his picture window, in view of the neighbors, because he gets excited when he has an audience.

REFER TO CITY ORDINANCES FOR SPECIFICS AND ADDITIONAL ELEMENTS.

E. Family Crimes

#A2-025

1. **Abandonment of a Child** occurs when a parent, lawful guardian or other adult lawfully charged with the care and custody of a child under 15 deserts the child in any place with the intent to abandon the child. This is a Class C Felony.

The courts have been very particular about proof regarding the intent to abandon, and the definition of desert. In one Oregon case, the mother of a 3 year old agreed to sell her daughter for $1500. The mother never liked the child, and a neighbor suggested that she give the girl up for adoption. The mother said she wouldn't give her up without getting some money. The neighbor told the police. A policeman posed as a person interested in "buying" a child. The mother visited with the officer and his "wife" for 45 minutes to get a feel for her daughter's new home. After 45 minutes she agreed to sell her child. She took the cash and left her daughter. She was arrested outside the house and prosecuted for Child Abandonment. The Appellate Court reversed the decision of the trial court because it found that the mother did not "intend to abandon" the child. She spent 45 minutes assuring herself that the new home was right for her daughter. The mother, in her own pathetic way, was trying to place her daughter in a good home, and did not, therefore, desert her with the intent to abandon her.

Example: The young mother who left her child playing with toys in Toys R Us and then moved with her boyfriend to another state, evidenced the intent to abandon. After she was finally found and arrested, she tearfully said that not a day went by when she didn't think about her 3 year old boy, hoping he was O.K.

2. **Child Neglect I** was not included in the original lesson plan.

Example : Police raid a home where suspects are in the process of cooking a batch of methamphetamine

in what is obviously the bedroom of a small child. The child's bed is 5 feet from the "lab."

#A2-026
OH
ORS 163.545

3. **Child Neglect II** occurs when a person who has lawful custody or control of a child under 10, with criminal negligence, leaves the child unattended for such amount of time as may likely endanger the health or welfare of the child.

   This applies to parents, grandparents and baby-sitters as well. The amount of time is not clearly specified. It is dependent on the circumstances. This is a Class A Misdemeanor.

   Examples: 1) On a 90 degree day in July a mother leaves her sleeping infant in a closed car while she runs into the house to make a phone call. She is gone 10 minutes. The temperature inside the car is over 125 degrees when she returns. 2) A baby-sitter leaves a deaf 4 year old child alone for 30 minutes so she can run to the market. 3) A drug using parent after shooting-up passes out and the child wanders outside and is found there by the police.

   In each of these examples it is likely that the child's welfare or health would be endangered by the acts of the adults.

#A2-027
OH
ORS 163.575

4. **Endangering the Welfare of a Minor** is a complicated statute covering a variety of activities. If a suspect knowingly:
   a. induces, causes or permits an unmarried child under 18 to witness an act of sexual contact or sadomasochistic abuse; **or**
   b. permits a person under 18 years old to enter or remain in a place where unlawful activity involving controlled substances is maintained or conducted, **or**
   c. induces, causes or permits a person under 18 years old to participate in gambling, **or**
   d. distributes, sells or causes to be sold, tobacco in any form to a person under 18 years of age, **or**

e. sells to a person under 18 years of age any device in which tobacco, cocaine, marijuana or any other controlled substance can be burned (bong, chillum, pipe, water pipe, etc.).

f. Police raid a home where suspects are in the process of cooking a batch of methamphetamine in what is obviously the bedroom of a small child. The child's bed is 5 feet from the "lab."

This is a Class A Misdemeanor, except it will be a violation if the conduct involved is selling tobacco, or the selling of a device for smoking tobacco.

V. Controlled Substances & Alcohol

A. Controlled Substances

Definitions :

Delivery :

Manufacture :

ORS 161.015

Possession :

#A2-014
OH
ORS 475.992, 475.005

1. **Delivery of a Controlled Substance**
This offense involves the actual, constructive or attempted transfer from one person to another of a controlled substance. This does not apply to someone who is authorized to administer or dispense, i.e. a physician or pharmacist. Courts in Oregon have found that Possession with intent to deliver constitutes delivery even when no actual transfer is shown. this is commonly called a "Boyd" delivery, named after the case where the Oregon courts expanded the definition of delivery to include possession with the intent to deliver. Further, a suspect who is the agent of the buyer, and just introduces the buyer to the seller, is also guilty of delivery. An attempted transfer is punished the same as a completed transfer. The recipient is not guilty of delivery.

OH

Controlled substances are drugs listed in Schedules I-V of the Federal Controlled Substances Act. Schedule I substances include opiates, heroin and hallucinogenics like LSD, peyote, psilocybin, mescaline and marijuana. Schedule II substances

include cocaine, opium, methadone and methamphetamines. Schedule III substances include stimulants, depressants and narcotics like codeine. Schedule IV and V substances contain only small amounts of narcotics (codeine).

Examples:
1) After being stopped on the street, defendant is found to be in possession of six individually packaged bindles of cocaine, an amount consistent with street level dealing, a razor blade and $308.00 in cash. Defendant cannot explain where he obtained the money and insists he does not take drugs. Even though there is no evidence of an actual transfer, there is evidence of possession with the intent to deliver or an attempted transfer.

2) Defendant consents to a search of his house. Police find defendant to be n possession of five grams of heroin, several small, empty ziplock baggies, drugs transaction records, scales, a pager and cell phone.. No actual transfer was observed, however, all items found indicate defendant intended to sell the drugs he had in his possession.

#A2-015
OH
ORS 475.992, 475.005

2. **Manufacture of Controlled Substance** occurs when a suspect grows, plants, cultivates, harvests, cooks, synthesizes, prepares or processes a controlled substance. Packaging and labeling constitute manufacture. This does not apply to authorized practitioners, scientists, pharmacists, etc. Examples: 1) A farmer grows one acre of very nice, six foot tall marijuana plants. 2) Police raid a home where suspects are in the process of cooking a batch of methamphetamine in what is obviously the bedroom of a small child. The child's bed is 5 feet from the "lab." 3) Heather gets a prescription for amphetamines from Daddy, who is also her personal physician. She decides she can make some pocket money at college by placing a few tablets into individual small bags. She hopes to give them to her sorority sisters.

#A2-016
OH
ORS 475.992

Discuss precursor / counterfeit substances

3. **Possession of Controlled Substance**, or PCS, requires that the suspect unlawfully possess a controlled substance. Unlawful possession requires that the suspect either know he is possessing, or intend to possess controlled substances.

   Unlawful possession can be established by showing that the suspect knew that what he or she had control of was a controlled substance. Also, evidence that controlled substances were possessed in a container other than the original container will establish knowledge that it is a controlled substance.

   Examples :

   - Constructive
   - Actual

OH

Lane County Grid

ORS 475.996 , 475.999
OH
Handout

4. **Penalties for Controlled Substance Offenses** vary depending on the Schedule in which the controlled substance is found. Delivery to minors is also an enhanced penalty. Refer to overhead for specifics.

   There are factors that will "enhance" the penalties for drug crimes. Some of the aggravating factors are as listed in the handout.
(create handout)

   Delivery within 1000 ft. of a school is just one example.

   Notice : existence of forfeiture laws.

#A2-017
OH
ORS 475.993

Current Ballot measure in 98. This is still up for review.

5. **Frequenting Place Where Controlled Substances are Used** is the correct charge to bring when a suspect keeps, maintains, frequents or remains at a place while knowingly permitting persons to use controlled substances at the place or to keep or sell them at the place.

   This is ordinarily a Class A misdemeanor, unless the controlled substance is < 1 ounce dried marijuana,

in which case the offense is a C violation and the penalty is a fine. (Check with local court systems.)

ADD : reference to child neglect.

Frequenting is defined as repeatedly or habitually visiting or resorting to. There must be more than one occurrence. You must be able to prove that the suspect had some knowledge that there were drugs at the location.

Example: 1) Mick allows Keith to keep his heroin at Mick's house, because Keith's girlfriend does not approve of drug use and throws the stuff away whenever she finds it.

ORS 162.295
ORS 162.212

6. **Tampering with drug records**.

#A2-028
OH
ORS 471.430

7. **Minor in Possession** , or MIP is a very common offense which occurs whenever a minor (under 21) attempts to purchase, purchases or acquires an alcoholic beverage. You can establish possession by proving that the minor accepted or consumed a bottle or drink containing alcohol. This doesn't apply to sacramental wine used during religious services. Minors may possess alcohol in their family home in the presence of their parents, but they can't leave the home with the alcohol. Likewise, only the parent of the individual minor can consent to the minor's possession.

Examples: 1) After the fall homecoming game a group of college freshman have a keg party. All of the students are minors. Any student who consumes the beer or has a cup of the beer in his or her possession is in violation of the statute. 2) Bill is visiting his best friend, Tony. During dinner, Tony's father offers the boys (both under 21) a glass of wine. Both accept. Bill is guilty of MIP. What is Tony's father guilty of? [Furnishing alcohol to a minor-- ORS 471.410(2)1]

VI. Public Order Offenses

#A2-029
OH
ORS 166.025

A. **Disorderly Conduct** is a crime with many possible scenarios.

Disorderly conduct crimes are incidents which require that either the defendant **intentionally** cause public inconvenience, annoyance or alarm or **recklessly create a risk** of causing public inconvenience, annoyance or alarm by

1. engaging in fighting or in violent tumultuous or threatening behavior : **or**
2. making unreasonable noise; **or**
3. disturbing any lawful assembly of persons without lawful authority; **or**
4. obstructing vehicular or pedestrian traffic on a public way; **or**
5. congregating with other persons in a public place and refusing to comply with a lawful order of the police to disperse; **or**
6. initiating or circulating a report, knowing it to be false, concerning an alleged or impending fire, explosion, crime, catastrophe or other emergence; **or**
7. creating a hazardous or physically offensive condition by any act which the person is not licensed to do.

Discussion Points

Examples of Disorderly Conduct :
(Which section of ORS 166.025 do the following examples violate? If there is not a violation of ORS 166.025, how could the facts be altered to make it a violation of the section?)

166.025 (a)

1. Three subjects run through the local mall while being rowdy. They yell and fight amongst themselves, knock over garbage cans, and threaten bystanders.

166.025(d)

2. Defendant has to deliver a package to a friend. When he pulls up in front of the defendant's apartment building there are no parking spots available. He puts on his hazard lights and runs into the building, parking his car in the only northbound lane of traffic. He is in the building for about five minutes. When he returns, the northbound

traffic is stopped, and cars are backed up around the block.

166.025(f)

3. Yelling "FIRE" in a crowded movie theater.

4. At 3 am, a transient is running through the streets of the commercial section of downtown. He is yelling about his mother. No one lives in this section of town and no one is on the streets. (No violation)

166.025(b)

Same situation but change the time to 11 am and the streets filled with people. (violation)

166.025 (c) & (e)

5. A skinhead group follows all the requirements and gains approval and permits for a rally in a public square. A second group of individuals find the views expressed by the skinheads to be reprehensible, attend the rally, and jeer and heckle the skinhead speakers. Their conduct interrupts the rally. Officers respond to the scene and order the protesters to leave the area. They refuse and continue to yell.

How is the right to use self-defense affected by this statute?

6. Two subjects get into a fight in front of their homes. The fight occurs on the sidewalk. (No violation - No members of the public are affected.)

#A2-030
OH
ORS 162.375

B. **Initiating a False Report** is the correct charge to make when a suspect knowingly initiates a false alarm or report which is transmitted to a fire department, law enforcement agency or other organization that deals with emergencies involving danger to life or property.

ADD: Element regarding initiating false report of Domestic Violence.

Examples: 1) Barb is upset with her boyfriend, Michael. She lends him her car and then calls the sheriff to report that her car was stolen by Michael. Michael is treated to a high risk vehicle stop. 2) Chip pulls a fire alarm at a local business, knowing that the alarm will directly alert the fire department.

#A2-031
OH
~~ORS 166.065~~

C. **Harassment**. This offense occurs when a suspect intentionally harasses or annoys another person by:

1. **Subjecting them to offensive physical contact.** This is the correct charge if there is contact without injury. If the contact is to the sexual or intimate parts of the victim, the offense becomes an A misdemeanor. Ordinarily this is a B misdemeanor.

   Examples: 1) Fred spits in Mark's face. 2) Ken grabs Michelle by the buttocks and squeezes. 3) Joan slaps Al in the face, without causing physical injury.

2. **Publicly insulting by abusive words or gestures in a manner which is likely to provoke a violent response.** This must be more than simply giving someone the "one finger salute." The insult must also by made in public, that is other people must have seen or heard it in addition to the complaining witness.

   Example: During a college PE class the suspect loudly and crudely belittles a fellow student by insulting the student's family, the student's sexual experience and orientation, and the student's physique. The student has finally had enough and charges at the suspect.

3 **Subjects another to alarm by conveying a false report, knowing it to be false, concerning death or serious physical injury to a person, which report would reasonably be expected to cause alarm.**

   Example: Sam is very angry with Ted, his supervisor. Sam calls Ted and after disguising his voice, Sam purports to be an emergency room physician at a hospital near Ted's home. Sam then tells Ted that Ted's toddler daughter has been seriously injured in an accident and is not expected to live more than an hour. Sam knows that Ted works 1 1/2 hours from his home and the hospital where he believes his daughter is being treated. Ted experiences extreme anguish and alarm.

4. **Subjects another to alarm by conveying a telephonic or written threat to inflict serious physical injury on that person, or to commit a felony involving the person or the property of the person, or the person's family, if the threat would reasonably be expected to cause alarm.** If you knowingly allow a telephone under your control to be used in violation of this section, you are guilty of harassment.

   Example: Ken intends to cause Julie to experience alarm and calls her on the phone, threatening to kidnap and torture Julie's little sister, Stacey. Ken's friend, James, knows what Ken plans to do and allows Ken to use his telephone to make the call.

#A2-032
OH
ORS 166.090

D. **Telephonic Harassment** occurs when a suspect **intentionally** harasses or annoys another person by

1. causing the telephone of another person to ring, such caller having no communicative purpose; **or**
2. causing such other person's telephone to ring and causing such other person to answer it, knowing that the caller has been forbidden from so doing by a person exercising lawful authority over the receiving telephone.

Examples:
1) Subject repeatedly calls victim every ten minutes during the night. Every time the victim answers the phone, the subject hangs up. Upon contact by police, subject admits calling the victim and hanging up. (How would this example be different if instead of hanging up, the subject yelled curse words at the victim after the victim answered the phone? NO VIOLATION)

2) Subject used to date victim's daughter. after the two broke up, victim told the subject he was not to come to the house or call on the phone. Victim is the person with lawful authority over the phone. Subject continues to call, and victim answers the phone. (Would the result be different if the victim allowed the calls to be answered by the answering machine or voice-mail? NO VIOLATION)

A2.5 – Weapons / Intimidation / Theft Crimes / Forgery / Negotiating a Bad Check / Fraudulent Use of a Credit Card

#A2-033
OH
ORS 166.240

E. **Carrying a Concealed Weapon**

1. carries concealed upon the person any
   a. switchblade knife / butterfly knife
   b. dirk
   c. dagger
   d. ice pick
   e. slung shot
   f. metal knuckles
   g. any instrument similar to a-f which could be used to injure person or property. [make this consistent with ORS 166.240 (1)]

2. Protected areas
   a. Inside house. OrApp 113.129 State v. Stevens

CHECK WITH AGENCIES ON SPECIFIC PRACTICES.
* CHECK LOCAL ORDINANCES.

#A2-034
OH
ORS 166.250

F. **Unlawful Possession of a Firearm**

1. Knowingly possesses an operable firearm and is
   a. under 18
   b. convicted felon
      1) add specific definitions
   c. guilty but insane of a felony
   d. found to be mentally ill
   e. concealed upon person without license
      1) openly carried in belt holster is not concealed
   f. concealed and readily accessible within any vehicle which is under the person's control or direction without license

G. **Felon in Possession of a Firearm or Restricted Weapon**

#A2-065
OH
ORS 166.270

1. convicted of felony under Oregon or Federal laws, or any other state.
   a. add specific definitions of convicted felon.

2. owns or has in possession or under custody or control
   a. any operable firearm.
   b. switchblade, blackjack, slung shot, sandclub, sandbag, sap glove, metal knuckles, dirk, dagger or stiletto

#A2-066
OH
ORS 166.155

H. **Intimidation II**

1. Because of the person's perception of the other's race, color, religion, national origin or sexual orientation:
   a. tampers or interferes with property, having no right to do so nor reasonable ground to believe the person has such right, with the intent to cause substantial inconvenience to another.
   b. intentionally subjects another to offensive physical contact
   c. intentionally subjects another person to alarm by threatening:
      1) to inflict serious physical injury upon or to commit a felony affecting such other person or member of the person's family; **OR**
      2) to cause substantial damage to the property of the other person or a member of the other person's family

#A2-067
OH
ORS 166.165

Assault ?
Menacing?

I. Intimidation I

1. two or more persons acting together, who because of their perception of a person's race, color, religion, national origin or sexual orientation:
   a. intentionally, knowingly or recklessly cause physical injury to another person; **OR**
   b. with criminal negligence cause physical injury to another person with a deadly weapon
   c. intentionally place another person in fear of imminent serious physical injury, **OR**
   d. do an act which if done by only one person would constitute Intimidation II

Examples :

1. Suspect observes a Native American male in a parking lot. He approaches the male, pulls out a knife and indicates to the victim that he intends to kill him because he hates Native Americans.
2. Suspect enters a Plaid Pantry store carrying a gun and a bag. He approaches a Hispanic clerk, points the gun at her and tells her to put all the money in the bag. On his way out the door he yells the following at her : "You and your Mexican friends should stay south of the border."

The suspect in example #1 clearly committed that crime of menacing because of his perception of the victim's ethic background. The suspect in example #2, however, is motivated to commit the robbery I / menacing in order to obtain money, rather than to menace the victim based upon his perception of her national origin. It is appropriate to charge suspect #1 with Intimidation I. Suspect #2 should be charged with Robbery I and Menacing.

VII. Property

#A2-036
OH
ORS 164.043

A. **Theft III**
1. by means other than extortion
   a. commits theft as defined in ORS 164.015 **and**
   b. total value of property in single or aggregate transaction is <$50
2. theft = to appropriate property of another to oneself or a third person, **or**
   a. appropriate =
      1) exercise control over property of another, permanently or for so extended a period or under such circumstances as to acquire the major portion of the economic value or benefit of such property, **OR**
      2) dispose of the property of another for the benefit of oneself or a third person

#A2-037
OH
ORS 164.045

B. **Theft II**
1. by means other than by extortion
   a. commits theft as defined in ORS 164.015 **and**
   b. total value of the property in single or aggregate transaction is > $50 but <$200 (theft by receiving) or <$750 any other case.

Example : Peter enters into a music store, takes five CDs and leaves the store without intending to pay. The total value of the CDs is $80.00

#A2-038
OH
ORS 164.055

C. **Theft I**
1. by means other than by extortion commits theft as defined in ORS 164.015 **and**
   a. total value of property in single or aggregate transaction is ≥ $200 (theft by receiving) or ≥ $750 (other cases), **OR**
   b. committed during riot, fire, explosion, catastrophe or other emergency in area affected thereby, **OR**
   c. theft is by receiving committed by buying, selling, borrowing or lending on the security of the property, **OR**
   d. subject of theft is firearm or explosive, **OR**

e. livestock animal, companion animal or wild animal removed from habitat or born of wild animal removed from habitat

Examples : 1) Susan takes $1,200.00 from the petty cash drawer at work to help pay for her gambling debts. Initially, when she decided to take the money, she intended to pay it back. however, after she gets home, Susan decides to fix the books and hide the fact that she took the money. 2) Bob, while visiting his cousing Joe, finds a gun worth $125.00 in Joe's bedroom. Bob takes the gun without Joe's permission.

#A2-039
OH
ORS 164.057

D. **Aggravated Theft I**
1. commits theft I of property, other than private vehicle, **AND**
2. value of property in single or aggregate transaction is ≥ $10,000

Example : 1) Dorothy places her wedding ring, worth $9000.00 in the ashtray of her car before she goes jogging. While Dorothy is jogging, Steve breaks into Dorothy's car, takes her ring and $1000.00 car stereo.

OH
ORS 164.065

Receive shipment of vitamins in mail, addressed to someone else --decide to keep

E. **Theft of Lost, Mislaid Property**
1. person comes into control of property and
2. knows or has good reason to know property
3. lost, mislaid or delivered by mistake as to nature or amount of the property or the identity of the recipient **IF**
4. with intent to deprive owner thereof, person fails to take reasonable measures to restore property to owner

ORS 164.075

F. **Theft by Extortion**
1. compels or induces another person to deliver property to the person or a third party by instilling fear that if the property is not delivered the actor or a third person will in the future
   a. cause physical injury to some person
   b. cause damage to property, **OR**
   c. engage in other conduct constituting a crime, **OR**

d. accuse some person of a crime or cause criminal charges to be instituted against the person, **OR**
e. expose a secret or publicize an asserted fact, whether true or false, tending to subject some person to hatred, contempt or ridicule, **OR**
f. cause, or continue a strike, boycott or other collective action injurious to some person's business, **OR**
g. testify or provide information or withhold testimony or information with respect to another's legal claim or defense, **OR**
h. use or abuse the position as a public servant by performing some act within or related to official duties, or by failing or refusing to perform an official duty, in such a manner as to affect some person adversely, **OR**
i. inflict any other harm that would not benefit the actor

ORS 164.085

***Notes from meeting say to combine with Theft I,II,III . They stand alone in the book. What to do now.

G. **Theft by Deception**

1. obtains property of another with intent to defraud
   a. creates or confirms another's false impression of law, value , intention or other state of mind, which actor does not believe to be true; **OR**
   b. fails to correct false impression which person previously created or confirmed; **OR**
   c. prevents another from acquiring information pertinent to the disposition of the property involved, **OR**
   d. deals or otherwise transfers or encumbers property, failing to disclose a lien, adverse claim or other legal impediment to the enjoyment of the property, whether such impediment is valid or not; **OR**
   e. promises performance which the person does not intend to perform or knows will not be performed

Example : 1) David knocks on Brenda's door. Brenda is 85 years old and lives alone. David introduces himself as an independent contractor whose specialty is maintaining and fixing roofs. David tells Brenda her roof is in bad condition. He further tells Brenda for $750.00, he will

clean and fix any problems. Brenda agrees to have the work done. She gives David $350.00 up-front. David informs Brenda he will start the work in a couple of hours. David never comes back. Brenda later learns David had contracted all of her elderly neighbors and made the same deal, without performing any of the work.

ORS 164.095

H. **Theft by Receiving**

1. receives, retains, conceals or disposes of property of another knowing or having good reason to know the property was the subject of theft

#A2-040
OH
ORS 164.125

I. **Theft of Services**

1. with intent to avoid payment, person obtains services that are available only for compensation, by force, threat, deception or other means to avoid payment of services, **OR**
2. having control over disposition of labor or of business, commercial or industrial equipment or facilities of another, person uses or diverts to the use of the person or a third party, such labor, equipment or facilities with the intent to derive for the person or third party a commercial benefit to which not entitled, **OR**
3. absconding without payment or offer to pay for hotel, restaurant or other services
4. obtaining the use of any communication system, including telephone, cable or computer, or obtaining public utility services without payment or offer to pay

Example : Eric stays in a hotel for two nigts. On the third day, Eric leaves early in the morning without paying for his room.

J. **Aggregation**

#A2-041
OH
ORS 164.135

K. **Unauthorized Use of a Vehicle**

1. takes, operates, exercises control over, rides in or otherwise uses another's vehicle, boat or aircraft without consent of owner
2. having custody of vehicle, boat or airplane pursuant to agreement with owner or another to perform a specific service for compensation (re: maintenance, repair or use) the person intentionally uses, or operates it without consent, for the person's own

Ferris Beuller's day off.

purpose in a manner constituting gross deviation from the agreed purpose, **OR**

3. person knowingly retains or withholds possession of vehicle from owner without consent for so lengthy a period beyond the specified time as to render such retention or possession a gross deviation from the agreement

VIII. Fraud or Deception

Definitions :

"Written Instrument " means any paper, document, instrument or article containing written or printed matter or the equivalent thereof, whether complete or incomplete, used for the purpose of reciting, embodying, conveying or recording information or constituting a symbol or evidence of value, right, privilege or identification, which is capable of being used to the advantage or disadvantage of some person.

To "Falsely Make" a written instrument means to make or draw a complete written instrument in its entirety, or an incomplete written instrument which purports to be an authentic creation of its ostensible maker, but which is not, either because the ostensible maker is fictitious or because, if real, the ostensible maker did not authorize the making or drawing thereof.

To "Falsely Complete" a written instrument means to transform, by adding, inserting or changing matter, an incomplete written instrument into a complete one, without the authority of anyone entitled to grant it, so that the complete written instrument falsely appears or purports to be in all respects an authentic creation of its ostensible maker or authorized by the ostensible maker.

To " Falsely Alter" a written instrument means to change, without authorization by anyone entitled to grant it, a written instrument, whether complete or incomplete, by means of erasure, obliteration, deletion, insertion of new matter, transposition of matter, or in any other manner, so that the instrument so altered falsely appears or purports to be in all

respects an authentic creation of its ostensible maker or authorized by the ostensible maker.

"Utter" means to issue, deliver, publish, circulate, disseminate, transfer or tender a written instrument or other object to another.

"Forged Instrument" means a written instrument which has been falsely made, completed or altered.

ORS 165.007

A. **Forgery II**
   1. with intent to injure or defraud
      a. falsely makes, completes or alters a written instrument, **OR**
      b. utters a written instrument the person knows to be forged

Example : Jason, without Nancy's permission, takes one of Nancy's checks and makes it out to himself for $10.00

#A2-042
OH
ORS 165.013

B. **Forgery I**
   1. forgery II + the written instrument is any of the following:
      a. money, securities, postage or revenue stamps, or other government issued instruments
      b. part of an issue of stock, bonds, etc.
      c. deed, will, codicil, contract or assignment
      d. check or credit card purchase slip $\geq$ $750
      e. public record
      f. against multiple victims in 30 day period
      g. against same victim within 180 day period

Examples : 1) Jason, without Nancy's permission, takes three of Nancy's checks, makes them out to himself for $500.00 each. 2) Jason, without Nancy's permission, takes three of Nancy's checks, makes them out to his brother Bill, for $500.00 each. Bill knowing that his brother filled in the information on each check without nancy's permission, deposits the checks into his bank account. 3) Mark, who has a warrant for his arrest, takes his roommates driver's license without his roommates' permission. Mark cuts out his roommates' picture and replaces it with his own.

#A2-043
OH
ORS 165.055

C. **Fraudulent Use of a Credit Card**

1. with intent to injure or defraud, uses credit card for purpose of obtaining property or services with knowledge that:
   a. card stolen or forged; **or**
   b. card revoked or canceled; **or**
   c. for any other reason the use is unauthorized by issuer or card holder

Example : Gabriela trades heroin for a stolen credit card. In the next two hours, Gabriela makes $2000 worth of purchases on the stolen credit card.

#A2-044
OH
ORS 165.065

D. **Negotiating a Bad Check**

1. makes, draws or utters a check or similar order for payment of money, knowing it will not be honored by drawee
2. *prima facie* evidence:
   a. drawer has no account with drawee at time check drawn or uttered;
   b. payment refused by drawee for lack of funds, upon presentation within 30 days after date of utterance, and the drawer fails to make good within 10 days of receiving notice of refusal.

Example : Chris writes a check for a $1,8500.00 stereo on an acount he knows he closed two years ago.

IX. Arson & Criminal Mischief

PO #45
OH
ORS 164.315

A. **Arson II**
1. by starting a fire or causing an explosion, the person intentionally damages any building of another that is not protected property

PO #46
OH
ORS 164.325

B. **Arson I**
1. by starting a fire or causing an explosion the person intentionally damages:
   a. protected property of another
   b. any property, whether the property of the person or another, and such act recklessly places another person in danger of physical injury or protected property of another in danger of damage;
   c. any property, whether property of person or another, and recklessly causes serious physical injury to a firefighter or peace officer acting in the line of duty relating to the fire.

PO #47
OH
ORS 164.335

C. **Reckless Burning**
1. recklessly damages property of another by fire or explosion

PO #48
OH
ORS 164.345

D. **Criminal Mischief III**
1. with intent to cause substantial inconvenience to the owner or to another person, and having no right to do so nor reasonable ground to believe that the person has such right, the person tampers or interferes with property of another

PO #49
OH
ORS 164.354

E. **Criminal Mischief II**
1. violates 163.345 + damage exceeds $100, **OR**
2. having no right to do so nor reasonable ground to believe that the person has such right, the person **intentionally** damages property of another, or the

person **recklessly** damages property of another in an amount exceeding $100

PO #50
OH
ORS 164.365

F. **Criminal Mischief I**
1. with intent to damage property, and having no right to do so nor reasonable ground to believe that the person has such right:
   a. damages or destroys property of another
      1) in amount exceeding $500
      2) by means of explosion
      3) by starting fire in an institution while committed to and confined in institution
      4) livestock
      5) property of public utility, telecommunications utility, railroad, public transportation facility or medical facility used in direct service to the public
      6) police animal and animal suffers death or serious physical injury, **OR**
      7) intentionally interfering with, obstructing or adulterating in any manner the service of a public utility, etc.
   b. intentionally uses, manipulates, arranges or rearranges the property of a public utility, etc. so to interfere with its efficiency

ORS 164.369

G. **Interfering with a Police Animal**
1. intentionally or knowingly injures or attempts to injure an animal the person knows or reasonably should know is a police animal while the animal is being used in the lawful discharge of its duty

PO #51
OH
ORS 164.245

H. **Criminal Trespass II**
1. person enters or remains unlawfully in or upon premises

PO #52
OH
ORS 164.255

I. **Criminal Trespass I**
1. enters or remains unlawfully in a dwelling, **OR**
2. having been denied future entry to a building pursuant to merchant's notice of trespass, reenters building during hours when the building is open to the public with the intent to commit theft therein

Example : A suspect previously trespassed from a shopping store and subsequently re-enters with the intent to commit theft. (Please Note : This can no longer be tried as Burglary 2)

PO #53
OH
ORS 164.215

J. **Burglary II**

1. person enters or remains unlawfully in a building with intent to commit a crime therein

Examples : 1) Harry smashes a window to a small convenience store. He and Chester enter the store and take 48 cartons of cigarettes. 2) Keith breaks into an unattached garage next to a residence. He takes a bicycle. 3) June breaks the lock to a storage facility and takes several items.

PO #54
OH
ORS 164.225

K. **Burglary I**

1. violates ORS 164.215 + building is a dwelling, OR if in effecting entry or while in a building or in immediate flight there from the person:
   a. is armed with burglar tools or deadly weapon; **OR**
   b. causes or attempts to cause physical injury to any person; **OR**
   c. uses or threatens to use a dangerous weapon

Examples : 1) Calvin breaks into the residence of his ex-wife and proceeds to choke his ex-wife's lover.
2) George breaks into a garage that is attached to a residence. He takes tools from the garage.
3) Casey's upper body is inside the window of a residence that he intends to burglarize. The resident of the house is able to prevent him from entering any further by hitting him over the head with a frying pan.

PO #55
OH
ORS 164.395

There is no attempted Robbery III.

L. **Robbery III**

1. in course of committing or attempting to commit theft person uses or threatens immediate use of physical force upon another person with intent to:
   a. prevent or overcome resistance to taking of property or retention of property immediately after taking; **OR**

b. compels owner or another to deliver property or engage in other conduct which might aid in commission of theft.

Example : 1) Candy leaves Nordstrom with 2 purses that she has not paid for. When store security approaches her, she hits and kicks at the security officer.

PO #56
OH
ORS 164.405

M. **Robbery II**

1. violates 164.395 + represents by word or conduct that person armed with what purports to be dangerous or deadly weapon, **OR**
2. is aided by another person actually present

Examples : 1) Forrest and Mike approach Jerry and demand Jerry's bike. jerry refuses to give up the bike. Forrest and Mike push and kick Jerry and take his bike. 2) Eric approaches a clerk at a 7-11 and advises the clerk that he will shoot him if he does not hand over the money in the till. 3) Judy approaches a teller and hands her a note indicating that she has a bomb in her purse which will detonate in the event that the teller refuses to hand over money.

PO #57
OH
ORS 164.395

N. **Robbery I**

1. violates 164.395 +
   a. armed with deadly weapon, **OR**
   b. uses or attempts to use a dangerous weapon, **OR**
   c. causes or attempts to cause serious physical injury to any person

Examples : 1) Harold approaches Kim with a loaded glock handgun and demands her purse. 2) Jeff puts a knife to Tomi's throat and demands the cash in her till. 3) Devon takes a lawnmower from Fred Meyer. He places the lawn mower in his truck. Two Fred Meyer employees attempt to stop Devon by placing their bodies in front of the vehicle. Devon guns the engine and hits one of the employees causing serious physical injury.

A2.7 – Escape / Resisting / Obstructing / Hindering / Animal Abuse & Neglect

X. State and Public Justice

#A2-058
OH
ORS 162.145

A. **Escape III**
1. person escapes from custody
2. Defense -- person escaping or attempting to escape from custody pursuant to illegal arrest
3. Custody = imposition of actual or constructive restraint by peace officer pursuant to arrest or court order (doesn't include juvenile facility, correctional facility or state hospital)

#A2-059
OH
ORS 162.155

B. **Escape II**
1. person uses or threatens to use physical force escaping from custody, **OR**
2. having been convicted or found guilty of a felony, the person escapes from custody imposed as a result thereof, **OR**
3. person escapes from correctional facility; **OR**
4. while under jurisdiction of Psychiatric Security Review BD person departs, is absent from or fails to return to this state without authorization of the BD

#A2-060
OH
ORS 162.165

C. **Escape I**
1. aided by another person actually present, person uses or threatens to use physical force in escaping from custody or correctional facility; **OR**
2. person uses or threatens to use dangerous or deadly weapon escaping from custody or correctional facility

ORS 162.205

D. **Failure to Appear I**
1. having been released by court order from correctional facility or from custody upon condition that they reappear personally as directed, the person intentionally fails to appear
2. underlying charge must be felony

ORS 162.195

E. **Failure to Appear II**
1. having been released by court order from correctional facility or from custody upon condition that they reappear personally as directed, the person intentionally fails to appear
2. underlying charge is misdemeanor or violation

#A2-061
OH
ORS 162.235

F. **Obstructing Governmental or Judicial Administration**
1. intentionally obstructs, impairs or hinders the administration of law or other governmental or judicial function by means of:
   a. intimidation
   b. force
   c. physical or economic interference or
   d. obstacle
2. doesn't apply to obstruction or interference with making of an arrest

ORS 162.247

G. **Interfering with a police officer**
1. A person commits the crime of interfering with a peace officer if the person, knowing that another person is a peace officer ;
   a. Intentionally acts in a manner that prevents, or attempts to prevent, a peace officer from performing the lawful duties of the peace officer with regards to another person; or
   b. Refuses to obey a lawful order by the peace officer.
2. Interfering with a peace officers is a Class A misdemeanor.
3. This section does not apply in situations in which a peace officer is making an arrest.

#A2-062
OH
ORS 162.315

H. **Resisting Arrest**
1. intentionally resists person known to be peace officer in making an arrest
2. "Resisting" = use or threatened use of violence or force that creates a substantial risk of injury to any person.

#A2-063
OH
ORS 162.325

I. **Hindering Prosecution**
1. with intent to hinder the apprehension, prosecution, conviction or punishment of a person who has committed a felony, **OR**

2. with intent to assist a person who has committed a felony in profiting or benefiting from the commission of the crime, the person:
   a. harbors or conceals;
   b. warns such person of impending discovery or apprehension;
   c. provides aid, i.e. money, transportation, weapon, disguise or other means of avoiding discovery or apprehension;
   d. prevents or obstructs, by means of force, intimidation or deception, anyone from performing an act which might aid in discovery or apprehension of such person;
   e. suppresses by any act of concealment, alteration or destruction physical evidence which might aid in the discovery or apprehension of such person; **or**
   f. aids such person in securing or protecting the proceeds of the crime

OH / Graph

J. **Giving false information to a police officer**

Greg Moawad is working on this section .

XI. Health, Decency and Animals

#A2-064
OH
ORS 167.315

A. **Animal Abuse II**
1. intentionally, knowingly or recklessly causes physical injury to an animal

ORS 167.320

B. **Animal Abuse I**
1. intentionally, knowingly or recklessly
   a. causes serious physical injury to an animal
   b. cruelly causes death of an animal

ORS 167.322

C. **Aggravated Animal Abuse I**
1. maliciously kills an animal, **OR**
2. intentionally or knowingly tortures an animal

#A2-065
OH
ORS 167.325
"Vicky Kittles"

D. **Animal Neglect II**
1. intentionally, knowingly, recklessly or with criminal negligence fails to provide minimum care for an animal in such person's custody or control

ORS 167.330

E. **Animal Neglect I**

1. intentionally, knowingly, recklessly or with criminal negligence
2. fails to provide minimum care for animal under person's custody or control
3. failure results in serious physical injury or death to animal

XII. MISCELLANEOUS PROVISIONS

#A2-068
OH
Handout
ORS 181.550(1) (c)

A. **Bias Crime Reporting Requirement**
   1. Agencies shall report statistics concerning crimes motivated by prejudice based on the victim's perceived:
      a. race
      b. color
      c. religion
      d. national origin
      e. sexual orientation
      f. marital status
      g. political affiliation or beliefs
      h. activity in or on behalf of or against a labor organization
      I. physical or mental handicap
      j. age
      k. economic or social status
      l. citizenship

#A2-070
OH
ORS 161.270

C. **Duress Defense**
   1. not a crime if actor coerced to do so by
      a. use or threatened use of unlawful physical force
      b. upon actor or third person
      c. force of such nature or degree as to overcome earnest resistance
   2. Does not apply to murder
   3. Not a defense for someone who intentionally or recklessly placed themselves in a situation where it was probable that they would be subjected to duress
   4. Generally not a defense for a spouse acting under orders from spouse, unless threat or use of physical force

#A2-071
OH
ORS 161.275

D. **Entrapment**
   1. not crime if actor induced to do act by law enforcement official, or person acting in cooperation

with law enforcement, for purpose of obtaining evidence to be used against actor in criminal prosecution.

2. induced = actor did not contemplate and **would not otherwise have engaged in the proscribed conduct**
3. Merely giving actor opportunity to commit offense doesn't amount to entrapment

XIII. Justification

#A2-074
OH
ORS 161.205

A. **Use of Physical Force** – Generally
   1. parent, guardian, supervising person
      a. may use **reasonable force**
      b. when and to extent **reasonably believes necessary**
      c. to maintain discipline or promote welfare of minor
   2. applies to teachers in school, at school events
   3. authorized official of jail, prison or correctional facility
      a. may use force when reasonably believes it is necessary to maintain order and discipline
   4. common carriers
      a. reasonably believe necessary to maintain order
      b. deadly force only when the person reasonably believes it is necessary to prevent death or serious physical injury
   5. person acting under reasonable belief another is **about to commit suicide,** (unless authorized by the Assisted Suicide Law) or inflict serious physical self-injury
      a. **force to extent reasonably believe necessary to thwart result**
   6. **in self-defense or in defending a third person, property, in making arrest or in preventing an escape**

ORS 161.209

B. **In Defense of Persons**
   1. from what person **reasonably believes** to be the **use or imminent use** of unlawful physical force
   2. may use a degree of force which person **reasonably believes necessary** for the purpose

ORS 161.215

C. **Limitations of use of force in Defense of Persons**

1. with intent to cause physical injury or death to another, the **person provokes** the use of unlawful physical force by that person, **OR**
2. the person is the **initial aggressor**, unless they **withdraw** from encounter and **effectively communicate** to the other person their intent to do so, and the other person (original victim) continues or threatens to continue the unlawful use of force
3. force involved is product of combat by agreement (**mutual combat**)

ORS 161.219

D. **Limitations on Use of Deadly Force in Defense of Person**

1. not justified unless person reasonably believes the other person is:
   a. **committing or attempting to commit a felony involving use or threatened imminent use of physical force against a person; OR**
   b. committing or attempting to commit a **burglary in a dwelling**;
   c. **using or about to use unlawful deadly force against a person**

ORS 161.225

E. **Use of Force in Defense of Premises**

1. person in **lawful possession or control** of premises
2. when and to extent **reasonably believes necessary**
3. to **prevent or terminate** what the person reasonably believes to be
4. commission or attempted commission of a **criminal trespass** in or upon the premises
5. **deadly physical force** only when person reasonably believes necessary to prevent commission of **arson or felony by force and violence by trespasser**, or in **defense of a person**

ORS 161.229

F. **Use of Force in Defense of Property**

1. **other than deadly force**
2. upon another person and to extent **reasonably believes necessary** to prevent or terminate the commission or attempted commission by the other person of **theft or criminal mischief of property**

ORS 161.235

G. **Use of Force in Making an Arrest or in Preventing an Escape**

1. only when and to the extent that the **peace officer reasonably believes** it necessary :
   a. to **make an arrest or prevent the escape from custody of an arrested person unless the peace officer knows the arrest is unlawful; OR**
   b. for **self-defense or to defend a third person** from what the officer **reasonably believes to be the use or imminent use of physical force** while making or attempting to make an arrest or while preventing or attempting to prevent an escape

ORS 161.239

H. **Use of Deadly Force in Making an Arrest or In Preventing an Escape**

1. peace officer may only use **when officer reasonably believes:**
   a. crime committed by person was a **felony or an attempt to commit a felony involving the use or threatened imminent use of physical force against a person**; OR
   b. crime committed by the person was **kidnapping, arson, escape I, burglary I or any attempt to commit such a crime;** OR
   c. when the use of **deadly physical force is necessary to defend the officer or another from the use or threatened imminent use of deadly physical force**; OR
   d. the crime committed was a **felony** or an attempted felony and under the **totality of the circumstances** existing at that time and place, the use of Force was necessary
   e. the **officer's life or personal safety is endangered**
   f. **will not justify reckless or criminal conduct by officer** amounting to an offense against or with respect to innocent persons whom the officer is not seeking to arrest or retain in custody

ORS 161.245

I. **Reasonable Belief**

1. a reasonable belief in facts or circumstances which **if true would constitute an offense**
2. if the believed facts or circumstances would not constitute an offense, an erroneous though not unreasonable belief that the law is otherwise does not render justifiable the use of force to make an arrest or to prevent an escape from custody,
3. **peace officer making: an arrest is justified in using physical force unless the arrest is unlawful and the officer knows it is unlawful**

ORS 161.249

J. **Use of Force by Private Person Assisting an Arrest**

1. a person who has been **directed by an officer to assist** the peace officer to make an arrest or to prevent an escape from custody is justified in using force when and to extent person **reasonably believes force necessary to carry out officer's direction**
2. when directed by peace officer to assist person **may use deadly force** only when:
   a. person **reasonably believes** deadly force **necessary for self-defense** or to **defend a third person** from what the person reasonably believes to be the **use or imminent use of deadly force**; OR
   b. person is **directed or authorized by officer** to use deadly force **unless** the **person knows that the officer is not authorized to use deadly force under the circumstances**

ORS 161.255

K. **Use of Force by Private Person Making Citizen's Arrest**

1. private person acting on their own account is justified in using force when and to the extent they **reasonably believe** it is necessary to make an arrest or to prevent the escape from custody of an arrested person
2. justified in using **deadly force** only when the person **reasonably believes** it necessary for **self-defense or to defend third person from use or imminent use of deadly physical force**

ORS 161.260

L. **Use of Force in Resisting Arrest Prohibited**

1. a person may not use force to resist an **arrest by a peace officer who is known or reasonably appears to be a peace officer**
2. **whether the arrest is lawful or unlawful**

ORS 161.265

M. **Use of Force to Prevent Escape**

1. a **guard or peace officer** employed in a correctional facility is justified in using physical force **including deadly force** when and to the extent that the guard or officer **reasonably believes necessary to prevent escape of prisoner**

Use of Force Handout

Jeopardy II

IVX. REVIEW

1999 BASIC ACADEMY

Chapters 161 and 166

Instructor: Wayne Pearson

I. Definitions at 161.015

A. *(6) "**PHYSICAL INJURY**" means impairment of physical condition or substantial pain.*

1. *Substantial pain* means:

2. *Impairment of physical condition* means:

B. *(8) "**SERIOUS PHYSICAL INJURY**" means physical injury which creates a substantial risk of death or which causes serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of any bodily organ.*

1. *Substantial risk of death* means:

2. *Causes serious and protracted disfigurement* ... What is that all about?

a. How long must it be to be protracted?

b. Examples that help define disfigurement:

3. *Causes protracted impairment of health* applies to what?

4. *Causes protracted loss or impairment of the **function** of any **bodily** organ*

a. What are some examples of bodily organs?

C. *(1) **"DANGEROUS WEAPON"** means any weapon, device, instrument, material or substance which under the circumstances in which it is used, attempted to be used or threatened to be used, is readily capable of causing death or serious physical injury.*

1. What are some examples of things that might constitute "*material*" or "*substance*"?

2. "*Used or attempted to be used.*" How does that phrase take into consideration the person's intent?

3. *Readily capable of death or serious physical injury.* How does this phrase work .... for instance, how much injury is required?

D. *(2) **"DEADLY WEAPON"** means any instrument, article or substance specifically designed for and presently capable of causing death or serious physical injury.*

1. *Instrument, article or substance* ..... What are some examples of such devices?

2. "*Specifically **designed** for*"..... By whom?

3. *and **presently** capable of* .... How far must one go before the item is no longer presently capable?

4. *Causing death or serious physical injury*

E. *(3) "**DEADLY PHYSICAL FORCE**" means physical force that under the circumstances in which it is used is readily capable of causing death or serious physical injury.*

1. *"Force"* , under the circumstances in which it is used.....

2. ***Readily capable** of causing death or serious physical injury.*

F. *(5) "**PERSON**" means a human being and, where appropriate, a public or private corporation, an unincorporated association, a partnership, a government or a governmental instrumentality.*

1. *Human being*
   a. See 163.005 -- *means a person who has been born and was alive at the time of the criminal act.*
2. Corporations, partnerships, etc.

G. *(9) "**POSSESS**" means to have physical possession or otherwise to exercise dominion or control over property.*

1. *Physical possession*

2. How does "to *exercise dominion or control over property"* differ from "physical possession?" How do either phrase relate to the phrase "constructive possession.?"

3. Can an item be possessed by more than one person at one time for purposes of this definition?

4. What if the person is simply "present" where an item is located?

H. *(10) **"PUBLIC PLACE"** means a place to which the general public has access and includes, but is not limited to, hallways, lobbies and other parts of apartment houses and hotels not constituting rooms or apartments designed for actual residence, and highways, streets, schools, places of amusement, parks, playgrounds and premises used in connection with public passenger transportation.*

1. *A place to which the general public has access*

2. *And includes, but is not limited to,*

3. What about:
   a. *Premises open to the public* (ORS 801.400)
      (1) *Any premises open to the general public for the use of motor vehicles, whether the premises are publicly or privately owned and whether or not a fee is charged for the use of the premises.*

   b. Public rights-of-way ..... streets and sidewalks

II. **161.067 Determining punishable offenses for violation of multiple statutory provisions, multiple victims, continuous conduct or repeated violations.** *(1) When the same conduct or criminal episode violates two or more statutory provisions and each provision requires proof of an element that the others do not, there are as many separately punishable offenses as there are separate statutory violations.*

1. Defendant steals and, during apprehension, drops and breaks a small lamp. Can the defendant be charged with both Theft and Criminal Mischief?

(2) When the same conduct or criminal episode, though violating only one statutory provision involves two or more victims, there are as many separately punishable offenses as there are victims.

1. Defendant shoots a gun in the direction of a crowd of about 25 people at a gun show. If defendant had no intent to harm anyone in the crowd, how many charges of Recklessly Endangering Another could you charge?

(3) When the same conduct or criminal episode violates only one statutory provision and involves only one victim, but nevertheless involves repeated violations of the same statutory provision against the same victim, there are as many separately punishable offenses as there are violations, except that each violation, to be separately punishable under this subsection, must be separated from other such violations by a sufficient pause in the defendant's criminal conduct to afford the defendant an opportunity to renounce the criminal intent.

1. Defendant engages in forcible deviate sexual intercourse and sexual intercourse with the victim, falls asleep, wakes up 1 hour later and engages in forcible deviate sexual intercourse, sexual intercourse and deviate sexual intercourse with the victim again. The defendant can be charged with how many Rape and how many Sodomy charges?

I. **161.085 Definitions with respect to culpability.**

A. (7) "**Intentionally**" or "**with intent**," *when used with respect to a result or to conduct described by a statute defining an offense, means that a person acts with a conscious objective to cause the result or to engage in the conduct so described.*

1. Will you need to investigate until direct evidence of culpability is found such as a statement by the defendant before the defendant can be charged with an intentional crime or can you rely on circumstantial evidence?

2. What does a person's conduct tell us about their culpability?

B. (8) "**Knowingly**" or "**with knowledge**," *when used with respect to conduct or to a circumstance described by a statute defining an offense, means that a person acts with an awareness that the conduct of the person is of a nature so described or that a circumstance so described exists.*

C. (9) **"Recklessly,"** *when used with respect to a result or to a circumstance described by a statute defining an offense, means that a person is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur or that the circumstance exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation.*

D. (10) **"Criminal negligence"** or **"criminally negligent,"** *when used with respect to a result or to a circumstance described by a statute defining an offense, means that a person fails to be aware of a substantial and unjustifiable risk that the result will occur or that the circumstance exists. The risk must be of such nature and degree that the failure to be aware of it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation.*

II. **161.125 Intoxication as defense.**
(1) The use of drugs or controlled substances, dependence on drugs or controlled substances or voluntary intoxication shall not, as such, constitute a defense to a criminal charge, but in any prosecution for an offense, evidence that the defendant used drugs or controlled substances, or was dependent on drugs or controlled substances, or was intoxicated may be offered by the defendant whenever it is relevant to negative an element of the crime charged.
(2) When recklessness establishes an element of the offense, if the defendant, due to the use of drugs or controlled substances, dependence on drugs or controlled substances or voluntary intoxication, is unaware of a risk of which the defendant would have been aware had the defendant been not intoxicated, not using drugs or controlled substances, or not dependent on drugs or controlled substances, such unawareness is immaterial.

III. **161.150 Criminal liability described.** *A person is guilty of a crime if it is committed by the person's own conduct or by the conduct of another for which the person is criminally liable, or both.*

IV. **161.155 Criminal liability for conduct of another.** *A person is criminally liable for the conduct of another person constituting a crime if:*

A. *(1) The person is made criminally liable by the statute defining the crime; or*

B. *(2) With the intent to promote or facilitate the commission of the crime the person:*

1. *(a) Solicits or commands such other person to commit the crime; or*

2. *(b) Aids or abets or agrees or attempts to aid or abet such other person in planning or committing the crime; or*

a. *Aids or abets* is not defined by the statutes so what does it include?

b. What are some examples of aiding or abetting?

c. When does a witness become an aider or abetter?

d. What about presence at the scene of the crime?

(1) Meth lab?

e. How much acting in concert or collusion between the parties does it take?

f. Once the least degree of concert or collusion is shown, what does the aider and abetter get charged with?

g. When must the aiding and abetting occur?

3. (c) *Having a legal duty to prevent the commission of the crime, fails to make an effort the person is legally required to make.* What are some examples of these types of liability?

C. So if there are no sections here that relate to "accessories after the fact," how does the criminal code deal with that type of behavior?

V. **161.160 Defense to criminal liability for conduct of another.** *In any prosecution for a crime in which criminal liability is based upon the conduct of another person pursuant to ORS 161.155,* ***it is no defense*** *that:*

A. *(1) Such other person has not been prosecuted for or convicted of any crime based upon the conduct in question or has been convicted of a different crime or degree of crime; or*

B. *(2) The crime, as defined, can be committed only by a particular class or classes of persons to which the defendant does not belong, and the defendant is for that reason legally incapable of committing the crime in an individual capacity.*

1. What would be an example of this?.

VI. **161.405 "Attempt" described.** *(1) A person is guilty of an attempt to commit a crime when the person intentionally engages in conduct which constitutes a substantial step toward commission of the crime.*

A. What happens to the crime penalty classification when an attempt is charged.?

B. What about attempting a crime that has only a reckless culpable mental state?

C. What is a "substantial step?"

D. What two factors must be present to constitute a "substantial step?"

E. The following examples are not insufficient as a matter of law (to establish a substantial step) if strongly corroborative of the actors criminal purpose:
   1. Lying in wait, searching for or following the contemplated victim of the crime;
   2. Enticing or seeking to entice the contemplated victim of the crime to go to the place contemplated for its commission;
   3. Reconnoitering the place contemplated for the commission of the crime;
   4. Unlawful entry of a structure, vehicle or enclosure in which it is contemplated that the crime will be committed;
   5. Possession of materials to be employed in the commission of the crime, which are specially designed for such unlawful use or which can serve no lawful purpose of the actor under the circumstances;
   6. Possession, collection or fabrication of materials to be employed in the commission of the crime, at or near the place contemplated for its commission, where such possession, collection or fabrication serves no lawful purpose of the actor under the circumstances;
   7. Solicitation an innocent agent to engage in conduct constituting an element of the crime. *1971 Criminal code commentary, Walters*, 311 Or 80 (1991)

F. Examples:?

VII. **161.425 Impossibility not a defense.** *In a prosecution for an attempt, it is no defense that it was impossible to commit the crime which was the object of the attempt where the conduct engaged in by the actor would be a crime if the circumstances were as the actor believed them to be.*

A. If impossibility is no defense to an attempt, then what are we punishing the defendant for?

B. What are the three types of impossibilities?

1.

2.

3.

VIII. **161.430 Renunciation as a defense to attempt.** *(1) A person is not liable under ORS 161.405 if, under circumstances manifesting a voluntary and complete renunciation of the criminal intent of the person,* ***the person avoids the commission of the crime attempted by abandoning the criminal effort and, if mere abandonment is insufficient to accomplish this avoidance, doing everything necessary to prevent the commission of the attempted crime.***

A. What does this "voluntary and complete" mean?

1. What about wanting to wait until another day to commit the crime?

2. What about deciding that the crime as planned is too difficult?

3. What about being scared-off because you think someone is watching you?

4. What about being talked out of it by a friend who convinces the defendant that going to jail is not worth the crime?

IX. **161.435 "Solicitation" described.** *(1) A person commits the crime of solicitation if with the intent of causing another to engage in specific conduct constituting a crime punishable as a felony or as a Class A misdemeanor or an attempt to commit such felony or Class A misdemeanor the person commands or solicits such other person to engage in that conduct.*

A. Notice the limited Classes of crimes that are covered.

B. What about the penalty for this crime (solicitation)?

C. What happens if you try to solicit another but your letter is sent to the police department instead and the person to be solicited never gets solicited?

D. How is this different from the *request or command* section we discussed relating to parties to crime?

E. *with the intent of causing another to engage in specific conduct constituting a crime* ..... This would not include such statements or solicitations such as "go out and revolt" or " if you ever see a police officer, you must not let them get you." Why?

1. But, does the solicitation need to be specific enough to align with a particular level of crime such as Theft I, Theft II or Theft III?

X. **161.440 Renunciation as defense to solicitation.** *(1) It is a defense to the crime of solicitation that the person soliciting the crime, after soliciting another person to commit a crime,* ***persuaded the person solicited not to commit the crime or otherwise prevented the commission of the crime,*** *under circumstances manifesting a complete and voluntary renunciation of the criminal intent.*

A. What about the "complete and voluntary" here?

XI. **161.450 "Conspiracy" described.** *(1) A person is guilty of criminal conspiracy if with the intent that conduct constituting a crime punishable as a felony or a Class A misdemeanor be performed, the person agrees with one or more persons to engage in or cause the performance of such conduct.*

A. *agrees with one or more persons*

B. Why is "conspiracy" often referred-to as a continuing crime?

C. Doesn't there have to be at least one overt act in furtherance of the criminal venture for the conspiracy to be complete?

XII. **161.460 Renunciation as defense to conspiracy**. *(1) It is a defense to a charge of conspiracy that the actor, after conspiring to commit a crime,* ***thwarted***

***commission of the crime which was the object of the conspiracy**, under circumstances manifesting a complete and voluntary renunciation of the criminal purpose of the actor. Renunciation by one conspirator does not, however, affect the liability of another conspirator who does not join in the renunciation of the conspiratorial objective.*

XIII. **161.475 Defenses to solicitation and conspiracy.**

A. *(1) Except as provided in subsection (2) of this section, **it is immaterial** to the liability of a person who solicits or conspires with another to commit a crime that:*

(a) The person or the person whom the person solicits or with whom the person conspires does not occupy a particular position or have a particular characteristic which is an element of such crime, if the person believes that one of them does; or

(b) The person whom the person solicits or with whom the person conspires is irresponsible or has an immunity to prosecution or conviction for the commission of the crime, or, in the case of conspiracy, has feigned the agreement; or

(c) The person with whom the person conspires has not been prosecuted for or convicted of the conspiracy or a crime based upon the conduct in question, or has previously been acquitted.

B. *(2) **It is a defense** to a charge of solicitation or conspiracy to commit a crime that if the criminal object were achieved, the actor would not be guilty of a crime under the law defining the offense or as an accomplice under ORS 161.150 to 161.165.*

1. Such as a statutory rape case as it relates to the victim?

XIV. **161.485 Multiple convictions barred in inchoate crimes.**

A. *(2) A person shall not be convicted of more than one offense defined by ORS 161.405, 161.435 and 161.450 for conduct designed to commit or to culminate in commission of the same crime.*

1. So can a person be convicted of both soliciting the co-conspirator and conspiracy (Solicitation and Conspiracy)?

2. Why do some people get charged with both?

B. *(3) A person shall not be convicted on the basis of the same course of conduct of both the actual commission of an offense and an attempt to*

commit that offense or solicitation of that offense or conspiracy to commit that offense.

1. So can a person be convicted of both Theft II & Attempted Theft II?

XV. **161.505 "Offense" described.** *An offense is conduct for which a sentence to a term of imprisonment or to a fine is provided by any law of this state or by any law or ordinance of a political subdivision of this state. An offense is either a crime or a violation or an infraction.*

XVI. **161.515 "Crime" described.** *(1) A crime is an offense for which a sentence of imprisonment is authorized. (2) A crime is either a felony or a misdemeanor.*

XVII. **161.525 "Felony" described.** *Except as provided in ORS 161.585 and 161.705, a crime is a felony if it is so designated in any statute of this state or if a person convicted under a statute of this state may be sentenced to a maximum term of imprisonment of more than one year.*

XVIII. **161.535 Classification of felonies.** *(1) Felonies are classified for the purpose of sentence into the following categories:*

(a) Class A felonies;
(b) Class B felonies;
(c) Class C felonies; and
(d) Unclassified felonies.

An offense defined outside this code which, because of the express sentence provided is within the definition of ORS 161.525, ***shall be considered an unclassified felony.***

XIX. **161.545 "Misdemeanor" described.** *A crime is a misdemeanor if it is so designated in any statute of this state or if a person convicted thereof may be sentenced to a maximum term of imprisonment of not more than one year.*

XX. **161.555 Classification of misdemeanors**. *(1) Misdemeanors are classified for the purpose of sentence into the following categories:*

(a) Class A misdemeanors;
(b) Class B misdemeanors;
(c) Class C misdemeanors; and
(d) Unclassified misdemeanors.

(2) (...) An offense defined outside this code which, because of the express sentence provided is within the definition of ORS 161.545, ***shall be considered an unclassified misdemeanor.***

(3) An offense defined by a statute of this state, but without specification as to its classification or as to the penalty authorized upon conviction, shall be considered a Class A misdemeanor.

XXI. **161.565 "Violation" described; misdemeanor treated as violation.** *(1) An offense is a violation if:*

(a) The offense is so designated in the statute defining the offense;

(b) The statute prescribing the penalty for the offense provides that the offense is punishable only by a fine, forfeiture, fine and forfeiture or other civil penalty; or

(c) The offense is declared to be a violation for purposes of the particular case, as provided in subsection (2) of this section.

(2) Upon the date scheduled for the first appearance of the defendant upon any misdemeanor charge, other than a misdemeanor created under ORS 811.540 and 813.010, the district attorney may declare on the record the intention whether to treat the offense in the case as a violation. The case shall proceed as a misdemeanor unless the district attorney affirmatively states that the case shall proceed as a violation.

A. ***153.805. Trial of violation; burden of proof; disclosure; affidavit as testimony.***

1. *The trial of any violation is by the court without a jury.*
2. *The state, municipality or political subdivision has the burden of proving the alleged violation by a preponderance of the evidence.*
3. *The pretrial discovery rules in ORS 135.805 to 135.873 apply to violation cases.*
4. *The defendant may not be required to be a witness in the trial of any violation.*
5. *Notwithstanding any other provision of law, a court, in any trial of a violation, may admit the affidavit of any witness into evidence as testimony in lieu of taking the testimony orally and in court. The authority granted under this subsection is subject to all of the following:*
   a. *In order to allow testimony to be presented by affidavit in the manner provided by this subsection, a court must adopt rules allowing for the testimony and providing procedures for use of the testimony.*
   b. *A court shall allow testimony by affidavit under this subsection only upon the written signed waiver of the defendant of the right to have the testimony presented orally in court.*

c. *A court may allow testimony by affidavit under this subsection with respect to any matter including, but not limited to, matters described in ORS 40.460.*

d. *Nothing in this subsection requires the defendant or any other witness to waive the right to appear if other testimony is taken by affidavit as provided in this subsection.*

B. ***153.808. Defense counsel not provided; appearance of district attorney.***

1. *At any trial involving a violation only, the defendant shall not be provided with defense counsel at public expense.*
2. *At any trial involving a violation only, the district attorney may aid in preparing evidence and obtaining witnesses but shall not appear, except upon good cause shown to the court, unless counsel for the defendant appears. The court shall insure that the district attorney is given timely notice if defense counsel is to appear at trial.*

XXII. **161.605 Maximum prison terms for felonies.** *The maximum term of an indeterminate sentence of imprisonment for a felony is as follows:*

(1) For a Class A felony, 20 years.
(2) For a Class B felony, 10 years.
(3) For a Class C felony, 5 years.
(4) For an unclassified felony as provided in the statute defining the crime.

XXIII. **161.615 Prison terms for misdemeanors.** *Sentences for misdemeanors shall be for a definite term. The court shall fix the term of imprisonment within the following maximum limitations:*

(1) For a Class A misdemeanor, 1 year.
(2) For a Class B misdemeanor, 6 months.
(3) For a Class C misdemeanor, 30 days.
(4) For an unclassified misdemeanor, as provided in the statute defining the crime.

XXIV. **161.625 Fines for felonies.** *(1) A sentence to pay a fine for a felony shall be a sentence to pay an amount, fixed by the court, not exceeding:*

(a) $300,000 for a Class A felony.
(b) $200,000 for a Class B felony.
(c) $100,000 for a Class C felony.
(2) A sentence to pay a fine for an unclassified felony shall be a sentence to pay an amount, fixed by the court, as provided in the statute defining the crime.

XXV. **161.635 Fines for misdemeanors and violations.** *(1) A sentence to pay a fine for a misdemeanor shall be a sentence to pay an amount, fixed by the court, not exceeding:*

(a) $5,000 for a Class A misdemeanor.

(b) $2,000 for a Class B misdemeanor.

(c) $1,000 for a Class C misdemeanor.

(2) A sentence to pay a fine for an unclassified misdemeanor shall be a sentence to pay an amount, fixed by the court, as provided in the statute defining the crime.

(3) Except as provided in subsection (4) of this section, a sentence to pay a fine for a violation shall be a sentence to pay an amount, fixed by the court, not exceeding $250.

1. Aren't there some statutory fines for violations that are potentially greater than $250?

Chapter 166

XXVI. **166.015 Riot.** *(1) A person commits the crime of riot if while participating with five or more other persons the person engages in tumultuous and violent conduct and thereby intentionally or recklessly creates a grave risk of causing public alarm.*

A. *Participating with* ..... "It must be shown that the rioters were involved in a common disorder; it is not enough to show that numerous individuals were engaged in similar unrelated activities.

1. What about mere presence without taking part by word or deed?

B. *"Public alarm"* ..... means:

C. What is the most difficult investigative aspect of a riot?

XXVII. **166.025 Disorderly conduct.**

(1) A person commits the crime of disorderly conduct if, with intent to cause public inconvenience, annoyance or alarm, or recklessly creating a risk thereof, the person:

(a) Engages in fighting or in violent, tumultuous or threatening behavior; or

(b) Makes unreasonable noise; or
(c) Disturbs any lawful assembly of persons without lawful authority; or
(d) Obstructs vehicular or pedestrian traffic on a public way; or
(e) Congregates with other persons in a public place and refuses to comply with a lawful order of the police to disperse; or
(f) Initiates or circulates a report, knowing it to be false, concerning an alleged or impending fire, explosion, crime, catastrophe or other emergency; or
(g) Created a hazardous or physically offensive condition by any act which the person is not licensed or privileged to do.

A. Note the difference between the two culpable mental states. Which would be easier to gather evidence for?

B. How many people must be present so as to constitute "public"?
   1. The courts have recently ruled that no members of the public need to be called as witnesses to establish the public nature of the offense.

   2. What evidence is then needed at a minimum to establish a case for Disorderly Conduct?

   3. What if citizens are present as witnesses and are willing to testify?

   4. Does the act need to be committed on public property like a public street, sidewalk or park?

C. *(a) Engages in fighting or in violent, tumultuous or threatening behavior*

   1. "Threatening behavior" means:

      a. What about threatening statements?

   2. How does self defense become involved in a "fighting" investigation?

      a. Arrive at a fist fight in the Mall or inside a tavern. Do we arrest all the fighters, especially the ones on top, and charge them with Disorderly Conduct?

b. How do you investigate these types of calls? By the time you arrive the fight has already begun.

D. *(b) Makes unreasonable noise*
1. How does "free speech" become an issue in an investigation under this subsection?

E. *(c) Disturbs any lawful assembly of persons without lawful authority*
1. How does "free speech" become an issue in an investigation under this subsection?

F. *(d) Obstructs vehicular or pedestrian traffic on a public way*
1. What are "public ways"?

G. *(e) Congregates with other persons in a public place and refuses to comply with a lawful order of the police to disperse;*
1. *Congregates* (...) and ...what does that do to your investigation?

2. "Lawful order" ... who does that need to come from?

H. *(g) Created a hazardous or physically offensive condition by any act which the person is not licensed or privileged to do.*
1. Public urination? ....
2. Public exposure of anus? ....
3. Public exposure of female breasts? ...
4. Throwing a firecracker in a crowded theater?.....
5. A smelly (physically offensive) person? ...

XXVIII. **166.065 Harassment.**

(1) A person commits the crime of harassment if the person intentionally:

(a) Harasses or annoys another person by:

(A) Subjecting such other person to offensive physical contact; or

(B) Publicly insulting such other person by abusive words or gestures in a manner intended and likely to provoke a violent response;

(b) Subjects another to alarm by conveying a false report, known by the conveyor to be false, concerning death or serious physical injury to a person, which report reasonably would be expected to cause alarm; or

(c) Subjects another to alarm by conveying a telephonic or written threat

to inflict serious physical injury on that person or to commit a felony involving the person or property of that person or any member of that person's family, which threat reasonably would be expected to cause alarm.

(2) A person is criminally liable for harassment if the person knowingly permits any telephone under the person's control to be used in violation of subsection (1) of this section.

(3) Harassment is a Class B misdemeanor.

(4) Notwithstanding subsection (3) of this section, harassment is a Class A misdemeanor if a person violates subsection (1) of this section by subjecting another person to offensive physical contact and the offensive physical contact consists of touching the sexual or other intimate parts of the other person.

A. *(a) Harasses or annoys another person by: (A) Subjecting such other person to offensive physical contact; or*

1. Does it need to be both an offensive physical contact and found annoying by the victim?

2. Is the entire crime dependent upon the subjective reaction of your victim?

3. Does the offensive physical contact need be to the skin of the victim?

4. What about a closed fist slug to the face that does not amount to an Assault IV?

5. What does case law say about "by **causing** her (victim) to place her mouth on a dog's (genitals)?"

B. *(b) Subjects another to alarm by conveying a false report, known by the conveyor to be false, concerning death or serious physical injury to a person, which report reasonably would be expected to cause alarm; or*

C. *(c) Subjects another to **alarm** by conveying a telephonic or written **threat** to inflict serious physical injury on that person or to commit a felony involving the person or property of that person or any member of that person's family, **which threat reasonably would be expected to cause alarm.***

1. In either (b) or *(c)* above, what if the complainant is not alarmed?
2. Telephonic or written
   a. What if the threat is in person?

3. Threat of serious physical injury or felony

4. Threat reasonably expected to cause alarm

   a. Do we need to prove that the defendant intended to do the act that caused the alarm in order to prove that the threat would have reasonably been expected to cause alarm?
   b. Victim says "no possibility of a bomb going off because I knew it was Jeff, knew he was behind bars, and I knew he couldn't have planted a bomb." What effect does such a statement by the victim have on this charge?

D. *person knowingly permits any telephone under the person's control to be used in violation of subsection (1) of this section.*

XXIX. **166.075 Abuse of venerated objects.**
(1) A person commits the crime of abuse of venerated objects if the person intentionally abuses a public monument or structure, a place of worship or the national or state flag.
(2) As used in this section and ORS 166.085, "abuse" means to deface, damage, defile or otherwise physically mistreat in a manner likely to outrage public sensibilities.

A. What about expressive acts (those that are a substitute for speech) like burning a flag at a rally?

XXX. **166.076 Abuse of a memorial to the dead.**
(1) A person commits the crime of abuse of a memorial to the dead if the person intentionally:
(a) Destroys, mutilates, defaces, injures or removes any:
(A) Tomb, monument, gravestone or other structure or thing placed as or designed for a memorial to the dead; or
(B) Fence, railing, curb or other thing intended for the protection or for the ornamentation of any structure or thing listed in subparagraph (A) of this paragraph; or

(b) Destroys, mutilates, removes, cuts, breaks or injures any tree, shrub or plant within any structure listed in paragraph (a) of this subsection.

A. May also constitute another crime .... any ideas?

XXXI. **166.085 Abuse of corpse in the second degree.**

(1) A person commits the crime of abuse of corpse in the second degree if, except as otherwise authorized by law, the person intentionally:

(a) Abuses a corpse; or

(b) Disinters, removes or carries away a corpse.

(3) As used in this section and ORS 166.087, "abuse of corpse" includes treatment of a corpse by any person in a manner not recognized by generally accepted standards of the community or treatment by a professional person in a manner not generally accepted as suitable practice by other members of the profession, as may be defined by rules applicable to the profession.

XXXII. **166.087 Abuse of corpse in the first degree.**

(1) A person commits the crime of abuse of corpse in the first degree if the person:

(a) Engages in sexual activity with a corpse or involving a corpse; or

(b) Dismembers, mutilates, cuts or strikes a corpse.

XXXIII. **166.090 Telephonic harassment.**

(1) A telephone caller commits the crime of telephonic harassment if the caller intentionally harasses or annoys another person:

(a) By causing the telephone of the other person to ring, such caller having no communicative purpose; or

(b) By causing such other person's telephone to ring and causing such other person to answer it, knowing that the caller has been forbidden from so doing by a person exercising lawful authority over the receiving telephone.

A. *intentionally harasses or annoys*

1. What about our victim that is unaffected by the caller?

B. *By causing the telephone of the other person to ring, such caller having no communicative purpose*

1. What types of calls are these?

2. What about a person who calls and wants to talk to the victim about the condition of the victim's sexual organs?
   a. Violate this section?
   b. Violate the harassment section?

3. What about the person who calls "for entertainment"?

C. *By causing such other person's telephone to ring and causing such other person to answer it, knowing that the caller has been forbidden from so doing by a person exercising lawful authority over the receiving telephone.*
   1. What about a person who just keeps calling to talk to your kids and you want it stopped?
   2. Bill collectors?
   3. How would you advise the reception secretary at the Lloyd Center administrative offices to handle future calls by a person who was calling to ask about her sexual practices?
      a. Who must tell the suspect not to call back?

   4. What about:
      a. Answering machines;
      b. Viewing caller ID; or
      c. Someone else answering the phone for the victim?

XXXIV. **166.115 Interfering with public transportation.**

(1) A person commits the crime of interfering with public transportation if, with intent to harass, annoy or alarm, the person subjects the operator of any bus to offensive physical contact when the bus is operated by or under contract to any public body in order to provide public transportation.
(2) As used in this section, "public body" means the state, any city, county or special district, or any other political subdivision or municipal or public corporation.

A. *with intent to harass, annoy or alarm*
   1. What about our victim that is unaffected by the actor?

B. *to offensive physical contact*

C. *when the bus is operated ..... in order to provide public transportation.*

1. Bus being test driven by the mechanic at the repair yard?
2. Football player urinates into a zip-lock sandwich bag and throws it forward onto the bus driver on a trip from Roseburg to Portland for a playoff game.
   a. What would it be?

XXXV. **166.155 Intimidation in the second degree.**

(1) A person commits the crime of intimidation in the second degree if the person:

(a) Tampers or interferes with property, having no right to do so nor reasonable ground to believe that the person has such right, with the intent to cause substantial inconvenience to another because of the person's perception of the other's race, color, religion, national origin or sexual orientation;

(b) Intentionally subjects another to offensive physical contact because of the person's perception of the other's race, color, religion, national origin or sexual orientation; or

(c) Intentionally, because of the person's perception of race, color, religion, national origin or sexual orientation of another or of a member of the other's family, subjects such other person to alarm by threatening:

(A) To inflict serious physical injury upon or to commit a felony affecting such other person, or a member of the person's family; or

(B) To cause substantial damage to the property of the other person or of a member of the other person's family.

(2) Intimidation in the second degree is a Class A misdemeanor.

(3) For purposes of this section:

(a) "Property" means any tangible personal property or real property.

(b) "Sexual orientation" means heterosexuality, homosexuality or bisexuality.

A. *because of the person's perception*

1. Do we have to prove that the person's perception or belief was correct?

2. How much of a role must the unlawful motivation play?

B. *race, color, religion, national origin or sexual orientation*

1. What about sex, marital status, physical or mental handicap or age?

C. *Tampers or interferes with property, having no right to do so nor reasonable ground to believe that the person has such right, with the intent to cause substantial inconvenience to another because of the person's perception of the other's race, color, religion, national origin or sexual orientation*

1. *Tampers or interferes with property*

2. *with the intent to cause substantial inconvenience*
   a. Letting the air out of the victims tires because of race?
   b. Writing a hate message on the complainants sidewalk in chalk?
   c. Breaking into a church and destroying the worship area with an axe because of religious bias?

D. *Intentionally subjects another to offensive physical contact because of the person's perception of the other's race, color, religion, national origin or sexual orientation*

1. What if contact with sexual or intimate part?

E. *Intentionally, because of the person's perception of race, color, religion, national origin or sexual orientation of another or of a member of the other's family, subjects such other person to alarm by threatening:*
(A) To inflict serious physical injury upon or to commit a felony affecting such other person, or a member of the person's family; ***or***
(B) To cause substantial damage to the property of the other person or of a member of the other person's family.

1. How is this section different from the Harassment "threats" section?

2. Is this any other crime we have studied?

XXXVI. **166.165 Intimidation in the first degree.**

(1) Two or more persons acting together commit the crime of intimidation in the first degree, if the persons:

(a)...

(A)Intentionally, knowingly, or recklessly cause physical injury to another person because of the actors' perception of that person's race, color, religion, national origin or sexual orientation; or

(B) With criminal negligence cause physical injury to another person by means of a deadly weapon because of the actors' perception of that person's race, color, religion, national origin or sexual orientation;

(b) Intentionally, because of the actors' perception of another person's race, color, religion, national origin or sexual orientation, place another person in fear of imminent serious physical injury; or

(c) Commit such acts as would constitute the crime of intimidation in the second degree, if undertaken by one person acting alone.

(2) Intimidation in the first degree is a Class C felony.

(3) "Sexual orientation" has the meaning given that term in ORS 166.155.

A. *Two or more persons acting together*

1. What about a serious bigoted Assault IV done by one person?

2. Must both persons must act with the requisite intent?

3. Does this crime punish beliefs?

B. *Intentionally, knowingly, or recklessly cause physical injury to another person*

1. This crime is .....

C. *With criminal negligence cause physical injury to another person by means of a deadly weapon*

1. This crime is .....

D. *Intentionally..... place another person in fear of imminent serious physical injury*

1. How is this different from Menacing?

a. **163.190. Menacing.** (1) A person commits the crime of menacing if by word or conduct the person intentionally attempts to place another person in fear of imminent serious physical injury.

E. *Commit such acts as would constitute the crime of **intimidation in the second degree**, if undertaken by one person acting alone.*

XXXVII. **181.550 (1) (c) Bias crime reporting requirement.**

A. *Agencies shall report statistics concerning crimes motivated by prejudice based upon the victim's perceived:*

1. *Race*
2. *Color*
3. *Religion*
4. *National origin*
5. *Sexual orientation*
6. *Marital status*
7. *Political affiliation or belief*
8. *Activity in or on behalf of or against a labor organization*
9. *Physical or mental handicap*
10. *Age*
11. *Economic or social status*
12. *Citizenship*

a. How do you participate in reporting this type of behavior?

b. There will be test question(s) on this material.

XXXVIII. **166.180 Negligently wounding another.** *Any person who, as a result of failure to use ordinary care under the circumstances, wounds any other person with a bullet or shot from any firearm, or with an arrow from any bow, shall be punished by imprisonment in the county jail for a period not to exceed six months, or by a fine not to exceed $500, or both.*

A. See Assault IV....differences?

1. **163.160. Assault in the fourth degree.**

(1) A person commits the crime of assault in the fourth degree if the person:

(a) Intentionally, knowingly or recklessly causes physical injury to another; or

(b) With criminal negligence causes physical injury to another by means of a deadly weapon.

XXXIX. **166.190 Pointing firearm at another**. *Any person over the age of 12 years who, with or without malice, purposely points or aims any loaded or empty pistol, gun, revolver or other firearm, at or toward any other person*

within range of the firearm, except in self-defense, shall be fined upon conviction in any sum not less than $10 nor more than $500, or be imprisoned in the county jail not less than 10 days nor more than six months, or both.

A. "Toward" means:

B. How does this differ from Menacing?

1. **163.190. Menacing.** (1) A person commits the crime of menacing if by word or conduct the person intentionally attempts to place another person in fear of imminent serious physical injury.

XL. **166.210 Definitions.** *As used in ORS 166.250 to 166.270, 166.280, 166.291 to 166.295 and 166.410 to 166.470:*
(1) "Antique firearm" (.....)
(2) "Firearm" means a weapon, by whatever name known, which is designed to expel a projectile by the action of powder and which is readily capable of use as a weapon.
(3) "Firearms silencer" means any device for silencing, muffling or diminishing the report of a firearm.
(4) "Handgun" means any conventional pistol or revolver using a fixed cartridge containing a propellant charge, primer and projectile, and designed to be aimed or fired otherwise than from the shoulder and which fires a single shot for each pressure on the trigger device.
(5) "Machine gun" means a weapon of any description by whatever name known, loaded or unloaded, which is designed or modified to allow two or more shots to be fired by a single pressure on the trigger device.
(6) "Minor" means a person under 18 years of age.
(7) "Parole and probation officer" has the meaning given that term in ORS 181.610.
(8) "Short-barreled rifle" means a rifle having one or more barrels less than 16 inches in length and any weapon made from a rifle if the weapon has an overall length of less than 26 inches.
(9) "Short-barreled shotgun" means a shotgun having one or more barrels less than 18 inches in length and any weapon made from a shotgun if the weapon has an overall length of less than 26 inches.

A. *"Firearm" means a weapon, by whatever name known, which is designed to expel a projectile by the action of powder and which is readily* ***capable of use as a weapon.***

1. Does the gun need to be loaded?

2. Does the gun need to be shown as operable?

3. Police reports should include:
   a.
   b.
   c.

XLI. **166.220 Unlawful use of weapon.**

(1) A person commits the crime of unlawful use of a weapon if the person:

(a) Attempts to use unlawfully against another, or carries or possesses with intent to use unlawfully against another, any dangerous or deadly weapon as defined in ORS 161.015; or

(b) Intentionally discharges a firearm, blowgun, bow and arrow, crossbow or explosive device within the city limits of any city or within residential areas within urban growth boundaries at or in the direction of any person, building, structure or vehicle within the range of the weapon without having legal authority for such discharge.

(2) This section does not apply to:

(.....)

A. *Attempts to use unlawfully against another, or carries or possesses with intent to use unlawfully against another, any dangerous or deadly weapon.*
   1. *Attempts to use* ..... what will that also be?
   2. *Carry or possess with the intent to use* .... ***against another.***

      a. What about a baseball bat under the front seat ..... for protection?

      b. What about a suspect who gets tire chains ... brings them back to the altercation?

   3. *Unlawfully*
      a. What about carrying a weapon to use against another in self defense?

B. *Intentionally discharges a firearm, blowgun, bow and arrow, crossbow or explosive device within the city limits of any city at or in the direction of any person, building, structure or vehicle within the range of the weapon without having legal authority for such discharge.*

1. What about discharge within the City of Portland.

2. Straight up or into the ground?

XLII. **166.240 Carrying of concealed weapons.** *(1) Except as provided in subsection (2) of this section, any person who carries concealed upon the person any knife having a blade that projects or swings into position by force of a spring or by centrifugal force and commonly known as a switchblade knife, any dirk, dagger, ice pick, slung shot, metal knuckles, or any similar instrument by the use of which injury could be inflicted upon the person or property of any other person, commits a Class B misdemeanor.*

A. *carries concealed upon the person*
   1. "Carries" means:

   2. "Concealed" means:

   3. "Upon the person" means:

B. *any knife having a blade that projects or swings into position by force of a spring or by centrifugal force and commonly known as a switchblade knife, any dirk, dagger, ice pick, slung shot, metal knuckles,*
   1. ***And*** *commonly known*....what does that mean?

   2. What are dirks and daggers?

   3. Why are ice picks included and not ice tongs?

   4. What are metal knuckles?

   5. What if it is a defensive weapon or the person says they only carry it for defensive purposes?

C. *any similar instrument by the use of which injury could be inflicted upon the person or property of any other person*

1. *Similar* means:

2. What about weapons not listed that are designed and intended as a weapon to inflict bodily injury or death?

D. Is a person found carrying a handgun concealed upon the person charged with Carrying a Concealed Weapon?

E. What about carrying these items concealed in your own home?

F. What about a switchblade or dagger carried in a sheath on the belt?

XLIII. **166.250 Unlawful possession of firearms.**

(1) Except as otherwise provided in this section, ORS 166.260, 166.270, 166.274, 166.280, 166.291, 166.292 or 166.410 to 166.470, a person commits the crime of unlawful possession of a firearm if the person knowingly:

(a) Carries any firearm concealed upon the person, without having a license to carry the firearm as provided in ORS 166.291 and 166.292;

(b) Carries concealed and readily accessible to the person within any vehicle which is under the person's control or direction any handgun, without having a license to carry such firearm as provided in ORS 166.291 and 166.292; or

(c) Possesses a firearm and:

(A) Is under 18 years of age;

(B)(I) While a minor, was found to be within the jurisdiction of the juvenile court for having committed an act which, if committed by an adult, would constitute a felony or a misdemeanor involving violence, as defined in ORS 166.470; and

(ii) Was discharged from the jurisdiction of the juvenile court within four years prior to being charged under this section;

(.....)

(2) This section does not prohibit:

(a) A minor, who is not otherwise prohibited under subsection (1)(c) of this section, from possessing a firearm:

(A) Other than a handgun, if the firearm was transferred to the minor by the minor's parent or guardian or by another person with the consent of the minor's parent or guardian; or

(B) Temporarily for hunting, target practice or any other lawful purpose; or

(b) Any citizen of the United States over the age of 18 years who resides in or is temporarily sojourning within this state, and who is not within the excepted classes prescribed by ORS 166.270

and subsection (1) of this section, from owning, possessing or keeping within the person's place of residence or place of business any handgun, and no permit or license to purchase, own, possess or keep any such firearm at the person's place of residence or place of business is required of any such citizen. As used in this subsection, "residence" includes a recreational vessel or recreational vehicle while used, for whatever period of time, as residential quarters.

(3) Firearms carried openly in belt holsters are not concealed within the meaning of this section.

A. *Knowingly ..... carries any firearm concealed upon the person, without having a license to carry the firearm*

1. All firearms or just handguns?

    a. What about loaded and operable?

2. "Concealed upon the person" means:

3. Where are these permits valid?

B. *Knowingly ..... carries concealed and readily accessible to the person within any vehicle which is under the person's control or direction any handgun, without having a license to carry such firearm*

1. "Concealed and readily accessible" means:

2. *Under his control and direction*

    a. What about the passenger who puts the gun under the seat?

    b. What if the owner was in the car riding as a passenger and a gun was found in the glove box....Who all would you charge?

C. *Possesses a firearm and: ..... (A) Is under 18 years of age;*

1. But, watch the limited exceptions.

    a. *A minor, who is not otherwise prohibited under subsection (1)(c)*...(B) &*(C)*

(1) "Other than a handgun....."

(2) "Temporarily....."

D. Can a person carry a concealed gun in his or her own residence?

E. *Firearms carried openly in belt holsters are not concealed within the meaning of this section.*
   1. Why is this section here?

XLIV. **166.270 Certain felons forbidden to possess firearms.**
(1) Any person who has been convicted of a felony under the law of this state or any other state, or who has been convicted of a felony under the laws of the Government of the United States, who owns or has in the person's possession or under the person's custody or control any firearm, commits the crime of felon in possession of a firearm.
(2) Any person who has been convicted of a felony under the law of this state or any other state, or who has been convicted of a felony under the laws of the Government of the United States, who owns or has in the person's possession or under the person's custody or control any instrument or weapon having a blade that projects or swings into position by force of a spring or by centrifugal force and commonly known as a switchblade knife, or any instrument or weapon commonly known as a blackjack, slung shot, sandclub, sandbag, sap glove or metal knuckles, or who carries a dirk, dagger or stiletto, commits the crime of felon in possession of a restricted weapon.
(3) For the purposes of this section, a person "has been convicted of a felony" if, at the time of conviction for an offense, that offense was a felony under the law of the jurisdiction in which it was committed. Provided, however, that such conviction shall not be deemed a conviction of a felony if:
(a) The court declared the conviction to be a misdemeanor at the time of judgment; or
(b) The offense was for possession of marijuana and the conviction was prior to January 1, 1972.
(4) Subsection (1) of this section shall not apply to any person who has been:
(a) Convicted of only one felony under the law of this state or any other state, or who has been convicted of only one felony under the laws of the United States, which felony did not involve criminal homicide, as defined in ORS 163.005, or the possession or use of a firearm or switchblade knife, and who has been discharged from imprisonment, parole or probation for said offense for a period of 15 years prior to the date of alleged violation of subsection (1) of this section; or

(b) Granted relief from the disability under 18 U.S.C. s 925© or has had the person's record expunged under the laws of this state or equivalent laws of another jurisdiction.

A. *who owns or has in the person's possession or under the person's custody or control*
   1. "Possession" means:

B. *any firearm*

C. *any instrument or weapon having a blade that projects or swings into position by force of a spring or by centrifugal force and commonly known as a switchblade knife, or any instrument or weapon commonly known as a blackjack, slung shot, sandclub, sandbag, sap glove or metal knuckles*
   1. How has this section been affected by recent case law?

   2. Are there any other sections that we have studied that may have the same issues?

D. *or who carries a dirk, dagger or stiletto*
   1. We know about the first two, what about "stiletto"?

E. *Convicted of a felony*
   1. Does the suspect need to have served any time in jail or what about a person who serves a short county jail term as a condition of probation on a felony?

   2. Does this charge require that the state prove that defendant "knew" that he or she was a "felon?"

   3. What about the defendant who is on or successfully has completed probation?

   4. Under some circumstances, a felony can be reduced to a misdemeanor after the person has successfully completed parole or probation....What effect?

F. The Omnibus Consolidated Appropriations Act of 1997, which amends the Gun Control Act of 1968 (eff. Sept. 30, 1996) requires that all persons who are convicted of misdemeanor domestic violence must surrender any firearms and ammunition. Felony, 10 years and/or $250,000 fine.

1. **How does this effect police officers?**

2. DV crime is defined as *use or attempted use of physical force or the threatened use of a deadly weapon.*
3. DV relationship: committed by:
   a. Spouse or former spouse
   b. Parent or guardian of the victim
   c. By a person with whom the victim shares a child
   d. By a person who is living with or has lived with the victim as a spouse, parent or guardian.
4. Remember, this is federal law and the definitions relating to domestic violence listed here are not the same as domestic violence definitions that you will use for purposes of mandatory arrests under Oregon law.

XLV. **166.272 Unlawful possession of machine guns, certain short-barreled firearms and firearms silencers.** *(1) A person commits the crime of unlawful possession of a machine gun, short-barreled rifle, short-barreled shotgun or firearms silencer if the person knowingly possesses any machine gun, short-barreled rifle, short-barreled shotgun or firearms silencer not registered as required under federal law.*
(2) Unlawful possession of a machine gun, short-barreled rifle, short barreled shotgun or firearms silencer is a Class B felony.
(3) A peace officer may not arrest or charge a person for violating subsection (1) of this section if the person has in the person's immediate possession documentation showing that the machine gun, short-barreled rifle, short barreled shotgun or firearms silencer is registered as required under federal law.
(4) It is an affirmative defense to a charge of violating subsection (1) of this section that the machine gun, short-barreled rifle, short barreled shotgun or firearms silencer was registered as required under federal law.

A. Remember "knowingly possess"

B. Does the state need to show that defendant knew that he/she possessed the gun and that defendant knew it was not properly registered?

XLVI. **166.350 Unlawful possession of armor piercing ammunition.** *(1) A person commits the crime of unlawful possession of armor piercing ammunition if the person:*

(a) Makes, sells, buys or possesses any handgun ammunition the bullet or projectile of which is coated with Teflon or any chemical compound with properties similar to Teflon and which is intended to penetrate soft body armor, such person having the

intent that the ammunition be used in the commission of a felony; or

(b) Carries any ammunition described in paragraph (a) of this subsection while committing any felony during which the person or any accomplice of the person is armed with a firearm.

(2) As used in this section, "handgun ammunition" means ammunition principally for use in pistols or revolvers notwithstanding that the ammunition can be used in some rifles.

A. *such person* ***having the intent*** *that the ammunition be used in the commission of a* felony, or

B. *while committing any felony*

XLVII. **166.360 Definitions** for ORS 166.360 to 166.380. *As used in ORS 166.360 to 166.380, unless the context requires otherwise:*

(1) "Capitol building" means the Capitol, the Supreme Court Building, the State Office Building, the State Library Building, the Labor and Industries Building, the State Transportation Building, the Agriculture Building or the Public Service Building and includes any new buildings which may be constructed on the same grounds as an addition to the group of buildings listed in this subsection.

*(***)*

(3) "Public building" means a hospital, capitol building, a public or private school, college or university, a county courthouse, a city hall or the residence of any state official elected by the state at large, and the grounds adjacent to each such building. The term also includes that portion of any other building occupied by an agency of the state or a municipal corporation, as defined in ORS 297.405.

A. Subsection (A) seems to be all Salem

B. *and the grounds adjacent to each such building*

C. *also includes that portion of any other building occupied by an agency of the state or a municipal corporation*

1. City buildings but does it include the "grounds adjacent to" those buildings?

XLVIII. **166.370 Possession of firearm or dangerous weapon in public building; exceptions; discharging firearm at school.**

(1) Any person who intentionally possesses a loaded or unloaded firearm or any other instrument used as a dangerous weapon, while in or on a public building, shall upon conviction be guilty of a Class C felony.

(2) Subsection (1) of this section does not apply to:

(a) A sheriff, police officer, other duly appointed peace officers or a corrections officer while acting within the scope of employment.
(b) A person summoned by a peace officer to assist in making an arrest or preserving the peace, while the summoned person is engaged in assisting the officer.
(c) A member of the military forces of this state or the United States, when engaged in the performance of duty.
(d) ***A person who is licensed under ORS 166.291 and 166.292 to carry a concealed handgun.***
(e) A person who is authorized by the officer or agency that controls the public building to possess a firearm in that public building.
(f) ***Possession of a firearm on school property if the firearm:***
(A) Is possessed by a person who is not otherwise prohibited from possessing the firearm; and
(B) Is unloaded and locked in a motor vehicle.

(3)(a) Any person who knowingly, or with reckless disregard for the safety of another, discharges or attempts to discharge a firearm at a place that the person knows is a school shall upon conviction be guilty of a Class C felony.

(***)

(4) Notwithstanding the provisions of subsection (2)(d) of this section, a person who is licensed under ORS 166.291 and 166.292 to carry a concealed handgun may not possess a firearm in a courtroom, jury room, judge's chambers or the areas adjacent thereto that the presiding judge determines should be free of firearms to insure the safety of the litigants, court personnel, witnesses and others.

(***)

(7) As used in this section, "dangerous weapon" means a dangerous weapon as that term is defined in ORS 161.015.

A. *any other instrument used as a dangerous weapon*
   1. What does this mean?

B. Note the persons not affected by subsection (1)
C. *knowingly, or with reckless disregard for the safety of another, discharges or attempts to discharge a firearm at a place that the person knows is a school*
   1. `Who would be guilty of this subsection and not guilty of subsection (1)?. ..... Both are Class C felonies

XLIX. **166.649 Throwing an object off an overpass in the second degree.**
(1) A person commits the crime of throwing an object off an overpass in the second degree if the person:
(a) With criminal negligence throws an object off an overpass; and

(b) Knows, or reasonably should have known, that the object was of a type or size to cause damage to any person or vehicle that the object might hit.

*(* * *)*

(3) As used in this section and ORS 166.651, "overpass " means a structure carrying a roadway or pedestrian pathway over a roadway.

L. **166.651 Throwing an object off an overpass in the first degree.**

(1) A person commits the crime of throwing an object off an overpass in the first degree if the person:

(a) Recklessly throws an object off an overpass; and

(b) Knows, or reasonably should have known, that the object was of a type or size to cause damage to any person or vehicle that the object might hit.

A. *Recklessly throws an object off an overpass*

1. Almost impossible to think of a situation where a throwing would occur and it not be at least reckless.
   a. What is "reckless" again?

B. *Knows, or reasonably should have known, that the object was of a type or size to cause damage to any person or vehicle that the object might hit.*

1. Does there have to be a victim or someone endangered by the object?

C. *a structure carrying a roadway or pedestrian pathway* ***over a roadway***

1. Roadway is not defined ..... so .....what does it include?
2. Bikepath?
3. Railroad?
4. River?
5. Park?

CHAPTER 162

I. PERJURY AND RELATED OFFENSES

Applicable Definitions:

1. "Benefit" means gain or advantage to the beneficiary or to a third person pursuant to the desire or consent of the beneficiary.

2. "Material" means that which could have affected the course or outcome of any proceeding or transaction. Whether a false statement is material in a given factual situation is a question of law.

NOTE: For a false statement to be "material" it must be one that could influence the course or outcome of the proceeding or transaction. The issue generally is whether the alleged falsification was material to a central issue in the proceeding.

QUESTION: Why are the elements of a crime considered "material issues" in a criminal case?

3. "Statement" means any representation of fact and includes a representation of opinion, belief or other state of mind where the representation clearly relates to state of mind apart from or in addition to any facts which are the subject of the representation.

4. "Sworn Statement" means any statement knowingly given under any form of oath or affirmation attesting to the truth of what is stated.

5. "Transaction" has been defined as including "all that takes place in the conducting of any item of business or an affair."

A. PERJURY - ORS 162.065

Definition: A person commits the crime of perjury if the person makes a false sworn statement in regard to a material issue, knowing it to be false.

Defining cases:

State v. Hayes: Defendant was asked in his sex abuse trial whether he had ever been "mean" to his grand children. He answered: "I've never been mean to any of my kids or grand kids." The state then called 4 grand children to testify that he had abused them all. The court found that the prosecuting attorney failed to be sufficiently specific when he asked the defendant if

he had ever been mean. A perjury prosecution may not be based on an inference that a defendant meant one thing when he said another.

State v. Park: Defendant applied for a diversion for a recent DUII citation. His affidavit indicated that he did not have any prior DUII or driving related homicides. The defendant had a prior criminally negligent homicide conviction.

QUESTION: Can a sworn affidavit form the basis for a perjury charge? Yes ____ No ____

State v. Romero: Defendant falsified his name and date of birth on an affidavit of indigency in order to qualify for a court appointed attorney. Issue = Was his falsification material to his case? A false statement need not actually affect a proceeding or transaction in order to be material. It is enough that the statements could have affected its course or outcome.

QUESTION: What makes an affidavit a sworn statement?

State v. Carr: Defendant lied in an affidavit. Affidavits are notarized with sufficient formality to impress on the person the seriousness of his/her act.

State v. Real: Defendant is stopped by an officer who discovers marijuana, heroin and cocaine. At the scene, the defendant tells the officer that the drugs belong to him. At trial, however, the defendant tells the jury that the drugs did not belong to him. QUESTION: Can a perjury conviction be based solely on the contradictory statement of a single witness?
Yes ____ No ____

In any prosecution for perjury or false swearing, the falsity of a statement may not be established solely through contradiction by the testimony of a single witness. Corroboration is required.

QUESTION: How much corroboration is required?

QUESTION: What if the officer had the defendant's fingerprints on the container holding the drugs? Could the state prove perjury?
Yes ____ No ____

QUESTION: What if the prosecution offered statements from the defendant's friends implicating the defendant along with the officers testimony. Could the state prove perjury?
Yes ____ No ____

QUESTION: What if the friend who testified was a co-defendant?

Could the officer's testimony along with the co-defendant's establish perjury?
Yes ____ No ____

QUESTION: What if the officer smelled marijuana in the car in addition to having the defendant's confession that the marijuana belonged to him. Are the officer's olfactory talents sufficient corroboration for a perjury conviction?
Yes ____ No ____

B. FALSE SWEARING - ORS 162.075

Definition: A person commits the crime of false swearing if the person makes a false sworn statement knowing it to be false.

QUESTION: What distinguishes perjury from false swearing?

C. UNSWORN FALSIFICATION - ORS 162.085

Definition: A person commits the crime of unsworn falsification if the person knowingly makes any false written statement to a public servant in connection with an application for any benefit.

QUESTION: What distinguishes false swearing from unsworn falsification.

IT IS NO DEFENSE TO THE ABOVE CRIMES THAT:

1. The statement was inadmissible under the rules of evidence;

2. The oath or affirmation was taken or administered in an irregular manner; or

3. The defendant mistakenly believed the false statement to be immaterial.

D. RETRACTION AS A DEFENSE: It is a defense to a prosecution for perjury or false swearing committed in an official proceeding that the defendant retracted the false statement:

1. In a manner showing a complete and voluntary retraction of the prior false statement; and

2. During the course of the same official proceeding in which it was made; and

3. Before the subject matter of the official proceeding is

submitted to the ultimate trier of fact.

QUESTION: Will a defendant be able to assert that the oath given was given in an irregular manner in his defense for the crime of perjury? Yes ____ No ____

QUESTION: Defendant lied on the witness stand about a material fact. He retracts the lie after the jury has begun to deliberate in the jury room. Has the defendant committed perjury?
Yes ____ No ____

II. ESCAPE

DEFINITIONS:

1. "CUSTODY" = The imposition of actual or constructive restraint by a peace officer pursuant to an arrest or court order, but does not include detention in a correctional facility or state hospital.

2. "CORRECTIONAL FACILITY" = Any place used for the confinement of persons charged with or convicted of a crime or otherwise confined under a court order and includes but is not limited to a juvenile facility. "Correctional facility" applies to a state hospital only as to persons detained therein charged with or convicted of a crime, or detained therein after acquittal of a crime by reason of mental disease or defect.

3. "ESCAPE" = The unlawful departure of a person from custody or a correctional facility. "Escape" includes the unauthorized departure or absence from this state or failure to return to this state by a person who is under the jurisdiction of the Psychiatric Security Review Board. "Escape" does not include failure to comply with provisions of conditional release.

NOTE: Conditional release is release pending trial generally through a release program which monitors a defendant's behavior and whereabouts.

4. "UNAUTHORIZED DEPARTURE" = Means the unauthorized departure of a person confined by court order in a juvenile facility or a state hospital that, because of the nature of the court order, is not a correctional facility, or the failure to return to custody after any form of temporary release or transitional leave from a correctional facility.

A. ESCAPE I - ORS 162.165

Definition: A person commits escape I if:

1. Aided by another person actually present, the person uses or threatens to use physical force in escaping from custody or

a correctional facility; or

2. The person uses or threatens to use a dangerous weapon escaping from custody.

B. ESCAPE II - ORS 162.155

Definition: A person commits escape II when:

1. Using or threatening to use force escaping from custody; or

2. Having been convicted or found guilty of a felony, the person escapes from custody imposed as a result thereof; or

3. The person escapes from a correctional facility; or

4. While under the supervision of the PSRB, the person departs, is absent from or fails to return to this state without authorization of the board.

QUESTION: When escaping from prison Harry threatened the guard with a razor blade. What crime did Harry commit?

QUESTION: Defendant departs from his home during a court ordered home detention program imposed as a sentence for Assault III. Did he commit the crime of Escape II?
Yes _____ No _____

QUESTION: Defendant violated conditions of pre-trial release by not staying home. Did he commit the crime of Escape II?
Yes _____ No _____ Explain your answer:

C. ESCAPE III - ORS 162.145

Definition: A person commits escape in the third degree when s/he escapes from custody.

QUESTION: Define "custody"

QUESTION: An officer approaches suspect to engage in mere conversation. The suspect flees from the officer. Has the suspect committed Escape III? Yes _____ No _____
Explain your answer:

DEFENSE: It is a defense to a prosecution of Escape III if the person escaping or attempting to escape was in custody pursuant to an illegal arrest.

QUESTION: A defendant escapes from an officer who is taking him to detox for minor in possession of alcohol. Has the defendant committed Escape III? Yes ____ No ____
Explain your answer:

E. UNAUTHORIZED DEPARTURE - ORS 162.175

Definition: A person commits unauthorized departure if:

1. The person makes an unauthorized departure; or

2. Not being an inmate therein, the person aids another in making or attempting to make an unauthorized departure.

QUESTION: Define what unauthorized departure means and how it differs from Escape II.

CASES DEFINING ESCAPE

1. State v. Esmond: Defendant's departure from his home during a court ordered home detention program constituted Escape II. A defendant who is sentenced to constructive custody at his home commits Escape II if he leaves the home without the permission of his probation officer.

2. State v. Schaffer: Court is faced with jail overcrowding so the court orders defendant who is released from jail to report to the courtroom every day from 8 until 5 to serve his sentence. Defendant's failure to appear for his courtroom confinement imposed due to lack of jail space constituted Escape II because the court had declared the courtroom a correctional facility.

3. State v. Wilde: Defendant violated conditions of pre-trial release by not staying home. This did not amount to an escape because it related to "pre-trial release" rather than court ordered confinement after sentencing.

4. State v. McCauley: Defendant who had just been convicted of murder escaped from court guards and was missing for 2 days. Defendant's custody status was a result of the jury's verdict so it didn't matter that the court had not yet sentenced the defendant to custody. (McCauley was already in custody during the trial)

5. State v. McVay: Defendant was M.I.P. When the officer tried to take the defendant to detox, the defendant ran. Custody must be restraint pursuant to authority to arrest. Officer was not authorized to "arrest" for a violation so the defendant was not in custody when he fled.

6. State v. Langley: Defendant was in a "transitional program"

at OSH which allowed him to live in a cottage on OSH grounds. He had a pass to leave the grounds but was gone beyond the time period. He killed 2 people. Defendant who is in the custody of a correctional facility but who is not physically confined there is otherwise in custody.

III. OBSTRUCTING GOVERNMENTAL OR JUDICIAL ADMINISTRATION - ORS 162.235

Definition: A person commits the crime of obstructing governmental or judicial administration if the person intentionally obstructs, impairs or hinders the administration of law or other governmental or judicial function by means of intimidation, force, physical or economic interference or obstacle.

Caselaw:

State v. Matilla: A civil officer attempted to serve an eviction notice. The defendant refused to open the door to accept the notice. Officers arrived. The defendant threatened to shoot them. He placed a crutch up against the door to prevent entry into the home. Once inside the home the officers found an M-1 rifle in the defendant's bedroom.

NOTE: This charge does not apply to situations where the governmental or judicial action is unlawful.

IV. REFUSING TO ASSIST A POLICE OFFICER 162.245

Definition: A person commits this crime if upon command by a person known by the person to be a peace officer the person unreasonably refuses or fails to assist in effecting an authorized arrest or preventing another from committing a crime.

QUESTION: Officer, who is attempting to arrest a combative defendant, asks a passerby to assist him in making an arrest. The passerby refuses. Has he committed the crime of refusing to assist a police officer? Yes ____ No ____
Explain your answer:

NOTE: The key words in the refusing to assist statute are: "unreasonably refuses."

V. INTERFERING WITH A PEACE OFFICER

Definition: A person commits the crime of Interfering with a Peace Officer if the person, knowing that another person is a peace officer:

(1) Intentionally acts in a manner that prevents, or attempts to prevent, a peace officer from performing the lawful duties of the peace officer with regards to another person; or

(2) Refuses to obey a lawful order by the peace officer.

VI. TAMPERING WITH A WITNESS - ORS 162.285

Definition: A person commits the crime of tampering with a witness if:

A. The person knowingly induces or attempts to induce a witness or a person the person believes may be called as a witness in any official proceeding to offer false testimony or unlawfully withhold any testimony; or

B. The person knowingly induces or attempts to induce a witness to be absent from any official proceeding to which the person has been legally summoned.

QUESTION: What does induce mean in this statute. Does it require payment of money?

Definitions:

"Official Proceeding" = any proceeding before any judicial, legislative or administrative body or officer, wherein sworn statements are received, and includes any referee, hearing examiner, commissioner, notary or other person taking sworn statements in connection with such proceedings.

"Testimony" = oral or written statements that may be offered by a witness in an official proceeding.

QUESTION: If a defendant induces his friend to lie at grand jury concerning charges against the defendant, has he committed the crime of Tampering with a Witness? Yes ____ No ____

Caselaw:

State v. Wagner: The defendant was charged with sex abuse. The defendant induced his children and wife to leave the court's jurisdiction before they were served for trial. QUESTION: Can the state prove Tampering with a Witness given these facts?
Yes ____ No ____

NOTE: In order to be considered a witness in an official proceeding, the witness must be personally served for the proceeding.

QUESTION: The defendant induces his friend to leave the jurisdiction to avoid testifying in defendant's trial. The friend is aware of the proceeding because his daughter was given the

subpoena by the process server. The friend fails to appear for trial. Can the state prove Tampering with a Witness given these facts? Yes ____ No ____

Personal service requires that the witness be served in person.

VII. TAMPERING WITH PHYSICAL EVIDENCE - 162.295

Definition: A person commits the crime of tampering with physical evidence if, with intent that it be used, introduced, rejected or unavailable in an official proceeding which is then pending or to the knowledge of such person is about to be instituted, the person:

a. Destroys, mutilates, alters, conceals or removes physical evidence impairing its verity or availability; or

b. Knowingly makes, produces or offers any false physical evidence; or

c. Prevents the production of physical evidence by an act of force, intimidation or deception against any person

"PHYSICAL EVIDENCE" = Any article, object, record, document or other evidence of physical substance.

QUESTIONS: Does the proceeding have to be pending in order to establish the crime?

What if a forensic scientist for the defense recklessly destroys a piece of evidence that was intended for use in a trial. Do these facts establish tampering with physical evidence? If so, why. If not, why not.

VIII. RESISTING ARREST - ORS 162.315

Definition: A person commits the crime of resist arrest if the person intentionally resists a person known by the person to be a peace officer in making an arrest.

"Resist," as used in this section, means the use or threatened use of violence, physical force or any other means that creates a substantial risk of physical injury to any person and includes behavior clearly intended to prevent being taken into custody by overcoming the actions of the arresting officer. The behavior does not have to result in actual physical injury to the arresting officer. Passive resistance does not constitute behavior intended to prevent being taken into custody.

IT IS NOT A DEFENSE to resist arrest under this section that the peace officer lacked legal authority to make the arrest,

provided the peace officer was acting under color of official authority.

QUESTION: If a defendant does not "resist" when initially arrested, but later kicks at and hits an officer at the garage at the justice center, has the defendant committed the crime of resisting arrest?
Yes ____ No ____

Caselaw: State v. Bolden: "Arrest" means the entire course of events during which an officer effectuates and maintains custody over the arrestee.

QUESTION: Must an officer receive injuries in order for the state to prove resisting arrest? Yes ____ No ____

QUESTION: Officers perform an illegal stop and entry into a motor vehicle which contain methamphetamine. The defendant resists arrest when the officers take him into custody. The judge throws out the evidence of methamphetamine possession based on the exculsionary rule. Is the resist arrest charge a viable charge once the underlying charge for the arrest is dismissed?
Yes ____ No ____

Caselaw: State v. Janicke: The court refused to extend the exclusionary rule to evidence of crimes committed against officers during what turned out to be an illegal stop/entry.

QUESTION: Does a defendant commit the crime of Resist Arrest when the only person he puts at risk of physical injury is himself?
Yes ____ No ____

Caselaw: State v. Allison: Defendant clutched the steering wheel of his car while officers attempted to arrest him. During this time, his car was running, he was intoxicated and he grabbed the officer's radio and placed it down his pants. Once out of the car he dug his heels into the ground as he was taken to the squad car. Resist arrest statute covers situations where there is a "substantial risk of physical injury to ANY PERSON, including the defendant.

QUESTION: Should the comparative size of the defendant and the arresting officer be considered when evaluating whether a defendant can be prosecuted for resist arrest?
Yes ____ No ____ Why or why not?

QUESTION: Defendant is arrested for trespassing during an anti-abortion protest. She refuses to place her hands behind her back to be cuffed. Additionally, she refuses to walk to the police vehicle, causing the arresting officers to carry her to the

vehicle. Has she committed resist arrest?
Yes ____ No ____

QUESTION: 5'4" defendant is arrested by 6'4", 300 lb. officer. She refuses to be cuffed. She pulls away at one point. She screams loudly at the arresting officer, causing her brother to come to the officer and intervene in the arrest. Has the defendant committed the crime of resist arrest?
Yes ____ No ____

Caselaw: State v. Hutchison: Defendant wrestled and scuffled and attempted to get away from the arresting officer. His wife also intervened. Passive resistance and nonviolent flight is not sufficient to prove resisting arrest; however, defendant's size (he was a big guy) and the fact that his wife began to assist him in the struggle was sufficient for purposes of the statute.

State v. Hassan: Diminutive size of the defendant, 5'4", compared to the 300 lb, 6'4" officer resulted in the court finding that the victim did not directly create a substantial risk of physical injury to the officer; however, the defendant's actions incited her brothers to join in the struggle. Actions which cause 3rd parties to present a substantial risk of physical injury are sufficient to find someone guilty of resist arrest.

QUESTION: Is a defendant justified in resisting arrest if the arresting officer uses excessive force in making the arrest?
Yes ____ No ____

Caselaw: State v. Wright: The defendant in this case suffered from a dislocated shoulder and extensive nerve damage as a result of the arrest. A doctor testified that the injuries could only be caused by excessive force. A defendant's resistance to arrest is justified if the officer uses excessive force in making the arrest. Note: The prosecuting attorney in this case should have questioned the officer extensively about whether the officer believed that he had to use such force in order to effect the arrest. The court should have looked to the necessity of the use of force under the circumstances.

QUESTION: Does a defendant need to be told that he is under arrest in order to prove resist arrest?

Caselaw: State v. Toelaer: Defendant's knowledge that the officer is making an arrest is not relevant.

IX. HINDERING PROSECUTION - ORS 162.325

Definition: A person commits the crime of hindering prosecution if, with intent to hinder the apprehension, prosecution, conviction or punishment of a person who has committed a crime punishable as a felony, or with the intent to assist a

person who has committed a crime punishable as a felony in profiting or benefiting from the commission of the crime, the person:

a. Harbors or conceals such person; or

b. Warns such person of impending discovery or apprehension; or

c. Provides or aids in providing such person with money, transportation, weapon, disguise or other means of avoiding discovery or apprehension; or

d. Prevents or obstructs, by means of force, intimidation or deception, anyone from performing an act which might aid in the discovery or apprehension of such person; or

e. Suppresses by any act of concealment, alteration or destruction physical evidence which might aid in the discovery or apprehension of such person; or

f. Aids such person in securing or protecting the proceeds of the crime.

X. COMPOUNDING A FELONY - ORS 162.335

Definition: A person commits this crime if the person accepts or agrees to accept any pecuniary benefit as consideration for refraining from reporting to law enforcement authorities the commission or suspected commission of any felony or information relating to a felony.

QUESTION: In Hindering and Compounding a Felony cases, does it matter that the principal offender is not apprehended, prosecuted, convicted or punished?

Yes ____ No ____

XI. CRIMINAL IMPERSONATION - ORS 162.365

Definition: A person commits the crime of criminal impersonation if with intent to obtain a benefit or to injure or defraud another the person falsely impersonates a public servant and does an act is\n such assumed character.

XII. CRIMINAL IMPERSONATION OF A PEACE OFFICER - ORS 162.367

Definition: A person commits the crime of criminal impersonation of a peace officer if the person uses false law enforcement identification in the commission of an offense.

"False Law Enforcement Identification" means a badge or an identification card that identifies the possessor of the badge or the card as a member of law enforcement and was not lawfully issued to the possessor by the law enforcement unit.

XIII. POSSESSION OF A FALSE LAW ENFORCEMENT I.D. CARD - ORS 162.369

Definition: See above definition of false law enforcement i.d.

XIV. INITIATING A FALSE REPORT - ORS 162.375

Definition: A person commits this crime when s/he knowingly initiates a false alarm or report which is transmitted to a fire department, law enforcement agency or other organization that deals with emergencies involving danger to life or property.

QUESTION: If a person reports a rape to 911 and the accused denies the rape and passes a polygraph, can the state prove that the alleged victim initiated a false report?
Yes ____ No ____

QUESTION: What level of proof is required to show that someone has made a false report?

QUESTION: Should the state consider filing initiating a false report charge against a victim if the witness's statements at trial are not convincing and the state loses the trial.
Yes ____ No ____

XV. GIVING FALSE INFORMATION FOR A CITATION - ORS 162. 385

Definition: A person commits this crime if s/he knowingly uses or gives a false or fictitious name, address or date of birth to any peace officer for the purpose of the officer's issuing or serving the person a citation.

QUESTION: Defendant is placed into custody for transportation to the Multnomah County Detention Center where he is to be lodged for the crime of Rape I. He knowingly provides a false name to the arresting officer. Has the defendant committed the crime of giving false information for a citation? Yes ____ No ____
Explain your answer:

XVI. OFFICIAL MISCONDUCT IN THE FIRST DEGREE - ORS 162. 415

Definition: A public servant commits the crime of official misconduct in the first degree if with intent to obtain a benefit or to harm another:

a. The public servant knowingly fails to perform a duty imposed upon the public servant by law or one clearly inherent in the nature of officer; or

b. The public servant knowingly performs an act constituting an unauthorized exercise in official duties.

QUESTION: Give an example of unauthorized exercise in official duties:

QUESTION: Can a third party, other than the public servant, be the recipient of the "benefit" in Official Misconduct cases?

Yes _____ No _____

XVII. OFFICIAL MISCONDUCT IN THE SECOND DEGREE - ORS 162. 405

Definition: A public servant commits the crime of official misconduct in the second degree if the person knowingly violates any statute relating to the office of the person.

CHAPTER 163

I. CULPABLE MENTAL STATE

A. Requirement of Culpability:

1. The minimal requirement of criminal liability is the performance by a person of conduct which includes a voluntary act or the omission to perform an act which the person is capable of performing.

2. A person is not guilty of an offense unless the person acts with a culpable mental state with respect to each material element of the offense that necessarily requires a culpable mental state.

B. Lack of Knowledge is Not a Defense:

Knowledge that conduct constitutes an offense, or knowledge of the existence, meaning or application of the statute defining an offense, is not an element of an offense unless the statute clearly so provides (See Sex Offenses)

C. Intoxication as a Defense

1. Evidence of Intoxication can be used to negate intentional and knowing conduct.
2. Evidence of Intoxication cannot be used to negate reckless or negligent conduct.

QUESTION: Does the voluntary use of or dependance on alcohol or drugs excuse criminal conduct given the above defense?

Yes ____ No ____

QUESTION: If a defendant has a .08% blood alcohol level, is s/he legally incapable of forming the intent to commit a crime?

Yes ____ No ____

D. Culpable States of Mind

1. Intentional: A person acts with a conscious objective to cause the result or to engage in the conduct so described.

2. Knowingly: A person acts with an awareness that the conduct of the person is of a nature so described or that a circumstance so described exists.

QUESTION: What type of evidence would you look for in assessing

whether a defendant has intentionally or knowingly committed a crime?

QUESTION: Does a defendant need to admit to intending his criminal conduct in order for the state to prove that he intended to commit a crime?

Yes ____ No ____

QUESTION: What evidence would you want to look at in order to establish that a defendant committed an act intentionally?

QUESTION: Can circumstantial evidence be used to prove intentional or knowing conduct?

____Yes ____NO

3. Reckless With Extreme Indifference to the Value of Human Life: This is not considered a separate culpable mental state from "Recklessly." It is different, however, in that it involves recklessness and conduct which manifests extreme indifference to the value of human life. Put simply, it means a state of mind where an individual cares little about the risk of death of a human being.

Look for this standard in egregious vehicular homicide cases.

4. Reckless: A person is aware of and consciously disregards substantial and unjustifiable risk that the result will occur or that the circumstance exists. The risk must be of such a nature and degree that disregard thereof constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation.

5. Criminal Negligence: A person fails to be aware of a substantial and unjustifiable risk that the result will occur or that the circumstance exists. The risk must be of such a nature and degree that the failure to be aware of it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation.

E. CRIMINAL LIABILITY: A person is criminally liable for the conduct of another person constituting a crime if:

1. The person is made criminally liable by the statute defining the crime; or

2. With the intent to promote or facilitate the commission of the crime the person:

a. Solicits or commands such other person to commit the crime; or

b. Aids and abets or agrees or attempts to aid or abet such other person in planning or committing the crime; or

c. Having a legal duty to prevent the commission of the crime, fails to make an effort the person is legally required to make.

QUESTION: If John stands by and watches his friends kill Eddie and makes no effort to help Eddie, is he responsible for the crime of murder? Yes ____ No ____

QUESTION: Can you think of an example where presence alone at the scene of a crime might result in criminal liability?

II. CRIMINAL HOMICIDE

Definition: A person commits criminal homicide if, without justification or excuse, the person intentionally, knowingly, recklessly or with criminal negligence causes the death of another human being.

Human Being: A person who has been born and was alive at the time of the criminal act.

A. Aggravated Murder - ORS 163.095

1. For Hire - per an agreement that the defendant receive money or something of value.

QUESTION: Must a defendant be in receipt of payment for the murder before s/he can be prosecuted under this statute?
Yes ____ No ____

2. By Soliciting and agreeing to pay a person money or a thing of value to kill another person.

3. Prior Homicide or Manslaughter I Conviction

QUESTION: Must the prior conviction be in the State of Oregon?
Yes ____ No ____

4. Multiple Victims in the same criminal episode

QUESTION: If a defendant kills a woman who is 6 months pregnant, has he committed aggravated murder? Yes ____ No ____

QUESTION: If a defendant kills someone on May 1, 1997 and then another person on May 2, 1997, has he committed aggravated murder?
Yes ____ No ____

5. In the course of maiming or torture

"Torture" = the intentional infliction of intense physical pain upon an unwilling victim as a separate objective apart from the defendant's responsibility for the death of the victim.

QUESTION: If a victim died during the course of a defendant's torturous act, is the defendant guilty of aggravated murder?
Yes ____ No ____ Explain your answer:

6. Victim's Status:
   a. Police Officer
   b. Corrections Official
   c. Judicial Officer
   d. Juror or Witness
   e. Employee or Officer of the Court
   f. Parole Board Member and Post Prison Supervision

NOTE: Aggravated Murder crimes based on the victim's status as a justice system employee require that the murder be related to the performance of the victim's official duties in the justice system.

QUESTION: Defendant is sentenced to 10 years in the penitentiary for Rape. When he gets out he vows to kill the prosecutor who put him away. The prosecutor is at home after a long day at the office when he is slain by the defendant. Has the defendant committed aggravated murder? Yes ____ No ____

   g. Murder in Penal Institution - (includes state, county and municipal facilities)
   h. Murder by Explosive Device

"EXPLOSIVE DEVICE" = a chemical compound, mixture, or device that is commonly used or intended for the purpose of producing a chemical reaction resulting in a substantially instantaneous release of gas and heat, including by not limited to dynamite, blasting powder, nitroglycerin, blasting caps, and nitrojelly, but excluding fireworks, black powder, smokeless powder, small arms ammo., and small ammo. primers.

   i. Murder Committed to Conceal Commission of a Crime

   j. Murder Committed to Conceal I.D. of Perpetrator

   k. Committed After Escape from Penal Institution

   l. Victim of Murder is under the age of 14

   m. Murder Committed in the Course of Commission of One of the Following Crimes or Attempt to Commit One of the Following Crimes:

1. Arson I
2. Criminal Mischief by use of Explosive Device
3. Burglary I
4. Escape I
5. Kidnapping I
6. Kidnapping II
7. Robbery I
8. Any Felony Sexual Offense
9. Compelling Prostitution
10. Assault in 1st Degree or Second Degree if committed intentionally or knowingly against and the victim is under 14.

QUESTION: Can a defendant be convicted of aggravated murder if s/he only attempts to commit one of the above listed 10 crimes and intentionally kills the victim during the attempted commission of that crime? Yes ____ No ____

B. Murder - ORS 163.115

1. Intentional

2. Felony Murder: When committed by a person acting either alone or with one or more persons who commits or attempts to commit any of the following crimes and in the course of and in furtherance of the crime the person is committing or attempting to commit, or during the immediate flight therefrom, the person, or another participant if there be any, causes the death of a person other than one of the participants:

a. Arson I
b. Criminal Mischief by Use of Explosive
c. Burglary I
d. Escape I
e. Kidnapping I
f. Kidnapping II
g. Robbery I
h. Any Felony Sexual Offense
i. Compelling Prostitution
j. Assault in the First or Second Degree if committed knowingly or intentionally and the victim is under the age of 14.

1. Defense to Felony Murder:

A. Defendant was not the only participant in underlying crime; and

B. Defendant did not commit the homicidal act or in any way solicit, request, command, importune, cause or aid in the commission thereof; and

C. Defendant was not armed with a dangerous or deadly weapon; and

D. Defendant had not reasonable ground to believe that any other participant was armed with a dangerous or

deadly weapon; and

F. Defendant had no reasonable ground to believe that any other participant intended to engage in conduct likely to result in death.

QUESTION: Can someone who facilitates a robbery by being the "lookout" also be responsible for felony murder if a co-defendant kills someone during the commission of that robbery? Yes ____ No ____

QUESTION: Assuming the facts in the above question, what if the defendant did not know that his partner was going to kill someone during the robbery. Is he still responsible for murder? Yes ____ No ____

QUESTION: Assuming the facts in the above question, what if the defendant did not know that his partner was going to kill someone during the robbery but he did know that his partner was armed with a handgun. Is he responsible for murder? Yes ____ No ____

C. Murder by Abuse - ORS 163.115 (c): When a person, recklessly under circumstances manifesting extreme indifference to the value of human life, causes the death of a child under 14 years of age or a dependant person, and:

1. The person has previously engaged in a pattern or practice or assault or torture of the victim or another child under 14 years of age or a dependent person; or

2. The person causes the death by neglect or maltreatment.

QUESTION: What is considered a pattern or practice of assault?

QUESTION: How might the state prove a pattern or practice of assault?

"DEPENDENT PERSON" = Means a person who because of either age or physical or mental disability is dependent upon another to provide for the person's physical needs.

AFFIRMATIVE DEFENSE:

3. Affirmative Defense: It is an affirmative defense that the child or dependent person was under care or treatment solely by spiritual means pursuant to the religious beliefs or practices of the child or person or the parent or guardian of the child or person.

D. Manslaughter I - ORS 163.118 : Criminal Homicide constitutes manslaughter in the first degree when:

1. It is committed recklessly under circumstances manifesting extreme indifference to the value of human life; or

LOOK FOR:

a. Driving Under the Influence + Extremely egregious driving/behavior (e.g. speed racing, combative driving, "road rage")

b. Shooting a gun toward people but not intending to kill someone

QUESTION: Define, reckless with extreme indifference to the value of human life:

2. It is committed intentionally by a defendant under the influence of extreme emotional disturbance; or

Extreme Emotional Disturbance reduces Murder to Manslaughter I so long as the following does not exist:

a. The disturbance must not be a result of the suspect's own intentional, knowing, reckless, or criminally negligent act, and there must be a reasonable explanation for the disturbance. The reasonableness of the conduct will be judged by what an ordinary person in the suspect's situation would do.

LOOK FOR: Spouse who encounters spouse having an affair.

EXTREME EMOTIONAL DISTURBANCE IS NOT A DEFENSE TO AGGRAVATED MURDER

QUESTION: Give an example of a murder case that might result in a Manslaughter I conviction based on the defense of Extreme Emotional Disturbance:

Note: E.E.D. is considered an affirmative defense which means that the defense must prove the defense by a preponderance of the evidence.

3. A person recklessly causes the death of a child under 14 years of age or a dependent person, and:

a. The person has previously engaged in a pattern or practice of assault or torture of the victim or another child under 14 years of age or a dependent person; or

b. The person causes the death by neglect or maltreatment.

AFFIRMATIVE DEFENSE: It is an affirmative defense to a charge of violating this section that the child or dependent person was under care or treatment solely by spiritual means pursuant to the religious beliefs or practices of the child or person or the parent or guardian of the child or person.

QUESTION: What state of mind reduces Murder to Manslaughter?

E. Manslaughter II - ORS 163.125

1. Committing a homicide recklessly *(AWARE OF AND CONSCIOUSLY DISREGARDS SUBSTANTIAL AND UNJUSTIFIABLE RISK ----GROSS DEVIATION FROM STANDARD OF CARE)*

LOOK FOR: Intoxication + Bad Driving

2. Intentionally aids another to commit suicide

3. The person, with criminal negligence, causes the death of a child under 14 years of age or a dependent person, and:

a. The person has previously engaged in a pattern or practice of assault or torture of the victim or another child under 14 years of age or a dependent person; or

b. The person causes the death by neglect or maltreatment.

AFFIRMATIVE DEFENSE: It is an affirmative defense to a charge of violating this section that the child or dependent person was under care or treatment solely by spiritual means pursuant to the religious beliefs or practices of the child or person or the parent or guardian of the child or person.

QUESTION: How do Manslaughter I and Manslaughter II differ?

F. Criminally Negligent Homicide - ORS 163.145

Definition: A person commits when, with criminal negligence, the person causes the death of another person.

LOOK FOR: Stupid mistakes. Suspect who fails to check & fix problem with vehicle/machine.

QUESTION: Define Criminal Negligence

QUESTION: What distinguishes criminally negligent homicide from conduct that causes death but is not criminal.

QUESTION: Give an example of each of the following criminal acts:

1. MANSLAUGHTER I:

2. MANSLAUGHTER II:

3. CRIMINALLY NEGLIGENT HOMICIDE:

III. ASSAULT CRIMES

FACTORS WHICH AGGRAVATE THE CRIME OF ASSAULT ARE:

1. THE CULPABLE STATE OF MIND
2. THE USE OF A DEADLY OR DANGEROUS WEAPON
3. THE SEVERITY OF THE INJURY
4. THE STATUS OF THE VICTIM

QUESTION: List the 4 culpable states of mind:

1.

2.

3.

4.

A. Assault I - ORS 163.185

Definition: Intentionally causing serious physical injury to another by means of a deadly or dangerous weapon.

QUESTION: Define deadly weapon:

QUESTION: Define dangerous weapon:

QUESTION: Can any item be considered a dangerous weapon if it is readily capable of causing death or serious physical injury in the manner in which it is used? _____Yes _____No

For example, can pavement be considered a "dangerous weapon?" _____Yes _____No

When can pavement be considered a "dangerous weapon?"

WATCH FOR: The weapon must be readily capable of causing death or serious physical injury under the circumstances in which it is used, attempted to be used, or threatened to be used. Concentrate on the injury that could have resulted, given the manner in which the weapon was used.

The Court of Appeals has stated that any article, "no matter how harmless it may appear when used for its customary purpose becomes a dangerous weapon when used in a manner that renders it capable of causing serious physical injury. " The Court has found cowboy boots, concrete sidewalks and automobiles to be dangerous weapons, but found that tennis shoes were not dangerous weapons.

B. ASSAULT II - ORS 163.175

Definition: Can be committed in the following 3 ways:

1. Intentionally or knowingly causes serious physical injury to another; or

2. Intentionally or knowingly causes physical injury to another by means of a deadly or dangerous weapon; or

3. Recklessly causes serious physical injury to another by means of a deadly or dangerous weapon under circumstances manifesting extreme indifference to the value of human life.

QUESTION: Define serious physical injury:

Define physical injury:

C. Assault III - ORS 163.165

Definition: Can be committed in the following 8 ways:

1. Recklessly causes serious physical injury to another by means of a deadly/dangerous weapon;

2. Recklessly causes serious physical injury to another under circumstances manifesting extreme indifference to the value of human life;

3. Recklessly causes physical injury to another by means of a deadly or dangerous weapon under circumstances manifesting extreme indifference to the value of human life;

4. Intentionally, knowingly or recklessly causes by means other than a motor vehicle, physical injury to the operator or a public transit vehicle while the operator is in control of or operating the vehicle;

5. While being aided by another person actually present, intentionally or knowingly causes physical injury to another person;

6. While committed to a juvenile detention facility, intentionally or knowingly causes physical injury to another knowing the other person is a staff member of a juvenile facility while the person is acting in his/her official capacity.

7. Intentionally, knowingly or recklessly causes physical injury to an emergency medical technician or paramedic while they are performing official duties.

8. Being at least 18 years of age, intentionally or knowingly causes physical injury to a child 10 years of age or younger.

QUESTION: Defendant hits a Tri-met driver after the driver exits the bus. Has the defendant committed Assault in the Third Degree?
Yes ____ No ____

D. Assault IV - ORS 163.160

Definition: Assault IV can be committed in the 3 following ways:

1. Intentionally, knowingly or recklessly causes physical injury to another; or

2. With criminal negligence causes physical injury to another by means of a deadly weapon.

3. Assault IV is a Class C felony if the person commits the crime of assault in the fourth degree and:

a. The person has previously been convicted of assaulting the same victim; or

b. The assault is witnessed by the person's or the victim's minor child or stepchild or a minor child residing within the household of the person or the victim.

QUESTION: Joe and Phil hit Steven causing physical injury to Steven. What crime have Joe and Phil committed?

QUESTION: Joe hits 9 year old Steven. What crime has Joe committed?

QUESTION: Under what circumstances does Assault IV become a felony offense?

E. Assaulting a Public Safety Officer - ORS 163.208

Definition: Same as Assault IV but defendant must know that victim is an officer who is working in his/her official capacity.

F. Menacing - ORS 163.190

Definition: A person commits the crime of menacing if by word or conduct the person intentionally attempts to place another in fear of imminent serious physical injury.

QUESTION: When determining whether the crime of menacing has occurred, should the officer concentrate on whether the victim felt threatened by the defendant or whether the defendant intended to make the victim fearful?
ANSWER:

G. Recklessly Endangering - ORS 163.195

Definition: Recklessly engaging in conduct which creates a substantial risk of serious physical injury to another person.

H. Criminal Mistreatment I - ORS 163.205

Definitions:

Elderly person: means a person 65 or over

Legal duty: includes but is not limited to a duty created by familial relationship, court order, contractual agreement or statutory or case law

Dependant person: means a person who because of either age or a physical or mental disability is dependent upon another to provide for the person's physical needs.

Definition: Criminal Mistreatment I can be committed in the following ways:

1. In violation of a legal duty to provide care for

another person or having assumed the permanent or temporary care, custody or responsibility for the supervision of another person, intentionally or knowingly withholds necessary and adequate food, physical care or medical attention from that other person; or

2. The person, in violation of a legal duty to provide care for a dependent person or elderly person, or having assumed the permanent or temporary care, custody or responsibility for the supervision of a dependent person or elderly person, intentionally or knowingly:

a. Causes physical injury

b. deserts the dependant or elderly person in a place with the intent to abandon that person;

c. leaves the dependent person or elderly person unattended at a place for such a period of time as may be likely to endanger the health or welfare of that person;

QUESTION: How long would the dependant or elderly person have to be left unattended in order to commit this crime?

d. Hides the dependent person's or elderly person's money or property or misappropriates the money/property

e. takes charge of a dependent or elderly person for the purpose of fraud

I. Criminal Mistreatment II - ORS 163.200

Definition: Criminal Mistreatment II can be committed in the 2 following ways:

1. In violation of a legal duty to provide care for another person, the person withholds necessary and adequate food, physical care or medical attention from that person.

2. Having assumed the permanent or temporary care, custody or responsibility for the supervision of another person, the person withhold necessary and adequate food, physical care or medical attention from that person.

QUESTION: How does Criminal Mistreatment I differ from Criminal Mistreatment II?

QUESTION: Emily's infant son has a broken femur but Emily does not have the money to take her son to the hospital. She waits 5 days before she eventually takes her son to the hospital. Has Emily committed a crime. Yes ____ No ____ If so, what crime has Emily committed?

IV. KIDNAPPING AND CUSTODIAL INTERFERENCE

A. Kidnapping II - ORS 163.225

Definition: A person commits Kidnap II if, with intent to interfere substantially with another's personal liberty, and without consent or legal authority, the person:

1. Takes the person from one place to another; or

2. Secretly confines the person in a place where the person is not likely to be found.

DEFENSE TO KIDNAP II: It is a defense to Kidnap II under subsection (1) of this section if:

(a) A person taken or confined is under 16 years of age; and

(b) The defendant is a relative of that person; and

(c) The sole purpose of the person is to assume control of that person.

B. Kidnap I - ORS 163. 235

Definition: A person commits Kidnap I if a person violates the Kidnap II statute with the following purposes:

1. To compel any person to pay or deliver money or property as ransom; or

2. To hold the victim as a shield or hostage; or

3. To cause physical injury to the victim; or

4. To terrorize the victim or another person

WATCH FOR THESE ISSUES:

1. Distance: The distance the victim is taken can be minimal; however, the Ct. of Appeals has determined that pushing the victim across a car seat is not a sufficient distance. However, the court has found that a distance of 55 feet is sufficient. The key inquiry is the defendant's intent to interfere substantially with the victim's personal liberty.

2. Secret Place: A room within the victim's own home can be made into a "secret place" by the efforts of the kidnapper

3. Purpose to Terrorize: Requires proof of intent to fill with terror.

4. Purpose to Cause Physical Injury: Besides the ordinary definition of causing physical injury, the Court of Appeals has

found that one who has the purpose of forcibly raping another has the purpose of causing physical injury.

QUESTION: Kidnapping II requires that a person take another from one place to another without their consent or:

QUESTION: Define "interfere substantially with a person's personal liberty:"

QUESTION: How far must a victim be taken to qualify for the charge of Kidnapping?

QUESTION: If defendant takes the victim to the back bedroom against her will and rapes her there, has he committed Kidnapping in the First Degree? Yes _____ No _____
What information would you want to know about the above case?

C. Custodial Interference II - ORS 163.245

Definition: A person commits if knowing or having reason to know that the person has no legal right to do so, the person takes, entices or keeps another person from the other person's lawful custodian or in violation of a valid joint custody order with intent to hold the other person permanently or for a protracted period.

Definition of "lawful custodian:" A parent, guardian or other person responsible by authority of law for the care, custody or control of another.

QUESTION: Does a mother who takes her infant child from the Children's Services Division where her child had been placed temporarily by the court, commit the crime of Custodial Interference II? Yes _____ No _____

D. CUSTODIAL INTERFERENCE I - ORS 163. 257

Definition: A person commits this crime if they violate the Custodial Interference II statute and also do the following:

1. Causes the person taken, enticed or kept from the lawful custodian or in violation of a valid joint custody order to be removed from the state; or

2. Expose that person to a substantial risk of illness or physical injury.

LOOK FOR: Abductions by a non-custodial parent who takes child across state lines or exposes child to substantial risk of illness or physical injury.

LOOK FOR: Evidence that the defendant intended to hold child for a permanent or protracted period of time. Note: the Court of Appeals has found that a father's removal of a child to another state against the mother's wishes was sufficient to establish that the defendant intended to hold children for a permanent or protracted period of time.

QUESTION: Jim, the non-custodial parent of 3 year old Lily, takes Lily from Oregon to Colorado without the consent of Lily's mother. He keeps her there for a month until the authorities locate Lily. What crime has Jim committed?

QUESTION: Alter the above facts to read that Jim takes Lily from Portland to Forrest Grove Oregon where the authorities eventually located Lily. What crime has Jim committed?

QUESTION: Alter the above facts to read that Jim takes Lily across town to live with him in a house where methamphetamine is produced. What crime has Jim committed?

V. SEXUAL OFFENSES

A. Definitions

1. Deviate Sexual Intercourse: sexual conduct between persons consisting of contact between the sex organs of one person and the mouth or anus of another.

2. Forcible Compulsion: physical force that overcomes earnest resistance; or a threat, express or implied, that places a person in fear of immediate or future death or physical injury to self or another person, or in fear that the person or another person will immediately or in the future be kidnapped.

QUESTION: Give an example of an implied threat.

QUESTION: Define earnest resistance.

3. Mentally Defective: Means that a person suffers from a mental disease or defect that renders the person incapable of appraising the nature of the conduct of the person.

4. Mentally Incapacitated: means that a person is rendered incapable of appraising or controlling the conduct of the person at the time of the alleged offense because of the influence of a controlled or other intoxicating substance administered to the person without the consent of the person or because of any other act committed upon the person without the consent of the person.

5. Physically helpless: means that a person is unconscious or for any other reason is physically unable to communicate unwillingness to an act.

QUESTION: Does this above definition include sleeping?
Yes ____ No ____

6. Sexual Contact: Means any touching of the sexual or other intimate parts of a person or causing such person to touch the sexual or other intimate parts of the actor for the purpose of arousing or gratifying the sexual desire of either party.

QUESTION: Do you think the area between the breasts is considered a sexual or intimate part of the body?
Yes ____ No ____

QUESTION: Are a child's undeveloped breasts an intimate or sexual part of the body?
Yes ____ No ____

7. Sexual Intercourse: has its ordinary meaning and occurs upon any penetration, however slight; emission is not required.

B. Incapacity to Consent:

1. Under 18, or
2. Mentally defective; or
3. Mentally incapacitated; or
4. Physically helpless

C. Ignorance as a Mistake

1. Ignorance is not a defense for crimes in which the criminality of conduct depends on child being less than 16; however,

2. When criminality depends on child being under 18 but over 16, it is an affirmative defense for the defendant to prove

that the defendant reasonably believed the child to be above the specified age.

LOOK FOR:

a. What victim conveyed to suspect about age
b. Victim's school status
c. Victim's work status
d. Information defendant receives from victim's friends.

QUESTION: When is ignorance a defense to a statutory sex crime?

3. If lack of consent is based solely on mentally defective, mentally incapacitated or physically helpless status, it is an affirmative defense for the defendant to prove that at the time of the act, the defendant did not know facts or conditions responsible for victim's incapacity to consent

D. Age as a Defense

1. If victim's lack of consent is due solely to incapacity to consent by reason of being less than the specified age, it is a defense that the actor was less than three years older than the victim at the time of the alleged offense.

2. In Unlawful Sexual Penetration II cases when the object used was the hand or any part thereof of the actor and in which the victim's lack of consent was due solely to incapacity to consent by reason of being less than a specified age, it is a defense that the actor was less than three years older than the victim at the time of the alleged offense.

E. Rape Crimes

1. Rape I - ORS 163.375

Definition: A person who has sexual intercourse with another person commits the crime of rape in the first degree if:

a. The victim is subjected to forcible compulsion by the person.

b. The victim is under 12 years of age;

c. The victim is under 16 years of age and is the person's sibling, of the whole or half blood, the person's child or the person's spouse's child; or

d. The victim is incapable of consent by reason of mental defect, mental incapacitation or physical helplessness.

QUESTION: If an 11 year old girl willingly engages in sexual

intercourse with an 18 year old male, has the 18 year old male committed Rape I? Yes ____ No ____

QUESTION: Does a 9 year old victim have to use earnest resistance during sexual intercourse with a male adult in order for the adult to be responsible for Rape I?

2. Rape II - ORS 163. 365

Definition: A person who has sexual intercourse with another person commits the crime of Rape II if the other person is under 14 years of age.

3. Rape III - ORS 163.355

Definition: A person who has sexual intercourse with another person commits the crime of Rape if the other person is under 16 years of age.

QUESTION: If 15 and 1/2 year old Kala agrees to have sexual intercourse with 18 year old Jim, has Jim committed the crime of Rape III? Yes ____ No ____

F. SODOMY CRIMES

1. SODOMY I - ORS 163.405

Definition: A person who engages in deviate sexual intercourse with another person or causes another to engage in deviate sexual intercourse commits the crime of sodomy in the first degree if:

a. The victim is subjected to forcible compulsion by the actor;

b. The victim is under 12 years of age;

c. The victim is under 16 years of age and is the actor's brother or sister, of the whole or half blood, the son or daughter of the actor or the son or daughter of the actor's spouse; or

d. The victim is incapable of consent by reason of mental defect, mental incapacitation or physical helplessness.

2. Sodomy II - ORS 163. 395

Definition: A person who engages in deviate sexual intercourse with another person or causes another to engage in deviate sexual intercourse commits the crime of sodomy in the second degree if the victim is under 14.

3. Sodomy III - ORS 163. 385

Definition: A person who engages in deviate sexual intercourse with another person or causes another to engage in deviate sexual intercourse commits the crime of sodomy in the third degree if the victim is under 16.

QUESTION: A stepfather sodomizes his 15 year old daughter. What crime has he committed?

QUESTION: Harry slips drugs in Jill's wine. Jill falls fast asleep. Harry then anally sodomizes Jill. What crime did Harry commit?

G. Unlawful Sexual Penetration Crimes

1. Unlawful Sexual Penetration I - 163.411

Definition: A person commits this crime if s/he penetrates the vagina, anus, or penis of another with any object other than the penis or mouth of the actor and:

a. the victim is subjected to forcible compulsion; or

b. the victim is under 12; or

c. The victim is incapable of consent by reason of mental defect, mental incapacitation or physical helplessness.

2. Unlawful Sexual Penetration II - ORS 163.408

Definition: A person commits this crime if s/he penetrates the vagina, anus or penis of another with any object other than the penis or mouth of the actor and the victim is under 14.

NOTE: Unlawful Sexual Penetration crimes do not require that the suspect commit the offense for the purpose of sexual arousal.

EXCEPTIONS TO SEXUAL PENETRATION CRIMES:

a. As part of a medically recognized treatment or diagnostic procedure.

b. Cavity search by law enforcement or medical personnel for contraband.

H. Sexual Abuse

1. SEX ABUSE I - 163.427

Definition: A person commits the crime of sexual abuse in the first degree when the person:

a. Subjects another person to sexual contact and:

1. The victim is less than 14
2. The victim is subject to forcible compulsion
3. The victim is incapable of consent by reason of being mentally defective, mentally incapacitated or physically helpless; or

b. Intentionally causes a person under 18 to touch or contact the mouth, anus or sex organs of an animal for the purpose of arousing or gratifying the sexual desire of a person.

QUESTION: Define sexual contact:

QUESTION: Define "intimate part of the body."

QUESTION: Is an inadvertent touch of an intimate or sexual part of a non-consenting victim's body considered criminal conduct?
Yes _____ No _____

NOTE: The undeveloped breasts of a child are "intimate" parts of the body for purposes of the statute. Touching "intimate" parts of the body through clothing is sufficient for purposes of the statute.

2. Sex Abuse II - ORS 163.425

Definition: A person commits the crime of Sex Abuse II when that person subjects another person to sexual intercourse, deviate sexual intercourse or, penetration of the vagina, anus or penis with any object other than the penis or mouth of the actor and the victim does not consent thereto.

3. Sex Abuse III - ORS 163.415

Definition: A person commits the crime of Sex Abuse III when that person subjects another person to sexual contact and:

a. The victim does not consent to the sexual contact; or

b. The victim is incapable of consent by reason of being under 18 years of age.

I. Contributing to Sexual Delinquency of a Minor - ORS 163.435

Definition: A person 18 years of age or older commits the crime of contributing to the sexual delinquency of a minor if:

a. Being a male, he engages in sexual intercourse with a

female under 18 years of age; or

b. Being a female, she engages in sexual; intercourse with a male under 18 years of age; or

c. The person engages in deviate sexual intercourse\se with another person under 18 years of age or causes that person to engage in deviate sexual intercourse.

J. Sexual Misconduct - ORS 163.445

Definition: A person commits the crime of sexual misconduct if the person engages in sexual intercourse or deviate sexual intercourse with an unmarried person under 18 years of age.

K. Public Indecency - ORS 163. 465

Definition: A person commits the crime of public indecency if while in, or in view of, a public place the person performs:

a. An act of sexual intercourse; or

b. An act of deviate sexual intercourse; or

c. An act of exposing the genitals of the person with the intent of arousing the sexual desire of the person or another person.

QUESTION: 18 year old Frank has sexual intercourse with 15 and a half year old Julie in his '63 VW bug parked in the Washington Park Zoo parking lot at 8:00 p.m. July 4, 1997. Has Frank committed any crime or crimes? If so, name the crime or crimes:

VI. OFFENSES AGAINST FAMILY

A. Definitions

1. Descendant: persons related by descending lineal consanguinity, step-children and lawfully adopted children.

2. Support: includes, but is not limited to, necessary and proper shelter, food, clothing, medical attention and education.

B. Bigamy - 163.515

Definition: Knowingly marrying or purporting to marry another person at a time when either is lawfully married.

C. Incest - 163.525

Definition: A person commits the crime of incest if the person marries or engages in sexual intercourse or deviate sexual intercourse with a person whom the person knows to be related to the person, either legitimately or illegitimately, as an ancestor, descendant or brother or sister of either the whole or half blood.

D. Abandonment of Child - 163.535

Definition: If, being a parent, lawful guardian or other person lawfully charged with the care or custody of a child under 15, the person deserts the child in any place with intent to abandon it.

E. Child Neglect I - ORS 163.547

Definition: A person having custody or control of a child under 16 years of age commits the crime of child neglect in the 1st degree if the person knowingly leaves the child, or allows the child to stay, in a vehicle where controlled substances are being criminally delivered or manufactured for consideration or profit or on premises and in the immediate proximity where controlled substances are criminally delivered or manufactured for consideration or profit.

F. Child Neglect II - ORS 163.545

Definition: A person having custody or control of a child under the age of 10 commits this crime if, with criminal negligence, the person leaves the child unattended in or at any place for such a period of time as may be likely to endanger the health or welfare of such child.

QUESTION: What period of time must a child be left unattended to reach the level of criminal conduct?

G. Endangering Welfare of Minor - ORS 163.575

Definition: Can be committed if person knowingly:

1. Induces, causes or permits an unmarried person under 18 to witness an act of sexual conduct or sadomasochistic abuse; or

2. Permits a person under 18 to enter or remain in a place where unlawful activity involving controlled substances is maintained or conducted; or

3. Induces, causes or permits a person under 18 years of age to participate in gambling; or

4. Distributes, sells, or causes to be sold tobacco in any form to a person under 18 or

5. Sells drug/cigarette smoking paraphernalia

H. FAILING TO SUPERVISE A CHILD - ORS 163.577

Definition: A person commits the offense of failing to supervise a child if the person is the parent, lawful guardian or other person lawfully charged with the care or custody of a child under 15 and the child:

1. violates curfew

2. does something that brings the child within the jurisdiction of juvenile court.

3. fails to attend school

VII. UNUSUAL WEAPONS

A. Unlawful Use of an Electrical Stun Gun, Tear Gas or Mace I ORS 163.213

Definition: A person commits the crime of unlawful use of an electrical stun gun, tear gas or mace in the first degree if the person knowingly discharges or causes to be discharged any electrical stun gun, tear gas weapon, mace, tear gas, pepper mace or any similar deleterious agent against another person, knowing the other person to be a peace officer, corrections officer, parole and probation officer, fire fighter or emergency medical technician or paramedic and while the other person is acting in the course of official duty.

B. Unlawful Use of an Electrical Stun Gun, Tear Gas or Mace II ORS 163.212

Definition: A person commits the crime of unlawful use of an electrical stun gun, tear gas or mace in the second degree if the person recklessly discharges and electrical stun gun, tear gas weapon, mace, tear gas, pepper mace or any similar deleterious agent against another person.

QUESTION: What are the two differences between the crimes of Unlawful Use of an Elec. ... I and Unlawful Use of an Elec....II?

1. _____

2. _____

VIII. COERCION - ORS 163.275

Definition: A person commits the crime of coercion when the person compels or induces another person to engage in conduct from which the other person has a legal right to abstain, or to abstain from engaging in conduct which the other person has a legal right to engage, by means of instilling in the other person a fear that,

if the other person refrains from the conduct compelled or induced or engages in conduct contrary to the compulsion or inducement, the actor or another will:

1. Unlawfully cause physical injury to some person; or

2. Unlawfully cause damage to property; or

3. Engage in conduct constituting a crime; or

4. Falsely accuse some person of a crime or cause criminal charges to be instituted against the person; or

5. Cause or continue a strike, boycott or other collective action injurious to some person's business, except that such a threat shall not be deemed coercive when the act or omission compelled is for the benefit of the group in whose interest the actor purports to act; or

6. Testify falsely or provide false information or withhold testimony or information with respect to another's legal claim or defense; or

7. Unlawfully use or abuse the person's position as a public servant by performing some act within or related to official duties, or by failing or refusing to perform an official duty, in such manner as to affect some person adversely.

A. Defense: In any prosecution for coercion committed by instilling in the victim a fear that the victim or another person would be charged with a crime, it is a defense that the defendant reasonably believed the threatened charge to be true and that the sole purpose of the defendant was to compel or induce the victim to take reasonable action to make good the wrong which was the subject of the threatened charge.

IX. INVASION OF PRIVACY 163.700

Definition: A Person commits the crime of Invasion of Privacy if:

A. The person knowingly makes or records a photograph, motion picture, videotape or other visual recording of another person in a state of nudity without the consent of the person being recorded; and

B. At the time of the visual recording is made or recorded, the person being recorded is in a place and circumstances where the person has a reasonable expectation of personal privacy.

NOTE: "Places and circumstances where the person has a reasonable expectation of personal privacy includes, but is not limited to, a bathroom, a dressing room, locker room that includes an area for dressing or showering, tanning booth and any area where a person undresses in an enclosed space that is not open to public view.

EXCEPTIONS TO ORS 163.700:

A. Any legitimate medical procedure performed by or under the direction of a person licensed to provide medical service for the purpose of medical diagnosis, treatment, education or research, including, but not limited to, the recording or medical procedures; and

B. Any activity undertaken in the course of bona fide law enforcement or corrections activity or necessary to the proper functioning of the criminal justice system, including but not limited to the operation and management of jails, prisons and other youth and adult corrections facilities.

X. STALKING ORS 163.732

Definitions:

"ALARM" Means to cause apprehension or fear resulting from the perception of danger

"COERCE" Means to restrain, compel or dominate by force or threat

"CONTACT" Includes but is not limited to the following:

1. Coming into visual or physical presence of the other person;
2. Following the other person
3. Waiting outside the home, property, place of work or school of the other person or of a member of that person's family or household;
4. Sending or making written communications in any form to the other person
5. Speaking with the other person by any means
6. Communicating with the other person through a 3rd person
7. Committing a crime against the other person
8. Communicating with a third person who has some relationship to the other person with the intent of affecting the third person's relationship with the other person
9. Communicating with business entities with the intent of affecting some right or interest of the other person
10. Damaging the other person's home, property, place of work or school; or
11. Delivering directly or through a third person any object to the home, property, place of work or school of the other person.

"HOUSEHOLD MEMBER" Means any person residing in the same residence as the victim

"IMMEDIATE FAMILY" Means father, mother, child, sibling, parent, spouse, grandparent, stepparent and stepchild

"REPEATED" Means 2 or more times

"SCHOOL" Means a public or private institution of learning or a child care facility.

DEFINITION OF STALKING:

A person commits the crime of STALKING if:

1. The person knowingly alarms or coerces another person or a member of that person's immediate family or household by engaging in repeated and unwanted contact with the other person:

2. It is objectively reasonable for a person in the victim's situation to have been alarmed or coerced by the contact; and

3. The repeated and unwanted contact caused the victim reasonable apprehension regarding the personal safety of the victim or a member of the victim's immediate family or household.

Stalking is generally a misdemeanor but becomes a felony if the following factors exist:
If a person has a prior conviction for stalking or violating a court's stalking protective order.

QUESTION: When determining whether a victim was "alarmed" or

"coerced", what standard should be utilized?

QUESTION: How many times must the unwanted contact occur before the contact can be considered "repeated" unwanted contact? _____

XI. STALKING CITATIONS

A person may initiate an action seeking a citation by presenting a complaint to a law enforcement officer or to any law enforcement agency. The complaint is a statement setting forth with particularity the conduct that is the basis for the complaint.

Upon initiation of the complaint, a law enforcement officer shall issue a citation ordering the person to appear in court within 3 judicial days and show cause why the court should not enter a court's stalking protective order when the officer has probable cause to believe that:

1. The person intentionally, knowingly or recklessly engages in repeated and unwanted contact with the other person or a member of the other person's immediate family or household thereby alarming or coercing the other person;

2. It is objectively reasonable for a person in the victim's situation to have been alarmed or coerced by the contact and

3. The repeated and unwanted contact caused the victim reasonable apprehension regarding the personal safety of the victim or a member of the victim's immediate family or household.

A person commits the crime of VIOLATING COURT'S STALKING ORDER when: ORS 163.750

1. The person has been served with the court's stalking protective order;

2. the person, subsequent to the service of the order, has engaged intentionally, knowingly or recklessly in conduct prohibited by the order; and

3. The conduct is prohibited contact or the conduct created reasonable apprehension regarding the personal safety of a person protected by the order

CHAPTER 164 OREGON REVISED STATUTES ET AL

THEFT

I. DEFINITIONS (ORS 164.005)

A. "theft" - with intent to deprive another of property or to appropriate property to the person or to a third person, the person:

1. takes, appropriates, obtains or withholds such property from an owner thereof: or

2. commits theft of property lost, mislaid or delivered by mistake;

3. commits theft by extortion, deception, or by receiving.

b. "appropriate"

1. exercise control over property of another, or to aid a third person to exercise control over property of another, permanently or for so extended a period or under circumstances as to acquire the major portion of the economic value or benefit; or

2. Dispose of the property of another for the benefit of oneself or a third person.

c. "Deprive property of another or deprive"

1. Withhold property of another or cause property of another to be withheld from that person permanently or for so extended a period or under such circumstances that the major portion of its economic value or benefit is lost to that person; or

2. dispose of the property in such a manner or under circumstances as to render it unlikely that an owner will recover such property.

D. "obtain""- includes nut is not limited to the bringing about of a transfer or purported transfer of property or of legal title interest therein, whether to the obtainer or another.

e. "owner" - means any person who has a right to possession thereof superior to that of the taker, obtainer or withholder.

f. "property"- any article, substance or thing of value, including, but not limited to, money, tangible and intangible personal property, real property, choses in action, evidence of debt or of contract.

g. "companion animal" - dog or cat posses by a person, business, or other, entity for purpose of companionship, security, hunting, herding or providing assistance in relation to a physical disability.

II. Aggregation (ORS 164.115(5))

1. The value of single theft transactions may be added together if the thefts were committed:

a. Against multiple victims by a similar means within a thirty day period: or

b. Against the same victim, or two or more persons who are joint owners, within a 180 day period.

III. Offenses

***** generally value means the market value of the property at the time and place of the crime. When value of the property cannot be reasonable ascertained it is presumed to be an amount less that $50.00 in the case of theft and less than 500 in any other case. *** NOTE *** value is still a key element in this offense.(ORS 164.115)

1. Theft III (ORS 164.043) - theft were total of the property in a single or aggregate transaction is under 50 dollars.

2. Theft II (ORS 164.045) - theft were total value of the property in a single or aggregate transaction is $50 or more but is under $200 in a case of theft by receiving and under 750 in any other case.

3. Theft I (ORS 164.055)-

a. the total value of the property in a single or aggregate transaction is 200 or more in case of theft by receiving, and 750 or more in any other case; or

b. committed during riot, fire, explosion, catastrophe, or other emergency in an area affected thereby; or

c. theft is by receiving, committed by buying, selling, borrowing or lending on the security of the property (Gill v. Cupp, 78 Or App 505 (1986). The value of property stolen is irrelevant when the charge is selling stolen property.); or

d. the theft is of a firearm or explosive; or

e. the theft is of livestock animal, a companion animal, or a wild animal removed from habitat or born of a wild animal removed from habitat.

4. Aggravated theft I (ORS 164.057)- person commits theft I with respect to property other than a motor vehicle used primarily for personal rather than commercial transportation, and value in single or aggregate transaction is $10,000.00 or more.

5. Theft of lost or mislaid property (ORS 164.065) - person comers into control of property that the person knows or has reason to know is lost, mislaid, or delivered by mistake. (this knowledge will be determined by circumstantial evidence) Person is required to take reasonable steps to restore property to the owner.

6. Theft by extortion (ORS 164.075) - person compels or induces another to deliver property to the person or to a third person by instilling in the other a fear that, if the property is not so delivered, the actor or a third person will in the future:
a. cause physical injury to someone;

b. cause damage to property; or

c. engage in other conduct constituting a crime;or

d. accuse someone of a crime or cause criminal charges to be filed;or

e. expose a fact about someone that would tend to subject person to hatred, contempt, ridicule; or

f. cause or continue a strike, boycott or other action that would injure a person's business.

g. give or withhold information regarding anothers legal claim or defense.

h. Use or abuse the position as a public servant by preforming some act within or related to official duties , or by failing or refusing to preform an official duty i such a manner that would adversely affect another

i. inflict any other harm that would not benefit the actor.

7. Theft by deception (ORS 164.085) - with I N T E N T to defraud the person

a. creates or confirms anothers false impression of value, intention or other state of mind that the actor does not believe

***** this does not include aggressive bargaining or persons with superior bargaining skills*****

b. fails to correct a false impression **which the person previously created** or confirmed

***** person 1 offers for sale to person 2 a Rolex wrist watch he believe to be a phoney knock off for 25.00. Person 2 recognizes the watch to be an authentic Rolex with 5,000.00. Person 2 buys the watch - is he guilty of theft by deception ? NO.

c. prevents another from acquiring information pertinent to the disposition of the property involved

d. sells or otherwise encumbers property, failing to disclose a lien, or legal impediment

e. promises performance which the person does not intend to perform or knows will not be performed.

***** in cases of bad checks it is prima facia evidence of theft by deception if the person who wrote the check (drawer) had no account with the institution that the check is written on. Or if payment is refused by the drawee (the bank) for lack of funds, upon presentation within 30 days after the date of utterance (date check presented for payment) and the drawer(person who

wrote check) fails to make good within 10 days after receiving notice of refusal.

8. Theft by receiving (ORS 164.095) - person receives, retains, conceals m, or disposes of property of another knowing or having good reason to know that the property was the subject of a theft

***** The police officers mere conversation or interviews of the subject is going to bring out evidence of this crime. For example - ask subject so Joe gave you an expensive car audio system - does Joe have a job ? where did Joe say he got it? did the fact that there was no box and the wires were cut on the back indicate anything to you?

9. Right to possession (ORS 164.105)

***** person 1 takes $1000.00 worth of jeans from M & F he takes the jeans to his car and puts them into the trunk. The person 1 goes back into the mall to get an orange julius drink because all this thieving has made him thirsty. While person 1 is buying the orange julius person 2 gets into person 1's trunk and takes the jeans. Is person 2 guilty of theft? (yes) who is the victim? (Person 1). per Oregon law a person who obtains possession of property by theft or other illegal means shall be deemed to have a right to possession superior to that of another person who takes, obtains, withholds,the property from that person by means of theft.

***** Person 1 and Person 2 own a car as joint owners. They get into a fight and person 1 takes the car and leaves for an indefinite time. Can person 2 file theft charges against person 1? (no) Joint owners of property do not have a superior right to possession over the other owners.

10. Theft of services (ORS 164.125) - with I N T E N T to avoid payment the person obtains services that are available only for compensation by force threat deception or other means to avoid payment.

***** typical dine and dash, going over toll bridge without paying toll etc.

GO TO CASE LAW EXAMPLES

11. Unauthorized use of a motor vehicle (ORS 164.135) -

(a) The person takes, operates , exercises control over, rides in or otherwise uses another's vehicle, boat or aircraft without consent of the owner

***** NOTE this section does not talk about I N T E N T therefore the mental state is knowingly.

(b) person agrees to take custody of vehicle for another and uses it for that deviate from the original agreement.

***** Person 1 is a mechanic and agrees to do some mechanic work on person 2" street rod. Person 1 does the work but instead of calling person 2 and telling him to pick up his car person 1 takes it to the weekend drag races and uses it to compete in the drag races. Is person 1 committing UUMV? (YES)

GO TO CASE LAW EXAMPLES

12. criminal possession of rented or leased personal property (ORS 164.140)-

a. Person rents an item of personal property from a commercial renter under WRITTEN AGREEMENT which provides for the return of the items to a particular place at a particular time, the person fails to return item as specified, is therefore served by mail with a written demand to return the item and KNOWINGLY (must be sent by certified mail) fails to return thew item within ten business days from date of mailing the demand

13. Defenses (ORS 164.035)-

a. Honest claim of right.

b. unaware that the property was that of another

c. that the defendant reasonably believed def was entitled to the property involved or had a right to acquire or dispose of it.

d. In theft by receiving it is a defense that the def received, retained, concealed, or disposed of the property with intent to restore it to the owner.

e. property involved is that of the defendants spouse unless they are not living together as man and wife A N D were living in separate abodes at the time of the alleged theft.

***** Police are going to see this most often when responding to domestic calls. Pre divorce usually involves a period of separation during which time due to financial concerns the parties live in the same house but occupy different parts.

BURGLARY

1. DEFINITIONS (ORS 164.205)

A. "building' in addition to ordinary meaning booth, vehicle, boat, aircraft or other structure adapted for overnight accommodation of persons or for carrying on of business therein. If separate units each unit is in addition to being a part of such building, they are separate buildings.

b. "Dwelling" building which regularly or intermittently is occupied by a person lodging therein at night, whether or not the person is actually present.

c. "enter or remain unlawfully"

1. to enter or remain in or upon premises when the premises, at the time of such entry or remaining, are not open to the public OR when the entrant is not otherwise licensed or privileged to be there.

2. failure to leave premises that are open to the public after being lawfully directed to do so by a person in charge.

d. "open to the public" premises by their physical nature, function, custom of, usage, notice or lack thereof, or other circumstances at the time would lead a reasonable person to believe that no permission to enter or remain is required.

e. "Person in charge" a representative or employee of person who has lawful control by ownership, tenancy, official relationship, other legal relationship (I.E. LESSEE). It includes but is not limited to person designated by a board of directors, governing body of any political subdivision of this state.

f. "Premises" any building and any real property, wether privately or publicly held.

II. OFFENSES

1. Burglary II (ORS 164.225)- (Except in the case of criminal trespass I) if person enters or remains unlawfully in a building with intent to commit a crime therein.

2. Burglary I (ORS 164.225) - person commits burg I and the building is a dwelling, or if effecting entry or while in the building in flight therefrom the person

a. is armed with burglary tools (164.235- acetylene torch, electric arc, burning bar, thermal lance, or similar device able to burn through steel, or other solid material, or nitroglycerene, dynamite, gun powder or other explosive, tool or other device adapted or designed or commonly used for forcible entry into premises or theft by a physical taking) or a deadly weapon; or

2. causes attempts to cause physical to ant person, or

3. uses or threatens to use a dangerous weapon.

TRESPASS

I. OFFENSES

1. Criminal trespass II by a guest (ORS 164.243) - a person who is registered at a hotel and is in transient lodging and refuses to leave after being directed to do so after departure date of the guests reservation. (NOTE - if they are not in **transient housing** then we must go through F.E.D).

****

Note officers must understand this concept. All following characteristics MUST be present for there to be transient occupancy:

1. Occupancy is charged on a daily basis and is payable no less frequently that every two weeks

2. lodging operator provides maid and linen services daily or every two days

3. if occupancy exceeds 5 days the occupant has a business address or residence other than the transient lodging.

****

2. Criminal trespass II (ORS 164.245)- enter or remain unlawfully in or upon a premises unlawfully.

3. Criminal trespass I (ORS 164.255)-

a. Enter or remain unlawfully in a dwelling

b. having been denied future entry to a building per a merchants notice of trespass , reenter the building during during hours when the building is open to the public with the intent to commit theft therein.

4. Criminal trespass while in possession of a firearm (ORS 164.265)- while in possession of a firearm the person enters or remains unlawfully in or upon premises.

5. closure of premises to motor propelled vehicles (ORS 164 .270)-land owner can close privately owned property by posting signs 8" wide 11" wide saying "closed to motor vehicles" must display business name, address, phone number. Must be posted at normal points every 350 feet.

6. unlawful entry to a motor vehicle (ORS 164.272)- enters a motor vehicle or ant part of the motor vehicle with intent to commit a crime. " note - enters means inserting any part of the body or anything connecting with the body.

GO TO CASE LAW EXAMPLES

ARSON AND criminal MISCHIEF

1. DEFINITIONS (ORS 164.305)-

A. 'Police animal" - dog or horse used in police work by a certified police officer.

B. "Protected property" - means any place structure or thing customarily occupied by people including public buildings and forest lands.

c. "property of another" - property in which anyone other than the actor has a legal or equitable interest that the actor has no right to defeat or impair even though the actor may have such an interest.

II. OFFENSES

A. Arson I (ORS 164.325) - starting a fire or causing an explosion OR the person intentionally damages:

1. protected property of another;
2. any property, whether property of the person or the property of the other, and such act **recklessly** places another person in danger of physical injury or protected property of another in danger of damage; or
3. ant property, persons or others, and recklessly causes serious physical injury to a firefighter or peace officer acting in the line of duty relating to the fire.

B. Arson II (ORS 164.315) - Starting a fire or causing an explosion, the person intentionally damages any building of another that is not protected property.

C. Reckless burning(ORS 164.335) - Recklessly damages property of another by fire or explosion.

**********DEFINITIONS FOR CRIM MISCHIEF**********

" Institution" - includes state and local correction facilities, mental health facilities, juvenile detention facilities, and training schools.

"Medical facility" - health care facility, licensed physician's office, or anywhere a licensed health care practitioner provides health care services.

"Public utility" - includes cooperatives, people's utility district or other municipal corp providing, gas, electric, gas, water, communication, or other utility service,

"Public trans facility" - prop, structure, equipment, used for or in connection with the transportation of persons for hire by rail, air, or bus, including any rail cars, buses or airplanes used to carry out such transportation,

D. Criminal mischief III (ORS 164.345) - with intent to cause substantial inconvience to the owner or other person, and having no right or reasonable

ground to believe that the person had such right, the person tampers or interferes with the property of another.

E. Criminal mischief II (ORS 164.354) -

1. Crim misch III and damage exceeds 100.00

2. **recklessly** damages property of another, no right nor reasonable grounds to believe they had a right, in an amount exceeding 100.00.

3. **Intentionally** damages property of another

F. Criminal Mischief I (ORS 164.365) - intent to damage property , having to right to or reasonable ground to believe that the person had such right, damages the property of another:

1. more than 500.00
2. by explosive
3. starting a fire in an institution in which the person is committed
4. property is livestock(def 164.055)
5. property is a public utility, telecommunication utility, railroad, public trans facility or medical facility used in direct service to the public
6. police animal and police animal suffers injury or serious physical injury
7. intentionally interfering with, obstructing or adulterating in any manner the service of a public utility, tele comm, railroad, public trans facility, or medical facility,
8. Intentionally, uses, or manipulates, arranges or rearranges property of PU, TU, RR, PT, MF, used in direct service to the public so as to interfere with its efficiency

F. "Interfering with police animal" - Intentualy or knowingly injures or attempts to injure an animal the person knows or reasonably should know is a police animal while the police animal is being used in the lawful discharge of its duty.

****

Note - a common misperception is that one may aggregate criminal mischief similar to theft. This is N O T true the only theory under which we can combined criminal mischief offenses is by proving that the offenses were part of the same act and transaction. Two criteria to show same act and transaction:

1. close in time
2. close in proximity

****

COMPUTER CRIME

1. DEFINITIONS (ORS 164.377)

A. "Access" - communicate, store data in, retrieve data from or otherwise make use of any resource of a computer, computer system or network.

B. " Computer" - includes but not limited to an electronic device which performs arithmetic or memory functions by the manipulations of electronic, magnetic or optical signals or impulses, includes all in put out, and electrical storage, software or communications facilities, which are connected or relates to such a device in a system or network

c. Computer network" - a series of instructions used by a computer which permits the the functioning of the computer in a manner designed to provide appropriate products from the computer.

d. "Computer software" - computer programs, procedures and associates documentation concerned with the operation of the computer

e. "computer system" - related or connected computer devices, equipment, and software - includes state lottery devices.

f. "Data" - information, knowledge, facts, concepts, computer software, programs, or instructions.

g. "Property" - information, programs, intellectual property, any other tangible or intangible item of value.

h. "proprietary information" - scientific, commercial, or technical information

I. "Services" - computer time, data processing, and storage functions

II. OFFENSE

1. Computer crime (ORS 164.377(2)) - knowingly accesses, attempts to access, or uses, or attempts to use, any computer, system , network or part thereof :

a. to defraud
b. false or fraudulently obtaining money, property, or services
c. committing theft
d. knowingly and with out authorization destroys, alters, damages computer, comp system, network, system data, software
e. Knowingly access or uses with out authority

EXAMPLES = ACCESS TO BILLBOARDS ETC.

GRAFFITI-RELATED OFFENSES

I. DEFINITIONS (ORS 164.381)

A. Graffiti - inscriptions, words, figures, designs, that are marked, etched, scratched, painted, pasted or otherwise affixed to the surface of property.

B. Graffiti implement - paint, ink, chalk, dye, or any substance or any instrument, or article designed tor adapted for spraying, marking, etching, scratching, or carving surfaces.

II. OFFENSES

1. Unlawfully applying Graffiti (ORS 164.383)- person having no right or reasonable grounds to believe they had such right damages property of another by applying graffiti.

2. Unlawfully possessing graffiti implement (ORS 164.386) - person possess a graffiti implement with intent to use said implement to unlawfully apply graffiti.

ROBBERY

I. OFFENSES

A. Robbery III (ORS 164.395) - in the course of committing or attempting to commit theft the person uses or threatens the immediate use of physical force upon another person with intent of :

1. preventing or overcoming resistance to the taking of the property or to retention thereof immediately after the taking; or

2. compelling the owner of such property or other person to deliver the property or to engage in other conduct which might aid in the commission of the theft.

B. Robbery II (ORS 164.405) - commits violation of 164.395 and
1. purports to be armed with a deadly or dangerous weapon; or
2. **is aided by another actually present (MOST COMMON IN JUVENILE CASES).**

c. Robbery I (ORS 164.415) - Commits violation of 163.395 and
1. is armed with a deadly weapon; or
2. uses or attempts to use a dangerous weapon;
3. causes or attempts to cause serious physical injury to any person.

GO TO CASE LAW EXAMPLES

PLACING OFFENSIVE SUBSTANCES IN WATERS, ON HIGHWAY, OR OTHER PROPERTY
ORS 164.785

A. It is unlawful for anyone, even the person in charge of the property, to discard dead animals carcass, or part thereof, excrement, putrid, nauseous, decaying etc into any spring, river brook, creek, branch, well, irrigation, drainage ditch, irrigation ditch, cistern or pond of water.

B. it is unlawful to place these types of material in any roadway, alley, rail road right of way, lot, field, meadow or common

*** this section does not apply to spreading of manure or other agricultural practises.

ENDANGERING AIRCRAFT
ORS 164.885

1. person knowingly:

a. throws an object at or drops an object on an aircraft

b. discharges a bow and arrow, gun, airgun, or firearm at or toward an air craft

c. tampers with aircraft or aircraft equipment, fuel, lubricant, or parts so as to impair safety, efficiency or operation of the aircraft, unless with consent of the owner, operator ,or possessor; or

d. places, sets, arms, or causes to be discharged any spring gun, trap, explosive, with the intent of damaging, destroying, or discouraging the operation of any aircraft.

1999
USE OF FORCE

Instructor: Mike Kuykendall

I. General introduction on use of force theory

A. The law values life above all things and seeks to avoid forceful encounters between citizens.

1. Historical perspective-this concept has governed since the middle ages.

2. But what about the rights of property owners? Do they have any rights?

B. This class is a class on legal theory and its application for police officers.

1. Statutes lay out what the law is.

(a) How are laws made?

(1) examples of different law making bodies and types of laws they make.

(b) To whom do they apply?

2. Caselaw gives guidance and clarification.

(a) What is caselaw?

(b) How are appellate decisions made?

3. In addition, Portland Police Bureau General Orders give specific directives to Portland Police Bureau officers.

(a) Who makes these orders?

(b) Why are they necessary?

C. Oregon law is very specific as to the right of <u>every</u> person concerning the use physical force.

1. Analysis of the law of justification

(a) ORS 161.190 ***JUSTIFICATION AS A DEFENSE***

In any prosecution for an offense, justification, as defined in ORS 161.195 to 161.275, <u>is a defense</u>.

(1) What is meant by "a defense"?

(b) ORS 161.195 ***JUSTIFICATION DESCRIBED***

Conduct which would otherwise constitute an offense is justifiable and not criminal when it is required or authorized by law or by a judicial decree or is performed by a public servant in the reasonable exercise of official powers, duties or functions.

(1) When is something required or authorized by law?

(2) When is something required by a judicial decree?

(3) When is something performed by a public servant in the reasonable exercise of official powers, duties or functions?

D. <u>Police officers and citizens stand with equal footing under most of the ORS.</u>

E. Police officers have <u>additional authority</u> to use force under circumstances that a citizen could not. The Legislature has promulgated laws specific to law enforcement.

1. ORS 161.235 **USE OF PHYSICAL FORCE IN MAKING AN ARREST OR IN PREVENTING AN ESCAPE.**

2. ORS 161.239 **USE OF DEADLY PHYSICAL FORCE IN MAKING AN ARREST OR IN PREVENTING AN ESCAPE.**

F. The United States Supreme Court has a say in all of this in *Tennessee v. Garner*.

1. Firing a shot at a fleeing escapee is the equivalent of arresting that person, and, therefore, must be supported by probable cause.

G. PPB officers are also required to function within their general orders regarding the use of force.

1. 1010.10 **USE OF DEADLY PHYSICAL FORCE**
2. 1010.20 **USE OF PHYSICAL FORCE**
3. 1030.00 **USE OF BATON**
4. 1040.00 **AEROSOL RESTRAINTS**
5. 1050.00 **LESS LETHAL SHOTGUN AND MUNITIONS**
6. 870.20 **HANDCUFFING, SEARCHING AND TRANSPORTATION OF PERSONS UNDER ARREST OF DETAINED**

H. So, there are 3 concepts at work for officers in use of deadly physical force situations--the goal is to never have an officer indicted.

1. ORS requires an officer to "reasonably believe" a certain condition exists before deadly force is allowed.

2. Federal caselaw in *Tennessee v. Garner* requires probable cause before deadly force is allowed to effect an arrest.

3. PPB general order requires probable cause **and** a significant threat before deadly force allowed

II. Introduction to use of force legal theory

A. There are terms that must be clearly understood, most of which you may have studied in a previous class on ORS chapter 161:

1. *Physical injury means an injury that*
   (a) impairs a person's physical condition, or
   (b) causes substantial pain.
      (1) examples of physical injury

2. *Serious physical injury means a physical injury that either:*
   (a) creates a substantial risk of death, or
   (b) causes serious and protracted disfigurement, or
   (c) causes protracted impairment of health, or
   (d) causes protracted loss or impairment of the function of any bodily organ
   (1) examples of serious physical injury

3. *Deadly weapon means any instrument, article or substance specifically designed for and presently capable of causing death or serious physical injury.*
   (a) examples of deadly weapons

4. *Dangerous weapon means any weapon, device, instrument, material, or substance which under the circumstances in which it is used, attempted to be used, or threatened to be used, is readily capable of causing death or serious physical injury.*
   (a) examples of dangerous weapons

5. *Physical force includes, but is not limited to, the use of electrical stun gun, tear gas or mace.*
   (a) can someone use physical force but not cause an injury?

6. *Deadly physical force means physical force that under the circumstances in which it is used is readily capable of causing death or serious physical injury.*

7. ORS 161.245 *reasonable belief* means

   (a) *(1) a reasonable belief in facts or circumstances which, if true, would in law constitute an offense.*
   If the believed facts or circumstances would not in law constitute an offense, an erroneous though not unreasonable belief that the law is otherwise does not render justifiable the use of force to make an arrest or to prevent an escape from custody.

(b) *(2) a peace officer who is making an arrest is justified in using physical force unless the arrest is unlawful and is known by the officer to be unlawful.*

(c) When is an arrest unlawful?

(d) How do the above provisions affect law enforcement?

8. ORS 131.005 *Probable cause means that there is a substantial objective basis for believing that more likely than not an offense has been committed and a person to be arrested has committed it.*

(a) "substantial objective basis..." who decides what this is?

(b) "more likely than not..." what does this really mean, and what do I need to do to establish this in my report?

B. Use of force generally

1. ORS 161.205 **USE OF PHYSICAL FORCE GENERALLY**

The use of physical force upon another person that would otherwise constitute an offense is justifiable and not criminal under any of the following circumstances:

(a) parent, guardian, supervising person of a minor or an incompetent person

(1) may use reasonable physical force

(2) when and to the extent reasonably believes necessary

(3) to maintain discipline or promote the welfare of the minor or incompetent person

(4) applies to teachers in school, school events on or off of school property

(b) an authorized official of jail, prison, or correctional facility

(1) may use physical force when reasonably believes it is necessary to maintain order and discipline.

(c) common carriers of passengers

(1) may use physical force when reasonably necessary to maintain order

(2) deadly force only when the person reasonably believes it is necessary to prevent death or serious physical injury.

(d) person acting under reasonable belief another is about to commit suicide or inflict serious physical self-injury

(1) may use physical force to extent reasonably believed necessary to thwart the result.

(e) in self-defense or in defending a third person, in defending property, in making an arrest or in preventing an escape.

2. Use of physical force - **General Order 10.10.20**
The Portland Police Bureau authorizes its members to use physical force in a police action:
(a) when and to the extent it is reasonably necessary to accomplish some official purpose, and

(b) the amount of physical force authorized may vary in degree and shall only be the amount of force that is reasonably necessary, depending upon the circumstances of each situation taken as a whole, to accomplish the official purpose.

(1) Is this different than the ORS?

C. The objective/subjective operation of ORS 161.209 **USE OF PHYSICAL FORCE IN DEFENSE OF A PERSON**
1. The standard test applied to all use of force scenarios is controlled by this statute:

A person is justified in using physical force upon another person
(a) for self-defense, or

(b) to defend a third person:
(1) from what the person reasonably believes to be the use or imminent use of unlawful physical force, and

(2) the person may use a degree of force which the person

reasonably believes is necessary for the purpose.

2. **Objective standard**--was it reasonable to believe that the use of unlawful force by another was imminent? What factors contributed to this decision?

3. **Subjective standard**--did you use that degree of force that was reasonably necessary under the circumstances?

4. What may be reasonable for an untrained citizen may be unreasonable for a sworn officer, i.e. trained in defensive tactics, has mace and baton, etc.

5. You take your training home with you and therefore you are always a police officer. (Subjectively under ORS, actually per **general order 10.10.10**).

6. You need to begin thinking about articulation of the underlying facts you observed.

7. What will the reasonableness of your conduct will be determined from?
   (a) What you know

   (b) What you can articulate about what you saw

   (c) How and to what degree you responded

8. PPB officers are all held to the standard set out in your PPB general order. Why?

9. The PPB general order is specifically designed to limit you in keeping your conduct within the confines of the law.

III. The operation of the use of force statutes generally

A. Analysis of ORS 161.215 **LIMITATIONS ON USE OF PHYSICAL FORCE IN DEFENSE OF A PERSON** A person is not justified in using physical force upon another person if:

1. With intent to cause physical injury or death to another, the person provokes the use of unlawful physical force by that person, or

2. The person is the initial aggressor, unless they withdraw from the encounter and effectively communicate to the other person their intent to do so, and the other person continues or threatens to continue the unlawful use of force, or

3. The force involved is a product of combat by agreement **(Mutual combat)**

State v. Gibson (1978) defendant came to his wife's aid in a scuffle with a bartender, where it was the wife who acted unlawfully in the first instance by grabbing the bartender, also a woman, whom she thought was "giving her man a bad time." Can defendant be prosecuted for assault if the bartender is injured?

B. Analysis of ORS 161.219 **LIMITATIONS ON USE OF DEADLY PHYSICAL FORCE IN DEFENSE OF PERSON** Deadly force is:

1. Not justified unless the person reasonably believes the other person is
   (a) committing or attempting to commit a felony involving use or threatened use of physical force against a person, or

   (b) committing or attempting to commit a burglary in a dwelling, or

(c) using or about to use unlawful deadly force against a person.

2. **Objective/subjective test** as it relates to private citizens v. police officers
   (a) objective factors = use of unlawful force imminent

   (b) subjective factors = did person use degree of force reasonably necessary for the purpose

3. What is the difference between a citizen and a p/o under the deadly force statute?

A. Analysis of ORS 161.225 **USE OF PHYSICAL FORCE IN DEFENSE OF PREMISES** A person is justified in using physical force upon another person:
   1. Person in lawful possession or control of premises

   2. When and to extent reasonably believes necessary

   3. To prevent or terminate what the person reasonably believes to be

   4. Commission or attempted commission of a criminal trespass in or upon the premises

   5. Deadly physical force only when reasonably believes necessary to prevent commission of arson or felony by force and violence by a trespasser, or in defense of a person.

      (a) is this a shift away from deadly force?

      (b) how does the law apply to arson?

D. Analysis of ORS 161.229 **USE OF FORCE IN DEFENSE OF PROPERTY**
   1. Other than deadly force: there is no lawful use of deadly force to defend property alone.

   2. May use physical force upon another person and to the extent reasonably necessary to prevent or terminate the commission or attempted commission by the other person of theft or criminal mischief of property.

3. Are there scenarios where a defense of property may shift to self-defense?

E. Analysis of ORS 161.235 **USE OF FORCE IN MAKING AN ARREST OR PREVENTING ESCAPE** (This is the 1st law enforcement statute)
A peace officer is justified in using physical force upon another person:

1. Only when and to the extent that the peace officer reasonably believes it necessary:
   (a) to make an arrest or prevent the escape from custody of an arrested person unless the peace officer knows the arrest is unlawful; or

   (b) for self-defense or to defend a third person from what the officer reasonably believes to be the use or imminent use of physical force while making or attempting to make an arrest or while preventing an escape

   Stephens v. City of st. Helens (1962)a drunk refused to move from a chair in the police station. The court held that the officer's use of a device called a "come along" or "iron claw" which caused a shoulder separation, among other injuries, was not reasonable. Why?

F. Analysis of ORS 161.239 **USE OF DEADLY FORCE IN MAKING AN ARREST OR PREVENTING AN ESCAPE**
This is the law in Oregon re: fleeing felons. (Fleeing felons handouts and policy discussion)

1. Peace officer may only use deadly force when officer reasonably believes:
   (a) crime committed by a person was a felony involving the use or threatened use of physical force against a person; or

   (b) crime committed by the person was kidnapping, arson, escape 1, burglary 1, or any attempt to commit such crime; or

   (c) when the use of deadly physical force is necessary to defend the officer or another from the use or threatened imminent use of deadly physical force; or

   (d) the crime committed was a felony or an attempted felony and under the totality of the circumstances existing at that time and place, the use of force was necessary; or

   (e) the officer's life or personal safety are endangered.

2. Will not justify reckless or criminally negligent conduct by an officer amounting to an offense against or with respect to innocent persons whom the officer is not seeking to arrest or retain in custody.

Lander v. Miles (1868) court held that firing a gun to secure an arrest is not justifiable when the arrest can be secured by less dangerous means.

Rich v. Cooper (1963) suspect resisted being placed in police car after duii arrest and po struck with sap 3 times: "Disputable presumption that a peace officer acted in good faith."

3. Tennessee v. Garner (1984) U.S. Supreme Court (Handout)
   (a) "where the officer has probable cause to believe that the suspect poses a threat of serious physical harm, either to the officer or to others, it is not constitutionally unreasonable to prevent escape by using deadly force".

   (b) how does Oregon law regarding use of deadly force to apprehend fleeing felons differ?

   (c) what was the supreme court's rationale for this?

      (1) legally, shooting a person is a "seizure" of that person.

      (2) philosophically, "the use of deadly force to prevent the escape of all felony suspects, whatever the circumstances, is constitutionally unreasonable. It is not better that all felony suspects die than that they escape. Where the suspect poses no immediate threat to the officer and no threat to others, the harm resulting from failing to apprehend him does not justify the use deadly force to do so...a police may not seize an unarmed, nondangerous suspect by shooting him dead".

4. Has Oregon adopted to the federal mandate?
   (a) Examine Aaskay v. Maloney (1917). Police detectives, having arrested one who they had reason to believe, and evidently believed, had committed a felony, had the right, when he broke away, to use such means and degree of force as was reasonably necessary to recapture him, including shooting at him, if without evil design and under circumstances of imperative duty.
   (1) Is this the law today? Why not?

   (b) State v. Haro (1993) ORS 161.209 and 161.219 must be read together, as they refer to each other. Therefore, the "necessity"

requirement applies to all uses of physical force.

(c) we need to modify our statute to be in compliance with Garner: cross out "Reasonable belief" and add "probable cause". (Bullet=arrest).

5. The probable cause standard deals only with arrest situations.
   (a) for self-defense , defense of others, a reasonable belief is all that is necessary.

   (b) what's the difference, then, between reasonable belief v. probable cause in a force situation?

6. How does the PPB general order on use of deadly force fit into all of this?

   Use of deadly physical force-general order 10.10.10

   "The use of statutorily defined weapons, barricades and vehicle ramming, constitutes deadly physical force.

   The Bureau recognizes that members may be required to use deadly force when their life or the life of another is jeopardized by the actions of others. Therefore, state statute and Bureau policy provide for the use of deadly force under the following circumstances:

   (a) members may use deadly force to protect themselves or others from what they reasonably believe to be an immediate threat of death or serious physical injury,

   (b) a member may use deadly force to effect the capture or prevent the escape of a suspect where the officer has probable cause to believe that the suspect poses a significant threat of death or serious physical injury to the officer or others, and, if feasible, some warning has been given."

G. Analysis of ORS 161.245 **REASONABLE BELIEF STATUS OF UNLAWFUL ARREST**

1. You can be wrong on the facts but never wrong on the law.

H. Analysis of ORS 161.249 **USE OF PHYSICAL FORCE BY PRIVATE PERSON ASSISTING ARREST**

Do not do this...

1. A person who has been directed by an officer to assist the peace officer to

make an arrest or to prevent an escape from custody is justified in using force when and to the extent the person reasonably believes force necessary to carry out officer's direction.

2. When directed by peace officer to assist, person may use deadly force only when:
   (a) person reasonably believes deadly force necessary for self-defense or to defend a third person from what the person reasonably believes to be the use or imminent use of deadly force; or

   (b) the person is directed or authorized by officer to use deadly force unless the person knows that the officer is not authorized to use deadly force under the circumstances.

3. What problems can you foresee when a citizen is directed or authorized to assist an officer making an arrest?

I. Analysis of ORS 161.255 **USE OF PHYSICAL FORCE BY PRIVATE PERSON MAKING CITIZENS ARREST**

This is arrest situation only (not a self defense situation); deadly force may not be used when merely arresting.

1. Private person acting on their own account is justified in using physical force when and to the extent they reasonably believe it is necessary to make an arrest or to prevent the escape from custody of an arrested person.

2. Justified in using deadly force only when the person reasonably believes it necessary for self-defense or to defend third person from use or imminent use of deadly physical force.

J. Analysis of ORS 161.260 **USE OF PHYSICAL FORCE IN RESISTING ARREST PROHIBITED**

1. A person may not use force to resist an arrest by a peace officer who is known or reasonably appears to be a peace officer.

2. Whether the arrest is lawful or unlawful

   Careful!

3. This statute only governs reasonable force by police officers who are making an arrest.

4. Excessive force triggers the self-defense statutes as to the arrested person; the arrested person would be defending against armed police officers.

5. Where does that leave us on the objective and subjective tests? Free reign for citizen?

K. Analysis of ORS 161.265 **USE OF FORCE TO PREVENT ESCAPE**

1. A guard or peace officer employed in a correctional facility is justified in using physical force including deadly force when and to the extent that the guard or officer reasonably believes necessary to prevent escape of prisoner.
   (a) how does this fit with Tennessee v. Garner and State v. Haro?

IV. General orders regarding other force issues
A. Use of baton G.O. 10.30.00

B. Aerosol restraints G.O. 10.40.00

1. Pepper mace is physical force for everyone
2. Mere possession of it does not immediately give rise to the use of physical force
3. There may be specific articulated facts that give rise to the use of physical force
4. There may be specific articulated facts that give rise to a greater level of force (deadly) in any scenario, but the mace will only be a contributing factor

C. Handcuffing, searching, and transportation of persons under arrest and detained G.O. 870.20
D. Non-lethal force such as the bean-bag shotgun. G.O. _____

V. Defenses
A. Choice of evils defense – ORS 161.200
1. Conduct which would otherwise constitute an offense is justifiable and not criminal when:
   (a) necessary as an emergency measure to avoid an imminent public or private injury, and

   (b) the threatened injury is of such gravity, that according to the ordinary standards of intelligence and morality, the desirability and urgency of avoiding the injury clearly outweigh the desirability of avoiding the injury sought to be prevented by the statute defining the offense in issue.

2. Kids need food--shoplift okay?
   Work in North Portland. And need gun--ccw okay?

3. Self-defense is considered a statutory choice of evils. Why?

B. Duress--ORS 161.270

1. Not a crime if actor coerced to do so by
   (a) use or threatened use of unlawful physical force
   (b) upon actor or third person
   (c) force of such nature or degree as to overcome earnest resistance

2. Does not apply to murder
3. Not a defense for someone who intentionally or recklessly placed themselves in a situation where it would be probable that they would be subjected to duress.

State v. Fitzgerald (1973) inmate passed hacksaw to another because he had been told by escapee he had friends on the outside who would get the defendant==too vague a threat of future injury.

State v. Fowler (1978) third person held knife to the defendant's brother, but defendant and brother had 2 opportunities to leave = no duress.

4. Generally not a defense for a spouse acting under orders from spouse, unless there is a threat or use of physical force.

C. Entrapment == ORS 161.275

1. Not a crime if actor induced to do an act by law enforcement official, or person acting in cooperation with law enforcement, for purpose of obtaining evidence to be used against the actor in a criminal prosecution

2. Induced = actor did not contemplate and would not otherwise have engaged in the proscribed conduct

3. Merely giving the actor the opportunity to commit the offense doesn't amount to entrapment.

D. Intoxication == ORS 161.125

1. Intoxication can negate intentional or knowing mental state, but not a reckless mental state.

VI. Warrants

A. Arrest warrant-ORS 133.235

1. P/O shall state the officer's authority and reason for the arrest (3)
2. In order to make an arrest, a peace officer may use physical force (4)

3. In order to execute an arrest warrant, a peace officer may enter premises in which the officer has probable cause to believe the person to be arrested to be present

4. If, after giving notice of the officers identity, authority, and purpose, the officer is not admitted, the officer may enter the premises, and by a breaking, if necessary.

B. Search warrant == ORS 133.605

1. The executing officer may use the degree of force, short of deadly physical force, against persons, to effect an entry or to open containers, as is reasonably necessary for the execution of the search warrant with all practicable safety.

2. Deadly force only where officer:
   (a) reasonably believes that there is a substantial risk that things to be seized will be used to cause death or serious physical injury if their seizure is delayed and that the force used creates no substantial risk of injury to persons other than those obstructing the officer, or
   (b) reasonably believes that the use of deadly physical force is necessary to defend the officer or another person from the use of threatened imminent use of deadly physical force.

State v. Mitchell (1971) Oregon recognizes exigent circumstances exception to the warrant requirement

State v. Wetteland (1972) generally, officers must knock and announce before entering premises unless some exigent circumstances.

State v. Steffes (1970) defendant, whose name matched that of a man involved in a series of hotel robberies, who had just been released from the pen, and that hotel clerks had stated that robber used a gun in each case, justified entry without knocking.

VII. Community caretaking provisions ORS133.033 (1991)

A. Any peace officer of this state is authorized to perform community caretaking functions–any lawful act inherent in the duty of a peace officer and to serve and protect the public, including:

1. Enter and remain on premises of another, or stop or re-direct traffic, if it reasonably appears to be necessary to
   (a) prevent serious harm to any person or property

   (b) render aid to injured or ill persons

(c) locate missing persons

B. How does community caretaking affect law enforcement?

VIII. Mere conversation-do force statutes apply?

IX. Group discussion-force scenario

A. You and your partner are called to the scene of a domestic disturbance at a house. When you arrive the neighbors report loud arguments and they are concerned about the safety of the occupants. You approach the door and you hear loud arguing.

What do you do?

B. You knock on the door 5 times and yell police, but get no response. What do you do?

C. You step back and look through the window, and see two people in the back in the kitchen, arguing. It looks to you that it possibly might be getting physical but you can't tell because you only can see them passing in the doorway. What do you do?

D. You see a punch thrown by someone and you enter. The woman is clearly more aggressive and is yelling at the man, calling him a worthless piece of dirt. The man is fairly docile. What do you do?

E. The woman keeps coming at the man and looks like she might hit him. What do you do?

F. She keeps coming towards the man and you have to push her away. What do you do?

G. She approaches a 3rd time, you push her and she pushes you and says I'm going to kill him, and she does not respond rationally. What do you do? (Asp, mace, gun, takedown, cuff, arrest?)

H. Man starts reacting to what is occurring, and gets verbally hostile. What do you do? Search for officer safety okay?

I. Woman on ground starts kicking at you violently. What do you do?

J. Man pulls gun. What do you do?

(Of course, at this point you have a right to defend yourself against the man's deadly physical force. But 20-20 hindsight guaranteed to ask why you did not search for officer safety earlier)

Portland Police Bureau
Training Division
Lesson Plan

I. **Course Title** Person Encounters and Search and Seizure

II. **Instructor** DDA Wayne Pearson

III. **Date/Time** (To be set)

IV. **Training Audience** Basic Academy Police Officers

V. **Course Goals**

The purpose of this training is to give the students a working knowledge of procedural law as it pertains to person encounters, and search and seizure.

VI. **Performance Objectives**

(To be filled in later)

VII. **Course Outline**

(See Presentation Material)

VIII. **Lesson Plan**

(See Presentation Material)

IX. **Community Policing Application**

(To be filled in later)

X. **Training Aid Requirements**

(To be filled in later)

XI. **Examination Questions**

Exam questions over this material will be provided exclusively by DDA Wayne Pearson for the PPB procedural law exam.

XII. **Lesson Plan Prepared By DDA Wayne Pearson**

XIII. Presentation Material

PERSON ENCOUNTERS

AND

SEARCH AND SEIZURE

This document is for use as an interactive outline in conjunction with the PPB Basic Academy. Each student is responsible for following the outline through the corresponding lectures and completing the outline with notes taken during class. The procedures exam will cover both the printed portions of the outline, as well as, the lectures relevant to the outline.

To begin with, you have already learned that evidence will be suppressed in a criminal action for certain unlawful police seizures. According to ORS 136.432:

A court may not exclude relevant evidence and otherwise admissible evidence in a criminal action on the grounds that it was obtained in violation of any statutory provision unless exclusion of the evidence is required by:

1. The United States Constitution or the Oregon Constitution;
2. The rules of evidence governing privileges and the admission of hearsay; or
3. The rights of the press

How does this affect the statutes that we will study concerning the limitations placed on officers by the Oregon Legislature?

Of course, constitutional violations will still be the subject of a motion to suppress in a related criminal prosecution.

Of course this does NOT mean that officers need not concern themselves with the statutes or the case law that has and will interpret these statutes in relation to lawfully allowed officer conduct.

Violations of statute will still be enforced through:

1.

2.

3.

As a result, we will learn the statutory parameters of good search and seizure law established by the Oregon Legislature along with the constitutional parameters as have been outlined by the Oregon and Federal Appellate Courts.

MERE CONVERSATION

1. DEFINITION: Mere conversation with a citizen occurs in any setting where there has been no significant restriction of the citizen.
   1. The concept is as simple as the officer's right to be free to walk up to a citizen, talk, and ask some questions.
      1. It=s value is that you may:
         1. Interact with citizens outside restrictions associated with all forms of detention
         2. <u>Ask</u> questions of interest
         3. Make sensory observation

2. Mere conversation then must avoid a direct or indirect restraint or seizure of the person such that the encounter satisfies the constitutional standard as non-significant restriction or interference with the person.

1. For Oregon constitutional purposes, a person is restrained or "seized" when, either:

1. **A law enforcement officer intentionally and significantly restricts, interferes with, or otherwise deprives an individual of that individual's liberty or freedom of movement ... OR**

2. **Whenever an individual believes that (a) above has occurred and such belief is objectively reasonable in the circumstances.**

2. Specifically, the court said, "We hold that a "seizure" of a person occurs under Article I, section 9, of the Oregon Constitution (a) if a law enforcement officer intentionally and significantly restricts, interferes with, or otherwise deprives an individual of that individual's liberty or freedom of movement; or (b) whenever an individual believes that (a), above has occurred and such belief is objectively reasonable in the circumstances. (...) **Under these 'seizure' standards, law enforcement officers remain free to approach persons on the street or in public places, seek their cooperation or assistance, request or impart information, or question them without being called upon to articulate a certain level of suspicion in justification if a particular encounter proves fruitful. A street or public place encounter does not amount to an Article I, section 9 seizure merely because the encounter may involve inconvenience or annoyance for the citizen and the other party to the encounter is known to be a law enforcement officer.** Even physical contact does not transform the encounter into a 'seizure' if it is a normal means of attracting a person's attention (e.g., policeman tapping citizen on the shoulder at the outset to get a citizen's attention). (...) Rather, the encounter is a 'seizure' of a person only if the officer engages in conduct significantly beyond that accepted in ordinary social intercourse. **The pivotal factor is whether the officer, even if making inquiries a private citizen would not, has otherwise conducted himself in a manner that would be perceived as non-offensive contact if it had occurred between two ordinary citizens."**

State v. Holmes,
311 Or 400 (1991)

3. The court has indicated a desire to move away from a standard that depends on the officer's state of mind and to the objective standard described above. In applying the above standard, answers to questions like "Would you have let the defendant go if he would have started to walk away?" are not the focus of the court=s examination. Instead, the court will examine whether the officer's **actions** intentionally and significantly restricted, interfered with, or otherwise deprived the defendant of that defendant's liberty or freedom of movement.

3. MERE INQUIRY by a police officer without significant restriction of liberty is not a "SEIZURE OR STOP" constitutionally and requires no justification.
4. A constitutional "SEIZURE OR STOP" does occur, and therefore must be justified by reasonable suspicion or probable cause, when the officer significantly restricts a person's liberty by:
    1. Physical force (or)
    2. A show of authority
    3. In such a manner as to be "offensive."
5. HOWEVER, ANY INDIRECT RESTRAINT CAN BE CORRECTED.
    1. The strongest and best advice to officers who are beginning to develop their communication techniques and styles in this area is to simply integrate a clear statement of mere conversation into the dialogue. Just as has been learned by officers in the Miranda rights area, giving information prior to getting information does not establish an unworkable law-enforcement setting.
        1. It can be as simple as: "You know, if you need to go, just let me know . . . we can talk to you some other time."
        2. No matter what words are used to communicate "free to go", the words MUST clearly communicate to the person that they ARE "free to go."

2. What "circumstances" or factors have the courts reviewed in assessing show of authority or use of physical force.

3. There will always exist one constant in most cases of mere conversation . . . the officer will be in uniform, associated with a marked police car, and asking some questions.

4. Beyond the uniform, patrol car, and questions come all the other aspects of a mere conversation. Although the courts continue to examine the many facets of the various types of mere conversation done by officers, some factors have been identified as important, and officers developing their personal communication techniques in this area should be aware of how the court has analyzed each one. The list is by no means exhaustive, but the courts' analysis seem to continually revolve back to show of authority and use of physical force.
5. In mere conversation settings without the equivalent of: "You're free to go", the following factors and their concepts should be kept in mind.
    1. **Demeanor and tone of voice**
    2. **Place where the person to be encountered is located.**
        1. In other words, where was the person when the encounter occurred?

3. **Activity by the person** immediately before contact.
   1. Persons who are stationary:

   2. Persons whose travel is interrupted by an encounter initiated by an officer:

   3. But, by use of good skills in a mere conversation encounter, people who are moving may still provide opportunities for a lawful mere conversation type encounter. This is more recently true even where the officers placement effectively would cause the defendant to maneuver around the officer to proceed.

4. **Questions v. Directives**
   1. Although the court seems to be relaxing the bright line between questions during mere conversation and directives during mere conversation, the distinction still has importance in analyzing a lawful mere conversation encounter.

   2. To begin with, questions must truly be "questions"

   3. When in the form of a question, generally, the scope of the inquiry is unrestricted.
   4. A "question" increasingly being used during a mere conversation encounter is "Can I search you?"
      1. For valid consent to search to follow, all components of a knowing and voluntary consent must be involved and reported.

      2. A request for consent to search during mere conversation does not constitute a stop.
   5. Asking to see identification:

   6. Questions like "Hey, could you come over here a minute?" which require the person to alter his course:

7. More recently, the court has further softened its concern in this area by allowing officers to request, by directive, a person to stop and talk. In two separate cases a person was exiting a vehicle and walking away when the officer calls out to the person "Sir, wait." In yet another case, a person was under a car working when the officer asked the person to come out from beneath the car. In all three cases, the court ruled that no stop had occurred by virtue of the officer's directive or question that required the suspect to change course.

8. Notwithstanding the courts recent softening of the distinction between questions and directives, there is still considerable case law disapproving of directives during mere conversation. Directives by the officer risk being viewed as a "show of authority" and a significant interference with the person's liberty.

    1. ACome out of the house with your hands up.=

9. In summary, there are three acceptable levels of verbal interaction with a person during mere conversation.
    1. A question of any kind that **does not** require the person to alter course in order to respond.
    2. A question of any kind that **does** require the person to alter course in order to respond.
    3. A **directive** given in a non-offensive manner and, generally for a non-investigative purpose.

5. **Time of day and length of encounter**
    1. Be especially aware of situations wherein the person makes repeated moves to leave, but the subsequent question by the officer results in the person's remaining to answer the question.

6. **Seizing or retaining personal property**
    1. Asking to see personal property:
    2. Looking at personal property:
    3. Touching personal property tendered by consent of the person:
    4. Retention of the personal property:

7. **Position and number of officers and position of officers' vehicles**
    1. Position of the officers:

    2. Position of the police vehicles:

8. **Use of force**

9. **Display of weapons**
   1. The obvious is withdrawing a gun.
   2. The things to be aware of are:

10. **Use of overhead lights, flashing yellow lights, spotlights and flashlights.**
   1. Overhead lights:
   2. Spotlights:
   3. Flashing yellow lights:
   4. Flashlights:

11. **Obvious pursuit**
   1. Obvious pursuit occurs when a defendant, upon becoming aware of the officer's presence, clearly demonstrates no intention to converse or have contact with the officer, the officer then demonstrates an intention to pursue and/or contact anyway. Can mere conversation occur when the defendant thereafter submits to the officer's pursuit?
   2. While defendant is running and the officer is pursuing, but before the defendant is caught or submits, has a seizure occurred?

12. **Warrant/record check**
   1. BRIGHT LINE: Record checks must not be done in the person's presence.
   2. Suggested procedures:

DETENTIONS

6. DEFINITION: The temporary restraint of a person **to facilitate the enforcement of a violation**
7. JUSTIFICATION: The officer must believe the person has committed a violation in the officer's presence or, pursuant to statute, have probable cause to believe the person has committed a traffic violation because the description was relayed to the officer from another officer who did observe the violation.

ORS 810.410 (2) *A police officer may issue a citation to a person for a traffic violation at any place within or outside the jurisdictional authority of the governmental unit by which the police officer is authorized to act when* ***the traffic violation is committed in the police officer's presence or when the police officer has probable cause to believe an offense has occurred based on a description of the vehicle or other information received from a police officer who observed the traffic violation****.*

ORS 810.420. Citation in radar cases. *When the speed of a vehicle has been checked by radio microwaves or other electrical device, the driver of the vehicle may be stopped, detained and issued a citation by a police officer if the officer is in uniform and has either:*

(1) Observed the recording of the speed of the vehicle by the radio microwaves or other electrical device; or

(2) ***Probable cause to detain based upon a description of the vehicle or other information received from the officer who has observed the speed of the vehicle recorded****.*

1. The courts have ruled that the officer must first have at least **probable cause** to believe that the person to be detained has committed a violation in the officer=s presence before a lawful detention can be conducted.

2. In addition to the statutes cited above, **the court** has also sanctioned a detention of a person based upon information from a second officer that the second officer had an violation committed in the second officer's presence.

8. HISTORICAL
   A. Until 1983, police officers could arrest for violations.
   B. 1983 Legislature replaced the right to arrest with the right to conduct a detention . . .

The right to detain
for a limited time
while performing statutory functions

9. This area only applies to VIOLATIONS.
   1. TRAFFIC VIOLATIONS:
      1. ORS 810.410 (3) *A police officer:*
         1. Shall not arrest a person for a traffic violation

         2. May stop and detain a person for a traffic violation for the purposes of investigation reasonably related to the traffic violation, identification and issuance of the citation."
         3. May make an inquiry into circumstances arising during the course of a detention and

investigation under paragraph (b) of this subsection that give rise to a reasonable suspicion of criminal activity.

4. May make an inquiry to ensure the safety of the officer, the person stopped or other persons present, including an inquiry regarding the presence of weapons.

5. May use the degree of force reasonably necessary to make the stop and ensure the safety of the peace officer, the person stopped or other persons present.

6. *May request consent to search in relation to the circumstances referred to in paragraph (c) of this subsection or to search for items of evidence otherwise subject to search or seizure under ORS 133.535.*

(1) Does this include evidence of the violation too?

(2) ***133.535 <u>Permissible objects of search and seizure</u>.*** *The following are subject to search and seizure under ORS 133.525 to 133.703:*
(1) Evidence of or information concerning the commission of a criminal offense;
(2) Contraband, the fruits of crime, or things otherwise criminally possessed;
(3) Property that has been used, or is possessed for the purpose of being used, to commit or conceal the commission of an offense; ***AND***
(4) A person for whose arrest there is probable cause or who is unlawfully held in concealment.

(3) Examples:

7. What are the two types of inquiries described in this statute and how do they differ under this statutory structure?

(1) Do you have.....?

(2) Can I search.....?

2. VIOLATIONS:

1. Pursuant to Section 10, Chapter 1051, Oregon Laws 1999, **STOP AND DETENTION FOR VIOLATION**:

(1) An enforcement officer may not arrest, stop or detain a person for the commission of a violation except to the extent provided in this section and ORS 810.410.
(2) An enforcement officer may stop and detain any person if the officer has reasonable grounds to believe that the person has committed a violation. An enforcement officer may stop and detain any employee, agent or representative of a firm, corporation or other organization if the officer has reasonable grounds to believe that the firm, corporation or other organization has committed a violation.
(3) Except as provided in subsection (4) of this section, ***the period of detention may be only as long as is necessary to:***

*(a) **Establish the identity of the person**, firm, corporation or organization believed to have committed the violation;*
*(b) **Conduct any investigation reasonably related to the violation; and***
*(c) **Issue a citation for the violation.***
(4) The authority of an enforcement officer to stop and detain a person for a traffic violation as defined by ORS 801.550 is governed by ORS 810.410.

2. What=s missing here?

10. STATUTORY RIGHTS SUMMARY
    1. During a non-traffic **violation** detention, a police officer has the statutory right to:
        1. Investigate the violation
        2. Investigate identity
        3. Issue the appropriate citation

    2. During a **traffic violation** detention, a police officer has the statutory right to:
        1. Investigate the violation
        2. Investigate identity
        3. Issue the appropriate citation
        4. If reasonable suspicion develops, may make inquiry into that crime
        5. Make officer safety related inquiry
        6. Use force when reasonably necessary
        7. May request consent to search for Aitems of evidence≅

11. Beyond the specific statutory rights, the court interprets the constitution to blend the needs of law enforcement with the need to keep the detention brief.
    1. The courts have voiced their concern as follows:

    "The constitutional and statutory law blends into a single rule: Traffic stops should be the minimum possible intrusion on Oregon motorists, and not an excuse to begin questioning, searching, or investigating that is unrelated to the traffic reason for the stop."

    State v. Carter/Dawson,
    34 Or. App. at 32 (1978)

    The above statement has been quoted by the Oregon Supreme Court in later cases, but has not been expressly adopted.

    State v. Jackson,
    296 Or. 430 (1984)

    But, it does provide the proper mind set for beginning a violation detention.

    With the enactment of Chapter 313, Oregon Laws 1997, Section 1, we can now expect the Oregon Supreme Court to begin to examine this concept in more detail in the future on constitutional grounds.

12. From that mind-set and with the specific statutory rights in mind, other **important additional procedural tools** have been identified and sanctioned by the Oregon Appellate Courts for use by officers during a lawful detention and at any point prior to dissipation of the underlying offenses.

1. Asking for an Oregon Driver's License on any detention of the driver of an auto stopped by the officer:

2. Running a records check on the person during the detention:

3. Requesting a vehicle registration from the driver of an auto stopped by the officer:

4. Using a flashlight for the recorded purpose of keeping the detained person under observation and watching body movements:

5. Cover officers engaging the passengers or other persons present in mere conversation while the primary officer processes the detained person:
   1. This is only a procedure that can be used if there are two or more officers involved in the detention.

   2. However, where the officer testifies that the detention was for the purpose of investigating a violation committed by the passenger, attempts at mere conversation get compromised.

6. Entering the defendant's vehicle to seize evidence of the violation:

7. Even asking the defendant=s consent to get out of the car must be related to the processing of the violation unless there is reasonable suspicion or probable cause to change the course of the investigation beyond the violation.

8. The right to expand the scope of the inquiry beyond the traffic violation when the officer can establish reasonable suspicion to believe the detained person has committed a crime.

9. Based upon recent case law, the best advice may be to end the detention and return to mere conversation.
   1. We will cover this in more detail at the end of the ADetention≅ section.

10. Conducting a detention for an observed violation even though the police officer has secondary suspicions about other activities:
    1. Referred to occasionally as:
       "Pre-text detentions"

11. Delaying the detention until the timing/location is procedurally acceptable:

12. Examining the documents and permits that are involved in the detention:

13. Approaching a lawfully detained vehicle from either the passenger or driver side and making lawful observations of the vehicle's interior from either vantage point:

14. Using the observations made during a lawful detention to justify a subsequent stop or arrest for some other crime. As an example, a detention for expired vehicle tags may provide observable facts sufficient to support a subsequent stop or arrest for DUII:
    1. In such situations, it is not necessary to further investigate the underlying violation in order to somehow validate the stop. Once reasonable suspicion or probable cause exists to investigate a crime, no further action on the violation is required unless the officer chooses to do so.

        1. What must the report recite in these types of contacts?

13. CONCERNS BEYOND OFFICER RIGHTS
    1. Dissipation:

    2. Returning to mere conversation at the end of the detention:
        1. However, be sure that, in addition to telling the defendant that he is Afree to go,≅ officer(s) **do not present a physical obstacle** to the defendant=s movement should the defendant decide to not engage in mere conversation and elect to drive away.

        2. Be sure to **include a temporal break.**

    3. If a detention escalates into an arrest for Failure to Display a Driver's License, such arrest and custody may only continue for such time as is reasonably necessary to investigate and verify the person's identity. ORS 807.570 (4). The exact moment that identity is verified or established will be resolved by the facts known to the officer in each individual case.

STOPS

14. DEFINITION: A temporary restraint of a citizen's liberty by an officer

15. JUSTIFICATION: Reasonable suspicion to believe a **crime** has been or is about to be committed, and the suspect to be stopped has committed it.
    1. This justification carries both an **objective and subjective component**. The officer must both subjectively believe that he or she has reasonable suspicion to believe that the suspect has committed a crime and that belief must be objectively reasonable.

16. STATUTORY AUTHORIZATION - ORS 131.605 through 131.625
    1. Definitions at ORS 131.605
        1. "Crime" has the meaning provided for that term in ORS 161.515.
        2. A "frisk" is an external patting of a person's outer clothing.
        3. "Dangerous weapon," "deadly weapon" and "person" have the meaning provided for those terms in ORS 161.015.
        4. 'Is about to commit' means unusual conduct that leads a peace officer reasonably to conclude in light of the officer's training and experience that criminal activity may be afoot.
        5. 'Reasonably suspects' means that a peace officer holds a belief that is reasonable under the totality of the circumstances existing at the time and place the peace officer acts as authorized in ORS 131.605 to 131.625.
        6. A 'stop' is a temporary restraint of a person's liberty by a peace officer lawfully present in any place.

    2. Stopping of persons at ORS 131.615
        1. A peace officer who reasonably suspects that a person has committed or is about to commit a crime may stop the person and, after informing the person that the peace officer is a peace officer, make a reasonable inquiry.

            1. "(H)as committed or is about to commit a crime:"
            2. Remember to always be ready to answer the question ... **What specific crime or crimes did you have reasonable suspicion to believe the defendant had committed?**
            3. Reasonable inquiry?

        2. The detention and inquiry shall be conducted in the vicinity of the stop and for no longer than a reasonable time.
            1. "Reasonable time:"

            2. Running a record check/warrant check on the suspect:

            3. AVicinity of the stop:≅
        3. The inquiry shall be considered reasonable if **it is** limited to:
            1. The immediate circumstances that aroused the officer's suspicion;

            2. Other circumstances arising during the course of the detention and inquiry that give rise to a reasonable suspicion of criminal activity; and

(1) Why might these circumstances have to be separately denoted in relation to the original circumstances?

3. **Ensuring the safety of the officer, the person stopped or other persons present, including an inquiry regarding the presence of weapons.**

(1) What form must this inquiry take?

4. **The inquiry may include a request for consent to search in relation to the circumstances specified in subsection (3) of this section or to search for items of evidence otherwise subject to search or seizure under ORS 133.535.**

1. There are two attributes to this section allowing officers to request consent:
   (1) Requests for consent to search in relation to officer safety issues presented in subsection (c) above ***(Ensuring the safety of the officer, the person stopped or other persons present, including an inquiry regarding the presence of weapons.)***

      (1) Does this mean an officer can follow ADo you have any weapons in the car?≅ with ADo you mind if I look just to be sure?≅

   (2) Requests for consent to search for Aitems of evidence≅

      (1) Examples: ***Remember the defintition***

2. **Remember,** this statutory section only allows the officer to request consent to search.....it is not an authorization to search anything or anywhere without consent.

5. **A peace officer making a stop may use the degree of force reasonably necessary to make the stop and ensure the safety of the peace officer, the person stopped or other persons who are present.**
   1. Handcuffing during the stop:

   2. What if suspect presents an articulable escape risk and no risk of safety to the officer?
   3. If such force or cuffing is necessary, the circumstances will now require Miranda warnings before any interrogation even though no arrest or custody is involved legally.

3. Frisking of stopped persons at ORS 131.625
   1. A peace officer may frisk a stopped person for dangerous or deadly weapons if the officer reasonably suspects that the person is armed and dangerous to the officer or other person present.
      1. How does this differ from subsection (c) above?
      2. What does it take to develop reasonable suspicion to believe that the defendant is armed and dangerous?
         (1) AAttack risk≅ sheet.

2. If, in the course of the frisk, the peace officer feels an object which the peace officer reasonably suspects is a dangerous or deadly weapon, the peace officer may take such action as is reasonably necessary to take possession of the weapon.

17. Since the statutory procedures are fairly straight forward, it is only a question of "what is reasonable suspicion" that remains.
    1. That will be individual to each case, but the decisions of the Court of Appeals and Supreme Court have shed a great deal of light on this area.
    2. The cases seem to break down into two types that we will review:
        1. Cases where a crime has been reported
        2. Cases where no crime has been reported
    3. Reasonable suspicion is less than probable cause but more than a hunch, which is unsupported by specific articulable facts.
        1. Not just a suspicion, but a reasonable suspicion

        2. Observable facts together with rational inferences

        3. And, even though reasonable suspicion may not be based entirely upon an officers' training and experience, the SIGNIFICANCE of particular facts may be evaluated on the basis of an officer's training and experience. This means that any time an officer relies on even a shred of training or experience in establishing reasonable suspicion to act, it must be presented in the report and on the witness stand.

        4. Named citizens who make personal observations and then volunteer that information to a police officer are presumed to be credible and reliable.
            1. Can named citizens also give opinions on matters to which the general public has common knowledge?

        5. An unnamed informant's information may or may not be useable to establish reasonable suspicion depending on the relative **reliability** of the unnamed informant. This is not a question of "Was the information provided by the unnamed informant enough to constitute reasonable suspicion?" Rather, it is a question of "Should we believe the informant?" The court will and an officer should first review the following three factors in deciding whether or not the citizen's report is reliable:
            1. Was the informant exposed to possible criminal or civil prosecution if the report was false?
                (1) This factor is satisfied where the informant delivers the information to the officer in person.

            2. Was the report based upon the personal observations of the informant?
                (1) Here, an officer may infer that the information is based on the informant's personal observations if the information contains sufficient detail to suggest that it must have been observed.

3. Finally, did the officer's own observations corroborate the informant's information?
   (1) The officer may corroborate the tip either by observing the illegal activity or by finding the person, the vehicle and the location substantially as described by the informant.

18. A crime has been reported.
   1. Summary of factors the court has looked-for in assessing reasonable suspicion.
      1.

      2.

      3.

      4.

19. No crime has been reported.
   1. At about 1:00 a.m. on a Saturday morning, defendant was driving behind a police car. He turned into the parking lot of an automobile supply business and parked his automobile. He left his automobile and was approaching the front door of the building when he was stopped by the police officer. The business was closed. There were automobile parts located around the building and the officer was concerned that the defendant intended to commit burglary. The officer asked the defendant what his purpose was. Defendant stated that he was there to pick up some parts and that he had the owner's permission. The defendant was then asked to show the officer his operator's license. When he could not produce one, the officer detained defendant while he "ran a records check" and thereby discovered the suspension.
      State v. Anderson
      46 Or. App. 501
      612 P.2d 309 (1980)
   2. About 1:30 a.m. in an "exceptionally heavy" burglary area on River Road in Eugene, Oregon, Officers Koop and Ware, who were patrolling in the area, saw two men emerge from the shadows adjacent to a church. One of the men was carrying an object but Officer Koop could not tell what it was. He was concerned, knowing that the church and businesses in the area were closed and that there were seldom many people on foot in the area this time of night. Having in mind it was an area of "numerous burglaries and thefts," Officer Koop decided to stop the men to make inquiry. When he stopped the men and asked for identification, he saw that the object defendant was carrying was the kind of jacket normally worn by a high school or junior high school student. Officer Koop considered this to be unusual. *State v. Vanderberg*
      550 P.2d 1248 (1976)
   3. The officer observed a car parked in the sand on the beach. "He radioed the vehicle license plate number to the police dispatcher, who then gave him defendant's name as the registered owner and said that the registered owner's license was suspended under circumstances that, if he were to drive, he would be committing a felony. (...) Later that evening, the officer saw the car being driven on a public street and followed it. He was able to see only the back of the driver's head and could not tell the driver's age or gender.
      State v. Panko,
      101 Or App 6, (1990)

20. Other stop related issues
   1. Outside the statutory authority in Chapter 131 ORS, the courts have identified the authority to conduct stops based on reasonable suspicion in some non-"crime" situations.

   2. **Furtive\evasive behaviors alone**:

1. What observations should an officer be prepared to make when the officer, with or without reasonable suspicion, sees a person run from the officer upon becoming aware of the presence of that officer?
   1.
   2.
   3.

3. **Dissipation**:

4. **Following and delaying** the stop:

5. BE PRECISE! Stop authority may not always apply to other people in the vicinity of the suspect or suspects immediately associated with the crime.

6. What about secondary suspicions before or during the stop?

ARREST

21. Definition: Actual or constructive restraint

22. Justification without a warrant: Probable cause to believe a crime has been committed and the person to be arrested has committed it.
   1. **Statutorily**, probable cause has been defined to mean "*that there is a substantial objective basis for believing that more likely than not an offense has been committed and a person to be arrested has committed it.*" ORS 131.005 (11)
   2. **Constitutionally**, probable cause, when examined by the courts as a constitutional standard, has been described as follows:

      " In *State v. Owens*, 302 Or 196, 204, 729 P2d 524 (1986), this court stated, in the context of **defining probable cause to arrest**:

      "Probable cause under the Oregon Constitution has both a subjective and an objective component. **An officer must subjectively believe that a crime has been committed and thus that a person or thing is subject to seizure, and this belief must be objectively reasonably in the circumstances.** The test is not simply what a reasonable officer could have believed when he conducted a warrantless search or seizure, but it is what this officer actually believed, based upon the underlying facts of which he was cognizant, together with his own training and experience."

      State v. Esplin

1. There are then two components to probable cause.
   1. 1. the SUBJECTIVE,
   2. and 2. the OBJECTIVE

3. The existence or not of probable cause is examined at the moment that the officer acts upon it.

4. Probable cause to arrest without first securing a warrant lasts as long as the probable cause does not dissipate. The common law rule allowing warrantless arrests at any time after probable cause is gathered seems to have been secured by the United States Supreme Court and there does not appear to be any trend toward a change for either felony or misdemeanor arrests.
   1. So, how long does probable cause last?

23. Justification for an arrest *with a warrant*: The warrant will "*command any peace officer to arrest the person for whom the warrant was issued.*" ORS 133.140
   1. Is there a **good-faith exception** where it later turns out that the person arrested is not the person listed in the warrant?

24. What is an arrest?
   1. *Arrest is "placing a person under actual or constructive restraint*

   (or)

   to take a person into custody for the purpose of charging him with an offense."

   (...)

   A stop is not an arrest. ORS 133.005 (1)

   1. What of the officers' intention to issue a citation rather than taking the defendant to jail?

2. Just a reminder, an arrest is a Fourth Amendment seizure. That is why it=s foundation must be based upon probable cause.
3. Arrest as an investigative tool.
   1. Arrests don't need to be based on proof positive.
      1. Simply the statutory standard of more likely than not. ORS 131.005 (11)
   2. Probable cause = power of arrest = power to hold for days = power to search incident to arrest.
   3. Probable cause may justify the arrest of more than one person.
      1. If, for example, a policeman sees A and B bending over a dead man and each accuses the other of killing the victim, there is probable cause for the arrest of either or both and the arrest of A does not preclude the arrest of B. Similarly, if A is found one

block north of a recently robbed bank and matches the description of the robber, the arrest of A does not preclude the subsequent arrest of B who also matches the description and is found one block south of the bank. In either case, it would be reasonable for the police to arrest both A and B on probable cause even though they believe that only one of them committed the crime. The purpose of the arrest, however, is not the traditional and statutory purpose of an arrest: to charge the arrestee with crime. **Rather, it is to initiate a short-term process of sorting out, usually on the scene, to determine which person should be charged with crime, i.e., arrested in the full sense of the word.** Thus the initial "arrest" is really in the nature of a stop or detention rather than a true arrest.

State v. Jordan,
36 Or. App. 45, (1978)

4. Under ***only*** the seven following ways may a police officer enter a constitutionally protected area such as a home or non-public office space to make an arrest (remember crimes only!):
   1. Search warrant
   2. Consent
   3. Arrest warrant
   4. Hot pursuit
   5. Imminent attempt to escape
      1. What about the mere possibility of escape?
   6. Imminent destruction of evidence
   7. Imminent injury to person or property

5. Does entry include crossing the residential threshold under the following circumstances:

1. The officer knocks on the door which is subsequently answered by the person to be arrested.
2. This is to be a probable cause arrest without a warrant.

3. The person to be arrested will not come out onto the porch to talk to the officer so the officer **reaches across the threshold, grabs and removes the defendant from the residence.**

6. Remember, absent true exigency (imminent), probable cause no matter how strong, standing alone, does not justify a forcible entry into private premises.

7. **Ordering a person to come outside** a constitutionally protected area constitutes a seizure at the moment the commandment is made. Such a maneuver may only be used where one of the seven exceptions applies and the order is the alternative for the forced entry.
8. Probable cause can be built from:
   1. Named citizens
      1. Named citizens who initiate a report to an officer concerning their own observations are **presumed credible and reliable**.
   2. The collective information known to other police officers and dispatchers

   3. Defendants known record or modus operandi.

   4. Observable facts interpreted or evaluated through the police officer's training and experience

   5. Flight by the suspects upon becoming aware of citizens or police officers in the area:
      1. But, remember, not flight standing alone.

   6. Confidential informants whose reliability can be specifically supported.

   7. Combinations of 1 through 6 above
9. A peace officer may arrest for any crime the officer did not observe when the officer has probable cause to believe the person to be arrested has committed the crime.
   ORS 133.310

10. Examples:
    1. Probable cause to believe DCS on a street corner:
       "Around 11:20 p.m., Portland Police Officer Mahuna was driving to work in his personal car when he stopped at a red light at the intersection of Northeast Killingsworth and Albina Streets [in the City of Portland]. Immediately in front of his car was a van that also had stopped for the light. Mahuna could see both the driver and a passenger through a window in the back of the van. He also could see defendant standing near a bus shelter on the adjacent sidewalk, about ten feet away. The officer saw the passenger in the van gesture to defendant and say something to defendant, although he could not hear what the passenger said. Defendant looked to the left and to the right, stepped into the street and approached the van. Defendant put his head and one hand into the open passenger window for about three seconds. He then turned and walked away. Mahuna saw no money or any other objects exchanged. As defendant walked back toward the sidewalk, he put his right hand into his right rear pants pocket. Mahuna did not, however, see whether defendant put any object into his pocket. The light then turned green, and both the van and Mahuna drove away. At that point, Mahuna believed

that he had just witnessed a hand-to-hand drug transaction. In his experience, the area is a known location for such transactions; he had made numerous arrests for possession and delivery of a controlled substance at that very corner. Mahuna refrained from arresting defendant because he was not yet on duty.

> "Two hours later, while on duty, Mahuna returned to the intersection of Northeast Killingsworth and Albina Streets. He saw defendant standing on the same corner. Mahuna stopped, got out of his car, approached defendant and told defendant to put his hands on his head. Defendant did so, while Mahuna patted down his right rear pocket. Mahuna felt an object in the pocket that he suspected was rock cocaine. He reached into the pocket and removed a plastic bag containing what appeared to be cocaine. Mahuna then arrested defendant * * *."
>
> 146 Or. App. at 461-62.

In addition, the following facts are important: The bus stop was a place at which, according to Mahuna, drug dealing was going on "twenty-four hours a day, seven days a week." Such intense commercial activity was made possible by the fact that the bus stop was only one half-block from an apartment complex that served, again according to Mahuna, as a kind of "safe haven" for drug dealers, who either live in or have keys to the complex. Mahuna explained that a dealer typically would keep a significant store of drugs in the complex, but would venture onto the street with only a small amount, because in an emergency it would be easier to quickly dispose of such an amount. Once they made a sale, Mahuna testified, dealers would return to the complex to obtain more drugs and go through the same process again.

Mahuna also testified that many "hand-to-hand" drug sales occurred at the location of the bus stop. The transactions, which took only a few seconds, would occur either at the corner or around the corner and part way down a side street. Mahuna explained that "a lot" of people did not like to conduct their drug transactions on Killingsworth, which is a major arterial street in the area.

Finally, Mahuna testified that, although he did not actually see anything pass to or from defendant's hand when defendant reached inside the van, what he saw was consistent with other "hand-to-hand" drug transactions that he had observed at that very corner.

As noted, defendant moved to suppress the evidence seized from him. The trial court granted the motion, ruling that, although Mahuna believed that he earlier had observed a drug transaction, that belief was not objectively reasonable, without some observation that defendant actually had exchanged something tangible with someone in the van.

On the state's appeal, the Court of Appeals characterized Mahuna's actions in his encounter with defendant as an arrest. 146 Or.App. at 462-63, 934 P.2d 467. We agree. The Court of Appeals then concluded, however, that Mahuna did not have probable cause to arrest defendant. *Id.* at 463, 934 P.2d 467. For the reasons that follow, we disagree with that conclusion.

Under ORS 133.310(1)(a), an officer may arrest a person without a warrant "if the officer has probable cause to believe that the person has committed * * * [a] felony." The amount of objective knowledge required to provide "probable cause" to make such an arrest is defined in ORS 131.005(11): An arresting officer has probable cause to arrest if "there is a substantial objective basis for believing that more likely than not an offense has been committed and a person to be arrested has committed it." Those statutory standards are met in this case.

Relying on his previous experience, Mahuna testified that: (1) due to the availability of a "safe haven" for dealers in a nearby apartment complex, drug transactions were occurring at the location of the bus stop on a more-or-less continuous basis; (2) defendant was at that location late at night, with no other apparent purpose for being there; (3) when hailed by the occupant of the van, defendant looked both up and down the street before going to the van, as if to assure that he would not be observed closely when he reached it; (4) defendant's interaction with the occupants of the van was consistent with a "hand-to-hand" drug transaction, considering its duration, intensity, furtiveness, and defendant's apparent pocketing of something immediately afterward; (5) defendant was back at his post later that same evening, reinforcing the belief that he was dealing drugs on the corner.

From Mahuna's testimony, we have no difficulty concluding that he subjectively believed that defendant had committed a crime. Under the totality of the circumstances, we further conclude that Mahuna's belief was objectively reasonable. Especially significant, in our view, is the fact that defendant was back at the corner two hours after his encounter with the van. Given all that Mahuna already had witnessed and the specific nature of that location as a drive-up drug dispensing location near "crack central," it was more likely than not that defendant was dealing drugs at that corner and was, when Mahuna saw him the second time, actually in possession of drugs. It follows that Mahuna had probable cause to arrest defendant and that the ensuing seizure of drugs from defendant was lawful as a seizure incident to the arrest.

The Court of Appeals' contrary conclusion in this case appears to have turned, at least in part, on the failure of Mahuna actually to see anything in defendant's hand during the encounter with the van. 146 Or.App. at 465, 934 P.2d 467. But seeing something in a suspected dealer's hand cannot be the sine qua non of probable cause, any more than any other single fact. The fact that a drug transaction was occurring could be inferred from the totality of the circumstances surrounding the event. Ultimately, the question in every case is whether the totality of the circumstances, i.e., the direct evidence and the inferences that fairly may be drawn from that evidence, establish probable cause. As we have explained, the evidence and inferences in this case readily fulfill that role.

The Court of Appeals' majority relied on this court's opinion in *State v. Bates*, 304 Or. 519, 747 P.2d 991 (1987), as supporting the opposite conclusion. In *Bates*, the defendant was stopped for a traffic infraction late at night in an area characterized (without elaboration) by one of the arresting officers as a "high crime residential" area. A television and a videocassette recorder were in plain view in the defendant's car. Although the defendant produced a valid Washington driver's license, the officers were suspicious. Seeing the end of "some kind of a bag" on the floor beneath the defendant's feet, the officers asked the defendant to pull the bag from between his feet so that the officers could see what it was. When the defendant did not comply, one of the officers drew his service revolver, ordered the defendant to get out of his car, and seized the bag. The bag contained drugs and ammunition; a further search of the car disclosed a loaded handgun. The defendant was convicted of possessing the drugs and the gun. The Court of Appeals affirmed without opinion. *State v. Bates*, 85 Or.App. 428, 736 P.2d 629 (1987).

On review, this court reversed. The *Bates* court addressed each of the objective facts that was relied on by the arresting officers but concluded that, whether considered alone or together, those facts did not justify the officer's search of the defendant's car. As most pertinent here, the Court of Appeals' majority relied on the following passage from *Bates*:

> " '[The officer's] suspicions in this regard may have been an excellent guess--the kind resulting from a sixth sense that many officers develop over the years. But, again, there is no objective quality to them that entitles them to any weight, either individually or collectively, in the constitutional calculus. Neither the hour nor the "high crime" nature of the area tells us whether this defendant is likely to be a criminal, unless there is some reason to think that everyone driving in that particular area at that time of night is up to no good * * *.' "
>
> *Martin*, 146 Or.App. at 463, 934 P.2d 467 (citing Bates, 304 Or at 526) (emphasis in original).

This court continues to adhere to the analysis and principles set forth in *Bates*. This case, however, is different. The key contrast between the facts in *Bates* and the facts in this case is that, as we have explained, there is abundant evidence, all of which we have summarized, that creates probable cause to believe that "this" defendant was engaged in criminal activity. The arresting officer in Bates acted--so far as that record disclosed--on the basis of a suspicion, i.e., a hunch. Here, both Mahuna's observations and his conclusions, filtered through the lens of his experience, are shown in his testimony to be objectively reasonable. That difference dictates the difference in outcome between the two cases.

State v. Martin,
327 Or 17 (1998)

25. Searches Incident to an Arrest (SIA)

1. Any SIA must be based upon a lawful arrest.
    1. The officer must be able to articulate the facts and interpretations of those facts which establish the probable cause for the arrest.

2. An arrest is an arrest and, therefore, the right to search incident to that arrest generally is not affected by whether or not the officer ultimately cites the arrestee in lieu of continued custody or books the arrestee into jail.

3. To lawfully SIA, the officer should, at the least, be able to testify that the person was "technically under arrest" for the crime or each crime that the officer wants to search incident thereto.
    1. Is it necessary for an officer to tell the defendant that he or she is under arrest before the SIA can occur?

2. Is it necessary that an officer first decide to arrest the defendant for the crime the officer has probable cause to believe has been committed before the SIA can occur?
3. Lastly, is it necessary for the officer to subsequently charge the defendant with the additional crime the officer had probable cause to believe had been committed for the SIA that the officer conducted to be lawful?

4. The above case law is especially true in situations involving "progressive probable cause". In situations where there has been no arrest of the defendant, it is still preferable to either make the arrest or be at least able to testify that the defendant was "technically under arrest" at the time of the SIA.

4. What can be searched for? (**object of the search**)
   1. Police officers have the right to search for the following 3 groups of items:
      1. Weapons
      2. Articles of escape
      3. Evidence of Athe≅ crime for which the person has been arrested

5. While searching for those objects, what areas may be searched? (**scope of the search**)
   1. **Person**
   2. The **area within the immediate control** of the suspect.
      1. This has in the past been referred-to a the wingspread or lunge area but those words may be too limiting in relation to the Oregon Courts' use of the phrase "within the immediate control of the suspect."
      2. "Within the immediate control of the suspect" includes:
      3. The "area within the immediate control of the suspect" in a vehicle includes:

6. While searching for those objects in those areas, into how small a closed container can the officer search? (**intensity of the search**)
   1. For WEAPONS AND ARTICLES OF ESCAPE on persons and the area within the immediate control of the suspect.
      1. The search of a person for weapons and/or articles of escape is always begun by an external pat-down.
      2. Ordering or requesting the defendant to remove the items from all pockets:

3. Where the officer can articulate why an external pat-down will not suffice to assure the preclusion of weapons or articles of escape:

4. If upon pat-down, the officer can articulate the presence of unidentifiable items which may be weapons or articles of escape:

5. If no weapons or articles of escape are detected on pat-down, a more detailed search for them can be conducted where the officer believes that there is reasonable suspicion, based upon specific articulable facts, that the defendant might pose a risk of serious physical injury or a serious escape risk to the officer.
   (1) Opening closed containers:

6. If upon initial exterior inspection the officer **comes to believe** that a container possesses an article of escape:

2. For EVIDENCE OF THE CRIME for which the person was arrested on persons and in the area within the immediate control of the suspect:
   1. The officer may search into any place for "evidence" of **the** crime including the pockets of the suspect. The officer need only articulate what those items might be and how they might fit into the space to be searched?
   2. When the arrest is based upon an outstanding warrant, the officer can search for evidence of **the** crime if the officer has probable cause to believe that evidence of the past crime will still be found on the person.

3. Unless opening a closed container or entering some constitutionally protected area to look for the items listed above in the manner listed above, there is no general right to simply open any container found so as to determine it's contents.

7. While searching for those objects in those areas and into those specific spaces, within what period of time must the SIA take place? (**Time within which the search must occur**)
   1. "Incident to an arrest" means close in time to the arrest.

   2. A SIA should, then, be done at a time prior to the point at which the processing at the arrest scene reaches a LOGICAL STOPPING POINT.

OFFICER SAFETY RESPONSES

26. The Supreme Court of the State of Oregon has made one thing exceptionally clear:

A police officer may take reasonable steps to protect himself or others if, during a lawful encounter with a citizen, the officer develops a reasonable suspicion, based upon specific and articulable facts, that the citizen might

pose an immediate threat of serious physical injury to the officer or to others then present.

State v. Bates,
304 Or. 519 (1987)

27. Clearly there are those situations where an officer safety related response is necessary.....and with the above guideline in mind, these necessary responses are allowed!

28. But remember, all aspects of the legal basis for such responses described above must be satisfied and **the report must reflect** each aspect of that basis. Each component of the above legal basis can be examined to better understand this important officer right.

1. **A lawful encounter**
    1. BRIGHT LINE: The officer should be involved in an action that is a function or duty of the office.

    2. What about a mere conversation encounter?

2. **A reasonable suspicion based upon specific articulable facts**
    1. This is perhaps the most important aspect of taking action to protect officer safety. Not only must each officer develop the awareness of the types of **behaviors** that are predictors and indicators of future violence but, more importantly, each officer must learn to **report and testify** as to the significance of those observations.
    2. The biggest pitfall in this area of police work is the temptation to simply reduce the reported reason for taking action to Afor officer safety.≅ The court will require specific behaviors beyond general concerns.

    3. In reporting the factors which caused the police officer to take reasonable steps for officer safety, reports should articulate specific behavioral observations of the defendant and other information known to the officer such as:
        1. Aggressive behavior
        2. Hostile behavior
        3. Intoxicated behavior
        4. Uncooperative behavior, especially failure to keep hands visible
        5. Threatening behavior
        6. The presence of a weapon or an apparent weapon
        7. Background information known to the officer which bears on the safety of the specific encounter
        8. See the AAttack Risk≅ sheet.

3. **The person might pose an immediate risk of serious physical injury.**
    1. Mere access to weapons does not give rise to a reasonable suspicion that defendant posed an immediate threat of using them.

4. **To the officer or others present**
    1. This includes many community policing and investigatory encounters where the threat may well be to a third person.

29. Once reasonable suspicion has been established, the officer is not limited to a "pat down", but may take reasonable steps to ensure the officer's safety.

30. When dealing with purses, bags, backpacks and other closed containers, the officer may determine that the reasonable step to ensure officer safety is to take possession of the container when there is a reasonable suspicion that it may contain a weapon. In only certain circumstances does the officer have the right to open such containers.

31. More on reasonable steps
    1. Must police officers, in all cases, ask questions before frisking?
    2. Entering a vehicle to seize an apparent weapon:
    3. Does the weapon have to be an illegal weapon?
    4. Does the defendant have to be in the car for the officer to be able to go into the car and seize a weapon for safety?
    5. When going beyond the external pat-down:
        1. Take safety precautions in order of seriousness to officers.

OTHER LIMITED RIGHTS TO SEARCH OR SEIZE WITHOUT A WARRANT

32. EXCEPTIONS GENERALLY
    1. These narrowly drawn and individually distinct exceptions are in addition to the rights to search previously discussed in PERSON ENCOUNTERS.
    2. Each exception must be applied to the street situations individually even though ultimately more than one exception may apply to allow a search.
    3. When presented with a street situation where a question of search or seizure arises, remember each exception and review each one to determine any applicability. NOTE: these exceptions are listed in no special order.
        1. Search incident to arrest
        2. Stop and frisk

3. Officer safety response

4. Consent

5. Probable cause plus exigent circumstances

6. Community caretaking

7. Plain vs. open view

8. Inventory

9. Emergency aid doctrine

10. Searches of mislaid property

4. Remember, the preferred method for conducting searches in Oregon is by search warrant. The above exceptions are just that; exceptions to the preferred search procedure which is to secure a warrant.

33. **CONSENT**

1. The consent exception has been summarized by the Court as follows:
   AUnder the consent exception to the warrant requirement, the state must prove by a preponderance of the evidence that someone having the authority to do so voluntarily gave the police consent to search the defendant's person or property and that any limitations on the scope of the consent were complied with.≅
   State v. Weaver,
   319 Or 212 (1994)
2. Requesting and gaining consent is too simple.
   1. As simple as: "Can I search you?";
      Answer: "Sure, go ahead!"

   2. As a result, although there are legal considerations, the officer's personal communication skills will normally make or break an officer's success ratio in this area.
3. Again, where an officer is requesting consent, the request must be in the form of a question.

4. Of course, some persons will simply volunteer consent.
5. As a general rule, consent must precede the search and seizure for the exception to apply to evidence seized. This is because most requests for consent imply that the officer will conduct the consented-to search only if and after consent has been given.

6. However, a consent can apply retroactively to validate a search or seizure that would otherwise be unlawful. Such a request for retroactive consent must specifically include terminology which relates

back to an earlier search such that it is clear that the consent given applies to the earlier search. As an example, an officer may be searching inside a constitutionally protected area for what the officer believes to be a legitimate reason sanctioned by the Oregon constitution as interpreted by the Oregon Appellate Courts when the officer finds an unexpected item of considerable evidentiary significance. Some officers have stopped the search at that point, left the item of evidence in place, and returned t ask the suspect for general consent to search the area. For such a tactic to validate the later seizure of the previously observed item based upon a valid consent search, the officer must not trade upon or take advantage of the previous search to obtain defendant=s consent. Such a consent has been referred-to as retroactive consent. Of course, this is only of importance where the officer wants to attempt to gain a useable consent in addition to the other warrantless search exception that formed the basis for the original search.

7. Remember, in the absence of any evidence to the contrary, a consent will be treated as being intended by the consent giver as prospective only.
8. Seeking a voluntary consent as a viable police tool works well because consent is a waiver of a constitutional right.
    1. **Does the officer need probable cause or reasonable suspicion** to be able to ask for consent?

    2. Does defendant=s refusal to consent to a search help the officer establish reasonable suspicion or probable cause?

9. The consent must be shown by a "preponderance of the evidence" to be voluntary.
    1. To be voluntary, the officer must avoid conduct that is either intimidating or coercive and any circumstances that might Aimpair defendant=s capacity to make a knowing, voluntary, and intelligent choice.

    2. Intelligent waivers can involve situations where the officer informs the person of the consequences of refusing to give consent. Of course, such a communication may be viewed as "coercive."
    3. How does intoxication affect a knowing and voluntary consent?

    4. <u>HOWEVER</u>, to be voluntary, police officers do not need to:
        1.
        2.
        3.
        4.
        5.

10. Persons may give consent **by conduct.**

11. A person can give lawful consent to accompany an officer to some other location such as the police precinct.

12. Consent can be limited.
    1. When officers rely on consent as the basis for a search, they act only with the authority that they are given by the consenting person. **A consent to search may be confined in scope to specific items or persons, restricted to certain areas or limited in purpose or time.**

    2. How does the request for consent affect the scope of the search which results from an affirmative response to that request?

        1. However, even a broad grant of authority to search is not without limits. The critical question is what would a reasonable person have understood the consent to encompass.

    3. How does the **defendant's response** to the officers' initial request for consent affect the scope of the search.

    4. Consent can be limited by the words used by a **defendant who requests the officers enter** into a constitutionally protected area.

13. Consent may be revoked.

    1. Absent an express revocation, a consent is presumed to continue.

14. Third party consent
    1. The RULE: Consent by one who possesses common authority over premises is generally valid as against the absent defendant with whom that authority is shared. The authority which justifies the third party consent does not rest upon the law of property, with its attendant historical and legal refinements ... but rests rather on **mutual use** of the property by persons generally having joint access or control for most purposes...

    2. Common authority is **not an ownership** or property law question.

    3. What is the effect of the statement of a consent-giver such as "I live here?"

        1. What about the consenting party=s partner=s nightstand or closet?

4. What about items being stored on the premises for a third person?

5. Is there a "good faith rule" in situations involving apparent common authority?

6. Generally, lessors and landlords do not have authority to take the officer into a renter or lessee's residence.

7. To enter with a third party who has a LIMITED right to be on the premises, must the officer also be acting within that limited right?

8. Can a child give valid consent for a search of the family home?

15. Once consent is obtained, the officer may **request** the consenter to take a particular position to facilitate the acquired right to search.

34. PROBABLE CAUSE PLUS EXIGENT CIRCUMSTANCES

1. P/C alone = the need to get a warrant

   P/C plus E/C = the practical necessity to conduct the search now

2. Exigent circumstances have been described as "practical necessity".
3. The investigating officer must be aware of the time expense it takes to get a telephonic search warrant so as to know the "practical necessity" of searching without one.
   1. Must be looking for a clear opportunity to get a warrant

4. Probable cause plus exigent circumstances is most often used as the **mobile vehicle exception**.
   1. The Oregon/Supreme Court held that a motor vehicle can present an exigent circumstance under the following **rule**:

      1. **If the motor vehicle is mobile at the time it is stopped by the officer**

         and

         either before or after the stop, the officer establishes probable cause to believe the vehicle contains evidence of crime or contraband

         then

         The officer can conduct a full immediate search of the vehicle for those items.

   2. The court has been willing to extend the exception to vehicles that were not stopped by the officer but, nonetheless, were vehicles which presented the requisite exigency. Although

the courts speak in terms of **moving, mobile and occupied,** the cases seem to place the most emphasis on **mobile and occupied.**

1. What are the limits the courts have placed upon the terms **mobile** and **occupied**?

3. This right extends to areas not touched by the officers' rights to search incident to an arrest.
4. No one **must** be arrested for this exception to apply.

5. How extensive can a search under the mobile vehicle exception be?

6. But, don't forget the need for probable cause.

7. **Immediate** means that the search under this exception must be commenced as promptly after the seizure as is reasonable in the circumstances.

8. As with all exceptions to the warrant requirement, officers must avoid the deliberate posturing of a situation so as to evade the warrant requirement. Under this exception, an example might be waiting for about an hour for the defendant to drive away from a park so that the officer could "stop a moving vehicle" and apply the mobile vehicle exception. Although the court has not been willing to infer a bad motive in these situations, they will most certainly suppress any evidence seized as a result of a proven deliberate scheme to evade the warrant requirement.

35. **PLAIN V. OPEN VIEW**

1. This exception involves a seizure doctrine.

2. It is first important to distinguish where this warrantless seizure doctrine applies.
   1. **Plain view describes a situation where the officer is inside a constitutionally protected area and is looking inside that area.**

      1. When in this situation, **no warrant is required to seize** evidence of crime or contraband.
   2. **Open view describes a situation where the officer is outside a constitutionally protected area and is looking into that area.**

      1. When in this situation, **a warrant or an exception to the warrant requirement is required** to enter the area and seize the evidence

3. There are **two requirements** then for a valid plain view seizure.
   1. **Justifiable prior intrusion into a constitutionally protected area**

      1. Examples:

2. What portions of private property are open to the public and as a result are also open to a police officer to enter?

2. **Probable cause for the item to be seized**

4. Is inadvertence required for a plain view seizure?

36. **COMMUNITY CARETAKING**

1. In a 1988 opinion, the Supreme Court ruled that there was no "generic community caretaking function." It went on to point out that whether or not law enforcement officers have specific functions is a matter of statutory law. Since there was no "community caretaking" statute defining an officers functions when acting in a community caretaking situation, the court suppressed evidence found by an officer who entered a constitutionally protected area on a "generic community caretaking" mission. Since then, the Supreme Court has indicated that, where there is a statute granting such authority, evidence found in plain view while performing such statutory duties may be used in evidence in a criminal prosecution.

2. ORS 133.033 recently provided statutory authority for police officers to affect constitutional rights while performing community caretaking functions.

1. **133.033** *peace officer; community caretaking functions.*

(1) Except as otherwise expressly prohibited by law, ***any peace officer of this state, as defined in ORS 133.005, is authorized to perform community caretaking functions.***

(2) ***As used in this section, "community caretaking functions" means any lawful acts that are inherent in the duty of the peace officer to serve and protect the public. "Community caretaking functions" includes, but is not limited to:***

(a) ***The right to enter or remain upon the premises of another if it reasonably appears to be necessary to:***

(A) *Prevent serious harm to any person or property;*

(B) Render aid to injured or ill persons; or

(C) Locate missing persons.

(b) The right to stop or redirect traffic or aid motorists or other persons when such action reasonably appears to be necessary to:

(A) *Prevent serious harm to any person or property;*

(B) Render aid to injured or ill persons; or

(C)Locate missing persons.

(3) Nothing contained in this section shall be construed to limit the authority of a peace officer that is inherent in the office or that is granted by any other provision of law.

3. In summary, this statute provides the statutory authority to perform these type of functions because the Supreme Court has held that no such inherent community caretaking authority exists within the Oregon Constitution beyond the Emergency Aid Doctrine discussed later in the outline.

4. The only unresolved issue is to what extent a police officer, faced with a community caretaking issue, must first acquire a search warrant.

5. Community caretaking is really a "justifiable prior intrusion into a constitutionally protected area" as required for plain view seizures.

37. INVENTORY

1. Inventories can be required by a governmental agency for people or things. The most common inventory of a person involves those being processed into a secure facility such as a jail or detoxification center. The most common inventory of a thing involves the inventory of a vehicle being impounded by an officer.

2. THE INVENTORY OF CONTENTS OF IMPOUNDED VEHICLES OR PEOPLE

1. A police officer may inventory anything or person lawfully impounded provided that authorization exists for the procedure used, such as a statute, ordinance or departmental general order, that requires law enforcement officers to inventory vehicles under the circumstances and that expressly delineates the purposes and limits of the officers' authority.

2. This concept is best embodied by a simple **THREE-STEP RULE:**
   1. **The vehicle or person must be lawfully impounded.**
   2. **The inventory must not deviate from the ordinance, statute or departmental procedure which sets-out the inventory procedure.**
   3. **The inventory procedure does not include opening closed containers beyond the scope of the ordinance or statute.**

Chapter 14.10
POLICE DUTIES TO INVENTORY PROPERTY
(Added by Ord. No. 168241, Oct. 26, 1994.)

Sections:

14.10.010 Purpose.

This Chapter is meant to exclusively apply to the process for conducting an inventory of the personal property in an impounded vehicle and the personal possessions of a person in police custody and shall not be interpreted to affect any other statutory or constitutional right(s) that police officers may employ to search persons or search or seize possessions for other purposes.

14.10.020 Definitions.

For the purpose of this Chapter, the following definitions shall apply:

A. **"Valuables"** means:

1. Cash money of an aggregate amount of $50 or more; or
2. Individual items of personal property with a value of over $500.

B. **"Open container"** means a container which is unsecured or incompletely secured in such a fashion that the container's contents are exposed to view.

C. **"Closed container"** means a container whose contents are not exposed to view.

D. **"Police custody"** means either:
1. The imposition of restraint as a result of an 'arrest' as that term is defined at ORS 133.005 1.;
2. The imposition of actual or constructive restraint by a police officer pursuant to a court order;
3. The imposition of actual or constructive restraint by a police officer pursuant to ORS Chapter 426;
4. The imposition of actual or constructive restraint by a police officer for purposes of taking the restrained person to an approved facility for the involuntary confinement of persons pursuant to Oregon law.

E. **"Police officer"** means any officer of the Portland Bureau of Police or the Port of Portland Police Department.

14.10.030 Inventories of Impounded Vehicles.

A. The contents of all vehicles impounded by a police officer will be inventoried. The inventory shall be conducted before constructive custody of the vehicle is released to a third-party towing company except under the following circumstances:
1. If there is reasonable suspicion to believe that the safety of either the police officer(s) or any other person is at risk, a required inventory will be done as soon as safely practical; or
2. If the vehicle is being impounded for evidentiary purposes in connection with the investigation of a criminal offense, the inventory will be done after such investigation is completed.

B. The purpose for the inventory of an impounded vehicle will be to:
1. Promptly identify property to establish accountability and avoid spurious claims to property;
2. Assist in the prevention of theft of property;
3. Locate toxic, flammable or explosive substances; or
4. Reduce the danger to persons and property.

C. Inventories of impounded vehicles will be conducted according to the following procedure:
1. An inventory of personal property and the contents of open containers will be conducted throughout the passenger and engine compartments of the vehicle including, but not limited to, accessible areas under or within the dashboard area, in any pockets in the doors or in the back of the front seat, in any console between the seats, under any floor mats and under the seats;
2. In addition to the passenger and engine compartments as described above, an inventory of personal property and the contents of open containers will also be conducted in the following locations:
   a. Any other type of unlocked compartments that are a part of the vehicle including, but not limited to, unlocked vehicle trunks and unlocked car- top containers; and
   b. Any locked compartments including, but not limited to, locked vehicle trunks, locked hatchbacks and locked car-top containers, if either the keys are available to be released with the vehicle to the third-party towing company or an unlocking mechanism for such compartment is available within the vehicle.
3. Unless otherwise provided in this Chapter, closed containers located either within the vehicle or any of the vehicle's compartments will not be opened for inventory purposes.
4. Upon completion of the inventory, the police officer will complete a report as directed by the Chief of such officer's department.
5. Any valuables located during the inventory process will be listed on a property receipt. A copy of the property receipt will either be left in the vehicle or tendered to the person in control of the vehicle if such person is present. The valuables will be dealt with in such manner as directed by the Chief of the police officer's department.

14.10.040 Inventories of Persons In Police Custody.

A. A police officer will inventory the personal property in the possession of a person taken into police custody and such inventory will be conducted whenever:
1. Such person will be either placed in a secure police holding room or transported in the secure portion of a police vehicle; or
2. Custody of the person will be transferred to another law enforcement agency, correctional facility, or "treatment facility" as that phrase is used in ORS 426.460 or such other lawfully approved facility for the involuntary confinement of persons pursuant to Oregon Revised Statute.

B. The purpose of the inventory of a person in police custody will be to:
1. Promptly identify property to establish accountability and avoid spurious claims to property; or

2. Fulfill the requirements of ORS 133.455 to the extent that such statute may apply to certain property held by the police officer for safekeeping; or
3. Assist in the prevention of theft of property; or
4. Locate toxic, flammable or explosive substances; or
5. Locate weapons and instruments that may facilitate an escape from custody or endanger law enforcement personnel; or
6. Reduce the danger to persons and property.

C. Inventories of the personal property in the possession of such persons will be conducted according to the following procedures:
1. An inventory will occur prior to placing such person into a holding room or a police vehicle, whichever occurs first. However, if reasonable suspicion to believe that the safety of either the police officer(s) or the person in custody or both are at risk, an inventory will be done as soon as safely practical prior to the transfer of custody to another law enforcement agency or facility.
2. To complete the inventory of the personal property in the possession of such person, the police officer will remove all items of personal property from the clothing worn by such person. In addition, the officer will also remove all items of personal property from all open containers in the possession of such person.
3. A closed container in the possession of such person will have its contents inventoried only when:
   a. The closed container is to be placed in the immediate possession of such person at the time that person is placed in the secure portion of a custodial facility, police vehicle or secure police holding room;
   b. Such person requests that the closed container be with them in the secure portion of a police vehicle or a secure police holding room; or
   c. The closed container is designed for carrying money and/or small valuables on or about the person including, but not limited to, closed purses, closed coin purses, closed wallets and closed fanny packs.

D. Valuables found during the inventory process will be noted by the police officer in a report as directed by the Chief of such officer's department.

E. All items of personal property neither left in the immediate possession of the person in custody nor left with the facility or agency accepting custody of the person, will be handled in the following manner:
1. A property receipt will be prepared listing the property to be retained in the possession of the respective police department and a copy of that receipt will be tendered to the person in custody when such person is released to the facility or agency accepting custody of such person;
2. The property will be dealt with in such manner as directed by the Chief of such officer's department.

F. All items of personal property neither left in the immediate possession of the person in custody nor dealt with as provided in Subsection 14.10.040(E) above, will be released to the facility or agency accepting custody of the person so that they may:
1. Hold the property for safekeeping on behalf of the person in custody, and
2. Prepare and deliver a receipt, as may be required by ORS 133.455, for any valuables held on behalf of the person in custody.

---

3. **"Lawful impound"**

1. To be a lawful impound, there must be a statutory or ordinance source for the authority to impound the person or vehicle.

   (1) Examples:

2. Must the vehicle be towed or the person transported?

3. What about impounding or transporting solely or partially to form a basis to inventory (search) the contents of the vehicle or of a person=s pocket?

4. For an impound to be lawful, the impound process must follow the terms of the enabling ordinance, statute or departmental general order.

5. Remember, this is not a search incident to arrest procedure. The allowable purpose of an inventory is simply to "inventory." However, any evidence or contraband that is located in plain view during the inventory will be subject to seizure under the 'plain view' doctrine.

38. Emergency Aid Doctrine
    1. This very narrow exception to the warrant requirement known as the Emergency Aid Doctrine is applicable when the following conditions are met:
        1. **The police *must have reasonable grounds to believe that there is an emergency and an immediate need for their assistance for the protection of life.***
        2. **The emergency must be a *true* emergency - the officer's good faith belief alone is insufficient.**
        3. **The search must not be primarily motivated by an intent to arrest or to seize evidence.**
        4. **The *officer must reasonable suspect* that the *area or place to be searched is associated* with the emergency and that, by making a warrantless entry, the officer will discover something that will alleviate the emergency.**
            1. The court specifically declined to hold officers to a probable cause connection between the place to be searched and the emergency. Instead, only a requirement that there be a reasonable suspicion to believe that such a connection exists.

39. Searches of Abandoned, Lost or Mislaid Property
    1. Officers will see the need to search abandoned, lost or mislaid property for identification so as to facilitate it's return to the proper person.
        1. The purpose of the search must be limited to a search for ID.

        2. What happens once some ID is found?

    2. Can closed containers be opened?

    3. Of course, this is different from a situation where the suspect disclaims any interest in the property to be searched. This situation is presented when an officer, upon finding a receptacle, asks those persons present whose it is. All persons deny ownership. What is the legal effect of such a denial?

I. Course Title: Internal Affairs Division Class

II. Instructors: Sergeant John P. Smith & Sergeant Jeff Barker

III. Date/Time: October 7, 1998 / 1100-1200

IV. Training Audience: Advanced Academy 98-3

V. Course Goals: To provide a basic understanding of the mission of Internal Affairs and the complaint investigation process.

VI. Performance Objectives:

Upon completion of this course the student will be able to:

1. Understand the purpose of Internal Affairs.
2. Understand the IAD investigative process
3. List the complaint categories
4. List the case/complaint findings
5. Understand the purging of IAD files
6. Understand contractual obligations and rights

VII. Course Outline:

A. Purpose of IAD
B. IAD Investigative Process
C. Complaint Categories
D. Case Findings
E. Purging of IAD Files
F. Officer Contractual Obligations and Rights

VIII. Lesson Plan:

A. Purpose of IAD
-monitor performance
-provide leadership
-assisting Bureau in meeting value of accountability

B. IAD Investigative Process
-complaint acceptance
-complaint designation(service, personnel performance deficiency, misconduct, unlawful employment practice, criminal)
-complaint investigation

C. Complaint Categories
-(property, use of force, conduct, communication, procedure, performance, disparate treatment)

D. Case Findings
-(exonerated, insufficient evidence, unfounded, sustained, declined, inquiry, mediation)

E. Purging of IAD Files
-time requirements

F. Officer Contractual Obligations and Rights
-Union representation

Lesson Plan prepared by Sergeant John P. Smith, #19657.

Q A.

TALKING POINTS
for
PORTLAND POLICE BUREAU
ADVANCED ACADEMY

I. INTRODUCTION

A. Thank you for the opportunity to speak to your group.

B. I am glad that you share my interest in one of my favorite topics--our community and the crime issue.

II. OVERVIEW OF CRIMINAL JUSTICE SYSTEM

A. Spokes on a wheel

1. Police

2. Courts

3. Prosecution

4. Defense

5. Corrections

B. Need all of the components working together to move forward.

III. CRIME SITUATION

A. Scorecard on the local level for '97

1. Case Summary

	1997
Misdemeanors/Violations/TRAFFIC Issued:	11,184
DUII Issued:	3,522
Domestic Violence (M & F) Issued:	1,562
Felonies Issued:	9,274
Total Issued:	25,542
Misdemeanors/Violations/Traffic Declined:	3,923
DUII Declined:	96
Domestic Violence (M & F) Declined:	2,863
Felonies Declined:	2,380
Total Declined:	9,262

2. Homicides

1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
53	48	42	60	49	64	60	50	48	50

3. Child Abuse

	1992	1993	1994	1995	1996	1997
MDT Case Reviews	4996	6144	6253	5895	2865	3663
Children Involved	7181	8418	8078	7843	4280	5975

B. Drugs a Continuing Problem

1. Felony Drug Cases Issued by DA

1989	1990	1991	1992	1993	1994	1995	1996	1997
2726	2681	2561	3347	3725	3590	4430	4133	4487

2. Locally, we have established a Drug Court which has helped get people into treatment.

C. Juvenile Crime

1. Nationally, juveniles are becoming involved in more serious crime at a younger age.

2. Locally, we have seen the same phenomena. November 1994 passage of Ballot Measure #11 by over 70% of voters in Oregon sent a clear message.

V. BALLOT MEASURE #11

A. An initiative petition

B. Went into effect April 1, 1995

C. Means that Ballot Measure #11 offenses (listed on the attached handout)

1. When committed by juveniles 15, 16 and 17 years old, that the juveniles must be tried in adult court and, if convicted, serve the mandatory sentence in the adult system.

2. When committed by adults and convicted the adults must serve the mandatory sentence.

D. Impacts of Ballot Measure #11

1. Significant changes throughout the criminal justice system in the procedures around arraigning, charging and prosecuting juveniles.

2. Significant increases in the length of time juveniles and adults will be incarcerated which translates into the need for greater prison capacity at the state level and, due to changes at the state level, (the domino effect) the need for additional jail capacity at the local level.

3. A great deal of attention has been given to the impact on juveniles but as of September 22, 1998, there have been 642 juveniles arrested on Measure #11 charges but 3,628 adults have been arrested or charged.

4. The real impact is on the adult side because, with the mandatory sentences there is little opportunity to negotiate sentences therefore little incentive to plea.

VI. SENTENCING GUIDELINES

A. Ballot Measure #11, because it was an initiative petition, is not entirely integrated with Oregon's Sentencing Guidelines.

B. The intent of Sentencing Guidelines is to insure an even handed response to both the crimes and the persons charged with the crimes - that persons with similar criminal histories convicted of a burglary in Gold Beach or Harney County receive a similar sentence to a person convicted in Multnomah or Clackamas County.

C. Sentencing Guidelines Grid (handout)

VII. JAIL CAPACITY

A. Between Ballot Measure #11 and SB #1145 Multnomah County is going to need additional jail capacity. Ballot Measure #11 will put offenders in prison for longer periods of time which will take up space currently used for those offenders who are in the lower regions of the Sentencing Guidelines Grid.

B. SB #1145 places responsibility for offenders sentenced to 12 months or less at the county level. In Multnomah County we expect about 700 additional offenders will become our responsibility as a result of this bill. These offenders became the responsibility of the county in January, 1997.

C. Each county was required to submit a plan to the state as to how the county will incarcerate, supervise and monitor these offenders sentenced to 12 months or less.

D. Multnomah County's plan includes building an additional 330 beds and acquiring 150 secure beds for alcohol and drug treatment to hold the 700 additional offenders we are expected to have in our local criminal justice system. On March 2, 1998, a total of 280 new jail beds were launched at Inverness Jail.

E. These 330 beds will be in addition to what is in place in Multnomah County. We also must recognize the need to accommodate the increasing population in this area and the continuing crime rate.

G. Though they are basic to an effective public safety program, we know that jails alone are not the answer.

H. Budget reductions from Measure 47 will place an added burden on criminal justice agencies.

VIII. ROLE OF PROSECUTION

A. Traditional prosecution -- responding to the individual crime.

1. In trial.
2. Negotiating pleas.
3. Getting convictions.
4. Sending the "bad guys and gals" off to jail.

B. Standard view of the prosecutor

1. Fighting crime
2. In the courtroom.
3. In the courthouse.

4. On a case by case basis.

(The whole move toward community policing requires us to look at the prosecution component and examine who we work with the police.)

IX. THE PROSECUTOR AND COMMUNITY POLICING

A. What are the concerns police officers hear about from citizens?

1. Livability crimes

2. Maintenance and order crimes

3. Misdemeanors

B. How can the prosecutor help the police with these crimes?

1. Can stick with the traditional criminal justice response; arrest, prosecute and attempt to punish, crime by crime.

2. Determine if there are other ways to get at the crime problems that affect our neighborhoods day in and day out.

3. Determine if there are non criminal justice remedies to standard public safety issues like, theft and vandalism, car prowls, offensive public behavior, aggressive pan handling and illegal camping.

5. Basically requires a reexamination of the methods used by the District Attorney's Office to serve the citizens -- customer service so to speak.

C. The prosecutor supports the police role.

1. Police officers with years of experience and expertise in traditional police work are now being asked to look for new tools in solving community crime problems.

2. The police are creative, they develop possibilities and need to be supported by the prosecutor and the courts. (Such as the trespass authority issue.)

4. The prosecutor can answer the questions police have about whether or not they can do something different.

5. Prosecutor and police can work together to bring greater definition to community policing.

Which leads us to:

X. OVERRIDING GOAL

A. We all know that a clean, safe and vibrant community offers the best climate for families, for business, for recreation and for education.

B. A safe community is essential to our "quality of life". We need to improve the "quality of life" within our community.

C. How can we work together to do that? By developing and implementing long term strategies that attack "maintenance and order" crimes such as theft and vandalism, car prowls and street disorder crimes.

D. We are trying what we call the Neighborhood DA Program and a Community Court in NE Portland.

XI. NEIGHBORHOOD DA PROGRAM

A. Began as a response to concerns from one district (Lloyd/Holliday) re: crime.

B. Now in place in five geographic areas within Multnomah County and a sixth deputy is located with Tri-Met.

1. The original project began in November of 1990 in the Lloyd District.

2. In April of 1991 a second program was put in place in the residential communities of North and Northeast Portland.

3. In January of 1993 the third program was established in the Central Business District of Portland.

4. In November, 1993 the fourth program began in the City of Gresham.

5. The fifth program began in July 1994 in the Southeast area of Portland. It includes a support enforcement component.

6. Thanks to Tri-Met a sixth deputy began work on crime problems associated with public transportation in August 1995.

7. Thanks to the City of Portland's Local Law Enforcement Block Grant, a seventh DDA began work in the outer SE neighborhoods in November 1996.

XII. COMMUNITY COURT

A. A Community Court opened March 4, 1998, at the King Neighborhood Facility.

B. It is in session the first and third Wednesday of each month with Judge Clifford Freeman presiding.

C. Targets non person misdemeanor-low level, quality of life, crimes.

D. Eligible defendants reside in North or Northeast precincts or commit the crime in those target areas.

E. It is a plea court where defendants are sentenced to community service.

F. Between March and September we have had an appearance rate of 78% and a completion rate of 71%.

G. It has an active Community Advisory Board and we all want to see the Community Court expanded both in scope and location.

H. Southeast Portland (Lentz & Brentwood-Darlington) and Downtown Portland are our next target areas.

I. We want to get to the point where police officers can cite directly to the Community Court in your neighborhood.

J. I believe one of the key factors behind these changes has been community policing.

1. We also work closely with law enforcement (community policing) in each of these neighborhoods. Community policing changes the way law enforcement does their job. It has an impact on what police need from the prosecutor. Community policing also affects the public's perception of and expectations from the justice system.

2. Community policing is having wide ranging effects. We have had to change the way we do business and it is beginning to change the way courts do business -- community courts.

PPA ADVANCED ACADEMY PRESENTATION

* Check in with Training Division Staff on arrival

I Introduce Self - write name on blackboard

- Bureau experience
- PPA experience
- going to pass on useful info - no test questions

II During last several years PPA has been given time during the Advance Academy to discuss PPA issues with new officers and issues of importance to us

- Remind class that PPA means the "collective us." We have all bonded together to form a union to collectively represent all of our best interests and the PPA officers aren't "the PPA." The Union officers work for and represent the membership.

III Deadly Force Representations

- A great, accomplishment of the PPA was working with the Police Bureau and D.A.'s office to establish policy for legal representation of officers involved in use of deadly force situations.

- A few years ago officers were not allowed Union reps or attorneys when involved in shootings. (Any citizen has the right to an attorney in similar situations.)

- With increased violence on streets and increased number of officer-involved shootings (16 in 1992 involving about 40 PPA members), the representation issue had to be resolved. It was very acrimonious at first with City. In years past in some cases, shooting officers were treated similarly to suspects. This has all changed now and the PPA was successful in having a new G.O. 1010.10 (Use of Deadly Force) implemented.

* Read this G.O. and become very familiar with it. Chances are that at least some of you will be involved in a use of deadly force case.

Here is what to do when involved in the use of deadly force or on a call where another officer is involved in the use of deadly force:

1. Take care of the tactical situation, advise supervisors, do the police-related business.

2. Call the Association President - do not worry about the President getting too many calls - The President worries about not getting a call.

3. Call or have someone else immediately call the President or Secretary-Treasurer of the PPA directly. The PPA and the PPA attorney will normally respond to the scene. Do not discuss with anyone what happened until the PPA or PPA attorney have had a chance to talk to you.

YOU DON'T DISCUSS HOW THE DEFENSE ATTORNEY IS APPOINTED.
THE PARAGRAPH BELOW NEEDS TO ORGANIZED CHRONOLOGICALLY.

You might do a walk-through with your attorney present. After the PPA rep and attorney talk to you, they will make a decision on whether or not to call in one of the PPA's criminal defense lawyers. These lawyers are normally called in if the use of force has resulted in injury or death. The defense attorney is the PPA member's personal attorney and acts in your best interest as an advocate. After discussing the incident with the member, they *** THEY WHO*** will make a joint decision on whether or not to partake in an interview, but most importantly, when the interview will take place. Because of stress, it is much more appropriate to conduct the interview hours later or even the next day. The PPA rep will be available in Detective Division to run interference during the investigation.

Attorney will represent the PPA member through the Grand Jury process. Don't worry about the costs of the attorney; the PPA pays the bill and is reimbursed by the City by contract.

Questions?

IV Grievances by PPA; on behalf of [redacted], discuss [redacted] arbitration and other current grievances

[redacted]

Questions)

V Discuss current issues: i.e., IAD, contract, etc.

Questions

VI Internal Affairs

Internal Affairs is in a state of change. They are presently enforcing **"quality control"** - that is they are asking to see your notebook for the incident involved and they will 'ding' you if it is not per G.O. CYA!

Always, Always take an association rep with you to IA. That is what we are here for. Notify a rep as soon as you are notified about the hearing so the rep can be sure they are available. We can usually find someone to go with you and IA has been good in the past about rescheduling if necessary.

We are there to help you through the process, we are not there to help anybody "make up" a story. The truth is not only important, it is all important in IA.

VII Retention Hearings

(Use your experience as a coach here)

- All PPB officers must successfully complete 18 months probationary period. Entire time is a learning experience for the new officer.
- If Training Division perceives a pattern of problems, then the probationary officer can be required to go through a formal retention hearing process to see if they should be dismissed or allowed to continue employment.
- About 5% of all new hires are dismissed during probation.
- Advice: You will make mistakes, learn from them, listen to your coaches, strive to learn the job and make improvements. Talk to your coaches, talk to Training Division staff - they are there to help you learn. We all want you to succeed. Place other personal issues on hold, if possible.

- If you have serious problems and are required to go through a retention hearing, you have the right to have any Bureau member of your choice assist?`/represent you. The PPA does not have the absolute right to represent you, but we can and will. Leo Painton has represented numerous probationary officers in hearings and has developed expertise in the process. If you are advised of a retention hearing, call him at the PPA office.

  Remember, the Training Division wants you to succeed and will do everything it can to retain you. They have too much invested in you to try to throw you away. Their goal is to see you succeed, not fail.

  Questions?

VIII Public Safety Act and other outside issues.

Explain the Public Safety Act briefly. Cover deferred compensation changes in the law; its your money. Inactive accounts and payout decisions.

IX Community Policing

Community Policing can only work with an educated, professional force. The association works hard to maintain pay and working conditions that will attract the high caliber of people you will want to work with.

X Encourage interest and involvement in PPA. It's only as strong and professional as we make it.

The Association is US. We encourage newer officers to get involved.

Questions?

Instructors:
Sgt. Leon Lefebvre
Sgt. Jeanne Stevenson

PEER SUPPORT EDUCATIONAL PROGRAM

I. INTRODUCTION
   A. Personal Background
   B. Injury Experience

II. FORMATION OF DISABLED OFFICERS' TEAM
   A. Development of Benefits Officer
   B. Employees Assistant Program
      1) EAP Coordinator - Robert King
      2) Liaison Officer - Cyndi Rose
   C. On the Job Injury Packet

III. PROVIDE EXAMPLES
   A. FBI Statistics for Injuries in the Line of Duty
   B. PPB injury Log

IV. INFORMATION
   A. American With Disabilities Act
   B. G.O. 410.00
   C. Civil Rights/Law Suits

V. RESPONSIBILITY
   A. Classmates/Themselves
   B. Validation of Feelings
   C. Emotions Experienced
   D. Post Traumatic Stress Disorder Handout

VI. SENSITIVITY
   A. Appropriate/Inappropriate Comments
   B. Be Considerate Not Cynical
   C. Handout on Support Fellow Officers Involved in Shootings and Other Traumatic Incidents

VII. QUESTION AND ANSWER PERIOD.

CRIMINAL JUSTICE CODE OF ETHICS

AS A CRIMINAL JUSTICE OFFICER, my fundamental duty is to serve humankind; to safeguard lives and property; to protect all persons against deception, the weak against oppression or intimidation, and the peaceful against violence or disorder; and to respect the Constitutional rights of all people to liberty, equality, and justice.

I WILL keep my private life unsullied as an example to all; maintain courageous calm in the face of danger, scorn, or ridicule; develop self-restraint; and be constantly mindful of the welfare of others. Honest in thought and deed in both my personal and official life, I will be exemplary in obeying the laws of the land and the regulations of my department. Whatever I see or hear of a confidential nature or that is confided to me in my official capacity, will be kept ever secret unless revelation is necessary in the performance of my duty.

I WILL never act officiously or permit personal feelings, prejudices, animosities, or friendships to influence my decisions. Without compromise and with relentlessness, I will uphold the laws affecting the duties of my profession courteously and appropriately without fear or favor, malice or ill will, never employing unnecessary force or violence, and never accepting gratuities.

I RECOGNIZE my position as a symbol of public faith, and I accept it as a public trust to be held so long as I am true to the ethics of The Criminal Justice System. I will constantly strive to achieve these objectives and ideals, dedicating myself before God[1] to my chosen profession.

X _____ *I swear before God to the above.*

_____ *I affirm to the above.*

Chris Humphreys — *Signature*

32784 — *BPSST Number*

2-22-99 — *Date*

Chris Humphreys — *Print Name*

[1] *Reference to religious affirmation may be omitted where objected by the officer.*

Basic #200

PORTLAND METROPOLITAN REGIONAL BASIC ACADEMY #2001-1

JUNE 4, 2001

TRAUMATIC INCIDENT AWARENESS REFERENCE MATERIAL

Material Compiled and Presented by
Denney Kelley

Stress Continuum

General Stress	Cumulative Stress	Critical Incident Stress	Posttraumatic Stress Disorder
Inescapable	Build-up of general stress	Caused by traumatic event	Requires 30+ days of symptoms post-incident, including: 1. Intrusion 2. Avoidance 3. Arousal
Normal	Destructive over time	Normal	Debilitating
Distress	Burnout	Painful/upsetting but normal	PTSD

Note: No amount of cumulative stress will result in Critical Incident Stress or PTSD.

Defining Critical Incident

Solomon-Any situation that results in an overwhelming sense of vulnerability or loss of control.

Mitchell-Any situation faced by emergency service personnel that causes them to experience unusual strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later.

Fay-An event which challenges ones worldview and produces a temporary state of psychological unbalance and emotional turmoil. (Mitchell)

NORMAL TRAUMATIC STRESS REACTIONS

1. During the Incident

   - Sensory acuity heightened and focused (tunnel vision 67%).
   - Functioning on "auto pilot," training kicks in.
   - Time distortion, slow (67%) or fast (16%) motion.
   - Depersonalization.
   - Auditory distortion, diminished (51%) or increased (18%) sound.
   - Rate of respiration increases.
   - Non-essential bodily functions shut down.
   - Pulse and blood pressure increase.
   - Hormonal release including adrenaline, cortisol and thyroxine.

2. Immediately Following the Event

   - Stress hormones continue at elevated levels.
   - Hyper vigilance.
   - Difficulty tracking.
   - Headache.
   - Nausea, vomiting, diarrhea.
   - Agitation.
   - Anger at what happened.
   - Exaggerated startle reflex, "jumpy."
   - Muscle tremors.
   - Feeling unusually cold or warm.
   - Hyperventilation/lightheaded feeling.
   - Profuse sweating.

Note: Many officers report that they do not feel the full impact of the incident until two or three days afterwards.

3. 72 Hours to 30 Days Post Incident

- Sleep/Appetite Disturbances.
- Agitation.
- Irritability/Anger Outbursts.
- Hyper vigilance.
- Difficulty concentrating.
- Headaches/nausea/other physical complaints.
- Mood swings.
- Shame/guilt.
- Preoccupation with the incident.
- Unusual feelings of vulnerability.
- Recurrent/intrusive/distressing memories.
- Nightmares.
- Flashbacks.
- Anxiety when exposed to events that resemble or symbolize the incident.
- Feeling like an outsider or distant from others.
- "What's the use" attitude or resignation to early death.
- Restricted range of emotions.
- Escapist or numbing behaviors.
- Depressed immunity/increased susceptibility to illness.

Critical Incident Stress Information Sheet

You have experienced a traumatic event or a critical incident (any incident that causes someone to experience unusually strong emotional reactions which have the potential to interfere with their ability to function). Even though the event may be over, you may now be experiencing or may experience later, some strong emotional or physical reactions. It is very commons, in fact quite *normal*, for people to experience emotional aftershocks when they have passed through a horrible event.

Sometimes the emotional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. And, in some cases, weeks or months may pass before the stress reactions appear.

The signs and symptoms of a stress reaction may last a few days, a few weeks or a few months and occasionally longer, depending on the severity of the traumatic event. With understanding and the support of loved ones, the stress reactions usually pass more quickly. Occasionally, the traumatic event is so painful that professional assistance from a counselor may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by him or herself.

Here are some common signs and signals of a stress reaction:

Physical*	Cognitive	Emotional	Behavioral
Chills	Confusion	Fear	Withdrawal
Thirst	Nightmares	Guilt	Antisocial acts
Fatigue	Uncertainty	Grief	Inability to rest
Nausea	Hypervigilance	Panic	Intensified pacing
Fainting	Suspiciousness	Denial	Erratic movements
Twitches	Intrusive images	Anxiety	Change in social activity
Vomiting	Blaming someone	Agitation	Change in speech patterns
Dizziness	Poor problem solving	Irritability	Loss or increase of appetite
Weakness	Poor abstract thinking	Depression	Hyperalert to environment
Chest pain	Poor attention/ decision making	Intense anger	Increased alcohol consumption
Headaches	Poor concentration/ memory	Apprehension	Change in usual communications
Elevated BP	Disorientation of time, place or person	Emotional shock	
Rapid heart rate	Difficulty identifying objects or people	Emotional outbursts	
Muscle tremors	Heightened or lowered alertness	Feeling overwhelmed	
Shock symptoms	Increased or decreased awareness of surroundings	Loss of emotional control	
Grinding of teeth		Inappropriate emotional response	
Visual difficulties			
Profuse sweating			
Difficulty breathing			

**Any of these symptoms may indicate the need for medical evaluation.*

ABNORMAL TRAUMATIC STRESS REACTIONS

1. The persistence of any normal symptom(s) beyond a period of 30 days.

2. The presence of any symptom(s) to such a degree that normal social or occupational functioning is impaired.

3. Suicidal ideation.

4. A marked increase in the consumption of alcohol or other drugs.

5. Increased risk taking to the point of foolhardiness.

6. Episodes of domestic violence.

7. Obsessive second guessing.

BIO-CHEMISTRY OF TRAUMATIC STRESS

1. Assessing a situation as life threatening results in a massive release of hormones. The purpose of this "chemical dump" is to permit a person to function at absolute peak efficiency for a brief period of time.

2. The amount of hormones released amounts to essentially an "overdose." The trade off nature has made is in favor of short-term effects from this overdose in exchange for the heightened abilities necessary for immediate survival.

3. These chemicals remain active in the body for up to two weeks and cause many of the symptoms associated with trauma.

4. Every detail associated with a life threatening incident is permanently etched into the memory but because of the effects of the stress hormones, these memories may be "filed" incorrectly.

5. This "misfiling" may cause gaps in what you recall, flashbacks, nightmares, or anxiety experienced seemingly at random. These are normal reactions to abnormal circumstances.

6. Physical exercise on a regular basis beginning within 24 hours of the traumatic incident and continuing on a daily basis can help "burn off" the hormones causing the symptoms.

7. Consumption of caffeine immediately after a traumatic incident and/or consumption of alcohol within a period of 72 hours after a traumatic event can make the symptoms worse.

THE THREE FACTORS WHICH PREDICT THE SEVERITY OF TRAUMA REACTIONS

1. Prior History of the Individual

   - Individuals with prior unresolved traumas and problems maybe more susceptible to psychological injury.

2. The Perceived Severity of the Trauma

   - Sudden, unexpected.
   - Person experiences vulnerability.
   - Person experiences loss of control.
   - Outcome.
   - Degree of injury, threat, death to self and others.

3. Nature of the Recovery Environment (what happens to person afterward)

   - Treatment by agency.
   - Peer support.
   - Command staff support.
   - Support from friends and family.
   - Psychological debriefing and treatment.
   - Public support.

Of the above three factors, No. 3, the Nature of the Recovery Environment, is the most important. How a person is treated afterward usually makes the biggest difference in how quickly they recover.

PRIMARY FACTORS IN RECOVERY FROM STRESS AND TRAUMA

1. Self-Care

   - Healthy lifestyle choices.
   - Social/emotional support network of friends, peers, family.
   - Proactive in solving own problems (educate self about problems and coping strategies, seek help when needed, avoid victim mentality).
   - Spiritual foundation (not necessarily religious) that provides values, meaning, and purpose to life.

2. Peer Support

   - Peer support and counseling training.
   - Traumatic incident support team.
   - Alcohol recovery support team.
   - Peer adviser team.
   - Disabled officer support team.
   - Significant other support team.

3. Good Supervision and Administrative Support

   - Commitment to physical and emotional welfare of employees.
   - Training in supervision skills and mental health issues.
   - Administrative support for good supervision.
   - Good role modeling by supervisors.
   - Innovative program development.
   - Willingness to confront problems.
   - **People are First.**

4. Mental Health Professionals

- Training for employees and supervisors.
- Clinical supervision in peer support issues.
- Traumatic incident debriefings.
- Psychotherapy.
- Consultation as problems arise.
- Psychological evaluations.

Peer Support Checklist

DO:

- ☐ Remember confidentiality.
- ☐ Respond in person as quickly as possible. Be prepared to spend some time with him/her.
- ☐ Get the individual some distance from the immediate scene.
- ☐ Let the person determine how much contact s/he wants to have with you; however, *never leave someone alone if you have concerns about his/her state of mind.*
- ☐ Remind the individual that his/her physical, sensory, emotional, and thinking symptoms are normal.
- ☐ Assist the person in contacting his/her family.
- ☐ Offer to stay with or help him/her locate a suitable friend to stay with overnight for a day or two.
- ☐ Ask questions that show your concern such as, "How are you doing?" or "What can I do for your family?"
- ☐ Be careful about making statements to the effect of, "I'm glad to see you're OK." It is better to say, "I'm sorry you had to go through that."
- ☐ Listen non-judgmentally. Listening is doing something.
- ☐ Be prepared to repeat instructions and information.
- ☐ Suggest the individual use an answering machine to screen his/her phone calls for a period of days.
- ☐ Encourage him/her to consider the use of available administrative leave.
- ☐ Know your limits. Support the individual to get professional help when necessary.

Portland Police Bureau
Training Division
Lesson Plan

I. **Course Title** Use of Force

II. **Instructor** DDA Mike Kuykendall

III. **Date/Time** January 10, 2002

IV. **Training Audience** Advanced Academy #2001-4

V. **Course Goals**

To familiarize students with the laws regarding use of force as it pertains to the officers' careers as police officers.

VI. **Performance Objectives**

DPSST Performance Objectives

1. A2.8-002- Given a set of facts, determine if "Choice of Evils" can be supported.
2. A2.8-003- Given a set of facts, determine if "Duress" can be supported.
3. A2.8-004- Given a set of facts, determine if the defense of "Entrapment" can be supported. (Community Policing and Problem Solving)
4. A2.8-005- Demonstrate the ability to pass the "Use of Force exam" with a score of 100% (Required for successful completion of the Basic Police Course).

PPB Performance Objectives

VII. **Course Outline**

(See Presentation Material)

VIII. **Lesson Plan**

(See Presentation Material)

IX. **Community Policing Application**

(To be filled in later)

X. **Training Aid Requirements**

(To be filled in later)

XI. **Exam Questions**

Exam questions will be provided by DPSST on specified performance objectives, and DDA Mike Kuykendall for the PPB law exam.

XII. Lesson Plan Prepared By DDA Mike Kuykendall

XIII. Presentation Material

BASIC ACADEMY 2000
USE OF FORCE
Instructor: Mike Kuykendall

I. General introduction on use of force theory

1. The law values life above all things and seeks to avoid forceful encounters between citizens.

    1. Historical perspective-this concept has governed since the middle ages.

    2. But what about the rights of property owners? Do they have any rights?

B. This class is a class on legal theory and its application for police officers.

    1. Statutes lay out what the law is.

        a. How are laws made?

            (1) examples of different law making bodies and types of laws they make.

        b. To whom do they apply?

2. Caselaw gives guidance and clarification.
   a. What is caselaw?

   b. How are appellate decisions made?

3. In addition, Portland Police Bureau General Orders give specific directives to Portland Police Bureau officers.

   a. Who makes these orders?

   b. Why are they necessary?

C. Oregon law is very specific as to the right of every person concerning the use physical force.

1. Analysis of the law of justification

   a. ORS 161.190 ***JUSTIFICATION AS A DEFENSE***
   In any prosecution for an offense, justification, as defined in ORS 161.195 to 161.275, is a defense.

      (1) What is meant by "a defense"?

   b. ORS 161.195 ***JUSTIFICATION DESCRIBED***
   Conduct which would otherwise constitute an offense is justifiable and not criminal when it is required or authorized by law or by a judicial decree or is performed by a public servant in the reasonable exercise of official powers, duties or functions.

      (1) When is something required or authorized by law?

      (2) When is something required by a judicial decree?

(3) When is something performed by a public servant in the reasonable exercise of official powers, duties or functions?

D. Police officers and citizens stand with equal footing under most of the ORS.

E. Police officers have additional authority to use force under circumstances that a citizen could not. The Legislature has promulgated laws specific to law enforcement.

1. ORS 161.235 **USE OF PHYSICAL FORCE IN MAKING AN ARREST OR IN PREVENTING AN ESCAPE.**

2. ORS 161.239 **USE OF DEADLY PHYSICAL FORCE IN MAKING AN ARREST OR IN PREVENTING AN ESCAPE.**

F. The United States Supreme Court has a say in all of this in *Tennessee v. Garner*.

1. Firing a shot at a fleeing escapee is the equivalent of arresting that person, and, therefore, must be supported by probable cause.

G. PPB officers are also required to function within their general orders regarding the use of force.

1. 1010.10 **USE OF DEADLY PHYSICAL FORCE**
2. 1010.20 **USE OF PHYSICAL FORCE**
3. 1030.00 **USE OF BATON**
4. 1040.00 **AEROSOL RESTRAINTS**
5. 1050.00 **LESS LETHAL SHOTGUN AND MUNITIONS**

H. So, there are 3 concepts at work for officers in use of deadly physical force situations--the goal is to never have an officer indicted.

1. ORS requires an officer to "reasonably believe" a certain condition exists before deadly force is allowed.

2. Federal caselaw in *Tennessee v. Garner* requires probable cause to believe that the suspect poses a threat of serious physical harm before deadly force is allowed to effect an arrest.

3. PPB general order requires probable cause **and** a significant threat before deadly force allowed

II. Introduction to use of force legal theory

A. There are terms that must be clearly understood, most of which you may have studied in a previous class on ORS chapter 161:

1. *Physical injury means an injury that*

a. impairs a person's physical condition, or

b. causes substantial pain.

(1) examples of physical injury

2. *Serious physical injury means a physical injury that either:*

a. creates a substantial risk of death, or

b. causes serious and protracted disfigurement, or

c. causes protracted impairment of health, or

d. causes protracted loss or impairment of the function of any bodily organ

(1) Examples of serious physical injury

3. *Deadly weapon means any instrument, article or substance specifically designed for and presently capable of causing death or serious physical injury.*

   a. Examples of deadly weapons

4. *Dangerous weapon means any weapon, device, instrument, material, or substance which under the circumstances in which it is used, attempted to be used, or threatened to be used, is readily capable of causing death or serious physical injury.*

   a. Examples of dangerous weapons

5. *Physical force includes, but is not limited to, the use of electrical stun gun, tear gas or mace.*

   a. can someone use physical force but not cause an injury?

6. *Deadly physical force means physical force that under the circumstances in which it is used is readily capable of causing death or serious physical injury.*

7. ORS 161.245 *Reasonable belief* means

   a. *A reasonable belief in facts or circumstances which, if true, would in law constitute an offense.*
   If the believed facts or circumstances would not in law constitute an offense, an erroneous though not unreasonable belief that the law is otherwise does not render justifiable the use of force to make an arrest or to prevent an escape from custody.

b. *A peace officer who is making an arrest is justified in using physical force unless the arrest is unlawful and is known by the officer to be unlawful.*

c. When is an arrest unlawful?

How do the above provisions affect law enforcement?

8. ORS 131.005 *Probable cause means that there is a substantial objective basis for believing that more likely than not an offense has been committed and a person to be arrested has committed it.*

a. "substantial objective basis..." who decides what this is?

b. "more likely than not..." what does this really mean, and what do I need to do to establish this in my report?

B. Use of force generally

1. ORS 161.205 **USE OF PHYSICAL FORCE GENERALLY**
The use of physical force upon another person that would otherwise constitute an offense is justifiable and not criminal under any of the following circumstances:

a. parent, guardian, supervising person of a minor or an incompetent person

(1) may use reasonable physical force

(2) when and to the extent reasonably believes necessary

(3) to maintain discipline or promote the welfare of the minor or incompetent person

(4) applies to teachers in school, school events on o off of school property

b. an authorized official of jail, prison, or correctiona facility

(1) may use physical force when reasonably believes it i necessary to maintain order and discipline.

c. common carriers of passengers

(1) may use physical force when reasonably necessary t maintain order

(2) deadly force only when the person reasonably believe it is necessary to prevent death or serious physica injury.

(d) person acting under reasonable belief another is about t commit suicide or inflict serious physical self-injury

(1) may use physical force to extent reasonably believe necessary to thwart the result.

(e) in self-defense or in defending a third person, i defending property, in making an arrest or in preventin an escape.

2. Use of physical force - **General Order 10.10.20**
The Portland Police Bureau authorizes its members to use physical force in a police action:

(a) when and to the extent it is reasonably necessary to accomplish some official purpose, and

(b) the amount of physical force authorized may vary in degree and shall only be the amount of force that is reasonably necessary, depending upon the circumstances of each situation taken as a whole, to accomplish the official purpose.

(1) Is this different than the ORS?

C. The objective/subjective operation of ORS 161.209 **USE OF PHYSICAI FORCE IN DEFENSE OF A PERSON**

1. The standard test applied to all use of force scenarios is controlled by this statute:

A person is justified in using physical force upon another person

(a) for self-defense, or

(b) to defend a third person:

(1) from what the person reasonably believes to be the use or imminent use of unlawful physical force, and

(2) the person may use a degree of force which the person reasonably believes is necessary for the purpose.

2. **Objective standard**--was it reasonable to believe that the use of unlawful force by another was imminent? What factors contributed to this decision?

3. **Subjective standard**--did you use that degree of force that was reasonably necessary under the circumstances?

4. What may be reasonable for an untrained citizen may be

unreasonable for a sworn officer, i.e. trained in defensive tactics, has mace and baton, etc.

5. You take your training home with you and therefore you are always a police officer. (Subjectively under ORS, actually per **general order 10.10.10**).

6. You need to begin thinking about articulation of the underlying facts you observed.

7. What will the reasonableness of your conduct will be determined from?

   (a) What you know

   (b) What you can articulate about what you saw

   (c) How and to what degree you responded

8. PPB officers are all held to the standard set out in your PPB general order. Why?

9. The PPB general order is specifically designed to limit you in keeping your conduct within the confines of the law.

III. The operation of the use of force statutes generally

A. Analysis of ORS 161.215 **LIMITATIONS ON USE OF PHYSICAL FORCE IN DEFENSE OF A PERSON** A person is not justified in using physical force upon another person if:

1. With intent to cause physical injury or death to another, the

person provokes the use of unlawful physical force by that person, or

2. The person is the initial aggressor, unless they withdraw from the encounter and effectively communicate to the other person their intent to do so, and the other person continues or threatens to continue the unlawful use of force, or

3. The force involved is a product of combat by agreement

(Mutual combat)

State v. Gibson (1978) defendant came to his wife's aid in a scuffle with a bartender, where it was the wife who acted unlawfully in the first instance by grabbing the bartender, also a woman, whom she thought was "giving her man a bad time." Can defendant be prosecuted for assault if the bartender is injured?

B. Analysis of ORS 161.219 **LIMITATIONS ON USE OF DEADLY PHYSICAL FORCE IN DEFENSE OF PERSON** Deadly force is:

1. Not justified unless the person reasonably believes the other person is

(a) committing or attempting to commit a felony involving use or threatened use of physical force against a person, or

(b) committing or attempting to commit a burglary in a dwelling, or

(c) using or about to use unlawful deadly force against a person.

2. Objective/subjective test

(a) As it relates to private citizens v. police officers

(b) objective factors = use of unlawful force imminent

(c) subjective factors = did person use degree of force reasonably necessary for the purpose

3. What is the difference between a citizen and a p/o under the deadly force statute?

C. Analysis of ORS 161.225 **USE OF PHYSICAL FORCE IN DEFENSE OF PREMISES** A person is justified in using physical force upon another person:

1. Person in lawful possession or control of premises

2. When and to extent reasonably believes necessary

3. To prevent or terminate what the person reasonably believes to be

4. Commission or attempted commission of a criminal trespass in or upon the premises

5. <u>Deadly physical force</u> only when reasonably believes necessary to prevent commission of arson or felony by force and violence by a trespasser, or in defense of a person.

(a) is this a shift away from deadly force?

(b) how does the law apply to arson?

D. Analysis of ORS 161.229 **USE OF FORCE IN DEFENSE OF PROPERTY**

1. <u>Other than deadly force:</u> there is no lawful use of deadly force to defend property alone.

2. May use physical force upon another person and to the extent reasonably necessary to prevent or terminate the commission or attempted commission by the other person of theft or criminal mischief of property.

3. Are there scenarios where a defense of property may shift t self-defense?

E. Analysis of ORS 161.235 **USE OF FORCE IN MAKING AN ARREST C PREVENTING ESCAPE** (This is the 1st law enforcement statute)
A peace officer is justified in using physical force upon anothe person:

1. Only when and to the extent that the peace officer reasonabl believes it necessary:

   (a) to make an arrest or prevent the escape from custody of a arrested person unless the peace officer knows the arres is unlawful; or

   (b) for self-defense or to defend a third person from what th officer reasonably believes to be the use or imminent us of physical force while making or attempting to make a arrest or while preventing an escape

   Stephens v. City of st. Helens (1962)a drunk refused to mov from a chair in the police station. The court held that th officer's use of a device called a "come along" or "iron claw which caused a shoulder separation, among other injuries, wa not reasonable. Why?

F. Analysis of ORS 161.239 **USE OF DEADLY FORCE IN MAKING AN ARREST OI PREVENTING AN ESCAPE**
This is the law in Oregon re: fleeing felons. (Fleeing felons handouts and policy discussion)

1. Peace officer may only use deadly force when officer reasonably believes:

   (a) crime committed by a person was a felony involving the use or threatened use of physical force against a person; or

   (b) crime committed by the person was kidnapping, arson, escape 1, burglary 1, or any attempt to commit such crime; or

   (c) when the use of deadly physical force is necessary to defend the officer or another from the use or threatened imminent use of
   deadly physical force; or

(d) the crime committed was a felony or an attempted felony and under the totality of the circumstances existing at that time and
place, the use of force was necessary; or

(e) the officer's life or personal safety are endangered.

2. Will not justify reckless or criminally negligent conduct by an officer amounting to an offense against or with respect to innocent persons whom the officer is not seeking to arrest or retain in custody.

Lander v. Miles (1868) court held that firing a gun to secure an arrest is not justifiable when the arrest can be secured by less dangerous means.

Rich v. Cooper (1963) suspect resisted being placed in police car after duii arrest and po struck with sap 3 times: "Disputable presumption that a peace officer acted in good faith."

3. Tennessee v. Garner (1984) U.S. Supreme Court (Handout)

(a) "where the officer has probable cause to believe that the suspect poses a threat of serious physical harm, either to the officer or to others, it is not constitutionally unreasonable to prevent escape by using deadly force"..

(b) how does Oregon law regarding use of deadly force to apprehend fleeing felons differ?

(c) what was the supreme court's rationale for this?

(1) legally, shooting a person is a "seizure" of that person.

(2) philosophically, "the use of deadly force to prevent the escape of all felony suspects, whatever the circumstances, is constitutionally unreasonable. It is not better that all felony suspects die than that they escape. Where the suspect poses no immediate threat to the officer and no threat to others, the harm resulting from failing to apprehend him does not justify the use deadly force to do so...a police may

not seize an unarmed, nondangerous suspect by shooting him dead".

4. Has Oregon adopted to the federal mandate?

Examine Aaskay v. Maloney (1917). Police detectives, having arrested one who they had reason to believe, and evidently believed, had committed a felony, had the right, when he broke away, to use such means and degree of force as was reasonably necessary to recapture him, including shooting at him, if without evil design and under circumstances of imperative duty.
(1) Is this the law today? Why not?

(b) State v. Haro (1993) ORS 161.209 and 161.219 must be read together, as they refer to each other. Therefore, the "necessity" requirement applies to all uses of physical force.

(c) we need to modify our statute to be in compliance with Garner: cross out "Reasonable belief" and add "probable cause". (Bullet=arrest).

5. The probable cause standard deals only with arrest situations.

(a) for self-defense , defense of others, a reasonable belief is all that is necessary.

(b) what's the difference, then, between reasonable belief v. probable cause in a force situation?

6. How does the PPB general order on use of deadly force fit into all of this?

Use of deadly physical force-general order 10.10.10

"The use of statutorily defined weapons, barricades and vehicle ramming, constitutes deadly physical force.

The Bureau recognizes that members may be required to use deadly force when their life or the life of another is jeopardized by the actions of others. Therefore, state statute and Bureau policy provide for the use of deadly force under the following circumstances:

(a) members may use deadly force to protect themselves or

others from what they reasonably believe to be an immediate threat of death or serious physical injury,

(b) a member may use deadly force to effect the capture or prevent the escape of a suspect where the officer has probable cause to believe that the suspect poses a significant threat of death or serious physical injury to the officer or others, and, if feasible, some warning has been given."

(1) carotid hold

G. Analysis of ORS 161.245 **REASONABLE BELIEF STATUS OF UNLAWFUL ARREST**

1. You can be wrong on the facts but never wrong on the law.

H. Analysis of ORS 161.249 **USE OF PHYSICAL FORCE BY PRIVATE PERSON ASSISTING ARREST**

Do not do this...

1. A person who has been directed by an officer to assist the peace officer to make an arrest or to prevent an escape from custody is justified in using force when and to the extent the person reasonably believes force necessary to carry out officer's direction.

2. When directed by peace officer to assist, person may use deadly force only when:

(a) person reasonably believes deadly force necessary for self-defense or to defend a third person from what the person reasonably believes to be the use or imminent use of deadly force; or

(b) the person is directed or authorized by officer to use deadly force unless the person knows that the officer is not authorized to use deadly force under the circumstances.

3. What problems can you foresee when a citizen is directed or authorized to assist an officer making an arrest?

I. Analysis of ORS 161.255 **USE OF PHYSICAL FORCE BY PRIVATE PERSON MAKING CITIZENS ARREST**

This is arrest situation only (not a self defense situation); deadly force may not be used when merely arresting.

1. Private person acting on their own account is justified in using physical force when and to the extent they reasonably believe it is necessary to make an arrest or to prevent the escape from custody of an arrested person.

2. Justified in using deadly force only when the person reasonably believes it necessary for self-defense or to defend third person from use or imminent use of deadly physical force.

J. Analysis of ORS 161.260 **USE OF PHYSICAL FORCE IN RESISTING ARREST PROHIBITED**

1. A person may not use force to resist an arrest by a peace officer who is known or reasonably appears to be a peace officer.

2. Whether the arrest is lawful or unlawful

Careful!

3. This statute only governs reasonable force by police officers who are making an arrest.

4. Excessive force triggers the self-defense statutes as to the arrested person; the arrested person would be defending against armed police officers.

5. Where does that leave us on the objective and subjective tests? Free reign for citizen?

K. Analysis of ORS 161.265 **USE OF FORCE TO PREVENT ESCAPE**

1. A guard or peace officer employed in a correctional facility is justified in using physical force including deadly force when and to the extent that the guard or officer reasonably believes necessary to prevent escape of prisoner.

(a) how does this fit with Tennessee v. Garner and State v. Haro?

IV. General orders regarding other force issues

A. Use of baton G.O. 10.30.00

B. Aerosol restraints G.O. 10.40.00

1. Pepper mace is physical force for everyone

2. Mere possession of it does not immediately give rise to the use of physical force

3. There may be specific articulated facts that give rise to the use of physical force

4. There may be specific articulated facts that give rise to a greater level of force (deadly) in any scenario, but the mace will only be a contributing factor

C. Handcuffing, searching, and transportation of persons under arrest and detained G.O. 870.20

V. Defenses

DPSST Performance Objective A2.8-002

A. Choice of evils defense-ORS 161.200

1. Conduct which would otherwise constitute an offense is justifiable and not criminal when:

(a) necessary as an emergency measure to avoid an imminent public or private injury, and

(b) the threatened injury is of such gravity, that according to the ordinary standards of intelligence and morality, the desirability and urgency of avoiding the injury clearly outweigh the desirability of avoiding the injury sought to be prevented by the statute defining the offense in issue.

2. Kids need food--shoplift okay?
Work in North Portland. And need gun--ccw okay?

3. Self-defense is considered a statutory choice of evils. Why?

DPSST Performance Objective A2.8-003

B. Duress--ORS 161.270

1. Not a crime if actor coerced to do so by

(a) use or threatened use of unlawful physical force

(b) upon actor or third person

(c) force of such nature or degree as to overcome earnes resistance

2. Does not apply to murder

3. Not a defense for someone who intentionally or recklessly place themselves in a situation where it would be probable that the would be subjected to duress.

State v. Fitzgerald (1973) inmate passed hacksaw to another becaus he had been told by escapee he had friends on the outside who woul get the defendant==too vague a threat of future injury.
State v. Fowler (1978) third person held knife to the defendant's brother, but defendant and brother had 2 opportunities to leave = n duress.

4. Generally not a defense for a spouse acting under orders fro spouse, unless there is a threat or use of physical force.

DPSST Performance Objective A2.8-004

C. Entrapment==ORS 161.275

1. Not a crime if actor induced to do an act by law enforcement official, or person acting in cooperation with law enforcement, for purpose of obtaining evidence to be used against the actor in a criminal prosecution

2. Induced = actor did not contemplate and would not otherwise have engaged in the proscribed conduct

3. Merely giving the actor the opportunity to commit the offense doesn't amount to entrapment.

D. Intoxication==ORS 161.125

1. Intoxication can negate intentional or knowing mental state, but not a reckless mental state.

VI. Warrants

A. Arrest warrant-ORS 133.235

1. P/O shall state the officer's authority and reason for the arrest
2. In order to make an arrest, a peace officer may use physical force

B. Search warrant==ORS 133.605

1. The executing officer may use the degree of force, short of deadly physical force, against persons, to effect an entry or to open containers, as is reasonably necessary for the execution of the search warrant with all practicable safety.

2. Deadly force only where officer:

(a) reasonably believes that there is a substantial risk that things to be seized will be used to cause death or serious physical injury if their seizure is delayed and that the force used creates no substantial risk of injury to persons other than those obstructing the officer, or

(b) reasonably believes that the use of deadly physical force is necessary to defend the officer or another person from the use of threatened imminent use of deadly physical force.

State v. Mitchell (1971) Oregon recognizes exigent circumstances exception to the warrant requirement

State v. Wetteland (1972) generally, officers must knock and announce before entering premises unless some exigent circumstances.

State v. Steffes (1970) defendant, whose name matched that of a man involved in a series of hotel robberies, who had just been released from the pen, and that hotel clerks had stated that robber used a gun in each case, justified entry without knocking.

VII. Community caretaking provisions ORS133.033 (1991)

A. Any peace officer of this state is authorized to perform community

caretaking functions-any lawful act inherent in the duty of a peac officer and to serve and protect the public, including:

1. Enter and remain on premises of another, or stop or re-direct traffic, if it reasonably appears to be necessary to

   (a) prevent serious harm to any person or property

   (b) render aid to injured or ill persons

   (c) locate missing persons

2. How does community caretaking affect law enforcement?

VIII. Mere conversation-do force statutes apply?

IX. Group discussion-force scenario

A. You and your partner are called to the scene of a domestic disturbance at a house. When you arrive the neighbors report loud arguments and they are concerned about the safety of the occupants. You approach the door and you hear loud arguing.

What do you do?

B. You knock on the door 5 times and yell police, but get no response. What do you do?

C. You step back and look through the window, and see two people in the back in the kitchen, arguing. It looks to you that it possibly might be getting physical but you can't tell because you only can see them passing in the doorway. What do you do?

D. You see a punch thrown by someone and you enter. The woman is clearly more aggressive and is yelling at the man, calling him a worthless piece of dirt. The man is fairly docile. What do you do?

E. The woman keeps coming at the man and looks like she might hit him. What do you do?

F. She keeps coming towards the man and you have to push her away. What do you do?

G. She approaches a 3rd time, you push her and she pushes you and says I'm going to kill him, and she does not respond rationally. What do

you do? (Asp, mace, gun, takedown, cuff, arrest?)

H. Man starts reacting to what is occurring, and gets verbally hostile What do you do? Search for officer safety okay?

I. Woman on ground starts kicking at you violently. What do you do?

J. Man pulls gun. What do you do?

(Of course, at this point you have a right to defend yourself against the man's deadly physical force. But 20-20 hindsight guaranteed to ask why you did not search for officer safety earlier)

Portland Police Bureau
Training Division
Lesson Plan

I. **Course Title** Person Encounters and Search and Seizure

II. **Instructor** DDA Wayne Pearson

III. **Date/Time** January 14, 17, & 28, 2002

IV. **Training Audience** Advanced Academy #2001-4

V. **Course Goals**

The purpose of this training is to give the students a working knowledge of procedural law as it pertains to person encounters, and search and seizure.

VI. **Performance Objectives**

(To be filled in later)

VII. **Course Outline**

(See Presentation Material)

VIII. **Lesson Plan**

(See Presentation Material)

IX. **Community Policing Application**

(To be filled in later)

X. **Training Aid Requirements**

(To be filled in later)

XI. **Examination Questions**

Exam questions over this material will be provided exclusively by DDA Wayne Pearson for the PPB procedural law exam.

XII. **Lesson Plan Prepared By DDA Wayne Pearson**

XIII. Presentation Material

PERSON ENCOUNTERS

AND

SEARCH AND SEIZURE

This document is for use as an interactive outline in conjunction with the PPB Basic Academy. Each student is responsible for following the outline through the corresponding lectures and completing the outline with notes taken during class. The procedures exam will cover both the printed portions of the outline, as well as, the lectures relevant to the outline.

To begin with, you have already learned that evidence will be suppressed in a criminal action for certain unlawful police seizures. According to ORS 136.432:

A court may not exclude relevant evidence and otherwise admissible evidence in a criminal action on the grounds that it was obtained in violation of any statutory provision unless exclusion of the evidence is required by:

1. The United States Constitution or the Oregon Constitution;
2. The rules of evidence governing privileges and the admission of hearsay; or
3. The rights of the press

How does this affect the statutes that we will study concerning the limitations placed on officers by the Oregon Legislature?

Of course, constitutional violations will still be the subject of a motion to suppress in a related criminal prosecution.

Of course this does NOT mean that officers need not concern themselves with the statutes or the case law that has and will interpret these statutes in relation to lawfully allowed officer conduct.

Violations of statute will still be enforced through:

1.

2.

3.

As a result, we will learn the statutory parameters of good search and seizure law established by the Oregon Legislature along with the constitutional parameters as have been outlined by the Oregon and Federal Appellate Courts.

MERE CONVERSATION

1. DEFINITION: Mere conversation with a citizen occurs in any setting where there has been no significant restriction of the citizen.
   1. The concept is as simple as the officer's right to be free to walk up to a citizen, talk, and ask some questions.
      1. It's value is that you may:
         1. Interact with citizens outside restrictions associated with all forms of detention
         2. Ask questions of interest
         3. Make sensory observation

2. Mere conversation then must avoid a direct or indirect restraint or seizure of the person such that the encounter satisfies the constitutional standard as non-significant restriction or interference with the person.

1. For Oregon constitutional purposes, a person is restrained or "seized" when, either:

1. **A law enforcement officer intentionally and significantly restricts, interferes with, or otherwise deprives an individual of that individual's liberty or freedom of movement ... OR**

2. **Whenever an individual believes that (a) above has occurred and such belief is objectively reasonable in the circumstances.**

2. Specifically, the court said, "We hold that a "seizure" of a person occurs under Article I, section 9, of the Oregon Constitution (a) if a law enforcement officer intentionally and significantly restricts, interferes with, or otherwise deprives an individual of that individual's liberty or freedom of movement; or (b) whenever an individual believes that (a), above has occurred and such belief is objectively reasonable in the circumstances. (...) **Under these 'seizure' standards, law enforcement officers remain free to approach persons on the street or in public places, seek their cooperation or assistance, request or impart information, or question them without being called upon to articulate a certain level of suspicion in justification if a particular encounter proves fruitful. A street or public place encounter does not amount to an Article I, section 9 seizure merely because the encounter may involve inconvenience or annoyance for the citizen and the other party to the encounter is known to be a law enforcement officer.** Even physical contact does not transform the encounter into a 'seizure' if it is a normal means of attracting a person's attention (e.g., policeman tapping citizen on the shoulder at the outset to get a citizen's attention). (...) Rather, the encounter is a 'seizure' of a person only if the officer engages in conduct significantly beyond that accepted in ordinary social intercourse. **The pivotal factor is whether the officer, even if making inquiries a private citizen would not, has otherwise conducted himself in a manner that would be perceived as non-offensive contact if it had occurred between two ordinary citizens."**

State v. Holmes,
311 Or 400 (1991)

3. The court has indicated a desire to move away from a standard that depends on the officer's state of mind and to the objective standard described above. In applying the above standard, answers to questions like "Would you have let the defendant go if he would have started to walk away?" are not the focus of the court's examination. Instead, the court will examine whether the officer's **actions** intentionally and significantly restricted, interfered with, or otherwise deprived the defendant of that defendant's liberty or freedom of movement.

3. MERE INQUIRY by a police officer without significant restriction of liberty is not a "SEIZURE OR STOP" constitutionally and requires no justification.
4. A constitutional "SEIZURE OR STOP" does occur, and therefore must be justified by reasonable suspicion or probable cause, when the officer significantly restricts a person's liberty by:
    1. Physical force (or)
    2. A show of authority
    3. In such a manner as to be "offensive."
5. HOWEVER, ANY INDIRECT RESTRAINT CAN BE CORRECTED.
    1. The strongest and best advice to officers who are beginning to develop their communication techniques and styles in this area is to simply integrate a clear statement of mere conversation into the dialogue. Just as has been learned by officers in the Miranda rights area, giving information prior to getting information does not establish an unworkable law-enforcement setting.
        1. It can be as simple as: "You know, if you need to go, just let me know . . . we can talk to you some other time."
        2. No matter what words are used to communicate "free to go", the words MUST clearly communicate to the person that they ARE "free to go."

2. What "circumstances" or factors have the courts reviewed in assessing show of authority or use of physical force.

3. There will always exist one constant in most cases of mere conversation . . . the officer will be in uniform, associated with a marked police car, and asking some questions.

4. Beyond the uniform, patrol car, and questions come all the other aspects of a mere conversation. Although the courts continue to examine the many facets of the various types of mere conversation done by officers, some factors have been identified as important, and officers developing their personal communication techniques in this area should be aware of how the court has analyzed each one. The list is by no means exhaustive, but the courts' analysis seem to continually revolve back to show of authority and use of physical force.
5. In mere conversation settings without the equivalent of: "You're free to go", the following factors and their concepts should be kept in mind.
    1. **Demeanor and tone of voice**
    2. **Place where the person to be encountered is located.**
        1. In other words, where was the person when the encounter occurred?

3. **Activity by the person** immediately before contact.
   1. Persons who are stationary:

   2. Persons whose travel is interrupted by an encounter initiated by an officer:

   3. But, by use of good skills in a mere conversation encounter, people who are moving may still provide opportunities for a lawful mere conversation type encounter. This is more recently true even where the officers placement effectively would cause the defendant to maneuver around the officer to proceed.

4. **Questions v. Directives**
   1. Although the court seems to be relaxing the bright line between questions during mere conversation and directives during mere conversation, the distinction still has importance in analyzing a lawful mere conversation encounter.

   2. To begin with, questions must truly be "questions"

   3. When in the form of a question, generally, the scope of the inquiry is unrestricted.
   4. A "question" increasingly being used during a mere conversation encounter is "Can I search you?"
      1. For valid consent to search to follow, all components of a knowing and voluntary consent must be involved and reported.

      2. A request for consent to search during mere conversation does not constitute a stop.
   5. Asking to see identification:

   6. Questions like "Hey, could you come over here a minute?" which require the person to alter his course:

   7. More recently, the court has further softened its concern in this area by allowing officers to request, by directive, a person to stop and talk. In two separate cases a person was exiting a vehicle and walking away when the officer calls out to the person "Sir, wait." In yet another case, a person was under a car working when the officer asked the person to come

out from beneath the car. In all three cases, the court ruled that no stop had occurred by virtue of the officer's directive or question that required the suspect to change course.

8. Notwithstanding the courts recent softening of the distinction between questions and directives, there is still considerable case law disapproving of directives during mere conversation. Directives by the officer risk being viewed as a "show of authority" and a significant interference with the person's liberty.

    1. "Come out of the house with your hands up."

9. In summary, there are three acceptable levels of verbal interaction with a person during mere conversation.
    1. A question of any kind that **does not** require the person to alter course in order to respond.
    2. A question of any kind that **does** require the person to alter course in order to respond.
    3. A **directive** given in a non-offensive manner and, generally for a non-investigative purpose.

5. **Time of day and length of encounter**
    1. Be especially aware of situations wherein the person makes repeated moves to leave, but the subsequent question by the officer results in the person's remaining to answer the question.

6. **Seizing or retaining personal property**
    1. Asking to see personal property:
    2. Looking at personal property:
    3. Touching personal property tendered by consent of the person:
    4. Retention of the personal property:

7. **Position and number of officers and position of officers' vehicles**
    1. Position of the officers:

    2. Position of the police vehicles:.

8. **Use of force**

9. **Display of weapons**
   1. The obvious is withdrawing a gun.
   2. The things to be aware of are:

10. **Use of overhead lights, flashing yellow lights, spotlights and flashlights.**
   1. Overhead lights:
   2. Spotlights:
   3. Flashing yellow lights:
   4. Flashlights:

11. **Obvious pursuit**
   1. Obvious pursuit occurs when a defendant, upon becoming aware of the officer's presence, clearly demonstrates no intention to converse or have contact with the officer, the officer then demonstrates an intention to pursue and/or contact anyway. Can mere conversation occur when the defendant thereafter submits to the officer's pursuit?
   2. While defendant is running and the officer is pursuing, but before the defendant is caught or submits, has a seizure occurred?

12. **Warrant/record check**
   1. BRIGHT LINE: Record checks must not be done in the person's presence.
   2. Suggested procedures:

DETENTIONS

6. DEFINITION: The temporary restraint of a person **to facilitate the enforcement of a violation**
7. JUSTIFICATION: The officer must believe the person has committed a violation in the officer's

presence or, pursuant to statute, have probable cause to believe the person has committed a traffic violation because the description was relayed to the officer from another officer who did observe the violation.

ORS 810.410 (2) *A police officer may issue a citation to a person for a traffic violation at any place within or outside the jurisdictional authority of the governmental unit by which the police officer is authorized to act when* ***the traffic violation is committed in the police officer's presence or when the police officer has probable cause to believe an offense has occurred based on a description of the vehicle or other information received from a police officer who observed the traffic violation.***

ORS 810.420. Citation in radar cases. *When the speed of a vehicle has been checked by radio microwaves or other electrical device, the driver of the vehicle may be stopped, detained and issued a citation by a police officer if the officer is in uniform and has either:*

(1) Observed the recording of the speed of the vehicle by the radio microwaves or other electrical device; or

(2) ***Probable cause to detain based upon a description of the vehicle or other information received from the officer who has observed the speed of the vehicle recorded.***

1. The courts have ruled that the officer must first have at least **probable cause** to believe that the person to be detained has committed a violation in the officer's presence before a lawful detention can be conducted.

2. In addition to the statutes cited above, **the court** has also sanctioned a detention of a person based upon information from a second officer that the second officer had an violation committed in the second officer's presence.

8. HISTORICAL
   A. Until 1983, police officers could arrest for violations.
   B. 1983 Legislature replaced the right to arrest with the right to conduct a detention . . .

      The right to detain
      for a limited time
      while performing statutory functions

9. This area only applies to VIOLATIONS.
   1. TRAFFIC VIOLATIONS:
      1. ORS 810.410 (3) *A police officer:*
         1. Shall not arrest a person for a traffic violation

         2. May stop and detain a person for a traffic violation for the purposes of investigation reasonably related to the traffic violation, identification and issuance of the citation."
         3. May make an inquiry into circumstances arising during the course of a detention and investigation under paragraph (b) of this subsection that give rise to a reasonable suspicion of criminal activity.

         4. May make an inquiry to ensure the safety of the officer, the person stopped or other persons present, including an inquiry regarding the presence of weapons.

         5. May use the degree of force reasonably necessary to make the stop and ensure the

safety of the peace officer, the person stopped or other persons present.

6. *May request consent to search in relation to the circumstances referred to in paragraph (c) of this subsection or to search for items of evidence otherwise subject to search or seizure under ORS 133.535.*

(1) Does this include evidence of the violation too?

*(2) 133.535 **Permissible objects of search and seizure.** The following are subject to search and seizure under ORS 133.525 to 133.703:*
(1) Evidence of or information concerning the commission of a criminal offense;
(2) Contraband, the fruits of crime, or things otherwise criminally possessed;
*(3) Property that has been used, or is possessed for the purpose of being used, to commit or conceal the commission of an offense; **AND***
(4) A person for whose arrest there is probable cause or who is unlawfully held in concealment.

(3) Examples:

7. What are the two types of inquiries described in this statute and how do they differ under this statutory structure?

(1) Do you have.....?

(2) Can I search.....?

2. VIOLATIONS:

1. Pursuant to Section 10, Chapter 1051, Oregon Laws 1999, **STOP AND DETENTION FOR VIOLATION**:

(1) An enforcement officer may not arrest, stop or detain a person for the commission of a violation except to the extent provided in this section and ORS 810.410.
(2) An enforcement officer may stop and detain any person if the officer has reasonable grounds to believe that the person has committed a violation. An enforcement officer may stop and detain any employee, agent or representative of a firm, corporation or other organization if the officer has reasonable grounds to believe that the firm, corporation or other organization has committed a violation.
*(3) Except as provided in subsection (4) of this section, **the period of detention may be only as long as is necessary to:***
*(a) **Establish the identity of the person**, firm, corporation or organization believed to have committed the violation;*
*(b) **Conduct any investigation reasonably related to the violation; and***
*(c) **Issue a citation for the violation.***
(4) The authority of an enforcement officer to stop and detain a person for a traffic violation as defined by ORS 801.550 is governed by ORS 810.410.

2. What's missing here?

10. STATUTORY RIGHTS SUMMARY

1. During a non-traffic **violation** detention, a police officer has the statutory right to:
   1. Investigate the violation
   2. Investigate identity
   3. Issue the appropriate citation

2. During a **traffic violation** detention, a police officer has the statutory right to:
   1. Investigate the violation
   2. Investigate identity
   3. Issue the appropriate citation
   4. If reasonable suspicion develops, may make inquiry into that crime
   5. Make officer safety related inquiry
   6. Use force when reasonably necessary
   7. May request consent to search for "items of evidence"

11. Beyond the specific statutory rights, the court interprets the constitution to blend the needs of law enforcement with the need to keep the detention brief.

1. The courts have voiced their concern as follows:

"The constitutional and statutory law blends into a single rule: Traffic stops should be the minimum possible intrusion on Oregon motorists, and not an excuse to begin questioning, searching, or investigating that is unrelated to the traffic reason for the stop."

State v. Carter/Dawson,
34 Or. App. at 32 (1978)

The above statement has been quoted by the Oregon Supreme Court in later cases, but has not been expressly adopted.

State v. Jackson,
296 Or. 430 (1984)

But, it does provide the proper mind set for beginning a violation detention.

With the enactment of Chapter 313, Oregon Laws 1997, Section 1, we can now expect the Oregon Supreme Court to begin to examine this concept in more detail in the future on constitutional grounds.

12. From that mind-set and with the specific statutory rights in mind, other **important additional procedural tools** have been identified and sanctioned by the Oregon Appellate Courts for use by officers during a lawful detention and at any point prior to dissipation of the underlying offenses.

1. Asking for an Oregon Driver's License on any detention of the driver of an auto stopped by the officer:

2. Running a records check on the person during the detention:

3. Requesting a vehicle registration from the driver of an auto stopped by the officer:

4. Using a flashlight for the recorded purpose of keeping the detained person under observation and watching body movements:

5. Cover officers engaging the passengers or other persons present in mere conversation while the primary officer processes the detained person:
    1. This is only a procedure that can be used if there are two or more officers involved in the detention.

    2. However, where the officer testifies that the detention was for the purpose of investigating a violation committed by the passenger, attempts at mere conversation get compromised.

6. Entering the defendant's vehicle to seize evidence of the violation:

7. Even asking the defendant's consent to get out of the car must be related to the processing of the violation unless there is reasonable suspicion or probable cause to change the course of the investigation beyond the violation.

8. The right to expand the scope of the inquiry beyond the traffic violation when the officer can establish reasonable suspicion to believe the detained person has committed a crime.

9. Based upon recent case law, the best advice may be to end the detention and return to mere conversation.
    1. We will cover this in more detail at the end of the "Detention" section.

10. Conducting a detention for an observed violation <u>even though</u> the police officer has secondary suspicions about other activities:
    1. Referred to occasionally as:
        "Pre-text detentions"

11. Delaying the detention until the timing/location is procedurally acceptable:

12. Examining the documents and permits that are involved in the detention:

13. Approaching a lawfully detained vehicle from either the passenger or driver side and making lawful observations of the vehicle's interior from either vantage point:

14. Using the observations made during a lawful detention to justify a subsequent stop or arrest for some other crime. As an example, a detention for expired vehicle tags may provide observable facts sufficient to support a subsequent stop or arrest for DUII:
    1. In such situations, it is not necessary to further investigate the underlying violation in order to somehow validate the stop. Once reasonable suspicion or probable cause exists to investigate a crime, no further action on the violation is required unless the officer chooses to do so.

        1. What must the report recite in these types of contacts?

13. CONCERNS BEYOND OFFICER RIGHTS
    1. Dissipation:

    2. Returning to mere conversation at the end of the detention:
        1. However, be sure that, in addition to telling the defendant that he is "free to go," officer(s) **do not present a physical obstacle** to the defendant's movement should the defendant decide to not engage in mere conversation and elect to drive away.

        2. Be sure to **include a temporal break.**

    3. If a detention escalates into an arrest for Failure to Display a Driver's License, such arrest and custody may only continue for such time as is reasonably necessary to investigate and verify the person's identity. ORS 807.570 (4). The exact moment that identity is verified or established will be resolved by the facts known to the officer in each individual case.

STOPS

14. DEFINITION: A temporary restraint of a citizen's liberty by an officer

15. JUSTIFICATION: Reasonable suspicion to believe a **crime** has been or is about to be committed, and the suspect to be stopped has committed it.
    1. This justification carries both an **objective and subjective component**. The officer must both subjectively believe that he or she has reasonable suspicion to believe that the suspect has committed a crime and that belief must be objectively reasonable.

16. STATUTORY AUTHORIZATION - ORS 131.605 through 131.625
    1. Definitions at ORS 131.605
        1. "Crime" has the meaning provided for that term in ORS 161.515.
        2. A "frisk" is an external patting of a person's outer clothing.

3. "Dangerous weapon," "deadly weapon" and "person" have the meaning provided for those terms in ORS 161.015.
4. 'Is about to commit' means unusual conduct that leads a peace officer reasonably to conclude in light of the officer's training and experience that criminal activity may be afoot.
5. 'Reasonably suspects' means that a peace officer holds a belief that is reasonable under the totality of the circumstances existing at the time and place the peace officer acts as authorized in ORS 131.605 to 131.625.
6. A 'stop' is a temporary restraint of a person's liberty by a peace officer lawfully present in any place.

2. Stopping of persons at ORS 131.615

1. A peace officer who reasonably suspects that a person has committed or is about to commit a crime may stop the person and, after informing the person that the peace officer is a peace officer, make a reasonable inquiry.

1. "(H)as committed or is about to commit a crime:"
2. Remember to always be ready to answer the question ... **What specific crime or crimes did you have reasonable suspicion to believe the defendant had committed?**
3. Reasonable inquiry?

2. The detention and inquiry shall be conducted in the vicinity of the stop and for no longer than a reasonable time.
   1. "Reasonable time:"

   2. Running a record check/warrant check on the suspect:

   3. "Vicinity of the stop:"
3. The inquiry shall be considered reasonable if **it is** limited to:
   1. The immediate circumstances that aroused the officer's suspicion;

   2. **Other circumstances arising during the course of the detention and inquiry that give rise to a reasonable suspicion of criminal activity; and**
      (1) Why might these circumstances have to be separately denoted in relation to the original circumstances?

   3. **Ensuring the safety of the officer, the person stopped or other persons present, including an inquiry regarding the presence of weapons.**
      (1) What form must this inquiry take?

4. **The inquiry may include a request for consent to search in relation to the circumstances specified in subsection (3) of this section or to search for items of evidence otherwise subject to search or seizure under ORS 133.535.**
   1. There are two attributes to this section allowing officers to request consent:

(1) Requests for consent to search in relation to officer safety issues presented in subsection (c) above *(Ensuring the safety of the officer, the person stopped or other persons present, including an inquiry regarding the presence of weapons.)*

(1) Does this mean an officer can follow "Do you have any weapons in the car?" with "Do you mind if I look just to be sure?"

(2) Requests for consent to search for "items of evidence"

(1) Examples: ***Remember the defintition***

2. **Remember,** this statutory section only allows the officer to request consent to search.....it is not an authorization to search anything or anywhere without consent.

5. **A peace officer making a stop may use the degree of force reasonably necessary to make the stop and ensure the safety of the peace officer, the person stopped or other persons who are present.**

1. Handcuffing during the stop:

2. What if suspect presents an articulable escape risk and no risk of safety to the officer?
3. If such force or cuffing is necessary, the circumstances will now require Miranda warnings before any interrogation even though no arrest or custody is involved legally.

3. Frisking of stopped persons at ORS 131.625

1. A peace officer may frisk a stopped person for dangerous or deadly weapons if the officer reasonably suspects that the person is armed and dangerous to the officer or other person present.
   1. How does this differ from subsection (c) above?
   2. What does it take to develop reasonable suspicion to believe that the defendant is armed and dangerous?
      (1) "Attack risk" sheet.

2. If, in the course of the frisk, the peace officer feels an object which the peace officer reasonably suspects is a dangerous or deadly weapon, the peace officer may take such action as is reasonably necessary to take possession of the weapon.

17. Since the statutory procedures are fairly straight forward, it is only a question of "what is reasonable suspicion" that remains.

1. That will be individual to each case, but the decisions of the Court of Appeals and Supreme Court have shed a great deal of light on this area.
2. The cases seem to break down into two types that we will review:
   1. Cases where a crime has been reported
   2. Cases where no crime has been reported

3. Reasonable suspicion is less than probable cause but more than a hunch, which is unsupported by specific articulable facts.
   1. Not just a suspicion, but a reasonable suspicion

   2. Observable facts together with rational inferences

   3. And, even though reasonable suspicion may not be based entirely upon an officers' training and experience, the SIGNIFICANCE of particular facts may be evaluated on the basis of an officer's training and experience. This means that any time an officer relies on even a shred of training or experience in establishing reasonable suspicion to act, it must be presented in the report and on the witness stand.

   4. Named citizens who make personal observations and then volunteer that information to a police officer are presumed to be credible and reliable.
      1. Can named citizens also give opinions on matters to which the general public has common knowledge?

   5. An unnamed informant's information may or may not be useable to establish reasonable suspicion depending on the relative **reliability** of the unnamed informant. This is not a question of "Was the information provided by the unnamed informant enough to constitute reasonable suspicion?" Rather, it is a question of "Should we believe the informant?" The court will and an officer should first review the following three factors in deciding whether or not the citizen's report is reliable:
      1. Was the informant exposed to possible criminal or civil prosecution if the report was false?
         (1) This factor is satisfied where the informant delivers the information to the officer in person.

      2. Was the report based upon the personal observations of the informant?
         (1) Here, an officer may infer that the information is based on the informant's personal observations if the information contains sufficient detail to suggest that it must have been observed.

      3. Finally, did the officer's own observations corroborate the informant's information?
         (1) The officer may corroborate the tip either by observing the illegal activity or by finding the person, the vehicle and the location substantially as described by the informant.

18. A crime has been reported.
   1. Summary of factors the court has looked-for in assessing reasonable suspicion.
      1.

      2.

      3.

4.

19. No crime has been reported.

1. At about 1:00 a.m. on a Saturday morning, defendant was driving behind a police car. He turned into the parking lot of an automobile supply business and parked his automobile. He left his automobile and was approaching the front door of the building when he was stopped by the police officer. The business was closed. There were automobile parts located around the building and the officer was concerned that the defendant intended to commit burglary. The officer asked the defendant what his purpose was. Defendant stated that he was there to pick up some parts and that he had the owner's permission. The defendant was then asked to show the officer his operator's license. When he could not produce one, the officer detained defendant while he "ran a records check" and thereby discovered the suspension.
   State v. Anderson
   46 Or. App. 501
   612 P.2d 309 (1980)
2. About 1:30 a.m. in an "exceptionally heavy" burglary area on River Road in Eugene, Oregon, Officers Koop and Ware, who were patrolling in the area, saw two men emerge from the shadows adjacent to a church. One of the men was carrying an object but Officer Koop could not tell what it was. He was concerned, knowing that the church and businesses in the area were closed and that there were seldom many people on foot in the area this time of night. Having in mind it was an area of "numerous burglaries and thefts," Officer Koop decided to stop the men to make inquiry. When he stopped the men and asked for identification, he saw that the object defendant was carrying was the kind of jacket normally worn by a high school or junior high school student. Officer Koop considered this to be unusual. *State v. Vanderberg*
   550 P.2d 1248 (1976)
3. The officer observed a car parked in the sand on the beach. "He radioed the vehicle license plate number to the police dispatcher, who then gave him defendant's name as the registered owner and said that the registered owner's license was suspended under circumstances that, if he were to drive, he would be committing a felony. (...) Later that evening, the officer saw the car being driven on a public street and followed it. He was able to see only the back of the driver's head and could not tell the driver's age or gender.
   State v. Panko,
   101 Or App 6, (1990)

20. Other stop related issues

1. Outside the statutory authority in Chapter 131 ORS, the courts have identified the authority to conduct stops based on reasonable suspicion in some non-"crime" situations.

2. **Furtive\evasive behaviors alone**:
   1. What observations should an officer be prepared to make when the officer, with or without reasonable suspicion, sees a person run from the officer upon becoming aware of the presence of that officer?
      1.
      2.
      3.

3. **Dissipation**:

4. **Following and delaying** the stop:

5. BE PRECISE! Stop authority may not always apply to other people in the vicinity of the suspect or suspects immediately associated with the crime.

6. What about secondary suspicions before or during the stop?

ARREST

21. Definition: Actual or constructive restraint

22. Justification <u>without a warrant</u>: Probable cause to believe a crime has been committed and the person to be arrested has committed it.
    1. **Statutorily**, probable cause has been defined to mean "*that there is a substantial objective basis for believing that more likely than not an offense has been committed and a person to be arrested has committed it.*" ORS 131.005 (11)
    2. **Constitutionally**, probable cause, when examined by the courts as a constitutional standard, has been described as follows:

> " In *State v. Owens*, 302 Or 196, 204, 729 P2d 524 (1986), this court stated, in the context of **defining probable cause to arrest**:
>
> "Probable cause under the Oregon Constitution has both a subjective and an objective component. **An officer must subjectively believe that a crime has been committed and thus that a person or thing is subject to seizure, and this belief must be objectively reasonably in the circumstances.** The test is not simply what a reasonable officer could have believed when he conducted a warrantless search or seizure, but it is what this officer actually believed, based upon the underlying facts of which he was cognizant, together with his own training and experience."
>
> *State v. Esplin*
> 314 Or 296 (1992)

    1. There are then two components to probable cause.
        1. 1. the SUBJECTIVE,
        2. and 2. the OBJECTIVE

    3. The existence or not of probable cause is examined at the moment that the officer acts upon it.

    4. Probable cause to arrest without first securing a warrant lasts as long as the probable cause does not dissipate. The common law rule allowing warrantless arrests at any time after probable cause is gathered seems to have been secured by the United States Supreme Court and there does not appear to be any trend toward a change for either felony or misdemeanor arrests.
        1. So, how long does probable cause last?

23. Justification for an arrest *with a warrant*: The warrant will "*command any peace officer to arrest the person for whom the warrant was issued.*" ORS 133.140
    1. Is there a **good-faith exception** where it later turns out that the person arrested is not the person listed in the warrant?

24. What is an arrest?
    1. *Arrest is "placing a person under actual or constructive restraint*

    (or)

    to take a person into custody for the purpose of charging him with an offense."

    (...)

    A stop is not an arrest. ORS 133.005 (1)

    1. What of the officers' intention to issue a citation rather than taking the defendant to jail?

    2. Just a reminder, an arrest is a Fourth Amendment seizure. That is why it's foundation must be based upon probable cause.
    3. Arrest as an investigative tool.
        1. Arrests don't need to be based on proof positive.
            1. Simply the statutory standard of more likely than not. ORS 131.005 (11)
        2. Probable cause = power of arrest = power to hold for days = power to search incident to arrest.
        3. Probable cause may justify the arrest of more than one person.
            1. If, for example, a policeman sees A and B bending over a dead man and each accuses the other of killing the victim, there is probable cause for the arrest of either or both and the arrest of A does not preclude the arrest of B. Similarly, if A is found one block north of a recently robbed bank and matches the description of the robber, the arrest of A does not preclude the subsequent arrest of B who also matches the description and is found one block south of the bank. In either case, it would be reasonable for the police to arrest both A and B on probable cause even though they believe that only one of them committed the crime. The purpose of the arrest, however, is not the traditional and statutory purpose of an arrest: to charge the arrestee with crime. **Rather, it is to initiate a short-term process of sorting out, usually on the scene, to determine which person should be charged with crime, i.e., arrested in the full sense of the word**. Thus the initial "arrest" is really in the nature of a stop or detention rather than a true arrest.

                State v. Jordan,
                36 Or. App. 45, (1978)

    4. Under ***only*** the seven following ways may a police officer enter a constitutionally protected area such as a home or non-public office space to make an arrest (remember crimes only!):
        1. Search warrant

2. Consent

3. Arrest warrant

4. Hot pursuit

5. Imminent attempt to escape

    1. What about the mere possibility of escape?

6. Imminent destruction of evidence

7. Imminent injury to person or property

5. Does entry include crossing the residential threshold under the following circumstances:
    1. The officer knocks on the door which is subsequently answered by the person to be arrested.
    2. This is to be a probable cause arrest without a warrant.
    3. The person to be arrested will not come out onto the porch to talk to the officer so the officer **reaches across the threshold, grabs and removes the defendant from the residence.**
6. Remember, absent <u>true</u> exigency (imminent), probable cause no matter how strong, standing alone, does not justify a forcible entry into private premises.
7. **Ordering a person to come outside** a constitutionally protected area constitutes a seizure at the moment the commandment is made. Such a maneuver may only be used where one of the seven exceptions applies and the order is the alternative for the forced entry.
8. Probable cause can be built from:
    1. Named citizens
        1. Named citizens who initiate a report to an officer concerning their own observations are **presumed credible and reliable**.
    2. The collective information known to other police officers and dispatchers

3. Defendants known record or modus operandi.

4. Observable facts interpreted or evaluated through the police officer's training and experience

5. Flight by the suspects upon becoming aware of citizens or police officers in the area:
   1. But, remember, not flight standing alone.

6. Confidential informants whose reliability can be specifically supported.

7. Combinations of 1 through 6 above

9. A peace officer may arrest for any crime the officer did not observe when the officer has probable cause to believe the person to be arrested has committed the crime.
   ORS 133.310

10. Examples:
   1. Probable cause to believe DCS on a street corner:

"Around 11:20 p.m., Portland Police Officer Mahuna was driving to work in his personal car when he stopped at a red light at the intersection of Northeast Killingsworth and Albina Streets [in the City of Portland]. Immediately in front of his car was a van that also had stopped for the light. Mahuna could see both the driver and a passenger through a window in the back of the van. He also could see defendant standing near a bus shelter on the adjacent sidewalk, about ten feet away. The officer saw the passenger in the van gesture to defendant and say something to defendant, although he could not hear what the passenger said. Defendant looked to the left and to the right, stepped into the street and approached the van. Defendant put his head and one hand into the open passenger window for about three seconds. He then turned and walked away. Mahuna saw no money or any other objects exchanged. As defendant walked back toward the sidewalk, he put his right hand into his right rear pants pocket. Mahuna did not, however, see whether defendant put any object into his pocket. The light then turned green, and both the van and Mahuna drove away. At that point, Mahuna believed that he had just witnessed a hand-to-hand drug transaction. In his experience, the area is a known location for such transactions; he had made numerous arrests for possession and delivery of a controlled substance at that very corner. Mahuna refrained from arresting defendant because he was not yet on duty.

> "Two hours later, while on duty, Mahuna returned to the intersection of Northeast Killingsworth and Albina Streets. He saw defendant standing on the same corner. Mahuna stopped, got out of his car, approached defendant and told defendant to put his hands on his head. Defendant did so, while Mahuna patted down his right rear pocket. Mahuna felt an object in the pocket that he suspected was rock cocaine. He reached into the pocket and removed a plastic bag containing what appeared to be cocaine. Mahuna then arrested defendant * * *."
>
> 146 Or. App. at 461-62.

In addition, the following facts are important: The bus stop was a place at which, according to Mahuna, drug dealing was going on "twenty-four hours a day, seven days a week." Such intense commercial activity was made possible by the fact that the bus stop was only one half-block from an apartment complex that served, again according to Mahuna, as a kind of "safe haven" for drug dealers, who either live in or have keys to the complex. Mahuna explained that a dealer typically would keep a significant store of drugs in the complex, but would venture onto the street with only a small amount, because in an emergency it would be easier to quickly dispose of such an amount. Once they made a sale, Mahuna testified, dealers would return to the complex to obtain more drugs and go through the same process again.

Mahuna also testified that many "hand-to-hand" drug sales occurred at the location of the bus stop. The transactions, which took only a few seconds, would occur either at the corner or around the corner and part way down a side street. Mahuna explained that "a lot" of people did not like to conduct their drug transactions on Killingsworth, which is a major arterial street in the area.

Finally, Mahuna testified that, although he did not actually see anything pass to or from defendant's hand when defendant reached inside the van, what he saw was consistent with other "hand-to-hand" drug transactions that he had observed at that very corner.

As noted, defendant moved to suppress the evidence seized from him. The trial court granted the motion, ruling that, although Mahuna believed that he earlier had observed a drug transaction, that belief was not objectively reasonable, without some observation that defendant actually had exchanged something tangible with someone in the van.

On the state's appeal, the Court of Appeals characterized Mahuna's actions in his encounter with defendant as an arrest. 146 Or.App. at 462-63, 934 P.2d 467. We agree. The Court of Appeals then concluded, however, that Mahuna did not have probable cause to arrest defendant. *Id.* at 463, 934 P.2d 467. For the reasons that follow, we disagree with that conclusion.

Under ORS 133.310(1)(a), an officer may arrest a person without a warrant "if the officer has probable cause to believe that the person has committed * * * [a] felony." The amount of objective knowledge required to provide "probable cause" to make such an arrest is defined in ORS 131.005(11): An arresting officer has probable cause to arrest if "there is a substantial objective basis for believing that more likely than not an offense has been committed and a person to be arrested has committed it." Those statutory standards are met in this case.

Relying on his previous experience, Mahuna testified that: (1) due to the availability of a "safe haven" for dealers in a nearby apartment complex, drug transactions were occurring at the location of the bus stop on a more-or-less continuous basis; (2) defendant was at that location late at night, with no other apparent purpose for being there; (3) when hailed by the occupant of the van, defendant looked both up and down the street before going to the van, as if to assure that he would not be observed closely when he reached it; (4) defendant's interaction with the occupants of the van was consistent with a "hand-to-hand" drug transaction, considering its duration, intensity, furtiveness, and defendant's apparent pocketing of something immediately afterward; (5) defendant was back at his post later that same evening, reinforcing the belief that he was dealing drugs on the corner.

From Mahuna's testimony, we have no difficulty concluding that he subjectively believed that defendant had committed a crime. Under the totality of the circumstances, we further conclude that Mahuna's belief was objectively reasonable. Especially significant, in our view, is the fact that defendant was back at the corner two hours after his encounter with the van. Given all that Mahuna already had witnessed and the specific nature of that location as a drive-up drug dispensing location near "crack central," it was more likely than not that defendant was dealing drugs at that corner and was, when Mahuna saw him the second time, actually in possession of drugs. It follows that Mahuna had probable cause to arrest defendant and that the ensuing seizure of drugs from defendant was lawful as a seizure incident to the arrest.

The Court of Appeals' contrary conclusion in this case appears to have turned, at least in part, on the failure of Mahuna actually to see anything in defendant's hand during the encounter with the van. 146 Or.App. at 465, 934 P.2d 467. But seeing something in a suspected dealer's hand cannot be the sine qua non of probable cause, any more than any other single fact. The fact that a drug transaction was occurring could be inferred from the totality of the circumstances surrounding the event. Ultimately, the question in every case is whether the totality of the circumstances, i.e., the direct evidence and the inferences that fairly may be drawn from that evidence, establish probable cause. As we have explained, the evidence and inferences in this case readily fulfill that role.

The Court of Appeals' majority relied on this court's opinion in *State v. Bates,* 304 Or. 519, 747 P.2d 991 (1987), as supporting the opposite conclusion. In *Bates*, the defendant was stopped for a traffic infraction late at night in an area characterized (without elaboration) by one of the arresting officers as a "high crime residential" area. A television and a videocassette recorder were in plain view in the defendant's car. Although the defendant produced a valid Washington driver's license, the officers were suspicious. Seeing the end of "some kind of a bag" on the floor beneath the defendant's feet, the officers asked the defendant to pull the bag from between his feet so that the officers could see what it was. When the defendant did not comply, one of the officers drew his service revolver, ordered the defendant to get out of his car, and seized the bag. The bag contained drugs and ammunition; a further search of the car disclosed a loaded handgun. The defendant was convicted of possessing the drugs and the gun. The Court of Appeals affirmed without opinion. *State v. Bates,* 85 Or.App. 428, 736 P.2d 629 (1987).

On review, this court reversed. The *Bates* court addressed each of the objective facts that was relied on by the arresting officers but concluded that, whether considered alone or together, those facts did not justify the officer's search of the defendant's car. As most pertinent here, the Court of Appeals' majority relied on the following passage from *Bates:*

" '[The officer's] suspicions in this regard may have been an excellent guess--the kind resulting from a sixth sense that many officers develop over the years. But, again, there is no objective quality to them that entitles them to any weight, either individually or collectively, in the constitutional calculus. Neither the hour nor the "high crime" nature of the area tells us whether this defendant is likely to be a criminal, unless there is some reason to think that everyone driving in that particular area at that time of night is up to no good * * *.' "

Martin, 146 Or.App. at 463, 934 P.2d 467 (citing Bates, 304 Or at 526) (emphasis in original).

This court continues to adhere to the analysis and principles set forth in *Bates*. This case, however, is different. The key contrast between the facts in *Bates* and the facts in this case is that, as we have explained, there is abundant evidence, all of which we have summarized, that creates probable cause to believe that "this" defendant was engaged in criminal activity. The arresting officer in Bates acted--so far as that record disclosed--on the basis of a suspicion, i.e., a hunch. Here, both Mahuna's observations and his conclusions, filtered through the lens of his experience, are shown in his testimony to be objectively reasonable. That difference dictates the difference in outcome between the two cases.

State v. Martin,
327 Or 17 (1998)

25. Searches Incident to an Arrest (SIA)

1. Any SIA must be based upon a lawful arrest.
    1. The officer must be able to articulate the facts and interpretations of those facts which establish the probable cause for the arrest.

2. An arrest is an arrest and, therefore, the right to search incident to that arrest generally is not affected by whether or not the officer ultimately cites the arrestee in lieu of continued custody or books the arrestee into jail.

3. To lawfully SIA, the officer should, at the least, be able to testify that the person was "technically under arrest" for the crime or each crime that the officer wants to search incident thereto.
    1. Is it necessary for an officer to tell the defendant that he or she is under arrest before the SIA can occur?

    2. Is it necessary that an officer first decide to arrest the defendant for the crime the officer has probable cause to believe has been committed before the SIA can occur?
    3. Lastly, is it necessary for the officer to subsequently charge the defendant with the additional crime the officer had probable cause to believe had been committed for the SIA that the officer conducted to be lawful?

    4. The above case law is especially true in situations involving "progressive probable cause". In situations where there has been no arrest of the defendant, it is still preferable to either make the arrest or be at least able to testify that the defendant was "technically under arrest" at the time of the SIA.

4. What can be searched for? **(object of the search)**
    1. Police officers have the right to search for the following 3 groups of items:
        1. Weapons

        2. Articles of escape
        3. Evidence of "the" crime for which the person has been arrested

5. While searching for those objects, what areas may be searched? (**scope of the search**)
   1. **Person**

   2. The **area within the immediate control** of the suspect.
      1. This has in the past been referred-to a the wingspread or lunge area but those words may be too limiting in relation to the Oregon Courts' use of the phrase "within the immediate control of the suspect."
      2. "Within the immediate control of the suspect" includes:

      3. The "area within the immediate control of the suspect" in a vehicle includes:

6. While searching for those objects in those areas, into how small a closed container can the officer search? (**intensity of the search**)
   1. For WEAPONS AND ARTICLES OF ESCAPE on persons and the area within the immediate control of the suspect.
      1. The search of a person for weapons and/or articles of escape is always begun by an external pat-down.
      2. Ordering or requesting the defendant to remove the items from all pockets:

      3. Where the officer can articulate why an external pat-down will not suffice to assure the preclusion of weapons or articles of escape:

      4. If upon pat-down, the officer can articulate the presence of unidentifiable items which may be weapons or articles of escape:

      5. If no weapons or articles of escape are detected on pat-down, a more detailed search for them can be conducted where the officer believes that there is reasonable suspicion, based upon specific articulable facts, that the defendant might pose a risk of serious physical injury or a serious escape risk to the officer.
         (1) Opening closed containers:

      6. If upon initial exterior inspection the officer **comes to believe** that a container possesses an article of escape:
   2. For EVIDENCE OF THE CRIME for which the person was arrested on persons and in the area within the immediate control of the suspect:
      1. The officer may search into any place for "evidence" of **the** crime including the pockets of the suspect. The officer need only articulate what those items might be and how they might fit into the space to be searched?

2. When the arrest is based upon an outstanding warrant, the officer can search for evidence of **the** crime if the officer has probable cause to believe that evidence of the past crime will still be found on the person.

3. Unless opening a closed container or entering some constitutionally protected area to look for the items listed above in the manner listed above, there is no general right to simply open any container found so as to determine it's contents.

7. While searching for those objects in those areas and into those specific spaces, within what period of time must the SIA take place? **(Time within which the search must occur)**
   1. "Incident to an arrest" means close in time to the arrest.

   2. A SIA should, then, be done at a time prior to the point at which the processing at the arrest scene reaches a LOGICAL STOPPING POINT.

OFFICER SAFETY RESPONSES

26. The Supreme Court of the State of Oregon has made one thing exceptionally clear:

A police officer may take reasonable steps to protect himself or others if, during a lawful encounter with a citizen, the officer develops a reasonable suspicion, based upon specific and articulable facts, that the citizen might pose an immediate threat of serious physical injury to the officer or to others then present.

State v. Bates,
304 Or. 519 (1987)

27. Clearly there are those situations where an officer safety related response is necessary.....and with the above guideline in mind, these necessary responses are allowed!

28. But remember, all aspects of the legal basis for such responses described above must be satisfied and **the report must reflect** each aspect of that basis. Each component of the above legal basis can be examined to better understand this important officer right.
   1. **A lawful encounter**
      1. BRIGHT LINE: The officer should be involved in an action that is a function or duty of the office.

      2. What about a mere conversation encounter?

   2. **A reasonable suspicion based upon specific articulable facts**
      1. This is perhaps the most important aspect of taking action to protect officer safety. Not only must each officer develop the awareness of the types of **behaviors** that are predictors and

indicators of future violence but, more importantly, each officer must learn to **report and testify** as to the significance of those observations.

2. The biggest pitfall in this area of police work is the temptation to simply reduce the reported reason for taking action to "for officer safety." The court will require specific behaviors beyond general concerns.

3. In reporting the factors which caused the police officer to take reasonable steps for officer safety, reports should articulate specific behavioral observations of the defendant and other information known to the officer such as:
    1. Aggressive behavior
    2. Hostile behavior
    3. Intoxicated behavior
    4. Uncooperative behavior, especially failure to keep hands visible
    5. Threatening behavior
    6. The presence of a weapon or an apparent weapon
    7. Background information known to the officer which bears on the safety of the specific encounter
    8. See the "Attack Risk" sheet.

3. **The person might pose an immediate risk of serious physical injury.**
    1. Mere access to weapons does not give rise to a reasonable suspicion that defendant posed an immediate threat of using them.

4. **To the officer or others present**
    1. This includes many community policing and investigatory encounters where the threat may well be to a third person.

29. Once reasonable suspicion has been established, the officer is not limited to a "pat down", but may take reasonable steps to ensure the officer's safety.

30. When dealing with purses, bags, backpacks and other closed containers, the officer may determine that the reasonable step to ensure officer safety is to take possession of the container when there is a reasonable suspicion that it may contain a weapon. In only certain circumstances does the officer have the right to open such containers.

31. More on reasonable steps
    1. Must police officers, in all cases, ask questions before frisking?
    2. Entering a vehicle to seize an apparent weapon:

    3. Does the weapon have to be an illegal weapon?

    4. Does the defendant have to be in the car for the officer to be able to go into the car and seize a weapon for safety?

5. When going beyond the external pat-down:
   1. Take safety precautions in order of seriousness to officers.

OTHER LIMITED RIGHTS TO SEARCH OR SEIZE WITHOUT A WARRANT

32. EXCEPTIONS GENERALLY
   1. These narrowly drawn and individually distinct exceptions are in addition to the rights to search previously discussed in PERSON ENCOUNTERS.

   2. Each exception must be applied to the street situations individually even though ultimately more than one exception may apply to allow a search.

   3. When presented with a street situation where a question of search or seizure arises, remember each exception and review each one to determine any applicability. NOTE: these exceptions are listed in no special order.
      1. Search incident to arrest

      2. Stop and frisk

      3. Officer safety response

      4. Consent

      5. Probable cause plus exigent circumstances

      6. Community caretaking

      7. Plain vs. open view

      8. Inventory

      9. Emergency aid doctrine

      10. Searches of mislaid property

   4. Remember, the preferred method for conducting searches in Oregon is by search warrant. The above exceptions are just that; exceptions to the preferred search procedure which is to secure a warrant.

33. **CONSENT**
   1. The consent exception has been summarized by the Court as follows:
   "Under the consent exception to the warrant requirement, the state must prove by a preponderance of the evidence that someone having the authority to do so voluntarily gave the police consent to

search the defendant's person or property and that any limitations on the scope of the consent were complied with."

State v. Weaver,
319 Or 212 (1994)

2. Requesting and gaining consent is too simple.
   1. As simple as: "Can I search you?";
      Answer: "Sure, go ahead!"

   2. As a result, although there are legal considerations, the officer's personal communication skills will normally make or break an officer's success ratio in this area.
3. Again, where an officer is requesting consent, the request must be in the form of a question.

4. Of course, some persons will simply volunteer consent.
5. As a general rule, consent must precede the search and seizure for the exception to apply to evidence seized. This is because most requests for consent imply that the officer will conduct the consented-to search only if and after consent has been given.

6. However, a consent can apply retroactively to validate a search or seizure that would otherwise be unlawful. Such a request for retroactive consent must specifically include terminology which relates back to an earlier search such that it is clear that the consent given applies to the earlier search. As an example, an officer may be searching inside a constitutionally protected area for what the officer believes to be a legitimate reason sanctioned by the Oregon constitution as interpreted by the Oregon Appellate Courts when the officer finds an unexpected item of considerable evidentiary significance. Some officers have stopped the search at that point, left the item of evidence in place, and returned t ask the suspect for general consent to search the area. For such a tactic to validate the later seizure of the previously observed item based upon a valid consent search, the officer must not trade upon or take advantage of the previous search to obtain defendant's consent. Such a consent has been referred-to as retroactive consent. Of course, this is only of importance where the officer wants to attempt to gain a useable consent in addition to the other warrantless search exception that formed the basis for the original search.

7. Remember, in the absence of any evidence to the contrary, a consent will be treated as being intended by the consent giver as prospective only.
8. Seeking a voluntary consent as a viable police tool works well because consent is a waiver of a constitutional right.
   1. **Does the officer need probable cause or reasonable suspicion** to be able to ask for consent?

   2. Does defendant's refusal to consent to a search help the officer establish reasonable suspicion or probable cause?

9. The consent must be shown by a "preponderance of the evidence" to be voluntary.

1. To be voluntary, the officer must avoid conduct that is either intimidating or coercive and any circumstances that might "impair defendant's capacity to make a knowing, voluntary, and intelligent choice.

2. Intelligent waivers can involve situations where the officer informs the person of the consequences of refusing to give consent. Of course, such a communication may be viewed as "coercive."
3. How does intoxication affect a knowing and voluntary consent?

4. HOWEVER, to be voluntary, police officers do not need to:
   1.
   2.
   3.
   4.
   5.

10. Persons may give consent **by conduct.**

11. A person can give lawful consent to accompany an officer to some other location such as the police precinct.

12. Consent can be limited.
    1. When officers rely on consent as the basis for a search, they act only with the authority that they are given by the consenting person. **A consent to search may be confined in scope to specific items or persons, restricted to certain areas or limited in purpose or time.**

    2. How does the request for consent affect the scope of the search which results from an affirmative response to that request?

       1. However, even a broad grant of authority to search is not without limits. The critical question is what would a reasonable person have understood the consent to encompass.

    3. How does the **defendant's response** to the officers' initial request for consent affect the scope of the search.

    4. Consent can be limited by the words used by a **defendant who requests the officers enter** into a constitutionally protected area.

13. Consent may be revoked.

1. Absent an express revocation, a consent is presumed to continue.

14. Third party consent

1. The RULE: Consent by one who possesses common authority over premises is generally valid as against the absent defendant with whom that authority is shared. The authority which justifies the third party consent does not rest upon the law of property, with its attendant historical and legal refinements ... but rests rather on **mutual use** of the property by persons generally having joint access or control for most purposes...

2. Common authority is **not an ownership** or property law question.

3. What is the effect of the statement of a consent-giver such as "I live here?"

1. What about the consenting party's partner's nightstand or closet?

4. What about items being stored on the premises for a third person?

5. Is there a "good faith rule" in situations involving apparent common authority?

6. Generally, lessors and landlords do not have authority to take the officer into a renter or lessee's residence.

7. To enter with a third party who has a LIMITED right to be on the premises, must the officer also be acting within that limited right?

8. Can a child give valid consent for a search of the family home?

15. Once consent is obtained, the officer may **request** the consenter to take a particular position to facilitate the acquired right to search.

34. **PROBABLE CAUSE PLUS EXIGENT CIRCUMSTANCES**

1. P/C alone = the need to get a warrant

P/C plus E/C = the practical necessity to conduct the search now

2. Exigent circumstances have been described as "practical necessity".
3. The investigating officer must be aware of the time expense it takes to get a telephonic search warrant so as to know the "practical necessity" of searching without one.
1. Must be looking for a clear opportunity to get a warrant

4. Probable cause plus exigent circumstances is most often used as the **mobile vehicle exception**.
   1. The Oregon/Supreme Court held that a motor vehicle can present an exigent circumstance under the following **rule**:

      1. **If the motor vehicle is mobile at the time it is stopped by the officer**

         and

         either before or after the stop, the officer establishes probable cause to believe the vehicle contains evidence of crime or contraband

         then

         The officer can conduct a full immediate search of the vehicle for those items.

   2. The court has been willing to extend the exception to vehicles that were not stopped by the officer but, nonetheless, were vehicles which presented the requisite exigency. Although the courts speak in terms of **moving, mobile and occupied**, the cases seem to place the most emphasis on **mobile and occupied.**

      1. What are the limits the courts have placed upon the terms **mobile** and **occupied**?

   3. This right extends to areas not touched by the officers' rights to search incident to an arrest.
   4. No one **must** be arrested for this exception to apply.

   5. How extensive can a search under the mobile vehicle exception be?

   6. But, don't forget the need for probable cause.

   7. **Immediate** means that the search under this exception must be commenced as promptly after the seizure as is reasonable in the circumstances.

   8. As with all exceptions to the warrant requirement, officers must avoid the deliberate posturing of a situation so as to evade the warrant requirement. Under this exception, an example might be waiting for about an hour for the defendant to drive away from a park so that the officer could "stop a moving vehicle" and apply the mobile vehicle exception. Although the court has not been willing to infer a bad motive in these situations, they will most certainly suppress any evidence seized as a result of a proven deliberate scheme to evade the warrant requirement.

35. **PLAIN V. OPEN VIEW**
   1. This exception involves a seizure doctrine.

   2. It is first important to distinguish where this warrantless seizure doctrine applies.

1. **Plain view describes a situation where the officer is inside a constitutionally protected area and is looking inside that area.**

    1. When in this situation, **no warrant is required to seize** evidence of crime or contraband.

2. **Open view describes a situation where the officer is outside a constitutionally protected area and is looking into that area.**

    1. When in this situation, **a warrant or an exception to the warrant requirement is required** to enter the area and seize the evidence

3. There are **two requirements** then for a valid plain view seizure.
    1. **Justifiable prior intrusion into a constitutionally protected area**

        1. Examples:

        2. What portions of private property are open to the public and as a result are also open to a police officer to enter?
    2. **Probable cause for the item to be seized**

4. Is inadvertence required for a plain view seizure?

36. **COMMUNITY CARETAKING**

1. In a 1988 opinion, the Supreme Court ruled that there was no "generic community caretaking function." It went on to point out that whether or not law enforcement officers have specific functions is a matter of statutory law. Since there was no "community caretaking" statute defining an officers functions when acting in a community caretaking situation, the court suppressed evidence found by an officer who entered a constitutionally protected area on a "generic community caretaking" mission. Since then, the Supreme Court has indicated that, where there is a statute granting such authority, evidence found in plain view while performing such statutory duties may be used in evidence in a criminal prosecution.

2. ORS 133.033 recently provided statutory authority for police officers to affect constitutional rights while performing community caretaking functions.
    1. **133.033** *peace officer; community caretaking functions.*
    (1) Except as otherwise expressly prohibited by law, ***any peace officer of this state, as defined in ORS 133.005, is authorized to perform community caretaking functions.***

    (2) As used in this section, "community caretaking functions" means any lawful acts that are inherent in the duty of the peace officer to serve and protect the public. "Community caretaking functions" includes, but is not limited to:
    (a) The right to enter or remain upon the premises of another if it reasonably appears to be necessary to:

(A) *Prevent serious harm to any person or property;*
(B) Render aid to injured or ill persons; or
(C) Locate missing persons.

(b) The right to stop or redirect traffic or aid motorists or other persons when such action reasonably appears to be necessary to:
(A) *Prevent serious harm to any person or property;*
(B) Render aid to injured or ill persons; or
(C)Locate missing persons.

(3) Nothing contained in this section shall be construed to limit the authority of a peace officer that is inherent in the office or that is granted by any other provision of law.

3. In summary, this statute provides the statutory authority to perform these type of functions because the Supreme Court has held that no such inherent community caretaking authority exists within the Oregon Constitution beyond the Emergency Aid Doctrine discussed later in the outline.
4. The only unresolved issue is to what extent a police officer, faced with a community caretaking issue, must first acquire a search warrant.

5. Community caretaking is really a "justifiable prior intrusion into a constitutionally protected area" as required for plain view seizures.

37. INVENTORY

1. Inventories can be required by a governmental agency for people or things. The most common inventory of a person involves those being processed into a secure facility such as a jail or detoxification center. The most common inventory of a thing involves the inventory of a vehicle being impounded by an officer.

2. THE INVENTORY OF CONTENTS OF IMPOUNDED VEHICLES OR PEOPLE

1. A police officer may inventory anything or person lawfully impounded provided that authorization exists for the procedure used, such as a statute, ordinance or departmental general order, that requires law enforcement officers to inventory vehicles under the circumstances and that expressly delineates the purposes and limits of the officers' authority.

2. This concept is best embodied by a simple **THREE-STEP RULE:**
   1. **The vehicle or person must be lawfully impounded.**

   2. **The inventory must not deviate from the ordinance, statute or departmental procedure which sets-out the inventory procedure.**

   3. **The inventory procedure does not include opening closed containers beyond the scope of the ordinance or statute.**

PROPERTY

(Added by Ord. No. 168241, Oct. 26, 1994.)

Sections:

14.10.010 Purpose.

This Chapter is meant to exclusively apply to the process for conducting an inventory of the personal property in an impounded vehicle and the personal possessions of a person in police custody and shall not be interpreted to affect any other statutory or constitutional right(s) that police officers may employ to search persons or search or seize possessions for other purposes.

14.10.020 Definitions.

For the purpose of this Chapter, the following definitions shall apply:

A. **"Valuables"** means:
   1. Cash money of an aggregate amount of $50 or more; or
   2. Individual items of personal property with a value of over $500.

B. **"Open container"** means a container which is unsecured or incompletely secured in such a fashion that the container's contents are exposed to view.

C. **"Closed container"** means a container whose contents are not exposed to view.

D. **"Police custody"** means either:
   1. The imposition of restraint as a result of an 'arrest' as that term is defined at ORS 133.005 1.;
   2. The imposition of actual or constructive restraint by a police officer pursuant to a court order;
   3. The imposition of actual or constructive restraint by a police officer pursuant to ORS Chapter 426;
   4. The imposition of actual or constructive restraint by a police officer for purposes of taking the restrained person to an approved facility for the involuntary confinement of persons pursuant to Oregon law.

E. **"Police officer"** means any officer of the Portland Bureau of Police or the Port of Portland Police Department.

14.10.030 Inventories of Impounded Vehicles.

A. The contents of all vehicles impounded by a police officer will be inventoried. The inventory shall be conducted before constructive custody of the vehicle is released to a third-party towing company except under the following circumstances:
   1. If there is reasonable suspicion to believe that the safety of either the police officer(s) or any other person is at risk, a required inventory will be done as soon as safely practical; or
   2. If the vehicle is being impounded for evidentiary purposes in connection with the investigation of a criminal offense, the inventory will be done after such investigation is completed.

B. The purpose for the inventory of an impounded vehicle will be to:
   1. Promptly identify property to establish accountability and avoid spurious claims to property;
   2. Assist in the prevention of theft of property;
   3. Locate toxic, flammable or explosive substances; or
   4. Reduce the danger to persons and property.

C. Inventories of impounded vehicles will be conducted according to the following procedure:
   1. An inventory of personal property and the contents of open containers will be conducted throughout the passenger and engine compartments of the vehicle including, but not limited to, accessible areas under or within the dashboard area, in any pockets in the doors or in the back of the front seat, in any console between the seats, under any floor mats and under the seats;
   2. In addition to the passenger and engine compartments as described above, an inventory of personal property and the contents of open containers will also be conducted in the following locations:
      a. Any other type of unlocked compartments that are a part of the vehicle including, but not limited to, unlocked vehicle trunks and unlocked car- top containers; and
      b. Any locked compartments including, but not limited to, locked vehicle trunks, locked hatchbacks and locked car-top containers, if either the keys are available to be released with the vehicle to the third-party towing company or an unlocking mechanism for such compartment is available within the vehicle.
   3. Unless otherwise provided in this Chapter, closed containers located either within the vehicle or any of the vehicle's compartments will not be opened for inventory purposes.

4. Upon completion of the inventory, the police officer will complete a report as directed by the Chief of such officer's department.
5. Any valuables located during the inventory process will be listed on a property receipt. A copy of the property receipt will either be left in the vehicle or tendered to the person in control of the vehicle if such person is present. The valuables will be dealt with in such manner as directed by the Chief of the police officer's department.

14.10.040 Inventories of Persons In Police Custody.

A. A police officer will inventory the personal property in the possession of a person taken into police custody and such inventory will be conducted whenever:
1. Such person will be either placed in a secure police holding room or transported in the secure portion of a police vehicle; or
2. Custody of the person will be transferred to another law enforcement agency, correctional facility, or "treatment facility" as that phrase is used in ORS 426.460 or such other lawfully approved facility for the involuntary confinement of persons pursuant to Oregon Revised Statute.

B. The purpose of the inventory of a person in police custody will be to:
1. Promptly identify property to establish accountability and avoid spurious claims to property; or
2. Fulfill the requirements of ORS 133.455 to the extent that such statute may apply to certain property held by the police officer for safekeeping; or
3. Assist in the prevention of theft of property; or
4. Locate toxic, flammable or explosive substances; or
5. Locate weapons and instruments that may facilitate an escape from custody or endanger law enforcement personnel; or
6. Reduce the danger to persons and property.

C. Inventories of the personal property in the possession of such persons will be conducted according to the following procedures:
1. An inventory will occur prior to placing such person into a holding room or a police vehicle, whichever occurs first. However, if reasonable suspicion to believe that the safety of either the police officer(s) or the person in custody or both are at risk, an inventory will be done as soon as safely practical prior to the transfer of custody to another law enforcement agency or facility.
2. To complete the inventory of the personal property in the possession of such person, the police officer will remove all items of personal property from the clothing worn by such person. In addition, the officer will also remove all items of personal property from all open containers in the possession of such person.
3. A closed container in the possession of such person will have its contents inventoried only when:
   a. The closed container is to be placed in the immediate possession of such person at the time that person is placed in the secure portion of a custodial facility, police vehicle or secure police holding room;
   b. Such person requests that the closed container be with them in the secure portion of a police vehicle or a secure police holding room; or
   c. The closed container is designed for carrying money and/or small valuables on or about the person including, but not limited to, closed purses, closed coin purses, closed wallets and closed fanny packs.

D. Valuables found during the inventory process will be noted by the police officer in a report as directed by the Chief of such officer's department.

E. All items of personal property neither left in the immediate possession of the person in custody nor left with the facility or agency accepting custody of the person, will be handled in the following manner:
1. A property receipt will be prepared listing the property to be retained in the possession of the respective police department and a copy of that receipt will be tendered to the person in custody when such person is released to the facility or agency accepting custody of such person;
2. The property will be dealt with in such manner as directed by the Chief of such officer's department.

F. All items of personal property neither left in the immediate possession of the person in custody nor dealt with as provided in Subsection 14.10.040(E) above, will be released to the facility or agency accepting custody of the person so that they may:
1. Hold the property for safekeeping on behalf of the person in custody, and
2. Prepare and deliver a receipt, as may be required by ORS 133.455, for any valuables held on behalf of the person in custody.

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3. **"Lawful impound"**

1. To be a lawful impound, there must be a statutory or ordinance source for the authority to impound the person or vehicle.

   (1) Examples:

2. Must the vehicle be towed or the person transported?

3. What about impounding or transporting solely or partially to form a basis to inventory (search) the contents of the vehicle or of a person's pocket?

4. For an impound to be lawful, the impound process must follow the terms of the enabling ordinance, statute or departmental general order.

5. Remember, this is not a search incident to arrest procedure. The allowable purpose of an inventory is simply to "inventory." However, any evidence or contraband that is located in plain view during the inventory will be subject to seizure under the 'plain view' doctrine.

38. Emergency Aid Doctrine
   1. This very narrow exception to the warrant requirement known as the Emergency Aid Doctrine is applicable when the following conditions are met:
      1. **The police *must have reasonable grounds to believe that there is an emergency and an immediate need for their assistance for the protection of life.***
      2. **The emergency must be a *true* emergency - the officer's good faith belief alone is insufficient.**
      3. **The search must not be primarily motivated by an intent to arrest or to seize evidence.**
      4. **The *officer must reasonable suspect* that the *area or place to be searched is associated* with the emergency and that, by making a warrantless entry, the officer will discover something that will alleviate the emergency.**
         1. The court specifically declined to hold officers to a probable cause connection between the place to be searched and the emergency. Instead, only a requirement that there be a reasonable suspicion to believe that such a connection exists.

39. Searches of Abandoned, Lost or Mislaid Property
   1. Officers will see the need to search abandoned, lost or mislaid property for identification so as to facilitate it's return to the proper person.
      1. The purpose of the search must be limited to a search for ID.

      2. What happens once some ID is found?

   2. Can closed containers be opened?

   3. Of course, this is different from a situation where the suspect disclaims any interest in the property to be searched. This situation is presented when an officer, upon finding a receptacle, asks those persons present whose it is. All persons deny ownership. What is the legal effect of such a denial?

PORTLAND POLICE BUREAU

TRAINING OUTLINE

Title: Public Information Officer

Instructor: Lt. Cliff Madison

Instructional Goals: To make officers familiar with police/media relationships. To review the General Order and Oregon Public Record Laws dealing with public release of information.

Performance Objectives:

1. Officers should have basic understanding of police/press relationships. This will include dealing with the conflicts of goals of news versus goals of police.

2. They should know at least three types of information appropiate to release and three types that are inappropiate to release. This information will be reviewed from G.O. 631.35-Appendix A, Portland Police Bureau Press Guidelines.

3. Know with whom responsibility lies for public information and special circumstances when the information is controlled.

Outline:

1. History of Office
    A. Formed 1974 by Chief Bruce Baker
    B. Reason:
        1. Speed of media coverage at a scene
        2. Watergate- distrust of government
        3. Prior to PIO, no prescribed method of dealing with press

2. Current Policy
    A. Handout G.O. 631.35
    B. Handout Oregon Bar Press Guideline

3. Public Record
    A. Most police reports public records
    B. Media reviews arrest logs and runsheets
    C. Media has CAD link-up on dispatched call locations

4. Media review capabilities
    A. Access to reports by case #
    B. Access to information by request
        1. Review exceptions-confidential

    C. Monitor police radio-CAD link-up
        1. Key words
            a. Murder
            b. Hostage
            c. Shooting
            d. Bomb

5. Crime Scene
    A. Murder-make it big area
    B. If general public is allowed, so is press
    C. If they can see it, they can take pictures
    D. Advise them of your need to secure area and the possible dangers

6. Officers contact with media
    A. Positive attitude-they have a job to do, so do you
    B. Honesty-you have nothing to hide
    C. Appearance
    D. Avoid being baited
    E. Chose your words

####

PORTLAND POLICE BUREAU
TRAINING DIVISION
ADVANCED ACADEMY 98-3

I.	COURSE TITLE:	Portland Police Bureau (PPB) Advanced Academy Defensive Tactics Course.
II.	INSTRUCTORS:	Officer Paul Dolbey
III.	DATE/TIME:	October 5, 1998 - December 18, 1998
IV.	TRAINING AUDIENCE:	PPB Officers of AA 98-3 (Refer to Class Roster).
V.	COURSE GOALS:	Stated goal for PPB Defensive Tactics. Refer to PPB Defensive Tactics Manual. To prepare the police officer to use Defensive Tactics when appropriate and in ways to minimize the risk of injury to the public, the police officer, and the law violator.
VI.	COURSE OBJECTIVES:	Group 1 learning objectives stated on page 11 of the PPB Defensive Manual.
VII.	COURSE OUTLINE:	Refer to Part II under Section 1-28.
VIII.	LESSON PLAN:	See Lesson Plan for Sessions 1 through 14 beginning on the next page.

VII. Lesson Plan AA 98-3

SESSION 1

October 7, 1998/(Wednesday)
Full Group 1300-1700 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES
# *SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1. Intro by Officer Dolbey **(Discuss visualization training)** CONSISTANCY – SEMI-ANNUALLY WE HAVE TO RETRAIN YOU OFC.	1. Background and history of the DT program and the instructors 2. DT Program philosophy vs DPSST 3. Overview of DT objectives – DISCUSS TESTS. 4. Class rules & expectations *("NOT THE WAY JUST A WAY"* **5. Safety/injury statement-blood, injuries & log, horseplay** 6. DT Manuals	30 Min.	Chalkboard & paper O/H Objectives O/H Physical Problem Statement DTM 3
2. Health & Fitness	1. Exercising & stretching 2. Leg strength for better shooting	15 Min.	
3. Survival Priorities	1. Safety of the Officer 2. Safety of the Public 3. Safety/Apprehension of the subject	15 Min.	O/H Safety Priorities DTM 2
4. Learning Objectives 1 (Pg. 5)	1. 3 Basic Responsibilities	25 Min.	Flip Chart pg 3.
5. Principles & Concepts (Pg. 4)	1. Defin. of Principles & Concepts		O.H. pg. 4
6. Principles A & B (Pg. 4) EX. → JEFF GUN INCID.	1. Action-Reaction Principle 2. Distraction – WE TEACH PRINCIPALS ANYTHING CAN BE USED AS DISTRACT. a. Discuss strikes and kicks.		FLIP CHART
7. Concepts 1 & 2 (Pg. 5)	1. Levels of Control 2. Adequate Control is Essential		O/H Levels of Control DTM 11 12 Flip Chart
8. Appropriate Control REVIEW OF CONT. SHOTS.	1. Appropriate Control Exercise 2. Appropriate Control Spectrum 3. Too much or too little control 4. Reasonable & sufficient control	35 Min.	Chalk Board O/H Appropriate Control DTM 4,5
9. Threat Assessment	1. Knife exercise 2. Discuss the 5 areas of threats	25 Min.	Rubber Knife, red handles
10. Full Body Search	1. Search Policy Statement & G.O. 2. Weapons Found Book 3. Full Body Search	75 Min.	Search G.O. 1, 22 Weapons Found Book WEAPONS.
SUMMARY	*Check lesson plan for next session & equipment needed.	5 Min.	*Workout clothes*

Materials: Lesson Plan, Duty belt, red handles, flip chart, overheads, rubber knife, and AA manuals.

VII. Lesson Plan AA 98-3

SESSION 2

October, 12 (Monday)	**October 12, 1998 (Monday)**
Group A / 0800-1145 Hours	**Group B / 1315-1700 Hours**

PRESENTATION MATERIAL			INSTRUCTOR CUES	
#	*SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1.	Introduction	1. Discuss what will be covered	5 Min.	
2.	Learning Objectives 2 (Pg. 3)	1. 4 Steps of self-evaluation	35 Min.	Flip Chart DTM Pg 3.
3.	Principles C & E (Pg. 4)	1. Domination – [illegible] 2. Yielding – [illegible]		Pg 4
4.	Concepts 3 & 7 (Pg. 5 & 6)	1. Control Tech. vs Survival Tech 2. Control vs Force		O/H Control & Force DTM 04 / 5
5.	Choice of Options	1. Discuss the 3 areas where the choice options are formulated	20 Min.	O/H Choice of Options DTM 8
6.	Control & Balance Philosophy	1. Any control is better than no control 2."Accordion control" 3. Components of Control 4. Extended & Condensed strength 5. Good base and Tri-pod theory 6. Perpendicular balance position	30 Min.	O/H Control DTM 15, 16, 17, 18
7.	Handswitches	1. Handswitch rules	15 Min.	DTM 19
	WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
8.	Interview Position & Verbal Control	1. Elements of interview position 2. Min. safety dist. prior to hands on	25 Min.	DT Room
9.	Minimum Custody Control Hold	1. Purpose & hazards of the hold 2. One & two hand control	30 Min.	
10.	Close Proximity/Use of Handgun	1. Purpose & demo body position. 2. Movement Drills	20 Min.	Duty Belt Red handles
	SUMMARY	*Check lesson plan for next session & equipment.	5 Min.	*Street clothes

Materials: Duty belt, red handles, flip chart, introduction outline, handouts, pencils, pens and manuals.

VII. Lesson Plan AA 98-3

SESSION 3

October 26, 1998 (Monday)
Group B /1200 - 1600 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES	
#	*SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1.	Introduction	1. Discuss what will be covered	5 Min.	
	WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
2.	REVIEW	1. Interview to 2 Hand Min. Custody	30 Min.	DT Room
3.	Basic Standing Custody Procedure	1. Basic Custody Position 2. Basic Custody to Handcuffing	40 Min.	Duty belt Red handles
4.	Standing Frisk to Custody	1. Frisk & Release 2. Frisk to Custody 3. Frisk to Custody w/hand switch	55 Min.	Handout, Weapons Found book, Duty belt
5.	Wristlock	1. Frisk & Release 2. Rear approach to frisk & handcuff	40 Min.	
	Defensive Ground Fighting & Counter Tactics	1. Front Choke & Rear choke 2. Guillotine & Headlock	45 Min.	
	SUMMARY	*Check lesson plan for next session	5 Min.	Workout Clothes

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VII. Lesson Plan AA 98-3

SESSION 4

October 29, 1998 (Thursday) Group A / 0800-1200 Hours	October 29, 1998 (Thursday) Group B / 1300-1700 Hours

PRESENTATION MATERIAL		INSTRUCTOR CUES	
# SUBJECT	*APPLICATION METHOD*	*EST TIME*	
1. Introduction	1. Discuss what will be covered	5 Min.	
WARM UP	1. Sit-ups, push-ups, stretches (100 30+5)	10 Min.	DT Room
2. REVIEW.	1. Interview to 2 Hand Min. Custody 2. Front wrist lock/basic cust. position	20 Min. 30 Min.	DT Room
3. Standing Frisk to Custody	1. Frisk & Release 2. Frisk to Custody 3. Frisk to Custody w/hand switch	55 Min.	Duty belt/red h.
4. Close Proximity use of Handgun	1.Purpose & demo body position 2.Movement drills	30 Min.	Duty belt/red h.
5. Defensive ground fighting	1. Front choke hold (wall)/Rear choke 2. Guillotine and Headlock	40 Min.	Duty belt/red h.
6. Full Body Search	1. Policy statement & G.O. 2. Full body search demo/Weap Fnd. Bk	45 Min.	Weapon found book/ Policy O.H.
GROUP B			
1. Learning Objectives 3 & 4 (Pg. 3)	1. 4 Steps of Control 2. Basic Elements Necessary for Correct Application.	20 Min.	Flip Chart
3. Principles D (Pg. 4)	1. Confidence		
4. Concepts 5 & 8 (Pg. 5,6)	1. Control is Non-competitive 2. Force as a Necessary Element of Control		
WARM UP	1. Sit-ups, push-ups, stretches, (120 30+5)	15 Min.	DT Room
5. REVIEW	1. Front Wrist Lock 2. Basic Standing Cust. Position 3. Standing Frisk to custody	45 Min.	DT Room
6. Uncuffing Procedure	1. Uncuffing position & removal 2. Handcuff exchange at jail	35 Min.	
7. 2 on 1 Control	1. Discuss purpose of 2 on 1 control 2. 2 Officer custody, control & release	35 Min.	
8. Full Body Search	1. Policy statement and G.O. 2. Full body search demo/Weap. Fnd. Bk	40 Min.	Weapon found book/Policy O.H.
8. San Kajyo (Standing custody)	1. Standing to handcuffing	35 Min.	
9. Judo Lock (Standing custody)	1. Rollover and Shoot the Window technique.	35 Min.	

VII. Lesson Plan AA 98-3

SESSION 4

October 29, 1998 (Thursday) Group A / 0800-1200 Hours	October 29, 1998 (Thursday) Group B / 1300-1700 Hours

PRESENTATION MATERIAL		INSTRUCTOR CUES	
# SUBJECT	*APPLICATION METHOD*	*EST TIME*	
1. Introduction	1. Discuss what will be covered	5 Min.	
WARM UP	1. Sit-ups, push-ups, stretches 100 30+5	10 Min.	DT Room
2. REVIEW	1. Interview to 2 Hand Min. Custody	30 Min.	DT Room
EW→3. Basic Standing Custody Procedure	1. Basic Custody Position to handcuffing	40 Min.	Duty belt/red h.
4. Standing Frisk to Custody	1. Frisk & Release 2. Frisk to Custody 3. Frisk to Custody w/hand switch	55 Min.	Handout, Weapons Found book, Duty belt
5. CLOSE PROXIMITY USE OF HANDGUN ~~5. Wristlock~~	~~1. Frisk & Release~~ ~~2. Rear approach to frisk & handcuff~~	~~60~~ Min.	
6. Defensive Ground Fighting & Counter Tactics	1. Front Choke & Rear choke 2. Guillotine & Headlock	45 Min.	
SUMMARY	*Check lesson plan for next session	5 Min.	Workout Clothes
Group B			
1. Learning Objectives 3 & 4 (Pg. 3)	1. 4 Steps of Control 2. Basic Elements Necessary for Correct Application.	20 Min.	Flip Chart
3. Principles D (Pg. 4)	1. Confidence		
4. Concepts 5 & 8 (Pg. 5,6)	1. Control is Non-competitive 2. Force as a Necessary Element of Control		
WARM UP	1. Sit-ups, push-ups, stretches,	15 Min.	DT Room
5. REVIEW	1. Standing Frisk to Custody 2. Review Full Body Search (CONCEAL WEAPONS !) 3. Wristlock	45 Min.	DT Room CONCEAL WEAPONS
6. Uncuffing Procedure	1. Uncuffing position & removal 2. Handcuff exchange at jail	35 Min.	
7. 2 on 1 Control	1. Discuss purpose of 2 on 1 control 2. 2 Officer custody, control & release	35 Min.	
8. San Kajyo (Standing custody)	1. Standing to handcuffing	35 Min.	
9. Judo Lock (Standing custody)	1. Rollover and Shoot the Window technique.	35 Min.	

VII. Lesson Plan AA 98-3

SESSION 5

November 2, 1998 (Monday)
Group A/ 1200 - 1600 Hours

PRESENTATION MATERIAL		INSTRUCTOR CUES	
# *SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1 Introduction	1. Discuss what will be covered	5 Min.	
2 Learning Objectives 3 & 4 (Pg. 3)	1. 4 Steps of Control 2. Basic Elements Necessary for Correct Application.	20 Min.	Flip Chart
3 Principles D (Pg. 4)	1. Confidence		
4 Concepts 5 & 8 (Pg. 5,6)	1. Control is Non-competitive 2. Force as a Necessary Element of Control		
WARM UP	1. Sit-ups, push-ups, stretches, rolls & balanced stance.	15 Min.	DT Room
5 REVIEW	1. Standing Frisk to Custody 2. Review Full Body Search (**CONCEAL WEAPONS !**) 3. Wristlock →	45 Min.	DT Room **CONCEAL WEAPONS**
6 Uncuffing Procedure	1. Uncuffing position & removal 2. Handcuff exchange at jail	35 Min.	
7 2 on 1 Control	1. Discuss purpose of 2 on 1 control 2. 2 Officer custody, control & release	35 Min.	
8 San Kajyo (Standing custody)	1. Standing to handcuffing	35 Min.	
9 Judo Lock (Standing custody)	1. Rollover and Shoot the Window technique.	35 Min.	
SUMMARY	*Check lesson plan for next session & equipment needed.	5 Min.	
DEFENSIVE GROUND	1. [illegible] 2. [illegible]		

VII. Lesson Plan AA 98-3

SESSION 6

NOVEMBER 5, 1998 (Thursday)
Group B/ 0800 -1700 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES	
#	*SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1.	Introduction	1. Discuss what will be covered	5 Min.	
2.	Learning Objectives 5 (Pg. 3)	1. 3 Factors contributing to the failure to use correct DT.	20 Min.	Flip Chart
3.	Concepts 4 & 6 (Pg. 5,6)	1. Role of the P/O is Non-provocative 2. Attitude is a personal responsibility		
	WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
4.	REVIEW	1. Standing Frisk to Custody w/Full Body Search (CONCEAL WEAPONS !) 2. Uncuffing Technique 3. Wristlock, San Kajyo, ~~Judo Lock~~ 4. ~~2 on 1 Control~~	70 Min.	DT Room CONCEAL WEAPONS
	Basic Prone To Custody	1. Basic prone to cuffing procedure	45 Min.	
6.	Turnovers	1. Explain Purpose 2. Straight arm & Bent arm	35 Min.	
	LUNCH			
7.	San Kajyo Takedown	1. Takedown to Custody	35 min.	
8.	Judo Lock Takedown	1. Takedown to Custody	35 Min.	
9.	Arm Bar Takedown	1. Arm bar takedown to custody	35 Min.	
10.	Outside Shoulder Lock	1. Takedown to prone custody	35 Min.	
11.	Cover/Contact Philosophy	1. San Diego shooting video 2. PPB's Cover/Contact philosophy	45 Min.	San Diego video
12.	In & Out of Vehicles JUDO LOCK. 2 on 1 CONTROL.	1. Controlled removal of driver 2. Removal & placement of the driver 3. Shoe removal, Clearing of hands 4. Removal from the back seat	60 Min.	Basement Lot, Car keys
	SUMMARY	*Check lesson plan for next session & equipment.	5 Min.	*Street clothes

Materials: Lesson plan,

VII. Lesson Plan AA 98-3

SESSION 7

November 9, 1998 (Monday)
Group A & B /1200-1600 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES
# *SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1. Introduction	1. Discuss what will be covered	5 Min.	
2. Foot Pursuit Procedures	1. Discuss foot pursuit tactics 2. Jeffries debriefing	60 Min.	"Foot Pursuit" Handout
3. Officer Survival	1. Discuss the will to survive 2. Show article of HPD bike officer 3. L.A.Officer Whitfield shooting	45 Min.	HPD bike officer article, Whitfield video
4. **"Rescue 911"** Video	1. **"Rescue 911"** Video a. Discuss & Critique	40 Min.	**"Rescue 911"** Video
5. Handling Prisoner Video	1. **"Handling Prisoners"** video 2. Discuss & Critique	45 Min.	**"Handling Prisoners"** Video
6. Handgun Identification Techniques	1. Handgun I.D. Video	40 Min.	Handgun Video
SUMMARY	*Check lesson plan for next session & equipment needed.	5. Min.	

VII. Lesson Plan AA 98-3

SESSION 8

November 10, 1998 (Tuesday)
Group A / 0800 - 1700 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES	
#	*SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1.	Introduction	1. Discuss the on-going training the Officers will be receiving	10 Min.	
2.	Learning Objectives 5 (Pg. 3)	1. 3 Factors contributing to the failure to use correct DT.	20 Min.	Flip Chart
3.	Concepts 4 & 6 (Pg. 5,6)	1. Role of the P/O is Non-provocative 2. Attitude is a personal responsibility		
	WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
4.	REVIEW	1. Standing Frisk to Custody w/Full Body Search (CONCEAL WEAPONS !) 2. Uncuffing Technique 3. Wristlock, San Kajyo, Judo Lock 4. 2 on 1 Control	70 Min.	DT Room **CONCEAL WEAPONS**
5.	Basic Prone To Custody	1. Basic prone to cuffing procedure	45 Min.	
6.	Turnovers	1. Explain Purpose 2. Straight arm & Bent arm	35 Min.	
	LUNCH			
7.	San Kajyo Takedown	1. Takedown to Custody	35 min.	
8.	Judo Lock Takedown	1. Takedown to Custody	35 Min.	
9.	Arm Bar Takedown	1. Arm bar takedown to custody	35 Min.	
10.	Outside Shoulder Lock	1. Takedown to prone custody	35 Min.	
11.	Cover/Contact Philosophy	1. San Diego shooting video 2. PPB's Cover/Contact philosophy	45 Min.	**San Diego video**
12.	In & Out of Vehicles	1. Controlled removal of driver 2. Removal & placement of the driver 3. Shoe removal, Clearing of hands 4. Removal from the back seat	60 Min.	Basement Lot, Car keys
	SUMMARY	*Check lesson plan for next session & equipment.	5 Min.	*Street clothes

VII. Lesson Plan AA 98-3

SESSION 9

November 11, 1998 (Wednesday)
Group A /1200-1400 Hours Group B /1400 -1600

PRESENTATION MATERIAL			INSTRUCTOR CUES	
#	*SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1.	Introduction	1. Discuss what will be covered	10 Min.	
	WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
	Review	1. Control Holds to Takedown	20 Min.	
2.	½ Wrist Lock	1. Takedown to Custody	30 Min.	DT Room
3.	Kodo Gashi	1. Takedown to Custody	30 Min.	DT Room
	SUMMARY	*Check lesson plan for next session & equipment needed.	5 Min.	

POCKET
2 MTS.

VII. Lesson Plan AA 98-3

SESSION 10

November 12 , 1998 (Thursday)
Group B /0800-1700 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES	
#	*SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1.	Introduction	1. Discuss what will be covered	10 Min.	
	WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
	REVIEW	1. Control Holds & Takedowns 2. Frisk & Searches to Custody	70 Min.	
2.	High Risk Prone Procedures	1. Explaine & Demo Cover/Contact	45 Min.	DT Room
3.	Low Profile Full Body Frisk	1. Frisk & Release/To Custody	40 Min.	
4.	Kneeling Frisk to Custody	1. Frisk & Release/To Custody	40 Min.	
	LUNCH			
5.	Shotgun Retention	1. Explain need to carry shotgun 2. Front & rear, 1 & 2 hand grabs	45 Min.	Yellow shotgun, dummy rounds
6.	Shotgun As An Impact Weapon	1. Explain use as an impact weapon 2. 4 Steps as an impact weapon 3. 4 step striking method 4. Use as firearm after impact 5. Function check & armory tag	30 Min.	Flip chart
7.	Handgun Retention	1. **"Handgun Retention"** Video 2. Discuss 3 Phases of Retention 3. **BASIC REACTION POSITION** 4. Hand removal techniques	60 Min.	DT Room **"Handgun Retention"** Video Flip chart
8.	Handgun Recovery	1. Handgun Recovery a. Pointed at Officer b. Officer points weapon at SB 2. Close proximity recovery	25 Min.	DT Room
9.	Post Shooting Procedures * IN & OUT OF VEHICLE. * Pocket Trick	1. Tactical Step of the "Officer Involved" 2. "Cover Officer" Pre-approach Steps 3. "Custody Team" Approach Steps 4. Sharp & Bender radio tape 5. Demonstrate 3 Officer approach 6. Demonstrate various SB positions a. SB face down, gun to the side b. SB face down, gun under the SB c. SB face up, gun to the side d. SB seated up against a wall	60 Min.	DT Room Red handles Bender & Sharp shooting tape
	SUMMARY	*Check lesson plan for next session	5 Min.	

VII. Lesson Plan AA 98-3

SESSION 11

November 16, 1998 (Monday)
Group A /1200-1600 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES
# *SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1. Introduction	1. Discuss what will be covered	10 Min.	
~~2. So. Carolina Trooper Video~~	1. View and discuss the video	60 Min.	So. Carolina Trooper Video
WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
~~3. Defensive Ground Fighting & Counter Tactics~~	1. Back Crawl & Roll over position 2. Down defensive position 3. Pendulum Base position 4. PO on Back - Choke hold 5. PO on Back - Strikes	40 Min.	*Street clothes
~~4. MOTD (Multiple Officer Takedown)~~	1. Explain purpose & technique 2. Static and 2 on 1 takedown	30 Min.	
~~Close Quarter Strikes~~	1. Palm Thrust 2. Forearm Strikes & Knee Strikes 3. Control Holds	45 Min.	Impact bags
SUMMARY	*Check lesson plan for next session & equipment needed.	5 Min.	
1. WARM UP. 2. REVIEW. 3. HIGH RISK [illegible] 4. [illegible] 5. [illegible]	→ 1. ALL [illegible] HOLDS 2. STANDING FIRING		

VII. Lesson Plan AA 98-3

SESSION 12

November 17, 1998 (Tuesday)
Group X 1200-1600 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES	
#	*SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1.	Introduction	1. Discuss what will be covered	10 Min.	
2.	So. Carolina Trooper Video	1. View and discuss the video	60 Min.	So. Carolina Trooper Video
	WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
3.	Defensive Ground Fighting & Counter Tactics	1. Back Crawl & Roll over position 2. Down defensive position 3. Pendulum Base position 4. PO on Back - Choke hold 5. PO on Back - Strikes	40 Min.	*Street clothes
4.	MOTD (Multiple Officer Takedown)	1. Explain purpose & technique 2. Static and 2 on 1 takedown	30 Min.	
	Close Quarter Strikes	1. Palm Thrust 2. Forearm Strikes & Knee Strikes 3. Control Holds	45 Min.	Impact bags
	SUMMARY	*Check lesson plan for next session & equipment needed.	5 Min.	
*	POST SHOOTING			
*	1 HOUR REVIEW.			

VII. Lesson Plan AA 98-3

SESSION 13

November 23, 1998 (Monday)
Group A /0800-1700 Hours

PRESENTATION MATERIAL			INSTRUCTOR CUES	
#	*SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1.	Introduction	1. Discuss what will be covered	10 Min.	
	WARM UP	1. Sit-ups, push-ups, stretches	10 Min.	DT Room
	REVIEW	1. Control Holds & Takedowns 2. Frisk & Searches to Custody	70 Min.	
*	2. ~~High Risk Prone Procedures~~	1. Explaine & Demo Cover/Contact	45 Min.	DT Room
*	3. ~~Low Profile Full Body Frisk~~	1. Frisk & Release/To Custody	40 Min.	
*	4. ~~Kneeling Frisk to Custody~~	1. Frisk & Release/To Custody	40 Min.	
	LUNCH			
5.	Shotgun Retention	1. Explain need to carry shotgun 2. Front & rear, 1 & 2 hand grabs	45 Min.	Yellow shotgun, dummy rounds
	Shotgun As An Impact Weapon	1. Explain use as an impact weapon 2. 4 Steps as an impact weapon 3. 4 step striking method 4. Use as firearm after impact 5. Function check & armory tag	30 Min.	Flip chart
*	7. Handgun Retention	1. "Handgun Retention" Video 2. Discuss 3 Phases of Retention 3. **BASIC REACTION POSITION** 4. Hand removal techniques	60 Min.	DT Room **"Handgun Retention"** Video Flip chart
*	8. Handgun Recovery	1. Handgun Recovery a. Pointed at Officer b. Officer points weapon at SB 2. Close proximity recovery	25 Min.	DT Room
	9. Post Shooting Procedures	1. Tactical Step of the "Officer Involved" 2. "Cover Officer" Pre-approach Steps 3. "Custody Team" Approach Steps 4. Sharp & Bender radio tape 5. Demonstrate 3 Officer approach 6. Demonstrate various SB positions a. SB face down, gun to the side b. SB face down, gun under the SB c. SB face up, gun to the side d. SB seated up against a wall	60 Min.	DT Room Red handles Bender & Sharp shooting tape
	SUMMARY	*Check lesson plan for next session	5 Min.	

VII. Lesson Plan AA 98-3

SESSION 14	
November 24, 1998 (Tuesday) Group B /0800 - 1700 Hours	November 25, 1998 (Wednesday) Group A /0800 - 1700

PRESENTATION MATERIAL TEST DAY!			INSTRUCTOR CUES
# *SUBJECT*	*APPLICATION METHOD*	*EST TIME*	
1. Introduction	1. Discuss the ongoing training the officer will be receiving	10 Min.	
2. Explain Evaluation Procedures	1. Discuss Physical Assessment format. 2. Pass out Evaluation Forms 3. Pass out grading system forms 4. Discuss criteria for pass/no pass 5. Discuss remedial training	15 Min.	Physical Assessment form, grading forms, clipboards, pencils
3. Review	1. Review control holds/frisk & searches on the assessment form	60 Min.	DT Room
4. **PHYSICAL ASSESSMENT TEST**	1. Two at a time testing 2. Physical Assesment - Concealed Weapons on standing frisk 3. Discuss assessment performance	180 Min.	Concealed weapons, Assessment forms
5. LUNCH			
6. **WRITTEN TEST**	1. Distribute Written Test	45 Min.	Classroom, Written test
7. Asp Review	1. Review strike areas/opening, closing	15 Min.	DT Room
8. "Hobble" Review	1. Review techniques	25 Min.	
9. Aerosol Restraint Review	1. Review tactical aspects/G.O.	30 Min.	
10. PR-24 Review	1. Chops and thrusts	30 Min.	
11. Closing Statement/Critiques	1. Thank students/complete critiques **THANK ALL INSTRUCTORS**	30 Min.	Class Room

incl. Breaking glass video

Portland Police Bureau

Levels of Control

(July 1, 2002)

LEVEL of CONTROL	METHOD of CONTROL	SUBJECT'S BEHAVIOR
Mere Presence	Officer's presence	Compliance
Verbal Control	• Verbal request • Questioning • Order	• Compliance • Verbal noncompliance
Physical Control	• Control holds • Pressure point control	Passive resistance
	• Aerosol restraint • Taser: Touch Stun • Taser: Probes	• Physical resistance • Indicates intent to engage in physical resistance
Impact Weapons	• Baton • Strikes & Kicks	• Aggressive physical resistance • Indicates intent to engage in aggressive physical resistance
	Less lethal specialty munitions	• Aggressive physical resistance • Armed or potentially armed, capable of causing serious physical injury or death
Deadly Force	Firearms	Deadly Force

M26 Taser deployed in pilot project, July 1, 2002

Foot Pursuits

Pursuing subjects on foot is one of the most dangerous police actions that officers can engage in. Approximately 50% of arrests result in either a vehicle or foot pursuit, and many times a foot pursuit occurs after a vehicle pursuit. A police officer involved in a foot pursuit is at a total disadvantage unless a cover officer is present. Many foot pursuits end with the subject being tackled by the officer and a grappling match ensuing. Because of a police officer's instinct to pursue and apprehend a fleeing subject (the predator-prey instinct), the adrenaline rush and "must catch" mindset often overshadow safe tactics in apprehending the subject.

1. Foot Pursuit vs. Tactical Apprehension

   A. Foot Pursuit Definition – A pursuit on foot by officers where *good visual contact*, including of the suspect's hand, is maintained at all times, and the suspect is *readily capable of being apprehended.*

      1. A foot pursuit should end when the officers lose visual contact with the suspect, and a tactical apprehension should begin.

      2. Officers can re-engage in a foot pursuit when they regain visual contact of the subject and he is readily capable of being apprehended.

B. Tactical Apprehension – a *tactical search and apprehension* for a subject could be accomplished by:

1. Perimeter/block searches
2. Cover/contact search
3. K9 track
4. SERT

Note: When the officer loses visual contact with the suspect and ends the foot pursuit, he should actively organize the apprehension of the suspect.

2. Advantages and Disadvantages of Foot Pursuits

A. Advantages

1. The immediate apprehension of the subject.

2. More likely to locate and/or recover evidence or contraband in the suspect's possession.

B. Disadvantages

1. Action-reaction principle applied against the officer by the suspect.

a. The suspect stops and turns around on the officer while the officer's momentum takes him into the suspect.

b. The suspect pulls out a weapon (gun or knife) before the officer has time to react.

c. Because of the close proximity of the suspect, the officer has minimal time to assess a threat.

2. Predator-Prey Instinct

a. Because police officers are ingrained to catch those who run, they end up tackling a potentially armed suspect and risk losing their weapons to the suspect.

b. Many times, officers chase individuals who run for no reason, and the officer doesn't know why he is chasing someone until he catches him.

3. Physical Factors

a. The officer may be too fatigued to take control of the suspect.

b. The adrenaline rush may cause the officer to react at a higher level of control than is reasonable.

c. The officer may be too winded to communicate.

d. Physical injury may occur as a result of the sudden, all-out exertion of a foot pursuit.

4. Environmental and Location Hazards

a. The officer is exposed to terrain obstacles (holes in the ground, chain link fences, low-hanging wires, shrubs, curbs).

b. The suspect may know the area better than the officer, and lead the officer into hazards.

c. The officer may not be aware of dogs or homeowners protecting their property.

d. The officer may be pursuing the suspect through traffic.

e. Pursuing a suspect at night limits the officers' visibility.

f. When the officer apprehends the suspect, he may not know his location and will be unable to direct any assistance.

5. Apprehension Dangers

a. Because officers run at different speeds, one may outrun his cover. When the officer catches up to the suspect, he may be alone when he attempts custody.

b. Many times when the suspect is taken down, there is a physical confrontation during the custody.

6. Absolute "Don'ts" of Foot Pursuits

a. **Do not engage in a foot pursuit of an armed suspect.**

1. Officers should not walk up to an armed susupect and put hands on to take him into custody. The officer should use the high risk approach.

2. Armed suspects have a definite advantage in reaction if they decide to use a weapon against the officer.

3. When a foot pursuit turns into a deadly force situation, the foot pursuit should be terminated immediately.

b. **Do not pursue an individual with your gun out.**

1. Pursuing officers may trip and the weapon could discharge.

2. If the officer catches up to the suspect, there is a possibility of a handgun retention problem.

3. The officer's sidearm should remain holstered during a foot pursuit.

3. Foot Pursuit Techniques

A. Cover/Contact Pursuits (Two Officers)

1. Fleeing suspects should be pursued by at least two officers who maintain visual contact with each other. Once visual contact (cover/contact) is lost, the risk to the lone officer escalates and the pursuit is terminated.

2. During any custody situation, the officer should use cover units to assist in effecting the arrest.

B. Paralleling the Suspect

1. Officers should not follow directly behind the suspect during the pursuit. Pursue slightly off to the side and preferably with gun side away.

2. If the officers are in close proximity to each other, the second officer should also be offset in his position (on the same side of the suspect).

C. Follow A Different Route

1. Officers should not follow the exact route of the suspect. If the suspect goes over a fence, the officer should go over at a different location, if he is able to maintain a visual.

2. The officer must be aware of manufactured hazards, as the suspect may intentionally lead the officer through obstacles or hazards that could be dangerous for the officer.

3. The officer may choose the tactic of cutting off the path of the fleeing suspect. This may place the officer in front of the suspect at close quarters and could be hazardous.

D. Knock-Down Technique

1. When officers catch up to the suspect, they often grab onto him and take him to the ground. To maintain a position of advantage and the officers' balance, the knock-down technique was developed.

2. The technique also allows the officers to use more options of control while the suspect is on the ground and the officers are on their feet.

3. Technique

   a. While the officer is paralleling the suspect and gets close enough to touch the suspect, the officer should shove the suspect hard from the rear, in the middle of the back between the shoulders.

   b. This will cause the suspect's body to go ahead of his feet and fall forward onto the ground.

   c. The officers (cover and contact) will then veer off at an angle away from the suspect's arms and get distance between the officers and the suspect, while the officers then move to the head of the suspect.

d. The officer will then give verbal commands to the suspect to stay on the ground and get into a prone position, as follows: "Hands out away from your body. Palms up. Cross your feet. Put your ear on the ground."

e. The officer also has some time to consider options while the suspect is trying to recover from the fall. The options include:

1. Physical control with the cover officer there (two on one control to custody).
2. The use of pepper spray or the baton.
3. High risk, if the situation dictates.

4. Foot Pursuit Threat Indicators

A. The officer who recognizes threat indicators of a suspect who is being pursued can be prepared if the suspect's intent changes from escape to a threat to the officer. Threat indicators include:

1. Looking back – The suspect who looks back at the officer may be looking and preparing for the right opportunity to turn on the officer (target acquisition).

2. Change of stride – If the suspect appears to be slowing down, he could be trying to draw the officer in. If the suspect's stride appears to speed up, especially to get around corners or blind spots, he may be attempting to get to that blind spot to wait and ambush the officer.

3. Hand and shoulder movement – The officer must be aware of the suspect's hand movement toward the waistband or other threat areas. Reading the movement of the shoulders will indicate if the suspect is moving toward his waistband. If the suspect's shoulders start to dip or turn, that could indicate that he is planning to stop or turn toward the officer.

5. Tactical Apprehension Techniques

A. The tactical apprehension is set up to organize a safe search and apprehension of a fleeing suspect. These are some of the techniques the officer should employ to enhance officer safety during this tactic.

1. "L" movement – When the suspect goes around a corner, the officer does not go around with the suspect. The officer moves out wide, using cover, and looks down and around the corner to obtain a visual of the suspect and provide direction information.

2. Slicing the pie – Similar to the "L" movement, but a slower and more methodical clearance of the corner. The slicing the pie technique is a more cautious clearing of a corner and also can be used when there is no cover to move behind or when the officer believes that the suspect is waiting around the corner.

3. Perimeter/ block search – Setting a perimeter affords officers the time and options (K9, SERT, block search) to go in safely and apprehend the suspect.

4. Cover/contact – Considering that this foot pursuit may ultimately end in a custody, the officer should have that second officer present to effect the arrest.

Attack Risk: The 3 R's (Recognizing, Responding & Reporting)

Michael G. Conner, Psy.D

Abstract

Police, by virtue of their experience dealing with violence are unique in their ability to recognize and respond to an imminent or immediate risk of violence. Reliable and thorough discussion of judgments, the basis of those judgments and the responses taken by officers will promote the rapid recognition of an attack risk, improve memory of events, as well as insure better judgment and appropriate action in the future. Training and further research focused on police officer recognition, response and reporting behaviors with regard to a variable attack risk is necessary. Potential outcomes include improved officer and public safety, better management of personal and public liability, more effective prosecution, better community/police relations, improved officer health and emotional well-being, as well as a providing a greater sense of accountability to the public when there is a use of deadly force.

Key words: attack risk, violence risk, threat assessment

The author wishes to acknowledge the City of Portland, the Bureau of Police Training Division, Captain Roy Kindrick, and Deputy District Attorney Wayne Pearson of Multnomah County, Oregon. Without their support, this project would not have been possible.

Police officers face life-threatening situations in which they have only moments to act. They also face situations in which they must react instinctively and then hope their actions were appropriate and they can live with the consequences. Police, by virtue of their experience dealing with violence, are unique in their ability to recognize the risk of an attack. Recognizing when people represent an imminent or immediate danger, or an "attack risk" is critical to officer safety and the safety of others. It can make the difference between the safety of an officer, serious injury, or the loss of life.

Police must not only identify threats to their own safety, but the immediate safety of others. Managing and diffusing people who are potentially violent requires the officer to recognize the attack risk and then take action. The time from recognition to action can be a matter of seconds or minutes.

Recognizing a risk of violence requires an officer to respond. When officers respond, they may observe the situation further, investigate, or take immediate actions to reduce that risk. The difference between an immediate and imminent risk is difficult to define. An immediate risk of violence involves a situation where a subject is capable and threatening immediate physical harm. In these cases, the subject has both ability and perceived intent. Most police-subject encounters do not involve an immediate risk, but rather a risk that is imminent. An imminent risk of violence involves a situation where the subject represents a risk of attack, but their ability or intent is not immediate. There is an apparent progression of behavior that is escalating toward an immediate threat or escalation toward violence.

Recognizing the difference between a risk of violence that is immediate or imminent is easier in retrospect, and difficult when an immediate response is necessary to manage, diffuse or eliminate that risk. In most cases, an officer's assessment of an attack risk is automatic, based on the unique circumstance of a situation as it unfolds, and may not be conscious at the time action is necessary. When there is a significant

risk of physical harm or loss of life, the actions taken by an officer in response to a threat may be the same regardless of whether this risk is deemed imminent or immediate.

The process of recognition, investigation and the actions taken may also produce information and evidence crucial for subsequent prosecution of subjects, as well as managing public and personal liability. The full extent of what police officers recognize and consider when facing a subject five feet away, or even twenty feet away, is not usually clear or apparent to citizen bystanders. This fact alone can confuse the public and leads to misunderstandings regarding the necessary actions taken by officers.

While officer can be very accurate in recognizing the risk of an attack, many officers have experienced difficulty documenting the full extent of their observations and their actions following high risk and violent calls. Full and accurate memory is even more difficult when events unfold rapidly.

There is little question that police are increasingly expected by the public to legally and professionally articulate the basis of their actions when dealing with potentially violent people. There are three critical questions at the heart of these expectations.

1. Did the subject pose an immediate and significant risk of attack or violence?
2. Can the evaluation of that attack risk be articulated?
3. Were the actions taken by officers valid and reasonable?

The answers to these questions are critical to public safety, prosecution, managing personal and public liability, safeguarding the officer's health and emotional well-being, and ensuring the officer's career and life is not ruined. When police do not answer these questions, public opinions are formed on the basis of appearances and incomplete information. Potentially successful prosecutions can fail and civil suite against officers and their departments can ensue.

Police officers, by their contact with people who become violent, gain real life experience recognizing the risk of an attack and violence. Years of experience observing and dealing with people defines the seasoned officer who possesses a unique knowledge about human behavior during police encounters. Bystanders, who do not have this experience or knowledge, have great difficulty appreciating the risk of violence that officers must quickly recognize, manage and defuse.

When an officer must use force, we might wish that decision could be supported by research on interpersonal violence and aggression. Unfortunately, published research on violence involves theories that are incomplete and do not address the issue of an immediate attack risk in a comprehensive and practical manner.

Historically, the focus of psychological research has been on identifying the risk of future violence for purposes of sentencing, rehabilitation, treatment, parole, probation and guiding public policy. Researchers have focused on predicting the risk of violence in the future and not issues of concern to an officer facing potentially dangerous people, writing reports, or giving depositions and ultimately testimony in a court of law. No comprehensive effort has produced the necessary tools that would allow police to reliably and validly debrief and document the basis of their actions taken in response to a threat of violence.

An extensive review of the literature in national and international data bases were undertaken in conjunction with 700 hours of field observations, as well as studies of 80 video taped training exercises and discussions with police officers in Portland, Oregon. A framework for understanding and training in attack risk was developed. The framework was then reviewed by street officers, field supervisors, police administration, as well as district, city and private attorneys. A checklist of predictors of an immediate risk of attack was organized for training purposes and use in the field. This checklist was then subjected to field trials in law enforcement, private security and

with other professionals who deal with potentially violent subjects and patients. A survey of 21 officers indicated that officers believed the checklist increased their ability to recognize an attack risk and improved their ability to document and articulate the basis of their actions.

Predictors Of Immediate Risk

The type of call. Police must gather and consider information from multiple sources and perspectives. In most cases, the first available source of information and predictor of violence is "the type of call." The type of call is a predictor that both describes and characterizes a call in general. There are eight predictors that characterize a potentially high attack risk call.

1. Subject(s) with weapons or implements of destruction
2. Fights, assaults or aggressive behavior
3. Subject(s) barricaded or avoiding capture
4. Family or domestic disputes
5. Intoxication or drug use
6. Hostile groups, gatherings, demonstrations
7. Mentally ill subject(s)
8. Suicidal or homicidal behavior

There is no absolute order of these predictors that rank calls from highest to lowest risk. However, the more of these predictors, the greater the risk in general. For example, calls involving a domestic dispute would have a lower attack risk than if the subjects were also intoxicated and weapons were known to be present.

"Reads" (appearance and behavior). The type of call does not fully describe the immediate attack risk nor is it a reliable predictor alone. When the type of call is based on unconfirmed or unreliable sources (e.g. a 911 call), the type of call is not sufficient. Further evaluation and information are needed. Upon arrival to a call, officers attempt to confirm the nature of the call, but they will also observe and interpret the behavior of the people present. Officers will sometimes refer to this as "reading" a situation. No matter what type of call, an officer's actions will be guided by the conscious and unconscious impact of his or her observations (i.e. "their read").

The appearance and behavior of a subject can be a highly valid and reliable means of identifying, predicting and describing the immediate risk of violence. There are three categories of predictors that officers consider about a subject's behavior and appearance.

4. Visual
5. Verbal
6. Changing behaviors

Visual predictors can be specifically identified by observing the subject's head, face, eyes, neck, hands, body movements, general appearance and patterns of behavior in a group of people. Verbal predictors include sounds and statements which relate information in terms of what is actually said, but also how it is said - the corresponding rhythm, rate, pitch, and volume. For example, a high risk situation might be one that involves a disheveled person with impaired balance who is repeatedly interrupting and demanding in a loud voice that people get back. His eyebrows might be furrowed and he is standing in a combative posture with his hands clenched while making repeated target glances toward the officer's holstered weapon.

How a subject's behavior changes or progresses can be associated with an increasing or decreasing attack risk. A more frequent display of reads or increasing number of visual and verbal predictors can indicate an increasing risk of attack. Likewise a decreasing number may indicate a decreasing attack risk. However, there are patterns of behavior in which the number of visual and verbal observations are decreasing and the attack risk can be increasing. Finally, there are specific progressions, or sequences of behavior, which are clearly associated with an increasing and immediate risk of attack risk.

Examples of progressions include situations where eye contact is indirect and becomes more

direct, eyebrows become furrowed and hands become clenched with evidence of whitened knuckles. A subject's behavior might progress to the use of profanity with increasing loudness, begin pacing from side to side, and then move back and forth in an approaching and retreating manner toward an officer. This would reflect a progression of behavior in which the attack risk is significant and increasing. An abrupt change from more active behavior to one of immobility, unresponsiveness and a "reptilian stare" would indicate an increasing risk, not a decreasing risk.

Triggering Influences. In managing and diffusing potentially dangerous situations, police attempt to manage, control or eliminate influences that may "trigger" or reduce the threshold for violence. Triggering influences increase the risk of attack or violence. At the same time, managing, reducing or eliminating triggers can reduce the risk of attack. There are three types of triggering influences.

1. Situational
2. Chemical
3. Medical and mental health

Situational triggers include environmental conditions and the behaviors of bystanders and other disputants present. Situational influences can usually be managed directly by the arriving or cover officer's actions - and thereby reduce the risk of attack. The presence of potential weapons, hostile people nearby who are harassing or threatening a subject, and even loud noise that over stimulate or impair communication can increase the risk of attack. Each time a trigger can be managed, reduced or eliminated, the attack risk will be consciously or unconsciously reassessed by the officer. How subjects react to an officer's response will dictate what officers do next.

Chemical triggers include drugs and other chemical agents that increase the potential for violence and increase the risk of an attack. Chemical triggers (drugs & alcohol) are sometimes referred to as "hair-triggers". Situational triggers are external influences on a subject. They come from his or her surroundings. Unlike situational triggers, chemical triggers are internal biological influences that cannot be physically or directly managed by police. Time, detoxification, or medical attention is often necessary to reduce the risk of a chemical trigger. Alcohol, cocaine, amphetamines, PCP or volatile inhalants (e.g. glue) are chemicals that may trigger violence in a situation where a person might not otherwise be violent. Side effects and adverse reactions to medications, industrial chemicals or pesticides can trigger aggressive and violent responses.

Finally, the subject's mental and medical health status can increase the risk of attack. Untreated medical conditions, emergencies or psychological disorders may produce delusional states, hallucinations, impaired thinking, or changes in mood that impair judgment and reduce impulse control. For example, head injuries, severe infections, post-seizure confusion, pain, and metabolic disorders such as uncontrolled diabetes may temporarily alter a subject's mental and emotional state. The resulting behavior and interaction between the subject and police can escalate behavior that leads to violence.

History and Background. The history and background of a subject is an important source of information and can tell you a great deal about the immediate risk of attack or violence - especially when other predictors are present. There are four categories of predictors regarding a subject's history and background.

1. Recent aggressive or violent behavior
2. Past history of aggressive and violent behavior
3. Social stress and background
4. Mental health history

Information regarding a subject's history and background may be available or can be obtained by the arriving officers (and field supervisors when they arrive). In many cases, the best single predictor of violence in the future can be discerned from the subject's past history of violence. The immediate risk of an attack is greater based on a subject's pattern of violence

and if there has been a recent history or episode of violence. An extensive history of violence that is increasingly violent, combined with a lethal trend, is a strong predictor of future violence, especially when the subject is confronted with similar conditions (such as a police response). If that same individual has just attacked someone, or we have information that confirms a very recent attack, there is an even greater risk of attack.

Information regarding a subject's social history and the stress in his or her life provides information regarding events that are associated with aggression and violence. Social stress and background can include a recent or long history of problems. Conflicts and emotional pressures in a person's background will contribute to impatience, increased frustration, anger, aggressive tendencies or the possibility of resorting to violence as a solution. Loss of employment, legal entanglements, violent peers, a poor social support system, or a divorce involving a child custody dispute are examples of situations in which there may be unresolved emotional pressures and a risk of an aggressive response.

For many years, researchers have suggested that mental illness is not significantly associated with crime and it does not present a significant risk of future violence. The results of these research investigations have been contrary to the experience of many police officers who are brought into contact with subjects having an untreated or history chronic mental health problems. Until now, there has been no research that accurately observed and examines what police respond to and why. Prior research conclusions are anecdotal and rely heavily on incomplete court documents and police records meant for other purposes. Research is only now beginning to observe and recognize the possibility of what many police have observed. A history of mental illness is associated with a future risk of violence as well as an immediate risk of violence.

Mental illness such as schizophrenia, manic-depression, mood disorders, other psychotic disorders, as well as some personality disorders are sources of stress and are risk factors - especially when other attack risk behaviors and triggers are present. Borderline, antisocial and psychopathic personality disorders are commonly associated with a risk of violence. Borderline personality disorders are frequently associated with self-mutilation and suicidal behavior. Females with borderline personality disorder characteristically have destructive interpersonal relationships and in many cases will inspire violence on the part of their "significant other" males.

Of great concern is the combined impact of mental illness and drug use that can produce bizarre and unpredictable behavior. For example, the impact on impulse control from the use of drugs such as LSD and the disorganizing effects associated with psychotic mental illnesses contribute to the attack risk and reduce the likelihood of control and compliance. Individuals with mental disorders as well drug and alcohol abuse have been associated with a form of "suicide by cop". These subjects will draw police officers into circumstance where they will threaten with premeditation and compel an officer to use deadly force against them as a means to commit suicide.

Motivations. The motivation of a subject can explain the source, purpose and direction behavior will take. There are eleven basic motivations associated with attack risk. These motivations are described below in terms of their usefulness in recognizing, understanding and diffusing a potentially violent person.

1. Defending or securing freedom
2. Gaining or maintaining a sense of control
3. Behavioral "carry-over" from one situation to another, and displacement from recent or ongoing violence
4. Survival or protection against a "perceived danger or threat"
5. Overpowering opposition or resistance by reflex
6. Dispensing punishment or justice

7. Maintaining, changing or improving one's image, status or reputation
8. Blaming, acting out or releasing emotional pressure
9. Provoking others as a means to invite punishment or to relieve guilt
10. Civil or rationalized violence for a cause
11. Individual observation of violence with group diffusion of individual responsibility or consequences

Understanding the motivation of a subject can both explain, as well as guide the officer's strategy and actions. The power of these motivations and their association with a risk of attack may be evident on arrival or quickly recognized by the responding officer. Some situations present enough evidence that officers can form a judgment as to the subject's motivation. A subject who becomes aggressive when he believes he will be arrested (when in fact he was not going to be) is different from a subject who is acting tough and threatening to improve his image in a gang. These situations might carry significant and similar risks, but might be approached differently. Understanding a subject's motivation can guide officers in their approach and manner of engagement. How officers respond will change the level of risk.

Mental and Emotional Status. Finally, the subject's mental and emotional status provides information about their ability to communicate and relate to others, solve problems and control behavior. An example of an impaired mental and emotional status would be a subject who demonstrates repeated and rapid changes in mood, is easily distracted, is restless, speaks rapidly implying possession of special powers, and has difficulty staying with a conversation. Observations regarding the subject's quality of speech, ability to answer questions, emotional state, mood swings or unusual behaviors can be observed and later documented.

Implications For Law Enforcement

When an officer is en-route to a call, he or she will consider the type of call and cover available. Upon arrival, officers listen and observe general body movements and group behavior in the context of recent events. The most significant recent events include any threatening or violent behavior. Up close, officers may observe subtle or rapid changes in behavior, facial expressions, changes in voice, tension discharging movements, subtle attacking and defending behaviors, proximity changes, progressions of behavior and much more. Officers will attempt to observe, investigate, manage or eliminate influences that may trigger violence and thereby reduce the risk of attack. Prior experience or knowledge combined with the officer's assessment of the subject's motivation will be considered in estimating the risk and developing a strategy to manage and diffuse a potentially violent situation.

When an officer must use force, or there is a loss of life, the emotional impact to that officer can be enormous. Traumatic events can become repressed (or blocked from memory) without appropriate debriefing. Subsequent interviews with officers and others who were present at the scene may at first seem incomplete. The pressures of internal reviews and investigations can make full recall even more difficult and may confuse ensuing investigations. The emotional and psychological stress of lethal incidents and subsequent investigations can lead to impaired judgment, diminished officer safety, stress disorders, early retirement, or an unnecessary resignation of competent officers.

A recent concern expressed by a growing number of police officers is the impact of not shooting someone when shooting that person is justified. Not shooting when one could shoot can be more devastating to an officer than shooting the person. If these observations are indeed true, then there is reason to believe that truly heroic actions on the part of an officer during use of force situations may impair that officer's capacity to accurately recognize and respond appropriately to the next attack risk.

Besides managing and diffusing people who are potentially dangerous, officers are expected to justify their actions to district attorneys, grand juries, to criminal and civil courts, during

internal investigations, to the media, government officials and during public inquiries. The spectacle generated by media interests can strongly impact current and future training priorities, public funding for law enforcement and police-community relations. This has important implications for law enforcement.

First of all, police officers face situations in which it is necessary to restrain, search and confine the movements of individuals for the purposes of officer safety. The reason for such action is the attack risk and is often referred to as "officer safety." In these circumstances, the officer's response and any use of restraint or force must be reasonable considering the circumstances. Many standards of law and internal policies do not require an officer to be absolutely certain regarding a threat to officer or public safety, but they do require his or her judgments be reasonable given the circumstances.

Describing and documenting the sequence from "recognition to action" can be unreliable and complicated without a reliable vocabulary. Simply saying the subject looked "angry", "uncooperative", "aggressive", "hinky" or "hostile' is an opinion and not a useful description. Behavioral descriptions are very different from characterizations and are based on a report of observations and progressions of behavior that allow others to reach their own conclusions while avoiding the use of jargon or stereotypes.

The ability to articulate what happened and why, forms the essential basis for any evaluation that follows. If an officer does not articulate the basis of his or her actions prior to the use of force, how can his or her actions be justified? In cases where officers must respond to a high number of calls, an officer's ability to remember and latter testify can be difficult. The inability of an officer to accurately recall the basis of an attack risk based on a call that happened months or years ago can lead to successful civil claims against police as well as motions for dismissal in criminal cases.

Second, and equally important - there is no magic or "sixth sense" about the risk of attack. Many officers say there was a risk of violence when they suddenly "knew" they were in danger. As a consequence, police will often maintain that only police can understand, appreciate and evaluate the reliability of this sudden "knowing." This perception on the part of police officers is unfortunate because many officers will unnecessarily fear and then resist documenting the basis of their actions.

Third, armed with the ability to articulate the basis of their actions and describe the risk of attack, the public and citizen review boards, as well as community governments are in a position to understand, appreciate and evaluate situations involving use of force. Media and the public have begun to capture the actions of police on video tape. Unfortunately, the basis and full extent of what police officers recognize and respond to is not apparent in videotape records alone. The context of the situation as it unfolds, the type of the call, as well as numerous subtle behaviors are not captured or evident on video.

Public policy, police-community relations and an officer's career are shaped by the officer's recognition and response to a dangerous subject as well as the officer's ability to articulate what happened and why. While bystanders may not perceive an officer's actions were necessary or appropriate, the officer may in fact be responding and acting appropriately. Street officers need the ability to rapidly assess attack risk, take the appropriate action, as well as to recall and articulate the basis of their actions. Without the ability to recognize, recall and articulate the basis of judgments, officers tend to under report effective actions, as well as the valid and reasonable basis guiding their actions.

Training and research in behavioral sciences and training have shown that reflexes, memory and judgments improve when people constructively debrief their experience. Police officers already debrief issues involving officer and public safety, their mental and emotional experience, strategic and tactical considerations. However,

much of this debriefing is unsystematic, informal, discussed in general terms, and may rely on police jargon or references to a similar calls to describe the behavior and context.

Good judgment is not just the result of common sense and experience dealing with people who become violent. Discussion among peers, between a coach and trainee, or documentation for purposes of a report promotes conscious reflection and self-critique. Reliable and thorough discussion of judgments, the basis of those judgments, and the actions taken by an officer will promote the rapid identification of attack risk, improve an officer's memory of the events that happened, as well as insure better judgment and appropriate action in the future. The ultimate outcome is improved officer and public safety, as well as a greater sense of accountability to the public.

Many police already possess the expert ability to recognize the risk of attack. However, new recruits and even seasoned officers are not formally trained to precisely and consciously recognize the full range of predictors they automatically and even unconsciously respond to, nor are they formally trained to recall and accurately describe the basis of their actions.

Officers are already familiar with the use checklists and guides that outline observations and behaviors of subjects that may be intoxicated. In a like manner, checklists and guides can also be developed to help police to recognize, recall and describe the risk of attack. Checklists based on field observations and content validation can be used to help train officers to recognize, respond and report the risk of an attack in a reliable, valid and useful manner. This information has tremendous value to police crisis and hostage negotiators.

The goal of training should be to make the process of recognizing and describing risk factors less mysterious, more consistent with departmental policy and more conscious on the part of the responding officer. The basis of a significant attack risk can be thoroughly identified, documented and discussed in valid and reasonable terms.

Michael Conner, Psy.D, is a clinical and medical psychologist and the Director for Bend Psychological Services and Education Options. He serves also as Director for Planning and Program Development for Mentor Research Institute, a nonprofit public health and safety organization. He supervises and provides training for the Horizon Airline Crisis Intervention Response Program. His practice includes crisis intervention services and consultation nationally for families, adults and youth at risk. He provides training primarily to law enforcement in evaluating attack risk and communication tactics to manage and diffuse angry, aggressive, violent and suicidal behavior. He holds earned degrees in engineering, counseling and professional psychology. He completed a post-doctoral fellowship in the Kaiser Permanente Graduate Medical Education Program working in health education, primary medical care, emergency and inpatient psychiatric services. He is an adjunct instructor in the criminal justice program at Portland Community College. He is a licensed clinical psychologist. He is Board Certified by the American Academy of Experts in Traumatic Stress in Emergency Crisis Response, School Crisis Response and Traumatic Stress. He interned at Kaiser Permanente, Oregon. Dr. Conner can be reached by e-mail at Conner@CrisisCounseling.com, phone at 514.388.5660 or mail at Bend Psychological Services, 965 NE Wiest Way, Bend Oregon, 97701.

End

Attack Risk

I. READS

A. Verbal

- ☐ Loud; high pitch & rapid rate of speech
- ☐ Speech is abrupt or clipped
- ☐ Challenging or insulting
- ☐ Demanding or threatening
- ☐ Ignoring or disputing directives or limits
- ☐ Statements or threats of revenge, violence or suicide
- ☐ Blaming others or statements of being persecuted
- ☐ Negative response to reasonable rules, requests or directives
- ☐ Demands for increased space
- ☐ Disoriented (uncertain of name; date; location)
- ☐ Disorganized, rambling or bizarre speech
- ☐ Delusional statements. Responding verbally to hallucinations. Bizarre opinions.
- ☐ Repeated interrupting
- ☐ Abrupt "yes" or "no" responses with little thought to the conversation
- ☐ Unusual silence; onset of emotional block
- ☐ Impaired or limited verbal skills or ability

B. Visual

- ☐ Appearance (sickly; impaired balance, gait, or body control; strange movements)
- ☐ Hygiene (incontinence; sores; unsanitary)
- ☐ Grooming (disheveled; bizarre; outlandish; inappropriate; torn; dirty; soiled; unkempt; recent severe or mutilated hair cut)

Head & Neck

- ☐ Eyebrows (furrowed, lowered, drawn together, vertical line between brow)
- ☐ Eyes (reptilian stare; target glance)
- ☐ Mouth (lips pressed together & straight or down; lips in square shout shape; facial grimace; grinding teeth; jaw muscles tense)
- ☐ Nostrils (dilated; flaring without exhaustion)
- ☐ Carotids (pulsing; distended)
- ☐ Chin thrust
- ☐ Neck muscles (tense or pulsing)
- ☐ Temple (tensing; pulsing)
- ☐ Skin (perspiring; red, blanched or pale)

Hands

- ☐ Clenched fists,
- ☐ Flexing; white knuckles
- ☐ Tremors; shaking
- ☐ Masking or hiding fists, shaking or tremors
- ☐ Pounding fists or slapping hand(s)
- ☐ Hand or palm thrust; finger jab; backhand brush or swipe
- ☐ Perspiring or moist hand(s)

General Body Movement or Stance

- ☐ Movements to an area that may contain or has weapons
- ☐ Combative posturing (bladed; braced; covering; shoulder set or drop)
- ☐ illustrators of internal distraction
- ☐ Restless; pacing; aimless activity
- ☐ Kicking; heel, toe or full foot stomp(ing)
- ☐ Changing posture; crouching
- ☐ Shoulder rocking and rotation
- ☐ Backing away; distancing gestures
- ☐ Charging; claiming or taking ground
- ☐ Scanning; hyper-alertness

Group Behavior or Movements

- ☐ Subject displays aggressive "reads" in a group
- ☐ Distancing, flight or escape behavior
- ☐ Rapid perimeter disruption
- ☐ Crowd gathering rapidly toward a focus

C. Changing Behavior (progressions)

- ☐ Calm then restless
- ☐ Shifting from relaxed to tight
- ☐ Abdominal-thoracic expansion (puffing)
- ☐ More rapid speech; higher pitch
- ☐ Rapid or repeated mood change
- ☐ Onset or increasing profanity, abusive or insulting language or behavior
- ☐ Approach-avoidance behavior
- ☐ Eye contact initially indirect then increasingly direct, onset of reptilian stare
- ☐ Challenge position (eye to eye; toe to toe)
- ☐ Increasing activity & tension discharging
- ☐ Onset of fight or flight pause (looking down & placing hand on head)

II. TRIGGERS

A. Chemical Triggers (internal)

- ☐ Alcohol; sedatives; antianxiety medications
- ☐ Volatile inhalants (e.g., glues; paint; etc..)
- ☐ Stimulants (amphetamines; cocaine)
- ☐ Narcotics (morphine, heroin, codeine
- ☐ Hallucinogens (LSD; PCP, etc..)
- ☐ Prescription drug abuse or side-effects
- ☐ High dosage of over-the-counter drugs

B. Situational Triggers (external)

- ☐ Weapon or potential weapon present
- ☐ Bystander behavior (mere bystander presence; disputants can observe and pick-up on bystander Attack Reads)
- ☐ Disputants behavior (presence of a disputant; disputants can observe and pick-up on each other's agressive behavior)
- ☐ Uncomfortable environment (hot; humid; difficult to see or hear)
- ☐ Awareness of an injury inflicted by another
- ☐ Officer presence (mere presence & number)
- ☐ Officer behavior (moving; restraining, cuffing; arresting; display of weapons)

C. Medical/Mental Health Triggers

- ☐ Off medications which treat emotional or mental disorders
- ☐ Auditory hallucinations (commanding; derogatory; mocking; threatening)
- ☐ Visual hallucinations or illusions
- ☐ Hallucinations of sensation (infestations; electrification; insertions; sharp objects)
- ☐ Delusions (persistent & totally unrealistic)
- ☐ Recent pain or injury
- ☐ Diabetes (critically low blood sugar)
- ☐ Post seizure confusion, anger or fear
- ☐ Infection, toxic or metabolic disorder
- ☐ Head trauma or head injury

III. HISTORY

A. Recent History

- ☐ Recently assaulted; unresolved conflict
- ☐ Barricaded; evading contact or capture
- ☐ Recently aggressive or violent
- ☐ Rapid loss of competence or functioning
- ☐ Recent possession of a weapon

B. Past History

- ☐ Long history of violence and aggression
- ☐ Past aggression or violence when using alcohol or drugs (& currently using)
- ☐ Hospitalized in past year as a danger to self or others in relation to mental illness
- ☐ Frequently aggressive or violent
- ☐ Past use of lethal weapons
- ☐ Violence is rewarded or goes unpunished
- ☐ Childhood (age 6 to 12 yrs - fire setting; animal cruelty & violent to family or others)

C. Social History

- ☐ Violent peers, family, or friends
- ☐ Lost or threatened social status
- ☐ Lost or threatened love relationship
- ☐ Marital, domestic or custody dispute
- ☐ Trouble at work or loss of job
- ☐ Financial or legal problems
- ☐ Weak family or community support base

D. Mental Health History

- ☐ Chronic chemical addiction & abuse
- ☐ Paranoia; or paranoid schizophrenia
- ☐ Manic-depressive (bipolar disorder)
- ☐ Personality disorder (Anti-social; Explosive; Borderline; Psychopathic)
- ☐ Severe depression, suicidal statements
- ☐ Repeated self-mutilating with scarring

IV. MOTIVATIONS

- ☐ Defending or securing freedom
- ☐ Gaining or maintaining a sense of control
- ☐ Behavior carried over from recent violence
- ☐ Survival or protection against a perceived danger or threat
- ☐ Overpowering opposition or resistance
- ☐ Dispensing punishment, justice or revenge
- ☐ Maintaining, changing or improving one's image, status or reputation
- ☐ Blaming, acting out or releasing emotional pressure
- ☐ Inviting self-punishment (relief from guilt)
- ☐ Civil or rationalized disobedience
- ☐ Individual observation of violence with group diffusion of individual responsibility or consequences ("wilding")

MENTAL & EMOTIONAL STATUS

- ☐ Consciousness (stuporous; clouded drowsy; changing level)
- ☐ Disorientated (re: name; date; location)
- ☐ Attitude (uncooperative; argumentative; guarded; distrusting; coercive; hostile)
- ☐ Speech (disorganized; rambling; bizarre; incoherent; tangential; pressured)
- ☐ Thought process (racing; wandering; confused; disorganized)
- ☐ Judgment & problem solving (poor, irrational; impulsive)
- ☐ Impaired recent or long term memory
- ☐ Emotional state (expansive; fearful, sad; inappropriate, angry; irritable; aggressive)
- ☐ Excessive energy, restless, agitated
- ☐ Mood or feelings out of proportion or do not fit the situation; feelings of unreality
- ☐ Rapid or unusual mood swings; rapid or very recent onset of an emotional block
- ☐ Delusions - unrealistic or unusual beliefs of (persecution; greatness; importance; a conspiracy; their identity; guilt; danger; the future; death; jealousy; being influenced; having special roles, powers, relationships or invulnerability)
- ☐ Hallucinations (hearing; seeing; smelling or feeling something that does not exist)
- ☐ Illusions (misinterpreting actual stimuli)
- ☐ Obsessive thoughts which are reoccurring; intrusive; or distracting
- ☐ An Increase in compulsive behavior seen in repeated behaviors & mannerisms

Portland Police Bureau

Levels of Control

(March 30, 2004)

LEVEL OF CONTROL	METHOD OF CONTROL	SUBJECT'S BEHAVIOR
Mere Presence	Officer's presence	Compliance
Verbal Control	• Verbal request • Questioning • Order	• Compliance • Verbal noncompliance
Physical Control	• Control holds • Pressure point control	Passive resistance
	• Aerosol restraint • Taser: Touch Stun • Taser: Probes	• Physical resistance. • Indicates intent to engage in physical resistance.
Impact Weapons	• Baton • Strikes & Kicks	• Aggressive physical resistance. • Indicates intent to engage in aggressive physical resistance.
	Less lethal specialty munitions	• Aggressive physical resistance • Indicates intent to engage in aggressive physical resistance • Armed or potentially armed, capable of causing serious physical injury or death.
Deadly Force	Firearms	Deadly Force

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LEVEL OF CONTROL	METHOD OF CONTROL	SUBJECT'S BEHAVIOR
MERE PRESENCE	Officer's Presence	Compliance
VERBAL CONTROL	Verbal Request Questioning Order	Compliance Verbal Noncompliance
PHYSICAL CONTROL	Control Holds Pressure Point Control	Passive Resistance
	Aerosol Restraint *M26 Taser-Drive Stun* *M26Taser-Probes*	Physical Resistance*
IMPACT WEAPONS	Baton Strikes & Kicks	**Aggressive Physical Resistance
	Less Lethal Specialty Munitions	Aggressive Physical Resistance Armed or Potentially Armed Capable of Causing Serious Physical Injury or Death
DEADLY FORCE	Firearms	Deadly Force

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Tips and Techniques

Portland Police Bureau

VOL. XLII No. 9 August 14, 2006

Request from Emergency Rooms to call ahead

The purpose of this bulletin is to assist officers with bringing in mentally ill patients to the Providence and Portland Adventist Emergency Rooms.

The staff and management of both hospitals has requested that any officer who is bringing in a voluntary or in-voluntary patient, please call ahead or get someone else to call ahead for them to notify the charge nurse of their impending arrival. (The charge nurse is like the Sergeant of the nurses in the emergency room.)

The reason for this request is that the walk-in traffic at all area emergency room's has gone up over the past several years. The hospital ER's are going on "divert" for ambulance traffic more and more frequently. The resulting wait for a bed is now much longer than it used to be, and could be several hours or more. Providence has told me that they are getting 10-15 walk in psych patients a day, and an average 350 psych patients a month. As a result of all this traffic both hospitals are asking for our help in calling ahead so the charge nurse can work out several issues:

- Which room or bed is most appropriate due to the sex or age of the patient.
- Is the patient combative? -extra nurses and security should be present when the patient arrives.
- Is this a returning patient that has been in their system before?
- Is this a voluntary or in-voluntary?

They have also requested that if we drop off a voluntary patient, that we give them a copy of the Special report. After we leave this may be the only record the staff has to refer to, as to why the person came in.

When we do call the charge nurse, they would like to have the following information:

- Name
- D.O.B.
- Reason for transport
- E.T.A.
- Combative or non-combative?

The 24/7 phone number for the charge nurse at the Providence ER is: **503-215-7230**
The 24/7 phone number for the charge nurse at the Portland Ad. ER is: **503-251-6155**

If you have any questions please call the CIT Coordinators Office at 503-823-0183.

ROSANNE M. SIZER
Chief of Police

06-09
Page 1 of 1
Submitted by: Officer Paul Ware, CIT
Original Issue Date: August 14, 2006
Original Number: *VOL. XLII, No. 9*

In-service 2005-06
Course 0530141

2006 In-Service Lesson Plan
Dr. Mary Zinkin
Communication and Conflict

I. Opening - Introduction: 15 minutes
   a. State my qualifications and experience
      i. Consultant practice in conflict resolution over 20 years
      ii. Created own Ph.D. in Conflict Resolution
      iii. Co-Founded Masters Program in Conflict Resolution at PSU
      iv. Train Hillsboro Police Department for 10 years, full 32-hour mediation training entire department, sworn/nonsworn
      v. Volunteer member of Use of Force and Performance Review Board, received training from PPB and have done ride-alongs
      vi. Read/been trained by Gilmartin, Grossman, Artwohl, Blum, deBecker, Lewinski
      vii. Personal story of being shot
   b. Go around room so officers can introduce themselves to me – name, work they do/precinct, how long with Bureau

II. Review Objectives: 5 minutes
   a. More understanding of own conflict attitudes and behaviors – affect how use yourself as "tool" on street
   b. More ability to recognize assumptions/perceptions
      i. When need to act on without checking out first
      ii. When better to check out before act on
      iii. Acknowledge job demands ability in both...difficult judgment calls

III. State Assumptions: 5 minutes
   a. All know a lot, and all have things to learn
   b. Conflict not inherently good/bad...how it's dealt with determines whether positive or negative
   c. Avoidance is most common response to conflict and yet can lead to it becoming bigger problem. The more we learn about how to deal with it, the more it can become a positive experience in our lives – lead to healthier relationships and communities.

IV. Conflict Attitude Questionnaire Activity – handout – 25 minutes
   a. Complete individually – 30 questions – not about right/wrong – understand more how affected by experiences with conflict
   b. Discuss in pairs – explore differences to learn from
   c. Discuss as group – check out assumptions of how group answers –
      i. Establish room for differences without judgment – different family background, gender, interpretations of questions, personalities, successes/failures in conflict resolution in past
      ii. Discuss importance of all that is needed to resolve conflict
         1. Logic/Reason/Clarity/Decision Making (stereotypically male)

Course 0530141

2. Feelings/Process/Understanding (stereotypically female)
3. Communication Skills – willingness to assert, listen
4. Create environment to engage in conflict when gut reaction is to avoid the stress of it

V. Present Conflict Behavior Model – Thomas Kilmann 1976 – handout – 20 minutes

a. Discuss five options – Avoid, Accommodate, Control, Compromise, Collaboration
b. Clarify not one best way to resolve conflict – depends on situation, relationship, timing, power, goals, long-term consequences.
c. Define difference between compromise and collaboration by discussing briefly interests/positions. Confront basic assumption in conflict that there it's always about scarce resources. Use orange example.

VI. Story Exercise – handout – 30 minutes
a. Give directions to read, answer statements.
b. Divide into groups to obtain consensus
c. Give answers and then list scores for group in comparison to individuals
d. Discuss importance of learning about own assumptions, ability to learn from others perceptions, sometimes question mark is best answer particularly in conflict resolution so can be a learning experience rather than a battle. Challenging when there are "right answers". Also comment on process of reaching group consensus – if people gave in to reach agreement, argued forcefully for their answer, etc.

VII. Closing – 5 minutes
a. Thank everyone for participation.
b. State appreciation and gratitude for work they do, choice they've made to take risks to protect others.

Materials

Three handouts
Flip chart/pens
White Board

Additional Resources

List on white board:
Gilmartin – Emotional Survival for Law Enforcement
Grossman – On Killing
Artwohl - Deadly Force Encounters
Blum - Force Under Pressure: How Cops Live and Why They Die
deBecker – Gift of Fear

Course 0405055

PART 1: INTRODUCTIONS, GOALS, AND OBJECTIVES (15 minutes)

Introduction **This is a basic beginning level training.**	▪ My name is ____ and I work for the City of Portland. I am in the___. ▪ We are here today to talk about the effects of culture on communication. Communication is something that all of us do in many different settings every day. How well we communicate, has a huge impact on our effectiveness at work. ▪ We have been engaged with other Bureaus for two and a half years bringing the same type of information we're going to share with you today. The difference being your training is a collaborative effort between our office and members of your bureau to personalize the training and make this a regular part of your in-service. Next year it is our intent to present another level of training. ▪ What we are going to do is to start talking to you on how culture affects us with other folks, how we are raised, our background, norms, and how they can effect communication with other people. ▪ We have several objectives for the day. It is our intent help you gain some greater self-awareness, better understand your attitudes and biases, and how they might impact your effectiveness on the job. You will also learn about culture, which will help you work with others and assist you with communicating more effectively. ▪ We want to increase your understanding among members of your own group, which should happen as you increase your communication skills. ▪ Through better communication we hope to add to your tools to help you perform better and go home safe at the end of the day. ▪ We will spend some time going over some terms that the City would like us to utilize while on the job. This is just because we would like for all of our employees to use the same terms. ▪ Your own cultural identity impacts your behaviors. This session will help you better; understand the effects of communication and behavior.
Activity **Assure them that you know that they have had much practice in quickly sizing people up and that this little activity will give them an opportunity to demonstrate how astute they are.** **Work on this activity for a few minutes, by writing your responses on the flip chart. Then go down the list and address each item, let them know how accurate (or inaccurate, as the case may be) they are. Use this is a starting point for a discussion about how we all make assumptions based on visible characteristics**	Part of your job is to make observations about people you encounter. Can anyone think of an example to illustrate this? What about you officer_____, what is the first thing that comes to mind when you make a traffic stop?? What is it you want to know about the person you're stopping? Do you size them up physically, mentally? **Write these things down on the board or flipchart.** If you were to stop me, what assumptions could you make about me based on what you see? ▪ What is my race? ▪ My age? ▪ Weight ▪ Where do I live? ▪ What is my educational background? ▪ Where was I born? ▪ What is my religion? ▪ Educational level? **Write these things down on the board or flipchart.**

GOALS AND OBJECTIVE

Materials	▪ **Power Point Slides 2 & 3** ▪ **Flip Charts** ▪ **Markers**
Objectives **Check in at the end to make sure their concerns were addressed if any.**	▪ There are several objectives for the day. ▪ **Greater self-awareness:** The first objective is to assist you in understanding your own attitudes and biases and how they can impact your effectiveness on the job. ▪ **Improved communication skills:** This will also help us learn about culture in such a way that it can assist us to communicate more effectively. ▪ **Increased understanding among Police Bureau employees:** Which will happen as you increase your communication skills. ▪ **Better police-community relations:** These activities can have a positive impact the ability to connect more effectively with community members. This can be done in spite of the sometimes-negative situations you are placed in. ▪ "Can anyone give an example of a situation when better communication might have made you safer?" (Add Examples from previous classes) Here are some examples: ▪ An officer that thought he knew what the perp. was like based on his dress and he mistakenly thought the suspect was an upstanding citizen because he wore a suit and tie. Later on he found out criminals can be well dressed. ▪ One officer in a previous class shared that while on duty he followed a man at the airport dressed in a red sweatshirt. From the back the man appeared suspicious as he hurried through the airport with the hood of the shirt covering his head. The officer literally chased the man and physically stopped him and when he spun him around the man was wearing an Avis uniform. He was in a hurry to use the restroom. ▪ **"Do you have any additional goals?" If so please tell me so they can be written down on the flip chart as well.**
Goals	▪ We will spend some time going over the definitions of important terminology the City would like us to use. Please go to the page with the definitions on it. Examples: o Culture o Cultural competency o Diversity o Generalizations o Stereotypes We are not going to discuss contemporary cultural designations today but the next level of training we will review what people want to be called and why it is important to know current racial and ethnic terms. ▪ By the end of this session, you should be able to name the elements of your own cultural identity. You should also be able to understand how your cultural identity can impact your behavior. ▪ This training will help you understand how to communicate in a more culturally competent way.

PART 2: AGENDA (5 minutes)

Objective **The objective of this segment is to provide participants with an overview of what to expect during this training.**	▪ The curriculum will introduce you to the knowledge and skills that will help you work more effectively with diverse community members.
Materials ▪ **Power Point Slide No. 4** ▪ **Handouts** ▪ **Flip charts**	
Directions **Present the overall framework of the curriculum to the participants.**	▪ Certain aspects of diversity can be more troublesome to interpersonal relationships. You will be discussing some of the aspects of diversity. We will discuss stereotyping and other barriers to communication. ▪ The session includes interactive activities, so you will have opportunities to move around as well as interact with others in the room. ▪ You will also have opportunities to ask questions. We want you to leave the session with as much helpful information as possible.

PART 3: SETTING GROUND RULES (5 minutes)

Materials ▪ **Handouts: "Setting Ground Rules"** ▪ **Two Easels and flip charts** ▪ **Markers**	
Objectives ▪ **To provide a way to manage conflict, should any occur?**	▪ All training situations have some operating guidelines so that everyone feels comfortable.
Explain that the purpose of establishing ground rules for any training session is to create a safe learning environment. **Directions** **Keep one flip chart blank and the other one should have the ground rules already written on it.** **You can then provide your own insights into both the definition and the importance of respectful listening, or whatever ground rule you choose to use as an illustration.** **If you suggest: "taking risks," explain that it means we tend to learn more if we are able to go outside our own comfort zone**	▪ It is common for people to come to diversity training with a full range of feelings, expectation, and preconceived ideas about the training itself as well as about other cultural groups. ▪ The purpose of establishing ground rules is to ensure that all members of the group have an opportunity to share, ask questions, and have their ideas and concerns respected by the group as a whole. ▪ Establishing ground rules amounts to an agreement among participants about how they want to work together during the workshop. It is important that all of us are 'on the same page' about how we interact during this session. ▪ An example of a typical ground rule is 'respectful listening.' What do you think that means? Does anyone have an example that would illustrate what 'respectful listening' means? Giving your full attention to the speaker. ▪ **Here are the ground rules that have been established. Others can be the ones we have here on the flipchart:** 1. **Be open** to the ideas of others and to new information. 2. **No blaming or put-downs** because it diminishes trust and causes others to shut down. 3. **Take responsibility** when making statements – speak only for yourself by using "I" statements. 4. **Participate at your own comfort level,** speaking when you want to and passing when you would rather not talk. 5. **Observe confidentiality.** Please avoid using names or ranks, which may describe a specific person. 6. **Be willing to take risks.** Sometimes this means confronting one's own attitudes and behaviors in ways that can be unsettling, but in ways that can also create personal growth. ▪ Do any of these need further clarification? ▪ Please raise you hands if you can agree to abide by these guidelines. ▪ You can remind the group of any of the ground rules during the course of the session. ▪ This list can be added to at any point, with the consent of your group

PART 4: FIND YOUR MATCH ACTIVITY (15 minutes)

Materials	▪ Flip chart ▪ Pencils
Introduction	▪ Good morning. My name is _____. Please refer to your packet and turn to the exercise called "Find Your Match."
Refer to the "My Match" handout	▪ Please write your answers to the questions listed below in the column headed "ME", you will have three (3) minutes to complete this task.
Call time after 3 minutes	▪ For the next phase of this activity I am going to ask you to stand up, go to the middle of the room and find someone in the room that has the same answers as yours and have them sign their name in the "My Match" column. When you have found a match for a question you will move on to the next question, until you have found a match for each one of your answers. Each person may be your match for only one question. Please start now.
Call time after 5 minutes	▪ Please "freeze" where you are and pair off with the person your standing next to and find a place to sit down. If you do not know the officer sitting next to you, introduce yourself and tell them something about yourself.
Ask participants the following questions	▪ Raise your hand if you got 11 matches, 6-10 matches, 0-5 matches ▪ Which matches were the easiest to find? ▪ Which matches were the hardest to find? ▪ Share with your partner which ethnic, cultural, or racial groups you most closely identify with. **Ask participants to share their answer.** ▪ Share with your partner which ethnic, cultural or racial groups other than your own are you most familiar/comfortable with. **Ask participants to share their answer.** ▪ Share with your partner which ethnic, cultural or racial groups they are least familiar with. **Ask participants to share their answer.**
Write the participants responses to these questions on the flip chart. *If needed, ask participants to elaborate on their responses to these questions.* **Learning Points**	▪ Do you think there is a police culture? ▪ What are the aspects of a police culture? ▪ Are their sub-cultures within the police bureau? ▪ What are those sub-cultures? ▪ Do you think police culture is the same throughout the country or across jurisdictions? ▪ We know a little more about our colleagues. ▪ We know we have resources among ourselves to assist us when we are seeking opportunities to learn about other cultures. ▪ We all belong to more than one culture: Age, profession, gender. ▪ In getting to know each other better, we realize that we can share much in common with those who appear different from us, often contrary to our initial expectations.
Have participants return to their original seats.	▪ Part of being culturally competent is being open to new information and seeking information about others.

PART 5: DEFFINITION OF TERMS (5 minutes)

Directions **Purpose:** **To help us frame terminology in a more personal way, and have them connect it to the Police Bureau.** **Talk about the culture of the Bureau generally as well as the ways in which the cultures of the various precincts differ from one another, even though they share the larger culture of the Bureau.** Help participants understand the difference between generalizations and stereotypes. Using the example above, to stereotype would take the generalization several steps further and assume that every high school student is going to be immature, impulsive, and will behave in a number of specifically negative ways.	▪ The reason for going over the definitions is to help everyone have a common understanding of the terms used in class and which are related to diversity work in general. ▪ These terms are being used citywide. It is important that all city employees operate with the same definition of terms with respect to diversity issues. ▪ Does anyone have any questions about any of the definitions? ▪ **Have participants read the list of terms from the sheet in their packet. The terms are defined as follows:** 1. **Culture:** The learned and shared values, beliefs, and behaviors of a group of interacting people. 2. **Cultural Competency:** The understanding and skills to communicate and work effectively with all members of the community. How are they culturally competent and would they help us in the daily performance of our jobs? 3. **Cultural Diversity:** The characteristics we use to put others and ourselves into groups. 4. **Generalization:** The tendency of a majority of people in a cultural group to hold certain values and beliefs and to engage in certain patterns of behavior. Making generalizations can be an efficient way of dealing with others because it makes it possible to take shortcuts in our interactions. May someone give an example of a time when a generalization might be helpful? **(For example, it would be a generalization to assume that most high school students lack maturity and might be expected to act impulsively in certain situations. How could a generalization like this be helpful to a police officer in certain situations?)** 5. **Stereotype:** The application of a generalization to every person in a cultural group, or generalizing from only a few members of a group to the entire group. 6. **Diversity:** The similarities and differences in human characteristics and cultures that act as barriers and bridges to understanding and communicating with others. You will be doing an exercise a little later that will illustrate this. 7. **Diversity development:** The building of institutional capacity to attract and support a diverse workforce and to utilize the perspectives, knowledge, and skills offered by a diverse workforce. May I get a volunteer to explain why this would be desirable to any organization, and particularly to the Bureau?

PART 6: DIMENSIONS OF CULTURE: ICEBERG ANALOGY (15 minutes)

Materials **Introduction**	▪ Power Point Slide #5 ▪ Handout: Iceberg Theory ▪ Flip chart with drawing of an iceberg. Please refer to your handout called the Iceberg Theory.
Lecture **Have participants call out words which they think would describe the immediately visible aspects of culture. Write the participants responses on the top portion of the iceberg on the flip chart, above the waterline.**	▪ Culture can easily be compared to an iceberg because the part that is visible above the surface is only a small portion of the total picture. It is commonly accepted that the part of an iceberg that we can see – the part above the water line – is only about 10% of the whole iceberg. People are the same way: what we see, what is immediately visible is only about 10% of their cultural attributes. You probably see 15% based on your profession and training. ▪ The distinguishing characteristics of a person are often below the surface. These hidden aspects, though not visible, make up a larger part of our cultural makeup than the "tip of the iceberg.; But they don't become visible until we go "deep sea diving". The more we know about what is below the surface of the cultural iceberg, the more we can actually know about what actually defines that person. **What are the <u>immediately</u> visible aspects of a culture? What's above the waterline?** **Answer Examples:** ▪ Physical features ▪ Gender ▪ Age ▪ Language ▪ Clothing ▪ Food ▪ Music ▪ Religion, etc **What are the visible aspects of a person you observe in your role as a police officer?** **Answer/Examples:** ▪ Tattoos ▪ Behaviors ▪ Hygiene ▪ Gang colors

Have participants call out words which they think would describe the <u>less</u> visible aspects of culture. Write the participants responses on the lower portion of the iceberg on the flip chart, below the waterline.	**What are the <u>less</u> visible aspects of a culture which describe the deeper parts of culture? What's below the waterline?** **Answer/Examples:** ▪ Values ▪ Beliefs ▪ Attitudes ▪ Perceptions ▪ Assumptions ▪ Life experiences
Learning Points	▪ Like the iceberg, we can only "see" 10% of a person's cultural attributes. We cannot see the most important dimensions of a person's culture, including values, attitudes, and beliefs. ▪ Although most of who we are is below the surface, we tend to make assumptions based on the tip of the iceberg, the visible portion, which often results in misjudgments. ▪ If we want to get to really know about a person, we need to look below the surface. This will lead to better communication and stronger relationships. ▪ We have most control over the attributes under the waterline, and yet we respond to others based on the tip; ▪ Culture clash is often triggered by the attributes on the tip of the iceberg. This prevents us from going any deeper and checking out whether, despite surface differences, there are similarities in the fundamental attributes. ▪ When we clash culturally with people, it is often triggered by the attributes at the top of the iceberg. This prevents us from going any deeper into the cultural identities of others. Getting stuck in the stereotypes and assumptions that come from focusing on only the dimensions of culture that we can see, keeps us from developing good relationships and many times misjudging. ▪ The more we know about others, the better we will understand them is a logical conclusion. And if we understand them better, our communication will be better and our relationships can become much stronger.

PART 7: CULTURAL INFLUENCES (20 minutes)

Objectives: **To allow us to see where our own cultural influences come from. Also to distinguish between cultural patterns and stereotyping.**	Power Point Slide # 6
Materials: **Handouts are in your material**	
Directions: **Why do we judge based on 10-15 % or what we can see of a person?** ▪ **Their answers will vary widely, but many of them will cite such sources as their parents, the media, school, church, etc.** ▪ **Discuss with participants the other sources of negative input if not mentioned: TV, textbooks, events, personal experiences, and films, the media, etc.** ▪ **Help them understand that messages that are learned early become assumptions and part of our mental filters. They then affect both what we think and how we feel about those who are different, which in turn**	▪ From an early age, we are given information, both accurate and inaccurate, about people. This information comes from many different sources and becomes part of our belief systems, our assumptions, and our mental filters. ▪ Search your past and think about your personal sources of information. ▪ Please write the sources down one source in each box on the handout that you were given. You can add more boxes if you need to. ▪ Although you will not be turning the sheets in, you will be sharing the information with a partner. ▪ You will have three minutes to complete your chart. ▪ Now that you have determined the sources of the messages you received, think about times that you might have received negative input about people who are different from you and your family. Mark those boxes. ▪ Then share with your partner information about what you were told regarding people who were different from you and your family in some way. Write where there information came from down on the board. Then ask them the following. ▪ How does that information have an effect on your work today? Think about your relationships with co-workers or the public: Do any negative messages from the past influence how you react to the people you interact with in your job? ▪ The vast majority of the time, people do not intend to give out negative messages about others, but many of us do so because those are the messages we received ourselves, and we are just passing on what we have learned. Sometimes those kinds of message are subtle, and sometimes they are overt, but they always have a great deal of power. This is one reason it is so important for each of us to know and understand our own attitudes and programming: so we can change for the better those beliefs and attitudes that drive our behavior. This way we can stop the cycle of passing on misinformation to others. ▪ Another reason these assumptions are so difficult to change is that we are often not conscious of what we assume about those who are different. Our assumptions are simply '**on automatic**,' and we

impacts our behavior. **If you have a story of a time you were wrong in making an assumption, share it.**	behave in ways that are ingrained. ▪ Stereotyping is also part of the issue. We just react to people based on old, internalized messages that we often are not even aware of. Our reactions have little or nothing to do with whom the people really are, but are just grounded in old stereotypes that we have been harboring for years. ▪ Earlier in the program, we defined a stereotype as the application of a generalization to every person in a cultural group, or generalizing from only a few members of a group to the entire group. ▪ It can be very difficult to undo stereotypical thinking because those attitudes usually become fixed and frozen and keep us from being open to who individuals really are. Each of us has to be motivated to change those kinds of ingrained attitudes, however, it can be done. ▪ It is possible to move out of being "on automatic" and into a greater consciousness of our own reactions by: 1. Realizing that everyone is raised with messages that become filters. Even those you interact with while you are on the job. 2. Knowing what our own filters are and how they cause us to react to others in negative ways. 3. Making a decision to not act on the filters that create automatic and perhaps inappropriate assumptions about a group or individual. 4. Seeking new information in an effort to create new and more informed filters through which we pass the information that comes to all of us every day. 5. Using this new information to make better judgments about what is real vs. what is merely perceived. ▪ Give yourself some time to *pause* before you react in any given situation. Ask yourself, 'Am I basing my reactions on something that is true and accurate, or am I being driven to act based on old messages in my mental filters, messages that have nothing to do with my current situation or the person I am dealing with?

Bridges and Barriers

SIMILARITIES

"We assume that words and gestures have universal meanings. We assume that if both parties speak the same language – English, for example – that the message we *send* matches the message that is *received.* But we cannot count on others interpreting language in exactly the same way that we do, for many reasons. What do you feel when you are similar to someone and how can our similarities be a bridge?

Write responses down in each of the four quadrants on the board.

- Safe
- Make assumptions
- Feel words/gestures mean the same thing

Do we check our assumptions?

"Differing communication styles can lead to making negative judgments about one another. These negative judgments can cause communication to come to a standstill as well, so that the message isn't heard at all. How can a difference be a barrier to communication?

Examples: An example of this would be when one person talks with a great deal of emotion; the other person could judge them as being aggressive.

A person who speaks very deliberately could be seen as being unmotivated or not very committed to the conversation.

- Feel betrayed when similarities don't mean the same thing.
- We feel unsafe
- The same language doesn't mean the same thing
- Don't know how to respond
- Don't know lay of land
- When there's a difference in beliefs, it becomes a barrier.

Do we check our assumptions?

DIFFERENCES

How can our difference be a bridge to communication?

- Open
- Curious
- We can learn new things and Find common grounds
- We ask questions
- Form meaningful relationships

Do we check our assumptions?

When is a difference a barrier to communication? Do we read body language alone? How do we feel?

- Are we unsure
- Uncomfortable?
- Cautious how we interrupt others
- Style differences = value differences

PART 9: CLOSURE AND EVALUATIONS (10-12 minutes)

Materials	▪ Handouts ▪ Flip charts ▪ Markers
Group Action Planning	▪ To create an action plan based on what they learned today.
Directions	▪ **Ask the large group,** What worked for you today? ▪ What didn't work? ▪ Write suggestions on the flip chart. ▪ What would you like to learn next? How are you going to use this information?
Evaluations	▪ **Pass out the evaluation forms.** Please fill them out and hand them in before they take your break.

In closing

What you have heard today should illustrate the importance of looking for feedback, (verbal and non-verbal) checking your assumptions about others and asking yourself is what I am doing or about to do based on what is in my mental filters, or something real? Am I operating on the visible 10% of this person and allowing my programming to take over?

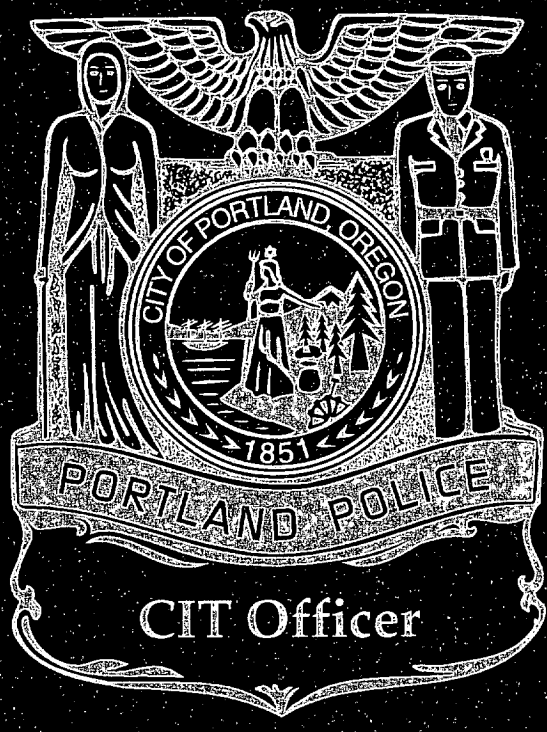
If your answer is yes, you may be doing yourself and the other person a great injustice.

"I want to say Thank You for your participation today"

Ask class to fill out evaluations and you are done.

Portland Police Bureau

CRISIS INTERVENTION TEAM



CIT Officer

MAKING A DIFFERENCE TOGETHER

CIT Training
June 26th - 29th, 2006
Portland, Oregon

Crisis Intervention Training/2006
06-26-06 to 06-29-06

Time	Monday	Tuesday	Wednesday	Thursday
0700-0800	Intro to CIT	Site Visit Procedures	Site Visit	Suicide Intervention
0800-0900	Consumer Perspective	Mental Status Exam	Site Visits	Crisis Intervention
0900-1000	Overview of Mental Illness	Autism	Site Visits	Crisis Intervention
1000-1100	Overview of Mental Illness	Childhood Disorders	Site Visits	Scenario training
1100-1200	LUNCH	LUNCH	Site Visits	LUNCH
1200-1300	"I'm still here!" video	Personality Disorders	Site Visits	Scenario Training
1300-1400	Hostage Negotiations	Personality Disorders	Site Visits	Scenario Training
1400-1500	Hostage Negotiations	Civil Commitment O.A.C.	Site Visits	Scenario Training
1500-1600	MR/DD-Bill West	PTSD	Site Visits	Policy & Procedures
1600-1700	MR/DD-Leslie Goodlow	PTSD	Site Visits	Graduation!

CIT Instructors/June 2006

Overview of Mental Illness: Dr. Melissa Buboltz, OHSU. Dept. of Psychiatry
3181 SW Sam Jackson Park Rd., UHN 80
Portland , OR., 97201-3098
503-494-8144
E-mail: psych@ohsu.edu

Mental Status Exam: Dr. Neil Falk, Cascadia
2415 SE 43rd Ave., Suite 100
Portland, OR., 97206
503-963-2575
E-mail: www.cascadiabhc.org

Personality Disorders: Katie Gotch, Clinical Coordinator, Sex Offender Unit
Department of Adult Community Justice
1415-B SE 122nd Ave.
Portland, OR., 97233
503-988-3136 x27633
E-mail: www.co.multnomah.or.us/dcj/

Civil Commitment: Jean Dentinger, Involuntary Commitment Investigator
Department of Community & Family Services
421 SW 6th Ave., Suite 600
Portland, OR., 97204
503-988-5464x27297

Childhood Disorders: Loretta Cone, LCSW & Wendy Hoffman, LCSW
Morrison Center, Child and Family Services.
1818 SE Division
Portland , OR., 97202
503-258-4382

Post Traumatic Stress Disorder: Dr. David w. Greaves, Ph.D., V.A.
3710 SW U.S. Veterans Hospital Rd.
Portland, OR., 97239
503-220-8262 x51039

Mental Retardation/Developmental Disabilities: Leslie Goodlow, Multnomah County
421 SW 6th Ave., Suite 600
Portland, OR..97204
503-988-3653

Mental Retardation/Developmental Disabilities: Bill West, ARC-Adult Case Coordinator
619 SW 11th Avenue, Suite 234
Portland, OR. 97205
503-223-7279

Hostage Negotiation: Det. Wayne Svilar, HNT, PPB
1111 SW 2nd Ave., 13th Floor
Portland, OR. 97204
503-823-0400

Introduction to CIT, Autism, "I'm Still Here!", Suicide Intervention, Crisis Intervention, Scenario Training, and Policy and Procedures: Officer Paul Ware, PPB
1111 SW 2nd Ave., Room 1180
Portland, OR. 97204
Office: 503-823-0183
Cell: 503-793-6564

Crisis Intervention Training/2006
Wednesday, 06/28/06

Time	Group A	Group B
0800-0830		Cascadia
0930-1030		Goodwill
0930-1130	Inverness Jail	
1100-1200		Hooper Detox
1300-1400	Rainbow Adult Living	
1330-1530		Inverness Jail
1430-1530	Hooper Detox	
1600-1630	Cascadia	

Crisis Intervention Training/2006
Site Visit Contact List

Cascadia Clinic: 2415 SE 43rd Avenue
Portland, OR. 97206
503-963-2565
Contact: Alison Noice, Counselor

Goodwill Industries: 1943 SE 6th Avenue.
Portland, OR. 97214
503-238-6100 (Main Number)
Contact: Dave Phapf, 503-238-6177
Note: Please meet in the east visitors lobby, and not in the store.

Inverness Jail: 11540 NE Inverness Drive
Portland, OR. 97220
Contact: Shift Lt.
Note: Inverness is a correctional facility, and we will be putting our firearms in a lockbox before we go inside. Be sure and bring your Bureau issued ID card with you. Please leave all knives, extra mags, cell phones, pagers, batons, pepper spray, and anything considered contraband in you car.

Hooper Detox: 20 NE M.L.K. Jr. Blvd.
Portland, OR. 97232
503-238-2067
Contact:Debbie Molson, Manager
Note: Please meet in the business lobby on the MLK side.

Rainbow Adult Living: 1440 SE Hawthorne
Portland, OR. 97214
503-231-1608
Contact: Greg Ruf

Portland Police Bureau

Crisis Intervention Team

Instruction Manual

CIT Mission Statement:

"The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis."

Introduction to CIT

Critical Community Incidents:

January, 1992 - Portland P.B. Incident
Nathan Thomas Shooting

August 20, 1994 - Gresham P.D. Incident
Fred Meyer Shooting

August 24, 1994 - Portland P.B. Incident
Eviction Shooting

P.P.B. Responds to Needs:

- Community Partnership developed:
  - Portland Police Bureau
  - Multnomah County Behavioral Health System
  - AMI - Multnomah (Now NAMI - Multnomah)
- Committee formed to Investigate Programs:
  - LASO team response
  - Developing Specialized Unit (LAPD, etc.)
  - Memphis P.D. CIT Program

Memphis Response to Mental Health Crisis:

- Memphis found prior to 1987 that:
  - Police were not prepared to deal with the M.I.
  - Family members of M.I. Persons distrusted police.
  - Criminal Justice and Mental Health systems were adversaries.
  - Police response often resulted in arrests and injuries. (Liability for agencies)

Memphis CIT Program Is Created

- A 40 hour CIT curriculum is created by the Mental Health Professionals. Including:
  - Mental illness diagnosis and symptomology.
  - Crisis intervention and communication skills.
  - Interaction with consumers and family of consumers.
  - Visitation of treatment/residential facilities.
  - Role-playing and scenario work in practicing crisis resolution skills.

Memphis Learns:

- Memphis found that after CIT started:
  - Crisis Response: Immediate
  - Officers are highly skilled in verbal de-escalation techniques.
  - Family members of mentally ill request CIT officers on incidents.
  - A partnership provides solutions to mental health issues.
  - Most patients are taken to medical facilities with less injuries sustained and without criminal arrest.

Memphis CIT Program Is Chosen As Model:

– Four representatives of the committee attended Memphis CIT training in October of 1994.

–These participants strongly recommend the Memphis program.

– Chief Moose authorizes program in January of 1995 and assigns Sgt. Karl McDade as first CIT Coordinator.

– 60 law enforcement personnel are trained in August of 1995 and P.P.B. CIT begins.

Current Portland Police Bureau CIT Information:

- Since August of 1995 P.P.B. has conducted twice yearly CIT training for numerous Metro area police personnel.
  - Class size is usually limited to 20-25 participants
- Currently over 284 persons have been trained.
- Portland Police have 130 active CIT members.
  - Currently, 105 PPB Patrol Officers are the Back bone of the program.
  - (Active strength will fluctuate with promotions and off-street police assignments)

Who Else Has Been Trained?

– Gresham Police Department
– Oregon State Police
– Federal Bureau of Investigation
– Multnomah County Sheriff's Office
– Multnomah County Adult Community Justice
– Lake Oswego Police Department
– Portland Public Schools PD (Disbanded)
– Tigard Police Department
– Troutdale Police Department
– Washington County Sheriffs' Office

Who Else Has Been Trained?

- Medford PD
- Klamath County Sheriff's Office
- Beaverton PD
- Longview WA PD
- Wheat Ridge CO PD
- Arvada CO PD
- Portland State University Public Safety
- Clatsop County SO
- Vancouver WA PD

Portland's CIT Training Includes:

- 40 hours of instruction in:
  - Overviewing Mental Illness
  - Cognitive and Mood disorders
  - PTSD, A/D, Dual Diagnosis issues
  - Personality disorders
  - Rights of the M.I. And Commitment Law
  - Mental Status Exam and Medications
  - Family/Consumer and Community Resource Panels, and Cultural Response Panel
  - Crisis Intervention, Crisis Cycle, and Suicide Intervention
  - Site Visits and Scenario/Role-plays

How Does CIT Work?

- Street level police personnel are designated CIT in Dispatch computer.
- When a CIT related incident occurs, by PPB Directives, BOEC Dispatch assigns the closest CIT Officer as primary investigating unit.
- CIT Officer commands the incident until relieved by a supervisor if needed.

Qualities of PPB CIT

- Officer's volunteer for this training and skill certification.
- Officer's are willing to take this added work load and responsibility for no extra pay or incentive.
- Officer's typically have an interest in becoming a better police officer through this training.
- Officer's may also have someone close to them who suffers from an M.I. or D.D. And/or has known someone who does.

Important Needs/Wants:

– A Centralized Facility or Designated Hospital for Patient Intake.

–Coordination and Constant Communication Between Police, Consumers, Family and the Mental Health System.

–Simple/Streamlined Avenues of Action For Crisis Management. Treatment Plans Should Begin After the Crisis Over.

Important Needs/Wants:

–Keep Providing Training Opportunities For Police as They are the First Responders In the Mental Health Crisis System.

–Partnership with Project Respond as they also operate on a 24/7 basis

Benefits!

- The community is better served by its respective police agency.
- Less injury is sustained by both police and mentally ill/developmentally disabled persons.
- Police become better communicators and problem solvers. (Within and Without the M.H.System)
- Less money is spent on special police responses (i.e. SWAT/HNT) and civil liability litigation.

...And People Who Suffer From a Disease Are Treated With the Compassion and Respect Due All People!

Frequency of CIT

Source: CIT Database

- Mental Health Response Report:
  - 1999: 1359 - w/39% receiving CIT
  - 2000: 1690 - w/40% receiving CIT
  - 2001: 2062 - w/49% receiving CIT
  - 2002: 1746 - w/48% receiving CIT
  - 2003: 1907 - w/32% receiving CIT
  - 2004: 1999 - w/34% receiving CIT

Frequency of CIT

Source: CIT Database

- Involuntary Peace Officer Custody:
  - 1999: 905 - w/42% receiving CIT
  - 2000: 919 - w/48% receiving CIT
  - 2001: 910 - w/60% receiving CIT
  - 2002: 687 - w/60% receiving CIT
  - 2003: 651 - w/37% receiving CIT
  - 2004: 651 - w/39% receiving CIT

Frequency of CIT

Source: CIT Database

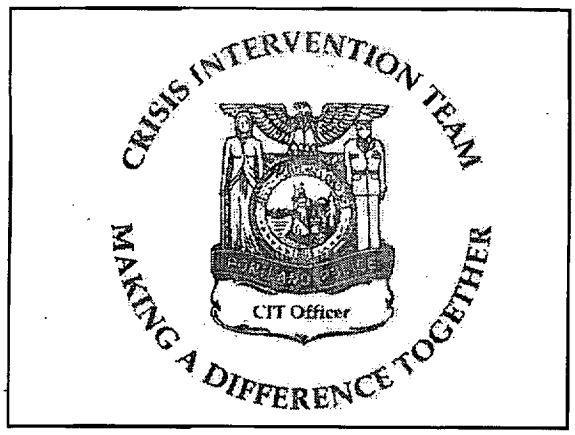
- Voluntary Assist / Transport:
  - 1999: 255 - w/28% receiving CIT
  - 2000: 570 - w/32% receiving CIT
  - 2001: 777 - w/40% receiving CIT
  - 2002: 370 - w/48% receiving CIT
  - 2003: 338 - w/34% receiving CIT
  - 2004: 301 - w/31% receiving CIT

Frequency of CIT

Source: CIT Database

- Director's Custody / Transport:
  - 1999: 66 - w/33% receiving CIT
  - 2000: 112 - w/32% receiving CIT
  - 2001: 175 - w/38% receiving CIT
  - 2002: 267 - w/40% receiving CIT
  - 2003: 376 - w/32% receiving CIT
  - 2004: 399 - w/39% receiving CIT

Thank You!


CRISIS INTERVENTION TEAM
CIT Officer
MAKING A DIFFERENCE TOGETHER

ASSESSMENT MODEL

RECOGNIZING PERSONS WITH MENTAL ILLNESS

The purpose of this activity is to provide officers with guidelines for identifying mentally ill persons. Emphasize that officers only have to be capable of identifying major behaviors indicative of a mental illness; they do not have to identify specific types of mental disorders. That is the function of a mental health professional. Whereas mental health professionals determine the type and severity of illness, officers only have to make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder.

Discussion Points

1. Generally, what is known about people with mental illnesses?

   - Depending on the severity of the disorder, mentally ill persons can be difficult to distinguish from persons not having a mental disorder.
   - Persons with a mental illness can be quite intelligent, perceptive, and articulate.
   - They can be employed and maintain familial relationships.
   - With the onset of their disorder, however, they become unable to deal realistically with the world.
   - Their thoughts and actions are not based on reality.
   - Their ability to think clearly is impaired.

2. What are the general characteristics that indicate a mental illness?

   - The behavior and mood of the person are inappropriate to the setting.
   - The behavior of the person tends to be inflexible.
   - The behavior of the person tends to be impulsive.

3. What are specific indicators of mental illness?

   - Sudden changes in lifestyle

     -can be both a cause and indicator of mental illness
     -involves an inability or unwillingness to fulfill one's expected role and responsibilities.

   - Major changes in behavior

     -behavior may have undergone sudden and drastic change
     -behavior may be marked by exaggerated mood swings
     -person may show lack of judgment regarding family, job, money, or property
     -person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic or fright

  -anxiety is intense and unfounded
  -person is in a state of panic or fright
  -person may have trembling hands, dry mouth, or sweaty palms
  -person may be "frozen" with fear

- Believes others are plotting against him

  -person has an unreal fear of being watched, talked about, followed, persecuted, or harmed (e.g. a large man believing a frail, elderly woman is trying to strangle him)
  -person cannot separate reality and imagination

- Hallucinations

  -person experience events that have no objective source, but that are nonetheless real to him or her
  -most common hallucinations are seeing or hearing things, but can involve any of the senses, such as:

  feel - most commonly of bugs crawling on the body
  smell - often of gas associated with death plots
  taste - usually of poisons in food
  hearing - voices telling the person to do something
  sight - visions of God, the dead, or horrible things.

  -hallucinations can also be induced by drug or alcohol abuse

- Delusions

  -personal beliefs that are not based on reality
  -can cause the person to view the world from a unique or peculiar perspective
  -often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person beliefs he or she is God, a saint, a famous person, or possesses a special talent or beauty)

- Depression

  -accompanies many mental disorders in varying degrees
  -often characterized by a persistent, general malaise
  -serious depression can involve withdrawal from family, job, and social involvement.

- Obsessions

  -recurrent thoughts, ideas, or images that the person cannot dismiss from mind usually involve behavior that the person finds unacceptable (e.g. a woman may believe

that every man she encounters is trying to seduce her)
-can cause tension and high level of anxiety

- Unexplained losses of memory

-not the normal forgetting of everyday things, but failing to remember the day, year, where one is, etc.
-not to be confused with loss of memory that often accompanies aging

- Confusion

-inability to focus on particular topic or interaction
-might be an indication that person has an obsession
-also caused by stroke, diabetic coma, intoxication, senility

- Impossible body ailments

-at first, symptoms are mild and may even fool doctors
-common beliefs are a body part growing, heart stopped, or chest filling with food

- Persons who suffer from mental illness must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are uncomfortable or annoying. Unlike hallucinations, these side effects are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize the presence of the side effects. Some of the major noticeable side effects include:

-minor stiffness, a rigid shuffling gait
-an at rest, hand jerk
-acute muscle spasms, tilted head
-a constant, fine, fast tremor
-blurry vision
-rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or-in severe cases-facial distortion

BPLS

Basic Psychiatric Life Support

Portland Police Version

1. Goal

This summary is intended to provide police and other justice professionals with a basic outline of techniques for dealing with patients suffering from acute psychiatric disturbances. The emphasis is on an initial approach, urgent or emergent evaluation, and basics of intervention.

2. Introduction

Dealing with patients suffering from psychiatric disorders is often perceived as frightening by those infrequently exposed to these problems. The area of psychiatry itself may seem foreign for several reasons:

Psychiatry deals with biopsychosocial issues (1) that typically straddle multiple areas:

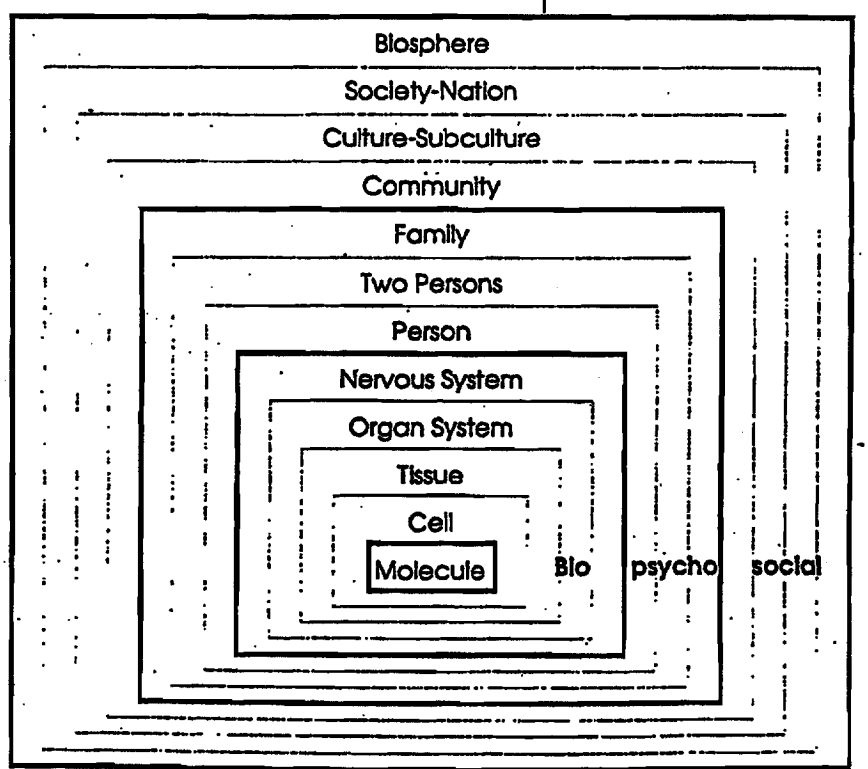


Figure 1: Biopsychosocial Model

There is no clear boundary between actions based on personal choice, social difficulties, psychological distress, or on a clearly biological disease. Multiple factors simultaneously influence the ultimate actions of an individual. Identifying and treating mental illness is complex, requires time, and may make the field appear diffuse and unclear.

Additionally, "gold standard tests" which would allow certain attribution of specific signs and symptoms to a specific disorder are generally not available. There is no X-Ray or blood test for bipolar disorder, for example. If a patient has signs of several disorders, multiple diagnoses must be considered, and frequently multiple diagnoses must be given. This may make the professionals operating in the field seem divided and without focus.

Finally, patients with psychiatric conditions often contact nonpsychiatric care providers first. They may adapt their complaints to match the specialty or "language" of the professional they are seeing. Thus, patients with similar ultimate diagnoses may present to a family doctor with physical complaints, to a mental health

professional with mental health complaints (2) (and likely to peace officers with safety concerns). Knowledge of mental illness can help the professional direct the patient safely into appropriate evaluation and treatment.

Top priority must be the professional's immediate physical safety.

The Basic Psychiatric Life Support model presented here is an attempt present the area of acute psychiatric practice in a way that is reductionistic, yet robust. The approach is generally algorithmic, similar to the Basic Cardiac Life Support course (3), which has brought emergency medical thinking to a broad audience. The structure of the algorithms here is determined by several factors which can be subsumed under the term "priority":

Severity: How bad is the disorder/injury?
Urgency: How fast must a response occur to be effective?
Remediability: How much difference will any response make?
Sequence: Does one step require a prior step?
Natural History: Balancing low frequency events with high morbidity against high frequency events with low morbidity.

3. Initial Triage

Even when it is clear that the appropriate or desired intervention is a psychiatric evaluation and/or treatment, attention must be given to its priority. (It is understood that here we are generally talking about noncatastrophic conditions in which the clinician has some realistic choices about how to proceed.)

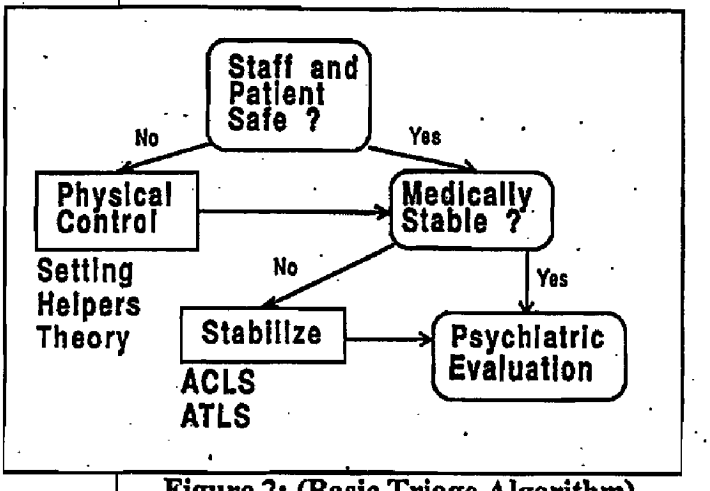


Figure 2: (Basic Triage Algorithm)

Top priority must be the clinician's immediate physical safety. What good can an injured or dead helper be? (Second priority is then the patient's own immediate physical safety.) If the clinician and patient are not physically safe, such safety must be provided for. Secondly, the patient must be medically stable to undergo psychiatric evaluation. If such medical stability is in question, immediate steps must be taken (after assuring physical safety) to intervene on this level. It is then the third priority to begin with a psychiatric evaluation, which will include the evaluation for suicide or homicide potential.

Also, attention must be given to the fact that a crisis represents the perception of an event or situation as intolerable, as an intolerable difficulty that exceeds the resources and coping mechanisms of the person defining the crisis. Such a concept must not be confused with that of an emergency,

which represents a sudden (and often distressing) event that may lead to serious psychological or physical consequences if there is no adequate response. This distinction is difficult, and at times one will need to proceed under the assumption of an emergency, even when it may ultimately prove that the problem is better identified as a crisis.

4. Physical Safety

That it is top priority to evaluate the potential of immediate harm to the professional and secondarily the patient comes as no surprise to police officers. This is their daily concern. We are looking for such basics as absence of weapons, a secure physical environment, and a patient that is reasonably able to modulate their behavior. The goal is to establish short term safety.

In essence, the concern is to identify and remain prepared for potential immediate violence, which represents a relatively rare event, but one with significant potential for injury or even death (4,5). It follows that attention must be given to issues of safety before they are needed. Protocols must be clear and well rehearsed.

4.1 Strategies:
To briefly review, the controllable variables can be grouped into three main categories: physical setting, personnel, and a theoretical model to guide the approach. Police safety techniques discuss these areas in detail, so here we will only list some areas of emphasis in the psychiatric arena for comparison.

4.1.1 Physical setting:
Structural requirements include the absence of dangerous or potentially dangerous objects, ideally access from multiple directions, monitoring and emergency communication systems, some provisions for confidentiality, and the opportunity to physically restrain a patient.

Each setting that the professional will work in should be rapidly reviewed a "worst case scenario" considerations in mind and steps should be taken to ensure as much safety in these settings as possible.

If physical restraint is used, sufficient help should be available to safely overwhelm the patient.

4.1.2 Personnel:
Just as the physical surroundings deserve attention, the professional must be completely aware of the help that is going to be available in an emergency. Specifically mental health trained, 24 hours per day, capability would be ideal. Such personnel should have an understanding of the medical model of overwhelming force. Police techniques that rely on verbal instructions or combative techniques (including pain holds) designed for persons with intact mental functioning can lead to difficulties. Patient injuries can occur in instances where the patient is incapable of understanding the purpose and context of police interventions due to a medical or psychiatric disorder. (See particularly the section on psychotic disorders.)

Medical (or paramedic) backup as well as collaboration with mental health professionals or outreach teams that might have some prior experience with the patient can also be very helpful. Such collaboration, however, re-

quires careful prior planning so that management at the scene of an incident can proceed smoothly.

Estimating the patient's control and deciding when the professional must assume control is key.

4.1.3 Theoretical Model:
Attempts at verbal intervention generally precede physical restraint. A clear model to decide when to switch modalities is necessary. One such model is presented here for comparison. It is intended as an ever-present scheme in the background of the evaluator's mind, while carrying out other tasks such as obtaining a history and performing a physical and/or mental status examination. It is again intended as an example only:

Patient's Response:	Staff Intervention:	My Response:
Aggression	Physical control	Fear
Hostility	Pseudochoice ("If...then...")	Anger
Anger	Real choices (Must be acceptable)	Anxiety
Anxiety	Support Encourage Ventilate Reassure "Extras"	Calm

Figure 3: (Interaction Grid) (Adapted from: (6))

The figure represents an interaction grid: three segments (columns) are subdivided into four corresponding levels (rows) of interaction. The first column represents the patient's emotional response within the interaction, the third, the professional's emotional responses which are assumed to mirror the patient's. The key is that the clinician must gradually develop a sense for their own personal response to each of the patient's stages. In the column between are strategies for intervention.

Exceptions:
The model of gradual escalation through the various levels from anxious, to angry, to hostile, and ultimately to aggressive, can be obviated by a number of medical and psychiatric conditions. In particular, an organically disturbed (e.g.: intoxicated or delirious) patient may escalate abruptly from a seemingly calm or anxious state to an outright aggressive one. Similarly, psychosis, with the inherent lack of reality contact (and defining thought disorder or loose associations), may jump from one stage to the other with little or no warning. It is here that the professional's personal emotional response may be the only "early warning" that is possible. This means that in the example suggested in Figure 3, the professional entering a patient's room for the first time, finding a fear response developing abruptly, should immediately be prepared to provide for physical control and safety.

5. Medical Emergencies

In the context of the triage algorithm (figure 2), medical emergencies are considered those conditions which would require stabilization of the patient prior to a psychiatric interview.

Procedures for such interventions have generally already been established, and most professionals will be familiar with examples of them: BCLS and ACLS protocols for medical and ATLS for surgical emergencies. Vital signs should be obtained if at all possible and as early as possible. They should be considered a requirement prior to the end of any emergency psychiatric intervention. Beyond this, a brief medical history, review of systems, and physical evaluation is usually necessary to rule out immediate medical problems.

6. Basic Psychiatric Interviewing

Moving to psychiatric intervention, we can distinguish: Interview techniques, evaluation (process and content), assessment, and treatment.

Any interview consists of at least three phases, with attention to four simultaneous areas:

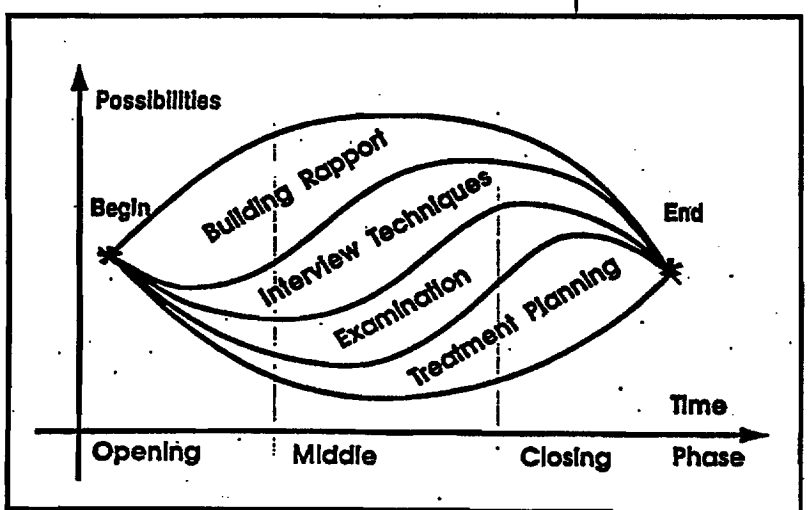


Figure 4: (Interviewing Process) (Adapted from: (7))

The beginning or opening phase of an interview emphasizes the establishment of rapport. The middle phase emphasizes the collection of information and the examination of the patient's current functioning. The closing phase emphasizes summarizing the information and communication of treatment decisions.

In the opening phase, questions will generally be open-ended, encouraging the patient to speak. Facilitative techniques, such as empathic statements, can be used to support this. In the middle phase, questions can frequently become more focused and steering techniques are used to direct the interview into content areas that are desired. Such steering techniques could be thought of as analogous to "back doors." For example, questions on the degree of depression can ultimately lead to questions of suicidality and specific suicidal plans:

„How depressed have you ever gotten?" „Have you ever been so depressed that you didn't want to live?" „Have you ever been so depressed that suicide started making sense?" „Have you ever planned or attempted suicide?" „How are things now?"

Similarly, questions about anger can lead to homicidal plans and questions regarding fear can lead to psychosis. While specific content areas need to be covered in the interview, attention to the process of the interaction will allow the professional to follow a nat-

In any interview the professionl's initial overriding concern is to develop solid rapport with the patient.

Knowing the relative importance of historical information can lead the interview.

ural „flow" of the conversation. Additional steering techniques can help when necessary topics don't come up naturally: „Now that we've talked about you, let's talk a little about your family." In the closing phase, the clinician may summarize and be speaking more (though frequently checking with the patient to be sure of understanding). The ultimate outcome of a successful interview should be an agreement about the next steps to be taken in a treatment plan.

7. Psychiatric Evaluation

The content of the evaluation generally includes a longitudinal (over time) component, the history, and a cross sectional (here and now) examination, typically, the mental status examination. This information leads to a diagnostic impression, which then guides the intervention strategy. While in an ideal case a relatively extensive history and thorough mental status examination will be obtained, the urgency of the moment may reduce this to current history with core mental status questions. Ultimately with a minimally cooperative patient, focus of the history should be to elicit a chief complaint and of the mental status examination to ask orientation questions.

7.1. Psychiatric History:
The history is usually obtained from the patient, though frequently outside corroborative information is needed. Generally this is done with, in emergencies without, the patient's permission. Depending on the urgency of the problem, intervention may need to occur before this information is complete or available. Obviously, no final disposition is possible until all of the information has been obtained and thoroughly considered.

The content is quite similar to that obtained in other areas of medicine. (In the following table(s) the asterisks identify the relative level of importance of the item). In emergencies, one would fall back on the most important items, clarifying these first.

Identifying Information
Chief Complaint (Suicide/Homicide?) ***
History of the Current Situation:**
Course Over Time**
Palliative and Provocative Factors
Review of Systems
Current Medications**
Current Drug Use Pattern**
Past Medical History*
Past Psychiatric History:
Hospital Admissions*
Biomedical Treatments (Medications)**
Suicide (Homicide) Attempts**
Past Alcohol and Drug Use*
Family History:
Genetic Risk Factors
Developmental History:
Family "Roles"
Defensive Mechanisms
Social History:
Current Level of Functioning
Prior Level of Functioning
Support System*

Table 1: History content

7.2. Mental Status Examination:
The mental status examination is intended to provide a cross sectional view of the patient's mental functioning at the current instant in time. It is a formalized method of obtaining and recording information on the higher cortical functions of the patient. To facilitate recall, four general areas can

be delineated: (Examples to serve as mnemonic devices are added in parentheses, and asterisks again denote the relative importance.)

1. General Inspection:
(Overview: "How does the patient look?")

Appearance: (Describing a "photograph") Height, weight, dress, grooming, etc.

Motor Behavior: (Describing the „silent movie") Movements, tics and mannerisms, level of activity, etc.

Speech: (Adding the "sound track") Rate, pressure, intonation, articulation, etc.

Attitude: (Putting it all together) Changes, relatedness with the interviewer, etc.

2. Emotions ("How does the patient feel?")

Mood: (The "climate") Depressed, happy, sad, irritable, etc. The patient describes the mood themselves. Their report will relate to a more extended period of time than the interviewer alone will have been able to observe.

Affect: (The "weather") Type: tearful, angry, etc.; Range: broad, full, narrow, flat, etc.; Stability: Labile, stable, etc. The interviewer attempts to describe the currently observed affective state of the patient in detail.

Congruence: The consistency between the observed emotions and reported mood with the context and content of the interview is observed. Loss of reality contact sometimes expresses itself here in lack of congruence.

3. Thoughts:** ("Software" analogy: "How does the patient think?")

Process:** This describes the logical flow of thoughts:

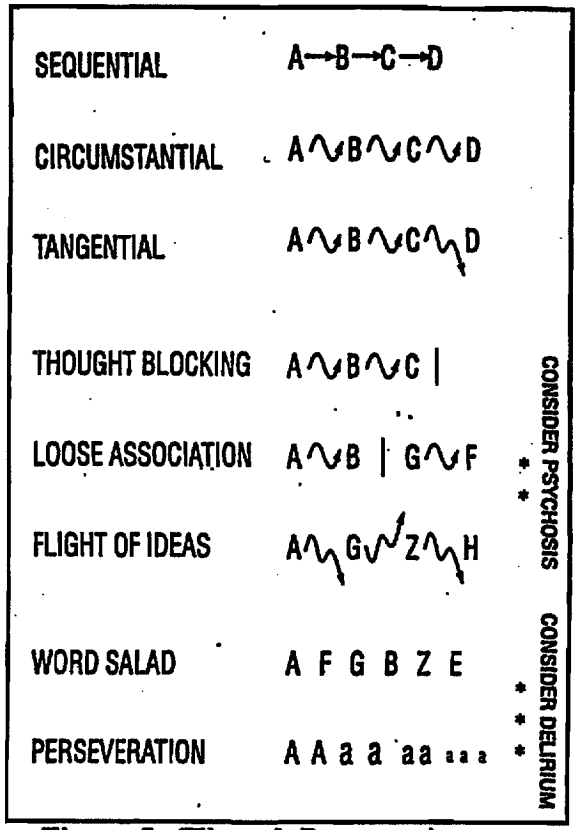


Figure 5: (Though Processes)

These can be considered to be on a spectrum from best organized to completely disorganized. On one end of the extreme, thoughts are expected to be sequential and concisely presented. At the other end of the extreme, no coherent thoughts can be discerned. There is literally word salad or perseveration. The most important stage*** is when loose associations (breaks in the logical flow) occur. They define psychosis. Tangential thinking may be dis-

When loose associations are present, consider psychosis; when there is word salad, consider delirium.

Orientation is the bedrock on which all other cognitive functions can be considered to rest.

tinguished from loose by the interviewers reaction: The thoughts: "What was my last question? How did we get onto this?" denote tangentiality. The thought: "Where did that come from?" denotes loose associations, and should be checked out. Worse disturbance generally indicates a worse disorder.

Content:** Here the thoughts themselves are grouped and unusual or important themes noted. In particular, any psychiatric interviewer will have to comment on suicidal*** or homicidal*** thoughts. These must be specifically sought out, as must be preoccupations and delusions* such as those indicating loss of reality contact, either in a non-bizarre or bizarre (completely impossible) context.

Perceptions:** How does the patient observe the world around them. Are illusions, hallucinations, auditory, visual, or tactile hallucinations**, depersonalization, derealization, ideas of reference, thought broadcasting, thought insertion, etc. present?

Using the computer analogy, thoughts can be considered to have disturbances that affect the logical order (poorly functioning program), abnormalities of content (database errors), and input errors.

4. Cognitive Evaluation*:** (Hardware analogy: "How is the machinery working?")

The following areas are all considered part of the cognitive function. In order to remember them, one might use the model of a familiar, reversible, toxic encephalopathy: alcohol intoxication. When one thinks of a person entering a bar and getting progressively intoxicated, ultimately to the point of coma, one can visualize the stages that they go through. Using this analogy, the extreme care needed to observe and document disturbances of orientation, attention, and concentration becomes clear.

Orientation: Time, place, and person.
Attention Concentration: Serial 7's, 3's, digit
span, (usual is 7 digits forward, and 4 backward), spell "world" forward and backward.
Memory:
Registration: "Repeat after me"
Immediate Retention: 3 objects after 3' Recent Past: Events of the last few days Remote Past: Events several years ago
Abstraction: Ability to „get the big picture:"
Proverbs, similarities.
Intelligence: Fund of knowledge (consistent
with the patient's education): vocabulary, presidents. general knowledge questions.
Judgment: Conceptualize outcomes: Stamped
envelope, smoke in a theater scenarios.
Impulse Control: Ability to modulate impulses.
Insight: Awareness of illness.

Table 2: Cognitive Evaluation

The list is an attempt at such a hierarchical organization (using the above analogy) from the most severe to the least severe level of disturbance. If complete testing is not possible, it is useful to move to ever more basic cognitive tests.

8. Assessment

There are generally two parts to an assessment: 1) Organizing the information gathered in the history and mental status examination, and 2) Making a formal psychiatric diagnosis. Establishing a diagnosis may, however, be secondary to organizing the information in such a way that focuses attention on triage priorities. Broad diagnostic categories are considered first and allow stabilization and referral to more definitive evaluation and treatment. For our purposes, short range outcome is the major consideration.

Review of outcomes research shows that top priorities, which express themselves as variables affecting patient disposition, include:

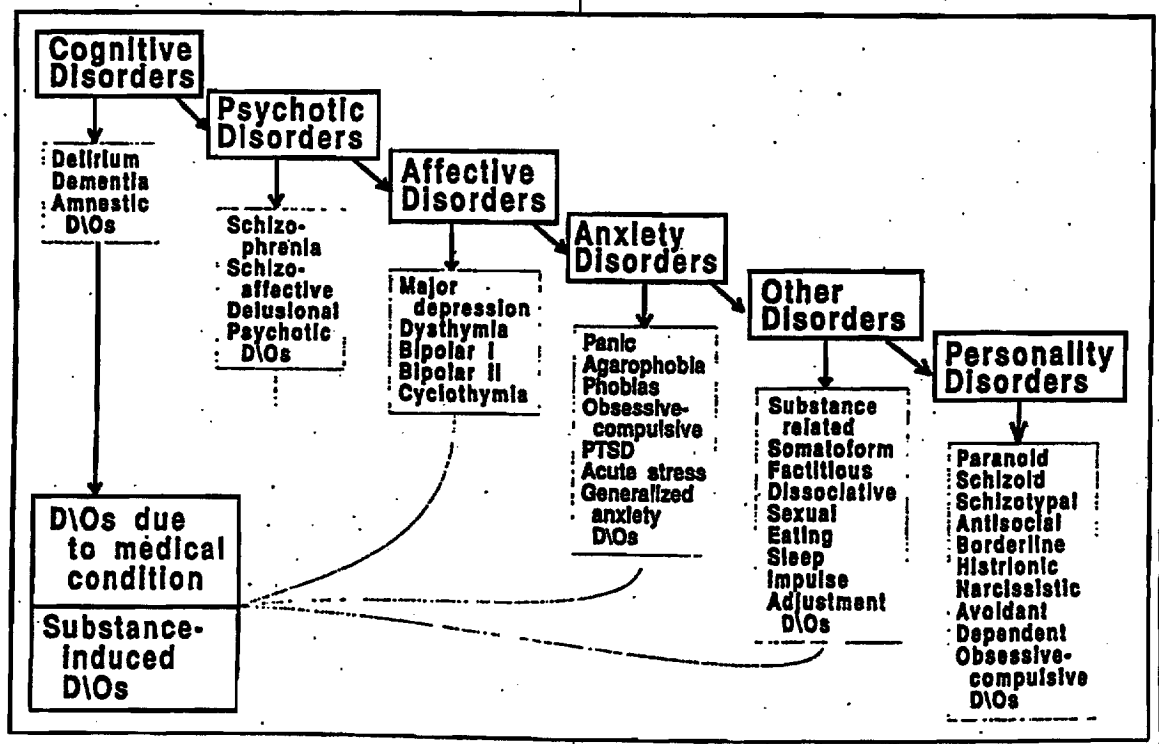
Dangerousness, prominence of symptoms (as clinical variables), clinical experience and knowledge of resources (as clinician variables), family members' support and desire for a specific outcome (as family variables), and referral source such as police, together with assessment of system options (3).

8.1 Impression:

Given the need for organization of diagnostic considerations, a clear idea about a diagnostic hierarchy is helpful. Which disorders take precedence over others? Why? Such a hierarchy is implicit in the DSM IV (8), producing a "cascade" of disorder groups. Generally, the hierarchy implies that treatment must be directed toward diagnoses higher in the model before treatment for lower priority diagnoses can be fully effective. Also, the more "biological" a disorder, the more likely it is to be found on the left; the more "psychological" a disorder, the more likely it is to be on the right.

Disorders induced by medical conditons or substances are listed with each group, but mut be considered first.

Figure 6: Differential Diagnostic Cascade



There are many medical emergency conditions that may initially present as a psychiatric disturbance.

Cognitive Disorders must be considered first. These are delirium (a medical emergency), dementia, and amnestic disorders. Problems where some outside influence causes what appears to be a psychiatric disorder are listed with each disorder group. Examples include substance intoxication, withdrawal, or medical illnesses. They must also be considered as the first priority. All of these disorders affect the brain's ability to function, and could be considered "machinery" or "hardware" problems. Treatment of these disorders will require attention to the underlying disorder. The most important is delirium***, characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention. This is heralded by disorientation and severely disorganized thought processes.

Psychotic Disorders*** must be considered next. These are illnesses. which affect the patient's ability to distinguish real from not real. They generally include major psychotic disorders such as Schizophrenia and are characterized by thought process (loosening of association or worse) or thought content (delusions) or perceptual disturbances (for example, auditory hallucinations). These can generally be considered "thinking problems." They are heralded by loose associations, delusions and or hallucinations. Treatment will usually involve the use of neuroleptics.

Affective Disorders are disorders that affect the mood. The mood may be depressed, elevated, or irritable. Major Depression and Bipolar Disorders (Manic Depressive Disorders) are the main illnesses. here. Both of these disorders can be accompanied by psychosis and when this is the case, the psychosis must be treated first. Treatments will often include medication such as antidepressants or mood stabilizers (thymoleptics).

Anxiety Disorders lead to excessive and inappropriate worry or panic. Examples include phobias, panic disorder, post traumatic stress disorder, the new acute stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. As implied by the hierarchy, removal of precipitants (such as Hyperthyroidism, psychosis or mood disorders) clearly takes precedence over symptom oriented treatment with, for example, Benzodiazepines.

Other Axis I disorder Groups follow in the diagnostic cascade.

Finally, toward the psychological side of the biopsychosocial diagnostic spectrum are Axis II Disorders:

Personality Disorders are problems with an individual's overall coping abilities. They should be considered if there is a long standing (since adolescence) pervasive (affecting all parts of an individual's life) pattern of maladaptive (causing personal distress or impairing functioning) behavior. In these patients the developmental "tool kit" might be thought of as not fully developed, frequently under the influence of traumatic disturbances in their childhood. DSM IV (8) generally distinguishes three groups: Cluster A (odd and eccentric), Cluster B (dra-

matic erratic and emotional) and Cluster C (anxious or fearful). Under stress, such individuals can display symptoms from any of the other diagnostic groups and a thorough evaluation, along with attention to the diagnostic hierarchy, is crucial prior to the diagnosis of a personality disorder. Treatment generally involves a carefully coordinated program of psychotherapeutic and social interventions. Since these conditions can mimic and coexist with many of the Axis I disorders, their identification and treatment take time and may be perceive as the most frustrating task for the professionals trying to help. Clear attention to who is responsible for what (interpersonal boundaries) is crucial to the management of these conditions.

In summary, it should be remembered that, many individuals suffer from several disorders simultaneously. One disorder does not generally exclude another, though if symptoms can be ascribed to a diagnosis further up in the hierarchy, then that diagnosis must be given. Thus, for example, a patient who is intoxicated, yet suffers from Schizophrenia, would likely show signs both of cognitive impairment and reality impairment, and would be given both diagnoses. Treatment must then also address both disorders.

8.2 Biopsychosocial Diagnosis:

In order to organize all of this information, the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) (8) has designed its multiaxial system of diagnosis. The diagnosis is recorded in five axes, whereby multiple diagnoses are encouraged when the criteria for the specific disorders are met.

Axis I: Psychiatric Clinical Syndrome ("Nature") Axis II: Personality Disorders or Traits ("Nurture") Axis III: Physical Disorders Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning (GAF Score).

Table 3: DSM IV Multiaxial System of Diagnosis

Many patient suffer from several disorders simultaneously that must all be identified.

9. Interventions

Beside the assurance of immediate physical safety outlined above, treatments will generally come in four major areas: general safety, biological treatments, psychological treatments, and social interventions.

Longer term safety issues are much more complex to evaluate. Generally the clinician is only able to identify broad groups of patients at risk for harm to self or others but cannot predict the future behavior with any reasonable certainty over more than a few hours or even days (4). One of the best and most important predictors is that of past behavior. Another key consideration is the presence of destabilizing factors such as intoxication.

9.1 Immediate Safety Interventions:

As outlined before, emergent intervention may require physical restraint. The principal behind the safe use of such restraint is overwhelming force. We cannot assume that a patient has

The clinician assumes the responsibility when there is significant danger or competence is low.

the mental capacity to recognize directions, physical cues (painful or nonpainful), and to respond appropriately. When a patient is physically restrained attention must be given to the legal framework (doctor's court hold or police officer hold, etc.). Also, the patient must then be observed very closely since this group of patients is at higher risk of having significant coexisting physical illnesses that can place them in danger, especially since the usual complaints of feeling ill may not occur. Once a professional has assumed responsibility for the patient they are responsible for the "whole" patient!

Similarly, chemical restraints can be used in some emergency conditions. Neuroleptics (Inapsine) or Benzodiazepines (Ativan) have been advocated and are often used in the medical setting.

9.2 General Safety:

Patients who present a danger to themselves or others are unable to care for themselves, or fail outpatient management, or require 24 hour observation for diagnostic assessment or ongoing round-the-clock medical treatment will require hospitalization. As long as such patients are willing to be hospitalized on a voluntary basis, there is little question as to how to proceed.

Involuntary Admission: In most states, if the patient represents a danger to himself or others due to a mental disorder, and/or is unable to care for their basic needs (grave disability), there is a process that allows emergent and urgent hospital admission on an involuntary basis. This is generally regulated in the Commitment Statutes. Difficulties arise when it is unclear how far the patient's rights of self determination go in comparison to the professional's ethical obligation to intervene in the face of a psychiatric disorder (right to competent treatment).

In this respect, a grid that plots danger against competency may be useful to the professional:

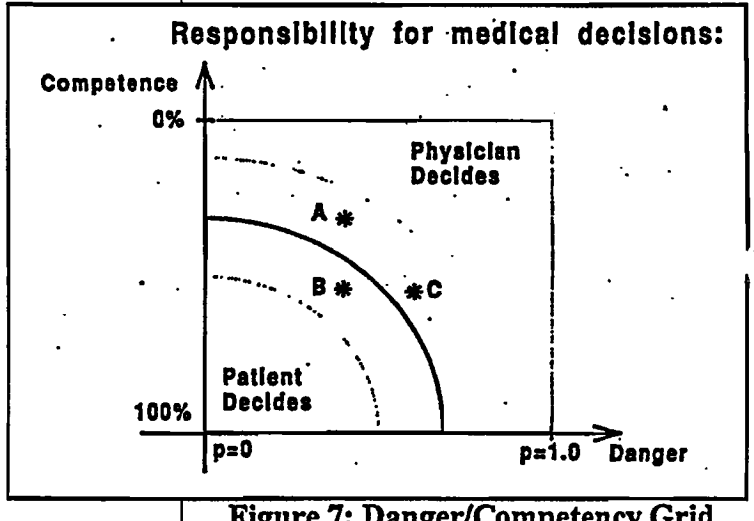


Figure 7: Danger/Competency Grid (Adapted from (10))

As outlined in this grid, competency is plotted against danger. In the lower left hand corner, patients who are in an area of low danger, yet have a high degree of competence, are clearly in charge of their treatment, irrespective of the clinician's preference. Simultaneously, patients that have either an extremely low level of competence (such as the severely disabled Alzheimer's patient wandering on the street) or are in an extreme degree of danger (such as an occluded airway)

must be treated by the clinician even against their will. Frequently, the situation is much less clear. Despite this, the law allows only for a dichotomous choice: One is asked to act as if the grid were bisected by a clean line. Nevertheless, it is quickly apparent that the gray band of mixed cases in the middle represents many cases and a significant clinical dilemma. For example, patients A, B, and C may differ only in some minor respects, yet patient A and C will be involuntarily admitted where B may not. Patient B may, for example, present with depression, suicidal ideations of several months' duration, and some poorly formulated thoughts of possibly taking an overdose. Patient C, similar in all ways, may, however, be contemplating the use of a firearm and has access to such. Clearly, patient C would require involuntary admission. Patient A, on the other hand, while in a situation just as B, may be intoxicated, lowering their level of competence. Clearly as well, here the clinician must intervene (even if only temporarily until competence is restored/intoxication resolved).

Involuntary admission in Oregon is regulated by the Oregon Revised Statutes (ORS 426). If a patient represents a danger to himself or others due to a mental disorder and is unable to agree to voluntary admission, the patient may be admitted against his/her will. The doctor's court hold (DCH) documents the belief of two licensed physicians or a physician and a qualified mental health professional that such a danger and mental illness exists. Outside of the hospital setting, the police or mental health program is needed to make such a determination. A police officer custody report (POCR) documents that a police officer has reason to believe that such danger and illness exists. A mental health program can also initiate such a police officer hold (Mental Health Director's Hold). When the mental disturbance does not rise to the level of danger but there is question about the individual's ability to care for themselves, any two interested persons may file a two party notice (TPN) with a county mental health agency. From the filing of all of these notices, a court investigation

The patient's safety for two weeks on their own may be key to deciding on potential danger.

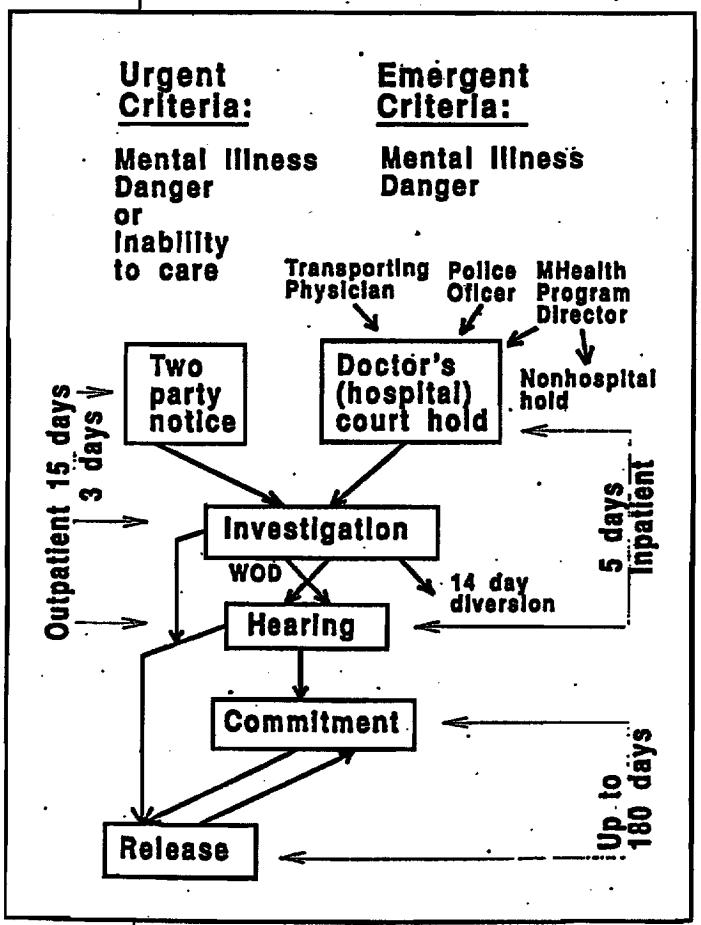


Figure 8: ORS 426

The patient should be treated in the least restrictive, yet safe, environment.

is initiated. This investigation may lead to a hearing (or to patient release). The hearing may lead to commitment. The main difference between the two routes in Oregon is that the emergent route (which includes only the criteria of mental illness and danger) requires that the patient be kept in the hospital and must not exceed five working days to the point of a hearing. The urgent route proceeds on an outpatient basis and 15 days may pass prior to a hearing. Therefore, frequently the question of danger must be phrased as: "Is this patient safe for 15 days in an outpatient setting?"

9.3 Biological Treatments:

In this area we generally think of the use of pharmacotherapeutic agents. Also, in general, one will have to consider psychiatric consultation in this context. Brief attention was given to the use of chemical (and physical) restraints earlier. An introduction into the basic psychopharmacology would clearly be beyond the scope of this brief review. Nevertheless, we should be clear that addressing an organic or cognitive mental disorder generally requires attention to or treatment of the underlying disorder. Thus, for example, treatment of hypo- or hyperthyroidism or delirium tremens would require the appropriate medical treatment for those conditions, not the psychopharmacologic treatment of the mental expressions of the illness (though there are exceptions where both becomes necessary). Psychotic disorders generally require antipsychotics (neuroleptics). Affective disorders will generally be treated with antidepressants and/or mood stabilizers, including Lithium, Tegretol, or Valproate. Anxiety disorders will frequently be treated with antianxiety agents, such as Benzodiazepines or Buspirone. As indicated by the differential diagnostic hierarchy, such agents must be used cautiously in combination.

From a psychiatric emergency viewpoint, it is extremely important to remember that treatment with neuroleptics, antidepressants, and mood stabilizers generally requires two to four weeks to be effective. Therefore, their initiation is frequently not part of an emergency, more triage-based intervention, no matter how badly one wants to help fast. Pharmacologic measures are generally very focused, directed at supporting a prior developed treatment plan and prescriptions are kept small. Careful coordination with outpatient treatment providers is crucial.

9.4 Psychological Treatments (Psychotherapy):

Similar to the section on pharmacotherapy, an introduction into psychotherapy is beyond the scope of this review. The emergency setting, as well as the realities of the treatment system, currently favor more focused, outcome oriented treatments that are frequently in the cognitive or behavioral realm. In many emergency settings general principles of crisis intervention apply: One attempts to restabilize the patient who has reached a point of instability and overload ("the straw that broke the camel's back") and support their process of reorganization through the phases of acute

decompensation, denial, anger, bargaining, grieving, and recovery. Such a hypothetical course of a crisis is outlined below:

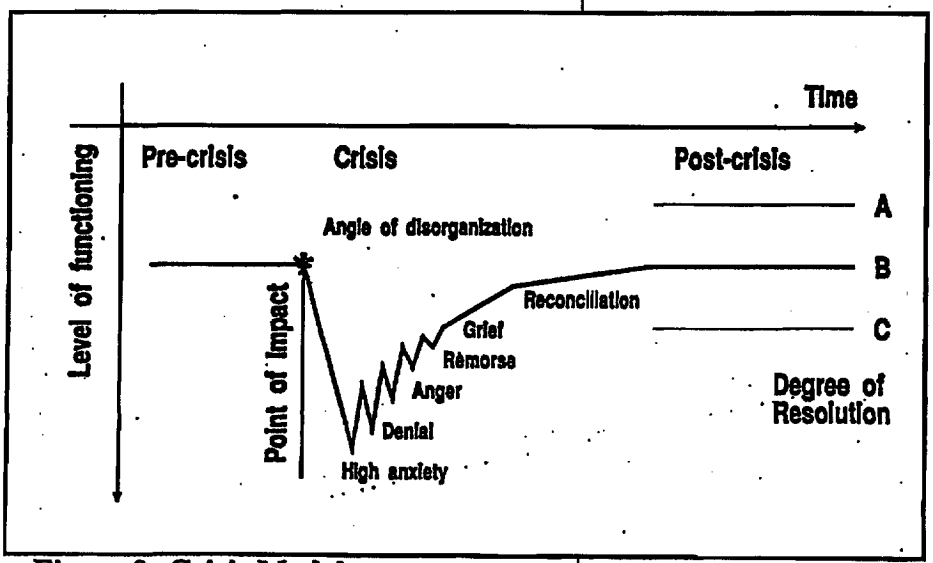


Figure 9: Crisis Model

Psychotherapeutic intervention could take on the following form: One assesses the biological, psychological and social realities that the patient brings to the situation. These are crucial for understanding the resiliency or stability of the patient's "system." Then focus on the balance between stressors and support system will allow a determination to be made on the severity and urgency of the current crisis. Stressors or supports are then manipulated where possible to help restabilize the patient.

Psychotherapeutic intervention using a debriefing model may also be appropriate. Such a model could be thought of as having four parts (see table 4). It may be used with individuals and groups. In the interaction, the four phases are explicitly separated. In the first phase facts are gathered from all participants. Statements about how one feels are excluded. (It is made clear that they are legitimate, but will be talked about separately). In the second phase, affects/feelings are clarified and discussed. Here the attempt is to collect a broad range of emotional responses, validating them. The disconnection from the facts and the legitimacy of the patient's own emotional response is emphasized. In the third phase the group is educated about what to expect (both in terms of future events and emotions); in the fourth,

Crisis intervention rebalances a percieved disparity between stressors and suuports.

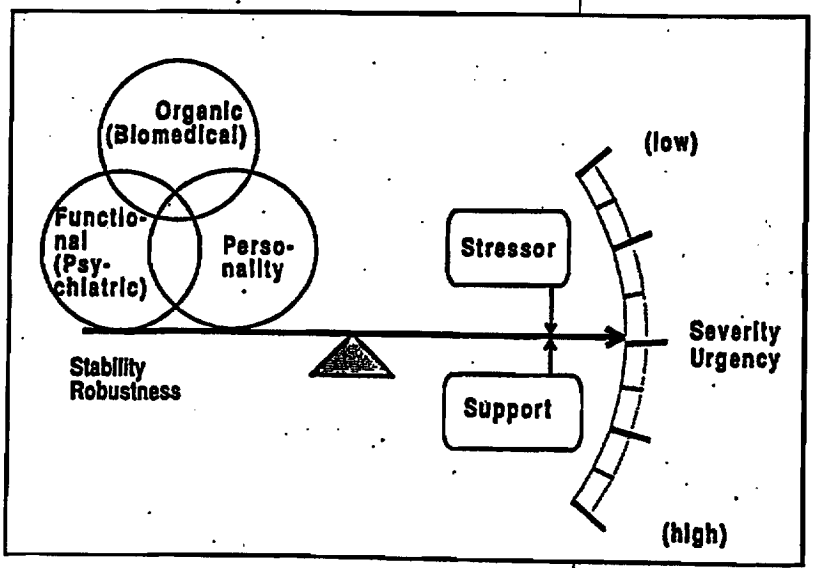


Figure 10: Crisis Intervention

The critical incident debriefing model may also be useful for the professional faced by trauma.

plans are made for any necessary follow-up.

1. Clarify the facts of the crisis ("What happened?").
2. Clarify the feelings ("How do you feel about this?").
3. Review the usual response to crises: (teaching phase).
   - Phase of Disbelief or Denial.
   - Phase of Shock or Confusion.
   - Phase of Anger.
   - Phase of Grief and Sadness.
   - Phase of Acceptance.
4. Problem solving or reopening the social world/contacts and ultimate resolution (reinforce adaptation and a plan for the future).

Table 4: Critical Incident Debriefing

In less formalized psychotherapeutic work three simple rules may help in the beginning:

1. When the patient presents a complaint, always validate it.
2. However, in doing so, acknowledge it in a way that will allow for reinterpreatation. Thus, it may be crucial to a psychotic patient to hear: "Oh, that sounds frightening," but it would be unwise to agree that the FBI may be indeed plotting.
3. Finally, offer a reinterpretation of the complaint that will direct the patient to action toward an useful goal. ("When you experience such voices, it may be a sign that you need to take a time out/take more medication.")

9.5 Social Interventions:

In this area, the realities of the patient's living are addressed. Clearly, attention must be given to food and shelter, as well as clothing. Where these are not immediate concerns, issues of disability may be the stated or covert objectives that should receive attention. While seeking psychiatric hospitalization in order to find shelter is understandable, it is clearly not the most efficient use of resources, and it would be the professional's task to support the legitimacy of such patient desires, yet to help the patient address their needs directly.

10. Summary

This outline is clearly intended as a forum for ongoing discussion and not as a finished document. It does, however, attempt to make explicit some of the core principles underlying emergency psychiatric evaluation and intervention. Since the subtleties of human interaction can clearly not be adequately addressed by such an approach, it is worth remembering that the experienced professional on the scene generally has access to significantly more information, including personal reactions, that can be crucial to accurately assessing the patient's situation. Pairing such clinical experience and "feel" for patients' needs with a clear diagnostic and therapeutic structure will hopefully provide some of the redundancy necessary to assure safe clinical interactions.

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Version: 7-10-95

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NOTES

NOTES

Overview of Mental Illness

An Overview of Mental Illness

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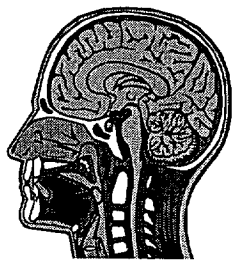
Objectives

- Define & better understand mental illness
- Symptoms & diagnosis of some common psychiatric disorders
- Treatment
  - Medications
  - Social support
  - Therapy

What are Mental Illnesses?

- Disorders characterized by impairment of one's thoughts, moods, and/or behaviors
- Resulting in consequences in functioning (work, school, family)
- Cannot be overcome by will power; not related to a person's "character"

Is it a Mind, or a Brain?

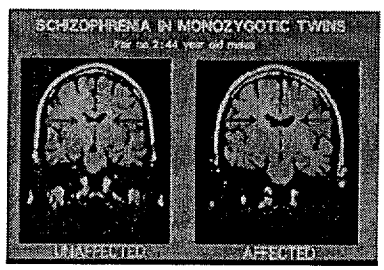


It's Both!!!

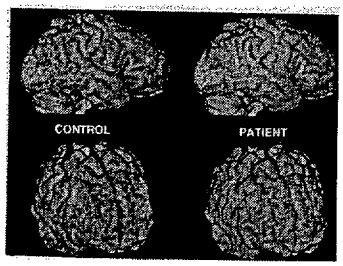
Mental Illness

- Biological factors
  - Genetics
  - Brain Injury

Problems in Brain Structure



Problems in Brain Function



Problems in Brain Function

- Abnormalities in neurotransmitters of the brain.
- Glutamate, gamma -aminobutyric acid, serotonin, norepinephrine, and dopamine have been implicated in depression and mania

Mental Illness

- External psychosocial stressors
  - Divorce, Financial loss, Death of family member, Trauma
- Illness is often a combination of biological and psychosocial factors
  - Genetic predisposition+ psychological trauma+ prolonged stressors

Who Has Mental Illness?

- Affects persons of all ages, races, religions, ethnicities, or socio-economic statuses.
- NOT the result of personal or moral weakness, lack of character, or low intelligence.
- 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year.
- Basically EVERYONE has risk.

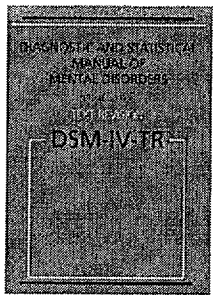
Healthy Understanding

- All mental health symptoms are gross exaggerations of normal human traits/emotions
- When these traits/emotions become intense enough to cause dysfunction, illness results

Normal vs. Symptom

Sad	Depressed
Happy	Manic
Imaginative	Psychotic
Poor Student	Learning Disabled
Inattentive	Attention Deficit
Detail Oriented	Obsessive
Nervous	Anxious/Panicked

Diagnoses & Symptoms



Common Mental Illnesses

- Depression
- Bipolar Disorder (Manic Depression)
- Schizophrenia
- Anxiety disorders
  - Post Traumatic Stress Disorder
  - Panic Disorder
  - Obsessive Compulsive Disorder
- Borderline Personality Disorder

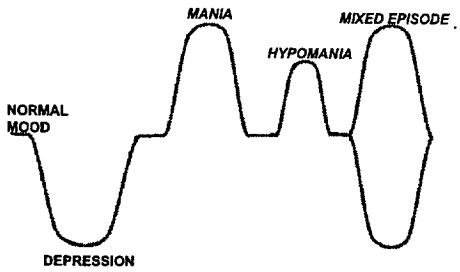
Major Depression

- Depressed mood and or loss of interest or pleasure
- 4 or more of following symptoms:
  - Weight change
  - Sleep change
  - Motor system change
  - Fatigue/Low energy
  - Feeling worthless/guilty
  - Poor concentration
  - Suicidal thoughts

Bipolar Disorder

- "Manic depession"
- Manic episode: elevated or irritable mood and 3 of the following:
  - Increased self-esteem (grandiose)
  - Decreased need for sleep
  - Increased or pressured speech
  - Racing thoughts (flight of ideas)
  - Distractibility
  - Increased activity
  - Increased risky behavior

Bipolar Disorder



Psychosis

- Syndrome with any of the following:
  - Hallucinations (false perceptions)
  - Delusions (false belief)
  - Disorganization
    - Speech
    - Thoughts
    - Behavior

Psychosis

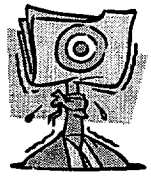
- May be seen in many disorders including the following:
  - Schizophrenia
  - Substance use
  - Bipolar disorder
  - Depression
  - Dementia
  - Delirium

Schizophrenia

- **2 of the following symptoms:**
  - **Delusions**
  - **Hallucinations**
  - **Disorganized Speech**
  - **Disorganized or Catatonic Behavior**
  - **Negative Symptoms**
    - **Flat affect**
    - **Lack of speech**
    - **Lack of motivation/activity**
    - **Lack of hygiene**
    - **Lack of social awareness**

Anxiety Disorders

- Post-Traumatic Stress Disorder
- Panic Attacks (disorder)
- OCD



Post Traumatic Stress Disorder

- Follows identifiable trauma
  - Combat, natural disaster
  - Domestic violence, rape
  - Childhood abuse
- Re-experiencing (recollections, nightmares)
- Avoidance
- Increased arousal (sleep disturbance, anger outbursts, poor concentration, hypervigilance, increased startle response)

Panic Attack

- **At least 4 of the following:**
  - Pounding heart
  - Sweating
  - Shaking
  - Shortness of breath
  - Feeling of choking
  - Chest pain
  - Nausea
  - Fear of going crazy
  - Fear of dying
  - Numbness
  - Chills
  - Dissociation
  - Lightheadedness

Obsessive Compulsive Disorder

Obsessions

- **Recurrent, persistent, and intrusive thoughts**
- **Attempts made to suppress thoughts**
- **Not simply excessive worry**

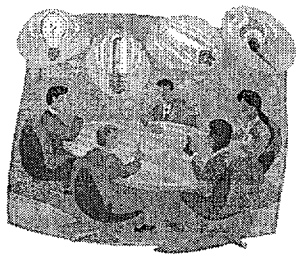
Compulsions

- **Repetitive behaviors done to decrease distress**

Borderline Personality Disorder

- Instability of interpersonal relationships and mood
- Quasi-suicide attempts (may be medically dangerous)
- Self-harm (non-suicidal) to soothe emotions (cutting, burning)
- Often preceded by childhood abuse

Who Are Mental Health Team Members?



Team Members

- Social Worker
  - Degree in Social Work, usually a Masters Degree
  - BSW, MSW, LCSW
- Counselor
  - Degree in Counseling, usually a Masters Degree
  - BA, MA, LPC, LMFT

Team Members

- Psychologist
  - Degree in Psychology, usually a Masters or Doctorate
  - BA, MA, PhD, PsyD
- Psychiatrist
  - Medical Doctor
  - MD, DO

Team Members

- Nurse
  - Degree in Nursing, usually a Bachelors
  - LPN, RN, BSN
- Nurse Practitioner
  - Degree in Nursing, plus an advanced degree
  - PMHNP, ANP, FNP

Role Definitions

- Case Manager
  - Usually helps client obtain services (medical care, housing, entitlements, etc.)
- Therapist/Counselor
  - Provides counseling services

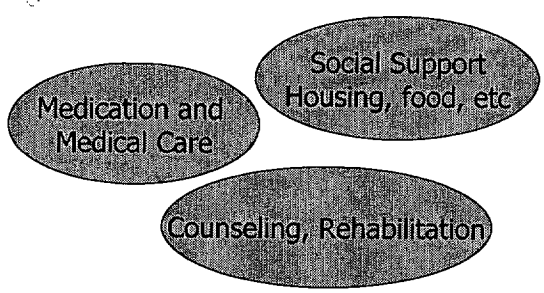
Role Definitions

- Psychologist
  - Performs testing and evaluations, can provide therapy
- Psychiatrist/Nurse Practitioner
  - Performs evaluations, prescribes medications, can provide therapy

Treatment

- Mental Illnesses are Treatable
- 70% to 90% of people with serious mental illnesses show significant improvement in symptoms and quality of life IF they receive proper treatment
- Early identification and treatment is key

Three Elements of Treatment



Medications

- Antidepressants:
  - Prozac, Zoloft, Celexa, Lexapro, Paxil
  - Effexor, Wellbutrin
  - Amitriptyline, Nortriptyline

Medications

- Mood stabilizers
  - Lithium, Depakote, Lamictal, Tegretol
  - Treatment of bipolar disorder, personality disorders

Medications

- Antipsychotic medications
  - Seroquel, Geodon, Risperdal, Abilify, Clozaril, Zyprexa
  - Haldol, Trilafon, Thorazine
  - Used to treat psychotic disorders such as schizophrenia, bipolar disorder, meth-induced psychosis

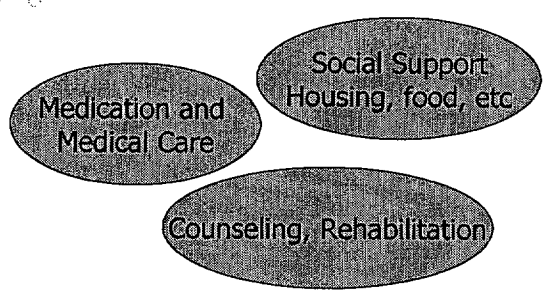
Medications

- Benzodiazepines
  - Ativan, Valium, Klonopin, Xanax, Librium
  - Used to treat anxiety disorders
  - Drugs of abuse, street value
  - Dangerous in combination with alcohol or opiates

Limitations of Medications

- Adherence to regimen
- Expensive
- Serious side effects
- May be ineffective

Three Elements of Treatment



Community Treatment

- Hospitals as brief respites for stabilization at times of increased symptoms.
- Most people with mental illness live in the community
- "Least Restrictive" setting

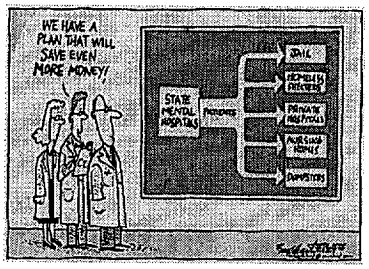
Housing, Counseling, Social Support

- Mostly provided by community mental health agencies such as Cascadia, LifeWorks etc.
- Case workers, social workers, and counselors
  - Help clients get to correct agencies
  - Gets clients signed up for social services

Problems in the Community

- Stigma
  - Negative attitudes about people who have mental illnesse
  - Causes poor care, discrimination, suffering for individual and family

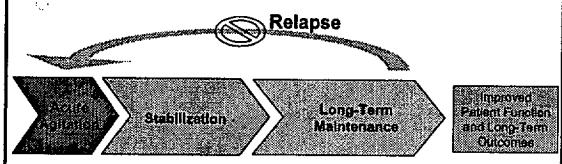
Problems in the Community
Limited Resources



Consequences of Lack of Treatment

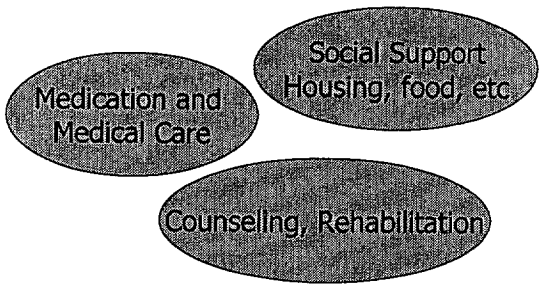
- Unnecessary Disability, Unemployment
  - Loss of drive and dignity
- Substance Abuse
  - Self medicating
- Homelessness
- Inappropriate incarceration
- Poor quality of life, Suicide
- Lack of treatment estimated to cost US economy $100 billion/year

Continuum of Care



Police are apt to see individual only at their "worst"

Three Elements of Treatment



Therapy

- Supportive therapy
- Dynamic psychotherapy
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Interpersonal Therapy
- Most important is for pts to have a therapeutic alliance with their therapist and a safe, accepting, affirming, and honest place to talk about their experience.

Overlap with Substance Abuse

- Common to have mental illness and substance abuse at the same time
- Need to address both problems at once
- "Either / or" thinking is not helpful
- Alcohol, Hallucinogens, Methamphetamine, Cocaine, Opiates

Recovery

Mental health organizations have changed their approach to helping people with mental illness. It is no longer about accepting long-term disability and treating symptoms but rather about helping people recover.

74% of people diagnosed with schizophrenia recover with early intervention[1]

80% of people diagnosed with depression recover[2]

[1] NIMH, 2003
[2] National Advisory Mental Health Council, 1996

Police as Care Givers

- People with mental illness live in the community, often with few social supports
- Police are first responders in situations of disruptive behavior
- Mentally Ill people are not "bad"
- You can make a real difference!

Violence

- People with severe mental illness are much more likely to hurt themselves than hurt others
- Occasionally delusions result in violence, especially need to protect self from imagined danger

Violence

- Individuals with mental illness are much more likely to be a victim than to cause violence
- According to National Crime Victimization Survey, more than one quarter of persons with SMI had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population

Resources

- The National Alliance on Mental Illness (NAMI)
  - great resource for families
  - reliable, understandable information about all of these disorders and their social consequences, with links to many more useful sites.
- www.NAMI.org

Discussion

PTSD

POST TRAUMATIC

STRESS DISORDER

Working with Post-Traumatic Stress Disorder

Training for Law Enforcement Officers provided by

The Portland VA Medical Center

Trauma

- Actual or threatened death or serious injury to self (or witness threat to someone else)
- Threat to the physical integrity of oneself (or witness threat to someone else)

Sources of Trauma

- Military Service
- Law Enforcement
- Emergency Response
- Accidents
- Natural Disasters
- Criminal Acts

Post-Traumatic Response

- Typical or normal response to an extraordinary experience includes changes in mood, thoughts, and sensory experiences.
- Sometimes, the symptoms persist for a prolonged period of time; can lead to PTSD.
- Effect on behavior, relationships, occupation, social presentation, sleep, to name a few

Post-Traumatic Response

- The "fight or flight" survival response: A basic biological adaptation to threat
- This survival mode can temporarily persist into life after trauma
- Normal recovery is a gradual process that comes with integration back into familiar roles over several months

Three Major Areas of Impact

- Changes in Thinking
- Changes in Emotions
- Changes in Physiology and Behavior

Changes in Thinking

- Unwanted "re-living" of the trauma
- Distressing memories
- Disturbing dreams or nightmares
- Upset when reminded of traumatic event

Changes in Thinking for Vets

- Changes in Attitude and Outlook
  - Preoccupation with news about the war
  - Worry about friends still deployed overseas
  - Miss excitement of combat, urges to return
  - Confused about direction and meaning in life
  - Blaming self for actions in war zone
  - Loss of "innocence" and belief in former values

Changes in Emotions

- Feeling unsafe, on guard
- Irritability and outbursts of anger
- Anxious, apprehensive, panicky, stressed out
- Feelings of Guilt or Shame
- Feeling alienated from others and society ("I don't fit in anymore!")
- Loss of interest and enjoyment in life
- Down, depressed, hopeless
- Shutting down and emotional numbness

Changes in Physiology and Behavior

- Trouble with Sleep
- Easily startled & jumpy
- Physical symptoms and health problems
- Problems with concentration and attention
- Avoiding people, places, or things that are reminiscent of trauma
- Increased use of alcohol or drugs
- Withdrawn, sullen, uncommunicative
- Overly controlling and worried about safety

Post Traumatic Stress Disorder

- When symptoms persist and significantly effect everyday functioning
- Prolonged, severe symptoms in each of the areas mentioned (thinking, mood, physiology or "hypervigilance")

People at risk for PTSD

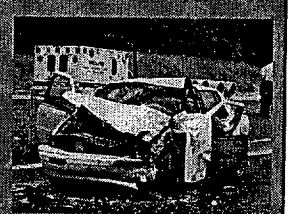
- Veterans
- Victims of domestic abuse
- Other crime victims
- Survivors of accidents or disasters
- Emergency Response personnel (Police officers too)

Post Traumatic Stress Disorder: Official Criteria

- The trauma is persistently re-experienced
- Persistent avoidance of stimuli associated with the trauma & numbing of general responsiveness
- Persistent symptoms of increased arousal
- Symptoms last more than a month

Re-experiencing the Trauma

- Unwanted, intrusive memories
- Recurring dreams
- Intense distress when reminded of the event
- A sense that the trauma is recurring



Avoidance

- Tries to avoid any discussion related to trauma
- Avoids places, activities, etc. related to trauma
- Cannot recall details of trauma

Numbing

- Less interest or participation in life events
- Feeling detached or estranged from others
- Limited range of emotional expression
- Sense of foreshortened future

Increased Arousal

- We like to think of ourselves as a big dominant predator type.

Our biological wiring is more consistent to that of a prey species than a predator species.

We respond to threats with predictable adaptations

- Arousal: Fight, Flight, or Freeze
- Changes in thinking (automatic remembering)
- Learning Cues: avoiding the bad stuff to survive

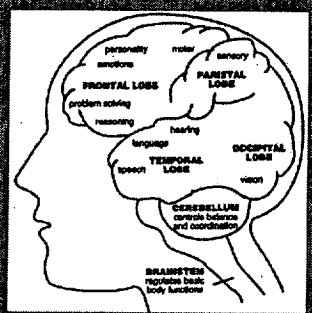
Fight, Flight, or Freeze Response

- Attack the threat
- Run from the threat
- Not be seen by the threat

Automatic Biological Response to Stress

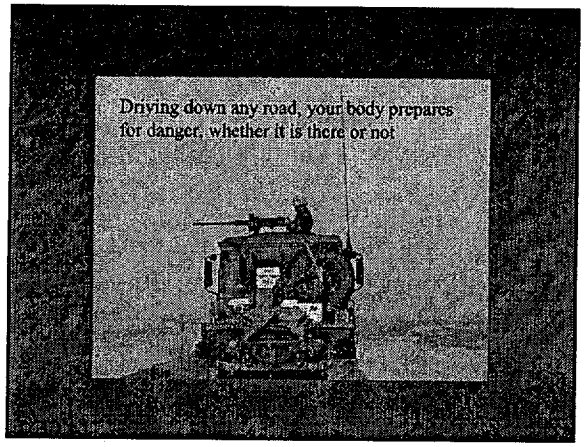
- Blood flow increases; increased heart rate and blood pressure
- Chemical changes in body (adrenaline)
- Muscles tense in preparation for action
- Digestion and immune system shut down since they are not a priority
- These responses constitute biological underpinnings of anger and fear

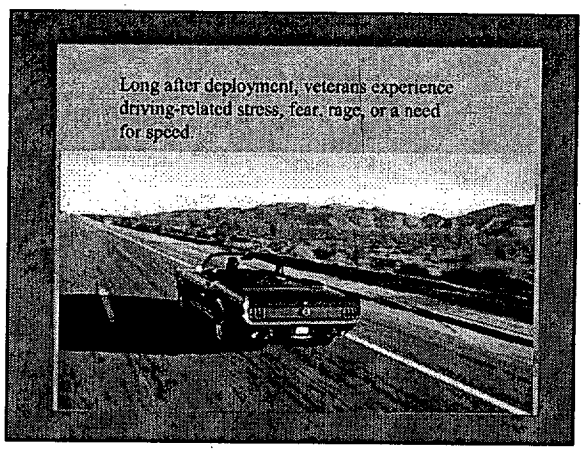
Higher Brain Processing



Example of Stress Response

Soldiers drive down the middle of the road at full speed, being very aware of parked cars, overpasses, etc.





Returning Veterans

- Many Veterans returning from Iraq and Afghanistan
- Dealing with Post-Deployment readjustment
- Normal and common reaction to recent experiences
- Can have major impact of functioning

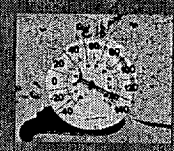
Returning OEF/OIF Veterans: Multiple Stressors & Concerns

Pre-existing Issues

- Uncertain deployment duration a significant contributor
- Rushed pre-deployment marriages or pregnancies
- Other stressors already existing related to work or family
- Pre-existing mental health issues

Deployment Issues

- Prolonged separation from loved ones and everything they're used to
- Job stress (long hours, fast pace, do everything with bosses, subordinates, peers)
- Constant threat to life
- Financial stresses
- Demanding physical environment



Post-Deployment Issues

- Family/Home environment has changed
- Everyone wants to talk about the war
- Problems with relationships, work, etc.
- Attempt to re-capture the "adrenaline" felt while deployed
- PTSD symptoms

Case Examples

How to recognize and respond to people struggling with Post-traumatic Stress

PTSD not the same as Acute Stress Reaction

- Emergency or disaster response requires that you deal with immediate issues.
- You will likely have to deal with PTSD in situations that have nothing to do with the trauma.
- People will not always be forthcoming about their traumatic experiences
- PTSD victims do not always show up on the radar

Important Concepts

- De-escalation
- The perception of control
- Grounding
- Distraction
- Reading their motives
- Diagnosis vs. recognition

Case #1

- Respond to a call from wife of recently returned veteran.
- He is locked in his room, has been drinking, and is looking for his guns.
- Wife has guns secured in locked cabinet. She has the key.
- Husband is more sullen than angry.

Questions…

- How would you engage this person?
- What do you need to consider when talking with him?
- What facts should you get from this man?
- What is your action plan?

Case #2

- A female in her early 30s is pulled over for traffic violation.
- She seems anxious and appears fearful of you.
- In your conversation, you learn that she has recently separated from abusive boyfriend.
- She has 3 small children at home.

Questions….

- How would you engage this person?
- What do you need to consider when talking with her?
- What facts should you get from this woman?
- What is your action plan?

Case #3

- You see a car driving in a wild, zig-zag pattern as it passes under an overpass.
- It returns to normal, lawful driving immediately after.
- You decide to pull the car over, and find a 26-year-old male.
- He has no prior record, and it a recently returned veteran.

Questions....

- How would you engage this person?
- What do you need to consider when talking with him?
- What facts should you get from this man?
- What is your action plan?

Case #4

- There is a report of a possible fight at a bar in your precinct.
- When you arrive, you find a man arguing with two other men.
- The lone man has a ball cap with a Marines logo. He looks pretty buff and is no older than 25 years old.
- He sees you coming and begins to look agitated.

Questions....

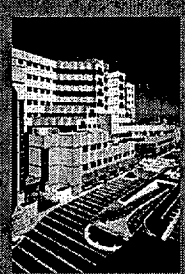
- How would you engage this person?
- What do you need to consider when talking with him?
- What facts should you get from this man?
- What is your action plan?

Resources

Community agencies that can help with PTSD

Veterans

- Portland VA Medical Center; 503-220-8262.
- Portland Vet Center (Sandy Blvd.); 503-273-5370.
- Veteran's Service Organizations: VSOs (VFW, American Legion, DAV, etc.).



Veterans (con't.)

- Post Deployment Reintegration Team
  *Staffed by Oregon National Guardsmen
  *Help with mental health, employment, etc.
  *Helpline is open 24/7
  *1-888-688-2264

General Resources

- Community services
- Church organizations or direct contact with clergy
- Family resources

Post Traumatic Stress Disorder

1.Symptoms develop following exposure to an extreme traumatic event that involves

- Direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to physical integrity of another person
- Witnessing an event as described above
- Learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate

2. The persons response involves intense fear, helplessness, or horror. In children this may be manifested by disorganized or agitated behavior.

3. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. In children this can include play where themes or aspects of the trauma are expressed
- Recurrent or distressing dreams of the event. In children there may be frightening dreams without recognizable content

Acting or felling that the traumatic event were recurring. Can include hallucinations and flashbacks

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity to internal or external cues that symbolize or resemble an aspect of the traumatic event

4. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness

- Efforts to avoid thoughts, feelings or conversation associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall important aspects of the trauma
- Diminished interest and participation in activities
- Feeling of detachment or estrangement from others
- Restricted range of affect
- Sense of a foreshortened future

5. Persistent symptoms of arousal

- Difficulty falling or staying asleep
- Irritability or anger outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

6. Prevalence rates for the general population range from 1% to 14%. Rates for at risk populations such as combat veterans, crime victims, ect. range from 3% to 58%

7. In about 50% of cases symptoms resolve within 3 months. In many cases symptoms persist longer than 12 months

8. Individuals with PTSD are at increased risk of developing a substance use disorder. Substance use exacerbated symptoms of PTSD

GUIDE TO ACCOMPANY

POST TRAUMATIC STRESS DISORDER

FEATURES OF PTSD

A. Traumatic event/significant stressor.

B. Re-experiencing of the traumatic event.

C. Numbing of responsiveness

D. Anxiety-based autonomic and cognitive symptoms.

DIAGNOSTIC CRITERIA FOR PTSD

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma by at least one of the following:

1. Recurrent and intrusive recollections of the event (nightmares).
2. Recurrent dreams of the event.
3. Sudden acting or feeling as if the traumatic event were re-occurring (flashbacks).

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

1. Marked diminished interest in one or more significant activities.
2. Feeling of detachment or estrangement from others.
3. Constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

1. Hyperalertness or exaggerated startle response.
2. Sleep disturbance.
3. Guilt about surviving when others have not, or about behavior required for survival.
4. Memory impairment or trouble concentrating.
5. Avoidance of activities that arouse recollection of the traumatic event.
6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.
7. Self-medication via alcohol/drug/pill abuse--chain smoking--overeating--anger mismanagement.

PTSD SUBTYPES

308.30 Post-traumatic Stress Disorder, Acute

- Onset of symptoms within six months of the trauma.
- Duration of symptoms less than six months.

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

- Duration of symptoms six months or more (Chronic)
- Onset of symptoms at least six months after the trauma (Delayed)

TRAUMATIC EVENTS THAT CAN PRECIPITATE PTSD

A. Rape

B. Natural Disaster

C. War--combat

PRECIPITATING TRAUMA & SIGNIFICANT STRESSORS OF COMBAT

- Exposure to death and mutilation of people and destruction and desolation of environment.

- Personal acts of violence, fighting, killing, and destroying.

- Danger and threat to life.

- Depersonalization and dehumanization of the military environment and the war experience.

- Discontinuity between war and non-war environment.

Additional Stressors of War

- Political and moral debate and controversy about combat, social and political divisiveness (draft evasion; marches, demonstrations, protests, and political debate). Creating a state of confusion and uncertainty; weakening morale; heightening vulnerability; diminishing social support and sanction; resulted in a homecoming by avoidance, rejection, and antagonism.

- System of rotation, limited tour of duty and periods of rest and recuperation with rapid individual entry and exit reduced morale and cohesiveness; rendered unit maneuvers more difficult and exposed participants to a more stressful transition.

- Restrictive policies (no plan to win the war; abandonment of captured territory; orders to request permission from higher authority before engaging the enemy) heightened danger, contributed to mistrust and lack of confidence in leadership.

Themes of "Post-Vietnam Syndrome."

- Guilt feelings and self-punishment.
- Feelings of being scapegoated.
- Rage and other violent impulses against indiscriminate targets.
- Combat brutality and it's attendant "psychic numbing."
- Alienation from one's own feelings and from other people.
- Doubt about ability to love and trust others.

TREATMENT OPTIONS FOR PTSD

A. Behavioral Techniques: Relocation, Desensitization

B. Education Techniques: Assertiveness, Relaxation

C. Supportive Techniques: Reflective Listening

D. Family Therapy

E. Hypno Therapy

F. Individual Therapy

G. Peer Group Therapy

H. Flooding, Abreactive Therapy

I. Gestalt Technique

J. Grief Psycho Therapy

K. Guilt and Regret Issues in Counseling

L. Anger and Stress Management

[Events]

VIETNAM: WHAT I REMEMBER

From "Patriotism Revisited," by David W. Powell, a memoir submitted last October to a creative writing class at the University of Arizona in Tucson. Powell served as a marine in Vietnam from 1965 to 1967.

The following events come to my conscious memory uninvited. I not only remember them vividly, I reexperience them with all my senses:

Froze with fright, standing up, the first time I was under fire

Watched two marines try to break open the skull of a dead Viet Cong with a large rock

Observed a marine intentionally shoot a girl four or six years of age

Watched the girl's grandfather carry her into our line of fire, sobbing

Had a lieutenant who delighted in sneaking up on me when I was on watch at night

Was offered a blood-soaked flak jacket and a helmet with a bullet hole through it as my first field equipment

Had my boots rot off during an operation in the field

Observed two captured nurses being beaten and raped by marines

Rifle-butted a girl of twelve in the face when she would not move away

Strangled a captured Viet Cong for refusing to talk to an interpreter

Discovered brain matter on barbed wire I was stretching out

Observed a marine laugh as he stepped on the chest of a dead Viet Cong and watched blood squirt out of the enemy's wounds

Awoke to find a buffalo leech on my leg

Was abandoned under fire when a rocket jammed in my launcher

Was abandoned under fire when I was shot

Hit head and fell in open field. Watched my fellow marines run by me to seek cover for themselves

Received letter from wife telling me how much fun she and a girlfriend had on Friday nights when they went out to bars to dance

Watched fellow marine shoot himself in the foot to get evacuated

Heard same man cry in his sleep when he was returned to the company

Found marine boot with foot in it in a hedgerow

Almost run over by retreating U.S. tank

Saw Lt. Spivey hit a head-high booby trap

Nearly murdered villager for stealing my laundry

Watched Prestridge test his new M-16 by shooting a woman getting water from a nearby well

Identified Haas's remains

Exchanged letters with Haas's mother

Had an artillery canister fall six inches in front of my head

Was about to put on fresh boots when I discovered lice swimming in them

Saw seven-foot python climbing in ceiling just above my head

Bullets sounding like bees digging up ground all around me

Nearly trapped in Da Nang village my last night in Vietnam

Robbed by marines while I slept in Okinawa after tour was over

Circled over El Toro air base for two hours so that President Johnson could land and be photographed greeting returning veterans

•

Since my return I have held eighteen different jobs and have been unemployed for several six-month periods. This is a direct result of my Post Traumatic Stress Disorder, specifically a disdain for being told to do tasks I do not want to do; an exaggerated startle response, which is terribly embarrassing to me; and a lack of control over emotional flooding.

I divorced my first wife two years after I got out of the service. I divorced my second wife in 1982. I separated from a four-year relationship in 1987. I have not had a significant relationship with a woman since then. I have no significant male or female friendships. I am aloof from my immediate family, who live in Tucson, Arizona.

PTSD SYMPTOMS

- MISTRUST
- DEPRESSION
- ISOLATION
- RAGE REACTIONS
- AVOIDANCE OF FEELINGS; ALIENATION
- GUILT/SHAME AND DOUBT
- ANXIETY REACTIONS
- SLEEP DISTURBANCE AND NIGHTMARES
- INTRUSIVE THOUGHTS

Trauma Recovery and Counseling Center
5999 Stevenson Avenue, Suite 404
Alexandria, Virginia 22304
David P. Niles, EdD., CCMHC (703) 823-6102

MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
1120 S.W. THIRD AVENUE, 4TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3976

Dear Survivor:

This booklet is about the experience of being hurt on purpose by other people, and the changes in your life that it leaves behind.

You may wonder if what happened to you was bad enough to be called abuse. If you have to ask that question, it probably was. If you cannot remember large parts of your life, it almost certainly was.

I am sorry you are having to read this out of a book.... These things are better dealt with face-to-face. The effects of violence are best helped by different and more positive experiences with people. In a correctional institution, this is hard to do.

Take your time reading this. Use whatever parts seem helpful in your situation. Be patient with yourself. It will take time and work, but you <u>can</u> feel better.

Take care,

Joe Parker, RN

MULTNOMAH COUNTY OREGON

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Dear Colleagues,

In providing mental health care for corrections populations, management of Post Traumatic Stress Disorder has a central place.

Some clients come into the system as a result of acts in some way related to previous experiences of abuse. Many come as a result of self treatment of major symptoms by means of illegal drugs or alcohol.

Although psychotropic medications play an important role for many clients in controlling physical symptoms of the disorder, psychological treatment has proven to be very important in improving functioning and quality of life.

Since mental health resources are so limited in corrections, self-help educational materials must be used whenever possible. This booklet has been very helpful for our clients and staff, and we hope it will be helpful for your clients as well.

Sincerely,

Joe Parker, RN

POST TRAUMATIC STRESS DISORDER (PTSD)

WHAT DOES POST TRAUMATIC STRESS DISORDER MEAN?

Post is the Latin word for "after".

Trauma is the German word for "nightmare", but in English, it is used for any kind of injury, physical or psychological.

Stress is a force that changes the shape of things (including people).

Disorder refers to things that are a problem in a person's life now.

To understand PTSD, it is necessary to tell two stories.

> Once upon a time, several blind men wanted to understand about elephants.
>
> An elephant was brought to them, and they all approached it from different directions.
>
> One felt the tail, and said "an elephant is like a rope"!
>
> Another found a leg, and said, "no, an elephant is like a tree trunk".
>
> A third walked into the side of the elephant, and said, "really, an elephant is like a wall".
>
> Others found the ear, the trunk, a tusk, and each felt his part of the elephant was the real elephant.
>
> Each blind man was right about his part of the elephant, but none of them really understood about elephants.

The story of Post Traumatic Stress Disorder is similar.

PTSD was first recognized after the American Civil War.

Doctors noticed that some soldiers who had been in heavy combat complained of having attacks of fast heartbeat, chest pain, difficulty breathing, and fear that they were dying or going crazy.

The symptoms were similar to heart attacks. Not having the scientific equipment to investigate further, they assumed the attacks were a form of heart disease. They called it "soldiers' heart".

DEPARTMENT OF HUMAN SERVICES
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We now know the attacks are not heart disease. They result from rushes of adrenalin, triggered by bad memories or nightmares.

A few years after the war, most people forgot about the problem, but the part of the elephant they had found was real.

World War I was the first time very large numbers of explosive shells were used in battle.

It was noticed that some combat veterans, afterward, had trouble with feeling somewhat dazed or confused, and with poor concentration and memory.

This seemed similar to what happened in many brain injuries. It was thought that the concussions of the shells caused tiny spots of bleeding in the brain. They called it "shell shock".

Eventually, a lot of autopsies were done on soldiers who had died of other causes, and no such bleeding was found. It was recognized that the symptoms resulted from extreme stress, not brain damage.

It should be remembered that many people with PTSD, especially from child abuse and domestic violence, have had damage from blows to the head. Both symptoms of brain injury and effects of overwhelming stress may be present in the same person.

A few years after the war, the matter was again dropped, but they had found another part of the elephant.

When World War II came, it took until June of 1944 to redevelop the treatment methods used in 1918.

In that war, they learned two important things. The severity of a person's symptoms was directly related to how much stress he or she had undergone, over how much time.

It was calculated that of 100 men in continuous combat, every single one would break down within 189 days. They called it "combat fatigue", or "combat exhaustion".

It also became clear that there is no such thing as a stress-proof person. Certainly some people break before others, but with enough stress and enough time, everybody breaks. They had another part of the elephant.

After World War II, it was assumed (never investigated, just assumed) that symptoms of traumatic stress went away in 6 months or a year, after the war was over.

Only after the Vietnam War did it become clear that PTSD symptoms could appear it any time, during or after the war. The symptoms could go on, better or worse from time-to-time, all of a person's life.

The severity of the symptoms is influenced by how much emotional support a person has available during and after trauma.

Veterans of an unpopular war, such as Vietnam, were clearly affected by the fact that nobody wanted to talk about it later.

Survivors of child abuse and domestic violence are more severely affected because family or friends, who normally would provide support, are the perpetrators of the violence.

In the late 1970's feminist writers began publicizing the fact that far more child abuse, sexual abuse, and domestic violence were occurring than previously admitted.

Studies began to reveal that domestic violence is a problem in about 25% of all families, regardless of race, religion, income or education. About 16% of all girls and 8% of all boys are sexually abused before the age of 18 years. Rapes reported to the authorities may represent less than 10% of those that actually occur. About 10% of the adult population is alcoholic. Inclusion of other abusable substances may raise the figure to double that.

Very few people are directly involved in wars, but most people have a family.

Unlike in times past, the feminists and Vietnam veterans have not shut up and gone away. Post Traumatic Stress Disorder is now an official diagnosis in the diagnostic and statistical manual.

Consciously or unconsciously, the brain remembers everything. Trauma really happens, and it changes who you are. You cannot seriously hurt human beings and expect them to forget it and be alright afterwards.

People who have Post-Traumatic Stress Disorder often worry about whether they are "crazy".

The word "psychotic" (or crazy) usually means experiencing or believing things that are not real: being "out of touch with reality".

People with PTSD's have essentially the opposite problem. They are in too much contact with reality, and in contact with realities that most people have the privilege of not knowing about.

It is just as possible to be sick from too much contact with reality, as from not enough.

That is the whole elephant.

The official definition of Post Traumatic Stress Disorder includes a combination of the following:

1. An extreme, painful experience, which would be severely stressful for almost anyone.

2. Continuing psychological "re-runs" of the events, including:

   a. frequent thoughts and memories about what happened, even when trying to avoid them.

   b. repeating nightmares about the trauma.

   c. suddenly feeling or acting as if the events were happening again (flashbacks).

   d. strong, painful feelings set off by things which are in some way related to what happened.

3. Ongoing attempts to avoid memories and feelings by:

   a. becoming generally numb to everything, by cutting off most feelings, both good and bad.

   b. avoiding activities or situations which may bring back memories and feelings.

   c. loss of large areas of memory about past life.

   d. loss of interest in things most other people care about, feeling different and cut off from other people.

   e. lack of any sense of having a future.

4. Continuous extreme physical alertness, including:

   a. constantly watching for signs of danger, with "startle responses", and trouble sleeping.

   b. trouble concentrating on business in the present world.

   c. irritability, outbursts of anger.

   d. physical reactions similar to what happened during past trauma (tremors, sweating, nausea etc.)

5. These symptoms continue for more than a month and can begin anytime from immediately to years after the trauma.

PSYCHOLOGICAL ABUSE

Children come into the world knowing nothing about themselves: whether they are smart or stupid, good or bad, lovable or unlovable. They can only learn these things from family, from people around them. If they are given "poison information", they have little choice but to believe it.

For the abuser psychological abuse has several advantages:

1. It leaves no physical marks. Unless the child becomes extremely depressed or psychotic there is no evidence to show in court.

2. It is safe. There is no risk of accidentally killing the child and being sent to prison. There is no problem with the child getting big enough to physically fight back or use a weapon.

3. It is easy. Psychological abuse can be kept up for years, wearing away at a child like rust. There is no great amount of energy or time involved.

Psychological abuse takes several forms. They are usually used together - it is rare for an abuser to use only one type.

1. Rejecting

   "I hate you, you ruined my life". "You are not my child" Nothing the child is or does is ever good enough.

2. Isolating

   Keeping the child away from any people other than abusers. This prevents the child from learning anything about him or herself except the "poison information" provided by the abusers.

3. Ignoring

   Not responding to anything the child is, says, or does. Psychologically/emotionally "not there" for the child.

4. Corrupting

   Involving the child in crimes, early alcohol/drug use, sexual activities, etc. that leaves the child unable to be part of normal society.

5. Terrorizing

   Keeping the child constantly in fear of being hurt, making the child watch others being hurt, keeping the child emotionally out of control most of the time.

PHYSICAL ABUSE

A large part of the "normal population" consider it legitimate to use physical force to discipline children. "Spanking" with an open hand is commonplace in our society. Abuse, fueled by uncontrolled anger or intoxication, goes far beyond ordinary discipline. Abusers almost always blame their violence on the child or spouse who is the victim. This is confusing to survivors, who need to know what level of violence qualifies as "abuse".

Abuse includes some combination of the following features:

1. Severity of injury. Cuts, bruises, broken bones, being strangled or knocked unconscious.....and sometimes death.

2. Weapons. Clubs, knives, guns and other instruments capable of causing severe injury or death. Life or death for the child depends totally on how well the abuser controls the weapon.

3. Use of pretexts. A child is punished for anything or nothing. The "rules" are made up as the abuser goes along, and change without warning. The child is never safe.

4. The abuser is out of control. Through alcohol/drugs, mental illness or personal choice, the abuser does not control amounts of force used. The child may be crippled or killed at any time.

It is sometimes useful, to understand the severity of a survivor's current symptoms, to put together a lifetime total assault history. Multiply the total number of each type of assault per day/week/month by the total amount of time exposed to the various abusers. Be sure to count both assaults in childhood and in adult life. The total number sometimes explains a lot about why you are having so many symptoms.

Finally, estimate the number of days on which the survivor could be sure of not being hurt. Sometimes this number is painfully small.

Adults who recognize their actions toward children as abusive often fear to tell anyone, out of fear they will go to jail or lose custody of their children. In reality, many social services agencies work with parents who have abused, or fear they may abuse their children, to learn to stop the violence and keep their children. Parents Anonymous is free and a good place to start.

SEXUAL ABUSE

Normal sexuality is the exchange of pleasure between two freely consenting people. Abuse is the wrongful use of a human being, as a thing, for the pleasure of another. Sexual abuse commonly involves:

1. Use of force or threat to control a person who is not consenting. The threats may be against the victim, ("Do what I want or I'll kill you...."), against others, (If I don't get what I want from you, I will just go after your little sister..."), or against the abuser himself, ("If you tell anyone, I will have to kill myself, and it will be all your fault...").

2. Use of lies to overcome resistance, ("I'm doing this to teach you, for your own good", "Everybody does this", "You want it, I know you do".). Lies can take the place of open violence.

3. Secrecy. Normal sexual relationships may go on in private, but they are not themselves secret. The demand for secrecy almost always indicates wrongdoing, and usually includes some kind of threat. ("You won't be by special girl anymore", "It would break your mother's heart", "You will be put in an institution".).

4. Betrayal of responsibility. Children have to depend on older people for protection, for food, clothing, shelter, and for truthful information about how to get along in the world. An adult who uses a child's natural needs in order to use the child's body, is committing a crime. Sometimes the betrayal hurts more than the fear, the isolation or the injuries.

The most basic drives of human beings, and of all animals, are to survive and to reproduce. The use of power to control a child is ultimately based on the threat to hurt, abandon, or kill. The child does whatever is necessary to survive. Energy that should go into growing up, is spent on trying to just get by, day by day.

Use of sex as a weapon strikes a child's basic ability to relate to, and trust, other human beings. It attacks a person's sense of being connected to other people, both in the present world, and to past and future generations.

Sexual abuse is like any other serious injury: some people survive and do well, some people only get by, and some end up not surviving at all. Good help and the right choices can make your life more nearly normal, and much happier than it might otherwise have been.

To be hurt, especially on purpose by other people, makes everyone sad and ashamed. In thinking about their lives and symptoms, most people tend to underestimate the severity of their experiences, and overestimate the amount of control they had over what happened.

HISTORY

The brain has mechanisms like "circuit breakers" which block out memories too bad to handle at a given time. The memory loss is usually "spotty", not complete, and gets better or worse depending on a person's stress level and how much help is available.

Trying to force the memory, by emotional pressure, drugs or hypnosis, often hurts rather than helps. If the brain needs to block out a memory, it usually has good reason. People tend to "face reality" as fast as they can. Pushing becomes just another form of violence.

It is common to have to work on plans for recovery with incomplete information. Often, some of the most important facts come out only quite late in the process.

Because the traumatic experience really happened, and really hurt, PTSD symptoms tend to continue, better at some times, worse at others, most of a person's life. Careful planning and use of recovery skills can greatly increase the amount of "good time" and make the bad times less frequent and less severe.

Putting together a written history of your life, and understanding the effect the traumatic parts had, usually helps make sense of many things that have happened in your life, during the abuse and after. It is very important in making plans for your recovery. Making the most complete possible history is a long term project. Memories come back in bits and pieces. Information from other people and from records also will come in bits and pieces. Some things may never be known.

This will be a stressful process, both in the effort spent in trying to remember, and in the energy needed to cope with what is remembered. Sadly, insight into what happened usually improves symptoms, but seldom completely removes them.

It helps to keep written notes, to avoid losing hard won information to the ups and downs of memory. Putting it in writing also seems to help keep things real, when so often they seem unreal, or even impossible.

1. Lay out a "life line", beginning with your birth. Put in any markers that will keep track of time: places you lived, where you went to school, births, marriages, deaths, institutions you were in, etc.

2. Talk to family, friends, teachers, ministers, neighbors and anyone else who may have information about your life.

   Keep in mind that some of these people truly did not know, some did not want to know, some knew but did nothing, and some may have profited in some way from what happened. (For example, as long as the violence was directed at you, it was not aimed at them.)

3. If you decide to talk with the perpetrator, be very careful of your safety. Many are still dangerous. Be clear about what you are trying to do. If you want the perpetrator to confirm memories you can barely believe yourself, be prepared to be called a liar, crazy, or to be told you wanted or deserved what happened. Try not to hope for too much: most perpetrators do not admit responsibility or say they are sorry.

   If your purpose is to confront the perpetrator with your anger and your knowledge that what was done was wrong, then, other than being careful for your safety, how the person reacts is not very important.

   If the perpetrator is confronted in the process of warning other family and friends about the danger he or she presents, be aware that some other people may react in much the same way as the perpetrator might.

   You cannot afford to attach your sense of self worth to the reactions of other people, because their responses have to do with who they are, not who you are.

4. Pay special attention to periods of time you cannot remember, or that others will not discuss with you. The more hurtful the experience, the more likely it will have been blocked out.

   Sometimes it is possible to work backward from things that are known: who was living with us at the time, who was drinking at that time etc.

5. Send for copies of any hospital or institution records that may be available. Although you have a right to see and copy most records pertaining to you, sometimes the help of an attorney or health care provider may be needed. Be aware that many professional people are careful not to ask questions they do not want to hear answers to. Some of the records may be in a sort of code, that is: "chaotic family life" may mean drunken violence on a daily basis, and "sexually molested" may cover rape, sodomy and torture.

Put your notes in a safe place. You may wish to add to them from time to time, as you find new information. Sometimes reviewing them will help you understand some new problem in your life.

LIFE CHANGES

Extremely hurtful experiences, ones that produce more fear, pain and anger then anyone can handle, leave behind four ongoing sets of behaviors. These are not so much "scars" as attempts to cope with trauma. Like any kind of treatment, if carried too far, they can become part of the problem, not part of the solution.

1. You begin intense, continuous study of the experience, trying to understand why those things happened, and how to keep them from happening again.

This involves constant thinking about the events, to the point it may interfere with other activities. You may have repetitive dreams about the events which may be so intense as to interfere with sleep and set off adrenalin reactions. The feelings can be so powerful that it can seem as if you are living in two different "movies" at the same time: the "bad old days" and "now".

Once you understand how the process works, you feel less disoriented, less out of control, and more able to cope.

Learning more information about trauma <u>does</u> help. You can take classes, read about it, and talk with others who have been through similar things.

2. You learn to constantly scan the environment for signs of danger. The scanning is compulsive - you cannot turn it off, so you have to plan for it.

Recognizing signs of threat may trigger strong reactions, sometimes as strong as the original events did. These reactions may be completely out of line with what is going on in the real world at the time.

Sometimes, you may well be aware of the connections between the present "trigger" and past experiences, even if you cannot control your reaction. At other times, the connection may be unconscious. You first become aware of your <u>reaction</u>, and may or may not later be able to connect it with the past.

The responses may be so intense as to feel like the trauma is actually happening again, that you are back in the bad old days. This is called a flashback. It can feel very crazy to find yourself feeling, saying, or doing things that do not relate to the present world.

To begin to control various kinds of flashbacks, it is important to map out your usual triggers, where they are likely to be encountered, and what your usual reactions are. Some triggers can be avoided almost completely, and should be. Others may be harder to avoid, or you may have good reason to take the chances involved in running into them.

Survival planning may include ways of minimizing exposure, arranging for support ahead of time, developing a "cool down" procedure, and concrete emergency plans in case of losing control.

3. Your body goes in chronic "red-alert", always ready to fight or run. Physical symptoms include extreme muscle tension ("the shakes"), headaches, high blood pressure, involuntary startle reactions and trouble sleeping. You feel afraid all the time, even when you have no present reason to.

It is in attempting to control <u>these</u> symptoms that so many people with PTSD get involved with alcohol and illegal drugs. Expert use of legitimate psychiatric and blood pressure medications can control most physical symptoms of PTSD. <u>They do not provide a high, are not addicting, are legal, and are much safer than street drugs</u>.

As survivors move forward in recovery, some may no longer need medication, others will need it only during bad times, and some may need it always.

Serious trauma can change the way a person's nervous system works, sometimes permanently. Even after allowing for the effects of brain damage and other injuries from violence, PTSD is a physical illness.

4. You are continually prepared to be hurt again, to lose again. The difference between the way life was supposed to be, and the way it turned out for you is a chronic stress.

You learn to avoid getting involved with other people for fear they will turn on you. You try not to care about people, animals or possessions, because sooner or later you expect them to be taken from you. You go so numb that you cannot feel anything, including good things. Being that numb <u>hurts</u>. Being cut off from good things, including people, makes you <u>sad</u>.

Emotions may swing like a pendulum, from overstimulated, hyperalert, fearful and angry, to depressed, numb and out of contact with the world around you. The extreme feelings often come and go in waves, and at times you actually may be out of control. Stabilizing this swing is a central goal of a recovery plan. Such a plan may include:

a. Mapping triggers and arranging your life to avoid recurring flashbacks.

b. Learning to recognize and avoid hurtful people.

c. Avoiding the use of drugs which temporarily improve symptoms, but make them worse on the "rebound". If needed, symptoms can be controlled with legitimate medications.

d. Reducing your exposure to new injury. (For instance, stay out of places that serve alcohol...)

e. Stopping current patterns of behavior which may be replays or reenactments of your own previous trauma, such as prostitution, fighting, child abuse.

f. Actions to make the real world safer are much more helpful than just trying to cope with your feelings about what might happen. Good locks and a dog are more helpful than lying in bed trying not to be afraid.

Extreme traumatic experiences, especially if they happened at a young age, can make you different from most other people. Of special interest are two groups of people who may seem very strange to you: predators and normal people.

DEALING WITH OTHER PEOPLE

A person's usual everyday approach to life and to other people is called a personality. A personality is made up of a person's biological inheritance (genes), the total set of things that have happened in the person's life, and the history of choices the person has made.

Every life is like a hand of cards. Some people play whatever they get well, others badly. Only a small number of people choose to hurt others. Even among people abused as children, 70% do not choose to hurt others.

Predators come in three forms:

A. Non-controllers:

All people have angry feelings, and all people have the impulse to hurt someone at times. Some choose not to control those impulses. Many choose to use alcohol and drugs, and let the chemicals block their impulse control. Others do whatever they feel like, sober or otherwise. Their attitude is: "I feel like shit, so somebody's going to pay..."

People who are loaded occasionally have the bad judgement to pick on somebody tougher than they are, but most, sober or not, are quite careful to act out their impulses on people who cannot effectively fight back.

B. Users:

Some people act as if they were the only real human being in the world, and other people are more like plants. If they want something, they simply take it, as if they were harvesting vegetables. Users have no sense of other people's rights and feelings, and do not consider that a problem.

It is not that they have something that other people do not. Rather, users are missing something most people have: a conscience, that is, internal personal limits on what they do. Any control of their behavior must be provided by others, and often by force.

C. Sadists:

People who enjoy humiliating and hurting others, and who do so while in full control of themselves., may make up as much as 10% of the population. They are found in all parts of society, with all levels of education and income. For some, other people's pain is sexually stimulating. Others like the feeling of power that comes with hurting people who cannot stop them.

The definition of sadism includes ongoing pattern of:

1. Using physical violence, threats or lies to control another person and inflict pain.

2. Humiliating and degrading a person in front of others.

3. Using a position of authority such as that of a parent to inflict unusually severe "discipline".

4. Being fascinated by violence, weapons, torture etc.

5. Finding the suffering of other people and animals funny, pleasurable or sexually stimulating.

Some sadistic people are very obvious. Others are so subtle that all you notice is that you feel bad when around them. Abuse survivors have had to learn to ignore their own feelings just to survive. Learning to recognize , and trust, your feelings and to take rapid action to protect yourself, sometimes takes a lot of work.

Cruel people often are quick to notice people who expect to lose, and will move in quickly. They avoid people who look like they know they have rights, and have people who love them, because they are likely to fight back.

It is necessary to learn to act like a person with value and rights, long before you can really feel it. In time, it will become real, not an act.

Normal people:

To deal with normal people, you must understand that the world they live in is very different from yours. They are not afraid all the time. They can feel many more things than pain, fear, and anger.

1. They have rarely felt so much pain that they have lost control of themselves, and certainly have not had that kind of pain caused intentionally by another person.

2. They do not assume they are at fault any time anything goes wrong.

3. They expect to be treated fairly, to be respected, and to love and be loved.

4. They can feel pleasure without drugs, they are depressed only occasionally, and do not know what being numb is about.

5. They expect to have a fair amount of control over their lives, and expect to live to be old.

With time and effort, you can learn to deal with people whose lives have been luckier than yours. One barrier will probably always remain: most normal people do not want to live in the world you know. Many will block you out so they can stay comfortable, not because you are doing something wrong. It is important not to reject all normal people, because there are always some who will work quite hard to understand how your life has been, even if they have had no similar experience themselves.

FINDING PEOPLE YOU CAN TALK TO

Think of how long it took you to put together the pieces of your history, make an accounting of how the abuse changed your life, and deal with your emotional reactions to that. You never had a choice about facing that because you had to live it.

Finding someone to talk to about it is not quick or simple. Some people will listen because they have had to live with abuse too. They may or may not be able to tolerate terrible stories at a given time. Listening to your story may bring up feelings they find too painful to deal with.

Others will listen because they are unusually committed to helping other people, or care a lot about you personally. Finding people who can listen is a key part of surviving. It involves several specific steps:

1. Talk with them about some part of your life that is fairly ordinary, and see if they really <u>listen</u>. If they listen poorly to the very ordinary, they certainly will not hear the really ugly. If they listen, then:

2. Choose a "medium bad" part of your story, one not too hard to handle if things go badly, and tell that. If they change the subject, turn mean, or drop a relationship, they probably are not worth any more effort.

   If they get panicky or go numb, you may have found another person with an abuse history. Keep in mind that they may or may not consciously recall the experience. Given plenty of time and personal space, these people <u>may</u> talk with you. Just as it was with you, pushing hurts rather than helps.

3. Once you know a person really well, you may choose to tell him or her the very worst things that happened, the ones that would really hurt if not handled with gentleness and respect. After you tell another person the very worst, and are met with kindness and respect, the memories never have quite the same power over you again.

4. Sometimes you will know people you care about, and very much would like to talk to, but you really feel they could not tolerate the ugly details. You may choose to tell them only some of the story, or even none.

   It is not fair that you should have to spend your energy to protect them from <u>hearing about</u> what you had to <u>live</u>, but occasionally it is necessary.

TRIGGERS

Human beings are creatures that <u>learn</u>, and keep on learning all of their lives, whether they want to or not.

They learn to recognize danger by noticing signs that were associated with past hurtful experiences. If the past experiences were severe, there may be a strong physical or emotional response, even if the conscious mind does not know what set it off.

These signs are called "triggers". People who have a good understanding of what situations set them off, can plan to avoid them, or to deal with the reactions. They come to feel much more in control of themselves.

Triggers can be internal, that is, can be a thought or a memory, as well as an outside event. Triggers take several forms:

1. Single Triggers: One sign alone is enough to set off a reaction. Examples: beer breath, body odor, being yelled at, seeing someone else hurt, violence or happy family situations shown on TV.

2. Compound Triggers: Several things, coming together, will set off a reaction, when each would not have been enough if it appeared alone. Examples: being touched, by someone who is angry, and has beer on his breath; or blood, on bed sheets, in the morning.

3. State-dependent triggers: One or several things which set off a reaction only when a person is tired, alone, in pain, intoxicated, etc. Without the changed mental and/or physical state, the particular signs are not enough to set off a reaction.

It is helpful to keep a log of what is happening around you, and what you were thinking about, just before your body and emotions "went off". Because of memory loss caused by stress, finding the trigger that set off a reaction can take time. Tracking down a trigger may also bring back lost memories. At other times, putting together more personal history will help identify triggers you had not recognized before.

FORGIVENESS

Abuse survivors often are pressed to "forgive" the perpetrator. The pressure may come from others, especially family members, or from the survivor's own beliefs about what should be done.

Forgiveness is a word for something that does not exist in the real world. There is no way to go back and act as if nothing ever happened, which is what most people want and most people think forgiveness means. People other then the survivor made bad choices, with terrible outcomes, and became worse people as a result.

The survivor may choose not to seek revenge, may choose to continue some contact with the abuser, and may try to support any positive change that the perpetrator may attempt, but there is no way the survivor can control what the abuser chose to do. If the survivor had been able to control other people's decisions, there would have been no abuse.

Children want very badly for their family to be good people, even in the face of strong evidence that they are not. They will blame themselves for things other people did. They will claim that they were somehow in control, rather than face the fact that they were helpless and that the bad choices were made by others. Survivors have nothing to be forgiven for, because they did not make the choices.

The abuser can choose to give up violence, take responsibility for the damage, and work toward rebuilding a family. Failing that, the survivor may have to piece together a family out of whatever is left, without the abuser.

A LAST WORD

A new family can be built out of the people who choose to be part of your life, whether or not they were born into it. A real family is something people do together, not something they are.

Building a new life may take terrible faith and courage. Some days it will seem easy, on other days, impossible. You go on living, with the unwanted knowledge of what evil people have done and can do, including what you yourself may have done and can do. Sometimes it takes all the courage you have just to get up and get dressed in the morning, knowing what can happen.

I wish you luck and courage on your journey. You will always have my respect.

Joe Parker, RN

THE PENDULUM SWING

REEXPERIENCING

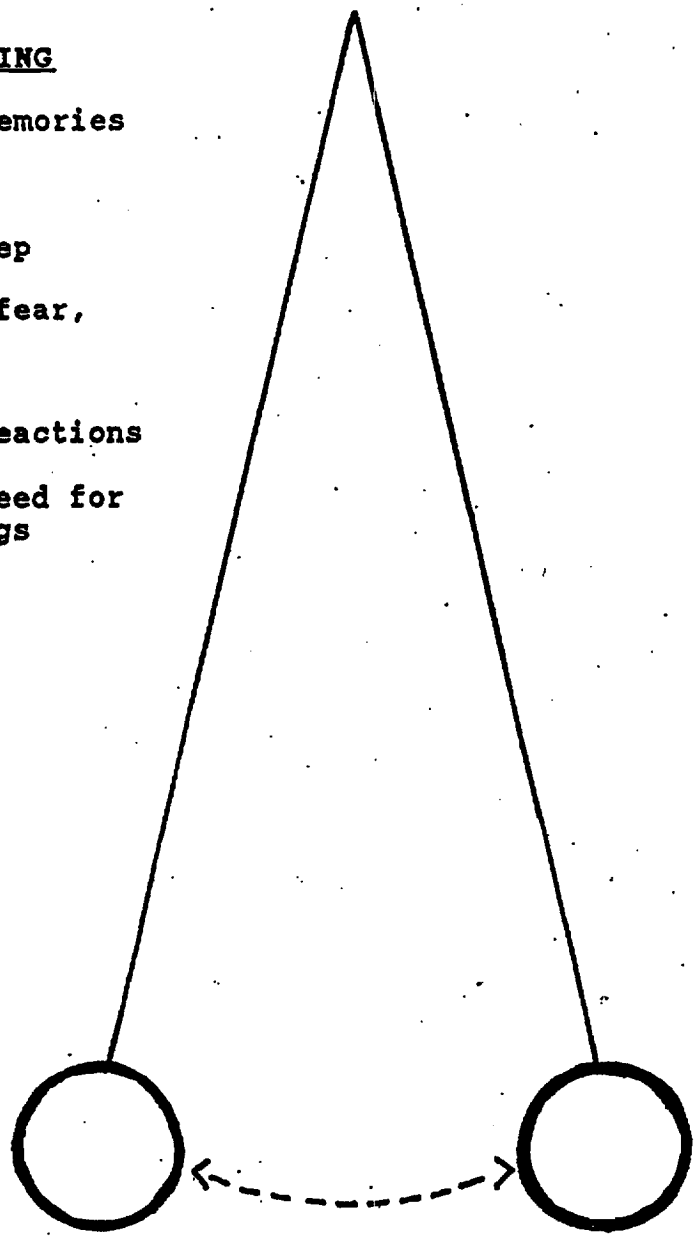
- intrusive memories
- nightmares
- loss of sleep
- attacks of fear,
- flashbacks
- "startle" reactions
- increased need for alcohol/drugs

NUMBING

- feeling nothi...
- loss of nor... interests
- detachment from others
- memory loss
- avoidance of reminders
- depression

TOO AGITATED TO WORK ON PROBLEMS.

TOO MUCH ENERGY.



UNABLE TO HOPE FOR THINGS TO GET BETTER.

NOT ENOUGH ENERGY.

"HEALING WINDOW"

Enough energy to work on problems, and enough hope to want to.

NOTES

NOTES

ALCOHOL AND DRUGS

Alcohol, Drugs, and Chronic Mental Illness

1. Substance Abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period

- Recurrent use resulting in failure to fulfill major role obligations at work, home, or school
- Recurrent use in situations where it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

2. Substance Dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:

- Tolerance
- Withdrawal
- Substance taken in larger amounts or over a longer time than was intended
- Persistent desire or unsuccessful attempts to control use
- Great deal of time spent in obtaining, using, and recovering from the drug
- Important social, occupational, or recreational activities are given/ reduced due to use
- Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

3. Addiction is a chronic, progressive, terminal disease. Substance use result in changes in the brain which maintain addictive behavior

4. Incidence of substance abuse among individuals with chronic mental illness is higher than that of the general population.

ECA Studies:

Lifetime Prevalence

	General Population	Dx. Of Schiz
Any SubstanceUse Disorder	16.7%	47.0%
Any Alcohol Disorder	13.5%	33.7%
Alcohol Dependence	7.9%	24.0%
Alcohol Abuse	5.6%	9.7%
Any Other Drug Disorder	6.1%	27.5%
Drug Dependence	3.5%	12.9%
Drug Abuse	2.6%	14.6%
Marijuana Depend/Abuse	4.3%	
Cocaine Depend/Abuse	0.2%	
Opiate Depend/Abuse	1.2%	
Amphetamine Depend/Abuse	1.7%	
Hallucinogen Depend/Abuse	0.3%	

5. Incidence of mental illness among individuals with a substance use disorder is greater than the general population

ECA Studies

Lifetime Prevalence	General Population	Alcohol Dx.	Drug Dx.
Any Mental Dx.	22.5%	36.6%	53.1%
Schizophrenia	0.7%	3.8%	6.8%
Any Affective	8.3%	13.4%	26.4%
Any Anxiety	14.6%	19.4%	28.3%

6. Reasons for use of substances by individuals with mental illness can include social, self medication, and addiction

Social:

- Means to behave like non-mentally ill peers
- Opportunities to be around others w/o high social demands
- Creates a sense of belonging to a social group

Self-Medication:

- Anxiety Reduction
- Improved ability to concentrate
- Improved energy level
- Increased sense of ability to function and well being
- Improved mood

Addiction:

- Physical and psychological dependence
- Altered brain function

7. Use of substance by individuals with chronic mental illness typically result in increases in symptoms of psychiatric disorders and reduced ability to function

8. Effective treatment involves simultaneous treatment of both the mental illness and substance use disorder

ALCOHOL AND DRUG

- WHAT TO LOOK FOR IN ASSESSING THE
- POTENTIAL FOR VIOLENT BEHAVIOR

- RISK FACTORS FOR HOMICIDE

- BLOOD ALCOHOL CONCENTRATION

- DEPRESSANTS
  - Alcohol
  - Opiates/Narcotics
  - Sedatives/Hypnotics/Anxiolytics

- ALCOHOL AND DRUG OVERVIEW

- INDICATORS OF DRUG USE

- OTHER DRUGS

- HALLUCINOGENS, PHENCYCLIDINE
- (PCP), AND RELATED SUBSTANCES

- INHALANTS

- DRUG PROBLEMS IN EMERGENCY
- ROOMS

ALCOHOL and DRUG (continued)

- RISK FACTORS FOR SUICIDE
- STIMULANTS
- SUBSTANCE ABUSE AND THE BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE.
- QUICK LIST OF SUBSTANCES AND THEIR SYMPTOMS

WHAT TO LOOK FOR IN ASSESSING THE POTENTIAL FOR VIOLENT BEHAVIOR

- A psychiatric diagnosis that includes violent or impulsive behavior among its criteria
- A previous history of violent behavior
- A history of substance abuse
- An injury to the head
- An injury to the central nervous system
- A previous history of physical abuse by others
- A previous history of suicidal behavior
- A previous history of delusions or hallucinations—particularly command hallucinations

Source: Lukas, S. (1993). Where to Start and What to Ask. New York: W. W. Norton & Co.

Risk Factors for Homicide

- Access to/ownership of guns
- Use of a weapon in prior abusive incidents
- Threats with weapon(s)
- Threats to kill
- Serious injury to victim(s) in prior abusive relationships
- Threats of suicide
- Drug or alcohol abuse
- History of forced sex with female partners
- Obsessiveness/extreme jealousy/extreme dominance

Blood Alcohol Concentration

Blood Alcohol Concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process

capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most states for drunkenness, which is 0.08 percent.

BAC can be measured by breath, blood, or urine vehicle tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury.

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are
impaired in most people long before they exhibit visible signs of drunkenness. While most states define legal intoxication for purposes of driving at a BAC of 0.08 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

The legal intoxication level in most states is 0.08 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.08 percent is reached.

Factors that will affect the BAC in a person:

- How much alcohol you drink.
- How fast you drink. The quicker you drink, the higher your peak BAC will be. The liver gets rid of alcohol at the average rate of one drink per hour (12 oz. beer, 5 oz. wine, 1 shot of distilled liquor). If a person drinks faster than this, the remainder will circulate in the blood stream until the liver can get rid of it.
- Body weight. Heavier people will be less affected by the same amount of alcohol than lighter people. They have more blood and water in their bodies in which to dilute the alcohol.
- Food in the stomach. When there is food in the stomach, alcohol is absorbed slower into the blood stream. The BAC rises more rapidly in those who drink on an empty stomach, because there is no food in which to dilute the alcohol.
- The type of alcohol you drink. The stronger a drink is (the higher the alcohol concentration, distilled alcohol first, wine second, beer third), the more quickly it is absorbed. This partially explains why hard liquor has more of an apparent " kick" than wine or beer.

- Type of mixer used. Water and fruit juices mixed with alcohol slow the absorption process, while carbonated beverages will speed it up. Carbon dioxide speeds the alcohol through the stomach and intestine into the bloodstream, creating a rapid rise in BAC.

- Temperature of the drink. Warm alcohol is absorbed quicker than cold alcohol.

- If you are male or female. Women reach higher BAC's faster because they have less water in their bodies and more adipose tissue (fat), which is not easily penetrated by alcohol. Therefore, a man and woman, with all other factors being equal, both drinking the same amount of alcohol will have different BAC levels. Hers will be higher. A woman's menstrual cycle will also affect her rate of absorption. They will experience their highest BAC's premenstrually. In addition, there is also evidence that a woman taking birth control pills, will absorb alcohol faster, resulting in higher BAC levels.

Depressants

Alcohol

- Most people do not think of alcohol as a drug

- Medical consequences usually show up after years of heavy drinking

- Has a profound effect on the chemistry of emotions

- Increases the hazards of other drugs when used in combination, to include: more severe side effects, more frequent adverse effects, and diminished effectiveness of the medication

- Remains in the body for four or more hours, depending on amount ingested

- Can result in respiratory depression, cardiac irregularities, coma. Using marijuana with alcohol inhibits vomiting and can increase the likelihood of overdose

- Other causes of serious injury or death can result from aspiration of vomitus, accidents from impaired judgment and coordination, fighting resulting from disinhibitory effects and increased aggressiveness, and suicide resulting from increased impulsivity/or depression.

- Medical complications include cirrhosis of the liver, brain damage and hypertension are common with high dose/long term use. Poor nutrition and self-care can be see with advanced alcoholism.

Appeal of the Drug:
- anxiety reduction
- social lubrication
- disinhibition

Specific Effects:
- rapid tolerance
- sedation
- impaired concentration
- impaired coordination
- rapidly fluctuating moods
- disinhibition

Signs of Use:
Slurred speech; uncoordinated movements; unsteady gait; nystagmus; flushed face; aggressive and/or disinhibited behavior; rapid mood shifts; impaired judgment and/or functioning.

Withdrawal Symptoms:
A hangover is the withdrawal syndrome from acute ingestion of alcohol. Nausea, vomiting, malaise, weakness, autonomic hyperactivity, anxiety, depression, irritability, transient hallucinations or illusions, headache, insomnia, and possible delirium may appear within 24 hours after use has stopped and last 3-10 days in the case of long-term alcohol dependence.

Withdrawal from alcohol can also include: convulsions; delirium tremens (DT's) and hallucinations. Withdrawal from alcohol can be medically dangerous and produce serious medical complications, and detoxification procedures must be monitored because abrupt withdrawal can be life-threatening. Withdrawal for the alcohol dependent person can last well beyond the time for which medical supervision is necessary. Symptoms can last for weeks or months.

Opiates /Narcotics

- Includes pain medications such as morphine, Demerol, Dilaudid, Darvon, Percodan, Vicodin, codeine, as well as heroin and methadone.

- It is theorized that many addicts and alcoholics have problems in their natural pain-regulating mechanisms that leave them vulnerable to addictive disease.

- Routes of administration can be oral, IV, intranasal, or through inhalation.

- Users are more likely to die from overdose than from withdrawal.

Appeal of the Drug:

- reduced sensitivity to pain
- "rush" of the initial effect (euphoria)
- tranquility
- reduced anxiety

Signs of Use:

- Pupillary constriction or dilation
- drowsiness
- slurred speech
- impairment in attention or memory behavior that suggests euphoria followed by apathy, dysphoria, psychomotor retardation, impaired judgment, or impaired functioning may also be signs of use

Specific Effects:

- rapid tolerance
- reduced sensitivity to pain
- sedation
- reduced anxiety
- excessive dryness (constipation
- sluggish muscle tone
- low blood pressure
- slowed pulse
- cough suppression
- shallow breathing
- slowed motor response
- inability to focus thoughts
- euphoria
- apathy

Sedatives/Hypnotics/Anxiolytics

Sedatives sedate or calm.

Hypnotics induce sleep.

Anxiolytics reduce ongoing anxiety.

The most commonly prescribed and abused are benzodiazepines. These include: Valium; Librium; Dalmane; Halcion; Ativan; Klonipin; and Xanax. The BZs are chosen for anxiety reduction and as sleep aids because they are safer and more effective than other sedatives. Overdose is virtually impossible if these drugs are not mixed with alcohol: however, withdrawal must be carefully monitored because abrupt withdrawal can be life threatening.

Signs of Use:
Slurred speech, uncoordinated movements, unsteady gait, impaired judgment.

Withdrawal Symptoms:
(Noted after prolonged use--usually 90 days at low doses.) Symptoms include anxiety, restlessness, dysphoria, and muscle twitches. Withdrawal from high doses can include severe anxiety, tremors, sweating, agitation, psychosis or seizure.

Alcohol and Drug Overview

The DSM-IV presents 12 classes of psychoactive substances that can cause organic impairment. These include:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opiods
- Phencyclidine & related substances
- Sedatives/Hypnotics/Anxiolytics
- Other/Unknown

1) Depressants

Alcohol, Opioids, Sedatives, Hypnotics, Anxiolytics

These psychoactive drugs have a primarily *sedative* effect and a strong potential to create dependence. The effects are experienced as reduction in tension, disinhibition, relief from anxiety, reduced stimulation, calmness or tranquility Their primary hazards include respiratory depression, coma, and death by injury due to accident.

2) Stimulants

Amphetamines, Cocaine, Caffeine, Nicotine

The primary effect of these drugs is *excitation* or *arousal.* They have a strong potential to create dependence because of the transient sense of pleasure and reward they provide. They are experienced as focused thought processes, euphoric mood and increased energy. Their primary hazards to life include: convulsive seizure, cardiac arrest or death by injury (due to wildly reckless driving, paranoia, agitation, aggression and/or psychotic behavior.

3) Other Drugs

Cannabis, Hallucinogens, Phencyclidine (PCP), Inhalants, Other/Unknown

These drugs cannot easily be grouped into a depressant or stimulant class as they have some characteristics of each. Hallucinogens and PCP are sometimes called *psychedelics.* They produce perceptual distortion in the form of sensory illusions or hallucinations and increased awareness of internal and external stimuli. Hallucinogens do not create physical dependence or high levels of physical toxicity, whereas this does not appear to be the case with PCP. These drugs may induce or contribute to *panic attacks.* They may cause death through *loss of reality testing* due to sensory distortion (e.g., not responding to pain, "flying" out a window). PCP can result in death due to overdose or to an accident caused by loss of motor control.

INDICATORS OF DRUG USE

- Neglect of significant personal concerns such as health, hygiene, personal appearance, housing needs or nutritional needs. Weight loss, poor appetite or obvious dental decay may be seen. Neglect is the result of drug seeking behavior and mental deterioration.
- Inexplicable sudden changes in personality, for example the sudden onset of aggression and/or paranola.
- Acute changes in mental functioning, such as the onset of drowsiness, confusion or disorientation.
- Acute mood changes, including euphoria, depression or irritability.
- Recurring signs of drug withdrawal such as irritability, confusion, restlessness, tremor, sweating, cramps, and the complaint of 'aching bones.'
- Homelessness and itinerancy (frequent moving from place to place).
- Significant and repeated inconsistencies in statements to persons such as health care workers, and general lack of cooperation.
- The need to regularly take large amounts of benzodiazepine medication or other sedating medication.
- Attempts to manipulate health care workers with such talk as: "You know I need X and if I don't get X, I won't be able to control myself," etc.
- 'Track marks,' usually seen as longitudinal scars on the inside of the elbow areas, due to chronic intravenous drug use.

- Continued inability to provide identification.
- The complaint of insomnia, without obvious reason. Remember that marijuana abuse may be a possible cause of insomnia.
- 'Doctor shopping,' or the indiscriminate consultation of numerous doctors to obtain medication.
- Accusations of theft or confirmed involvement in crime to support a 'habit.'
- Denial of the problem may occur and should not be accepted if signs of drug use are present.

Other Drugs

Cannabis (Marijuana)

- Can be smoked in a pipe, rolled into cigarette paper or compressed into hashish or hashish oil.
- Comprised of about 400 chemicals, with the cannabinols (particularly delta-9 THC) and the cannabidiols creating the primary psychoactive effect.
- Potency is much higher than it was 10-20 years ago.
- Most of the marijuana in this country has a sedative effect and calms the user.
- Some users seek the dissociative effect of the drug—a feeling of distance from other people, which can make them feel safer in uncomfortable situations.
- The half-life of marijuana is eight days. It takes approximately two months to rid the body of all traces of the substance.
- Low doses result in impaired short-term memory.
- High doses result in: difficulty in concentration; difficulty managing emotions; amotivation; impaired ability to operate a car or other machinery; impaired job/school performance; distancing in relationships.

Appeal of the drug:

- dispels boredom
- narrows focus of concentration
- distorts time
- exaggerates the senses and emotions

- reduces anxiety
- dissociative effects

Specific Effects:
- decreases anxiety
- produces shifts in concentration
- produces a dissociative reaction
- alters perception of space and time
- alters judgment of speed and distance
- decreases motivation and concentration
- alters functioning of the hypothalamus and pituitary glands
- increases heart rate, decreases blood pressure
- lowers pressure within the eyes

Signs of Use:
Physical signs can include reddened eye, increased appetite, dry mouth, and rapid heart beat.

Withdrawal Symptoms:
Agitation, inability to concentrate, sleep problems, craving, decreased appetite, anxiety and discomfort around other people. Severity of symptoms depends upon the dose and length of use. For the average user, the symptoms are usually mild with a gradual onset because of the long-life of the drug. Users can rarely identify withdrawal symptoms due to marijuana because they often begin to occur several weeks after date of last use.

Hallucinogens, Phencyclidine (PCP), and Related Substance

- Primary effect involves changes in thought content, sensory perception and subjective emotional experience.

- Psychedelics cause intensified sensations, mixed-up sensations (synesthesia), illusions, delusions, hallucinations, stimulation, and impaired judgment and reasoning.

- The most commonly used psychedlics are: LSD, MDMA, PCP, peyote, and psilocybin mushrooms.

- PCP and Other Psychedelics: PCP, an animal tranquilizer causes mind-body distortions and a sensory deprived state.

- PCP has characteristics of depressants and stimulants.

- Easy and inexpensive to manufacture.

- Commonly mixed with other drugs and used as substitute for other chemicals without user's awareness.

- PCP is frequently found as adulterant for street drugs sold as LSD, Ecstasy, and/or THC.

- With repeated use the drug can be stored in the body for weeks or months beyond cessation of use.

- Higher doses can cause paralysis, loss of consciousness, amnesia, violence, and psychosis.

Appeal of the Drug:
- alters sensory input
- accentuates mood
- creates illusions
- synesthesia
- dissociative reaction
- loss of body and ego boundaries
- sense that mundane events aren't important
- sense of bonding and affiliation (ecstasy)

Specific Effects:
- tachycardia
- increased blood pressure
- increased body temperature
- pupil dilation
- visual illusions, perceptual changes
- emotional lability
- slowed time perception
- dissociative
- mild tolerance possible
-

Most Severe Hazards:
- panic reaction
- alters perception of time and space
- interferes with reflexes
- accidents common
- possible toxic psychosis
- drug-precipitated functional psychosis
- flashbacks

Signs of Use:

- Pupillary dilation; tachycardia; sweating; palpitations; blurred vision; tremors; uncoordinated movements
- Behaviors indicating marked depression or anxiety; ideas of reference; fear of "going crazy;" paranoid ideas; panic; impaired judgment and functioning
- Reports of perceptual changes: intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias, euphoria, mysticism or religiosity

Withdrawal Symptoms:
No physical dependence occurs with hallucinogens and no withdrawal syndrome has been documented, even after prolonged use of high doses.

Inhalants

- Includes volatile organic compounds such as: gasoline, glue, paint, cleaning agents, aerosol propellants, nitrous oxide (laughing gas) and amyl and butyl nitrate.

- Effects occur within 7-10 seconds and last no more than 30 minutes to one hour.

- Neurologic damage can include hearing and visual impairment, loss of coordination and memory, and learning disabilities. Mental impairment may be irreversible, though not usually progressive after abuse ceases.

- More users are preadolescents and young teens who do not have access to more "sophisticated" drugs, while others live in institutional settings or do not have enough money for other drugs.

- A common method of administration is to pour or spray the chemical onto a rag, place it over the nose and mouth, and inhale (huffing), or place in a plastic bag and inhale (bagging), or breathing in the inhalant directly from the container (sniffing).

Appeal of the drug:
- creates an intoxicated state
- effects are immediate and last from 5 to 45 minutes
- readily available through legal channels

Specific Effects (may vary depending on exact substance):
- mild intoxication
- possible hallucinations
- rapid onset of action
- create visual disturbances
- decrease appetite
- loss of memory

- unsteady gait

Most Severe Hazards:

- organ damage (including brain damage, liver damage, pancreatitis, kidney failure
- accidents, head trauma resulting from impaired judgment and coordination
- inflammation in joints, muscle weakness
- destroy red and white blood cells
- central nervous system depression or overstimulation
- cardiac arrhythmia (irregular heartbeat) and cardiac failure
- damage due to anoxia (lack of oxygen)

Signs of Use:

- rash around nose and mouth
- chemical breath, body odors
- residue
- red glassy watery eyes and dilated pupils
- slow, thick, slurred speech
- irritation of the throat/lungs/nose, nausea, headache
- dizziness
- nystagmus
- pains in chest and stomach
- fatigue
- staggering gait, disorientation, lack of coordination
- stupor
- euphoria
- belligerence
- assaultiveness
- impaired judgment and functioning

Reports of Drug Problems in Emergency Rooms (In many cases, more than one drug is found in incoming patients)	
DRUGS	**% of Patients Who Tested Positive**
1. Alcohol in combination with other drugs	32.6%
2. Cocaine	28.4%
3. Heroin/morphine, codeine, or other opioids	17.3%
4. Acetaminophen, aspirin, ibuprofen	13.9%
5. Benzodiazepines (Xanax, Valium, Ativan, Klonipin	10.4%
6. Antidepressants (Elavil, Prozac)	8.6%
7. Marijuana	8.6%
8. Methamphetamine/amphetamine	5.1%
9. Antihistamine	1.7%
10. OTC sleeping aids	1.3%

In some parts of the country, particularly San Francisco and on the West Coast, ER staff are seeing more and more Methamphetamine-Induced Psychosis.

Cocaine still causes the most deaths, although there has been an increase in deaths related to heroin overdose.

SUBSTANCE ABUSE AND BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE

Intoxication		Withdrawal States		Substance-Induced Paranoid Psychotic States	Substance-Induced Organic Brain Syndromes
High	Low	High	Low	High	High
Alcohol	Opiates	Alcohol	Opiates	Meth	Alcohol Withdrawal
PCP		Sedative		Cocaine	Sedative Withdrawal
Cocaine		Stimulants		PCP	PCP Intoxication
Meth					Inhalant Intoxication
Inhalants					Cocaine Intoxication
*LSD					Brain Injuries

Adapted from: Potter-Efron, R. & Potter-Efron, P. (eds.) 1990. Aggression, Family Violence and Chemical Dependency. New York: The Haworth Press.

Quick List - Substance Use Symptoms

SUBSTANCE	INTOXICATION SYMPTOMS	WITHDRAWAL SYMPTOMS
Depressants	slurred speech; incoordination; unsteady gait; impairment in attention or memory	nausea or vomiting; malaise or weakness; tachycardia; sweating; anxiety or irritability; hypotension; coarse tremor of hands, tongue, and eyelids; insomnia; grand mal seizures
Stimulants	euphoria; grandiosity; hypervigilance; fighting; pupillary dilation; elevated blood pressure; perspiration or chills; nausea or vomiting	severe depression; irritablity; anxiety; fatigue; insomnia or hypersomnia; psychomotor agitation; intense craving for the substance
Opiates and Analgesics	initial euphoria followed by apathy, dysphoria, psychomotor retardation; impaired judgment; pupillary constriction; drowsiness; slurred speech; impaired attention or memory	cravings for opiates; all symptoms of severe influenza
Cannabinols (Marijuana)	euphoria; feeling of relaxation; sleepiness; heightened sexual arousal; anxiety; suspiciousness or paranoid ideation; sensation of slowed time; inappropriate laughter; social withdrawal; impaired judgment; bloodshot eyes; increased appetite ("junk" food); tachycardia; dry mouth	marked anxiety; emotional lability; depersonalization; possible persecutory delusions

Hallucinogens	illusions; hallucinations (visual) synesthesia; euphoria; mystical or religious experiences; pupillary dilation; tachycardia; sweating; palpitations; blurring of vision; tremors; incoordination; Bad Trip: anxiety and depression; ideas of reference; fear of losing one's mind; paranoid ideation	no apparent withdrawal symptoms; delusional disorder may develop; mood disorder may develop; post-hallucinogen perception disorder may develop ("flash back")
Solvents/Inhalants	euphoria; giddiness; light-headedness; slurred speech; lethargy; depressed reflexes; tremor; blurred vision; stupor or coma; belligerence; assaultiveness; apathy; impaired judgment; dizziness; nystagmus; eye irritation; irriation of throat, lungs, and nose	same as with the Depressants
PCP	belligerence; assaultiveness; impulsiveness; unpredictability; psychomotor agitation; vertical and horizontal nystagmus; increased blood pressure and heart rate; numbness or diminished responsiveness to pain; ataxia; muscle rigidity and seizures; bizarre and violent behavior; paranoid ideation	similar to Hallucinogens

adapted from: Fauman, M., (1994). Study Guide to DSM-IV. Washington D.C.: American Psychiatric Press, Inc.

NOTES

Childhood Disorders

Childhood Disorders

Psychiatric Disorders in Children and Adolescents

- About 20% of US children and adolescents (15 million), ages 9-17, have a diagnosable psychiatric disorders.
- As reported in the Surgeon General's Conference on Children's Mental Health in January, 2001:
  1 One in ten children and adolescents suffer some mental illness severe enough to cause some level of impairment.
  2 It is estimated that fewer than one in five of these children receive needed treatment in any given year.

I. Social background

A. Barriers to treatment

1. Limited governmental funding directed toward child and adolescent mental health services.
2. Limited treatment services/programs.
   - Less mental health treatment services for children than for adults.
     In Portland, the number of psychiatric inpatient beds for:
     Adults=193
     Children and adolescents=52
3. Increasing number of child and adolescent patients.
   - At CTC, number of patients seen under 18:
     In 1997 = 360
     In 2000 = 1,492
4. Increasing demand for mental health professionals.
   - Children and adolescent patients may wait 6–8 weeks or longer for an appointment with a child and adolescent psychiatrist

B. Stigma

Parents may be fearful they may be blamed for their child's emotional and behavioral problems. Children are sometimes teased or directly stigmatized by classmates.

II. Common Disorders

Four disorders (ADHD, Oppositional-Defect Disorder, Conduct Disorder and Autism) have onset and are usually first diagnosed in childhood or Adolescence.

A. Disruptive Behavior Disorders

1. Attention-Deficit/Hyperactivity Disorder

- A disorder where an inappropriate degree of hyperactivity-impulsivity and/or inattention is exhibited.
- Some of the following symptoms must be present before age 7.
- More frequent in males than females.

- Prevalence – 3-5% in school aged children.
- Most commonly diagnosed disorder in child/adolescent psychiatry.
- Symptoms

  a. Inattention

  1. Often fails to give close attention to details, makes careless mistakes in schoolwork, or other activities.
  2. Often has difficulty sustaining attention in tasks or play activities.
  3. Often doesn't seem to listen when spoken to directly.
  4. Often doesn't follow through on instructions and fails to finish schoolwork or chores.
  5. Often has difficulty organizing tasks and activities.
  6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork, homework).
  7. Often loses things necessary for tasks and activities (e.g., toys, school assignments, pencils, books).
  8. Is often easily distracted by extraneous stimuli.
  9. Is often forgetful in daily activities.

  b. Hyperactivity:

  1. Fidgets with hands, squirms in seat.
  2. Often leaves seat (in classroom).
  3. Often runs about, climbs excessively in situations in which it is inappropriate (In adolescents may be limited to feelings of restlessness).
  4. Often has difficulty playing or engaging in leisure activities quietly.
  5. Is often "on the go" or acts as if "driven by a motor".
  6. Often talks excessively.

  c. Impulsivity:

  7. Often blurts out answers before questions have been completed.
  8. Often has difficulty awaiting turn.
  9. Often interrupts or intrudes upon others (e.g., butts into conversations or games).

- Associated disorders or symptoms

  Learning disorders.
  Oppositional Defiant Disorder-tantrums, bossiness, stubbornness, poor patience.
  Conduct Disorder-aggression.
  Mood disorders-poor self esteem, depression, rejection by peers, and conflict with family.

2. **Oppositional-Defiant Disorder**

- A disorder where children or adolescents display a pattern of openly uncooperative and negative, disobedient and hostile behavior.
- More prevalent in males than females before puberty; rates equal after puberty.
- Usually evident before age 8.
- Symptoms
  1. Often loses temper.
  2. Often argues with adults.
  3. Often actively defies or refuse to comply with adult's request or rules.
  4. Often deliberately annoys people.
  5. Often blames others for his/her mistakes or misbehavior.
  6. Is often touchy or easily annoyed by others.
  7. Is often angry or resentful.
  8. Is often spiteful or vindictive.
- Associated disorders or symptoms

  ADHD is common.
  Oppositional-defiant disorder can (but does not always) precede conduct disorder.
  Depression – low self-esteem.
  Substance abuse.

3. **Conduct Disorder**

- A disorder in which there is a repetitive and persistent pattern of the violation of the basic rights of others OR major age appropriate roles.
- More common in males than females.
- May begin in childhood or adolescence.
- Symptoms

  a. Aggression to people and animals
     1. Often bullies, threatens, intimidates others.
     2. Often initiates physical fights.
     3. Has used a weapon (e.g. bat, brick, broken bottle, knife, gun) that can cause serious physical harm.
     4. Has been physically cruel to people.
     5. Has been physical cruel to animals.
     6. Has stolen while confronting a victim (mugging, purse-snatching, extortion, bank robbery).
     7. Has forced someone into sexual activity.

b. Destruction of property
   8. Has deliberately engaged in fire setting with intention of causing serious damage.
   9. Has deliberately destroyed others' property.

c. Deceitfulness or theft
   10. Has broken into someone else's house, building, car.
   11. Often lies to obtain goods/favors or avoid obligations.
   12. Has stolen items of nontrivial value without confrontation of a victim (e.g. shoplifting, forgery).

d. Serious violation of rules
   13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
   14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
   15. Often truant from school, beginning before age 13 years.

- Associated disorders or symptoms
  ADHD.
  ODD (may precede CD) –temper outbursts, poor frustration tolerance.
  Depression – low self-esteem, irritability.
  Substance abuse.

- **Police response to children and adolescents with a disruptive behavior disorder (ADHD, ODD, CD)**
  a. Usually police come into contact with these children or adolescents because of their anger outbursts or physical and/or verbal threats of harm.
  b. They may be argumentative or minimize problem behaviors.
  c. Direct questioning with authoritative approach.
  d. Obtain and carefully consider information provided by adult witnesses.
  e. Inquire whether the child is in current mental health treatment and (if applicable) taking medications.

B. Autistic Disorder (to be covered in Developmental Disability section)

- A disorder characterized by patterns of delay and impairment in the development of social interaction and communication and the development of restricted interests and activities.
- Onset is prior to age 3 years.
- 3 to 4 times more common in males.
- Coexistent disorders or symptoms
  Mental retardation 20% have normal IQ.
  30% have mild to moderate mental retardation.
  50% have severe or profound mental retardation.

ADHD – disruptive, impulsive.
Self-injury (e.g., head banging).
Obsessive – compulsive disorder – compulsive, repetitive behaviors.

- **Police response to children and adolescents with Autistic Disorders.**
  a. Usually police come into contact with these children because of self-injury, impulsive behaviors or anger outbursts.
  b. These children are unlikely to make eye contact or communicate/answer any questions.
  c. Obtain as much information from adult witnesses, parents or guardian.
  d. These children do not do well with change. If they have an attachment to an object, consider letting them hold on to it.

C. Anxiety Disorders

- The most common mental health problem that occurs in children and adolescents.
- According to one large-scale study of 9-17 year olds, as many as 13% had an anxiety disorder in a year.
- Common anxiety disorders

1. Phobias

- Excessive or unreasonable marked and persistent fear of a specific object or situation or fear of a social or performance situation where the person is exposed to scrutiny and fears embarrassment.
- Exposure to that object or situation causes an immediate anxiety response. In children, anxiety may be expressed by crying, tantruming, freezing or clinging.
- In children, most common fears-fear of dark, fear of harm to an attachment figure; fear of animals.
- In adolescents – fear of heights, fear of public speaking.

2. Generalized Anxiety Disorder

- A disorder characterized by excessive anxiety and worry, where the individual finds it difficult to control the worry.
- Most common in middle childhood.
- Symptoms (only one required for children): Restlessness or feeling keyed up or on edge, being easily fatigued; difficulty concentrating or mind going blank, irritability, muscle tension, or sleep disturbance.

3. Panic Disorder

- A disorder characterized by recurrent, unexpected panic attacks.
- Panic attacks are discrete periods of intense fear or discomfort in which symptoms develop abruptly and reach a peak within 10 minutes.

- Symptoms include palpitations, sweating, trembling, shortness or breath, feeling of choking, chest pain, nausea, dizziness, derealization or depersonalization, fear of losing control or fear of dying.
- Uncommon before puberty.
- Usually begins in adolescence or early adulthood.

4. **Obsessive-Compulsive Disorder**
   - A disorder characterized by recurrent obsessions or compulsions that cause distress, are time consuming, or interfere with individual's functioning.
   - Majority of children and adolescents have both obsessions and compulsions.
   - Mean age of onset = 10 years.
   - Obsessions: Recurrent or persistent thoughts, impulses or images that are experienced as intensive and inappropriate, cause marked anxiety or distress and are not simply excessive worries about real-life problems.
   - Compulsions: Repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession. The behaviors or mental acts are aimed at preventing or reducing distress.
   - Most common symptoms of OCD in childhood are obsessive contamination fears accompanied by compulsive washing and avoidance of contaminated objects.
5. **Post-traumatic Stress Disorders**. (will be covered in PTSD section)
   - Disorder where child/adolescent has been exposed to a traumatic event, where they experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury or threat of physical harm to self or others. The individual's response involved intense fear, helplessness or horror (in children this may be expressed by disorganized or agitated behaviors).
   - Symptoms

     Re-experiencing – In children, nightmares or repetitive play or drawings in which themes or aspects of trauma are expressed.
     Avoidance-of reminders of the event and numbing of general Responsiveness.
     Increased arousal – difficulty sleeping is common in children.

   - In general, girls are more symptomatic than boys.
   - Common traumatic events- Domestic violence, natural disaster, shootings.
   - Younger children have more avoidant symptoms; older children have more re-experiencing and increased arousal.

- **Police response to children or adolescents with anxiety disorders**
  a. Usually police come into contact with these children because of "out-of-control behavior" related to intense anxiety.
  b. Be reassuring, speak slowly and calmly.
  c. Give the child time to relax.
  d. Most of these children want relief and will accept help.
  e. Allow them to be in the company of someone familiar as you are questioning them.
  f. Suicide risk is increased with anxiety.

D. Mood Disorders

1. **Bipolar Disorder** – (covered in Overview of Mental Illness)
   - Mood disorder where there is or has been a manic episode.
   - In children and adolescents, irritability more common than euphoria
   - Most common symptoms
     High activity level; rapid speech; highly distractible; racing thoughts; hypersexuality (in children-profanity, sexual comments, masturbation; in adolescents-increased sexual activity); and risk taking (in children, fighting; in adolescents, wild driving).
   - First episode may be mania or depression.
   - 20-30% of youth with major depression go on to have manic episodes.
2. **Major Depression** (covered in Overview of Mental Illness)
   - Mood disorder characterized by depression or irritability (irritability is more common).
   - Common symptoms in children
     Anxiety – phobias.
     Somatic complaints – headaches and/or stomachaches.
     Behavioral problems- temper tantrums.
     Sleep/appetite disturbance.
     Suicidal thoughts or attempts.

- **Police response to children and adolescents with mood disorders**
  a. Usually police will come in contact with these children/adolescents because of dangerous behaviors to self/others.
  b. The manic child/adolescent may be speaking rapidly or make no sense.
  c. The depressed child/adolescent may be irritable, tearful or speak little.

d. Risk for suicide in both disorders. (In mania, may be more in form of self-endangering behaviors).
e. Consider strongly information provided by witness even if child/adolescent denying further suicidal thoughts.
f. Inquire whether child/adolescent is in current mental health treatment or on medication.

E. **Schizophrenia** (covered in Overview of Mental Illness)

- Disorder characterized by psychotic symptoms (hallucinations, delusions, illogical thinking).
- Onset most typically in the adolescent.
- Onset in childhood extremely uncommon and has relatively poor outcome.
- In childhood, auditory hallucinations may include command hallucinations or commenting about the child. May have to do with monsters. Magical thinking is common.
- Childhood schizophrenia occurs predominantly in males.

- **Police response to child/adolescent with schizophrenia**:
  a. Usually will come in contact with these adolescents because of odd or agitated behavior.
  b. These children/adolescents may be paranoid of the police.
  c. Reassure them you want to help, you do not want them harmed and will do all you can to keep them safe.
  d. They may become combative.
  e. They may be talking to themselves. Don't challenge nor accept their delusions, just listen matter-of-factly.

B. Legal Issues

1. Consent to psychiatric or chemical dependency treatment.
   In Oregon a minor 14 years or older may consent for their own mental health, alcohol or drug treatment, excluding methadone. Parent/guardian can be advised of treatment when disclosure is clinically appropriate and serves the best interest of the minor.
2. Drug Testing
   A child under 14 can be tested without their knowledge or consent.
3. Parental rights
   An order of sole custody of a child to one parent does not deprive the non-custodial parent of authorizing medical treatment for their child. Only terminated parental rights by a court order denies the parent of the ability to authorize treatment for their child.

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
    - I won't be here.
    - You won't have to deal with me.
    - You'd be better off without me.
    - Life is meaningless.
    - Death is probably a solution to my problems.
    - Would you miss me if something happened to me?
    - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
    - reckless driving, skating, bike-riding, swimming alone
    - drug-experimentation
    - sexual promiscuity
    - fighting, baiting others towards physical confrontation
    - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

NOTES

Autism

Autism & Law Enforcement Roll Call Briefing Handout, (Debbaudt, 2005)

NOTE: This handout supplements information contained in the Autism & Law Enforcement Roll Call Briefing Video.

The video and handout were designed to bring you a basic understanding of children and adults who have Autism and Aspergers Syndrome when you meet them in field situations.

Patrol in the 21st century is very diverse duty. People with autism are part of that diversity. Autism is America's fastest growing developmental disability. The rate of autism has seen a ten-fold increase. Autism is estimated to affect as many as one in every 166 children (CDC-NCBDDD, 2004).

Research indicates that people, who have developmental disabilities, including autism, will have up to seven times more contacts with police than a member of the general public. (Curry et al, 1993)

Definition:

Autism is a neurologically based developmental disability that seriously affects a person's ability to communicate, socialize, and make judgments. Autism also affects the person's sensory responses to even normal levels of lights, sounds, touches, odors, and tastes. It is typically observed by age three, and is more common in males than females. It is not caused by the way parents raise their children. Despite ongoing research, there is no known cause or cure, although people with autism can make remarkable gains.

Autism is referred to as a spectrum disorder. It affects each person differently and ranges from mild to severe. Other terms for autism may include: Asperger Syndrome, High Functioning Autism or Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). Parents and professionals have learned through experience and education how to recognize the common traits of autism. No one expects a responding officer to be able to diagnose autism, but here are some diagnostic behaviors and characteristics you may observe:

- Autism may or may not be physically obvious; there may be no particular physical marker
- Be non-verbal or have limited speech
- Avoid eye contact
- Prefer to be alone
- Lack fear of real danger
- Apparent insensitivity or high tolerance for pain
- Have difficulty in expressing needs; does not use gestures
- Unusual responses to lights, sounds, or other sensory input
- Seek sensory stimulation, including heavy pressure
- Have difficulty interacting with others
- Avoidance of touch
- Sustained unusual repetitive actions
- Inappropriate laughing or giggling
- Inappropriate attachment to objects

- Spin or twirl objects and exhibit finger, arm, or wrist flicking
- If verbal, may have trouble with correct speech volume (i.e., loud to whisper, and/or monotone, computer-like vocal intonation)
- Appear as if deaf, cover their ears and look away
- Display clumsiness, toe-walk or have difficulty running
- Rock back and forth
- Talk to themselves or no one in particular
- Echo words and phrases
- Display fascination with water, lights, reflections and shiny objects

Wandering and Autism

As with the Alzheimer's patient, children and adults with autism may wander away from caregivers.

Missing Persons

Child or adult has wandered away from parent or caregiver at home or school:

- The person may also wander into traffic or attempt to enter nearby homes or dwellings
- Search nearby water sources
- Encourage families to provide key information to the 911 database
- Recommend a good locksmith, burglar alarm company, or electronic alert system

Other Common Reasons for Autism Related Contacts or 911 Calls

Parent or caregiver actions are misinterpreted or appear as assault. Person displays unusual behavior in community setting where they are not known. These behaviors may be interpreted by others as suspicious, threatening, criminal in nature, or as someone high on drugs or other substances. Unaware of the person's autism, citizens will call 911. Rearranging or making order out of store displays or products may appear as shoplifting. The person may display escalated behavior in the community, at school, or at home. Escalated behavior may be in the form of rocking, pacing, grunting, noisemaking, utterances, running into walls, head banging or hiding under mattresses or other large objects. These behaviors may be a form of self-stimulation or a sensory reaction to objects and influences in the environment.

Communication, Behavior, and Responding to the Call

The behaviors that children and adults with autism display will challenge your training and instincts. Behaviors, as seen in the video, draw attention, may seem suspicious, and will result in increased 911 calls.

Understand that the individual with autism:

- May inappropriately approach or run towards officers
- In emergencies, may flail against medical procedures; may attempt to re-enter dangerous environment (i.e., a burning home, flee into traffic, or touch a downed power line)
- May be non-verbal. About 50% of this population is non-verbal
- Can become upset with changes in routine for apparently trivial reasons
- May not recognize your uniform or marked vehicle, or understand what is expected of them if they do
- May not understand your verbal commands or use of slang expressions
- May not understand your command presence, body language and non-verbal communications, such as rolling of eyes, raising of eyebrows, shrugs, or hand signals
- People with autism may be attracted to shiny objects and actually reach for your badge, radio, keys, belt buckle, or weapon
- May display repetitive, self-stimulation behaviors, such as twirling an object or themselves, finger or hand flicking, body rocking, pacing, or talking to themselves
- Sensory overload may cause flight from lights, sirens, canine partners, aromas or even a light, comforting touch
- Be aware that your attempts to stop these behaviors may result with the person's escalated, self-protective actions, such as a "fight or flight" reaction

Response

You may learn the person has autism from your dispatcher, someone at the scene, or the person himself or herself. Here are some tips for responding officers:

- Make sure the person is unarmed and maintain a safe distance because they may suddenly invade your personal space
- Talk calmly and softly
- Speak in direct, short phrases such as: "Stand up now." or "Go to the car."
- Avoid figurative expressions, such as: "What's up your sleeve?" or "Are you pulling my leg?"
- Allow for delayed responses to your questions or commands
- Repeat and/or rephrase
- Consider use of pictures, written phrases and commands, and sign language
- Use low gestures for attention; avoid rapid pointing or waving
- Examine for presence of medical alert jewelry or tags, or an autism handout card
- Model calming body language (such as slow breathing and keeping hands low)
- Model the behavior you want the person to display

De-escalation

You may be called to respond to a situation where the person with autism is displaying escalated behavior that has alarmed a citizen or is apparently beyond the control of the parent or caregiver.These calls will challenge the training and instincts of even the most experienced veteran.

Consider:

•A person may not react well to changes in routine or the presence of uniformed strangers
• Person may display "fight or flight" reaction when approached
• Officers should not interpret the person's failure to respond to orders or questions as a lack of cooperation or a reason for increased force
• Seek information and assistance from parent or others at the scene about how to communicate with and de-escalate the persons behavior
• Avoid stopping repetitive behaviors unless there is risk of injury to yourself or others. If the individual is holding and appears to be fascinated with an inanimate object, consider allowing subject to hold the item for the calming effect (if officer safety is not jeopardized by doing so)
• Be aware of person's self-protective responses and sensitivities to even usual lights, sounds, touches, orders, and animals
• If possible, turn off sirens and flashing lights and remove canine partners, crowds, or other sensory stimulation from the scene
• Evaluate for injury: the person may not ask for help or show any indications of pain, even though injury seems apparent
• Examine for presence of medical alert jewelry or tag
• Be aware that the person may be having a seizure
• If the person's behavior escalates, use geographic containment and maintain a safe distance until any inappropriate behaviors lessen
• Remain alert to the possibility of outbursts or impulsive acts
• Use your discretion. If you have determined that the person is unarmed and have established geographic containment, use the available time to allow the person to de-escalate themselves without your intervention
• Use of pepper spray may heighten sensory reaction and escalated behavior

Restraint

Despite your best efforts, you may have to restrain the person with autism and take them into custody. You may be responding to a public safety emergency, or a criminal justice situation. These are the highest risk situations for officers.

Be aware of the following when using standard force or restraint techniques:

• People with autism may have under-developed trunk muscles-hypotonia-and may not be able to support their airway
• After takedown, avoid positional asphyxia. Turn person on their side often to allow normal breathing to occur
• Monitor the person's condition frequently to prevent further trauma or injury
• People with autism may have seizures. Up to 40% of this population has some form of seizure disorder
• Asthma and heart conditions are also common. Be aware of associated medical conditions and medication requirements
• The person may not recognize the futility of resistance and continue to struggle. Continue to use communication, de-escalation, and calming response techniques
• For officer safety, avoid standing too near or behind. The person may suddenly lurch backward

Arrest

You may have a person with autism in custody that you have arrested or will be committed involuntarily to a mental health facility.
Document autism in your initial report.
Consider a medical evaluation.

Alert jail authorities and suggest an isolation facility. A person with autism would be at extreme risk in the general prison population.

Whenever possible, contact parents or caregivers.

Interview

The person with autism will have difficulty processing your questions. They may be unable to give name, address, phone number, or be unable to present ID when asked. Expect your interview to take longer. The person may have the information you need. However, they may be difficult to understand.

It is common for people with autism to repeat your words and phrases. This is known as *echolalia*. Be aware that a person with autism may also model your body language and emotional state.

Here are some tips for interviewing a person with autism:

• Do not take a lack of eye contact, the changing of subjects, or answers that are vague, evasive or blunt as evidence of guilty knowledge
• The person may truly not understand Miranda warnings even when they say they do

• To avoid confusion, ask questions that rely on narrative responses
• Consider asking a series of unrelated "yes" or "no" questions to determine the style and dependability of the response
• If you have learned that the person has autism or Asperger Syndrome, prior to questioning, consider contacting a specialist familiar with these conditions

With their unusual responses to your questions, the person with autism may challenge all of your training. Follow procedure, but also follow your gut instincts if you feel something isn't quite right with the subject of your investigation. As in the old adage: if the statement or confession is "too good to be true," it probably is.

Victims

People with autism are oftentimes victims of crime, such as: sexual, verbal or physical assault. This can occur anywhere. Investigators can overcome the communication barriers of interviewing the person with autism when they become familiar with the person's communication style and background. Review fresh records and interview others who know the person well. Ask parents, caregivers, and people who know the victim for tips about how the person gives and receives information. If not verbal, how do they communicate?

Further:

• Seek permission to and consider videotaping the interview
• Consider having a person the victim trusts present at the interview
• Avoid uniforms or authority clothing
• Get to know the person's communication style through casual conversation before any attempt to get recollection of event
• Plan questioning based on person's ability level
• Develop good rapport; use person's first name
• Use simple, direct language and deal with one issue at a time
• Get the witness to recreate the context in his or her own words-ask questions that require a narrative answer
• Make sure your words and their words have meanings that you both understand to be the same
• Make sure that you and the victim-witness understand who is being referred to when using pronouns
• Be alert to non-verbal cues that suggest the witness does not understand, is confused, or does not agree with the question you asked or the statements you have made (i.e., restlessness, frowning, and extremely long pauses)
• The victim may not want to answer questions more than once (explain first that you may have to ask questions more than once)
• Let victim know it is OK to say "no" to your questions

- Become convinced the person understands or is known to tell the truth
- Avoid leading questions
- Carefully establish timelines
- Learn person's schedule and determine events through this context, rather than asking, "What time did it happen?"
- Person may have short attention span. Consider several short interviews
- Be alert to a spontaneous disclosure of evidence. (Farrar, 1996)

Community Policing Options:

For officer safety and to reduce liability, create opportunities to meet people who have autism, their families, and support organizations.

911 data base red flag alert programs can provide key information for a safe, successful resolution to a contact with an individual with autism. Consider proactively offering the 911 database as an option to parents and care providers

Seek opportunities to visit schools, work and recreation facilities, and the homes where people with autism live. Invite people with autism, their families, advocates, and supporters to visit your stations and participate in law enforcement events. This can enhance officer education in the areas of recognition and response to the vulnerable person who has autism and enhance citizen education of the roles and responsibilities of law enforcement professionals. Officers and persons with autism can learn from each other during these controlled, safe, and non-stressful interactions

Applying skills, tolerance, and public relations when interacting with children and adults who have autism, their families, care providers, and supporters are the best approaches to ensure officer and citizen safety, make the best use of your valuable time and resources, and avoid litigation.

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For referral to a local autism advocacy organization, E-mail ddpi@flash.net
For video inquiries and further information, contact:
Dennis Debbaudt at 772-398-9756 (son with autism may answer phone)

Person-Specific Checklist for 911 Systems, First-Responders,and Emergency Room Staff

Name of child or adult

Current photograph and physical description including height, weight, eye and hair color, any scars or other identifying marks

Names, home, cell and pager phone numbers and addresses of parents or caregivers and emergency contact persons

Sensory, medical, or dietary issues, if any

Inclination for elopement and any atypical behaviors or characteristics that may attract attention

Favorite attractions and locations where person may be found

Likes, dislikes--approach and de-escalation techniques

Method of communication, if non-verbal - sign language, picture boards, written word

ID wear - jewelry, tags, on clothes, nonpermanent tattoo

Map and address guide to nearby properties with water sources and dangerous locations highlighted

Blueprint or drawing of home, with bedrooms of individual highlighted
(From *Autism, Advocates and Law Enforcement Professionals*, Dennis Debbaudt, 2003)

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http://policeandautism.cjb.net/

Personality Disorders

PERSONALITY DISORDERS

Personality Disorders:

Diagnosis, Profiling and Relation to Crime

Katherine Gotch, MA
Clinical Coordinator
Sex Offender Unit

1

Training Overview

- A review of how a personality disorder is diagnosed
- A review of significant personality disorders likely to be encountered by people working in criminal justice
- The relationship of personality disorders to crime

2

DSM-IV Five Axis System

- Axis I: Clinical Disorders (mental health = meds)
- Axis II: Personality Disorders & MR/DD (= no meds)
- Axis III: General Medical Conditions
- Axis IV: Psychosocial/ Environmental Problems
- Axis V: Global Assessment of Functioning 0-100

3

Facts About Personality Disorders

- Person experiences life differently from that of the general population.
- The diagnosis is meant to tell us "how bad" things are and act as a guide for interventions.
- The main weakness is that they do not discriminate within the diagnosis (e.g. chronic petty thief and serial killer get same diagnosis)

4

What is a personality disorder?

How It Is Diagnosed

- Onset in adolescence/ early adulthood
- Pervasive, Rigid and Inflexible
  - Social, Work, Relationships, Life Skills
- Stable over time
- Leads to distress or impairment:
  Thinking/perception, feeling, impulse control, behavior

5

Facts About Personality Disorders

- Different personality disorders share similar traits:
  - Egotism: e.g. blame others for their problems
  - Impulsivity
  - Poor interpersonal relationships
  - Risk for violence
  - Poor Insight and problems self-correcting
- All personality disorders have distinguishing features:
  - E.G. the dramatic attention-seeking of Histrionic PD

6

Facts About Personality Disorders

- A person can have *more than one* personality disorder (e.g. Antisocial and Narcissistic)
- A person can have *traits* of more than one PD
  (e.g. PDNOS: Personality Disorder Not Otherwise Specified, with...)
- A person can have traits without the full personality disorder diagnosis
  (e.g. "Borderline Personality Organized" or "Antisocial Traits")

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WARNING!

DO NOT FREAK OUT!

8

Multiple Diagnosis

- The Possibilities Are Endless!:
  - Emotional Disorders (e.g. depression) AND
  - Psychotic Disorder (e.g. schizophrenia) AND
  - Personality Disorders (e.g. Antisocial PD) AND
  - Substance Dependence (e.g. methamphetamine)
- In general, the more diagnoses the person has, the worse the prognosis and the more bizarre the behavior (e.g. fire-setting for sexual pleasure).

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Multiple Diagnosis: Mental Illness & PD's

Sex offender sought; made death threats

The Multnomah County Sheriffs' Office is looking for a convicted sex offender who is considered armed and extremely dangerous.

Lt. Michael Shults, a sheriff's spokesman, said 31-year-old William Croskrey made death threats to his parole officer and had been seen recently in downtown Portland and in the Gresham area.

Shults said Croskrey was convicted of two counts of attempted first-degree sex abuse in 2001. He said Croskrey targets boys and girls ages 4 to 8, prostitutes, mentally disabled women and girls and often takes advantage of adults.

As part of probation, Croskrey is forbidden to

CROSKREY
Police say children at risk

DSM-IV Personality Disorder Clusters

- Cluster A: Mature or "Odd" Type
- Cluster B: Immature Type
- Cluster C: Anxious Type

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DSM-IV PERSONALITY DISORDERS

Cluster A: Mature Type

SOME CORRELATION WITH CRIMINAL BEHAVIOR

Paranoid

Schizoid

Schizotypal

12

DSM-IV PERSONALITY DISORDERS (cont.)

Cluster B: Immature Type

THE HIGHEST CORRELATION WITH CRIMINAL BEHAVIOR

Antisocial

Narcissistic

Borderline

Histrionic

13

DSM-IV PERSONALITY DISORDER (Cont.)

Cluster C: "Anxious or fearful"

THE LOWEST CORRELATION WITH CRIMINAL BEHAVIOR

Avoidant

Dependant

Obsessive-Compulsive

14

How Can You Tell?
Signs of a Personality Disorder

- Perpetual and repetitive conflicts/ confusion in relating to others
- Deceitfulness/ manipulation in relating to you
- Feel confused/ crazy when you are around them
- Consistent feelings of annoyance/ irritation
- People generally insult them when referring to them (e.g. "asshole, jerk, idiot, creep, bitch.")

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PRACTICAL APPLICATION: Where would you get the info?

- Psych reports, chronos, a review of their criminal history and crimes (motivations: predatory, fun, sadistic, reactive)
- PPB keeps seeing the same person over and over
- Primary symptoms during a face to face interaction:
  - What they say (content and themes)
  - How they say it (emotions or lack thereof)
  - Emotional response to their crimes (justify? remorse? pride?)
  - Crime scene itself/ Behaviors (e.g. overkill)

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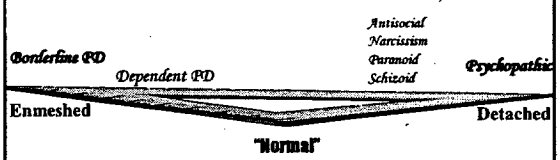
Attachment: "Normal" & Pathological



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PRACTICAL APPLICATION: Why Attachment Matters...

- Degree of attachment tells you:
  - What to expect from the person
  - What risk they pose to you as an officer
  - How to approach the person
  - How to verbally "disarm" the person
  - How to interact when interviewing/ interrogating

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Signs of Detachment: *TAKING*

- Exploitation of others (e.g. pimping, living off others, assaults, stealing from loved ones)
- Lack of negative emotions when separating
- Multiple & severe violent acts in love relationships
- Lack of remorse/ guilt for harmful behavior
- Cannot describe social emotions (love)

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Signs of Over-Attachment: *TAKEN CARE OF*

- Crisis when separated from the person they "care" about ("can't live without them")
- Overly intense relationships
- Fear of abandonment and pathological jealousy
- Use of power and control tactics in an effort to keep the person

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Practical Application for Law Enforcement

- PD's tell us something about what type of crimes they are likely to commit
- Crime scenes/ criminal history and types of crimes tell us something about a person's PD
- Interviews/ Interactions can be structured or altered to optimize information gathering from a specific PD

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PRACTICAL APPLICATION:
All PD's Increase Risk for Violence

- Impulsivity
- Low frustration tolerance
- Reactive to criticism (unstable narcissism)
- Repetitive antisocial acts
- Egocentricity & entitlement
- Poor attachments/ dehumanizing others
- Poor insight/ glibness
- Suspiciousness about motives of others

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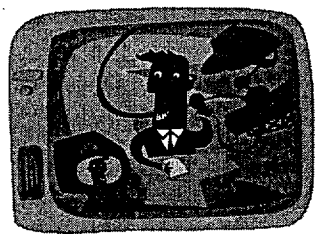
Where to find them...



Channel 11

Personality Disorder Television

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The Personality Disorders

Significant PD's and their relation to crime

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CLUSTER A

Suspicious, Odd & Eccentric

25

Paranoid PD

- Diagnosis: Must have 4 or more of the following:
  - Suspicious without sufficient basis
  - Preoccupied with unjustified doubts about friends, family.
  - Reluctant to confide in others b/c of unwarranted fear
  - Reads hidden demeaning/threatening messages into benign remarks
  - Persistently bears grudges
  - Perceives attacks on his/her character
  - Recurrent suspicions of infidelity by spouse

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Paranoid Personality Disorder

- Main Trait: Suspiciousness, Mistrust
- View of World: Dangerous
- View of Self: Mistreated
- View of Others: Malevolent
- Deal with World by: Secretiveness
- Attitudes: "You can't trust anyone." I must protect myself."
- E.G.: Columbine shooters, spree killers, Sipowitz in NYPD blue

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Paranoid PD

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Paranoid Personality Disorder

- *Differs from schizophrenia/ delusional thought through bizarre content of thought:*

PD: "I don't talk about personal information to anyone because the federal government could use it to charge me for crimes I didn't commit."

Delusional: "Democracy is the road to Socialism, and Socialism is Communism in a hurry... I'm against democracy – I'm a republican."

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Paranoid PD Crimes & Interviewing

- Violent crimes, including pre-emptive strikes and reactive violence.
- Motive: To reduce or eliminate the perceived threat; revenge; fear-anger often present.
- Approach: honest and direct; unemotional; disarm and give space; "give the rope;" expect resistance

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Giving the Rope

- HIM: "I'm going to sue you...you should have legal present with you right now."
- ME: "Well I don't, so why don't you talk about what you want to."
- HIM: "...You are my enemy (i.e. work for the county). We are in a war of attrition...You are the son of Satan in my eyes."

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Avoidant & Schizoid PD

- Difference is: Avoidant people want relationships but are afraid, Schizoids do not want relationships and have shallow emotional responses.
- Loners: they avoid contact with other people, often mistaken as being depressed or traumatized
- Significant signs of Schizoid:
  - Have very secretive lives
  - Poor relationship skills
  - Explosive, "temper tantrums"

32

SCHIZOID PD

- Must have four of the seven:
  - Neither desires nor enjoys close relationships
  - Always chooses solitary activities
  - Little interest in sex
  - Little pleasure in activities
  - Lacks close friends or confidants
  - Indifferent to praise/ criticism
  - Emotionally cold, detached, flat

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Schizoid

- Main Trait: Indifference toward others
- View of World: Uninteresting
- View of Themselves: Self-sufficient
- View of Others: Impersonal/ Blank/ Cold
- Deal with World through: Solitude
- Attitudes: "No big deal," "Who Cares"
- E.G.: The Unabomber, Panty Thief

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Schizoid

"I don't go looking for relationships...I don't need the drama and the bullshit...I've got enough of my own bullshit to deal with."

35

Avoidant

"I've never been very good at relationships...I always seem to fuck them up."

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Schizoid PD Crimes

- Crimes: Reactive violence when people intrude; Exploitive and sadistic crimes
- Approach: direct and unemotional; a difficult interview because they usually adhere to secretive, withholding and guarded style; may try to use "shock" to get you to back off.

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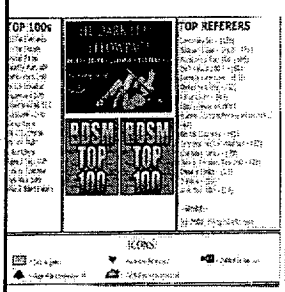
Schizoid Sexual Sadist?



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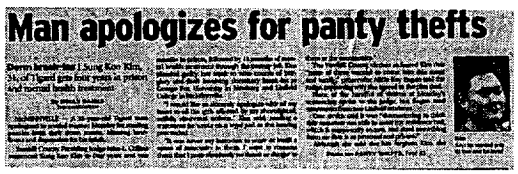
I'm Sorry...

- "It was never my intention to scare or instill a sense of insecurity in them..."
- Blamed loneliness and depression for the fetish


Man apologizes for panty thefts

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But what about...?

- Stealing 3,000 pair of panties
- Over 40,000 images on his computer of women being tortured, raped, eviscerated and mutilated
- Links to websites like: asphyxiation2, stranguling_whores, necrofeat, realcorpsephotos, femalestrangulation, facesofdeathfanclub, corpseoftheweek
- A document entitled OSU which was a list of steps of how to torture and murder women
- Computer searches of women on the OSU swim team

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Schizotypal PD

- Must have 5 of the 6:
  - Magical Thinking that borders on delusional
  - Person is reality based (e.g. knows date, time, place, etc.)
  - Unusual perceptual experiences, illusions, odd speech
  - Lack of close friends, except other eccentrics
  - Odd, eccentric, peculiar
  - Excessive social anxiety, paranoia, does not fit in

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Schizotypal?

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Schizotypal

- Main Trait: Eccentric
- View of the World: Fascinating
- View of Themselves: Gifted, Insightful, Perceptive
- View of Others: Ordinary
- Deal with the World by: eccentric, grandiose ideas or plans
- E.G.: James Huberty, Kramer (Seinfeld), Phoebe (friends), Andy Kaufman

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Schizotypal

"I believe that we were placed here on this planet by aliens...it says so in the bible...THINE kingdom come, THINE will be done...and I believe they will come back to this planet and save us...No, I have never had communications with aliens."

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Schizotypal PD

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Schizotypal PD Crimes

- Crimes: may seem like a motiveless, but it is usually a vendetta/resentments against society/ victims because of sense of isolation/ feeling like they don't fit in (i.e. blames others for this)
- Approach: Nonjudgmental; connection through understanding strange beliefs (i.e. there is narcissism involved)

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Cluster C

Obsessive/Compulsive

47

Obsessive-Compulsive DO

- Must have four of the eight:
  - Preoccupied with details, rules, lists
  - Perfectionism that interferes with task completion
  - Can't discard/ Excessively devoted to a few things (addiction, killing)
  - Addictive/ compulsive tendencies: low restraint
  - Rigid and stubborn
  - Overcontientious/ inflexible
  - Miserly (tendency to hoard)
  - Reluctant to delegate tasks: must control

48

Good Obsessive-Compulsive DO

- My "friend" and colleague Rick (like you?):
  - Organizes my desk when he comes into my office
  - Diligently pursues criminals
  - No mistakes on his written work
  - Puts bad people back in jail and prison

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Bad Obsessive-Compulsive PD

Dean Schwartzmiller, child molestor

Chilling, handwritten lists of more than 36,000 suspected sex acts with boys has led investigators to what may be the most extensive case of child molestation in U.S. history.

The lists, written in loopy cursive on 1,350 pages in seven multicolored, spiral-bound notebooks, have names and apparent codes for various sex acts, according to San Jose police. They were found last month in the San Jose home of convicted child molester Dean Arthur Schwartzmiller, 63, who is now in jail on felony molestation charges involving two local 12-year-old boys.

"If any of these numbers are even close to accurate, then it is one of the most significant child molestation finds that we have ever encountered," said San Jose Police Lt. Scott Cornfield, who called the case "horrendous."

Headings for the grim logs include "Blond Boys," "Cute Boys," "Boys who say no," and boys by specific sex act, Cornfield said.

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Obsessive-Compulsive DO

- Main Trait: Rigidity
- View of World: Contaminated
- View of Themselves: Righteous
- View of Others: Lax or Lazy
- Deal with the World by: Control
- E.G.: Timothy McVeigh, Monica (Friends), Agent Smith (Matrix), Niles (Frazier), David Fisher (Six Feet Under)

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OCPD

"I've spent my entire life thinking about and using sex to deal with my problems and to feel good."

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OCPD Crimes

- Crimes: Sex crimes, A/D related crimes, property, sometimes violent crimes (e.g. fire setting)
- Approach: Must have all your ducks in row when interviewing BECAUSE THEY WILL

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Cluster B

Dramatic (i.e. drama queens) and Criminal

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Histrionic Personality Disorder

- Main Trait: Over-expressiveness
- View of World: Impressionistic
- View of Self: Charming, Center of Attention
- View of Others: Admirers
- Deal with World by: Performing
- E.G.: Jack (Will and Grace), Michael Jackson, Bachelor women

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Histrionic PD

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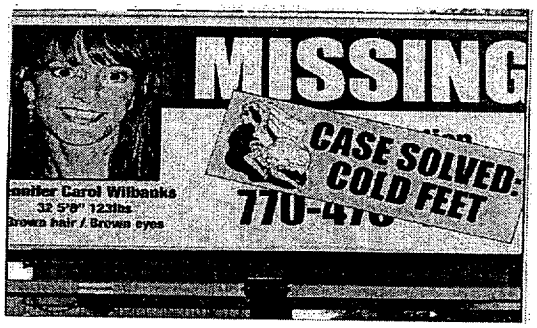
Histrionic or Borderline PD?



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Borderline Personality Disorder

- Must have four of the nine:
  - Frantic efforts to avoid real or imagined abandonment
  - Identity diffusion (who am I?)
  - Unstable, overly intense relationships:
    - Angel or devil?
  - Impulsivity in sex, binge eating, spending
  - Recurrent suicidal gestures
  - Emotional instability
    - jealousy
    - Crisis
    - manipulation

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Borderline Personality Disorder

- Main Trait: Unstable, intense relationships; drama and ***CRISIS***
- View of World: Rejecting
- View of Themselves: Vulnerable, Abandoned
- View of Others: Angels or Devils
- Deal with World by: Emotional justification
- E.G.: Glen Close (Fatal Attraction), Mimi (Drew Carey), Marilyn Monroe, Princess Diana

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Very Bad Borderlines

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Borderline PD

- Me: "How would your sister know if you had cut on yourself?"
- Him: "Because I would wince when she hugged me."

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Borderline PD Crimes

- Crimes: Highly impulsive, hostile acts motivated by jealousy, anger/ rage, fear of abandonment/ jealousy
- Approach: Take advantage of intermittent remorse and mood swings; create moods to disrupt thinking; normalize/ act unemotional and rational to decrease emotions; take time

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Narcissistic Personality Disorder

- Must have five of the nine:
  - Grandiose sense of self-importance
  - Believes he is special
  - Preoccupied with fantasies of success, power, brilliance
  - Requires excessive admiration
  - Sense of entitlement
  - Interpersonally exploitive, predatory
  - Lacks empathy
  - Envious
  - Arrogant

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Benign vs. Malignant Narcissistic PD

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Malignant Narcissistic PD

STEPHEN JAFFE
Enron's ex-CFO Fastow kept mum before a hostile H
hea

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Narcissistic Personality Disorder

- Main Trait: Grandiosity
- View of World: Theirs
- View of Themselves: Special
- View of Others: Their servants
- Deal with the World by: Image Management
- E.G.: Most world leaders, Frazier, Dennis Finch (Just Shoot Me)

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Narcissistic PD

"I survived the 70's...There was a time when there wasn't a woman in Beaverton that my partner or myself hadn't had sex with...sometimes it was as many as 3-4 per night."

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Narcissistic PD Crimes

- Crimes: exploitive and cannot view the impact their crimes have on others
- Approach: emphasize their uniqueness and get them to brag, support their special qualities, and give them the rope (they like to talk)

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Antisocial Personality Disorder

- Must have three of nine:
  - Failure to conform to laws
  - Deceitfulness
  - Impulsivity
  - Irritability
  - Reckless disregard for others' safety
  - Irresponsibility
  - Lack of remorse
  - Juvenile delinquency

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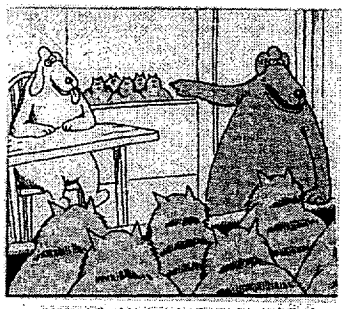
Antisocial PD



"A cat killer! Is that the face of a cat killer? Cat chaser maybe. But hey—who isn't!"

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Antisocial Personality Disorder

- Main Trait: Exploitation
- View of World: Dog Eat Dog
- View of Self: Superior
- View of Others: Suckers
- Deal with World: Opportunism
- E.G.: A large portion of the people you will meet in criminal justice system

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The Antisocial Lifestyle

- The Details that end up on most risk tools:
  - Self-regulation problems
  - Histories of violent crimes
  - Non violent crimes
  - Substance use (esp. alcohol/stimulants)
  - Poor employment record
  - Irresponsibility in finances/ home
  - Poor response to conditions of P/P

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Antisocial PD Crimes

- Crimes: Can be the full range, including highly specialized (burglaries) to criminal versatility
- Approach: Depends upon chronicity:
  - With those who have had treatment, work the "relapse" and "good thing we stopped it" angle
  - With chronic criminals, be straight forward and direct, and work the "game" and "respect" angles

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Antisocial Continuum

Non.....Mild.....Moderate...Chronic ASPD....Psychopathic

[————————————————————]

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Psychopathy

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Psychopathy as a Severe Personality Disorder

- A combination of Antisocial/ Narcissistic Personality Disorders
- Two views of Psychopathic Violence
  - Cold-blooded Predator
  - Impulsive, Charming Thug
- High risk for violence of a lifespan (3-4x higher risk)
  - Violence that is instrumental
  - Violence that is impulsive

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Two Views of the Psychopath

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Psychopathy:

Two Personality Disorders

- NARCISSISM
  - Superficial Charm
  - Grandiosity
  - Pathological Lying
  - Manipulation
  - Shallow emotions
  - Lack of Guilt
  - Callous/Lack of Remorse
- ANTISOCIAL
  - Need for Stimulation
  - Criminal Versatility
  - Irresponsibility
  - Poor Behavioral Controls
  - Failure to Accept Responsibility
  - Juvenile Delinquency
  - Parole Violations
  - Lack of Plans

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Psychopathy as a Severe Personality Disorder

- Significant Signs:
  - Responsible for majority of serious crime
  - Responsible for 50% of law enforcement deaths
  - Long history of crime with an early onset
  - Uses people as objects/ little to no attachment
  - Extremely self-centered and grandiose
  - Remorseless, Lacking in guilt, Lacking in social emotions
  - Expert liars and manipulators

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How Psychopaths Differ from "Garden Variety" Offenders

- Shallow Emotions
- Callous Lack of Empathy
- Lack of Guilt
- Lack of a Conscience
- Inability to form mutually satisfying relationships (i.e. attachment).
  - No social network to moderate behavior
  - Very shallow attachments with change agents
- Offender is cold, cunning, and calculating.

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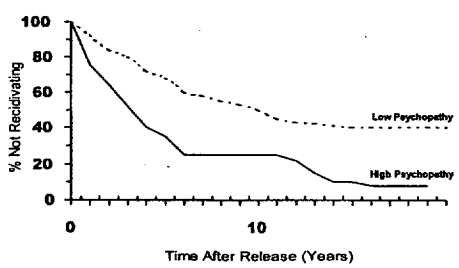
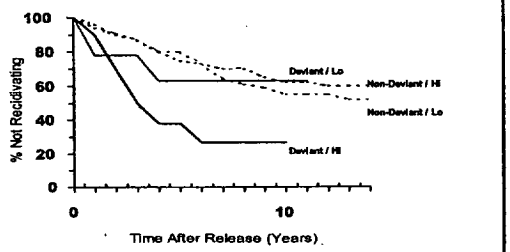
Psychopathy and Violent Recidivism

Any Violence

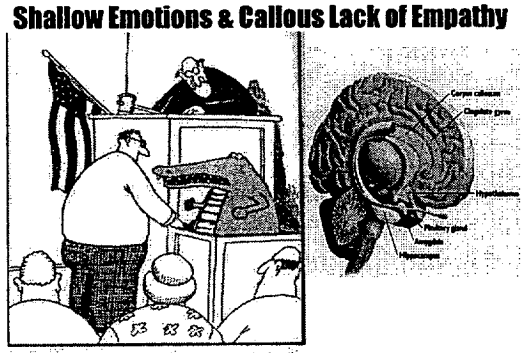


Psychopathy, Sexual Arousal & Recidivism

Sexual Violence



Shallow Emotions & Callous Lack of Empathy



"Well, of COURSE I did it in cold blood, you idiot! ...I'm a reptile!"

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PRACTICAL APPLICATION: How Psychopaths Differ

- More likely to pose a threat to your safety.
- Can be overly compliant to curry favor/disarm.
  (Offender wants to "look good")
- Expanding victim pool.
  - Predatory behavior extends to anyone, including you
- More likely to con/ manipulate, deceive and disarm you.

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Psychopathic Crimes

- Crimes: Criminally versatile opportunists
- Approach: Direct, unemotional and professional; must have ducks in a row – this may be a game to them, play into their narcissism.

85

Ward Weaver

"He's an incredibly good manipulator and a really good liar."

- -Kristi Sloan, Ward Weaver's ex-wife

"Do you seriously think I would be able to kill somebody and bury them in my back yard without someone seeing something?

Ward Weaver to ex-wife Kristi Sloan

Ward Weaver said he is the FBI's prime suspect in the investigation of the disappearance of two 13-year-old girls from Oregon City, Ore. (ABCNEWS.com)

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What is love?

"I would have to say that love is like a hot marshmallow. It's warm, sticky and it fills you up."

- Answer by a psychopathic offender when asked to define this emotion.

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Review

- Personality disorders are pervasive and inflexible ways of approaching the world.
- Personality disorders are strongly suggested in people with criminal backgrounds.
- Personality disorders influence:
  - The crimes a person is likely to commit
  - How a investigators/evaluators should approach an interview

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About the Speaker

Katherine Gotch, MA is currently employed as the Clinical Coordinator for the Sex Offender Unit in Multnomah County. Her six years in the field of forensic psychology includes employment at the Massachusetts Treatment Center for Sexually Violent Predators, as a community sex offender treatment provider and as a therapist for dual diagnosis individuals . Her current work includes treatment and evaluation of sex offenders, mentally ill offenders, psychopaths and violent offenders.

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Personality Disorders Training
Crisis Intervention training
Portland Police
5/18/00

Outline

I. Overview

A. Definition: DMSIV A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adult, is stable over time and leads to distress or impairment.

B. Types:

1. Cluster A Paranoid, Schizoid, Schizotypal,
   - odd or eccentric
2. Cluster B: Antisocial, Borderline, Histrionic, Narcissitic,
   - dramatic, emotional or erratic
3. Cluster C: Avoident, Dependent, Obsessive Compulsive
   - anxious or fearful

II. Development of Personality Disorder

A. Stress / Coping Skill Relationship

B. Sense of Self

C. Impairments

1. self harm
2. self defeating behavior
3. relationships
4. abandonment issues

III. Management of Behavior

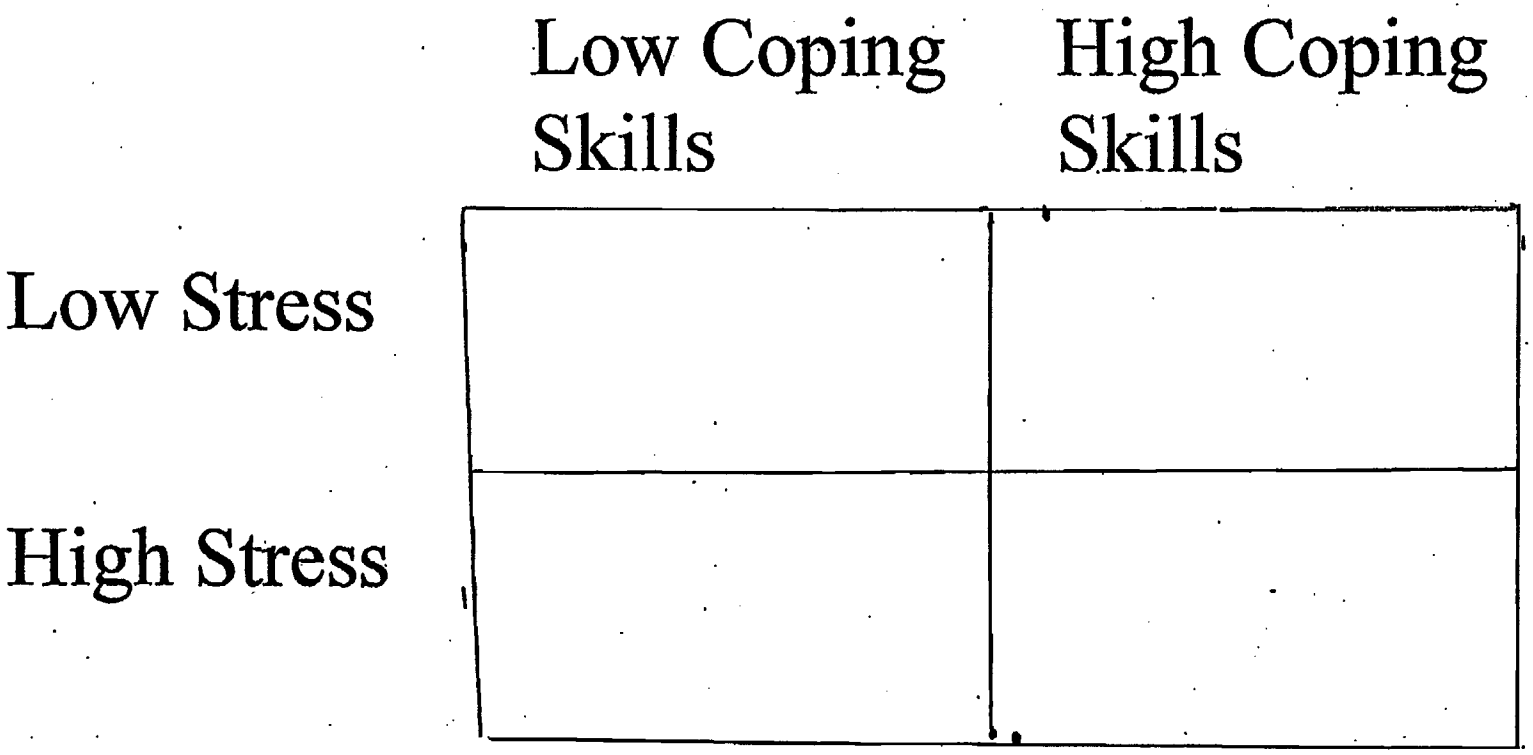
A. Neutrality

B. Clarifying Expectations

C. Setting limits

D. Supportive feedback

Stress/Coping Skill Relationship



NOTES

Mental Status Exam

MENTAL STATUS EXAM

CIT Training -- The Mental Status Exam

Neil Falk, MD
May 9, 2000

A Mental Status Exam (MSE) is the mental health worker's equivalent of a medical provider's physical exam -- an examination of an individual to help determine if they have an illness. A very quick MSE can be performed quite easily, as many of the basics are common sense. The examination can even occur at a distance, and without the individual's participation -- a lot can be gained just by observation.

- **Appearance**

  -- How is the individual dressed? Examples of dress which may indicate a mental illness include:

  -- Inappropriate for weather (e.g. -- many layers in summer)
  -- Inappropriate for context (e.g. -- pajamas in the street)
  -- Odd or bizarre clothing
  -- Very dirty/foul smelling/tattered clothing

  -- How is the individual's hygiene? examples of hygiene which may indicate a mental illness include:

  -- Very dirty/foul smelling clothing
  -- Very dirty/foul smelling body
  -- Poor dental condition

  -- How is the individual behaving? Examples of behavior which may indicate a mental illness include:

  -- Responding to internal stimuli (i.e. -- "talking to self")
  -- Standing still/staring for prolonged periods (e.g. - catatonia)
  -- Disorganized/non-goal directed actions
  -- "Odd" actions, or interactions with others in the environment (e.g. -- bizarre mannerisms, posturing, agitated towards others, ignored by large group, being viewed with suspicion by group or vice versa)
  -- Abnormally fast or slow movement pattern/energy level

• Thought Processes

The thought processes of the mentally ill are, by definition, disturbed. Mentally ill individuals may:

-- have disorganized thoughts (e.g. -- tangential thinking, loose associations, flight of ideas, etc.)
-- have "bizarre" thoughts (e.g. -- delusions of persecution, grandeur, conspiracies, etc.)
-- have blocked thoughts (i.e. -- long pauses during thinking)
-- persevere on one topic

• Speech

The speech of mentally ill individuals often is abnormal -- a reflection of their abnormal thought processes. Mentally ill individuals may:

-- speak abnormally fast or slow
-- use words abnormally (paraphasic errors)
-- use nonsense words
-- create words (neologisms)
-- be hard to interrupt (pressured speech)

•Miscellaneous

-- mood (how the person *says* he/she is feeling)
-- affect (how the person *appears* to be feeling)
-- suicidal/homicidal thoughts
  -- plan
  -- access to enact plan
  -- intent to carry out plan
  -- chronicity
-- hallucinations (usually auditory in the mentally ill)
-- cognitive abilities
  -- memory (short, intermediate, and long term)
  -- concentration/distractibility
  -- abstract thoughts (often mentally ill individuals cannot think abstractly)

•Generalities

-- If it doesn't feel safe, don't do it!!
-- Mentally ill people are people, and deserve common respect.
-- Listen carefully.
-- Allow the individual to talk at length at least once.
-- Don't be afraid of silences. They often bring out symptoms.
-- Try to be an ally, not an adversary.

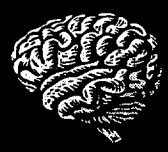
	Appearance	Thought Processes	Speech
Psychotic/Schizo -phrenic	Disheveled, Poor hygiene, Disorganized	Disorganized, Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to disheveled, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Intoxicated	Anything and everything	Anything and everything	Anything and everything

NOTES

The Mental Status Exam

Neil Falk, MD
Program Medical Director
Crisis & Secure Residential Services
Cascadia Behavioral Healthcare, Inc.
Portland, OR

Or..., What's Going On In There?



What is an MSE?

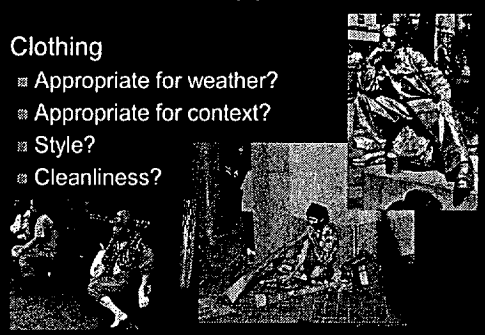
- Mental health worker's equivalent of a medical provider's physical exam
- Quick MSE can be performed quite easily
  - Many of the basics are common sense
  - Exam can occur at a distance
  - Exam can even occur without the individual's participation

Components of the MSE

- General Appearance
- Thought Content
- Thought Process
- Speech
- Mood/Affect
- Psychosis
- Cognition

General Appearance

- Clothing
  - Appropriate for weather?
  - Appropriate for context?
  - Style?
  - Cleanliness?

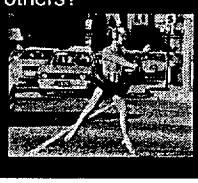


General Appearance

- Hygiene
  - Personal
  - Dental
  - Environmental
  - Clothing

General Appearance

- Behavior
  - Goal-Directed/Organized?
  - Appropriate for context?
  - Speed?
  - Response from others?
  - Co-operative?



Thought Content

- What is the individual saying?
  - Delusions (of persecution, grandeur, conspiracies, etc.)
  - Relevancy to situation
  - Perseveration

Thought Process

- How is the individual saying it?
  - Organization (e.g. circumferential, tangential, loose associations, flight of ideas, word salad, etc.)
  - Thought Blocking (i.e. long pauses during talking)
  - Perseveration

Speech

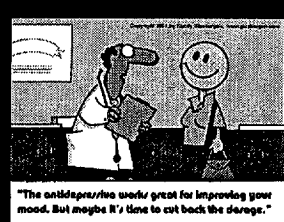
- Speed
- Pressure
- Abnormal Words
  - Paraphasic errors
  - Nonsense words
  - Neologisms

Mood/Affect

- Mood
  - How the person *says* he/she is feeling
  - *Subjective* evaluation

Mood/Affect

- Affect
  - How the person *appears* to feel
  - *Objective* evaluation



Mood/Affect

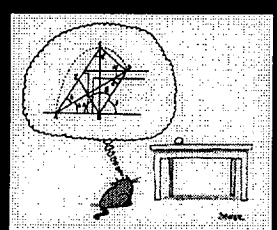
- Suicidal/Homicidal Thoughts
  - Plan
  - Access to enact plan
  - Intent to carry out plan
  - Chronicity

Psychosis

- Hallucinations
  - [illegible]
  - Visual -- Intoxicated states
  - Tactile --Intoxicated/Withdrawal States
  - Gustatory -- Neurologic Illness
  - Olfactory -- Neurologic Illness
- Responding to internal stimuli

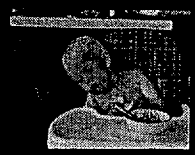
Cognition

- Ability to think clearly & accurately
- Dependent on educational history



Cognition

- Level of alertness
  - Conscious, sedated, etc.
- Orientation
  - Person
  - Place
  - Time
  - Situation
- Estimate of Intelligence
  - IQ
  - Fund of knowledge



Cognition

- Memory
  - Short
  - Intermediate
  - Long term
- Concentration/distractibility
  - Serial 7's
  - Backwards Lists
    - Presidents
    - Months of the year
    - Days of the week
    - D-L-R-O-W

Cognition

- Abstract thoughts
  - Proverbs
    - Don't cry over spilled milk
    - A bird in the hand is worth two in the bush
    - People who live in glass houses shouldn't throw stones
    - A golden hammer breaks an iron door
    - A black coal strikes cold, a red coal strikes hot
  - Spontaneous Similes and/or Metaphors

Generalities

- If it doesn't feel safe, don't do it!!
- Mentally ill people are people, and deserve common respect.
- Listen carefully.
- Allow the individual to talk at length at least once.
- Don't be afraid of silences. They often bring out symptoms.
- Try to be an ally, not an adversary.

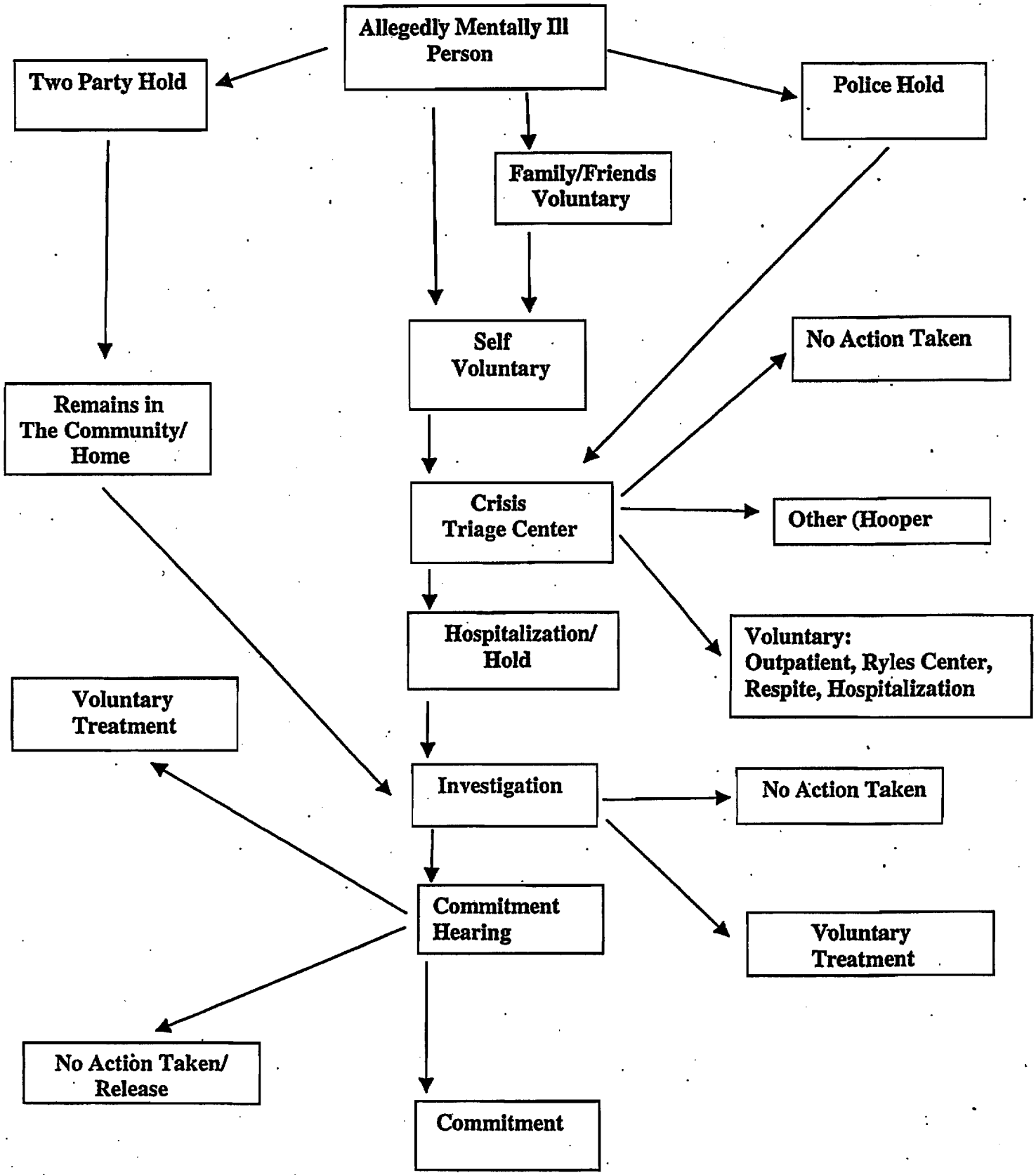
Generalities

	Appearance	Thought Processes	Behavior
Psycholic	Dishevelled, Poor hygiene, Disorganized	Disorganized Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to dishevided, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Demented	Normal groom and dress to dishevelled, slowed or rapid behavior	Impoverished, confabulation, may be irritable	Variable
Intoxicated	Anything & Everything	Anything & Everything	Anything & Everything

Civil Commitment

COMMITMENT LAWS

THE COMMITMENT PROCESS



THE COMMITMENT PROCESS

THE DIFFERENCES BETWEEN A TWO-PARTY PETITION AND A HOSPITAL MEDICAL DOCTORS HOLD

TWO-PARTY PETITION

Used for issues of inability to care/deterioration of function.

Person remains in the community/home

Investigation completed within fourteen calendar days (two weeks)

Can be signed by any two-parties/people

HOSPITAL MEDICAL DOCTOR HOLD

Should be used only in cases of imminent danger to self or others

Person held in hospital

Investigation completed within five working days

Must be signed by two MD's or one MD and qualified health professional

THE COMMITMENT PROCESS

The Civil Commitment process is governed by the Oregon Revised Statutes 426 and the Administrative Rules (interpretation of the Statutes) from the Oregon Mental Health Division. The Statutes define what the legal definition of mental illness is. Legally, mentally ill means; a person because of a mental disorder, is one of the following:

A) Dangerous to self or others.

B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

C) A person who:

1) Is chronically mentally ill by the following definition (also known as "Expanded Criteria"):

a) Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility

AND

b) Is exhibiting symptoms or similar behavior to those that preceded or led to one or more of the hospitalizations or inpatient placements.

AND

c) Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Civil Commitment is a legal process not a clinical one. It has been designed as a legal procedure. At times, the logic of legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of family, significant others, or treatment providers.

The goals of the Mental Health Division in the Civil Commitment process:

A) To promote the well being of persons who are allegedly mentally ill and who are mentally ill and who are mentally ill during the involuntary care, custody, and treatment of mental illness pursuant to ORS 426.

B) To promote the protection of the civil rights of persons who are allegedly mentally ill or who are mentally ill.

C) To encourage the consistent application of ORS 426.

D) To encourage the provision of care, custody, and treatment of persons in the least restrictive environment that is available within existing resources.

THE COMMITMENT PROCESS

E) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through Civil Commitment, whenever possible.

F) To encourage that the Director (local community mental health system knowledgeable of the statues and administrative rules and provides leadership that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS. 426.

G) To provide for the safety of the community and the person when that person is dangerous to others or self as a result of a mental illness.

The Commitment process can be initiated, by giving Notice in writing (under oath) to the County Mental Health Program, by two persons, the County Health Officer, or any Magistrate. The Court will be immediately notified and the Community Mental Health Program will start (within 3 judicial days) An investigation to determine whether there is probable cause to believe the person is in fact mentally ill. Judicial days do not include weekends or Court holidays. The person is not usually in custody or detained during this process.

Emergency care, detention in a hospital and treatment can occur through the following ways:

A) A Peace Officer who has probable cause to believe a person is dangerous to self or to others and is in need of immediate care, custody of a person and remove them to the nearest hospital or approved non hospital facility, a physician will examine the person immediately. If the physician finds the person t be in need of emergency care or treatment for mental illness, the person to be in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the physician), otherwise the person shall be released from custody.

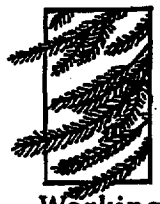
THE COMMITMENT PROCESS

B) A physician believes a person, who is at a hospital or approved non hospital, is dangerous to self or to others and is in need of emergency care or treatment for mental illness, can initiate a hospital hold and detain the person for emergency care. Under no circumstance shall any person be detained for more than 5 judicial days, following the signing of the hospital hold, without a Court Hearing.

C) A Designee of the Community Mental Health Program may, with probable cause that a person is dangerous to self or to others, or, additionally, (if the person is on a conditional release, outpatient commitment, trial visit) is unable to provide for personal needs, direct a Peace Officer to take custody and remove the person t o a hospital or approved non hospital facility for evaluation by a physician. This is called a "Director's Custody". If the physician finds the person is in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the Physician), otherwise the person shall be released from custody.

RIGHTS OF THE MENTALLY ILL

NOTES



OREGON ADVOCACY CENTER
Working for the Rights of Individuals with Disabilities

Rights of Persons with Mental Illness

Crisis Intervention Team Training
Portland, Oregon
November 14th, 2000

Janice Perciano and Jan Friedman
Oregon Advocacy Center

Voice: 503-243-2081 • 1-800-452-1694 • TTY: 1-800-556-5351 • Fax: 503-243-1738
620 S.W. Fifth Avenue • 5th Floor • Portland, Oregon 97204-1428

WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

Mental Health--the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental illness--the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alteration in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems--patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

.....

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**

- **A range of treatments exists for most mental disorders.**

.....

Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment . Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

.....

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable.

.....

Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Excerpts from **U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of health, National Institute of Mental Health , 1999.**

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Persons with mental illness have the **same rights as everyone else**.

Why aren't persons with mental illness treated the same?

1. Stigma--shame, hidden subject, accepted to mistreat, make fun of persons with mental illness

2. Misconceptions

   A. Violent--studies show that persons with mental illness are no more likely to be violent than anyone else, but often are portrayed in the media as violent

   B. Stupid--persons with mental illness have the same ranges of intelligence as everyone else, sometimes persons with mental illness are confused with persons with retardation--not the same

   C. Incompetent--everyone is presumed competent unless shown otherwise--persons with mental illness are presumed competent to make decisions even if civilly committed--only under specific circumstances is a person determined to be incompetent (guardianship, conservatorship, outside consultant determination regarding medication of person on commitment)

   D. Delusional--only some persons with mental illness experience delusional thinking--and even for these persons the delusions occur only some of the time

3. Protection of the person with mental illness--social workers, family, care givers, police etc. often want to treat persons with mental illness in what is perceived to be the best interests of the person with mental illness--may be in conflict with what the individual chooses and may be patronizing

4. Protection of society/family from hardship and/ or danger--actions are taken against a person with mental illness to protect others

5. Ignorance and fear--belief by persons without mental illness that persons with mental illness are extremely different than themselves and that mental illness may "spread"

LAWS SPECIFICALLY AFFECTING PERSONS WITH MENTAL ILLNESSES

1. CIVIL COMMITMENT

WHAT IS CIVIL COMMITMENT?

Civil commitment is a process in which a judge decides whether a person who is alleged to be mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment. A person in the process of a commitment sometimes is called an Alleged Mentally Ill Person (AMIP). A civil commitment is not a criminal conviction and will not go on a criminal record.

When a civil commitment petition has been filed, an investigator from the community mental health program (CMHP) will investigate the need for the commitment. Depending on the investigator's decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a right to an attorney and to have witnesses testify. The judge then makes a decision whether the person should be committed. If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting. The maximum commitment period is 180 days, although a person can be ordered to stay hospitalized beyond the 180 days in recommitment proceedings.

WHO CAN BE COMMITTED

Oregon Revised Statutes (ORS) chapters 426 and 427 contain the law regarding civil commitment. A judge can commit a person for up to 180 days if the judge finds by clear and convincing evidence, that the person

> Has a mental disorder and, because of that mental disorder, is:
>
> Dangerous to self or others, or
>
> Unable to provide for basic needs (like health and safety).

Or, the judge can find that a person is:

> Diagnosed as having a major mental illness (such as chronic schizophrenia or manic- depression), and

Has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

ORS 426.005; ORS 426.130

HOW THE CIVIL COMMITMENT PROCESS BEGINS

1) The commitment process may be started by a county health officer, a judge, or any two persons filing papers in court. Or, the process may be started by a doctor or community mental health program director ordering a person to be held involuntarily in a hospital. ORS 426.070; ORS 426.228 through ORS 426.234.

2) When the papers are filed, the CMHP program must send out a mental health investigator to interview the person and others who know about the person. This investigator advises a judge whether or not to hold a court hearing. ORS 426.070; ORS 426.074.

WHERE THE PERSON STAYS BEFORE THE HEARING

A person against whom a civil commitment petition is filed may stay in the community unless the judge orders the person to be taken into custody or a doctor or CMHP director directs the person be in custody. The person can be in custody only if he or she is considered to be mentally ill and a danger to self or others. A person who is mentally ill and unable to provide for basic needs cannot be held in custody unless the person's inability to provide for basic needs is so extreme that the person is a danger to self. A person held before a hearing is on a precommitment hold or in precommitment detention. ORS 426.070; ORS 426.228; ORS 426.231; ORS 426.232; ORS 426.233.

If a person is held in custody on a precommitment hold, he or she cannot be held in jail unless he or she is charged with a crime or is a serious danger to hospital staff or property. ORS 426.140. The person may be held in a hospital or a nonhospital facility. A nonhospital facility is a facility approved by the Mental Health and Developmental Disability Services Division (MHDDSD) to provide adequate security, psychiatric, nursing and other services. ORS 426.005(e).

A person on a precommitment hold has the right to be held in a mental health facility providing care, custody and treatment required for mental and physical health and safety. In other words, the person can only be held in a place with staff trained to provide mental health treatment. ORS 426.072(2)(a); ORS 426.228.

LENGTH OF TIME A PERSON CAN BE HELD BEFORE A HEARING
A person cannot be held in custody on a precommitment hold longer than five working days without a court hearing. If five working days pass and there is no court hearing, a person is free to leave the hospital unless he or she has asked to postpone the hearing or has agreed to be hospitalized voluntarily under a diversion program. In other words, a person cannot be held longer than five working days unless a judge says so. ORS 426.095.

HOW LEGAL RIGHTS ARE AFFECTED BY COMMITMENT
In general, most legal rights are not affected by civil commitment. A person who is committed retains all legal and civil rights, including the right to vote and make contracts unless a court has found the person incompetent. ORS 426.385.

Some specific rights can be limited as a result of civil commitment:

Firearms - Persons who have been committed are forbidden from owning, buying, or possessing firearms. ORS 426.130(1)(D); ORS 166.250 (1)(D).

Future commitments - If a person is committed twice within the past three years, he or she can be committed more easily in the future. ORS 426.495.

Driving - Commitment can affect a person's ability to get or keep a driver's license. If a person has a mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle, the person cannot be licensed. ORS 807.090; ORS 807.700; ORS 809.410(16).

II. AMERICANS WITH DISABILITIES ACT (ADA)

The ADA protects persons with disabilities from discrimination in these areas:

1. Employment--This includes hiring, termination benefits, working conditions, etc.

2. Public Accommodations--This includes hotels, offices, shopping malls, restaurants, sports arenas, schools, zoos, hospitals, theaters, grocery stores, homeless shelters, libraries, etc.

3. Public Entities--This includes all local and state governmental services and programs.

4. Transportation--This includes buses, trains, lights rail must be accessible or

alternatives offered.

5. Telecommunications--This includes that telecommunication services must be made accessible for speech and/or hearing impaired persons.

Persons with mental illnesses are protected by the ADA if the mental illness substantially limits one or more of the major life activities of the person. Major life activities means activities such as working, learning, sleeping, thinking and walking. Persons who have a record of such an impairment or who are perceived to have such an impairment are also protected.

In addition to the ADA, which is federal law, Oregon has state laws prohibiting discrimination in employment and public accommodations.

III. FAIR HOUSING LAWS

The federal Fair Housing Act was passed in 1968 as part of the Civil Rights Act of 1968. The Fair Housing Act prohibited discrimination based on race, color, religion or national origin in the sale, rental or financing of housing. In 1974, Congress added a provision prohibiting housing discrimination based on sex.

In 1988, Congress added provisions prohibiting housing discrimination based on mental and/or physical disabilities. Under the law, landlords and sellers cannot discriminate against a person because the person has a mental illness and must make reasonable accommodations for a person disability. The law does not apply in some cases where the landlord or seller is acting with regard to his or her private house or small apartment building. The law also allows the rejection of any tenant or buyer who would directly threaten the health or safety of other individuals or would cause substantial physical damage to the property of others.

Oregon also has a state law prohibiting discrimination based on physical or mental disability in selling, leasing or renting of houses and apartments.

IV. RIGHTS IN THE COMMUNITY AND IN FACILITIES

STATUTORY AND CONSTITUTIONAL RIGHTS

Many people receive mental health services outside the state hospital. Even persons who are civilly committed often receive treatment in private hospitals that have contracts with the state. Additionally, more people are receiving services in facilities, group homes and independent residences rather than in hospitals.

A person who is receiving services outside the state hospital system has the same rights as any other person in the community. Some of the rights that all persons in the United States are the right to:

*Vote

*Exercise freedom of speech, freedom of association and freedom of religion.

*Have privacy, including the right to marry and have children.

*Be free from discrimination based on race, gender, color, national origin or disability.

In 1993, the legislature passed legislation that sets out some specific rights of persons receiving mental health or developmental disabilities services. A person who is receiving mental health or developmental disabilities services outside of the state hospital has the right to:

*Have a written treatment plan and participate in making the plan.

*Choose from available services and have those services provided in the least restrictive way.

*Receive only services to which a person gives informed, voluntary, written consent.

*Receive medication only for individual clinical needs.

*Not be involuntarily terminated or transferred from services without prior notice and the right to be notified of available sources for necessary services.

*Receive humane services, be protected from harm and have reasonable privacy.

*Be free from abuse and neglect.

*Report abuse and neglect without retaliation.

*Exercise religious freedom.

*Not be required to perform labor, except personal chores, without being paid.

*Visit with family, friends, advocates, legal and medical professionals.

*Be told about rights and how to report abuse.

*Assert grievances and have them considered in a fair, timely and impartial manner.

*Communicate with any rights program or advocate.

*Exercise these rights without any reprisal or punishment.

ORS 430.210.

V. ABUSE REPORTING

Since 1991, the law has required the reporting and investigating of abuse of persons with mental illness who are receiving mental health services in the community. Abuse is defined as:

*Any death caused by other than accidental or natural means.

*Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.

*Willful infliction of physical pain or injury.

*Sexual harassment or exploitation, including any sexual contact between an employee of a facility or community program and an adult who is receiving mental health services.

The law requires private and public officials to report abuse if they have reasonable cause to believe abuse occurred. This means that all doctors, nurses, aides, psychologists, employees of county mental health programs, employees of mental health services providers, clergy, attorneys, outreach workers, social workers, therapists, police and others must report abuse.

Abuse may be reported to the Mental Health and Developmental Disability Services Division (MHDDSD), the county mental health program or the police. The office that receives the abuse report must then conduct an investigation or make sure that an investigation is conducted. The person who may have been the victim of the abuse must be provided protective services if needed. The investigating office must complete a report of the investigation and send it to MHDDSD. ORS 430.735 through 430.765.

VI. INFORMED CONSENT TO TREATMENT

A person can receive mental health treatment, including medications, only if the person gives his or her informed consent. This means the person must be told what the benefits and risks of treatment are and must make a voluntary decision.

A person cannot be forced to take a particular medication just because everyone thinks it would be good for him or her. The exception is when a person has been civilly committed and two doctors have agreed that the person is unable to make decisions. In this case, if the proper procedures are followed, the person may be subjected to treatment that she or he does not want.

VII. GUARDIANSHIP

If a person is "incapacitated", a judge may appoint a guardian for her or him. A guardian can only be appointed by a judge. A parent does not have the powers of a guardian if the individual is 18 or over unless the judge has appointed the parent a s guardian.

TELEPHONE NUMBERS FOR ADVOCACY GROUPS AND LEGAL ASSISTANCE

American Civil Liberties Union	503-227-3186
Fair Housing Council	503-223-8295
Multnomah County Legal Aid	503-224-4086
National Alliance for the Mentally Ill	800-343-6264
Oregon Advocacy Center	503-243-2081
Toll-free	800-452-1694
TTY	503-323-9161
Toll-free TTY	800-556-5351
Oregon Legal Services	
Central Office	503-234-1534
Farm Workers' Office	503-981-5291
Hillsboro Office	503-648-7163
Native American Office	503-223-9483
Oregon State Bar	
Lawyer Referral Service	503-684-3763
Toll-free	800-452-7636
State Public Defender	503-378-3349
U.S. Office of Civil Rights	206-615-2290
Toll-free	800-362-1710

WORKING FOR THE RIGHTS OF INDIVIDUALS WITH DISABILITIES

GOVERNMENT AGENCIES

Adult and Family Services Division	503-731-3111
Bureau of Labor and Industries	503-731-4200
Equal Employment Opportunity Commission	206-220-6883
Toll-free 800-669-4000	
TTY 206-220-6882	
Mental Health and Developmental Disability Services Division	503-945-9499
Office of Mental Health Services	503-945-9700
Office of Client Rights	503-945-9495
Psychiatric Security Review Board	503-229-5596
Senior and Disabled Services Division	503-945-5811
Toll-free 800-232-3020	
Social Security Administration	800-772-1213

ADVOCACY/CONSUMER GROUPS

Mind Empowered, Inc	503-231-4137
Oregon Advocacy Center	503-243-2081
Toll-free 800-452-1694	
TTY 503-323-9161	
Toll-free TTY	800-556-5351
Oregon Alliance for the Mentally Ill	503-370-7774
Recovery, Inc 503-231-1334	

Brief History of Treatment of Persons with Mental Illness in England and the United States

Early 1300s--English law categorized persons with mental disabilities as lunatics or idiots.

Pre-1600s--Persons with mental illness were cared for at home or sent to poorhouses, workhouses, jails.

1600s-- "Madhouses" created to confine persons with mental illness. The madhouses were unhealthy settings with harsh and punitive "treatment". Persons were chained, abused and publicly displayed.

1700s-- "Asylums" were developed to provide healthy environment and "moral treatment".

Mid-1700s--Persons with mental illness in England were placed in St. Mary of Bethlehem which became known as "Bedlam".

"Bethlehem--or Bedlam as it was called--was a favorite Sunday excursion spot for Londoners, who came to stare at the madmen through the iron gates. Should they survive the filthy conditions, the abominable food, the isolation and the darkness, and the brutality of their keepers, the patients of Bedlam were intitled to treatment--emetics, purgatives, bloodletting and various so-called harmless tortures provided by special paraphenalia." The History of Psychiatry, F.G. Alexander and S.T. Selesnick

1752--Pennsylvania Hospital opened with several cells for the "insane". The method of commitment was informal. A few words scribbled on a piece of paper were enough to get a person locked up.

1773--In Williamsburg, Virginia, the first US institution specialized for the "insane" opened.

Late 1800s--Large public institutions were filled with chronic patients receiving little treatment.

1883--Oregon State Insane Asylum opened in Salem (renamed Oregon State Hospital in 1907).

1900-1960--Hospitals emphasized treatment but no effective treatment was available. Institution populations continued to grow.

1907--Eastern Oregon Hospital opened in Pendleton.

> When we have a disturbed or noisy patient to deal with [prior to a lobotomy operation] in the University Hospital or Doctors Hospital we administer two, three or more electroshock treatments in rapid succession. Psychosurgery in the Treatment of Mental Disorders and Intractable Pain, Walter Freeman and James Watts, 1950.

1955--560,000 persons with mental illness were confined in hospitals (1/2 of all hospital beds).

1959--The average daily population in Oregon State Hospital and Eastern Oregon Hospital was 4909.

1960-1975--Deinstitutionalization resulted in the release of vast numbers of persons from institutions.

1961--Dammasch State Hospital opened in Wilsonville.

1975 to present--Communities recognized that deinstitutionalization could not succeed unless accompanied by adequate community support programs.

1977--Psychiatric Security Review Board created in Oregon to supervise persons found affected by mental disease or defect in criminal matters.

1990 to present--Managed care implemented for provision of mental health services.

Deaths at Dammasch State Hospital (DSH)--June 25, 1993 to October 8, 1993.

June 25, 1993--DC died at DSH--No medical examiner review but adequacy of medical treatment questioned.

August 29, 1993--JW died choking on pancakes. He was alone in his room, unmonitored despite swallowing problems.

August 29, 1993--LL died choking on pancakes. Staff called 911 but did not intubate LL or manually cut an airway.

September 19, 1993--KM died as a result of coronary arteriosclerosis. Staff had given her Haldol despite a diagnosis of mental retardation (IQ 54) and no diagnosis of mental illness. Staff found her lying on her bed. She had no pulse but was warm. Staff made a emergency request for a doctor. Thirteen minutes elapsed before a doctor arrived.

October 18, 1993--PG suffocated while being placed in physical restraints. A towel pulled over his mouth contributed to the death.

1995--Dammasch State Hospital closed.. Oregon State Hospital at Portland opened with capacity of 68.

1997--Current Oregon State Hospital capacity is for 727 beds, including hospital beds, residential beds, child and adolescent beds.

FAMILY AND CONSUMER

PERSPECTIVE

WHAT IT'S LIKE

Being crazy hurts. For one who has been there, the idea of going crazy out of moral weakness, because it is easier than "facing reality," is utterly bizarre.

The major mental illnesses, like most other illnesses, carry with them an early-appearing and almost ever-present feeling of "sickness" and exhaustion.

As it gets better and worse, there are times when you may be unable to function at all, perhaps being unable even to get out of bed.

At these times, investigation is needed to determine whether you are suffering extreme stress of real-work origin, suffering from a resurgence of mental illness symptoms, or whether there is some unrelated medical problem, such as an abscessed tooth or the flu.

Too often, these episodes are viewed as bouts of laziness and "lack of motivation," and treated with harassment or even termination from a treatment program.

Unless this phenomenon, and ways of coping with it, are explained to you, you too may come to believe you are lazy and good-for-nothing.

You become aware that your perceptions are unreliable, that you are having sensory experiences that others do not share.

As you struggle for some understanding of what is happening to you, you find yourself clutching at extreme and bizarre explanations.

When you try to talk to other people about your experiences, you discover there is no common language for them. You find yourself putting together an unsatisfactory and embarrassing patchwork of religious, occult, or scientific words.

When you do talk to people, they may lapse into shocked silence, change the subject, or reject your statements as weird and you as crazy.

If you are not aware the perceptions are different from those of other people, you are even more disabled. Whenever you try to do something or talk to someone, all sorts of things go wrong, which you do not understand.

Because you cannot predict whether your perceptions and interpretations of events are acceptable to others as "real," you begin to be afraid to talk about your feeling at all. If you have not yet felt there was something wrong/bad about you before, you do now. You become very lonely.

Since you gave no safe way to compare your "crazy ideas" with what normal people define as real, your ideas/delusions become more detailed, more organized, and more strongly held.

Extreme and uncontrollable emotions rush through you: fear, confusion, anger, despair.

The feelings are overwhelming. You see yourself doing things you cannot stop. It comes to you that you are no longer in control of your life. You are forced to depend on other people for some things, even if you do not want to.

You begin to fear that you may do something awful, something that will make people get rid of you forever.

You worry that whatever has happened to you may be permanent, that you may never be all right again.

Pain becomes very familiar. It comes to have form and texture like terrain.

If pain is fairly steady and continuous, you can sometimes almost tune it out. But if someone offers you more hurt, whether it be emotional battering or physical, you are suddenly desperate and hostile. You are tired, tired, tired, and do not have the energy to take any more. Sometimes you have to take it anyway.

At times the pain/craziness comes in overwhelming waves. Like most people, you think that pain will somehow never crush you. Somehow new reserves of strength will appear, effective treatments will be found, or, in the extreme, that you will simply pass out.

Then one day, you lose control of your mind, your body, everything. You'll lose your bowels and scream and scream and scream, like a little pig squirming in the dirt. And it does not stop.

Having broken, having been totally <u>helpless</u> forever after leaves you feeling fragile in a way that other people do not. In wonderment you watch "normal people" go about their lives, full of energy, confident, unknowing. There is an abyss between you.

If you hurt bad enough, you try anything to feel better: self-help books, religion, sex, drugs, alcohol, and anything you can think of.

Some things make you feel a little better, some do nothing, and many of them make you feel a lot worse.

In desperation, sometimes just drinking or drugging yourself into unconsciousness seems a worthy goal.

The risks of triggering further psychotic episodes and the risk of alcohol and drug addiction are substantial. It is hard to be interested in future consequences of things when you are not sure you have a future or want one.

If you get strung out on alcohol or drugs you will have another difficulty. The people who work with alcoholics and drug addicts do not want you because you are crazy. The people who work with the mentally ill do not want you because you are an alcoholic or an addict. You can only go to special, expensive, "dual diagnosis" programs. If you have three or more diagnoses, you are likely to end up in jail.

Seriously mentally ill people have a suicide rate of 20-30 times that of the normal population. At greatest risk are those who are too ill to have a normal life, and not sick enough to be unaware of it.

Hardly anyone <u>wants</u> to commit suicide.

As the years go by, you exhaust the treatment options open to you. Hospitals and doctors get tired of you because you never get better.

You drift away from your family. You cannot hold a job, or maintain a sexual relationship.

If you talk to others about your feelings, you come under pressure to shut up and act normal. Your desperation makes <u>them</u> uncomfortable.

You feel helpless, lonely, and as if you have nowhere you belong. You cannot stand being trapped in all that pain. All these are bad enough, but it is the crushing, never ending <u>tiredness</u> that ultimately gets you. You kill yourself because you <u>have</u> to.

What you would really like to hear is: "We know you are very tired, and you feel awful most of the time. We do not want you to go away. We want you to live.

"But if the time comes when you really cannot take anymore, and you have to die, we will be very sad, but we will understand.

"Whether you get better or not, and whether you live or not, we love you anyway."

Confused and frightened people tend to try to clamp tight control on whatever or whoever upsets them. It is rare to be given this recognition of your pain and permission to do whatever you have to do, but if you are, it is very comforting.

It tends to relieve some of your guilt feelings for being such a mess, and such a disappointment to your family and friends.

If you are like many seriously mentally ill people, you have known since sometime in childhood that there is something very wrong with you.

Functioning at school was very hard. You have less and less success in living up to the expectations of your family, and in being like other people.

Others' attempts to shape you up are sometimes drastic. You are likely to have the experience of being threatened, ridiculed, or punished for things that you do not understand, cannot do, or cannot stop doing.

Parents, teachers, school counselors, and pediatricians rarely are familiar with mental illness in children. Many professionals take the de facto stand that major mental illness and suicide virtually do not occur in young children, and that all such problems come from "labeling" and "bad parenting."

Your family withers under the implied or open accusation that they made you crazy. They become too intimidated to talk to you, out of fear that they will "say something wrong" and cause you to shatter in a million pieces.

Communication within your family is loaded with fear and guilt, and is further complicated by your thought or mood disorder.

Nobody will tell you what it going on. In loneliness and isolation your fears and crazy ideas grow.

Your parents are scapegoated by relatives, neighbors, and authorities. They begin exchanging recriminations themselves. They become more and more exhausted and discouraged.

You are torn between wanting to stay with your family because you hope you belong there, and wanting to leave because you caused them so much pain.

If your family breaks up or you withdraw from them and you do not find some other support system, you fall on the not so tender mercies of the state.

As you move out into the world, you find you are only comfortable with "social equals," people similarly ill or otherwise damaged, and those rare people who are willing to some extent to understand your experience and feel your pain.

Talking with straight people is nerve wracking. You can never be sure when something you say will come out all weird, and you will be recognized as a crazy person and gotten rid of.

Hungry for human contact, you approach other people, only to discover that they are afraid of you. They assume that if you are mentally ill, you are by definition suicidal and violent.

You had been so wrapped up in being afraid yourself, that it comes as a humiliating shock to find that <u>normal</u> people are afraid of <u>you</u>. Some of them will even take the position that if you are or ever have been crazy, you cannot be trusted with anything, ever.

When out in the community, you are anxiously self-conscious, aware that at any moment a mannerism, a social misstep, or something "inappropriate" will unmask you as a crazy and embarrass anyone you may be with.

You fear being stared at, made fun of, or even being attacked by street creeps always on the lookout for someone with a high victim profile.

If you are too sick to have a hope of concealing it, you can only wait to be hurt and try to keep on going.

Being disabled, you fall into the hands of caretakers.

Sometimes you feel like an abandoned ship, to be taken over by any normal person who wants to, as if they had some kind of salvage rights.

At times you spend a lot of energy fending off such people, trying to hold onto the right to run those parts of your life that you still can.

Caretakers come in various roles, with a variety of titles and letters after their names. Some are very skilled and genuinely helpful, a lot more manage to get by, and some are definitely part of the problem, not part of the solution.

You have no choice about being sick, and no choice about depending on caretakers at times. Even within a given type of service or a particular agency, you seldom have a choice. Your "case" is "assigned" to someone by a "catchment area," "admission rotation," or whatever.

Caretakers control access to medication, asylum (the hospital), money (welfare, SSI), and food (stamps). They decide whether to allow you the sick role, or whether to define you as bad, crazy, or stupid. They can invalidate what you say or do, and call upon the court to have you carted away.

Appeals from their decisions are costly, time consuming, difficult, or impossible. In no way is their relationship a voluntary one between equals.

For a caretaker to operate humanely in such an unequal relationship, a very high level of skill and integrity is required. When you have no choice, you need the best.

Paradoxically, the mental health system tends to assign the least experienced and lowest status workers to screening and to the seriously ill, and the most trained and highest status professionals to the less needy but "more interesting" (more likely to get better) clients.

Like all human beings, some mental healthers have their prejudices, some of which may have a major impact on your life. Some of these prejudices include that, if you are:

a. Poor--you are just trying to get free room and board;
b. Black--you have paranoid schizophrenia;
c. Old--you are hopelessly senile;
d. Male--you are violent;
e. Young and female--you are manipulative or seductive;
f. Young and male--you are a doper;
g. Admitted to a hospital from jail--you are faking;
h. Physically ill--it's all in your head;
i. Failing to get better--you are unmotivated.

In your dealings with mental health workers, you will encounter some common problems:

Mental healthers sometimes seem to see you as a kind of agent of insanity, and immediately start a power struggle over who is to be in control of the relationship.

They seem to fail to see that you have no desire to keep, much less propagate, your crazy ideas. You would get rid of them in a minute if you could only figure out how to do it.

They will frequently refuse to tell you your diagnosis and probable course of your illness. With no real information to go on, you are left to your imagination, which is often worse than anything a doctor could tell you.

What they tell you about the expected effects of your medications and possible side effects is commonly very sketchy. You sometimes have nasty surprises.

Although PRN (extra, as needed) medications are routinely prescribed in the hospital, you are rarely provided them outside. Somehow, life in the community is supposed to be much less stressful, and besides, you might "abuse" the medications.

You find yourself viewed with a general distrust. Everything you say or do is "evaluated" and subject to "clinical judgment," to determine its "real meaning." Yet basic investigative techniques, such as talking to everyone involved and cross-checking their stories, are omitted.

At times, this is due to lack of time or carelessness, but too often it comes from an ego trip wherein professionals feel that their qualifications enable them to discern deep truths virtually by remote control.

It is terribly frustrating to try to communicate with such people, because nothing you say is accepted at face value, but is changed into something unpredictably different.

Meanwhile, they want you to "develop a trust relationship" with them, but changes in staff and program priorities may come much faster than your ability to trust can handle.

You may have to cope with mental healthers who take basically useful approaches to problems and carry them to such lengths that they become problems themselves.

It is helpful to convey to you the expectation that you will get better, but not so helpful to fail to teach yourself care skills and work with the emotional problems that arise when it becomes clear that you are not improving.

Inventorying your symptoms and problems is a necessary beginning of a treatment plan, but concentrating only on what is wrong with you and ignoring the strengths and abilities you still have is not so useful.

Good general counseling skills and effective community organization are necessary to help you improve and maintain your quality of life. However, they do not eliminate the need for detailed knowledge of the symptoms, experiences, and problems which affect you as part of your mental illness, or as effects of your medications.

Anyone working with seriously ill people must be willing to take control at times when you are too disabled to carry on necessary life functions. Unfortunately, mental health work attracts numbers of people whose need to control others is so great that they tend to discourage your own sense of your own competence, and dampen any drive you may have toward free and self-reliant living.

This is a rip-off, because they imply that since you are incompetent, you may rely on them to meet your needs. The first time you get in trouble outside normal business hours or without an appointment, you may have a rude awakening.

You <u>have</u> no choice about learning to take care of yourself and your fellow crazy people as best you can. The response of the mental health system is often just too slow and unpredictable.

It is reasonable for mental health workers to hope for some emotional gratification from their work, but sometimes you are too sick, and have nothing to give in return. Sometimes, when you are not getting any better, your therapists get desperate and start "shot gunning" you with multiple medications and rapid, ill-thought-out changes in your treatment plan.

You may not be listened to when you try to explain what has worked for you in the past.

Since your records are usually following a hospital or an agency or two behind you, you may suddenly be taken off a regimen on which you had been stable, and which took months of experimenting to develop.

The principle seems to be "change something, whether it helps or not," rather than feel helpless.

Other times, some workers get frustrated and bitter, and put increasing pressure on you to "get well or get lost." This can be mutual: they cannot forgive you for not getting better, and you cannot forgive them for not getting you better.

If you are crazy, you can usually count on being poor.

If you are severely disabled, you will probably be on welfare, at least at first.

Your welfare grant is based on a fraction of what a study of local prices determines to be the minimum livable allotment.

Social Security (SSI) is somewhat more, but you are unlikely to successfully complete the complex application process without determined help from a case manager or a family member.

In either case, you will have a welfare medical card. Since there are restrictions on the services covered, and because the majority of local physicians do not take welfare patients, your medical care is likely to be poor and without continuity.

You will probably have bad teeth, as well. Dental care is only available for emergencies, and for a low dollar amount, resulting mostly in extractions.

Your clothing is likely to be poor, ill fitting and mismatched, coming from thrift stores, and sometimes carrying institutional marks.

Drifting in and out of hospitals, jails, and boarding houses, most of your possessions will have long since been lost or stolen. You may have little in the way of toilet articles, and you may smell.

Your status as a second class citizen, a loser, is displayed for all to see. In addition to the practical problems of poverty, there are the emotional effects. If you are one who has learned to count personal worth in terms of possessions, you are doubly poor.

There is a strong streak of Calvinism in our society: being poor is seen as evidence that you are also bad.

If you go into a nice store, clerks follow you around waiting for you to steal something. Some mental health workers dress especially well to avoid being mistaken for patients.

If you are unable to be productive, many feel you should be uncomfortable. It would be immoral, somehow contributing to your delinquency, to give you things you cannot earn.

You meet people who would obviously be willing to let you starve to death if it were their choice. To your humiliation is added an element of real fear.

You may find yourself begging and stealing, in violation of your own principles. You pack rat, assembling collections of junk, rather than have nothing at all.

Sometimes it is hard not to hate the caretakers around you, who have built a comfortable lifestyle upon your misfortune.

Sex is important to people, to sick people no less than to people who have the privilege of being healthy. Like everything else, mental illness messes it up.

When you are depressed, when you hurt so bad you have to be completely numb in order to function at all, the numbness itself becomes another kind of discomfort. You want to feel <u>something</u>, anything but more pain. You think of sex as a strong, good feeling, and try it. You run into a wall of pain and exhaustion. You cannot get aroused, you cannot tolerate intercourse. You experience one more crushing failure. Perhaps you are no longer a woman or a man anymore.

If you are high, in a manic state, you may be very sexually active. It may feel wonderful, or, if your high has reached an agitated, desperate stage, it may feel frenzied and out of control.

When you come down, it can be mortifying. You may have VD treatment, abortion, divorce papers, and new enemies waiting for you.

If you have a thought disorder, you may be too scattered to figure out what you need, or disorganized or fearful to effectively seek out a partner. If you find a partner, he or she is likely to be a "social equal." With both of you crazy things can get confusing.

Institutions do not make provisions for sexual privacy. Quite the contrary. Your sexual experiences are likely to take place in bushes or on the floors of out-of-the-way restrooms.

You risk a personal confrontation with the fact that many people, but especially high control institution types, do not feel crazy people are entitled to sex lives. They may also have reasonable concerns about competency to consent, and about civil liability.

If you are male, and your activities or choice of partner are not approved of, you may be written up in records as "sexually inappropriate with one of our sickest female patients" ("rapist").

If you are a female, you may be described in your chart as "sexually inappropriate with men" (presumably numerous, "whore").

If you are gay or lesbian, you are doubly disapproved of, and you risk having drastic action taken against you, especially premature discharge from treatment.

If you are young, and have homosexual experiences during prolonged institutionalization, which are common, you may have to keep it deeply secret afterward, and wrestle, usually alone, with the question of what your sexual orientation actually may be.

A complication of trying to have a sex life while under psychiatric treatment is that many psychotropic medications are sexually disabling in many people. You may find yourself unable to get aroused, or you may be aroused but unable to climax, or climax is long delayed.

You may be told about this when being instructed about your medications, but frequent not. If you can get up the nerve to raise the issue, often a reduction of dose or a change to another drug will take care of the problem.

If you cannot, you get more depressed at this additional evidence that your life is ruined.

When you are poor, crazy, and unwanted, you hunger for warmth and touching, on almost any terms. Sometimes you fall into the hands of cruel and exploitive people.

Sometimes you hope you will have a child, as a fulfillment of your identity as an adult human being, and in hopes of having someone to be with, who will love you. Frequently, this ends in tragedy, as you have children you cannot take care of, and they are taken away from you.

Because mentally ill people often are fairly helpless, they are frequent crime victims. Criminals often are aware that you may have no interested family or friends, and are easily discredited in court. Therefore, there is little risk of being prosecuted for any crime against you, short of murder.

The sword is two-edged: because you are "insane" you may receive no consequences for repeated antisocial acts. You risk developing habits of behavior that drive away your support system, and ultimately land you in the hospital or on Skid Row.

When you lose your mental health, you go through the same pattern of responses for any other major loss. Dr. Elizabeth Kubler-Ross's "Stages of Dying" is a fairly accurate model.

1. Shock. You never expect to go crazy, nor do you expect to find out one day that you have been crazy for a long time.

   You are stunned, confused, afraid. For a period of time, you are in shock and unable to do anything to help yourself.

2. Denial. You buy time to deal with overwhelming anxiety producing situations, by denying them. You try to go on living as if the problem did not exist, while your subconscious mind works on some way to cope with the problem.

   Other people, who are not sick, get frustrated and angry because you do not do whatever they think you should do about the situation.

   Since it is not their problem, they are not overwhelmed by anxiety, and they can view the whole affair more objectively.

   The crunch comes when they pressure you to "face this thing, right now!" and accuse you of "wanting to stay sick."

   The reason you are unwilling to do the things they demand, such as going to a clinic, taking medication, and giving up "unrealistic" life plans, is because you do not want to be sick. Therefore, you do not want anything to do with anything even remotely related to being crazy.

   Since your denial is basically driven by anxiety, the more you are harassed about "facing the facts," the more delayed as you're coming to terms with your situation.

3. Anger. When you realize that your life is going to be more painful and more limited than the lives of other people who are of no greater merit than yourself, you get mad.

   Since many people view the family as the source of all problems, you may direct, and be encouraged to direct, your anger at them. Often having strong guilt feelings themselves, they may agree that you are entitled to be angry at them.

   You may also vent your anger at mental health workers, whose very presence in your life is an undesirable reminder of how you have been cheated of a normal life.

   You may carry a powerful resentment against people who have the privilege of normalcy, who have jobs, friends, money, cars, and other things that you do not.

4. Bargaining. As it becomes clear that this insanity business is for real, and it shows no signs of going away, you want to make a deal.

   You try unusual diets, stranger religions, street drugs, anything that offers the faintest hope of making a difference.

You promise God that you will devote the rest of your life to medical research and serve to the poor, if only this cross will be taken from you.

Occasionally, someone recovers for no reason known to man. Not very often.

5. Depression. When you realize that no deals are being made, blaming people makes no difference, and the craziness is not going away. You are very, very sad.

   You have a right to be. Through no fault of your own, your life has been ruined. You may never have the job, children, a car, or even one day free of pain for the rest of your life. The temptation to give up and die is very great.

6. Acceptance. After a time, usually a long time, you find a way to accept yourself and what has happened, and to go on with your life.

   There are three things that you have to understand:

   a. You must take care of yourself and meet as many of your own needs as you can, either yourself or through relationships with other people which are mutual, equal and loving.

      By virtual biological law, people meet their own needs and those of their loved ones first. Only what is left over is offered to others.

      This is as true of mental health workers as anyone else. They provide specific services, and a measure of emotional support, but rarely as love as exchanged among equals.

   b. Blaming people, whether yourself, your family, or anyone else, is a waste of time.

      Too much psychodynamic, insight-oriented therapy is a thinly disguised search for someone to hold responsible.

      There is no way you can recover a piece of your life from someone, as if it were money damages. You may not be able to forgive or forget, but you have to withdraw your energy from the past, and go on.

   c. You have to find some reason, some mission in life to justify going on, in spite of the pain and lack of orderly success.

      If you are religious, it may be the faith that you are in this world to be tested, or to learn something essential for your spiritual development, and that your

Appendix

Some reasons mentally ill people contact crisis services are:

1. You may need help with a practical, real-world problem. If you spent a lot of your life being crazy, you may be missing whole areas of competence which are taken for granted by normal people, such as riding the bus, dealing with a traffic ticket, or returning defective merchandise to a store.

2. You may need help putting an idea in words, defining a problem clearly so that you can work on solving it, or communicating feelings to someone in a relationship. If you have a thought disorder, the most important area of communication in words can be extremely difficult.

3. You may need emotional support for a necessary decision not popular with your immediate support system. The people in your college psychology class may be delivering fulminating denunciations of psychotropic medications, but you have to stay on them, or end up in the hospital or dead.

4. You may have symptoms that relate to a developing medical problem, and you need help figuring out whether you need medical care, or whether these are just some new variations on your hallucinations and delusions.

5. You may be experiencing new or threatening psychiatric symptoms, such as prolonged sleep loss or command hallucinations ordering you to kill yourself. You may need help deciding how serious these are, and what to do about them.

6. You may need a perception check: does it seem likely that you are important enough for the FBI to bug your phone, or is that probably just a crazy idea?

7. You may need help finding specific local mental health or social services.

8. You may be without food, clothing, shelter, or essential medical care.

9. You may be in legal trouble, and need help conveying to those defending you, the nature of your illness and your disabilities.

suffering has a place in the overall cosmic picture. For others it may be the goal of someday writing a book, which you hope will help normal people understand the experiences and needs of the mentally ill.

For a few who have luck, brains, and a terrible determination, it may be possible to go back into the wilderness to try to lead a few brothers and sisters to freedom. They become mental health workers themselves.

It may be the love of family, fear of death, or even plain stubbornness, but there has to be a reason.

If the pain is futile, it is also intolerable.

COMMUNITY RESOURCES

NETWORK
Behavioral HealthCare, Inc.

Resume of Low-Income Housing Experience

Date of Inception	Project
March 1985	Tillicum Court Apartments

Under the corporate ownership of Southeast Network Housing Services, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing in studio and 1 bedroom apartments, as well as skills training and support services, are provided on-site. Additional psychiatric and clinical services are available through the Network's Rehabilitation and Community Services divisions.

March 1987 — 70th Street House

The Network provides residential care in a transitional group home setting to 12 individuals having mental illness. Twenty-four hour supervision, skills training, and counselor support are provided on-site as are meals, medication and money management. The facility is leased from the Housing Authority of Portland and operated by the Network. All residents are low income and supported by entitlement programs.

May 1988 — Nawikka Court Apartments

Under the corporate ownership of Southeast Network Housing Services II, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing is provided in 1 bedroom units with additional services provided as described for Tillicum Court.

ADMINISTRATION
5415 SE Milwaukie Avenue • Portland, Oregon 97202
(503)238-0769 • FAX(503)233-2861

January 1992

Pisgah Home/Harriet Court Apartments

The Network provides both residential care (Pisgah Home) and supported housing (Harriet Court) to individuals having mental illness at these co-located program sites. Fifteen Pisgah tenants receive twenty-four hour supervision, assistance with activities of daily living (hygiene, grooming, etc.), money, medication and crisis management; skills training and counseling. Fifteen Henry Court tenants live independently and receive skills training and support from on-site staff as appropriate to their needs. Tenants in either program reside in private rooms with private baths. Congregate meals are available. The Network owns and manages the facility in which it operates these programs. All tenants have incomes below 50% of median; many are supported by entitlements.

November 1993

Woodstock Court Apartments

The Network operates this nine (9) unit complex under lease from the Housing Authority of Portland, the project's co-developer (with Network). Eight studio units are rented to homeless individuals having mental illness. An on-site manager occupies a 9th unit. The Network provides skills training and support services including medication monitoring and a meal preparation skills program. The Network manages all aspects of this housing. All tenants have incomes below 50% of median, typically from entitlement payments.

May 1994

Lafayette Apartments

The Network owns and operates this thirty two (32) unit complex which provides supported independent living in studio and in one bedroom apartments to individuals having mental illness. On-site management and optional skills training and support services including medication monitoring and meal preparation training are provided. All tenants have incomes below 30% of median and are generally supported by entitlement programs.

October 1994

Kernlodge Home

Quint 26

The Network operates these two, five (5) unit homes under lease from The Housing Authority of Portland, the project's co-developer (with Network). Each home contains five SRO units (a private bedroom and bath), and shared space that includes kitchen, dining room, living room, laundry, and individual pantry/food storage areas. This shared housing affords its tenants privacy, security, and comfort in a small, group-oriented, neighborhood-friendly building. Tenants are low income persons having mental illness who are capable of living in an unsupervised setting. The buildings do not have live-in management, but are regularly monitored by the staff of Network Behavioral HealthCare, Inc. The Network provides the residents with skills training, case management, twenty-four hour emergency on-call psychiatric, health, vocational, socialization, recreational and medication monitoring services. All tenants have incomes below 50% of area median and are generally supported by entitlement payments.

January 1995

Lents Court

The Network operates this five (5) unit home under lease from The Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge and Quint 26 described above. All tenants are low income veterans who are clients of the VA Domaciliary Program. All support services are provided by the VA under a Letter of Understanding with Network.

January 1996

Tea Link Home

The Network operates this five (5) unit home under lease from the Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge, Quint 26 and Lents Court described above. All tenants are low income Asians. All support services are provided by the Chinese Mental Health Program.

March 1996

Hopewell Apartments

Under the corporate ownership of EcuNet Housing, Inc., a partnership between Network and Ecumenical Ministries of Oregon, Network operates this 8 one bedroom and 4 two bedroom HUD 811 apartment building. Hopewell offers low income people with HIV disease and psychiatric disabilities housing and a program of services to help them live as independently as possible. On-site management is available. Tenants pay about 30% of their income for rent and utilities and are required to meet HUD income eligibility requirements.

June 1996

Clinton Street Apartments

The Network owns and operates this 16 unit complex (15 studio apartments and 1 one bedroom apartment) to provide housing with linked support services for low income individuals with mental illness. The project has an on-site manager who provides skills training and support services including medication monitoring, case coordination, and recovery services. All tenants have incomes below 50% of area median and are generally supported by entitlement programs.

September 1996

Tabor House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. All six tenants are low income individuals who are capable of living in an unsupervised, supportive setting. Each has a private bedroom and shares use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

November 1996

75th Ave. Adult Foster Care

Network owns and operates this five resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 50% of area median and are supported by entitlement programs.

August 1998

Powell Blvd. Apartments

Under the ownership of Powell Boulevard Apartments, Inc., a not-for-profit corporation sponsored by REACH Community Development, Network operates this 20 unit HUD 811 project for the benefit of low income persons having co-existing mental illness and substance abuse disorders. Tenants occupy studio, 1 bedroom, and 2 bedroom units, and participate in a program of services designed to promote independence and sobriety. On-site management and supports are available to supplement psychiatric and addictions services provided through Network's Project STOP or other treatment providers. All tenants have incomes below 50% of area median and pay approximately 30% of their income for rent and utilities.

March 1999

Woodstock House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. The tenants are low income women who are capable of living in an unsupervised, supportive setting. The home is configured to allow the rental of individual bedrooms to single women or two bedroom suites to small families. Tenants share the use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

April 1999

Residential Intensive Treatment Services

The Network owns and manages this ten unit transitional housing program in which residential treatment is provided to individuals having mental illness and addictions issues. Tenants are referred by Multnomah County Community Corrections and receive twenty-four hour supervision, addictions treatment, assistance with activities of daily living, money, medication and crisis management; skills training and counseling. Tenants reside in private rooms with half baths during their three month stay. All tenants have incomes below 50% of median; many are supported by entitlements.

January 2000

Nadine Place

Network owns and operates this eight resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 30% of area median and are supported by entitlement programs

Tenants of these residential programs receive housing and on-site services as specified above. In addition, tenants are welcome to participate in the full range of community treatment and rehabilitation programs offered by The Network. These programs include case management; medical and psychiatric consultation; vocational, recreational and socialization services, substance abuse recovery services; psycho-social clubhouse; crisis/triage services; individual and group counseling; and medication management.

MEDICATIONS

MEDICATIONS AND THEIR SIDE EFFECTS

Psychiatric researchers believe that people suffering from many mental illnesses have imbalances in the way their brain metabolizes certain chemicals, called neurotransmitters. Because neurotransmitters are the messengers the nerve cells use to communicate with one another, these imbalances may result in the emotional, physical and intellectual problems that mentally ill people suffer. Psychiatric medications are like any other medicine a doctor would prescribe. They are formulated to treat specific conditions, and they must be monitored by a physician. All medicines have positive and negative effects. Whether or not a person will experience side effects cannot be predicted. Responses to medications are individual. Most medications psychiatrists prescribe may take a few days or a few weeks to become fully effective. The listed medications and their side effects are some of the most common but it is certainly not a complete list.

MEDICATIONS AND THEIR SIDE EFFECTS

Antidepressents	Most Common Side Effects
Amitriptyline (Elavil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, worsening of heart disease, dizziness when first standing up
Amoxapine (Asendin)	Worsening of heart disease, sleepiness, agitation, insomnia, anxiety
Bupropion (Wellbutrin)	Agitation, dry mouth, insomia, headache, nausea, vomiting, constipation, tremor
Clomipramine (Anafranil)	Dry mouth, sleepiness, tremor, weight gain, sweating, dizziness when first standing up, blurred vision, constipation, trouble having orgasm, trouble urinating, nausea
Desipramine (Norpramin)	Dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, dizziness when first standing up
Doxepin (Sinequan)	Sleepiness, sweating, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, weight gain, dizziness when first standing up
Fluoxetine (Prozac)	Agitation, anxiety, insomnia, drowsiness, tremor, loss of appetite, nausea, diarrhea, headaches, dizziness, problems with orgasm
Imipramine (Tofranil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain sweating
Maprotiline (Ludiomil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, weight gain
Nefazodone (Serzone)	Sleepiness, dizziness when first standing up, nausea, headache
Nortriptyline (Pamelor)	Sleepiness, dry mouth, trouble urinating, constipation, blurred vision, weight gain
Paroxetine (Paxil)	Nausea, sleepiness, fatigue, dizziness, insomnia, sweating, tremor, loss of appetite, anxiety, trouble having an orgasm
Protriptyline (Vivactil)	Dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, insomnia, anxiety
Sertraline (Zoloft)	Nausea, diarrhea, tremor, dizziness, insomnia, sleepiness, sweating, fry mouth, delay in having an orgasm
Trazodone (Desyrel)	Sleepiness, worsening of heart disease, dizziness when first standing up, nausea, vomiting
Trimipramine (Surmontil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Venlafaxine (Effexor)	Sedation, nausea, sweating, dry mouth, dizziness, weakness, constipation, decreased appetite, vomiting, anxiety, tremor, blurred vision, problems with orgasm, headache
Fluvoxamine (Luvox)	Sleepiness, insomnia, anxiety, tremor, nausea, loss of appetite, vomiting sweating, delayed orgasm

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche" =the mind and "tropos" = turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics; that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially highly addictive, produce fairly rapid tolerance and are extremely difficult to withdraw from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal, as bad as it feels, is actually easier, quicker and safer than benzodiazapine withdrawal.

Common side effects are sedation, dry mouth, depression, and memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are non-addictive and do not produce tolerance. The anti-depressants work to restore balance in the neurotransmitter systems, which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics
Elavil (amitriptyline)

Tofranil (imipramine)
Norpramine (desipramine)
Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

The second generation or "atypical" compounds
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)
Serzone (nefazadone)
Remeron (mirtazapine)

The SSRI's (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

The MAOs (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The ANTI-MANICS (also referred to as mood stabilizers) are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. Non-addictive and does not produce tolerance. Research has shown that these medications are also helpful in preventing the recurrence of severe mood swings.
Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The ANTI-PSYCHOTICS also called Neuroleptics are used to treat psychotic symptoms. As such they are believed to work by restoring balance in the neurotransmitter systems (primarily dopamine) which mediate thought processes, perception and mood. They are non-addictive and do not produce tolerance.
Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)
Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
The "new generation" anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Seroquel (quetiapine)
Orap (pimozide) used mainly for Tourette's Syndrome

The Anti-Parkinson medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The ATTENTION DEFICIT DISORDER/HYPERACTIVITY medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. These medications can produce dependence and tolerance. They are less often prescribed now as many of the SSRI anti-depressants and a

couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)
Adderol (contains both dextro and levo amphetamine)

There are probably newer medications in all the above classes since this has been written but this list is fairly inclusive.

Keep in mind that side effects can occur with any chemical you take in. Such things as aspirin and tylenol can be deadly. Side effects are reported when they occur in more than 2% of the population taking a particular medication. Most often they are dosage related or a sensitivity to a particular medication which can be substituted with one which is better tolerated. If you have a condition which warrants taking a psychotropic medication, odds are that you and loved ones around you suffer more from the condition than you ever will from a side effect.

ANTI-PSYCHOTIC DRUGS

ACETOPHENAZINE (TINDAL) MESORIDAZINE (SERENTIL) TRIFLUOPERAZINE (STELAZINE) THIOTHIXENE (NAVANE) RESPERIDONE (RISPERDAL) LOXATANE (LOXAPINE) CHLORPROMAZINE (THORAZINE) HALOPERIDOL (HALDOL) THIORAZINE (MELLARIL) PIMOZIDE (ORAP) MOLIDONE (MOBAN) CHLORPROTHIXENE (TARACTAN) FLUPHENAZINE (PROLIXIN) TRIFLUOPERAZINE (STELAZINE) PERPHENAZINE (TRILAFON) CLOZAPINE (CLOZARIL)	Side effects include dry mouth, blurred vision, constipation, and drowsiness. Some people taking the medications can experience a difficulty in urinating that ranges from mild problems beginning urination to complete inability to do so, a condition that requires prompt medical attention. Other side effects include greater risk for sunburn, changes in white blood cell count (with clozapine), low blood pressure when standing or sitting up, akathisia, dystonia, parkinsonism, and tardive dyskinesia. Tardive dyskinesia is one of the most serious side effects of anti-psychotic medications. This condition affects between 20 and 25 percent of persons taking antipsychotic drugs. Tardive dyskinesia causes involuntary muscular movements, and though it can affect any muscle group, it often affects facial muscles. There is no known cure for these involuntary movements (though some drugs, including reserpine and levodopa may help) and tardive dyskinesia may be permanent unless its onset is detected early.

Anti-psychotic drug list from Kay Peterson/Project Respond/Portland, Or. 7-15-1999

NOTES

PSYCHIATRIC MEDS BY TRADE NAME

CODES:

AA=anti-anxiety
AD=anti-depressant
AD/MAOI=anti-depressant (can be life threatening when mixed with tyramine, eg some alchols & cheeses)
AD/TCA=antidepressant (higher risk of fatal OD)
AP=anti-psychotic
ALZ=for Alzheimers disease
HYP=hypnotics, meds used for sleep
MR=muscle relaxants((not a psych med/may effectbehavior)
MS/AC=mood stabilizers; and /or anticonsulvsant
NAR=narcotics,(for pain mgmt, may effect behavior)
SE- meds commonly used for side effects of anti-psychotics
STIM=stimulants

Adaptin	AD	doxepin
Adderall	STIM	dextroamphetamine
Akineton	SE	biperiden
Amytal	SLP	amobarbital
Anafranil	AD/TCA*	clomipramine
Antabuse	Etoh block	disulfiram
Aricept	ALZ	donepezil
Artane	SE	trihexyphenidyl
Ascendin	AD	amoxapine
Atarax	AA	hydroxyzine
Ativan	AA	lorazepam
Aventyl	AD/TCA*	nortriptyline
Benadryl	SE	diphenhydramine
Buspar	AA	buspirone
Centrax	AA	prazepam
Clozaril	AP	clozapine
Cogentin	SE	benztropine
Cognex	ALZ	tacrine
Cylert	STIM	pemoline
Dalmane	HYP	flurazepam
Darvocet	NAR	propoxyphene
Demerol	NAR	meperidine
Depakane	MS/AC	valproic acid
Depakote	MS/AC	valproic acid
Desyrel	AD	trazadone
Dilantin	AC	phenytoin
Dilaudid	NAR	hydromorphone
Effexor	AD	venlafaxine
Elavil	AD/TCA*	amitriptyline
Endep	AD/TCA*	amitriptyline
Equanil	AA	meprobamate
Eskalith	MS	lithium

Floricet	NAR	butalbital with aspirin
Florinal	NAR	butalbital with tylenol
Flexoril	MR	cyclobenzaprene
Halcion	HYP	triazolam
Haldol	AP	haloperidol
Inderal	SE/AA	propranolol
Isoptin	AA/MS	verapamil
Janimine	AD/TCA*	imipramine
Kemadrin	SE	procyclidine
Klonopin	AA	clonazepam
Librium	AA	chlordiazepoxide
Lioresal	MR	baclofen
Lithobid	MS	lithium
Loxitane	AP	loxapine
Ludiomil	AD	maprotiline
Lortabs	NAR	hydrocodone
Luvox	AD	fluvoxamine
Marplan	AD/MAOI	isocarboxazid
Mellaril	AP	thiorazine
Miltown	AA	meprobamate
Moban	AP	molidone
Mysoline	AC	primidone
Nardil	AD/MAOI	phenelzine
Navane	AP	thiothixene
Nembutal	HYP	pentobarbital
Noctec	HYP	chloral hydrate
Norpramin	AD/TCA*	desipramine
Orap	AP	pimozide
Pamelor	AD/TCA*	nortriptyline
paraldehyde	HYP	paraldehyde
Parnate	AD/MAOI	tranycypromine
Paxil	AD	paroxidine
Percocet	NAR	oxycodone with tylenol
Percodan	NAR	oxycodone with aspirin
Pertofrane	AD/TCA*	desipramine
Placidyl	HYP	ethchlorvynol
Prolixin	AP	fluphenazine
ProSom	HYP	estazolam
Prozac	AD	fluoxetine

Rela	MR	carisoprodol
Remeron	AD	mirtazapine
Restoril	HYP	temazepam
Risperdal	AP	resperidone
Ritalin	STIM	methyphenidate
Robaxin	MR	methocarbamol
Seconal	HYP	secobarbital
Serax	AA	oxazepam
Serentil	AP	mesoridazine
Serzone	AD	nefazodone
Seroquel	AP	quitiapine
Sinequan	AD/TCA*	doxepin
Soma	MR	carisoprodol
Stelazine	AP	trifluoperazine
Surmontil	AD/TCA*	trimipramine
Symmetrel	SE	amantadine
Taractan	AP	chlorprothixene
Tegretol	MS/AC	carbamazepine
Tenormin	SE	atenolol
Thorazine	AP	chlorpromazine
Tindal	AP	acetophenazine
Tofranil	AD/TCA*	imipramine
Tranxene	AA	clorazepate
Trilafon	AP	perphenazine
Tylenol/codeine	NAA	acetominophen with codeine
Tylox	NAA	oxycodone with aspirin
Valium	AA	diazepam
Vistaril	AA	hydroxyzine
Vivactil	AD/TCA*	proptriptyline
Wellbutrin	AD	bupropion
Xanax	AA	alprazolam
Zoloft	AD	sertraline
Zyban	AD	buproprion
Zyprexa	AP	olanzapine

GENERIC NAME	TRADE	TYPE
acetominophen with codeine	Tylenol/codeine	NAR
acetophenazine	Tindal	AP
alprazolam	Xanax	AA
amantadine	Symmetrel	SE
amitriptyline	Elavil	AD/TCA*
amitriptyline	Endep	AD/TCA*
amobarbital	Amytal	SLP
amoxapine	Ascendin	AD
atenolol	Tenormin	SE
baclofen	Lioresal	MR
benztropine	Cogentin	SE
biperiden	Akineton	S
bupropion	Wellbutrin	AD
buproprion	Zyban	AD
buspirone	Buspar	AA
butalbital with aspirin	Fioricet	NAR
butalbital with tylenol	Fiorinal	NAR
carbamazepine	Tegretol	MS/AC
carisoprodol	Rela	MR
carisoprodol	Soma	MR
chloral hydrate	Noctec	HYP
chlordiazepoxide	Librium	AA
chlorpromazine	Thorazine	AP
clomipramine	Anafranil	AD/TCA*
chlorprothixene	Taractan	AP
clozapine	Clozaril	AP
clorazepate	Tranxene	AA
clonazepam	Klonopin	AA
cyclobenzaprene	Flexoril	MR
desipramine	Norpramin	AD/TCA*
desipramine	Pertofrane	AD/TCA*
dextroamphetamine	Adderall	STIM
diazepam	Valium	AA
diphenhydramine	Benadryl	SE
disulfiram	Antabuse	Etoh block
donepezil	Aricept	ALZ
doxepin	Adaptin	AD
doxepin	Sinequan	AD/TCA*
estazolam	ProSom	HYP
ethchlorvynol	Placidyl	HYP
fluoxetine	Prozac	AD
fluphenazine	Prolixin	AP
flurazepam	Dalmane	HYP
fluvoxamine	Luvox	AD
haloperidol	Haldol	AP
hydrocodone	Lortabs	NAR
hydromorphone	Dilaudid	NAR
hydroxyzine	Atarax	AA

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAA
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MR
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAA
oxycodone with aspirin	Tylox	NAA
oxycodone with tylenol	Percocet	NAA
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAA
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAA
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MA
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAA
oxycodone with aspirin	Tylox	NAA
oxycodone with tylenol	Percocet	NAA
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAA
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

thiorazine	Mellaril	AP
thiothixene	Navane	AP
tranycypromine	Parnate	AD/MAOI
trazodone	Desyrel	AD
triazolam	Halcion	HYP
trifluoperazine	Stelazine	AP
trihexyphenidyl	Artane	SE
trimipramine	Surmontil	AD/TCA*
valproic acid	Depakane	MS/AC
valproic acid	Depakote	MS/AC
venlafaxine	Effexor	AD
verapamil	Isoptin	AA/MS

MEDICAL EMERGENCIES include but are not limited to:

Anti-psychotics (AP) may cause a syndrome with muscle rigidity, fever, fast pulse rate, high blood pressure, confusion.

Anti-psychotics (AP) may cause muscle stiffness and tightening, tremors, and effect swallowing.

Tricyclic anti-depressants (AD/TCA*) present a higher risk of lethal overdose, especially if combined with alcohol; if combined with cocaine can produce heart failure.

Antabuse (disulfiram) if combined with alcohol will cause flushing, sweating, headache,palpitations, difficulty breathing, rapid heart beat, drop in blood pressure, nausea & vomiting; may lead to serious drop in blood pressure and death.

Medication-related seizures , a situation which should be evaluated at the hospital.

Certain anti-depressants (AD/MAOI) if combined with alcohol , certain cheeses and other foods containing tyramine will cause blood pressure crisis.

Delirium is a medical emergency, which includes symptoms of irritability, significant distractability, hallucinations,

Meds such as anti-anxiety agents and hypnotics have a higher risk of lethal overdose particularly if combined with alcohol.

OTHER RISKS OF PSYCHIATRIC MEDICATIONS INCLUDE:

Susceptability to sunburn-particularly with certain antipsychotics.

Higher risk of dehydration- particularly with lithium.

Anti-cholinergic side effects , including dry mouth, blurred vision, constipation, difficulty urinating, impotence, constipation.

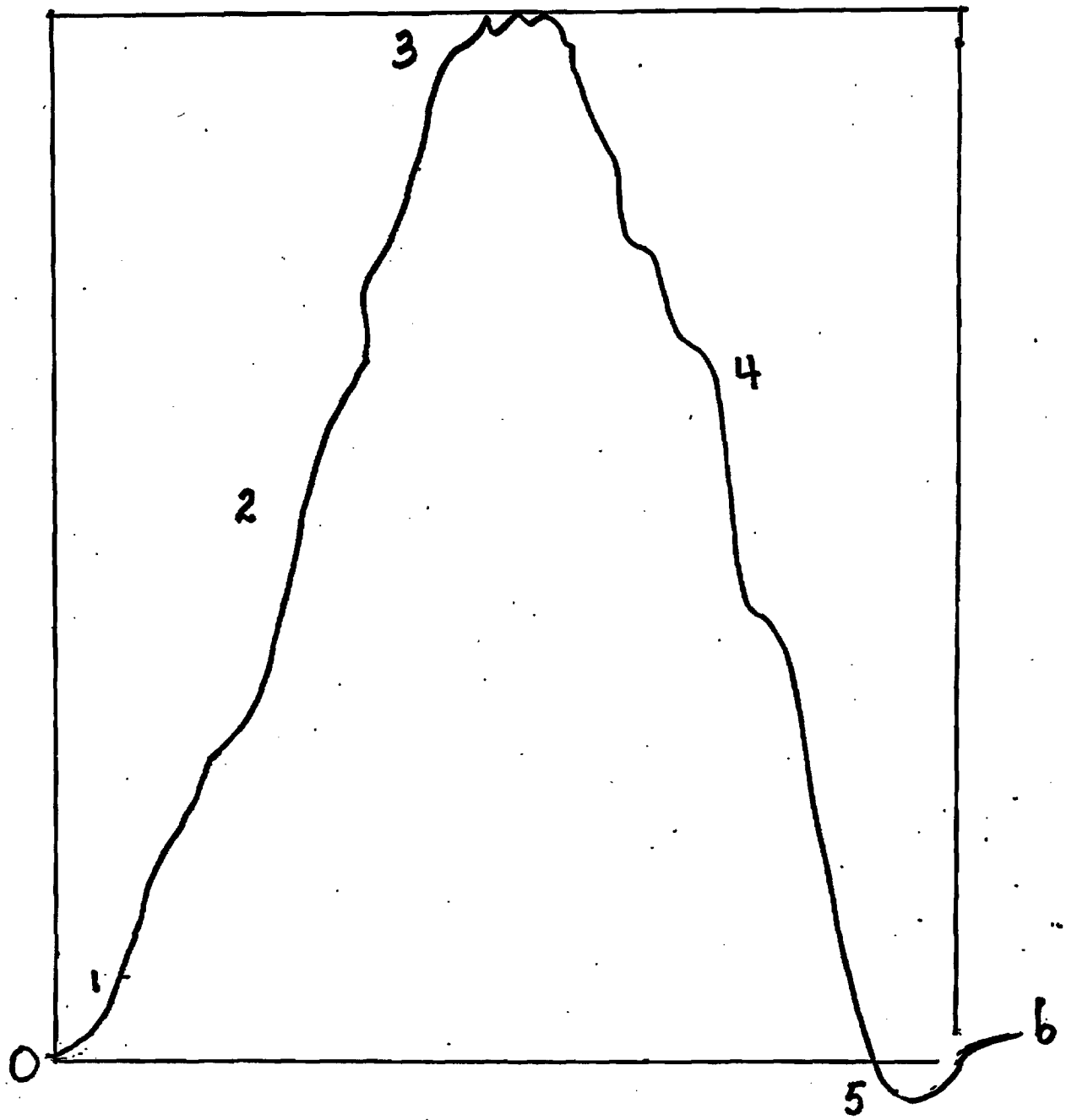
Many medications can cause allergic reactions as well as unexpected reactions with other medications, foods, alcohol, drugs.

Compiled by Project Respond for the Portland Police Department.

Crisis Intervention

CRISIS CYCLE

The Crisis Cycle



0 - Normal State
1 - Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post crisis depletion
6. Stabilization

CRISIS CYCLE

0. Normal state.

1. Stimulation

Something has happened to cause the person to become:

Excited or
Active or
Upset or
Physically uncomfortable

Cause can be external or internal or both.

External
Something someone else said or did.
Environment: hot, cold, crowded.

Internal
Physical illness, injury or pain.
Emotional upset
Mental illness: mood disorders, hallucinations.

2. Escalation

Obvious signs of distress.
Observable physical changes and changes in behavior.
(if you don't know the person, it may be hard to know what is a change)

Examples:
Red face
Tense muscles (tight face, clenched fists)
Talking more or louder. (some get quiet/withdrawn)
-Increased activity : Pacing, rocking, etc.

3. Crisis

Out of control.
May scream, yell, curse.
May wave arms or stamp feet.
May assault.

4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

Basic Psychiatric Life Support Model

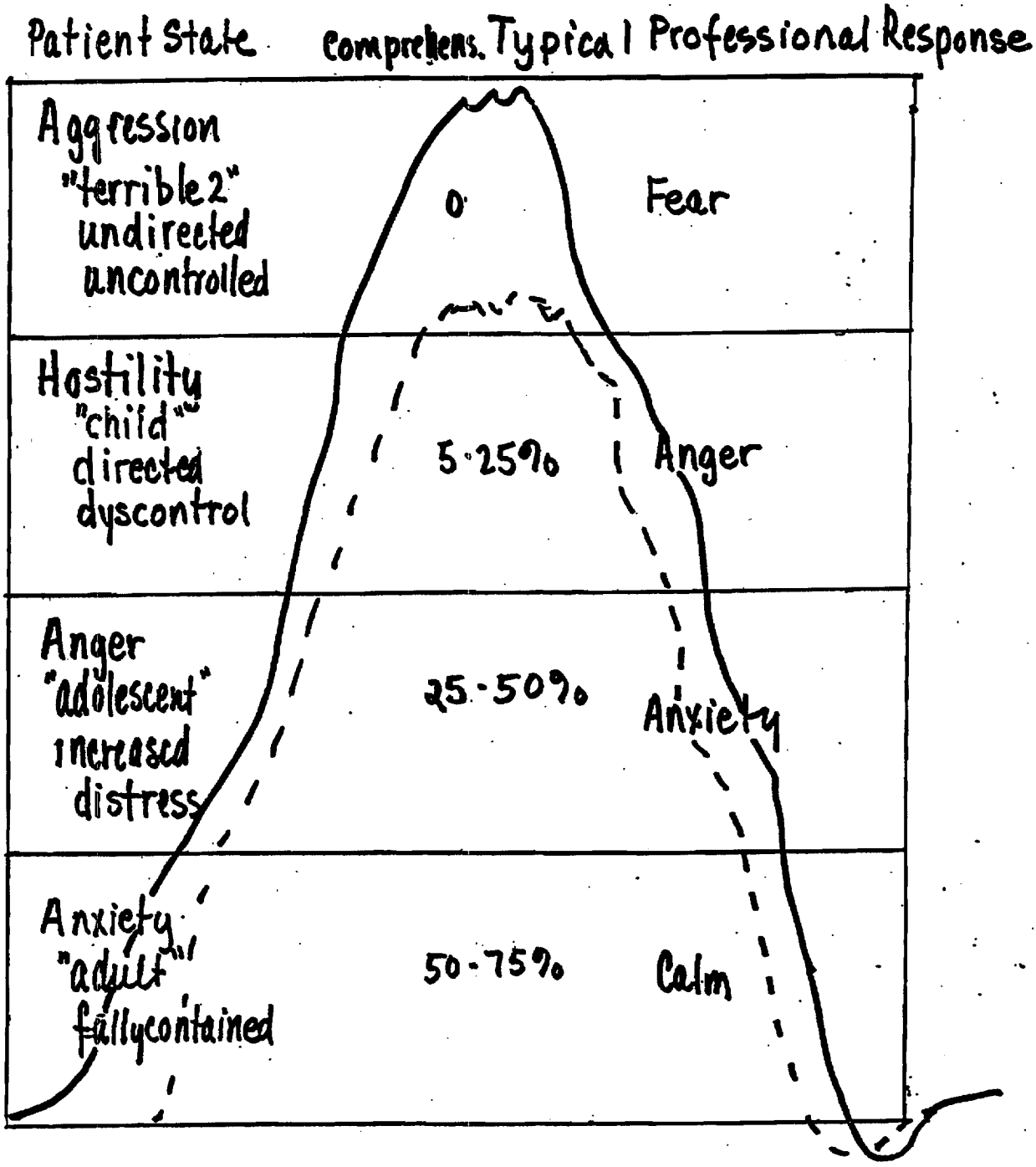
Patient State

Aggression "terrible 2" undirected uncontrolled
Hostility "child" directed dyscontrol
Anger "adolescent" increased distress
Anxiety "adult" fully contained

Basic Psychiatric Life Support Model

Patient State	% comprehension
Aggression "terrible 2" undirected uncontrolled	0-5%
Hostility "child" directed dyscontrol	5-25%
Anger "adolescent" increased distress	25-50%
Anxiety "adult" fullycontained	50-75%

Crisis Cycles with Basic Psychiatric Life Support Model



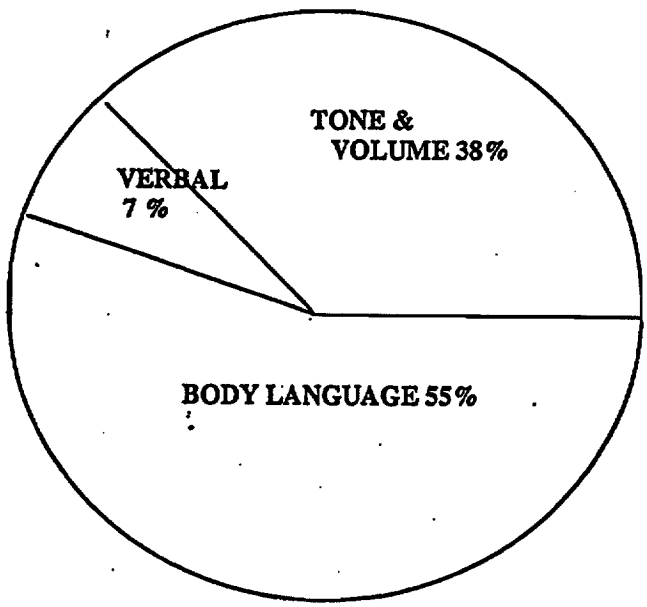
Managing Behavioral Emergencies

As trained crisis intervention specialists, your most likely subjects will be out of control chronically mentally ill persons, angry domestics, suicidal people in public places (bridge jumpers), barricaded individuals, and/or intoxicated persons displaying bizarre behaviors. What do these folks have in common? All will demonstrate some degree of serious impairment in their ability to communicate effectively. This presents a challenge to the police specialist who is attempting to negotiate an alternative to violent behaviors.

One of the few tools that mental health workers have available in dealing with agitated people is the ability to talk down potential assailants. Here are some useful ideas and techniques. The following focus will examine strategies in which you might maximize your ability to deal with agitated people. None of the material in itself is new. The objective for this presentation is to examine principles of applying effective communication techniques to de-escalate agitated persons when possible.

COMMUNICATION

When individuals are highly stressed, non-verbal communication becomes dominant.



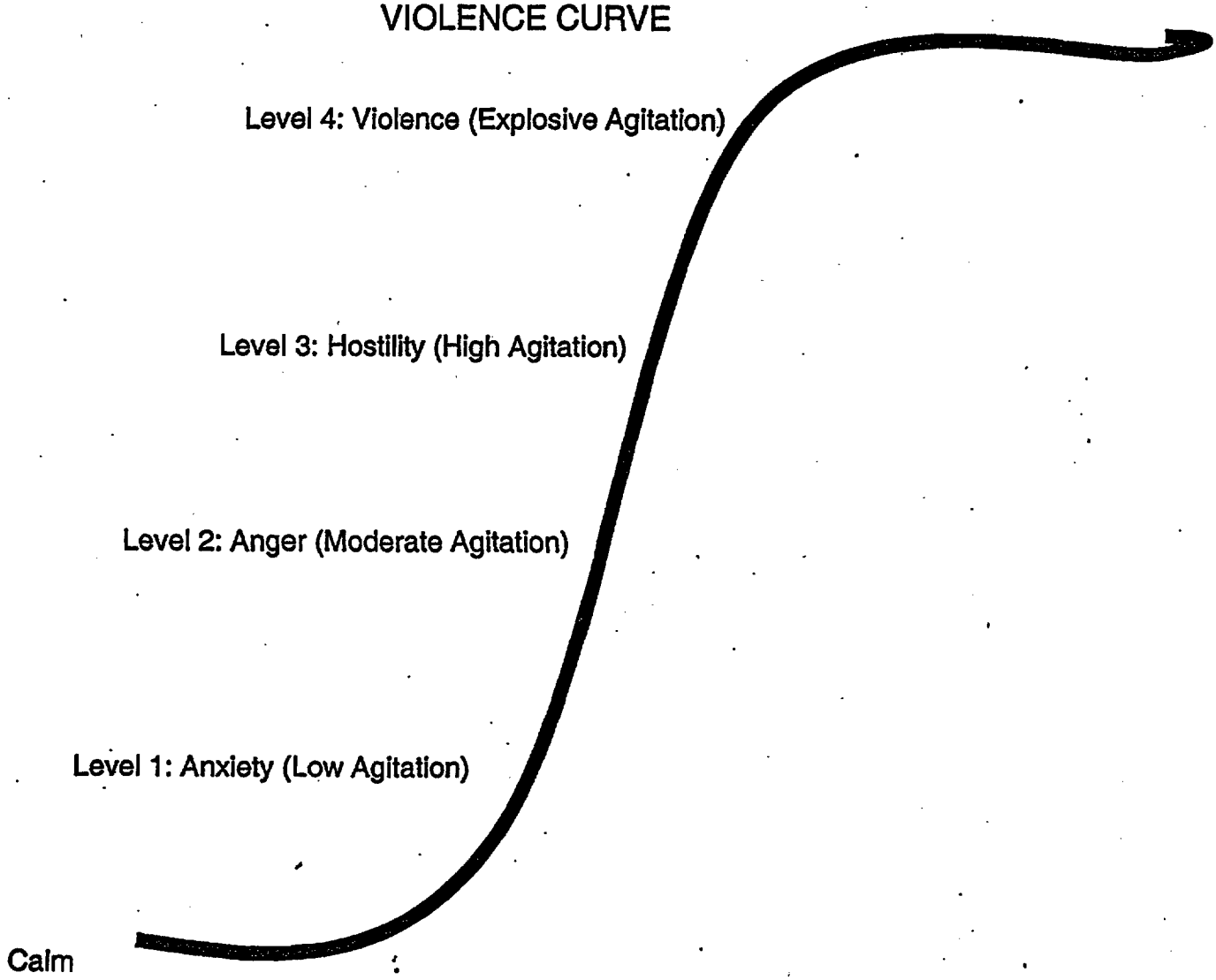
Communication
Communication is a people process. It is an interactive phenomenon, which involves more than words. Messages are often the result of a combination of words, behaviors, and context. Parts of the message are:

Verbal Components
1. Content
2. Speech
   - Rate productivity
   - Tone
   - Volume
   - Congruency with other messages

Nonverbal Components
1. Stance
2. Gestures – transient movements of the body or face
3. Eye movements
4. Facial expressions
5. Personal attire
6. Motor movements

Factors that influence communication
1. Culture/ Religion
2. Sex roles
3. Social class
4. Perceptions or internal experiences
5. Values

VIOLENCE CURVE



The above violence curve does not take into consideration variables of acute mental illness or intoxicants or both. Behaviors of individuals so affected will be erratic and tend not to follow progressive patterns.

CONCRETE THINKING

SUSPECT/ PERSON	CIT OFFICER RESPONSE
LEVEL 4: VIOLENCE	ANGER / FEAR
LEVEL 3: HOSTILITY	FEAR
LEVEL 2: ANGER	ANXIETY
LEVEL 1: ANXIETY	EMPATHY
CALM	SUPPORTIVE

Interaction

The escalation of violence chart describes the interaction and dynamic between the subject and officer. Both parties are human beings and are products of their upbringing, social norms, and survival instincts.

During the calm state of the violence chart, the subject is at ease. It is relatively easy to interact with such individuals even if they show perceptual distortions. When the subject shows anxiety as in level 1, it is not difficult to engage the person with a degree of sympathy or empathy. However, once the subject begins to exhibit symptoms of anger as in level 2, the CIT officer will normally experience symptoms of anxiety. When the subject is openly aggressive/abusive as in level 4, anger/fear may be the response.

The problem for both the subject and CIT officer is that as we move up the scale, the ability to effectively communicate diminishes. The subject's tunnel vision increases and thinking becomes more concrete as he/she gets more wound up. The officer likewise becomes more concrete as the stress level increases. The police officer has the additional disadvantage of needing to suspend emotions in order to perform well. Separating out feelings and increasing cerebral activity to

perform a technical function is common amongst emergency service workers. Unfortunately, this approach is counterproductive to the process of communication (which we described earlier as a people process interchange of ideas and feelings). The police officer must somehow bridge the paradox between suspending his/her emotions temporarily while listening for emotional cues in an effort to be effective.

The goal of the police officer in dealing with emotionally charged individuals is to pace and guide them into levels more conducive to mutual interchange. Communication skills for the police officer are like any other technical skill. Training and experience promote access to the skill — especially under emergent conditions.

Level 1: Anxiety
A subjective and uncomfortable emotion, which results from threats to the person. Accompanying feelings are dread and helplessness. The goal is to restore the person's sense of control by providing emotional support and negotiating an alternate action to the crisis.

Physical Attending Skills
- Facing the person squarely.
- Adopting an open posture.
- Leaning towards the person.
- Maintaining direct eye contact.
- Retaining a relaxed posture.
- Promoting a relaxing environment.

Responding Skills
- Emotional labeling
- Paraphrasing
- "I" statements
- Reflection / Mirroring
- Minimal reassurance
- Effective silence
- Open statements

Psychological Attending Skills
- What level of agitation did the patient display?
- What central theme concerned the patient?
- Was there evidence of drugs or alcohol that might interfere with predictability?

Intervention
- Negotiate through active listening

Level 2: Anger

Anger is a feeling state or emotion that serves to neutralize the helpless dread of anxiety. Anger can be functional in that the expression gives the person a sense of power. The danger is that anger can quickly escalate into physical expression or violence.

Angry people become less flexible in their ability to think. That is, they become more concrete as emotions rise. It is easier to understand that which can be touched or seen. Visual (nonverbal) messages become more important during stressful events. During stress periods, your verbal communication is required to be shorter, simpler, and more directive.

You goal is to keep the subject conversing with you and use time and your relationship to de-escalate the agitation.

Three Primary Techniques

1. Diffusing the adversarial emotion by acknowledging the anger. "I can see that you're very angry," or, "I'm sorry you're so upset." This has an impact when people become agitated and more concrete in their thinking because they automatically relate in terms of good or evil. That is, they may see themselves as victims and you as the aggressor. Acknowledging their concerns may serve to personalize and close this ever-increasing gap and provide you with a better chance of continuing an effective way of communicating. Remember, acknowledging the person's concern is not the same as agreeing with their position.

2. Advise giving or providing guidance in choosing a course of action or assuming a new role can help. Keep the advice very here and now, e.g. "you might be more safe on the sidewalk," or, "perhaps we could talk privately."

3. Provide choices. Offer a different course of action (A or B) or, one course of action that the person may choose to do or not (A or not A).

Remember that nonverbal interactions of posture, eye contact, tone, volume and pace are very important in the process of de-escalating the person.

Physical Attending Skills

- Facing the person at a 45-degree angle.
- Adopt an open posture
- Lean in to listen
- Maintain direct eye contact.
- Retain relaxed posture
- Promote a relaxing environment

Responding Skills

- Respect

- Empathy
- Genuineness
- Speech Delivery
- Volume
- Calm Tone
- Productivity — keep dialogue simple.
- Content focus — keep immediate to the key issue.
- Pace speech to slow the person's agitated tempo.

Psychological Attending Skills

- Analysis
- What level of agitation.

Drugs and alcohol

- What central theme concerns the person?
- Can the anger issue be identified?
- What level did you leave the person?

Intervention

- Diffuse the adversarial momentum by affirming the anger.
- Advice giving. Directing to follow your good plan.
- Providing choices. Either A or B. A or –A.

Level 3: Hostility

Hostility is anger with a focused recipient. Hostile people are easy to detect. They are more openly irritable, demanding, argumentative, antagonistic or oppositional. Their voice volume can often be loud and threatening. This is the next stage to violence and must be dealt with caution given the potentially quick transition time. The subject is very concrete and more reliance is placed on the police officer's nonverbal and brief response. The goal is to obtain immediate control of the situation and diffuse to a less agitated (more manageable) stage.

The hostility stage is highly dynamic and the subject may move about displaying varying intensities. Each intervention episode should be less than 60 seconds in duration and often needs to be repeated before successfully diffusing the person/subject to the anger stage.

Four techniques in gaining control of the situation

1. Limit setting: Clearly state the boundaries of behavior that you will allow. "I need for you to lower your voice," "please step outside," "I need for you to leave," "please step back, I'm uncomfortable with you so close." The nonverbal approach is serious, professional, and authoritative. Hand signals are used to communicate. The verbal tone and volume are consistent with

the serious message. Sentences are less than 5 words and repeated rather than elaborated.

2. Diffuse the adversarial stance by acknowledging the anger: Timing is critical. Immediately (microseconds) following limit setting, or "punching a hole" in the defensive tirade. Affirm the individual by acknowledging his/her emotional state. This is a critical test point. If the subject/person accepts ("damn right I'm angry), then continue to dialogue using verbal and nonverbal skills to move to the more manageable Anger Stage. However, if the subject/person continues unabated despite repeated tries, be concerned that the escalation may result in violence.
3. Provide directives: Firmly tell the individual what you want him/her to do.
4. Give Warning: Clearly state as neutrally as possible the consequences of a given course of action.

The approach

1. Dealing with potentially violent people is frightening. You might be as charged as the subject. Try to maintain control by purposely taking deep breaths. Remember that you are going to try and regain control of the situation by communication. It isn't going to impress anyone if you squeak out your directives with residual air.
2. Approach the subject squarely from the side to avoid direct kicks. Keep an open posture (to avoid being perceived as attacking) and keep your hands out of your pockets.
3. Keep approximately two arm lengths distance from person.
4. Do not attempt to communicate by touch.
5. Maintain eye contact and an upright posture in an effort to convey control. Communication is continuous. The eyes coupled with facial gestures may provide advance warning of attack.

The Interaction

1. Do not engage in accusations, arguments, and demands for justification from the subject. This will result in a power struggle, which will prove futile. Winning arguments is not as important as fulfilling the job that you were called on to perform. Do not succumb to their baiting.
2. Work as a team, which may be part of a prearranged set of actions in dealing with emergent situations. Don't get maneuvered into being split apart as good guy, bad guy. "I can't talk to this cop. He's a jerk. I can see that you are a reasonable person. Can we privately discuss my request?"
3. Keep your verbalizations short and simple. Remember that the subject is operating very concretely and will only hear portions of what you will try to verbalize. Repeat your short request as opposed to paraphrasing.
4. Define clear expectations for the subject and communicate these positively and firmly.
5. Limit or address only those behaviors that clearly interfere with the client's welfare or the rights of others.

6. Confine the limits only to those that can be carried out. Empty limits only reinforce the patient's notion that you can not be relied upon. Likewise don't promise that which you cannot deliver. You will only be setting someone else up for potential violence.
7. Practice pat phrases and have them available. Under stress, it is more difficult to be creative. Timing your response is important in disarming an aggressor.

Physical Attending Skills

- Face the person squarely but approach at a 45-degree angle.
- Open posture. Keep your hands out of your pocket.
- Upright Posture. Denotes seriousness and control.
- Relaxed Posture. Denotes lack of intimidation.
- Do not communicate by touch.
- Maintain eye contact — look for advance warning of attack.
- If you point at an object or area, do not take your eyes off the subject.
- Remain two arm lengths away.

Responding Skills

- Genuineness
- Respect
- Speech Delivery
- Volume: Avoid shouting.
- Tone: Confident, assured and serious. Avoid challenging and condescending inflections.
- Rate: Purposely slow to de-escalate.
- Productivity: Keep sentences very short and simple.
- Repeat rather than elongate.
- Content: Here and now. Focus on your directive.
- Do not get "baited" into justifying or arguing.
- Avoid discussions leading to splitting. Confine warnings or promises to those that can be carried out.

Psychological Attending Skills

- Analysis
- What level of agitation?
- Have the person been using drugs and/or alcohol?
- What themes are being presented?
- Any "baiting or key words?
- What level did you leave the person?

Intervention

- Limit setting. Clearly state the boundaries of the behavior you will tolerate.
- Acknowledge the anger and focus.
- Provide directives. Firmly tell the individual what you want him/her to do.
- Warning. Clearly state as neutrally as possible the consequences of his/her behavior.

Level 4: Violence

Response Guidelines

Violence is aggression with a focus on destruction. Violence has injury as its goal. Violence may be verbal (if disruptive or hurtful enough) and/ or physical. The goal is to protect oneself. The goal is not to win but be useful at another time.

The Interaction

- Let your face drain of gestures
- Drop your shoulders indicating relinquishment
- Remain at 45-degrees to the person
- Don't make any sudden moves
- Don't take insults and taunting personally
- Don't be baited
- Do not take your eyes off the patient
- Clearly indicate to the aggressor that you intend to disengage and withdraw, e.g. "I quit, " or" "I'm out of here" messages
- Start moving away towards your escape
- Move slowly and methodically
- Continue your verbal and non-verbal communication to indicate retreat
- You can remain at bay waiting for reinforcements to arrive or totally withdraw.

Active Listening Concepts

Listening for Emotions

People communicate on two levels:

- Content — the simple facts
- Emotions — the emotional reaction to the facts

Train yourself to listen for the emotional message behind the content. Emotional reaction and subsequent behavior make the situation a crisis, not the fact of the situation. How a person feels about a situation will strongly influence what he/she does. Controlling the subject's emotions will help control the subject's behavior.

Listening for Values

- What people think are important
- What people prize

There may be a need to clarify the subject's values. Values influence behavior. The crux of the situation may be a value conflict.

Active Listening Skills

- Emotional labeling
- Paraphrasing
- Reflecting / Mirroring
- Effective pauses (silence)
- Minimal encouragers
- "I" Messages
- Open-ended Questions

Emotional Labeling

- The first active listening skill to be used in an incident.
- The intent of emotion labeling is to respond to the emotions heard in the subject's voice rather than content.
- Demonstrates that you are really listening and tuned into what the subject is emotionally experiencing.
- Do not tell a person how they are feeling, but rather how they *seem* or *sound* like they are feeling to you.
- Do not be afraid to label emotions incorrectly.
- Be aware of missing emotions.
- Listen for conflicts in the feelings expressed.
- Never hesitate: label every emotion you hear.
- Note when the emotions are inappropriate to the situation described.
- Be aware of your emotions and what the subject is hearing from you.
- Use throughout the negotiation / intervention whenever you hear emotions expressed.
- Do not use when you are being verbally attacked.

Emotional Labeling Examples

- You sound _____
- You seem _____
- I hear _____

Paraphrasing

- A summary in your words as to what you were just told.
- Demonstrates you are listening.

- Creates empathy and rapport because it demonstrates you have heard and understand.
- Creates empathy and support.
- Clarifies content, checks perception, and highlights issues.
- Obtains additional intelligence.

Paraphrasing Examples
- Are you telling me...
- Are you saying...

Reflecting / Mirroring
- Repeating back the last word or phrase the subject just said.
- Gives feedback that is very exact.
- Asks for more intelligence without guiding the direction.
- Gets intelligence when you do not have enough to ask a good question.

Effective Pauses (Silence)
- An effective pause is silence.
- Silence is effective if it serves your purpose.
- Most people are not comfortable with silence and will fill it with talk.

Uses of Silence
- When you are about to say something important.
- When you have just said something important.
- When the subject is trying to "psych" you out.

Minimal Encourages
- The sounds you make, especially on the telephone, to let the other person now you are present and listening.
- May be short questions such as: "really?", "Oh?", "When?"
- Does not interfere with the flow of the conversation.
- Lets the subject know you are present and listening.

Uses of Minimal Encouragers
- Helps build rapport.
- Encourages the subject to continue talking.

"I" Messages
- Enables us to let the subject know how they are making us feel, why we feel that way, and what they can do to remedy the situation.
- Conveys the above information in a non-threatening way and does not put the subject on the defensive.

Uses of an "I" Message

- When communication is difficult because of the intense emotions being directed at you.
- When the subject is making communication impossible.
- When you need to refocus the subject.
- When you are being verbally attacked.

Examples of "I" Messages

- I feel _____(emotion or feeling)
- When you_____(his/her behavior)
- Because _____(your reason)

Open-Ended Questions

- Questions that cannot be answered with a "yes" or a "no."
- To obtain information without asking a lot of questions.
- Usually begins with the words: how, what, when, where.

Uses of Open-Ended Questions

- To help a subject start talking.
- To elicit examples of specific behavior.
- To obtain additional intelligence.
- To focus on the subject's feelings.

Problems Caused by Closed-Ended Questions

- Gives a feeling of interrogation, which makes rapport difficult to build.
- Causes you to work harder thinking up new questions.

NOTES

INTERVENTION IN THE CRISIS CYCLE

INTERVENTION

A. APPROACHING THE SCENE
   1. Calls
   2. Information before you arrive
   3. Monitor your own emotional state
   4. Leave prejudices/bias/predisposition behind

B. ON THE SCENE
   1. Assess the situation and stabilize, if necessary

C. CRISIS INTERVENTION
   1. Crisis cycle
      a. Intervention at each stage of the cycle
      b. Different levels of understanding, perception and development at each stage
         (1) Look at face, voice and posture for signs of what level
      c. Stages of cycle
         (1) Normal state
            (a) 100% perception and ability to reason
            (b) Acts as an adult
            (c) Person experiences no emotional content
            (d) Officer is calm
            (e) Can problem solve
         (2) Stimulation (internal/external)
            (a) 50-75% perception and ability to reason/understand
               1) Agitated behavior
            (b) Acts as a teenager
            (c) Person experiences anxiety
            (d) Officer is calm
            (e) Action officer should take
               1) Use simple sentences
               2) Use calming body language
               3) Keep voice low and calm
         (3) Escalation
            (a) 5-24% perception and ability to reason/understand
               1) Loud, aggressive, flushed
            (b) Acts as an 8-year old having a tantrum
            (c) Person experiences fear; frustration
            (d) Officer is anxious
            (e) Actions officer should take
               1) Use sentences of less than 5 words
               2) Make one immediate request
               3) Repeat continually
               4) Body language and voice firm but calm
         (4) Crisis
            (a) 0-5% perception and ability to reason/understand
               1) Out of control

(b) Acts like "terrible two's"
(c) Person experiences anger
(d) Officer is fearful/frustrated
(e) Actions officer should take
1) Use firm, one sentence commands
2) Repeat continually
3) Make decision regarding use of physical force

(5) De-escalation
(a) As consumer de-escalates, officer uses the same techniques down the de-escalation
(b) Consumer may suffer post-crisis depression
(c) Escalation can cycle up and down

(6) Things to remember
(a) Take your time
1) Person cannot remain in crisis state forever
(b) Constantly read feedback from consumer
(c) Stop doing anything that escalates the consumer
(d) Continue anything that de-escalates the consumer

(e) Have only one officer talk to the consumer at a time
1) Trade off if not effective

2. Communication skills

a. Verbal skills
(1) Tell person you are there to help
(2) Introduce self by first name
(3) Ask and use their name
(4) Do not involve yourself in their delusions; show you understand that they believe it is really happening
(5) Ask clarifying questions in terms of "I" statements
(a) "I don't understand this"
(b) "I'm afraid you'll hurt yourself"
(c) "I can't figure out why"
(6) Use personalized statements
(a) "Your holding that rock makes me nervous"
(7) Do not argue
(8) Actively listen
(a) Do not be afraid of silence
(b) Wait for responses
(c) Echo their feelings "You seem to be angry"
(9) Show concern and understanding
(a) Nod head while they are talking; indicate listening with "I see", "Uh, huh", etc.
(10) Treat person with respect
(11) Do not use offensive terms or sarcastic remarks
(12) Tell people what you are going to do
(a) Do not make promise you cannot keep
(13) If person becomes agitated, change subject

b. Non-verbal skills
   (1) Feedback loop
      (a) Watch reactions of consumer to you
      (b) Stop action if escalates consumer
   (2) Open body language
      (a) Rule of palms
         1) Palms open
      (b) Stand slightly to the side/bladed
      (c) Take safe, but not defensive stance
         1) More relaxed posture
         2) Head tilted
         3) Be ready/appear relaxed
      (d) Keep hands off paraphernalia
   (3) Eye contact
      (a) Try to make eye contact
         1) Some people like it as sign of personal contact
         2) May make some people nervous
      (b) Try to remain at eye level
   (4) Body space
      (a) Rule of 3
         1) Remain 3 arms length away at first contact
      (b) May need to move in to establish personal contact
   (5) Move slowly
      (a) Announce action to consumer

c. Questions to ask
   (1) Ask what is happening that caused crisis
   (2) Ask about past history
      (a) Case worker
      (b) Counselor
      (c) Treatment
   (3) Ask how they resolved similar situations in past
   (4) Ask what clinic they go to or where they go for treatment
   (5) Ask if they are taking medication(s)
   (6) Ask the names of their medication(s).
   (7) Ask if they would like to see a doctor
   (8) Ask if they are thinking of taking their own life
      (a) How
      (b) Do they have the means (gun, knife, pills)
      (c) Have they ever tried it before
   (9) Ask if they are hearing voices
      (a) Are they telling you to do something

d. Officer safety reminders
   (1) Never deny the possibility of violence
      (a) Persons with mental illness are not more violent than the "normal" population but may be more unpredictable
   (2) If hearing voices, ask what the voices are saying

(3) Keep relaxed approach, but not complacent
(4) Watch consumer's hands
(5) Upon transport, always handcuff even if this risks re-exciting the subject; tell the person what you are going to do and why

Fear

A perceived need (sometimes irrational) to escape, defend against, or eliminate a perceived threat of personal injury.

Visual signals

Posture: Tense and prepared to defend, hide or run away.

Skin color: Pale or ashen.

Facial expression: Wide-eyed and fearful.

Auditory signals

Voice quality: Whining, pleading, gasping, bursts of speech, may be unable to speak.

Breathing: Rapid, shallow, irregular.

Confirming history

Personal history of abuse / victimization and/or withdrawal, sometimes punctuated by assaultive outbursts.

Crisis Intervention for: Fear

Goal: Threat Reduction

The basic assumption is that communication patterns that reduce the perceived threat will also reduce the probability that the assault will escalate to battery. Conversely, communication patterns that add to the perceived threat can be expected to increase the probability of battery. Here are some guidelines for reducing threat:

Posture: relaxed and open; hands in full view

Gestures: slow, palms-up

Position: slightly off to the side of the fearful client, and far enough away (8-10 feet, if possible) to make it clear that an attack on the client is not being planned.

- positions directly in front of, or any position behind a frightened person can be expected to increase the perceived threat
- positions at or below the eye level of the frightened person can be expected to reduce the perceived threat

Voice quality: firm, reassuring, confident

Speech content: logical, encouraging calm reflection; promising to help if possible, but not promising something that is not possible

Eye contact: if the frightened person seems to seek eye contact as an additional source of reassurance, it should be given freely; if the frightened person tries to avoid eye contact it should not be forced on them. There are many cultures that discourage or limit communication through eye contact.

Physical contact: some frightened people (particularly children) need to have reassurance communicated through touch. Touch should be "offered", not given without permission, and should be light with slow movements.

Frustration

An irrational attempt to gain control by physically attacking the source of frustration.

Visual signals

Posture: Tense and prepared to attack.

Skin color: Tones of purple or red; splotches.

Facial expression: Tense, focused, and angry.

Auditory signals

Voice quality: Menacing, aggressive, loud.

Breathing: Loud, deep, long, heavy.

Confirming history

History of low frustration tolerance, coupled with impulsiveness.

Crisis Intervention for: Frustration

Goal: Control

The basic assumption is that patterns of communication that demonstrate and "lend" control will contribute to the restoration of the internal control of the frustrated client. Conversely, communication that demonstrates loss of control will likely increase the probability that the frustrated person will lose their ability to control an impulse to attack. Here are some guidelines for exerting control:

Posture: self-confident, commanding

Gestures: firm, commanding, palms out or down

Position: directly in front of the frustrated client, and just outside of his/her striking range.

- A position within striking distance of a frustrated person communicates a challenge or a desire to fight.
- A position well outside of striking distance of a frustrated person communicates undue caution or fear, and unwittingly points out vulnerability and willingness to be a target for release of frustration.

Voice quality: quiet, firm, commanding in tones low enough to make the frustrated person strain to hear

Speech content: repetitive, confident commands without threat

Eye contact: direct and accompanied by facial expressions which indicate that a firm command is being given.

Physical contact: if physical contact is required to prevent the frustrated person from escalating from assault to battery, it should be made firmly but without excessive movement or pain that would indicate loss of control.

Manipulation

An indirect attempt to obtain or avoid something in exchange for not losing emotional control. Manipulation becomes dangerous when assault is used as a tool in the attempt. Remember: Beneath every manipulative demand there is a legitimate request. Manipulation can take a variety of forms, including:

The temper tantrum

In this case the manipulating person starts by making a calm, but unreasonable (given the circumstances) request. When the persons' requests / demands are not met, they threaten violence by appearing to lose control: yelling, banging, stomping, etc.

Playing the numbers

In this case the manipulating person attempts to "play" people against each other, hoping that in the confusion their request / demand will be met. Group care settings provide an abundance of opportunities for this form of manipulation.

Promoting confusion

In this case the manipulating person brings in related, but irrelevant, matters into the discussion, leaving the professional wondering what the client really wants, or how the issues being raised by the person relate to the request / demand being made.

Visual and auditory signals

Although the signals are often difficult to interpret at any particular moment, there is a definite and recognizable pattern :

- The initial set of signals often occur in a whining voice, usually with a "gimme" attached, and with the affect of a pitiable victim.
- If that doesn't work, the next step is a series of marginally related accusations, comparisons, and other trivia, uttered in more aggressive tones.
- If that doesn't work, the next step is threats and actions against property.
- Finally, when all else has failed, assault is attempted.

Confirming history

A history of losing control or attacking physically when feeling deprived or oppressed.

Crisis Intervention for: Manipulation

Goal: Detachment

The basic assumption is that communication patterns that tend to indicate refusal to become involved in manipulation will decrease the likelihood that the manipulative person will attempt to gain something through complete loss of control resulting in battery. Conversely, communication that indicates openness to the manipulative demand increases the belief that the demand will be met at the next higher level of loss of control. Here are some guidelines for detaching yourself from a manipulative game:

Posture: closed, relaxed

Gestures: idiosyncratic gestures of disapproval or mild irritation (toe or finger tapping, eye rolling, "disgusted" sighing and nodding, arm folding, etc.)

Position: close enough to physically intervene if necessary, but far enough away to show non-involvement (4-5 feet)

- turning slightly away to show non-involvement is appropriate, but do not turn your back

Voice quality: detached, mechanical, slightly bored

Speech content: quiet, repetitive, "broken record" commands

Eye contact: avoid eye contact by looking at the hairline, chin, shoulders, etc.

Physical contact: if physical contact with the person who is manipulating becomes necessary, it should be handled as quickly and unemotionally as possible. Try to make contact with clothing only, not flesh. Punitive and vengeful forcefulness should be avoided, since it will add to the belief that the manipulation could have been successful if it had been done differently.

Intimidation

A calculated attempt to get something in exchange for physical safety or freedom from the threat of injury. "Don't make me hurt you" is the flavor of the message you get from many of the people who intimidate.

Visual and auditory signals

Basically neutral or unremarkable, with the exception of a menacing voice quality and/or threatening words and posture. Often people who are attempting to intimidate use physical menacing / crowding (standing very close to or over the person being intimidated) as a way to threaten danger.

As in manipulation, there is a definite and recognizable pattern of change in signals:

- First, there is a clear and often strongly stated demand.
- If the demand isn't met, this is followed by a believable threat of physical injury coupled with a reminder that injury can be avoided by complying with the demand.
- Finally, refusal to comply or delay in complying is followed by the attempt to injure through assault.

While we often respond to attempts to manipulate with annoyance and irritation ("here we go again", or "give me a break"), we often respond to intimidation with fear and a belief that we might really get hurt!

Confirming history

A history of bullying, extortion, and other criminal assault.

Note: This form of assaultive behavior is often used by persons diagnosed as "anti-social personalities" or "sociopaths".

PRECAUTIONS (DON'TS)

REMEMBER, DON'T:

1. Deny the possibility of violence when early signs of agitation are first noticed.
2. Underestimate information given by others regarding behavioral clues.
3. Engage in behaviors that can be interpreted as aggressive.
4. Allow others to interact simultaneously while you are attempting to talk.
5. Make promise you can not keep.
6. Allow feelings of fear, anger, or hostility to interfere with self control and professional demeanor.
7. Argue, give orders, or disagree unless absolutely necessary.
8. Be placating by giving in and agreeing to all the real and imagined ills of the person.
9. Become condescending by using cynical, sarcastic, or satirical remarks.
10. Let your own importance be acted out in a know-it-all manner.
11. Raise your voice, put a sharp edge, or use threats to gain compliance.
12. Mumble, speak hesitantly, or use a tone so low that you can't be understood.
13. Argue over small points.
14. Attempt to reason with anyone under the influence of a mind altering substance.
15. Attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.
16. Allow a crowd to congregate.
17. Corner, or be cornered: give the person expanded space.
18. Ask why?
19. Deny the opportunity to save face.
20. Rush, be rushed, or lose your own cool!

RESOLVING CRISIS

02/09/95

1. INTRODUCE YOURSELF. PERSONALIZE CONTACT. "MY NAME IS JOHN. WHAT'S YOURS?"

2. USE A CALM VOICE.

3. UTILIZE RELAXED BODY LANGUAGE.

4. TELL PERSON YOU ARE THERE TO HELP THEM.

5. AVOID ARGUING.

6. SHOW GENUINE CONCERN BY ASKING MANY QUESTIONS.

7. ASK THE PERSON WHAT IS HAPPENING RIGHT NOW TO CAUSE THIS CRISIS.

8. ACTIVELY LISTEN. REPEAT BACK WHAT YOU HEAR THE PERSON COMMUNICATING ABOUT THEIR FEELINGS. REPORT BACK TO THE SUBJECT THE EMOTION YOU THINK THEY ARE FEELING. "YOU'RE FEELING ANGRY." "YOU'RE FEELING ANXIOUS." "YOU'RE FEELING FRIGHTENED."

9. ASK THE PERSON ABOUT HIS OR HER PAST HISTORY OF CRISIS.

10. ASK THE PERSON HOW THEY HAVE RESOLVED CRISIS IN THE PAST.

11. ASK ABOUT FRIENDS, RELATIVES, COUNSELORS, CASEWORKERS OR OTHER POSSIBLE SUPPORT PEOPLE.

12. OBSERVE THE SUBJECTS BODY LANGUAGE.

13. IF THE PERSON BECOMES MORE AGITATED CHANGE THE SUBJECT.

14. STATE CLARIFYING QUESTIONS IN TERMS OF THE OFFICER HAVING A PROBLEM:

"I DON'T UNDERSTAND THIS . . . "
"THAT ROCK IN YOUR HAND MAKES ME NERVOUS."
"I'M AFRAID YOU'LL HURT YOURSELF."
"I CAN'T FIGURE OUT WHY . . . "

15. GIVE INFORMATION. EXPLORE OPTIONS WITH SUBJECT.

16. TREAT PEOPLE WITH RESPECT.

17. TELL THE PERSON WHAT YOU ARE GOING TO DO TO HELP THEM.

18. ALWAYS KEEP YOUR WORD.

THE RULES

1- THE RULE OF TIME

2- THE RULE OF THREE

3- THE RULE OF FIVE

4- THE RULE OF PALMS

5- THE RULE OF ECHOS

6- THE RULE OF CALM

MR/DD

CRISIS INTERVENTION WITH PERSONS WITH DEVELOPMENTAL DISABILITY

NOTES

Course Title: The Crisis Cycle

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 4:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To introduce the crisis cycle as a model for understanding the stages of crisis. Implications for interventions will be discussed.

Performance Objectives:

1. The officer will be able to identify the stages that a person goes through when in crisis.

2. The officer will be able to identify and list typical emotional responses of officers intervening in crisis.

3. The officer will identify the language comprehension levels accompanying crisis stages and the implications for intervention.

Course Outline:

The Crisis Cycle: the emotional and behavioral stages people experience when in crisis (Oregon Intervention System model

0. Normal State
1. Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post-crisis depletion
6. Stabilization

The Escalation Grid (Basic Psychiatric Life Support Model)

1. Anxiety
2. Anger
3. Hostility
4. Aggression

How the Crisis Cycle and the Grid fit together

1. Emotional and behavioral interactions
2. Two crisis cycles juxtaposed
3. The Grid- typical responses of professional interveners

A. Anxiety- calm
B. Anger- anxiety
C. Hostility- anger
D. Aggression- fear

4. Recognizing your own responses
5. Setting aside your own responses

The effect of emotional state on communication

1. Comprehension decreases as control decreases
2. Implication for intervention strategies
   A. "adult", "adolescent", "child", "terrible 2"
   B. Simplify language
   C. Become more concrete

G. Effects of the system

Implications of characteristics

Finding out if there is someone who can help

1. Who are the players?
2. What questions can you ask to get useful information?

WHAT ARE MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES?

Definitions. There are many different definitions of mental retardation and developmental disabilities. Agencies typically have their own complex definitions, which may differ from agency to agency. The definitions below are "unofficial.

Mental Retardation. Intellectual functioning that is significantly below average, along with substantial limitations in adaptive behavior (for example, ability to independently perform activities of daily living or function in society.) Mental retardation originates during the developmental period (before 18 in most definitions) and is likely to be lifelong. Generally, a person who has an I.Q. score of 70 or lower is considered to have mental retardation.

Note about terminology: many people do not like to have the term "mental retardation" applied to them, because of unpleasant history or associations. Some prefer the term "developmental disability" or "cognitive disability". Some refer to themselves as "slow" or a "slow learner".

Developmental Disability. This is a broader term than mental retardation. A developmental disability is a disability caused by a neurological condition. It originates during the developmental period, it is likely to be lifelong, and it requires training and support similar to that needed by a person with mental retardation. Besides mental retardation, common causes of developmental disability are cerebral palsy, epilepsy, and autism. **Cerebral palsy** is a catchall term for a variety of disorders that affect a persons ability to move and to maintain posture and balance. Walking ability and speech are often affected. **Epilepsy**, also called seizure disorder, is a condition that causes seizures of various kinds. Some seizures cause a person to fall, lose consciousness, and have jerking movements of the whole body for several minutes. Others cause involuntary movements of a part of the body without loss of consciousness, and still others cause a brief loss of consciousness without falling. Mild forms of cerebral palsy or epilepsy are not considered developmental disabilities under the above definition. **Autism** is a severe developmental disability affecting communication, social interaction, and behavior.

Mental Illness vs. Mental Retardation. Mental retardation/ developmental disability is not the same as mental illness. Hallucinations and delusions are characteristic of some mental illnesses; they are not characteristic of MR/DD. Neither are mania or depression characteristic of mental retardation. A person with mental retardation can be expected to act rationally at their functional level. However, a person with mental retardation or another developmental disability may also have an additional disability such as a mental illness or a drug or alcohol addiction.

Other Disabilities. There are other disabilities and health conditions which affect cognitive (intellectual) functioning and which therefore may be confused with mental retardation. A disability from head injury to an adult is not mental retardation, nor is dementia from conditions such as Alzheimers or late stage alcoholism. A person who has recently had a seizure may have a short period of impaired functioning which may be mistaken for mental retardation.

Institutionalization. In the past, many individuals with developmental disabilities, even those with mild mental retardation were routinely institutionalized. Beginning in the late 1960's, it began to be generally understood that people with developmental disabilities had the right and the ability to live in the community. Programs such as group homes and semi-independent living programs were established to provide training and support in the community and people began coming out of institutions in increasing numbers. However, some people were discharged without appropriate

Do you want to call them now?
Is it OK if I call them?

If you are at a group home or foster home(or other situation in which someone seems to be in a staff role) in a crisis, and the staff seems to be unsure what to do:

Ask: Do you have someone you can call to help you in a crisis?
In a foster home there may not be anyone. In a group home or supported living situation, there should always be a way to contact administrators in an emergency.

SOME SUGGESTIONS FOR COMMUNICATING WITH A PERSON WHO HAS MENTAL RETARDATION

- Keep language simple, but not childish.
- Avoid abstractions or technicalities. Be concrete.
- Avoid yes/no questions, or questions that suggest the answer you expect.
- When you give instructions:
  - Give one at a time
  - Be clear and direct
  - Be sure the person understood. One way to do this is to ask them to repeat it back.
- Don't talk to others in front of the person, as if the person wasn't there.
- If the person has any reading/writing ability, write down simple reminders if they need to do something later. Ask if they have a calendar you can write it on.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

supports and others lost supports for budgetary or other reasons. The movement to "deinstitutionalize" people continues to the present. Today, Fairview and Eastern Oregon Training Centers are still in operation, but they are much smaller than they were in the past.

Being institutionalized affects people seriously. A history of being in an institution sometimes helps explain behaviors that are otherwise hard to understand. Usually the younger the person went into the institution, and the longer they remained, the more serious the effect. In an institution, people are deprived of the opportunity to learn what it's like to live in a regular family and community, and so it is much harder for them to develop appropriate social skills. They have limited opportunity to develop normal human relationships, and little modeling of how people act in normal situations. To survive, some people learned to comply with anyone who acted as if they were in a position of authority. The lack of privacy caused some not to have regard for their own privacy or that of others. For some, the lack of respect for their personal property taught them that if they valued something they needed to carry or wear it or it would be taken. People had few choices and little control over their own lives. Many people were sexually or physically abused by other residents or by staff, and they have the same kinds of problems other sexual abuse survivors have. These can include low self esteem, sexual acting out, lack of trust in others, Post Traumatic Stress Disorder and depression.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

SOME CHARACTERISTICS OF INDIVIDUALS WITH MENTAL RETARDATION: IMPLICATIONS FOR LAW ENFORCEMENT

In order to successfully manage an encounter with a person with mental retardation, whether a victim, suspect, or witness, it is important for the officer to recognize the disability. Recognizing the disability and managing the encounter are often one and the same.

Each person with mental retardation is an individual. People with the same measured I.Q., whether they have mental retardation or not, vary widely in their skills, interests, personality and communication style. Listed below are some characteristics that may be more likely to occur in a person with mental retardation. There won't be anyone for whom all (or even most) of these factors apply. For some individuals with mental retardation few or none will apply.

Communication issues

- Does not communicate at the level of typical persons of the same age group
- Limited vocabulary or limited grammatical skills
- Speech defect
- Unable to read or write or limited ability
- Difficulty understanding questions
- Difficulty answering questions; may give "standard" or "parrotted" responses
- Appears to understand when they do not, may not want to admit lack of understanding
- Fails to comply with rules; this may be due to lack of understanding

Interaction issues

- An excessive desire to please others
- Behavior on a level below the person's age
- Crowding personal space when interacting with others
- Tendency to be overwhelmed by authority
- Becomes hostile or withdrawn rather than admit lack of understanding
- Low frustration tolerance

Judgement/knowledge issues

- Does not fully understand seriousness of situations
- Limited safety awareness; may be easily victimized
- Judgements regarding "friends" are the most difficult
- Easily persuaded or influenced by others
- Lack knowledge on how to protect themselves

Performance abilities. May be limited in some of these areas:

- Reading and writing
- Using the telephone
- Understanding finances
- Making change
- Understanding need to budget to cover living expenses
- May give away money or belongings
- Following complicated directions

- Telling time
- Keeping appointments
- Managing activities of daily living , such as hygiene, housekeeping, cooking

Effects of our culture (or system) and common attitudes about disabilities
These are often as limiting as the effects of the disability itself.

- Praised for compliance
- "Protected" by being "kept in"
- "Protected" by not being given sexual information
- Not taught about their rights
- Segregated from others; heavily dependent on caregivers
- Abuse may not be taken seriously
- Live in high risk environments

SOME IMPORTANT IMPLICATIONS OF THESE CHARACTERISTICS
The victim who has mental retardation:

- Higher risk of victimization, especially for sexual assault and robbery
- May be victimized by caregivers or "friends"
- May not understand that what has happened is a crime or that law enforcement can help

The suspect who has mental retardation:

- May admit to things he/she did not do, in order to comply or please
- May have been a follower or coerced by persons with higher abilities
- May not understand what you tell them about their rights (Miranda warnings)

Suspects, victims, and witnesses

- May tell you what they think is the "right answer"

FINDING OUT IF THERE IS SOMEONE WHO CAN HELP
This may also help you determine what the disability is.

Ask: Do you have a Case Manager?
Do you have their card?
(if no card) Who do they work for? Where is their office?

Ask: Is there someone who is paid to help you?(with money, making appointments, fixing meals,etc)
Do you have their card?
Do you have their phone number?
Would you like to call them now?
Is it OK if I call them?

Ask: Do you have a family member that helps you with things? A neighbor? Someone else?
Do you have their phone number?

Multnomah County Developmental Disabilities Services Division

"WHAT ARE ALL THESE PROGRAMS AND WHO'S IN CHARGE HERE ANYWAY?"

The Developmental Disabilities Services Divison (DDSD) is part of the Multnomah County Department of Community and Family Services. Until recently DDSD was called the "Developmental Disabilities Division" and before that, the "Developmental Disabilities Program". Offices are in the Commonwealth Building, 421 SW 6th, Suite 400, Portland, OR 97204, (503) 248-3658. Office hours are Monday through Friday 8:00 to 5:00 P.M.

The Division provides case management for eligible individuals. It also contracts with private providers (some non-profit and some for-profit) to provide residential and vocational services to some individuals. These residential and vocational services are funded mostly with state and federal money, and are under many state and federal regulations. The state and the county both have oversight responsibility for these programs.

Case Manager - Everyone served by the Division has one. This is the person in the Division who works directly with the individual, the family (especially for kids), and any residential, vocational, or other programs that the individual participates in. **This is who you should ask for when you need help for a particular individual.** The Division no longer calls case managers "case managers", but many other people do, so if you ask for the case manager, everyone will know who you're talking about. These people are now mostly called:

Family Consultant (for children)
Service Coordinator (for adults)

If a person urgently needs help and the case manager is not available, there is a **Backup Worker** available during business hours.

Protective Services Investigator - A specialized case manager who investigates allegations of abuse or neglect of adults served by the Division. (Services to Children and Families – SCF- investigates for children.) Police may deal with a Protective Services Investigator if the abuse or neglect involves criminal behavior. To make a Protective Services referral, report the suspected abuse to the individual's case manager (or the Backup Worker) and a Protective Services Investigator will be assigned.

Managers and supervisors - Every Service Coordinator/Family Consultant has one. You can ask for the supervisor if you can't get what you want from (or can't reach) the Service Coordinator/Family Consultant or the Backup Worker.

Division Manager - The person in charge of the Division.

RESIDENTIAL PROGRAMS

These are the programs that provide support in day to day living for some individuals with developmental disabilities. Most individuals with developmental disabilities do not have any paid supports; they live by themselves or with friends or family. There are many who need or want services which are not available due to funding constraints.

24-hour Residential ("Group homes")- These programs provide 24 hour staffing for support of individuals. The "typical" program is a 5- person group home. A few are larger. Some are "apartment model". In those, the staff will be present in the complex, but often not in the individual's apartment. **The people who work directly with individuals are generally called "direct care staff", although in some** agencies, they have other titles like "Community Support Specialist". Typically they work shifts and do not live in the home, although there are exceptions. **Group Homes typically have a house manager or site manager. The direct care staff should be able to reach the house manager or another administrative staff person by phone or beeper at all times, and you may want to ask them to do so if there's a problem.**

Semi-Independent Living Programs (SILP)- A program that provides support (typically 2-4 hours per week) to individuals who live in their own apartments. The individual has telephone access to a staff person in emergencies. If you think an individual may be in a SILP program, you may want to ask them if they have a staff person they can call.

Supported Living - A program that's more individualized than 24-hour residential programs but typically provides more support than SILP. There may be live in staff or "paid roommate", or direct care staff working shifts, or support workers dropping in. As in SILP, the individual has 24 hour access to staff by telephone, at any time staff is not with them.

The three kinds of programs listed above) are run by private agencies, under contract with the Division. All individuals served by these agencies are also served by and receive service payments through the Division (except for a very few individuals who pay privately). Agencies typically operate more than one home or site and several operate more than one program. Each agency has an **administrator** who may be called an Executive Director. The administrator or someone designated by the administrator should be available at all times in real emergencies

Adult Foster Care (AFC) - Adult foster care provides 24 hour care to individuals in private homes. **The provider is the person in charge**, who contracts to provide services. There may also be a **resident manager** and one or more **caregivers.** Typically either the provider or the resident manager lives in the home. Each Adult Foster home is licensed by the Multnomah County Adult Care Home Program, and then various agencies, including the Developmental Disabilities Services Division, arrange for service provision to individuals. Some individual make private pay arrangements for Adult Foster care, not through an agency.

Other kinds of residential supports - Individuals may have various kinds of respite (temporary) care, in group homes, in AFC, or with private individuals. Or they may have some paid supports in limited areas like money management. If they are elderly or physically disabled, they may receive foster care, personal care services, or other kinds of services from Senior and Disabled Services Division. If they have mental illness, they may receive help from a mental health agency.

Prepared by Lee Greer, Service Coordinator/Behavior Specialist
Multnomah County Developmental Disabilities Services Division
5/00

CHILD AND ADOLESCENT ASSESSMENT AND INTERVENTION

NOTES

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
  - I won't be here.
  - You won't have to deal with me.
  - You'd be better off without me.
  - Life is meaningless.
  - Death is probably a solution to my problems.
  - Would you miss me if something happened to me?
  - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
  - reckless driving, skating, bike-riding, swimming alone
  - drug-experimentation
  - sexual promiscuity
  - fighting, baiting others towards physical confrontation
  - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

NOTES

IR, SERT and Protective Services

Leslie Goodlow-Baldwin, MSW
Program Manager
Developmental Disabilities
Protective Services

Introduction

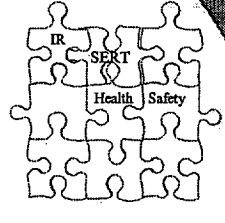
- This training is to povide information on a variety of issues related to Incident Reports and the SERT system.
- Attendees will learn the following items:
  - How to correctly complete an incident report
  - The importance of mandatory reporting
  - What happens during the SERT process
  - In-home Rule effective 1/01/2004
  - PS process and procedures

Agenda

- Definitions
- Mandatory Reporting
- Incident Reports and documentation
- Protective Service referrals and process
- SERT process, documentation and outcome data collection

Overview

- Ensuring the health and Safety of all our clients is the prime responsibility of DDSD.
- Accurate and complete documentation of incidents, follow-up and outcomes is the glue that ties all of the topics today, together.



"Adult" means a person who:

1. Is mentally ill or developmentally disabled;
2. Is 18 years of age or older
3. Receives services from a community program or facility or care provider which is licensed or certified by or contracts with the department.

"ABUSE" means one or more of the following:

(a) Any death caused by other than accidental or natural means or occurring in unusual circumstances.

Examples:

- Suicide
- Accidental or natural death with neglect or other allegations

"ABUSE" means cont.

b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

"ABUSE" means cont.

(c) Willful infliction of physical pain or injury;

- Bruises
- Medication mismanagement resulting in injury
- Physical fights involving an adult
- Domestic violence included

"ABUSE" means cont.

(d) Sexual harassment or exploitation, including but not limited to, any sexual contact between an employee of a community facility or community program and an adult.

- Any sexual contact between an employee, provider or other care giver and the adult.
- Unwelcome sexual contact directed toward the adult by anyone else.
- Consensual or nonconsensual with staff
- Rape or sexual assault included.

"ABUSE" means cont.

(e) Neglect that leads to physical harm through withholding of services necessary to maintain health and well being.

- Withholding food and hydration

Residential/Vocational and AFH OARs also include:

1) Failure to act/neglect
2) Verbal mistreatment
3) Restriction on freedom of movement
4) Physical/chemical restraints (must also have an injury)
5) Financial exploitation

Vocabulary continued:

Community Program – the community mental health and developmental disabilities program as established in ORS 430.620 through 430.700.

SERT – Serious Event Review Team

Incident Report – written report of any injury, accident, act of physical aggression or unusual incident involving an individual.

LEA – Law enforcement agency

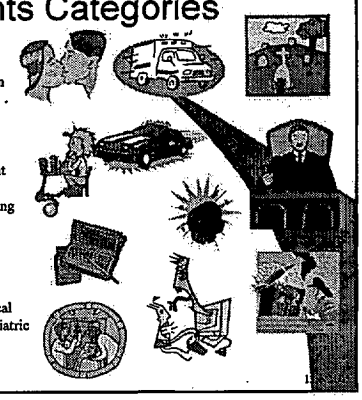
1. Any city or municipal police department
2. Any County Sheriff's Office
3. The Oregon State Police
4. Any District Attorney

Mandatory Reporting

- **What it means** - Any public or private official, who while acting in an official capacity, comes in contact with and has reasonable cause to believe that the adult has suffered abuse, or that any person with whom the official comes in contact while acting in an official capacity has abused the adult.
- **Who is a mandatory reporter?** – Employees of the Department of Human Services, County Health Department, **Community Mental Health and Developmental Disabilities Program** or private agency contracting with a public body to provide any community mental health services.
- **What does this mean for you?** – You are required to report to LEA any incidents that may be a crime, regardless of the victim's willingness to participate with law enforcement.

SERT Events Categories

1. Death
2. Abuse/Physical
3. Willful infliction of pain
4. Abuse/Restraint
5. Sexual Abuse
6. Neglect/Negligence
7. Abuse/Verbal
8. Restriction of movement
9. Financial Exploitation
10. Inappropriately expending personal funds
11. Fire Department called
12. Police Called
13. Criminal Referral made
14. Ambulance Called
15. Hospitalization – Medical
16. Hospitalization – Psychiatric
17. ER Visit



SERT Incident Report Review Process

1. Staff person receives information regarding an incident with a client.
2. Determines if meets SERT criteria.
    1. IF no, writes PN and attaches to faxed copy of the form. SC documents on tracking log.
    2. IF yes, completes a PINK SERT Incident report form.
3. Puts completed form with supplemental information attached into the folder at the back-up cube.

SERT Incident Report Review Process

SERT incident reports will be reviewed by the PS Screener

1. Screener reviews incident for the following:
    a) Does the incident meet SERT criteria??
    b) Is this a PS referral?
    c) Does incident meet PS definition?
        i. If yes – Send to Tracy, opened as a case and assigned to an investigator.
        ii. If no – Screener will review and determine if follow-up is needed
    d) Screener will assign an IR number to the form. Send a copy of the form to Tracy for data entry. The original pink is sent to the SC for follow-up.
    e) When follow-up is complete, the form is given to the supervisor for signature.
    f) After supervisor signs, return original pink to Tracy for final data entry. Tracy sends original and "copies of relevant" case notes to the file room.

Protective Services Referrals & Investigations

As stated earlier, any Incident that meets the SERT categories 2-10 are always referred to Protective Services for Referral!

The remaining categories can be considered for PS referral depending upon the incident.

The screener reviews the incident to determine if it meets the criteria for investigation as outlined in the OARs.

Key points to know regarding what gets opened vs. not opened.

- We do not do investigations on clients under the age of 18. Those issues are referred to DHS-Child Welfare. But, you still need to fill out a SERT incident report form.
- Neglect either in-home or by contracted staff requires injury or significant risk of injury.
- We do not open investigations for financial exploitation by non-contracted staff (In-home)

What happens when a PS referral is called in to the County?

- The allegation is written up by the staff person who received the call or incident report.
- The Incident is reviewed by the protective services screener, who determines if the allegation meets criteria as outlined in the OARs.
- If no, then the incident is sent back to the service coordinator with recommendations for follow-up.
- If so, the case is opened and assigned to an investigator.

Protective Services Investigations

- The investigator contacts any witnesses, the service coordinator and the alleged victim.
- He/She will also review the ISP, medical documentation, financial documentation, and any other relevant information.
- The final person to be interviewed is usually the alleged perpetrator.
- After the interviews and documentation review, the investigator will compile the information and make a determination of finding.
- The findings will be either substantiated, unsubstantiated or inconclusive.

Protective Services Referrals & Investigations

Additional Key Points:

- ADS reports that come in over the weekend need to be forwarded immediately to the screener. Screener will review for PS/SERT issues.
- Referrals for PS involving possible neglect by Hospitals and other facilities. Hospital complaints need to forwarded to DHS, the on-line complaint form.
- Nursing home referrals go through Aging.

Protective Services Investigations, cont.

- Substantiated means that there was a preponderance of evidence indicating that the AP was at fault.
- Unsubstantiated means that there was not sufficient evidence proving fault.
- Inconclusive means that there was evidence of injury or harm, but it is not clear who or what is the cause.

Summary

- Important to remember, if you are not sure, turn it in anyway!
- Protective services is here to ensure [illegible] health and safety, but also that providers are safe as well.
- If it's not written down, it didn't happen!

Where to Get More Information

- MHDDSD web-site
- Call our office – 503-988-3658
- Call the Office of Investigations and Training at 503-945-9483

Suicide Intervention

SUICIDE INTERVENTION

Suicide Awareness

Portland Police Bureau

Definition of Suicide

"Suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution."

Dr. Ed Shneidman, Psychache, 1993

Startling Statistics
2000 data

- One suicide every 18 minutes
- 11th ranking cause of death in the US
- 734,000 suicide attempts every year
- 5 million living Americans have attempted suicide
- Each suicide affects at least 6 people intimately
- Firearms used in 57% of suicides

Frequency of US suicides

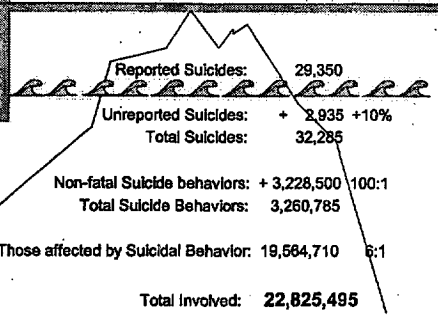
One

Suicide

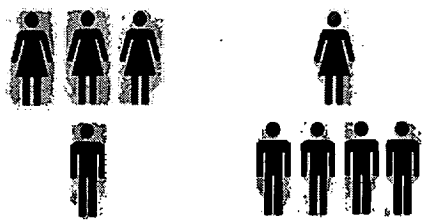
every 18

minutes

Tip of the Iceberg
USA 2000 data



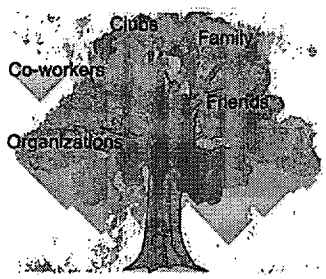
Suicide Demographics
Gender



Female:male ratio is 3:1
for **attempted** suicide

Female:male ratio is 1:4
for **completed** suicide

Who is affected by a Suicide?



You

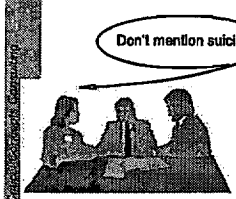
Are!

Motivations for Suicide

Loss or change in an important relationship
To avoid or end perceived pain
Escape intolerable situation
Gain attention
Manipulate/punish others
Punish self
Become a martyr

Common myths about Suicide

- Happens without warning
- Low risk after mood improvement
- Once suicidal, always suicidal
- Intent on dying



- So rare, they won't do it
- Runs in the family
- No note ==> no suicide

Direct Verbal Clues

I'm going to kill myself

I wish I were dead

You'd be better off without me

I might as well be dead

If ...doesn't happen, I'm going to end it

I'm going to commit suicide

Indirect Verbal Clues

I can't go on any longer — I'm taking the plunge

We all have to say goodbye sometime

Nobody needs me anymore — I'm tired of life

You won't be seeing me any more

Life has lost meaning for me — I can't take it any more

You'd be better off without me

I can't take the pain — Eat my gun

You're going to regret how you treated me

Cash in my chips — Fold my hand

Major Predictors of Suicidal Behavior

Current plan:

- ♦Specificity of their plan
- ♦Availability of means
- ♦Lethality of method

Previous History:

- ♦A prior suicide attempt
- ♦A family history of suicide behaviors

Resources available

Do's of Intervention

- Remain calm
- Help define the problem
- Rephrase thoughts
- Focus on central issue
- Stay close
- Emphasize temporary nature of problem

** Listen ** Listen ** Listen **

Do Nots of Intervention

Don't overlook signs

- Don't sound shocked
- Don't offer empty promises
- Don't debate morality
- Don't leave person alone

Don't remain the ONLY person helping

Important Questions

Have you been thinking of hurting or killing yourself?

- How would you kill yourself?
- Do you have the means available?
- Have you ever attempted suicide?
- Has anyone in your family attempted or completed suicide?
- What are the odds that you will kill yourself?
- What has been keeping you alive so far?
- What do you think the future holds in store for you?

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Web site:
copdoc.home.att.net

Suicide Prevention

- Develop your interview around a knowledge base and your questions will follow.
- Interviewing: The Basic Rule, "Always ask"
- Straightforward...Do you have thoughts of hurting or killing yourself? Ask the S word.

  How would you do it? Specificity.
  When and where would you do it? Specificity.
  Do you have the means to do it? Lethality.
  Why now? What is the final straw?
  Why *not* now? What are the protective factors?
  When and with what in the past? What was their impression of it?
  What level of control do you feel? How are your brakes?

- **Reasons for Suicide:**

#1. Person is in acute distress.
#2. Suicidal individuals are ambivalent: see choice as "life or death". Engage in the "I win" game = If I live I win, if I die I win. Good example is the "Police assisted suicide"...drop the gun or we'll shoot.
#3. Person is cut off from outside support and therefore focus on relationships in the institutional setting.

In hospital studies (John Hopkins/Harvard Medical School) it was found that the symptoms prior to suicide included: Dysphoria (86%), Psychosis (50%), Somatic Anxiety (43%), Psychic Anxiety (93%), Agitation (79%), Lability (93%)

Farberow (1966) studied 218 suicide cases and found the predominant pre-suicide behaviors for the "active group" to be: restlessness, agitation, hyperactivity, pacing and sleep disturbance. For the "passive group" they were: severe depression, isolation, muteness, withdrawal, complaints about health and ambivalence about being in a hospital.

- **Risk Factors:** Sex, sexual orientation, age, alcohol/drug; plan, means (especially firearms), emotional upset, mood disorder, psychosis, physical health, incarceration, support system, recent loss or anniversary of loss, severe anxiety or turmoil, global insomnia, delusions of doom and gloom. Decrease the risk factors and you decrease the risk.
- **Highest Risk:** White, male, recent loss (job, spouse, financial support) alcohol on board. Risk increases with age after fifty. Has a realistic plan and the means to carry it out especially possession or access to a firearm.

- **High Risk:** Incarceration, alcohol or drugs on board, humiliation over arrest/charges (e.g. sex offense, particularly first arrest). Highest risk is during the first few hours of incarceration.

- **The Lethal Triad:** An upset person, with a firearm, with alcohol on board.

- **Important for jail and hospital settings:** Death by hanging is second only to firearms as the means of suicide. Approximately 17.2% of male suicides are by ligature and 14.3% of female suicides. (63.3% and 41.3% for males and females by firearm).

- Stats:
- Females threaten suicide more frequently than males by a factor of 3X.
- Males succeed at suicide more frequently than females by a factor of 3X.
- Incidence of female suicide is relatively stable.
- Rough guess is that there are around 25 attempts for every successful completion. This is an average as among the young there are about 100 attempts per success but among the elderly it may be about 4:1 to as high as 2:1.
- Elderly, white males have the highest incidence of successful suicide.
- 33% of elderly suicides saw their M.D.s the week of the suicide.
- People with a history of abuse as children have a 30 fold increase in risk.
- Oregon ranks 9th in the U.S in suicide rate.
- Suicide is the leading cause of death in people with bi-polar disorder:
  Major depression...20% BUT 98% of suicides are seriously depressed.
  Bi-Polar ... 25% to 50%
  General Population...1%
- In Schizophrenia, 20 to 40% attempt suicide while 10 to 15 % succeed.
- Nationally the rate is 12/100K/year
- This increases to 380/100K/year for people with untreated mental illness.
- Suicide ranks as the 9th leading cause of death in the U.S.
  3rd for fifteen to twenty-four year olds
  14th for elderly
- There has been a 200% increase in suicide rates among Black males.
- Successful suicide rates in the U.S. are: 8:2 male to female....9:1 white to non-white.....7:2 white males to white females.....8:2 non-white males to non-white females
- 2 to 6% of suicides occur in hospital settings (620 to 1800/year or 3/day or 1 per 8hr shift.
- In Oregon, the rate is 12 to 32 per year in hospital settings.
- Nationally, the rate of suicide on Medical/Surgical Units is 42/100K.
- On Psychiatric Units this increases to 90-150/100K. (In Finnish psych units the rate is 400/100K)

- Always take threats seriously even from those you believe are manipulating. Personality disordered individuals have been known to kill themselves just to prove they meant what they said ("I'll show you").

- One in ten with a diagnosis of Borderline Personality Disorder will eventually suicide.

- Look for sudden changes in mood, e.g. a depressed individual who suddenly seems to have "gotten over it". They may have made up their mind to proceed with a suicide.

- Look for classical symptoms of depression; ask about: appetite, sleep, energy, sexual drive-interest-performance, concentration, and mood. What you are looking for are changes, which may be sudden or have been occurring over the past few weeks.
- Most common: **Anergia**...loss of energy.
  Anhedonia...loss of enjoyment or capacity for pleasure.
  Loss of sexual drive, interest, response.
  Hypophagia...loss of appetite with accompanying weight loss.
  Hyperphagia...excessive eating with accompanying weight gain.
  Insomnia...difficulty falling or staying asleep.
  Hypersomnia...excessive sleeping with no sense of rest.
  Loss of concentration, short attention span.
  Low mood, tearfulness, irritability, hopelessness, and despair.
  Excessive guilt.

- Some people may not acknowledge being depressed but they may endorse many items on the list above.

- Suicidal individuals can hide it from you and carry out a successful suicide. You will be left wondering about what more you should have or could have done.

- **Substance Abuse and Suicide:** Lifetime risk 2 to 3% (Two to three times the national average). 15 to 25% of all suicides are by alcoholics. Intoxication is associated with 50% of all suicides.

- **Sobriety is essential.** Substance abuse increases lifetime risk of suicide by 2-3X. 15 to 20% of all suicides are by alcoholics. The highest risk in this group is a male with a long history of drinking who also has a co-morbid psychiatric disorder. Intoxication is associated with 50% of all suicides. Alcohol produces "alcohol myopia" which is the inability to perceive consequences of behavior.

- **Buffers, the "Wall of Resistance":** A strong religious prohibition against suicide. Clean and sober. Intact support system. Willingness to examine options and make a no-harm contract. For women, the best protector against suicide is a child. The more children, the lower the risk...ask "what will become of your children?". A job, a pet, a counselor or therapist. Duty to others. Medication compliance. Good health. Good friends. Job skills, job security. Safe environment and difficult access to means. At

the top of the list is hope. Anything that provides a glimmer of hope to a suicidal individual may be enough to prevent their suicide.

In the final analysis the final decision rests with the individual. However, most suicidal people do not want to die. They want to find a way to live and ambivalence exists right to the moment of death. Reduce risk factors and enhance protective factors and you reduce the risk of suicide.

Primary source of information comes from materials provided by AFSP, the American Foundation for Suicide Prevention

SUICIDAL BEHAVIOR

- Suicidal Behavior
- Suicide Plan
- History of Past Events
- The Persons Resources
- Recent Loss
- Physical Illness
- Drinking and other Substance Abuse
- Physical Isolation
- Dramatic Changes
- Mental Illness
- Suicide Prevention

Suicidal Behavior[2]

A common myth regarding suicide is that people who commit or attempt to commit suicide are mentally ill. Although people who are suicidal are usually in emotional turmoil and although suicide is often preceded by periods of depression, these conditions do not necessarily indicate mental illness. The mentally ill may attempt and commit suicide, but not all that attempt suicide are mentally ill.

Suicide in the United States is the 10th leading cause of death among adults and the second among adolescents. For every suicide there are 8 to 10 attempts, or about 300,000 attempts annually. Suicide knows no boundaries. It cuts across race, class, age, and sex, though its frequency varies with different groups. It is not an illness or an inherited disease as is sometimes believed but is usually a response to a life crisis that the person sees no other way of alleviating. Though many persons who commit suicide are in a temporary state of acute crisis, some are chronically self-destructive and continually attempt suicide.

Listed below are some of the major signs of suicidal behavior. A suicide can still occur without these signs being present, however. At the same time an officer should not hesitate to consider the person suicidal if on ly on e or two signs are apparent. It is impossible to predict suicide in any absolute sense, but inclusions of these signs and guidelines for officers will remove much of the guesswork associated with suicide assessment.

Suicide Plan
Many persons who attempt or commit suicide do so by design. The plan begins with the idea of suicide; suicidal people do not act on impulse but weigh the factors involved. The plan also involves the method of suicide and its lethality. A plan involving a gun will have more likelihood of being effective that will a plan involving tranquilizers. The availability of the means is also a factor. For example, if the person threatens to use a gun and he is a gun owner, the means is clearly available. The final element of a plan is its specificity — time, place, and circumstances. If a person indicates he will commit suicide within two days at a specific time and place, and he has the lethal means, he is a higher suicide risk than one without a plan. The more specific the plan, the higher the risk.

History of Past Attempts
The majority of people who commit suicide have made previous attempts.

The Person's Resources
The officer should assess two types of resources, internal and external. If the person feels life is worthless and that little hope for improvement exists, he or she is lacking internal resources and should be considered a high risk. Lack of

external resources, such as family or friends, or an inability to communicate with those persons is also an indication of high risk.

Recent Loss
Any recent personal loss or the threat of losing a life partner, parent, status, money, or job increases the person's risk of suicide.

Physical Illness
Having a serious illness, especially on that is terminal, that threatens one's values or status, or that is or likely to dramatically affect one's self image increases the risk of suicide.

Drinking and other Substance Abuse
Alcohol or drug abuse is often a sign of other problems, especially if the abuse is recent, and should be included in a suicide assessment. Also, use of alcohol or drugs often increases the risk of loss of control or an increase in impulsive behavior. Alcohol also increases the lethality of a drug overdose

Physical Isolation
The risk of suicide increases when a person is both physically and emotionally isolated. Isolation can cause people to feel they do not belong to a family or society and can increase feelings of worthlessness and other negative self-images. Even temporary isolation may be an impetus for suicide.

Dramatic Changes
A sudden, dramatic, or unexplainable change in lifestyle or behavior may be a clue to suicide contemplation. Change in one's social network and environment such as relocation or retirement can be very upsetting. Also, unexplained changes in behavior are often a symptom of a larger problem, which may in turn increase the risk of suicide.

Mental Illness
Persons who hear voices directing them to commit suicide are certainly in a high-risk situation. However, the number of persons who fall into this category is quite small. If a person indicates that other people, or voices, are controlling his or her behavior, those signs should not be ignored.

In an attempt to determine the existence of any of these signs, the officer must communicate with the person in a calm, direct, and matter of fact way. Talk about the finality of the act and use the terms "suicide," "death," "kill your self." Talking about suicide does not prompt the person to commit the act. The best way an officer can help the person is to discuss the person's problems, the suicide plan, and realistic alternatives. Communication with the person not only enables the officer to gather information regarding the risk, but it is also helpful for the suicidal person. Often the suicidal person has been lacking communication and the

offer's efforts tell him or her that someone is interested and concerned about finding an alternative solution.

[2] All the preceding information about suicide was copied with permission from: Improving the Police Response to the Mentally Disabled, Police Executive Research Forum, 1986.

Suicide Prevention

Suicidal Clues

- Verbal: "it doesn't matter anymore", "you won't be hearing from me again"
- Situational: hopeless and helpless.
- Behavioral: stripping of possessions or relationships, in appropriate calmness/flatness, past attempts.
- What is the Immediate Problem?
- What has happened in last 24 hours that makes you want to kill yourself?
- Identify the problems/situation.
- Identity the loss.
- Talk about it/ventilate feelings.

Identify Hook

- What is still important to the person?
- What still has value/meaning?
- Keep returning to the hook.

Determine Motivation

- What is objective/goal of suicide action?
- What is person hoping to accomplish?

Develop Non-Lethal Alternative Option

- To diffuse crisis state
- To accomplish objective/goal

Develop Specific Plan of Action

- Be realistic.
- Make a list.
- Go to next step.

Referral

- When appropriate.
- When crisis has ended.

Suicide Prevention

Suicidal Clues

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Suggested Dialogue

- Look I can see you're really (label emotion) right now. I just want to talk with you for awhile.
- I really care about what happens to you. That's why I have this job.
- I know talking about this is really rough, but we can take it slow.
- I sense you're really down on yourself right now.

- Do you really want to die, or do you want to not hurt so much?

Finality of Death

- Once you're dead, you're not going to get another chance.
- You know if you kill yourself to get back at _____, all that's going to happen is that you'll be dead. We can't be sure of _____'s reaction. _____ may not care at all. Therefore _____ wins. You're dead and _____'s going to go on with their life.
- I guess right now you want to get away from the hurt, but dying (method) is pretty painful. Let's talk about some other way to get this pain out of your life.

Hooks

Parents

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

Children

- How do you think it will affect (name/'s) if you kill yourself?
- You know, if you kill yourself, you'll never see _____ grow up, graduate, get married. I can tell you care about them a lot.

Job, Career, Hobby

- You know, you've told me that you've made some pretty important breakthroughs in your job, if you killed yourself, you'll never have that satisfaction again.
- You were telling me about your (hobby), you're pretty proud of _____. What will happen to _____ if you die, will they just get tossed in the trash?

Pets

- What about _____? Who will take care of _____? I guess _____ will have to be destroyed.

Explore Plans / Thoughts

- What do you want to have happen? What would need to happen for you to feel better, feel like you could go on?
- What do you think (you/we) could do to make things not hurt so much?

Policy & Procedures

850.20 MENTAL HEALTH CRISES, RESPONSE TO

Index: Title

Refer: ORS 161.336(5) Conditional Release by Psychiatric Security Review Board: Termination or Modification of Conditional Release
ORS 181.530 Commitments
ORS 426.228 Police Officer Taking Person into Custody – Mental Treatment
ORS 430.735 – 765 Duty of Certain Persons (incl. Peace Officers) to Report Abuse of Mentally Ill or Developmentally Disabled Adults
Report of Peace Officer Custody of an Allegedly Mentally Ill Person (CIT Coordinator)
Report of Peace Officer Custody of an Allegedly Mentally Ill Person as Directed by a Community Mental Health Director (CIT Coordinator)

POLICY (850.20)

It is common for members to have contact with persons who by their actions indicate that they may have a mental illness. No person shall be taken into custody for mental illness alone. A mentally ill person will only be taken into custody when he/she has also committed an arrestable offense, has a valid detention order against him/her, or has demonstrated by his/her actions, as observed by a reliable person, that he/she poses a danger to him/herself or to others; and is in need of immediate

care, custody or treatment for a mental illness.

PROCEDURES (850.20)

Directive Specific Definition

Abuse is:

a. Any death caused by other than accidental or natural means.
b. Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.
c. Willful infliction of physical pain or injury.
d. Sexual harassment or exploitation, including but not limited to any sexual contact between an employee of a facility or community program and an adult mentally ill or developmentally disabled person who receives services from the community program or facility.

Mandatory Reporting Requirements (850.20)

Members will complete an Investigation Report for allegations of abuse to mentally ill and developmentally disabled persons and forward a copy of the report to the Multnomah County Mental Health Division or to the Developmental Disabilities Services Division. Members will report non-criminal matters to the Gatekeeper Program as listed in the Problem Solving Resource Guide.

Crisis Intervention Team (CIT) (850.20)

CIT consists of sworn members who have completed the qualifying CIT training and who choose to be members. CIT members assigned to patrol will be used for incidents involving persons in a crisis due to a mental illness or developmental disability.

BOEC will dispatch the nearest CIT officer assigned to the precinct of occurrence as the primary investigator. If no precinct CIT officers are available, BOEC will search citywide for an available CIT member to respond. CIT officers will notify his/her supervisor when leaving precinct boundaries. BOEC will dispatch cover units, including additional CIT members, as appropriate. If a CIT member is dispatched as the primary, he/she will investigate the incident and make appropriate custodies, transports or referrals. He/She will remain the lead investigator, unless relieved by a supervisor or not needed due to a change in circumstances before the CIT member's arrival.

Members involved in an incident requiring CIT should request their response. If the member has already taken a person into custody, he/she may still request CIT for assistance in making appropriate referrals or for assistance in processing the person. In this case, CIT will not act as the primary investigator.

Supervisors may use CIT members to make initial contact with subject(s) involved in incidents requiring the Hostage Negotiation Team (HNT). CIT will not be used in place of HNT, but HNT may use CIT as needed.

Dispositions (850.20)

Members will consider the nature of the situation and the behavior of the allegedly mentally ill person involved in determining the appropriate disposition of the person. Members may choose from the following options:

a. Refer to a mental health agency, crisis hotline or other related service agency. Resource information can be located through the Police Information Line or the Problem Solving Resource Guide.

b. Consult with a mental health or medical professional. Members can request, through BOEC, a Mobile Crisis Team to respond to the scene, if available. Members may contact the person's health professionals, the mental health crisis line or other appropriate resource agencies.

c. Transport the person to a mental health or medical facility for voluntary care when no other means of transportation are readily available. Assisted persons should not be dangerous and be able to manage their behavior. Members should escort persons into the waiting area and introduce the person to facility staff. Members are not required to standby. Members will complete a Special Report and document the incident and transport.

d. Take the person into custody (civil) when there is probable cause that the person is a danger to him/herself or another person and is in need of immediate care, custody or treatment for mental illness and transport him/her to the appropriate secure evaluation unit or to the nearest designated hospital for a mental health evaluation.

e. Take the person into custody for an arrestable offense, or in the case of a citeable offense, cite the person and either take the person into custody (civil) for a mental health evaluation or voluntarily transport the person to a treatment facility.

Peace Officer Custody for an Allegedly Mentally Ill Person (Civil Custody Report) (850.20)

When taking an allegedly mentally ill person into custody (civil) for a mental health evaluation, members will:

a. Transport the individual to the appropriate secure evaluation facility, or if there is no secure evaluation facility or if the unit is on divert, to the nearest designated hospital emergency department that conducts mental health evaluations.

b. Remain at the facility until a physician determines whether the person will be admitted. If not admitted, the member may arrest the person for an offense, transport the person back to the original custody location or both. In the case where no arrest is made and the person chooses not to return to the location of custody, the person will be released outside the care facility.

c. Complete an Investigation Report and a Civil Custody Report, before leaving the facility.

d. Make copies of both reports. Leave the original Civil Custody Report and a copy of the Investigation Report with the secure evaluation unit or the receiving hospital. Turn in the original Investigation Report along with a copy of the Civil Custody Report to a supervisor before the end of his/her shift.

Peace Officer Custody of an Allegedly Mentally Ill Person per a Mental Health Director (Director's Custody Report) (850.20)

When assisting a community health and developmental disabilities program director or designee in taking an allegedly mentally ill person into custody, members will:

a. Verify the authority of the person signing the Director's Custody Report and ordering the custody (civil). Approved Qualified Mental Health Professionals (QMHP) have identification cards from Multnomah County.
b. Take into custody (civil) the person named on the Director's Custody Report and notify a supervisor.
c. Obtain the Director's Custody Report from the director or designee and transport the person to the medical facility as designated by the director.
d. Remain at the facility until a physician determines whether the person will be admitted unless released by facility security. In the case where facility security relieved the officer and the person was not admitted, the officer may be requested to return to the facility and must transport the individual back to the original contact location.
e. Complete a Special Report documenting the custody (civil) and transport.
f. Leave the original Director's Custody Report and a copy of the Special Report with the secure evaluation unit or the receiving hospital.
g. Turn in the original Special Report along with a copy of the Director's Custody Report to a supervisor before the end of his/her shift.

Psychiatric Security Review Board (PSRB) Orders of Revocation (850.20)

PSRB will direct members to take PSRB supervised persons into custody on Revocation Orders, which are comparable to arrest warrants. When a member is notified of a PSRB Revocation Order, typically through a PSRB LEDS message reading: "No Criminal Warrant, PSRB Order for mandatory return to Oregon State Hospital" members will:

a. Take the person named in the Revocation Order into custody and notify a supervisor.
b. Ensure the Oregon State Hospital Communications Center is notified (see the Problem Solving Resource Guide for the number).
c. Transport, with one other member, the person to the Oregon State Hospital Communications Center. If additional verification of Revocation Order is

needed, the PSRB Executive Director may be contacted (see the Problem Solving Resource Guide for the number).

d. Document the incident on a Police Custody Report and turn it into a supervisor before the end of his/her shift.

Escaped Mental Patients (850.20)

Members may be requested to take escaped patients into custody. This will be done only when:

a. An escapee from a state hospital was committed under ORS 181.530 due to a conviction of a crime or committed as sexually dangerous. Notice can be in writing or by teletype.

b. A civilly committed person unlawfully escapes from a residential facility and the facility produces the order of commitment.

c. An escapee is deemed to be a danger to him/herself or others.

If escapees meet the above criteria, members should:

a. Take the escapee into custody (civil) and transport him/her to the appropriate secure evaluation unit or nearest designated hospital.

b. Contact the facility escaped from and notify them of location to pick up their escapee.

c. Complete a Special Report documenting the incident and transport, to include the name of the person notified at the escaped facility, and submit the report to a supervisor before the end of his/her shift.

Warrants of Detention/Trial Visitation (850.20)

During pre-trial civil commitment processes, an allegedly mentally ill person may be released into the community and be investigated by a civil commitment investigator. A civil warrant of detention may also be issued by a judge to take a mentally ill person into custody. Members should not become involved in these activities unless called to an incident to assist a civil commitment investigator or civil deputy in fulfilling his/her mission. The statutory authority to serve a warrant of detention rests with the county sheriff.

Assisting Hospitals with Mentally Ill Patients and Walk-aways (850.20)

Members will not become involved in incidents within a secure evaluation unit or an emergency care hospital, unless the facility cannot give appropriate care or a person becomes violent, resistive or refuses to go with facility arranged transportation to an appropriate facility. Secure evaluation units and hospitals are responsible for transports to the other care facilities. Members will not take into custody voluntarily admitted patients who have walked away from a hospital or facility, unless their actions at the time indicate they are a danger to themselves or others and are in need of immediate care, custody and treatment for mental illness.

Records Division Responsibilities (850.20)

Records will flag those persons taken into civil custody in PPDS as Allegedly Mentally Ill and forward copies of all mental health related reports to the CIT Coordinator.

RESPONSIBILITY, ACCOUNTABILITY AND CONTROL (850.20)

Supervisors will ensure that appropriate dispatch and use of CIT procedures are followed and ensure against the misuse of CIT. Supervisors will also ensure their members follow the investigations and reporting requirements. The CIT Coordinator will review all reports forwarded by Records and will act as a liaison between the Bureau and the mental health community.

REPORT OF PEACE OFFICER

CUSTODY OF AN ALLEGEDLY MENTALLY ILL PERSON

TO THE TREATING PHYSICIAN OF AN APPROVED HOSPITAL OR NONHOSPITAL FACILITY (attach original to Notice of Mental Illness)

In the matter of _____ (allegedly mentally ill)

Date of birth _____ Address _____

City _____, County _____

I, _____ a peace officer of the city _____

Multnomah County, Oregon, BPSST No. _____, took the above named person into custody at _____m., on the ____ day of _____, 20____, in Multnomah County, Oregon, for the following specific reasons:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

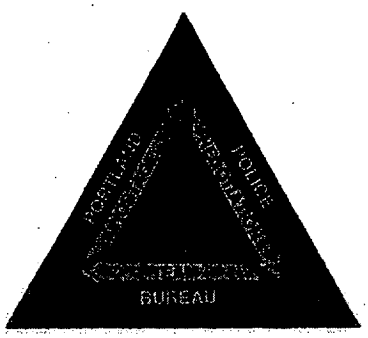
pursuant to:

( ) ORS 426.228(1) because I have probable cause to believe the above named person is a mentally ill person who is dangerous to self or other and in need of immediate care, custody or treatment for mental illness.

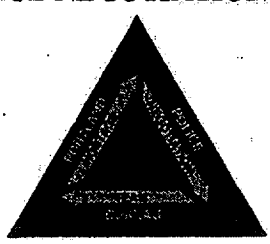
_____

police officer signature

Hostage Negotiation



HOSTAGE NEGOTIATION TEAM



Instructor:

Sergeant Wayne Svilar

503-823-0833

TEAM STRUCTURE

- Team Commanders Lt. Jeff Kaer and Lt. John Eckhart
  - Team Supervisors
    - Sgt. Wayne Svilar
    - Sgt. Bob Day
    - Sgt. John Brooks
      - Technical Detective Troy King
      - Squad 1 (5 detectives)
      - Squad 2 (5 detectives)
      - Squad 3 (5 detectives)

NEED FOR HNT

- Munich Olympics 1972
- Van's Olympic Room 1976
- Ringside 1980's
- Tate/Graves 1985

NEGOTIATOR SELECTION

- Police Detective
  - Good Interviewing Skills
  - Good Communication Skills
  - Demonstrated Good Judgment
  - Calm Demeanor
  - Special Skills (technical, language, etc)
  - Role (Team) Player

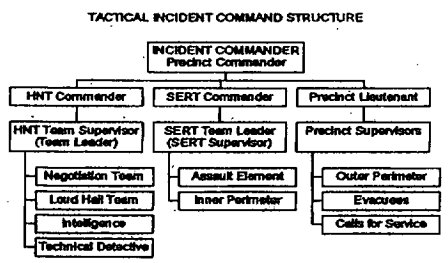
NEGOTIATOR TRAINING

- Basic Hostage Negotiation School (FBI)
- Monthly training (3 hrs.) for entire team
- Western States Hostage Negotiation Association yearly (3 day) seminar
- California Association of Hostage Negotiations
- Joint Training with FBI and other agencies

WHEN HNT RESPONDS

- Hostage Situations (Negotiate)
- Barricaded Subjects (Crisis Intervention)
- Sniper Situations
- Suicidal Subjects
- High Risk Search Warrants

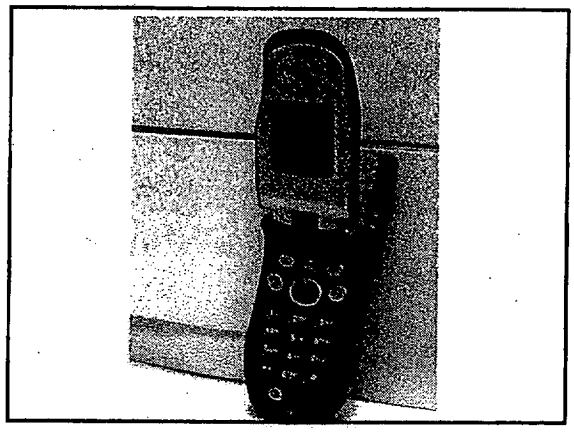
TACTICAL INCIDENT COMMAND STRUCTURE

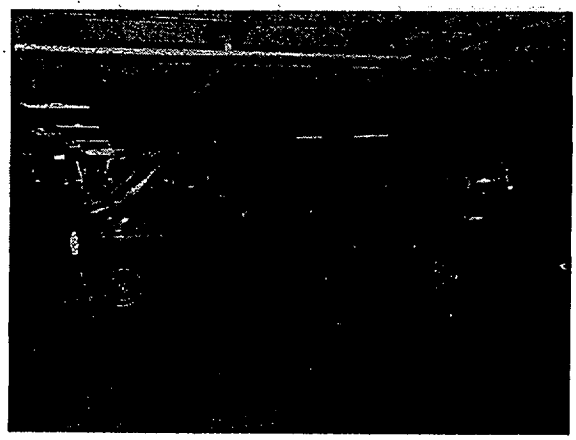


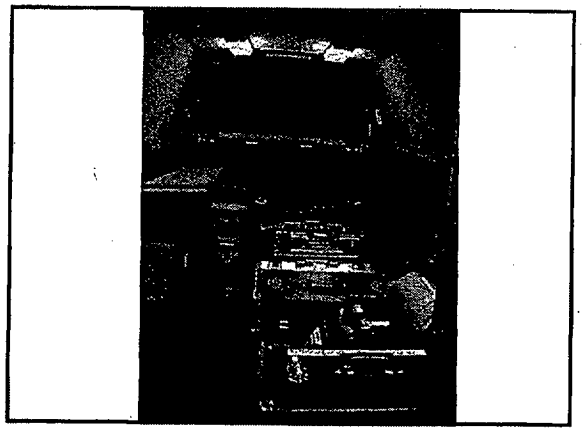
HNT ASSIGNMENTS

- Primary Negotiator
- Secondary Negotiator
- Loud Hail Team
- Intelligence Officer
- Intelligence Coordinator
- Log Keeper
- Technical/Communications Officer

EQUIPMENT







WHAT HAPPENS AT A "TYPICAL" HNT CALL

- HNT & SERT are activated by uniform
- Initial Briefing
  - Incident Commander
- Negotiation Post
  - Location
  - Equipment Set Up / Phone "Tie Down"

WHAT HAPPENS AT A "TYPICAL" HNT CALL

- Intelligence Gathering
  - Victims
  - Witnesses
  - Relatives
  - Friends
  - Co-Workers
  - Other Officers (Police, Parole & Probation, etc)
  - Doctors
  - Mental Health Contacts

WHAT HAPPENS AT A "TYPICAL" HNT CALL

- Contact the Subject
  - Telephone
  - Loud Hail
  - "Throw Phone"
  - Face to Face
- Communicate
  - With the Subject
  - With Command
  - With SERT

WHAT HAPPENS AT A "TYPICAL" HNT CALL

- Communications Tactics
  - Listen
  - Rapport / Trust
  - Time
- Negotiated Surrender

WHY NOT JUST...

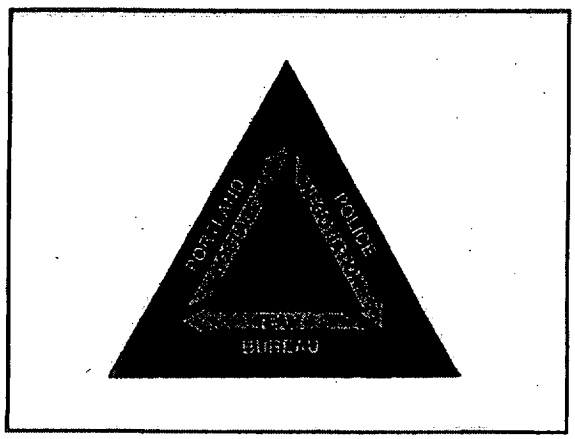
- Assault the location and force the subject out?
- Let their mother speak to them?
- Why not just leave?

Audio Examples

- Hostage (Strayer) 1988
- Barricade (McClure) 1995
- High Risk (Briar Place) 1991

QUESTION & ANSWERS

Sergeant Wayne Svilar
Detective Division
Hostage Negotiation Team
503-823-0833


PORTLAND
POLICE
BUREAU

COMMON ACRONYMS

(AMHSA) ADULT MENTAL HEALTH AND SUBSTANCE ABUSE
(AFS) ADULT AND FAMILY SERVICES
(ARC) ASSOCIATION OF RETARDED CITIZENS
(ADHD) ATTENTION DEFICIT HYPERACTIVITY DISORDER
(ADD) ATTENTION DEFICIT DISORDER
(BHD) BEHAVIORAL HEALTH DIVISION
(CMI) CHRONICALLY MENTALLY ILL
(CAMHSA) CHILD & ADOLESCENT MENTAL HEALTH AND SUBSTANCE ABUSE
(CCMH) CLACKAMAS COUNTY MENTAL HEALTH
(CIT) CRISIS INTERVENTION TEAM
(CRT) CRISIS RESPONSE TEAM
(CTC) CRISIS TRIAGE CENTER
(DCFS) DEPARTMENT OF COMMUNITY AND FAMILY SERVICES
(DSM4) DIAGNOSTIC AND STATISTICAL MANUAL
(DSO) DISABILITY SERVICES OFFICE
(EAP) EMPLOYEE ASSISTANCE PROGRAM
(ISP) INDIVIDUAL SERVICE PLAN
(MRDD) MENTALLY RETARDED DEVELOPMENTAL DISABILITY
(MHRC) METROPOLITAN HUMAN RIGHTS COMMISSION
(NAMI) NATIONAL ALLIANCE FOR THE MENTALLY ILL
(OAC) OREGON ADVOCACY CENTER
(PSRB) PSYCHIATRIC SECURITY REVIEW BOARD
(SDSD) SENIOR DISABLED SERVICES DIVISION
(SCF) SERVICES TO CHILDREN AND FAMILIES
(SSDI) SOCIAL SECURITY DISABILTIY
(SSI) SUPPLEMENTAL SECURITY DISABILITY

Notes

NOTES

NOTES

2005

Crisis Intervention Training/2005
12-05-05 to 12-08-05

Time	Monday	Tuesday	Wednesday	Thursday
0700-0800	Intro to CIT	Autism	Site Visit	Suicide Intervention
0800-0900	Overview of Mental Illness	"I'm still here!"	Site Visits	Crisis Intervention
0900-1000	Overview of Mental Illness	PTSD	Site Visits	Crisis Intervention
1000-1100	Mental Status Exam	PTSD	Site Visits	Scenario training
1100-1200	LUNCH	LUNCH	Site Visits	LUNCH
1200-1300	Personality Disorders	Site Visits Procedures	Site Visits	Scenario Training
1300-1400	Personality Disorders	MR/DD	Site Visits	Scenario Training
1400-1500	Family/Consumer Panel	MR/DD	Site Visits	Scenario Training
1500-1600	Civil Commitment	Hostage Negotiations	Site Visits	Policy & Procedures
1600-1700	Childhood Disorders	Hostage Negotiations	Site Visits	Graduation!

CIT Instructors/December 2005

Overview of Mental Illness: Dr. John Bates, OHSU. Dept. of Psychiatry
3181 SW Sam Jackson Park Rd., UHN 80
Portland , OR., 97201-3098 503-494-8311
E-mail: batesj@ohsu.edu

Mental Status Exam: Dr. Neil Falk, Cascadia
2415 SE 43rd Ave., Suite 100
Portland, OR., 97206 503-963-2575
E-mail: www.cascadiabhc.org

Personality Disorders: Curtis St. Denis, Clinical Coordinator
Department of Adult Community Justice
1415-B SE 122nd Ave.
Portland, OR., 97233 503-988-3190
E-mail: www.co.multnomah.or.us/dcj/

Civil Commitment: Jean Dentinger, Involuntary Commitment Investigator
Department of Community & Family Services
421 SW Oak St., Suite 520
Portland, OR., 97204 503-988-5464x27297

Childhood Disorders: Loretta Cone, LCSW & Wendy Hoffman, LCSW
Morrison Center, Child and Family Services.
1818 SE Division
Portland , OR., 97202 503-230-8884

Post Traumatic Stress Disorder: Dr. Jim Sardo, V.A.
3710 SW U.S. Veterans Hospital Rd.
Portland, OR., 97239 503-220-8262x33977

Mental Retardation/Developmental Disabilities: Leslie Goodlow, Multnomah County
421 SW Oak St., Suite 610
Portland, OR..97204 503-988-3653

Mental Retardation/Developmental Disabilities: Bill West, ARC-Adult Case Coordinator
619 SW 11th Avenue, Suite 234
Portland, OR. 97205 503-223-7279

Hostage Negotiation: Det. Wayne Svilar, PPB
1111 SW 2nd Ave., 13th Floor
Portland, OR. 97204 503-823-0400

Introduction to CIT, Autism, "I'm Still Here!", Suicide Intervention, Crisis Intervention, Scenario Training, and Policy and Procedures: Officer Paul Ware, PPB
1111 SW 2nd Ave., Room 1180
Portland, OR. 97204 503-823-0183

Crisis Intervention Training/2005
Wednesday, 12/07/05

Time	Group A	Group B
0800-0830		Cascadia
0930-1030		Goodwill
0930-1130	Inverness Jail	
1100-1200		Hooper Detox
1300-1400	Rainbow Adult Living	
1330-1530		Inverness Jail
1430-1530	Hooper Detox	
1600-1630	Cascadia	

Crisis Intervention Training/2005
Site Visit Contact List

Cascadia Clinic: 2415 SE 43rd Avenue
Portland, OR. 97206
503-963-2565
Contact: Alison Noice, Counselor

Goodwill Industries: 1943 SE 6th Avenue.
Portland, OR. 97214
503-238-6100 (Main Number)
Contact: Dave Phapf, 503-238-6177
Note: Please meet in the east visitors lobby, and not in the store.

Inverness Jail: 11540 NE Inverness Drive
Portland, OR. 97220
Contact: Shift Lt.
Note: Inverness is a correctional facility, and we will be putting our firearms in a lockbox before we go inside. Be sure and bring your Bureau issued ID card with you. Please leave all knives, extra mags, cell phones, pagers, batons, pepper spray, and anything considered contraband in you car.

Hooper Detox: 20 NE M.L.K. Jr. Blvd.
Portland, OR. 97232
503-238-2067
Contact: Jeanne Rivers, Manager
Note: Please meet in the business lobby on the MLK side.

Rainbow Adult Living: 1440 SE Hawthorne
Portland, OR. 97214
503-231-1608
Contact: Greg Ruf

Portland Police Bureau

Crisis Intervention Team

Instruction Manual

Section 1: Mental Illness

CIT Mission Statement:

"The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis."

Introduction to CIT.

Critical Community Incidents:

January, 1992 - Portland P.B. Incident
Nathan Thomas Shooting

August 20, 1994 - Gresham P.D. Incident
Fred Meyer Shooting

August 24, 1994 - Portland P.B. Incident
Eviction Shooting

P.P.B. Responds to Needs:

- Community Partnership developed:
  - Portland Police Bureau
  - Multnomah County Behavioral Health System
  - AMI - Multnomah (Now NAMI - Multnomah)
- Committee formed to Investigate Programs:
  - LASO team response
  - Developing Specialized Unit (LAPD, etc.)
  - Memphis P.D. CIT Program

Memphis Response to Mental Health Crisis:

- Memphis found prior to 1987 that:
  - Police were not prepared to deal with the M.I.
  - Family members of M.I. Persons distrusted police.
  - Criminal Justice and Mental Health systems were adversaries.
  - Police response often resulted in arrests and injuries. (Liability for agencies)

Memphis CIT Program Is Created

- A 40 hour CIT curriculum is created by the Mental Health Professionals. Including:
  - Mental illness diagnosis and symptomology.
  - Crisis intervention and communication skills.
  - Interaction with consumers and family of consumers.
  - Visitation of treatment/residential facilities.
  - Role-playing and scenario work in practicing crisis resolution skills.

Memphis Learns:

- Memphis found that after CIT started:
  - Crisis Response: Immediate
  - Officers are highly skilled in verbal de-escalation techniques.
  - Family members of mentally ill request CIT officers on incidents.
  - A partnership provides solutions to mental health issues.
  - Most patients are taken to medical facilities with less injuries sustained and without criminal arrest.

Memphis CIT Program Is Chosen As Model:

– Four representatives of the committee attended Memphis CIT training in October of 1994.

–These participants strongly recommend the Memphis program.

–Chief Moose authorizes program in January of 1995 and assigns Sgt. Karl McDade as first CIT Coordinator.

–60 law enforcement personnel are trained in August of 1995 and P.P.B. CIT begins.

Current Portland Police Bureau CIT Information:

- Since August of 1995 P.P.B. has conducted twice yearly CIT training for numerous Metro area police personnel.
  - Class size is usually limited to 20-25 participants
- Currently over 284 persons have been trained.
- Portland Police have 130 active CIT members.
  - Currently, 105 PPB Patrol Officers are the Back bone of the program.
  - (Active strength will fluctuate with promotions and off-street police assignments)

Who Else Has Been Trained?

– Gresham Police Department
– Oregon State Police
– Federal Bureau of Investigation
– Multnomah County Sheriff's Office
– Multnomah County Adult Community Justice
– Lake Oswego Police Department
– Portland Public Schools PD (Disbanded)
– Tigard Police Department
– Troutdale Police Department
– Washington County Sheriffs' Office

Who Else Has Been Trained?

- Medford PD
- Klamath County Sheriff's Office
- Beaverton PD
- Longview WA PD
- Wheat Ridge CO PD
- Arvada CO PD
- Portland State University Public Safety
- Clatsop County SO
- Vancouver WA PD

Portland's CIT Training Includes:

- 40 hours of instruction in:
  - Overviewing Mental Illness
  - Cognitive and Mood disorders
  - PTSD, A/D, Dual Diagnosis issues
  - Personality disorders
  - Rights of the M.I. And Commitment Law
  - Mental Status Exam and Medications
  - Family/Consumer and Community Resource Panels, and Cultural Response Panel
  - Crisis Intervention, Crisis Cycle, and Suicide Intervention
  - Site Visits and Scenario/Role-plays

How Does CIT Work?

- Street level police personnel are designated CIT in Dispatch computer.
- When a CIT related incident occurs, by PPB Directives, BOEC Dispatch assigns the closest CIT Officer as primary investigating unit.
- CIT Officer commands the incident until relieved by a supervisor if needed.

Qualities of PPB CIT

- Officer's volunteer for this training and skill certification.
- Officer's are willing to take this added work load and responsibility for no extra pay or incentive.
- Officer's typically have an interest in becoming a better police officer through this training.
- Officer's may also have someone close to them who suffers from an M.I. or D.D. And/or has known someone who does.

Important Needs/Wants:

– A Centralized Facility or Designated Hospital for Patient Intake.

–Coordination and Constant Communication Between Police, Consumers, Family and the Mental Health System.

–Simple/Streamlined Avenues of Action For Crisis Management. Treatment Plans Should Begin After the Crisis Over.

Important Needs/Wants:

–Keep Providing Training Opportunities For Police as They are the First Responders In the Mental Health Crisis System.

–Partnership with Project Respond as they also operate on a 24/7 basis

Benefits!

- The community is better served by its respective police agency.
- Less injury is sustained by both police and mentally ill/developmentally disabled persons.
- Police become better communicators and problem solvers. (Within and Without the M.H.System)
- Less money is spent on special police responses (i.e. SWAT/HNT) and civil liability litigation.

...And People Who Suffer From a Disease Are Treated With the Compassion and Respect Due All People!

Frequency of CIT

Source: CIT Database

- Mental Health Response Report:
  - 1999: 1359 - w/39% receiving CIT
  - 2000: 1690 - w/40% receiving CIT
  - 2001: 2062 - w/49% receiving CIT
  - 2002: 1746 - w/48% receiving CIT
  - 2003: 1907 - w/32% receiving CIT
  - 2004: 1999 - w/34% receiving CIT

Frequency of CIT

Source: CIT Database

- Involuntary Peace Officer Custody:
  - 1999: 905 - w/42% receiving CIT
  - 2000: 919 - w/48% receiving CIT
  - 2001: 910 - w/60% receiving CIT
  - 2002: 687 - w/60% receiving CIT
  - 2003: 651 - w/37% receiving CIT
  - 2004: 651 - w/39% receiving CIT

Frequency of CIT

Source: CIT Database

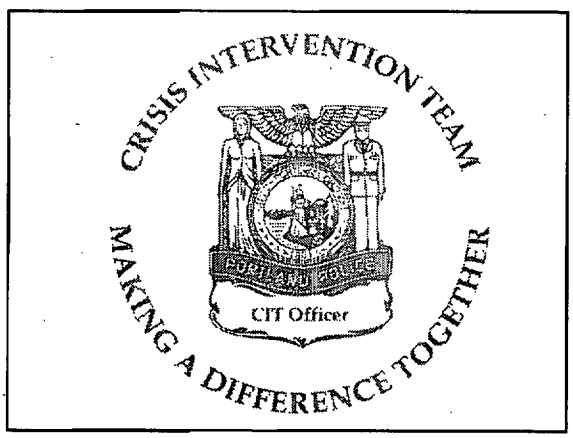
- Voluntary Assist / Transport:
  - 1999: 255 - w/28% receiving CIT
  - 2000: 570 - w/32% receiving CIT
  - 2001: 777 - w/40% receiving CIT
  - 2002: 370 - w/48% receiving CIT
  - 2003: 338 - w/34% receiving CIT
  - 2004: 301 - w/31% receiving CIT

Frequency of CIT

Source: CIT Database

- Director's Custody / Transport:
  - 1999: 66 - w/33% receiving CIT
  - 2000: 112 - w/32% receiving CIT
  - 2001: 175 - w/38% receiving CIT
  - 2002: 267 - w/40% receiving CIT
  - 2003: 376 - w/32% receiving CIT
  - 2004: 399 - w/39% receiving CIT

Thank You!


CRISIS INTERVENTION TEAM
CIT Officer
MAKING A DIFFERENCE TOGETHER

ASSESSMENT MODEL

RECOGNIZING PERSONS WITH MENTAL ILLNESS

The purpose of this activity is to provide officers with guidelines for identifying mentally ill persons. Emphasize that officers only have to be capable of identifying major behaviors indicative of a mental illness; they do not have to identify specific types of mental disorders. That is the function of a mental health professional. Whereas mental health professionals determine the type and severity of illness, officers only have to make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder.

Discussion Points

1. Generally, what is known about people with mental illnesses?

   - Depending on the severity of the disorder, mentally ill persons can be difficult to distinguish from persons not having a mental disorder.
   - Persons with a mental illness can be quite intelligent, perceptive, and articulate.
   - They can be employed and maintain familial relationships.
   - With the onset of their disorder, however, they become unable to deal realistically with the world.
   - Their thoughts and actions are not based on reality.
   - Their ability to think clearly is impaired.

2. What are the general characteristics that indicate a mental illness?

   - The behavior and mood of the person are inappropriate to the setting.
   - The behavior of the person tends to be inflexible.
   - The behavior of the person tends to be impulsive.

3. What are specific indicators of mental illness?

   - Sudden changes in lifestyle

     -can be both a cause and indicator of mental illness
     -involves an inability or unwillingness to fulfill one's expected role and responsibilities.

   - Major changes in behavior

     -behavior may have undergone sudden and drastic change
     -behavior may be marked by exaggerated mood swings
     -person may show lack of judgment regarding family, job, money, or property
     -person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic or fright

  -anxiety is intense and unfounded
  -person is in a state of panic or fright
  -person may have trembling hands, dry mouth, or sweaty palms
  -person may be "frozen" with fear

- Believes others are plotting against him

  -person has an unreal fear of being watched, talked about, followed, persecuted, or harmed (e.g. a large man believing a frail, elderly woman is trying to strangle him)
  -person cannot separate reality and imagination

- Hallucinations

  -person experience events that have no objective source, but that are nonetheless real to him or her
  -most common hallucinations are seeing or hearing things, but can involve any of the senses, such as:

    feel - most commonly of bugs crawling on the body
    smell - often of gas associated with death plots
    taste - usually of poisons in food
    hearing - voices telling the person to do something
    sight - visions of God, the dead, or horrible things.

  -hallucinations can also be induced by drug or alcohol abuse

- Delusions

  -personal beliefs that are not based on reality
  -can cause the person to view the world from a unique or peculiar perspective
  -often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person beliefs he or she is God, a saint, a famous person, or possesses a special talent or beauty)

- Depression

  -accompanies many mental disorders in varying degrees
  -often characterized by a persistent, general malaise
  -serious depression can involve withdrawal from family, job, and social involvement.

- Obsessions

  -recurrent thoughts, ideas, or images that the person cannot dismiss from mind usually involve behavior that the person finds unacceptable (e.g. a woman may believe

that every man she encounters is trying to seduce her)
-can cause tension and high level of anxiety

- Unexplained losses of memory

-not the normal forgetting of everyday things, but failing to remember the day, year, where one is, etc.
-not to be confused with loss of memory that often accompanies aging

- Confusion

-inability to focus on particular topic or interaction
-might be an indication that person has an obsession
-also caused by stroke, diabetic coma, intoxication, senility

- Impossible body ailments

-at first, symptoms are mild and may even fool doctors
-common beliefs are a body part growing, heart stopped, or chest filling with food

- Persons who suffer from mental illness must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are uncomfortable or annoying. Unlike hallucinations, these side effects are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize the presence of the side effects. Some of the major noticeable side effects include:

-minor stiffness, a rigid shuffling gait
-an at rest, hand jerk
-acute muscle spasms, tilted head
-a constant, fine, fast tremor
-blurry vision
-rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or-in severe cases-facial distortion

Basic **P**sychiatric **L**ife **S**upport

Portland Police Version

1. Goal

This summary is intended to provide police and other justice professionals with a basic outline of techniques for dealing with patients suffering from acute psychiatric disturbances. The emphasis is on an initial approach, urgent or emergent evaluation, and basics of intervention.

2. Introduction

Dealing with patients suffering from psychiatric disorders is often perceived as frightening by those infrequently exposed to these problems. The area of psychiatry itself may seem foreign for several reasons:

Psychiatry deals with biopsychosocial issues (1) that typically straddle multiple areas:

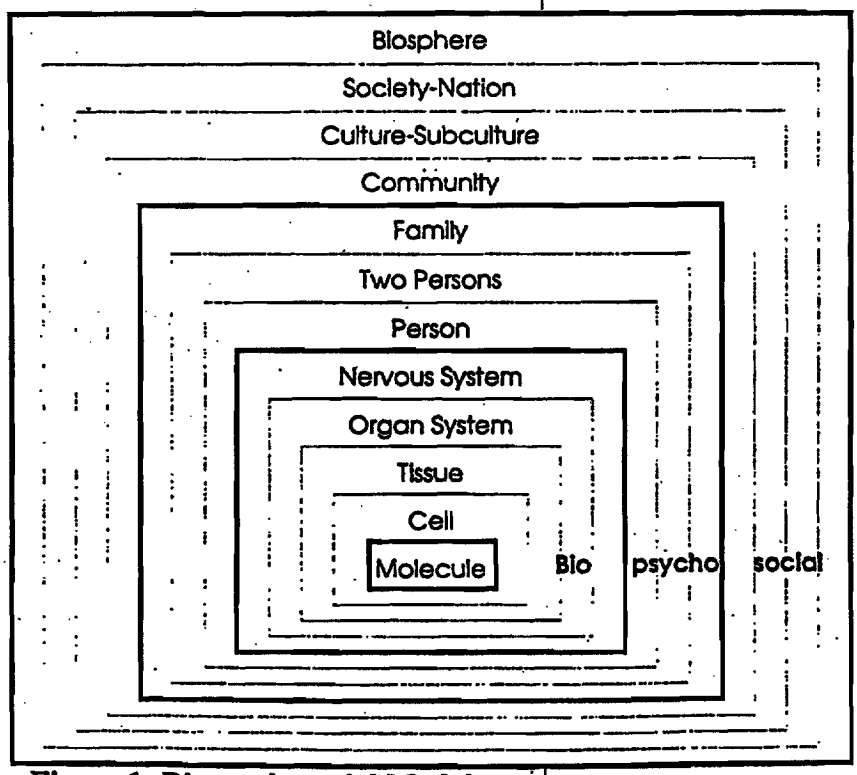


Figure 1: Biopsychosocial Model

There is no clear boundary between actions based on personal choice, social difficulties, psychological distress, or on a clearly biological disease. Multiple factors simultaneously influence the ultimate actions of an individual. Identifying and treating mental illness is complex, requires time, and may make the field appear diffuse and unclear.

Additionally, "gold standard tests" which would allow certain attribution of specific signs and symptoms to a specific disorder are generally not available. There is no X-Ray or blood test for bipolar disorder, for example. If a patient has signs of several disorders, multiple diagnoses must be considered, and frequently multiple diagnoses must be given. This may make the professionals operating in the field seem divided and without focus.

Finally, patients with psychiatric conditions often contact nonpsychiatric care providers first. They may adapt their complaints to match the specialty or "language" of the professional they are seeing. Thus, patients with similar ultimate diagnoses may present to a family doctor with physical complaints, to a mental health

professional with mental health complaints (2) (and likely to peace officers with safety concerns). Knowledge of mental illness can help the professional direct the patient safely into appropriate evaluation and treatment.

Top priority must be the professional's immediate physical safety.

The Basic Psychiatric Life Support model presented here is an attempt present the area of acute psychiatric practice in a way that is reductionistic, yet robust. The approach is generally algorithmic, similar to the Basic Cardiac Life Support course (3), which has brought emergency medical thinking to a broad audience. The structure of the algorithms here is determined by several factors which can be subsumed under the term "priority":

Severity: How bad is the disorder/injury?

Urgency: How fast must a response occur to be effective?

Remediability: How much difference will any response make?

Sequence: Does one step require a prior step?

Natural History: Balancing low frequency events with high morbidity against high frequency events with low morbidity.

3. Initial Triage

Even when it is clear that the appropriate or desired intervention is a psychiatric evaluation and/or treatment, attention must be given to its priority. (It is understood that here we are generally talking about noncatastrophic conditions in which the clinician has some realistic choices about how to proceed.)

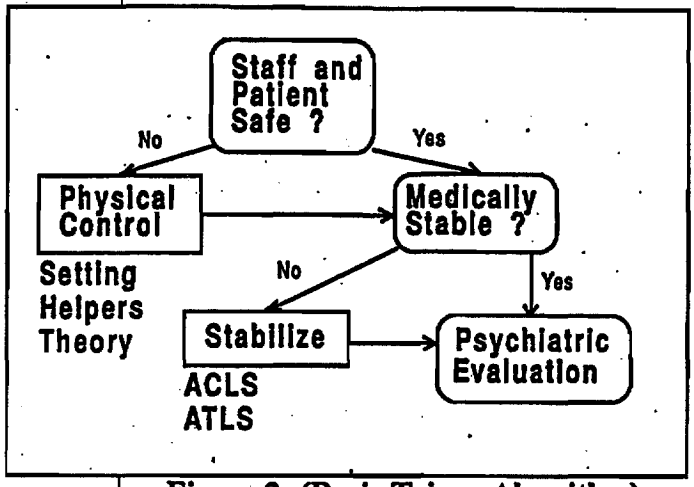


Figure 2: (Basic Triage Algorithm)

Top priority must be the clinician's immediate physical safety. What good can an injured or dead helper be? (Second priority is then the patient's own immediate physical safety.) If the clinician and patient are not physically safe, such safety must be provided for. Secondly, the patient must be medically stable to undergo psychiatric evaluation. If such medical stability is in question, immediate steps must be taken (after assuring physical safety) to intervene on this level. It is then the third priority to begin with a psychiatric evaluation, which will include the evaluation for suicide or homicide potential.

Also, attention must be given to the fact that a crisis represents the perception of an event or situation as intolerable, as an intolerable difficulty that exceeds the resources and coping mechanisms of the person defining the crisis. Such a concept must not be confused with that of an emergency,

which represents a sudden (and often distressing) event that may lead to serious psychological or physical consequences if there is no adequate response. This distinction is difficult, and at times one will need to proceed under the assumption of an emergency, even when it may ultimately prove that the problem is better identified as a crisis.

4. Physical Safety

That it is top priority to evaluate the potential of immediate harm to the professional and secondarily the patient comes as no surprise to police officers. This is their daily concern. We are looking for such basics as absence of weapons, a secure physical environment, and a patient that is reasonably able to modulate their behavior. The goal is to establish short term safety.

In essence, the concern is to identify and remain prepared for potential immediate violence, which represents a relatively rare event, but one with significant potential for injury or even death (4,5). It follows that attention must be given to issues of safety before they are needed. Protocols must be clear and well rehearsed.

4.1 Strategies:

To briefly review, the controllable variables can be grouped into three main categories: physical setting, personnel, and a theoretical model to guide the approach. Police safety techniques discuss these areas in detail, so here we will only list some areas of emphasis in the psychiatric arena for comparison.

4.1.1 Physical setting:

Structural requirements include the absence of dangerous or potentially dangerous objects, ideally access from multiple directions, monitoring and emergency communication systems, some provisions for confidentiality, and the opportunity to physically restrain a patient.

Each setting that the professional will work in should be rapidly reviewed a "worst case scenario" considerations in mind and steps should be taken to ensure as much safety in these settings as possible.

If physical restraint is used, sufficient help should be available to safely overwhelm the patient.

4.1.2 Personnel:

Just as the physical surroundings deserve attention, the professional must be completely aware of the help that is going to be available in an emergency. Specifically mental health trained, 24 hours per day, capability would be ideal. Such personnel should have an understanding of the medical model of overwhelming force. Police techniques that rely on verbal instructions or combative techniques (including pain holds) designed for persons with intact mental functioning can lead to difficulties. Patient injuries can occur in instances where the patient is incapable of understanding the purpose and context of police interventions due to a medical or psychiatric disorder. (See particularly the section on psychotic disorders.)

Medical (or paramedic) backup as well as collaboration with mental health professionals or outreach teams that might have some prior experience with the patient can also be very helpful. Such collaboration, however, re-

quires careful prior planning so that management at the scene of an incident can proceed smoothly.

Estimating the patient's control and deciding when the professional must assume control is key.

4.1.3 Theoretical Model:
Attempts at verbal intervention generally precede physical restraint. A clear model to decide when to switch modalities is necessary. One such model is presented here for comparison. It is intended as an ever-present scheme in the background of the evaluator's mind, while carrying out other tasks such as obtaining a history and performing a physical and/or mental status examination. It is again intended as an example only:

Patient's Response:	Staff Intervention:	My Response:
Aggression	Physical control	Fear
Hostility	Pseudochoice ("If...then...")	Anger
Anger	Real choices (Must be acceptable)	Anxiety
Anxiety	Support Encourage Ventilate Reassure "Extras"	Calm

Figure 3: (Interaction Grid) (Adapted from: (6))

The figure represents an interaction grid: three segments (columns) are subdivided into four corresponding levels (rows) of interaction. The first column represents the patient's emotional response within the interaction, the third, the professional's emotional responses which are assumed to mirror the patient's. The key is that the clinician must gradually develop a sense for their own personal response to each of the patient's stages. In the column between are strategies for intervention.

Exceptions:
The model of gradual escalation through the various levels from anxious, to angry, to hostile, and ultimately to aggressive, can be obviated by a number of medical and psychiatric conditions. In particular, an organically disturbed (e.g.: intoxicated or delirious) patient may escalate abruptly from a seemingly calm or anxious state to an outright aggressive one. Similarly, psychosis, with the inherent lack of reality contact (and defining thought disorder or loose associations), may jump from one stage to the other with little or no warning. It is here that the professional's personal emotional response may be the only "early warning" that is possible. This means that in the example suggested in Figure 3, the professional entering a patient's room for the first time, finding a fear response developing abruptly, should immediately be prepared to provide for physical control and safety.

5. Medical Emergencies

In the context of the triage algorithm (figure 2), medical emergencies are considered those conditions which would require stabilization of the patient prior to a psychiatric interview.

Procedures for such interventions have generally already been established, and most professionals will be familiar with examples of them: BCLS and ACLS protocols for medical and ATLS for surgical emergencies. Vital signs should be obtained if at all possible and as early as possible. They should be considered a requirement prior to the end of any emergency psychiatric intervention. Beyond this, a brief medical history, review of systems, and physical evaluation is usually necessary to rule out immediate medical problems.

6. Basic Psychiatric Interviewing

Moving to psychiatric intervention, we can distinguish: Interview techniques, evaluation (process and content), assessment, and treatment.

Any interview consists of at least three phases, with attention to four simultaneous areas:

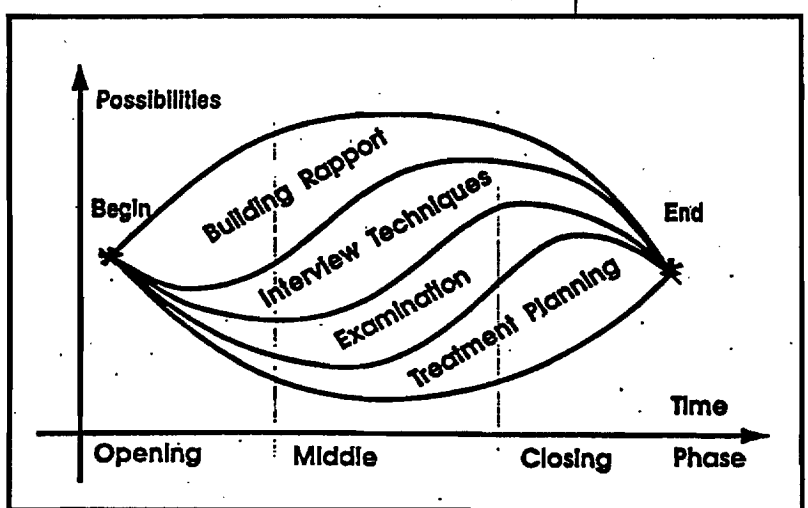


Figure 4: (Interviewing Process) (Adapted from: (7))

The beginning or opening phase of an interview emphasizes the establishment of rapport. The middle phase emphasizes the collection of information and the examination of the patient's current functioning. The closing phase emphasizes summarizing the information and communication of treatment decisions.

In the opening phase, questions will generally be open-ended, encouraging the patient to speak. Facilitative techniques, such as empathic statements, can be used to support this. In the middle phase, questions can frequently become more focused and steering techniques are used to direct the interview into content areas that are desired. Such steering techniques could be thought of as analogous to "back doors." For example, questions on the degree of depression can ultimately lead to questions of suicidality and specific suicidal plans:

„How depressed have you ever gotten?" „Have you ever been so depressed that you didn't want to live?" „Have you ever been so depressed that suicide started making sense?" „Have you ever planned or attempted suicide?" „How are things now?"

Similarly, questions about anger can lead to homicidal plans and questions regarding fear can lead to psychosis. While specific content areas need to be covered in the interview, attention to the process of the interaction will allow the professional to follow a nat-

In any interview the professionl's initial overriding concern is to develop solid rapport with the patient.

ural „flow" of the conversation. Additional steering techniques can help when necessary topics don't come up naturally: „Now that we've talked about you, let's talk a little about your family." In the closing phase, the clinician may summarize and be speaking more (though frequently checking with the patient to be sure of understanding). The ultimate outcome of a successful interview should be an agreement about the next steps to be taken in a treatment plan.

Knowing the relative importance of historical information can lead the interview.

7. Psychiatric Evaluation

The content of the evaluation generally includes a longitudinal (over time) component, the history, and a cross sectional (here and now) examination, typically, the mental status examination. This information leads to a diagnostic impression, which then guides the intervention strategy. While in an ideal case a relatively extensive history and thorough mental status examination will be obtained, the urgency of the moment may reduce this to current history with core mental status questions. Ultimately with a minimally cooperative patient, focus of the history should be to elicit a chief complaint and of the mental status examination to ask orientation questions.

7.1. Psychiatric History:
The history is usually obtained from the patient, though frequently outside corroborative information is needed. Generally this is done with, in emergencies without, the patient's permission. Depending on the urgency of the problem, intervention may need to occur before this information is complete or available. Obviously, no final disposition is possible until all of the information has been obtained and thoroughly considered.

The content is quite similar to that obtained in other areas of medicine. (In the following table(s) the asterisks identify the relative level of importance of the item). In emergencies, one would fall back on the most important items, clarifying these first.

Identifying Information
Chief Complaint (Suicide/Homicide?) ***
History of the Current Situation:**
Course Over Time**
Palliative and Provocative Factors
Review of Systems
Current Medications**
Current Drug Use Pattern**
Past Medical History*
Past Psychiatric History:
Hospital Admissions*
Biomedical Treatments (Medications)**
Suicide (Homicide) Attempts**
Past Alcohol and Drug Use*
Family History:
Genetic Risk Factors
Developmental History:
Family "Roles"
Defensive Mechanisms
Social History:
Current Level of Functioning
Prior Level of Functioning
Support System*

Table 1: History content

7.2. Mental Status Examination:
The mental status examination is intended to provide a cross sectional view of the patient's mental functioning at the current instant in time. It is a formalized method of obtaining and recording information on the higher cortical functions of the patient. To facilitate recall, four general areas can

be delineated: (Examples to serve as mnemonic devices are added in parentheses, and asterisks again denote the relative importance.)

1. General Inspection:
(Overview: "How does the patient look?")

Appearance: (Describing a "photograph") Height, weight, dress, grooming, etc.

Motor Behavior: (Describing the „silent movie") Movements, tics and mannerisms, level of activity, etc.

Speech: (Adding the "sound track") Rate, pressure, intonation, articulation, etc.

Attitude: (Putting it all together) Changes, relatedness with the interviewer, etc.

2. Emotions ("How does the patient feel?")

Mood: (The "climate") Depressed, happy, sad, irritable, etc. The patient describes the mood themselves. Their report will relate to a more extended period of time than the interviewer alone will have been able to observe.

Affect: (The "weather") Type: tearful, angry, etc.; Range: broad, full, narrow, flat, etc.; Stability: Labile, stable, etc. The interviewer attempts to describe the currently observed affective state of the patient in detail.

Congruence: The consistency between the observed emotions and reported mood with the context and content of the interview is observed. Loss of reality contact sometimes expresses itself here in lack of congruence.

3. Thoughts:** ("Software" analogy: "How does the patient think?")

Process:** This describes the logical flow of thoughts:

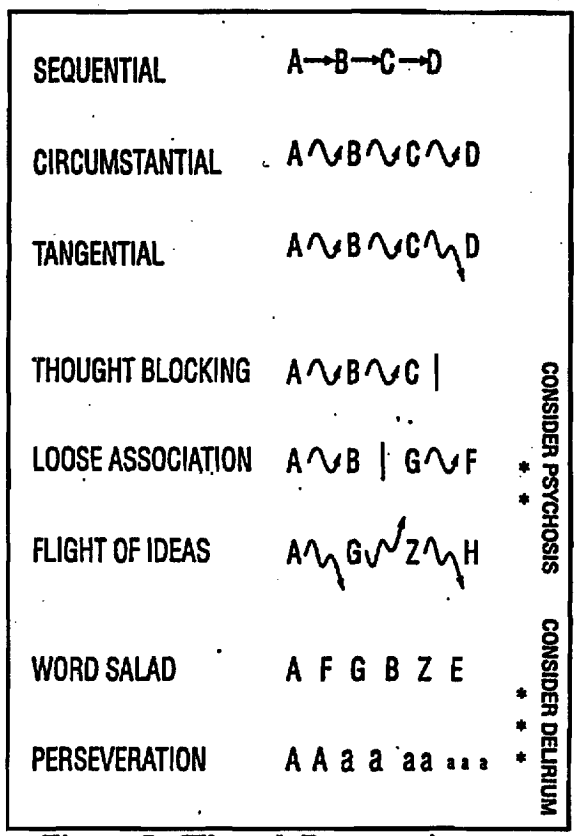


Figure 5: (Though Processes)

These can be considered to be on a spectrum from best organized to completely disorganized. On one end of the extreme, thoughts are expected to be sequential and concisely presented. At the other end of the extreme, no coherent thoughts can be discerned. There is literally word salad or perseveration. The most important stage*** is when loose associations (breaks in the logical flow) occur. They define psychosis. Tangential thinking may be dis-

When loose associations are present, consider psychosis; when there is word salad, consider delirium.

Orientation is the bedrock on which all other cognitive functions can be considered to rest.

tinguished from loose by the interviewers reaction: The thoughts: "What was my last question? How did we get onto this?" denote tangentiality. The thought: "Where did that come from?" denotes loose associations, and should be checked out. Worse disturbance generally indicates a worse disorder.

Content:** Here the thoughts themselves are grouped and unusual or important themes noted. In particular, any psychiatric interviewer will have to comment on suicidal*** or homicidal*** thoughts. These must be specifically sought out, as must be preoccupations and delusions* such as those indicating loss of reality contact, either in a non-bizarre or bizarre (completely impossible) context.

Perceptions:** How does the patient observe the world around them. Are illusions, hallucinations, auditory, visual, or tactile hallucinations**, depersonalization, derealization, ideas of reference, thought broadcasting, thought insertion, etc. present?

Using the computer analogy, thoughts can be considered to have disturbances that affect the logical order (poorly functioning program), abnormalities of content (database errors), and input errors.

4. Cognitive Evaluation*:** (Hardware analogy: "How is the machinery working?")

The following areas are all considered part of the cognitive function. In order to remember them, one might use the model of a familiar, reversible, toxic encephalopathy: alcohol intoxication. When one thinks of a person entering a bar and getting progressively intoxicated, ultimately to the point of coma, one can visualize the stages that they go through. Using this analogy, the extreme care needed to observe and document disturbances of orientation, attention, and concentration becomes clear.

Orientation: Time, place, and person.
Attention Concentration: Serial 7's, 3's, digit
span, (usual is 7 digits forward, and 4 backward), spell "world" forward and backward.
Memory:
Registration: "Repeat after me"
Immediate Retention: 3 objects after 3' Recent Past: Events of the last few days Remote Past: Events several years ago
Abstraction: Ability to „get the big picture:"
Proverbs, similarities.
Intelligence: Fund of knowledge (consistent
with the patient's education): vocabulary, presidents. general knowledge questions.
Judgment: Conceptualize outcomes:
Stamped
envelope, smoke in a theater scenarios.
Impulse Control: Ability to modulate impulses.
Insight: Awareness of illness.

Table 2: Cognitive Evaluation

The list is an attempt at such a hierarchical organization (using the above analogy) from the most severe to the least severe level of disturbance. If complete testing is not possible, it is useful to move to ever more basic cognitive tests.

8. Assessment

There are generally two parts to an assessment: 1) Organizing the information gathered in the history and mental status examination, and 2) Making a formal psychiatric diagnosis. Establishing a diagnosis may, however, be secondary to organizing the information in such a way that focuses attention on triage priorities. Broad diagnostic categories are considered first and allow stabilization and referral to more definitive evaluation and treatment. For our purposes, short range outcome is the major consideration.

Review of outcomes research shows that top priorities, which express themselves as variables affecting patient disposition, include:

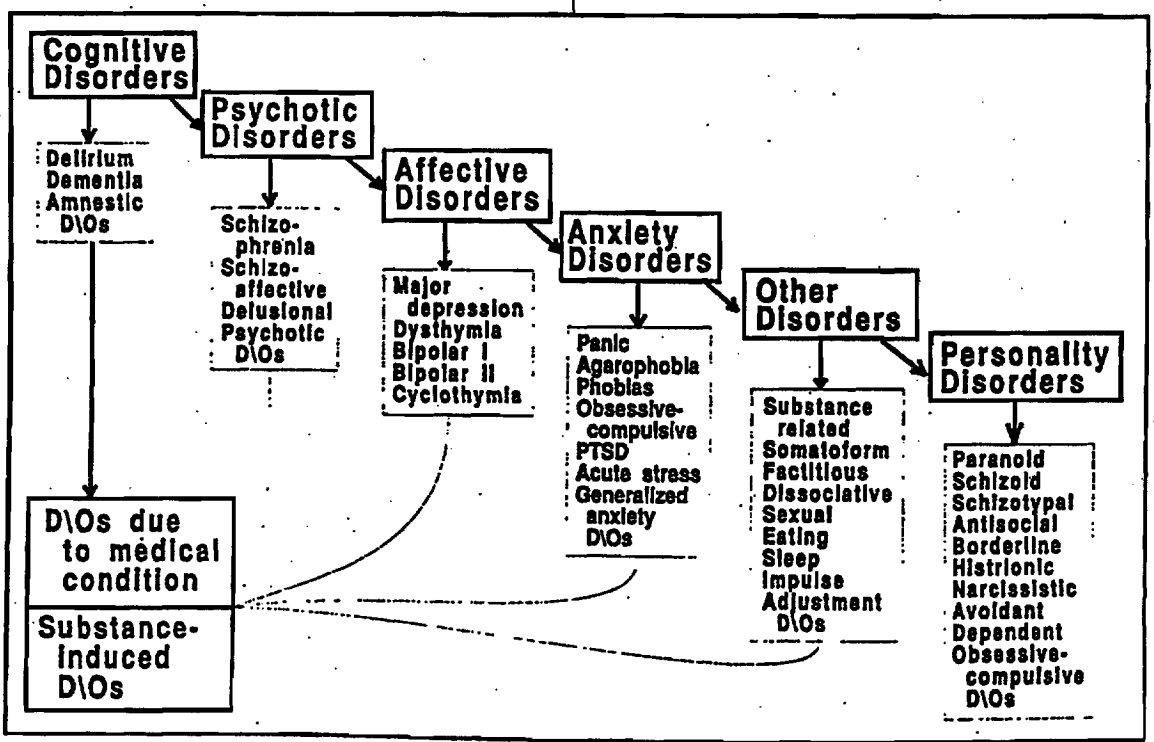
Dangerousness, prominence of symptoms (as clinical variables), clinical experience and knowledge of resources (as clinician variables), family members' support and desire for a specific outcome (as family variables), and referral source such as police, together with assessment of system options (3).

8.1 Impression:

Given the need for organization of diagnostic considerations, a clear idea about a diagnostic hierarchy is helpful. Which disorders take precedence over others? Why? Such a hierarchy is implicit in the DSM IV (8), producing a "cascade" of disorder groups. Generally, the hierarchy implies that treatment must be directed toward diagnoses higher in the model before treatment for lower priority diagnoses can be fully effective. Also, the more "biological" a disorder, the more likely it is to be found on the left; the more "psychological" a disorder, the more likely it is to be on the right.

Disorders induced by medical conditons or substances are listed with each group, but mut be considered first.

Figure 6: Differential Diagnostic Cascade



There are many medical emergency conditions that may initially present as a psychiatric disturbance.

Cognitive Disorders must be considered first. These are delirium (a medical emergency), dementia, and amnestic disorders. Problems where some outside influence causes what appears to be a psychiatric disorder are listed with each disorder group. Examples include substance intoxication, withdrawal, or medical illnesses. They must also be considered as the first priority. All of these disorders affect the brain's ability to function, and could be considered "machinery" or "hardware" problems. Treatment of these disorders will require attention to the underlying disorder. The most important is delirium***, characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention. This is heralded by disorientation and severely disorganized thought processes.

Psychotic Disorders*** must be considered next. These are illnesses. which affect the patient's ability to distinguish real from not real. They generally include major psychotic disorders such as Schizophrenia and are characterized by thought process (loosening of association or worse) or thought content (delusions) or perceptual disturbances (for example, auditory hallucinations). These can generally be considered "thinking problems." They are heralded by loose associations, delusions and or hallucinations. Treatment will usually involve the use of neuroleptics.

Affective Disorders are disorders that affect the mood. The mood may be depressed, elevated, or irritable. Major Depression and Bipolar Disorders (Manic Depressive Disorders) are the main illnesses. here. Both of these disorders can be accompanied by psychosis and when this is the case, the psychosis must be treated first. Treatments will often include medication such as antidepressants or mood stabilizers (thymoleptics).

Anxiety Disorders lead to excessive and inappropriate worry or panic. Examples include phobias, panic disorder, post traumatic stress disorder, the new acute stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. As implied by the hierarchy, removal of precipitants (such as Hyperthyroidism, psychosis or mood disorders) clearly takes precedence over symptom oriented treatment with, for example, Benzodiazepines.

Other Axis I disorder Groups follow in the diagnostic cascade.

Finally, toward the psychological side of the biopsychosocial diagnostic spectrum are Axis II Disorders:

Personality Disorders are problems with an individual's overall coping abilities. They should be considered if there is a long standing (since adolescence) pervasive (affecting all parts of an individual's life) pattern of maladaptive (causing personal distress or impairing functioning) behavior. In these patients the developmental "tool kit" might be thought of as not fully developed, frequently under the influence of traumatic disturbances in their childhood. DSM IV (8) generally distinguishes three groups: Cluster A (odd and eccentric), Cluster B (dra-

matic erratic and emotional) and Cluster C (anxious or fearful). Under stress, such individuals can display symptoms from any of the other diagnostic groups and a thorough evaluation, along with attention to the diagnostic hierarchy, is crucial prior to the diagnosis of a personality disorder. Treatment generally involves a carefully coordinated program of psychotherapeutic and social interventions. Since these conditions can mimic and coexist with many of the Axis I disorders, their identification and treatment take time and may be perceive as the most frustrating task for the professionals trying to help. Clear attention to who is responsible for what (interpersonal boundaries) is crucial to the management of these conditions.

In summary, it should be remembered that, many individuals suffer from several disorders simultaneously. One disorder does not generally exclude another, though if symptoms can be ascribed to a diagnosis further up in the hierarchy, then that diagnosis must be given. Thus, for example, a patient who is intoxicated, yet suffers from Schizophrenia, would likely show signs both of cognitive impairment and reality impairment, and would be given both diagnoses. Treatment must then also address both disorders.

8.2 Biopsychosocial Diagnosis:

In order to organize all of this information, the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) (8) has designed its multiaxial system of diagnosis. The diagnosis is recorded in five axes, whereby multiple diagnoses are encouraged when the criteria for the specific disorders are met.

Axis I: Psychiatric Clinical Syndrome ("Nature") Axis II: Personality Disorders or Traits ("Nurture") Axis III: Physical Disorders Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning (GAF Score).

Table 3: DSM IV Multiaxial System of Diagnosis

Many patient suffer from several disorders simultaneously that must all be identified.

9. Interventions

Beside the assurance of immediate physical safety outlined above, treatments will generally come in four major areas: general safety, biological treatments, psychological treatments, and social interventions.

Longer term safety issues are much more complex to evaluate. Generally the clinician is only able to identify broad groups of patients at risk for harm to self or others but cannot predict the future behavior with any reasonable certainty over more than a few hours or even days (4). One of the best and most important predictors is that of past behavior. Another key consideration is the presence of destabilizing factors such as intoxication.

9.1 Immediate Safety Interventions:

As outlined before, emergent intervention may require physical restraint. The principal behind the safe use of such restraint is overwhelming force. We cannot assume that a patient has

The clinician assumes the responsibility when there is significant danger or competence is low.

the mental capacity to recognize directions, physical cues (painful or nonpainful), and to respond appropriately. When a patient is physically restrained attention must be given to the legal framework (doctor's court hold or police officer hold, etc.). Also, the patient must then be observed very closely since this group of patients is at higher risk of having significant coexisting physical illnesses that can place them in danger, especially since the usual complaints of feeling ill may not occur. Once a professional has assumed responsibility for the patient they are responsible for the "whole" patient!

Similarly, chemical restraints can be used in some emergency conditions. Neuroleptics (Inapsine) or Benzodiazepines (Ativan) have been advocated and are often used in the medical setting.

9.2 General Safety:

Patients who present a danger to themselves or others are unable to care for themselves, or fail outpatient management, or require 24 hour observation for diagnostic assessment or ongoing round-the-clock medical treatment will require hospitalization. As long as such patients are willing to be hospitalized on a voluntary basis, there is little question as to how to proceed.

Involuntary Admission: In most states, if the patient represents a danger to himself or others due to a mental disorder, and/or is unable to care for their basic needs (grave disability), there is a process that allows emergent and urgent hospital admission on an involuntary basis. This is generally regulated in the Commitment Statutes. Difficulties arise when it is unclear how far the patient's rights of self determination go in comparison to the professional's ethical obligation to intervene in the face of a psychiatric disorder (right to competent treatment).

In this respect, a grid that plots danger against competency may be useful to the professional:

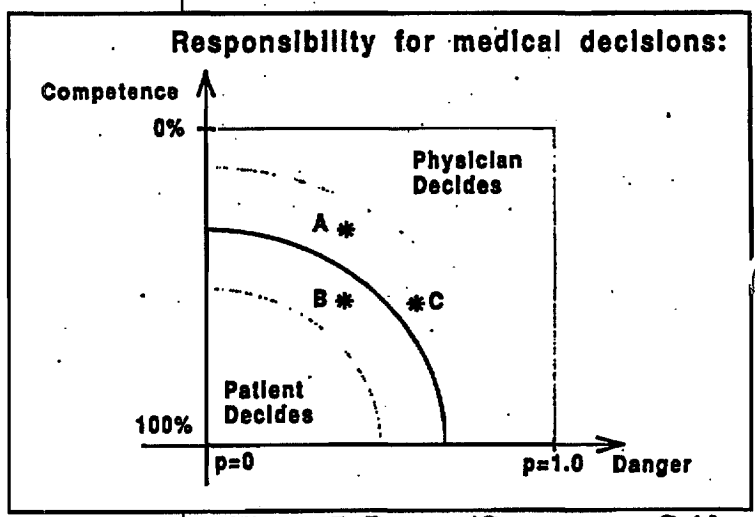


Figure 7: Danger/Competency Grid (Adapted from (10))

As outlined in this grid, competency is plotted against danger. In the lower left hand corner, patients who are in an area of low danger, yet have a high degree of competence, are clearly in charge of their treatment, irrespective of the clinician's preference. Simultaneously, patients that have either an extremely low level of competence (such as the severely disabled Alzheimer's patient wandering on the street) or are in an extreme degree of danger (such as an occluded airway)

must be treated by the clinician even against their will. Frequently, the situation is much less clear. Despite this, the law allows only for a dichotomous choice: One is asked to act as if the grid were bisected by a clean line. Nevertheless, it is quickly apparent that the gray band of mixed cases in the middle represents many cases and a significant clinical dilemma. For example, patients A, B, and C may differ only in some minor respects, yet patient A and C will be involuntarily admitted where B may not. Patient B may, for example, present with depression, suicidal ideations of several months' duration, and some poorly formulated thoughts of possibly taking an overdose. Patient C, similar in all ways, may, however, be contemplating the use of a firearm and has access to such. Clearly, patient C would require involuntary admission. Patient A, on the other hand, while in a situation just as B, may be intoxicated, lowering their level of competence. Clearly as well, here the clinician must intervene (even if only temporarily until competence is restored/intoxication resolved).

Involuntary admission in Oregon is regulated by the Oregon Revised Statutes (ORS 426). If a patient represents a danger to himself or others due to a mental disorder and is unable to agree to voluntary admission, the patient may be admitted against his/her will. The doctor's court hold (DCH) documents the belief of two licensed physicians or a physician and a qualified mental health professional that such a danger and mental illness exists. Outside of the hospital setting, the police or mental health program is needed to make such a determination. A police officer custody report (POCR) documents that a police officer has reason to believe that such danger and illness exists. A mental health program can also initiate such a police officer hold (Mental Health Director's Hold). When the mental disturbance does not rise to the level of danger but there is question about the individual's ability to care for themselves, any two interested persons may file a two party notice (TPN) with a county mental health agency. From the filing of all of these notices, a court investigation

The patient's safety for two weeks on their own may be key to deciding on potential danger.

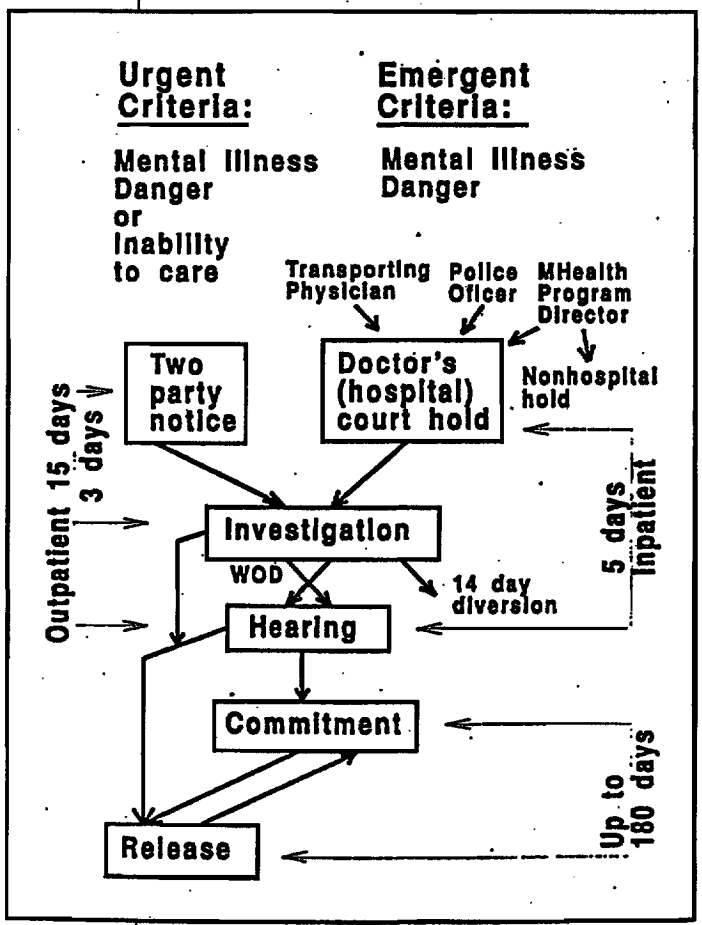


Figure 8: ORS 426

The patient should be treated in the least restrictive, yet safe, environment.

is initiated. This investigation may lead to a hearing (or to patient release). The hearing may lead to commitment. The main difference between the two routes in Oregon is that the emergent route (which includes only the criteria of mental illness and danger) requires that the patient be kept in the hospital and must not exceed five working days to the point of a hearing. The urgent route proceeds on an outpatient basis and 15 days may pass prior to a hearing. Therefore, frequently the question of danger must be phrased as: "Is this patient safe for 15 days in an outpatient setting?"

9.3 Biological Treatments:

In this area we generally think of the use of pharmacotherapeutic agents. Also, in general, one will have to consider psychiatric consultation in this context. Brief attention was given to the use of chemical (and physical) restraints earlier. An introduction into the basic psychopharmacology would clearly be beyond the scope of this brief review. Nevertheless, we should be clear that addressing an organic or cognitive mental disorder generally requires attention to or treatment of the underlying disorder. Thus, for example, treatment of hypo- or hyperthyroidism or delirium tremens would require the appropriate medical treatment for those conditions, not the psychopharmacologic treatment of the mental expressions of the illness (though there are exceptions where both becomes necessary). Psychotic disorders generally require antipsychotics (neuroleptics). Affective disorders will generally be treated with antidepressants and/or mood stabilizers, including Lithium, Tegretol, or Valproate. Anxiety disorders will frequently be treated with antianxiety agents, such as Benzodiazepines or Buspirone. As indicated by the differential diagnostic hierarchy, such agents must be used cautiously in combination.

From a psychiatric emergency viewpoint, it is extremely important to remember that treatment with neuroleptics, antidepressants, and mood stabilizers generally requires two to four weeks to be effective. Therefore, their initiation is frequently not part of an emergency, more triage-based intervention, no matter how badly one wants to help fast. Pharmacologic measures are generally very focused, directed at supporting a prior developed treatment plan and prescriptions are kept small. Careful coordination with outpatient treatment providers is crucial.

9.4 Psychological Treatments (Psychotherapy):

Similar to the section on pharmacotherapy, an introduction into psychotherapy is beyond the scope of this review. The emergency setting, as well as the realities of the treatment system, currently favor more focused, outcome oriented treatments that are frequently in the cognitive or behavioral realm. In many emergency settings general principles of crisis intervention apply: One attempts to restabilize the patient who has reached a point of instability and overload ("the straw that broke the camel's back") and support their process of reorganization through the phases of acute

decompensation, denial, anger, bargaining, grieving, and recovery. Such a hypothetical course of a crisis is outlined below:

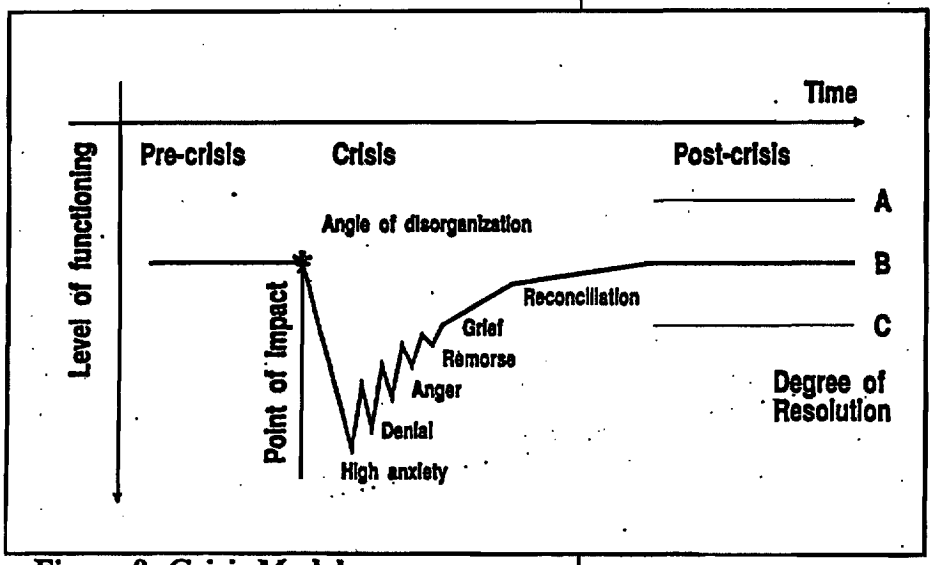


Figure 9: Crisis Model

Psychotherapeutic intervention could take on the following form: One assesses the biological, psychological and social realities that the patient brings to the situation. These are crucial for understanding the resiliency or stability of the patient's "system." Then focus on the balance between stressors and support system will allow a determination to be made on the severity and urgency of the current crisis. Stressors or supports are then manipulated where possible to help restabilize the patient.

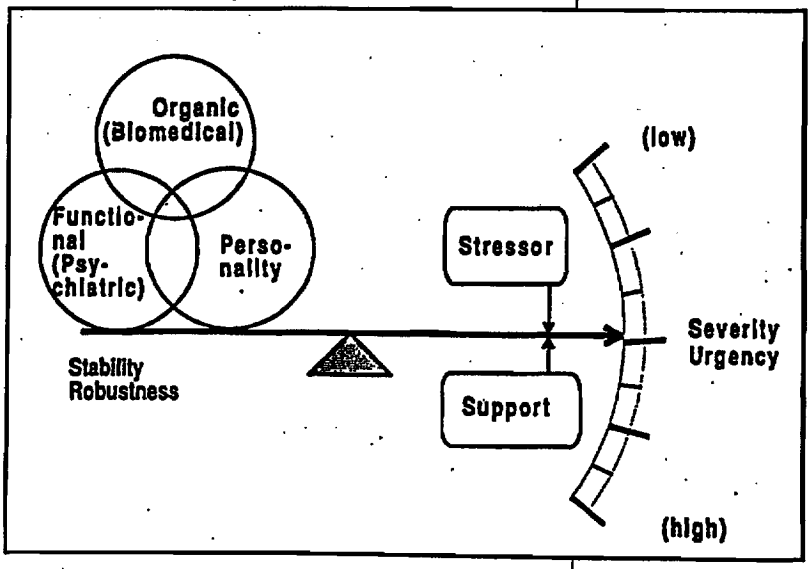


Figure 10: Crisis Intervention

Psychotherapeutic intervention using a debriefing model may also be appropriate. Such a model could be thought of as having four parts (see table 4). It may be used with individuals and groups. In the interaction, the four phases are explicitly separated. In the first phase facts are gathered from all participants. Statements about how one feels are excluded. (It is made clear that they are legitimate, but will be talked about separately). In the second phase, affects/feelings are clarified and discussed. Here the attempt is to collect a broad range of emotional responses, validating them. The disconnection from the facts and the legitimacy of the patient's own emotional response is emphasized. In the third phase the group is educated about what to expect (both in terms of future events and emotions); in the fourth,

Crisis intervention rebalances a percieved disparity between stressors and suuports.

The critical incident debriefing model may also be useful for the professional faced by trauma.

plans are made for any necessary follow-up.

1. Clarify the facts of the crisis ("What happened?").
2. Clarify the feelings ("How do you feel about this?").
3. Review the usual response to crises: (teaching phase).
   - Phase of Disbelief or Denial.
   - Phase of Shock or Confusion.
   - Phase of Anger.
   - Phase of Grief and Sadness.
   - Phase of Acceptance.
4. Problem solving or reopening the social world/contacts and ultimate resolution (reinforce adaptation and a plan for the future).

Table 4: Critical Incident Debriefing

In less formalized psychotherapeutic work three simple rules may help in the beginning:

1. When the patient presents a complaint, always validate it.
2. However, in doing so, acknowledge it in a way that will allow for reinterpreatation. Thus, it may be crucial to a psychotic patient to hear: "Oh, that sounds frightening," but it would be unwise to agree that the FBI may be indeed plotting.
3. Finally, offer a reinterpretation of the complaint that will direct the patient to action toward an useful goal. ("When you experience such voices, it may be a sign that you need to take a time out/take more medication.")

9.5 Social Interventions:

In this area, the realities of the patient's living are addressed. Clearly, attention must be given to food and shelter, as well as clothing. Where these are not immediate concerns, issues of disability may be the stated or covert objectives that should receive attention. While seeking psychiatric hospitalization in order to find shelter is understandable, it is clearly not the most efficient use of resources, and it would be the professional's task to support the legitimacy of such patient desires; yet to help the patient address their needs directly.

10. Summary

This outline is clearly intended as a forum for ongoing discussion and not as a finished document. It does, however, attempt to make explicit some of the core principles underlying emergency psychiatric evaluation and intervention. Since the subtleties of human interaction can clearly not be adequately addressed by such an approach, it is worth remembering that the experienced professional on the scene generally has access to significantly more information, including personal reactions, that can be crucial to accurately assessing the patient's situation. Pairing such clinical experience and "feel" for patients' needs with a clear diagnostic and therapeutic structure will hopefully provide some of the redundancy necessary to assure safe clinical interactions.

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Version: 7-10-95

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NOTES

NOTES

NOTES

Overview of Mental Illness

An Overview of Mental Illness

John Bates, M.D.
Psychiatric Resident
Oregon Health & Science University

Training session for the Portland Police Department
December 5, 2005

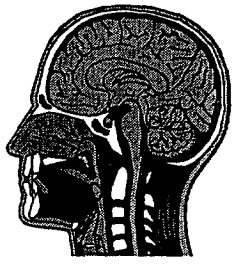
Objectives

- Define & better understand mental illness
- Symptoms & Diagnosis of some common disorders
- Treatment
  - Medications
  - Social support
  - Counseling
- What you can do and possibly expect.

What are Mental Illnesses?

- Serious disturbances in a person's ability to:
- perceive and process ordinary reality
- to organize one's thoughts
- to have a normal mood
- To such an extent that Ordinary life function (work, school, family) is impaired or impossible.
- These disturbances are not willful actions; cannot be overcome by effort alone; are nobody's fault.

Is it a Mind, or a Brain?

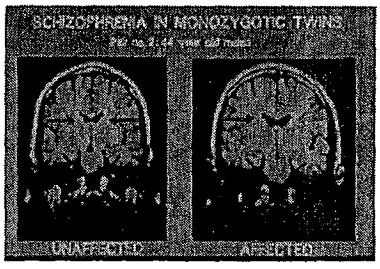


It's Both!!!

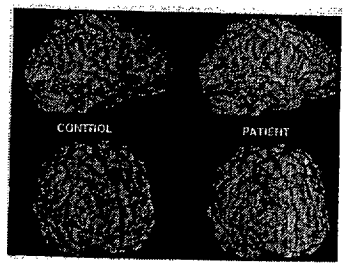
Mental Illness: Both Mind and Brain!

- Illness of the brain, the organ of thoughts & emotions (the mind), as well as behaviors
- Genetics, Brain Injury...
- Illness of the psyche
- External psychosocial stressors
  - Divorce, Financial loss, Abuse, Death of spouse Trauma...
- Can disrupt person's ability to relate to others & capacity for coping with demands of life

Problems in Brain Structure



Problems in Brain Function



Problems in Brain Function

- Abnormalities in neurotransmitters of the brain.
- Glutamate, gamma -aminobutyric acid, serotonin, norepinephrine, and dopamine have been implicated in depression and mania

Problems in the Mind

- Prolonged stressors mixed with prior psychological trauma.
- Combinations of psychosocial stressors.
  - Dysfunctional Coping Skills
  - Dysfunctional Beliefs and Images

Who Has Mental Illness?

- Affects persons of all ages, races, religions, ethnicities, or socio-economic statuses.
- NOT the result of personal or moral weakness, lack of character, or low intelligence.
- 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year.
- Basically EVERYONE has risk.

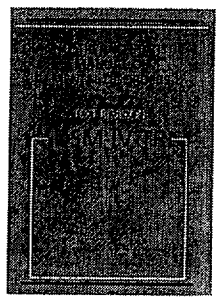
Healthy Understanding

- All mental health symptoms are gross exaggerations of normal human traits/emotions
- When these traits/emotions become intense enough to cause dysfunction, illness results

Normal vs. Symptom

Sad	Depressed
Happy	Manic
Imaginative	Psychotic
Poor Student	Learning Disabled
Inattentive	Attention Deficit
Detail Oriented	Obsessive
Nervous	Anxious/Panicked

Diagnoses & Symptoms



Common Mental Illnesses

- Depression
- Bipolar Disorder (Manic Depression)
- Schizophrenia
- Anxiety disorders
  - Post Traumatic Stress Disorder
  - Panic Disorder
  - Obsessive Compulsive Disorder
- Borderline Personality Disorder

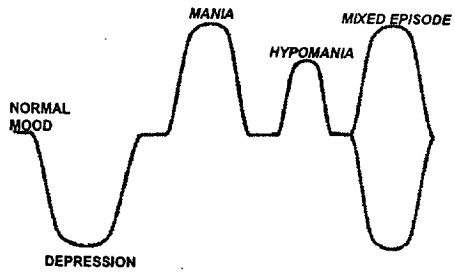
Major Depression (unipolar)

- Depressed mood and or loss of interest in pleasure
- 4 or more of following symptoms:
  - Weight change
  - Sleep change
  - Motor system change
  - Low energy
  - Feeling worthless/guilty
  - Poor concentration
  - Suicidal thoughts

Bipolar Disorder

- Major Depression + Mania
- Elevated or irritable mood
- 3 of following symptoms:
  - Increased self-esteem (grandiose)
  - Decreased sleep (without fatigue)
  - Increased or pressure speech
  - Racing thoughts (flight of ideas)
  - Distractibility
  - Increased activity
  - Increased risky behavior

Bipolar Disorder



Psychosis

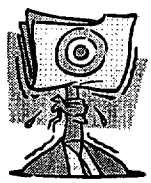
- Syndrome (NOT an illness) with any of the following:
- Hallucinations (false perceptions)
- Delusions (unreal ideas)
- Disorganization
  - Speech
  - Thoughts
  - Behavior
- Catatonia

Schizophrenia

- **2 of the following symptoms:**
  - **Delusions**
  - **Hallucinations**
  - **Disorganized Speech**
  - **Disorganized or Catatonic Behavior**
  - **Negative Symptoms**
    - **Flat affect**
    - **Lack of speech**
    - **Lack of motivation/activity**
    - **Lack of hygiene**
    - **Lack of social awareness**

Anxiety Disorders

- Post-Traumatic Stress Disorder
- Panic Attacks (disorder)
- OCD



Post Traumatic Stress Disorder

- Follows identifiable trauma
  - Combat
  - Domestic violence, rape
  - May persist from childhood abuse
- Flashbacks (re-experiencing), Avoidance, Insomnia, Nightmares, Startle, Hypervigilance
- Commonly accompanied by depression and anxiety disorders
- Medications, group therapy, support

Panic Attack

- **Syndrome (but can become a disorder)**
- **10 minutes or more at least 4 of the following:**
  - Pounding heart
  - Sweating
  - Shaking
  - Shortness of breath
  - Feeling of choking
  - Chest pain
  - Nausea
  - Fear of going crazy
  - Fear of dying
  - Numbness
  - Chills
  - Dissociation
  - Lightheadedness

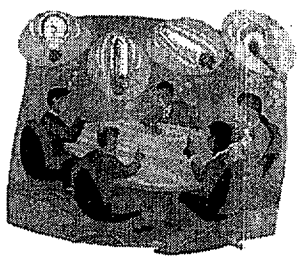
Obsessive Compulsive Disorder

- **Obsessions**
  - **Recurrent, persistent, and intrusive thoughts with anxiety**
  - **Attempts made to suppress thoughts**
  - **Not simply excessive worry**
- **Compulsions**
  - **Repetitive behaviors done to decrease anxiety, but are excessive or unrelated**

Borderline Personality Disorder

- May follow Abuse in Childhood
- "Immature" "Needy"
- Sensitive to emotional slights
- Quasi-suicide attempts (may be medically dangerous)
- Self-harm (non-suicidal) to soothe emotions (cutting, burning)

Who Are Mental Health Team Members?



Team Members

- Social Worker
  - Degree in Social Work, usually a Masters Degree
  - BSW, MSW, LCSW
- Counselor
  - Degree in Counseling, usually a Masters Degree
  - BA, MA, LPC, LMFT

Team Members

- Psychologist
  - Degree in Psychology, usually a Masters or Doctorate
  - BA, MA, PhD, PsyD
- Psychiatrist
  - Medical Doctor
  - MD, DO

Team Members

- Nurse
  - Degree in Nursing, usually a Bachelors
  - LPN, RN, BSN
- Nurse Practitioner
  - Degree in Nursing, plus an advanced degree
  - PMHNP, ANP, FNP

Role Definitions

- Case Manager
  - Usually helps client obtain services (medical care, housing, entitlements, etc.)
- Therapist/Counselor
  - Provides counseling services

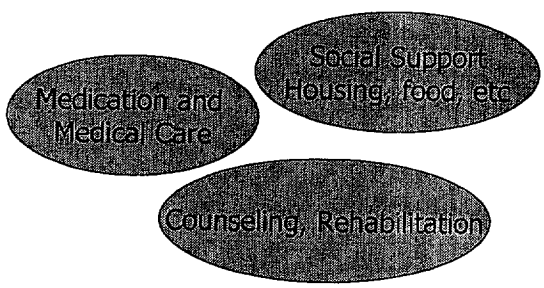
Role Definitions

- Psychologist
  - Performs testing and evaluations, can provide counseling
- Psychiatrist/Nurse Practitioner
  - Performs evaluations, prescribes medications, can provide counseling

Treatment

- Mental Illnesses are Treatable
- 70% to 90% of people with serious mental illnesses show significant improvement in symptoms and quality of life IF they receive proper treatment

Three Elements of Treatment



Medications

- Major Depression:
  - SSRI: fluoxetine, sertraline, trazodone, citalopram, escitalopram
  - Atypicals: venlafaxine, bupropion
  - Amitriptyline

Medications

- Bipolar Disorder
  - Lithium cabonate, valproic acid
  - lamotrigine, Carbamazapine
  - olanzapine, ziprasidone, risperidone, quetiapine
- Schizophrenia
  - olanzapine, ziprasidone, risperidone, quetiapine
  - haloperidol, fluphenazine, perphenazine
  - thioridizine, chlorpromazine

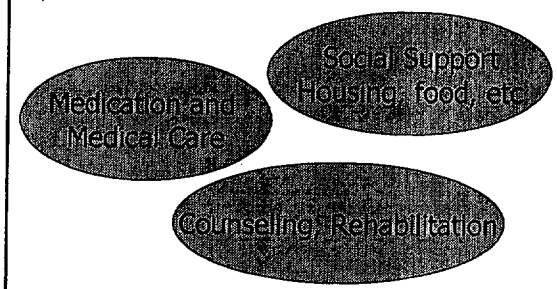
Medications

- Anxiety Disorders
  - SSRI: fluoxetine, sertraline, trazodone, citalopram, escitalopram
  - Atypicals: venlafaxine, bupropion
  - Amitriptyline
  - lorazepam, alprazolam, clonazepam, diazepam

Medications

- Borderline Personality disorder
- Multiple medications, often have polypharmacy with little or no effect on illness.
- Can see combination of all of the previously mentioned medications.

Three Elements of Treatment



Community Treatment

- Hospitals as brief respites for stabilization at times of increased symptoms.
- Most people with mental illness live in the community
- "Least Restrictive" setting

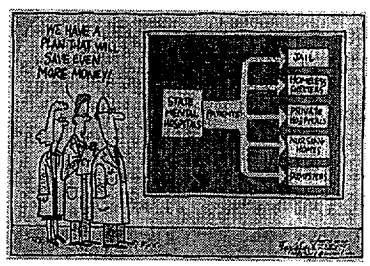
Housing, Counseling, Social Support

- Mostly provided by community mental health agencies such as Cascadia, LifeWorks etc.
- Case workers, social workers, and counselors
  - Help clients get to correct agencies
  - Gets clients signed up for social services

Problems in the Community

- #1: Stigma
- Negative Attitudes about people who have mental illnesses
  - Ignorance & fear
- Causes poor care, discrimination, suffering for individual and family
  - No social support
  - Becomes an "embarrassment" rather than an illness

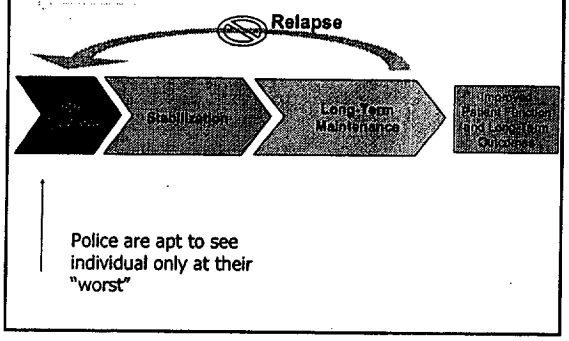
Problems in the Community #2: Limited Resources



Consequences of Lack of Treatment

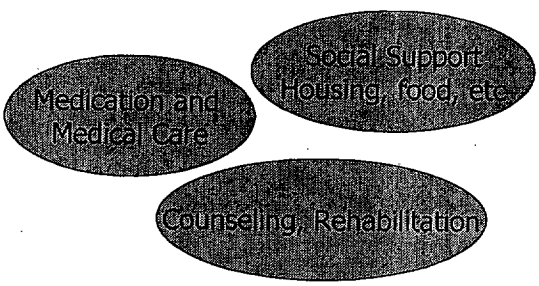
- Unnecessary Disability, Unemployment
  - Loss of drive and dignity
- Substance Abuse
  - Self medicating
- Homelessness
- Inappropriate incarceration
- Wasted Lives, Suicide
- Lack of treatment estimated to cost US economy $100 billion/year

Continuum of Care



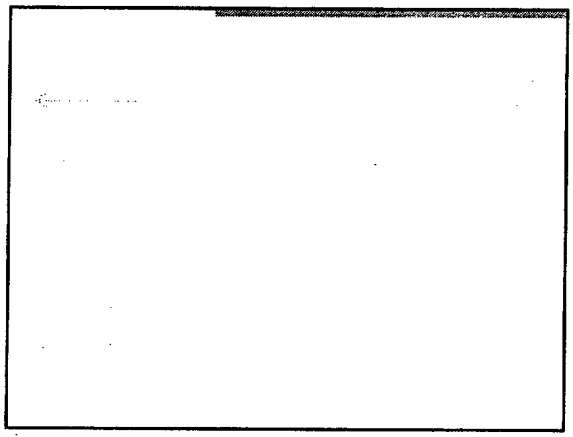
Police are apt to see individual only at their "worst"

Three Elements of Treatment



Counseling/Therapy

- Multiple theories about talk therapy.
- Dynamic psychotherapy
- Cognitive Behavioral Therapy (CBT)
- Dilectical Behavioral Therapy (DBT)
- Interpersonal Therapy
- Etc.
- Basically it is good for people to have a safe, accepting, affirming, and honest place to talk about what they are going through.



Overlap with Substance Abuse

- Common to have mental illness and substance abuse at the same time
- Need to address both problems at once
- "Either / or" thinking is not helpful
- Alcohol, MJ, Hallucinogens, Methamphetamine, Cocaine, others

Police as Care Givers

- People with mental illness live in the community, often with few social supports
- Police are first responders in situations of disruptive behavior
- Mentally Ill people are not "bad"
- You can make a real difference!

Violence as a Symptom

- Rare however, may posture if very paranoid or delusional
- Occasionally delusions cause violence, especially need to protect self from imagined danger
- Much more apt to be victim than to cause violence

References

- The National Alliance for the Mentally Ill (NAMI) website has a wealth of reliable, understandable information about all of these disorders and their social consequences, with links to many more useful sites.
- www.NAMI.org

Discussion

CRISIS INTERVENTION TEAM TRAINING
MAY 15, 2000

OVERVIEW OF MENTAL ILLNESS

WHAT IS MENTAL ILLNESS?

A biologically based brain disease characterized by

- perceptual disturbance
- mood lability
- lack of motivation
- and in extreme cases, suicidality.

Mental Illness can impact all areas of a person's functioning including

- **Social** — difficulty getting and/or maintaining necessities of life i.e. food, clothing, and shelter
- **Occupational** — difficulty acquiring and/or maintaining employment
- **Interpersonal** — difficulty maintaining relationships with friends, co-workers, partners, spouses, parents, children

Symptoms of mental illness may be exacerbated by environmental stressors including

- Poverty
- Homelessness
- Difficulty accessing medical care
- Poor nutrition
- Drug and alcohol addiction

Symptoms of mental illness may be alleviated by medicine and social supports including

Help in --

- keeping up an apartment
- shopping for food
- budgeting money
- attending to hygiene
- planning social activities
- making friends and maintaining relationships
- Easy access to mental health care that is affordable and tailored to the needs of the person

WHAT MENTAL ILLNESS IS NOT

- Mental illness is not a character flaw.
- Mental illness is not a guarantee that the person will be violent.
- Mental illness is not anyone's fault.
- Having a mental illness does not mean there is no hope.

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Thought Disorders

- Hallucinations that might cause people to see, hear, feel, taste or sense things that aren't there
- Talk to self
- disorganized thoughts
- Paranoia, delusions, or bizarre thoughts
- Minimal display of emotion
- Poor hygiene/malodorous
- May wear multiple layers of clothing or inappropriate clothes for the weather
- May have multiple bags filled with what might appear to be garbage

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Mania:

- Expansive irritable mood
- Decreased need for sleep
- Heightened self-esteem
- Grandiose ideas
- Pressured speech /inability to interrupt them
- Distractibility
- Poor impulse control (e.g. buying sprees, sexual indiscretions)
- Possible break with reality, i.e. psychosis

WHAT A PERSON WITH MENTAL ILLENSS MIGHT EXPERIENCE

People with major depressive disorder often do not act in a bizarre manner

Common symptoms of depression include:

- Depressed mood most of the day, nearly every day
- Loss of interest or pleasure in all or most activities of the day
- Significant weight loss or gain
- Difficulty sleeping or sleeping too much
- Fatigue or loss of energy
- Feelings of worthlessness
- Recurrent thoughts of death or thoughts of suicide

It is a myth that depression is a normal part of the aging process. It is important to remember that depression is an illness which can be successfully treated.

IF YOU HAVE TO TAKE THE PERSON INTO CUSTODY ON A HOLD SOMETIMES IT IS HELPFUL TO:

- Ask the person if they have ever been in handcuffs before
- Tell the person that you came to help them, not to hurt them
- Tell them they are not under arrest or in trouble
- Tell them you know that they are not a bad person
- Tell them your boss says you have to put them in handcuffs, it is the rule, it's nothing personal

ORGANIC AND PSYCHOTIC

MENTAL ILLNESS

WHAT IS PSYCHOSIS

Psychosis is defined by a complex of symptoms that include:

Delusions (false beliefs in something that is so at odds with the prevailing societal consensus as to be recognized as ranging from the improbable to the bizarre).

Hallucinations (the experience of sensation in the absence of external stimulation, most commonly auditory, but in drug induced states or other organic states can include visual, olfactory, gustatory, and tactile sensations. That is hearing, seeing, smelling, tasting and feeling.)

Incoherence (unintelligible speech or speech which may make sense but conveys little or no information even though the person may talk a lot).

Loosening of Associations (the lack of connection in a person's flow of thought so that ideas seem to generate other ideas which have no logic to their sequence).

Catatonia (marked excitement or profound stupor and muteness to the degree that a person is at risk for life threatening exhaustion or is unable to carry out basic functions such as food seeking and feeding).

Gross Disorganization (marked difficulty in organizing behavior so that a person may be disoriented to time, place and identity, may be unable to respond to others or unable to respond in an understandable manner).

There is a range of conditions which may produce psychotic behavior. This may vary from; a brief reactive psychosis which is a response to excessively traumatic stress (for example: combat); to substance induced psychotic reactions; to psychosis due to a progressive brain deterioration such as in a dementia like Alzheimer's; and psychosis due to a chronic mental disorder such as schizophrenia or severe mood disorder as in psychotic depression or in psychotic mania.

The neurobiological basis of psychosis appears to stem largely, but not exclusively, from the disruption of dopamine transporting systems in the brain. This can be due to endogenous (internal) causes such as mental illness or dementia but also may be due to exogenous (external) causes such as head trauma or exposure to certain chemicals.

For our purposes, we are concerned with those chemicals which have reinforcing properties in the brain and are likely to be abused. Repeated use of

substances such as alcohol, speed, crank, coke, crack, hallucinogenics, designer drugs, increases the risk of developing a drug induced psychosis or "triggering" an existing condition such as schizophrenia or severe mood disorder. This appears to be due to the dopaminergic (dopamine stimulating) action of these substances in the brain.

The most common psychiatric symptom resulting from repeated or heavy use of any of the amphetamine type drugs is delusional thinking. Paranoid delusions of persecution and other bizarre or unusual explanations of events are frequently seen. Accompanying this paranoia can be agitation, anxiety and aggressive behavior so that persons in a drug induced psychotic state have much more potential for violent acts including homicide and suicide.

Think of the brain as an elaborate circuit board with very complex electrical interconnections which form our self-awareness, our experiences, our thoughts, our sensations, our perceptions, our memories. If you pour water on a circuit board it shorts out due to the water acting as an electrical conductor between parts of the circuits that weren't meant to be connected. Drugs act the same way in the brain except instead of water being the disruptive electrical conductor, they act on the neurotransmitters which conduct electrical activity. If the brain is no longer able to carry out established interconnected patterns of electrical activity and different pathways become involved, what the brain experiences is psychosis. What others see is that the psychotic person does not make sense and is responding to stimulation that is internal and not shared or understood by others.

Usually, if an individual abstains from drugs, the psychotic symptoms will go away with time. The symptoms generally go away within hours to days, although they can last several months and, for some unfortunate individuals, they may become permanent. **The population at highest risk for permanent damage is the one with an existing mental illness or mood disorder or, has a predisposition to develop a mental illness or mood disorder.**

At this time, the single most effective known treatment for psychotic disorders is the use of anti-psychotic medications. These are believed to have a stabilizing effect on the dopamine balance in the brain. These medications, however, are not 100% effective and they carry some risk of side effects. About 25% of people with psychotic symptoms do not obtain a favorable response to existing anti-psychotic medications. Hallucinations, confusion and disorganization generally respond to anti-psychotic medications but delusional thinking tends to be less responsive. Ideally however, treatment should combine medications with social therapies to be the most effective. There are some individuals who can recover without the use of medications but they are in a minority.

Denial is a major element making for great difficulty in the treatment of psychotic states that are either drug induced or due to chronic mental disorders. Frequently, the person experiencing the psychotic effects of drugs or of mental illness believes that what his senses are telling him is an accurate reflection of external reality. This is what we all believe and rely on to navigate through the world. When someone tells a psychotic individual that what they are experiencing is not "real", it is very difficult to make a convincing argument. What is going on in that person's brain is their reality so they must deny any challenges to that reality and refuse to accept any offers of treatment and refuse to believe that they might need treatment.

A common outcome is that a psychotic person comes to the attention of the police. A quick determination is made if the psychotic person poses some danger to themselves or others and is not willing to obtain voluntary treatment. The individual is transported to an emergency psychiatric facility where they can be detained against their will, for up to five court days. During this time an investigator must make a determination as to whether or not the person is to go to Civil Court before a judge and psychiatric examiners for an involuntary commitment hearing. The Civil Court has the authority to place the person under the care and custody of the Mental Health Division for a period not to exceed 180 days if they find the person continues to be mentally ill, a danger to self or others and is unable or unwilling to accept voluntary care. While under commitment and within the guidelines of the law, a person can be administered psychiatric medications against their will.

Go back now to the earlier statement that most drug induced psychotic states clear in a few hours to a few days. If a person in this condition is taken to a psychiatric emergency holding facility they are likely to be released without a commitment hearing. But, for the person whose symptoms persist, they stand a good chance of being committed and placed in a psychiatric hospital.

If a crime was committed at the time the person was picked up by the police, the person may have a detainer placed on them while in the hospital and then be transferred to jail once their symptoms have cleared. If the crime is serious enough, a mentally ill offender may go straight to jail and then quickly to court for a judge's order to be sent to Oregon State Hospital Forensic Unit for evaluation or treatment. Petty crimes committed while the person is psychotic are often dismissed if the court feels that the individual is getting the treatment they need. Repeat offenders are not as likely to be looked upon with such leniency particularly if they persist in denying they need treatment or do not follow through with treatment.

Mental illness is not a state of bliss. It can be a world filled with fear and confusion. Whether psychosis is drug induced or not doesn't make any

difference to your brain but the choice to use or not use drugs of abuse will make a major difference in how your brain is going to function.

Organic Disorders

a. Definition
    1. A class of conditions caused directly by abnormalities of brain structure or by alterations of brain neurochemistry or neurophysiology (e.g., delirium, dementia, amnesic syndrome, organic hallucinosis, organic delusional syndrome, organic mood syndrome, organic personality syndrome, etc.)

b. General symptoms
    1. Confusion, memory disturbance, disjointed speech, slow mentation, and substance abuse

    2. Physical signs
        a. Breath smells
        b. Blood shot eyes
        c. Runny nose
        d. Needle tracks
        e. Slurred speech
        f. Unsteady on feet
        g. Bizarre behavior and speech

    3. Head Trauma
        a. Permanent
        b. Slow mentation
        c. Impulsive
        d. Seizures
        e. Personality change

    4. Stroke
        a. Usually older person
        b. Paralysis
        c. Difficulty speaking

5. Dementia
   a. Older person
   b. Confused, especially about personal information
   c. Combative
   d. Often in a nursing home or has a specific care provider

6. Medical Causes
   a. Diabetic not taking insulin
   b. Drug overdose
   c. Delirium – fluctuating levels of consciousness
   d. Past seizures
   e. Off seizure medications
   f. Physical illness (sweating, nausea, vomiting)

Psychotic Disorders

a. Definition

1. A disturbance of perception and thought process is a broad description of this category. The psychotic symptoms represent manifestations of disturbances in the flow, processing, and interpretation of information in the central nervous system. These symptoms can be mild to severe. (Mental Health : A Report of the Surgeon General)
2. Hallucinations are the most common group of symptoms that result from this disordered processing and interpretation of sensory information. An example is the frequently described hallucination of hearing voices.
3. Hallucinations may include:
    a. auditory
    b. smell
    c. feel
    d. visual
    e. physical
4. Delusions are a more complex group of symptoms resulting from this disordered interpretation of information. A delusion is a false belief that an individual holds despite evidence to the contrary. A common example is paranoia, in which a person has delusional beliefs that others are trying to harm him. Any attempts to persuade the person that these beliefs are unfounded typically fail and may further entrench the delusional belief.
5. Psychotic thought processes are characteristically loose, disorganized, illogical, or bizarre. These thought processes frequently produce bizarre observable patters of behavior that is also disorganized and bizarre.

Schizophrenia

a. The cause of schizophrenia has not yet been determined although research points to the interaction of genetic endowment and major environmental upheaval during the development of the brain. (Mental Health: A Report of the Surgeon General)
b. Part of the psychotic disorders schizophrenia frequently have marked disturbances in logical thought process.
c. Symptoms can include:
    1. Hallucinations
    2. Delusions
    3. Disorganized thoughts and behaviors
    4. Loose or illogical thoughts
    5. Agitation
    6. Flat or blunted affect
    7. Concrete thoughts
    8. Anhedonia (inability to experience pleasure
    9. Poor motivation, spontaneity, and initiative

MOOD DISORDERS

Mood Disorders

a. A group of clinical conditions characterized by a disturbance of mood, loss of that sense of control, and a subjective experience of great distress. This disturbance of mood can be manifested by either stained feeling or sustained elevation of mood. As with psychosis the disturbance of the mood occurs in a variety of patterns associated with different mental illnesses. (Mental Health: A Report of the Surgeon General)

Bipolar or Manic Depressive

a. Symptoms include mood swings from the lows of depression to the highs of mania. These episodes alternate and in some cases can be predicted. Severely affected people have a "rapid cycling" bipolar illness, in which the mood swings occur almost continuously.
b. Depression: symptoms include melancholy, sad, miserable most of the time. Loss of interest in life and pleasures. There can be a decreased energy level, fatigue, fits of weeping or constantly feeling like crying, and an unusually high degree of irritability. There is also a on going thoughts of suicide in severe cases.
c. Manic symptoms include a feeling of power, increased energy, seductive, elated, euphoric. Other symptoms include talks too fast, loud and without stopping. Thoughts race from one idea to the next in rapid succession without much logic. Stop eating, sleeping which in turn can change mood to irritability, anger, paranoia.

Major Depression

a. Ongoing feelings of melancholy, sad and miserable most of the time with loss of interest in life and pleasures. These episodes can also include decreased energy, fatigue, fits of weeping or constantly feeling like crying. Symptoms may

vary with individual, but are long lasting and affect the quality of life for the person.

b. The though process is constantly negative with hopelessness dominating present and future. Anxiety, dread can increased the individual's inability to function. Difficulty in concentration and making decisions; experience feelings of guilt, self-loathing, or worthlessness. Preoccupies with death and suicidal thoughts or attempts.
c. Physically individuals may experience disruptions in normal eating and sleeping patterns. Some are unable to sleep and others may sleep more hours than usual.
d. Behavior includes inability to get work done and difficulty in reading or studying. There is a great difficulty in accomplishing simply tasks such as washing, dressing, and eating. There may also be some restlessness and agitation. The characteristics include slowed thoughts, movements, and speech; walk stooped and shuffling gait

NOTES

NOTES

PTSD

POST TRAUMATIC

STRESS DISORDER

Stress, Fatigue, Trauma and Resiliency:

Post-deployment coping and readjustment among returning OIF and OEF Veterans

James Sardo, Ph.D.
Portland VA Medical Center
Capt, USAFR, BSC

November, 2005

Goals

- Provide background data on OEF/OIF Veterans – the real scope of the problem.
- Describe specific factors in the AOR that contribute to Operational Stress problems.
- Describe human adaptation to threats – (a.k.a. "stress").
- Provide anecdotal information from recently returned Veterans on transition difficulties
- Open discussion on strategies for working OIF/OEF Vet.

Background

- My observations in OIF I
- Anecdotal information from other deployed clinicians – OIF I and OIF II
- Recent Data from WRMC
- MHAT I and MHAT II
- What returning Veterans are telling us at the VA.

Mental Health Issues- OIF I, Southern Central Iraq

- Uncertain deployment duration a significant contributor
- Many service members – especially Guard/Reserve members Family Care plans were six month plans
- Living conditions were a big contributor
- Guard/Reserve c/o inadequate preparation occupationally and personally (psychological, medical, spiritual)
- Depression, PTSD and Adjustment D/O equally common

OIF I/II LRMC

Data courtesy of Lt Col Sally Harvey, USA

Most Common Diagnoses

Adjustment Disorder	38%
Depression/Bipolar	31%
Anxiety/ASD/PTSD	12%
Personality Disorder	10%
Psychosis	8%
Substance Abuse	5%**

** disproportionately higher in those presenting for VA services

Two Additional Returning Clinicians

Afghanistan and Iraq

- Similar experience with Depression as a predominant complaint
- Guard and Reserve members utilizing more mental health resources and these often around home/marriage/$ issues
- Cumulative Stress an important operational consideration

Recent Observations OIF and OEF

Step down unit at WRMC

- Mar 03 – Apr 05- total = 477
- Males, Army, E-3 to E-6, ages 20 – 29
- Diagnoses
  - Depression – 105 total cases (22%) – 25% of these had a secondary diagnosis of PTSD
  - PTSD – 99 total cases (21%)
  - Adjustment Disorder – 68 total cases (14%)

MHAT I and MHAT II

- Improvements in preparation and treatment
  - Anxiety 7% ☎ 5%
  - PTSD 15% ☎ 10%
  - Depression 7% ☎ 5% *
  - Unit Morale 72% ☎ 54% **
- Guard/Reserve ① MH needs
- Recommendations:
  - Role of Leadership
  - MH Forward
  - Reduce stigma

**Predeployment rates of 6.3%*

*** A good thing*

Recent Experiences in Portland

- Mostly Guard
- Many complaints of job stress persist
- Numbers increasing quickly
- Mixed presentations – drinking, PTSD, depression, marital, focal anxiety
- Failing marriages nascent substance use disorders and anger problems often triggers for seeking care
- Three to four month delay in presentation

Recent Experiences in Portland

- Small but growing number of Veterans with serious mental illness that emerged during/since deployment.
- Several Veterans report stereotypical "combat" related behavior leading to personal, occupational, legal problems
- Secondary problems and pre-existing problems as frequently interfering with life and resulting in legal issues.

Combat and Operational Stress (COSR)

- Its just as likely – if not more so – that you will encounter Veterans with adjustment reactions to stress as posttraumatic stress.
- If you separate anyone from their life, family, friends and general predictability for a year, they will have problems readjusting – nevermind the shooting and IED's

What do we know about stress in the AOR?

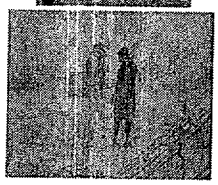
- "Job Stress"
  - Long Hours -
  - Newly formed units (includes many changes and disrupted support systems)
  - High operational tempo
  - Now living, working, eating, showering, using the same gym, same bathroom, etc as your boss, subordinates and coworkers
  - Differences between "in garrison" individual and unit functioning

What do we know about perideployment stress?

- Relationship Stress
  - Long deployments
  - Multiple deployments
  - Rushed pre-deployment marriages
  - Rushed pregnancies
  - Operational Stress-related irritability & numbing
  - Usual communication styles no longer in place
  - Pre-existing strained relationships fail
  - Helpless to assist family with newly emerged or ongoing crises (e.g. parents, children with illnesses)
  - Reserve/Guard families dispersed and often far from military family supports
  - People do crazy stuff (wrong things, time, person)

What do we know about stress in the AOR?

- Additional Sources of Stress:
  - Financial problems
  - Guard and Reserve with employment and business problems
  - Physical/environmental conditions
  - General case of helplessness and/or hopelessness
  - Disconnect from established support systems, faith communities or other critical supports that may have been forestalling difficulties



and . . . there's Combat Stress

FYI

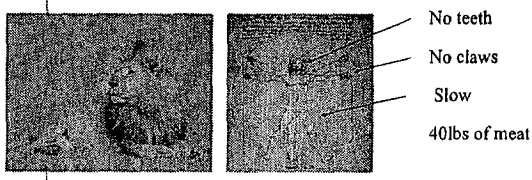
- Stress is as much about something going *right* as it is about something going *wrong.*

FYI

- We like to think of ourselves as a big dominant predator type.

FYI

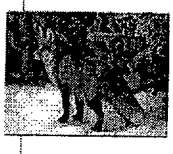
- We like to think of ourselves as a big dominant predator type.

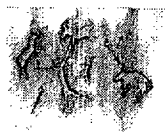


Snack Food

FYI

- Either through intelligent design or evolution, we ended up wired like a prey species.





We respond to threats with a series of predictable holistic adaptations which allow for increased chances for survival

- Arousal – Fight, Flight, Freeze.
- Changes in thinking – intrusive remembering.
- Learning Cues – avoid the bad stuff and live.

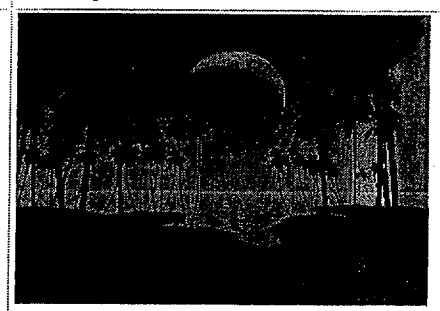
Fight, Flight, Freeze Response

- If I'm a potential snack, best not to be seen.
- If I'm seen, best to get away uninjured.
- If I can't get away, best to fight like h***.

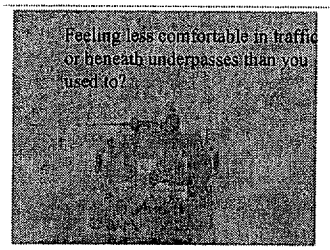
Fight, Flight, Freeze Response

- Blood flow changes.
- Chemical changes.
- Muscle tension.
- Heart rate.
- Stomach.
- Biological underpinnings of anger and fear.

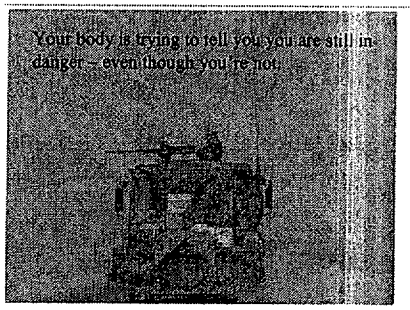
Fight, Flight, Freeze Response



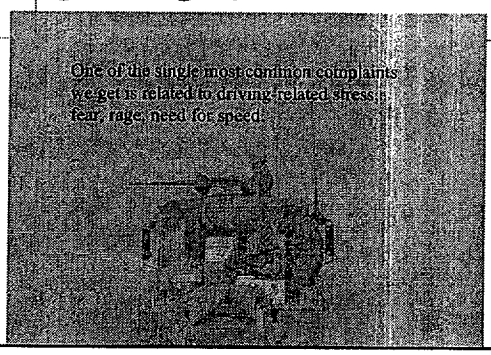
Fight, Flight, Freeze



Fight, Flight, Freeze



Fight, Flight, Freeze

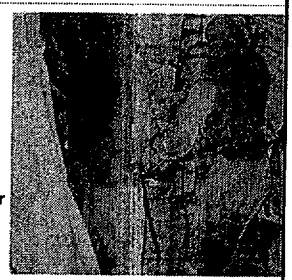


Intrusive Thinking

- Thoughts, images, feelings
  - Brain says – remember so you can survive.
  - Chaotic fragmented memories – coherent narrative.
- Nightmares and dreams.
  - Very debilitating.
  - Fatigue can make these worse – which makes you more fatigued which . . .

Avoidance and numbing

- Explicit reminders.
- Subtle reminders.
- Sights, sounds, smells, sensations.
- Crowds.
- Loss of control.
- Mistakes – or the people that make them.
- Disconnect – protect, cover up, minimize.
- Numbing through anger and biological numbing.



Reentry

- Readjusting to civilian life.
- After the honeymoon.
- Things have changed.
- Everyone wants to talk to you about it.
- Shopping therapy.
- Parenting issues.
- 2 - 6 months for readjustment.
- High risk activity.
- Threat-related thinking *and* behavior

Impact of Posttraumatic Stress on Families

- Cycles of normality (or intensity) and emotional distancing.
- Walking in egg shells.
- Feeling helpless and unable to help.
- Veterans commonly struggle with seeking help – "everyone else is doing fine, I'll be ok too."

Impact of Posttraumatic Stress on Families

- Workaholism
  - WWII/Korea and retirement.
- Start lots of projects.
- Drinking – symptom management.
- Mistakes are not tolerated.
- How was July 4th?
  - Specific triggers etc.
- Excessive focus on safety

Anecdotal Information

- Intense anxiety responses and panic related to specific driving triggers
  - Over passes, parked cars, absence of mounted weapons, cell phones, too restricted in driving options.
  - 88 Mikes – "Guns up, hammer down!"
- 11 Bravo – crowds, uncontrolled settings, weapons present = very aggressive response . . .don't think, just act

Anecdotal Information

- Vet's drinking to sleep or tolerate social situations.
- Marital Problems related to emotional distancing & anger
  - Just add alcohol and stir . . . .
- Startled Vet in Home Depot, patterned practiced aggression + hyperstarle = shame/embarrassment.

Anecdotal Information

- Recapturing the rush
  - Accidental deaths increase after every war – driving, adrenaline seeking, fighting.
  - Stimulant abuse
- Suicidality
  - Passive
  - Active
- Initial period of threat-related thinking.
  - Carrying weapons
  - Perception that loss of control = danger

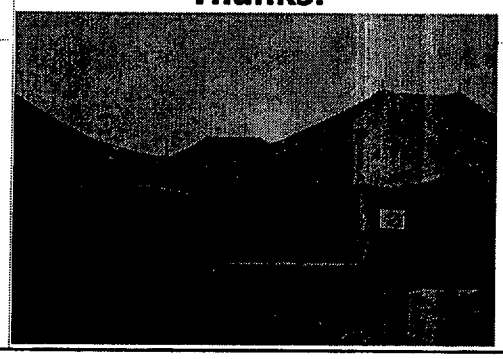
Additional Issues

- DESNOS
- Comorbidity
- AXIS II conditions
- Secondary gain issues

Questions & Discussion

- So what does an OIF Vet look like?
- PTSD – explanation vs excuse.
- Good police practice trumps mental health interventions
- Dissociation vs hallucinations vs intoxication.
- Deescalating – the *perception* of control
- Grounding, dearousal, distraction

Thanks!



Post Traumatic Stress Disorder

1.Symptoms develop following exposure to an extreme traumatic event that involves

- Direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to physical integrity of another person
- Witnessing an event as described above
- Learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate

2. The persons response involves intense fear, helplessness, or horror. In children this may be manifested by disorganized or agitated behavior.

3. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. In children this can include play where themes or aspects of the trauma are expressed
- Recurrent or distressing dreams of the event. In children there may be frightening dreams without recognizable content

Acting or felling that the traumatic event were recurring. Can include hallucinations and flashbacks

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity to internal or external cues that symbolize or resemble an aspect of the traumatic event

4. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness

- Efforts to avoid thoughts, feelings or conversation associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall important aspects of the trauma
- Diminished interest and participation in activities
- Feeling of detachment or estrangement from others
- Restricted range of affect
- Sense of a foreshortened future

5. Persistent symptoms of arousal

- Difficulty falling or staying asleep
- Irritability or anger outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

6. Prevalence rates for the general population range from 1% to 14%. Rates for at risk populations such as combat veterans, crime victims, ect. range from 3% to 58%

7. In about 50% of cases symptoms resolve within 3 months. In many cases symptoms persist longer than 12 months

8. Individuals with PTSD are at increased risk of developing a substance use disorder. Substance use exacerbated symptoms of PTSD

GUIDE TO ACCOMPANY

POST TRAUMATIC STRESS DISORDER

FEATURES OF PTSD

A. Traumatic event/significant stressor.

B. Re-experiencing of the traumatic event.

C. Numbing of responsiveness

D. Anxiety-based autonomic and cognitive symptoms.

DIAGNOSTIC CRITERIA FOR PTSD

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma by at least one of the following:

1. Recurrent and intrusive recollections of the event (nightmares).
2. Recurrent dreams of the event.
3. Sudden acting or feeling as if the traumatic event were re-occurring (flashbacks).

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

1. Marked diminished interest in one or more significant activities.
2. Feeling of detachment or estrangement from others.
3. Constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

1. Hyperalertness or exaggerated startle response.
2. Sleep disturbance.
3. Guilt about surviving when others have not, or about behavior required for survival.
4. Memory impairment or trouble concentrating.
5. Avoidance of activities that arouse recollection of the traumatic event.
6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.
7. Self-medication via alcohol/drug/pill abuse--chain smoking--overeating--anger mismanagement.

PTSD SUBTYPES

308.30 Post-traumatic Stress Disorder, Acute

- Onset of symptoms within six months of the trauma.
- Duration of symptoms less than six months.

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

- Duration of symptoms six months or more (Chronic)
- Onset of symptoms at least six months after the trauma (Delayed)

TRAUMATIC EVENTS THAT CAN PRECIPITATE PTSD

A. Rape

B. Natural Disaster

C. War--combat

PRECIPITATING TRAUMA & SIGNIFICANT STRESSORS OF COMBAT

- Exposure to death and mutilation of people and destruction and desolation of environment.

- Personal acts of violence, fighting, killing, and destroying.

- Danger and threat to life.

- Depersonalization and dehumanization of the military environment and the war experience.

- Discontinuity between war and non-war environment.

<u>Additional Stressors of War</u>

- Political and moral debate and controversy about combat, social and political divisiveness (draft evasion; marches, demonstrations, protests, and political debate). Creating a state of confusion and uncertainty; weakening morale; heightening vulnerability; diminishing social support and sanction; resulted in a homecoming by avoidance, rejection, and antagonism.

- System of rotation, limited tour of duty and periods of rest and recuperation with rapid individual entry and exit reduced morale and cohesiveness; rendered unit maneuvers more difficult and exposed participants to a more stressful transition.

- Restrictive policies (no plan to win the war; abandonment of captured territory; orders to request permission from higher authority before engaging the enemy) heightened danger, contributed to mistrust and lack of confidence in leadership.

Themes of "Post-Vietnam Syndrome."

- Guilt feelings and self-punishment.
- Feelings of being scapegoated.
- Rage and other violent impulses against indiscriminate targets.
- Combat brutality and it's attendant "psychic numbing."
- Alienation from one's own feelings and from other people.
- Doubt about ability to love and trust others.

TREATMENT OPTIONS FOR PTSD

A. Behavioral Techniques: Relocation, Desensitization

B. Education Techniques: Assertiveness, Relaxation

C. Supportive Techniques: Reflective Listening

D. Family Therapy

E. Hypno Therapy

F. Individual Therapy

G. Peer Group Therapy

H. Flooding, Abreactive Therapy

I. Gestalt Technique

J. Grief Psycho Therapy

K. Guilt and Regret Issues in Counseling

L. Anger and Stress Management

[Events]

VIETNAM: WHAT I REMEMBER

From "Patriotism Revisited," by David W. Powell, a memoir submitted last October to a creative writing class at the University of Arizona in Tucson. Powell served as a marine in Vietnam from 1965 to 1967.

The following events come to my conscious memory uninvited. I not only remember them vividly, I reexperience them with all my senses:

Froze with fright, standing up, the first time I was under fire

Watched two marines try to break open the skull of a dead Viet Cong with a large rock

Observed a marine intentionally shoot a girl four or six years of age

Watched the girl's grandfather carry her into our line of fire, sobbing

Had a lieutenant who delighted in sneaking up on me when I was on watch at night

Was offered a blood-soaked flak jacket and a helmet with a bullet hole through it as my first field equipment

Had my boots rot off during an operation in the field

Observed two captured nurses being beaten and raped by marines

Rifle-butted a girl of twelve in the face when she would not move away

Strangled a captured Viet Cong for refusing to talk to an interpreter

Discovered brain matter on barbed wire I was stretching out

Observed a marine laugh as he stepped on the chest of a dead Viet Cong and watched blood squirt out of the enemy's wounds

Awoke to find a buffalo leech on my leg

Was abandoned under fire when a roc[illegible] jammed in my launcher

Was abandoned under fire when I was shot

Hit head and fell in open field. Watched my fellow marines run by me to seek cover for themselves

Received letter from wife telling me how much fun she and a girlfriend had on Friday nights when they went out to bars to dance

Watched fellow marine shoot himself in the foot to get evacuated

Heard same man cry in his sleep when he was returned to the company

Found marine boot with foot in it in a hedgerow

Almost run over by retreating U.S. tank

Saw Lt. Spivey hit a head-high booby trap

Nearly murdered villager for stealing my laundry

Watched Prestridge test his new M-16 by shooting a woman getting water from a nearby well

Identified Haas's remains

Exchanged letters with Haas's mother

Had an artillery canister fall six inches in front of my head

Was about to put on fresh boots when I discovered lice swimming in them

Saw seven-foot python climbing in ceili[illegible] just above my head

Bullets sounding like bees digging up ground all around me

Nearly trapped in Da Nang village my last night in Vietnam

Robbed by marines while I slept in Okinawa after tour was over

Circled over El Toro air base for two hours so that President Johnson could land and be photographed greeting returning veterans

• •

Since my return I have held eighteen different jobs and have been unemployed for several six-month periods. This is a direct result of my Post Traumatic Stress Disorder, specifically a disdain for being told to do tasks I do not want to do; an exaggerated startle response, which is terribly embarrassing to me; and a lack of control over emotional flooding.

I divorced my first wife two years after I got out of the service. I divorced my second wife in 1982. I separated from a four-year relationship in 1987. I have not had a significant relationship with a woman since then. I have no significant male or female friendships. I am aloof from my immediate family, who live in Tucson, Arizona.

PTSD SYMPTOMS

- MISTRUST
- DEPRESSION
- ISOLATION
- RAGE REACTIONS
- AVOIDANCE OF FEELINGS; ALIENATION
- GUILT/SHAME AND DOUBT
- ANXIETY REACTIONS
- SLEEP DISTURBANCE AND NIGHTMARES
- INTRUSIVE THOUGHTS

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HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
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PORTLAND, OREGON 97204
(503) 248-3976

Dear Survivor:

This booklet is about the experience of being hurt on purpose by other people, and the changes in your life that it leaves behind.

You may wonder if what happened to you was bad enough to be called abuse. If you have to ask that question, it probably was. If you cannot remember large parts of your life, it almost certainly was.

I am sorry you are having to read this out of a book.... These things are better dealt with face-to-face. The effects of violence are best helped by different and more positive experiences with people. In a correctional institution, this is hard to do.

Take your time reading this. Use whatever parts seem helpful in your situation. Be patient with yourself. It will take time and work, but you <u>can</u> feel better.

Take care,

Joe Parker, RN

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Dear Colleagues,

In providing mental health care for corrections populations, management of Post Traumatic Stress Disorder has a central place.

Some clients come into the system as a result of acts in some way related to previous experiences of abuse. Many come as a result of self treatment of major symptoms by means of illegal drugs or alcohol.

Although psychotropic medications play an important role for many clients in controlling physical symptoms of the disorder, psychological treatment has proven to be very important in improving functioning and quality of life.

Since mental health resources are so limited in corrections, self-help educational materials must be used whenever possible. This booklet has been very helpful for our clients and staff, and we hope it will be helpful for your clients as well.

Permission is hereby granted to reproduce this material in any form and quantity necessary, for any use except for resale.

Sincerely,

Joe Parker, RN

POST TRAUMATIC STRESS DISORDER (PTSD)

WHAT DOES POST TRAUMATIC STRESS DISORDER MEAN?

Post is the Latin word for "after".

Trauma is the German word for "nightmare", but in English, it is used for any kind of injury, physical or psychological.

Stress is a force that changes the shape of things (including people).

Disorder refers to things that are a problem in a person's life now.

To understand PTSD, it is necessary to tell two stories.

> Once upon a time, several blind men wanted to understand about elephants.
>
> An elephant was brought to them, and they all approached it from different directions.
>
> One felt the tail, and said "an elephant is like a rope"!
>
> Another found a leg, and said, "no, an elephant is like a tree trunk".
>
> A third walked into the side of the elephant, and said, "really, an elephant is like a wall".
>
> Others found the ear, the trunk, a tusk, and each felt his part of the elephant was the real elephant.
>
> Each blind man was right about his part of the elephant, but none of them really understood about elephants.

The story of Post Traumatic Stress Disorder is similar.

PTSD was first recognized after the American Civil War.

Doctors noticed that some soldiers who had been in heavy combat complained of having attacks of fast heartbeat, chest pain, difficulty breathing, and fear that they were dying or going crazy.

The symptoms were similar to heart attacks. Not having the scientific equipment to investigate further, they assumed the attacks were a form of heart disease. They called it "soldiers' heart".

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We now know the attacks are not heart disease. They result from rushes of adrenalin, triggered by bad memories or nightmares.

A few years after the war, most people forgot about the problem, but the part of the elephant they had found was real.

World War I was the first time very large numbers of explosive shells were used in battle.

It was noticed that some combat veterans, afterward, had trouble with feeling somewhat dazed or confused, and with poor concentration and memory.

This seemed similar to what happened in many brain injuries. It was thought that the concussions of the shells caused tiny spots of bleeding in the brain. They called it "shell shock".

Eventually, a lot of autopsies were done on soldiers who had died of other causes, and no such bleeding was found. It was recognized that the symptoms resulted from extreme stress, not brain damage.

It should be remembered that many people with PTSD, especially from child abuse and domestic violence, have had damage from blows to the head. Both symptoms of brain injury and effects of overwhelming stress may be present in the same person.

A few years after the war, the matter was again dropped, but they had found another part of the elephant.

When World War II came, it took until June of 1944 to redevelop the treatment methods used in 1918.

In that war, they learned two important things. The severity of a person's symptoms was directly related to how much stress he or she had undergone, over how much time.

It was calculated that of 100 men in continuous combat, every single one would break down within 189 days. They called it "combat fatigue", or "combat exhaustion".

It also became clear that there is no such thing as a stress-proof person. Certainly some people break before others, but with enough stress and enough time, everybody breaks. They had another part of the elephant.

After World War II, it was assumed (never investigated, just assumed) that symptoms of traumatic stress went away in 6 months or a year, after the war was over.

Only after the Vietnam War did it become clear that PTSD symptoms could appear it any time, during or after the war. The symptoms could go on, better or worse from time-to-time, all of a person's life.

The severity of the symptoms is influenced by how much emotional support a person has available during and after trauma.

Veterans of an unpopular war, such as Vietnam, were clearly affected by the fact that nobody wanted to talk about it later.

Survivors of child abuse and domestic violence are more severely affected because family or friends, who normally would provide support, are the perpetrators of the violence.

In the late 1970's feminist writers began publicizing the fact that far more child abuse, sexual abuse, and domestic violence were occurring than previously admitted.

Studies began to reveal that domestic violence is a problem in about 25% of all families, regardless of race, religion, income or education. About 16% of all girls and 8% of all boys are sexually abused before the age of 18 years. Rapes reported to the authorities may represent less than 10% of those that actually occur. About 10% of the adult population is alcoholic. Inclusion of other abusable substances may raise the figure to double that.

Very few people are directly involved in wars, but most people have a family.

Unlike in times past, the feminists and Vietnam veterans have not shut up and gone away. Post Traumatic Stress Disorder is now an official diagnosis in the diagnostic and statistical manual.

Consciously or unconsciously, the brain remembers everything. Trauma really happens, and it changes who you are. You cannot seriously hurt human beings and expect them to forget it and be alright afterwards.

People who have Post-Traumatic Stress Disorder often worry about whether they are "crazy".

The word "psychotic" (or crazy) usually means experiencing or believing things that are not real: being "out of touch with reality".

People with PTSD's have essentially the opposite problem. They are in too much contact with reality, and in contact with realities that most people have the privilege of not knowing about.

It is just as possible to be sick from too much contact with reality, as from not enough.

That is the whole elephant.

The official definition of Post Traumatic Stress Disorder includes a combination of the following:

1. An extreme, painful experience, which would be severely stressful for almost anyone.

2. Continuing psychological "re-runs" of the events, including:

   a. frequent thoughts and memories about what happened, even when trying to avoid them.

   b. repeating nightmares about the trauma.

   c. suddenly feeling or acting as if the events were happening again (flashbacks).

   d. strong, painful feelings set off by things which are in some way related to what happened.

3. Ongoing attempts to avoid memories and feelings by:

   a. becoming generally numb to everything, by cutting off most feelings, both good and bad.

   b. avoiding activities or situations which may bring back memories and feelings.

   c. loss of large areas of memory about past life.

   d. loss of interest in things most other people care about, feeling different and cut off from other people.

   e. lack of any sense of having a future.

4. Continuous extreme physical alertness, including:

   a. constantly watching for signs of danger, with "startle responses", and trouble sleeping.

   b. trouble concentrating on business in the present world.

   c. irritability, outbursts of anger.

   d. physical reactions similar to what happened during past trauma (tremors, sweating, nausea etc.)

5. These symptoms continue for more than a month and can begin anytime from immediately to years after the trauma.

PSYCHOLOGICAL ABUSE

Children come into the world knowing nothing about themselves: whether they are smart or stupid, good or bad, lovable or unlovable. They can only learn these things from family, from people around them. If they are given "poison information", they have little choice but to believe it.

For the abuser psychological abuse has several advantages:

1. It leaves no physical marks. Unless the child becomes extremely depressed or psychotic there is no evidence to show in court.

2. It is safe. There is no risk of accidentally killing the child and being sent to prison. There is no problem with the child getting big enough to physically fight back or use a weapon.

3. It is easy. Psychological abuse can be kept up for years, wearing away at a child like rust. There is no great amount of energy or time involved.

Psychological abuse takes several forms. They are usually used together - it is rare for an abuser to use only one type.

1. Rejecting

   "I hate you, you ruined my life". "You are not my child" Nothing the child is or does is ever good enough.

2. Isolating

   Keeping the child away from any people other than abusers. This prevents the child from learning anything about him or herself except the "poison information" provided by the abusers.

3. Ignoring

   Not responding to anything the child is, says, or does. Psychologically/emotionally "not there" for the child.

4. Corrupting

   Involving the child in crimes, early alcohol/drug use, sexual activities, etc. that leaves the child unable to be part of normal society.

5. Terrorizing

   Keeping the child constantly in fear of being hurt, making the child watch others being hurt, keeping the child emotionally out of control most of the time.

PHYSICAL ABUSE

A large part of the "normal population" consider it legitimate to use physical force to discipline children. "Spanking" with an open hand is commonplace in our society. Abuse, fueled by uncontrolled anger or intoxication, goes far beyond ordinary discipline. Abusers almost always blame their violence on the child or spouse who is the victim. This is confusing to survivors, who need to know what level of violence qualifies as "abuse".

Abuse includes some combination of the following features:

1. Severity of injury. Cuts, bruises, broken bones, being strangled or knocked unconscious.....and sometimes death.

2. Weapons. Clubs, knives, guns and other instruments capable of causing severe injury or death. Life or death for the child depends totally on how well the abuser controls the weapon.

3. Use of pretexts. A child is punished for anything or nothing. The "rules" are made up as the abuser goes along, and change without warning. The child is never safe.

4. The abuser is out of control. Through alcohol/drugs, mental illness or personal choice, the abuser does not control amounts of force used. The child may be crippled or killed at any time.

It is sometimes useful, to understand the severity of a survivor's current symptoms, to put together a lifetime total assault history. Multiply the total number of each type of assault per day/week/month by the total amount of time exposed to the various abusers. Be sure to count both assaults in childhood and in adult life. The total number sometimes explains a lot about why you are having so many symptoms.

Finally, estimate the number of days on which the survivor could be sure of not being hurt. Sometimes this number is painfully small.

Adults who recognize their actions toward children as abusive often fear to tell anyone, out of fear they will go to jail or lose custody of their children. In reality, many social services agencies work with parents who have abused, or fear they may abuse their children, to learn to stop the violence and keep their children. Parents Anonymous is free and a good place to start.

SEXUAL ABUSE

Normal sexuality is the exchange of pleasure between two freely consenting people. Abuse is the wrongful use of a human being, as a thing, for the pleasure of another. Sexual abuse commonly involves:

1. Use of force or threat to control a person who is not consenting. The threats may be against the victim, ("Do what I want or I'll kill you...."), against others, (If I don't get what I want from you, I will just go after your little sister..."), or against the abuser himself, ("If you tell anyone, I will have to kill myself, and it will be all your fault...").

2. Use of lies to overcome resistance, ("I'm doing this to teach you, for your own good", "Everybody does this", "You want it, I know you do".). Lies can take the place of open violence.

3. Secrecy. Normal sexual relationships may go on in private, but they are not themselves secret. The demand for secrecy almost always indicates wrongdoing, and usually includes some kind of threat. ("You won't be by special girl anymore", "It would break your mother's heart", "You will be put in an institution".).

4. Betrayal of responsibility. Children have to depend on older people for protection, for food, clothing, shelter, and for truthful information about how to get along in the world. An adult who uses a child's natural needs in order to use the child's body, is committing a crime. Sometimes the betrayal hurts more than the fear, the isolation or the injuries.

The most basic drives of human beings, and of all animals, are to survive and to reproduce. The use of power to control a child is ultimately based on the threat to hurt, abandon, or kill. The child does whatever is necessary to survive. Energy that should go into growing up, is spent on trying to just get by, day by day.

Use of sex as a weapon strikes a child's basic ability to relate to, and trust, other human beings. It attacks a person's sense of being connected to other people, both in the present world, and to past and future generations.

Sexual abuse is like any other serious injury: some people survive and do well, some people only get by, and some end up not surviving at all. Good help and the right choices can make your life more nearly normal, and much happier than it might otherwise have been.

To be hurt, especially on purpose by other people, makes everyone sad and ashamed. In thinking about their lives and symptoms, most people tend to underestimate the severity of their experiences, and overestimate the amount of control they had over what happened.

HISTORY

The brain has mechanisms like "circuit breakers" which block out memories too bad to handle at a given time. The memory loss is usually "spotty", not complete, and gets better or worse depending on a person's stress level and how much help is available.

Trying to force the memory, by emotional pressure, drugs or hypnosis, often hurts rather than helps. If the brain needs to block out a memory, it usually has good reason. People tend to "face reality" as fast as they can. Pushing becomes just another form of violence.

It is common to have to work on plans for recovery with incomplete information. Often, some of the most important facts come out only quite late in the process.

Because the traumatic experience really happened, and really hurt, PTSD symptoms tend to continue, better at some times, worse at others, most of a person's life. Careful planning and use of recovery skills can greatly increase the amount of "good time" and make the bad times less frequent and less severe.

Putting together a written history of your life, and understanding the effect the traumatic parts had, usually helps make sense of many things that have happened in your life, during the abuse and after. It is very important in making plans for your recovery. Making the most complete possible history is a long term project. Memories come back in bits and pieces. Information from other people and from records also will come in bits and pieces. Some things may never be known.

This will be a stressful process, both in the effort spent in trying to remember, and in the energy needed to cope with what is remembered. Sadly, insight into what happened usually improves symptoms, but seldom completely removes them.

It helps to keep written notes, to avoid losing hard won information to the ups and downs of memory. Putting it in writing also seems to help keep things real, when so often they seem unreal, or even impossible.

1. Lay out a "life line", beginning with your birth. Put in any markers that will keep track of time: places you lived, where you went to school, births, marriages, deaths, institutions you were in, etc.

2. Talk to family, friends, teachers, ministers, neighbors and anyone else who may have information about your life.

   Keep in mind that some of these people truly did not know, some did not want to know, some knew but did nothing, and some may have profited in some way from what happened. (For example, as long as the violence was directed at you, it was not aimed at them.)

3. If you decide to talk with the perpetrator, be very careful of your safety. Many are still dangerous. Be clear about what you are trying to do. If you want the perpetrator to confirm memories you can barely believe yourself, be prepared to be called a liar, crazy, or to be told you wanted or deserved what happened. Try not to hope for too much: most perpetrators do not admit responsibility or say they are sorry.

   If your purpose is to confront the perpetrator with your anger and your knowledge that what was done was wrong, then, other than being careful for your safety, how the person reacts is not very important.

   If the perpetrator is confronted in the process of warning other family and friends about the danger he or she presents, be aware that some other people may react in much the same way as the perpetrator might.

   You cannot afford to attach your sense of self worth to the reactions of other people, because their responses have to do with who they are, not who you are.

4. Pay special attention to periods of time you cannot remember, or that others will not discuss with you. The more hurtful the experience, the more likely it will have been blocked out.

   Sometimes it is possible to work backward from things that are known: who was living with us at the time, who was drinking at that time etc.

5. Send for copies of any hospital or institution records that may be available. Although you have a right to see and copy most records pertaining to you, sometimes the help of an attorney or health care provider may be needed. Be aware that many professional people are careful not to ask questions they do not want to hear answers to. Some of the records may be in a sort of code, that is: "chaotic family life" may mean drunken violence on a daily basis, and "sexually molested" may cover rape, sodomy and torture.

Put your notes in a safe place. You may wish to add to them from time to time, as you find new information. Sometimes reviewing them will help you understand some new problem in your life.

LIFE CHANGES

Extremely hurtful experiences, ones that produce more fear, pain and anger then anyone can handle, leave behind four ongoing sets of behaviors. These are not so much "scars" as attempts to cope with trauma. Like any kind of treatment, if carried too far, they can become part of the problem, not part of the solution.

1. You begin intense, continuous study of the experience, trying to understand why those things happened, and how to keep them from happening again.

This involves constant thinking about the events, to the point it may interfere with other activities. You may have repetitive dreams about the events which may be so intense as to interfere with sleep and set off adrenalin reactions. The feelings can be so powerful that it can seem as if you are living in two different "movies" at the same time: the "bad old days" and "now".

Once you understand how the process works, you feel less disoriented, less out of control, and more able to cope.

Learning more information about trauma <u>does</u> help. You can take classes, read about it, and talk with others who have been through similar things.

2. You learn to constantly scan the environment for signs of danger. The scanning is compulsive - you cannot turn it off, so you have to plan for it.

Recognizing signs of threat may trigger strong reactions, sometimes as strong as the original events did. These reactions may be completely out of line with what is going on in the real world at the time.

Sometimes, you may well be aware of the connections between the present "trigger" and past experiences, even if you cannot control your reaction. At other times, the connection may be unconscious. You first become aware of your <u>reaction</u>, and may or may not later be able to connect it with the past.

The responses may be so intense as to feel like the trauma is actually happening again, that you are back in the bad old days. This is called a flashback. It can feel very crazy to find yourself feeling, saying, or doing things that do not relate to the present world.

To begin to control various kinds of flashbacks, it is important to map out your usual triggers, where they are likely to be encountered, and what your usual reactions are. Some triggers can be avoided almost completely, and should be. Others may be harder to avoid, or you may have good reason to take the chances involved in running into them.

Survival planning may include ways of minimizing exposure, arranging for support ahead of time, developing a "cool down" procedure, and concrete emergency plans in case of losing control.

3. Your body goes in chronic "red-alert", always ready to fight or run. Physical symptoms include extreme muscle tension ("the shakes"), headaches, high blood pressure, involuntary startle reactions and trouble sleeping. You feel afraid all the time, even when you have no present reason to.

It is in attempting to control <u>these</u> symptoms that so many people with PTSD get involved with alcohol and illegal drugs. Expert use of legitimate psychiatric and blood pressure medications can control most physical symptoms of PTSD. <u>They do not provide a high, are not addicting, are legal, and are much safer than street drugs</u>.

As survivors move forward in recovery, some may no longer need medication, others will need it only during bad times, and some may need it always.

Serious trauma can change the way a person's nervous system works, sometimes permanently. Even after allowing for the effects of brain damage and other injuries from violence, PTSD is a physical illness.

4. You are continually prepared to be hurt again, to lose again. The difference between the way life was supposed to be, and the way it turned out for you is a chronic stress.

You learn to avoid getting involved with other people for fear they will turn on you. You try not to care about people, animals or possessions, because sooner or later you expect them to be taken from you. You go so numb that you cannot feel anything, including good things. Being that numb <u>hurts</u>. Being cut off from good things, including people, makes you <u>sad</u>.

Emotions may swing like a pendulum, from overstimulated, hyperalert, fearful and angry, to depressed, numb and out of contact with the world around you. The extreme feelings often come and go in waves, and at times you actually may be out of control. Stabilizing this swing is a central goal of a recovery plan. Such a plan may include:

a. Mapping triggers and arranging your life to avoid recurring flashbacks.

b. Learning to recognize and avoid hurtful people.

c. Avoiding the use of drugs which temporarily improve symptoms, but make them worse on the "rebound". If needed, symptoms can be controlled with legitimate medications.

d. Reducing your exposure to new injury. (For instance, stay out of places that serve alcohol...)

e. Stopping current patterns of behavior which may be replays or reenactments of your own previous trauma, such as prostitution, fighting, child abuse.

f. Actions to make the real world safer are much more helpful than just trying to cope with your feelings about what might happen. Good locks and a dog are more helpful than lying in bed trying not to be afraid.

Extreme traumatic experiences, especially if they happened at a young age, can make you different from most other people. Of special interest are two groups of people who may seem very strange to you: predators and normal people.

DEALING WITH OTHER PEOPLE

A person's usual everyday approach to life and to other people is called a personality. A personality is made up of a person's biological inheritance (genes), the total set of things that have happened in the person's life, and the history of choices the person has made.

Every life is like a hand of cards. Some people play whatever they get well, others badly. Only a small number of people choose to hurt others. Even among people abused as children, 70% do not choose to hurt others.

Predators come in three forms:

A. Non-controllers:

All people have angry feelings, and all people have the impulse to hurt someone at times. Some choose not to control those impulses. Many choose to use alcohol and drugs, and let the chemicals block their impulse control. Others do whatever they feel like, sober or otherwise. Their attitude is: "I feel like shit, so somebody's going to pay..."

People who are loaded occasionally have the bad judgement to pick on somebody tougher than they are, but most, sober or not, are quite careful to act out their impulses on people who cannot effectively fight back.

B. Users:

Some people act as if they were the only real human being in the world, and other people are more like plants. If they want something, they simply take it, as if they were harvesting vegetables. Users have no sense of other people's rights and feelings, and do not consider that a problem.

It is not that they have something that other people do not. Rather, users are missing something most people have: a conscience, that is, internal personal limits on what they do. Any control of their behavior must be provided by others, and often by force.

C. Sadists:

People who enjoy humiliating and hurting others, and who do so while in full control of themselves., may make up as much as 10% of the population. They are found in all parts of society, with all levels of education and income. For some, other people's pain is sexually stimulating. Others like the feeling of power that comes with hurting people who cannot stop them.

The definition of sadism includes ongoing pattern of:

1. Using physical violence, threats or lies to control another person and inflict pain.

2. Humiliating and degrading a person in front of others.

3. Using a position of authority such as that of a parent to inflict unusually severe "discipline".

4. Being fascinated by violence, weapons, torture etc.

5. Finding the suffering of other people and animals funny, pleasurable or sexually stimulating.

Some sadistic people are very obvious. Others are so subtle that all you notice is that you feel bad when around them. Abuse survivors have had to learn to ignore their own feelings just to survive. Learning to recognize , and trust, your feelings and to take rapid action to protect yourself, sometimes takes a lot of work.

Cruel people often are quick to notice people who expect to lose, and will move in quickly. They avoid people who look like they know they have rights, and have people who love them, because they are likely to fight back.

It is necessary to learn to act like a person with value and rights, long before you can really feel it. In time, it will become real, not an act.

Normal people:

To deal with normal people, you must understand that the world they live in is very different from yours. They are not afraid all the time. They can feel many more things than pain, fear, and anger.

1. They have rarely felt so much pain that they have lost control of themselves, and certainly have not had that kind of pain caused intentionally by another person.

2. They do not assume they are at fault any time anything goes wrong.

3. They expect to be treated fairly, to be respected, and to love and be loved.

4. They can feel pleasure without drugs, they are depressed only occasionally, and do not know what being numb is about.

5. They expect to have a fair amount of control over their lives, and expect to live to be old.

With time and effort, you can learn to deal with people whose lives have been luckier than yours. One barrier will probably always remain: most normal people do not want to live in the world you know. Many will block you out so they can stay comfortable, not because you are doing something wrong. It is important not to reject all normal people, because there are always some who will work quite hard to understand how your life has been, even if they have had no similar experience themselves.

FINDING PEOPLE YOU CAN TALK TO

Think of how long it took you to put together the pieces of your history, make an accounting of how the abuse changed your life, and deal with your emotional reactions to that. You never had a choice about facing that because you had to live it.

Finding someone to talk to about it is not quick or simple. Some people will listen because they have had to live with abuse too. They may or may not be able to tolerate terrible stories at a given time. Listening to your story may bring up feelings they find too painful to deal with.

Others will listen because they are unusually committed to helping other people, or care a lot about you personally. Finding people who can listen is a key part of surviving. It involves several specific steps:

1. Talk with them about some part of your life that is fairly ordinary, and see if they really listen. If they listen poorly to the very ordinary, they certainly will not hear the really ugly. If they listen, then:

2. Choose a "medium bad" part of your story, one not too hard to handle if things go badly, and tell that. If they change the subject, turn mean, or drop a relationship, they probably are not worth any more effort.

   If they get panicky or go numb, you may have found another person with an abuse history. Keep in mind that they may or may not consciously recall the experience. Given plenty of time and personal space, these people may talk with you. Just as it was with you, pushing hurts rather than helps.

3. Once you know a person really well, you may choose to tell him or her the very worst things that happened, the ones that would really hurt if not handled with gentleness and respect. After you tell another person the very worst, and are met with kindness and respect, the memories never have quite the same power over you again.

4. Sometimes you will know people you care about, and very much would like to talk to, but you really feel they could not tolerate the ugly details. You may choose to tell them only some of the story, or even none.

   It is not fair that you should have to spend your energy to protect them from hearing about what you had to live, but occasionally it is necessary.

TRIGGERS

Human beings are creatures that learn, and keep on learning all of their lives, whether they want to or not.

They learn to recognize danger by noticing signs that were associated with past hurtful experiences. If the past experiences were severe, there may be a strong physical or emotional response, even if the conscious mind does not know what set it off.

These signs are called "triggers". People who have a good understanding of what situations set them off, can plan to avoid them, or to deal with the reactions. They come to feel much more in control of themselves.

Triggers can be internal, that is, can be a thought or a memory, as well as an outside event. Triggers take several forms:

1. Single Triggers: One sign alone is enough to set off a reaction. Examples: beer breath, body odor, being yelled at, seeing someone else hurt, violence or happy family situations shown on TV.

2. Compound Triggers: Several things, coming together, will set off a reaction, when each would not have been enough if it appeared alone. Examples: being touched, by someone who is angry, and has beer on his breath; or blood, on bed sheets, in the morning.

3. State-dependent triggers: One or several things which set off a reaction only when a person is tired, alone, in pain, intoxicated, etc. Without the changed mental and/or physical state, the particular signs are not enough to set off a reaction.

It is helpful to keep a log of what is happening around you, and what you were thinking about, just before your body and emotions "went off". Because of memory loss caused by stress, finding the trigger that set off a reaction can take time. Tracking down a trigger may also bring back lost memories. At other times, putting together more personal history will help identify triggers you had not recognized before.

FORGIVENESS

Abuse survivors often are pressed to "forgive" the perpetrator. The pressure may come from others, especially family members, or from the survivor's own beliefs about what should be done.

Forgiveness is a word for something that does not exist in the real world. There is no way to go back and act as if nothing ever happened, which is what most people want and most people think forgiveness means. People other then the survivor made bad choices, with terrible outcomes, and became worse people as a result.

The survivor may choose not to seek revenge, may choose to continue some contact with the abuser, and may try to support any positive change that the perpetrator may attempt, but there is no way the survivor can control what the abuser chose to do. If the survivor had been able to control other people's decisions, there would have been no abuse.

Children want very badly for their family to be good people, even in the face of strong evidence that they are not. They will blame themselves for things other people did. They will claim that they were somehow in control, rather than face the fact that they were helpless and that the bad choices were made by others. Survivors have nothing to be forgiven for, because they did not make the choices.

The abuser can choose to give up violence, take responsibility for the damage, and work toward rebuilding a family. Failing that, the survivor may have to piece together a family out of whatever is left, without the abuser.

A LAST WORD

A new family can be built out of the people who choose to be part of your life, whether or not they were born into it. A real family is something people do together, not something they are.

Building a new life may take terrible faith and courage. Some days it will seem easy, on other days, impossible. You go on living, with the unwanted knowledge of what evil people have done and can do, including what you yourself may have done and can do. Sometimes it takes all the courage you have just to get up and get dressed in the morning, knowing what can happen.

I wish you luck and courage on your journey. You will always have my respect.

Joe Parker, RN

THE PENDULUM SWING

REEXPERIENCING

- intrusive memories
- nightmares
- loss of sleep
- attacks of fear,
- flashbacks
- "startle" reactions
- increased need for alcohol/drugs

NUMBING

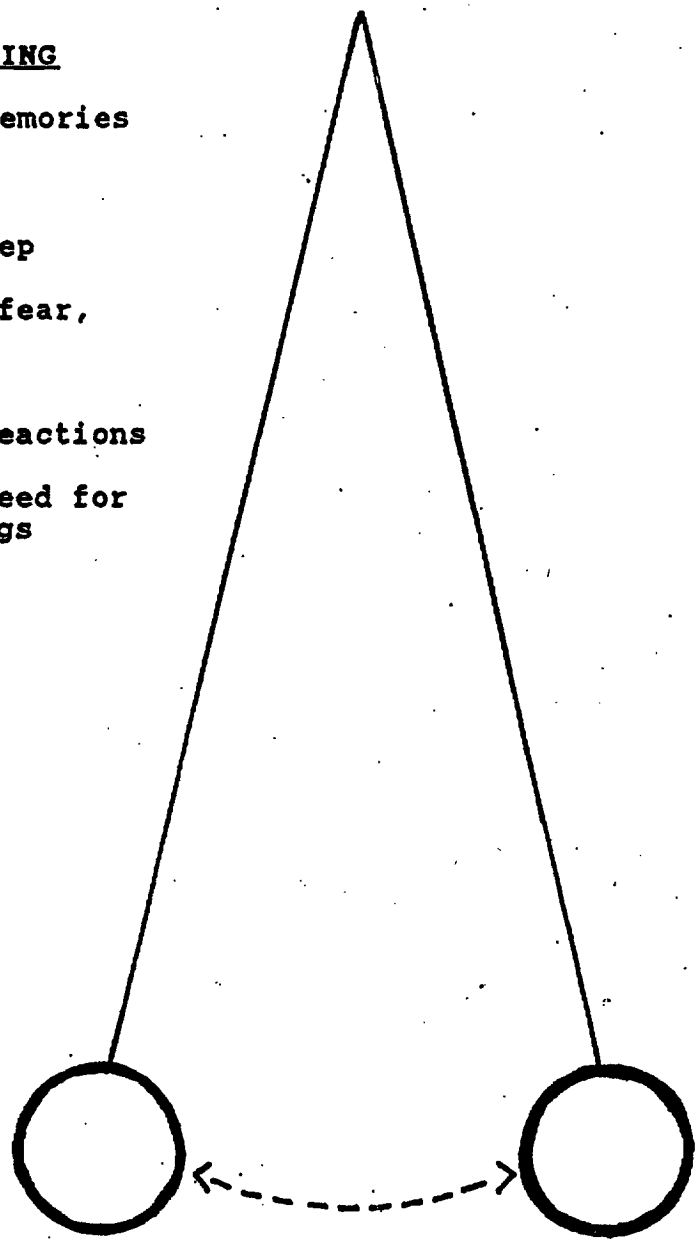
- feeling nothi
- loss of nor... interests
- detachment from others
- memory loss
- avoidance of reminders
- depression

TOO AGITATED TO WORK ON PROBLEMS.

TOO MUCH ENERGY.

UNABLE TO HOPE FOR THINGS TO GET BETTER.

NOT ENOUGH ENERGY.



"HEALING WINDOW"

Enough energy to work on problems, and enough hope to want to.

NOTES

NOTES

ALCOHOL AND DRUGS

Alcohol, Drugs, and Chronic Mental Illness

1. Substance Abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period

- Recurrent use resulting in failure to fulfill major role obligations at work, home, or school
- Recurrent use in situations where it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

2. Substance Dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:

- Tolerance
- Withdrawal
- Substance taken in larger amounts or over a longer time than was intended
- Persistent desire or unsuccessful attempts to control use
- Great deal of time spent in obtaining, using, and recovering from the drug
- Important social, occupational, or recreational activities are given/ reduced due to use
- Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

3. Addiction is a chronic, progressive, terminal disease. Substance use result in changes in the brain which maintain addictive behavior

4. Incidence of substance abuse among individuals with chronic mental illness is higher than that of the general population.

ECA Studies:

Lifetime Prevalence

	General Population	Dx. Of Schiz
Any SubstanceUse Disorder	16.7%	47.0%
Any Alcohol Disorder	13.5%	33.7%
Alcohol Dependence	7.9%	24.0%
Alcohol Abuse	5.6%	9.7%
Any Other Drug Disorder	6.1%	27.5%
Drug Dependence	3.5%	12.9%
Drug Abuse	2.6%	14.6%
Marijuana Depend/Abuse	4.3%	
Cocaine Depend/Abuse	0.2%	
Opiate Depend/Abuse	1.2%	
Amphetamine Depend/Abuse	1.7%	
Hallucinogen Depend/Abuse	0.3%	

5. Incidence of mental illness among individuals with a substance use disorder is greater than the general population

ECA Studies

Lifetime Prevalence	General Population	Alcohol Dx.	Drug Dx.
Any Mental Dx.	22.5%	36.6%	53.1%
Schizophrenia	0.7%	3.8%	6.8%
Any Affective	8.3%	13.4%	26.4%
Any Anxiety	14.6%	19.4%	28.3%

6. Reasons for use of substances by individuals with mental illness can include social, self medication, and addiction

Social:

- Means to behave like non-mentally ill peers
- Opportunities to be around others w/o high social demands
- Creates a sense of belonging to a social group

Self-Medication:

- Anxiety Reduction
- Improved ability to concentrate
- Improved energy level
- Increased sense of ability to function and well being
- Improved mood

Addiction:

- Physical and psychological dependence
- Altered brain function

7. Use of substance by individuals with chronic mental illness typically result in increases in symptoms of psychiatric disorders and reduced ability to function

8. Effective treatment involves simultaneous treatment of both the mental illness and substance use disorder

ALCOHOL AND DRUG

- WHAT TO LOOK FOR IN ASSESSING THE
- POTENTIAL FOR VIOLENT BEHAVIOR

- RISK FACTORS FOR HOMICIDE

- BLOOD ALCOHOL CONCENTRATION

- DEPRESSANTS
  - Alcohol
  - Opiates/Narcotics
  - Sedatives/Hypnotics/Anxiolytics

- ALCOHOL AND DRUG OVERVIEW

- INDICATORS OF DRUG USE

- OTHER DRUGS

- HALLUCINOGENS, PHENCYCLIDINE
- (PCP), AND RELATED SUBSTANCES

- INHALANTS

- DRUG PROBLEMS IN EMERGENCY
- ROOMS

ALCOHOL and DRUG (continued)

- RISK FACTORS FOR SUICIDE
- STIMULANTS
- SUBSTANCE ABUSE AND THE BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE.
- QUICK LIST OF SUBSTANCES AND THEIR SYMPTOMS

WHAT TO LOOK FOR IN ASSESSING THE POTENTIAL FOR VIOLENT BEHAVIOR

- A psychiatric diagnosis that includes violent or impulsive behavior among its criteria
- A previous history of violent behavior
- A history of substance abuse
- An injury to the head
- An injury to the central nervous system
- A previous history of physical abuse by others
- A previous history of suicidal behavior
- A previous history of delusions or hallucinations—particularly command hallucinations

Source: Lukas, S. (1993). Where to Start and What to Ask. New York: W. W. Norton & Co.

Risk Factors for Homicide

- Access to/ownership of guns
- Use of a weapon in prior abusive incidents
- Threats with weapon(s)
- Threats to kill
- Serious injury to victim(s) in prior abusive relationships
- Threats of suicide
- Drug or alcohol abuse
- History of forced sex with female partners
- Obsessiveness/extreme jealousy/extreme dominance

Blood Alcohol Concentration

Blood Alcohol Concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process

capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most states for drunkenness, which is 0.08 percent.

BAC can be measured by breath, blood, or urine vehicle tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury.

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are
impaired in most people long before they exhibit visible signs of drunkenness. While most states define legal intoxication for purposes of driving at a BAC of 0.08 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

The legal intoxication level in most states is 0.08 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.08 percent is reached.

Factors that will affect the BAC in a person:

- How much alcohol you drink.

- How fast you drink. The quicker you drink, the higher your peak BAC will be. The liver gets rid of alcohol at the average rate of one drink per hour (12 oz. beer, 5 oz. wine, 1 shot of distilled liquor). If a person drinks faster than this, the remainder will circulate in the blood stream until the liver can get rid of it.

- Body weight. Heavier people will be less affected by the same amount of alcohol than lighter people. They have more blood and water in their bodies in which to dilute the alcohol.

- Food in the stomach. When there is food in the stomach, alcohol is absorbed slower into the blood stream. The BAC rises more rapidly in those who drink on an empty stomach, because there is no food in which to dilute the alcohol.

- The type of alcohol you drink. The stronger a drink is (the higher the alcohol concentration, distilled alcohol first, wine second, beer third), the more quickly it is absorbed. This partially explains why hard liquor has more of an apparent " kick" than wine or beer.

- Type of mixer used. Water and fruit juices mixed with alcohol slow the absorption process, while carbonated beverages will speed it up. Carbon dioxide speeds the alcohol through the stomach and intestine into the bloodstream, creating a rapid rise in BAC.

- Temperature of the drink. Warm alcohol is absorbed quicker than cold alcohol.

- If you are male or female. Women reach higher BAC's faster because they have less water in their bodies and more adipose tissue (fat), which is not easily penetrated by alcohol. Therefore, a man and woman, with all other factors being equal, both drinking the same amount of alcohol will have different BAC levels. Hers will be higher. A woman's menstrual cycle will also affect her rate of absorption. They will experience their highest BAC's premenstrually. In addition, there is also evidence that a woman taking birth control pills, will absorb alcohol faster, resulting in higher BAC levels.

Depressants

Alcohol

- Most people do not think of alcohol as a drug

- Medical consequences usually show up after years of heavy drinking

- Has a profound effect on the chemistry of emotions

- Increases the hazards of other drugs when used in combination, to include: more severe side effects, more frequent adverse effects, and diminished effectiveness of the medication

- Remains in the body for four or more hours, depending on amount ingested

- Can result in respiratory depression, cardiac irregularities, coma. Using marijuana with alcohol inhibits vomiting and can increase the likelihood of overdose

- Other causes of serious injury or death can result from aspiration of vomitus, accidents from impaired judgment and coordination, fighting resulting from disinhibitory effects and increased aggressiveness, and suicide resulting from increased impulsivity/or depression.

- Medical complications include cirrhosis of the liver, brain damage and hypertension are common with high dose/long term use. Poor nutrition and self-care can be see with advanced alcoholism.

Appeal of the Drug:
- anxiety reduction
- social lubrication
- disinhibition

Specific Effects:
- rapid tolerance
- sedation
- impaired concentration
- impaired coordination
- rapidly fluctuating moods
- disinhibition

Signs of Use:
Slurred speech; uncoordinated movements; unsteady gait; nystagmus; flushed face; aggressive and/or disinhibited behavior; rapid mood shifts; impaired judgment and/or functioning.

Withdrawal Symptoms:
A hangover is the withdrawal syndrome from acute ingestion of alcohol. Nausea, vomiting, malaise, weakness, autonomic hyperactivity, anxiety, depression, irritability, transient hallucinations or illusions, headache, insomnia, and possible delirium may appear within 24 hours after use has stopped and last 3-10 days in the case of long-term alcohol dependence.

Withdrawal from alcohol can also include: convulsions; delirium tremens (DT's) and hallucinations. Withdrawal from alcohol can be medically dangerous and produce serious medical complications, and detoxification procedures must be monitored because abrupt withdrawal can be life-threatening. Withdrawal for the alcohol dependent person can last well beyond the time for which medical supervision is necessary. Symptoms can last for weeks or months.

Opiates /Narcotics

- Includes pain medications such as morphine, Demerol, Dilaudid, Darvon, Percodan, Vicodin, codeine, as well as heroin and methadone.
- It is theorized that many addicts and alcoholics have problems in their natural pain-regulating mechanisms that leave them vulnerable to addictive disease.
- Routes of administration can be oral, IV, intranasal, or through inhalation.
- Users are more likely to die from overdose than from withdrawal.

Appeal of the Drug:

- reduced sensitivity to pain
- "rush" of the initial effect (euphoria)
- tranquility
- reduced anxiety

Signs of Use:

- Pupillary constriction or dilation
- drowsiness
- slurred speech
- impairment in attention or memory behavior that suggests euphoria followed by apathy, dysphoria, psychomotor retardation, impaired judgment, or impaired functioning may also be signs of use

Specific Effects:

- rapid tolerance
- reduced sensitivity to pain
- sedation
- reduced anxiety
- excessive dryness (constipation
- sluggish muscle tone
- low blood pressure
- slowed pulse
- cough suppression
- shallow breathing
- slowed motor response
- inability to focus thoughts
- euphoria
- apathy

Sedatives/Hypnotics/Anxiolytics

Sedatives sedate or calm.

Hypnotics induce sleep.

Anxiolytics reduce ongoing anxiety.

The most commonly prescribed and abused are benzodiazepines. These include: Valium; Librium; Dalmane; Halcion; Ativan; Klonipin; and Xanax. The BZs are chosen for anxiety reduction and as sleep aids because they are safer and more effective than other sedatives. Overdose is virtually impossible if these drugs are not mixed with alcohol: however, withdrawal must be carefully monitored because abrupt withdrawal can be life threatening.

Signs of Use:
Slurred speech, uncoordinated movements, unsteady gait, impaired judgment.

Withdrawal Symptoms:
(Noted after prolonged use--usually 90 days at low doses.) Symptoms include anxiety, restlessness, dysphoria, and muscle twitches. Withdrawal from high doses can include severe anxiety, tremors, sweating, agitation, psychosis or seizure.

Alcohol and Drug Overview

The DSM-IV presents 12 classes of psychoactive substances that can cause organic impairment. These include:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opiods
- Phencyclidine & related substances
- Sedatives/Hypnotics/Anxiolytics
- Other/Unknown

1) Depressants

Alcohol, Opioids, Sedatives, Hypnotics, Anxiolytics

These psychoactive drugs have a primarily *sedative* effect and a strong potential to create dependence. The effects are experienced as reduction in tension, disinhibition, relief from anxiety, reduced stimulation, calmness or tranquility Their primary hazards include respiratory depression, coma, and death by injury due to accident.

2) Stimulants

Amphetamines, Cocaine, Caffeine, Nicotine

The primary effect of these drugs is *excitation* or *arousal.* They have a strong potential to create dependence because of the transient sense of pleasure and reward they provide. They are experienced as focused thought processes, euphoric mood and increased energy. Their primary hazards to life include: convulsive seizure, cardiac arrest or death by injury (due to wildly reckless driving, paranoia, agitation, aggression and/or psychotic behavior.

3) Other Drugs

Cannabis, Hallucinogens, Phencyclidine (PCP), Inhalants, Other/Unknown

These drugs cannot easily be grouped into a depressant or stimulant class as they have some characteristics of each. Hallucinogens and PCP are sometimes called *psychedelics*. They produce perceptual distortion in the form of sensory illusions or hallucinations and increased awareness of internal and external stimuli. Hallucinogens do not create physical dependence or high levels of physical toxicity, whereas this does not appear to be the case with PCP. These drugs may induce or contribute to *panic attacks*. They may cause death through *loss of reality testing* due to sensory distortion (e.g., not responding to pain, "flying" out a window). PCP can result in death due to overdose or to an accident caused by loss of motor control.

INDICATORS OF DRUG USE

- Neglect of significant personal concerns such as health, hygiene, personal appearance, housing needs or nutritional needs. Weight loss, poor appetite or obvious dental decay may be seen. Neglect is the result of drug seeking behavior and mental deterioration.
- Inexplicable sudden changes in personality, for example the sudden onset of aggression and/or paranoia.
- Acute changes in mental functioning, such as the onset of drowsiness, confusion or disorientation.
- Acute mood changes, including euphoria, depression or irritability.
- Recurring signs of drug withdrawal such as irritability, confusion, restlessness, tremor, sweating, cramps, and the complaint of 'aching bones.'
- Homelessness and itinerancy (frequent moving from place to place).
- Significant and repeated inconsistencies in statements to persons such as health care workers, and general lack of cooperation.
- The need to regularly take large amounts of benzodiazepine medication or other sedating medication.
- Attempts to manipulate health care workers with such talk as: "You know I need X and if I don't get X, I won't be able to control myself," etc.
- 'Track marks,' usually seen as longitudinal scars on the inside of the elbow areas, due to chronic intravenous drug use.

- Continued inability to provide identification.
- The complaint of insomnia, without obvious reason. Remember that marijuana abuse may be a possible cause of insomnia.
- 'Doctor shopping,' or the indiscriminate consultation of numerous doctors to obtain medication.
- Accusations of theft or confirmed involvement in crime to support a 'habit.'
- Denial of the problem may occur and should not be accepted if signs of drug use are present.

Other Drugs

Cannabis (Marijuana)

- Can be smoked in a pipe, rolled into cigarette paper or compressed into hashish or hashish oil.
- Comprised of about 400 chemicals, with the cannabinols (particularly delta-9 THC) and the cannabidiols creating the primary psychoactive effect.
- Potency is much higher than it was 10-20 years ago.
- Most of the marijuana in this country has a sedative effect and calms the user.
- Some users seek the dissociative effect of the drug—a feeling of distance from other people, which can make them feel safer in uncomfortable situations.
- The half-life of marijuana is eight days. It takes approximately two months to rid the body of all traces of the substance.
- Low doses result in impaired short-term memory.
- High doses result in: difficulty in concentration; difficulty managing emotions; amotivation; impaired ability to operate a car or other machinery; impaired job/school performance; distancing in relationships.

Appeal of the drug:

- dispels boredom
- narrows focus of concentration
- distorts time
- exaggerates the senses and emotions

- reduces anxiety
- dissociative effects

Specific Effects:
- decreases anxiety
- produces shifts in concentration
- produces a dissociative reaction
- alters perception of space and time
- alters judgment of speed and distance
- decreases motivation and concentration
- alters functioning of the hypothalamus and pituitary glands
- increases heart rate, decreases blood pressure
- lowers pressure within the eyes

Signs of Use:
Physical signs can include reddened eye, increased appetite, dry mouth, and rapid heart beat.

Withdrawal Symptoms:
Agitation, inability to concentrate, sleep problems, craving, decreased appetite, anxiety and discomfort around other people. Severity of symptoms depends upon the dose and length of use. For the average user, the symptoms are usually mild with a gradual onset because of the long-life of the drug. Users can rarely identify withdrawal symptoms due to marijuana because they often begin to occur several weeks after date of last use.

Hallucinogens, Phencyclidine (PCP), and Related Substance

- Primary effect involves changes in thought content, sensory perception and subjective emotional experience.

- Psychedelics cause intensified sensations, mixed-up sensations (synesthesia), illusions, delusions, hallucinations, stimulation, and impaired judgment and reasoning.

- The most commonly used psychedlics are: LSD, MDMA, PCP, peyote, and psilocybin mushrooms.

- PCP and Other Psychedelics: PCP, an animal tranquilizer causes mind-body distortions and a sensory deprived state.

- PCP has characteristics of depressants and stimulants.

- Easy and inexpensive to manufacture.

- Commonly mixed with other drugs and used as substitute for other chemicals without user's awareness.

- PCP is frequently found as adulterant for street drugs sold as LSD, Ecstasy, and/or THC.

- With repeated use the drug can be stored in the body for weeks or months beyond cessation of use.

- Higher doses can cause paralysis, loss of consciousness, amnesia, violence, and psychosis.

Appeal of the Drug:
- alters sensory input
- accentuates mood
- creates illusions
- synesthesia
- dissociative reaction
- loss of body and ego boundaries
- sense that mundane events aren't important
- sense of bonding and affiliation (ecstasy)

Specific Effects:
- tachycardia
- increased blood pressure
- increased body temperature
- pupil dilation
- visual illusions, perceptual changes
- emotional lability
- slowed time perception
- dissociative
- mild tolerance possible
-

Most Severe Hazards:
- panic reaction
- alters perception of time and space
- interferes with reflexes
- accidents common
- possible toxic psychosis
- drug-precipitated functional psychosis
- flashbacks

Signs of Use:

- Pupillary dilation; tachycardia; sweating; palpitations; blurred vision; tremors; uncoordinated movements
- Behaviors indicating marked depression or anxiety; ideas of reference; fear of "going crazy;" paranoid ideas; panic; impaired judgment and functioning
- Reports of perceptual changes: intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias, euphoria, mysticism or religiosity

Withdrawal Symptoms:
No physical dependence occurs with hallucinogens and no withdrawal syndrome has been documented, even after prolonged use of high doses.

Inhalants

- Includes volatile organic compounds such as: gasoline, glue, paint, cleaning agents, aerosol propellants, nitrous oxide (laughing gas) and amyl and butyl nitrate.

- Effects occur within 7-10 seconds and last no more than 30 minutes to one hour.

- Neurologic damage can include hearing and visual impairment, loss of coordination and memory, and learning disabilities. Mental impairment may be irreversible, though not usually progressive after abuse ceases.

- More users are preadolescents and young teens who do not have access to more "sophisticated" drugs, while others live in institutional settings or do not have enough money for other drugs.

- A common method of administration is to pour or spray the chemical onto a rag, place it over the nose and mouth, and inhale (huffing), or place in a plastic bag and inhale (bagging), or breathing in the inhalant directly from the container (sniffing).

Appeal of the drug:
- creates an intoxicated state
- effects are immediate and last from 5 to 45 minutes
- readily available through legal channels

Specific Effects (may vary depending on exact substance):
- mild intoxication
- possible hallucinations
- rapid onset of action
- create visual disturbances
- decrease appetite
- loss of memory

- unsteady gait

Most Severe Hazards:

- organ damage (including brain damage, liver damage, pancreatitis, kidney failure
- accidents, head trauma resulting from impaired judgment and coordination
- inflammation in joints, muscle weakness
- destroy red and white blood cells
- central nervous system depression or overstimulation
- cardiac arrhythmia (irregular heartbeat) and cardiac failure
- damage due to anoxia (lack of oxygen)

Signs of Use:

- rash around nose and mouth
- chemical breath, body odors
- residue
- red glassy watery eyes and dilated pupils
- slow, thick, slurred speech
- irritation of the throat/lungs/nose, nausea, headache
- dizziness
- nystagmus
- pains in chest and stomach
- fatigue
- staggering gait, disorientation, lack of coordination
- stupor
- euphoria
- belligerence
- assaultiveness
- impaired judgment and functioning

Reports of Drug Problems in Emergency Rooms (In many cases, more than one drug is found in incoming patients)	
DRUGS	**% of Patients Who Tested Positive**
1. Alcohol in combination with other drugs	32.6%
2. Cocaine	28.4%
3. Heroin/morphine, codeine, or other opioids	17.3%
4. Acetaminophen, aspirin, ibuprofen	13.9%
5. Benzodiazepines (Xanax, Valium, Ativan, Klonipin	10.4%
6. Antidepressants (Elavil, Prozac)	8.6%
7. Marijuana	8.6%
8. Methamphetamine/amphetamine	5.1%
9. Antihistamine	1.7%
10. OTC sleeping aids	1.3%

In some parts of the country, particularly San Francisco and on the West Coast, ER staff are seeing more and more Methamphetamine-Induced Psychosis.

Cocaine still causes the most deaths, although there has been an increase in deaths related to heroin overdose.

SUBSTANCE ABUSE AND BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE

Intoxication		Withdrawal States		Substance-Induced Paranoid Psychotic States	Substance-Induced Organic Brain Syndromes
High	Low	High	Low	High	High
Alcohol	Opiates	Alcohol	Opiates	Meth	Alcohol Withdrawal
PCP		Sedative		Cocaine	Sedative Withdrawal
Cocaine		Stimulants		PCP	PCP Intoxication
Meth					Inhalant Intoxication
Inhalants					Cocaine Intoxication
*LSD					Brain Injuries

Adapted from: Potter-Efron, R. & Potter-Efron, P. (eds.) 1990. Aggression, Family Violence and Chemical Dependency. New York: The Haworth Press.

Quick List - Substance Use Symptoms

SUBSTANCE	INTOXICATION SYMPTOMS	WITHDRAWAL SYMPTOMS
Depressants	slurred speech; incoordination; unsteady gait; impairment in attention or memory	nausea or vomiting; malaise or weakness; tachycardia; sweating; anxiety or irritability; hypotension; coarse tremor of hands, tongue, and eyelids; insomnia; grand mal seizures
Stimulants	euphoria; grandiosity; hypervigilance; fighting; pupillary dilation; elevated blood pressure; perspiration or chills; nausea or vomiting	severe depression; irritability; anxiety; fatigue; insomnia or hypersomnia; psychomotor agitation; intense craving for the substance
Opiates and Analgesics	initial euphoria followed by apathy, dysphoria, psychomotor retardation; impaired judgment; pupillary constriction; drowsiness; slurred speech; impaired attention or memory	cravings for opiates; all symptoms of severe influenza
Cannabinols (Marijuana)	euphoria; feeling of relaxation; sleepiness; heightened sexual arousal; anxiety; suspiciousness or paranoid ideation; sensation of slowed time; inappropriate laughter; social withdrawal; impaired judgment; bloodshot eyes; increased appetite ("junk" food); tachycardia; dry mouth	marked anxiety; emotional lability; depersonalization; possible persecutory delusions

Hallucinogens	illusions; hallucinations (visual) synesthesia; euphoria; mystical or religious experiences; pupillary dilation; tachycardia; sweating; palpitations; blurring of vision; tremors; incoordination; Bad Trip: anxiety and depression; ideas of reference; fear of losing one's mind; paranoid ideation	no apparent withdrawal symptoms; delusional disorder may develop; mood disorder may develop; post-hallucinogen perception disorder may develop ("flash back")
Solvents/Inhalants	euphoria; giddiness; light-headedness; slurred speech; lethargy; depressed reflexes; tremor; blurred vision; stupor or coma; belligerence; assaultiveness; apathy; impaired judgment; dizziness; nystagmus; eye irritation; irriation of throat, lungs, and nose	same as with the Depressants
PCP	belligerence; assaultiveness; impulsiveness; unpredictability; psychomotor agitation; vertical and horizontal nystagmus; increased blood pressure and heart rate; numbness or diminished responsiveness to pain; ataxia; muscle rigidity and seizures; bizarre and violent behavior; paranoid ideation	similar to Hallucinogens

adapted from: Fauman, M., (1994). Study Guide to DSM-IV. Washington D.C.: American Psychiatric Press, Inc.

NOTES

Childhood Disorders

Childhood Disorders

Psychiatric Disorders in Children and Adolescents

- About 20% of US children and adolescents (15 million), ages 9-17, have a diagnosable psychiatric disorders.
- As reported in the Surgeon General's Conference on Children's Mental Health in January, 2001:
  1 One in ten children and adolescents suffer some mental illness severe enough to cause some level of impairment.
  2 It is estimated that fewer than one in five of these children receive needed treatment in any given year.

I. Social background

A. Barriers to treatment

1. Limited governmental funding directed toward child and adolescent mental health services.
2. Limited treatment services/programs.
   - Less mental health treatment services for children than for adults.
     In Portland, the number of psychiatric inpatient beds for:
     Adults=193
     Children and adolescents=52
3. Increasing number of child and adolescent patients.
   - At CTC, number of patients seen under 18:
     In 1997 = 360
     In 2000 = 1,492
4. Increasing demand for mental health professionals.
   - Children and adolescent patients may wait 6–8 weeks or longer for an appointment with a child and adolescent psychiatrist

B. Stigma

Parents may be fearful they may be blamed for their child's emotional and behavioral problems. Children are sometimes teased or directly stigmatized by classmates.

II. Common Disorders

Four disorders (ADHD, Oppositional-Defect Disorder, Conduct Disorder and Autism) have onset and are usually first diagnosed in childhood or Adolescence.

A. Disruptive Behavior Disorders

1. Attention-Deficit/Hyperactivity Disorder

- A disorder where an inappropriate degree of hyperactivity-impulsivity and/or inattention is exhibited.
- Some of the following symptoms must be present before age 7.
- More frequent in males than females.

- Prevalence – 3-5% in school aged children.
- Most commonly diagnosed disorder in child/adolescent psychiatry.
- Symptoms

a. Inattention

1. Often fails to give close attention to details, makes careless mistakes in schoolwork, or other activities.
2. Often has difficulty sustaining attention in tasks or play activities.
3. Often doesn't seem to listen when spoken to directly.
4. Often doesn't follow through on instructions and fails to finish schoolwork or chores.
5. Often has difficulty organizing tasks and activities.
6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork, homework).
7. Often loses things necessary for tasks and activities (e.g., toys, school assignments, pencils, books).
8. Is often easily distracted by extraneous stimuli.
9. Is often forgetful in daily activities.

b. Hyperactivity:

1. Fidgets with hands, squirms in seat.
2. Often leaves seat (in classroom).
3. Often runs about, climbs excessively in situations in which it is inappropriate (In adolescents may be limited to feelings of restlessness).
4. Often has difficulty playing or engaging in leisure activities quietly.
5. Is often "on the go" or acts as if "driven by a motor".
6. Often talks excessively.

c. Impulsivity:

7. Often blurts out answers before questions have been completed.
8. Often has difficulty awaiting turn.
9. Often interrupts or intrudes upon others (e.g., butts into conversations or games).

- Associated disorders or symptoms

Learning disorders.
Oppositional Defiant Disorder-tantrums, bossiness, stubbornness, poor patience.
Conduct Disorder-aggression.
Mood disorders-poor self esteem, depression, rejection by peers, and conflict with family.

2. **Oppositional-Defiant Disorder**
   - A disorder where children or adolescents display a pattern of openly uncooperative and negative, disobedient and hostile behavior.
   - More prevalent in males than females before puberty; rates equal after puberty.
   - Usually evident before age 8.
   - Symptoms
     1. Often loses temper.
     2. Often argues with adults.
     3. Often actively defies or refuse to comply with adult's request or rules.
     4. Often deliberately annoys people.
     5. Often blames others for his/her mistakes or misbehavior.
     6. Is often touchy or easily annoyed by others.
     7. Is often angry or resentful.
     8. Is often spiteful or vindictive.
   - Associated disorders or symptoms

     ADHD is common.

     Oppositional-defiant disorder can (but does not always) precede conduct disorder.

     Depression – low self-esteem.

     Substance abuse.

3. **Conduct Disorder**
   - A disorder in which there is a repetitive and persistent pattern of the violation of the basic rights of others OR major age appropriate roles.
   - More common in males than females.
   - May begin in childhood or adolescence.
   - Symptoms

     a. Aggression to people and animals
        1. Often bullies, threatens, intimidates others.
        2. Often initiates physical fights.
        3. Has used a weapon (e.g. bat, brick, broken bottle, knife, gun) that can cause serious physical harm.
        4. Has been physically cruel to people.
        5. Has been physical cruel to animals.
        6. Has stolen while confronting a victim (mugging, purse-snatching, extortion, bank robbery).
        7. Has forced someone into sexual activity.

b. Destruction of property
   8. Has deliberately engaged in fire setting with intention of causing serious damage.
   9. Has deliberately destroyed others' property.

c. Deceitfulness or theft
   10. Has broken into someone else's house, building, car.
   11. Often lies to obtain goods/favors or avoid obligations.
   12. Has stolen items of nontrivial value without confrontation of a victim (e.g. shoplifting, forgery).

d. Serious violation of rules
   13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
   14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
   15. Often truant from school, beginning before age 13 years.

- Associated disorders or symptoms
  ADHD.
  ODD (may precede CD) –temper outbursts, poor frustration tolerance.
  Depression – low self-esteem, irritability.
  Substance abuse.

- **Police response to children and adolescents with a disruptive behavior disorder (ADHD, ODD, CD)**
  a. Usually police come into contact with these children or adolescents because of their anger outbursts or physical and/or verbal threats of harm.
  b. They may be argumentative or minimize problem behaviors.
  c. Direct questioning with authoritative approach.
  d. Obtain and carefully consider information provided by adult witnesses.
  e. Inquire whether the child is in current mental health treatment and (if applicable) taking medications.

B. Autistic Disorder (to be covered in Developmental Disability section)

- A disorder characterized by patterns of delay and impairment in the development of social interaction and communication and the development of restricted interests and activities.
- Onset is prior to age 3 years.
- 3 to 4 times more common in males.
- Coexistent disorders or symptoms
  Mental retardation 20% have normal IQ.
  30% have mild to moderate mental retardation.
  50% have severe or profound mental retardation.

ADHD – disruptive, impulsive.
Self-injury (e.g., head banging).
Obsessive – compulsive disorder – compulsive, repetitive behaviors.

- **Police response to children and adolescents with Autistic Disorders.**
  a. Usually police come into contact with these children because of self-injury, impulsive behaviors or anger outbursts.
  b. These children are unlikely to make eye contact or communicate/answer any questions.
  c. Obtain as much information from adult witnesses, parents or guardian.
  d. These children do not do well with change. If they have an attachment to an object, consider letting them hold on to it.

C. Anxiety Disorders

- The most common mental health problem that occurs in children and adolescents.
- According to one large-scale study of 9-17 year olds, as many as 13% had an anxiety disorder in a year.
- Common anxiety disorders

1. Phobias

- Excessive or unreasonable marked and persistent fear of a specific object or situation or fear of a social or performance situation where the person is exposed to scrutiny and fears embarrassment.
- Exposure to that object or situation causes an immediate anxiety response. In children, anxiety may be expressed by crying, tantruming, freezing or clinging.
- In children, most common fears-fear of dark, fear of harm to an attachment figure; fear of animals.
- In adolescents – fear of heights, fear of public speaking.

2. Generalized Anxiety Disorder

- A disorder characterized by excessive anxiety and worry, where the individual finds it difficult to control the worry.
- Most common in middle childhood.
- Symptoms (only one required for children): Restlessness or feeling keyed up or on edge, being easily fatigued; difficulty concentrating or mind going blank, irritability, muscle tension, or sleep disturbance.

3. Panic Disorder

- A disorder characterized by recurrent, unexpected panic attacks.
- Panic attacks are discrete periods of intense fear or discomfort in which symptoms develop abruptly and reach a peak within 10 minutes.

- Symptoms include palpitations, sweating, trembling, shortness or breath, feeling of choking, chest pain, nausea, dizziness, derealization or depersonalization, fear of losing control or fear of dying.
- Uncommon before puberty.
- Usually begins in adolescence or early adulthood.

4. **Obsessive-Compulsive Disorder**
   - A disorder characterized by recurrent obsessions or compulsions that cause distress, are time consuming, or interfere with individual's functioning.
   - Majority of children and adolescents have both obsessions and compulsions.
   - Mean age of onset = 10 years.
   - Obsessions: Recurrent or persistent thoughts, impulses or images that are experienced as intensive and inappropriate, cause marked anxiety or distress and are not simply excessive worries about real-life problems.
   - Compulsions: Repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession. The behaviors or mental acts are aimed at preventing or reducing distress.
   - Most common symptoms of OCD in childhood are obsessive contamination fears accompanied by compulsive washing and avoidance of contaminated objects.
5. **Post-traumatic Stress Disorders.** (will be covered in PTSD section)
   - Disorder where child/adolescent has been exposed to a traumatic event, where they experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury or threat of physical harm to self or others. The individual's response involved intense fear, helplessness or horror (in children this may be expressed by disorganized or agitated behaviors).
   - Symptoms

     Re-experiencing – In children, nightmares or repetitive play or drawings in which themes or aspects of trauma are expressed.
     Avoidance-of reminders of the event and numbing of general Responsiveness.
     Increased arousal – difficulty sleeping is common in children.

   - In general, girls are more symptomatic than boys.
   - Common traumatic events- Domestic violence, natural disaster, shootings.
   - Younger children have more avoidant symptoms; older children have more re-experiencing and increased arousal.

- **Police response to children or adolescents with anxiety disorders**
  a. Usually police come into contact with these children because of "out-of-control behavior" related to intense anxiety.
  b. Be reassuring, speak slowly and calmly.
  c. Give the child time to relax.
  d. Most of these children want relief and will accept help.
  e. Allow them to be in the company of someone familiar as you are questioning them.
  f. Suicide risk is increased with anxiety.

D. Mood Disorders

1. **Bipolar Disorder** – (covered in Overview of Mental Illness)
   - Mood disorder where there is or has been a manic episode.
   - In children and adolescents, irritability more common than euphoria
   - Most common symptoms
     High activity level; rapid speech; highly distractible; racing thoughts; hypersexuality (in children-profanity, sexual comments, masturbation; in adolescents-increased sexual activity); and risk taking (in children, fighting; in adolescents, wild driving).
   - First episode may be mania or depression.
   - 20-30% of youth with major depression go on to have manic episodes.
2. **Major Depression** (covered in Overview of Mental Illness)
   - Mood disorder characterized by depression or irritability (irritability is more common).
   - Common symptoms in children
     Anxiety – phobias.
     Somatic complaints – headaches and/or stomachaches.
     Behavioral problems- temper tantrums.
     Sleep/appetite disturbance.
     Suicidal thoughts or attempts.

- **Police response to children and adolescents with mood disorders**
  a. Usually police will come in contact with these children/adolescents because of dangerous behaviors to self/others.
  b. The manic child/adolescent may be speaking rapidly or make no sense.
  c. The depressed child/adolescent may be irritable, tearful or speak little.

d. Risk for suicide in both disorders. (In mania, may be more in form of self-endangering behaviors).
e. Consider strongly information provided by witness even if child/adolescent denying further suicidal thoughts.
f. Inquire whether child/adolescent is in current mental health treatment or on medication.

E. Schizophrenia (covered in Overview of Mental Illness)

- Disorder characterized by psychotic symptoms (hallucinations, delusions, illogical thinking).
- Onset most typically in the adolescent.
- Onset in childhood extremely uncommon and has relatively poor outcome.
- In childhood, auditory hallucinations may include command hallucinations or commenting about the child. May have to do with monsters. Magical thinking is common.
- Childhood schizophrenia occurs predominantly in males.

- **Police response to child/adolescent with schizophrenia**:
  a. Usually will come in contact with these adolescents because of odd or agitated behavior.
  b. These children/adolescents may be paranoid of the police.
  c. Reassure them you want to help, you do not want them harmed and will do all you can to keep them safe.
  d. They may become combative.
  e. They may be talking to themselves. Don't challenge nor accept their delusions, just listen matter-of-factly.

B. Legal Issues

1. Consent to psychiatric or chemical dependency treatment.
   In Oregon a minor 14 years or older may consent for their own mental health, alcohol or drug treatment, excluding methadone. Parent/guardian can be advised of treatment when disclosure is clinically appropriate and serves the best interest of the minor.
2. Drug Testing
   A child under 14 can be tested without their knowledge or consent.
3. Parental rights
   An order of sole custody of a child to one parent does not deprive the non-custodial parent of authorizing medical treatment for their child. Only terminated parental rights by a court order denies the parent of the ability to authorize treatment for their child.

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
    - I won't be here.
    - You won't have to deal with me.
    - You'd be better off without me.
    - Life is meaningless.
    - Death is probably a solution to my problems.
    - Would you miss me if something happened to me?
    - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
    - reckless driving, skating, bike-riding, swimming alone
    - drug-experimentation
    - sexual promiscuity
    - fighting, baiting others towards physical confrontation
    - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

NOTES

CHILD AND ADOLESCENT ASSESSMENT AND INTERVENTION

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NOTES

Autism

Autism & Law Enforcement Roll Call Briefing Handout, (Debbaudt, 2005)

NOTE: This handout supplements information contained in the Autism & Law Enforcement Roll Call Briefing Video.

The video and handout were designed to bring you a basic understanding of children and adults who have Autism and Aspergers Syndrome when you meet them in field situations.

Patrol in the 21st century is very diverse duty. People with autism are part of that diversity. Autism is America's fastest growing developmental disability. The rate of autism has seen a ten-fold increase. Autism is estimated to affect as many as one in every 166 children (CDC-NCBDDD, 2004).

Research indicates that people, who have developmental disabilities, including autism, will have up to seven times more contacts with police than a member of the general public. (Curry et al, 1993)

Definition:

Autism is a neurologically based developmental disability that seriously affects a person's ability to communicate, socialize, and make judgments. Autism also affects the person's sensory responses to even normal levels of lights, sounds, touches, odors, and tastes. It is typically observed by age three, and is more common in males than females. It is not caused by the way parents raise their children. Despite ongoing research, there is no known cause or cure, although people with autism can make remarkable gains.

Autism is referred to as a spectrum disorder. It affects each person differently and ranges from mild to severe. Other terms for autism may include: Asperger Syndrome, High Functioning Autism or Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). Parents and professionals have learned through experience and education how to recognize the common traits of autism. No one expects a responding officer to be able to diagnose autism, but here are some diagnostic behaviors and characteristics you may observe:

- Autism may or may not be physically obvious; there may be no particular physical marker
- Be non-verbal or have limited speech
- Avoid eye contact
- Prefer to be alone
- Lack fear of real danger
- Apparent insensitivity or high tolerance for pain
- Have difficulty in expressing needs; does not use gestures
- Unusual responses to lights, sounds, or other sensory input
- Seek sensory stimulation, including heavy pressure
- Have difficulty interacting with others
- Avoidance of touch
- Sustained unusual repetitive actions
- Inappropriate laughing or giggling
- Inappropriate attachment to objects

- Spin or twirl objects and exhibit finger, arm, or wrist flicking
- If verbal, may have trouble with correct speech volume (i.e., loud to whisper, and/or monotone, computer-like vocal intonation)
- Appear as if deaf, cover their ears and look away
- Display clumsiness, toe-walk or have difficulty running
- Rock back and forth
- Talk to themselves or no one in particular
- Echo words and phrases
- Display fascination with water, lights, reflections and shiny objects

Wandering and Autism

As with the Alzheimer's patient, children and adults with autism may wander away from caregivers.

Missing Persons

Child or adult has wandered away from parent or caregiver at home or school:

- The person may also wander into traffic or attempt to enter nearby homes or dwellings
- Search nearby water sources
- Encourage families to provide key information to the 911 database
- Recommend a good locksmith, burglar alarm company, or electronic alert system

Other Common Reasons for Autism Related Contacts or 911 Calls

Parent or caregiver actions are misinterpreted or appear as assault. Person displays unusual behavior in community setting where they are not known. These behaviors may be interpreted by others as suspicious, threatening, criminal in nature, or as someone high on drugs or other substances. Unaware of the person's autism, citizens will call 911. Rearranging or making order out of store displays or products may appear as shoplifting. The person may display escalated behavior in the community, at school, or at home. Escalated behavior may be in the form of rocking, pacing, grunting, noisemaking, utterances, running into walls, head banging or hiding under mattresses or other large objects. These behaviors may be a form of self-stimulation or a sensory reaction to objects and influences in the environment.

Communication, Behavior, and Responding to the Call

The behaviors that children and adults with autism display will challenge your training and instincts. Behaviors, as seen in the video, draw attention, may seem suspicious, and will result in increased 911 calls.

Understand that the individual with autism:

- May inappropriately approach or run towards officers
- In emergencies, may flail against medical procedures; may attempt to re-enter dangerous environment (i.e., a burning home, flee into traffic, or touch a downed power line)
- May be non-verbal. About 50% of this population is non-verbal
- Can become upset with changes in routine for apparently trivial reasons
- May not recognize your uniform or marked vehicle, or understand what is expected of them if they do
- May not understand your verbal commands or use of slang expressions
- May not understand your command presence, body language and non-verbal communications, such as rolling of eyes, raising of eyebrows, shrugs, or hand signals
- People with autism may be attracted to shiny objects and actually reach for your badge, radio, keys, belt buckle, or weapon
- May display repetitive, self-stimulation behaviors, such as twirling an object or themselves, finger or hand flicking, body rocking, pacing, or talking to themselves
- Sensory overload may cause flight from lights, sirens, canine partners, aromas or even a light, comforting touch
- Be aware that your attempts to stop these behaviors may result with the person's escalated, self-protective actions, such as a "fight or flight" reaction

Response

You may learn the person has autism from your dispatcher, someone at the scene, or the person himself or herself. Here are some tips for responding officers:

- Make sure the person is unarmed and maintain a safe distance because they may suddenly invade your personal space
- Talk calmly and softly
- Speak in direct, short phrases such as: "Stand up now." or "Go to the car."
- Avoid figurative expressions, such as: "What's up your sleeve?" or "Are you pulling my leg?"
- Allow for delayed responses to your questions or commands
- Repeat and/or rephrase
- Consider use of pictures, written phrases and commands, and sign language
- Use low gestures for attention; avoid rapid pointing or waving
- Examine for presence of medical alert jewelry or tags, or an autism handout card
- Model calming body language (such as slow breathing and keeping hands low)
- Model the behavior you want the person to display

De-escalation

You may be called to respond to a situation where the person with autism is displaying escalated behavior that has alarmed a citizen or is apparently beyond the control of the parent or caregiver.These calls will challenge the training and instincts of even the most experienced veteran.

Consider:

•A person may not react well to changes in routine or the presence of uniformed strangers
• Person may display "fight or flight" reaction when approached
• Officers should not interpret the person's failure to respond to orders or questions as a lack of cooperation or a reason for increased force
• Seek information and assistance from parent or others at the scene about how to communicate with and de-escalate the persons behavior
• Avoid stopping repetitive behaviors unless there is risk of injury to yourself or others. If the individual is holding and appears to be fascinated with an inanimate object, consider allowing subject to hold the item for the calming effect (if officer safety is not jeopardized by doing so)
• Be aware of person's self-protective responses and sensitivities to even usual lights, sounds, touches, orders, and animals
• If possible, turn off sirens and flashing lights and remove canine partners, crowds, or other sensory stimulation from the scene
• Evaluate for injury: the person may not ask for help or show any indications of pain, even though injury seems apparent
• Examine for presence of medical alert jewelry or tag
• Be aware that the person may be having a seizure
• If the person's behavior escalates, use geographic containment and maintain a safe distance until any inappropriate behaviors lessen
• Remain alert to the possibility of outbursts or impulsive acts
• Use your discretion. If you have determined that the person is unarmed and have established geographic containment, use the available time to allow the person to de-escalate themselves without your intervention
• Use of pepper spray may heighten sensory reaction and escalated behavior

Restraint

Despite your best efforts, you may have to restrain the person with autism and take them into custody. You may be responding to a public safety emergency, or a criminal justice situation. These are the highest risk situations for officers.

Be aware of the following when using standard force or restraint techniques:

• People with autism may have under-developed trunk muscles-hypotonia-and may not be able to support their airway
• After takedown, avoid positional asphyxia. Turn person on their side often to allow normal breathing to occur
• Monitor the person's condition frequently to prevent further trauma or injury
• People with autism may have seizures. Up to 40% of this population has some form of seizure disorder
• Asthma and heart conditions are also common. Be aware of associated medical conditions and medication requirements
• The person may not recognize the futility of resistance and continue to struggle. Continue to use communication, de-escalation, and calming response techniques
• For officer safety, avoid standing too near or behind. The person may suddenly lurch backward

Arrest

You may have a person with autism in custody that you have arrested or will be committed involuntarily to a mental health facility.
Document autism in your initial report.
Consider a medical evaluation.

Alert jail authorities and suggest an isolation facility. A person with autism would be at extreme risk in the general prison population.

Whenever possible, contact parents or caregivers.

Interview

The person with autism will have difficulty processing your questions. They may be unable to give name, address, phone number, or be unable to present ID when asked. Expect your interview to take longer. The person may have the information you need. However, they may be difficult to understand.

It is common for people with autism to repeat your words and phrases. This is known as *echolalia*. Be aware that a person with autism may also model your body language and emotional state.

Here are some tips for interviewing a person with autism:

• Do not take a lack of eye contact, the changing of subjects, or answers that are vague, evasive or blunt as evidence of guilty knowledge
• The person may truly not understand Miranda warnings even when they say they do

• To avoid confusion, ask questions that rely on narrative responses
• Consider asking a series of unrelated "yes" or "no" questions to determine the style and dependability of the response
• If you have learned that the person has autism or Asperger Syndrome, prior to questioning, consider contacting a specialist familiar with these conditions

With their unusual responses to your questions, the person with autism may challenge all of your training. Follow procedure, but also follow your gut instincts if you feel something isn't quite right with the subject of your investigation. As in the old adage: if the statement or confession is "too good to be true," it probably is.

Victims

People with autism are oftentimes victims of crime, such as: sexual, verbal or physical assault. This can occur anywhere. Investigators can overcome the communication barriers of interviewing the person with autism when they become familiar with the person's communication style and background. Review fresh records and interview others who know the person well. Ask parents, caregivers, and people who know the victim for tips about how the person gives and receives information. If not verbal, how do they communicate?

Further:

• Seek permission to and consider videotaping the interview
• Consider having a person the victim trusts present at the interview
• Avoid uniforms or authority clothing
• Get to know the person's communication style through casual conversation before any attempt to get recollection of event
• Plan questioning based on person's ability level
• Develop good rapport; use person's first name
• Use simple, direct language and deal with one issue at a time
• Get the witness to recreate the context in his or her own words-ask questions that require a narrative answer
• Make sure your words and their words have meanings that you both understand to be the same
• Make sure that you and the victim-witness understand who is being referred to when using pronouns
• Be alert to non-verbal cues that suggest the witness does not understand, is confused, or does not agree with the question you asked or the statements you have made (i.e., restlessness, frowning, and extremely long pauses)
• The victim may not want to answer questions more than once (explain first that you may have to ask questions more than once)
• Let victim know it is OK to say "no" to your questions

- Become convinced the person understands or is known to tell the truth
- Avoid leading questions
- Carefully establish timelines
- Learn person's schedule and determine events through this context, rather than asking, "What time did it happen?"
- Person may have short attention span. Consider several short interviews
- Be alert to a spontaneous disclosure of evidence. (Farrar, 1996)

Community Policing Options:

For officer safety and to reduce liability, create opportunities to meet people who have autism, their families, and support organizations.

911 data base red flag alert programs can provide key information for a safe, successful resolution to a contact with an individual with autism. Consider proactively offering the 911 database as an option to parents and care providers

Seek opportunities to visit schools, work and recreation facilities, and the homes where people with autism live. Invite people with autism, their families, advocates, and supporters to visit your stations and participate in law enforcement events. This can enhance officer education in the areas of recognition and response to the vulnerable person who has autism and enhance citizen education of the roles and responsibilities of law enforcement professionals. Officers and persons with autism can learn from each other during these controlled, safe, and non-stressful interactions

Applying skills, tolerance, and public relations when interacting with children and adults who have autism, their families, care providers, and supporters are the best approaches to ensure officer and citizen safety, make the best use of your valuable time and resources, and avoid litigation.

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Farrar, P. (1996) Preparing for the Interview. In L. Hutchinson MacLean (ed) Admissible in Court: Interviewing Witnesses Who Live With Disabilities. Lethridge, Alberta, Canada: Hutchinson MacLean Productions.

For referral to a local autism advocacy organization, E-mail ddpi@flash.net
For video inquiries and further information, contact:
Dennis Debbaudt at 772-398-9756 (son with autism may answer phone)

Person-Specific Checklist for 911 Systems, First-Responders,and Emergency Room Staff

Name of child or adult

Current photograph and physical description including height, weight, eye and hair color, any scars or other identifying marks

Names, home, cell and pager phone numbers and addresses of parents or caregivers and emergency contact persons

Sensory, medical, or dietary issues, if any

Inclination for elopement and any atypical behaviors or characteristics that may attract attention

Favorite attractions and locations where person may be found

Likes, dislikes--approach and de-escalation techniques

Method of communication, if non-verbal - sign language, picture boards, written word

ID wear - jewelry, tags, on clothes, nonpermanent tattoo

Map and address guide to nearby properties with water sources and dangerous locations highlighted

Blueprint or drawing of home, with bedrooms of individual highlighted
(From *Autism, Advocates and Law Enforcement Professionals*, Dennis Debbaudt, 2003)

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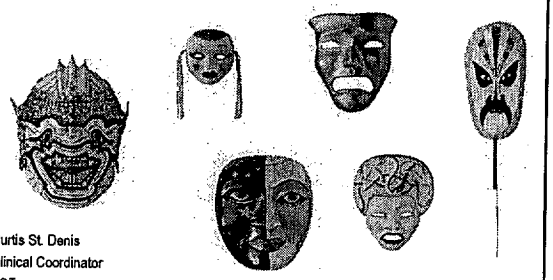
Personality Disorders

PERSONALITY DISORDERS

Personality Disorders:

Diagnosis, Profiling and Relation to Crime



Curtis St. Denis
Clinical Coordinator
SST

1

Training Overview

- A review of how people a personality disorder is diagnosed
- A review of significant personality disorders likely to be encountered by people working in criminal justice
- The relationship of personality disorders to crime

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DSM-IV Five Axis System

- Axis I: Clinical Disorders (mental health = meds)
- Axis II: Personality Disorders & MR/DD (= no meds)
- Axis III: General Medical Conditions
- Axis IV: Psychosocial/ Environmental Problems
- Axis V: Global Assessment of Functioning 0-100

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Facts About Personality Disorders

- Person has a lifestyle that differs significantly from that of the general population.
- The diagnosis is meant to tell us "how bad" things are and act as a guide for interventions.
- The main weakness is that they do not discriminate within the diagnosis (e.g. chronic petty thief and serial killer get same diagnosis)

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What is a personality disorder?

How It Is Diagnosed

- Onset in adolescence/ early adulthood
- Pervasive, Rigid and Inflexible
  - Social, Work, Relationships, Life Skills
- Stable over time
- Leads to distress or impairment:
  Thinking/perception, feeling, impulse control, behavior

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Facts About Personality Disorders

- Different personality disorders share similar traits:
  - Egotism ; e.g. blame others for their problems
  - Impulsivity
  - Poor interpersonal relationships
  - Risk for violence
  - Poor Insight and problems self-correcting
- All personality disorders have distinguishing features:
  - E.G. the dramatic attention-seeking of Histrionic PD

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Facts About Personality Disorders

- A person can have *more than one* personality disorder (e.g. Antisocial and Narcissistic)
- A person can have *traits* of more than one PD
  (e.g. PDNOS: Personality Disorder Not Otherwise Specified, with...)
- A person can have traits or features without the full personality disorder diagnosis
  (e.g. "Borderline Personality Organized" or "Antisocial Traits")

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Multiple Diagnosis

- The Possibilities Are Endless!:
  - Emotional Disorders (e.g. depression) AND
  - Mental Illness (e.g. schizophrenia) AND
  - Personality Disorders (e.g. Antisocial PD) AND
  - Substance Dependence (e.g. methamphetamine)
- In general, the more diagnoses the person has, the worse the prognosis and the more bizarre the behavior (e.g. fire-setting for sexual pleasure).

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DSM-IV Personality Disorder Clusters

- Cluster A: Mature or "Odd" Type
- Cluster B: Immature Type
- Cluster C: Anxious Type

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DSM-IV PERSONALITY DISORDERS

Cluster A: Mature Type

SOME CORRELATION WITH CRIMINAL BEHAVIOR

Paranoid

Schizoid

Schizotypal

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DSM-IV PERSONALITY DISORDERS (cont.)

Cluster B: Immature Type

THE HIGHEST CORRELATION WITH CRIMINAL BEHAVIOR

Antisocial

Narcissistic

Borderline

Histrionic

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DSM-IV PERSONALITY DISORDER (Cont.)

Cluster C: "Anxious or fearful"

THE LOWEST CORRELATION WITH CRIMINAL BEHAVIOR

Avoidant

Dependant

Obsessive-Compulsive

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How Can You Tell?
Signs of a Personality Disorder

- Perpetual and repetitive conflicts/ confusion in relating to others
- Deceitfulness/ manipulation in relating to you
- Feel confused/ crazy when you are around them
- Consistent feelings of annoyance/ irritation
- People generally insult them when referring to them (e.g. "asshole, jerk, idiot, creep, bitch.")

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PRACTICAL APPLICATION:
Where would you get the info?

- Psych reports, chronos, a review of their criminal history and crimes
- PPB keeps seeing the same person over and over
- Primary symptoms during a face to face interaction:
  - What they say (content and themes)
  - How they say it (emotions or lack thereof)
  - Emotional response to their crimes (justify? remorse? pride?)
  - Crime scene itself/ Behaviors (e.g. overkill)

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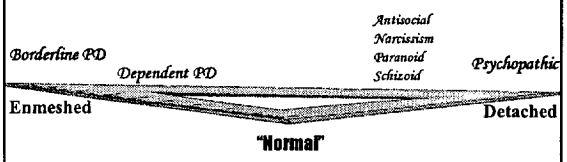
Attachment: "Normal" & Pathological



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PRACTICAL APPLICATION: Why Attachment Matters...

- Degree of attachment tells you:
  - What to expect from the person
  - What risk they pose to you as an officer
  - How to approach the person
  - How to verbally "disarm" the person
  - How to interact when interviewing/ interrogating

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Signs of Detachment: *TAKING*

- Exploitation of others (e.g. pimping, living off, assaults, stealing from loved ones)
- Lack of negative emotions when separating
- Multiple & severe violent acts in love relationships
- Lack of remorse/ guilt for harmful behavior
- Cannot describe social emotions (love)

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Signs of Over-Attachment: *TAKEN CARE OF*

- Crisis when separated from the person they "care" about ("can't live without them")
- Overly intense relationships
- Fear of abandonment and pathological jealousy
- Use of power and control tactics in an effort to keep the person

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Practical Application for Law Enforcement

- PD's tell us something about what type of crimes they are likely to commit
- Crime scenes/ criminal history and types of crimes tell us something about a person's PD
- Interviews/ Interactions can be structured or altered to optimize information gathering from a specific PD

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PRACTICAL APPLICATION: Risk for Related to Violence

- Impulsivity
- Low frustration tolerance
- Reactive to criticism (unstable narcissism)
- Repetitive antisocial acts
- Egocentricity & entitlement
- Poor attachments/ dehumanizing others
- Poor insight/ glibness
- Suspiciousness about motives of others

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The Personality Disorders

Significant PD's and their relation to crime

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CLUSTER A

Suspicious, Odd & Eccentric

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Paranoid PD

- Diagnosis: Must have 4 or more of the following:
  - Suspicious without sufficient basis
  - Preoccupied with unjustified doubts about friends, family.
  - Reluctant to confide in others b/c of unwarranted fear
  - Reads hidden demeaning/threatening messages into benign remarks
  - Persistently bears grudges
  - Perceives attacks on his/her character
  - Recurrent suspicions of infidelity by spouse

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Paranoid Personality Disorder

- Main Trait: Suspiciousness, Mistrust
- View of World: Dangerous
- View of Self: Mistreated
- View of Others: Malevolent
- Deal with World by: Secretiveness
- Attitudes: "You can't trust anyone." I must protect myself."
- E.G.: Columbine shooters, spree killers, Sipowitz in NYPD blue

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Paranoid Personality Disorder

➲ *Differs from schizophrenia/delusional thought through bizarre content of thought:*

PD: "I don't talk about personal information to anyone because the federal government could use it to charge me for crimes I didn't commit."

Delusional: "Democracy is the road to Socialism, and Socialism is Communism in a hurry...I'm against democracy – I'm a republican."

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Paranoid PD Crimes & Interviewing

➲ Violent crimes, including pre-emptive strikes and reactive violence.

➲ Motive: To reduce or eliminate the perceived threat; revenge; fear-anger often present.

➲ Approach: honest and direct; unemotional; disarm and give space; "give the rope;" expect resistance

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Giving the Rope

➲ HIM: "I'm going to sue you...you should have legal present with you right now."

➲ ME: "Well I don't, so why don't you talk about what you want to."

➲ HIM: "...You are my enemy (i.e. work for the county). We are in a war of attrition...You are the son of Satan in my eyes."

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Avoidant & Schizoid PD

- Difference is: Avoidant people want relationships but are afraid, Schizoids do not want relationships and have shallow emotional responses.
- Loners: they avoid contact with other people, often mistaken as being depressed or traumatized
- Significant signs of Schizoid:
  - Have very secretive lives
  - Poor relationship skills
  - Explosive, "temper tantrums"

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SCHIZOID PD

- Must have four of the seven:
  - Neither desires nor enjoys close relationships
  - Always chooses solitary activities
  - Little interest in sex
  - Little pleasure in activities
  - Lacks close friends or confidants
  - Indifferent to praise/ criticism
  - Emotionally cold, detached, flat

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Schizoid

- Main Trait: Indifference toward others
- View of World: Uninteresting
- View of Themselves: Self-sufficient
- View of Others: Impersonal/ Blank/ Cold
- Deal with World through: Solitude
- Attitudes: "No big deal," "Who Cares"
- E.G.: The Unabomber, Panty Thief

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Schizoid

"I don't go looking for relationships...I don't need the drama and the bullshit...I've got enough of my own bullshit to deal with."

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Avoidant

"I've never been very good at relationships...I always seem to fuck them up."

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Schizoid PD Crimes

- Crimes: Reactive violence when people intrude; Exploitive and sadistic crimes
- Approach: direct and unemotional; a difficult interview because they usually adhere to secretive, withholding and guarded style; may try to use "shock" to get you to back off.

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Schizotypal PD

- Must have 5 of the 6:
  - Magical Thinking that borders on delusional
  - Person is reality based (e.g. knows date, time, place, etc.)
  - Unusual perceptual experiences, illusions, odd speech
  - Lack of close friends, except other eccentrics
  - Odd, eccentric, peculiar
  - Excessive social anxiety, paranoia, does not fit in

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Schizotypal

- Main Trait: Eccentric
- View of the World: Fascinating
- View of Themselves: Gifted, Insightful, Perceptive
- View of Others: Ordinary
- Deal with the World by: eccentric, grandiose ideas or plans
- E.G.: James Huberty, Kramer (Seinfeld), Phoebe (friends), Andy Kaufman

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Schizotypal

"I believe that we were placed here on this planet by aliens...it says so in the bible...THINE kingdom come, THINE will be done...and I believe they will come back to this planet and save us...No, I have never had communications with aliens."

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Schizotypal PD Crimes

- Crimes: may seem like a motiveless, but it is usually a vendetta/resentments against society/ victims because of sense of isolation/ feeling like they don't fit in (i.e. blames others for this)
- Approach: Nonjudgmental; connection through understanding strange beliefs (i.e. there is narcissism involved)

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Cluster C

Obsessive/Compulsive

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Obsessive-Compulsive DO

- Must have four of the eight:
  - Preoccupied with details, rules, lists
  - Perfectionism that interferes with task completion
  - Can't discard/ Excessively devoted to a few things (addiction, killing)
  - Addictive/ compulsive tendencies: low restraint
  - Rigid and stubborn
  - Overcontientious/ inflexible
  - Miserly (tendency to hoard)
  - Reluctant to delegate tasks: must control

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Obsessive-Compulsive DO

- Main Trait: Rigidity
- View of World: Contaminated
- View of Themselves: Righteous
- View of Others: Lax or Lazy
- Deal with the World by: Control
- E.G.: Timothy McVeigh, Monica (Friends), Agent Smith (Matrix), Niles (Frazier), David Fisher (Six Feet Under)

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OCPD

"I've spent my entire life thinking about and using sex to deal with my problems and to feel good."

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OCPD Crimes

- Crimes: Sex crimes, A/D related crimes, property, sometimes violent crimes (e.g. fire setting)
- Approach: Must have all your ducks in row when interviewing BECAUSE THEY WILL

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Cluster B

Dramatic (i.e. drama queens) and Criminal

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Histrionic Personality Disorder

- Main Trait: Over-expressiveness
- View of World: Impressionistic
- View of Self: Charming, Center of Attention
- View of Others: Admirers
- Deal with World by: Performing
- E.G.: Jack (Will and Grace), Michael Jackson, Bachelor women

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Borderline Personality Disorder

- Must have four of the nine:
  - Frantic efforts to avoid real or imagined abandonment
  - Identity diffusion (who am I?)
  - Unstable, overly intense relationships:
    - Angel or devil?
  - Impulsivity in sex, binge eating, spending
  - Recurrent suicidal gestures
  - Emotional instability
    - jealousy
    - Crisis
    - manipulation

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Borderline Personality Disorder

- Main Trait: Unstable, intense relationships, drama and ***CRISIS***
- View of World: Rejecting
- View of Themselves: Vulnerable, Abandoned
- View of Others: Angels or Devils
- Deal with World by: Emotional justification
- E.G.: Glen Close (Fatal Attraction), Mimi (Drew Carey), Marilyn Monroe, Princess Diana

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Borderline PD

- Me: "How would your sister know if you had cut on yourself?"
- Him: "Because I would wince when she hugged me."

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Borderline PD Crimes

- Crimes: Highly impulsive, hostile acts motivated by jealousy, anger/ rage, fear of abandonment/ jealousy
- Approach: Take advantage of intermittent remorse and mood swings; create moods to disrupt thinking

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Narcissistic Personality Disorder

- Must have five of the nine:
  - Grandiose sense of self-importance
  - Preoccupied with fantasies of success, power, brilliance
  - Believes he is special
  - Requires excessive admiration
  - Sense of entitlement
  - Interpersonally exploitive, predatory
  - Lacks empathy
  - Envious
  - Arrogant

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Narcissistic Personality Disorder

- Main Trait: Grandiosity
- View of World: Theirs
- View of Themselves: Special
- View of Others: Their servants
- Deal with the World by: Image Management
- E.G.: Most world leaders, Frazier, Dennis Finch (Just Shoot Me)

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Narcissistic PD

"I survived the 70's...There was a time when there wasn't a woman in Beaverton that my partner or myself hadn't had sex with...sometimes it was as many as 3-4 per night."

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Narcissistic PD Crimes

- Crimes: exploitive and cannot view the impact their crimes have on others
- Approach: emphasize their uniqueness and get them to brag, support their special qualities, and give them the rope (they like to talk)

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Antisocial Personality Disorder

- Must have three of nine:
  - Failure to conform to laws
  - Deceitfulness
  - Impulsivity
  - Irritability
  - Reckless disregard for others' safety
  - Irresponsibility
  - Lack of remorse
  - Juvenile delinquency

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Antisocial Personality Disorder

- Main Trait: Exploitation
- View of World: Dog Eat Dog
- View of Self: Superior
- View of Others: Suckers
- Deal with World: Opportunism
- E.G.: A large portion of the people you will meet in criminal justice system

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The Antisocial Lifestyle

- The Details that end up on most risk tools:
  - Self-regulation problems
  - Histories of violent crimes
  - Non violent crimes
  - Substance use (esp. alcohol/stimulants)
  - Poor employment record
  - Irresponsibility in finances/ home
  - Poor response to conditions of P/P

55

Antisocial PD Crimes

- Crimes: Can be the full range, including highly specialized (burglaries) to criminal versatility
- Approach: Depends upon chronicity:
  - With those who have had treatment, work the "relapse" and "good thing we stopped it" angle
  - With chronic criminals, be straight forward and direct, and work the "game" and "respect" angles

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Antisocial Continuum

Non.....Mild.....Moderate...Chronic ASPD....Psychopathic

[----------]

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Psychopathy as a Severe Personality Disorder

- A combination of Antisocial/ Narcissistic Personality Disorders
- Two views of Psychopathic Violence
  - Cold-blooded Predator
  - Impulsive Thug
- High risk for violence of a lifespan (3-4x higher risk)
  - Violence that is instrumental
  - Violence that is impulsive

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Psychopathy: Two Personality Disorders

- NARCISSISM
  - Superficial Charm
  - Grandiosity
  - Pathological Lying
  - Manipulation
  - Shallow emotions
  - Lack of Guilt
  - Callous/Lack of Remorse
- ANTISOCIAL
  - Need for Stimulation
  - Criminal Versatility
  - Irresponsibility
  - Poor Behavioral Controls
  - Failure to Accept Responsibility
  - Juvenile Delinquency
  - Parole Violations
  - Lack of Plans

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Psychopathy as a Severe Personality Disorder

- Significant Signs:
  - Responsible for majority of serious crime
  - Responsible for 50% of law enforcement deaths
  - Long history of crime with an early onset
  - Uses people as objects/ little to no attachment
  - Extremely self-centered and grandiose
  - Remorseless, Lacking in guilt, Lacking in social emotions
  - Expert liars and manipulators

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How Psychopaths Differ from "Garden Variety" Offenders

- Shallow Emotions
- Callous Lack of Empathy
- Lack of Guilt
- Lack of a Conscience
- Inability to form mutually satisfying relationships (i.e. attachment).
  - No social network to moderate behavior
  - Very shallow attachments with change agents
- Offender is cold, cunning, and calculating.

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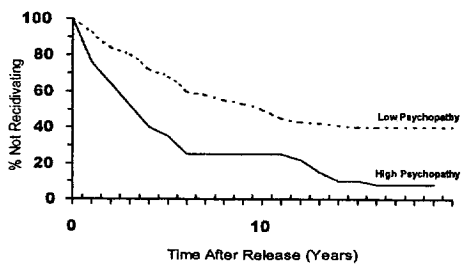
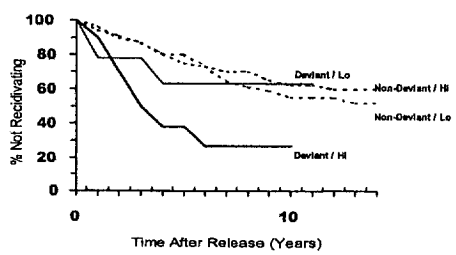
Psychopathy and Violent Recidivism

Any Violence



Psychopathy, Sexual Arousal & Recidivism

Sexual Violence



PRACTICAL APPLICATION: How Psychopaths Differ

- More likely to pose a threat to your safety.
- Can be overly compliant to curry favor/disarm. (Offender wants to "look good")
- Expanding victim pool.
  - Predatory behavior extends to anyone, including you
- More likely to con/ manipulate, deceive and disarm you.

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Psychopathic Crimes

- Crimes: Criminally versatile opportunists
- Approach: Direct, unemotional and professional; must have ducks in a row – this may be a game to them, play into their narcissism.

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What is love?

"I would have to say that love is like a hot marshmallow. It's warm, sticky and it fills you up."

- Answer by a psychopathic offender when asked to define this emotion.

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Review

- Personality disorders are pervasive and inflexible ways of approaching the world.
- Personality disorders are strongly suggested in people with criminal backgrounds.
- Personality disorders influence:
  - The crimes a person is likely to commit
  - How a investigators/evaluators should approach an interview

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QUIZ?

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Personality Disorders Training
Crisis Intervention training
Portland Police
5/18/00

Outline

I. Overview

A. Definition: DMSIV A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adult, is stable over time and leads to distress or impairment.

B. Types:

1. Cluster A Paranoid, Schizoid, Schizotypal,
   - odd or eccentric
2. Cluster B: Antisocial, Borderline, Histrionic, Narcissitic,
   - dramatic, emotional or erratic
3. Cluster C: Avoident, Dependent, Obsessive Compulsive
   - anxious or fearful

II. Development of Personality Disorder

A. Stress / Coping Skill Relationship

B. Sense of Self

C. Impairments

1. self harm
2. self defeating behavior
3. relationships
4. abandonment issues

III. Management of Behavior

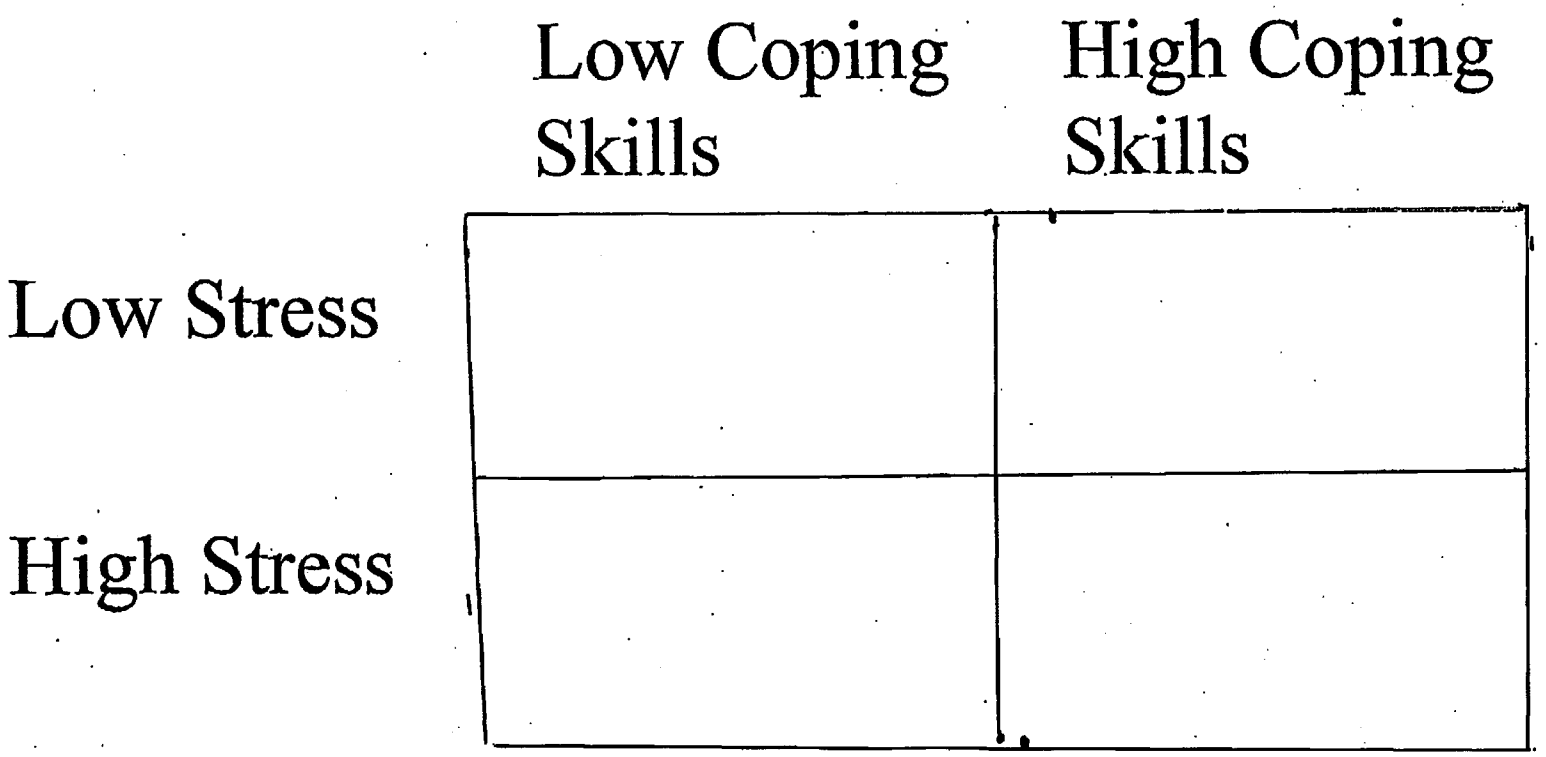
A. Neutrality

B. Clarifying Expectations

C. Setting limits

D. Supportive feedback

Stress/Coping Skill Relationship



NOTES

Mental Status Exam

MENTAL STATUS EXAM

CIT Training -- The Mental Status Exam

Neil Falk, MD
May 9, 2000

A Mental Status Exam (MSE) is the mental health worker's equivalent of a medical provider's physical exam -- an examination of an individual to help determine if they have an illness. A very quick MSE can be performed quite easily, as many of the basics are common sense. The examination can even occur at a distance, and without the individual's participation -- a lot can be gained just by observation.

- Appearance

  -- How is the individual dressed? Examples of dress which may indicate a mental illness include:

  -- Inappropriate for weather (e.g. -- many layers in summer)
  -- Inappropriate for context (e.g. -- pajamas in the street)
  -- Odd or bizarre clothing
  -- Very dirty/foul smelling/tattered clothing

  -- How is the individual's hygiene? examples of hygiene which may indicate a mental illness include:

  -- Very dirty/foul smelling clothing
  -- Very dirty/foul smelling body
  -- Poor dental condition

  -- How is the individual behaving? Examples of behavior which may indicate a mental illness include:

  -- Responding to internal stimuli (i.e. -- "talking to self")
  -- Standing still/staring for prolonged periods (e.g. - catatonia)
  -- Disorganized/non-goal directed actions
  -- "Odd" actions, or interactions with others in the environment (e.g. -- bizarre mannerisms, posturing, agitated towards others, ignored by large group, being viewed with suspicion by group or vice versa)
  -- Abnormally fast or slow movement pattern/energy level

• Thought Processes

The thought processes of the mentally ill are, by definition, disturbed. Mentally ill individuals may:

-- have disorganized thoughts (e.g. -- tangential thinking, loose associations, flight of ideas, etc.)
-- have "bizarre" thoughts (e.g. -- delusions of persecution, grandeur, conspiracies, etc.)
-- have blocked thoughts (i.e. -- long pauses during thinking)
-- persevere on one topic

• Speech

The speech of mentally ill individuals often is abnormal -- a reflection of their abnormal thought processes. Mentally ill individuals may:

-- speak abnormally fast or slow
-- use words abnormally (paraphasic errors)
-- use nonsense words
-- create words (neologisms)
-- be hard to interrupt (pressured speech)

•Miscellaneous

-- mood (how the person *says* he/she is feeling)
-- affect (how the person *appears* to be feeling)
-- suicidal/homicidal thoughts
  -- plan
  -- access to enact plan
  -- intent to carry out plan
  -- chronicity
-- hallucinations (usually auditory in the mentally ill)
-- cognitive abilities
  -- memory (short, intermediate, and long term)
  -- concentration/distractibility
  -- abstract thoughts (often mentally ill individuals cannot think abstractly)

- Generalities

  -- If it doesn't feel safe, don't do it!
  -- Mentally ill people are people, and deserve common respect.
  -- Listen carefully.
  -- Allow the individual to talk at length at least once.
  -- Don't be afraid of silences. They often bring out symptoms.
  -- Try to be an ally, not an adversary.

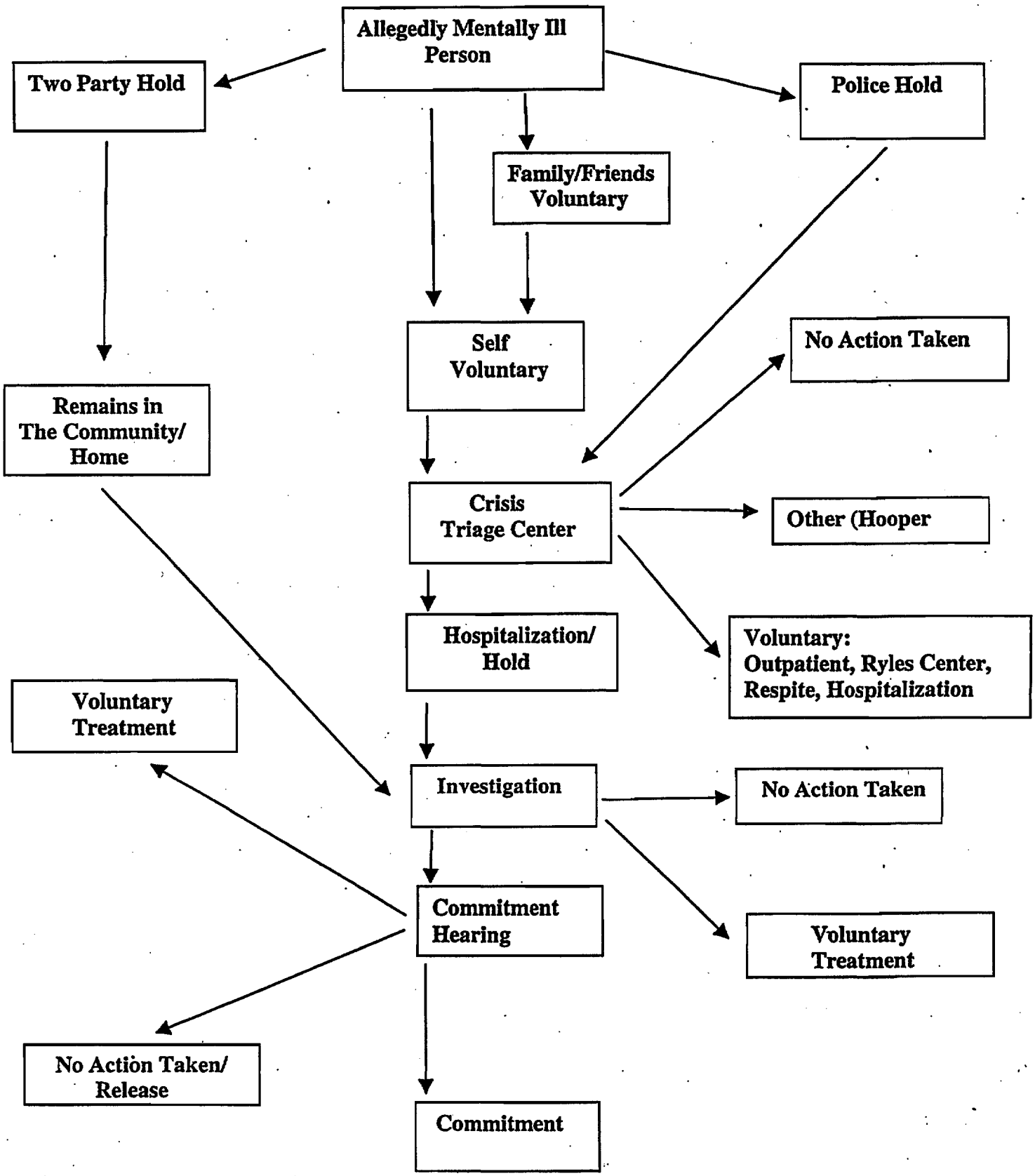
	Appearance	Thought Processes	Speech
Psychotic/Schizo -phrenic	Disheveled, Poor hygiene, Disorganized	Disorganized, Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to disheveled, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Intoxicated	Anything and everything	Anything and everything	Anything and everything

NOTES

Civil Commitment

COMMITMENT LAWS

THE COMMITMENT PROCESS



THE COMMITMENT PROCESS

THE DIFFERENCES BETWEEN A TWO-PARTY PETITION AND A HOSPITAL MEDICAL DOCTORS HOLD

TWO-PARTY PETITION

Used for issues of inability to care/deterioration of function.

Person remains in the community/home

Investigation completed within fourteen calendar days (two weeks)

Can be signed by any two-parties/people

HOSPITAL MEDICAL DOCTOR HOLD

Should be used only in cases of imminent danger to self or others

Person held in hospital

Investigation completed within five working days

Must be signed by two MD's or one MD and qualified health professional

THE COMMITMENT PROCESS

The Civil Commitment process is governed by the Oregon Revised Statutes 426 and the Administrative Rules (interpretation of the Statutes) from the Oregon Mental Health Division. The Statutes define what the legal definition of mental illness is. Legally, mentally ill means; a person because of a mental disorder, is one of the following:

A) Dangerous to self or others.

B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

C) A person who:

1) Is chronically mentally ill by the following definition (also known as "Expanded Criteria"):

a) Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility

AND

b) Is exhibiting symptoms or similar behavior to those that preceded or led to one or more of the hospitalizations or inpatient placements.

AND

c) Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Civil Commitment is a legal process not a clinical one. It has been designed as a legal procedure. At times, the logic of legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of family, significant others, or treatment providers.

The goals of the Mental Health Division in the Civil Commitment process:

A) To promote the well being of persons who are allegedly mentally ill and who are mentally ill and who are mentally ill during the involuntary care, custody, and treatment of mental illness pursuant to ORS 426.

B) To promote the protection of the civil rights of persons who are allegedly mentally ill or who are mentally ill.

C) To encourage the consistent application of ORS 426.

D) To encourage the provision of care, custody, and treatment of persons in the least restrictive environment that is available within existing resources.

THE COMMITMENT PROCESS

E) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through Civil Commitment, whenever possible.

F) To encourage that the Director (local community mental health system knowledgeable of the statues and administrative rules and provides leadership that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS. 426.

G) To provide for the safety of the community and the person when that person is dangerous to others or self as a result of a mental illness.

The Commitment process can be initiated, by giving Notice in writing (under oath) to the County Mental Health Program, by two persons, the County Health Officer, or any Magistrate. The Court will be immediately notified and the Community Mental Health Program will start (within 3 judicial days) An investigation to determine whether there is probable cause to believe the person is in fact mentally ill. Judicial days do not include weekends or Court holidays. The person is not usually in custody or detained during this process.

Emergency care, detention in a hospital and treatment can occur through the following ways:

A) A Peace Officer who has probable cause to believe a person is dangerous to self or to others and is in need of immediate care, custody of a person and remove them to the nearest hospital or approved non hospital facility, a physician will examine the person immediately. If the physician finds the person t be in need of emergency care or treatment for mental illness, the person to be in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the physician), otherwise the person shall be released from custody.

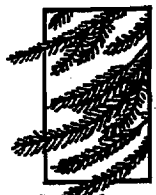
THE COMMITMENT PROCESS

B) A physician believes a person, who is at a hospital or approved non hospital, is dangerous to self or to others and is in need of emergency care or treatment for mental illness, can initiate a hospital hold and detain the person for emergency care. Under no circumstance shall any person be detained for more than 5 judicial days, following the signing of the hospital hold, without a Court Hearing.

C) A Designee of the Community Mental Health Program may, with probable cause that a person is dangerous to self or to others, or, additionally, (if the person is on a conditional release, outpatient commitment, trial visit) is unable to provide for personal needs, direct a Peace Officer to take custody and remove the person t o a hospital or approved non hospital facility for evaluation by a physician. This is called a "Director's Custody". If the physician finds the person is in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the Physician), otherwise the person shall be released from custody.

RIGHTS OF THE MENTALLY ILL

NOTES



OREGON ADVOCACY CENTER
Working for the Rights of Individuals with Disabilities

Rights of Persons with Mental Illness

Crisis Intervention Team Training
Portland, Oregon
November 14th, 2000

Janice Perciano and Jan Friedman
Oregon Advocacy Center

Voice: 503-243-2081 • 1-800-452-1694 • TTY: 1-800-556-5351 • Fax: 503-243-1738
620 S.W. Fifth Avenue • 5th Floor • Portland, Oregon 97204-1428

WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

Mental Health--the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental illness--the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alteration in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems--patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

.....

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**

- **A range of treatments exists for most mental disorders.**

.....

Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment . Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

.....

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable.

.....

Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Excerpts from **U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of health, National Institute of Mental Health , 1999.**

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Persons with mental illness have the **same rights as everyone else**.

Why aren't persons with mental illness treated the same?

1. Stigma--shame, hidden subject, accepted to mistreat, make fun of persons with mental illness

2. Misconceptions

   A. Violent--studies show that persons with mental illness are no more likely to be violent than anyone else, but often are portrayed in the media as violent

   B. Stupid--persons with mental illness have the same ranges of intelligence as everyone else, sometimes persons with mental illness are confused with persons with retardation--not the same

   C. Incompetent--everyone is presumed competent unless shown otherwise--persons with mental illness are presumed competent to make decisions even if civilly committed--only under specific circumstances is a person determined to be incompetent (guardianship, conservatorship, outside consultant determination regarding medication of person on commitment)

   D. Delusional--only some persons with mental illness experience delusional thinking--and even for these persons the delusions occur only some of the time

3. Protection of the person with mental illness--social workers, family, care givers, police etc. often want to treat persons with mental illness in what is perceived to be the best interests of the person with mental illness--may be in conflict with what the individual chooses and may be patronizing

4. Protection of society/family from hardship and/ or danger--actions are taken against a person with mental illness to protect others

5. Ignorance and fear--belief by persons without mental illness that persons with mental illness are extremely different than themselves and that mental illness may "spread"

LAWS SPECIFICALLY AFFECTING PERSONS WITH MENTAL ILLNESSES

1. CIVIL COMMITMENT

WHAT IS CIVIL COMMITMENT?

Civil commitment is a process in which a judge decides whether a person who is alleged to be mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment. A person in the process of a commitment sometimes is called an Alleged Mentally Ill Person (AMIP). A civil commitment is not a criminal conviction and will not go on a criminal record.

When a civil commitment petition has been filed, an investigator from the community mental health program (CMHP) will investigate the need for the commitment. Depending on the investigator's decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a right to an attorney and to have witnesses testify. The judge then makes a decision whether the person should be committed. If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting. The maximum commitment period is 180 days, although a person can be ordered to stay hospitalized beyond the 180 days in recommitment proceedings.

WHO CAN BE COMMITTED

Oregon Revised Statutes (ORS) chapters 426 and 427 contain the law regarding civil commitment. A judge can commit a person for up to 180 days if the judge finds by clear and convincing evidence, that the person

> Has a mental disorder and, because of that mental disorder, is:
>
> Dangerous to self or others, or
>
> Unable to provide for basic needs (like health and safety).

Or, the judge can find that a person is:

> Diagnosed as having a major mental illness (such as chronic schizophrenia or manic- depression), and

Has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

ORS 426.005; ORS 426.130

HOW THE CIVIL COMMITMENT PROCESS BEGINS

1) The commitment process may be started by a county health officer, a judge, or any two persons filing papers in court. Or, the process may be started by a doctor or community mental health program director ordering a person to be held involuntarily in a hospital. ORS 426.070; ORS 426.228 through ORS 426.234.

2) When the papers are filed, the CMHP program must send out a mental health investigator to interview the person and others who know about the person. This investigator advises a judge whether or not to hold a court hearing. ORS 426.070; ORS 426.074.

WHERE THE PERSON STAYS BEFORE THE HEARING

A person against whom a civil commitment petition is filed may stay in the community unless the judge orders the person to be taken into custody or a doctor or CMHP director directs the person be in custody. The person can be in custody only if he or she is considered to be mentally ill and a danger to self or others. A person who is mentally ill and unable to provide for basic needs cannot be held in custody unless the person's inability to provide for basic needs is so extreme that the person is a danger to self. A person held before a hearing is on a precommitment hold or in precommitment detention. ORS 426.070; ORS 426.228; ORS 426.231; ORS 426.232; ORS 426.233.

If a person is held in custody on a precommitment hold, he or she cannot be held in jail unless he or she is charged with a crime or is a serious danger to hospital staff or property. ORS 426.140. The person may be held in a hospital or a nonhospital facility. A nonhospital facility is a facility approved by the Mental Health and Developmental Disability Services Division (MHDDSD) to provide adequate security, psychiatric, nursing and other services. ORS 426.005(e).

A person on a precommitment hold has the right to be held in a mental health facility providing care, custody and treatment required for mental and physical health and safety. In other words, the person can only be held in a place with staff trained to provide mental health treatment. ORS 426.072(2)(a); ORS 426.228.

LENGTH OF TIME A PERSON CAN BE HELD BEFORE A HEARING

A person cannot be held in custody on a precommitment hold longer than five working days without a court hearing. If five working days pass and there is no court hearing, a person is free to leave the hospital unless he or she has asked to postpone the hearing or has agreed to be hospitalized voluntarily under a diversion program. In other words, a person cannot be held longer than five working days unless a judge says so. ORS 426.095.

HOW LEGAL RIGHTS ARE AFFECTED BY COMMITMENT

In general, most legal rights are not affected by civil commitment. A person who is committed retains all legal and civil rights, including the right to vote and make contracts unless a court has found the person incompetent. ORS 426.385.

Some specific rights can be limited as a result of civil commitment:

Firearms - Persons who have been committed are forbidden from owning, buying, or possessing firearms. ORS 426.130(1)(D); ORS 166.250 (1)(D).

Future commitments - If a person is committed twice within the past three years, he or she can be committed more easily in the future. ORS 426.495.

Driving - Commitment can affect a person's ability to get or keep a driver's license. If a person has a mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle, the person cannot be licensed. ORS 807.090; ORS 807.700; ORS 809.410(16).

II. AMERICANS WITH DISABILITIES ACT (ADA)

The ADA protects persons with disabilities from discrimination in these areas:

1. Employment--This includes hiring, termination benefits, working conditions, etc.

2. Public Accommodations--This includes hotels, offices, shopping malls, restaurants, sports arenas, schools, zoos, hospitals, theaters, grocery stores, homeless shelters, libraries, etc.

3. Public Entities--This includes all local and state governmental services and programs.

4. Transportation--This includes buses, trains, lights rail must be accessible or

alternatives offered.

5. Telecommunications--This includes that telecommunication services must be made accessible for speech and/or hearing impaired persons.

Persons with mental illnesses are protected by the ADA if the mental illness substantially limits one or more of the major life activities of the person. Major life activities means activities such as working, learning, sleeping, thinking and walking. Persons who have a record of such an impairment or who are perceived to have such an impairment are also protected.

In addition to the ADA, which is federal law, Oregon has state laws prohibiting discrimination in employment and public accommodations.

III. FAIR HOUSING LAWS

The federal Fair Housing Act was passed in 1968 as part of the Civil Rights Act of 1968. The Fair Housing Act prohibited discrimination based on race, color, religion or national origin in the sale, rental or financing of housing. In 1974, Congress added a provision prohibiting housing discrimination based on sex.

In 1988, Congress added provisions prohibiting housing discrimination based on mental and/or physical disabilities. Under the law, landlords and sellers cannot discriminate against a person because the person has a mental illness and must make reasonable accommodations for a person disability. The law does not apply in some cases where the landlord or seller is acting with regard to his or her private house or small apartment building. The law also allows the rejection of any tenant or buyer who would directly threaten the health or safety of other individuals or would cause substantial physical damage to the property of others.

Oregon also has a state law prohibiting discrimination based on physical or mental disability in selling, leasing or renting of houses and apartments.

IV. RIGHTS IN THE COMMUNITY AND IN FACILITIES

STATUTORY AND CONSTITUTIONAL RIGHTS

Many people receive mental health services outside the state hospital. Even persons who are civilly committed often receive treatment in private hospitals that have contracts with the state. Additionally, more people are receiving services in facilities, group homes and independent residences rather than in hospitals.

A person who is receiving services outside the state hospital system has the same rights as any other person in the community. Some of the rights that all persons in the United States are the right to:

*Vote

*Exercise freedom of speech, freedom of association and freedom of religion.

*Have privacy, including the right to marry and have children.

*Be free from discrimination based on race, gender, color, national origin or disability.

In 1993, the legislature passed legislation that sets out some specific rights of persons receiving mental health or developmental disabilities services. A person who is receiving mental health or developmental disabilities services outside of the state hospital has the right to:

*Have a written treatment plan and participate in making the plan.

*Choose from available services and have those services provided in the least restrictive way.

*Receive only services to which a person gives informed, voluntary, written consent.

*Receive medication only for individual clinical needs.

*Not be involuntarily terminated or transferred from services without prior notice and the right to be notified of available sources for necessary services.

*Receive humane services, be protected from harm and have reasonable privacy.

*Be free from abuse and neglect.

*Report abuse and neglect without retaliation.

*Exercise religious freedom.

*Not be required to perform labor, except personal chores, without being paid.

*Visit with family, friends, advocates, legal and medical professionals.

*Be told about rights and how to report abuse.

*Assert grievances and have them considered in a fair, timely and impartial manner.

*Communicate with any rights program or advocate.

*Exercise these rights without any reprisal or punishment.

ORS 430.210.

V. ABUSE REPORTING

Since 1991, the law has required the reporting and investigating of abuse of persons with mental illness who are receiving mental health services in the community. Abuse is defined as:

*Any death caused by other than accidental or natural means.

*Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.

*Willful infliction of physical pain or injury.

*Sexual harassment or exploitation, including any sexual contact between an employee of a facility or community program and an adult who is receiving mental health services.

The law requires private and public officials to report abuse if they have reasonable cause to believe abuse occurred. This means that all doctors, nurses, aides, psychologists, employees of county mental health programs, employees of mental health services providers, clergy, attorneys, outreach workers, social workers, therapists, police and others must report abuse.

Abuse may be reported to the Mental Health and Developmental Disability Services Division (MHDDSD), the county mental health program or the police. The office that receives the abuse report must then conduct an investigation or make sure that an investigation is conducted. The person who may have been the victim of the abuse must be provided protective services if needed. The investigating office must complete a report of the investigation and send it to MHDDSD. ORS 430.735 through 430.765.

VI. INFORMED CONSENT TO TREATMENT

A person can receive mental health treatment, including medications, only if the person gives his or her informed consent. This means the person must be told what the benefits and risks of treatment are and must make a voluntary decision.

A person cannot be forced to take a particular medication just because everyone thinks it would be good for him or her. The exception is when a person has been civilly committed and two doctors have agreed that the person is unable to make decisions. In this case, if the proper procedures are followed, the person may be subjected to treatment that she or he does not want.

VII. GUARDIANSHIP

If a person is "incapacitated", a judge may appoint a guardian for her or him. A guardian can only be appointed by a judge. A parent does not have the powers of a guardian if the individual is 18 or over unless the judge has appointed the parent a s guardian.

TELEPHONE NUMBERS FOR ADVOCACY GROUPS AND LEGAL ASSISTANCE

American Civil Liberties Union	503-227-3186
Fair Housing Council	503-223-8295
Multnomah County Legal Aid	503-224-4086
National Alliance for the Mentally Ill	800-343-6264
Oregon Advocacy Center	503-243-2081
Toll-free	800-452-1694
TTY	503-323-9161
Toll-free TTY	800-556-5351
Oregon Legal Services	
Central Office	503-234-1534
Farm Workers' Office	503-981-5291
Hillsboro Office	503-648-7163
Native American Office	503-223-9483
Oregon State Bar	
Lawyer Referral Service	503-684-3763
Toll-free	800-452-7636
State Public Defender	503-378-3349
U.S. Office of Civil Rights	206-615-2290
Toll-free	800-362-1710

WORKING FOR THE RIGHTS OF INDIVIDUALS WITH DISABILITIES

GOVERNMENT AGENCIES

Adult and Family Services Division	503-731-3111
Bureau of Labor and Industries	503-731-4200
Equal Employment Opportunity Commission	206-220-6883
Toll-free 800-669-4000	
TTY 206-220-6882	
Mental Health and Developmental Disability Services Division	503-945-9499
Office of Mental Health Services	503-945-9700
Office of Client Rights	503-945-9495
Psychiatric Security Review Board	503-229-5596
Senior and Disabled Services Division	503-945-5811
Toll-free 800-232-3020	
Social Security Administration	800-772-1213

ADVOCACY/CONSUMER GROUPS

Mind Empowered, Inc	503-231-4137
Oregon Advocacy Center	503-243-2081
Toll-free 800-452-1694	
TTY 503-323-9161	
Toll-free TTY	800-556-5351
Oregon Alliance for the Mentally Ill	503-370-7774
Recovery, Inc 503-231-1334	

Brief History of Treatment of Persons with Mental Illness in England and the United States

Early 1300s--English law categorized persons with mental disabilities as lunatics or idiots.

Pre-1600s--Persons with mental illness were cared for at home or sent to poorhouses, workhouses, jails.

1600s-- "Madhouses" created to confine persons with mental illness. The madhouses were unhealthy settings with harsh and punitive "treatment". Persons were chained, abused and publicly displayed.

1700s-- "Asylums" were developed to provide healthy environment and "moral treatment".

Mid-1700s--Persons with mental illness in England were placed in St. Mary of Bethlehem which became known as "Bedlam".

"Bethlehem--or Bedlam as it was called--was a favorite Sunday excursion spot for Londoners, who came to stare at the madmen through the iron gates. Should they survive the filthy conditions, the abominable food, the isolation and the darkness, and the brutality of their keepers, the patients of Bedlam were intitled to treatment--emetics, purgatives, bloodletting and various so-called harmless tortures provided by special paraphenalia." The History of Psychiatry, F.G. Alexander and S.T. Selesnick

1752--Pennsylvania Hospital opened with several cells for the "insane". The method of commitment was informal. A few words scribbled on a piece of paper were enough to get a person locked up.

1773--In Williamsburg, Virginia, the first US institution specialized for the "insane" opened.

Late 1800s--Large public institutions were filled with chronic patients receiving little treatment.

1883--Oregon State Insane Asylum opened in Salem (renamed Oregon State Hospital in 1907).

1900-1960--Hospitals emphasized treatment but no effective treatment was available. Institution populations continued to grow.

1907--Eastern Oregon Hospital opened in Pendleton.

> When we have a disturbed or noisy patient to deal with [prior to a lobotomy operation] in the University Hospital or Doctors Hospital we administer two, three or more electroshock treatments in rapid succession. Psychosurgery in the Treatment of Mental Disorders and Intractable Pain, Walter Freeman and James Watts, 1950.

1955--560,000 persons with mental illness were confined in hospitals (1/2 of all hospital beds).

1959--The average daily population in Oregon State Hospital and Eastern Oregon Hospital was 4909.

1960-1975--Deinstitutionalization resulted in the release of vast numbers of persons from institutions.

1961--Dammasch State Hospital opened in Wilsonville.

1975 to present--Communities recognized that deinstitutionalization could not succeed unless accompanied by adequate community support programs.

1977--Psychiatric Security Review Board created in Oregon to supervise persons found affected by mental disease or defect in criminal matters.

1990 to present--Managed care implemented for provision of mental health services.

Deaths at Dammasch State Hospital (DSH)--June 25, 1993 to October 8, 1993.

June 25, 1993--DC died at DSH--No medical examiner review but adequacy of medical treatment questioned.

August 29, 1993--JW died choking on pancakes. He was alone in his room, unmonitored despite swallowing problems.

August 29, 1993--LL died choking on pancakes. Staff called 911 but did not intubate LL or manually cut an airway.

September 19, 1993--KM died as a result of coronary arteriosclerosis. Staff had given her Haldol despite a diagnosis of mental retardation (IQ 54) and no diagnosis of mental illness. Staff found her lying on her bed. She had no pulse but was warm. Staff made a emergency request for a doctor. Thirteen minutes elapsed before a doctor arrived.

October 18, 1993--PG suffocated while being placed in physical restraints. A towel pulled over his mouth contributed to the death.

1995--Dammasch State Hospital closed.. Oregon State Hospital at Portland opened with capacity of 68.

1997--Current Oregon State Hospital capacity is for 727 beds, including hospital beds, residential beds, child and adolescent beds.

FAMILY AND CONSUMER PERSPECTIVE

WHAT IT'S LIKE

Being crazy hurts. For one who has been there, the idea of going crazy out of moral weakness, because it is easier than "facing reality," is utterly bizarre.

The major mental illnesses, like most other illnesses, carry with them an early-appearing and almost ever-present feeling of "sickness" and exhaustion.

As it gets better and worse, there are times when you may be unable to function at all, perhaps being unable even to get out of bed.

At these times, investigation is needed to determine whether you are suffering extreme stress of real-work origin, suffering from a resurgence of mental illness symptoms, or whether there is some unrelated medical problem, such as an abscessed tooth or the flu.

Too often, these episodes are viewed as bouts of laziness and "lack of motivation," and treated with harassment or even termination from a treatment program.

Unless this phenomenon, and ways of coping with it, are explained to you, you too may come to believe you are lazy and good-for-nothing.

You become aware that your perceptions are unreliable, that you are having sensory experiences that others do not share.

As you struggle for some understanding of what is happening to you, you find yourself clutching at extreme and bizarre explanations.

When you try to talk to other people about your experiences, you discover there is no common language for them. You find yourself putting together an unsatisfactory and embarrassing patchwork of religious, occult, or scientific words.

When you do talk to people, they may lapse into shocked silence, change the subject, or reject your statements as weird and you as crazy.

If you are not aware the perceptions are different from those of other people, you are even more disabled. Whenever you try to do something or talk to someone, all sorts of things go wrong, which you do not understand.

Because you cannot predict whether your perceptions and interpretations of events are acceptable to others as "real," you begin to be afraid to talk about your feeling at all. If you have not yet felt there was something wrong/bad about you before, you do now. You become very lonely.

Since you gave no safe way to compare your "crazy ideas" with what normal people define as real, your ideas/delusions become more detailed, more organized, and more strongly held.

Extreme and uncontrollable emotions rush through you: fear, confusion, anger, despair.

The feelings are overwhelming. You see yourself doing things you cannot stop. It comes to you that you are no longer in control of your life. You are forced to depend on other people for some things, even if you do not want to.

You begin to fear that you may do something awful, something that will make people get rid of you forever.

You worry that whatever has happened to you may be permanent, that you may never be all right again.

Pain becomes very familiar. It comes to have form and texture like terrain.

If pain is fairly steady and continuous, you can sometimes almost tune it out. But if someone offers you more hurt, whether it be emotional battering or physical, you are suddenly desperate and hostile. You are tired, tired, tired, and do not have the energy to take any more. Sometimes you have to take it anyway.

At times the pain/craziness comes in overwhelming waves. Like most people, you think that pain will somehow never crush you. Somehow new reserves of strength will appear, effective treatments will be found, or, in the extreme, that you will simply pass out.

Then one day, you lose control of your mind, your body, everything. You'll lose your bowels and scream and scream and scream, like a little pig squirming in the dirt. And it does not stop.

Having broken, having been totally <u>helpless</u> forever after leaves you feeling fragile in a way that other people do not. In wonderment you watch "normal people" go about their lives, full of energy, confident, unknowing. There is an abyss between you.

If you hurt bad enough, you try anything to feel better: self-help books, religion, sex, drugs, alcohol, and anything you can think of.

Some things make you feel a little better, some do nothing, and many of them make you feel a lot worse.

In desperation, sometimes just drinking or drugging yourself into unconsciousness seems a worthy goal.

The risks of triggering further psychotic episodes and the risk of alcohol and drug addiction are substantial. It is hard to be interested in future consequences of things when you are not sure you have a future or want one.

If you get strung out on alcohol or drugs you will have another difficulty. The people who work with alcoholics and drug addicts do not want you because you are crazy. The people who work with the mentally ill do not want you because you are an alcoholic or an addict. You can only go to special, expensive, "dual diagnosis" programs. If you have three or more diagnoses, you are likely to end up in jail.

Seriously mentally ill people have a suicide rate of 20-30 times that of the normal population. At greatest risk are those who are too ill to have a normal life, and not sick enough to be unaware of it.

Hardly anyone wants to commit suicide.

As the years go by, you exhaust the treatment options open to you. Hospitals and doctors get tired of you because you never get better.

You drift away from your family. You cannot hold a job, or maintain a sexual relationship.

If you talk to others about your feelings, you come under pressure to shut up and act normal. Your desperation makes them uncomfortable.

You feel helpless, lonely, and as if you have nowhere you belong. You cannot stand being trapped in all that pain. All these are bad enough, but it is the crushing, never ending tiredness that ultimately gets you. You kill yourself because you have to.

What you would really like to hear is: "We know you are very tired, and you feel awful most of the time. We do not want you to go away. We want you to live.

"But if the time comes when you really cannot take anymore, and you have to die, we will be very sad, but we will understand.

"Whether you get better or not, and whether you live or not, we love you anyway."

Confused and frightened people tend to try to clamp tight control on whatever or whoever upsets them. It is rare to be given this recognition of your pain and permission to do whatever you have to do, but if you are, it is very comforting.

It tends to relieve some of your guilt feelings for being such a mess, and such a disappointment to your family and friends.

If you are like many seriously mentally ill people, you have known since sometime in childhood that there is something very wrong with you.

Functioning at school was very hard. You have less and less success in living up to the expectations of your family, and in being like other people.

Others' attempts to shape you up are sometimes drastic. You are likely to have the experience of being threatened, ridiculed, or punished for things that you do not understand, cannot do, or cannot stop doing.

Parents, teachers, school counselors, and pediatricians rarely are familiar with mental illness in children. Many professionals take the de facto stand that major mental illness and suicide virtually do not occur in young children, and that all such problems come from "labeling" and "bad parenting."

Your family withers under the implied or open accusation that they made you crazy. They become too intimidated to talk to you, out of fear that they will "say something wrong" and cause you to shatter in a million pieces.

Communication within your family is loaded with fear and guilt, and is further complicated by your thought or mood disorder.

Nobody will tell you what it going on. In loneliness and isolation your fears and crazy ideas grow.

Your parents are scapegoated by relatives, neighbors, and authorities. They begin exchanging recriminations themselves. They become more and more exhausted and discouraged.

You are torn between wanting to stay with your family because you hope you belong there, and wanting to leave because you caused them so much pain.

If your family breaks up or you withdraw from them and you do not find some other support system, you fall on the not so tender mercies of the state.

As you move out into the world, you find you are only comfortable with "social equals," people similarly ill or otherwise damaged, and those rare people who are willing to some extent to understand your experience and feel your pain.

Talking with straight people is nerve wracking. You can never be sure when something you say will come out all weird, and you will be recognized as a crazy person and gotten rid of.

Hungry for human contact, you approach other people, only to discover that they are afraid of you. They assume that if you are mentally ill, you are by definition suicidal and violent.

You had been so wrapped up in being afraid yourself, that it comes as a humiliating shock to find that <u>normal</u> people are afraid of <u>you</u>. Some of them will even take the position that if you are or ever have been crazy, you cannot be trusted with anything, ever.

When out in the community, you are anxiously self-conscious, aware that at any moment a mannerism, a social misstep, or something "inappropriate" will unmask you as a crazy and embarrass anyone you may be with.

You fear being stared at, made fun of, or even being attacked by street creeps always on the lookout for someone with a high victim profile.

If you are too sick to have a hope of concealing it, you can only wait to be hurt and try to keep on going.

Being disabled, you fall into the hands of caretakers.

Sometimes you feel like an abandoned ship, to be taken over by any normal person who wants to, as if they had some kind of salvage rights.

At times you spend a lot of energy fending off such people, trying to hold onto the right to run those parts of your life that you still can.

Caretakers come in various roles, with a variety of titles and letters after their names. Some are very skilled and genuinely helpful, a lot more manage to get by, and some are definitely part of the problem, not part of the solution.

You have no choice about being sick, and no choice about depending on caretakers at times. Even within a given type of service or a particular agency, you seldom have a choice. Your "case" is "assigned" to someone by a "catchment area," "admission rotation," or whatever.

Caretakers control access to medication, asylum (the hospital), money (welfare, SSI), and food (stamps). They decide whether to allow you the sick role, or whether to define you as bad, crazy, or stupid. They can invalidate what you say or do, and call upon the court to have you carted away.

Appeals from their decisions are costly, time consuming, difficult, or impossible. In no way is their relationship a voluntary one between equals.

For a caretaker to operate humanely in such an unequal relationship, a very high level of skill and integrity is required. When you have no choice, you need the best.

Paradoxically, the mental health system tends to assign the least experienced and lowest status workers to screening and to the seriously ill, and the most trained and highest status professionals to the less needy but "more interesting" (more likely to get better) clients.

Like all human beings, some mental healthers have their prejudices, some of which may have a major impact on your life. Some of these prejudices include that, if you are:

a. Poor--you are just trying to get free room and board;
b. Black--you have paranoid schizophrenia;
c. Old--you are hopelessly senile;
d. Male--you are violent;
e. Young and female--you are manipulative or seductive;
f. Young and male--you are a doper;
g. Admitted to a hospital from jail--you are faking;
h. Physically ill--it's all in your head;
i. Failing to get better--you are unmotivated.

In your dealings with mental health workers, you will encounter some common problems:

Mental healthers sometimes seem to see you as a kind of agent of insanity, and immediately start a power struggle over who is to be in control of the relationship.

They seem to fail to see that you have no desire to keep, much less propagate, your crazy ideas. You would get rid of them in a minute if you could only figure out how to do it.

They will frequently refuse to tell you your diagnosis and probable course of your illness. With no real information to go on, you are left to your imagination, which is often worse than anything a doctor could tell you.

What they tell you about the expected effects of your medications and possible side effects is commonly very sketchy. You sometimes have nasty surprises.

Although PRN (extra, as needed) medications are routinely prescribed in the hospital, you are rarely provided them outside. Somehow, life in the community is supposed to be much less stressful, and besides, you might "abuse" the medications.

You find yourself viewed with a general distrust. Everything you say or do is "evaluated" and subject to "clinical judgment," to determine its "real meaning." Yet basic investigative techniques, such as talking to everyone involved and cross-checking their stories, are omitted.

At times, this is due to lack of time or carelessness, but too often it comes from an ego trip wherein professionals feel that their qualifications enable them to discern deep truths virtually by remote control.

It is terribly frustrating to try to communicate with such people, because nothing you say is accepted at face value, but is changed into something unpredictably different.

Meanwhile, they want you to "develop a trust relationship" with them, but changes in staff and program priorities may come much faster than your ability to trust can handle.

You may have to cope with mental healthers who take basically useful approaches to problems and carry them to such lengths that they become problems themselves.

It is helpful to convey to you the expectation that you will get better, but not so helpful to fail to teach yourself care skills and work with the emotional problems that arise when it becomes clear that you are not improving.

Inventorying your symptoms and problems is a necessary beginning of a treatment plan, but concentrating only on what is wrong with you and ignoring the strengths and abilities you still have is not so useful.

Good general counseling skills and effective community organization are necessary to help you improve and maintain your quality of life. However, they do not eliminate the need for detailed knowledge of the symptoms, experiences, and problems which affect you as part of your mental illness, or as effects of your medications.

Anyone working with seriously ill people must be willing to take control at times when you are too disabled to carry on necessary life functions. Unfortunately, mental health work attracts numbers of people whose need to control others is so great that they tend to discourage your own sense of your own competence, and dampen any drive you may have toward free and self-reliant living.

This is a rip-off, because they imply that since you are incompetent, you may rely on them to meet your needs. The first time you get in trouble outside normal business hours or without an appointment, you may have a rude awakening.

You <u>have</u> no choice about learning to take care of yourself and your fellow crazy people as best you can. The response of the mental health system is often just too slow and unpredictable.

It is reasonable for mental health workers to hope for some emotional gratification from their work, but sometimes you are too sick, and have nothing to give in return. Sometimes, when you are not getting any better, your therapists get desperate and start "shot gunning" you with multiple medications and rapid, ill-thought-out changes in your treatment plan.

You may not be listened to when you try to explain what has worked for you in the past.

Since your records are usually following a hospital or an agency or two behind you, you may suddenly be taken off a regimen on which you had been stable, and which took months of experimenting to develop.

The principle seems to be "change something, whether it helps or not," rather than feel helpless.

Other times, some workers get frustrated and bitter, and put increasing pressure on you to "get well or get lost." This can be mutual: they cannot forgive you for not getting better, and you cannot forgive them for not getting you better.

If you are crazy, you can usually count on being poor.

If you are severely disabled, you will probably be on welfare, at least at first.

Your welfare grant is based on a fraction of what a study of local prices determines to be the minimum livable allotment.

Social Security (SSI) is somewhat more, but you are unlikely to successfully complete the complex application process without determined help from a case manager or a family member.

In either case, you will have a welfare medical card. Since there are restrictions on the services covered, and because the majority of local physicians do not take welfare patients, your medical care is likely to be poor and without continuity.

You will probably have bad teeth, as well. Dental care is only available for emergencies, and for a low dollar amount, resulting mostly in extractions.

Your clothing is likely to be poor, ill fitting and mismatched, coming from thrift stores, and sometimes carrying institutional marks.

Drifting in and out of hospitals, jails, and boarding houses, most of your possessions will have long since been lost or stolen. You may have little in the way of toilet articles, and you may smell.

Your status as a second class citizen, a loser, is displayed for all to see. In addition to the practical problems of poverty, there are the emotional effects. If you are one who has learned to count personal worth in terms of possessions, you are doubly poor.

There is a strong streak of Calvinism in our society: being poor is seen as evidence that you are also bad.

If you go into a nice store, clerks follow you around waiting for you to steal something. Some mental health workers dress especially well to avoid being mistaken for patients.

If you are unable to be productive, many feel you should be uncomfortable. It would be immoral, somehow contributing to your delinquency, to give you things you cannot earn.

You meet people who would obviously be willing to let you starve to death if it were their choice. To your humiliation is added an element of real fear.

You may find yourself begging and stealing, in violation of your own principles. You pack rat, assembling collections of junk, rather than have nothing at all.

Sometimes it is hard not to hate the caretakers around you, who have built a comfortable lifestyle upon your misfortune.

Sex is important to people, to sick people no less than to people who have the privilege of being healthy. Like everything else, mental illness messes it up.

When you are depressed, when you hurt so bad you have to be completely numb in order to function at all, the numbness itself becomes another kind of discomfort. You want to feel <u>something</u>, anything but more pain. You think of sex as a strong, good feeling, and try it. You run into a wall of pain and exhaustion. You cannot get aroused, you cannot tolerate intercourse. You experience one more crushing failure. Perhaps you are no longer a woman or a man anymore.

If you are high, in a manic state, you may be very sexually active. It may feel wonderful, or, if your high has reached an agitated, desperate stage, it may feel frenzied and out of control.

When you come down, it can be mortifying. You may have VD treatment, abortion, divorce papers, and new enemies waiting for you.

If you have a thought disorder, you may be too scattered to figure out what you need, or disorganized or fearful to effectively seek out a partner. If you find a partner, he or she is likely to be a "social equal." With both of you crazy things can get confusing.

Institutions do not make provisions for sexual privacy. Quite the contrary. Your sexual experiences are likely to take place in bushes or on the floors of out-of-the-way restrooms.

You risk a personal confrontation with the fact that many people, but especially high control institution types, do not feel crazy people are entitled to sex lives. They may also have reasonable concerns about competency to consent, and about civil liability.

If you are male, and your activities or choice of partner are not approved of, you may be written up in records as "sexually inappropriate with one of our sickest female patients" ("rapist").

If you are a female, you may be described in your chart as "sexually inappropriate with men" (presumably numerous, "whore").

If you are gay or lesbian, you are doubly disapproved of, and you risk having drastic action taken against you, especially premature discharge from treatment.

If you are young, and have homosexual experiences during prolonged institutionalization, which are common, you may have to keep it deeply secret afterward, and wrestle, usually alone, with the question of what your sexual orientation actually may be.

A complication of trying to have a sex life while under psychiatric treatment is that many psychotropic medications are sexually disabling in many people. You may find yourself unable to get aroused, or you may be aroused but unable to climax, or climax is long delayed.

You may be told about this when being instructed about your medications, but frequent not. If you can get up the nerve to raise the issue, often a reduction of dose or a change to another drug will take care of the problem.

If you cannot, you get more depressed at this additional evidence that your life is ruined.

When you are poor, crazy, and unwanted, you hunger for warmth and touching, on almost any terms. Sometimes you fall into the hands of cruel and exploitive people.

Sometimes you hope you will have a child, as a fulfillment of your identity as an adult human being, and in hopes of having someone to be with, who will love you. Frequently, this ends in tragedy, as you have children you cannot take care of, and they are taken away from you.

Because mentally ill people often are fairly helpless, they are frequent crime victims. Criminals often are aware that you may have no interested family or friends, and are easily discredited in court. Therefore, there is little risk of being prosecuted for any crime against you, short of murder.

The sword is two-edged: because you are "insane" you may receive no consequences for repeated antisocial acts. You risk developing habits of behavior that drive away your support system, and ultimately land you in the hospital or on Skid Row.

When you lose your mental health, you go through the same pattern of responses for any other major loss. Dr. Elizabeth Kubler-Ross's "Stages of Dying" is a fairly accurate model.

1. Shock. You never expect to go crazy, nor do you expect to find out one day that you have been crazy for a long time.

   You are stunned, confused, afraid. For a period of time, you are in shock and unable to do anything to help yourself.

2. Denial. You buy time to deal with overwhelming anxiety producing situations, by denying them. You try to go on living as if the problem did not exist, while your subconscious mind works on some way to cope with the problem.

   Other people, who are not sick, get frustrated and angry because you do not do whatever they think you should do about the situation.

   Since it is not their problem, they are not overwhelmed by anxiety, and they can view the whole affair more objectively.

   The crunch comes when they pressure you to "face this thing, right now!" and accuse you of "wanting to stay sick."

   The reason you are unwilling to do the things they demand, such as going to a clinic, taking medication, and giving up "unrealistic" life plans, is because you do not want to be sick. Therefore, you do not want anything to do with anything even remotely related to being crazy.

   Since your denial is basically driven by anxiety, the more you are harassed about "facing the facts," the more delayed as you're coming to terms with your situation.

3. Anger. When you realize that your life is going to be more painful and more limited than the lives of other people who are of no greater merit than yourself, you get mad.

   Since many people view the family as the source of all problems, you may direct, and be encouraged to direct, your anger at them. Often having strong guilt feelings themselves, they may agree that you are entitled to be angry at them.

   You may also vent your anger at mental health workers, whose very presence in your life is an undesirable reminder of how you have been cheated of a normal life.

   You may carry a powerful resentment against people who have the privilege of normalcy, who have jobs, friends, money, cars, and other things that you do not.

4. Bargaining. As it becomes clear that this insanity business is for real, and it shows no signs of going away, you want to make a deal.

   You try unusual diets, stranger religions, street drugs, anything that offers the faintest hope of making a difference.

You promise God that you will devote the rest of your life to medical research and serve to the poor, if only this cross will be taken from you.

Occasionally, someone recovers for no reason known to man. Not very often.

5. Depression. When you realize that no deals are being made, blaming people makes no difference, and the craziness is not going away. You are very, very sad.

   You have a right to be. Through no fault of your own, your life has been ruined. You may never have the job, children, a car, or even one day free of pain for the rest of your life. The temptation to give up and die is very great.

6. Acceptance. After a time, usually a long time, you find a way to accept yourself and what has happened, and to go on with your life.

   There are three things that you have to understand:

   a. You must take care of yourself and meet as many of your own needs as you can, either yourself or through relationships with other people which are mutual, equal and loving.

      By virtual biological law, people meet their own needs and those of their loved ones first. Only what is left over is offered to others.

      This is as true of mental health workers as anyone else. They provide specific services, and a measure of emotional support, but rarely as love as exchanged among equals.

   b. Blaming people, whether yourself, your family, or anyone else, is a waste of time.

      Too much psychodynamic, insight-oriented therapy is a thinly disguised search for someone to hold responsible.

      There is no way you can recover a piece of your life from someone, as if it were money damages. You may not be able to forgive or forget, but you have to withdraw your energy from the past, and go on.

   c. You have to find some reason, some mission in life to justify going on, in spite of the pain and lack of orderly success.

      If you are religious, it may be the faith that you are in this world to be tested, or to learn something essential for your spiritual development, and that your

Appendix

Some reasons mentally ill people contact crisis services are:

1. You may need help with a practical, real-world problem. If you spent a lot of your life being crazy, you may be missing whole areas of competence which are taken for granted by normal people, such as riding the bus, dealing with a traffic ticket, or returning defective merchandise to a store.

2. You may need help putting an idea in words, defining a problem clearly so that you can work on solving it, or communicating feelings to someone in a relationship. If you have a thought disorder, the most important area of communication in words can be extremely difficult.

3. You may need emotional support for a necessary decision not popular with your immediate support system. The people in your college psychology class may be delivering fulminating denunciations of psychotropic medications, but you have to stay on them, or end up in the hospital or dead.

4. You may have symptoms that relate to a developing medical problem, and you need help figuring out whether you need medical care, or whether these are just some new variations on your hallucinations and delusions.

5. You may be experiencing new or threatening psychiatric symptoms, such as prolonged sleep loss or command hallucinations ordering you to kill yourself. You may need help deciding how serious these are, and what to do about them.

6. You may need a perception check: does it seem likely that you are important enough for the FBI to bug your phone, or is that probably just a crazy idea?

7. You may need help finding specific local mental health or social services.

8. You may be without food, clothing, shelter, or essential medical care.

9. You may be in legal trouble, and need help conveying to those defending you, the nature of your illness and your disabilities.

suffering has a place in the overall cosmic picture. For others it may be the goal of someday writing a book, which you hope will help normal people understand the experiences and needs of the mentally ill.

For a few who have luck, brains, and a terrible determination, it may be possible to go back into the wilderness to try to lead a few brothers and sisters to freedom. They become mental health workers themselves.

It may be the love of family, fear of death, or even plain stubbornness, but there has to be a reason.

If the pain is futile, it is also intolerable.

COMMUNITY RESOURCES

NETWORK
Behavioral HealthCare, Inc.

Resume of Low-Income Housing Experience

Date of Inception	Project
March 1985	Tillicum Court Apartments

Under the corporate ownership of Southeast Network Housing Services, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing in studio and 1 bedroom apartments, as well as skills training and support services, are provided on-site. Additional psychiatric and clinical services are available through the Network's Rehabilitation and Community Services divisions.

March 1987 — 70th Street House

The Network provides residential care in a transitional group home setting to 12 individuals having mental illness. Twenty-four hour supervision, skills training, and counselor support are provided on-site as are meals, medication and money management. The facility is leased from the Housing Authority of Portland and operated by the Network. All residents are low income and supported by entitlement programs.

May 1988 — Nawikka Court Apartments

Under the corporate ownership of Southeast Network Housing Services II, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing is provided in 1 bedroom units with additional services provided as described for Tillicum Court.

ADMINISTRATION
5415 SE Milwaukie Avenue • Portland, Oregon 97202
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January 1992

Pisgah Home/Harriet Court Apartments

The Network provides both residential care (Pisgah Home) and supported housing (Harriet Court) to individuals having mental illness at these co-located program sites. Fifteen Pisgah tenants receive twenty-four hour supervision, assistance with activities of daily living (hygiene, grooming, etc.), money, medication and crisis management; skills training and counseling. Fifteen Henry Court tenants live independently and receive skills training and support from on-site staff as appropriate to their needs. Tenants in either program reside in private rooms with private baths. Congregate meals are available. The Network owns and manages the facility in which it operates these programs. All tenants have incomes below 50% of median; many are supported by entitlements.

November 1993

Woodstock Court Apartments

The Network operates this nine (9) unit complex under lease from the Housing Authority of Portland, the project's co-developer (with Network). Eight studio units are rented to homeless individuals having mental illness. An on-site manager occupies a 9th unit. The Network provides skills training and support services including medication monitoring and a meal preparation skills program. The Network manages all aspects of this housing. All tenants have incomes below 50% of median, typically from entitlement payments.

May 1994

Lafayette Apartments

The Network owns and operates this thirty two (32) unit complex which provides supported independent living in studio and in one bedroom apartments to individuals having mental illness. On-site management and optional skills training and support services including medication monitoring and meal preparation training are provided. All tenants have incomes below 30% of median and are generally supported by entitlement programs.

October 1994

Kernlodge Home

Quint 26

The Network operates these two, five (5) unit homes under lease from The Housing Authority of Portland, the project's co-developer (with Network). Each home contains five SRO units (a private bedroom and bath), and shared space that includes kitchen, dining room, living room, laundry, and individual pantry/food storage areas. This shared housing affords its tenants privacy, security, and comfort in a small, group-oriented, neighborhood-friendly building. Tenants are low income persons having mental illness who are capable of living in an unsupervised setting. The buildings do not have live-in management, but are regularly monitored by the staff of Network Behavioral HealthCare, Inc. The Network provides the residents with skills training, case management, twenty-four hour emergency on-call psychiatric, health, vocational, socialization, recreational and medication monitoring services. All tenants have incomes below 50% of area median and are generally supported by entitlement payments.

January 1995

Lents Court

The Network operates this five (5) unit home under lease from The Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge and Quint 26 described above. All tenants are low income veterans who are clients of the VA Domaciliary Program. All support services are provided by the VA under a Letter of Understanding with Network.

January 1996

Tea Link Home

The Network operates this five (5) unit home under lease from the Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge, Quint 26 and Lents Court described above. All tenants are low income Asians. All support services are provided by the Chinese Mental Health Program.

March 1996

Hopewell Apartments

Under the corporate ownership of EcuNet Housing, Inc., a partnership between Network and Ecumenical Ministries of Oregon, Network operates this 8 one bedroom and 4 two bedroom HUD 811 apartment building. Hopewell offers low income people with HIV disease and psychiatric disabilities housing and a program of services to help them live as independently as possible. On-site management is available. Tenants pay about 30% of their income for rent and utilities and are required to meet HUD income eligibility requirements.

June 1996

Clinton Street Apartments

The Network owns and operates this 16 unit complex (15 studio apartments and 1 one bedroom apartment) to provide housing with linked support services for low income individuals with mental illness. The project has an on-site manager who provides skills training and support services including medication monitoring, case coordination, and recovery services. All tenants have incomes below 50% of area median and are generally supported by entitlement programs.

September 1996

Tabor House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. All six tenants are low income individuals who are capable of living in an unsupervised, supportive setting. Each has a private bedroom and shares use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

November 1996

75th Ave. Adult Foster Care

Network owns and operates this five resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 50% of area median and are supported by entitlement programs.

August 1998

Powell Blvd. Apartments

Under the ownership of Powell Boulevard Apartments, Inc., a not-for-profit corporation sponsored by REACH Community Development, Network operates this 20 unit HUD 811 project for the benefit of low income persons having co-existing mental illness and substance abuse disorders. Tenants occupy studio, 1 bedroom, and 2 bedroom units, and participate in a program of services designed to promote independence and sobriety. On-site management and supports are available to supplement psychiatric and addictions services provided through Network's Project STOP or other treatment providers. All tenants have incomes below 50% of area median and pay approximately 30% of their income for rent and utilities.

March 1999

Woodstock House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. The tenants are low income women who are capable of living in an unsupervised, supportive setting. The home is configured to allow the rental of individual bedrooms to single women or two bedroom suites to small families. Tenants share the use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

April 1999

Residential Intensive Treatment Services

The Network owns and manages this ten unit transitional housing program in which residential treatment is provided to individuals having mental illness and addictions issues. Tenants are referred by Multnomah County Community Corrections and receive twenty-four hour supervision, addictions treatment, assistance with activities of daily living, money, medication and crisis management; skills training and counseling. Tenants reside in private rooms with half baths during their three month stay. All tenants have incomes below 50% of median; many are supported by entitlements.

January 2000

Nadine Place

Network owns and operates this eight resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 30% of area median and are supported by entitlement programs

Tenants of these residential programs receive housing and on-site services as specified above. In addition, tenants are welcome to participate in the full range of community treatment and rehabilitation programs offered by The Network. These programs include case management; medical and psychiatric consultation; vocational, recreational and socialization services, substance abuse recovery services; psycho-social clubhouse; crisis/triage services; individual and group counseling; and medication management.

MEDICATIONS

MEDICATIONS AND THEIR SIDE EFFECTS

Psychiatric researchers believe that people suffering from many mental illnesses have imbalances in the way their brain metabolizes certain chemicals, called neurotransmitters. Because neurotransmitters are the messengers the nerve cells use to communicate with one another, these imbalances may result in the emotional, physical and intellectual problems that mentally ill people suffer. Psychiatric medications are like any other medicine a doctor would prescribe. They are formulated to treat specific conditions, and they must be monitored by a physician. All medicines have positive and negative effects. Whether or not a person will experience side effects cannot be predicted. Responses to medications are individual. Most medications psychiatrists prescribe may take a few days or a few weeks to become fully effective. The listed medications and their side effects are some of the most common but it is certainly not a complete list.

MEDICATIONS AND THEIR SIDE EFFECTS

Antidepressents	Most Common Side Effects
Amitriptyline (Elavil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, worsening of heart disease, dizziness when first standing up
Amoxapine (Asendin)	Worsening of heart disease, sleepiness, agitation, insomnia, anxiety
Bupropion (Wellbutrin)	Agitation, dry mouth, insomia, headache, nausea, vomiting, constipation, tremor
Clomipramine (Anafranil)	Dry mouth, sleepiness, tremor, weight gain, sweating, dizziness when first standing up, blurred vision, constipation, trouble having orgasm, trouble urinating, nausea
Desipramine (Norpramin)	Dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, dizziness when first standing up
Doxepin (Sinequan)	Sleepiness, sweating, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, weight gain, dizziness when first standing up
Fluoxetine (Prozac)	Agitation, anxiety, insomnia, drowsiness, tremor, loss of appetite, nausea, diarrhea, headaches, dizziness, problems with orgasm
Imipramine (Tofranil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Maprotiline (Ludiomil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, weight gain
Nefazodone (Serzone)	Sleepiness, dizziness when first standing up, nausea, headache
Nortriptyline (Pamelor)	Sleepiness, dry mouth, trouble urinating, constipation, blurred vision, weight gain
Paroxetine (Paxil)	Nausea, sleepiness, fatigue, dizziness, insomnia, sweating, tremor, loss of appetite, anxiety, trouble having an orgasm
Protriptyline (Vivactil)	Dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, insomnia, anxiety
Sertraline (Zoloft)	Nausea, diarrhea, tremor, dizziness, insomnia, sleepiness, sweating, fry mouth, delay in having an orgasm
Trazodone (Desyrel)	Sleepiness, worsening of heart disease, dizziness when first standing up, nausea, vomiting
Trimipramine (Surmontil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Venlafaxine (Effexor)	Sedation, nausea, sweating, dry mouth, dizziness, weakness, constipation, decreased appetite, vomiting, anxiety, tremor, blurred vision, problems with orgasm, headache
Fluvoxamine (Luvox)	Sleepiness, insomnia, anxiety, tremor, nausea, loss of appetite, vomiting, sweating, delayed orgasm

http:noah.cuny.edu/illness/mentalhealth/cornell/medications/antidepsideff.html 7-15-99

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche" =the mind and "tropos" = turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics; that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially highly addictive, produce fairly rapid tolerance and are extremely difficult to withdraw from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal, as bad as it feels, is actually easier, quicker and safer than benzodiazapine withdrawal.

Common side effects are sedation, dry mouth, depression, and memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do **not produce tolerance.** The anti-depressants work to restore balance in the neurotransmitter systems, which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics
Elavil (amitriptyline)

Tofranil (imipramine)
Norpramine (desipramine)
Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

The second generation or "atypical" compounds
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)
Serzone (nefazadone)
Remeron (mirtazapine)

The **SSRI's** (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

The **MAOs** (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The **ANTI-MANICS (also referred to as mood stabilizers)** are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. **Non-addictive** and does not produce tolerance. Research has shown that these medications are also helpful in preventing the recurrence of severe mood swings.
Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The ANTI-PSYCHOTICS also called Neuroleptics are used to treat psychotic symptoms. As such they are believed to work by restoring balance in the neurotransmitter systems (primarily dopamine) which mediate thought processes, perception and mood. They are non-addictive and do not produce tolerance.
Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)
Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
The "new generation" anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Seroquel (quetiapine)
Orap (pimozide) used mainly for Tourette's Syndrome

The Anti-Parkinson medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The ATTENTION DEFICIT DISORDER/HYPERACTIVITY medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. These medications can produce dependence and tolerance. They are less often prescribed now as many of the SSRI anti-depressants and a

couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)
Adderol (contains both dextro and levo amphetamine)

There are probably newer medications in all the above classes since this has been written but this list is fairly inclusive.

Keep in mind that side effects can occur with any chemical you take in. Such things as aspirin and tylenol can be deadly. Side effects are reported when they occur in more than 2% of the population taking a particular medication. Most often they are dosage related or a sensitivity to a particular medication which can be substituted with one which is better tolerated. If you have a condition which warrants taking a psychotropic medication, odds are that you and loved ones around you suffer more from the condition than you ever will from a side effect.

ANTI-PSYCHOTIC DRUGS

ACETOPHENAZINE (TINDAL) MESORIDAZINE (SERENTIL) TRIFLUOPERAZINE (STELAZINE) THIOTHIXENE (NAVANE) RESPERIDONE (RISPERDAL) LOXATANE (LOXAPINE) CHLORPROMAZINE (THORAZINE) HALOPERIDOL (HALDOL) THIORAZINE (MELLARIL) PIMOZIDE (ORAP) MOLIDONE (MOBAN) CHLORPROTHIXENE (TARACTAN) FLUPHENAZINE (PROLIXIN) TRIFLUOPERAZINE (STELAZINE) PERPHENAZINE (TRILAFON) CLOZAPINE (CLOZARIL)	Side effects include dry mouth, blurred vision, constipation, and drowsiness. Some people taking the medications can experience a difficulty in urinating that ranges from mild problems beginning urination to complete inability to do so, a condition that requires prompt medical attention. Other side effects include greater risk for sunburn, changes in white blood cell count (with clozapine), low blood pressure when standing or sitting up, akathisia, dystonia, parkinsonism, and tardive dyskinesia. Tardive dyskinesia is one of the most serious side effects of anti-psychotic medications. This condition affects between 20 and 25 percent of persons taking antipsychotic drugs. Tardive dyskinesia causes involuntary muscular movements, and though it can affect any muscle group, it often affects facial muscles. There is no known cure for these involuntary movements (though some drugs, including reserpine and levodopa may help) and tardive dyskinesia may be permanent unless its onset is detected early.

Anti-psychotic drug list from Kay Peterson/Project Respond/Portland, Or. 7-15-1999

NOTES

PSYCHIATRIC MEDS BY TRADE NAME

CODES:

AA=anti-anxiety
AD=anti-depressant
AD/MAOI=anti-depressant (can be life threatening when mixed with tyramine, eg some alchols & cheeses)
AD/TCA=antidepressant (higher risk of fatal OD)
AP=anti-psychotic
ALZ=for Alzheimers disease
HYP=hypnotics, meds used for sleep
MR=muscle relaxants((not a psych med/may effectbehavior)
MS/AC=mood stabilizers; and /or anticonsulusant
NAR=narcotics,(for pain mgmt, may effect behavior)
SE= meds commonly used for side effects of anti-psychotics
STIM=stimulants

Adaptin	AD	doxepin
Adderall	STIM	dextroamphetamine
Akineton	SE	biperiden
Amytal	SLP	amobarbital
Anafranil	AD/TCA*	clomipramine
Antabuse	Etoh block	disulfiram
Aricept	ALZ	donepezil
Artane	SE	trihexyphenidyl
Ascendin	AD	amoxapine
Atarax	AA	hydroxyzine
Ativan	AA	lorazepam
Aventyl	AD/TCA*	nortriptyline
Benadryl	SE	diphenhydramine
Buspar	AA	buspirone
Centrax	AA	prazepam
Clozaril	AP	clozapine
Cogentin	SE	benztropine
Cognex	ALZ	tacrine
Cylert	STIM	pemoline
Dalmane	HYP	flurazepam
Darvocet	NAR	propoxyphene
Demerol	NAR	meperidine
Depakane	MS/AC	valproic acid
Depakote	MS/AC	valproic acid
Desyrel	AD	trazadone
Dilantin	AC	phenytoin
Dilaudid	NAR	hydromorphone
Effexor	AD	venlafaxine
Elavil	AD/TCA*	amitriptyline
Endep	AD/TCA*	amitriptyline
Equanil	AA	meprobamate
Eskalith	MS	lithium

Floricet	NAR	butalbital with aspirin
Florinal	NAR	butalbital with tylenol
Flexoril	MR	cyclobenzaprene
Halcion	HYP	triazolam
Haldol	AP	haloperidol
Inderal	SE/AR	propranolol
Isoptin	AR/MS	verapamil
Janimine	AD/TCA*	imipramine
Kemadrin	SE	procyclidine
Klonopin	AR	clonazepam
Librium	AR	chlordiazepoxide
Lioresal	MR	baclofen
Lithobid	MS	lithium
Loxitane	AP	loxapine
Ludiomil	AD	maprotiline
Lortabs	NAR	hydrocodone
Luvox	AD	fluvoxamine
Marplan	AD/MAOI	isocarboxazid
Mellaril	AP	thioridazine
Miltown	AR	meprobamate
Moban	AP	molidone
Mysoline	AC	primidone
Nardil	AD/MAOI	phenelzine
Navane	AP	thiothixene
Nembutal	HYP	pentobarbital
Noctec	HYP	chloral hydrate
Norpramin	AD/TCA*	desipramine
Orap	AP	pimozide
Pamelor	AD/TCA*	nortriptyline
paraldehyde	HYP	paraldehyde
Parnate	AD/MAOI	tranycypromine
Paxil	AD	paroxidine
Percocet	NAR	oxycodone with tylenol
Percodan	NAR	oxycodone with aspirin
Pertofrane	AD/TCA*	desipramine
Placidyl	HYP	ethchlorvynol
Prolixin	AP	fluphenazine
ProSom	HYP	estazolam
Prozac	AD	fluoxetine

Rela	MR	carisoprodol
Remeron	AD	mirtazapine
Restoril	HYP	temazepam
Risperdal	AP	resperidone
Ritalin	STIM	methyphenidate
Robaxin	MR	methocarbamol
Seconal	HYP	secobarbital
Serax	AA	oxazepam
Serentil	AP	mesoridazine
Serzone	AD	nefazodone
Seroquel	AP	quitiapine
Sinequan	AD/TCA*	doxepin
Soma	MR	carisoprodol
Stelazine	AP	trifluoperazine
Surmontil	AD/TCA*	trimipramine
Symmetrel	SE	amantadine
Taractan	AP	chlorprothixene
Tegretol	MS/AC	carbamazepine
Tenormin	SE	atenolol
Thorazine	AP	chlorpromazine
Tindal	AP	acetophenazine
Tofranil	AD/TCA*	imipramine
Tranxene	AA	clorazepate
Trilafon	AP	perphenazine
Tylenol/codeine	NAA	acetominophen with codeine
Tylox	NAA	oxycodone with aspirin
Valium	AA	diazepam
Vistaril	AA	hydroxyzine
Vivactil	AD/TCA*	proptriptyline
Wellbutrin	AD	bupropion
Xanax	AA	alprazolam
Zoloft	AD	sertraline
Zyban	AD	buproprion
Zyprexa	AP	olanzapine

GENERIC NAME	TRADE	TYPE
acetominophen with codeine	Tylenol/codeine	NAR
acetophenazine	Tindal	AP
alprazolam	Xanax	AA
amantadine	Symmetrel	SE
amitriptyline	Elavil	AD/TCA*
amitriptyline	Endep	AD/TCA*
amobarbital	Amytal	SLP
amoxapine	Ascendin	AD
atenolol	Tenormin	SE
baclofen	Lioresal	MR
benztropine	Cogentin	SE
biperiden	Akineton	S
bupropion	Wellbutrin	AD
buproprion	Zyban	AD
buspirone	Buspar	AA
butalbital with aspirin	Fioricet	NAR
butalbital with tylenol	Fiorinal	NAR
carbamazepine	Tegretol	MS/AC
carisoprodol	Rela	MR
carisoprodol	Soma	MR
chloral hydrate	Noctec	HYP
chlordiazepoxide	Librium	AA
chlorpromazine	Thorazine	AP
clomipramine	Anafranil	AD/TCA*
chlorprothixene	Taractan	AP
clozapine	Clozaril	AP
clorazepate	Tranxene	AA
clonazepam	Klonopin	AA
cyclobenzaprene	Flexoril	MR
desipramine	Norpramin	AD/TCA*
desipramine	Pertofrane	AD/TCA*
dextroamphetamine	Adderall	STIM
diazepam	Valium	AA
diphenhydramine	Benadryl	SE
disulfiram	Antabuse	Etoh block
donepezil	Aricept	ALZ
doxepin	Adaptin	AD
doxepin	Sinequan	AD/TCA*
estazolam	ProSom	HYP
ethchlorvynol	Placidyl	HYP
fluoxetine	Prozac	AD
fluphenazine	Prolixin	AP
flurazepam	Dalmane	HYP
fluvoxamine	Luvox	AD
haloperidol	Haldol	AP
hydrocodone	Lortabs	NAR
hydromorphone	Dilaudid	NAR
hydroxyzine	Atarax	AA

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAA
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MA
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAA
oxycodone with aspirin	Tylox	NAA
oxycodone with tylenol	Percocet	NAA
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAA
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

thiorazine	Mellaril	AP
thiothixene	Navane	AP
tranycypromine	Parnate	AD/MAOI
trazodone	Desyrel	AD
triazolam	Halcion	HYP
trifluoperazine	Stelazine	AP
trihexyphenidyl	Artane	SE
trimipramine	Surmontil	AD/TCA*
valproic acid	Depakane	MS/AC
valproic acid	Depakote	MS/AC
venlafaxine	Effexor	AD
verapamil	Isoptin	AA/MS

MEDICAL EMERGENCIES include but are not limited to:

Anti-psychotics (AP) may cause a syndrome with muscle rigidity, fever, fast pulse rate, high blood pressure, confusion.

Anti-psychotics (AP) may cause muscle stiffness and tightening, tremors, and effect swallowing.

Tricyclic anti-depressants (AD/TCA*) present a higher risk of lethal overdose, especially if combined with alcohol; if combined with cocaine can produce heart failure.

Antabuse (disulfiram) if combined with alcohol will cause flushing, sweating, headache,palpitations, difficulty breathing, rapid heart beat, drop in blood pressure, nausea & vomiting; may lead to serious drop in blood pressure and death.

Medication-related seizures , a situation which should be evaluated at the hospital.

Certain anti-depressants (AD/MAOI) if combined with alcohol , certain cheeses and other foods containing tyramine will cause blood pressure crisis.

Delirium is a medical emergency, which includes symptoms of irritability, significant distractability, hallucinations,

Meds such as anti-anxiety agents and hypnotics have a higher risk of lethal overdose particularly if combined with alcohol.

OTHER RISKS OF PSYCHIATRIC MEDICATIONS INCLUDE:

Susceptability to sunburn-particularly with certain antipsychotics.

Higher risk of dehydration- particularly with lithium.

Anti-cholinergic side effects , including dry mouth, blurred vision, constipation, difficulty urinating, impotence, constipation.

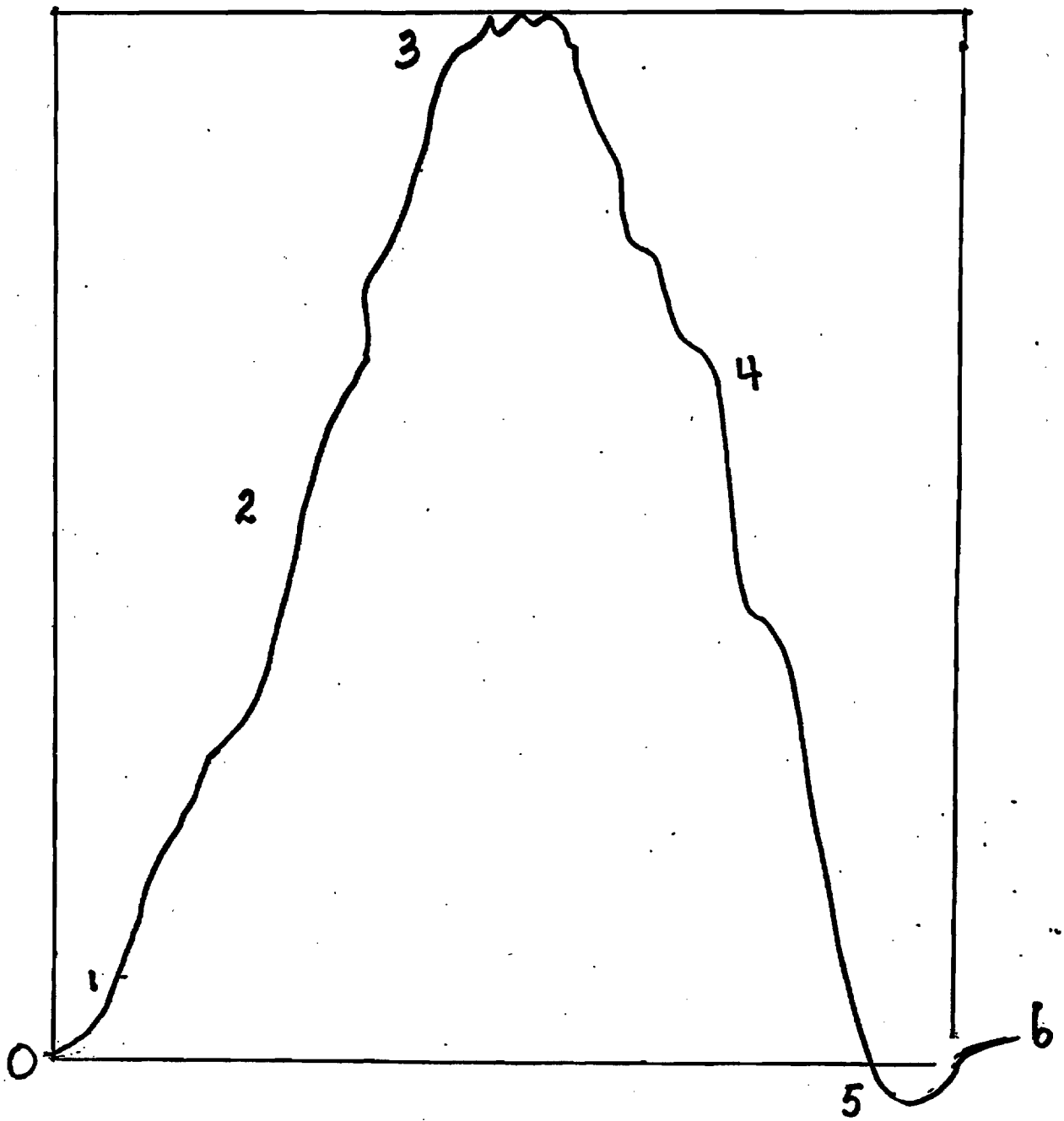
Many medications can cause allergic reactions as well as unexpected reactions with other medications, foods, alcohol, drugs.

Compiled by Project Respond for the Portland Police Department.

Crisis Intervention

CRISIS CYCLE

The Crisis Cycle



0 - Normal State
1 - Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post crisis depletion
6. Stabilization

CRISIS CYCLE

0. Normal state.

1. Stimulation

Something has happened to cause the person to become:

Excited or
Active or
Upset or
Physically uncomfortable

Cause can be external or internal or both.

External
Something someone else said or did.
Environment: hot, cold, crowded.

Internal
Physical illness, injury or pain.
Emotional upset
Mental illness: mood disorders, hallucinations.

2. Escalation

Obvious signs of distress.
Observable physical changes and changes in behavior. (if you don't know the person, it may be hard to know what is a change)

Examples:
Red face
Tense muscles (tight face, clenched fists)
Talking more or louder. (some get quiet/withdrawn)
-Increased activity : Pacing, rocking, etc.

3. Crisis

Out of control.
May scream, yell, curse.
May wave arms or stamp feet.
May assault.

4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

Basic Psychiatric Life Support Model

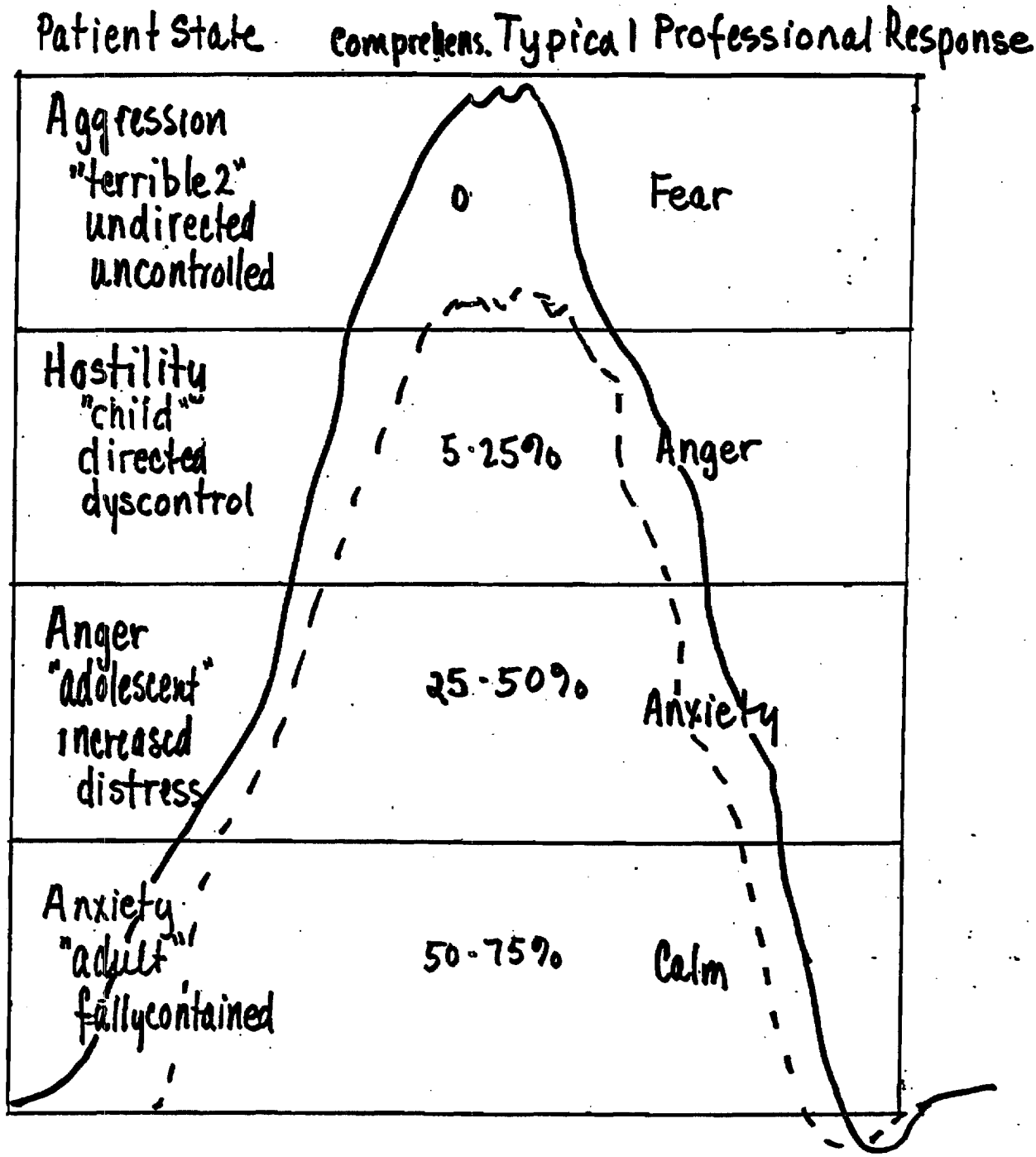
Patient State

Aggression "terrible 2" undirected uncontrolled
Hostility "child" directed dyscontrol
Anger "adolescent" increased distress
Anxiety "adult" fully contained

Basic Psychiatric Life Support Model

Patient State	% comprehension
Aggression "terrible 2" undirected uncontrolled	0-5%
Hostility "child" directed dyscontrol	5-25%
Anger "adolescent" increased distress	25-50%
Anxiety "adult" fullycontained	50-75%

Crisis Cycles with Basic Psychiatric Life Support Model



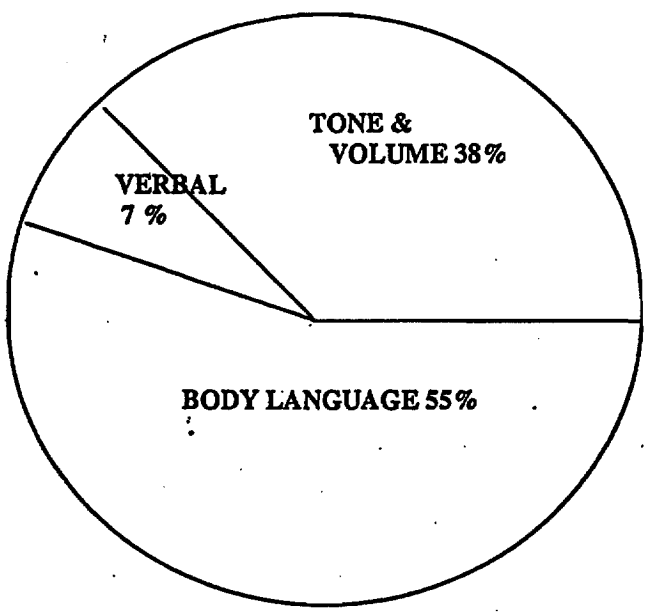
Managing Behavioral Emergencies

As trained crisis intervention specialists, your most likely subjects will be out of control chronically mentally ill persons, angry domestics, suicidal people in public places (bridge jumpers), barricaded individuals, and/or intoxicated persons displaying bizarre behaviors. What do these folks have in common? All will demonstrate some degree of serious impairment in their ability to communicate effectively. This presents a challenge to the police specialist who is attempting to negotiate an alternative to violent behaviors.

One of the few tools that mental health workers have available in dealing with agitated people is the ability to talk down potential assailants. Here are some useful ideas and techniques. The following focus will examine strategies in which you might maximize your ability to deal with agitated people. None of the material in itself is new. The objective for this presentation is to examine principles of applying effective communication techniques to de-escalate agitated persons when possible.

COMMUNICATION

When individuals are highly stressed, non-verbal communication becomes dominant.



Communication

Communication is a people process. It is an interactive phenomenon, which involves more than words. Messages are often the result of a combination of words, behaviors, and context. Parts of the message are:

Verbal Components

1. Content
2. Speech
   - Rate productivity
   - Tone
   - Volume
   - Congruency with other messages

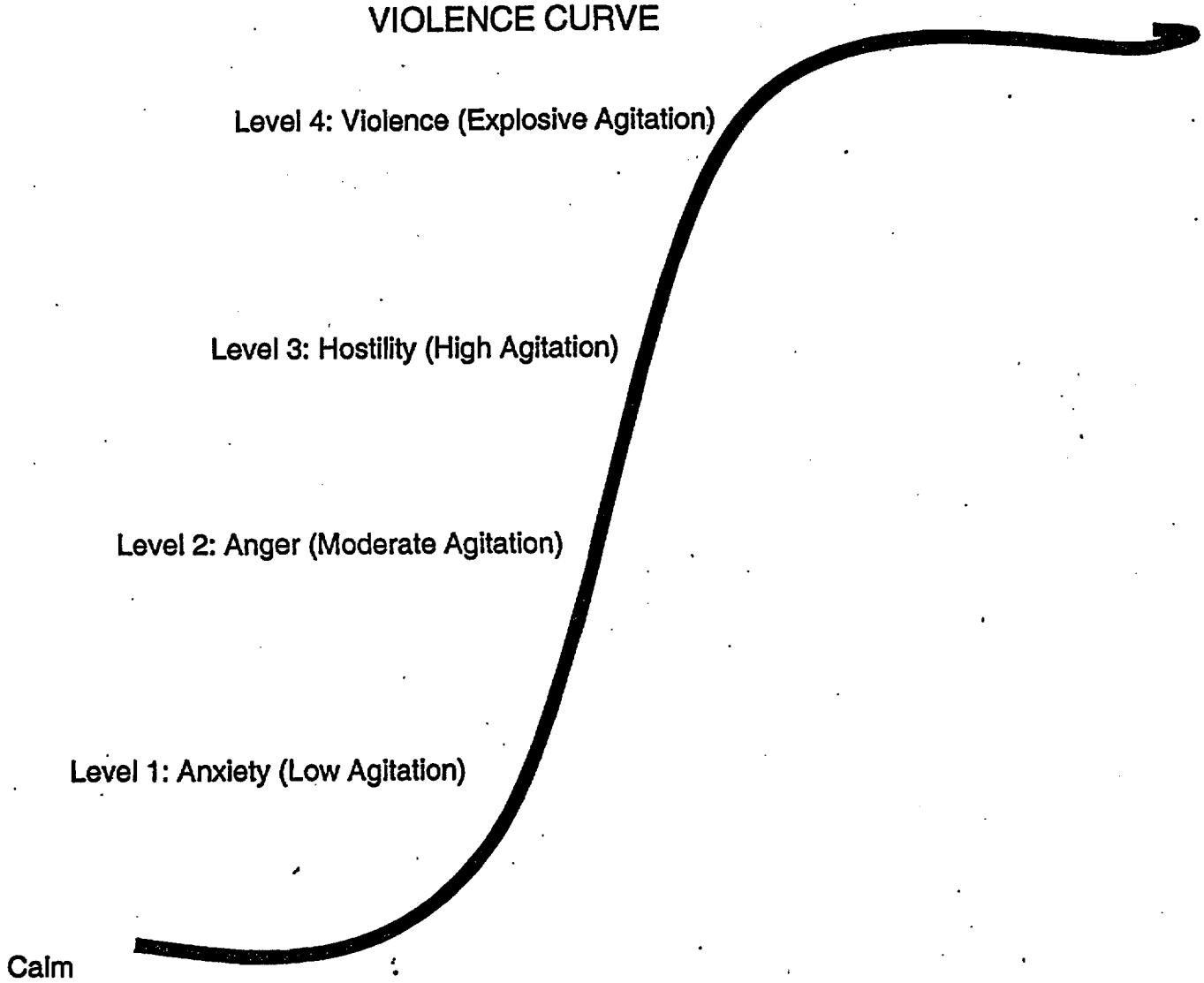
Nonverbal Components

1. Stance
2. Gestures – transient movements of the body or face
3. Eye movements
4. Facial expressions
5. Personal attire
6. Motor movements

Factors that influence communication

1. Culture/ Religion
2. Sex roles
3. Social class
4. Perceptions or internal experiences
5. Values

VIOLENCE CURVE



The above violence curve does not take into consideration variables of acute mental illness or intoxicants or both. Behaviors of individuals so affected will be erratic and tend not to follow progressive patterns.

CONCRETE THINKING

SUSPECT/ PERSON	CIT OFFICER RESPONSE
LEVEL 4: VIOLENCE	ANGER / FEAR
LEVEL 3: HOSTILITY	FEAR
LEVEL 2: ANGER	ANXIETY
LEVEL 1: ANXIETY	EMPATHY
CALM	SUPPORTIVE

Interaction

The escalation of violence chart describes the interaction and dynamic between the subject and officer. Both parties are human beings and are products of their upbringing, social norms, and survival instincts.

During the calm state of the violence chart, the subject is at ease. It is relatively easy to interact with such individuals even if they show perceptual distortions. When the subject shows anxiety as in level 1, it is not difficult to engage the person with a degree of sympathy or empathy. However, once the subject begins to exhibit symptoms of anger as in level 2, the CIT officer will normally experience symptoms of anxiety. When the subject is openly aggressive/abusive as in level 4, anger/fear may be the response.

The problem for both the subject and CIT officer is that as we move up the scale, the ability to effectively communicate diminishes. The subject's tunnel vision increases and thinking becomes more concrete as he/she gets more wound up. The officer likewise becomes more concrete as the stress level increases. The police officer has the additional disadvantage of needing to suspend emotions in order to perform well. Separating out feelings and increasing cerebral activity to

perform a technical function is common amongst emergency service workers. Unfortunately, this approach is counterproductive to the process of communication (which we described earlier as a people process interchange of ideas and feelings). The police officer must somehow bridge the paradox between suspending his/her emotions temporarily while listening for emotional cues in an effort to be effective.

The goal of the police officer in dealing with emotionally charged individuals is to pace and guide them into levels more conducive to mutual interchange. Communication skills for the police officer are like any other technical skill. Training and experience promote access to the skill — especially under emergent conditions.

Level 1: Anxiety
A subjective and uncomfortable emotion, which results from threats to the person. Accompanying feelings are dread and helplessness. The goal is to restore the person's sense of control by providing emotional support and negotiating an alternate action to the crisis.

Physical Attending Skills
- Facing the person squarely.
- Adopting an open posture.
- Leaning towards the person.
- Maintaining direct eye contact.
- Retaining a relaxed posture.
- Promoting a relaxing environment.

Responding Skills
- Emotional labeling
- Paraphrasing
- "I" statements
- Reflection / Mirroring
- Minimal reassurance
- Effective silence
- Open statements

Psychological Attending Skills
- What level of agitation did the patient display?
- What central theme concerned the patient?
- Was there evidence of drugs or alcohol that might interfere with predictability?

Intervention
- Negotiate through active listening

Level 2: Anger

Anger is a feeling state or emotion that serves to neutralize the helpless dread of anxiety. Anger can be functional in that the expression gives the person a sense of power. The danger is that anger can quickly escalate into physical expression or violence.

Angry people become less flexible in their ability to think. That is, they become more concrete as emotions rise. It is easier to understand that which can be touched or seen. Visual (nonverbal) messages become more important during stressful events. During stress periods, your verbal communication is required to be shorter, simpler, and more directive.

You goal is to keep the subject conversing with you and use time and your relationship to de-escalate the agitation.

Three Primary Techniques

1. Diffusing the adversarial emotion by acknowledging the anger. "I can see that you're very angry," or, "I'm sorry you're so upset." This has an impact when people become agitated and more concrete in their thinking because they automatically relate in terms of good or evil. That is, they may see themselves as victims and you as the aggressor. Acknowledging their concerns may serve to personalize and close this ever-increasing gap and provide you with a better chance of continuing an effective way of communicating. Remember, acknowledging the person's concern is not the same as agreeing with their position.

2. Advise giving or providing guidance in choosing a course of action or assuming a new role can help. Keep the advice very here and now, e.g. "you might be more safe on the sidewalk," or, "perhaps we could talk privately."

3. Provide choices. Offer a different course of action (A or B) or, one course of action that the person may choose to do or not (A or not A).

Remember that nonverbal interactions of posture, eye contact, tone, volume and pace are very important in the process of de-escalating the person.

Physical Attending Skills

- Facing the person at a 45-degree angle.
- Adopt an open posture
- Lean in to listen
- Maintain direct eye contact.
- Retain relaxed posture
- Promote a relaxing environment

Responding Skills

- Respect

- Empathy
- Genuineness
- Speech Delivery
- Volume
- Calm Tone
- Productivity — keep dialogue simple.
- Content focus — keep immediate to the key issue.
- Pace speech to slow the person's agitated tempo.

Psychological Attending Skills

- Analysis
- What level of agitation.

Drugs and alcohol

- What central theme concerns the person?
- Can the anger issue be identified?
- What level did you leave the person?

Intervention

- Diffuse the adversarial momentum by affirming the anger.
- Advice giving. Directing to follow your good plan.
- Providing choices. Either A or B. A or –A.

Level 3: Hostility

Hostility is anger with a focused recipient. Hostile people are easy to detect. They are more openly irritable, demanding, argumentative, antagonistic or oppositional. Their voice volume can often be loud and threatening. This is the next stage to violence and must be dealt with caution given the potentially quick transition time. The subject is very concrete and more reliance is placed on the police officer's nonverbal and brief response. The goal is to obtain immediate control of the situation and diffuse to a less agitated (more manageable) stage.

The hostility stage is highly dynamic and the subject may move about displaying varying intensities. Each intervention episode should be less than 60 seconds in duration and often needs to be repeated before successfully diffusing the person/subject to the anger stage.

Four techniques in gaining control of the situation

1. Limit setting: Clearly state the boundaries of behavior that you will allow. "I need for you to lower your voice," "please step outside," "I need for you to leave," "please step back, I'm uncomfortable with you so close." The nonverbal approach is serious, professional, and authoritative. Hand signals are used to communicate. The verbal tone and volume are consistent with

the serious message. Sentences are less than 5 words and repeated rather than elaborated.

2. Diffuse the adversarial stance by acknowledging the anger: Timing is critical. Immediately (microseconds) following limit setting, or "punching a hole" in the defensive tirade. Affirm the individual by acknowledging his/her emotional state. This is a critical test point. If the subject/person accepts ("damn right I'm angry), then continue to dialogue using verbal and nonverbal skills to move to the more manageable Anger Stage. However, if the subject/person continues unabated despite repeated tries, be concerned that the escalation may result in violence.
3. Provide directives: Firmly tell the individual what you want him/her to do.
4. Give Warning: Clearly state as neutrally as possible the consequences of a given course of action.

The approach

1. Dealing with potentially violent people is frightening. You might be as charged as the subject. Try to maintain control by purposely taking deep breaths. Remember that you are going to try and regain control of the situation by communication. It isn't going to impress anyone if you squeak out your directives with residual air.
2. Approach the subject squarely from the side to avoid direct kicks. Keep an open posture (to avoid being perceived as attacking) and keep your hands out of your pockets.
3. Keep approximately two arm lengths distance from person.
4. Do not attempt to communicate by touch.
5. Maintain eye contact and an upright posture in an effort to convey control. Communication is continuous. The eyes coupled with facial gestures may provide advance warning of attack.

The Interaction

1. Do not engage in accusations, arguments, and demands for justification from the subject. This will result in a power struggle, which will prove futile. Winning arguments is not as important as fulfilling the job that you were called on to perform. Do not succumb to their baiting.
2. Work as a team, which may be part of a prearranged set of actions in dealing with emergent situations. Don't get maneuvered into being split apart as good guy, bad guy. "I can't talk to this cop. He's a jerk. I can see that you are a reasonable person. Can we privately discuss my request?"
3. Keep your verbalizations short and simple. Remember that the subject is operating very concretely and will only hear portions of what you will try to verbalize. Repeat your short request as opposed to paraphrasing.
4. Define clear expectations for the subject and communicate these positively and firmly.
5. Limit or address only those behaviors that clearly interfere with the client's welfare or the rights of others.

6. Confine the limits only to those that can be carried out. Empty limits only reinforce the patient's notion that you can not be relied upon. Likewise don't promise that which you cannot deliver. You will only be setting someone else up for potential violence.
7. Practice pat phrases and have them available. Under stress, it is more difficult to be creative. Timing your response is important in disarming an aggressor.

Physical Attending Skills

- Face the person squarely but approach at a 45-degree angle.
- Open posture. Keep your hands out of your pocket.
- Upright Posture. Denotes seriousness and control.
- Relaxed Posture. Denotes lack of intimidation.
- Do not communicate by touch.
- Maintain eye contact — look for advance warning of attack.
- If you point at an object or area, do not take your eyes off the subject.
- Remain two arm lengths away.

Responding Skills

- Genuineness
- Respect
- Speech Delivery
- Volume: Avoid shouting.
- Tone: Confident, assured and serious. Avoid challenging and condescending inflections.
- Rate: Purposely slow to de-escalate.
- Productivity: Keep sentences very short and simple.
- Repeat rather than elongate.
- Content: Here and now. Focus on your directive.
- Do not get "baited" into justifying or arguing.
- Avoid discussions leading to splitting. Confine warnings or promises to those that can be carried out.

Psychological Attending Skills

- Analysis
- What level of agitation?
- Have the person been using drugs and/or alcohol?
- What themes are being presented?
- Any "baiting or key words?
- What level did you leave the person?

Intervention

- Limit setting. Clearly state the boundaries of the behavior you will tolerate.
- Acknowledge the anger and focus.
- Provide directives. Firmly tell the individual what you want him/her to do.
- Warning. Clearly state as neutrally as possible the consequences of his/her behavior.

Level 4: Violence

Response Guidelines

Violence is aggression with a focus on destruction. Violence has injury as its goal. Violence may be verbal (if disruptive or hurtful enough) and/ or physical. The goal is to protect oneself. The goal is not to win but be useful at another time.

The Interaction

- Let your face drain of gestures
- Drop your shoulders indicating relinquishment
- Remain at 45-degrees to the person
- Don't make any sudden moves
- Don't take insults and taunting personally
- Don't be baited
- Do not take your eyes off the patient
- Clearly indicate to the aggressor that you intend to disengage and withdraw, e.g. "I quit, " or" "I'm out of here" messages
- Start moving away towards your escape
- Move slowly and methodically
- Continue your verbal and non-verbal communication to indicate retreat
- You can remain at bay waiting for reinforcements to arrive or totally withdraw.

Active Listening Concepts

Listening for Emotions

People communicate on two levels:

- Content — the simple facts
- Emotions — the emotional reaction to the facts

Train yourself to listen for the emotional message behind the content. Emotional reaction and subsequent behavior make the situation a crisis, not the fact of the situation. How a person feels about a situation will strongly influence what he/she does. Controlling the subject's emotions will help control the subject's behavior.

Listening for Values

- What people think are important
- What people prize

There may be a need to clarify the subject's values. Values influence behavior. The crux of the situation may be a value conflict.

Active Listening Skills

- Emotional labeling
- Paraphrasing
- Reflecting / Mirroring
- Effective pauses (silence)
- Minimal encouragers
- "I" Messages
- Open-ended Questions

Emotional Labeling

- The first active listening skill to be used in an incident.
- The intent of emotion labeling is to respond to the emotions heard in the subject's voice rather than content.
- Demonstrates that you are really listening and tuned into what the subject is emotionally experiencing.
- Do not tell a person how they are feeling, but rather how they *seem* or *sound* like they are feeling to you.
- Do not be afraid to label emotions incorrectly.
- Be aware of missing emotions.
- Listen for conflicts in the feelings expressed.
- Never hesitate: label every emotion you hear.
- Note when the emotions are inappropriate to the situation described.
- Be aware of your emotions and what the subject is hearing from you.
- Use throughout the negotiation / intervention whenever you hear emotions expressed.
- Do not use when you are being verbally attacked.

Emotional Labeling Examples

- You sound _____
- You seem _____
- I hear _____

Paraphrasing

- A summary in your words as to what you were just told.
- Demonstrates you are listening.

- Creates empathy and rapport because it demonstrates you have heard and understand.
- Creates empathy and support.
- Clarifies content, checks perception, and highlights issues.
- Obtains additional intelligence.

Paraphrasing Examples
- Are you telling me...
- Are you saying...

Reflecting / Mirroring
- Repeating back the last word or phrase the subject just said.
- Gives feedback that is very exact.
- Asks for more intelligence without guiding the direction.
- Gets intelligence when you do not have enough to ask a good question.

Effective Pauses (Silence)
- An effective pause is silence.
- Silence is effective if it serves your purpose.
- Most people are not comfortable with silence and will fill it with talk.

Uses of Silence
- When you are about to say something important.
- When you have just said something important.
- When the subject is trying to "psych" you out.

Minimal Encourages
- The sounds you make, especially on the telephone, to let the other person now you are present and listening.
- May be short questions such as: "really?", "Oh?", "When?"
- Does not interfere with the flow of the conversation.
- Lets the subject know you are present and listening.

Uses of Minimal Encouragers
- Helps build rapport.
- Encourages the subject to continue talking.

"I" Messages
- Enables us to let the subject know how they are making us feel, why we feel that way, and what they can do to remedy the situation.
- Conveys the above information in a non-threatening way and does not put the subject on the defensive.

Uses of an "I" Message

- When communication is difficult because of the intense emotions being directed at you.
- When the subject is making communication impossible.
- When you need to refocus the subject.
- When you are being verbally attacked.

Examples of "I" Messages

- I feel _____(emotion or feeling)
- When you_____(his/her behavior)
- Because _____(your reason)

Open-Ended Questions

- Questions that cannot be answered with a "yes" or a "no."
- To obtain information without asking a lot of questions.
- Usually begins with the words: how, what, when, where.

Uses of Open-Ended Questions

- To help a subject start talking.
- To elicit examples of specific behavior.
- To obtain additional intelligence.
- To focus on the subject's feelings.

Problems Caused by Closed-Ended Questions

- Gives a feeling of interrogation, which makes rapport difficult to build.
- Causes you to work harder thinking up new questions.

NOTES

INTERVENTION IN THE CRISIS CYCLE

INTERVENTION

A. APPROACHING THE SCENE
   1. Calls
   2. Information before you arrive
   3. Monitor your own emotional state
   4. Leave prejudices/bias/predisposition behind

B. ON THE SCENE
   1. Assess the situation and stabilize, if necessary

C. CRISIS INTERVENTION
   1. Crisis cycle
      a. Intervention at each stage of the cycle
      b. Different levels of understanding, perception and development at each stage
         (1) Look at face, voice and posture for signs of what level
      c. Stages of cycle
         (1) Normal state
            (a) 100% perception and ability to reason
            (b) Acts as an adult
            (c) Person experiences no emotional content
            (d) Officer is calm
            (e) Can problem solve
         (2) Stimulation (internal/external)
            (a) 50-75% perception and ability to reason/understand
               1) Agitated behavior
            (b) Acts as a teenager
            (c) Person experiences anxiety
            (d) Officer is calm
            (e) Action officer should take
               1) Use simple sentences
               2) Use calming body language
               3) Keep voice low and calm
         (3) Escalation
            (a) 5-24% perception and ability to reason/understand
               1) Loud, aggressive, flushed
            (b) Acts as an 8-year old having a tantrum
            (c) Person experiences fear; frustration
            (d) Officer is anxious
            (e) Actions officer should take
               1) Use sentences of less than 5 words
               2) Make one immediate request
               3) Repeat continually
               4) Body language and voice firm but calm
         (4) Crisis
            (a) 0-5% perception and ability to reason/understand
               1) Out of control

(b) Acts like "terrible two's"
(c) Person experiences anger
(d) Officer is fearful/frustrated
(e) Actions officer should take
1) Use firm, one sentence commands
2) Repeat continually
3) Make decision regarding use of physical force

(5) De-escalation
(a) As consumer de-escalates, officer uses the same techniques down the de-escalation
(b) Consumer may suffer post-crisis depression
(c) Escalation can cycle up and down

(6) Things to remember
(a) Take your time
1) Person cannot remain in crisis state forever
(b) Constantly read feedback from consumer
(c) Stop doing anything that escalates the consumer
(d) Continue anything that de-escalates the consumer

(e) Have only one officer talk to the consumer at a time
1) Trade off if not effective

2. Communication skills

a. Verbal skills

(1) Tell person you are there to help
(2) Introduce self by first name
(3) Ask and use their name
(4) Do not involve yourself in their delusions; show you understand that they believe it is really happening
(5) Ask clarifying questions in terms of "I" statements
(a) "I don't understand this"
(b) "I'm afraid you'll hurt yourself"
(c) "I can't figure out why"

(6) Use personalized statements
(a) "Your holding that rock makes me nervous"

(7) Do not argue
(8) Actively listen
(a) Do not be afraid of silence
(b) Wait for responses
(c) Echo their feelings "You seem to be angry"

(9) Show concern and understanding
(a) Nod head while they are talking; indicate listening with "I see", "Uh, huh", etc.

(10) Treat person with respect
(11) Do not use offensive terms or sarcastic remarks
(12) Tell people what you are going to do
(a) Do not make promise you cannot keep

(13) If person becomes agitated, change subject

b. Non-verbal skills
   (1) Feedback loop
      (a) Watch reactions of consumer to you
      (b) Stop action if escalates consumer
   (2) Open body language
      (a) Rule of palms
         1) Palms open
      (b) Stand slightly to the side/bladed
      (c) Take safe, but not defensive stance
         1) More relaxed posture
         2) Head tilted
         3) Be ready/appear relaxed
      (d) Keep hands off paraphernalia
   (3) Eye contact
      (a) Try to make eye contact
         1) Some people like it as sign of personal contact
         2) May make some people nervous
      (b) Try to remain at eye level
   (4) Body space
      (a) Rule of 3
         1) Remain 3 arms length away at first contact
      (b) May need to move in to establish personal contact
   (5) Move slowly
      (a) Announce action to consumer
c. Questions to ask
   (1) Ask what is happening that caused crisis
   (2) Ask about past history
      (a) Case worker
      (b) Counselor
      (c) Treatment
   (3) Ask how they resolved similar situations in past
   (4) Ask what clinic they go to or where they go for treatment
   (5) Ask if they are taking medication(s)
   (6) Ask the names of their medication(s)
   (7) Ask if they would like to see a doctor
   (8) Ask if they are thinking of taking their own life
      (a) How
      (b) Do they have the means (gun, knife, pills)
      (c) Have they ever tried it before
   (9) Ask if they are hearing voices
      (a) Are they telling you to do something
d. Officer safety reminders
   (1) Never deny the possibility of violence
      (a) Persons with mental illness are not more violent than the "normal" population but may be more unpredictable
   (2) If hearing voices, ask what the voices are saying

(3) Keep relaxed approach, but not complacent
(4) Watch consumer's hands
(5) Upon transport, always handcuff even if this risks re-exciting the subject; tell the person what you are going to do and why

Fear

A perceived need (sometimes irrational) to escape, defend against, or eliminate a perceived threat of personal injury.

Visual signals

Posture: Tense and prepared to defend, hide or run away.

Skin color: Pale or ashen.

Facial expression: Wide-eyed and fearful.

Auditory signals

Voice quality: Whining, pleading, gasping, bursts of speech, may be unable to speak.

Breathing: Rapid, shallow, irregular.

Confirming history

Personal history of abuse / victimization and/or withdrawal, sometimes punctuated by assaultive outbursts.

Crisis Intervention for: Fear

Goal: Threat Reduction

The basic assumption is that communication patterns that reduce the perceived threat will also reduce the probability that the assault will escalate to battery. Conversely, communication patterns that add to the perceived threat can be expected to increase the probability of battery. Here are some guidelines for reducing threat:

Posture: relaxed and open; hands in full view

Gestures: slow, palms-up

Position: slightly off to the side of the fearful client, and far enough away (8-10 feet, if possible) to make it clear that an attack on the client is not being planned.

- positions directly in front of, or any position behind a frightened person can be expected to increase the perceived threat
- positions at or below the eye level of the frightened person can be expected to reduce the perceived threat

Voice quality: firm, reassuring, confident

Speech content: logical, encouraging calm reflection; promising to help if possible, but not promising something that is not possible

Eye contact: if the frightened person seems to seek eye contact as an additional source of reassurance, it should be given freely; if the frightened person tries to avoid eye contact it should not be forced on them. There are many cultures that discourage or limit communication through eye contact.

Physical contact: some frightened people (particularly children) need to have reassurance communicated through touch. Touch should be "offered", not given without permission, and should be light with slow movements.

Frustration

An irrational attempt to gain control by physically attacking the source of frustration.

Visual signals

Posture: Tense and prepared to attack.

Skin color: Tones of purple or red; splotches.

Facial expression: Tense, focused, and angry.

Auditory signals

Voice quality: Menacing, aggressive, loud.

Breathing: Loud, deep, long, heavy.

Confirming history

History of low frustration tolerance, coupled with impulsiveness.

Crisis Intervention for: Frustration

Goal: Control

The basic assumption is that patterns of communication that demonstrate and "lend" control will contribute to the restoration of the internal control of the frustrated client. Conversely, communication that demonstrates loss of control will likely increase the probability that the frustrated person will lose their ability to control an impulse to attack. Here are some guidelines for exerting control:

Posture: self-confident, commanding

Gestures: firm, commanding, palms out or down

Position: directly in front of the frustrated client, and just outside of his/her striking range.

- A position within striking distance of a frustrated person communicates a challenge or a desire to fight.
- A position well outside of striking distance of a frustrated person communicates undue caution or fear, and unwittingly points out vulnerability and willingness to be a target for release of frustration.

Voice quality: quiet, firm, commanding in tones low enough to make the frustrated person strain to hear

Speech content: repetitive, confident commands without threat

Eye contact: direct and accompanied by facial expressions which indicate that a firm command is being given.

Physical contact: if physical contact is required to prevent the frustrated person from escalating from assault to battery, it should be made firmly but without excessive movement or pain that would indicate loss of control.

Manipulation

An indirect attempt to obtain or avoid something in exchange for not losing emotional control. Manipulation becomes dangerous when assault is used as a tool in the attempt. Remember: Beneath every manipulative demand there is a legitimate request. Manipulation can take a variety of forms, including:

The temper tantrum

In this case the manipulating person starts by making a calm, but unreasonable (given the circumstances) request. When the persons' requests / demands are not met, they threaten violence by appearing to lose control: yelling, banging, stomping; etc.

Playing the numbers

In this case the manipulating person attempts to "play" people against each other, hoping that in the confusion their request / demand will be met. Group care settings provide an abundance of opportunities for this form of manipulation.

Promoting confusion

In this case the manipulating person brings in related, but irrelevant, matters into the discussion, leaving the professional wondering what the client really wants, or how the issues being raised by the person relate to the request / demand being made.

Visual and auditory signals

Although the signals are often difficult to interpret at any particular moment, there is a definite and recognizable pattern :

- The initial set of signals often occur in a whining voice, usually with a "gimme" attached, and with the affect of a pitiable victim.
- If that doesn't work, the next step is a series of marginally related accusations, comparisons, and other trivia, uttered in more aggressive tones.
- If that doesn't work, the next step is threats and actions against property.
- Finally, when all else has failed, assault is attempted.

Confirming history

A history of losing control or attacking physically when feeling deprived or oppressed.

Crisis Intervention for: Manipulation

Goal: Detachment

The basic assumption is that communication patterns that tend to indicate refusal to become involved in manipulation will decrease the likelihood that the manipulative person will attempt to gain something through complete loss of control resulting in battery. Conversely, communication that indicates openness to the manipulative demand increases the belief that the demand will be met at the next higher level of loss of control. Here are some guidelines for detaching yourself from a manipulative game:

Posture: closed, relaxed

Gestures: idiosyncratic gestures of disapproval or mild irritation (toe or finger tapping, eye rolling, "disgusted" sighing and nodding, arm folding, etc.)

Position: close enough to physically intervene if necessary, but far enough away to show non-involvement (4-5 feet)

- turning slightly away to show non-involvement is appropriate, but do not turn your back

Voice quality: detached, mechanical, slightly bored

Speech content: quiet, repetitive, "broken record" commands

Eye contact: avoid eye contact by looking at the hairline, chin, shoulders, etc.

Physical contact: if physical contact with the person who is manipulating becomes necessary, it should be handled as quickly and unemotionally as possible. Try to make contact with clothing only, not flesh. Punitive and vengeful forcefulness should be avoided, since it will add to the belief that the manipulation could have been successful if it had been done differently.

Intimidation

A calculated attempt to get something in exchange for physical safety or freedom from the threat of injury. "Don't make me hurt you" is the flavor of the message you get from many of the people who intimidate.

Visual and auditory signals

Basically neutral or unremarkable, with the exception of a menacing voice quality and/or threatening words and posture. Often people who are attempting to intimidate use physical menacing / crowding (standing very close to or over the person being intimidated) as a way to threaten danger.

As in manipulation, there is a definite and recognizable pattern of change in signals:

- First, there is a clear and often strongly stated demand.
- If the demand isn't met, this is followed by a believable threat of physical injury coupled with a reminder that injury can be avoided by complying with the demand.
- Finally, refusal to comply or delay in complying is followed by the attempt to injure through assault.

While we often respond to attempts to manipulate with annoyance and irritation ("here we go again", or "give me a break"), we often respond to intimidation with fear and a belief that we might really get hurt!

Confirming history

A history of bullying, extortion, and other criminal assault.

Note: This form of assaultive behavior is often used by persons diagnosed as "anti-social personalities" or "sociopaths".

PRECAUTIONS (DON'TS)

REMEMBER, DON'T:

1. Deny the possibility of violence when early signs of agitation are first noticed.
2. Underestimate information given by others regarding behavioral clues.
3. Engage in behaviors that can be interpreted as aggressive.
4. Allow others to interact simultaneously while you are attempting to talk.
5. Make promise you can not keep.
6. Allow feelings of fear, anger, or hostility to interfere with self control and professional demeanor.
7. Argue, give orders, or disagree unless absolutely necessary.
8. Be placating by giving in and agreeing to all the real and imagined ills of the person.
9. Become condescending by using cynical, sarcastic, or satirical remarks.
10. Let your own importance be acted out in a know-it-all manner.
11. Raise your voice, put a sharp edge, or use threats to gain compliance.
12. Mumble, speak hesitantly, or use a tone so low that you can't be understood.
13. Argue over small points.
14. Attempt to reason with anyone under the influence of a mind altering substance.
15. Attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.
16. Allow a crowd to congregate.
17. Corner, or be cornered: give the person expanded space.
18. Ask why?
19. Deny the opportunity to save face.
20. Rush, be rushed, or lose your own cool!

RESOLVING CRISIS

02/09/95

1. INTRODUCE YOURSELF. PERSONALIZE CONTACT. "MY NAME IS JOHN. WHAT'S YOURS?"

2. USE A CALM VOICE.

3. UTILIZE RELAXED BODY LANGUAGE.

4. TELL PERSON YOU ARE THERE TO HELP THEM.

5. AVOID ARGUING.

6. SHOW GENUINE CONCERN BY ASKING MANY QUESTIONS.

7. ASK THE PERSON WHAT IS HAPPENING RIGHT NOW TO CAUSE THIS CRISIS.

8. ACTIVELY LISTEN. REPEAT BACK WHAT YOU HEAR THE PERSON COMMUNICATING ABOUT THEIR FEELINGS. REPORT BACK TO THE SUBJECT THE EMOTION YOU THINK THEY ARE FEELING. "YOU'RE FEELING ANGRY." "YOU'RE FEELING ANXIOUS." "YOU'RE FEELING FRIGHTENED."

9. ASK THE PERSON ABOUT HIS OR HER PAST HISTORY OF CRISIS.

10. ASK THE PERSON HOW THEY HAVE RESOLVED CRISIS IN THE PAST.

11. ASK ABOUT FRIENDS, RELATIVES, COUNSELORS, CASEWORKERS OR OTHER POSSIBLE SUPPORT PEOPLE.

12. OBSERVE THE SUBJECTS BODY LANGUAGE.

13. IF THE PERSON BECOMES MORE AGITATED CHANGE THE SUBJECT.

14. STATE CLARIFYING QUESTIONS IN TERMS OF THE OFFICER HAVING A PROBLEM:

"I DON'T UNDERSTAND THIS . . . "
"THAT ROCK IN YOUR HAND MAKES ME NERVOUS."
"I'M AFRAID YOU'LL HURT YOURSELF."
"I CAN'T FIGURE OUT WHY . . . "

15. GIVE INFORMATION. EXPLORE OPTIONS WITH SUBJECT.

16. TREAT PEOPLE WITH RESPECT.

17. TELL THE PERSON WHAT YOU ARE GOING TO DO TO HELP THEM.

18. ALWAYS KEEP YOUR WORD.

THE RULES

1- THE RULE OF TIME

2- THE RULE OF THREE

3- THE RULE OF FIVE

4- THE RULE OF PALMS

5- THE RULE OF ECHOS

6- THE RULE OF CALM

MR/DD

IR, SERT and Protective Services

Leslie Goodlow-Baldwin, MSW
Program Manager
Developmental Disabilities
Protective Services

Introduction

- This training is to povide information on a variety of issues related to Incident Reports and the SERT system.
- Attendees will learn the following items:
  - How to correctly complete an incident report
  - The importance of mandatory reporting
  - What happens during the SERT process
  - In-home Rule effective 1/01/2004
  - PS process and procedures

Agenda

- Definitions
- Mandatory Reporting
- Incident Reports and documentation
- Protective Service referrals and process
- SERT process, documentation and outcome data collection

Overview

- Ensuring the health and Safety of all our clients is the prime responsibility of DDSD.
- Accurate and complete documentation of incidents, follow-up and outcomes is the glue that ties all of the topics today, together.

"Adult" means a person who:

1. Is mentally ill or developmentally disabled;
2. Is 18 years of age or older
3. Receives services from a community program or facility or care provider which is licensed or certified by or contracts with the department.

"ABUSE" means one or more of the following:

(a) Any death caused by other than accidental or natural means or occurring in unusual circumstances.

Examples:

- Suicide
- Accidental or natural death with neglect or other allegations

"ABUSE" means cont.

b) Any physical injury caused by other than accidental means, or that appears to be at variance with the explanation given of the injury;

"ABUSE" means cont.

(c) Willful infliction of physical pain or injury;

- Bruises
- Medication mismanagement resulting in injury
- Physical fights involving an adult
- Domestic violence included

"ABUSE" means cont.

(d) Sexual harassment or exploitation, including but not limited to, any sexual contact between an employee of a community facility or community program and an adult.

- Any sexual contact between an employee, provider or other care giver and the adult.
- Unwelcome sexual contact directed toward the adult by anyone else.
- Consensual or nonconsensual with staff
- Rape or sexual assault included.

"ABUSE" means cont.

(e) Neglect that leads to physical harm through withholding of services necessary to maintain health and well being.

- Withholding food and hydration

Residential/Vocational and AFH OARs also include:

1) Failure to act/neglect
2) Verbal mistreatment
3) Restriction on freedom of movement
4) Physical/chemical restraints (must also have an injury)
5) Financial exploitation

Vocabulary continued:

Community Program – the community mental health and developmental disabilities program as established in ORS 430.610 through 430.700.

SERT – Serious Event Review Team

Incident Report – written report of any injury, accident, act of physical aggression or unusual incident involving an individual.

LEA – Law enforcement agency

1. Any city or municipal police department
2. Any County Sheriff's Office
3. The Oregon State Police
4. Any District Attorney

Mandatory Reporting

- **What it means** - Any public or private official, who while acting in an official capacity, comes in contact with and has reasonable cause to believe that the adult has suffered abuse, or that any person with whom the official comes in contact while acting in an official capacity has abused the adult.
- **Who is a mandatory reporter?** – Employees of the Department of Human Services, County Health Department, **Community Mental Health and Developmental Disabilities Program** or private agency contracting with a public body to provide any community mental health services.
- **What does this mean for you?** – You are required to report to LE any incidents that may be a crime, regardless of the victim's willingness to participate with law enforcement.

SERT Events Categories

1. Death
2. Abuse/Physical
3. Willful infliction of pain
4. Abuse/Restraint
5. Sexual Abuse
6. Neglect/Negligence
7. Abuse/Verbal
8. Restriction of movement
9. Financial Exploitation
10. Inappropriately expending personal funds
11. Fire Department called
12. Police Called
13. Criminal Referral made
14. Ambulance Called
15. Hospitalization – Medical
16. Hospitalization – Psychiatric
17. ER Visit

SERT Incident Report Review Process

1. Staff person receives information regarding an incident with a client.
2. Determines if meets SERT criteria.
    1. IF no, writes PN and attaches to faxed copy of the form. SC documents on tracking log.
    2. IF yes, completes a PINK SERT Incident report form.
3. Puts completed form with supplemental information attached into the folder at the back-up cube.

SERT Incident Report Review Process

SERT incident reports will be reviewed by the PS Screener

1. Screener reviews incident for the following:
    a) Does the incident meet SERT criteria??
    b) Is this a PS referral?
    c) Does incident meet PS definition?
        i. If yes – Send to Tracy, opened as a case and assigned to an investigator.
        ii. If no – Screener will review and determine if follow-up is necessary
    d) Screener will assign an IR number to the form. Send a copy of the form to Tracy for data entry. The original pink is sent to the SC for follow-up.
    e) When follow-up is complete, the form is given to the supervisor for signature.
    f) After supervisor signs, return original pink to Tracy for final data entry. Tracy sends original and "copies of relevant" case notes to the file room.

Protective Services Referrals & Investigations

As stated earlier, any Incident that meets the SERT categories 2-10 are always referred to Protective Services for Referral!

The remaining categories can be considered for PS referral depending upon the incident.

The screener reviews the incident to determine if it meets the criteria as outlined in the OARs.

Key points to know regarding what gets opened vs. not opened.

- We do not do investigations on clients under the age of 18. Those issues are referred to DHS-Child Welfare. But, you still need to fill out a SERT incident report form.
- Neglect either in-home or by contracted staff requires injury or significant risk of injury.
- We do not open investigations for financial exploitation by non-contracted staff (In-home)

What happens when a PS referral is called in to the County?

- The allegation is written up by the staff person who received the call or incident report.
- The Incident is reviewed by the protective services screener, who determines if the allegation meets criteria as outlined in the OARs.
- If no, then the incident is sent back to the service coordinator with recommendations for follow-up.
- If so, the case is opened and assigned to an investigator.

Protective Services Investigations

- The investigator contacts any witnesses, the service coordinator and the alleged victim.
- He/She will also review the ISP, medical documentation, financial documentation, and any other relevant information.
- The final person to be interviewed is usually the alleged perpetrator.
- After the interviews and documentation review, the investigator will compile the information and make a determination of finding.
- The findings will be either substantiated, unsubstantiated or inconclusive.

Protective Services Referrals & Investigations

Additional Key Points:

- ADS reports that come in over the weekend need to be forwarded immediately to the screener. Screener will review for PS/SERT issues.
- Referrals for PS involving possible neglect by Hospitals and facilities. Hospital complaints need to forwarded to DHS, their on-line complaint form.
- Nursing home referrals go through Aging.

Protective Services Investigations, cont.

- Substantiated means that there was a preponderance of evidence indicating that the AP was at fault.
- Unsubstantiated means that there was not sufficient evidence proving fault.
- Inconclusive means that there was evidence of injury or harm, but it is not clear who or what is the cause.

Summary

- Important to remember, if you are not sure, turn it in anyway!
- Protective services is here to ensure not only health and safety, but also that providers are safe as well.
- If it's not written down, it didn't happen!

Where to Get More Information

- MHDDSD web-site
- Call our office – 503-988-3658
- Call the Office of Investigations and Training at 503-945-9483

CRISIS INTERVENTION WITH PERSONS WITH DEVELOPMENTAL DISABILITY

NOTES

Course Title: The Crisis Cycle

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 4:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To introduce the crisis cycle as a model for understanding the stages of crisis. Implications for interventions will be discussed.

Performance Objectives:

1. The officer will be able to identify the stages that a person goes through when in crisis.

2. The officer will be able to identify and list typical emotional responses of officers intervening in crisis.

3. The officer will identify the language comprehension levels accompanying crisis stages and the implications for intervention.

Course Outline:

The Crisis Cycle: the emotional and behavioral stages people experience when in crisis (Oregon Intervention System model

0. Normal State
1. Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post-crisis depletion
6. Stabilization

The Escalation Grid (Basic Psychiatric Life Support Model)

1. Anxiety
2. Anger
3. Hostility
4. Aggression

How the Crisis Cycle and the Grid fit together

1. Emotional and behavioral interactions
2. Two crisis cycles juxtaposed
3. The Grid- typical responses of professional interveners

A. Anxiety- calm
B. Anger- anxiety
C. Hostility- anger
D. Aggression- fear

4. Recognizing your own responses
5. Setting aside your own responses

The effect of emotional state on communication

1. Comprehension decreases as control decreases
2. Implication for intervention strategies
   A. "adult", "adolescent", "child", "terrible 2"
   B. Simplify language
   C. Become more concrete

G. Effects of the system

Implications of characteristics

Finding out if there is someone who can help

1. Who are the players?
2. What questions can you ask to get useful information?

WHAT ARE MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES?

Definitions. There are many different definitions of mental retardation and developmental disabilities. Agencies typically have their own complex definitions, which may differ from agency to agency. The definitions below are "unofficial.

Mental Retardation. Intellectual functioning that is significantly below average, along with substantial limitations in adaptive behavior (for example, ability to independently perform activities of daily living or function in society.) Mental retardation originates during the developmental period (before 18 in most definitions) and is likely to be lifelong. Generally, a person who has an I.Q. score of 70 or lower is considered to have mental retardation.

Note about terminology: many people do not like to have the term "mental retardation" applied to them, because of unpleasant history or associations. Some prefer the term "developmental disability" or "cognitive disability". Some refer to themselves as "slow" or a "slow learner".

Developmental Disability. This is a broader term than mental retardation. A developmental disability is a disability caused by a neurological condition. It originates during the developmental period, it is likely to be lifelong, and it requires training and support similar to that needed by a person with mental retardation. Besides mental retardation, common causes of developmental disability are cerebral palsy, epilepsy, and autism. **Cerebral palsy** is a catchall term for a variety of disorders that affect a persons ability to move and to maintain posture and balance. Walking ability and speech are often affected. **Epilepsy**, also called seizure disorder, is a condition that causes seizures of various kinds. Some seizures cause a person to fall, lose consciousness, and have jerking movements of the whole body for several minutes. Others cause involuntary movements of a part of the body without loss of consciousness, and still others cause a brief loss of consciousness without falling. Mild forms of cerebral palsy or epilepsy are not considered developmental disabilities under the above definition. **Autism** is a severe developmental disability affecting communication, social interaction, and behavior.

Mental Illness vs. Mental Retardation. Mental retardation/ developmental disability is not the same as mental illness. Hallucinations and delusions are characteristic of some mental illnesses; they are not characteristic of MR/DD. Neither are mania or depression characteristic of mental retardation. A person with mental retardation can be expected to act rationally at their functional level. However, a person with mental retardation or another developmental disability may also have an additional disability such as a mental illness or a drug or alcohol addiction.

Other Disabilities. There are other disabilities and health conditions which affect cognitive (intellectual) functioning and which therefore may be confused with mental retardation. A disability from head injury to an adult is not mental retardation, nor is dementia from conditions such as Alzheimers or late stage alcoholism. A person who has recently had a seizure may have a short period of impaired functioning which may be mistaken for mental retardation.

Institutionalization. In the past, many individuals with developmental disabilities, even those with mild mental retardation were routinely institutionalized. Beginning in the late 1960's, it began to be generally understood that people with developmental disabilities had the right and the ability to live in the community. Programs such as group homes and semi-independent living programs were established to provide training and support in the community and people began coming out of institutions in increasing numbers. However, some people were discharged without appropriate

Do you want to call them now?
Is it OK if I call them?

If you are at a group home or foster home(or other situation in which someone seems to be in a staff role) in a crisis, and the staff seems to be unsure what to do:

Ask: Do you have someone you can call to help you in a crisis?
In a foster home there may not be anyone. In a group home or supported living situation, there should always be a way to contact administrators in an emergency.

SOME SUGGESTIONS FOR COMMUNICATING WITH A PERSON WHO HAS MENTAL RETARDATION

- Keep language simple, but not childish.
- Avoid abstractions or technicalities. Be concrete.
- Avoid yes/no questions, or questions that suggest the answer you expect.
- When you give instructions:
  - Give one at a time
  - Be clear and direct
  - Be sure the person understood. One way to do this is to ask them to repeat it back.
- Don't talk to others in front of the person, as if the person wasn't there.
- If the person has any reading/writing ability, write down simple reminders if they need to do something later. Ask if they have a calendar you can write it on.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

supports and others lost supports for budgetary or other reasons. The movement to "deinstitutionalize" people continues to the present. Today, Fairview and Eastern Oregon Training Centers are still in operation, but they are much smaller than they were in the past.

Being institutionalized affects people seriously. A history of being in an institution sometimes helps explain behaviors that are otherwise hard to understand. Usually the younger the person went into the institution, and the longer they remained, the more serious the effect. In an institution, people are deprived of the opportunity to learn what it's like to live in a regular family and community, and so it is much harder for them to develop appropriate social skills. They have limited opportunity to develop normal human relationships, and little modeling of how people act in normal situations. To survive, some people learned to comply with anyone who acted as if they were in a position of authority. The lack of privacy caused some not to have regard for their own privacy or that of others. For some, the lack of respect for their personal property taught them that if they valued something they needed to carry or wear it or it would be taken. People had few choices and little control over their own lives. Many people were sexually or physically abused by other residents or by staff, and they have the same kinds of problems other sexual abuse survivors have. These can include low self esteem, sexual acting out, lack of trust in others, Post Traumatic Stress Disorder and depression.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
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Multnomah County Developmental Disabilities Services Division
5/00

SOME CHARACTERISTICS OF INDIVIDUALS WITH MENTAL RETARDATION: IMPLICATIONS FOR LAW ENFORCEMENT

In order to successfully manage an encounter with a person with mental retardation, whether a victim, suspect, or witness, it is important for the officer to recognize the disability. Recognizing the disability and managing the encounter are often one and the same.

Each person with mental retardation is an individual. People with the same measured I.Q., whether they have mental retardation or not, vary widely in their skills, interests, personality and communication style. Listed below are some characteristics that may be more likely to occur in a person with mental retardation. There won't be anyone for whom all (or even most) of these factors apply. For some individuals with mental retardation few or none will apply.

Communication issues

- Does not communicate at the level of typical persons of the same age group
- Limited vocabulary or limited grammatical skills
- Speech defect
- Unable to read or write or limited ability
- Difficulty understanding questions
- Difficulty answering questions; may give "standard" or "parrotted" responses
- Appears to understand when they do not, may not want to admit lack of understanding
- Fails to comply with rules; this may be due to lack of understanding

Interaction issues

- An excessive desire to please others
- Behavior on a level below the person's age
- Crowding personal space when interacting with others
- Tendency to be overwhelmed by authority
- Becomes hostile or withdrawn rather than admit lack of understanding
- Low frustration tolerance

Judgement/knowledge issues

- Does not fully understand seriousness of situations
- Limited safety awareness; may be easily victimized
- Judgements regarding "friends" are the most difficult
- Easily persuaded or influenced by others
- Lack knowledge on how to protect themselves

Performance abilities. May be limited in some of these areas:

- Reading and writing
- Using the telephone
- Understanding finances
- Making change
- Understanding need to budget to cover living expenses
- May give away money or belongings
- Following complicated directions

- Telling time
- Keeping appointments
- Managing activities of daily living , such as hygiene, housekeeping, cooking

Effects of our culture (or system) and common attitudes about disabilities
These are often as limiting as the effects of the disability itself.

- Praised for compliance
- "Protected" by being "kept in"
- "Protected" by not being given sexual information
- Not taught about their rights
- Segregated from others; heavily dependent on caregivers
- Abuse may not be taken seriously
- Live in high risk environments

SOME IMPORTANT IMPLICATIONS OF THESE CHARACTERISTICS
The victim who has mental retardation:

- Higher risk of victimization, especially for sexual assault and robbery
- May be victimized by caregivers or "friends"
- May not understand that what has happened is a crime or that law enforcement can help

The suspect who has mental retardation:

- May admit to things he/she did not do, in order to comply or please
- May have been a follower or coerced by persons with higher abilities
- May not understand what you tell them about their rights (Miranda warnings)

Suspects, victims, and witnesses

- May tell you what they think is the "right answer"

FINDING OUT IF THERE IS SOMEONE WHO CAN HELP
This may also help you determine what the disability is.

Ask: Do you have a Case Manager?
Do you have their card?
(if no card) Who do they work for? Where is their office?

Ask: Is there someone who is paid to help you?(with money, making appointments, fixing meals,etc)
Do you have their card?
Do you have their phone number?
Would you like to call them now?
Is it OK if I call them?

Ask: Do you have a family member that helps you with things? A neighbor? Someone else?
Do you have their phone number?

Multnomah County Developmental Disabilities Services Division

"WHAT ARE ALL THESE PROGRAMS AND WHO'S IN CHARGE HERE ANYWAY?"

The Developmental Disabilities Services Divison (DDSD) is part of the Multnomah County Department of Community and Family Services. Until recently DDSD was called the "Developmental Disabilities Division" and before that, the "Developmental Disabilities Program". Offices are in the Commonwealth Building, 421 SW 6th, Suite 400, Portland, OR 97204, (503) 248-3658. Office hours are Monday through Friday 8:00 to 5:00 P.M.

The Division provides case management for eligible individuals. It also contracts with private providers (some non-profit and some for-profit) to provide residential and vocational services to some individuals. These residential and vocational services are funded mostly with state and federal money, and are under many state and federal regulations. The state and the county both have oversight responsibility for these programs.

Case Manager - Everyone served by the Division has one. This is the person in the Division who works directly with the individual, the family (especially for kids), and any residential, vocational, or other programs that the individual participates in. **This is who you should ask for when you need help for a particular individual.** The Division no longer calls case managers "case managers", but many other people do, so if you ask for the case manager, everyone will know who you're talking about. These people are now mostly called:

Family Consultant (for children)
Service Coordinator (for adults)

If a person urgently needs help and the case manager is not available, there is a **Backup Worker** available during business hours.

Protective Services Investigator - A specialized case manager who investigates allegations of abuse or neglect of adults served by the Division. (Services to Children and Families – SCF- investigates for children.) Police may deal with a Protective Services Investigator if the abuse or neglect involves criminal behavior. To make a Protective Services referral, report the suspected abuse to the individual's case manager (or the Backup Worker) and a Protective Services Investigator will be assigned.

Managers and supervisors - Every Service Coordinator/Family Consultant has one. You can ask for the supervisor if you can't get what you want from (or can't reach) the Service Coordinator/Family Consultant or the Backup Worker.

Division Manager - The person in charge of the Division.

RESIDENTIAL PROGRAMS

These are the programs that provide support in day to day living for some individuals with developmental disabilities. **Most individuals with developmental disabilities do not have any paid supports; they live by themselves or with friends or family.** There are many who need or want services which are not available due to funding constraints.

24-hour Residential ("Group homes")- These programs provide 24 hour staffing for support of individuals. The "typical" program is a 5- person group home. A few are larger. Some are "apartment model". In those, the staff will be present in the complex, but often not in the individual's apartment. **The people who work directly with individuals are generally called "direct care staff", although** in some agencies, they have other titles like "Community Support Specialist". Typically they work shifts and do not live in the home, although there are exceptions. **Group Homes typically have a house manager or site manager. The direct care staff should be able to reach the house manager or another administrative staff person by phone or beeper at all times, and you may want to ask them to do so if there's a problem.**

Semi-Independent Living Programs (SILP)- A program that provides support (typically 2-4 hours per week) to individuals who live in their own apartments. The individual has telephone access to a staff person in emergencies. If you think an individual may be in a SILP program, you may want to ask them if they have a staff person they can call.

Supported Living - A program that's more individualized than 24-hour residential programs but typically provides more support than SILP. There may be live in staff or "paid roommate", or direct care staff working shifts, or support workers dropping in. As in SILP, the individual has 24 hour access to staff by telephone, at any time staff is not with them.

The three kinds of programs listed above) are run by private agencies, under contract with the Division. All individuals served by these agencies are also served by and receive service payments through the Division (except for a very few individuals who pay privately). Agencies typically operate more than one home or site and several operate more than one program. Each agency has an **administrator** who may be called an Executive Director. The administrator or someone designated by the administrator should be available at all times in real emergencies

Adult Foster Care (AFC) - Adult foster care provides 24 hour care to individuals in private homes. **The provider is the person in charge**, who contracts to provide services. There may also be a **resident manager** and one or more **caregivers.** Typically either the provider or the resident manager lives in the home. Each Adult Foster home is licensed by the Multnomah County Adult Care Home Program, and then various agencies, including the Developmental Disabilities Services Division, arrange for service provision to individuals. Some individual make private pay arrangements for Adult Foster care, not through an agency.

Other kinds of residential supports - Individuals may have various kinds of **respite** (temporary) care, in group homes, in AFC, or with private individuals. Or they may have some paid supports in limited areas like money management. If they are elderly or physically disabled, they may receive foster care, personal care services, or other kinds of services from Senior and Disabled Services Division. If they have mental illness, they may receive help from a mental health agency.

Prepared by Lee Greer, Service Coordinator/Behavior Specialist
Multnomah County Developmental Disabilities Services Division
5/00

Suicide Intervention

SUICIDE INTERVENTION

Suicide Awareness

Portland Police Bureau

Definition of Suicide

"Suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution."

Dr. Ed Shneidman, Psychache, 1993

Startling Statistics
2000 data

- One suicide every 18 minutes
- 11th ranking cause of death in the US
- 734,000 suicide attempts every year
- 5 million living Americans have attempted suicide
- Each suicide affects at least 6 people intimately
- Firearms used in 57% of suicides

Frequency of US suicides

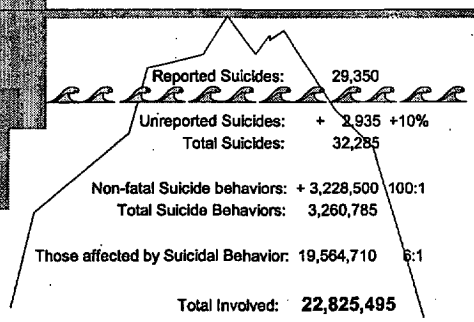
One

Suicide

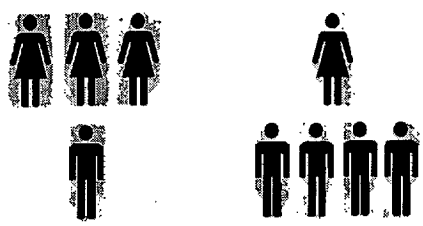
every 18

minutes

Tip of the iceberg
USA 2000 data



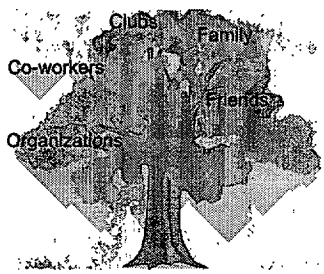
Suicide Demographics
Gender



Female:male ratio is 3:1
for **attempted** suicide

Female:male ratio is 1:4
for **completed** suicide

Who is affected by a Suicide?



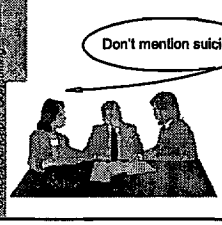
You Are!

Motivations for Suicide

Loss or change in an important relationship
To avoid or end perceived pain
Escape intolerable situation
Gain attention
Manipulate/punish others
Punish self
Become a martyr

Common myths about Suicide

- Happens without warning
- Low risk after mood improvement
- Once suicidal, always suicidal
- Intent on dying



- So rare, they won't do it
- Runs in the family
- No note ==> no suicide

Direct Verbal Clues

I'm going to kill myself

I wish I were dead

You'd be better off without me

I might as well be dead

If ...doesn't happen, I'm going to end it

I'm going to commit suicide

Indirect Verbal Clues

I can't go on any longer — I'm taking the plunge

We all have to say goodbye sometime

Nobody needs me anymore — I'm tired of life

You won't be seeing me any more

Life has lost meaning for me — I can't take it any more

You'd be better off without me

I can't take the pain — Eat my gun

You're going to regret how you treated me

Cash in my chips — Fold my hand

Major Predictors of Suicidal Behavior

Current plan:

- ♦Specificity of their plan
- ♦Availability of means
- ♦Lethality of method

Previous History:

- ♦A prior suicide attempt
- ♦A family history of suicide behaviors

Resources available

Do's of Intervention

- Remain calm
- Help define the problem
- Rephrase thoughts
- Focus on central issue
- Stay close
- Emphasize temporary nature of problem

** **Listen** ** **Listen** ** **Listen** **

Do Nots of Intervention

Don't overlook signs

- Don't sound shocked
- Don't offer empty promises
- Don't debate morality
- Don't leave person alone

Don't remain the ONLY person helping

Important Questions

Have you been thinking of hurting or killing yourself?

- How would you kill yourself?
- Do you have the means available?
- Have you ever attempted suicide?
- Has anyone in your family attempted or completed suicide?
- What are the odds that you will kill yourself?
- What has been keeping you alive so far?
- What do you think the future holds in store for you?

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Suicide Prevention

- Develop your interview around a knowledge base and your questions will follow.
- Interviewing: The Basic Rule, "Always ask"
- Straightforward...Do you have thoughts of hurting or killing yourself? Ask the S word.

  How would you do it? Specificity.
  When and where would you do it? Specificity.
  Do you have the means to do it? Lethality.
  Why now? What is the final straw?
  Why *not* now? What are the protective factors?
  When and with what in the past? What was their impression of it?
  What level of control do you feel? How are your brakes?

- **Reasons for Suicide:**

#1. Person is in acute distress.
#2. Suicidal individuals are ambivalent: see choice as "life or death".
Engage in the "I win" game = If I live I win, if I die I win. Good example is the "Police assisted suicide"...drop the gun or we'll shoot.
#3. Person is cut off from outside support and therefore focus on relationships in the institutional setting.

In hospital studies (John Hopkins/Harvard Medical School) it was found that the symptoms prior to suicide included: Dysphoria (86%), Psychosis (50%), Somatic Anxiety (43%), Psychic Anxiety (93%), Agitation (79%), Lability (93%)

Farberow (1966) studied 218 suicide cases and found the predominant pre-suicide behaviors for the "active group" to be: restlessness, agitation, hyperactivity, pacing and sleep disturbance. For the "passive group" they were: severe depression, isolation, muteness, withdrawal, complaints about health and ambivalence about being in a hospital.

- **Risk Factors:** Sex, sexual orientation, age, alcohol/drug; plan, means (especially firearms), emotional upset, mood disorder, psychosis, physical health, incarceration, support system, recent loss or anniversary of loss, severe anxiety or turmoil, global insomnia, delusions of doom and gloom. Decrease the risk factors and you decrease the risk.

- **Highest Risk:** White, male, recent loss (job, spouse, financial support) alcohol on board. Risk increases with age after fifty. Has a realistic plan and the means to carry it out especially possession or access to a firearm.

- **High Risk:** Incarceration, alcohol or drugs on board, humiliation over arrest/charges (e.g. sex offense, particularly first arrest). Highest risk is during the first few hours of incarceration.

- **The Lethal Triad:** An upset person, with a firearm, with alcohol on board.

- **Important for jail and hospital settings:** Death by hanging is second only to firearms as the means of suicide. Approximately 17.2% of male suicides are by ligature and 14.3% of female suicides. (63.3% and 41.3% for males and females by firearm).

- Stats:
- Females threaten suicide more frequently than males by a factor of 3X.
- Males succeed at suicide more frequently than females by a factor of 3X.
- Incidence of female suicide is relatively stable.
- Rough guess is that there are around 25 attempts for every successful completion. This is an average as among the young there are about 100 attempts per success but among the elderly it may be about 4:1 to as high as 2:1.
- Elderly, white males have the highest incidence of successful suicide.
- 33% of elderly suicides saw their M.D.s the week of the suicide.
- People with a history of abuse as children have a 30 fold increase in risk.
- Oregon ranks 9th in the U.S in suicide rate.
- Suicide is the leading cause of death in people with bi-polar disorder:
  Major depression...20% BUT 98% of suicides are seriously depressed.
  Bi-Polar ... 25% to 50%
  General Population...1%
- In Schizophrenia, 20 to 40% attempt suicide while 10 to 15 % succeed.
- Nationally the rate is 12/100K/year
- This increases to 380/100K/year for people with untreated mental illness.
- Suicide ranks as the 9th leading cause of death in the U.S.
  3rd for fifteen to twenty-four year olds
  14th for elderly
- There has been a 200% increase in suicide rates among Black males.
- Successful suicide rates in the U.S. are: 8:2 male to female....9:1 white to non-white.....7:2 white males to white females.....8:2 non-white males to non-white females
- 2 to 6% of suicides occur in hospital settings (620 to 1800/year or 3/day or 1 per 8hr shift.
- In Oregon, the rate is 12 to 32 per year in hospital settings.
- Nationally, the rate of suicide on Medical/Surgical Units is 42/100K.
- On Psychiatric Units this increases to 90-150/100K. (In Finnish psych units the rate is 400/100K)

- Always take threats seriously even from those you believe are manipulating. Personality disordered individuals have been known to kill themselves just to prove they meant what they said ("I'll show you").

- One in ten with a diagnosis of Borderline Personality Disorder will eventually suicide.

- Look for sudden changes in mood, e.g. a depressed individual who suddenly seems to have "gotten over it". They may have made up their mind to proceed with a suicide.

- Look for classical symptoms of depression; ask about: appetite, sleep, energy, sexual drive-interest-performance, concentration, and mood. What you are looking for are changes, which may be sudden or have been occurring over the past few weeks.
- Most common: **Anergia**...loss of energy.
  Anhedonia...loss of enjoyment or capacity for pleasure.
  Loss of sexual drive, interest, response.
  Hypophagia...loss of appetite with accompanying weight loss.
  Hyperphagia...excessive eating with accompanying weight gain.
  Insomnia...difficulty falling or staying asleep.
  Hypersomnia...excessive sleeping with no sense of rest.
  Loss of concentration, short attention span.
  Low mood, tearfulness, irritability, hopelessness, and despair.
  Excessive guilt.

- Some people may not acknowledge being depressed but they may endorse many items on the list above.

- Suicidal individuals can hide it from you and carry out a successful suicide. You will be left wondering about what more you should have or could have done.

- **Substance Abuse and Suicide:** Lifetime risk 2 to 3% (Two to three times the national average). 15 to 25% of all suicides are by alcoholics. Intoxication is associated with 50% of all suicides.

- **Sobriety is essential.** Substance abuse increases lifetime risk of suicide by 2-3X. 15 to 20% of all suicides are by alcoholics. The highest risk in this group is a male with a long history of drinking who also has a co-morbid psychiatric disorder. Intoxication is associated with 50% of all suicides. Alcohol produces "alcohol myopia" which is the inability to perceive consequences of behavior.

- **Buffers, the "Wall of Resistance":** A strong religious prohibition against suicide. Clean and sober. Intact support system. Willingness to examine options and make a no-harm contract. For women, the best protector against suicide is a child. The more children, the lower the risk...ask "what will become of your children?". A job, a pet, a counselor or therapist. Duty to others. Medication compliance. Good health. Good friends. Job skills, job security. Safe environment and difficult access to means. At

the top of the list is hope. Anything that provides a glimmer of hope to a suicidal individual may be enough to prevent their suicide.

In the final analysis the final decision rests with the individual. However, most suicidal people do not want to die. They want to find a way to live and ambivalence exists right to the moment of death. Reduce risk factors and enhance protective factors and you reduce the risk of suicide.

Primary source of information comes from materials provided by AFSP, the American Foundation for Suicide Prevention

SUICIDAL BEHAVIOR

- Suicidal Behavior
- Suicide Plan
- History of Past Events
- The Persons Resources
- Recent Loss
- Physical Illness
- Drinking and other Substance Abuse
- Physical Isolation
- Dramatic Changes
- Mental Illness
- Suicide Prevention

Suicidal Behavior[2]

A common myth regarding suicide is that people who commit or attempt to commit suicide are mentally ill. Although people who are suicidal are usually in emotional turmoil and although suicide is often preceded by periods of depression, these conditions do not necessarily indicate mental illness. The mentally ill may attempt and commit suicide, but not all that attempt suicide are mentally ill.

Suicide in the United States is the 10th leading cause of death among adults and the second among adolescents. For every suicide there are 8 to 10 attempts, or about 300,000 attempts annually. Suicide knows no boundaries. It cuts across race, class, age, and sex, though its frequency varies with different groups. It is not an illness or an inherited disease as is sometimes believed but is usually a response to a life crisis that the person sees no other way of alleviating. Though many persons who commit suicide are in a temporary state of acute crisis, some are chronically self-destructive and continually attempt suicide.

Listed below are some of the major signs of suicidal behavior. A suicide can still occur without these signs being present, however. At the same time an officer should not hesitate to consider the person suicidal if on ly on e or two signs are apparent. It is impossible to predict suicide in any absolute sense, but inclusions of these signs and guidelines for officers will remove much of the guesswork associated with suicide assessment.

Suicide Plan

Many persons who attempt or commit suicide do so by design. The plan begins with the idea of suicide; suicidal people do not act on impulse but weigh the factors involved. The plan also involves the method of suicide and its lethality. A plan involving a gun will have more likelihood of being effective that will a plan involving tranquilizers. The availability of the means is also a factor. For example, if the person threatens to use a gun and he is a gun owner, the means is clearly available. The final element of a plan is its specificity — time, place, and circumstances. If a person indicates he will commit suicide within two days at a specific time and place, and he has the lethal means, he is a higher suicide risk than one without a plan. The more specific the plan, the higher the risk.

History of Past Attempts

The majority of people who commit suicide have made previous attempts.

The Person's Resources

The officer should assess two types of resources, internal and external. If the person feels life is worthless and that little hope for improvement exists, he or she is lacking internal resources and should be considered a high risk. Lack of

external resources, such as family or friends, or an inability to communicate with those persons is also an indication of high risk.

Recent Loss
Any recent personal loss or the threat of losing a life partner, parent, status, money, or job increases the person's risk of suicide.

Physical Illness
Having a serious illness, especially on that is terminal, that threatens one's values or status, or that is or likely to dramatically affect one's self image increases the risk of suicide.

Drinking and other Substance Abuse
Alcohol or drug abuse is often a sign of other problems, especially if the abuse is recent, and should be included in a suicide assessment. Also, use of alcohol or drugs often increases the risk of loss of control or an increase in impulsive behavior. Alcohol also increases the lethality of a drug overdose

Physical Isolation
The risk of suicide increases when a person is both physically and emotionally isolated. Isolation can cause people to feel they do not belong to a family or society and can increase feelings of worthlessness and other negative self-images. Even temporary isolation may be an impetus for suicide.

Dramatic Changes
A sudden, dramatic, or unexplainable change in lifestyle or behavior may be a clue to suicide contemplation. Change in one's social network and environment such as relocation or retirement can be very upsetting. Also, unexplained changes in behavior are often a symptom of a larger problem, which may in turn increase the risk of suicide.

Mental Illness
Persons who hear voices directing them to commit suicide are certainly in a high-risk situation. However, the number of persons who fall into this category is quite small. If a person indicates that other people, or voices, are controlling his or her behavior, those signs should not be ignored.

In an attempt to determine the existence of any of these signs, the officer must communicate with the person in a calm, direct, and matter of fact way. Talk about the finality of the act and use the terms "suicide," "death," "kill your self." Talking about suicide does not prompt the person to commit the act. The best way an officer can help the person is to discuss the person's problems, the suicide plan, and realistic alternatives. Communication with the person not only enables the officer to gather information regarding the risk, but it is also helpful for the suicidal person. Often the suicidal person has been lacking communication and the

offer's efforts tell him or her that someone is interested and concerned about finding an alternative solution.

[2] All the preceding information about suicide was copied with permission from: Improving the Police Response to the Mentally Disabled. Police Executive Research Forum, 1986.

Suicide Prevention

Suicidal Clues

- Verbal: "it doesn't matter anymore", "you won't be hearing from me again"
- Situational: hopeless and helpless.
- Behavioral: stripping of possessions or relationships, in appropriate calmness/flatness, past attempts.
- What is the Immediate Problem?
- What has happened in last 24 hours that makes you want to kill yourself?
- Identify the problems/situation.
- Identity the loss.
- Talk about it/ventilate feelings.

Identify Hook

- What is still important to the person?
- What still has value/meaning?
- Keep returning to the hook.

Determine Motivation

- What is objective/goal of suicide action?
- What is person hoping to accomplish?

Develop Non-Lethal Alternative Option

- To diffuse crisis state
- To accomplish objective/goal

Develop Specific Plan of Action

- Be realistic.
- Make a list.
- Go to next step.

Referral

- When appropriate.
- When crisis has ended.

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Suggested Dialogue
- Look I can see you're really (label emotion) right now. I just want to talk with you for awhile.
- I really care about what happens to you. That's why I have this job.
- I know talking about this is really rough, but we can take it slow.
- I sense you're really down on yourself right now.

- Do you really want to die, or do you want to not hurt so much?

Finality of Death

- Once you're dead, you're not going to get another chance.
- You know if you kill yourself to get back at _____, all that's going to happen is that you'll be dead. We can't be sure of _____'s reaction. _____ may not care at all. Therefore _____ wins. You're dead and _____'s going to go on with their life.
- I guess right now you want to get away from the hurt, but dying (method) is pretty painful. Let's talk about some other way to get this pain out of your life.

Hooks

Parents

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

Children

- How do you think it will affect (name/'s) if you kill yourself?
- You know, if you kill yourself, you'll never see _____ grow up, graduate, get married. I can tell you care about them a lot.

Job, Career, Hobby

- You know, you've told me that you've made some pretty important breakthroughs in your job, if you killed yourself, you'll never have that satisfaction again.
- You were telling me about your (hobby), you're pretty proud of _____. What will happen to _____ if you die, will they just get tossed in the trash?

Pets

- What about _____? Who will take care of _____? I guess _____ will have to be destroyed.

Explore Plans / Thoughts

- What do you want to have happen? What would need to happen for you to feel better, feel like you could go on?
- What do you think (you/we) could do to make things not hurt so much?

Policy & Procedures

850.20 MENTAL HEALTH CRISES, RESPONSE TO

Index: Title

Refer: ORS 161.336(5) Conditional Release by Psychiatric Security Review Board: Termination or Modification of Conditional Release
ORS 181.530 Commitments
ORS 426.228 Police Officer Taking Person into Custody – Mental Treatment
ORS 430.735 – 765 Duty of Certain Persons (incl. Peace Officers) to Report Abuse of Mentally Ill or Developmentally Disabled Adults
Report of Peace Officer Custody of an Allegedly Mentally Ill Person (CIT Coordinator)
Report of Peace Officer Custody of an Allegedly Mentally Ill Person as Directed by a Community Mental Health Director (CIT Coordinator)

POLICY (850.20)

It is common for members to have contact with persons who by their actions indicate that they may have a mental illness. No person shall be taken into custody for mental illness alone. A mentally ill person will only be taken into custody when he/she has also committed an arrestable offense, has a valid detention order against him/her, or has demonstrated by his/her actions, as observed by a reliable person, that he/she poses a danger to him/herself or to others; and is in need of immediate

care, custody or treatment for a mental illness.

PROCEDURES (850.20)

Directive Specific Definition

Abuse is:

a. Any death caused by other than accidental or natural means.
b. Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.
c. Willful infliction of physical pain or injury.
d. Sexual harassment or exploitation, including but not limited to any sexual contact between an employee of a facility or community program and an adult mentally ill or developmentally disabled person who receives services from the community program or facility.

Mandatory Reporting Requirements (850.20)

Members will complete an Investigation Report for allegations of abuse to mentally ill and developmentally disabled persons and forward a copy of the report to the Multnomah County Mental Health Division or to the Developmental Disabilities Services Division. Members will report non-criminal matters to the Gatekeeper Program as listed in the Problem Solving Resource Guide.

Crisis Intervention Team (CIT) (850.20)

CIT consists of sworn members who have completed the qualifying CIT training and who choose to be members. CIT members assigned to patrol will be used for incidents involving persons in a crisis due to a mental illness or developmental disability.

BOEC will dispatch the nearest CIT officer assigned to the precinct of occurrence as the primary investigator. If no precinct CIT officers are available, BOEC will search citywide for an available CIT member to respond. CIT officers will notify his/her supervisor when leaving precinct boundaries. BOEC will dispatch cover units, including additional CIT members, as appropriate. If a CIT member is dispatched as the primary, he/she will investigate the incident and make appropriate custodies, transports or referrals. He/She will remain the lead investigator, unless relieved by a supervisor or not needed due to a change in circumstances before the CIT member's arrival.

Members involved in an incident requiring CIT should request their response. If the member has already taken a person into custody, he/she may still request CIT for assistance in making appropriate referrals or for assistance in processing the person. In this case, CIT will not act as the primary investigator.

Supervisors may use CIT members to make initial contact with subject(s) involved in incidents requiring the Hostage Negotiation Team (HNT). CIT will not be used in place of HNT, but HNT may use CIT as needed.

Dispositions (850.20)

Members will consider the nature of the situation and the behavior of the allegedly mentally ill person involved in determining the appropriate disposition of the person. Members may choose from the following options:

a. Refer to a mental health agency, crisis hotline or other related service agency. Resource information can be located through the Police Information Line or the Problem Solving Resource Guide.

b. Consult with a mental health or medical professional. Members can request, through BOEC, a Mobile Crisis Team to respond to the scene, if available. Members may contact the person's health professionals, the mental health crisis line or other appropriate resource agencies.

c. Transport the person to a mental health or medical facility for voluntary care when no other means of transportation are readily available. Assisted persons should not be dangerous and be able to manage their behavior. Members should escort persons into the waiting area and introduce the person to facility staff. Members are not required to standby. Members will complete a Special Report and document the incident and transport.

d. Take the person into custody (civil) when there is probable cause that the person is a danger to him/herself or another person and is in need of immediate care, custody or treatment for mental illness and transport him/her to the appropriate secure evaluation unit or to the nearest designated hospital for a mental health evaluation.

e. Take the person into custody for an arrestable offense, or in the case of a citeable offense, cite the person and either take the person into custody (civil) for a mental health evaluation or voluntarily transport the person to a treatment facility.

Peace Officer Custody for an Allegedly Mentally Ill Person (Civil Custody Report) (850.20)

When taking an allegedly mentally ill person into custody (civil) for a mental health evaluation, members will:

a. Transport the individual to the appropriate secure evaluation facility, or if there is no secure evaluation facility or if the unit is on divert, to the nearest designated hospital emergency department that conducts mental health evaluations.

b. Remain at the facility until a physician determines whether the person will be admitted. If not admitted, the member may arrest the person for an offense, transport the person back to the original custody location or both. In the case where no arrest is made and the person chooses not to return to the location of custody, the person will be released outside the care facility.

c. Complete an Investigation Report and a Civil Custody Report, before leaving the facility.

d. Make copies of both reports. Leave the original Civil Custody Report and a copy of the Investigation Report with the secure evaluation unit or the receiving hospital. Turn in the original Investigation Report along with a copy of the Civil Custody Report to a supervisor before the end of his/her shift.

Peace Officer Custody of an Allegedly Mentally Ill Person per a Mental Health Director (Director's Custody Report) (850.20)

When assisting a community health and developmental disabilities program director or designee in taking an allegedly mentally ill person into custody, members will:

a. Verify the authority of the person signing the Director's Custody Report and ordering the custody (civil). Approved Qualified Mental Health Professionals (QMHP) have identification cards from Multnomah County.
b. Take into custody (civil) the person named on the Director's Custody Report and notify a supervisor.
c. Obtain the Director's Custody Report from the director or designee and transport the person to the medical facility as designated by the director.
d. Remain at the facility until a physician determines whether the person will be admitted unless released by facility security. In the case where facility security relieved the officer and the person was not admitted, the officer may be requested to return to the facility and must transport the individual back to the original contact location.
e. Complete a Special Report documenting the custody (civil) and transport.
f. Leave the original Director's Custody Report and a copy of the Special Report with the secure evaluation unit or the receiving hospital.
g. Turn in the original Special Report along with a copy of the Director's Custody Report to a supervisor before the end of his/her shift.

Psychiatric Security Review Board (PSRB) Orders of Revocation (850.20)

PSRB will direct members to take PSRB supervised persons into custody on Revocation Orders, which are comparable to arrest warrants. When a member is notified of a PSRB Revocation Order, typically through a PSRB LEDS message reading: "No Criminal Warrant, PSRB Order for mandatory return to Oregon State Hospital" members will:

a. Take the person named in the Revocation Order into custody and notify a supervisor.
b. Ensure the Oregon State Hospital Communications Center is notified (see the Problem Solving Resource Guide for the number).
c. Transport, with one other member, the person to the Oregon State Hospital Communications Center. If additional verification of Revocation Order is

needed, the PSRB Executive Director may be contacted (see the Problem Solving Resource Guide for the number).

d. Document the incident on a Police Custody Report and turn it into a supervisor before the end of his/her shift.

Escaped Mental Patients (850.20)

Members may be requested to take escaped patients into custody. This will be done only when:

a. An escapee from a state hospital was committed under ORS 181.530 due to a conviction of a crime or committed as sexually dangerous. Notice can be in writing or by teletype.

b. A civilly committed person unlawfully escapes from a residential facility and the facility produces the order of commitment.

c. An escapee is deemed to be a danger to him/herself or others.

If escapees meet the above criteria, members should:

a. Take the escapee into custody (civil) and transport him/her to the appropriate secure evaluation unit or nearest designated hospital.

b. Contact the facility escaped from and notify them of location to pick up their escapee.

c. Complete a Special Report documenting the incident and transport, to include the name of the person notified at the escaped facility, and submit the report to a supervisor before the end of his/her shift.

Warrants of Detention/Trial Visitation (850.20)

During pre-trial civil commitment processes, an allegedly mentally ill person may be released into the community and be investigated by a civil commitment investigator. A civil warrant of detention may also be issued by a judge to take a mentally ill person into custody. Members should not become involved in these activities unless called to an incident to assist a civil commitment investigator or civil deputy in fulfilling his/her mission. The statutory authority to serve a warrant of detention rests with the county sheriff.

Assisting Hospitals with Mentally Ill Patients and Walk-aways (850.20)

Members will not become involved in incidents within a secure evaluation unit or an emergency care hospital, unless the facility cannot give appropriate care or a person becomes violent, resistive or refuses to go with facility arranged transportation to an appropriate facility. Secure evaluation units and hospitals are responsible for transports to the other care facilities. Members will not take into custody voluntarily admitted patients who have walked away from a hospital or facility, unless their actions at the time indicate they are a danger to themselves or others and are in need of immediate care, custody and treatment for mental illness.

POLICY AND PROCEDURE

Records Division Responsibilities (850.20)

Records will flag those persons taken into civil custody in PPDS as Allegedly Mentally Ill and forward copies of all mental health related reports to the CIT Coordinator.

RESPONSIBILITY, ACCOUNTABILITY AND CONTROL (850.20)

Supervisors will ensure that appropriate dispatch and use of CIT procedures are followed and ensure against the misuse of CIT. Supervisors will also ensure their members follow the investigations and reporting requirements. The CIT Coordinator will review all reports forwarded by Records and will act as a liaison between the Bureau and the mental health community.

REPORT OF PEACE OFFICER

CUSTODY OF AN ALLEGEDLY MENTALLY ILL PERSON

TO THE TREATING PHYSICIAN OF AN APPROVED HOSPITAL OR NONHOSPITAL FACILITY (attach original to Notice of Mental Illness)

In the matter of _____ (allegedly mentally ill)

Date of birth _____ Address _____

City _____, County _____

I, _____ a peace officer of the city _____

Multnomah County, Oregon, BPSST No. _____, took the above named person into custody at _____ m., on the ____ day of _____, 20____, in Multnomah County, Oregon, for the following specific reasons:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

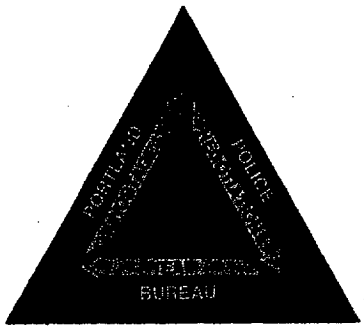
pursuant to:

( ) ORS 426.228(1) because I have probable cause to believe the above named person is a mentally ill person who is dangerous to self or other and in need of immediate care, custody or treatment for mental illness.

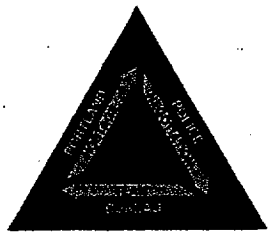
_____

police officer signature

Hostage Negotiation



HOSTAGE NEGOTIATION TEAM



Instructor:

Sergeant Wayne Svilar

503-823-0833

TEAM STRUCTURE

- Team Commanders Lt. Jeff Kaer and Lt. John Eckhart
  - Team Supervisors
    - Sgt. Wayne Svilar
    - Sgt. Bob Day
    - Sgt. John Brooks
      - Technical Detective Troy King
      - Squad 1 (5 detectives)
      - Squad 2 (5 detectives)
      - Squad 3 (5 detectives)

NEED FOR HNT

- Munich Olympics 1972
- Van's Olympic Room 1976
- Ringside 1980's
- Tate/Graves 1985

NEGOTIATOR SELECTION

- Police Detective
  - Good Interviewing Skills
  - Good Communication Skills
  - Demonstrated Good Judgment
  - Calm Demeanor
  - Special Skills (technical, language, etc)
  - Role (Team) Player

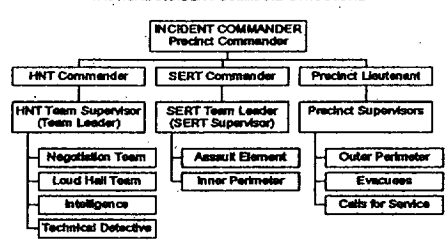
NEGOTIATOR TRAINING

- Basic Hostage Negotiation School (FBI)
- Monthly training (3 hrs.) for entire team
- Western States Hostage Negotiation Association yearly (3 day) seminar
- California Association of Hostage Negotiations
- Joint Training with FBI and other agencies

WHEN HNT RESPONDS

- Hostage Situations (Negotiate)
- Barricaded Subjects (Crisis Intervention)
- Sniper Situations
- Suicidal Subjects
- High Risk Search Warrants

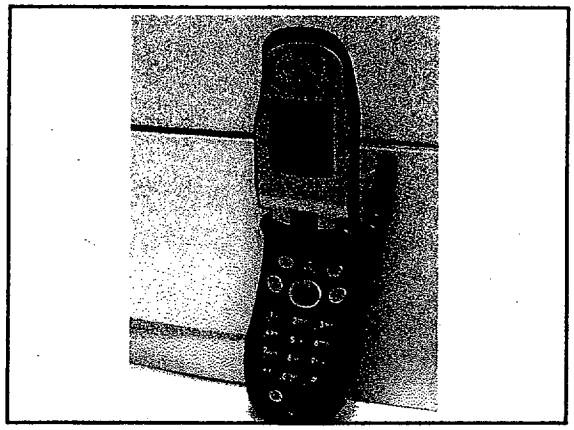
TACTICAL INCIDENT COMMAND STRUCTURE

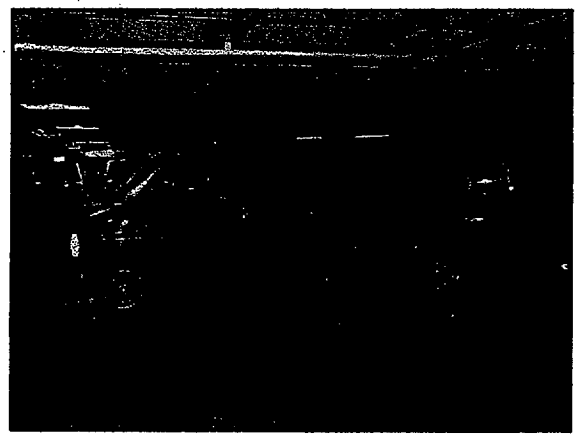


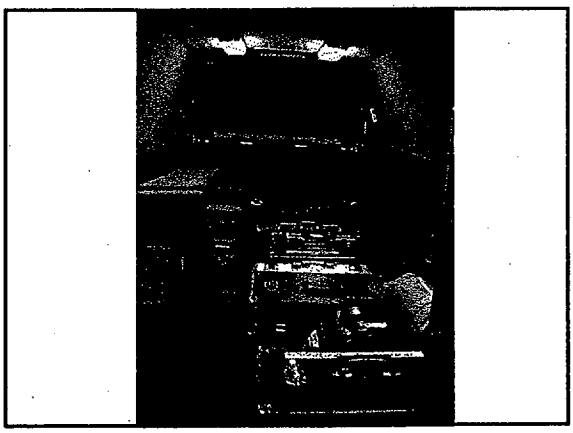
HNT ASSIGNMENTS

- Primary Negotiator
- Secondary Negotiator
- Loud Hail Team
- Intelligence Officer
- Intelligence Coordinator
- Log Keeper
- Technical/Communications Officer

EQUIPMENT







WHAT HAPPENS AT A "TYPICAL" HNT CALL

- HNT & SERT are activated by uniform
- Initial Briefing
  - Incident Commander
- Negotiation Post
  - Location
  - Equipment Set Up / Phone "Tie Down"

WHAT HAPPENS AT A "TYPICAL" HNT CALL

- Intelligence Gathering
  - Victims
  - Witnesses
  - Relatives
  - Friends
  - Co-Workers
  - Other Officers (Police, Parole & Probation, etc)
  - Doctors
  - Mental Health Contacts

WHAT HAPPENS AT A "TYPICAL" HNT CALL

- Contact the Subject
  - Telephone
  - Loud Hail
  - "Throw Phone"
  - Face to Face
- Communicate
  - With the Subject
  - With Command
  - With SERT

WHAT HAPPENS AT A "TYPICAL" HNT CALL

- Communications Tactics
  - Listen
  - Rapport / Trust
  - Time
- Negotiated Surrender

WHY NOT JUST...

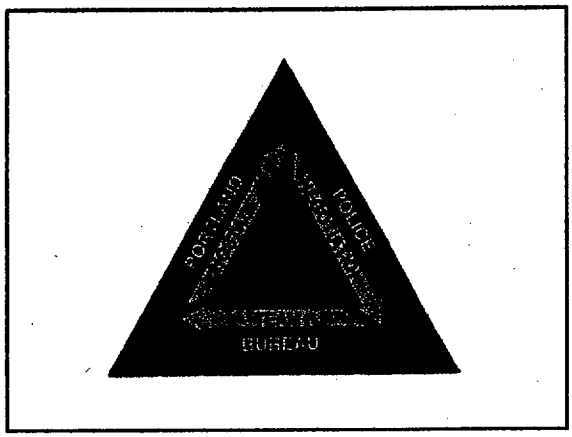
- Assault the location and force the subject out?
- Let their mother speak to them?
- Why not just leave?

Audio Examples

- Hostage (Strayer) 1988
- Barricade (McClure) 1995
- High Risk (Briar Place) 1991

QUESTION & ANSWERS

Sergeant Wayne Svilar
Detective Division
Hostage Negotiation Team
503-823-0833


BUREAU

COMMON ACRONYMS

(AMHSA) ADULT MENTAL HEALTH AND SUBSTANCE ABUSE
(AFS) ADULT AND FAMILY SERVICES
(ARC) ASSOCIATION OF RETARDED CITIZENS
(ADHD) ATTENTION DEFICIT HYPERACTIVITY DISORDER
(ADD) ATTENTION DEFICIT DISORDER
(BHD) BEHAVIORAL HEALTH DIVISION
(CMI) CHRONICALLY MENTALLY ILL
(CAMHSA) CHILD & ADOLESCENT MENTAL HEALTH AND SUBSTANCE ABUSE
(CCMH) CLACKAMAS COUNTY MENTAL HEALTH
(CIT) CRISIS INTERVENTION TEAM
(CRT) CRISIS RESPONSE TEAM
(CTC) CRISIS TRIAGE CENTER
(DCFS) DEPARTMENT OF COMMUNITY AND FAMILY SERVICES
(DSM4) DIAGNOSTIC AND STATISTICAL MANUAL
(DSO) DISABILITY SERVICES OFFICE
(EAP) EMPLOYEE ASSISTANCE PROGRAM
(ISP) INDIVIDUAL SERVICE PLAN
(MRDD) MENTALLY RETARDED DEVELOPMENTAL DISABILITY
(MHRC) METROPOLITAN HUMAN RIGHTS COMMISSION
(NAMI) NATIONAL ALLIANCE FOR THE MENTALLY ILL
(OAC) OREGON ADVOCACY CENTER
(PSRB) PSYCHIATRIC SECURITY REVIEW BOARD
(SDSD) SENIOR DISABLED SERVICES DIVISION
(SCF) SERVICES TO CHILDREN AND FAMILIES
(SSDI) SOCIAL SECURITY DISABILTIY
(SSI) SUPPLEMENTAL SECURITY DISABILITY

Notes

NOTES

NOTES

NOTES

Portland Police Bureau
Crisis Intervention Team

Lesson Plan for the PPB Officer's 2004 In-Service
Course Title: CIT/Mental Health Awareness

Instructor: Officer Paul Ware, CIT Coordinator

Prepared by: Officer Paul Ware, CIT Coordinator

Audience: Portland Police Bureau In-Service 2004

Time Frame: 2 hour

Course Goals:

Dealing with the Mentally Ill can be a very stressful experience for any Peace Officer. The goal of this class is to present officers with signs and symptoms of the major types of mental illness, and make it easier to recognize them. Also, the warning signs of suicidal behavior will be pointed out, and dealing with the suicidal or mentally ill person will be discussed. Benefits of verbal de-escalation will be explained, and the correct disposition of the reports associated with taking someone into custody will be described.

Performance Objectives:

1: Officers will be able to more easily recognize Schizophrenia, Bi-polar and Major Depression.

2: The warning signs of suicidal behavior will be easier to grasp and document.

3: Officers will be able to correctly fill out the report forms associated with taking someone into custody for an alleged mental illness.

4: Officers will have a better grasp on what verbal de-escalation techniques work well. Using the Rule of Palms, Rule of Five, Questions of Clarification and other techniques that can help the officer during the crisis.

*It should be noted that I will be asking for personal stories from CIT officers that are in the class as a way of including them, and giving accounts of what techniques work , and those that may not. Rather than schedule this kind of a thing, it will be done on an as needed basis to highlight a point in the lecture.

The lecture will include the Bureau's values of Compassion and Respect when dealing with the Mentally Ill.

Course Outline:

1300 Hrs: 1: Introduction

A) Hook: When is the last time you used your CIT skills?

(How often do you have a call that involves a person in mental health crisis? Do you see those types of calls going up or down?)

B) Overview of the class; Emphasize that this is a Bureau effort to build skills for it's Patrol Officers, and has not been mandated by any group. This will help the Bureaus effort to build on Community Policing. This class is not meant to substitute for a 40 hour CIT class. The CIT Advisory Committee also encouraged this as a good way to reach the largest number of patrol officers.

1: 1315 Hrs: Review of the major mental illnesses: Schizophrenia, Bi-polar and Major Depression. There are many more diagnosable illnesses, but we are going to be concentrating on these 3 today. The class exercise will done during this segment.

2: 1330 Hrs: Review of Suicide Awareness, and the most common reasons why people commit suicide. We will also talk about which demographic groups are at higher risk.

3: 1345 Hrs: Disposition of the paperwork when an Involuntary Hold, Voluntary Transport or Custody is done by Officers.

4: 1400 Hrs: 10 minute break

5: 1410 Hrs: Crisis Intervention, including a description of the Crisis Cycle, Communication Skills (Verbal and Non-Verbal), as well as Questions to Ask will be taught.

6: 1450 Hrs: End of Class

Review on Major Mental Illnesses:

A) What is a Major Mental Illness?

- A Major Mental Illness is Mental Illness that falls into a specific category of diagnosis
- A Mental Illness is a biologically based brain disease
- It can lead to a significant impairment of Social, Occupational and Interpersonal functioning
- Thought Disorders, Mood Disorders, and the ability to cope with stress are among the symptoms
- Legal definition: A substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life. (Why would this definition be significant? This would be the standard that is used by a court of law to involuntarily commit someone)

B) Cost of Major Mental Illness

- 5% of adults and 9% of teenagers are afflicted
- Billions are spent on treatment and lost productivity
- It can strike in any family, and affect the <u>entire</u> family

C) Three types of Mental Illness

1. Schizophrenia

-It effects about 1-2% of the entire adult population, will last for a lifetime, but can be managed and controlled with medication, therapy and assisted living conditions. (Which is cheaper, $100 for a 1 month supply of medication, or 1 ER visit at $1500 & 2 hours of your time) It is better for us to persuade those on medications to stay that way.

-It is commonly known as the "split personality" diagnosis, which is incorrect. Very few people with schizophrenia develop MPD (Multiple Personality Disorder). You have a better chance of being hit by lightning than meeting someone with MPD.

-The "first break" that is experienced by people with schizophrenia usually occurs between the ages of 18-25. Young people can be in college, the military, or at their first job when they develop symptoms. The "first break" is the first time that the person will have symptoms of schizophrenia.

-The medications that are used to treat schizophrenia are called "Antipsychotics". They include Thorazine, Haldol, Mellaril, Risperdal, Zyprexa, and Seroquel. Medication levels will need to re-balanced from time to time, depending on the patients needs.

SYMPTOMS

Delusions: A false belief that is contrary to reality.

- Someone might say to you that they are God, the head of the FBI, or the President. They also might believe that their activities are being monitored by the CIA.

Types of Delusions:

Persecutory: "Everyone is plotting against me"

Grandiose: "I am God"

Religious: "I can talk to God directly because I am Special"

Nihilistic: "The world will end next week!"

Hallucinations: Hearing or Seeing things that are not real

-Auditory hallucinations are the most common. People will tell you that they hear voices that they cannot get out of their head.

-Visual hallucinations are less common. (People who use lots of drugs like Meth and Coke will also develop these symptoms)

Disorganized Symptoms:

-The person will talk to you and appear to be talking in circles. The person may be dressed poorly, have bad hygiene, and may not be able to hold onto an idea long enough to even answer a simple question.

-They may pace in circles, or do repetitive behavior.

Class Exercise: The class will be divided into groups of 4. Two of the students will get a script of "voices" that they will talk into the ears of a student that is sitting in a chair. The student in the chair will try and have a conversation with the 4th person and will realize that with the voices talking relentlessly, it's very hard to concentrate on what the 4th person is asking them. This simulates what a person with schizophrenia has to deal wit on a daily basis.

2. Bi-Polar:

- Bi-polar is the new term for Manic Depression. It still means that the person has mood swings, sometimes in the extreme. If a person has more than 4 episodes (up and down swings) in a year, then the term "Rapid Cycling" can be applied.

-Medication's that are used to treat this chemical disorder of the brain are called "Mood Stabilizers". Lithium, Depakote are some of them. When a person is on the Mania end of the swing, then Antipsychotics may be used. When a person hits the depressive phase, then Antidepressants can be used.

-Being Bi-polar is hereditary and can be found among family members.

Symptoms:

- Mania Symptoms

  - Increased activity or energy level
  - Fast talking with fast ideas
  - Grandiose ideas
  - Decreased need for sleep
  - Increased sexual appetite
  - Mania symptoms can look just like Coke/Meth intoxication

- Depression Symptoms

  - Depressed mood or ideas
  - Decreased energy
  - Increased irritability
  - Less participation in usual activities
  - Change in appetite
  - Change in sleep patterns
  - Talk of suicide, or "ending it all"

3. Major Depression:

-A Major Depression can be defined as a persistent state of depression that significantly effects a person's mood, thoughts, relationship's, and daily activities.

-Depression is one of the leading causes of disability in the US.

-Major Depression can strike as much as 5% of the entire adult population in the US.

-Twice as many women suffer from depression as do men.

-Medications that are used to treat depression included Prozac, Zoloft, Paxil, Effexor and Wellbutrin. ECT or Electroconvulsive Therapy is still used to treat severe cases of depression.

-Depression is seen as having a direct link to suicide, as most suicidal people will deal with depression for days, weeks, or months before committing suicide.

Suicide Awareness

Reasons for Suicide*

Loss or change in an important relationship

To avoid or end perceived pain

Escape intolerable situation

Gain attention

Manipulate/punish others

Punish self

Become a martyr

Facts on Suicide*

- One Suicide every 18 minutes in US
- 11th ranking cause of death in the US

- 700,000+ suicide attempts every year
- 5 million living Americans have attempted suicide
- Each suicide affects at least 6 people intimately
- Firearms used in 57% of suicides
- Woman attempt suicide 3x more often than men do
- Men complete suicide 4x more often than woman do
- Oregon ranks 9th in the US for Suicide rates
- The Demographic groups that have higher rates of suicide are:

  -Elderly
  -Youth

Myths about Suicide*

- Happens without warning
- Low risk after mood improvement
- Once suicidal, always suicidal
- Intent on dying
- So rare, they won't do it
- Runs in the family
- No note = No suicide

Questions to ask

- Do you have any thoughts of hurting or killing yourself?
- How do you plan on doing it? (Do they specific plans?)
- When and Where do you plan on doing it? (Specific plan?)
- Why are you doing now? (Ask about any recent trauma or personal triggers)
- Have you ever tried to hurt or kill yourself before? (Ask when/where/why)

The difference between a gesture and attempt is intent

Intoxication will significantly increase the person chances of trying suicide

Never be afraid to ask the basic question's about what people are thinking!

*Facts on Suicide and Myths on Suicide was taken from material presented by Daniel W. Clark, Ph.D., "Suicide Awareness" with his permission.

Directive 850.20 & Report Disposition

Directive 850.20 contains all of the relevant policies and procedures that pertain to handling someone in a mental health crisis.
Under the subheading of "Dispositions", on page 353,(yellow book), section A-E, and that tells us what are options are.

Involuntary Custody

When a person is deemed to have meet the criteria for a hold, we shall handcuff that person, take them to an ER, and hand them over to the ER Doctor or RN on duty. We shall fill out an Investigation Report and a Peace Officers Hold before leaving the facility. We keep the original Investigation Report, and give a copy to the staff. We keep a copy of the Peace Officers Hold, and give the original to the staff.

Voluntary Transport

When a person has asked us for a ride to Mental Health facility or ER, we will document this by using a Special Report. Remember to walk the person into the facility to introduce them to the staff.

Director's Hold

When a QMHP, Qualified Mental Health Professional, (usually Project Respond) asks that you take someone into custody, handcuff them and take them the nearest ER, and wait until you are relieved by a Doctor or RN. Get a copy of the hold form that was written by the QMHP and attach it to the Special Report.

Escaped Mental Patients

Always have the dispatcher ask if the person that is "escaping", is on a Involuntary Hold or other court ordered hold. If the answer is no, then they are probably leaving on a voluntary basis.

Crisis Intervention

A. Approaching the Scene
   1. Calls
   2. Information before you arrive, (Another officer on Tac2)
   3. Monitor your own emotional state
   4. Leave prejudice/bias/predisposition behind

B. On the Scene
   1. Assess the situation and stabilize, if necessary, (Call for medical/fire if needed)

C. Crisis Intervention
   1. Crisis Cycle
      A. Intervention at each stage of the cycle
      B. Different levels of understanding, perception and development at each stage
         (1) Look at face, voice, and posture for signs of what level they are at
      C. Stages of Cycle
         (1) Normal state
            (a) 100% perception and ability to reason
            (b) Acts as an adult
            (c) Person experiences no emotional content
            (d) Officer is calm
            (e) Can problem solve
         (2) Stimulation (internal/external)
            (a) 50-75% perception and ability to reason/understand
               (1) Agitated behavior
            (b) Acts as a teenager
            (c) Person experiences anxiety
            (d) Officer is calm
            (e) Action officer should take
               (1) Use simple sentences
               (2) Use calming body language
               (3) Keep voice low and calm
         (3) Escalation
            (a) 5-24% perception and ability to reason/understand
               (1) Loud, aggressive, flushed
            (b) Acts as an 8-year old having a tantrum
            (c) Person experiences fear; frustration
            (d) Officer is anxious
            (e) Actions officer should take
               (1) Use sentences of less than 5 words
               (2) Make one immediate request
               (3) Repeat continually
               (4) Body language and voice firm, but calm
         (4) Crisis

(a) 0-5% perception and ability to reason/understand
(1) Out of control
(b) Acts like "terrible two's"
(c) Person experience anger
(d) Officer is fearful/frustrated
(e) Actions officer should take
(1) Use firm, one sentence commands
(2) Repeat continually
(3) Make decision regarding use of physical force

(5) De-escalation
(a) As consumer de-escalates, officer uses the same techniques down the de-escalation
(b) Consumer may suffer post-crisis depression
(c) Escalation can cycle up and down
(6) Things to remember
(a) Take your time
(1) Person cannot remain in crisis state forever
(b) Constantly read feedback from consumer
(c) Stop doing anything that escalates the consumer
(d) Continue anything that de-escalates the consumer
(e) Have only one officer talk to the consumer at a time
(1) Trade off if not effective

2. Communication Skills
a. Verbal Skills
(1) Tell person you are there to help
(2) Introduce self by first name
(3) Ask and use their name
(4) Do not involve yourself in their delusions; show you understand that they believe it is really happening
(5) Ask clarifying questions in terms of "I" statements
(a) "I don't understand this"
(b) "I'm afraid that you'll hurt yourself"
(c) "I can't figure out why"
(6) Use personalized statements
(a) "Your holding that rock makes me nervous"
(7) Do not argue
(8) Actively listen
(a) Do not be afraid of silence
(b) Wait for responses
(c) Echo their feelings "You seem to be angry"
(9) Show concern and understanding
(a) Nod head while they are talking; indicate listening with "I see", "Uh, huh", etc.
(10) Treat person with respect
(11) Do not use offensive terms or sarcastic remarks

(12) Tell people what you are going to do
(a) Do not make a promise you cannot keep
(13) If person becomes agitated, change subject

b. Non-verbal skills
(1) Feedback loop
(a) Watch reactions of consumer to you
(b) Stop action if it escalates consumer
(2) Open body language
(a) Rule of Palms
(1) Palms open
(b) Stand slightly to the side/balanced
(c) Take safe, but not defensive stance
(1) More relaxed posture
(2) Head tilted
(3) Be ready/appear relaxed
(d) Keep hands off paraphernalia
(3) Eye Contact
(a) Try to make eye contact
(1) Some people like it as sign of personal contact
(2) May make some people nervous
(b) Try to remain at eye level
(4) Body Space
(a) Rule of 3
(1) Remain 3 arms length away at first contact
(b) May need to move in to establish personal
(5) Move slowly
(a) Announce action to consumer

c. Questions to Ask
(1) Ask what is happening that caused the crisis
(2) Ask about past history
(a) Case worker
(b) Counselor
(c) Treatment
(3) Ask how they resolved similar situations in the past
(4) Ask what clinic they go to or where they go for treatment
(5) Ask if they are taking medication
(6) Ask the names of their medication
(7) Ask if they would like to see a doctor
(8) Ask if they are thinking of taking their own life
(a) How?
(b) Do they have the means? (gun, knife, pills)
(c) Have they ever tried it before?
(9) Ask if they are hearing voices
(a) Are they telling you to do something?

d. Officer Safety reminders
(1) Never deny the possibility of violence

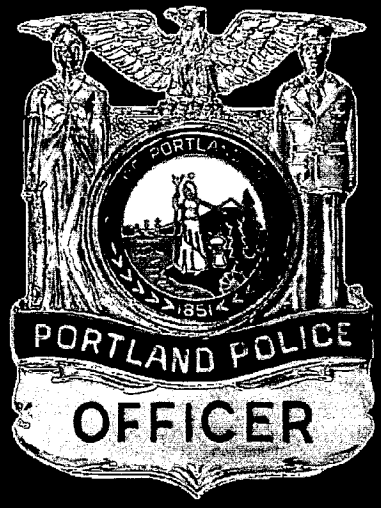
(a) Persons with mental illness are not more violent than the "normal" population but may be more unpredictable

(2) If hearing voices, ask what the voices are saying

(3) Keep relaxed approach, but not complacent

(4) Watch consumers hands

(5) Upon transport, always handcuff even if this risks re-exciting the subject; tell the person what you are going to do and why



CIT/Mental Health Awareness

2004/2005 In-Service

Course Outline

- Overview
- 1st Hour
  - Major Mental Illnesses
  - Suicide Awareness
  - Paperwork Disposition
- 2nd Hour
  - Crisis Intervention with Scenarios

Major Mental Illness

- Biologically based brain disease
- Significant impairment of Social, Occupational and Interpersonal functioning
- Thought Disorders, Mood Disorders, and the ability to cope with stress are symptoms

Major Mental Illness

- Legal definition: A substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

Major Mental Illness

- Cost of Major Mental Illness
- 5% of adults and 9% of teenagers are afflicted
- Billions are spent on treatment and lost productivity
- It can strike in any family, and affect the entire family

Major Mental Illness

- Three Types of Major Mental Illnesses
  - Schizophrenia
  - Bi-polar
  - Major Depression

Schizophrenia

- Effects 1-2% of entire population
- Will last for a lifetime, but can be controlled with medication, therapy and assisted living conditions
- Commonly known as the "split personality" diagnosis, which is incorrect. Very few will develop Multiple Personality Disorder
- The "first break" usually occurs from 18-25 years old. Symptoms are now present

Schizophrenia

- Medications that are used are called "Anti-psychotics"
- Thorazine, Haldol, Mellaril, Risperdal, Zyprexa, Seroquel
- Medication levels sometime need to be re-balanced

Schizophrenia

- Symptoms
  - Delusions: A false belief that is contrary to reality
    (Someone might say to you that they are God, the head of the FBI, or the President. They also might believe that activities are being monitored by the CIA)

Schizophrenia

- Types of Delusions
  - Persecutory: "Everyone is plotting against me"
  - Grandiose: "I am God"
  - Religious: "I can talk to God directly"
  - Nihilistic: "The world will end next week"

Schizophrenia

- Hallucinations: Hearing and Seeing things that are not real
  - Auditory hallucinations are the most common
  - People will tell you there are voices inside them they cannot control
  - Visual hallucinations are less common (Meth and Coke users will have tactile sensations)

Schizophrenia

- Disorganized symptoms
  - The person may be dressed poorly, have bad hygiene, and may not be able to hold an idea long enough to answer a simple question
  - They may pace and talk in circles, or do other repetitive behavior

Schizophrenia

- Class Exercise
  - Divide up into groups of 4
  - 2 will get the script of voices
  - 1 will sit in a chair
  - 1 will do the questioning
  - Exercise is to simulate what a schizophrenic person has to deal with 24/7

Bi-polar

- Bi-polar is the new term for Manic Depression
- It means the person will have mood swings, sometime in the extreme
- If a person has more than 4 episodes (up and down swings) in a year, then the term "Rapid Cycling" can be applied

Bi-polar

- Bi-polar is hereditary
- Medications that are used are called "Mood Stabilizers"
- Lithium, Depakote
- Mania side of swing/ Anti-psychotics
- Depressive side of swing/ Anti-depressants

Bi-polar

- Mania Symptoms
  - Increased activity or energy level
  - Fast talking with fast ideas
  - Grandiose ideas
  - Decreased need for sleep
  - Increased sexual appetite
  - Mimic Meth/Coke intoxication

Bi-polar

- Depression Symptoms
  - Depressed mood or ideas
  - Decreased energy
  - Increased irritability
  - Change in appetite
  - Change in sleep patterns
  - Talk of suicide

Major Depression

- Defined as: A persistent state of depression that significantly effects a person's mood, thought's, relationship's and daily activity
- One of the leading causes of disability in US
- Can strike as much as 5% of entire population
- 2x as many women effected than men

Major Depression

- Medications are called Anti-depressants
- Prozac, Zoloft, Paxil, Effexor, Wellbutrin
- ECT or Electroconvulsive Therapy is still used to treat severe forms of depression
- Depression has a direct link to suicide

Suicide Awareness

- Reasons for Suicide
- Loss or change in relationship
- To end pain
- Escape situation
- Gain attention
- Manipulate/punish others or self
- Become a martyr

Suicide Awareness

- Facts on Suicide
- One suicide every 18 minutes in US
- 11th ranking cause of death in US
- Every suicide affects 6 other people
- Women attempt suicide 3x more often than men do
- Men complete suicide 4x more often than women do

Suicide Awareness

Myths about suicide

- Happens without warning
- Low risk after mood improvement
- Once suicidal, always suicidal
- Intent on dying
- So rare, they won't do it
- No note = No suicide

Suicide Awareness

Questions to ask

- Do you have any thoughts of hurting or killing yourself?
- How do you plan on doing it? (specific plan)
- When and Where? (specific plan)
- Why do it now? (what has changed in your life?)
- Have you tried to kill yourself before?

Suicide Awareness

- The difference between gesture and attempt is the intent
- Intoxication will increase the chances of an attempt
- Never be afraid to ask the basic questions about what people are thinking!

Directive 850.20 & Report Disposition

- Directive 850.20 contains all the relevant policies and procedures on handling a person in a Mental Health Crisis
- The disposition's are in sections A-E

Report Dispositions

Involuntary Custody

- Investigation Report + Peace Officers Hold
- We keep original Investigation report/copy to staff. We keep copy of POH/ with original POH to staff

Report Dispositions

Voluntary Transport

- Document on a Special Report (Remember to introduce to staff/There are no ER drive thru lanes)

Report Disposition

Directors Hold

- Special Report (copy to staff, and attach copy of Directors Hold)
- This is an Involuntary Hold, so wait until relieved by staff

Report Dispositions

PSRB Order of Revocation

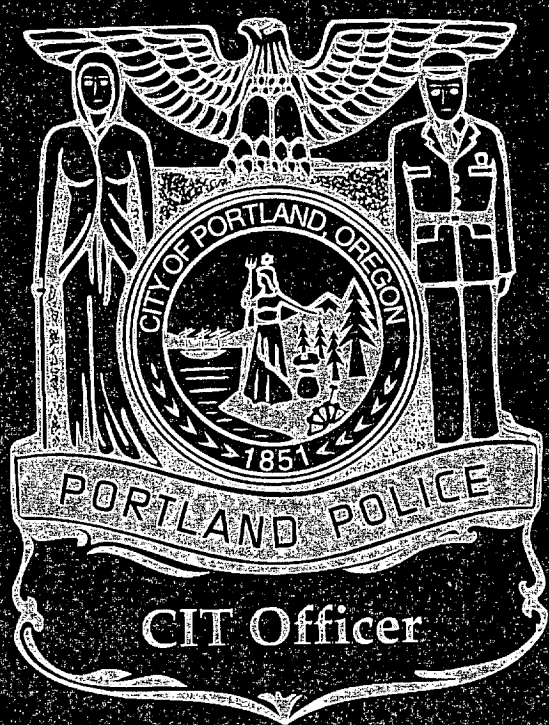
- Custody Report (enjoy the drive to Salem)

CIT Mission Statement

- The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis

Portland Police Bureau

CRISIS INTERVENTION TEAM



MAKING A DIFFERENCE TOGETHER

CIT Training
May 6th - 9th, 2003
Portland, Oregon

Crisis Intervention Training

Day:	Tuesday May 6	Wednesday May 7	Thursday May 8		Friday May 9
Location:	*Portland Adv./ ED "A"*	*Portland Adv./ ED "A"*	*Site Visit*		*Portland Adv./ ED "A"*
0700-0800	Class Introduction	Overview of Mental Health System			Crisis Intervention
0800-0900	Overview of Mental Illness	Aging Services			Crisis Intervention
0900-1000	Overview of Mental Illness	P.T.S.D.			Crisis Intervention
1000-1100	Childhood Disorders	Alcohol/Drugs			MR/DD
1100-1200	"Voices"	Personality Disorders			MR/DD
1200-1300	Lunch	Personality Disorders			Lunch
1300-1400	Mental Status Exam	Lunch			Scenarios
1400-1500	Family and Consumer Panel	Crisis Cycle/ Violence Curve			Scenarios
1500-1600	Civil Commitment	Suicide Intervention			Scenarios
1600-1700	P.S.R.B Consumer Rights	Modeling Mental Illness			Graduation

*On Friday, May 9th, we will be moving to the East Precinct at 737 SE 106th, for the scenario training. This will begin at 1300. Parking is available across the street from the precinct.

Crisis Intervention Training
Site Visits

Groups	A	B	C	D
0700-0800				
0800-0900			Faulkner	
0900-1000	Inverness	Inverness	Ryles	Ryles
1000-1100	Inverness	Inverness		
1100-1200	Detox	Detox	Rainbow	Faulkner
1200-1300	Lunch	Lunch	Lunch	Lunch
1300-1400	Ryles	Ryles	Inverness	Inverness
1400-1500	Rainbow	Cascadia	Inverness	Inverness
1500-1600		Rainbow	Detox	
1600-1700	Cascadia			Detox

CRISIS INTERVENTION SITE VISITS
MAY 8TH, 2003

Inverness Jail: 11540 NE Inverness, Portland, OR.
Contact: Kathy McCullough 503-988-5230
* As this is an active correctional facility, all officers should leave pepper spray, knifes, handcuffs , cell phones, pagers in their car. They will have a gun lock box at the front gate. Bring your Department issued ID card with you.

Faulkner Place: 13317 SE Powell Blvd., Portland, OR.
Contact: Neil Rotman 503-760-9606

Ryles Center: 3339 SE Division, Portland, OR.
Contact: Kay Endres or Deb Allison 503-231-4752 503-238-1477

Hooper Detox: 20 NE MLK Blvd., Portland, OR.
Contact: Jeanne Rivers 503-238-2067

Rainbow Adult Living: 3701 SE Belmont St., Portland, OR.
Contact: Greg Ruff 503-231-1608

Cascadia Clinic: SE 43rd/Division, Portland, OR.
Contact: Ginnie Churchill 503-253-6754
*Please use the west entrance.

Portland Police Bureau

Crisis Intervention Team

Instruction Manual

CIT Mission Statement:

"The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis."

Section 1 – MENTAL ILLNESS

***Overview of Mental Illness**

***Childhood Disorders**

***Personality Disorders**

***Post Traumatic Stress Disorder**

***Alcohol and Drugs**

Overview of Mental Illness

NAMI-Oregon
2620 Greenway Drive NE
Salem OR 97301
1-800-343-6264 · (503) 370-7774
FAX (503) 370-9452

FACTS ABOUT MENTAL ILLNESS

- Mental illnesses are physical brain disorders that profoundly disrupt a person's ability to think, feel, and relate to others and their environment.
- Mental illnesses are more common than cancer, diabetes, or heart disease.
- In any given year, more than five million Americans suffer from an acute episode of mental illness.
- One in every five families is affected in their lifetime by a severe mental illness, such as bipolar disorder, schizophrenia and major depression.
- One in ten children and adolescents have mental illnesses severe enough to cause some level of impairment. Yet fewer than one in five of these young people receives needed treatment.
- The treatment success rate for schizophrenia is 60 percent, 65 percent for major depression, and 80 percent for bipolar disorder. Comparatively, the success rate for treatments of heart disease ranges from 41- 52 percent.
- The number one reason for hospital admissions nationwide is a biological psychiatric condition. At any moment, almost 21 percent of all hospital beds are filled by people with a mental illness.
- The total price tag of mental illnesses in this country is $148 billion, including direct costs (hospitalizations, medications) and indirect costs (lost wages, family caregiving, losses due to suicide).
- Despite media focus on the exceptions, individuals receiving treatment for schizophrenia are no more prone to violence than the general public. Unfortunately, almost one-third of all U.S. jails incarcerate people with severe mental illnesses who have no charges against them, but are merely waiting for psychiatric evaluation or the availability of a psychiatric hospital bed. Today, roughly 283,000 people with severe mental illnesses are incarcerated in jails and prisons, mostly for crimes they committed because they were not being treated for their illness.
- On any given day, approximately 150,000 people with severe mental illness are homeless, living on the streets or in public shelters.
- Roughly 80 to 90 percent of people with serious brain disorders are unemployed.

CRISIS INTERVENTION TEAM TRAINING
MAY 15, 2000

OVERVIEW OF MENTAL ILLNESS

WHAT IS MENTAL ILLNESS?

A biologically based brain disease characterized by

- perceptual disturbance
- mood lability
- lack of motivation
- and in extreme cases, suicidality.

Mental Illness can impact all areas of a person's functioning including

- **Social** — difficulty getting and/or maintaining necessities of life i.e. food, clothing, and shelter
- **Occupational** — difficulty acquiring and/or maintaining employment
- **Interpersonal** — difficulty maintaining relationships with friends, co-workers, partners, spouses, parents, children

Symptoms of mental illness may be exacerbated by environmental stressors including

- Poverty
- Homelessness
- Difficulty accessing medical care
- Poor nutrition
- Drug and alcohol addiction

Symptoms of mental illness may be alleviated by medicine and social supports including

Help in --

- keeping up an apartment
- shopping for food
- budgeting money
- attending to hygiene
- planning social activities
- making friends and maintaining relationships
- Easy access to mental health care that is affordable and tailored to the needs of the person

WHAT MENTAL ILLNESS IS NOT

- Mental illness is not a character flaw.
- Mental illness is not a guarantee that the person will be violent.
- Mental illness is not anyone's fault.
- Having a mental illness does not mean there is no hope.

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Thought Disorders

- Hallucinations that might cause people to see, hear, feel, taste or sense things that aren't there
- Talk to self
- disorganized thoughts
- Paranoia, delusions, or bizarre thoughts
- Minimal display of emotion
- Poor hygiene/malodorous
- May wear multiple layers of clothing or inappropriate clothes for the weather
- May have multiple bags filled with what might appear to be garbage

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Mania:

- Expansive irritable mood
- Decreased need for sleep
- Heightened self-esteem
- Grandiose ideas
- Pressured speech /inability to interrupt them
- Distractibility
- Poor impulse control (e.g. buying sprees, sexual indiscretions)
- Possible break with reality, i.e. psychosis

WHAT A PERSON WITH MENTAL ILLENSS MIGHT EXPERIENCE

People with major depressive disorder often do not act in a bizarre manner

Common symptoms of depression include:

- Depressed mood most of the day, nearly every day
- Loss of interest or pleasure in all or most activities of the day
- Significant weight loss or gain
- Difficulty sleeping or sleeping too much
- Fatigue or loss of energy
- Feelings of worthlessness
- Recurrent thoughts of death or thoughts of suicide

It is a myth that depression is a normal part of the aging process. It is important to remember that depression is an illness which can be successfully treated.

IF YOU HAVE TO TAKE THE PERSON INTO CUSTODY ON A HOLD SOMETIMES IT IS HELPFUL TO:

- Ask the person if they have ever been in handcuffs before
- Tell the person that you came to help them, not to hurt them
- Tell them they are not under arrest or in trouble
- Tell them you know that they are not a bad person
- Tell them your boss says you have to put them in handcuffs, it is the rule, it's nothing personal

NOTES

Basic **P**sychiatric **L**ife **S**upport

Portland Police Version

1. Goal

This summary is intended to provide police and other justice professionals with a basic outline of techniques for dealing with patients suffering from acute psychiatric disturbances. The emphasis is on an initial approach, urgent or emergent evaluation, and basics of intervention.

2. Introduction

Dealing with patients suffering from psychiatric disorders is often perceived as frightening by those infrequently exposed to these problems. The area of psychiatry itself may seem foreign for several reasons:

Psychiatry deals with biopsychosocial issues (1) that typically straddle multiple areas:

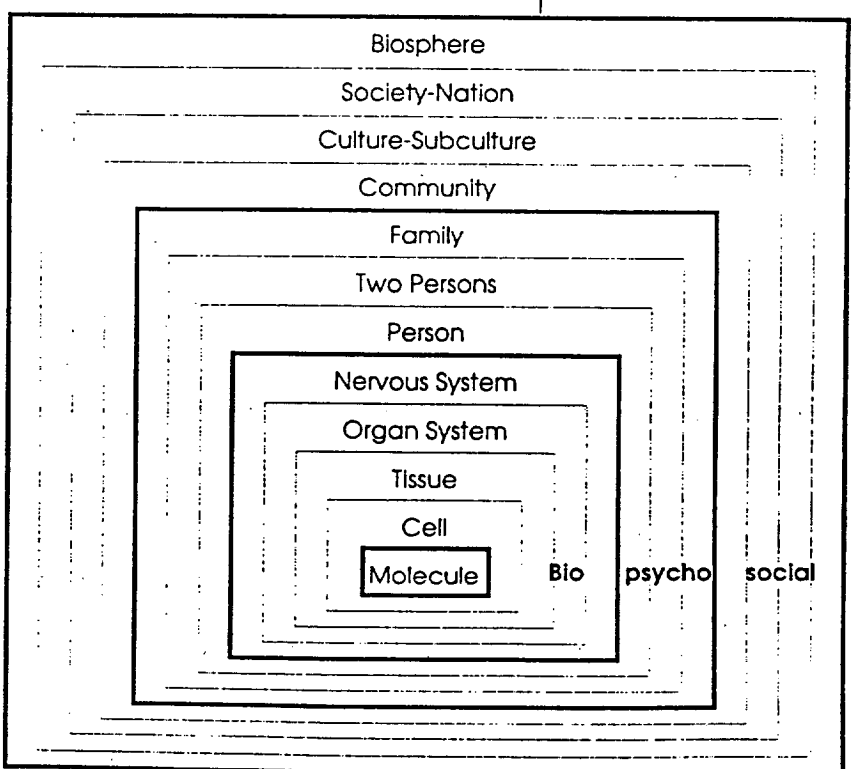


Figure 1: Biopsychosocial Model

There is no clear boundary between actions based on personal choice, social difficulties, psychological distress, or on a clearly biological disease. Multiple factors simultaneously influence the ultimate actions of an individual. Identifying and treating mental illness is complex, requires time, and may make the field appear diffuse and unclear.

Additionally, "gold standard tests" which would allow certain attribution of specific signs and symptoms to a specific disorder are generally not available. There is no X-Ray or blood test for bipolar disorder, for example. If a patient has signs of several disorders, multiple diagnoses must be considered, and frequently multiple diagnoses must be given. This may make the professionals operating in the field seem divided and without focus.

Finally, patients with psychiatric conditions often contact nonpsychiatric care providers first. They may adapt their complaints to match the specialty or "language" of the professional they are seeing. Thus, patients with similar ultimate diagnoses may present to a family doctor with physical complaints, to a mental health

professional with mental health complaints (2) (and likely to peace officers with safety concerns). Knowledge of mental illness can help the professional direct the patient safely into appropriate evaluation and treatment.

Top priority must be the professional's immediate physical safety.

The Basic Psychiatric Life Support model presented here is an attempt present the area of acute psychiatric practice in a way that is reductionistic, yet robust. The approach is generally algorithmic, similar to the Basic Cardiac Life Support course (3), which has brought emergency medical thinking to a broad audience. The structure of the algorithms here is determined by several factors which can be subsumed under the term "priority":

Severity: How bad is the disorder/injury?
Urgency: How fast must a response occur to be effective?
Remediability: How much difference will any response make?
Sequence: Does one step require a prior step?
Natural History: Balancing low frequency events with high morbidity against high frequency events with low morbidity.

3. Initial Triage

Even when it is clear that the appropriate or desired intervention is a psychiatric evaluation and/or treatment, attention must be given to its priority. (It is understood that here we are generally talking about noncatastrophic conditions in which the clinician has some realistic choices about how to proceed.)

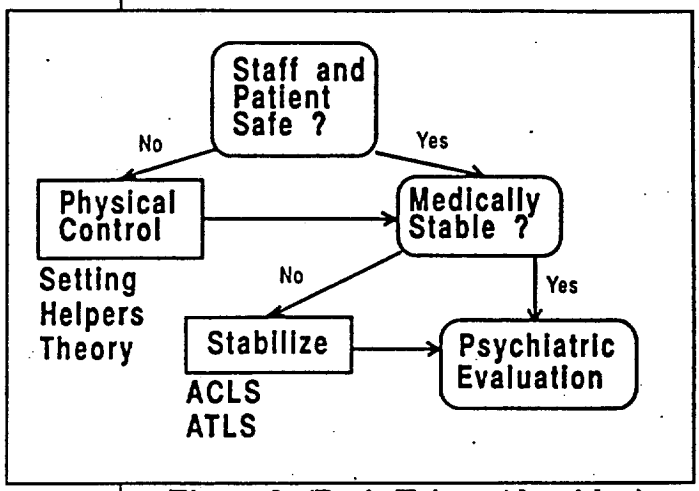


Figure 2: (Basic Triage Algorithm)

Top priority must be the clinician's immediate physical safety. What good can an injured or dead helper be? (Second priority is then the patient's own immediate physical safety.) If the clinician and patient are not physically safe, such safety must be provided for. Secondly, the patient must be medically stable to undergo psychiatric evaluation. If such medical stability is in question, immediate steps must be taken (after assuring physical safety) to intervene on this level. It is then the third priority to begin with a psychiatric evaluation, which will include the evaluation for suicide or homicide potential.

Also, attention must be given to the fact that a crisis represents the perception of an event or situation as intolerable, as an intolerable difficulty that exceeds the resources and coping mechanisms of the person defining the crisis. Such a concept must not be confused with that of an emergency,

which represents a sudden (and often distressing) event that may lead to serious psychological or physical consequences if there is no adequate response. This distinction is difficult, and at times one will need to proceed under the assumption of an emergency, even when it may ultimately prove that the problem is better identified as a crisis.

4. Physical Safety

That it is top priority to evaluate the potential of immediate harm to the professional and secondarily the patient comes as no surprise to police officers. This is their daily concern. We are looking for such basics as absence of weapons, a secure physical environment, and a patient that is reasonably able to modulate their behavior. The goal is to establish short term safety.

In essence, the concern is to identify and remain prepared for potential immediate violence, which represents a relatively rare event, but one with significant potential for injury or even death (4,5). It follows that attention must be given to issues of safety before they are needed. Protocols must be clear and well rehearsed.

4.1 Strategies:

To briefly review, the controllable variables can be grouped into three main categories: physical setting, personnel, and a theoretical model to guide the approach. Police safety techniques discuss these areas in detail, so here we will only list some areas of emphasis in the psychiatric arena for comparison.

4.1.1 Physical setting:

Structural requirements include the absence of dangerous or potentially dangerous objects, ideally access from multiple directions, monitoring and emergency communication systems, some provisions for confidentiality, and the opportunity to physically restrain a patient.

Each setting that the professional will work in should be rapidly reviewed a "worst case scenario" considerations in mind and steps should be taken to ensure as much safety in these settings as possible.

If physical restraint is used, sufficient help should be available to safely overwhelm the patient.

4.1.2 Personnel:

Just as the physical surroundings deserve attention, the professional must be completely aware of the help that is going to be available in an emergency. Specifically mental health trained, 24 hours per day, capability would be ideal. Such personnel should have an understanding of the medical model of overwhelming force. Police techniques that rely on verbal instructions or combative techniques (including pain holds) designed for persons with intact mental functioning can lead to difficulties. Patient injuries can occur in instances where the patient is incapable of understanding the purpose and context of police interventions due to a medical or psychiatric disorder. (See particularly the section on psychotic disorders.)

Medical (or paramedic) backup as well as collaboration with mental health professionals or outreach teams that might have some prior experience with the patient can also be very helpful. Such collaboration, however, re-

quires careful prior planning so that management at the scene of an incident can proceed smoothly.

Estimating the patient's control and deciding when the professional must assume control is key.

4.1.3 Theoretical Model:
Attempts at verbal intervention generally precede physical restraint. A clear model to decide when to switch modalities is necessary. One such model is presented here for comparison. It is intended as an ever-present scheme in the background of the evaluator's mind, while carrying out other tasks such as obtaining a history and performing a physical and/or mental status examination. It is again intended as an example only:

Patient's Response:	Staff Intervention:	My Response:
Aggression	Physical control	Fear
Hostility	Pseudochoice ("if...then...")	Anger
Anger	Real choices (Must be acceptable)	Anxiety
Anxiety	Support Encourage Ventilate Reassure "Extras"	Calm

Figure 3: (Interaction Grid) (Adapted from: (6))

The figure represents an interaction grid: three segments (columns) are subdivided into four corresponding levels (rows) of interaction. The first column represents the patient's emotional response within the interaction, the third, the professional's emotional responses which are assumed to mirror the patient's. The key is that the clinician must gradually develop a sense for their own personal response to each of the patient's stages. In the column between are strategies for intervention.

Exceptions:
The model of gradual escalation through the various levels from anxious, to angry, to hostile, and ultimately to aggressive, can be obviated by a number of medical and psychiatric conditions. In particular, an organically disturbed (e.g.: intoxicated or delirious) patient may escalate abruptly from a seemingly calm or anxious state to an outright aggressive one. Similarly, psychosis, with the inherent lack of reality contact (and defining thought disorder or loose associations), may jump from one stage to the other with little or no warning. It is here that the professional's personal emotional response may be the only "early warning" that is possible. This means that in the example suggested in Figure 3, the professional entering a patient's room for the first time, finding a fear response developing abruptly, should immediately be prepared to provide for physical control and safety.

5. Medical Emergencies

In the context of the triage algorithm (figure 2), medical emergencies are considered those conditions which would require stabilization of the patient prior to a psychiatric interview.

Procedures for such interventions have generally already been established, and most professionals will be familiar with examples of them: BCLS and ACLS protocols for medical and ATLS for surgical emergencies. Vital signs should be obtained if at all possible and as early as possible. They should be considered a requirement prior to the end of any emergency psychiatric intervention. Beyond this, a brief medical history, review of systems, and physical evaluation is usually necessary to rule out immediate medical problems.

6. Basic Psychiatric Interviewing

Moving to psychiatric intervention, we can distinguish: Interview techniques, evaluation (process and content), assessment, and treatment.

Any interview consists of at least three phases, with attention to four simultaneous areas:

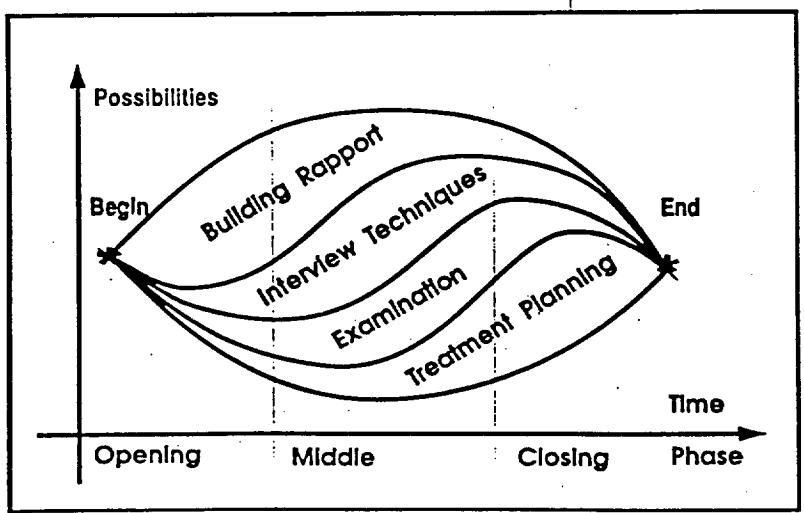


Figure 4: (Interviewing Process) (Adapted from: (7))

The beginning or opening phase of an interview emphasizes the establishment of rapport. The middle phase emphasizes the collection of information and the examination of the patient's current functioning. The closing phase emphasizes summarizing the information and communication of treatment decisions.

In the opening phase, questions will generally be open-ended, encouraging the patient to speak. Facilitative techniques, such as empathic statements, can be used to support this. In the middle phase, questions can frequently become more focused and steering techniques are used to direct the interview into content areas that are desired. Such steering techniques could be thought of as analogous to "back doors." For example, questions on the degree of depression can ultimately lead to questions of suicidality and specific suicidal plans:

„How depressed have you ever gotten?" „Have you ever been so depressed that you didn't want to live?" „Have you ever been so depressed that suicide started making sense?" „Have you ever planned or attempted suicide?" „How are things now?"

Similarly, questions about anger can lead to homicidal plans and questions regarding fear can lead to psychosis. While specific content areas need to be covered in the interview, attention to the process of the interaction will allow the professional to follow a nat-

In any interview the professionl's initial overriding concern is to develop solid rapport with the patient.

ural „flow" of the conversation. Additional steering techniques can help when necessary topics don't come up naturally: „Now that we've talked about you, let's talk a little about your family." In the closing phase, the clinician may summarize and be speaking more (though frequently checking with the patient to be sure of understanding). The ultimate outcome of a successful interview should be an agreement about the next steps to be taken in a treatment plan.

Knowing the relative importance of historical information can lead the interview.

7. Psychiatric Evaluation

The content of the evaluation generally includes a longitudinal (over time) component, the history, and a cross sectional (here and now) examination, typically, the mental status examination. This information leads to a diagnostic impression, which then guides the intervention strategy. While in an ideal case a relatively extensive history and thorough mental status examination will be obtained, the urgency of the moment may reduce this to current history with core mental status questions. Ultimately with a minimally cooperative patient, focus of the history should be to elicit a chief complaint and of the mental status examination to ask orientation questions.

7.1. Psychiatric History:

The history is usually obtained from the patient, though frequently outside corroborative information is needed. Generally this is done with, in emergencies without, the patient's permission. Depending on the urgency of the problem, intervention may need to occur before this information is complete or available. Obviously, no final disposition is possible until all of the information has been obtained and thoroughly considered.

The content is quite similar to that obtained in other areas of medicine. (In the following table(s) the asterisks identify the relative level of importance of the item). In emergencies, one would fall back on the most important items, clarifying these first.

Identifying Information
Chief Complaint (Suicide/Homicide?) ***
History of the Current Situation:**
Course Over Time**
Palliative and Provocative Factors
Review of Systems
Current Medications**
Current Drug Use Pattern**
Past Medical History*
Past Psychiatric History:
Hospital Admissions*
Biomedical Treatments (Medications)**
Suicide (Homicide) Attempts**
Past Alcohol and Drug Use*
Family History:
Genetic Risk Factors
Developmental History:
Family "Roles"
Defensive Mechanisms
Social History:
Current Level of Functioning
Prior Level of Functioning
Support System*

Table 1: History content

7.2. Mental Status Examination:

The mental status examination is intended to provide a cross sectional view of the patient's mental functioning at the current instant in time. It is a formalized method of obtaining and recording information on the higher cortical functions of the patient. To facilitate recall, four general areas can

be delineated: (Examples to serve as mnemonic devices are added in parentheses, and asterisks again denote the relative importance.)

1. General Inspection:
(Overview: "How does the patient look?")

Appearance: (Describing a "photograph") Height, weight, dress, grooming, etc.

Motor Behavior: (Describing the „silent movie") Movements, tics and mannerisms, level of activity, etc.

Speech: (Adding the "sound track") Rate, pressure, intonation, articulation, etc.

Attitude: (Putting it all together) Changes, relatedness with the interviewer, etc.

2. Emotions ("How does the patient feel?")

Mood: (The "climate") Depressed, happy, sad, irritable, etc. The patient describes the mood themselves. Their report will relate to a more extended period of time than the interviewer alone will have been able to observe.

Affect: (The "weather") Type: tearful, angry, etc.; Range: broad, full, narrow, flat, etc.; Stability: Labile, stable, etc. The interviewer attempts to describe the currently observed affective state of the patient in detail.

Congruence: The consistency between the observed emotions and reported mood with the context and content of the interview is observed. Loss of reality contact sometimes expresses itself here in lack of congruence.

3. Thoughts:** ("Software" analogy: "How does the patient think?")

Process:** This describes the logical flow of thoughts:

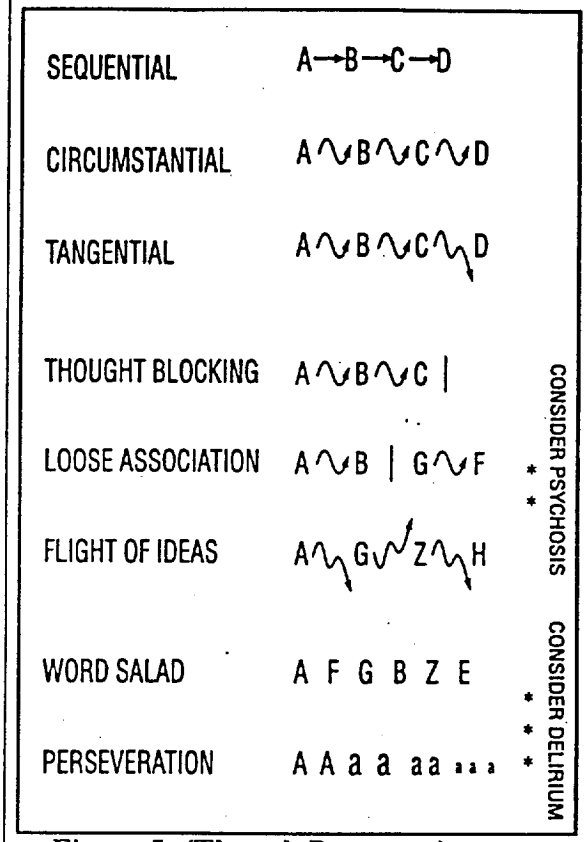


Figure 5: (Though Processes)

These can be considered to be on a spectrum from best organized to completely disorganized. On one end of the extreme, thoughts are expected to be sequential and concisely presented. At the other end of the extreme, no coherent thoughts can be discerned. There is literally word salad or perseveration. The most important stage*** is when loose associations (breaks in the logical flow) occur. They define psychosis. Tangential thinking may be dis-

When loose associations are present, consider psychosis; when there is word salad, consider delirium.

Orientation is the bedrock on which all other cognitive functions can be considered to rest.

tinguished from loose by the interviewers reaction: The thoughts: "What was my last question? How did we get onto this?" denote tangentiality. The thought: "Where did that come from?" denotes loose associations, and should be checked out. Worse disturbance generally indicates a worse disorder.

Content:** Here the thoughts themselves are grouped and unusual or important themes noted. In particular, any psychiatric interviewer will have to comment on suicidal*** or homicidal*** thoughts. These must be specifically sought out, as must be preoccupations and delusions* such as those indicating loss of reality contact, either in a non-bizarre or bizarre (completely impossible) context.

Perceptions:** How does the patient observe the world around them. Are illusions, hallucinations, auditory, visual, or tactile hallucinations**, depersonalization, derealization, ideas of reference, thought broadcasting, thought insertion, etc. present?

Using the computer analogy, thoughts can be considered to have disturbances that affect the logical order (poorly functioning program), abnormalities of content (database errors), and input errors.

4. Cognitive Evaluation*:** (Hardware analogy: "How is the machinery working?")

The following areas are all considered part of the cognitive function. In order to remember them, one might use the model of a familiar, reversible, toxic encephalopathy: alcohol intoxication. When one thinks of a person entering a bar and getting progressively intoxicated, ultimately to the point of coma, one can visualize the stages that they go through. Using this analogy, the extreme care needed to observe and document disturbances of orientation, attention, and concentration becomes clear.

Orientation: Time, place, and person.
Attention Concentration: Serial 7's, 3's, digit span, (usual is 7 digits forward, and 4 backward), spell "world" forward and backward.
Memory:
Registration: "Repeat after me"
Immediate Retention: 3 objects after 3' Recent Past: Events of the last few days Remote Past: Events several years ago
Abstraction: Ability to „get the big picture:"
Proverbs, similarities.
Intelligence: Fund of knowledge (consistent with the patient's education): vocabulary, presidents. general knowledge questions.
Judgment: Conceptualize outcomes: Stamped envelope, smoke in a theater scenarios.
Impulse Control: Ability to modulate impulses.
Insight: Awareness of illness.

Table 2: Cognitive Evaluation

The list is an attempt at such a hierarchical organization (using the above analogy) from the most severe to the least severe level of disturbance. If complete testing is not possible, it is useful to move to ever more basic cognitive tests.

8. Assessment

There are generally two parts to an assessment: 1) Organizing the information gathered in the history and mental status examination, and 2) Making a formal psychiatric diagnosis. Establishing a diagnosis may, however, be secondary to organizing the information in such a way that focuses attention on triage priorities. Broad diagnostic categories are considered first and allow stabilization and referral to more definitive evaluation and treatment. For our purposes, short range outcome is the major consideration.

Review of outcomes research shows that top priorities, which express themselves as variables affecting patient disposition, include:

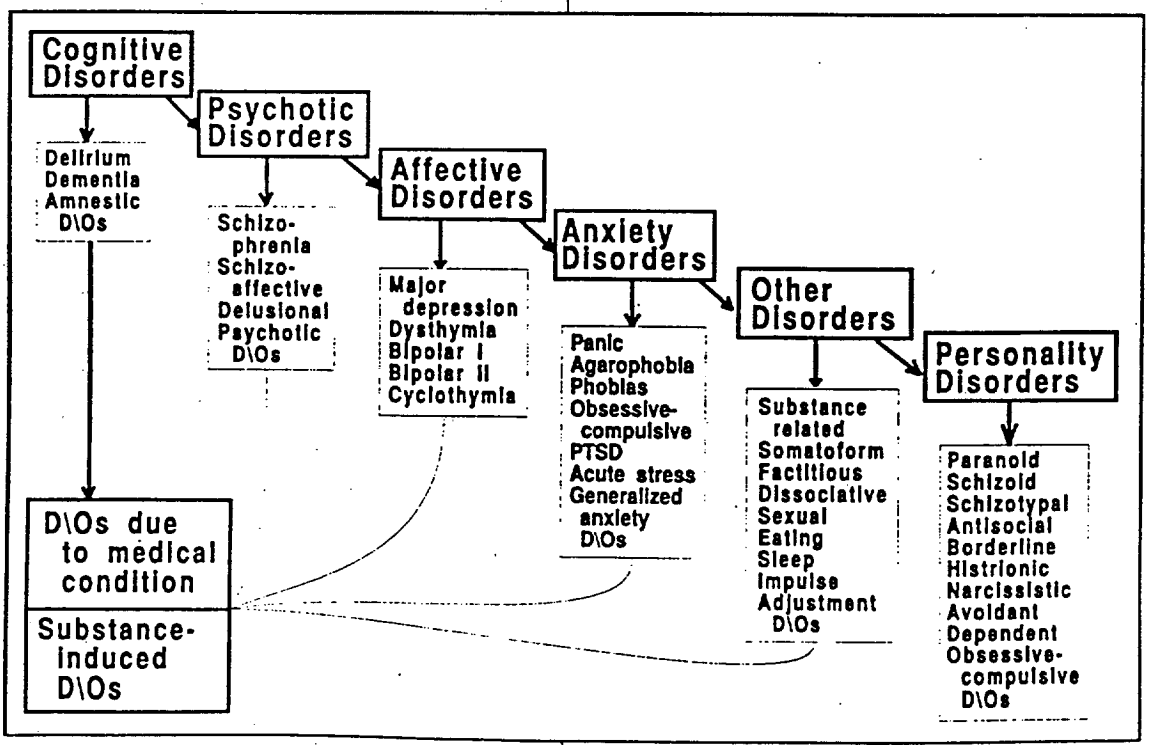
Dangerousness, prominence of symptoms (as clinical variables), clinical experience and knowledge of resources (as clinician variables), family members' support and desire for a specific outcome (as family variables), and referral source such as police, together with assessment of system options (3).

8.1 Impression:

Given the need for organization of diagnostic considerations, a clear idea about a diagnostic hierarchy is helpful. Which disorders take precedence over others? Why? Such a hierarchy is implicit in the DSM IV (8), producing a "cascade" of disorder groups. Generally, the hierarchy implies that treatment must be directed toward diagnoses higher in the model before treatment for lower priority diagnoses can be fully effective. Also, the more "biological" a disorder, the more likely it is to be found on the left; the more "psychological" a disorder, the more likely it is to be on the right.

Disorders induced by medical conditons or substances are listed with each group, but mut be considered first.

Figure 6: Differential Diagnostic Cascade



There are many medical emergency conditions that may initially present as a psychiatric disturbance.

Cognitive Disorders must be considered first. These are delirium (a medical emergency), dementia, and amnestic disorders. Problems where some outside influence causes what appears to be a psychiatric disorder are listed with each disorder group. Examples include substance intoxication, withdrawal, or medical illnesses. They must also be considered as the first priority. All of these disorders affect the brain's ability to function, and could be considered "machinery" or "hardware" problems. Treatment of these disorders will require attention to the underlying disorder. The most important is delirium***, characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention. This is heralded by disorientation and severely disorganized thought processes.

Psychotic Disorders*** must be considered next. These are illnesses. which affect the patient's ability to distinguish real from not real. They generally include major psychotic disorders such as Schizophrenia and are characterized by thought process (loosening of association or worse) or thought content (delusions) or perceptual disturbances (for example, auditory hallucinations). These can generally be considered "thinking problems." They are heralded by loose associations, delusions and or hallucinations. Treatment will usually involve the use of neuroleptics.

Affective Disorders are disorders that affect the mood. The mood may be depressed, elevated, or irritable. Major Depression and Bipolar Disorders (Manic Depressive Disorders) are the main illnesses. here. Both of these disorders can be accompanied by psychosis and when this is the case, the psychosis must be treated first. Treatments will often include medication such as antidepressants or mood stabilizers (thymoleptics).

Anxiety Disorders lead to excessive and inappropriate worry or panic. Examples include phobias, panic disorder, post traumatic stress disorder, the new acute stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. As implied by the hierarchy, removal of precipitants (such as Hyperthyroidism, psychosis or mood disorders) clearly takes precedence over symptom oriented treatment with, for example, Benzodiazepines.

Other Axis I disorder Groups follow in the diagnostic cascade.

Finally, toward the psychological side of the biopsychosocial diagnostic spectrum are Axis II Disorders:

Personality Disorders are problems with an individual's overall coping abilities. They should be considered if there is a long standing (since adolescence) pervasive (affecting all parts of an individual's life) pattern of maladaptive (causing personal distress or impairing functioning) behavior. In these patients the developmental "tool kit" might be thought of as not fully developed, frequently under the influence of traumatic disturbances in their childhood. DSM IV (8) generally distinguishes three groups: Cluster A (odd and eccentric), Cluster B (dra-

matic erratic and emotional) and Cluster C (anxious or fearful). Under stress, such individuals can display symptoms from any of the other diagnostic groups and a thorough evaluation, along with attention to the diagnostic hierarchy, is crucial prior to the diagnosis of a personality disorder. Treatment generally involves a carefully coordinated program of psychotherapeutic and social interventions. Since these conditions can mimic and coexist with many of the Axis I disorders, their identification and treatment take time and may be perceive as the most frustrating task for the professionals trying to help. Clear attention to who is responsible for what (interpersonal boundaries) is crucial to the management of these conditions.

In summary, it should be remembered that, many individuals suffer from several disorders simultaneously. One disorder does not generally exclude another, though if symptoms can be ascribed to a diagnosis further up in the hierarchy, then that diagnosis must be given. Thus, for example, a patient who is intoxicated, yet suffers from Schizophrenia, would likely show signs both of cognitive impairment and reality impairment, and would be given both diagnoses. Treatment must then also address both disorders.

8.2 Biopsychosocial Diagnosis:

In order to organize all of this information, the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) (8) has designed its multiaxial system of diagnosis. The diagnosis is recorded in five axes, whereby multiple diagnoses are encouraged when the criteria for the specific disorders are met.

Axis I: Psychiatric Clinical Syndrome ("Nature") Axis II: Personality Disorders or Traits ("Nurture") Axis III: Physical Disorders Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning (GAF Score).

Table 3: DSM IV Multiaxial System of Diagnosis

Many patient suffer from several disorders simultaneously that must all be identified.

9. Interventions

Beside the assurance of immediate physical safety outlined above, treatments will generally come in four major areas: general safety, biological treatments, psychological treatments, and social interventions.

Longer term safety issues are much more complex to evaluate. Generally the clinician is only able to identify broad groups of patients at risk for harm to self or others but cannot predict the future behavior with any reasonable certainty over more than a few hours or even days (4). One of the best and most important predictors is that of past behavior. Another key consideration is the presence of destabilizing factors such as intoxication.

9.1 Immediate Safety Interventions:

As outlined before, emergent intervention may require physical restraint. The principal behind the safe use of such restraint is overwhelming force. We cannot assume that a patient has

The clinician assumes the responsibility when there is significant danger or competence is low.

the mental capacity to recognize directions, physical cues (painful or nonpainful), and to respond appropriately. When a patient is physically restrained attention must be given to the legal framework (doctor's court hold or police officer hold, etc.). Also, the patient must then be observed very closely since this group of patients is at higher risk of having significant coexisting physical illnesses that can place them in danger, especially since the usual complaints of feeling ill may not occur. Once a professional has assumed responsibility for the patient they are responsible for the "whole" patient!

Similarly, chemical restraints can be used in some emergency conditions. Neuroleptics (Inapsine) or Benzodiazepines (Ativan) have been advocated and are often used in the medical setting.

9.2 General Safety:

Patients who present a danger to themselves or others are unable to care for themselves, or fail outpatient management, or require 24 hour observation for diagnostic assessment or ongoing round-the-clock medical treatment will require hospitalization. As long as such patients are willing to be hospitalized on a voluntary basis, there is little question as to how to proceed.

Involuntary Admission: In most states, if the patient represents a danger to himself or others due to a mental disorder, and/or is unable to care for their basic needs (grave disability), there is a process that allows emergent and urgent hospital admission on an involuntary basis. This is generally regulated in the Commitment Statutes. Difficulties arise when it is unclear how far the patient's rights of self determination go in comparison to the professional's ethical obligation to intervene in the face of a psychiatric disorder (right to competent treatment).

In this respect, a grid that plots danger against competency may be useful to the professional:

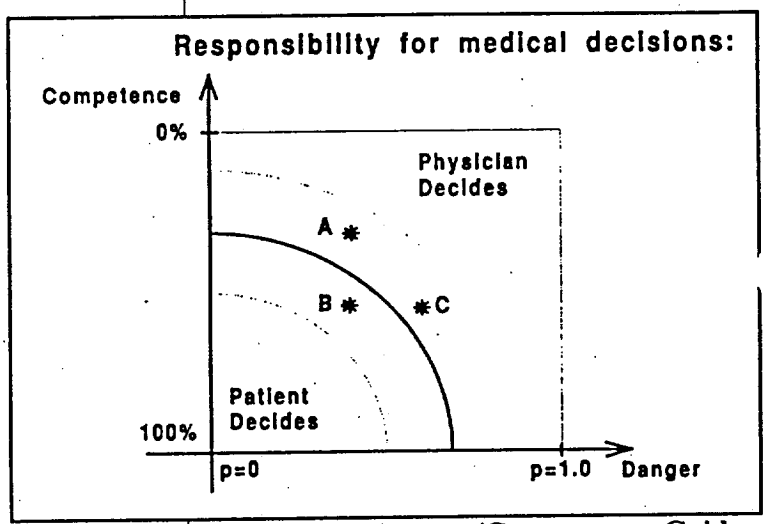


Figure 7: Danger/Competency Grid (Adapted from (10))

As outlined in this grid, competency is plotted against danger. In the lower left hand corner, patients who are in an area of low danger, yet have a high degree of competence, are clearly in charge of their treatment, irrespective of the clinician's preference. Simultaneously, patients that have either an extremely low level of competence (such as the severely disabled Alzheimer's patient wandering on the street) or are in an extreme degree of danger (such as an occluded airway)

must be treated by the clinician even against their will. Frequently, the situation is much less clear. Despite this, the law allows only for a dichotomous choice: One is asked to act as if the grid were bisected by a clean line. Nevertheless, it is quickly apparent that the gray band of mixed cases in the middle represents many cases and a significant clinical dilemma. For example, patients A, B, and C may differ only in some minor respects, yet patient A and C will be involuntarily admitted where B may not. Patient B may, for example, present with depression, suicidal ideations of several months' duration, and some poorly formulated thoughts of possibly taking an overdose. Patient C, similar in all ways, may, however, be contemplating the use of a firearm and has access to such. Clearly, patient C would require involuntary admission. Patient A, on the other hand, while in a situation just as B, may be intoxicated, lowering their level of competence. Clearly as well, here the clinician must intervene (even if only temporarily until competence is restored/intoxication resolved).

Involuntary admission in Oregon is regulated by the Oregon Revised Statutes (ORS 426). If a patient represents a danger to himself or others due to a mental disorder and is unable to agree to voluntary admission, the patient may be admitted against his/her will. The doctor's court hold (DCH) documents the belief of two licensed physicians or a physician and a qualified mental health professional that such a danger and mental illness exists. Outside of the hospital setting, the police or mental health program is needed to make such a determination. A police officer custody report (POCR) documents that a police officer has reason to believe that such danger and illness exists. A mental health program can also initiate such a police officer hold (Mental Health Director's Hold). When the mental disturbance does not rise to the level of danger but there is question about the individual's ability to care for themselves, any two interested persons may file a two party notice (TPN) with a county mental health agency. From the filing of all of these notices, a court investigation

The patient's safety for two weeks on their own may be key to deciding on potential danger.

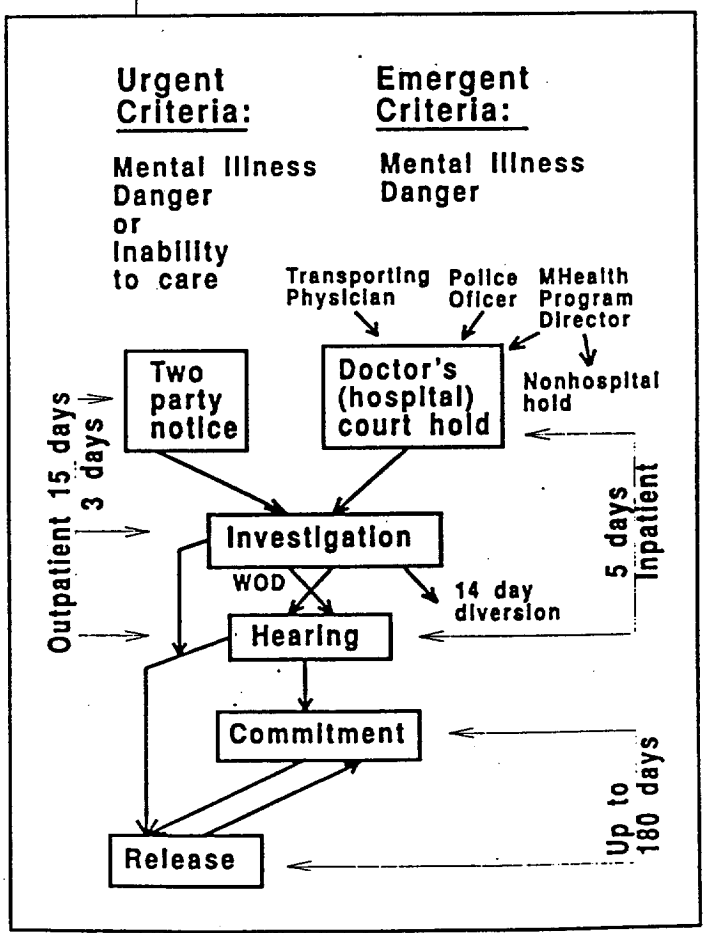


Figure 8: ORS 426

The patient should be treated in the least restrictive, yet safe, environment.

is initiated. This investigation may lead to a hearing (or to patient release). The hearing may lead to commitment. The main difference between the two routes in Oregon is that the emergent route (which includes only the criteria of mental illness and danger) requires that the patient be kept in the hospital and must not exceed five working days to the point of a hearing. The urgent route proceeds on an outpatient basis and 15 days may pass prior to a hearing. Therefore, frequently the question of danger must be phrased as: "Is this patient safe for 15 days in an outpatient setting?"

9.3 Biological Treatments:

In this area we generally think of the use of pharmacotherapeutic agents. Also, in general, one will have to consider psychiatric consultation in this context. Brief attention was given to the use of chemical (and physical) restraints earlier. An introduction into the basic psychopharmacology would clearly be beyond the scope of this brief review. Nevertheless, we should be clear that addressing an organic or cognitive mental disorder generally requires attention to or treatment of the underlying disorder. Thus, for example, treatment of hypo- or hyperthyroidism or delirium tremens would require the appropriate medical treatment for those conditions, not the psychopharmacologic treatment of the mental expressions of the illness (though there are exceptions where both becomes necessary). Psychotic disorders generally require antipsychotics (neuroleptics). Affective disorders will generally be treated with antidepressants and/or mood stabilizers, including Lithium, Tegretol, or Valproate. Anxiety disorders will frequently be treated with antianxiety agents, such as Benzodiazepines or Buspirone. As indicated by the differential diagnostic hierarchy, such agents must be used cautiously in combination.

From a psychiatric emergency viewpoint, it is extremely important to remember that treatment with neuroleptics, antidepressants, and mood stabilizers generally requires two to four weeks to be effective. Therefore, their initiation is frequently not part of an emergency, more triage-based intervention, no matter how badly one wants to help fast. Pharmacologic measures are generally very focused, directed at supporting a prior developed treatment plan and prescriptions are kept small. Careful coordination with outpatient treatment providers is crucial.

9.4 Psychological Treatments (Psychotherapy):

Similar to the section on pharmacotherapy, an introduction into psychotherapy is beyond the scope of this review. The emergency setting, as well as the realities of the treatment system, currently favor more focused, outcome oriented treatments that are frequently in the cognitive or behavioral realm. In many emergency settings general principles of crisis intervention apply: One attempts to restabilize the patient who has reached a point of instability and overload ("the straw that broke the camel's back") and support their process of reorganization through the phases of acute

decompensation, denial, anger, bargaining, grieving, and recovery. Such a hypothetical course of a crisis is outlined below:

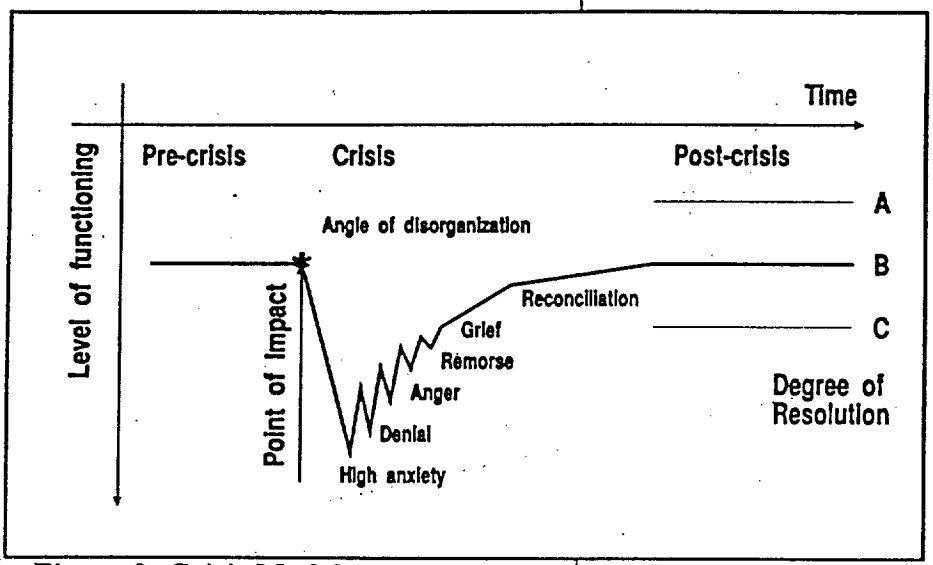


Figure 9: Crisis Model

Psychotherapeutic intervention could take on the following form: One assesses the biological, psychological and social realities that the patient brings to the situation. These are crucial for understanding the resiliency or stability of the patient's "system." Then focus on the balance between stressors and support system will allow a determination to be made on the severity and urgency of the current crisis. Stressors or supports are then manipulated where possible to help restabilize the patient.

Psychotherapeutic intervention using a debriefing model may also be appropriate. Such a model could be thought of as having four parts (see table 4). It may be used with individuals and groups. In the interaction, the four phases are explicitly separated. In the first phase facts are gathered from all participants. Statements about how one feels are excluded. (It is made clear that they are legitimate, but will be talked about separately). In the second phase, affects/feelings are clarified and discussed. Here the attempt is to collect a broad range of emotional responses, validating them. The disconnection from the facts and the legitimacy of the patient's own emotional response is emphasized. In the third phase the group is educated about what to expect (both in terms of future events and emotions); in the fourth,

Crisis intervention rebalances a percieved disparity between stressors and suuports.

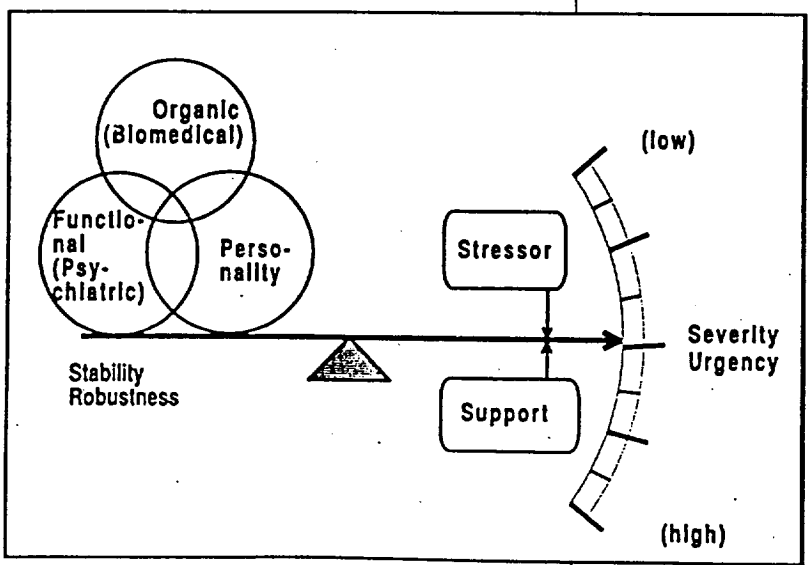


Figure 10: Crisis Intervention

The critical incident debriefing model may also be useful for the professional faced by trauma.

plans are made for any necessary follow-up.

1. Clarify the facts of the crisis ("What happened?").
2. Clarify the feelings ("How do you feel about this?").
3. Review the usual response to crises: (teaching phase).
   - Phase of Disbelief or Denial.
   - Phase of Shock or Confusion.
   - Phase of Anger.
   - Phase of Grief and Sadness.
   - Phase of Acceptance.
4. Problem solving or reopening the social world/contacts and ultimate resolution (reinforce adaptation and a plan for the future).

Table 4: Critical Incident Debriefing

In less formalized psychotherapeutic work three simple rules may help in the beginning:

1. When the patient presents a complaint, always validate it.
2. However, in doing so, acknowledge it in a way that will allow for reinterpreatation. Thus, it may be crucial to a psychotic patient to hear: "Oh, that sounds frightening," but it would be unwise to agree that the FBI may be indeed plotting.
3. Finally, offer a reinterpretation of the complaint that will direct the patient to action toward an useful goal. ("When you experience such voices, it may be a sign that you need to take a time out/take more medication.")

9.5 Social Interventions:

In this area, the realities of the patient's living are addressed. Clearly, attention must be given to food and shelter, as well as clothing. Where these are not immediate concerns, issues of disability may be the stated or covert objectives that should receive attention. While seeking psychiatric hospitalization in order to find shelter is understandable, it is clearly not the most efficient use of resources, and it would be the professional's task to support the legitimacy of such patient desires, yet to help the patient address their needs directly.

10. Summary

This outline is clearly intended as a forum for ongoing discussion and not as a finished document. It does, however, attempt to make explicit some of the core principles underlying emergency psychiatric evaluation and intervention. Since the subtleties of human interaction can clearly not be adequately addressed by such an approach, it is worth remembering that the experienced professional on the scene generally has access to significantly more information, including personal reactions, that can be crucial to accurately assessing the patient's situation. Pairing such clinical experience and "feel" for patients' needs with a clear diagnostic and therapeutic structure will hopefully provide some of the redundancy necessary to assure safe clinical interactions.

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Version: 7-10-95

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NOTES

NOTES

ORGANIC AND PSYCHOTIC

MENTAL ILLNESS

WHAT IS PSYCHOSIS

Psychosis is defined by a complex of symptoms which include:

Delusions (false beliefs in something that is so at odds with the prevailing societal consensus as to be recognized as ranging from the improbable to the bizarre).

Hallucinations (the experience of sensation in the absence of external stimulation, most commonly auditory, but in drug induced states or other organic states can include visual, olfactory, gustatory, and tactile sensations).

Incoherence (unintelligible speech or speech which may make sense but conveys little or no information even though the person may talk a lot).

Loosening of Associations (the lack of connection in a person's flow of thought so that ideas seem to generate other ideas which have no logic to their sequence).

Catatonia (marked excitement or profound stupor and muteness to the degree that a person is at risk for life threatening exhaustion or is unable to carry out basic functions such as food seeking and feeding).

Gross Disorganization (marked difficulty in organizing behavior so that a person may be disoriented to time, place and identity, may be unable to respond to others or unable to respond in an understandable manner).

There are a range of conditions which may produce psychotic behavior ranging from; a brief reactive psychosis which is a response to excessively traumatic stress (for example: combat); to substance induced psychotic reactions; to psychosis due to a progressive brain deterioration such as in a dementia like Alzheimer's; and psychosis due to a chronic mental disorder such as schizophrenia or severe mood disorder as in psychotic depression or in psychotic mania.

The neurobiological basis of psychosis appears to stem largely, but not exclusively, from the disruption of dopamine transporting systems in the brain. This can be due to endogenous (internal) causes such as mental illness or dementia but also may be due to exogenous (external) causes such as head trauma or exposure to certain chemicals.

For our purposes, **we are concerned with those chemicals which have reinforcing properties in the brain and are likely to be abused.** Repeated use of substances such as **alcohol, speed, crank, coke, crack, hallucinogenics, designer**

drugs, increases the risk of developing a drug induced psychosis or "triggering" an existing condition such as schizophrenia or severe mood disorder. This appears to be due to the dopaminergic (dopamine stimulating) action of these substances in the brain.

The most common psychiatric symptom resulting from repeated or heavy use of any of the amphetamine type drugs is delusional thinking. Paranoid delusions of persecution and other bizarre or unusual explanations of events are frequently seen. Accompanying this paranoia can be agitation, anxiety and aggressive behavior so that persons in a drug induced psychotic state have much more potential for violent acts including homicide and suicide.

Think of the brain as an elaborate circuit board with very complex electrical interconnections which form our self-awareness, our experiences, our thoughts, our sensations, our perceptions, our memories. If you pour water on a circuit board it shorts out due to the water acting as an electrical conductor between parts of the circuits that weren't meant to be connected. Drugs act the same way in the brain except instead of water being the disruptive electrical conductor, they act on the neurotransmitters which conduct electrical activity. If the brain is no longer able to carry out established interconnected patterns of electrical activity and different pathways become involved, what the brain experiences is psychosis. What others see is that the psychotic person does not make sense and that is responding to stimulation which is internal and not shared or understood by others.

Usually, if an individual abstains from drugs, **the psychotic symptoms will go away with time.** The symptoms generally go away within hours to days, although they may last several months and, for some unfortunate individuals, they may become permanent. **The population at highest risk for permanent damage is the one with an existing mental illness or mood disorder or, has a predisposition to develop a mental illness or mood disorder.**

At this time, the only known effective treatment for psychotic disorders is the use of anti-psychotic medications which tend to have a stabilizing effect on the dopamine balance in the brain. These medications are not 100% effective and they carry some risk of side effects. About 25% of people with psychotic symptoms do not obtain a favorable response to existing anti-psychotic medications. Hallucinations, confusion and disorganization generally respond to anti-psychotic medications but delusional thinking tends to be less responsive.

Denial is a major element making for great difficulty in the treatment of psychotic states that are either drug induced or due to chronic mental disorders. Frequently, the person experiencing the psychotic effects of drugs or of mental illness believes that what his senses are telling him is an accurate reflection of

external reality. This is what we all believe and rely on to navigate through the world. When someone tells a psychotic individual that what they are experiencing is not "real", it is very difficult to make a convincing argument. What is going on in that person's brain is their reality so they must deny any challenges to that reality and refuse to accept any offers of treatment and refuse to believe that they might need treatment.

A common outcome is that a psychotic person comes to the attention of the police. A quick determination is made if the psychotic person poses some danger to themselves or others and is not willing to obtain voluntary treatment. **The individual is transported to an emergency psychiatric facility where they can be detained against their will, for up to five court days.** During this time an investigator must make a determination as to whether or not the person is to go to Civil Court before a judge and psychiatric examiners for an involuntary commitment hearing. **The Civil Court has the authority to place the person under the care and custody of the Mental Health Division for a period not to exceed 180 days if they find the person continues to be mentally ill and a danger to self or others. While under commitment a person can be administered psychiatric medications against their will.**

Go back now to the earlier statement that most drug induced psychotic states clear in a few hours to a few days. If a person in this condition is taken to a psychiatric emergency holding facility they are likely to be released without a commitment hearing. **But, for the person whose symptoms persist, they stand a good chance of being committed and placed in a psychiatric hospital.**

If a crime was committed at the time the person was picked up by the police, the person will probably have a **detainer** placed on them while in the hospital and then be transferred to jail once their symptoms have cleared. **Petty crimes** committed while the person is psychotic are often dismissed if the court feels that the individual is getting the treatment they need. Repeat offenders are not as likely to be looked upon with such leniency particularly if they persist in denying they need treatment or do not follow through with treatment.

Mental illness is not a state of bliss. It can be a world filled with fear and confusion. Whether psychosis is drug induced or not doesn't make any difference to your brain but **the choice to use or not use drugs of abuse will make a major difference in how your brain is going to function.**

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche"=the mind and "tropos"=turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics, that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially **highly addictive**, produce fairly rapid tolerance and are extremely difficulty to withdraw from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal is actually easier, quicker and safer. Common side effects are sedation, dry mouth, depression, memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do not produce tolerance. The anti-depressants work to restore balance in the neurotransmitter systems which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics

Elavil (amitriptyline)
Tofranil (imipramine)
Norpramine (desipramine)

Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

the **second generation or "atypical" compounds**
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)

the **SSRI's** (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

the **MAOs** (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The **ANTI-MANICS** are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. **Non-addictive** and does not produce tolerance. Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The **ANTI-PSYCHOTICS** also called **Neuroleptics** are used to treat psychotic symptoms. As such they work to restore balance in the neurotransmitter systems which mediate thought processes, perception and mood. They are **non-addictive** and do not produce tolerance. Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)

Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
the **"new generation"** anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Orap (pimozide) used mainly for Tourette's Syndrome
GOOD ONE
The **Anti-Parkinson** medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The **ATTENTION DEFICIT DISORDER/HYPERACTIVITY** medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. These medications can produce dependence and tolerance. They are less often prescribed now as many of the SSRI anti-depressants and a couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)

There are others in all the above classes but this list is fairly inclusive.

Organic Disorders

a. Definition
    1. A class of conditions caused directly by abnormalities of brain structure or by alterations of brain neurochemistry or neurophysiology (e.g., delirium, dementia, amnesic syndrome, organic hallucinosis, organic delusional syndrome, organic mood syndrome, organic personality syndrome, etc.)

b. General symptoms
    1. Confusion, memory disturbance, disjointed speech, slow mentation, and substance abuse

    2. Physical signs
        a. Breath smells
        b. Blood shot eyes
        c. Runny nose
        d. Needle tracks
        e. Slurred speech
        f. Unsteady on feet
        g. Bizarre behavior and speech

    3. Head Trauma
        a. Permanent
        b. Slow mentation
        c. Impulsive
        d. Seizures
        e. Personality change

    4. Stroke
        a. Usually older person
        b. Paralysis
        c. Difficulty speaking

5. Dementia
   a. Older person
   b. Confused, especially about personal information
   c. Combative
   d. Often in a nursing home or has a specific care provider

6. Medical Causes
   a. Diabetic not taking insulin
   b. Drug overdose
   c. Delirium – fluctuating levels of consciousness
   d. Past seizures
   e. Off seizure medications
   f. Physical illness (sweating, nausea, vomiting)

Psychotic Disorders

a. Definition
   1. A disturbance of perception and thought process is a broad description of this category. The psychotic symptoms represent manifestations of disturbances in the flow, processing, and interpretation of information in the central nervous system. These symptoms can be mild to severe. (Mental Health : A Report of the Surgeon General)
   2. Hallucinations are the most common group of symptoms that result from this disordered processing and interpretation of sensory information. An example is the frequently described hallucination of hearing voices.
   3. Hallucinations may include:
      a. auditory
      b. smell
      c. feel
      d. visual
      e. physical
   4. Delusions are a more complex group of symptoms resulting from this disordered interpretation of information. A delusion is a false belief that an individual holds despite evidence to the contrary. A common example is paranoia, in which a person has delusional beliefs that others are trying to harm him. Any attempts to persuade the person that these beliefs are unfounded typically fail and may further entrench the delusional belief.
   5. Psychotic thought processes are characteristically loose, disorganized, illogical, or bizarre. These thought processes frequently produce bizarre observable patters of behavior that is also disorganized and bizarre.

Schizophrenia

a. The cause of schizophrenia has not yet been determined although research points to the interaction of genetic endowment and major environmental upheaval during the development of the brain. (Mental Health: A Report of the Surgeon General)
b. Part of the psychotic disorders schizophrenia frequently have marked disturbances in logical thought process.
c. Symptoms can include:
    1. Hallucinations
    2. Delusions
    3. Disorganized thoughts and behaviors
    4. Loose or illogical thoughts
    5. Agitation
    6. Flat or blunted affect
    7. Concrete thoughts
    8. Anhedonia (inability to experience pleasure
    9. Poor motivation, spontaneity, and initiative

MOOD DISORDERS

Mood Disorders

a. A group of clinical conditions characterized by a disturbance of mood, loss of that sense of control, and a subjective experience of great distress. This disturbance of mood can be manifested by either stained feeling or sustained elevation of mood. As with psychosis the disturbance of the mood occurs in a variety of patterns associated with different mental illnesses. (Mental Health: A Report of the Surgeon General)

Bipolar or Manic Depressive

a. Symptoms include mood swings from the lows of depression to the highs of mania. These episodes alternate and in some cases can be predicted. Severely affected people have a "rapid cycling" bipolar illness, in which the mood swings occur almost continuously.
b. Depression: symptoms include melancholy, sad, miserable most of the time. Loss of interest in life and pleasures. There can be a decreased energy level, fatigue, fits of weeping or constantly feeling like crying, and an unusually high degree of irritability. There is also a on going thoughts of suicide in severe cases.
c. Manic symptoms include a feeling of power, increased energy, seductive, elated, euphoric. Other symptoms include talks too fast, loud and without stopping. Thoughts race from one idea to the next in rapid succession without much logic. Stop eating, sleeping which in turn can change mood to irritability, anger, paranoia.

Major Depression

a. Ongoing feelings of melancholy, sad and miserable most of the time with loss of interest in life and pleasures. These episodes can also include decreased energy, fatigue, fits of weeping or constantly feeling like crying. Symptoms may

vary with individual, but are long lasting and affect the quality of life for the person.

b. The though process is constantly negative with hopelessness dominating present and future. Anxiety, dread can increased the individual's inability to function. Difficulty in concentration and making decisions; experience feelings of guilt, self-loathing, or worthlessness. Preoccupies with death and suicidal thoughts or attempts.
c. Physically individuals may experience disruptions in normal eating and sleeping patterns. Some are unable to sleep and others may sleep more hours than usual.
d. Behavior includes inability to get work done and difficulty in reading or studying. There is a great difficulty in accomplishing simply tasks such as washing, dressing, and eating. There may also be some restlessness and agitation. The characteristics include slowed thoughts, movements, and speech; walk stooped and shuffling gait

NOTES

Childhood Disorders

Psychiatric Disorders in Children and Adolescents

- About 20% of US children and adolescents (15 million), ages 9-17, have a diagnosable psychiatric disorders.
- As reported in the Surgeon General's Conference on Children's Mental Health in January, 2001:
  1 One in ten children and adolescents suffer some mental illness severe enough to cause some level of impairment.
  2 It is estimated that fewer than one in five of these children receive needed treatment in any given year.

I. Social background

A. Barriers to treatment

1. Limited governmental funding directed toward child and adolescent mental health services.
2. Limited treatment services/programs.
   - Less mental health treatment services for children than for adults.
     In Portland, the number of psychiatric inpatient beds for:
     Adults=193
     Children and adolescents=52
3. Increasing number of child and adolescent patients.
   - At CTC, number of patients seen under 18:
     In 1997 = 360
     In 2000 = 1,492
4. Increasing demand for mental health professionals.
   - Children and adolescent patients may wait 6–8 weeks or longer for an appointment with a child and adolescent psychiatrist

B. Stigma

Parents may be fearful they may be blamed for their child's emotional and behavioral problems. Children are sometimes teased or directly stigmatized by classmates.

II. Common Disorders

Four disorders (ADHD, Oppositional-Defect Disorder, Conduct Disorder and Autism) have onset and are usually first diagnosed in childhood or Adolescence.

A. Disruptive Behavior Disorders

1. Attention-Deficit/Hyperactivity Disorder

- A disorder where an inappropriate degree of hyperactivity-impulsivity and/or inattention is exhibited.
- Some of the following symptoms must be present before age 7.
- More frequent in males than females.

- Prevalence – 3-5% in school aged children.
- Most commonly diagnosed disorder in child/adolescent psychiatry.
- Symptoms

  a. Inattention

  1. Often fails to give close attention to details, makes careless mistakes in schoolwork, or other activities.
  2. Often has difficulty sustaining attention in tasks or play activities.
  3. Often doesn't seem to listen when spoken to directly.
  4. Often doesn't follow through on instructions and fails to finish schoolwork or chores.
  5. Often has difficulty organizing tasks and activities.
  6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork, homework).
  7. Often loses things necessary for tasks and activities (e.g., toys, school assignments, pencils, books).
  8. Is often easily distracted by extraneous stimuli.
  9. Is often forgetful in daily activities.

  b. Hyperactivity:

  1. Fidgets with hands, squirms in seat.
  2. Often leaves seat (in classroom).
  3. Often runs about, climbs excessively in situations in which it is inappropriate (In adolescents may be limited to feelings of restlessness).
  4. Often has difficulty playing or engaging in leisure activities quietly.
  5. Is often "on the go" or acts as if "driven by a motor".
  6. Often talks excessively.

  c. Impulsivity:

  7. Often blurts out answers before questions have been completed.
  8. Often has difficulty awaiting turn.
  9. Often interrupts or intrudes upon others (e.g., butts into conversations or games).

- Associated disorders or symptoms

  Learning disorders.
  Oppositional Defiant Disorder-tantrums, bossiness, stubbornness, poor patience.
  Conduct Disorder-aggression.
  Mood disorders-poor self esteem, depression, rejection by peers, and conflict with family.

2. **Oppositional-Defiant Disorder**

- A disorder where children or adolescents display a pattern of openly uncooperative and negative, disobedient and hostile behavior.
- More prevalent in males than females before puberty; rates equal after puberty.
- Usually evident before age 8.
- Symptoms
  1. Often loses temper.
  2. Often argues with adults.
  3. Often actively defies or refuse to comply with adult's request or rules.
  4. Often deliberately annoys people.
  5. Often blames others for his/her mistakes or misbehavior.
  6. Is often touchy or easily annoyed by others.
  7. Is often angry or resentful.
  8. Is often spiteful or vindictive.
- Associated disorders or symptoms

  ADHD is common.

  Oppositional-defiant disorder can (but does not always) precede conduct disorder.

  Depression – low self-esteem.

  Substance abuse.

3. **Conduct Disorder**

- A disorder in which there is a repetitive and persistent pattern of the violation of the basic rights of others OR major age appropriate roles.
- More common in males than females.
- May begin in childhood or adolescence.
- Symptoms

  a. Aggression to people and animals
     1. Often bullies, threatens, intimidates others.
     2. Often initiates physical fights.
     3. Has used a weapon (e.g. bat, brick, broken bottle, knife, gun) that can cause serious physical harm.
     4. Has been physically cruel to people.
     5. Has been physical cruel to animals.
     6. Has stolen while confronting a victim (mugging, purse-snatching, extortion, bank robbery).
     7. Has forced someone into sexual activity.

b. Destruction of property
   8. Has deliberately engaged in fire setting with intention of causing serious damage.
   9. Has deliberately destroyed others' property.

c. Deceitfulness or theft
   10. Has broken into someone else's house, building, car.
   11. Often lies to obtain goods/favors or avoid obligations.
   12. Has stolen items of nontrivial value without confrontation of a victim (e.g. shoplifting, forgery).

d. Serious violation of rules
   13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
   14. Has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period).
   15. Often truant from school, beginning before age 13 years.

- Associated disorders or symptoms
  ADHD.
  ODD (may precede CD) –temper outbursts, poor frustration tolerance.
  Depression – low self-esteem, irritability.
  Substance abuse.

- **Police response to children and adolescents with a disruptive behavior disorder (ADHD, ODD, CD)**
  a. Usually police come into contact with these children or adolescents because of their anger outbursts or physical and/or verbal threats of harm.
  b. They may be argumentative or minimize problem behaviors.
  c. Direct questioning with authoritative approach.
  d. Obtain and carefully consider information provided by adult witnesses.
  e. Inquire whether the child is in current mental health treatment and (if applicable) taking medications.

B. Autistic Disorder (to be covered in Developmental Disability section)

- A disorder characterized by patterns of delay and impairment in the development of social interaction and communication and the development of restricted interests and activities.
- Onset is prior to age 3 years.
- 3 to 4 times more common in males.
- Coexistent disorders or symptoms
  Mental retardation 20% have normal IQ.
  30% have mild to moderate mental retardation.
  50% have severe or profound mental retardation.

ADHD – disruptive, impulsive.
Self-injury (e.g., head banging).
Obsessive – compulsive disorder – compulsive, repetitive behaviors.

- **Police response to children and adolescents with Autistic Disorders.**
  a. Usually police come into contact with these children because of self-injury, impulsive behaviors or anger outbursts.
  b. These children are unlikely to make eye contact or communicate/answer any questions.
  c. Obtain as much information from adult witnesses, parents or guardian.
  d. These children do not do well with change. If they have an attachment to an object, consider letting them hold on to it.

C. Anxiety Disorders

- The most common mental health problem that occurs in children and adolescents.
- According to one large-scale study of 9-17 year olds, as many as 13% had an anxiety disorder in a year.
- Common anxiety disorders

1. Phobias

- Excessive or unreasonable marked and persistent fear of a specific object or situation or fear of a social or performance situation where the person is exposed to scrutiny and fears embarrassment.
- Exposure to that object or situation causes an immediate anxiety response. In children, anxiety may be expressed by crying, tantruming, freezing or clinging.
- In children, most common fears-fear of dark, fear of harm to an attachment figure; fear of animals.
- In adolescents – fear of heights, fear of public speaking.

2. Generalized Anxiety Disorder

- A disorder characterized by excessive anxiety and worry, where the individual finds it difficult to control the worry.
- Most common in middle childhood.
- Symptoms (only one required for children): Restlessness or feeling keyed up or on edge, being easily fatigued; difficulty concentrating or mind going blank, irritability, muscle tension, or sleep disturbance.

3. Panic Disorder

- A disorder characterized by recurrent, unexpected panic attacks.
- Panic attacks are discrete periods of intense fear or discomfort in which symptoms develop abruptly and reach a peak within 10 minutes.

- Symptoms include palpitations, sweating, trembling, shortness or breath, feeling of choking, chest pain, nausea, dizziness, derealization or depersonalization, fear of losing control or fear of dying.
- Uncommon before puberty.
- Usually begins in adolescence or early adulthood.

4. **Obsessive-Compulsive Disorder**
   - A disorder characterized by recurrent obsessions or compulsions that cause distress, are time consuming, or interfere with individual's functioning.
   - Majority of children and adolescents have both obsessions and compulsions.
   - Mean age of onset = 10 years.
   - Obsessions: Recurrent or persistent thoughts, impulses or images that are experienced as intensive and inappropriate, cause marked anxiety or distress and are not simply excessive worries about real-life problems.
   - Compulsions: Repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession. The behaviors or mental acts are aimed at preventing or reducing distress.
   - Most common symptoms of OCD in childhood are obsessive contamination fears accompanied by compulsive washing and avoidance of contaminated objects.
5. **Post-traumatic Stress Disorders**. (will be covered in PTSD section)
   - Disorder where child/adolescent has been exposed to a traumatic event, where they experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury or threat of physical harm to self or others. The individual's response involved intense fear, helplessness or horror (in children this may be expressed by disorganized or agitated behaviors).
   - Symptoms

     Re-experiencing – In children, nightmares or repetitive play or drawings in which themes or aspects of trauma are expressed.
     Avoidance-of reminders of the event and numbing of general Responsiveness.
     Increased arousal – difficulty sleeping is common in children.

   - In general, girls are more symptomatic than boys.
   - Common traumatic events- Domestic violence, natural disaster, shootings.
   - Younger children have more avoidant symptoms; older children have more re-experiencing and increased arousal.

- **Police response to children or adolescents with anxiety disorders**
  a. Usually police come into contact with these children because of "out-of-control behavior" related to intense anxiety.
  b. Be reassuring, speak slowly and calmly.
  c. Give the child time to relax.
  d. Most of these children want relief and will accept help.
  e. Allow them to be in the company of someone familiar as you are questioning them.
  f. Suicide risk is increased with anxiety.

D. Mood Disorders

1. **Bipolar Disorder** – (covered in Overview of Mental Illness)
   - Mood disorder where there is or has been a manic episode.
   - In children and adolescents, irritability more common than euphoria
   - Most common symptoms
     High activity level; rapid speech; highly distractible; racing thoughts; hypersexuality (in children-profanity, sexual comments, masturbation; in adolescents-increased sexual activity); and risk taking (in children, fighting; in adolescents, wild driving).
   - First episode may be mania or depression.
   - 20-30% of youth with major depression go on to have manic episodes.
2. **Major Depression** (covered in Overview of Mental Illness)
   - Mood disorder characterized by depression or irritability (irritability is more common).
   - Common symptoms in children
     Anxiety – phobias.
     Somatic complaints – headaches and/or stomachaches.
     Behavioral problems- temper tantrums.
     Sleep/appetite disturbance.
     Suicidal thoughts or attempts.

- **Police response to children and adolescents with mood disorders**
  a. Usually police will come in contact with these children/adolescents because of dangerous behaviors to self/others.
  b. The manic child/adolescent may be speaking rapidly or make no sense.
  c. The depressed child/adolescent may be irritable, tearful or speak little.

d. Risk for suicide in both disorders. (In mania, may be more in form of self-endangering behaviors).
e. Consider strongly information provided by witness even if child/adolescent denying further suicidal thoughts.
f. Inquire whether child/adolescent is in current mental health treatment or on medication.

E. Schizophrenia (covered in Overview of Mental Illness)

- Disorder characterized by psychotic symptoms (hallucinations, delusions, illogical thinking).
- Onset most typically in the adolescent.
- Onset in childhood extremely uncommon and has relatively poor outcome.
- In childhood, auditory hallucinations may include command hallucinations or commenting about the child. May have to do with monsters. Magical thinking is common.
- Childhood schizophrenia occurs predominantly in males.

- **Police response to child/adolescent with schizophrenia**:
  a. Usually will come in contact with these adolescents because of odd or agitated behavior.
  b. These children/adolescents may be paranoid of the police.
  c. Reassure them you want to help, you do not want them harmed and will do all you can to keep them safe.
  d. They may become combative.
  e. They may be talking to themselves. Don't challenge nor accept their delusions, just listen matter-of-factly.

B. Legal Issues

1. Consent to psychiatric or chemical dependency treatment.
   In Oregon a minor 14 years or older may consent for their own mental health, alcohol or drug treatment, excluding methadone. Parent/guardian can be advised of treatment when disclosure is clinically appropriate and serves the best interest of the minor.
2. Drug Testing
   A child under 14 can be tested without their knowledge or consent.
3. Parental rights
   An order of sole custody of a child to one parent does not deprive the non-custodial parent of authorizing medical treatment for their child. Only terminated parental rights by a court order denies the parent of the ability to authorize treatment for their child.

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
    - I won't be here.
    - You won't have to deal with me.
    - You'd be better off without me.
    - Life is meaningless.
    - Death is probably a solution to my problems.
    - Would you miss me if something happened to me?
    - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
    - reckless driving, skating, bike-riding, swimming alone
    - drug-experimentation
    - sexual promiscuity
    - fighting, baiting others towards physical confrontation
    - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

NOTES

NOTES

PERSONALITY DISORDERS

Personality Disorders Training
Crisis Intervention training
Portland Police
5/18/00

Outline

I. Overview

A. Definition: DMSIV A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adult, is stable over time and leads to distress or impairment.

B. Types:

1. Cluster A Paranoid, Schizoid, Schizotypal,
   - odd or eccentric

2. Cluster B: Antisocial, Borderline, Histrionic, Narcissitic,
   - dramatic, emotional or erratic

3. Cluster C: Avoident, Dependent, Obsessive Compulsive
   - anxious or fearful

II. Development of Personality Disorder

A. Stress / Coping Skill Relationship

B. Sense of Self

C. Impairments

1. self harm
2. self defeating behavior
3. relationships
4. abandonment issues

III. Management of Behavior

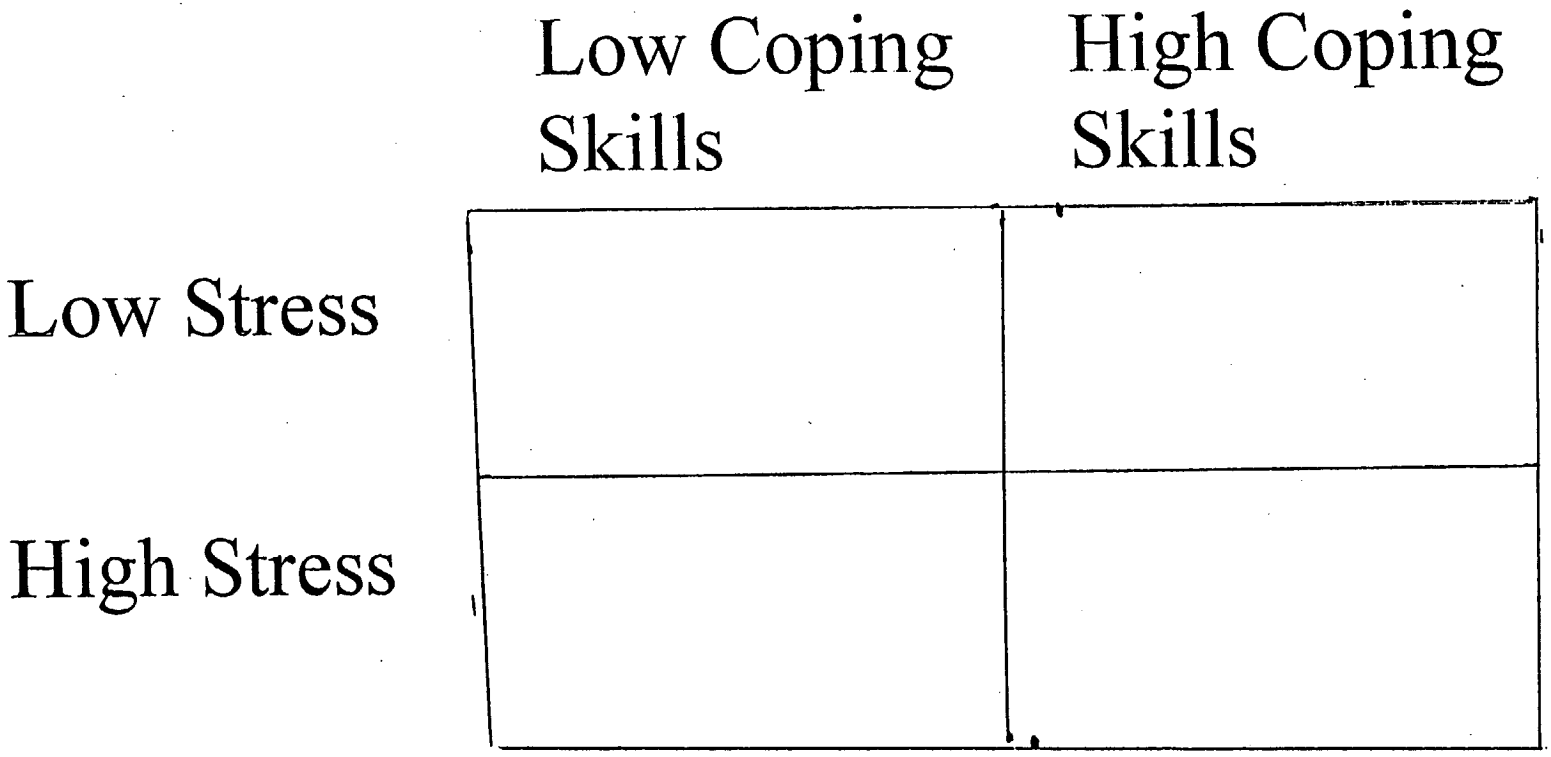
A. Neutrality

B. Clarifying Expectations

C. Setting limits

D. Supportive feedback

Stress/Coping Skill Relationship



NOTES

POST TRAUMATIC

STRESS DISORDER

Post Traumatic Stress Disorder

1.Symptoms develop following exposure to an extreme traumatic event that involves

- Direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to physical integrity of another person
- Witnessing an event as described above
- Learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate

2. The persons response involves intense fear, helplessness, or horror. In children this may be manifested by disorganized or agitated behavior.

3. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. In children this can include play where themes or aspects of the trauma are expressed
- Recurrent or distressing dreams of the event. In children there may be frightening dreams without recognizable content

Acting or felling that the traumatic event were recurring. Can include hallucinations and flashbacks

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity to internal or external cues that symbolize or resemble an aspect of the traumatic event

4. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness

- Efforts to avoid thoughts, feelings or conversation associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall important aspects of the trauma
- Diminished interest and participation in activities
- Feeling of detachment or estrangement from others
- Restricted range of affect
- Sense of a foreshortened future

5. Persistent symptoms of arousal

- Difficulty falling or staying asleep
- Irritability or anger outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

6. Prevalence rates for the general population range from 1% to 14%. Rates for at risk populations such as combat veterans, crime victims, ect. range from 3% to 58%

7. In about 50% of cases symptoms resolve within 3 months. In many cases symptoms persist longer than 12 months

8. Individuals with PTSD are at increased risk of developing a substance use disorder. Substance use exacerbated symptoms of PTSD

GUIDE TO ACCOMPANY

POST TRAUMATIC STRESS DISORDER

FEATURES OF PTSD

A. Traumatic event/significant stressor.

B. Re-experiencing of the traumatic event.

C. Numbing of responsiveness

D. Anxiety-based autonomic and cognitive symptoms.

DIAGNOSTIC CRITERIA FOR PTSD

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma by at least one of the following:

1. Recurrent and intrusive recollections of the event (nightmares).
2. Recurrent dreams of the event.
3. Sudden acting or feeling as if the traumatic event were re-occurring (flashbacks).

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

1. Marked diminished interest in one or more significant activities.
2. Feeling of detachment or estrangement from others.
3. Constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

1. Hyperalertness or exaggerated startle response.
2. Sleep disturbance.
3. Guilt about surviving when others have not, or about behavior required for survival.
4. Memory impairment or trouble concentrating.
5. Avoidance of activities that arouse recollection of the traumatic event.
6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.
7. Self-medication via alcohol/drug/pill abuse--chain smoking--overeating--anger mismanagement.

PTSD SUBTYPES

308.30 Post-traumatic Stress Disorder, Acute

- Onset of symptoms within six months of the trauma.
- Duration of symptoms less than six months.

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

- Duration of symptoms six months or more (Chronic)
- Onset of symptoms at least six months after the trauma (Delayed)

TRAUMATIC EVENTS THAT CAN PRECIPITATE PTSD

A. Rape

B. Natural Disaster

C. War--combat

PRECIPITATING TRAUMA & SIGNIFICANT STRESSORS OF COMBAT

- Exposure to death and mutilation of people and destruction and desolation of environment.

- Personal acts of violence, fighting, killing, and destroying.

- Danger and threat to life.

- Depersonalization and dehumanization of the military environment and the war experience.

- Discontinuity between war and non-war environment.

<u>Additional Stressors of War</u>

- Political and moral debate and controversy about combat, social and political divisiveness (draft evasion; marches, demonstrations, protests, and political debate). Creating a state of confusion and uncertainty; weakening morale; heightening vulnerability; diminishing social support and sanction; resulted in a homecoming by avoidance, rejection, and antagonism.

- System of rotation, limited tour of duty and periods of rest and recuperation with rapid individual entry and exit reduced morale and cohesiveness; rendered unit maneuvers more difficult and exposed participants to a more stressful transition.

- Restrictive policies (no plan to win the war; abandonment of captured territory; orders to request permission from higher authority before engaging the enemy) heightened danger, contributed to mistrust and lack of confidence in leadership.

Themes of "Post-Vietnam Syndrome."

- Guilt feelings and self-punishment.
- Feelings of being scapegoated.
- Rage and other violent impulses against indiscriminate targets.
- Combat brutality and it's attendant "psychic numbing."
- Alienation from one's own feelings and from other people.
- Doubt about ability to love and trust others.

TREATMENT OPTIONS FOR PTSD

A. Behavioral Techniques: Relocation, Desensitization

B. Education Techniques: Assertiveness, Relaxation

C. Supportive Techniques: Reflective Listening

D. Family Therapy

E. Hypno Therapy

F. Individual Therapy

G. Peer Group Therapy

H. Flooding, Abreactive Therapy

I. Gestalt Technique

J. Grief Psycho Therapy

K. Guilt and Regret Issues in Counseling

L. Anger and Stress Management

[Events]

VIETNAM: WHAT I REMEMBER

From "Patriotism Revisited," by David W. Powell, a memoir submitted last October to a creative writing class at the University of Arizona in Tucson. Powell served as a marine in Vietnam from 1965 to 1967.

The following events come to my conscious memory uninvited. I not only remember them vividly, I reexperience them with all my senses:

Froze with fright, standing up, the first time I was under fire

Watched two marines try to break open the skull of a dead Viet Cong with a large rock

Observed a marine intentionally shoot a girl four or six years of age

Watched the girl's grandfather carry her into our line of fire, sobbing

Had a lieutenant who delighted in sneaking up on me when I was on watch at night

Was offered a blood-soaked flak jacket and a helmet with a bullet hole through it as my first field equipment

Had my boots rot off during an operation in the field

Observed two captured nurses being beaten and raped by marines

Rifle-butted a girl of twelve in the face when she would not move away

Strangled a captured Viet Cong for refusing to talk to an interpreter

Discovered brain matter on barbed wire I was stretching out

Observed a marine laugh as he stepped on the chest of a dead Viet Cong and watched blood squirt out of the enemy's wounds

Awoke to find a buffalo leech on my leg

Was abandoned under fire when a rocket jammed in my launcher

Was abandoned under fire when I was shot

Hit head and fell in open field. Watched my fellow marines run by me to seek cover for themselves

Received letter from wife telling me how much fun she and a girlfriend had on Friday nights when they went out to bars to dance

Watched fellow marine shoot himself in the foot to get evacuated

Heard same man cry in his sleep when he was returned to the company

Found marine boot with foot in it in a hedgerow

Almost run over by retreating U.S. tank

Saw Lt. Spivey hit a head-high booby trap

Nearly murdered villager for stealing my laundry

Watched Prestridge test his new M-16 by shooting a woman getting water from a nearby well

Identified Haas's remains

Exchanged letters with Haas's mother

Had an artillery canister fall six inches in front of my head

Was about to put on fresh boots when I discovered lice swimming in them

Saw seven-foot python climbing in ceiling just above my head

Bullets sounding like bees digging up ground all around me

Nearly trapped in Da Nang village my last night in Vietnam

Robbed by marines while I slept in Okinawa after tour was over

Circled over El Toro air base for two hours so that President Johnson could land and be photographed greeting returning veterans

•

Since my return I have held eighteen different jobs and have been unemployed for several six-month periods. This is a direct result of my Post Traumatic Stress Disorder, specifically a disdain for being told to do tasks I do not want to do; an exaggerated startle response, which is terribly embarrassing to me; and a lack of control over emotional flooding.

I divorced my first wife two years after I got out of the service. I divorced my second wife in 1982. I separated from a four-year relationship in 1987. I have not had a significant relationship with a woman since then. I have no significant male or female friendships. I am aloof from my immediate family, who live in Tucson, Arizona.

PTSD SYMPTOMS

- MISTRUST
- DEPRESSION
- ISOLATION
- RAGE REACTIONS
- AVOIDANCE OF FEELINGS; ALIENATION
- GUILT/SHAME AND DOUBT
- ANXIETY REACTIONS
- SLEEP DISTURBANCE AND NIGHTMARES
- INTRUSIVE THOUGHTS

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HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
1120 S.W. THIRD AVENUE, 4TH FLOOR
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Dear Survivor:

This booklet is about the experience of being hurt on purpose by other people, and the changes in your life that it leaves behind.

You may wonder if what happened to you was bad enough to be called abuse. If you have to ask that question, it probably was. If you cannot remember large parts of your life, it almost certainly was.

I am sorry you are having to read this out of a book.... These things are better dealt with face-to-face. The effects of violence are best helped by different and more positive experiences with people. In a correctional institution, this is hard to do.

Take your time reading this. Use whatever parts seem helpful in your situation. Be patient with yourself. It will take time and work, but you <u>can</u> feel better.

Take care,

Joe Parker, RN

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Dear Colleagues,

In providing mental health care for corrections populations, management of Post Traumatic Stress Disorder has a central place.

Some clients come into the system as a result of acts in some way related to previous experiences of abuse. Many come as a result of self treatment of major symptoms by means of illegal drugs or alcohol.

Although psychotropic medications play an important role for many clients in controlling physical symptoms of the disorder, psychological treatment has proven to be very important in improving functioning and quality of life.

Since mental health resources are so limited in corrections, self-help educational materials must be used whenever possible. This booklet has been very helpful for our clients and staff, and we hope it will be helpful for your clients as well.

Sincerely,

Joe Parker, RN

POST TRAUMATIC STRESS DISORDER (PTSD)

WHAT DOES POST TRAUMATIC STRESS DISORDER MEAN?

Post is the Latin word for "after".

Trauma is the German word for "nightmare", but in English, it is used for any kind of injury, physical or psychological.

Stress is a force that changes the shape of things (including people).

Disorder refers to things that are a problem in a person's life now.

To understand PTSD, it is necessary to tell two stories.

> Once upon a time, several blind men wanted to understand about elephants.
>
> An elephant was brought to them, and they all approached it from different directions.
>
> One felt the tail, and said "an elephant is like a rope"!
>
> Another found a leg, and said, "no, an elephant is like a tree trunk".
>
> A third walked into the side of the elephant, and said, "really, an elephant is like a wall".
>
> Others found the ear, the trunk, a tusk, and each felt his part of the elephant was the real elephant.
>
> Each blind man was right about his part of the elephant, but none of them really understood about elephants.

The story of Post Traumatic Stress Disorder is similar.

PTSD was first recognized after the American Civil War.

Doctors noticed that some soldiers who had been in heavy combat complained of having attacks of fast heartbeat, chest pain, difficulty breathing, and fear that they were dying or going crazy.

The symptoms were similar to heart attacks. Not having the scientific equipment to investigate further, they assumed the attacks were a form of heart disease. They called it "soldiers' heart".

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We now know the attacks are not heart disease. They result from rushes of adrenalin, triggered by bad memories or nightmares.

A few years after the war, most people forgot about the problem, but the part of the elephant they had found was real.

World War I was the first time very large numbers of explosive shells were used in battle.

It was noticed that some combat veterans, afterward, had trouble with feeling somewhat dazed or confused, and with poor concentration and memory.

This seemed similar to what happened in many brain injuries. It was thought that the concussions of the shells caused tiny spots of bleeding in the brain. They called it "shell shock".

Eventually, a lot of autopsies were done on soldiers who had died of other causes, and no such bleeding was found. It was recognized that the symptoms resulted from extreme stress, not brain damage.

It should be remembered that many people with PTSD, especially from child abuse and domestic violence, have had damage from blows to the head. Both symptoms of brain injury and effects of overwhelming stress may be present in the same person.

A few years after the war, the matter was again dropped, but they had found another part of the elephant.

When World War II came, it took until June of 1944 to redevelop the treatment methods used in 1918.

In that war, they learned two important things. The severity of a person's symptoms was directly related to how much stress he or she had undergone, over how much time.

It was calculated that of 100 men in continuous combat, every single one would break down within 189 days. They called it "combat fatigue", or "combat exhaustion".

It also became clear that there is no such thing as a stress-proof person. Certainly some people break before others, but with enough stress and enough time, everybody breaks. They had another part of the elephant.

After World War II, it was assumed (never investigated, just assumed) that symptoms of traumatic stress went away in 6 months or a year, after the war was over.

Only after the Vietnam War did it become clear that PTSD symptoms could appear it any time, during or after the war. The symptoms could go on, better or worse from time-to-time, all of a person's life.

The severity of the symptoms is influenced by how much emotional support a person has available during and after trauma.

Veterans of an unpopular war, such as Vietnam, were clearly affected by the fact that nobody wanted to talk about it later.

Survivors of child abuse and domestic violence are more severely affected because family or friends, who normally would provide support, are the perpetrators of the violence.

In the late 1970's feminist writers began publicizing the fact that far more child abuse, sexual abuse, and domestic violence were occurring than previously admitted.

Studies began to reveal that domestic violence is a problem in about 25% of all families, regardless of race, religion, income or education. About 16% of all girls and 8% of all boys are sexually abused before the age of 18 years. Rapes reported to the authorities may represent less than 10% of those that actually occur. About 10% of the adult population is alcoholic. Inclusion of other abusable substances may raise the figure to double that.

Very few people are directly involved in wars, but most people have a family.

Unlike in times past, the feminists and Vietnam veterans have not shut up and gone away. Post Traumatic Stress Disorder is now an official diagnosis in the diagnostic and statistical manual.

Consciously or unconsciously, the brain remembers everything. Trauma really happens, and it changes who you are. You cannot seriously hurt human beings and expect them to forget it and be alright afterwards.

People who have Post-Traumatic Stress Disorder often worry about whether they are "crazy".

The word "psychotic" (or crazy) usually means experiencing or believing things that are not real: being "out of touch with reality".

People with PTSD's have essentially the opposite problem. They are in too much contact with reality, and in contact with realities that most people have the privilege of not knowing about.

It is just as possible to be sick from too much contact with reality, as from not enough.

That is the whole elephant.

The official definition of Post Traumatic Stress Disorder includes a combination of the following:

1. An extreme, painful experience, which would be severely stressful for almost anyone.

2. Continuing psychological "re-runs" of the events, including:

   a. frequent thoughts and memories about what happened, even when trying to avoid them.

   b. repeating nightmares about the trauma.

   c. suddenly feeling or acting as if the events were happening again (flashbacks).

   d. strong, painful feelings set off by things which are in some way related to what happened.

3. Ongoing attempts to avoid memories and feelings by:

   a. becoming generally numb to everything, by cutting off most feelings, both good and bad.

   b. avoiding activities or situations which may bring back memories and feelings.

   c. loss of large areas of memory about past life.

   d. loss of interest in things most other people care about, feeling different and cut off from other people.

   e. lack of any sense of having a future.

4. Continuous extreme physical alertness, including:

   a. constantly watching for signs of danger, with "startle responses", and trouble sleeping.

   b. trouble concentrating on business in the present world.

   c. irritability, outbursts of anger.

   d. physical reactions similar to what happened during past trauma (tremors, sweating, nausea etc.)

5. These symptoms continue for more than a month and can begin anytime from immediately to years after the trauma.

PSYCHOLOGICAL ABUSE

Children come into the world knowing nothing about themselves: whether they are smart or stupid, good or bad, lovable or unlovable. They can only learn these things from family, from people around them. If they are given "poison information", they have little choice but to believe it.

For the abuser psychological abuse has several advantages:

1. It leaves no physical marks. Unless the child becomes extremely depressed or psychotic there is no evidence to show in court.

2. It is safe. There is no risk of accidentally killing the child and being sent to prison. There is no problem with the child getting big enough to physically fight back or use a weapon.

3. It is easy. Psychological abuse can be kept up for years, wearing away at a child like rust. There is no great amount of energy or time involved.

Psychological abuse takes several forms. They are usually used together - it is rare for an abuser to use only one type.

1. Rejecting

   "I hate you, you ruined my life". "You are not my child" Nothing the child is or does is ever good enough.

2. Isolating

   Keeping the child away from any people other than abusers. This prevents the child from learning anything about him or herself except the "poison information" provided by the abusers.

3. Ignoring

   Not responding to anything the child is, says, or does. Psychologically/emotionally "not there" for the child.

4. Corrupting

   Involving the child in crimes, early alcohol/drug use, sexual activities, etc. that leaves the child unable to be part of normal society.

5. Terrorizing

   Keeping the child constantly in fear of being hurt, making the child watch others being hurt, keeping the child emotionally out of control most of the time.

PHYSICAL ABUSE

A large part of the "normal population" consider it legitimate to use physical force to discipline children. "Spanking" with an open hand is commonplace in our society. Abuse, fueled by uncontrolled anger or intoxication, goes far beyond ordinary discipline. Abusers almost always blame their violence on the child or spouse who is the victim. This is confusing to survivors, who need to know what level of violence qualifies as "abuse".

Abuse includes some combination of the following features:

1. Severity of injury. Cuts, bruises, broken bones, being strangled or knocked unconscious.....and sometimes death.

2. Weapons. Clubs, knives, guns and other instruments capable of causing severe injury or death. Life or death for the child depends totally on how well the abuser controls the weapon.

3. Use of pretexts. A child is punished for anything or nothing. The "rules" are made up as the abuser goes along, and change without warning. The child is never safe.

4. The abuser is out of control. Through alcohol/drugs, mental illness or personal choice, the abuser does not control amounts of force used. The child may be crippled or killed at any time.

It is sometimes useful, to understand the severity of a survivor's current symptoms, to put together a lifetime total assault history. Multiply the total number of each type of assault per day/week/month by the total amount of time exposed to the various abusers. Be sure to count both assaults in childhood and in adult life. The total number sometimes explains a lot about why you are having so many symptoms.

Finally, estimate the number of days on which the survivor could be sure of not being hurt. Sometimes this number is painfully small.

Adults who recognize their actions toward children as abusive often fear to tell anyone, out of fear they will go to jail or lose custody of their children. In reality, many social services agencies work with parents who have abused, or fear they may abuse their children, to learn to stop the violence and keep their children. Parents Anonymous is free and a good place to start.

SEXUAL ABUSE

Normal sexuality is the exchange of pleasure between two freely consenting people. Abuse is the wrongful use of a human being, as a thing, for the pleasure of another. Sexual abuse commonly involves:

1. Use of force or threat to control a person who is not consenting. The threats may be against the victim, ("Do what I want or I'll kill you...."), against others, (If I don't get what I want from you, I will just go after your little sister..."), or against the abuser himself, ("If you tell anyone, I will have to kill myself, and it will be all your fault...").

2. Use of lies to overcome resistance, ("I'm doing this to teach you, for your own good", "Everybody does this", "You want it, I know you do".). Lies can take the place of open violence.

3. Secrecy. Normal sexual relationships may go on in private, but they are not themselves secret. The demand for secrecy almost always indicates wrongdoing, and usually includes some kind of threat. ("You won't be by special girl anymore", "It would break your mother's heart", "You will be put in an institution".).

4. Betrayal of responsibility. Children have to depend on older people for protection, for food, clothing, shelter, and for truthful information about how to get along in the world. An adult who uses a child's natural needs in order to use the child's body, is committing a crime. Sometimes the betrayal hurts more than the fear, the isolation or the injuries.

The most basic drives of human beings, and of all animals, are to survive and to reproduce. The use of power to control a child is ultimately based on the threat to hurt, abandon, or kill. The child does whatever is necessary to survive. Energy that should go into growing up, is spent on trying to just get by, day by day.

Use of sex as a weapon strikes a child's basic ability to relate to, and trust, other human beings. It attacks a person's sense of being connected to other people, both in the present world, and to past and future generations.

Sexual abuse is like any other serious injury: some people survive and do well, some people only get by, and some end up not surviving at all. Good help and the right choices can make your life more nearly normal, and much happier than it might otherwise have been.

To be hurt, especially on purpose by other people, makes everyone sad and ashamed. In thinking about their lives and symptoms, most people tend to underestimate the severity of their experiences, and overestimate the amount of control they had over what happened.

HISTORY

The brain has mechanisms like "circuit breakers" which block out memories too bad to handle at a given time. The memory loss is usually "spotty", not complete, and gets better or worse depending on a person's stress level and how much help is available.

Trying to force the memory, by emotional pressure, drugs or hypnosis, often hurts rather than helps. If the brain needs to block out a memory, it usually has good reason. People tend to "face reality" as fast as they can. Pushing becomes just another form of violence.

It is common to have to work on plans for recovery with incomplete information. Often, some of the most important facts come out only quite late in the process.

Because the traumatic experience really happened, and really hurt, PTSD symptoms tend to continue, better at some times, worse at others, most of a person's life. Careful planning and use of recovery skills can greatly increase the amount of "good time" and make the bad times less frequent and less severe.

Putting together a written <u>history</u> of your life, and understanding the effect the traumatic parts had, usually helps make sense of many things that have happened in your life, during the abuse and after. It is very important in making plans for your recovery. Making the most complete possible history is a long term project. Memories come back in bits and pieces. Information from other people and from records also will come in bits and pieces. Some things may never be known.

This will be a stressful process, both in the effort spent in trying to remember, and in the energy needed to cope with what <u>is</u> remembered. Sadly, insight into what happened usually improves symptoms, but seldom completely removes them.

It helps to keep written notes, to avoid losing hard won information to the ups and downs of memory. Putting it in writing also seems to help keep things real, when so often they seem unreal, or even impossible.

1. Lay out a "life line", beginning with your birth. Put in any markers that will keep track of time: places you lived, where you went to school, births, marriages, deaths, institutions you were in, etc.

2. Talk to family, friends, teachers, ministers, neighbors and anyone else who may have information about your life.

   Keep in mind that some of these people truly did not know, some did not want to know, some knew but did nothing, and some may have profited in some way from what happened. (For example, as long as the violence was directed at you, it was not aimed at them.)

3. If you decide to talk with the perpetrator, be very careful of your safety. Many are still dangerous. Be clear about what you are trying to do. If you want the perpetrator to confirm memories you can barely believe yourself, be prepared to be called a liar, crazy, or to be told you wanted or deserved what happened. Try not to hope for too much: most perpetrators do not admit responsibility or say they are sorry.

   If your purpose is to confront the perpetrator with your anger and your knowledge that what was done was wrong, then, other than being careful for your safety, how the person reacts is not very important.

   If the perpetrator is confronted in the process of warning other family and friends about the danger he or she presents, be aware that some other people may react in much the same way as the perpetrator might.

   You cannot afford to attach your sense of self worth to the reactions of other people, because their responses have to do with who they are, not who you are.

4. Pay special attention to periods of time you cannot remember, or that others will not discuss with you. The more hurtful the experience, the more likely it will have been blocked out.

   Sometimes it is possible to work backward from things that are known: who was living with us at the time, who was drinking at that time etc.

5. Send for copies of any hospital or institution records that may be available. Although you have a right to see and copy most records pertaining to you, sometimes the help of an attorney or health care provider may be needed. Be aware that many professional people are careful not to ask questions they do not want to hear answers to. Some of the records may be in a sort of code, that is: "chaotic family life" may mean drunken violence on a daily basis, and "sexually molested" may cover rape, sodomy and torture.

Put your notes in a safe place. You may wish to add to them from time to time, as you find new information. Sometimes reviewing them will help you understand some new problem in your life.

LIFE CHANGES

Extremely hurtful experiences, ones that produce more fear, pain and anger then anyone can handle, leave behind four ongoing sets of behaviors. These are not so much "scars" as attempts to cope with trauma. Like any kind of treatment, if carried too far, they can become part of the problem, not part of the solution.

1. You begin intense, continuous study of the experience, trying to understand why those things happened, and how to keep them from happening again.

This involves constant thinking about the events, to the point it may interfere with other activities. You may have repetitive dreams about the events which may be so intense as to interfere with sleep and set off adrenalin reactions. The feelings can be so powerful that it can seem as if you are living in two different "movies" at the same time: the "bad old days" and "now".

Once you understand how the process works, you feel less disoriented, less out of control, and more able to cope.

Learning more information about trauma <u>does</u> help. You can take classes, read about it, and talk with others who have been through similar things.

2. You learn to constantly scan the environment for signs of danger. The scanning is compulsive - you cannot turn it off, so you have to plan for it.

Recognizing signs of threat may trigger strong reactions, sometimes as strong as the original events did. These reactions may be completely out of line with what is going on in the real world at the time.

Sometimes, you may well be aware of the connections between the present "trigger" and past experiences, even if you cannot control your reaction. At other times, the connection may be unconscious. You first become aware of your <u>reaction</u>, and may or may not later be able to connect it with the past.

The responses may be so intense as to feel like the trauma is actually happening again, that you are back in the bad old days. This is called a flashback. It can feel very crazy to find yourself feeling, saying, or doing things that do not relate to the present world.

To begin to control various kinds of flashbacks, it is important to map out your usual triggers, where they are likely to be encountered, and what your usual reactions are. Some triggers can be avoided almost completely, and should be. Others may be harder to avoid, or you may have good reason to take the chances involved in running into them.

Survival planning may include ways of minimizing exposure, arranging for support ahead of time, developing a "cool down" procedure, and concrete emergency plans in case of losing control.

3. Your body goes in chronic "red-alert", always ready to fight or run. Physical symptoms include extreme muscle tension ("the shakes"), headaches, high blood pressure, involuntary startle reactions and trouble sleeping. You feel afraid all the time, even when you have no present reason to.

It is in attempting to control <u>these</u> symptoms that so many people with PTSD get involved with alcohol and illegal drugs. Expert use of legitimate psychiatric and blood pressure medications can control most physical symptoms of PTSD. <u>They do not provide a high, are not addicting, are legal, and are much safer than street drugs</u>.

As survivors move forward in recovery, some may no longer need medication, others will need it only during bad times, and some may need it always.

Serious trauma can change the way a person's nervous system works, sometimes permanently. Even after allowing for the effects of brain damage and other injuries from violence, PTSD is a physical illness.

4. You are continually prepared to be hurt again, to lose again. The difference between the way life was supposed to be, and the way it turned out for you is a chronic stress.

You learn to avoid getting involved with other people for fear they will turn on you. You try not to care about people, animals or possessions, because sooner or later you expect them to be taken from you. You go so numb that you cannot feel anything, including good things. Being that numb <u>hurts</u>. Being cut off from good things, including people, makes you <u>sad</u>.

Emotions may swing like a pendulum, from overstimulated, hyperalert, fearful and angry, to depressed, numb and out of contact with the world around you. The extreme feelings often come and go in waves, and at times you actually may be out of control. Stabilizing this swing is a central goal of a recovery plan. Such a plan may include:

a. Mapping triggers and arranging your life to avoid recurring flashbacks.

b. Learning to recognize and avoid hurtful people.

c. Avoiding the use of drugs which temporarily improve symptoms, but make them worse on the "rebound". If needed, symptoms can be controlled with legitimate medications.

d. Reducing your exposure to new injury. (For instance, stay out of places that serve alcohol...)

e. Stopping current patterns of behavior which may be replays or reenactments of your own previous trauma, such as prostitution, fighting, child abuse.

f. Actions to make the real world safer are much more helpful than just trying to cope with your feelings about what might happen. Good locks and a dog are more helpful than lying in bed trying not to be afraid.

Extreme traumatic experiences, especially if they happened at a young age, can make you different from most other people. Of special interest are two groups of people who may seem very strange to you: predators and normal people.

DEALING WITH OTHER PEOPLE

A person's usual everyday approach to life and to other people is called a personality. A personality is made up of a person's biological inheritance (genes), the total set of things that have happened in the person's life, and the history of choices the person has made.

Every life is like a hand of cards. Some people play whatever they get well, others badly. Only a small number of people choose to hurt others. Even among people abused as children, 70% do not choose to hurt others.

Predators come in three forms:

A. Non-controllers:

All people have angry feelings, and all people have the impulse to hurt someone at times. Some choose not to control those impulses. Many choose to use alcohol and drugs, and let the chemicals block their impulse control. Others do whatever they feel like, sober or otherwise. Their attitude is: "I feel like shit, so somebody's going to pay..."

People who are loaded occasionally have the bad judgement to pick on somebody tougher than they are, but most, sober or not, are quite careful to act out their impulses on people who cannot effectively fight back.

B. Users:

Some people act as if they were the only real human being in the world, and other people are more like plants. If they want something, they simply take it, as if they were harvesting vegetables. Users have no sense of other people's rights and feelings, and do not consider that a problem.

It is not that they have something that other people do not. Rather, users are missing something most people have: a conscience, that is, internal personal limits on what they do. Any control of their behavior must be provided by others, and often by force.

C. Sadists:

People who enjoy humiliating and hurting others, and who do so while in full control of themselves., may make up as much as 10% of the population. They are found in all parts of society, with all levels of education and income. For some, other people's pain is sexually stimulating. Others like the feeling of power that comes with hurting people who cannot stop them.

The definition of sadism includes ongoing pattern of:

1. Using physical violence, threats or lies to control another person and inflict pain.

2. Humiliating and degrading a person in front of others.

3. Using a position of authority such as that of a parent to inflict unusually severe "discipline".

4. Being fascinated by violence, weapons, torture etc.

5. Finding the suffering of other people and animals funny, pleasurable or sexually stimulating.

Some sadistic people are very obvious. Others are so subtle that all you notice is that you feel bad when around them. Abuse survivors have had to learn to ignore their own feelings just to survive. Learning to recognize , and trust, your feelings and to take rapid action to protect yourself, sometimes takes a lot of work.

Cruel people often are quick to notice people who expect to lose, and will move in quickly. They avoid people who look like they know they have rights, and have people who love them, because they are likely to fight back.

It is necessary to learn to act like a person with value and rights, long before you can really feel it. In time, it will become real, not an act.

Normal people:

To deal with normal people, you must understand that the world they live in is very different from yours. They are not afraid all the time. They can feel many more things than pain, fear, and anger.

1. They have rarely felt so much pain that they have lost control of themselves, and certainly have not had that kind of pain caused intentionally by another person.

2. They do not assume they are at fault any time anything goes wrong.

3. They expect to be treated fairly, to be respected, and to love and be loved.

4. They can feel pleasure without drugs, they are depressed only occasionally, and do not know what being numb is about.

5. They expect to have a fair amount of control over their lives, and expect to live to be old.

With time and effort, you can learn to deal with people whose lives have been luckier than yours. One barrier will probably always remain: most normal people do not want to live in the world you know. Many will block you out so they can stay comfortable, not because you are doing something wrong. It is important not to reject all normal people, because there are always some who will work quite hard to understand how your life has been, even if they have had no similar experience themselves.

FINDING PEOPLE YOU CAN TALK TO

Think of how long it took you to put together the pieces of your history, make an accounting of how the abuse changed your life, and deal with your emotional reactions to that. You never had a choice about facing that because you had to live it.

Finding someone to talk to about it is not quick or simple. Some people will listen because they have had to live with abuse too. They may or may not be able to tolerate terrible stories at a given time. Listening to your story may bring up feelings they find too painful to deal with.

Others will listen because they are unusually committed to helping other people, or care a lot about you personally. Finding people who can listen is a key part of surviving. It involves several specific steps:

1. Talk with them about some part of your life that is fairly ordinary, and see if they really listen. If they listen poorly to the very ordinary, they certainly will not hear the really ugly. If they listen, then:

2. Choose a "medium bad" part of your story, one not too hard to handle if things go badly, and tell that. If they change the subject, turn mean, or drop a relationship, they probably are not worth any more effort.

   If they get panicky or go numb, you may have found another person with an abuse history. Keep in mind that they may or may not consciously recall the experience. Given plenty of time and personal space, these people may talk with you. Just as it was with you, pushing hurts rather than helps.

3. Once you know a person really well, you may choose to tell him or her the very worst things that happened, the ones that would really hurt if not handled with gentleness and respect. After you tell another person the very worst, and are met with kindness and respect, the memories never have quite the same power over you again.

4. Sometimes you will know people you care about, and very much would like to talk to, but you really feel they could not tolerate the ugly details. You may choose to tell them only some of the story, or even none.

   It is not fair that you should have to spend your energy to protect them from hearing about what you had to live, but occasionally it is necessary.

TRIGGERS

Human beings are creatures that learn, and keep on learning all of their lives, whether they want to or not.

They learn to recognize danger by noticing signs that were associated with past hurtful experiences. If the past experiences were severe, there may be a strong physical or emotional response, even if the conscious mind does not know what set it off.

These signs are called "triggers". People who have a good understanding of what situations set them off, can plan to avoid them, or to deal with the reactions. They come to feel much more in control of themselves.

Triggers can be internal, that is, can be a thought or a memory, as well as an outside event. Triggers take several forms:

1. Single Triggers: One sign alone is enough to set off a reaction. Examples: beer breath, body odor, being yelled at, seeing someone else hurt, violence or happy family situations shown on TV.

2. Compound Triggers: Several things, coming together, will set off a reaction, when each would not have been enough if it appeared alone. Examples: being touched, by someone who is angry, and has beer on his breath; or blood, on bed sheets, in the morning.

3. State-dependent triggers: One or several things which set off a reaction only when a person is tired, alone, in pain, intoxicated, etc. Without the changed mental and/or physical state, the particular signs are not enough to set off a reaction.

It is helpful to keep a log of what is happening around you, and what you were thinking about, just before your body and emotions "went off". Because of memory loss caused by stress, finding the trigger that set off a reaction can take time. Tracking down a trigger may also bring back lost memories. At other times, putting together more personal history will help identify triggers you had not recognized before.

FORGIVENESS

Abuse survivors often are pressed to "forgive" the perpetrator. The pressure may come from others, especially family members, or from the survivor's own beliefs about what should be done.

Forgiveness is a word for something that does not exist in the real world. There is no way to go back and act as if nothing ever happened, which is what most people want and most people think forgiveness means. People other then the survivor made bad choices, with terrible outcomes, and became worse people as a result.

The survivor may choose not to seek revenge, may choose to continue some contact with the abuser, and may try to support any positive change that the perpetrator may attempt, but there is no way the survivor can control what the abuser chose to do. If the survivor had been able to control other people's decisions, there would have been no abuse.

Children want very badly for their family to be good people, even in the face of strong evidence that they are not. They will blame themselves for things other people did. They will claim that they were somehow in control, rather than face the fact that they were helpless and that the bad choices were made by others. Survivors have nothing to be forgiven for, because they did not make the choices.

The abuser can choose to give up violence, take responsibility for the damage, and work toward rebuilding a family. Failing that, the survivor may have to piece together a family out of whatever is left, without the abuser.

A LAST WORD

A new family can be built out of the people who choose to be part of your life, whether or not they were born into it. A real family is something people do together, not something they are.

Building a new life may take terrible faith and courage. Some days it will seem easy, on other days, impossible. You go on living, with the unwanted knowledge of what evil people have done and can do, including what you yourself may have done and can do. Sometimes it takes all the courage you have just to get up and get dressed in the morning, knowing what can happen.

I wish you luck and courage on your journey. You will always have my respect.

Joe Parker, RN

THE PENDULUM SWING

REEXPERIENCING

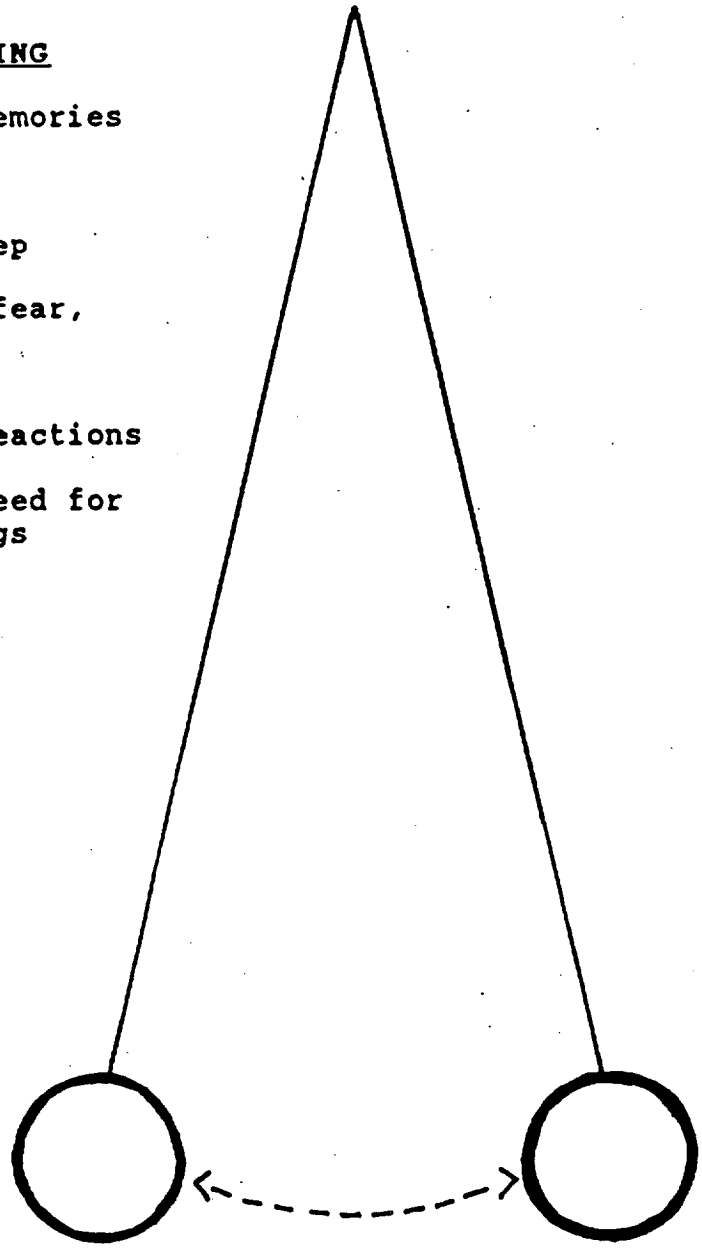
- intrusive memories
- nightmares
- loss of sleep
- attacks of fear,
- flashbacks
- "startle" reactions
- increased need for alcohol/drugs

NUMBING

- feeling nothing
- loss of normal interests
- detachment from others
- memory loss
- avoidance of reminders
- depression

TOO AGITATED TO WORK ON PROBLEMS.

TOO MUCH ENERGY.



UNABLE TO HOPE FOR THINGS TO GET BETTER.

NOT ENOUGH ENERGY.

"HEALING WINDOW"

Enough energy to work on problems, and enough hope to want to.

NOTES

NOTES

ALCOHOL AND DRUGS

Alcohol, Drugs, and Chronic Mental Illness

1. Substance Abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period

- Recurrent use resulting in failure to fulfill major role obligations at work, home, or school
- Recurrent use in situations where it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

2. Substance Dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:

- Tolerance
- Withdrawal
- Substance taken in larger amounts or over a longer time than was intended
- Persistent desire or unsuccessful attempts to control use
- Great deal of time spent in obtaining, using, and recovering from the drug
- Important social, occupational, or recreational activities are given/ reduced due to use
- Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

3. Addiction is a chronic, progressive, terminal disease. Substance use result in changes in the brain which maintain addictive behavior

4. Incidence of substance abuse among individuals with chronic mental illness is higher than that of the general population.

ECA Studies:

Lifetime Prevalence	General Population	Dx. Of Schiz
Any SubstanceUse Disorder	16.7%	47.0%
Any Alcohol Disorder	13.5%	33.7%
Alcohol Dependence	7.9%	24.0%
Alcohol Abuse	5.6%	9.7%
Any Other Drug Disorder	6.1%	27.5%
Drug Dependence	3.5%	12.9%
Drug Abuse	2.6%	14.6%
Marijuana Depend/Abuse	4.3%	
Cocaine Depend/Abuse	0.2%	
Opiate Depend/Abuse	1.2%	
Amphetamine Depend/Abuse	1.7%	
Hallucinogen Depend/Abuse	0.3%	

5. Incidence of mental illness among individuals with a substance use disorder is greater than the general population

ECA Studies Lifetime Prevalence	General Population	Alcohol Dx.	Drug Dx.
Any Mental Dx.	22.5%	36.6%	53.1%
Schizophrenia	0.7%	3.8%	6.8%
Any Affective	8.3%	13.4%	26.4%
Any Anxiety	14.6%	19.4%	28.3%

6. Reasons for use of substances by individuals with mental illness can include social, self medication, and addiction

Social:

- Means to behave like non-mentally ill peers
- Opportunities to be around others w/o high social demands
- Creates a sense of belonging to a social group

Self-Medication:

- Anxiety Reduction
- Improved ability to concentrate
- Improved energy level
- Increased sense of ability to function and well being
- Improved mood

Addiction:

- Physical and psychological dependence
- Altered brain function

7. Use of substance by individuals with chronic mental illness typically result in increases in symptoms of psychiatric disorders and reduced ability to function

8. Effective treatment involves simultaneous treatment of both the mental illness and substance use disorder

ALCOHOL AND DRUG

- WHAT TO LOOK FOR IN ASSESSING THE
- POTENTIAL FOR VIOLENT BEHAVIOR

- RISK FACTORS FOR HOMICIDE

- BLOOD ALCOHOL CONCENTRATION

- DEPRESSANTS
  - Alcohol
  - Opiates/Narcotics
  - Sedatives/Hypnotics/Anxiolytics

- ALCOHOL AND DRUG OVERVIEW

- INDICATORS OF DRUG USE

- OTHER DRUGS

- HALLUCINOGENS, PHENCYCLIDINE
- (PCP), AND RELATED SUBSTANCES

- INHALANTS

- DRUG PROBLEMS IN EMERGENCY
- ROOMS

ALCOHOL and DRUG (continued)

- RISK FACTORS FOR SUICIDE
- STIMULANTS
- SUBSTANCE ABUSE AND THE BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE.
- QUICK LIST OF SUBSTANCES AND THEIR SYMPTOMS

WHAT TO LOOK FOR IN ASSESSING THE POTENTIAL FOR VIOLENT BEHAVIOR

- A psychiatric diagnosis that includes violent or impulsive behavior among its criteria
- A previous history of violent behavior
- A history of substance abuse
- An injury to the head
- An injury to the central nervous system
- A previous history of physical abuse by others
- A previous history of suicidal behavior
- A previous history of delusions or hallucinations—particularly command hallucinations

Source: Lukas, S. (1993). Where to Start and What to Ask. New York: W. W. Norton & Co.

Risk Factors for Homicide

- Access to/ownership of guns
- Use of a weapon in prior abusive incidents
- Threats with weapon(s)
- Threats to kill
- Serious injury to victim(s) in prior abusive relationships
- Threats of suicide
- Drug or alcohol abuse
- History of forced sex with female partners
- Obsessiveness/extreme jealousy/extreme dominance

Blood Alcohol Concentration

Blood Alcohol Concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process

capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most states for drunkenness, which is 0.08 percent.

BAC can be measured by breath, blood, or urine vehicle tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury.

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are
impaired in most people long before they exhibit visible signs of drunkenness. While most states define legal intoxication for purposes of driving at a BAC of 0.08 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

The legal intoxication level in most states is 0.08 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.08 percent is reached.

Factors that will affect the BAC in a person:

- How much alcohol you drink.

- How fast you drink. The quicker you drink, the higher your peak BAC will be. The liver gets rid of alcohol at the average rate of one drink per hour (12 oz. beer, 5 oz. wine, 1 shot of distilled liquor). If a person drinks faster than this, the remainder will circulate in the blood stream until the liver can get rid of it.

- Body weight. Heavier people will be less affected by the same amount of alcohol than lighter people. They have more blood and water in their bodies in which to dilute the alcohol.

- Food in the stomach. When there is food in the stomach, alcohol is absorbed slower into the blood stream. The BAC rises more rapidly in those who drink on an empty stomach, because there is no food in which to dilute the alcohol.

- The type of alcohol you drink. The stronger a drink is (the higher the alcohol concentration, distilled alcohol first, wine second, beer third), the more quickly it is absorbed. This partially explains why hard liquor has more of an apparent " kick" than wine or beer.

- Type of mixer used. Water and fruit juices mixed with alcohol slow the absorption process, while carbonated beverages will speed it up. Carbon dioxide speeds the alcohol through the stomach and intestine into the bloodstream, creating a rapid rise in BAC.

- Temperature of the drink. Warm alcohol is absorbed quicker than cold alcohol.

- If you are male or female. Women reach higher BAC's faster because they have less water in their bodies and more adipose tissue (fat), which is not easily penetrated by alcohol. Therefore, a man and woman, with all other factors being equal, both drinking the same amount of alcohol will have different BAC levels. Hers will be higher. A woman's menstrual cycle will also affect her rate of absorption. They will experience their highest BAC's premenstrually. In addition, there is also evidence that a woman taking birth control pills, will absorb alcohol faster, resulting in higher BAC levels.

Depressants

Alcohol

- Most people do not think of alcohol as a drug

- Medical consequences usually show up after years of heavy drinking

- Has a profound effect on the chemistry of emotions

- Increases the hazards of other drugs when used in combination, to include: more severe side effects, more frequent adverse effects, and diminished effectiveness of the medication

- Remains in the body for four or more hours, depending on amount ingested

- Can result in respiratory depression, cardiac irregularities, coma. Using marijuana with alcohol inhibits vomiting and can increase the likelihood of overdose

- Other causes of serious injury or death can result from aspiration of vomitus, accidents from impaired judgment and coordination, fighting resulting from disinhibitory effects and increased aggressiveness, and suicide resulting from increased impulsivity/or depression.

- Medical complications include cirrhosis of the liver, brain damage and hypertension are common with high dose/long term use. Poor nutrition and self-care can be see with advanced alcoholism.

Appeal of the Drug:
- anxiety reduction
- social lubrication
- disinhibition

Specific Effects:
- rapid tolerance
- sedation
- impaired concentration
- impaired coordination
- rapidly fluctuating moods
- disinhibition

Signs of Use:
Slurred speech; uncoordinated movements; unsteady gait; nystagmus; flushed face; aggressive and/or disinhibited behavior; rapid mood shifts; impaired judgment and/or functioning.

Withdrawal Symptoms:
A hangover is the withdrawal syndrome from acute ingestion of alcohol. Nausea, vomiting, malaise, weakness, autonomic hyperactivity, anxiety, depression, irritability, transient hallucinations or illusions, headache, insomnia, and possible delirium may appear within 24 hours after use has stopped and last 3-10 days in the case of long-term alcohol dependence.

Withdrawal from alcohol can also include: convulsions; delirium tremens (DT's) and hallucinations. Withdrawal from alcohol can be medically dangerous and produce serious medical complications, and detoxification procedures must be monitored because abrupt withdrawal can be life-threatening. Withdrawal for the alcohol dependent person can last well beyond the time for which medical supervision is necessary. Symptoms can last for weeks or months.

Opiates /Narcotics

- Includes pain medications such as morphine, Demerol, Dilaudid, Darvon, Percodan, Vicodin, codeine, as well as heroin and methadone.

- It is theorized that many addicts and alcoholics have problems in their natural pain-regulating mechanisms that leave them vulnerable to addictive disease.

- Routes of administration can be oral, IV, intranasal, or through inhalation.

- Users are more likely to die from overdose than from withdrawal.

Appeal of the Drug:

- reduced sensitivity to pain
- "rush" of the initial effect (euphoria)
- tranquility
- reduced anxiety

Signs of Use:

- Pupillary constriction or dilation
- drowsiness
- slurred speech
- impairment in attention or memory behavior that suggests euphoria followed by apathy, dysphoria, psychomotor retardation, impaired judgment, or impaired functioning may also be signs of use

Specific Effects:

- rapid tolerance
- reduced sensitivity to pain
- sedation
- reduced anxiety
- excessive dryness (constipation
- sluggish muscle tone
- low blood pressure
- slowed pulse
- cough suppression
- shallow breathing
- slowed motor response
- inability to focus thoughts
- euphoria
- apathy

Sedatives/Hypnotics/Anxiolytics

Sedatives sedate or calm.

Hypnotics induce sleep.

Anxiolytics reduce ongoing anxiety.

The most commonly prescribed and abused are benzodiazepines. These include: Valium; Librium; Dalmane; Halcion; Ativan; Klonipin; and Xanax. The BZs are chosen for anxiety reduction and as sleep aids because they are safer and more effective than other sedatives. Overdose is virtually impossible if these drugs are not mixed with alcohol: however, withdrawal must be carefully monitored because abrupt withdrawal can be life threatening.

Signs of Use:
Slurred speech, uncoordinated movements, unsteady gait, impaired judgment.

Withdrawal Symptoms:
(Noted after prolonged use--usually 90 days at low doses.) Symptoms include anxiety, restlessness, dysphoria, and muscle twitches. Withdrawal from high doses can include severe anxiety, tremors, sweating, agitation, psychosis or seizure.

Alcohol and Drug Overview

The DSM-IV presents 12 classes of psychoactive substances that can cause organic impairment. These include:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opiods
- Phencyclidine & related substances
- Sedatives/Hypnotics/Anxiolytics
- Other/Unknown

1) Depressants

Alcohol, Opioids, Sedatives, Hypnotics, Anxiolytics

These psychoactive drugs have a primarily *sedative* effect and a strong potential to create dependence. The effects are experienced as reduction in tension, disinhibition, relief from anxiety, reduced stimulation, calmness or tranquility Their primary hazards include respiratory depression, coma, and death by injury due to accident.

2) Stimulants

Amphetamines, Cocaine, Caffeine, Nicotine

The primary effect of these drugs is *excitation* or *arousal.* They have a strong potential to create dependence because of the transient sense of pleasure and reward they provide. They are experienced as focused thought processes, euphoric mood and increased energy. Their primary hazards to life include: convulsive seizure, cardiac arrest or death by injury (due to wildly reckless driving, paranoia, agitation, aggression and/or psychotic behavior.

3) Other Drugs

Cannabis, Hallucinogens, Phencyclidine (PCP), Inhalants, Other/Unknown

These drugs cannot easily be grouped into a depressant or stimulant class as they have some characteristics of each. Hallucinogens and PCP are sometimes called *psychedelics*. They produce perceptual distortion in the form of sensory illusions or hallucinations and increased awareness of internal and external stimuli. Hallucinogens do not create physical dependence or high levels of physical toxicity, whereas this does not appear to be the case with PCP. These drugs may induce or contribute to *panic attacks*. They may cause death through *loss of reality testing* due to sensory distortion (e.g., not responding to pain, "flying" out a window). PCP can result in death due to overdose or to an accident caused by loss of motor control.

INDICATORS OF DRUG USE

- Neglect of significant personal concerns such as health, hygiene, personal appearance, housing needs or nutritional needs. Weight loss, poor appetite or obvious dental decay may be seen. Neglect is the result of drug seeking behavior and mental deterioration.

- Inexplicable sudden changes in personality, for example the sudden onset of aggression and/or paranoia.

- Acute changes in mental functioning, such as the onset of drowsiness, confusion or disorientation.

- Acute mood changes, including euphoria, depression or irritability.

- Recurring signs of drug withdrawal such as irritability, confusion, restlessness, tremor, sweating, cramps, and the complaint of 'aching bones.'

- Homelessness and itinerancy (frequent moving from place to place).

- Significant and repeated inconsistencies in statements to persons such as health care workers, and general lack of cooperation.

- The need to regularly take large amounts of benzodiazepine medication or other sedating medication.

- Attempts to manipulate health care workers with such talk as: "You know I need X and if I don't get X, I won't be able to control myself," etc.

- 'Track marks,' usually seen as longitudinal scars on the inside of the elbow areas, due to chronic intravenous drug use.

- Continued inability to provide identification.
- The complaint of insomnia, without obvious reason. Remember that marijuana abuse may be a possible cause of insomnia.
- 'Doctor shopping,' or the indiscriminate consultation of numerous doctors to obtain medication.
- Accusations of theft or confirmed involvement in crime to support a 'habit.'
- Denial of the problem may occur and should not be accepted if signs of drug use are present.

Other Drugs

Cannabis (Marijuana)

- Can be smoked in a pipe, rolled into cigarette paper or compressed into hashish or hashish oil.
- Comprised of about 400 chemicals, with the cannabinols (particularly delta-9 THC) and the cannabidiols creating the primary psychoactive effect.
- Potency is much higher than it was 10-20 years ago.
- Most of the marijuana in this country has a sedative effect and calms the user.
- Some users seek the dissociative effect of the drug—a feeling of distance from other people, which can make them feel safer in uncomfortable situations.
- The half-life of marijuana is eight days. It takes approximately two months to rid the body of all traces of the substance.
- Low doses result in impaired short-term memory.
- High doses result in: difficulty in concentration; difficulty managing emotions; amotivation; impaired ability to operate a car or other machinery; impaired job/school performance; distancing in relationships.

Appeal of the drug:

- dispels boredom
- narrows focus of concentration
- distorts time
- exaggerates the senses and emotions

- reduces anxiety
- dissociative effects

Specific Effects:
- decreases anxiety
- produces shifts in concentration
- produces a dissociative reaction
- alters perception of space and time
- alters judgment of speed and distance
- decreases motivation and concentration
- alters functioning of the hypothalamus and pituitary glands
- increases heart rate, decreases blood pressure
- lowers pressure within the eyes

Signs of Use:
Physical signs can include reddened eye, increased appetite, dry mouth, and rapid heart beat.

Withdrawal Symptoms:
Agitation, inability to concentrate, sleep problems, craving, decreased appetite, anxiety and discomfort around other people. Severity of symptoms depends upon the dose and length of use. For the average user, the symptoms are usually mild with a gradual onset because of the long-life of the drug. Users can rarely identify withdrawal symptoms due to marijuana because they often begin to occur several weeks after date of last use.

Hallucinogens, Phencyclidine (PCP), and Related Substance

- Primary effect involves changes in thought content, sensory perception and subjective emotional experience.

- Psychedelics cause intensified sensations, mixed-up sensations (synesthesia), illusions, delusions, hallucinations, stimulation, and impaired judgment and reasoning.

- The most commonly used psychedlics are: LSD, MDMA, PCP, peyote, and psilocybin mushrooms.

- PCP and Other Psychedelics: PCP, an animal tranquilizer causes mind-body distortions and a sensory deprived state.

- PCP has characteristics of depressants and stimulants.

- Easy and inexpensive to manufacture.

- Commonly mixed with other drugs and used as substitute for other chemicals without user's awareness.

- PCP is frequently found as adulterant for street drugs sold as LSD, Ecstasy, and/or THC.

- With repeated use the drug can be stored in the body for weeks or months beyond cessation of use.

- Higher doses can cause paralysis, loss of consciousness, amnesia, violence, and psychosis.

Appeal of the Drug:
- alters sensory input
- accentuates mood
- creates illusions
- synesthesia
- dissociative reaction
- loss of body and ego boundaries
- sense that mundane events aren't important
- sense of bonding and affiliation (ecstasy)

Specific Effects:
- tachycardia
- increased blood pressure
- increased body temperature
- pupil dilation
- visual illusions, perceptual changes
- emotional lability
- slowed time perception
- dissociative
- mild tolerance possible
-

Most Severe Hazards:
- panic reaction
- alters perception of time and space
- interferes with reflexes
- accidents common
- possible toxic psychosis
- drug-precipitated functional psychosis
- flashbacks

Signs of Use:

- Pupillary dilation; tachycardia; sweating; palpitations; blurred vision; tremors; uncoordinated movements
- Behaviors indicating marked depression or anxiety; ideas of reference; fear of "going crazy;" paranoid ideas; panic; impaired judgment and functioning
- Reports of perceptual changes: intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias, euphoria, mysticism or religiosity

Withdrawal Symptoms:
No physical dependence occurs with hallucinogens and no withdrawal syndrome has been documented, even after prolonged use of high doses.

Inhalants

- Includes volatile organic compounds such as: gasoline, glue, paint, cleaning agents, aerosol propellants, nitrous oxide (laughing gas) and amyl and butyl nitrate.

- Effects occur within 7-10 seconds and last no more than 30 minutes to one hour.

- Neurologic damage can include hearing and visual impairment, loss of coordination and memory, and learning disabilities. Mental impairment may be irreversible, though not usually progressive after abuse ceases.

- More users are preadolescents and young teens who do not have access to more "sophisticated" drugs, while others live in institutional settings or do not have enough money for other drugs.

- A common method of administration is to pour or spray the chemical onto a rag, place it over the nose and mouth, and inhale (huffing), or place in a plastic bag and inhale (bagging), or breathing in the inhalant directly from the container (sniffing).

Appeal of the drug:
- creates an intoxicated state
- effects are immediate and last from 5 to 45 minutes
- readily available through legal channels

Specific Effects (may vary depending on exact substance):
- mild intoxication
- possible hallucinations
- rapid onset of action
- create visual disturbances
- decrease appetite
- loss of memory

- unsteady gait

Most Severe Hazards:

- organ damage (including brain damage, liver damage, pancreatitis, kidney failure
- accidents, head trauma resulting from impaired judgment and coordination
- inflammation in joints, muscle weakness
- destroy red and white blood cells
- central nervous system depression or overstimulation
- cardiac arrhythmia (irregular heartbeat) and cardiac failure
- damage due to anoxia (lack of oxygen)

Signs of Use:

- rash around nose and mouth
- chemical breath, body odors
- residue
- red glassy watery eyes and dilated pupils
- slow, thick, slurred speech
- irritation of the throat/lungs/nose, nausea, headache
- dizziness
- nystagmus
- pains in chest and stomach
- fatigue
- staggering gait, disorientation, lack of coordination
- stupor
- euphoria
- belligerence
- assaultiveness
- impaired judgment and functioning

Reports of Drug Problems in Emergency Rooms (In many cases, more than one drug is found in incoming patients)	
DRUGS	**% of Patients Who Tested Positive**
1. Alcohol in combination with other drugs	32.6%
2. Cocaine	28.4%
3. Heroin/morphine, codeine, or other opioids	17.3%
4. Acetaminophen, aspirin, ibuprofen	13.9%
5. Benzodiazepines (Xanax, Valium, Ativan, Klonipin	10.4%
6. Antidepressants (Elavil, Prozac)	8.6%
7. Marijuana	8.6%
8. Methamphetamine/amphetamine	5.1%
9. Antihistamine	1.7%
10. OTC sleeping aids	1.3%

In some parts of the country, particularly San Francisco and on the West Coast, ER staff are seeing more and more Methamphetamine-Induced Psychosis.

Cocaine still causes the most deaths, although there has been an increase in deaths related to heroin overdose.

SUBSTANCE ABUSE AND BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE

Intoxication		Withdrawal States		Substance-Induced Paranoid Psychotic States	Substance-Induced Organic Brain Syndromes
High	Low	High	Low	High	High
Alcohol	Opiates	Alcohol	Opiates	Meth	Alcohol Withdrawal
PCP		Sedative		Cocaine	Sedative Withdrawal
Cocaine		Stimulants		PCP	PCP Intoxication
Meth					Inhalant Intoxication
Inhalants					Cocaine Intoxication
*LSD					Brain Injuries

Adapted from: Potter-Efron, R. & Potter-Efron, P. (eds.) 1990. Aggression, Family Violence and Chemical Dependency. New York: The Haworth Press.

Quick List - Substance Use Symptoms

SUBSTANCE	INTOXICATION SYMPTOMS	WITHDRAWAL SYMPTOMS
Depressants	slurred speech; incoordination; unsteady gait; impairment in attention or memory	nausea or vomiting; malaise or weakness; tachycardia; sweating; anxiety or irritablity; hypotension; coarse tremor of hands, tongue, and eyelids; insomnia; grand mal seizures
Stimulants	euphoria; grandiosity; hypervigilance; fighting; pupillary dilation; elevated blood pressure; perspiration or chills; nausea or vomiting	severe depression; irritablity; anxiety; fatigue; insomnia or hypersomnia; psychomotor agitation; intense craving for the substance
Opiates and Analgesics	initial euphoria followed by apathy, dysphoria, psychomotor retardation; impaired judgment; pupillary constriction; drowsiness; slurred speech; impaired attention or memory	cravings for opiates; all symptoms of severe influenza
Cannabinols (Marijuana)	euphoria; feeling of relaxation; sleepiness; heightened sexual arousal; anxiety; suspiciousness or paranoid ideation; sensation of slowed time; inappropriate laughter; social withdrawal; impaired judgment; bloodshot eyes; increased appetite ("junk" food); tachycardia; dry mouth	marked anxiety; emotional lability; depersonalization; possible persecutory delusions

Hallucinogens	illusions; hallucinations (visual) synesthesia; euphoria; mystical or religious experiences; pupillary dilation; tachycardia; sweating; palpitations; blurring of vision; tremors; incoordination; Bad Trip: anxiety and depression; ideas of reference; fear of losing one's mind; paranoid ideation	no apparent withdrawal symptoms; delusional disorder may develop; mood disorder may develop; post-hallucinogen perception disorder may develop ("flash back")
Solvents/Inhalants	euphoria; giddiness; light-headedness; slurred speech; lethargy; depressed reflexes; tremor; blurred vision; stupor or coma; belligerence; assaultiveness; apathy; impaired judgment; dizziness; nystagmus; eye irritation; irriation of throat, lungs, and nose	same as with the Depressants
PCP	belligerence; assaultiveness; impulsiveness; unpredictability; psychomotor agitation; vertical and horizontal nystagmus; increased blood pressure and heart rate; numbness or diminished responsiveness to pain; ataxia; muscle rigidity and seizures; bizarre and violent behavior; paranoid ideation	similar to Hallucinogens

adapted from: Fauman, M., (1994). Study Guide to DSM-IV. Washington D.C.: American Psychiatric Press, Inc.

NOTES

PROCEDURES

Section 2 – PROCEDURES

***Assessment Model**

***Mental Status Exam**

***Commitment Laws**

***Psychiatric Security Review Board**

***Consumer Rights / Rights of the Mentally Ill**

ASSESSMENT MODEL

RECOGNIZING PERSONS WITH MENTAL ILLNESS

The purpose of this activity is to provide officers with guidelines for identifying mentally ill persons. Emphasize that officers only have to be capable of identifying major behaviors indicative of a mental illness; they do not have to identify specific types of mental disorders. That is the function of a mental health professional. Whereas mental health professionals determine the type and severity of illness, officers only have to make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder.

Discussion Points

1. Generally, what is known about people with mental illnesses?

   - Depending on the severity of the disorder, mentally ill persons can be difficult to distinguish from persons not having a mental disorder.
   - Persons with a mental illness can be quite intelligent, perceptive, and articulate.
   - They can be employed and maintain familial relationships.
   - With the onset of their disorder, however, they become unable to deal realistically with the world.
   - Their thoughts and actions are not based on reality.
   - Their ability to think clearly is impaired.

2. What are the general characteristics that indicate a mental illness?

   - The behavior and mood of the person are inappropriate to the setting.
   - The behavior of the person tends to be inflexible.
   - The behavior of the person tends to be impulsive.

3. What are specific indicators of mental illness?

   - Sudden changes in lifestyle

     -can be both a cause and indicator of mental illness
     -involves an inability or unwillingness to fulfill one's expected role and responsibilities.

   - Major changes in behavior

     -behavior may have undergone sudden and drastic change
     -behavior may be marked by exaggerated mood swings
     -person may show lack of judgment regarding family, job, money, or property
     -person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic or fright

  -anxiety is intense and unfounded
  -person is in a state of panic or fright
  -person may have trembling hands, dry mouth, or sweaty palms
  -person may be "frozen" with fear

- Believes others are plotting against him

  -person has an unreal fear of being watched, talked about, followed, persecuted, or harmed (e.g. a large man believing a frail, elderly woman is trying to strangle him)
  -person cannot separate reality and imagination

- Hallucinations

  -person experience events that have no objective source, but that are nonetheless real to him or her
  -most common hallucinations are seeing or hearing things, but can involve any of the senses, such as:

  feel - most commonly of bugs crawling on the body
  smell - often of gas associated with death plots
  taste - usually of poisons in food
  hearing - voices telling the person to do something
  sight - visions of God, the dead, or horrible things.

  -hallucinations can also be induced by drug or alcohol abuse

- Delusions

  -personal beliefs that are not based on reality
  -can cause the person to view the world from a unique or peculiar perspective
  -often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person beliefs he or she is God, a saint, a famous person, or possesses a special talent or beauty)

- Depression

  -accompanies many mental disorders in varying degrees
  -often characterized by a persistent, general malaise
  -serious depression can involve withdrawal from family, job, and social involvement.

- Obsessions

  -recurrent thoughts, ideas, or images that the person cannot dismiss from mind usually involve behavior that the person finds unacceptable (e.g. a woman may believe

that every man she encounters is trying to seduce her)
-can cause tension and high level of anxiety

- Unexplained losses of memory

-not the normal forgetting of everyday things, but failing to remember the day, year, where one is, etc.
-not to be confused with loss of memory that often accompanies aging

- Confusion

-inability to focus on particular topic or interaction
-might be an indication that person has an obsession
-also caused by stroke, diabetic coma, intoxication, senility

- Impossible body ailments

-at first, symptoms are mild and may even fool doctors
-common beliefs are a body part growing, heart stopped, or chest filling with food

- Persons who suffer from mental illness must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are uncomfortable or annoying. Unlike hallucinations, these side effects are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize the presence of the side effects. Some of the major noticeable side effects include:

-minor stiffness, a rigid shuffling gait
-an at rest, hand jerk
-acute muscle spasms, tilted head
-a constant, fine, fast tremor
-blurry vision
-rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or-in severe cases-facial distortion

MENTAL STATUS EXAM

CIT Training -- The Mental Status Exam

Neil Falk, MD
May 9, 2000

A Mental Status Exam (MSE) is the mental health worker's equivalent of a medical provider's physical exam -- an examination of an individual to help determine if they have an illness. A very quick MSE can be performed quite easily, as many of the basics are common sense. The examination can even occur at a distance, and without the individual's participation -- a lot can be gained just by observation.

- Appearance

-- How is the individual dressed? Examples of dress which may indicate a mental illness include:

-- Inappropriate for weather (e.g. -- many layers in summer)
-- Inappropriate for context (e.g. -- pajamas in the street)
-- Odd or bizarre clothing
-- Very dirty/foul smelling/tattered clothing

-- How is the individual's hygiene? examples of hygiene which may indicate a mental illness include:

-- Very dirty/foul smelling clothing
-- Very dirty/foul smelling body
-- Poor dental condition

-- How is the individual behaving? Examples of behavior which may indicate a mental illness include:

-- Responding to internal stimuli (i.e. -- "talking to self")
-- Standing still/staring for prolonged periods (e.g. - catatonia)
-- Disorganized/non-goal directed actions
-- "Odd" actions, or interactions with others in the environment (e.g. -- bizarre mannerisms, posturing, agitated towards others, ignored by large group, being viewed with suspicion by group or vice versa)
-- Abnormally fast or slow movement pattern/energy level

• Thought Processes

The thought processes of the mentally ill are, by definition, disturbed. Mentally ill individuals may:

-- have disorganized thoughts (e.g. -- tangential thinking, loose associations, flight of ideas, etc.)
-- have "bizarre" thoughts (e.g. -- delusions of persecution, grandeur, conspiracies, etc.)
-- have blocked thoughts (i.e. -- long pauses during thinking)
-- persevere on one topic

• Speech

The speech of mentally ill individuals often is abnormal -- a reflection of their abnormal thought processes. Mentally ill individuals may:

-- speak abnormally fast or slow
-- use words abnormally (paraphasic errors)
-- use nonsense words
-- create words (neologisms)
-- be hard to interrupt (pressured speech)

•Miscellaneous

-- mood (how the person *says* he/she is feeling)
-- affect (how the person *appears* to be feeling)
-- suicidal/homicidal thoughts
    -- plan
    -- access to enact plan
    -- intent to carry out plan
    -- chronicity
-- hallucinations (usually auditory in the mentally ill)
-- cognitive abilities
    -- memory (short, intermediate, and long term)
    -- concentration/distractibility
    -- abstract thoughts (often mentally ill individuals cannot think abstractly)

•Generalities

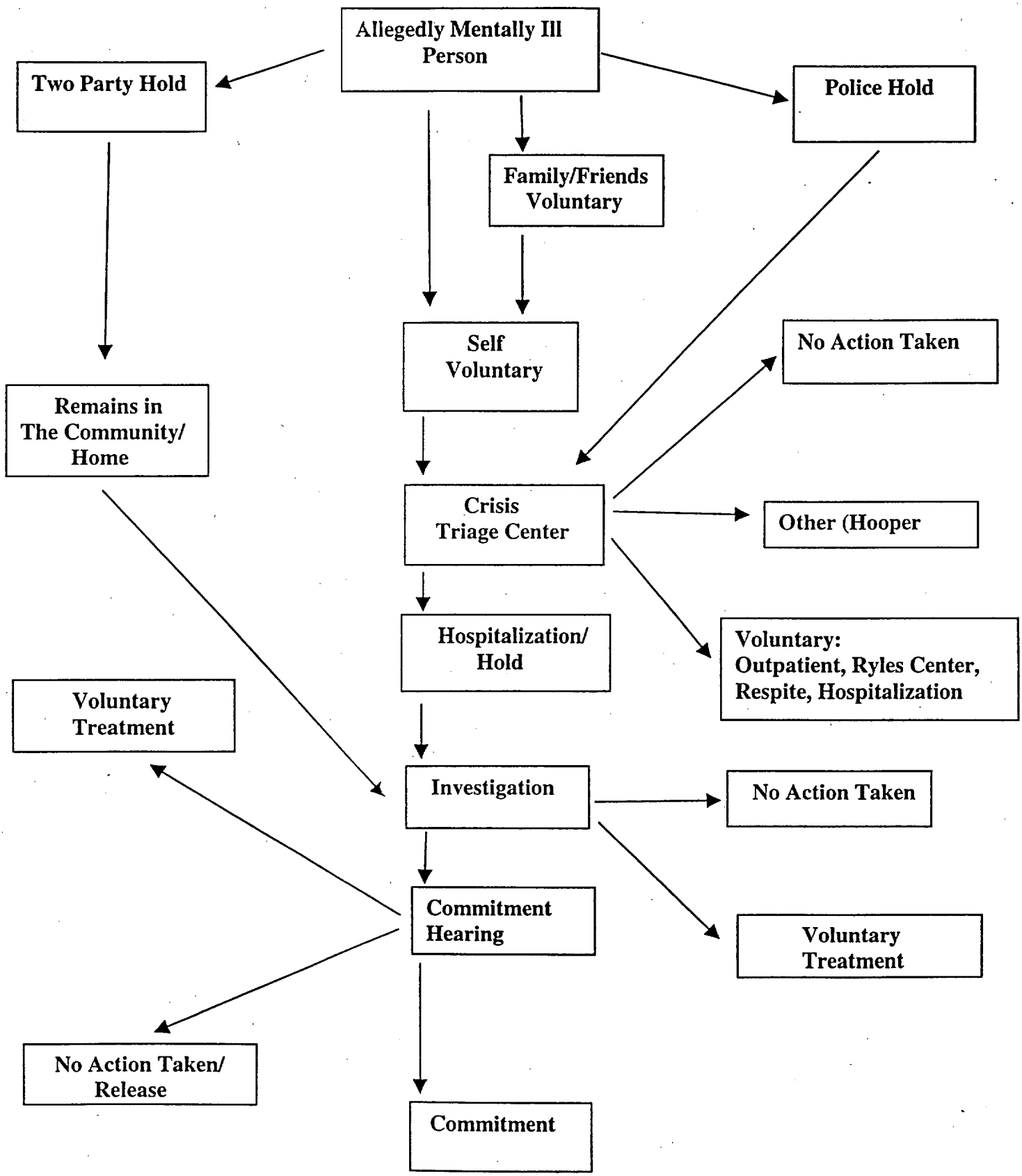
-- If it doesn't feel safe, don't do it!!
-- Mentally ill people are people, and deserve common respect.
-- Listen carefully.
-- Allow the individual to talk at length at least once.
-- Don't be afraid of silences. They often bring out symptoms.
-- Try to be an ally, not an adversary.

	Appearance	Thought Processes	Speech
Psychotic/Schizo -phrenic	Disheveled, Poor hygiene, Disorganized	Disorganized, Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to disheveled, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Intoxicated	Anything and everything	Anything and everything	Anything and everything

NOTES

COMMITMENT LAWS

THE COMMITMENT PROCESS



THE COMMITMENT PROCESS

THE DIFFERENCES BETWEEN A TWO-PARTY PETITION AND A HOSPITAL MEDICAL DOCTORS HOLD

TWO-PARTY PETITION

Used for issues of inability to care/deterioration of function.

Person remains in the community/home

Investigation completed within fourteen calendar days (two weeks)

Can be signed by any two-parties/people

HOSPITAL MEDICAL DOCTOR HOLD

Should be used only in cases of imminent danger to self or others

Person held in hospital

Investigation completed within five working days

Must be signed by two MD's or one MD and qualified health professional

THE COMMITMENT PROCESS

The Civil Commitment process is governed by the Oregon Revised Statutes 426 and the Administrative Rules (interpretation of the Statutes) from the Oregon Mental Health Division. The Statutes define what the legal definition of mental illness is. Legally, mentally ill means; a person because of a mental disorder, is one of the following:

A) Dangerous to self or others.

B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

C) A person who:

1) Is chronically mentally ill by the following definition (also known as "Expanded Criteria"):

a) Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility

AND

b) Is exhibiting symptoms or similar behavior to those that preceded or led to one or more of the hospitalizations or inpatient placements.

AND

c) Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Civil Commitment is a legal process not a clinical one. It has been designed as a legal procedure. At times, the logic of legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of family, significant others, or treatment providers.

The goals of the Mental Health Division in the Civil Commitment process:

A) To promote the well being of persons who are allegedly mentally ill and who are mentally ill and who are mentally ill during the involuntary care, custody, and treatment of mental illness pursuant to ORS 426.

B) To promote the protection of the civil rights of persons who are allegedly mentally ill or who are mentally ill.

C) To encourage the consistent application of ORS 426.

D) To encourage the provision of care, custody, and treatment of persons in the least restrictive environment that is available within existing resources.

THE COMMITMENT PROCESS

E) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through Civil Commitment, whenever possible.

F) To encourage that the Director (local community mental health system knowledgeable of the statues and administrative rules and provides leadership that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS. 426.

G) To provide for the safety of the community and the person when that person is dangerous to others or self as a result of a mental illness.

The Commitment process can be initiated, by giving Notice in writing (under oath) to the County Mental Health Program, by two persons, the County Health Officer, or any Magistrate. The Court will be immediately notified and the Community Mental Health Program will start (within 3 judicial days) An investigation to determine whether there is probable cause to believe the person is in fact mentally ill. Judicial days do not include weekends or Court holidays. The person is not usually in custody or detained during this process.

Emergency care, detention in a hospital and treatment can occur through the following ways:

A) A Peace Officer who has probable cause to believe a person is dangerous to self or to others and is in need of immediate care, custody of a person and remove them to the nearest hospital or approved non hospital facility, a physician will examine the person immediately. If the physician finds the person t be in need of emergency care or treatment for mental illness, the person to be in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the physician), otherwise the person shall be released from custody.

THE COMMITMENT PROCESS

B) A physician believes a person, who is at a hospital or approved non hospital, is dangerous to self or to others and is in need of emergency care or treatment for mental illness, can initiate a hospital hold and detain the person for emergency care. Under no circumstance shall any person be detained for more than 5 judicial days, following the signing of the hospital hold, without a Court Hearing.

C) A Designee of the Community Mental Health Program may, with probable cause that a person is dangerous to self or to others, or, additionally, (if the person is on a conditional release, outpatient commitment, trial visit) is unable to provide for personal needs, direct a Peace Officer to take custody and remove the person t o a hospital or approved non hospital facility for evaluation by a physician. This is called a "Director's Custody". If the physician finds the person is in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the Physician), otherwise the person shall be released from custody.

TITLE 35

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES; ALCOHOL AND DRUG ABUSE

Chapter 426

2001 EDITION

Persons with Mental Illness; Sexually Dangerous Persons

PERSONS WITH MENTAL ILLNESS

(Definitions)

426.005 Definitions for ORS 426.005 to 426.390. (1) As used in ORS 426.005 to 426.390, unless the context requires otherwise:

(a) "Department" means the Department of Human Services.

(b) "Director of the facility" means a superintendent of a state mental hospital, the chief of psychiatric services in a community hospital or the person in charge of treatment and rehabilitation programs at other treatment facilities.

(c) "Facility" means a state mental hospital, community hospital, residential facility, detoxification center, day treatment facility or such other facility as the department determines suitable, any of which may provide diagnosis and evaluation, medical care, detoxification, social services or rehabilitation for committed mentally ill persons.

(d) "Mentally ill person" means a person who, because of a mental disorder, is one or more of the following:

(A) Dangerous to self or others.

(B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

(C) A person who:

(i) Is chronically mentally ill, as defined in ORS 426.495;

(ii) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the department under ORS 426.060;

(iii) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements referred to in subsubparagraph (ii) of this subparagraph; and

(iv) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become a person described under either or both subparagraph (A) or (B) of this paragraph.

(e) "Nonhospital facility" means any facility, other than a hospital, that is approved by the department to provide adequate security, psychiatric, nursing and other services to persons under ORS 426.232 or 426.233.

(f) "Prehearing period of detention" means a period of time calculated from the initiation of custody during which a person may be detained under ORS 426.228, 426.231, 426.232 or 426.233.

(2) Whenever a community mental health and developmental disabilities program director, director of the facility, superintendent of a state hospital or administrator of a facility is referred to, the reference includes any designee such person has designated to act on the person's behalf in the exercise of duties. [1961 c.706 §25; 1973 c.838 §1; 1987 c.903 §5; 1989 c.993 §3; 1993 c.484 §11; 2001 c.900 §125]

(Hospitals)

426.010 State hospitals for mentally ill persons. Except as otherwise ordered by the Department of Human Services pursuant to ORS 179.325, the Oregon State Hospital in Salem, Marion County, and the Eastern Oregon Psychiatric Center in Pendleton, Umatilla County, shall be used as state hospitals for the care and treatment of mentally ill persons who are assigned to the care of such institutions by the department or who have previously been committed to such institutions. [Amended by 1955 c.651 §3; 1965 c.339 §23; 1965 c.595 §2; 1983 c.505 §1; 1999 c.983 §6]

426.020 Superintendents; chief medical officer. The superintendents of the hospitals mentioned in ORS 426.010 shall be persons the Department of Human Services considers qualified to administer the hospital. If the superintendent of any hospital is a physician licensed by the Board of Medical Examiners for the State of Oregon, the superintendent shall serve as chief medical officer. If the superintendent is not a physician, the assistant director or the designee of the assistant director shall appoint a physician to serve as chief medical officer who shall be in the unclassified service. [Amended by 1955 c.651 §4; 1969 c.391 §1; 1973 c.807 §2; 1987 c.158 §76]

426.030 [Amended by 1955 c.651 §5; 1957 c.43 §1; repealed by 1999 c.983 §7]

426.060 Commitment to Department of Human Services; authority of department to direct placement; transfer authority; delegation. (1) Commitments to the Department of Human Services shall be made only by the judge of a circuit court in a county of this state.

(2) The following is a nonexclusive list of powers the department may exercise concerning the placement of persons committed or persons receiving emergency care and treatment under ORS 426.070, 426.228 to 426.235 or 426.237:

(a) In its discretion and for reasons which are satisfactory to the department, the department may direct any court committed person to the facility best able to treat the person. The authority of the department on such matters shall be final.

(b) At any time, for good cause and in the best interest of the mentally ill person, the department may transfer a committed person from one facility to another. When

transferring a person under this paragraph, the department shall make the transfer:

(A) If the transfer is from a facility in one class to a facility of the same class, as provided by rule of the department;

(B) If the transfer is from a facility in one class to a facility in a less restrictive class, by following the procedures for trial visits under ORS 426.273; and

(C) If the transfer is from a facility in one class to a facility in a more restrictive class, by following the procedures under ORS 426.275.

(c) At any time, for good cause and in the best interest of the mentally ill person, the department may transfer a person receiving emergency care and treatment under ORS 426.070 or 426.228 to 426.235, or intensive treatment under ORS 426.237, between hospitals and nonhospital facilities approved by the department to provide emergency care or treatment as defined by rule of the department.

(d) Pursuant to its rules, the department may delegate to a community mental health and developmental disabilities program director the responsibility for assignment of mentally ill persons to suitable facilities or transfer between such facilities under conditions which the department may define. [Amended by 1955 c.651 §6; 1963 c.254 §1; 1967 c.534 §19; 1973 c.838 §2; 1975 c.690 §1; 1987 c.903 §6; 1993 c.484 §12]

(Commitment Procedure)

426.070 Initiation; notification required; recommendation to court; citation. (1) Any of the following may initiate commitment procedures under this section by giving the notice described under subsection (2) of this section:

(a) Two persons;

(b) The county health officer; or

(c) Any magistrate.

(2) For purposes of subsection (1) of this section, the notice must comply with the following:

(a) It must be in writing under oath;

(b) It must be given to the community mental health and developmental disabilities program director or a designee of the director in the county where the allegedly mentally ill person resides;

(c) It must state that a person within the county other than the person giving the notice is a mentally ill person and is in need of treatment, care or custody;

(d) If the commitment proceeding is initiated by two persons under subsection (1)(a) of this section, it may include a request that the court notify the two persons:

(A) Of the issuance or nonissuance of a warrant under this section; or

(B) Of the court's determination under ORS 426.130 (1); and

(e) If the notice contains a request under paragraph (d) of this subsection, it must also include the addresses of the two persons making the request.

(3) Upon receipt of a notice under subsections (1) and (2) of this section or when notified by a circuit court that the court received notice under ORS 426.234, the community mental health and developmental disabilities program director, or designee of the director, shall:

(a) Immediately notify the judge of the court having jurisdiction for that county under ORS 426.060 of the notification described in subsections (1) and (2) of this section.

(b) Immediately notify the Department of Human Services if commitment is proposed because the person appears to be a mentally ill person, as defined in ORS 426.005 (1)(d)(C). When such notice is received, the department may verify, to the extent known by the department, whether or not the person meets the criteria described in ORS 426.005 (1)(d)(C)(i) and (ii) and so inform the director or designee of the director.

(c) Initiate an investigation under ORS 426.074 to determine whether there is probable cause to believe that the person is in fact a mentally ill person.

(4) Upon completion, a recommendation based upon the investigation report under ORS 426.074 shall be promptly submitted to the court. If the community mental health and developmental disabilities program director determines that probable cause does not exist to believe that a person released from detention under ORS 426.234 (2)(c) or (3)(b) is a mentally ill person, the community mental health and developmental disabilities program director shall not submit a recommendation to the court.

(5) When the court receives notice under subsection (3) of this section:

(a) If the court, following the investigation, concludes that there is probable cause to believe that the person investigated is a mentally ill person, it shall, through the issuance of a citation as provided in ORS 426.090, cause the person to be brought before it at a time and place as it may direct, for a hearing under ORS 426.095 to determine whether the person is mentally ill. The person shall be given the opportunity to appear voluntarily at the hearing unless the person fails to appear or unless the person is detained pursuant to paragraph (b) of this subsection.

(b)(A) The judge may cause the allegedly mentally ill person to be taken into custody pending the investigation or hearing by issuing a warrant of detention under this subsection. A judge may only issue a warrant under this subsection if the court finds that there is probable cause to believe that failure to take the person into custody would pose serious harm or danger to the person or to others.

(B) To cause the custody of a person under this paragraph, the judge must issue a warrant of detention to the community mental health and developmental disabilities program director or designee, the sheriff of the county or designee, directing that person to take the allegedly mentally ill person into custody and produce the person at the time and place stated in the warrant.

(C) At the time the person is taken into custody, the person shall be informed by the community mental health and developmental disabilities program director, the sheriff or a designee of the following:

(i) The person's rights with regard to representation by or appointment of counsel as described in ORS 426.100; and

(ii) The warning under ORS 426.123.

(D) The court may make any orders for the care and custody of the person prior to the hearing as it considers necessary.

(c) If the notice includes a request under subsection (2)(d)(A) of this section, the court shall notify the two persons of the issuance or nonissuance of a warrant under this subsection. [Amended by 1957 c.329 §1; 1967 c.534 §20; 1973 c.838 §3; 1975 c.690 §2; 1979 c.408 §1; 1983 c.740 §149; 1987 c.903 §7; 1989 c.993 §4; 1993 c.484 §26; 1995 c.201 §2; 1995 c.498 §1]

426.072 Custody; care; responsibilities of treating physician; rules. (1) A hospital or nonhospital facility and a treating physician must comply with the following when an allegedly mentally ill person is placed in custody at the hospital or nonhospital facility:

(a) By a warrant of detention under ORS 426.070;

(b) By a peace officer under ORS 426.228 or other person authorized under ORS 426.233; or

(c) By a physician under ORS 426.232.

(2) In circumstances described under subsection (1) of this section, the hospital or nonhospital facility and treating physician must comply with the following:

(a) The person shall receive the care, custody and treatment required for mental and physical health and safety;

(b) The treating physician shall report any care, custody and treatment to the court as required in ORS 426.075;

(c) All methods of treatment, including the prescription and administration of drugs, shall be the sole responsibility of the treating physician. However, the person shall not be subject to electro-shock therapy or unduly hazardous treatment and shall receive usual and customary treatment in accordance with medical standards in the community;

(d) The treating physician shall be notified immediately of any use of mechanical restraints on the person. Every use of a mechanical restraint and the reasons therefor shall be made a part of the clinical record of the person over the signature of the treating physician; and

(e) The treating physician shall give the person the warning under ORS 426.123 at times the treating physician determines the person will reasonably understand the notice. This paragraph only requires the notice to be given as often as the physician determines is necessary to assure that the person is given an opportunity to be aware of the notice.

(3) The Department of Human Services shall adopt rules necessary to carry out this section, including rules regarding the content of the medical record compiled during the current period of custody. [1987 c.903 §9; 1993 c.484 §13; 1997 c.531 §1]

426.074 Investigation; procedure; content; report. The following is applicable to an investigation initiated by a community mental health and developmental disabilities program director, or a designee of the director, as part of commitment procedures under ORS 426.070 and 426.228 to 426.235:

(1) If the allegedly mentally ill person is held in custody before the hearing the investigation shall be completed at least 24 hours before the hearing under ORS 426.095, otherwise the investigation shall comply with the following time schedule:

(a) If the allegedly mentally ill person can be located, the investigator shall contact the person within three judicial days from the date the community mental health and developmental disabilities program director or a designee receives a notice under ORS 426.070 alleging that the person is mentally ill.

(b) Within 15 days from the date the community mental health and developmental disabilities program director or a designee receives a notice under ORS 426.070 alleging that a person is mentally ill, one of the following shall occur:

(A) The investigation shall be completed and submitted to the court.

(B) An application for extension shall be made to the court under paragraph (c) of this subsection.

(c) The community mental health and developmental disabilities program director, a designee or the investigator may file for an extension of the time under paragraph (b) of this subsection only if one of the following occurs:

(A) A treatment option less restrictive than involuntary in-patient commitment is actively being pursued.

(B) The allegedly mentally ill person cannot be located.

(d) A court may grant an extension under paragraph (c) of this subsection for a time and upon the terms and conditions the court considers appropriate.

(2) This subsection establishes a nonexclusive list of provisions applicable to the content of the investigation, as follows:

(a) The investigation conducted should, where appropriate, include an interview or examination of the allegedly mentally ill person in the home of the person or other place familiar to the person.

(b) Whether or not the allegedly mentally ill person consents, the investigation should include interviews with any persons that the investigator has probable cause to believe have pertinent information regarding the investigation. If the allegedly mentally ill person objects to the contact with any person, the objection shall be noted in the investigator's report.

(c) The investigator shall be allowed access to physicians, nurses or social workers and to medical records compiled during the current involuntary prehearing period of detention to determine probable cause and to develop alternatives to commitment. If commitment is proposed because the person appears to be a mentally ill person as defined in ORS 426.005 (1)(d)(C), the investigator shall be allowed access to medical records necessary to verify the existence of criteria described in ORS 426.005 (1)(d)(C). The investigator shall include pertinent parts of the medical record in the investigation report. Records and communications described in this paragraph and communications related thereto are not privileged under ORS 40.230, 40.235, 40.240 or 40.250.

(3) A copy of the investigation report shall be provided as soon as possible, but in no event later than 24 hours prior to the hearing, to the allegedly mentally ill person and to that person's counsel. Copies shall likewise be provided to counsel assisting the court, to the examiners and to the court for use in questioning witnesses. [1987 c.903 §10; 1989 c.993 §5; 1993 c.484 §14; 1997 c.649 §1]

426.075 Notice and records of treatment prior to hearing; procedures. This section establishes procedures that are required to be followed before the hearing if a court, under ORS 426.070, orders a hearing under ORS 426.095. The following apply as described:

(1) The court shall be fully advised of all drugs and other treatment known to have been administered to the allegedly mentally ill person that may substantially affect the ability of the person to prepare for or function effectively at the hearing. The following shall advise the court as required by this subsection:

(a) When not otherwise provided by paragraph (b) of this subsection, the community mental health and developmental disabilities program director or designee.

(b) When the person has been detained by a warrant of detention under ORS 426.070, 426.180, 426.228, 426.232 or 426.233, the treating physician.

(2) The court shall appoint examiners under ORS 426.110 sufficiently long before the hearing so that they may begin their preparation for the hearing. The records established by the Department of Human Services by rule and the investigation report shall be made available to the examiners at least 24 hours before the hearing in order that the examiners may review the medical record and have an opportunity to inquire of the medical personnel concerning the treatment of the allegedly mentally ill person relating to the detention period prior to the hearing.

(3) The medical record described in subsection (2) of this section shall be made available to counsel for the allegedly mentally ill person at least 24 hours prior to the hearing.

(4) When requested by a party to the action, the party's attorney shall subpoena physicians who are or have been treating the allegedly mentally ill person. Any treating physician subpoenaed under this subsection shall be subpoenaed as an expert witness. [1973 c.838 §8; 1975 c.690 §3; 1979 c.408 §2; 1987 c.903 §12; 1989 c.189 §1; 1993 c.484 §15]

426.080 Execution and return of citation or warrant of detention. The person serving a warrant of detention or the citation provided for by ORS 426.090 shall, immediately after service thereof, make a return upon the original warrant or citation showing the time, place and manner of such service and file it with the clerk of the court. In executing the warrant of detention or citation, the person has all the powers provided by ORS 133.235 and 161.235 to 161.245 and may require the assistance of any peace

officer or other person. [Amended by 1971 c.743 §366; 1973 c.836 §348; 1973 c.838 §4a]

426.090 Citation; service. The judge shall cause a citation to issue to the allegedly mentally ill person stating the nature of the information filed concerning the person and the specific reasons the person is believed to be mentally ill. The citation shall further contain a notice of the time and place of the commitment hearing, the right to legal counsel, the right to have legal counsel appointed if the person is unable to afford legal counsel, and, if requested, to have legal counsel immediately appointed, the right to subpoena witnesses in behalf of the person to the hearing and other information as the court may direct. The citation shall be served upon the person by delivering a duly certified copy of the original thereof to the person in person prior to the hearing. The person shall have an opportunity to consult with legal counsel prior to being brought before the court. [Amended by 1957 c.329 §2; 1967 c.459 §1; 1971 c.368 §1; 1973 c.838 §5; 1975 c.690 §4]

426.095 Commitment hearing; postponement; right to cross-examine; admissibility of investigation report. The following is applicable to a commitment hearing held by a court under ORS 426.070:

(1) The hearing may be held in a hospital, the person's home or in some other place convenient to the court and the allegedly mentally ill person.

(2) The court shall hold the hearing at the time established according to the following:

(a) Except as provided by paragraph (b) or (c) of this subsection, a hearing shall be held five judicial days from the day a court under ORS 426.070 issues a citation provided under ORS 426.090.

(b) Except as provided by paragraph (c) of this subsection, if a person is detained by a warrant of detention under ORS 426.070, a hearing shall be held within five judicial days of the commencement of detention.

(c) If requested under this paragraph, the court, for good cause, may postpone the hearing for not more than five judicial days in order to allow preparation for the hearing. The court may make orders for the care and custody of the person during a postponement as it deems necessary. If a person is detained before a hearing under ORS 426.070, 426.180, 426.228, 426.232 or 426.233 and the hearing is postponed under this paragraph, the court, for good cause, may allow the person to be detained during the postponement if the postponement is requested by the person or the legal counsel of the person. Any of the following may request a postponement under this paragraph:

(A) The allegedly mentally ill person.

(B) The legal counsel or guardian of the allegedly mentally ill person.

(C) The person representing the state's interest.

(3) The allegedly mentally ill person and the person representing the state's interest shall have the right to cross-examine all the following:

(a) Witnesses.

(b) The person conducting the investigation.

(c) The examining physicians or other qualified persons recommended by the Department of Human Services who have examined the person.

(4) The provisions of ORS 40.230, 40.235, 40.240 and 40.250 shall not apply to and the court may consider as evidence any of the following:

(a) Medical records for the current involuntary prehearing period of detention.

(b) Statements attributed by the maker of the medical records or the investigation report to witnesses concerning their own observations in the absence of objection or if such persons are produced as witnesses at the hearing available for cross-examination.

(c) The testimony of any treating physicians, nurses or social workers for the prehearing period of detention. Any treating physician, nurse or social worker who is subpoenaed as a witness for the proceeding shall testify as an expert witness under the provisions of ORS 40.410, 40.415, 40.420 and 40.425 and is subject to treatment as an expert witness in the payment of witness fees and costs.

(d) The investigation report prepared under ORS 426.074. Subject to the following, the investigation report shall be introduced in evidence:

(A) Introduction of the report under this paragraph does not require the consent of the allegedly mentally ill person.

(B) Upon objection by any party to the action, the court shall exclude any part of the investigation report that may be excluded under the Oregon Evidence Code on grounds other than those set forth in ORS 40.230, 40.235, 40.240 or 40.250.

(C) Neither the investigation report nor any part thereof shall be introduced into evidence under this paragraph unless the investigator is present during the proceeding to be cross-examined or unless the presence of the investigator is waived by the allegedly mentally ill person or counsel for the allegedly mentally ill person. [1973 c.838 §9; 1975 c.690 §5; 1987 c.903 §13; 1993 c.484 §16; 1997 c.649 §2]

426.100 Advice of court; appointment of legal counsel; fee; representation of state's interest. (1) At the time the allegedly mentally ill person is brought before the court, the court shall advise the person of the following:

(a) The reason for being brought before the court;

(b) The nature of the proceedings;

(c) The possible results of the proceedings;

(d) The right to subpoena witnesses; and

(e) The person's rights regarding representation by or appointment of counsel.

(2) Subsection (3) of this section establishes the rights of allegedly mentally ill persons in each of the following circumstances:

(a) When the person is held by warrant of detention issued under ORS 426.070.

(b) In commitment hearings under ORS 426.095.

(c) When the person is detained as provided under ORS 426.228, 426.232 or 426.233.

(d) In recommitment hearings under ORS 426.307.

(3) When provided under subsection (2) of this section, an allegedly mentally ill person has the following rights relating to representation by or appointment of counsel:

(a) The right to obtain suitable legal counsel possessing skills and experience commensurate with the nature of the allegations and complexity of the case during the proceedings.

(b) If the person does not have funds with which to retain legal counsel, the court will appoint legal counsel to represent the person without cost. If a person is unable to afford legal counsel, payment of expenses and compensation relating to legal counsel shall be made as provided under ORS 426.250.

(c) If the allegedly mentally ill person does not request legal counsel, the legal guardian, relative or friend may request the assistance of suitable legal counsel on behalf of the person.

(d) If no request for legal counsel is made, the court shall appoint suitable legal counsel unless counsel is expressly, knowingly and intelligently refused by the person.

(e) If the person is being involuntarily detained before a hearing on the issue of commitment, the right under paragraph (a) of this subsection to contact an attorney or under paragraph (b) of this subsection to have an attorney appointed may be exercised as soon as reasonably possible.

(f) In all cases suitable legal counsel shall be present at the hearing and may be present at examination and may examine all witnesses offering testimony, and otherwise represent the person.

(4) The responsibility for representing the state's interest in commitment proceedings, including, but not limited to, preparation of the state's case and appearances at commitment hearings is as follows:

(a) The Attorney General's office shall have the responsibility relating to proceedings initiated by state hospital staff that are any of the following:

(A) Recommitment proceedings under ORS 426.307; or

(B) Proceedings under ORS 426.228, 426.232 or 426.233.

(b) The district attorney if requested to do so by the governing body of the county.

(c) In lieu of the district attorney under paragraph (b) of this subsection, a counsel designated by the governing body of a county shall take the responsibility. A county governing body may designate counsel to take responsibility under this paragraph either for single proceedings or for all such proceedings the county will be obligated to pay for under ORS 426.250. If a county governing body elects to proceed under this paragraph, the county governing body shall so notify the district attorney. The expenses of an attorney appointed under this paragraph shall be paid as provided under ORS 426.250. [Amended by 1967 c.458 §1; 1971 c.368 §2; 1973 c.838 §6; 1975 c.690 §6; 1977 c.259 §1; 1979 c.574 §§1,2; 1979 c.867 §10; 1981 s.s. c.3 §133; 1987 c.903 §14; 1993 c.484 §17]

Note: The amendments to 426.100 by section 57, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.100. (1) At the time the allegedly mentally ill person is brought before the court, the court shall advise the person of the following:

(a) The reason for being brought before the court;

(b) The nature of the proceedings;

(c) The possible results of the proceedings;

(d) The right to subpoena witnesses; and

(e) The person's rights regarding representation by or appointment of counsel.

(2) Subsection (3) of this section establishes the rights of allegedly mentally ill persons in each of the following circumstances:

(a) When the person is held by warrant of detention issued under ORS 426.070.

(b) In commitment hearings under ORS 426.095.

(c) When the person is detained as provided under ORS 426.228, 426.232 or 426.233.

(d) In recommitment hearings under ORS 426.307.

(3) When provided under subsection (2) of this section, an allegedly mentally ill person has the following rights relating to representation by or appointment of counsel:

(a) The right to obtain suitable legal counsel possessing skills and experience commensurate with the nature of the allegations and complexity of the case during the proceedings.

(b) If the person is determined to be financially eligible for appointed counsel at state expense, the court will appoint legal counsel to represent the person. If a person is appointed counsel at state expense, payment of expenses and compensation relating to legal counsel shall be made as provided under ORS 426.250.

(c) If the allegedly mentally ill person does not request legal counsel, the legal guardian, relative or friend may request the assistance of suitable legal counsel on behalf of the person.

(d) If no request for legal counsel is made, the court shall appoint suitable legal counsel unless counsel is expressly, knowingly and intelligently refused by the person.

(e) If the person is being involuntarily detained before a hearing on the issue of commitment, the right under paragraph (a) of this subsection to contact an attorney or under paragraph (b) of this subsection to have an attorney appointed may be exercised as soon as reasonably possible.

(f) In all cases suitable legal counsel shall be present at the hearing and may be present at examination and may examine all witnesses offering testimony, and otherwise represent the person.

(4) The responsibility for representing the state's interest in commitment proceedings, including, but not limited to, preparation of the state's case and appearances at commitment hearings is as follows:

(a) The Attorney General's office shall have the responsibility relating to proceedings initiated by state hospital staff that are any of the following:

(A) Recommitment proceedings under ORS 426.307; or

(B) Proceedings under ORS 426.228, 426.232 or 426.233.

(b) The district attorney if requested to do so by the governing body of the county.

(c) In lieu of the district attorney under paragraph (b) of this subsection, a counsel designated by the governing body of a county shall take the responsibility. A county governing body may designate counsel to take responsibility under this paragraph either for single proceedings or for all such proceedings the county will be obligated to pay for under ORS 426.250. If a county governing body elects to proceed under this paragraph, the county governing body shall so notify the district attorney. The expenses of an attorney appointed under this paragraph shall be paid as provided under ORS 426.250.

426.110 Appointment of examiners; qualifications; fees. The following requirements relating to the appointment of examiners for purposes of a hearing under ORS 426.095 apply as described:

(1) The judge shall appoint one qualified examiner. If requested, the judge shall appoint one additional qualified examiner. A request for an additional examiner under this subsection must be made in writing and must be made by the allegedly mentally ill person or the attorney for the allegedly mentally ill person.

(2) To be qualified for purposes of this section, an examiner must meet all of the following qualifications:

(a) The person must agree to be an examiner.

(b) The person must be one of the following:

(A) A physician licensed by the Board of Medical Examiners for the State of Oregon who is competent to practice psychiatry as provided by the Department of Human Services by rule.

(B) Certified as a mental health examiner qualified to make examinations for involuntary commitment proceedings by the department. The department has authority to establish, by rule, requirements for certification as a mental health examiner for purposes of this subparagraph.

(3) The cost of examiners under this section shall be paid as provided under ORS 426.250. [Amended by 1973 c.838 §10; 1987 c.158 §77; 1987 c.903 §15]

426.120 Examination report; rules. (1) Persons appointed under ORS 426.110 to conduct the examination shall do the following:

(a) Examine the person as to mental condition;

(b) Initiate the examination process prior to the hearing. Any failure to comply with this paragraph shall not, in itself, constitute sufficient grounds to challenge the examination conducted by an examiner;

(c) Make their separate reports in writing, under oath, to the court; and

(d) Upon completion of the hearing, file the reports with the clerk of the court.

(2) The following is a nonexclusive list of requirements relating to the content of examination reports prepared under subsection (1) of this section:

(a) If the examining persons find, and show by their reports, that the person examined is a mentally ill person, the reports shall include a recommendation as to the type of treatment facility best calculated to help the person recover from mental illness.

(b) Each report shall also advise the court whether in the opinion of the examiner the mentally ill person would cooperate with and benefit from a program of voluntary treatment.

(c) Reports shall contain the information required by the Department of Human Services by rule. The department shall adopt rules necessary to carry out this paragraph.

(3) The examiner shall be allowed access to physicians, nurses or social workers and to medical records compiled during the current involuntary prehearing period of detention and the investigation report. Records and communications described in this sub-

section and communications related thereto are not privileged under ORS 40.230, 40.235, 40.240 or 40.250. [Amended by 1973 c.838 §11; 1975 c.690 §7; 1987 c.903 §16; 1997 c.649 §3]

426.123 Observation of person in custody; warning; evidence. (1) Whenever specifically required under ORS 426.070, 426.072, 426.180 or 426.234, a person shall be given a warning that observations of the person by the staff of the facility where the person is in custody may be used as evidence in subsequent court proceedings to determine whether the person should be or should continue to be committed as a mentally ill person.

(2) The warning described under subsection (1) of this section shall be given both orally and in writing.

(3) Failure to give a warning under this section does not in itself constitute grounds for the exclusion of evidence that would otherwise be admissible in a proceeding. [1987 c.903 §11; 1993 c.484 §18]

426.125 Qualifications and requirements for conditional release. The following qualifications, requirements and other provisions relating to a conditional release under ORS 426.130 apply as described:

(1) A court may only order conditional release if all of the following occur:

(a) The conditional release is requested by the legal guardian, relative or friend of the mentally ill person.

(b) The person requesting the conditional release requests to be allowed to care for the mentally ill person during the period of commitment in a place satisfactory to the judge.

(c) The person requesting the release establishes all of the following to the satisfaction of the court:

(A) Ability to care for the mentally ill person.

(B) That there are adequate financial resources available for the care of the mentally ill person.

(2) If the court determines to allow conditional release, the court shall order that the mentally ill person be conditionally released and placed in the care of the requester. The court shall establish any terms and conditions on the conditional release that the court determines appropriate.

(3) Any conditional release ordered under this section is subject to the provisions under ORS 426.275. [1987 c.903 §18]

426.127 Outpatient commitment. The following provisions are applicable to outpatient commitment under ORS 426.130 as described:

(1) The Department of Human Services may only place a person in an outpatient commitment if an adequate treatment facility is available.

(2) Conditions for the outpatient commitment shall be set at the time of the hearing under ORS 426.095 by the community mental health and developmental disabilities program director, or a designee for the director, for the county in which the hearing takes place. The conditions shall include, but not be limited to, the following:

(a) Provision for outpatient care.

(b) A designation of a facility, service or other provider to provide care or treatment.

(3) A copy of the conditions shall be given to all of the persons described in ORS 426.278.

(4) Any outpatient commitment ordered under this section is subject to the provisions under ORS 426.275.

(5) The community mental health and developmental disabilities program director or designee, for the county where a person is on outpatient commitment, may modify the conditions for outpatient commitment when a modification is in the best interest of the person. The director or designee shall send notification of such changes and the reasons for the changes to all those who received a copy of the original conditions under ORS 426.278. [1987 c.903 §19; 1989 c.171 §52]

426.130 Court determination of mental illness; discharge; release for voluntary treatment; conditional release; commitment; prohibition relating to firearms; period of commitment. (1) After hearing all of the evidence, and reviewing the findings of the examining persons, the court shall determine whether the person is mentally ill. If, in the opinion of the court, the person is:

(a) Not mentally ill, the person shall be discharged forthwith.

(b) Mentally ill based upon clear and convincing evidence, the court:

(A) Shall order the release of the individual and dismiss the case if:

(i) The mentally ill person is willing and able to participate in treatment on a voluntary basis; and

(ii) The court finds that the person will probably do so.

(B) May order conditional release under this subparagraph subject to the qualifications and requirements under ORS 426.125. If the court orders conditional release under this subparagraph, the court shall establish a period of commitment for the conditional release.

(C) May order commitment of the individual to the Department of Human Services for treatment if, in the opinion of the court, subparagraph (A) or (B) of this paragraph is not in the best interest of the mentally ill person. If the court orders commitment under this subparagraph:

(i) The court shall establish a period of commitment.

(ii) The department may place the committed person in outpatient commitment under ORS 426.127.

(D) Shall order that the person be prohibited from purchasing or possessing a firearm if, in the opinion of the court, there is a reasonable likelihood the person would constitute a danger to self or others or to the community at large as a result of the person's mental or psychological state as demonstrated by past behavior or participation in incidents involving unlawful violence or threats of unlawful violence, or by reason of a single incident of extreme, violent, unlawful conduct. When a court makes an order under this subparagraph, the court shall cause a copy of the order to be delivered to the sheriff of the county who will enter the information into the Law Enforcement Data System.

(2) A court that orders a conditional release or a commitment under this section shall establish a period of commitment for the person subject to the order. Any period of commitment ordered for commitment or conditional release under this section shall be for a period of time not to exceed 180 days.

(3) If the commitment proceeding was initiated under ORS 426.070 (1)(a) and if the notice included a request under ORS 426.070 (2)(d)(B), the court shall notify the two persons of the court's determination under subsection (1) of this section. [Amended by 1973 c.838 §12; 1975 c.690 §8; 1979 c.408 §3; 1987 c.903 §17; 1989 c.839 §36; 1993 c.735 §9; 1995 c.498 §2]

426.135 Counsel on appeal; costs of appeal. If a person determined to be mentally ill as provided in ORS 426.130 appeals the determination or disposition based thereon, and is unable to afford suitable legal counsel possessing skills and experience commensurate with the nature and complexity of the case to represent the person on appeal, the court, upon request of the person or upon its own motion, shall appoint suitable legal counsel to represent the person. The compensation for legal counsel and costs and expenses necessary to the appeal shall be determined and allowed by the appellate court as provided in ORS 135.055 if the circuit court is the appellate court or as provided in ORS 138.500 if the Court of Appeals or Supreme Court is the appellate court. The compensation, costs and expenses so allowed shall be paid as provided in ORS 138.500. [1979 c.867 §12; 1981 s.s. c.3 §134; 1985 c.502 §25]

Note: The amendments to 426.135 by section 58, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.135. If a person determined to be mentally ill as provided in ORS 426.130 appeals the determination or disposition based thereon, and is determined to be financially eligible for appointed counsel at state expense, upon request of the person or upon its own motion, the court shall appoint suitable legal counsel to represent the person. The compensation for legal counsel and costs and expenses necessary to the appeal shall be determined and paid by the public defense services executive director as provided in ORS 135.055 if the circuit court is the appellate court or as provided in ORS 138.500 if the Court of Appeals or Supreme Court is the appellate court. The compensation, costs and expenses shall be paid as provided in ORS 138.500.

426.140 Place of confinement; attendant. (1) No person, not incarcerated upon a criminal charge, who has been adjudged a mentally ill person or one against whom commitment proceedings have been instituted shall be confined in any prison, jail or other enclosure where those charged with a crime or a violation of a municipal ordinance are incarcerated, unless the person represents an immediate and serious danger to staff or physical facilities of a hospital or other facility approved by the Department of Human Services for the care, custody and treatment of the person.

(2) No allegedly mentally ill person who has been taken into custody shall be confined, either before or after the commitment hearing, without an attendant in direct charge of the person; and, if not confined in a community hospital, the sheriff or community mental health and developmental disabilities program director having the person in custody shall select some suitable person to act as attendant in quarters suitable for the comfortable, safe and humane confinement of the person and approved by the department. [Amended by 1973 c.838 §23; 1975 c.690 §9; 1977 c.764 §1]

426.150 Transportation to treatment facility. (1) Upon receipt of the order of commitment, the Department of Human Services or its designee shall take the mentally ill person into its custody, and insure the safekeeping and proper care of the person until delivery is made to an assigned treatment facility or its representative. The representative of the treating facility to which the person has been assigned, accompanied by any assistants the department or its designee may deem necessary, shall proceed to the place where the person is to be delivered into custody, and upon demand shall be given custody of the mentally ill person, together with the certified record required by ORS

426.170. The representative shall issue appropriate receipts therefor and immediately proceed to transport the committed mentally ill person safely to the facility to which the person has been assigned by the department and there make delivery of the person and the record to the director or a designated employee of the facility. In taking custody of the person, the department, its designee, or the representative of the facility has all the powers provided by ORS 133.225 and 161.255 and may require the assistance of any peace officer or other person.

(2) The committing judge, upon approval of the examining physicians or other qualified persons as recommended by the department and upon request of a guardian, friend or relative of the mentally ill person, may authorize the guardian, friend or relative to transport the person to the designated facility when the committing judge determines that means of transportation would not be detrimental to the welfare of the mentally ill person or to the public. [Amended by 1963 c.325 §1; 1973 c.838 §24; 1975 c.690 §10]

426.155 Release of information about person held in custody pending commitment proceeding or while committed or recommitted. (1) The provisions of this section apply to the release of information about a person who is held in custody either pending a commitment proceeding under ORS 426.070, 426.140, 426.228, 426.232, 426.233 or 426.237 (1)(b) or while committed or recommitted under ORS 426.005 to 426.390.

(2) Notwithstanding the provisions of ORS 179.495, 179.505 or 192.502 (2) and notwithstanding any other provision of ORS 426.005 to 426.390, a facility or nonhospital facility where a person is held shall establish procedures for releasing information as required under subsections (3) and (4) of this section.

(3)(a) If a person described in subsection (1) of this section authorizes disclosure as provided in subsection (5) of this section, upon request of a member of the family of the person, or any other person designated by the person, a facility or nonhospital facility where the person is held shall provide the family member or the designee with the following information:

(A) The person's diagnosis;

(B) The person's prognosis;

(C) The medications prescribed for the person and the side effects of medications prescribed, if any;

(D) The person's progress;

(E) Information about any civil commitment process, including the date, time and location of the person's commitment hearing; and

(F) Where and when the person may be visited.

(b) If a request for information is made under this subsection and the person described in subsection (1) of this section is unable to authorize disclosure as provided in subsection (5) of this section, the person requesting information shall be provided notice of the presence of the person described in subsection (1) of this section in any facility or nonhospital facility. Information shall not be provided under this paragraph if the physician of the person described in subsection (1) of this section determines that it would not be in the person's best interest to provide the information or if providing the information is prohibited by federal law.

(4) Upon the admission of any person to a facility or nonhospital facility under ORS 426.005 to 426.390, the facility or nonhospital facility shall make reasonable attempts to notify the person's next of kin, or any other person designated by the person, of the person's admission, unless the person requests that this information not be provided. The facility or nonhospital facility shall make reasonable attempts to notify the person's next of kin, or any other person designated by the person, of the person's release, transfer, serious illness, injury or death upon request of the family member or designee, unless the person requests that this information not be provided. The person shall be advised by the facility or nonhospital facility that the person has the right to request that this information not be provided.

(5) The person who is held in custody shall be notified by the facility or nonhospital facility that information about the person has been requested. Except as provided in subsection (3) of this section, the consent of the person who is held is required for release of information under subsections (3) and (4) of this section. If, when initially informed of the request for information, the person is unable to give voluntary and informed consent to authorize the release of information, notation of the attempt shall be made in the person's treatment record and daily efforts shall be made to secure the person's consent or refusal of authorization.

(6) Notwithstanding any other provision of this section, an individual eligible to receive information under subsection (3) of this section may not receive information unless the individual first agrees to make no further disclosure of the information. The agreement may be made orally.

(7) A facility or nonhospital facility that releases information under subsection (3) or (4) of this section shall:

(a) Notify the person who is held to whom, when and what information was released; and

(b) Note in the medical record of the person who is held:

(A) The basis for finding that the person gave voluntary and informed consent;

(B) The oral or written consent of the person who is held;

(C) To whom, when and what information was released;

(D) The agreement to the requirements of subsection (6) of this section by the person who requested information; and

(E) Any determination made by the person's physician under subsection (3)(b) of this section regarding the provision of notice of the presence of the person in any facility or nonhospital facility.

(8) A facility or nonhospital facility, including the staff of such facilities and nonhospital facilities, that releases information under this section or rules adopted under ORS 426.236 may not be held civilly or criminally liable for damages caused or alleged to be caused by the release of information or the failure to release information as long as the release was done in good faith and in compliance with subsections (3) and (4) of this section or rules adopted under ORS 426.236.

(9) The provisions of subsections (3) and (4) of this section do not limit the ability or obligation of facilities, nonhospital facilities, physicians, mental health care providers or licensed mental health professionals to provide information as otherwise allowed or required by law. [2001 c.481 §2]

Note: 426.155 was added to and made a part of 426.005 to 426.390 by legislative action but was not added to any other series therein. See Preface to Oregon Revised Statutes for further explanation.

426.160 Record of proceedings. The judge shall cause to be recorded in the court records a full account of proceedings had at all hearings and examinations conducted pursuant to ORS 426.005, 426.060 to 426.170, 426.217, 426.228, 426.255 to 426.292, 426.300 to 426.309, 426.385 and 426.395, together with the judgments and orders of the court and a copy of the orders issued. The account of the proceedings and transcripts of testimony if taken there at shall be delivered to the court clerk or court administrator who shall cause it to be sealed and neither the account of the proceedings nor the transcript of testimony if taken shall be disclosed to any person except:

(1) As provided in ORS 426.070 (5)(c), 426.130 (3) or 426.170;

(2) Upon request of the person subject to the proceedings, the legal representatives, or the attorney of the person; or

(3) Pursuant to court order. [Amended by 1965 c.420 §1; 1969 c.148 §1; 1973 c.838 §21; 1993 c.223 §11; 1993 c.484 §19; 1995 c.498 §3]

426.170 Delivery of certified copy of record. If any person is adjudged mentally ill and ordered committed to the Department of Human Services, a copy of the complete record in the case, certified to by the court clerk or court administrator, shall be given to the health officer of the county, or to the sheriff, for delivery to the director of the facility to which such mentally ill person is assigned. The record shall include the name, residence, nativity, sex and age of such mentally ill person and all other information that may be required by the rules and regulations promulgated by the department. [Amended by 1973 c.838 §25; 1993 c.223 §12]

426.175 [1969 c.371 §1; 1975 c.690 §11; 1977 c.764 §2; 1987 c.903 §20; 1991 c.901 §1; repealed by 1993 c.484 §27]

(Emergency and Voluntary Admissions)

426.180 Emergency commitment of certain Native Americans. (1) This section applies to commitments of a person from a reservation for land-based tribes of Native Americans when, under federal law, the state does not have jurisdiction of commitments on the reservation.

(2) When this section is applicable as provided under subsection (1) of this section, a person alleged to be mentally ill by affidavit of two other persons may be admitted to a state hospital for the mentally ill for emergency treatment, care and custody, provided such affidavit includes or is accompanied by all of the following:

(a) The circumstances constituting the emergency.

(b) Written application for admission to the hospital, executed in duplicate.

(c) A certificate to the effect that the person is so mentally ill as to be in need of immediate hospitalization.

(d) A medical history, including the name, condition, sex and age of the person.

(e) The name and address of the nearest relative or legal guardian, if any, of the person.

(3) The certificates, applications and medical histories shall be made upon forms prescribed by the Department of Human Services and shall be executed by the county health officer or by two physicians licensed by the Board of Medical Examiners, none of whom shall be related to the person by blood or marriage.

(4) When a person is admitted to a state hospital under this section, any physician treating the person shall give the person the warning under ORS 426.123.

(5) This section may be applied as provided by agreement with the ruling body of the reservation. Payment of costs for a commitment made under this section shall be as provided under ORS 426.250. [Amended by 1953 c.442 §2; 1975 c.690 §12; 1987 c.903 §21]

426.190 Admission on emergency commitment. Immediately upon execution of the documents mentioned in ORS 426.180, the person, together with the documents, shall be transported by the sheriff or other person on the authorization of the county health officers or deputy to the state hospital indicated by law to receive such patient. The chief medical officer of the state hospital may refuse to admit the person unless the chief medical officer is satisfied from the documents that an emergency exists, and that the person is so mentally ill as to be in need of immediate hospitalization. The superintendent shall file such documents in the office of the hospital, where they shall remain a matter of record. If the superintendent is satisfied that an emergency exists, and that such person is so mentally ill as to be in need of immediate hospitalization, the superintendent shall receive and care for as a patient in the hospital the person named in the documents. [Amended by 1969 c.391 §2]

426.200 Duties following emergency admission; application for voluntary admission; court commitment. Within 48 hours after admission under ORS 426.190, an examination as to the mental condition of any person so admitted shall be commenced and shall be conducted as expeditiously as possible by two staff physicians of the state hospital where the person has been received. If, after completion of the examination, the physicians certify that the person is so mentally ill as to be in need of treatment, care or custody, the superintendent shall, if the superintendent determines that further hospitalization is necessary, within 48 hours thereafter, either obtain from the mentally ill person a signed application for voluntary admission under the provisions of ORS 426.220 or file a complaint with the court having jurisdiction under ORS 426.060 in the county where the hospital is located, requesting a court commitment as provided by law. If the examining physicians certify that the person is not so mentally ill as to be in need of treatment, care or custody, the superintendent of the state hospital shall immediately discharge the person. Costs shall be paid as provided under ORS 426.250. [Amended by 1963 c.325 §2; 1975 c.690 §13; 1987 c.903 §22]

426.210 Limit of detention after commitment in emergency proceedings. In no event shall any person admitted to a state hospital pursuant to the emergency proceedings provided by ORS 426.180 to 426.200 be detained therein by virtue of such proceedings for more than five judicial days following admission. The court, for good cause, may allow a postponement and detention during the postponement as provided under ORS 426.095. [Amended by 1987 c.903 §23]

426.215 [1965 c.628 §1; 1973 c.838 §32; 1975 c.690 §14; 1977 c.764 §3; 1979 c.408 §4; 1985 c.743 §§1,2,3; 1987 c.368 §1; 1987 c.903 §§24,25; repealed by 1993 c.484 §27]

426.217 Change of status of committed patient to voluntary patient; effect of change. At any time after commitment by the court, the person, with the approval of the Department of Human Services or its designee, may change the status of the person to that of a voluntary patient. Notwithstanding ORS 426.220, any person who alters status to that of a voluntary patient under this section shall be released from the treating facility within 72 hours of the request of the person for release. [1973 c.838 §14; 1975 c.690 §15]

426.220 Voluntary admission; leave of absence; notice to parent or guardian. (1) Pursuant to rules and regulations promulgated by the Department of Human Services, the superintendent of any state hospital for the treatment and care of the mentally ill may admit and hospitalize therein as a patient, any person who may be suffering from nervous disorder or mental illness, and who voluntarily has made written application for such admission. No person under the age of 18 years shall be admitted as a patient to any such state hospital unless an application therefor in behalf of the person has been executed by the parent, adult next of kin or legal guardian of the person. Except when a period of longer hospitalization has been imposed as a condition of admission, pursuant to rules and regulations of the department, no person voluntarily admitted to any state hospital shall be detained therein more than 72 hours after the person, if at least 18 years of age, has given notice in writing of a desire to be discharged therefrom, or, if the patient is under the age of 18 years, after notice in writing has been given by the parent, adult next of kin or legal guardian of the person that such parent, adult next of kin or legal guardian desires that such person be discharged therefrom.

(2) Any person voluntarily admitted to a state hospital pursuant to this section may upon application and notice to the superintendent of the hospital concerned, be granted a temporary leave of absence from the hospital if such leave, in the opinion of the superintendent, will not interfere with

the successful treatment or examination of the applicant for leave.

(3) Upon admission or discharge of a minor to or from a state hospital the superintendent shall immediately notify the parent or guardian. [Amended by 1953 c.127 §2; 1963 c.325 §3; 1967 c.371 §1; 1969 c.273 §1]

426.222 [1953 c.597 §1; 1961 c.385 §1; 1969 c.391 §3; 1969 c.638 §4; repealed by 1975 c.690 §28]

426.223 Retaking persons in custody of or committed to department; assistance of peace officers and others. In retaking custody of a mentally ill person who has been committed to the Department of Human Services under ORS 426.130 and who has, without lawful authority, left the custody of the facility to which the person has been assigned under ORS 426.060, or in the case of an allegedly mentally ill person who is in custody under ORS 426.070, 426.095, 426.228 to 426.235 or 426.237 at a hospital or nonhospital facility and who has, without lawful authority, left the hospital or nonhospital facility, the facility director or designee has all the powers provided by ORS 133.225 and 161.255 and may require the assistance of any peace officer or other person. [1975 c.690 §25; 1993 c.484 §20]

426.224 [1953 c.597 §2; 1961 c.385 §2; 1969 c.391 §4; 1969 c.638 §5; repealed by 1975 c.690 §28]

426.225 Voluntary admission to state hospital of committed person; examination by physician. (1) If any person who has been committed to the Department of Human Services under ORS 426.127 or 426.130 (1)(b)(B) or (C) requests, during this period of commitment, voluntary admission to a state hospital, the superintendent shall cause the person to be examined immediately by a physician. If the physician finds the person to be in need of immediate care or treatment for mental illness, the person shall be voluntarily admitted upon request of the person.

(2) If any person who has been committed to the department under ORS 426.127 or 426.130 (1)(b)(B) or (C) requests, during this period of commitment, voluntary admission to a facility approved by the department, the administrator of the facility shall cause the person to be examined immediately by a physician. If the physician finds the person to be in need of immediate care or treatment for mental illness, and the department grants approval, the person shall be voluntarily admitted upon request of the person. [1989 c.993 §2]

426.226 [1953 c.597 §3; 1969 c.391 §5; 1969 c.638 §6; repealed by 1975 c.690 §28]

(Emergency Care and Treatment)

426.228 Custody; authority of peace officers and other persons; transporting to facility; reports; examination of person. (1) A peace officer may take into custody a person who the officer has probable cause to believe is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness. As directed by the community mental health and developmental disabilities program director, a peace officer shall remove a person taken into custody under this section to the nearest hospital or nonhospital facility approved by the Department of Human Services. The officer shall prepare a written report and deliver it to the treating physician. The report shall state:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the community mental health and developmental disabilities program director and a telephone number where the director may be reached at all times.

(2) A peace officer shall take a person into custody when the community mental health and developmental disabilities program director, pursuant to ORS 426.233, notifies the peace officer that the director has probable cause to believe that the person is imminently dangerous to self or to any other person. As directed by the community mental health and developmental disabilities program director, the peace officer shall remove the person to a hospital or nonhospital facility approved by the department. The community mental health and developmental disabilities program director shall prepare a written report that the peace officer shall deliver to the treating physician. The report shall state:

(a) The reason for custody;

(b) The date, time and place the person was taken into custody; and

(c) The name of the community mental health and developmental disabilities program director and a telephone number where the director may be reached at all times.

(3) If more than one hour will be required to transport the person to the hospital or nonhospital facility from the location where the person was taken into custody, the peace officer shall obtain, if possible, a certificate from a physician licensed by the Board of Medical Examiners for the State of Oregon stating that the travel will not be detrimental to the person's physical health and that the person is dangerous to self or to any other person and is in need of immediate care or treatment for mental illness. The physician shall have personally exam-

ined the allegedly mentally ill person within 24 hours prior to signing the certificate.

(4) When a peace officer or other authorized person, acting under this section, delivers a person to a hospital or nonhospital facility, a physician licensed by the Board of Medical Examiners for the State of Oregon shall examine the person immediately. If the physician finds the person to be in need of emergency care or treatment for mental illness, the physician shall proceed under ORS 426.232, otherwise the person shall not be retained in custody. If the person is to be released from custody, the peace officer or the community mental health and developmental disabilities program director shall return the person to the place where the person was taken into custody unless the person declines that service.

(5) A peace officer may transfer a person in custody under this section to the custody of a person authorized by the county governing body under ORS 426.233 (3). The peace officer may meet the authorized person at any location that is in accordance with ORS 426.140 to effect the transfer. When transferring a person in custody to an authorized person, the peace officer shall deliver the report required under subsections (1) and (2) of this section to the authorized person.

(6) A person authorized under ORS 426.233 (3) shall take a person into custody when directed to do so by a peace officer or by a community mental health and developmental disabilities program director under ORS 426.233.

(7) A person authorized under ORS 426.233 (3) shall perform the duties of the peace officer or the community mental health and developmental disabilities program director required by this section and ORS 426.233 if the peace officer or the director has not already done so.

(8) A person authorized under ORS 426.233 (3) may transfer a person in custody under this section to the custody of another person authorized under ORS 426.233 (3) or a peace officer. The authorized person transferring custody may meet another authorized person or a peace officer at any location that is in accordance with ORS 426.140 to effect the transfer. [1993 c.484 §2; 1997 c.531 §2]

Note: 426.228 to 426.238 were added to and made a part of 426.005 to 426.390 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

426.230 [Amended by 1955 c.651 §7; repealed by 1957 c.388 §17]

426.231 Physician hold; when authorized; statement required. (1) A physician licensed by the Board of Medical Examiners for the State of Oregon may hold a person for transportation to a treatment facility for up to 12 hours in a health care facility licensed under ORS chapter 431 and approved by the Department of Human Services if:

(a) The physician believes the person is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness;

(b) The physician is not related to the person by blood or marriage; and

(c) An admitting physician at the receiving facility consents to the transporting.

(2) Before transporting the person, the physician shall prepare a written statement that:

(a) The physician has examined the person within the preceding 12 hours;

(b) An admitting physician at the receiving facility has consented to the transporting of the person for examination and admission if appropriate; and

(c) The physician believes the person is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness.

(3) The written statement required by subsection (2) of this section authorizes a peace officer, a person authorized under ORS 426.233 or the designee of a community mental health and developmental disabilities program director to transport a person to the treatment facility indicated on the statement. [1993 c.484 §3; 1997 c.531 §3]

Note: See note under 426.228.

426.232 Physician emergency admission; notice; limit of hold. (1) When a physician licensed to practice medicine by the Board of Medical Examiners for the State of Oregon believes a person who is brought to a hospital or nonhospital facility by a peace officer under ORS 426.228, a person authorized under ORS 426.233 or a person who is at a hospital or nonhospital facility is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness, the physician may do one of the following:

(a) After consulting with a physician or a qualified mental health professional, as defined by rule of the Department of Human Services, detain the person and cause the person to be admitted or, if the person is already admitted, cause the person to be retained in a hospital where the physician has admitting privileges or is on staff. Neither the physician nor the qualified mental health professional may be related by blood or marriage to the person.

(b) Approve the person for emergency care or treatment at a nonhospital facility approved by the department.

(2) When approving a person for emergency care or treatment at a nonhospital facility under this section, the physician shall notify immediately the community mental health and developmental disabilities program director in the county where the person was taken into custody and maintain the person, if the person is being held at a hospital, for as long as is feasible given the needs of the person for mental or physical health or safety. However, under no circumstances may the person be held for longer than five judicial days. [1993 c.484 §4; 1995 c.201 §3; 1997 c.531 §4]

Note: See note under 426.228.

426.233 Authority of community mental health and developmental disabilities program director and of other persons; costs of transportation. (1)(a) A community mental health and developmental disabilities program director operating under ORS 430.610 to 430.695 or a designee thereof, under authorization of a county governing body, may take one of the actions listed in paragraph (b) of this subsection when the community mental health and developmental disabilities program director or designee has probable cause to believe a person:

(A) Is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness; or

(B)(i) Is a mentally ill person placed on conditional release under ORS 426.125, outpatient commitment under ORS 426.127 or trial visit under ORS 426.273; and

(ii) Is dangerous to self or to any other person or is unable to provide for basic personal needs and is not receiving the care that is necessary for health and safety and is in need of immediate care, custody or treatment for mental illness.

(b) The community mental health and developmental disabilities program director or designee under the circumstances set out in paragraph (a) of this subsection may:

(A) Notify a peace officer to take the person into custody and direct the officer to remove the person to a hospital or nonhospital facility approved by the Department of Human Services;

(B) Authorize involuntary admission of, or, if already admitted, cause to be involuntarily retained in a nonhospital facility approved by the department, a person approved for care or treatment at a nonhospital facility by a physician under ORS 426.232;

(C) Notify a person authorized under subsection (3) of this section to take the person into custody and direct the authorized person to remove the person in custody to a hospital or nonhospital facility approved by the department;

(D) Direct a person authorized under subsection (3) of this section to transport a person in custody from a hospital or a nonhospital facility approved by the department to another hospital or nonhospital facility approved by the department as provided under ORS 426.235; or

(E) Direct a person authorized under subsection (3) of this section to transport a person in custody from a facility approved by the department to another facility approved by the department as provided under ORS 426.060.

(2) A designee under subsection (1) of this section must be recommended by the community mental health and developmental disabilities program director, meet the standards established by rule of the department and be approved by the county governing body before assuming the authority permitted under subsection (1) of this section.

(3) The county governing body may, upon recommendation by the community mental health and developmental disabilities program director, authorize any person to provide custody and secure transportation services for a person in custody under ORS 426.228. In authorizing a person under this subsection, the county governing body shall grant the person the authority to do the following:

(a) Accept custody from a peace officer of a person in custody under ORS 426.228;

(b) Take custody of a person upon notification by the community mental health and developmental disabilities program director under the provisions of this section;

(c) Remove a person in custody to an approved hospital or nonhospital facility as directed by the community mental health and developmental disabilities program director;

(d) Transfer a person in custody to another person authorized under this subsection or a peace officer;

(e) Transfer a person in custody from a hospital or nonhospital facility to another hospital facility or nonhospital facility when directed to do so by the community mental health and developmental disabilities program director; and

(f) Retain a person in custody at the approved hospital or nonhospital facility until a physician makes a determination under ORS 426.232.

(4) A person authorized under subsection (3) of this section must be recommended by the community mental health and developmental disabilities program director, meet the standards established by rule of the department and be approved by the governing

body before assuming the authority granted under this section.

(5) The costs of transporting a person as authorized under ORS 426.060, 426.228 or 426.235 by a person authorized under subsection (3) of this section shall be the responsibility of the county whose peace officer or community mental health and developmental disabilities program director directs the authorized person to take custody of a person and to transport the person to a facility approved by the department, but the county shall not be responsible for costs that exceed the amount provided by the state for that transportation. A person authorized to act under subsection (3) of this section shall charge the cost of emergency medical transportation to, and collect that cost from, the person, third party payers or otherwise legally responsible persons or agencies in the same manner that costs for the transportation of other persons are charged and collected. [1993 c.484 §5; 1997 c.531 §5]

Note: See note under 426.228.

426.234 Duties of professionals at facility where person admitted; notification; duties of court. (1) At the time a person is admitted to or retained in a hospital or nonhospital facility under ORS 426.232 or 426.233, a physician, nurse or qualified mental health professional at the hospital or nonhospital facility shall:

(a) Inform the person of the person's right to representation by or appointment of counsel as described in ORS 426.100;

(b) Give the person the warning under ORS 426.123;

(c) Immediately examine the allegedly mentally ill person; and

(d) Set forth, in writing, the condition of the person and the need for emergency care or treatment.

(2)(a) At the time the person is admitted to or retained in a hospital under ORS 426.232, the physician shall contact the community mental health and developmental disabilities program director of the county in which the person resides, if the county of residence is different from the county in which the hospital is located. The community mental health and developmental disabilities program director may request that the physician notify the circuit court in the county in which the person resides. If the community mental health and developmental disabilities program director does not make the request authorized by this paragraph, the physician shall notify, immediately and in writing, the circuit court in the county in which the person is hospitalized.

(b) At the time the person is admitted to a hospital under ORS 426.232 after being brought to the hospital by a peace officer under ORS 426.228, the physician shall contact the community mental health and developmental disabilities program director of the county in which the person is hospitalized. The community mental health and developmental disabilities program director of the county in which the person is hospitalized may request that the physician notify the circuit court in the county in which the person is hospitalized. If the community mental health and developmental disabilities program director does not make the request authorized by this paragraph, the physician shall notify, immediately and in writing, the circuit court in the county in which the person was taken into custody.

(c) If, at any time prior to the hearing under ORS 426.070 to 426.130, the physician responsible for a person admitted or retained under ORS 426.232 determines that the person is not dangerous to self or others and is not in need of emergency care or treatment for mental illness, the physician may release the person from the detention authorized by ORS 426.232. The physician shall immediately notify the circuit court notified under this subsection and the community mental health and developmental disabilities program director of the person's release from detention.

(3)(a) At the time the person is admitted to or retained in a nonhospital facility under ORS 426.233, the community mental health and developmental disabilities program director in the county where the person was taken into custody shall contact the community mental health and developmental disabilities program director of the county in which the person resides, if the county of residence is different from the county in which the person was taken into custody. The community mental health and developmental disabilities program director of the county in which the person resides may request that the community mental health and developmental disabilities program director of the county in which the person was taken into custody notify the circuit court in the county where the person resides. Otherwise, the community mental health and developmental disabilities program director of the county in which the person was taken into custody shall notify, immediately and in writing, the circuit court in the county in which the person was taken into custody.

(b) If, at any time prior to the hearing under ORS 426.070 to 426.130, a community mental health and developmental disabilities program director, after consultation with a physician, determines that a person admitted or retained under ORS 426.233 is not dangerous to self or others and is not in need

of immediate care, custody or treatment for mental illness, the community mental health and developmental disabilities program director may release the person from detention. The community mental health and developmental disabilities program director shall immediately notify the circuit court originally notified under paragraph (a) of this subsection of the person's release from detention.

(4) When the judge of the circuit court receives notice under subsection (2) or (3) of this section, the judge immediately shall commence proceedings under ORS 426.070 to 426.130. In a county having a population of 100,000 or more, and when feasible in a county with a lesser population, the community mental health and developmental disabilities program director or designee who directs the peace officer or other authorized person to take a person into custody under ORS 426.233 shall not also conduct the investigation as provided for under ORS 426.074. Except when a person is being held under ORS 426.237 (1)(b), a person shall not be held under ORS 426.232 or 426.233 for more than five judicial days without a hearing being held under ORS 426.070 to 426.130.

(5) When the judge of the circuit court receives notice under subsection (2)(c) or (3)(b) of this section that a person has been released, and unless the court receives the recommendation required by ORS 426.070 (4), the judge shall dismiss the case no later than 14 days after the date the person was initially detained. [1993 c.484 §6; 1995 c.201 §1; 1997 c.531 §6; 2001 c.481 §3]

Note: See note under 426.228.

426.235 Transfer between hospital and nonhospital facilities. (1) The community mental health and developmental disabilities program director may transfer a person in custody under ORS 426.232, 426.233 or 426.237 (1)(b) to a hospital or nonhospital facility approved by the Department of Human Services at any time during the period of detention.

(2) A person in custody at a hospital may be transferred from the hospital only with the consent of the treating physician and when the director of a nonhospital facility approved by the department agrees to admit the person.

(3) A person in custody at a nonhospital facility approved by the department may be transferred to a hospital approved by the department only when a physician with admitting privileges agrees to admit the person.

(4) In transporting a person between a hospital and nonhospital facility under this section, the community mental health and developmental disabilities program director has all the powers provided in ORS 133.225 and 161.255 and may compel the assistance of any peace officer or other person.

(5) When a person is transferred under this section, the community mental health and developmental disabilities program director shall notify immediately the court notified under ORS 426.234 (2) or (3) of the fact of the transfer and of the location of the person. [1993 c.484 §7]

Note: See note under 426.228.

426.236 Rules. The Department of Human Services shall adopt rules necessary to carry out the provisions of ORS 426.155 and 426.228 to 426.238. [1993 c.484 §8; 2001 c.481 §4]

Note: See note under 426.228.

426.237 Prehearing detention; duties of community mental health and developmental disabilities program director; certification for treatment; court proceedings. (1) During a prehearing period of detention as provided in ORS 426.070, 426.140, 426.232 or 426.233, the community mental health and developmental disabilities program director shall do one of the following:

(a) Recommend, in an investigation report as provided in ORS 426.074, that the circuit court not proceed further in the matter if the community mental health and developmental disabilities program director does not believe the person is a mentally ill person.

(b) No later than three judicial days after initiation of a prehearing period of detention as provided in ORS 426.070, 426.140, 426.232 or 426.233, certify the detained person for a 14-day period of intensive treatment if:

(A) The community mental health and developmental disabilities program director and a psychiatrist, as defined by rule by the Department of Human Services, have probable cause to believe the person is a mentally ill person;

(B) The community mental health and developmental disabilities program director in the county where the person resides verbally approves the arrangements for payment for the services at the hospital or nonhospital facility; and

(C) The community mental health and developmental disabilities program director locates a hospital or nonhospital facility that:

(i) Is approved by the department and the community mental health and developmental disabilities program director in the county where the person resides; and

(ii) Can, in the opinion of the community mental health and developmental disabilities program director and the psychiatrist, pro-

vide intensive care or treatment for mental illness necessary and sufficient to meet the emergency psychiatric needs of the person.

(c) Recommend, in an investigation report as provided in ORS 426.074, that the circuit court hold a hearing under ORS 426.070 to 426.130 if the community mental health and developmental disabilities program director has probable cause to believe the person is a mentally ill person.

(2)(a) If the circuit court adopts the recommendation of the community mental health and developmental disabilities program director under subsection (1)(a) of this section, the circuit court shall enter an order releasing the person and dismissing the case. Unless the person agrees to voluntary treatment, if the person is being detained in a:

(A) Nonhospital facility, the director shall make discharge plans and insure the discharge of the person.

(B) Hospital, the treating physician shall make discharge plans and discharge the person.

(b) Upon release of the person, the community mental health and developmental disabilities program director shall attempt to notify the person's next of kin if the person consents to the notification.

(3)(a) If the detained person is certified for treatment under subsection (1)(b) of this section, the community mental health and developmental disabilities program director shall:

(A) Deliver immediately a certificate to the court having jurisdiction under ORS 426.060; and

(B) Orally inform the person of the certification and deliver a copy of the certificate to the person.

(b) The certificate required by paragraph (a) of this subsection shall include:

(A) A written statement under oath by the community mental health and developmental disabilities program director and the psychiatrist that they have probable cause to believe the person is a mentally ill person in need of care or treatment for mental illness;

(B) A treatment plan that describes, in general terms, the types of treatment and medication to be provided to the person during the 14-day period of intensive treatment;

(C) A notice of the person's right to an attorney and that an attorney will be appointed by the court or as otherwise obtained under ORS 426.100 (3);

(D) A notice that the person has a right to request and be provided a hearing under ORS 426.070 to 426.130 at any time during the 14-day period; and

(E) The date and time the copy of the certificate was delivered to the person.

(c) Immediately upon receipt of a certificate under paragraph (a) of this subsection, the court shall notify the person's attorney or appoint an attorney for the person if the person cannot afford one. Within 24 hours of the time the certificate is delivered to the court, the person's attorney shall review the certificate with the person. If the person and the person's attorney consent to the certification within one judicial day of the time the certificate is delivered to the circuit court and, except as provided in subsection (4) of this section, the court shall postpone the hearing required by ORS 426.070 to 426.130 for 14 days.

(d) When a person is certified for treatment under subsection (1)(b) of this section and accepts the certification:

(A) Except as otherwise provided in this paragraph, all methods of treatment, including the prescription and administration of drugs, shall be the sole responsibility of the treating physician. However, the person shall not be subject to electro-shock therapy or unduly hazardous treatment and shall receive usual and customary treatment in accordance with medical standards in the community.

(B) Except when the person expressly refuses treatment, the treating physician shall treat the person within the scope of the treatment plan provided the person under paragraph (b) of this subsection. The person's refusal of treatment constitutes sufficient grounds for the community mental health and developmental disabilities program director to request a hearing as provided in subsection (4)(a) of this section.

(C) If the person is in a hospital and the community mental health and developmental disabilities program director locates a nonhospital facility, approved by the department, that, in the opinion of the community mental health and developmental disabilities program director and the treating physician, can provide care or treatment for mental illness necessary and sufficient to meet the emergency psychiatric needs of the person, the treating physician shall discharge the person from the hospital and the community mental health and developmental disabilities program director shall remove the person to the nonhospital facility for the remainder of the 14-day intensive treatment period. If, however, in the opinion of the treating physician, the person's condition requires the person to receive medical care or treatment, the physician shall retain the person in the hospital.

(D) If the person is in a nonhospital facility, the community mental health and developmental disabilities program director shall transfer the person to a hospital approved by the department under the following conditions:

(i) If, in the opinion of a physician, the person's condition requires the person to receive medical care or treatment in a hospital; and

(ii) The physician agrees to admit the person to a hospital, approved by the department, where the physician has admitting privileges.

(E) If the person is transferred as provided in subparagraph (C) or (D) of this paragraph, the community mental health and developmental disabilities program director shall notify the circuit court, in the county where the certificate was filed, of the location of the person. The person may appeal the transfer as provided by rules of the department.

(e) If the person is in a hospital, the treating physician may discharge the person at any time during the 14-day period. The treating physician shall confer with the community mental health and developmental disabilities program director and the person's next of kin, if the person consents to the consultation, prior to discharging the person. Immediately upon discharge of the person, the treating physician shall notify the court in the county in which the certificate was filed initially.

(f) If the person is in a nonhospital facility, the community mental health and developmental disabilities program director may discharge the person at any time during the 14-day period. The community mental health and developmental disabilities program director shall consult with the treating physician and the person's next of kin, if the person consents to the consultation, prior to discharging the person. Immediately upon discharge of the person, the community mental health and developmental disabilities program director shall notify the court in the county in which the certificate was filed initially.

(g) The person may agree to voluntary treatment at any time during the 14-day period. When a person agrees to voluntary treatment under this paragraph, the community mental health and developmental disabilities program director immediately shall notify the court in the county in which the certificate was filed initially.

(h) A person consenting to 14 days of treatment under subsection (3)(c) of this section shall not be held longer than 14 days from the time of consenting without a hearing as provided in ORS 426.070 to 426.130.

(i) When the court receives notification under paragraph (e), (f) or (g) of this subsection, the court shall dismiss the case.

(4) The judge of the circuit court shall immediately commence proceedings under ORS 426.070 to 426.130 when:

(a) The person consenting to 14 days of treatment or the community mental health and developmental disabilities program director requests a hearing. The hearing shall be held without unreasonable delay. In no case shall the person be held in a hospital or nonhospital facility longer than five judicial days after the request for a hearing is made without a hearing being held under ORS 426.070 to 426.130.

(b) The community mental health and developmental disabilities program director acts under subsection (1)(c) of this section. In no case shall the person be held longer than five judicial days without a hearing under this subsection. [1993 c.484 §9]

Note: See note under 426.228.

426.238 Classifying facilities. The Department of Human Services may assign classifications, as defined by rule of the department, to facilities that provide care and treatment for persons committed to the department under ORS 426.130 or provide emergency care or treatment for persons pursuant to ORS 426.070, 426.228 to 426.235 or 426.237. The department may authorize a facility to retake custody of a person who unlawfully leaves a facility as provided in ORS 426.223. [1993 c.484 §10]

Note: See note under 426.228.

426.240 [Amended by 1959 c.652 §22; 1975 c.690 §16; repealed by 1977 c.764 §4 (426.241 enacted in lieu of 426.240)]

(Costs)

426.241 Payment of care, custody and treatment costs; denial of payment; rules. (1) The cost of emergency psychiatric care, custody and treatment related to or resulting from such psychiatric condition, provided by a hospital or other facility approved by the Department of Human Services and the community mental health and developmental disabilities program director of the county in which the facility is located, except a state mental hospital, for an allegedly mentally ill person admitted or detained under ORS 426.070, 426.140, 426.228, 426.232 or 426.233, or for a mentally ill person admitted or detained under ORS 426.150, 426.223, 426.273, 426.275 or 426.292, shall be paid by the county of which the person is a resident from state funds provided it for this purpose. The county is responsible for the cost when

state funds available therefor are exhausted. The hospital or other facility shall charge to and collect from the person, third party payers or other persons or agencies otherwise legally responsible therefor, the costs of the emergency care, custody and treatment, as it would for any other patient, and any funds received shall be applied as an offset to the cost of the services provided under this section.

(2) If any person is admitted to or detained in a state mental hospital under ORS 426.070, 426.140, 426.180 to 426.210, 426.228, 426.232 or 426.233 for emergency care, custody or treatment, the department shall charge to and collect from the person, third party payers or other persons or agencies otherwise legally responsible therefor, the costs as it would for other patients of the state mental hospitals under the provisions of ORS 179.610 to 179.770.

(3) If any person is adjudged mentally ill under the provisions of ORS 426.130, and the person receives care and treatment in a state mental hospital, the person, third party payers or other persons or agencies otherwise legally responsible therefor, shall be required to pay for the costs of the hospitalization at the state hospital, as provided by ORS 179.610 to 179.770, if financially able to do so.

(4) For purposes of this section and ORS 426.310 "resident" means resident of the county in which the person maintains a current mailing address or, if the person does not maintain a current mailing address within the state, the county in which the person is found, or the county in which a court committed mentally ill person has been conditionally released.

(5)(a) The department may deny payment for part or all of the emergency psychiatric services provided by a hospital or nonhospital facility under ORS 426.232, 426.233 or 426.237 when the department finds, upon review, that the allegedly mentally ill person's condition did not meet the admission criteria in ORS 426.232 (1), 426.233 (1) or 426.237 (1)(b)(A). The payer responsible under this section shall make a request for denial of payment for emergency psychiatric services provided under ORS 426.232, 426.233 or 426.237 in writing to the department.

(b) The department may require the following to provide the department with any information the department determines necessary to review a request for denial of payment made under this subsection and to make a finding, or to conduct review of emergency psychiatric services for the purpose of planning or defining standards in department rule:

(A) A hospital or nonhospital facility approved under ORS 426.228 to 426.235 or 426.237.

(B) A physician or a person providing emergency psychiatric services under ORS 426.228 to 426.235 or 426.237.

(c) The department shall adopt rules necessary to carry out the purposes of this subsection. [1977 c.764 §5 (enacted in lieu of 426.240); 1979 c.392 §1; 1981 c.750 §16; 1987 c.527 §1; 1993 c.484 §21]

426.250 Payment of costs related to commitment proceedings. The following is a nonexclusive list of responsibilities for payment of various costs related to commitment proceedings under this chapter and ORS 430.397 to 430.401 as described:

(1) Any physician or qualified person recommended by the Department of Human Services who is employed under ORS 426.110 to make an examination as to the mental condition of a person alleged to be mentally ill shall be allowed a fee as the court in its discretion determines reasonable for the examination.

(2) Witnesses subpoenaed to give testimony shall receive the same fees as are paid in criminal cases, and are subject to compulsory attendance in the same manner as provided in ORS 136.567 to 136.603. The attendance of out-of-state witnesses may be secured in the same manner as provided in ORS 136.623 to 136.637. The party who subpoenas the witness or requests the court to subpoena the witness is responsible for payment of the cost of the subpoena and payment for the attendance of the witness at a hearing. When the witness has been subpoenaed on behalf of an allegedly mentally ill person who is represented by court-appointed counsel, the fees and costs allowed for that witness shall be paid pursuant to ORS 135.055. If the costs of witnesses subpoenaed by the allegedly mentally ill person are paid as provided under this subsection, the procedure for subpoenaing witnesses shall comply with ORS 136.570.

(3) If a person with a right to a counsel under ORS 426.100 is unable to afford counsel, the court shall determine and allow, as provided in ORS 135.055, the reasonable expenses of the person and compensation for legal counsel. The expenses and compensation so allowed shall be paid by the state from funds available for the purpose.

(4) The department shall pay the costs of expenses incurred under ORS 426.100 by the Attorney General's office. Any costs for district attorneys or other counsel appointed to assume responsibility for presenting the state's case shall be paid by the county where the commitment hearing is held, subject to reimbursement under ORS 426.310.

(5) All costs incurred in connection with a proceeding under ORS 426.200, including the costs of transportation, commitment and delivery of the person, shall be paid by the county of which the person is a resident; or, if the person is not a resident of this state, then by the county from which the emergency admission was made.

(6) All costs incurred in connection with a proceeding under ORS 426.180 for the commitment of a person from a reservation for land-based tribes of Native Americans, including the cost of transportation, commitment and delivery of the person, shall be paid by the ruling body of the reservation of which the person is a resident. [Amended by 1965 c.420 §2; 1975 c.690 §17; 1977 c.764 §6; 1987 c.606 §9; 1987 c.903 §§26,26a]

Note: The amendments to 426.250 by section 59, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.250. The following is a nonexclusive list of responsibilities for payment of various costs related to commitment proceedings under this chapter and ORS 430.397 to 430.401 as described:

(1) Any physician or qualified person recommended by the Department of Human Services who is employed under ORS 426.110 to make an examination as to the mental condition of a person alleged to be mentally ill shall be allowed a fee as the court in its discretion determines reasonable for the examination.

(2) Witnesses subpoenaed to give testimony shall receive the same fees as are paid in criminal cases, and are subject to compulsory attendance in the same manner as provided in ORS 136.567 to 136.603. The attendance of out-of-state witnesses may be secured in the same manner as provided in ORS 136.623 to 136.637. The party who subpoenas the witness or requests the court to subpoena the witness is responsible for payment of the cost of the subpoena and payment for the attendance of the witness at a hearing. When the witness has been subpoenaed on behalf of an allegedly mentally ill person who is represented by appointed counsel, the fees and costs allowed for that witness shall be paid pursuant to ORS 135.055. If the costs of witnesses subpoenaed by the allegedly mentally ill person are paid as provided under this subsection, the procedure for subpoenaing witnesses shall comply with ORS 136.570.

(3) If a person with a right to a counsel under ORS 426.100 is determined to be financially eligible for appointed counsel at state expense, the public defense services executive director shall determine and pay, as provided in ORS 135.055, the reasonable expenses related to the representation of the person and compensation for legal counsel. The expenses and compensation so allowed shall be paid by the public defense services executive director from funds available for the purpose.

(4) The department shall pay the costs of expenses incurred under ORS 426.100 by the Attorney General's office. Any costs for district attorneys or other counsel appointed to assume responsibility for presenting the state's case shall be paid by the county where the commitment hearing is held, subject to reimbursement under ORS 426.310.

(5) All costs incurred in connection with a proceeding under ORS 426.200, including the costs of transportation, commitment and delivery of the person, shall be paid by the county of which the person is a resident; or, if the person is not a resident of this state, then by the county from which the emergency admission was made.

(6) All costs incurred in connection with a proceeding under ORS 426.180 for the commitment of a person from a reservation for land-based tribes of Native Americans, including the cost of transportation, commitment and delivery of the person, shall be paid by the ruling body of the reservation of which the person is a resident.

426.255 County to pay costs. Costs of hearings conducted pursuant to ORS 426.307, and the fees for physicians and other qualified persons shall be charged to the county of the person's residence in the same manner provided by ORS 426.310, whether the hearing is held in the county of residence or county of the treating facility. [1973 c.838 §19; 1987 c.803 §23; 1987 c.903 §27]

426.260 [Amended by 1955 c.651 §8; repealed by 1957 c.160 §6]

426.270 [Amended by 1955 c.651 §9; repealed by 1957 c.160 §6]

(Trial Visits; Conditional Release; Outpatient Commitment; Early Release)

426.273 Trial visits. (1) During a period of commitment of a patient under ORS 426.130, the Department of Human Services may grant a trial visit to the patient for a period of time and under any conditions the department shall establish. The department shall only grant a trial visit under this section if the trial visit is agreed to by the community mental health and developmental disabilities program director, or the designee of the director, for the county in which the person would reside.

(2) When in the opinion of the department, the committed person can be appropriately served by outpatient care during the period of commitment, the outpatient care may be required as a condition for trial visit for a period which, when added to the inpatient treatment period, shall not exceed the period of commitment. If outpatient care is required as a condition for a trial visit, the conditions shall include a designation of a facility, service or other provider to provide care or treatment.

(3) A copy of the conditions for trial visit shall be given to all of the persons listed in ORS 426.278.

(4) Any trial visit granted under this section is subject to the provisions under ORS 426.275.

(5) The director of the community mental health and developmental disabilities program, or designee, of the county in which a person who is on trial visit lives while on trial visit may modify the conditions for continued trial visit when such modification is in the best interest of the person. The director shall send notification of such changes and the reasons for the changes to all those

who received a copy of the original conditions under ORS 426.278. [1985 c.242 §2 (enacted in lieu of 426.290); 1987 c.903 §28]

426.275 Effect of failure to adhere to condition of placement. The following are applicable to placements of mentally ill persons that are made as conditional release under ORS 426.125, outpatient commitments under ORS 426.127 or trial visits under ORS 426.273 as described:

(1) If the person responsible under this subsection determines that the mentally ill person is failing to adhere to the terms and conditions of the placement, the responsible person shall notify the court having jurisdiction that the mentally ill person is not adhering to the terms and conditions of the placement. If the placement is an outpatient commitment under ORS 426.127 or a trial visit under ORS 426.273, the notifications shall include a copy of the conditions for the placement. The person responsible for notifying the court under this subsection is as follows:

(a) For conditional releases under ORS 426.125, the guardian, relative or friend in whose care the mentally ill person is conditionally released.

(b) For outpatient commitments under ORS 426.127, the community mental health and developmental disabilities program director, or designee of the director, of the county in which the person on outpatient commitment lives.

(c) For trial visits under ORS 426.273, the community mental health and developmental disabilities program director, or designee of the director, of the county in which the person on trial visit is to receive outpatient treatment.

(2) On its own motion, the court with jurisdiction of a mentally ill person on such placement may cause the person to be brought before it for a hearing to determine whether the person is or is not adhering to the terms and conditions of the placement. The person shall have the same rights with respect to notice, detention stay, hearing and counsel as for a hearing held under ORS 426.095. The court shall hold the hearing within five judicial days of the date the mentally ill person receives notice under this section. The court may allow postponement and detention during postponement as provided under ORS 426.095.

(3) Pursuant to the determination of the court upon hearing under this section, a person on placement shall either continue the placement on the same or modified conditions or shall be returned to the Department of Human Services for involuntary care and treatment on an inpatient basis subject to discharge at the end of the commitment period or as otherwise provided under this chapter and ORS 430.397 to 430.401.

(4) If the person on placement is living in a county other than the county of the court that established the current period of commitment under ORS 426.130 during which the trial visit, conditional release or outpatient commitment takes place, the court establishing the current period of commitment shall transfer jurisdiction to the appropriate court of the county in which the person is living while on the placement and the court receiving the transfer shall accept jurisdiction.

(5) The court may proceed as provided in ORS 426.307 or this section when the court:

(a) Receives notice under ORS 426.070 or 426.228 to 426.235; and

(b) Determines that the person is a mentally ill person on conditional release under ORS 426.125, outpatient commitment under ORS 426.127 or trial visit under ORS 426.273. [1985 c.242 §3 (enacted in lieu of 426.290); 1987 c.903 §29; 1993 c.484 §22]

426.278 Distribution of copies of conditions for outpatient commitment or trial visit. The following persons shall be given a copy of the conditions of a placement of a mentally ill person that is made as an outpatient commitment under ORS 426.127 or as a trial visit under ORS 426.273:

(1) The committed person;

(2) The community mental health and developmental disabilities program director, or designee of the director, of the county in which the committed person is to receive outpatient treatment;

(3) The director of any facility, service or other provider designated to provide care or treatment;

(4) The court of current commitment; and

(5) The appropriate court of the county in which the committed person lives during the commitment period if the person is living in a different county than the county of the court that made the current commitment. [1987 c.903 §30]

426.280 Limitations on liability. The following limitations on liability and circumstances are applicable to situations within this chapter and ORS 430.397 to 430.401:

(1) None of the following shall in any way be held criminally or civilly liable for the making of the notification under ORS 426.070, provided the person acts in good faith, on probable cause and without malice:

(a) The community mental health and developmental disabilities program director or designee of the director.

(b) The two petitioning persons.

(c) The county health officer.

(d) Any magistrate.

(e) Any peace officer or probation officer.

(f) Any physician attending the allegedly mentally ill person.

(g) The physician attached to a hospital or institution wherein the allegedly mentally ill person is a patient.

(2) The person conducting the investigation under ORS 426.070 and 426.074 shall not be held criminally or civilly liable for conducting the investigation, provided the investigator acts in good faith, on probable cause and without malice.

(3) The person representing the state's interest under ORS 426.100 shall not be held criminally or civilly liable for performing responsibilities under ORS 426.100 as long as the person acts in good faith and without malice.

(4) No person appointed under ORS 426.110 to conduct an examination under ORS 426.120 shall be held criminally or civilly liable for actions pursuant to ORS 426.120 if the examiner acts in good faith and without malice.

(5) No physician, hospital or judge shall be held criminally or civilly liable for actions pursuant to ORS 426.228, 426.231, 426.232, 426.234 or 426.235 if the physician, hospital or judge acts in good faith, on probable cause and without malice.

(6) No peace officer, person authorized under ORS 426.233, community mental health director or designee, hospital or other facility, physician or judge shall in any way be held criminally or civilly liable for actions pursuant to ORS 426.228 to 426.235 if the individual or facility acts in good faith, on probable cause and without malice.

(7) Any guardian, relative or friend of a mentally ill person who assumes responsibility for the mentally ill person under a conditional release under ORS 426.125 shall not be liable for any damages that are sustained by any person on account of the misconduct of the mentally ill person while on conditional release if the guardian, relative or friend acts in good faith and without malice.

(8) The persons designated in this subsection shall not be liable for damages that are sustained by any person or property on account of the misconduct of a mentally ill person while the mentally ill person is on outpatient commitment under ORS 426.127 if the designated person acts without willful and wanton neglect of duty. This subsection is applicable to all of the following:

(a) The community mental health and developmental disabilities program director and the designee of the director for the county in which the committed person resides.

(b) The superintendent or director of any staff of any facility where the mentally ill person receives treatment during the outpatient commitment.

(c) The Director of Human Services.

(d) The physician and the facility granting an outpatient commitment to a patient.

(9) For trial visits granted under ORS 426.273 and 426.275:

(a) None of the following shall be liable for a patient's expenses while on trial visit:

(A) The physician and the facility granting a trial visit to a patient;

(B) The superintendent or director of the facility granting a trial visit;

(C) The Director of Human Services; and

(D) The chief medical officer of the facility.

(b) The following persons shall not be liable for damages that are sustained by any person on account of the misconduct of such patient while on trial visit if the person acts without willful and wanton neglect of duty:

(A) The community mental health and developmental disabilities program director for the county in which the person resides;

(B) The superintendent, director or chief medical officer of any facility granting a trial visit to a patient;

(C) The physician responsible for the patient's trial visit;

(D) The Director of Human Services; or

(E) The employees and agents of persons listed in this paragraph. [Amended by 1961 c.228 §1; 1961 c.706 §26; 1969 c.597 §91; 1973 c.838 §26; 1985 c.242 §5; 1987 c.903 §31; 1993 c.484 §23; 1997 c.531 §7]

426.290 [Amended by 1959 c.513 §1; 1961 c.228 §2; 1969 c.391 §6; 1973 c.838 §27; 1975 c.690 §18; repealed by 1985 c.242 §1 (426.273, 426.275 and 426.292 enacted in lieu of 426.290)]

426.292 Release prior to expiration of term of commitment. Nothing in this chapter and ORS 430.397 to 430.401 prohibits the Department of Human Services from releasing a person from a hospital or other facility in which the person is being treated prior to the expiration of the period of commitment under ORS 426.130 when, in the opinion of the director of the facility or treating physician, the person is no longer mentally ill. [1985 c.242 §4 (enacted in lieu of 426.290)]

(Competency and Discharge)

426.295 Judicial determination of competency; restoration of competency. (1) No person admitted to a state hospital for the treatment of mental illness shall be con-

sidered by virtue of the admission to be incompetent.

(2) Upon petition of a person committed to a state hospital, or the guardian, relative or creditor of the person or other interested person, the court of competent jurisdiction in the county in which the state hospital is located or, if the petitioner requests a hearing in the county where the commitment originated, then the court in such county shall hold a hearing to determine whether or not the person in the state hospital is competent. A guardian who is not the petitioner shall be notified of the hearing at least three days before the date set for hearing. After the hearing the court shall enter an order pursuant to its finding and serve a copy of the order on the petitioner and forward a copy of the order to the committing court.

(3) When a person committed to a state hospital has been declared incompetent pursuant to subsection (2) of this section and is discharged from the hospital, the superintendent of the hospital shall advise the court which entered the order of incompetency whether or not, in the opinion of the chief medical officer of the hospital on the basis of medical evidence, the person is competent. The superintendent shall make a reasonable effort to notify the discharged person of the advice to the court. If the court is advised that the person is competent, the court shall enter an order to that effect. If the court is advised that the person is not competent, upon petition of the person, the guardian, relative or creditor of the person or other interested person, the court shall hold a hearing to determine whether or not the discharged person is competent. The court shall serve a copy of any order entered pursuant to this subsection on the person and forward a copy of such order to the committing court. [1965 c.628 §2; 1967 c.460 §1; 1969 c.391 §7]

426.297 Payment of expenses for proceeding under ORS 426.295. (1) The expenses of a proceeding under ORS 426.295 (2) shall be paid by the person, unless it appears from the affidavit of the person or other evidence that the person is unable to pay the expenses. If the person is unable to pay, the expenses of the proceedings shall be paid by the county of which the mentally ill person was a resident at the time of admission. If the county of residence cannot be established, the county from which the person was admitted shall pay the expenses.

(2) The expenses of the proceeding under ORS 426.295 (3) shall be paid by the petitioner.

(3) Any physician employed by the court to make an examination as to the mental condition of a person subject to a competency proceeding under ORS 426.295 or 426.380 to 426.390 shall be allowed a reasonable professional fee by order of the court. Witnesses summoned and giving testimony shall receive the same fees as are paid in ORS 44.415 (2). [1967 c.460 §2; 1989 c.980 §14]

426.300 Discharge of patients; application for public assistance. (1) The Department of Human Services shall, by filing a written certificate with the last committing court and the court of residence, discharge any patient from court commitment, except one held upon an order of a court or judge having criminal jurisdiction in an action or proceeding arising out of criminal offense when in its opinion the individual is no longer a mentally ill person or when in its opinion the transfer of the individual to a voluntary status is in the best interest of the treatment of the patient.

(2) The department may sign applications for public assistance on behalf of those patients who may be eligible for public assistance. [Amended by 1963 c.325 §4; 1967 c.549 §8; 1973 c.838 §22; 1997 c.249 §137]

426.301 Release of committed patient; certification of continued mental illness; service of certificate; content; period of further commitment; effect of failure to protest further commitment. (1) At the end of the 180-day period of commitment, any person whose status has not been changed to voluntary shall be released unless the Department of Human Services certifies to the court in the county where the treating facility is located that the person is still mentally ill and in need of further treatment. The department, pursuant to its rules, may delegate to the director of the treating facility the responsibility for making the certification. The director of the treating facility shall consult with the community mental health and developmental disabilities program director of the county of residence prior to making the certification. If the certification is made, the person will not be released, but the director of the treating facility shall immediately issue a copy of the certification to the person and to the community mental health and developmental disabilities program director of the county of residence.

(2) The certification shall be served upon the person by the director of the facility wherein the person is confined or the designee of the director. The director of the facility shall inform the court in writing that service has been made and the date thereof.

(3) The certification shall advise the person of all the following:

(a) That the department or facility has requested that commitment be continued for an additional period of time.

(b) That the person may consult with legal counsel and that legal counsel will be provided for the person without cost if the person is unable to afford legal counsel.

(c) That the person may protest this further commitment within 14 days, and if the person does not commitment will be continued for an indefinite period of time up to 180 days.

(d) That if the person does protest a further period of commitment, the person is entitled to a hearing before the court on whether commitment should be continued.

(e) That the person may protest either orally or in writing by signing the form accompanying the certification; that the person is entitled to have a physician or other qualified person as recommended by the department, other than a member of the staff at the facility where the person is confined, examine the person and report to the court the results of the examination.

(f) That the person may subpoena witnesses and offer evidence on behalf of the person at the hearing.

(g) That if the person is without funds to retain legal counsel or an examining physician or qualified person as recommended by the department, the court will appoint legal counsel, a physician or other qualified person at no cost to the person.

(4) Nothing in subsection (3) of this section requires the giving of the warning under ORS 426.123.

(5) The person serving the certification shall read and deliver the certification to the person and ask whether the person protests a further period of commitment. The person may protest further commitment either orally or by signing a simple protest form to be given to the person with the certification. If the person does not protest a further period of commitment within 14 days of service of the certification, the department or facility shall so notify the court and the court shall, without further hearing, order the commitment of the person for an additional indefinite period of time up to 180 days. [1973 c.838 §15; 1975 c.690 §19; 1987 c.903 §32]

Note: The amendments to 426.301 by section 60, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.301. (1) At the end of the 180-day period of commitment, any person whose status has not been changed to voluntary shall be released unless the Department of Human Services certifies to the court in the county where the treating facility is located that the person is still mentally ill and in need of further treatment. The department, pursuant to its rules, may delegate to the director of the treating facility the responsibility for making the certification. The director of the treating facility shall consult with the community mental health and developmental disabilities program director of the county of residence prior to making the certification. If the certification is made, the person will not be released, but the director of the treating facility shall immediately issue a copy of the certification to the person and to the community mental health and developmental disabilities program director of the county of residence.

(2) The certification shall be served upon the person by the director of the facility wherein the person is confined or the designee of the director. The director of the facility shall inform the court in writing that service has been made and the date thereof.

(3) The certification shall advise the person of all the following:

(a) That the department or facility has requested that commitment be continued for an additional period of time.

(b) That the person may consult with legal counsel and that legal counsel will be provided for the person without cost if the person is unable to afford legal counsel.

(c) That the person may protest this further commitment within 14 days, and if the person does not commitment will be continued for an indefinite period of time up to 180 days.

(d) That if the person does protest a further period of commitment, the person is entitled to a hearing before the court on whether commitment should be continued.

(e) That the person may protest either orally or in writing by signing the form accompanying the certification; that the person is entitled to have a physician or other qualified person as recommended by the department, other than a member of the staff at the facility where the person is confined, examine the person and report to the court the results of the examination.

(f) That the person may subpoena witnesses and offer evidence on behalf of the person at the hearing.

(g) That if the person is without funds to retain legal counsel or an examining physician or qualified person as recommended by the department, the court will appoint legal counsel, a physician or other qualified person.

(4) Nothing in subsection (3) of this section requires the giving of the warning under ORS 426.123.

(5) The person serving the certification shall read and deliver the certification to the person and ask whether the person protests a further period of commitment. The person may protest further commitment either orally or by signing a simple protest form to be given to the person with the certification. If the person does not protest a further period of commitment within 14 days of service of the certification, the department or facility shall so notify the court and the court shall, without further hearing, order the commitment of the person for an additional indefinite period of time up to 180 days.

426.303 Effect of protest of further commitment; advice of court. When the person protests a further period of commitment the Department of Human Services or facility designated in accordance with ORS 426.301 shall immediately notify the court and the court shall have the person brought before it and shall again advise the person that the department or facility has requested that commitment be continued for an additional period of time and that if the person does not protest this commitment the commitment will be continued for an indefinite period of time up to 180 days. The person

shall also be informed of the rights set forth in ORS 426.301. [1973 c.838 §16; 1975 c.690 §20]

426.305 [1955 c.522 §4; 1963 c.325 §5; repealed by 1965 c.628 §3]

426.307 Court hearing; continuance; attorney; examination; determination of mental illness; order of further commitment; period of commitment. If the person requests a hearing under ORS 426.301 or if the court proceeds under ORS 426.275 (5), the following provisions apply as described:

(1) The hearing shall be conducted as promptly as possible and at a time and place as the court may direct.

(2) If the person requests a continuance in order to prepare for the hearing or to obtain legal counsel to represent the person, the court may grant postponement and detention during postponement as provided under ORS 426.095.

(3) The person has the right to representation by or appointment of counsel as provided under ORS 426.100 subject to ORS 135.055, 151.430 to 151.480 and applicable contracts entered into under ORS 151.460.

(4) If the person requests an examination by a physician or other qualified person as recommended by the Department of Human Services and is without funds to retain a physician or other qualified person for purposes of the examination, the court shall appoint a physician or other qualified person, other than a member of the staff from the facility where the person is confined, to examine the person at no expense to the person and to report to the court the results of the examination.

(5) The provisions of ORS 40.230, 40.235, 40.240 and 40.250 do not apply to the use of medical records from the current period of commitment or to testimony related to such records or period of commitment in connection with hearings under this section. The court may consider as evidence such reports and testimony.

(6) The court shall then conduct a hearing and after hearing the evidence and reviewing the recommendations of the treating and examining physicians or other qualified persons, the court shall determine whether the person is still a mentally ill person and in need of further treatment. If in the opinion of the court the individual is still a mentally ill person by clear and convincing evidence and in need of further treatment, the court may order commitment to the department for an additional indefinite period of time up to 180 days.

(7) At the end of the 180-day period, the person shall be released unless the department or facility again certifies to the committing court that the person is still a mentally ill person and in need of further treatment, in which event the procedures set forth in ORS 426.301 to 426.307 shall be followed. [1973 c.838 §17; 1975 c.690 §21; 1979 c.408 §5; 1987 c.803 §24; 1987 c.903 §§33,33a; 1989 c.171 §53; 1993 c.484 §24; 1997 c.649 §4]

Note: The amendments to 426.307 by section 61, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

426.307. If the person requests a hearing under ORS 426.301 or if the court proceeds under ORS 426.275 (5), the following provisions apply as described:

(1) The hearing shall be conducted as promptly as possible and at a time and place as the court may direct.

(2) If the person requests a continuance in order to prepare for the hearing or to obtain legal counsel to represent the person, the court may grant postponement and detention during postponement as provided under ORS 426.095.

(3) The person has the right to representation by or appointment of counsel as provided under ORS 426.100 subject to ORS 135.055, 151.216 and 151.219.

(4) If the person requests an examination by a physician or other qualified person as recommended by the Department of Human Services and is without funds to retain a physician or other qualified person for purposes of the examination, the court shall appoint a physician or other qualified person, other than a member of the staff from the facility where the person is confined, to examine the person at no expense to the person and to report to the court the results of the examination.

(5) The provisions of ORS 40.230, 40.235, 40.240 and 40.250 do not apply to the use of medical records from the current period of commitment or to testimony related to such records or period of commitment in connection with hearings under this section. The court may consider as evidence such reports and testimony.

(6) The court shall then conduct a hearing and after hearing the evidence and reviewing the recommendations of the treating and examining physicians or other qualified persons, the court shall determine whether the person is still a mentally ill person and in need of further treatment. If in the opinion of the court the individual is still a mentally ill person by clear and convincing evidence and in need of further treatment, the court may order commitment to the department for an additional indefinite period of time up to 180 days.

(7) At the end of the 180-day period, the person shall be released unless the department or facility again certifies to the committing court that the person is still a mentally ill person and in need of further treatment, in which event the procedures set forth in ORS 426.301 to 426.307 shall be followed.

426.309 Effect of ORS 426.217 and 426.301 to 426.307 on other discharge procedure. ORS 426.217 and 426.301 to 426.307 do not restrict or limit the discharge procedures set forth in ORS 426.300. [1973 c.838 §20]

(Miscellaneous)

426.310 Reimbursement of county in case of nonresident patients. (1) If the mentally ill person is a resident of some other county in this state, the county making the commitment shall be reimbursed by the county of which the person is a resident. All

reasonable and actual expenses incurred and paid by the county by reason of the care, custody, treatment, investigation examination and commitment hearing shall, upon presentation of a copy of the order of the judge making the examination and commitment, together with a properly itemized and certified claim covering the expense, be promptly paid to the county by the county of which the person was a resident. The expenses reimbursed under this subsection shall include any expenses incurred to pay for representation of the state's interest under ORS 426.100 and 426.250.

(2) If an allegedly mentally ill person is a resident of some other county in this state, a county attempting a commitment shall be reimbursed by the county of which the person is a resident, as defined in ORS 426.241, for all actual, reasonable expenses incurred and paid by the county attempting commitment by reason of the care, custody, treatment, investigation examination and commitment hearing. The expenses reimbursed under this subsection shall include any expenses incurred to pay for representation of the state's interest under ORS 426.100 and 426.250. [Amended by 1975 c.690 §22; 1977 c.764 §7; 1979 c.392 §2; 1987 c.903 §34]

426.320 Payment of certain expenses by the state. When a mentally ill person is assigned to or transferred to a state mental hospital, all actual and necessary expenses incurred by the agent or attendant from the state hospital and the assistants of the agent or attendant, together with those of the person for transportation to the hospital, shall be paid by the state in the manner provided in ORS 426.330. [Amended by 1975 c.690 §23]

426.330 Presentation and payment of claims. The special funds authorized for the use of the superintendents of the Oregon State Hospital, the Eastern Oregon Psychiatric Center and the Eastern Oregon Training Center to better enable them promptly to meet the advances and expenses necessary in the matter of transferring patients to the state hospitals are continued in existence. The superintendents shall present their claims monthly with proper vouchers attached, showing the expenditures from the special funds during the preceding month, which claims, when approved by the Department of Human Services, shall be paid by warrant upon the State Treasurer against the fund appropriated to cover the cost of transporting the mentally diseased. [Amended by 1975 c.614 §14; 1985 c.565 §67]

426.340 [Repealed by 1975 c.690 §28]

426.350 [Amended by 1961 c.152 §1; repealed by 1971 c.64 §12]

426.360 [1961 c.513 §§1,2,3; 1969 c.597 §92; 1971 c.655 §246; 1977 c.253 §40; repealed by 2001 c.900 §261]

426.370 Withholding information obtained in certain commitment or admission investigations. A community mental health and developmental disabilities program director or designee may withhold information obtained during an investigation under ORS 426.070, 426.228, 426.232, 426.233 or 426.234 if the community mental health and developmental disabilities program director determines:

(1) That information was not included in its investigation report or otherwise used in a material way to support a determination by the community mental health and developmental disabilities program director that there was probable cause to believe a person was a mentally ill person; and

(2) Release of the information would constitute a clear and immediate danger to any person. [1989 c.993 §6; 1993 c.484 §25]

Note: 426.370 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 426 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

426.375 [1967 c.460 §5; repealed by 1973 c.838 §29]

(Rights of Committed Persons)

426.380 Availability of writ of habeas corpus. Any individual committed pursuant to ORS 426.005 to 426.223 and 426.241 to 426.380 shall be entitled to the writ of habeas corpus upon proper petition by the individual or a friend to any court generally empowered to issue the writ of habeas corpus in the county in which the state hospital in which the person is detained is located. [1967 c.460 §6]

426.385 Rights of committed persons; notice of limitation of rights; consent for certain procedures; psychosurgery prohibited; mechanical restraints. (1) Every mentally ill person committed to the Department of Human Services shall have the right to:

(a) Communicate freely in person and by reasonable access to telephones;

(b) Send and receive sealed mail, except that this right may be limited for security reasons in state institutions as described in ORS 426.010;

(c) Wear the clothing of the person;

(d) Keep personal possessions, including toilet articles;

(e) Religious freedom;

(f) A private storage area with free access thereto;

(g) Be furnished with a reasonable supply of writing materials and stamps;

(h) A written treatment plan, kept current with the progress of the person;

(i) Be represented by counsel whenever the substantial rights of the person may be affected;

(j) Petition for a writ of habeas corpus;

(k) Not be required to perform routine labor tasks of the facility except those essential for treatment;

(L) Be given reasonable compensation for all work performed other than personal housekeeping duties;

(m) Such other rights as may be specified by rule; and

(n) Exercise all civil rights in the same manner and with the same effect as one not admitted to the facility, including, but not limited to, the right to dispose of real property, execute instruments, make purchases, enter contractual relationships, and vote, unless the person has been adjudicated incompetent and has not been restored to legal capacity. Disposal of personal property in possession of the person in a state institution described in ORS 426.010 is subject to limitation for security reasons.

(2)(a) A person must be immediately informed, verbally and in writing, of any limitation:

(A) Of the right to send or receive sealed mail under subsection (1)(b) of this section; or

(B) Regarding the disposal of personal property under subsection (1)(n) of this section.

(b) Any limitation under this subsection and the reasons for the limitation must be stated in the person's written treatment plan.

(c) The person has the right to challenge any limitation under this subsection pursuant to rules adopted by the department. The person must be informed, verbally and in writing, of this right.

(3) Mentally ill persons committed to the department shall have the right to be free from potentially unusual or hazardous treatment procedures, including convulsive therapy, unless they have given their express and informed consent or authorized the treatment pursuant to ORS 127.700 to 127.737. This right may be denied to such persons for good cause as defined in administrative rule only by the director of the facility in which the person is confined, but only after consultation with and approval of an independent examining physician. Any denial shall be entered into the patient's treatment record and shall include the reasons for the denial. No patient shall be subjected to psychosurgery, as defined in ORS 677.190 (22)(b).

(4) Mechanical restraints shall not be applied to a person admitted to a facility unless it is determined by the chief medical officer of the facility or designee to be required by the medical needs of the person. Every use of a mechanical restraint and the reasons therefor shall be made a part of the clinical record of the person over the signature of the chief medical officer of the facility or designee.

(5) Nothing in this section prevents the department from acting to exclude contraband from its facilities and to prevent possession or use of contraband in its facilities.

(6) As used in this section:

(a) "Contraband" has the meaning given that term in ORS 162.135.

(b) "Security reasons" means the protection of the mentally ill person from serious and immediate harm and the protection of others from threats or harassment as defined by rule of the department. [1967 c.460 §4; 1973 c.838 §28; 1981 c.372 §3; 1983 c.486 §1; 1993 c.442 §16; 1995 c.141 §1; 2001 c.104 §152]

426.390 Construction. Nothing in ORS 426.295, 426.297 and 426.380 to 426.390 is intended to detract from the powers of a court under ORS chapter 125 or ORS 179.640. [1967 c.460 §7; 1973 c.823 §137; 1995 c.664 §96]

426.395 Posting of statement of patient rights. A simple and clear statement of rights guaranteed to patients committed to the division shall be prominently posted in each room frequented by patients in all facilities housing such patients. A copy of the statement shall be given to each patient upon admission and sent, upon request, to the legal counsel, guardian, relative or friend of the patient. [1973 c.838 §31]

426.405 [1983 c.536 §1; repealed by 2001 c.900 §261]

426.407 [1983 c.536 §2; repealed by 2001 c.900 §261]

426.410 [1969 c.638 §1; repealed by 1975 c.690 §28]

(Licensing of Persons Who May Order Restraint or Seclusion)

426.415 Licensing of persons who may order and oversee use of restraint and seclusion in facilities providing mental health treatment to individuals under 21 years of age; rules. (1) The Director of Human Services may adopt rules establishing requirements and procedures for licensing persons who may order, monitor and evaluate the use of restraint and seclusion in facilities providing intensive mental health treatment services to individuals under 21 years of age.

(2) A license may not be issued or renewed under rules adopted under this section unless the person applying for the license or renewal:

(a) Is employed by or providing services under contract with a provider that is certified by the Department of Human Services to provide intensive mental health treatment services for individuals under 21 years of age;

(b) Has successfully completed an emergency safety intervention training program approved by the director;

(c) Provides documented evidence of the person's ability to assess the psychological and physical well-being of individuals under 21 years of age;

(d) Meets other qualifications established by the director by rule for qualified mental health professionals; and

(e) Demonstrates knowledge of federal and state rules governing the use of restraint and seclusion in intensive mental health treatment programs for individuals under 21 years of age.

(3) The rules described in subsection (1) of this section shall:

(a) Specify procedures for issuing and renewing licenses;

(b) Establish a term of licensure;

(c) Require a person issued a license to satisfy annual training requirements relating to emergency safety intervention procedures;

(d) Specify grounds for denial, suspension or revocation of a license;

(e) Set any license or renewal fees the director determines are necessary; and

(f) Specify any other licensing provisions the director determines are necessary to comply with federal law or regulations or to operate a licensing system described in this section. [2001 c.807 §1]

Note: 426.415 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 426 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

426.450 [1971 c.622 §6; renumbered 430.397 in 1995]

426.460 [1971 c.622 §7; 1973 c.795 §3; 1979 c.744 §22; 1981 c.809 §1; 1985 c.565 §68; renumbered 430.399 in 1995]

426.470 [1971 c.622 §8; renumbered 430.401 in 1995]

CHRONICALLY MENTALLY ILL PERSONS

(Generally)

426.490 Policy. It is declared to be the policy and intent of the Legislative Assembly that the State of Oregon shall assist in improving the quality of life of chronically mentally ill persons within this state by insuring the availability of an appropriate range of residential opportunities and related support services. [1979 c.784 §1]

Note: 426.490 to 426.500 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 426 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

426.495 Definitions for ORS 426.490 to 426.500. As used in ORS 426.490 to 426.500, unless the context requires otherwise:

(1) "Case manager" means a person who works on a continuing basis with the chronically mentally ill person and is responsible for assuring the continuity of the various services called for in the discharge plan of the chronically mentally ill person including services for basic personal maintenance, mental and personal treatment, and appropriate education and employment.

(2) "Chronically mentally ill" means an individual who is:

(a) Eighteen years of age or older; and

(b) Diagnosed by a psychiatrist, a licensed clinical psychologist or a nonmedical examiner certified by the Department of Human Services as suffering from chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder or another chronic psychotic mental disorder other than those caused by substance abuse. For purposes of providing services in the community, the department may adopt rules consistent with this section and accepted professional practices in the fields of psychology and psychiatry more specifically to specify other criteria for determining who is chronically mentally ill.

(3) "Discharge plan" means a written plan prepared jointly with the chronically mentally ill person, mental health staff and case manager prior to discharge, prescribing for the basic and special needs of the person upon release from the hospital. [1979 c.784 §2; 1987 c.903 §35]

Note: See note under 426.490.

426.500 Powers and duties of Department of Human Services. For the purpose of carrying out the policy and intent of ORS 426.490 to 426.500, the Department of Human Services shall:

(1) Adopt rules for the administration of ORS 426.490 to 426.500;

(2) Prepare a written discharge plan for each chronically mentally ill person who is a patient at a state mental institution or who is committed to the department pursuant to ORS 426.005 to 426.223 and 426.241 to 426.380;

(3) Ensure that case managers are provided for each chronically mentally ill person described in subsection (2) of this section; and

(4) Disburse from any available funds:

(a) Funds for one LINC model in the area served by F. H. Dammasch State Hospital

and one LINC model in the area served by the Oregon State Hospital licensed under ORS 443.415;

(b) Discretionary funds for services necessary to implement a discharge plan, including but not limited to transportation, medication, recreation and socialization; and

(c) Funds to provide day treatment services, community psychiatric inpatient services, and work activity services for chronically mentally ill persons where needed. [1979 c.784 §3; 1999 c.59 §121]

Note: See note under 426.490.

(Community Housing)

426.502 Definitions for ORS 426.502 to 426.508. As used in ORS 426.502 to 426.508:

(1) "Chronically mentally ill" has the meaning given that term in ORS 426.495.

(2) "Community housing" means property and related equipment that are used or could be used to house chronically mentally ill persons. "Community housing" includes only multiple-unit residential housing occupied by only chronically mentally ill persons.

(3) "Construct" means to build, install, assemble, expand, alter, convert, replace or relocate. "Construct" includes to install equipment and to prepare a site.

(4) "Department" means the Department of Human Services.

(5) "Equipment" means furnishings, fixtures or appliances that are used or could be used to provide care in community housing.

(6) "Multiple-unit residential housing" means housing that provides four or more living units and spaces for common use by the occupants in social and recreational activities. "Multiple-unit residential housing" may include nonhousing facilities incidental or appurtenant to the housing that, in the determination of the department, improve the quality of the housing. [1999 c.983 §2]

426.504 Authority of department to develop community housing for chronically mentally ill persons; sale of community housing; conditions. (1) The Department of Human Services may, through contract or otherwise, acquire, purchase, receive, hold, exchange, demolish, construct, lease, maintain, repair, replace, improve and equip community housing for the purpose of housing chronically mentally ill persons.

(2) The department may dispose of community housing acquired under subsection (1) of this section in a public or private sale, upon such terms and conditions as the department considers advisable to increase the quality and quantity of community housing available for chronically mentally ill persons. In any instrument conveying fee title to community housing, the department shall include language that restricts the use of the community housing to housing for chronically mentally ill persons. Such restriction is not a violation of ORS 93.270.

(3) When exercising the authority granted to the department under this section, the department is not subject to ORS chapter 273 or ORS 270.100 to 270.190, 276.900 to 276.915 or 279.800 to 279.833. [1999 c.983 §3]

426.506 Community Mental Health Housing Fund; Community Housing Trust Account; report. (1) There is created in the State Treasury, separate and distinct from the General Fund, the Community Mental Health Housing Fund. All earnings on investments of moneys in the Community Mental Health Housing Fund shall accrue to the fund. Interest earned on moneys in the fund shall be credited to the fund. All moneys in the fund are continuously appropriated to the Department of Human Services to carry out the provisions of ORS 426.504.

(2) The Community Mental Health Housing Fund shall be administered by the department to provide housing for chronically mentally ill persons. As used in this subsection, "housing" may include acquisition, maintenance, repair, furnishings and equipment.

(3)(a) There is established within the Community Mental Health Housing Fund a Community Housing Trust Account. Notwithstanding the provisions of ORS 270.150, the department shall deposit into the account the proceeds, less costs to the state, received by the department from the sale of F. H. Dammasch State Hospital property under ORS 426.508. The department may expend, for the purposes set forth in ORS 426.504, any earnings credited to the account, including any interest earned on moneys deposited in the account, and up to five percent of the sale proceeds initially credited to the account by the Oregon Department of Administrative Services. At least 95 percent of the sale proceeds shall remain in the account in perpetuity. Proceeds deposited in the account may not be commingled with proceeds from the sale of any surplus real property owned, operated or controlled by the Department of Human Services and used as a state training center.

(b) Interest earned on moneys in the Community Housing Trust Account may be expended in the following manner:

(A) Seventy percent of interest earned on deposits in the account shall be expended for community housing purposes; and

(B) Thirty percent of interest earned on deposits in the account shall be expended for institutional housing purposes.

(c) Interest earned on deposits in the account shall not be used to support operating expenses of the department.

(4) The Community Mental Health Housing Fund shall consist of:

(a) Moneys appropriated to the fund by the Legislative Assembly;

(b) Sale proceeds and earnings from the account under subsection (3) of this section;

(c) Proceeds from the sale, transfer or lease of any surplus real property owned, operated or controlled by the department and used as community housing;

(d) Moneys reallocated from other areas of the department's budget;

(e) Interest and earnings credited to the fund; and

(f) Gifts of money or other property from any source, to be used for the purposes of developing housing for chronically mentally ill persons.

(5) The department shall adopt policies:

(a) To establish priorities for the use of moneys in the Community Mental Health Housing Fund for the sole purpose of developing housing for chronically mentally ill persons;

(b) To match public and private moneys available from other sources for developing housing for chronically mentally ill persons; and

(c) To administer the fund in a manner that will not exceed the State Treasury's maximum cost per transaction.

(6) The Department of Human Services shall collaborate with the Housing and Community Services Department to ensure the highest return and best value for community housing from the Community Mental Health Housing Fund.

(7) The Department of Human Services shall provide a report of revenues to and expenditures from the Community Mental Health Housing Fund as part of its budget submission to the Governor and Legislative Assembly under ORS chapter 291. [1999 c.983 §4; 2001 c.954 §31]

426.508 Sale of F. H. Dammasch State Hospital; fair market value; redevelopment of property; property reserved for community housing. (1) Notwithstanding ORS 421.611 to 421.630 or any actions taken under ORS 421.611 to 421.630, the Department of Corrections shall transfer the real property known as the F. H. Dammasch State Hospital and all improvements to the Oregon Department of Administrative Services to be sold for the benefit of the Department of Human Services.

(2)(a) Notwithstanding ORS 270.100 to 270.190, and except as provided in subsection (4) of this section, the Oregon Department of Administrative Services shall sell or otherwise convey the real property known as the F. H. Dammasch State Hospital in a manner consistent with the provisions of this section. Conveyance shall not include transfer to a state agency. The sale price of the real property shall equal or exceed the fair market value of the real property. The Oregon Department of Administrative Services shall engage the services of a licensed real estate broker or principal real estate broker to facilitate the sale of the real property.

(b) The Oregon Department of Administrative Services shall retain from the sale or other conveyance of the real property those costs incurred by the state in selling or conveying the real property, including costs incurred by the Department of Corrections in transferring the real property to the Oregon Department of Administrative Services. The remaining proceeds from the sale or other conveyance shall be transferred to the Community Housing Trust Account created under ORS 426.506 (3).

(3) Redevelopment of the real property formerly occupied by the F. H. Dammasch State Hospital shall be consistent with the Dammasch Area Transportation Efficient Land Use Plan developed by Clackamas County, the City of Wilsonville, the Oregon Department of Administrative Services, the Department of Land Conservation and Development, the Department of Transportation, the State Housing Council, the Department of Human Services and the Division of State Lands.

(4) The Oregon Department of Administrative Services shall reserve from the sale of the real property under subsection (2) of this section not more than 10 acres. The real property reserved from sale shall be transferred to the Department of Human Services for use by the Department of Human Services to develop community housing for chronically mentally ill persons. The Oregon Department of Administrative Services and the Department of Human Services shall jointly coordinate with the City of Wilsonville to identify the real property reserved from sale under this subsection. [1999 c.983 §5; 2001 c.300 §76; 2001 c.900 §253]

Note: The amendments to 426.508 by section 76, chapter 300, Oregon Laws 2001, become operative July 1, 2002. See section 85, chapter 300, Oregon Laws 2001. The text that is operative until July 1, 2002, including amendments by section 253, chapter 900, Oregon Laws 2001, is set forth for the user's convenience.

426.508. (1) Notwithstanding ORS 421.611 to 421.630 or any actions taken under ORS 421.611 to 421.630, the Department of Corrections shall transfer the real property known as the F. H. Dammasch State Hospital and all improvements to the Oregon Department of Admin-

istrative Services to be sold for the benefit of the Department of Human Services.

(2)(a) Notwithstanding ORS 270.100 to 270.190, and except as provided in subsection (4) of this section, the Oregon Department of Administrative Services shall sell or otherwise convey the real property known as the F. H. Dammasch State Hospital in a manner consistent with the provisions of this section. Conveyance shall not include transfer to a state agency. The sale price of the real property shall equal or exceed the fair market value of the real property. The Oregon Department of Administrative Services shall engage the services of a licensed real estate broker or real estate organization to facilitate the sale of the real property.

(b) The Oregon Department of Administrative Services shall retain from the sale or other conveyance of the real property those costs incurred by the state in selling or conveying the real property, including costs incurred by the Department of Corrections in transferring the real property to the Oregon Department of Administrative Services. The remaining proceeds from the sale or other conveyance shall be transferred to the Community Housing Trust Account created under ORS 426.506 (3).

(3) Redevelopment of the real property formerly occupied by the F. H. Dammasch State Hospital shall be consistent with the Dammasch Area Transportation Efficient Land Use Plan developed by Clackamas County, the City of Wilsonville, the Oregon Department of Administrative Services, the Department of Land Conservation and Development, the Department of Transportation, the State Housing Council, the Department of Human Services and the Division of State Lands.

(4) The Oregon Department of Administrative Services shall reserve from the sale of the real property under subsection (2) of this section not more than 10 acres. The real property reserved from sale shall be transferred to the Department of Human Services for use by the Department of Human Services to develop community housing for chronically mentally ill persons. The Oregon Department of Administrative Services and the Department of Human Services shall jointly coordinate with the City of Wilsonville to identify the real property reserved from sale under this subsection.

SEXUALLY DANGEROUS PERSONS

426.510 "Sexually dangerous person" defined. As used in ORS 426.510 to 426.680, unless the context otherwise requires, "sexually dangerous person" means a person who because of repeated or compulsive acts of misconduct in sexual matters, or because of a mental disease or defect, is deemed likely to continue to perform such acts and be a danger to other persons. [1963 c.467 §1; 1977 c.377 §1]

426.520 [1963 c.467 §2; repealed by 1977 c.377 §6]

426.530 [1963 c.467 §3; 1971 c.743 §367; 1973 c.836 §349; repealed by 1977 c.377 §6]

426.540 [1963 c.467 §4; repealed by 1977 c.377 §6]

426.550 [1963 c.467 §5; repealed by 1977 c.377 §6]

426.560 [1963 c.467 §6; repealed by 1977 c.377 §6]

426.570 [1963 c.467 §7; 1973 c.836 §350; repealed by 1977 c.377 §6]

426.580 [1963 c.467 §§8,9; 1973 c.443 §1; repealed by 1977 c.377 §6]

426.590 [1963 c.467 §10; repealed by 1977 c.377 §6]

426.610 [1963 c.467 §11; 1973 c.443 §2; repealed by 1977 c.377 §6]

426.620 [1963 c.467 §12; repealed by 1977 c.377 §6]

426.630 [1963 c.467 §13; repealed by 1977 c.377 §6]

426.640 [1963 c.467 §14; 1973 c.443 §3; 1975 c.380 §8; repealed by 1977 c.377 §6]

426.650 Voluntary admission to state institution. (1) Pursuant to rules promulgated by the Department of Human Services, the superintendent of any state hospital for the treatment and care of the mentally ill may admit and hospitalize therein as a patient any person in need of medical or mental therapeutic treatment as a sexually dangerous person who voluntarily has made written application for such admission. No person under the age of 18 years shall be admitted as a patient to any such state hospital unless an application therefor in behalf of the person has been executed by the parent, adult next of kin or legal guardian of the person. Pursuant to rules and regulations of the department, no person voluntarily admitted to any state hospital shall be detained therein more than 72 hours after the person, if at least 18 years of age, has given notice in writing of desire to be discharged therefrom, or, if the patient is under the age of 18 years, after notice in writing has been given by the parent, adult next of kin or legal guardian of the person that such parent, adult next of kin or legal guardian desires that such person be discharged therefrom.

(2) Any person voluntarily admitted to a state facility pursuant to this section may upon application and notice to the superintendent of the institution concerned, be granted a temporary leave of absence from the institution if such leave, in the opinion of the chief medical officer, will not interfere with the successful treatment or examination of the applicant. [1963 c.467 §15; 1969 c.391 §8; 1973 c.443 §4; 1973 c.827 §43; 1974 c.36 §11]

426.660 [1963 c.467 §16; repealed by 1973 c.443 §5]

426.670 Treatment programs for sexually dangerous persons. The Department of Human Services hereby is directed and authorized to establish and operate treatment programs, either separately within an existing state Department of Corrections institution, as part of an existing program within a Department of Human Services institution, or in specified and approved sites in the community to receive, treat, study and retain in custody, as required, such sexually dangerous persons as are committed under ORS 426.510 to 426.670. [1963 c.467 §17; 1965 c.481 §1; 1979 c.606 §1; 1987 c.320 §230]

426.675 Determination of sexually dangerous persons; custody pending sentencing; hearing; sentencing; rules. (1) When a defendant has been convicted of a sexual offense under ORS 163.305 to 163.467 or 163.525 and there is probable cause to believe the defendant is a sexually dangerous

person, the court prior to imposing sentence may continue the time for sentencing and commit the defendant to a facility designated under ORS 426.670 for a period not to exceed 30 days for evaluation and report.

(2) If the facility reports to the court that the defendant is a sexually dangerous person and that treatment available may reduce the risk of future sexual offenses, the court shall hold a hearing to determine by clear and convincing evidence that the defendant is a sexually dangerous person. The state and the defendant shall have the right to call and cross-examine witnesses at such hearing. The defendant may waive the hearing required by this subsection.

(3) If the court finds that the defendant is a sexually dangerous person and that treatment is available which will reduce the risk of future sexual offenses, it may, in its discretion at the time of sentencing:

(a) Sentence the defendant to probation on the condition that the person participate in and successfully complete a treatment program for sexually dangerous persons pursuant to ORS 426.670;

(b) Impose a sentence of imprisonment with the order that the defendant be assigned by the Director of the Department of Corrections to participate in a treatment program for sexually dangerous persons pursuant to ORS 426.670. The Department of Corrections and Department of Human Services shall jointly adopt administrative rules to coordinate assignment and treatment of prisoners under this subsection; or

(c) Impose any other sentence authorized by law. [1977 c.377 §3; 1979 c.606 §2; 1987 c.320 §231; 1993 c.14 §24]

426.680 Trial visits for probationer. (1) The superintendent of the facility designated under ORS 426.670 to receive commitments for medical or mental therapeutic treatment of sexually dangerous persons may grant a trial visit to a defendant committed as a condition of probation where:

(a) The trial visit is not inconsistent with the terms and conditions of probation; and

(b) The trial visit is agreed to by the community mental health and developmental disabilities program director for the county in which the person would reside.

(2) Trial visit here shall correspond to trial visit as described in ORS 426.273 to 426.292, except that the length of a trial visit may be for the duration of the period of probation, subject to the consent of the sentencing court. [1973 c.443 §7; 1977 c.377 §4; 1985 c.242 §7]

426.700 [1973 c.616 §1; repealed by 1981 c.372 §2]

426.705 [1973 c.616 §2; repealed by 1981 c.372 §2]

426.710 [1973 c.616 §6; repealed by 1981 c.372 §2]

426.715 [1973 c.616 §7; repealed by 1981 c.372 §2]

426.720 [1973 c.616 §8; repealed by 1981 c.372 §2]

426.725 [1973 c.616 §9; repealed by 1981 c.372 §2]

426.730 [1973 c.616 §10; repealed by 1981 c.372 §2]

426.735 [1973 c.616 §11; repealed by 1981 c.372 §2]

426.740 [1973 c.616 §12; repealed by 1981 c.372 §2]

426.745 [1973 c.616 §§13,14,15; repealed by 1981 c.372 §2]

426.750 [1973 c.616 §3; repealed by 1981 c.372 §2]

426.755 [1973 c.616 §4; repealed by 1981 c.372 §2]

426.760 [1977 c.148 §5; repealed by 1981 c.372 §2]

Gold Award

A Model for Management and Treatment of Insanity Acquittees

Psychiatric Security Review Board, State of Oregon

In the mid 1970s, both the public and the mental health professions in Oregon were concerned about the threat to the public presented by persons found not guilty of crimes due to insanity who were released from psychiatric hospitals. In addition, the forensic unit of the state mental hospital was overcrowded with insanity acquittees, but there were few community programs to supervise or treat dangerous mentally ill offenders who might be released.

At the same time, increased attention to the rights of mentally ill patients in the 1960s and 1970s had led to due-process reforms that made it difficult to legally detain mentally ill persons. The state often used procedures for insanity acquittees similar to those used for civilly committed persons—short hospital stays with little or no community monitoring. Existing laws placed authority for disposition of insanity acquittees on the criminal courts, which often lacked the time, resources, or expertise to make informed judgments about an individual's clinical condition or dangerousness to others.

To address these problems, the state of Oregon in 1978 established the Psychiatric Security Review Board, an independent, interdisciplinary program for monitoring persons who are found guilty except for insanity and who are considered to present a substantial danger to others. In recognition of its commitment to improved integration of mental health services within the criminal justice system and its responsibility to community and societal values, the State of Oregon's Psychiatric Security Review Board was selected to receive the 1994 Gold Achievement Award from the Hospital and Community Psychiatry Service of the American Psychiatric Association. The award is presented each year to recognize outstanding programs for mentally ill and developmentally disabled persons. It includes a $10,000 prize made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals. The award was presented October 1 at the opening session of the 46th Institute on Hospital and Community Psychiatry in San Diego.

The primary purpose of the Psychiatric Security Review Board, which is the first program of its kind in the United States, is to protect society through the postadjudication management and treatment of insanity acquittees, almost all of whom are chronically mentally ill. The board assumes sole authority for determining whether persons assigned by the courts to its jurisdiction should be committed to the state hospital, granted conditional release or have conditional release revoked, or be discharged from the board's authority if they are no longer mentally ill and dangerous to others. Unless discharged early, an insanity acquittee remains under the board's jurisdiction for the maximum sentence that could have been received if the person had been convicted. The program's conditional release component provides a mechanism for reducing the number and length of costly inpatient stays.

The Psychiatric Security Review Board successfully bridges the mental health and criminal justice systems, while acting independently of both systems. Persons come under the jurisdiction of the board through the courts and are treated and supervised by staff from the mental health system. About 65 new persons are placed under the board's jurisdiction each year. Currently the board is responsible for about 500 people, 180 of whom are on conditional release. In a study of criminal recidivism among 366 subjects who were conditionally released between 1978 and 1986, only 15 percent were rearrested while on conditional release.

Oregon's Psychiatric Security Review Board has received highly favorable attention from national organizations, including the endorsements of the American Psychiatric Association and the National Alliance for the Mentally Ill. Two other states—Connecticut and Utah—have established review boards that substantially replicate the Oregon program. The board's continued vitality during a period of budget constraints, legal assaults on mental health systems, and public opinion favoring abolishment of the insanity defense attests to the confidence it has inspired among defense and prosecuting attorneys, judges, mental health professionals, and the citizens of Oregon.

Organization of the board

Oregon's Psychiatric Security Review Board functions independently of the court system and the Oregon Mental Health and Developmental Disability Services Division, although it closely coordinates its activities with the mental health division, which provides treatment to insanity acquittees.

The board effectively integrates the disciplines of law, psychiatry, psychology, and social work. By law, two of its five part-time members must be a psychiatrist and a psychologist experienced in the criminal justice system, one an experienced parole and probation officer, one an attorney experienced in criminal trial practice, and one a member of the general public. The psychiatrist and the psychologist cannot be employees of the state mental health division. The attorney cannot be a district attorney or public defender. The board members receive per diem expenses for their meetings.

Board members are appointed by the governor and confirmed by the state senate for four-year terms. The current members are George Saslow, M.D., Stephen Scherr, Ph.D., Kim Drake (parole and probation officer), Hilda Galaviz-Stoller, J.D., and Vern Faatz (public member).

The board has four staff positions—an executive director, two administrative assistants, and a secretary. Mary Claire Buckley, J.D., an attorney with mental health law experience in both civil and criminal commitments, serves as executive director. Staff duties include working with the staff of Oregon State Hospital in Salem, which provides inpatient services for persons under the board's jurisdiction; with members of the bar; with staff of community mental health agencies; and with victims and families of insanity acquittees.

The board operates on a biennial budget, with funds appropriated by the Oregon state legislature. Current funding, approved through mid-1995, for administrative costs associated with operation of the board is about $630,000 for the two-year period. The Oregon Mental Health and Developmental Disability Services Division provides the funds for community care of insanity acquittees on conditional release. The division contracts with public and private agencies to provide a range of mental health services.

The basic cost for community supervision of an insanity acquittee is about $5,000 per year. The cost for acquittees who need enhanced outpatient services is about $9,000 per year and for the few who need extensive residential placement services, about $33,000 per year. These totals compare with an annual cost of $60,130 for inpatient care.

The 1994 H&CP Achievement Award Winners

The American Psychiatric Association honored five outstanding mental health programs in an awards presentation on October 1 at the opening session of the 46th Institute on Hospital and Community Psychiatry in San Diego. The Psychiatric Security Review Board of the State of Oregon received the Gold Award and a $10,000 prize made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals.

Four programs received certificates of significant achievement. They are the Alternative Family Program of Gulf Coast Community Care in Clearwater, Florida, the Emory Autism Resource Center in Atlanta, Evolving Consumer Households of the Massachusetts Mental Health Center in Boston, and Independence Center in St. Louis.

The winning programs were chosen from among 52 applicants by the 1994 H&CP Achievement Awards board, which was chaired by Don R. Lipsett, M.D., of Cambridge, Massachusetts. The awards have been presented annually since 1949. Descriptions of this year's winning programs are included in this issue, beginning on page 1127.

Population served

Since the 1970s, the clinical characteristics of insanity acquittees have become increasingly homogeneous due to adoption of more restrictive definitions of the insanity defense. For example, in 1983 Oregon eliminated the insanity defense for people with a sole diagnosis of personality disorder. Most persons involved in a successful insanity defense have a diagnosis of a chronic mental illness, primarily schizophrenia or other psychosis, and have extensive past experience with both the mental health and the criminal justice systems. The persons for whom the board is responsible are often the sickest patients in the population of chronic mentally ill persons.

In a sample of 758 persons assigned to the jurisdiction of the Psychiatric Security Review Board between 1978 and 1986, almost 90 percent were men, and half were between the ages of 20 and 30. Most were white, in keeping with the ethnic distribution of Oregon's population. They were generally unemployed or underemployed and either lived alone, with family, or in protected settings.

More than three-quarters of the group had a previous state hospital stay. The group as a whole had a mean of 3.1 prior psychiatric hospitalizations, 59 percent of them involuntary. Psychosis accounted for 72 percent of diagnoses—60 percent of the group had a diagnosis of schizophrenia, and 7 percent had bipolar disorder. Eleven percent had a personality disorder, 8 percent had mental retardation, and 5 percent had organic mental disorders. Substance abuse disorders accounted for only 3 percent of primary diagnoses, but 27 percent of the group had substance abuse problems.

The group had extensive involvement with the criminal justice system—a mean of 5.5 police contacts per person—before being assigned to the board's jurisdiction. Seventy-seven percent of the sample had previously been charged with criminal offenses. Seventy-three percent were assigned to the board's jurisdiction after charges involving felonies, and 27 percent after misdemeanors. The most frequently occurring felonies were assaults, burglaries, and unauthorized use of motor vehicles. Harassment was the most frequently occurring misdemeanor. Cases resulting in death of another—murder or manslaughter—accounted for 4 percent of the crimes.

How the board operates

Board powers. The Psychiatric Security Review Board was created by 1977 legislation—Oregon Revised

statutes, Sections 161.319–161.351, 161.385–161.395 (1977)—which transferred legal responsibility for many acquittees from the trial courts to the board as of January 1, 1978. The statute specifies that the primary concern of the board is protection of the public and gives the board sole authority for determining the placement of persons assigned to its jurisdiction.

To counterbalance these stipulations, the law provided substantial legal safeguards to persons under the board's jurisdiction, including rights to periodic hearings, legal representation at all hearings, cross-examination, subpoena power, independent professional evaluation before hearings, and appeal of the board's decisions to the Oregon appellate courts.

A key innovation is development of a well-supervised conditional release for insanity acquittees that covers both the individual's readiness for release and the availability of supervision and treatment in the community. The system allows for protection of the civil liberty interests of insanity acquittees by developing treatment in the least restrictive setting that is appropriate for each acquittee. The board may promptly revoke conditional release if it receives reports that the individual has violated the release conditions or that the individual's mental status has deteriorated. However, once a person is discharged from the board's jurisdiction, neither the trial court nor the board has any continuing authority over that person.

The board is a state agency administratively located within the Department of Administrative Services. Because authority over insanity acquittees is centralized in the board, which has specialized knowledge of the patient population and the care available for them, the state's interest in consistent application of rules and resources can be more easily accommodated than when decisions are made by a diverse group of trial court judges.

Commitment to the board's jurisdiction. Insanity defense cases in Oregon use a standard to define insanity that is based on the American Law Institute test. In 1983 the state changed the name of the plea used for insanity defense cases from "not responsible due to mental disease or defect" to "guilty except for insanity." A successful insanity defense initiates the Psychiatric Security Review Board's procedures for managing insanity acquittees.

After a finding of guilty except for insanity, the trial judge decides if the evidence shows that the defendant continues to be affected by a mental disease or defect and if the person presents a substantial danger to others. If the answer to either question is no, the state's jurisdiction terminates and the defendant is discharged; however, this outcome is relatively rare. The vast majority are not set free but are subject to management by the Psychiatric Security Review Board, which includes the probability of confinement and close supervision for an extended period of time.

> Most persons involved in a successful insanity defense have a diagnosis of a chronic mental illness and extensive past experience with both the mental health and the criminal justice systems.

The trial court judge determines the maximum length of this period based on the sentence the individual would have received if found criminally responsible for the offense. This time period is known in Oregon as the "insanity sentence," which ranges from year for a misdemeanor to a lifetime for murder. The court may assign individuals with multiple charges to the board's jurisdiction for longer periods reflecting consecutive sentencing.

The trial judge also determines whether there is a victim of the defendant's crime and whether the victim wishes to be notified if the board decides that the insanity acquittee will be conditionally released or discharged or if the acquittee escapes from supervision. If so, the board must make reasonable efforts to notify the victim of these events. Finally, the trial court judge determines whether the insanity acquittee will be initially placed in the forensic unit of the state hospital or in the community on conditional release.

Hearings. Insanity acquittees serve their "insanity sentence" within the mental health system either in the state hospital or in the community in a monitored conditional release program. The Oregon statutes require the Psychiatric Security Review Board to conduct periodic hearings for each individual it supervises. Each person is eligible for a hearing every six months. Insanity acquittees, hospital staff, and staff of community monitoring agencies may also request hearings. The board conducts about 300 full hearings each year.

Hearings are held once a week at Oregon State Hospital. Relaxed rules of evidence provide a less stringent burden of proof than in civil commitment hearings and allow board members to consider proceedings of the acquittee's trial, information submitted by interested parties, and the acquittee's entire psychiatric and criminal history.

During the days before the hearings, the board's staff compiles and provides to board members documents about the case, which may consists of several hundred pages. Over the last five years, the board has become more efficient in conducting hearings by employing a case summary coordinator to computerize records and then to index them for board members.

At least three board members must be present for a hearing. The state is represented by an assistant attorney general or local district attorney. The insanity acquittee has a right to legal counsel, and indigent persons are provided counsel without cost. Psychiatrists, social workers, and psychologists from the state hospital staff testify regarding the acquittee's mental health status and progress. The acquittee is present and can subpoena and cross-examine witnesses. All hearings are recorded,

and the transcript constitutes the record if the person decides to appeal the board's decision to the appellate court.

The burden of proof on all issues is by a preponderance of the evidence. The state bears the burden of persuasion in all hearings except those held to consider an acquittee's application for change of status, in which the person must prove his or her suitability for release or discharge.

All three board members must vote unanimously for a decision to be made at the hearing. If a consensus decision cannot be reached, the case file and transcript of the hearing are referred to the two board members who were not present and three of the five members must concur. At the conclusion of the hearing, the board's chair or acting chair gives the insanity acquittee and the attorney written notification advising of the right to appeal an adverse decision within 60 days from the date an order is signed. The board must provide a written order within 15 days of the hearing.

The board also conducts administrative hearings in which an insanity acquittee's conditional release or treatment plan is reviewed or modified. The acquittee does not have to be present for such hearings.

Hospitalization, conditional release, and discharge. Hospital care for insanity acquittees is provided at the Oregon State Hospital forensic unit in Salem. Almost 525 of the 700 beds at the state hospital are devoted to patients under the board's jurisdiction. The patient's treatment plan is developed by hospital staff, but major alterations in the plan, such as off-campus passes, must be approved by the Psychiatric Security Review Board.

Some patients who are assigned to the board's jurisdiction cannot be released into the community under any foreseeable conditions. But for others, conditional release is a reasonable prospect, provided they are closely monitored and supervised by mental health programs in the community. Community programs for insanity acquittees have been influenced by many of the major reforms that took place in community mental health in general in the late 1970s and early 1980s, particularly a refocusing on the needs of chronic mentally ill patients who were being discharged from state mental hospitals. In 1981 Oregon legislation recognized chronic mentally ill people as the population with the highest priority for public mental health services and reorganized community mental health programs to emphasize support services for them. Within this reorganization, a separate component for community services for released insanity acquittees was created.

The patient, the patient's attorney, or hospital staff members may file a request for conditional release. A patient may request a hearing for the board to consider conditional release every six months. The board then has 60 days within which to set that hearing. Hospital staff may submit a request for conditional release of a patient at any time. Those hearings are set as soon as possible.

At the board's request, a community program conducts a thorough evaluation of each insanity acquittee being considered for release. State law prohibits conditional release until the community program, in cooperation with the board, develops a plan to provide adequate supervision and treatment. The conditional release plan constitutes an agreement among the board, the Mental Health and Developmental Disability Services Division, the community program, and the insanity acquittee. The plan includes provisions for living arrangements, mental health aftercare, and case management.

The plan may specify that the acquittee reside in a specific group home and not change residence without approval of the case manager. He or she may be required to take medication under observation of group home staff, to attend a day treatment program, and to submit to drug screening and medical monitoring. The plan may also stipulate additional conditions; for example, the person may be prohibited from driving, using alcohol or other drugs, or contacting certain persons.

The board designates a particular person, usually the case manager, to monitor the insanity acquittee's progress and make reports to the board monthly or at any time the conditions of the release are violated or the acquittee's mental status changes. In addition, any police contact with the conditionally released person, even if he or she is a victim of a crime, is immediately reported to the board via the law enforcement data system computer. The community program usually reports to the board by telephone if a problem arises requiring prompt board action. On receipt of such a report, the board or its chairperson may immediately issue a written order revoking conditional release. This order constitutes a sufficient warrant for the police to take the person into custody. The person may not be jailed, but must be transported to the state hospital.

The entire process from report to rehospitalization may be accomplished within a few hours. The board must then hold a hearing within 20 days to decide if the person should remain committed to the hospital, return to conditional release, or be discharged. Data on persons under the board's jurisdiction before 1986 showed that although more than half of those on conditional release had their release revoked within a year, only a few revocations were due to new criminal charges. Most occurred because of violations of conditions of release such as a requirement to take medication or refrain from using alcohol or because of deteriorating mental health.

Persons may be discharged from the board's jurisdiction while in the hospital or on conditional release. At any hearing, the board must discharge a person found to be no longer affected by mental disorder or no longer presenting a substantial danger to others. Thus both criteria—mental disease or defect and dangerousness—must be met for the board to retain jurisdiction. A person is automatically discharged after having been under the board's jurisdiction for the duration of the "insanity sentence." At the end of the insanity sentence, the state has the option of instituting civil commitment procedures to retain custody of a person believed to meet criteria for civil commitment.

Research on outcomes

The Psychiatric Security Review Board monitors its own performance as well as that of the insanity acquittees it supervises. Quality improvement mechanisms include a full financial audit done by the Secretary of State's audit division every four years and an internal quarterly review using a productivity matrix developed by the board's staff. Performance measures (and their averages since 1992) include percentage of hearings held within statutory time limits (85.7 percent), percentage of conditional releases maintained per month (95.7 percent), and percentage of revocations based on new felonies (1.7 percent).

The board's centralized record keeping system has provided opportunities for extensive research on the characteristics of the forensic population and on service outcomes. Joseph Bloom, M.D., professor and chairman of the department of psychiatry at Oregon Health Sciences University, and his colleagues Douglas A. Bigelow, Ph.D., Bentson H. McFarland, M.D., Ph.D., Jeffrey Rogers, J.D., and Mary H. Williams, M.S., J.D., have studied various aspects of the Psychiatric Security Review Board's operation since its inception. A study funded by the National Institute of Mental Health developed in-depth information about a cohort of 758 persons assigned to the board's jurisdiction between 1978 and 1986, including data on their management while under the board's jurisdiction and on their involvement with the mental health and criminal justice systems after discharge.

The results showed that the system tended to use conditional release conservatively, in keeping with its mandate to protect the public; 68 percent of the study sample spent their entire insanity sentence or the entire study period in the hospital. Women were more likely than men to be conditionally released, as were subjects with fewer past contacts with the mental health and criminal justice systems and less serious crimes leading to board jurisdiction. Subjects whose conditional release was revoked tended to be younger, to have more extensive histories of substance abuse and of contact with the mental health and criminal justice systems, and to have spent more time in the hospital before conditional release. Follow-up an average of 53 months after subjects were discharged from the board's jurisdiction showed a significant decrease in the number of criminal justice contacts per year compared with the period before subjects became the board's responsibility. Among subjects who were arrested after discharge from the board's jurisdiction, there was an overall decrease in the number of felonies and an increase in the number of misdemeanors, compared with the period before board jurisdiction.

Plans for the future

The Psychiatric Security Review Board intends to continue to seek ways to increase its efficiency without jeopardizing its effectiveness. Current plans include training in administrative law procedure for board members and advanced training in computer technology for staff.

Staff of the Psychiatric Security Review Board also plan to increase efforts to fight state budget cuts that may threaten the board's existence. Adequate funding for the program beyond 1995 is not assured, as the final phase of a state initiative limiting the use of property tax revenue for government operations will go into effect that year. Staff plan to work with community organizations such as the Friends of Forensic, consisting of people with relatives and friends under supervision of the board, and the National Alliance for the Mentally Ill to mobilize support for continuing the board's mission of protecting public safety while promoting cost-effective supervision and treatment of mentally ill persons who commit crimes.

For more information, contact Mary Claire Buckley, J.D., Executive Director, Psychiatric Security Review Board, 620 Southwest Fifth, Number 907, Portland, Oregon 97204; telephone, 503-229-5596.

Applications for 1995 Achievement Awards

The Hospital and Community Psychiatry Service of the American Psychiatric Association is now accepting applications for the 1995 Achievement Awards. The awards will be presented at the Institute on Psychiatric Services (the new name for the Institute on Hospital and Community Psychiatry), to be held October 6–10, 1995, in Boston. The deadline for receipt of applications is January 6, 1995.

The American Psychiatric Association presents the awards each year to recognize programs that have made an outstanding contribution to the mental health field, that provide a model for other programs, and that have met challenges presented by limited financial or staff resources or other significant obstacles.

The winner of the first prize, the Gold Award, receives a $10,000 grant from Roerig, a division of Pfizer Pharmaceuticals. If more than one program is chosen as a Gold Award winner, the programs share the grant. The winner of the Gold Award also receives a plaque, and the winners of Significant Achievement Awards receive certificates.

Applicants should submit six copies (including the original) of a completed application form and a program description. Each program that applies will be visited by a representative of the local district branch of the American Psychiatric Association. The site visitor's evaluation will assist the Achievement Awards board in selecting the winning programs.

Ricardo P. Mendoza, M.D., of Torrance, California, is chair of the 1995 Achievement Awards board. To receive an application form or additional information, write Achievement Awards, APA, 1400 K Street, N.W., Washington, D.C. 20005, or telephone 202-682-6174.

PSRB EPR ENTRY

0028 05/04/01 11:08 (54MF) ** PAGE 01 **

REUR 0027 LEDS
QLW.OR026035C.LNU/W093003945

*** NOT A WARRANT ***
PSYC SECURITY REVIEW BD-COND'L RELEASE (BASED ON LNU)
EPR OR026035C NAM/A_____ ,J____ L___ .M.W. .05-09-1960
HGT/508 WGT/145 EYE/BLU HAI/BRO
OCA/82-515
FBI/_____ SID/_____ SOC/_____
OLN/ .OR.2000
OFF/1399 OFN/ATT ASSAULT I RTP/PCR DOE/03-26-2008
MIS/---N0TIFY PRB 0F ALL INQUIRIES BY AM MSG---0R CALL L0CAL MENTAL HEALTH
W0RKER L____ C_____ AT 541-7__-2___ X592
ENT: 09-25-1998 AT 1625 FROM MF BY/PSYC SECURITY REVIEW B0ARD (PRB)
UPD: 04-27-2001 AT 1008 FROM PRB1
LNU/W093003945

-- IF ENFORCEMENT ACTION IS TAKEN AGAINST THIS PERSON SEND A MESSAGE TO 'PRB'

** NO MORE PAGES **

PSRB ORDER OF REVOCATION (EIP ENTRY) - RESPONSE TO WARRANTS CHECK

0014 05/04/01 10:47 (54MF) ** PAGE 01 **

REUR 0013 LEDS
QW.OR026035C.DOB/010140.NAM/TEST,PSRB

NO CRIMINAL WARRANT

PSYCHIATRIC SECURITY REVIEW BOARD ORDER FOR MANDATORY RETURN TO OREGON STATE HOSPITAL. AUTHORITY ORS 161.336 (5)

(BASED ON DOB,NAM)
EIP OR026035C NAM/TEST,PSRB .F.W.OR.01-01-1940
HGT/600 WGT/200 EYE/BRO HAI/BRO
OCA/01-TEST
DOR/05-07-2001 RTP/PRB
MIS/TEST ONLY--HIT CONFIRMATION 503-945-2800--TAKE TO OREGON STATE HOSPITAL
2600 CENTER ST NE SALEM
ENT: 05-04-2001 AT 1045 FROM PRB1 BY/PSYC SECURITY REVIEW BOARD (PRB)
LNU/W033426754

** NO MORE PAGES **

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PSRB MESSAGE SENT TO LAW ENFORCEMENT DISPATCH

009 05/04/01 10:55 (54MG)

0022 PRB OR026035C 05/04/01 10:55 (54MF)
OR PSYCHIATRIC RV BD

THE PSYCHIATRIC SECURITY REVIEW BOARD HAS ISSUED AN ORDER OF REVOCATION AS FOLLOWS:

PSYCHIATRIC SECURITY REVIEW BOARD ORDER FOR MANDATORY RETURN TO OREGON STATE HOSPITAL. AUTHORITY ORS 161.336 (5)

(BASED ON LNU)
EIP OR026035C NAM/TEST,PSRB .F.W.OR.01-01-1940
HGT/600 WGT/200 EYE/BRO HAI/BRO
OCA/01-TEST
DOR/05-07-2001 RTP/PRB
MIS/TEST ONLY--HIT CONFIRMATION 503-945-2800--TAKE TO OREGON STATE HOSPITAL
2600 CENTER ST NE SALEM
ENT: 05-04-2001 AT 1045 FROM PRB1 BY/PSYC SECURITY REVIEW BOARD (PRB)
LNU/W033426754

PLEASE ATTEMPT TO TAKE THE SUBJECT INTO CUSTODY AT 123 S.E. FOURTH, PORTLAND, THE FOURTH STREET GROUP HOME. THE STAFF TELEPHONE NUMBER AT THE GROUP HOME IS 503-222-3333. THE SUBJECT'S MENTAL HEALTH CASE MANAGER AT NETWORK IS JOHN DOE (503-111-5555). THE SUBJECT MUST BE TRANSPORTED TO OREGON STATE HOSPITAL, 2600 CENTER ST NE, SALEM, PER THE ABOVE ENTRY.

MARY CLAIRE BUCKLEY
PSYCHIATRIC SECURITY REVIEW BOARD
503-229-5596 (8AM-5PM WEEKDAYS) -- FOR AFTER HOURS HIT CONFIRMATION CALL OREGON STATE HOSPITAL AT 503-945-2800

EOT *** *** ***

ORS 161.336(6)

The community mental health and developmental disabilities program director, the director of the facility providing treatment to a person on conditional release, any peace officer or any person responsible for the supervision of a person on conditional release may take a person on conditional release into custody or request that the person be taken into custody if there is reasonable cause to believe the person is a substantial danger to others because of mental disease or defect and that the person is in need of immediate care, custody or treatment. Any person taken into custody pursuant to this subsection shall immediately be transported to a state hospital designated by the Mental Health and Developmental Disability Services Division. A person taken into custody under this subsection shall have the same rights as any person appearing before the board pursuant to ORS 161.346.

Oregon
John A. Kitzhaber, M.D., Governor

Psychiatric Security Review Board
620 SW Fifth, Suite 907
Portland, OR 97204
(503) 229-5596
FAX (503) 229-5085
E-mail psrb@OregonVOS.net

HISTORY AND FUNCTIONING

OF THE

PSYCHIATRIC SECURITY REVIEW BOARD

I. Oregon's "Not Guilty by Reason of Insanity" Defense prior to the Psychiatric Security Review Board

A. Prior to 1971 Legislature:

A person who pled not guilty to a crime due to mental disease or defect in Oregon (NGI-not guilty by reason of insanity), had the burden of proving by a preponderance of the evidence that he/she was unable to distinguish right from wrong as a consequence of mental disease or defect. (Modified M'Naughton Rule)

B. 1971-1975:

In 1971, the Oregon Legislature passed a new "NGI" statute which used the American Law Institute Model Penal Code (ALI) view of criminal responsibility. The accused was found not responsible if suffering from a mental disease or defect and lacking the substantial ability to understand the nature of the act or to conform the conduct to the requirements of the law. The trial court then had three alternatives: The court could commit the person found "NGI" to the Mental Health Division for care, custody and treatment at the Oregon State Hospital; the court could oversee the supervision of the person in a manner similar to court probation; or the person could be released from supervision by the court.

When the court committed the "NGI" person to the Mental Health Division, the person remained at the state hospital until such time as the superintendent recommended to the trial court that the person was ready for release. The trial court then would hold a hearing and, where appropriate, the court could release the "NGI" person subject to conditions. When release was not appropriate, the court issued a new order of commitment. In no case was an "NGI" case to go longer than five years without a hearing for review.

By 1975, in response to concerns voiced by mental health professionals and trial judges, two task forces were appointed to investigate Oregon's criminal responsibility law and the impact of this law on the mental health system and the corrections system. A legislative package which became Oregon House Bill 2382 was compiled with the aim of solving some of the problems inherent in the 1971 statute.

II. 1977: Creation of the Psychiatric Security Review Board

Prior to the enactment of House Bill 2382 (ORS Chapter 161) by the 1977 Legislature, the trial court had the mandate to continue supervising "NGI" persons after sentencing. The court had neither the funds available nor adequate personnel to provide the needed supervision. Judges quickly discovered that they were unable to spend the time necessary to track "NGI" persons who were in the community, while attempting to carry a trial judge's case load. This was clearly evident by the difficulty in obtaining and locating persons under the Board's jurisdiction once the law went into effect in January, 1978.

As of January 1, 1978, supervision of all currently adjudicated "NGI" persons was transferred from the court to the Board. Insanity defense cases in which the court found the person suffered from mental disease or defect and presented a substantial danger were put under the jurisdiction of the Psychiatric Security Review Board (PSRB). The Board works cooperatively with, but independently of, the judicial and mental health systems. The Board's jurisdiction over persons using the insanity defense runs from the day of sentencing and, unless terminated early, continues for the maximum period of time the person could have been sentenced had the person been found guilty of the crime charged. Sentencing guidelines do not apply to these cases. Jurisdiction would be terminated early if the client no longer suffered from a mental disease or defect or no longer presented a substantial danger to others. An individual under the Board's jurisdiction receives credit for time served pursuant to the charge; time spent on unauthorized leave from the state hospital is added on to the jurisdictional maximum.

III. Legislative Changes to the Insanity Defense Since Inception

A. 1981 Legislation:

1. The major change to the statute was the deletion of persons from the Board who were classified solely a "danger to self."

2. Also built into the original statute was a "sunset" provision which stated that unless the Legislature in the 1981 session took affirmative action, the PSRB would cease to function on July 1, 1981, and its responsibilities and jurisdiction in insanity cases would revert to the committing judges. The Board was continued by the 1981 Legislature.

B. 1983 Legislation:

Major changes were proposed to the insanity defense and although a few were made none altered the basic functioning of the Board. The following changes were made:

1. The nomenclature was changed from "not responsible due to mental disease or defect" to "guilty except for insanity." The name change did not affect the insanity defense itself.

2. The definition of mental disease or defect in ORS 161.295(2) presently does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, and the Legislature added "nor do they include any abnormality constituting solely a personality disorder."

3. ORS 162.155(1)(d) was amended to allow for extradition of a person under the jurisdiction of the Psychiatric Security Review Board who leaves the state without authorization of the Board.

4. Jury instructions were developed on the issue of insanity.

5. The district attorney of each county would submit to the state court administrator statistical records containing information relating to the assertion and trial of mental disease or defect defenses under ORS 161.295 and 161.305.

C. 1985 Legislation:

1. A person on conditional release who leaves the state without authorization may be prosecuted for escape in the second degree. This provision expands the scope of prosecution for the crime of escape in the second degree to those persons on conditional release.

2. If it has been more than two years since a person under the Board's jurisdiction has had a hearing in which the burden of proof was on the state, then the burden shall be on the state. Thus, persons who regularly request hearings will not be penalized for exercising their statutory rights.

D. 1987 Legislation:

1. The Board members' per diem was increased to $212 with adjustments according to the executive pay plan. It is currently $283.55.

2. The timing of a revocation hearing was changed to 20 days from the date the person is returned to the custody of the Mental Health Division. It had been 20 days from the date of the revocation order.

E. 1989 Legislation:

The five-year hearing for persons in the custody of the Mental Health Division was eliminated. Persons on conditional release continue to receive this statutory hearing. Individuals in the state hospital have a statutory hearing every two years.

F. 1991 Legislation:

The time period within which the Attorney General has to review a conditional release plan drafted by hospital and community staff for those PSRB clients seeking release from the hospital was shortened from not less than 30 days to not less than 20 days prior to PSRB hearing.

G. 1993 Legislation:

Sex offender registration requirements were expanded to include persons found guilty except for insanity of certain enumerated sex offenses. When a Psychiatric Security Review Board client is discharged or placed on conditional release, Board staff shall enter the person's name and description, the description of the methodology of the offense and the address where the person expects to reside into the Law Enforcement Data System (LEDS).

H. 1995 Legislation:

The time period within which a person found guilty except for insanity may file a notice of appeal of the trial court's determination was extended from 30 days to 90 days after the order is entered in the register.

I. 2001 Legislation:

The timing of the transport by local law enforcement of a revoked PSRB client to Oregon State Hospital in Salem was changed from "immediate" to "as soon as practicable" when the revocation of conditional release is initiated by a designated authority other than the Board at night or on a weekend. This amendment brings the particular subsection into conformity with the timing statutorily mandated when the revocation is initiated by the Board.

I. Functioning of the Psychiatric Security Review Board

A. Membership of Board and Staff:

By statute, the membership of the PSRB consists of a psychiatrist and a psychologist experienced in the criminal justice system, an experienced parole and probation officer, an attorney experienced in criminal trial practice, and a member of the general public. The five Board positions are appointed by the governor and confirmed by the Senate for four-year terms. A chair is elected for a one-year term.

The Board's staff consists of an Executive Director, two administrative assistants and a secretary. The Executive Director oversees the day-to-day operations of the staff, including the monitoring of PSRB clients on conditional release, preparing orders resulting from Board hearings and affidavits and orders for revocation of conditional release. Preparation and presentation of the budget and legislative matters are performed by the director. She serves as agency spokesperson, maintaining a professional dialogue with persons in the mental health and corrections systems.

B. Board Hearings:

When the Board conducts a hearing, the person appearing before the Board has the right to be represented by an attorney. If the person cannot afford counsel, an attorney will be appointed. Currently, there is an attorney under contract with the State Court Administrator's Office to handle these cases as most persons under the Board's jurisdiction are indigent. After hearing testimony and reviewing exhibits, the Board must determine by a preponderance of the evidence whether or not the person continues to be affected by a mental disease or defect and whether the person presents a substantial danger to others. The Board also considers whether the person is appropriate for conditional release and whether an adequate and verified conditional release plan is available.

The Board meets in panels of three on a weekly basis. Prior to the hearing day, voluminous exhibit files are sent to panel members for review. There are generally eight to twelve cases set per hearing day, which take an average of 30 minutes per hearing. In addition, the Board considers an average of four administrative matters. A typical day will include several initial hearings of new patients, several patient requests for discharge or conditional release, a revocation hearing and perhaps an outpatient supervisor or hospital request for hearing. There are also mandatory two- and five-year hearings.

C. Commitment and Timing of Hearings:

If the record and testimony sustain findings that the person continues to be affected by a mental disease or defect and presents a substantial danger to others the person is committed to a state hospital designated by the Mental Health Division for care, custody and treatment. If a client can be adequately controlled and treated and there is a

placement available, the client can be conditionally released to the community. After the initial hearing, which must be held within 90 days of hospitalization, the person may petition for release every six months. Board staff then has sixty days to schedule the hearing. Hospital staff may petition for a hearing request for discharge or conditional release at any time.

D. **Conditional Release and Revocation**:

When release is appropriate and a verified plan is approved by the Board, the person is ordered released from the state hospital subject to the Board's specific conditions. These Board conditions include:

1. An appropriate housing situation;

2. Mental health treatment and supervision;

3. The designation of a person who agrees to report monthly to the Board concerning the released person's progress and who also agrees to notify the Board's director immediately of any violations of the release conditions; and

4. Any other special conditions such as taking of Antabuse, abstaining from alcohol and drugs, or submitting to random drug screen tests.

Once the Board staff receives information indicating a violation of the conditional release plan or change in mental status, the chairperson or a member of the Board reviews the record and recommends revocation. In the case of an extreme emergency, the executive director may execute a revocation, verifying it with a Board member within 72 hours. A revocation consists of a "warrant" which orders the person's release revoked and further orders any peace officer within the state to serve the warrant and transport the person back to the Forensic Psychiatric Programs at Oregon State Hospital. Pursuant to ORS 161.336(5), the Board then conducts a due process hearing within 20 days of the person's return to the custody of the Mental Health Division. At the hearing the Board makes findings on the appropriateness of the revocation and whether conditional release should be continued after hearing the testimony of psychiatric experts and considering all of the evidence on the record.

Typical reasons for a revocation include: discontinuance of medications, failure to come in for mental health appointments, experiencing an uncontrollable change in mental health status, use of nonprescribed drugs or alcohol.

E. **Appeals**:

When the person believes that the court erred in placing the person under the jurisdiction of the Board, the person may appeal from the court's order within 90 days of the court's entering of the judgment order. The court's judgment order is a "final" order for purposes of appeal.

A person under the jurisdiction of the Board may also petition the Court of Appeals for judicial review of the Board's findings within 60 days of the entering of the Board's order following a hearing.

F. **Cost**:

The Psychiatric Security Review Board is a State agency and the Legislature funds both the functioning of the Board and the funding of the mental health treatment and supervision of the patients in the community. The cost of the Oregon system involves a budget for the 2001-03 biennium of $738,229 for Board functioning, hearings and staff.

The 2001-03 biennium legislative allotment for community treatment and supervision of PSRB patients on conditional release is approximately $3.1 million.

G. **Statistics**:

The Board is required by statute to maintain extensive records on each patient. Currently the Board has approximately 580 clients; 238 individuals reside in the community on conditional release. Close to 85% of the Board's clients are male. Seventy-five percent of placements under the Board are for felonies; primarily assaults and burglaries.

V. Summary

The Psychiatric Security Review Board has been the focus of international attention and study. An NBC white paper on "Crime and Insanity" shown on television in April 1983 focused on Oregon as a model system. In addition, the American Psychiatric Association statement on the insanity defense in December 1983 recommends the model system presently in operation in the State of Oregon under the aegis of the Psychiatric Security Review Board. The APA was impressed that:

> *Confinement and release decisions for acquittals are made by an experienced body that is not naive about the nature of violent behavior committed by mental patients and that allows a quasi-criminal approach for managing such persons. Psychiatrists participate in the work of the Oregon Board, but they do not have primary responsibility. The Association believes that this is as it should be since*

the decision to confine and release persons who have done violence to society involves more than psychiatric considerations. The interest of society, the interest of the criminal justice system and the interest of those who have been or might be victimized by violence must also be addressed in confinement and release decisions.

A report of the National Commission on the Insanity Defense issued in March 1983 and entitled "Myths and Realities", sponsored by the National Mental Health Association, recommends the adoption of a special statute to address the disposition of the acquittees after a finding of not responsible by reason of insanity of a violent crime. In that report, the National Commission also discusses the Oregon code creating the Psychiatric Security Review Board.

In 1989 the National Alliance for the Mentally Ill set goals and priorities which included the passing of statutes which provide improved systems for insanity acquittees, citing the Oregon Psychiatric Security Review Board as a model for such a statute.

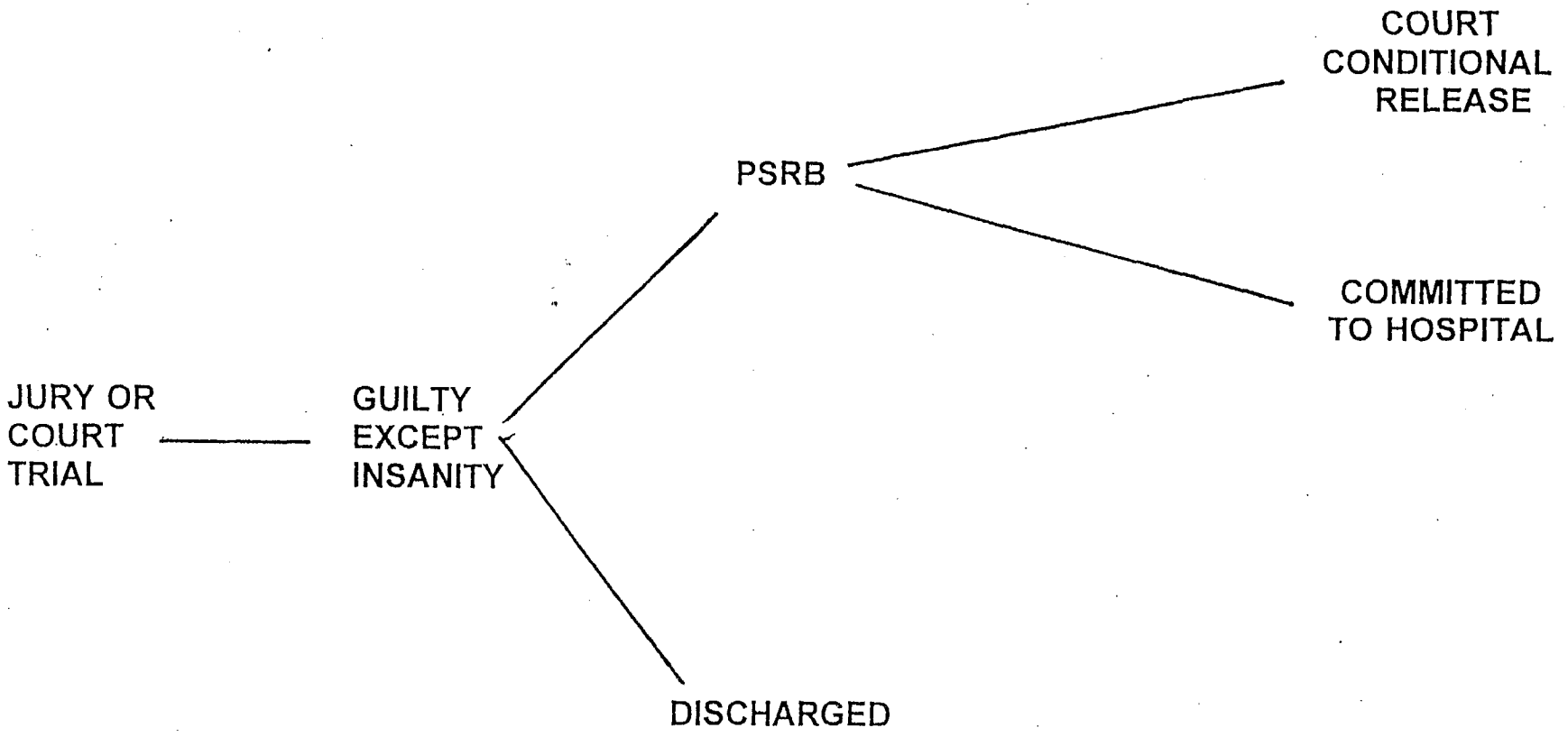
Most recently, the Psychiatric Security Review Board was named the APA's Hospital and Community Psychiatry's 1994 Gold Achievement Award winner. The award was given in recognition of the program's commitment to improved integration of mental health services within the criminal justice system and its responsibility to individual, community and societal values.

Oregon remains one of the states currently in the forefront of legal process in this area. Connecticut and Arizona have adopted the Oregon model. Other states, including Florida, Kentucky, Michigan, New Hampshire, and South Carolina have expressed an interest in this successful approach.

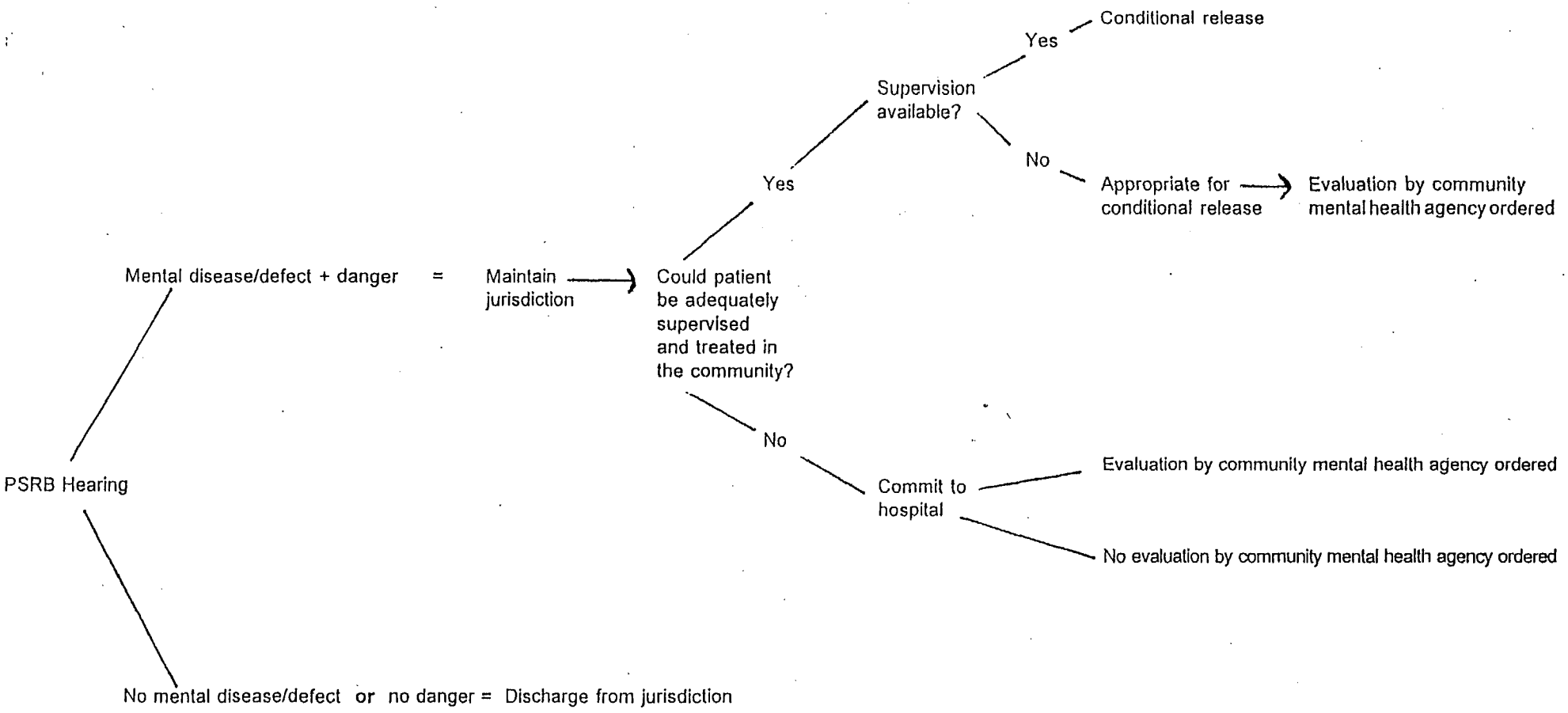
The insanity defense population will continue to be a part of our society. Oregon has chosen a unique approach by creating the Psychiatric Security Review Board which offers a multidisciplinary way of decision making. The Board's primary concern by statute is the protection of society. The system works well because of the ability of the Board to respond quickly to community emergencies and because the system balances the public's concern for safety, the treatment of persons in the community and the rights of the patients.

REVISED 10/01

COURT PROCESS - GUILTY EXCEPT INSANITY



PSRB HEARINGS PROCESS



Commitment to hospital - no further action until patient's next hearing
Evaluation - community mental health agency interviews patient to determine willingness to supervise
Appropriate for conditional release - could be adequately controlled and treated but need to put plan together
Conditional release - released to live in the community under close supervision

161.265 Use of physical force to prevent escape. A guard or other peace officer employed in a correctional facility, as that term is defined in ORS 162.135, is justified in using physical force including deadly physical force, when and to the extent that the guard or peace officer reasonably believes it necessary to prevent the escape of a prisoner from a correctional facility. [1971 c.743 §33]

161.270 Duress. (1) The commission of acts which would otherwise constitute an offense, other than murder, is not criminal if the actor engaged in the proscribed conduct because the actor was coerced to do so by the use or threatened use of unlawful physical force upon the actor or a third person, which force or threatened force was of such nature or degree to overcome earnest resistance.

(2) Duress is not a defense for one who intentionally or recklessly places oneself in a situation in which it is probable that one will be subjected to duress.

(3) It is not a defense that a spouse acted on the command of the other spouse, unless the spouse acted under such coercion as would establish a defense under subsection (1) of this section. [1971 c.743 §34; 1987 c.158 §22]

161.275 Entrapment. (1) The commission of acts which would otherwise constitute an offense is not criminal if the actor engaged in the proscribed conduct because the actor was induced to do so by a law enforcement official, or by a person acting in cooperation with a law enforcement official, for the purpose of obtaining evidence to be used against the actor in a criminal prosecution.

(2) As used in this section, "induced" means that the actor did not contemplate and would not otherwise have engaged in the proscribed conduct. Merely affording the actor an opportunity to commit an offense does not constitute entrapment. [1971 c.743 §35]

RESPONSIBILITY

161.290 Incapacity due to immaturity. (1) A person who is tried as an adult in a court of criminal jurisdiction is not criminally responsible for any conduct which occurred when the person was under 12 years of age.

(2) Incapacity due to immaturity, as defined in subsection (1) of this section, is a defense. [Formerly 161.380; 1995 c.422 §58]

161.295 Effect of mental disease or defect; guilty except for insanity. (1) A person is guilty except for insanity if, as a result of mental disease or defect at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.

(2) As used in chapter 743, Oregon Laws 1971, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor do they include any abnormality constituting solely a personality disorder. [1971 c.743 §36; 1983 c.800 §1]

Note: See note under 161.015.

161.300 Evidence of disease or defect admissible as to intent. Evidence that the actor suffered from a mental disease or defect is admissible whenever it is relevant to the issue of whether the actor did or did not have the intent which is an element of the crime. [1971 c.743 §37]

161.305 Disease or defect as affirmative defense. Mental disease or defect constituting insanity under ORS 161.295 is an affirmative defense. [1971 c.743 §38; 1983 c.800 §2]

161.309 Notice prerequisite to defense; content. (1) No evidence may be introduced by the defendant on the issue of insanity under ORS 161.295, unless the defendant gives notice of intent to do so in the manner provided in subsection (3) of this section.

(2) The defendant may not introduce in the case in chief expert testimony regarding partial responsibility under ORS 161.300 unless the defendant gives notice of intent to do so in the manner provided in subsection (3) of this section.

(3) A defendant who is required under subsection (1) or (2) of this section to give notice shall file a written notice of purpose at the time the defendant pleads not guilty. The defendant may file such notice at any time after the plea but before trial when just cause for failure to file the notice at the time of making the plea is made to appear to the satisfaction of the court. If the defendant fails to file notice, the defendant shall not be entitled to introduce evidence for the establishment of a defense under ORS 161.295 or 161.300 unless the court, in its discretion, permits such evidence to be introduced where just cause for failure to file the notice is made to appear. [1971 c.743 §§39,40,41; 1983 c.800 §3]

161.310 [Repealed by 1971 c.743 §432]

161.313 Jury instructions; insanity. When the issue of insanity under ORS 161.295 is submitted to be determined by a jury in the trial court, the court shall instruct the jury in accordance with ORS 161.327. [1983 c.800 §16]

161.315 Right of state to obtain mental examination of defendant; limitations. Upon filing of notice or the introduction of evidence by the defendant as provided in ORS 161.309 (3), the state shall have the

right to have at least one psychiatrist or licensed psychologist of its selection examine the defendant. The state shall file notice with the court of its intention to have the defendant examined. Upon filing of the notice, the court, in its discretion, may order the defendant committed to a state institution or any other suitable facility for observation and examination as it may designate for a period not to exceed 30 days. If the defendant objects to the examiner chosen by the state, the court for good cause shown may direct the state to select a different examiner. [1971 c.743 §42; 1977 c.380 §3]

161.319 Form of verdict on guilty except for insanity. When the defendant is found guilty except for insanity under ORS 161.295, the verdict and judgment shall so state. [1971 c.743 §43; 1977 c.380 §4; 1983 c.800 §4]

161.320 [Repealed by 1971 c.743 §432]

161.325 Entry of judgment of guilty except for insanity; order to include whether victim wants notice of hearings or release of defendant; blood or buccal testing upon judgment. (1) After entry of judgment of guilty except for insanity, the court shall, on the basis of the evidence given at the trial or at a separate hearing, if requested by either party, make an order as provided in ORS 161.327 or 161.329, whichever is appropriate.

(2) If the court makes an order as provided in ORS 161.327, it shall also:

(a) Determine on the record the offense of which the person otherwise would have been convicted; and

(b) Make specific findings on whether there is a victim of the crime for which the defendant has been found guilty except for insanity and, if so, whether the victim wishes to be notified, under ORS 161.326 (2), of any Psychiatric Security Review Board hearings concerning the defendant and of any conditional release, discharge or escape of the defendant.

(3) The court shall include any such findings in its order.

(4) Except under circumstances described in ORS 137.076 (4), whenever a defendant charged with any offense listed in ORS 137.076 (1) has been found guilty of that offense except for insanity, the court shall, in any order entered under ORS 161.327 or 161.329, direct the defendant to submit to the obtaining of a blood or buccal sample in the manner provided in ORS 137.076. [1971 c.743 §44; 1977 c.380 §5; 1979 c.885 §1; 1981 c.711 §1; 1983 c.800 §5; 1991 c.669 §8; 1999 c.97 §2]

161.326 Commission of crime by person under board jurisdiction; notice to victim. (1) Whenever a person already under the board's jurisdiction commits a new crime, the court or the board shall make the findings described in ORS 161.325 (2).

(2) If the trial court or the board determines that a victim desires notification as described in ORS 161.325 (2), the board shall make a reasonable effort to notify the victim of board hearings, conditional release, discharge or escape. [1981 c.711 §9]

Note: 161.326 and 161.387 were added to and made a part of ORS chapter 161 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

161.327 Order giving jurisdiction to Psychiatric Security Review Board; court to commit or conditionally release defendant; notice to board; appeal. (1) Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person would have been guilty of a felony, or of a misdemeanor during a criminal episode in the course of which the person caused physical injury or risk of physical injury to another, and if the court finds by a preponderance of the evidence that the person is affected by mental disease or defect and presents a substantial danger to others requiring commitment to a state mental hospital designated by the Department of Human Services or conditional release, the court shall order the person placed under the jurisdiction of the Psychiatric Security Review Board for care and treatment. The period of jurisdiction of the board shall be equal to the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(2) The court shall determine whether the person should be committed to a state hospital designated by the Department of Human Services or conditionally released pending any hearing before the board as follows:

(a) If the court finds that the person presents a substantial danger to others and is not a proper subject for conditional release, the court shall order the person committed to a state hospital designated by the Department of Human Services for custody, care and treatment pending hearing before the board in accordance with ORS 161.341 to 161.351.

(b) If the court finds that the person presents a substantial danger to others but that the person can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the court may order the person conditionally released, subject to those supervisory orders of the court as are in the best interests of justice, the protection of society and the welfare of the person. The court shall designate a person or state,

county or local agency to supervise the person upon release, subject to those conditions as the court directs in the order for conditional release. Prior to the designation, the court shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the court. After receiving an order entered under this paragraph, the person or agency designated shall assume supervision of the person pursuant to the direction of the Psychiatric Security Review Board. The person or agency designated as supervisor shall be required to report in writing no less than once per month to the board concerning the supervised person's compliance with the conditions of release.

(3) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others.

(4) In determining whether a person should be conditionally released, the court may order evaluations, examinations and compliance as provided in ORS 161.336 (4) and 161.346 (2).

(5) In determining whether a person should be committed to a state hospital or conditionally released, the court shall have as its primary concern the protection of society.

(6) Upon placing a person on conditional release, the court shall notify the board in writing of the court's conditional release order, the supervisor appointed, and all other conditions of release, and the person shall be on conditional release pending hearing before the board in accordance with ORS 161.336 to 161.351. Upon compliance with this subsection and subsections (1) and (2) of this section, the court's jurisdiction over the person is terminated and the board assumes jurisdiction over the person.

(7) An order of the court under this section is a final order appealable by the person found guilty except for insanity in accordance with ORS 19.205 (4). Notwithstanding ORS 19.255, notice of an appeal under this section shall be served and filed within 90 days after the order appealed from is entered in the register. The person shall be entitled on appeal to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is indigent, suitable counsel shall be appointed in the manner provided in ORS 138.500 (1), and the compensation for counsel and costs and expenses of the person necessary to the appeal shall be determined, allowed and paid as provided in ORS 138.500.

(8) Upon placing a person under the jurisdiction of the board, the court shall notify the person of the right to appeal and the right to a hearing before the board in accordance with ORS 161.336 (7) and 161.341 (4).

[1979 c.867 §5; 1979 c.885 §2; 1981 c.711 §2; 1981 s.s. c.3 §129; 1983 c.800 §6; 1989 c.790 §48; 1995 c.208 §1]

Note: The amendments to 161.327 by section 88, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

161.327. (1) Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person would have been guilty of a felony, or of a misdemeanor during a criminal episode in the course of which the person caused physical injury or risk of physical injury to another, and if the court finds by a preponderance of the evidence that the person is affected by mental disease or defect and presents a substantial danger to others requiring commitment to a state mental hospital designated by the Department of Human Services or conditional release, the court shall order the person placed under the jurisdiction of the Psychiatric Security Review Board for care and treatment. The period of jurisdiction of the board shall be equal to the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(2) The court shall determine whether the person should be committed to a state hospital designated by the Department of Human Services or conditionally released pending any hearing before the board as follows:

(a) If the court finds that the person presents a substantial danger to others and is not a proper subject for conditional release, the court shall order the person committed to a state hospital designated by the Department of Human Services for custody, care and treatment pending hearing before the board in accordance with ORS 161.341 to 161.351.

(b) If the court finds that the person presents a substantial danger to others but that the person can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the court may order the person conditionally released, subject to those supervisory orders of the court as are in the best interests of justice, the protection of society and the welfare of the person. The court shall designate a person or state, county or local agency to supervise the person upon release, subject to those conditions as the court directs in the order for conditional release. Prior to the designation, the court shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the court. After receiving an order entered under this paragraph, the person or agency designated shall assume supervision of the person pursuant to the direction of the Psychiatric Security Review Board. The person or agency designated as supervisor shall be required to report in writing no less than once per month to the board concerning the supervised person's compliance with the conditions of release.

(3) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others.

(4) In determining whether a person should be conditionally released, the court may order evaluations,

examinations and compliance as provided in ORS 161.336 (4) and 161.346 (2).

(5) In determining whether a person should be committed to a state hospital or conditionally released, the court shall have as its primary concern the protection of society.

(6) Upon placing a person on conditional release, the court shall notify the board in writing of the court's conditional release order, the supervisor appointed, and all other conditions of release, and the person shall be on conditional release pending hearing before the board in accordance with ORS 161.336 to 161.351. Upon compliance with this subsection and subsections (1) and (2) of this section, the court's jurisdiction over the person is terminated and the board assumes jurisdiction over the person.

(7) An order of the court under this section is a final order appealable by the person found guilty except for insanity in accordance with ORS 19.205 (4). Notwithstanding ORS 19.255, notice of an appeal under this section shall be served and filed within 90 days after the order appealed from is entered in the register. The person shall be entitled on appeal to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is financially eligible, suitable counsel shall be appointed in the manner provided in ORS 138.500 (1), and the compensation for counsel and costs and expenses of the person necessary to the appeal shall be determined and paid as provided in ORS 138.500.

(8) Upon placing a person under the jurisdiction of the board, the court shall notify the person of the right to appeal and the right to a hearing before the board in accordance with ORS 161.336 (7) and 161.341 (4).

Note: 161.327 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

161.328 Initiation of civil commitment proceedings. Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person would have been guilty of a misdemeanor during a criminal episode in the course of which the person did not cause physical injury or risk of physical injury to another, and if the court has probable cause to believe that the person is dangerous to self or others as a result of a mental disorder, the court may initiate civil commitment proceedings under ORS 426.070 to 426.130. [1981 c.711 §3; 1983 c.800 §7; 1987 c.903 §36; 1995 c.529 §1]

161.329 Order of discharge. Following the entry of a judgment pursuant to ORS 161.319 and the dispositional determination under ORS 161.325, if the court finds that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others and is not in need of care, supervision or treatment, the court shall order the person discharged from custody. [1971 c.743 §45; 1977 c.380 §6; 1981 c.711 §4]

161.330 [Repealed by 1971 c.743 §432]

161.332 "Conditional release" defined. As used in ORS 161.315 to 161.351 and 161.385 to 161.395, "conditional release" includes, but is not limited to, the monitoring of mental and physical health treatment. [1977 c.380 §1; 1983 c.800 §8]

161.335 [1971 c.743 §46; 1973 c.137 §1; 1975 c.380 §1; repealed by 1977 c.380 §10 (161.336 enacted in lieu of 161.335)]

161.336 Conditional release by Psychiatric Security Review Board; supervision by board; termination or modification of conditional release; hearing. (1) If the board determines that the person presents a substantial danger to others but can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the board may order the person conditionally released, subject to those supervisory orders of the board as are in the best interests of justice, the protection of society and the welfare of the person. The board may designate any person or state, county or local agency the board considers capable of supervising the person upon release, subject to those conditions as the board directs in the order for conditional release. Prior to the designation, the board shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the board. After receiving an order entered under this section, the person or agency designated shall assume supervision of the person pursuant to the direction of the board.

(2) Conditions of release contained in orders entered under this section may be modified from time to time and conditional releases may be terminated by order of the board as provided in ORS 161.351.

(3) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect requiring supervision when the disease may, with reasonable medical probability, occasionally become active and, when active, render the person a danger to others. The person may be continued on conditional release by the board as provided in this section.

(4)(a) As a condition of release, the board may require the person to report to any state or local mental health facility for evaluation. Whenever medical, psychiatric or psychological treatment is recommended, the board may order the person, as a condition of release, to cooperate with and accept the treatment from the facility.

(b) The facility to which the person has been referred for evaluation shall perform the evaluation and submit a written report

of its findings to the board. If the facility finds that treatment of the person is appropriate, it shall include its recommendations for treatment in the report to the board.

(c) Whenever treatment is provided by the facility, it shall furnish reports to the board on a regular basis concerning the progress of the person.

(d) Copies of all reports submitted to the board pursuant to this section shall be furnished to the person and the person's counsel. The confidentiality of these reports shall be determined pursuant to ORS 192.501 to 192.505.

(e) The facility shall comply with any other conditions of release prescribed by order of the board.

(5) If at any time while the person is under the jurisdiction of the board it appears to the board or its chairperson that the person has violated the terms of the conditional release or that the mental health of the individual has changed, the board or its chairperson may order the person returned to a state hospital designated by the Department of Human Services for evaluation or treatment. A written order of the board, or its chairperson on behalf of the board, is sufficient warrant for any law enforcement officer to take into custody such person and transport the person accordingly. A sheriff, municipal police officer, constable, parole or probation officer, prison official or other peace officer shall execute the order, and the person shall be returned as soon as practicable to the custody of the Department of Human Services. Within 20 days following the return of the person to the custody of the Department of Human Services, the board shall conduct a hearing. Notice of the time and place of the hearing shall be given to the person, the attorney representing the person and the Attorney General. The board may continue the person on conditional release or, if it finds by a preponderance of the evidence that the person is affected by mental disease or defect and presents a substantial danger to others and cannot be adequately controlled if conditional release is continued, it may order the person committed to a state hospital designated by the Department of Human Services. The state must prove by a preponderance of the evidence the person's unfitness for conditional release. A person in custody pursuant to this subsection shall have the same rights as any person appearing before the board pursuant to ORS 161.346.

(6) The community mental health and developmental disabilities program director, the director of the facility providing treatment to a person on conditional release, any peace officer or any person responsible for the supervision of a person on conditional release may take a person on conditional release into custody or request that the person be taken into custody if there is reasonable cause to believe the person is a substantial danger to others because of mental disease or defect and that the person is in need of immediate care, custody or treatment. Any person taken into custody pursuant to this subsection shall be transported as soon as practicable to a state hospital designated by the Department of Human Services. A person taken into custody under this subsection shall have the same rights as any person appearing before the board pursuant to ORS 161.346.

(7)(a) Any person conditionally released under this section may apply to the board for discharge from or modification of an order of conditional release on the ground that the person is no longer affected by mental disease or defect or, if still so affected, no longer presents a substantial danger to others and no longer requires supervision, medication, care or treatment. Notice of the hearing on an application for discharge or modification of an order of conditional release shall be made to the Attorney General. The applicant, at the hearing pursuant to this subsection, must prove by a preponderance of the evidence the applicant's fitness for discharge or modification of the order of conditional release. Applications by the person for discharge or modification of conditional release shall not be filed more often than once every six months.

(b) Upon application by any person or agency responsible for supervision or treatment pursuant to an order of conditional release, the board shall conduct a hearing to determine if the conditions of release shall be continued, modified or terminated. The application shall be accompanied by a report setting forth the facts supporting the application.

(8) The total period of commitment and conditional release ordered pursuant to this section shall not exceed the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(9) The board shall maintain and keep current the medical, social and criminal history of all persons committed to its jurisdiction. The confidentiality of records maintained by the board shall be determined pursuant to ORS 192.501 to 192.505.

(10) In determining whether a person should be committed to a state hospital, conditionally released or discharged, the board shall have as its primary concern the protection of society. [1977 c.380 §11 (enacted in lieu

of 161.335); 1979 c.885 §3; 1981 c.711 §5; 1983 c.800 §9; 1987 c.140 §1; 1989 c.790 §49; 2001 c.326 §1]

161.340 [1971 c.743 §47; 1975 c.380 §2; repealed by 1977 c.380 §12 (161.341 enacted in lieu of 161.340)]

161.341 Order of commitment; application for discharge or conditional release; release plan. (1) If the board finds, upon its initial hearing, that the person presents a substantial danger to others and is not a proper subject for conditional release, the board shall order the person committed to, or retained in, a state hospital designated by the Department of Human Services for custody, care and treatment. The period of commitment ordered by the board shall not exceed the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

(2) If at any time after the commitment of a person to a state hospital designated by the Department of Human Services under this section, the superintendent of the hospital is of the opinion that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others or that the person continues to be affected by mental disease or defect and continues to be a danger to others, but that the person can be controlled with proper care, medication, supervision and treatment if conditionally released, the superintendent shall apply to the board for an order of discharge or conditional release. The application shall be accompanied by a report setting forth the facts supporting the opinion of the superintendent. If the application is for conditional release, the application must also be accompanied by a verified conditional release plan. The board shall hold a hearing on the application within 60 days of its receipt. Not less than 20 days prior to the hearing before the board, copies of the report shall be sent to the Attorney General.

(3) The attorney representing the state may choose a psychiatrist or licensed psychologist to examine the person prior to the initial or any later decision by the board on discharge or conditional release. The results of the examination shall be in writing and filed with the board, and shall include, but need not be limited to, an opinion as to the mental condition of the person, whether the person presents a substantial danger to others and whether the person could be adequately controlled with treatment as a condition of release.

(4) Any person who has been committed to a state hospital designated by the Department of Human Services for custody, care and treatment or another person acting on the person's behalf may apply to the board for an order of discharge or conditional release upon the grounds:

(a) That the person is no longer affected by mental disease or defect;

(b) If so affected, that the person no longer presents a substantial danger to others; or

(c) That the person continues to be affected by a mental disease or defect and would continue to be a danger to others without treatment, but that the person can be adequately controlled and given proper care and treatment if placed on conditional release.

(5) When application is made under subsection (4) of this section, the board shall require a report from the superintendent of the hospital which shall be prepared and transmitted as provided in subsection (2) of this section. The applicant must prove by a preponderance of the evidence the applicant's fitness for discharge or conditional release under the standards of subsection (4) of this section, unless more than two years has passed since the state had the burden of proof on that issue, in which case the state shall have the burden of proving by a preponderance of the evidence the applicant's lack of fitness for discharge or conditional release. Applications for discharge or conditional release under subsection (4) of this section shall not be filed more often than once every six months commencing with the date of the initial board hearing.

(6) The board is not required to hold a hearing on a first application under subsection (4) of this section any sooner than 90 days after the initial hearing. However, hearings resulting from any subsequent requests shall be held within 60 days of the filing of the application.

(7)(a) In no case shall any person committed by the court under ORS 161.327 to a state hospital designated by the Department of Human Services be held in the hospital for more than 90 days from the date of the court's commitment order without an initial hearing before the board to determine whether the person should be conditionally released or discharged.

(b) In no case shall a person be held pursuant to this section for a period of time exceeding two years without a hearing before the board to determine whether the person should be conditionally released or discharged. [1977 c.380 §13 (enacted in lieu of 161.340); 1979 c.885 §4; 1981 c.711 §6; 1983 c.800 §10; 1985 c.192 §3; 1989 c.790 §50; 1991 c.244 §1]

161.345 [1971 c.743 §48; repealed by 1977 c.380 §14 (161.346 enacted in lieu of 161.345)]

161.346 Hearings on discharge, conditional release, commitment or modification; psychiatric reports; notice of hearing. (1) The board shall conduct hearings upon any application for discharge, conditional release, commitment or modification filed pursuant to ORS 161.336, 161.341 or 161.351 and as otherwise required by ORS 161.336 to 161.351 and shall make findings on the issues before it which may include:

(a) If the board finds that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others, the board shall order the person discharged from commitment or from conditional release.

(b) If the board finds that the person is still affected by a mental disease or defect and is a substantial danger to others, but can be controlled adequately if conditionally released with treatment as a condition of release, the board shall order the person conditionally released as provided in ORS 161.336.

(c) If the board finds that the person has not recovered from the mental disease or defect and is a substantial danger to others and cannot adequately be controlled if conditionally released on supervision, the board shall order the person committed to, or retained in, a state hospital designated by the Department of Human Services for care, custody and treatment.

(2) At any time, the board may appoint a psychiatrist or licensed psychologist to examine the person and to submit a report to the board. Reports filed with the board pursuant to the examination shall include, but need not be limited to, an opinion as to the mental condition of the person and whether the person presents a substantial danger to others, and whether the person could be adequately controlled with treatment as a condition of release. To facilitate the examination of the person, the board may order the person placed in the temporary custody of any state hospital or other suitable facility.

(3) The board may make the determination regarding discharge or conditional release based upon the written reports submitted pursuant to this section. If any member of the board desires further information from the examining psychiatrist or licensed psychologist who submitted the report, these persons shall be summoned by the board to give testimony. The board shall consider all evidence available to it which is material, relevant and reliable regarding the issues before the board. Such evidence may include but is not limited to the record of trial, the information supplied by the attorney representing the state or by any other interested party, including the person, and information concerning the person's mental condition and the entire psychiatric and criminal history of the person. All evidence of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs shall be admissible at hearings. Testimony shall be taken upon oath or affirmation of the witness from whom received. The officer presiding at the hearing shall administer oaths or affirmations to witnesses.

(4) The board shall furnish to the person about whom the hearing is being conducted, the attorney representing the person, the Attorney General, the district attorney and the court or department of the county from which the person was committed written notice of any hearing pending under this section within a reasonable time prior to the hearing. The notice shall include:

(a) The time, place and location of the hearing.

(b) The nature of the hearing and the specific action for which a hearing has been requested, the issues to be considered at the hearing and a reference to the particular sections of the statutes and rules involved.

(c) A statement of the authority and jurisdiction under which the hearing is to be held.

(d) A statement of all rights under subsection (6) of this section.

(5) Prior to the commencement of a hearing, the board or presiding officer shall inform each party as provided in ORS 183.413 (2).

(6) At the hearing, the person about whom the hearing is being held shall have the right:

(a) To appear at all proceedings held pursuant to this section, except board deliberations.

(b) To cross-examine all witnesses appearing to testify at the hearing.

(c) To subpoena witnesses and documents as provided in ORS 161.395.

(d) To be represented by suitable legal counsel possessing skills and experience commensurate with the nature and complexity of the case, to consult with counsel prior to the hearing and, if indigent, to have suitable counsel provided without cost.

(e) To examine all information, documents and reports which the board considers. If then available to the board, the information, documents and reports shall be disclosed to the person so as to allow examination prior to the hearing.

(7) A record shall be kept of all hearings before the board, except board deliberations.

(8) Upon request of any party before the board, or on its own motion, the board may continue a hearing for a reasonable period not to exceed 60 days to obtain additional information or testimony or for other good cause shown.

(9) Within 15 days following the conclusion of the hearing, the board shall provide to the person, the attorney representing the person, the Attorney General or other attorney representing the state, if any, written notice of the board's decision.

(10) The burden of proof on all issues at hearings of the board shall be by a preponderance of the evidence.

(11) If the board determines that the person about whom the hearing is being held is indigent, the board shall appoint suitable counsel to represent the person. Counsel so appointed shall be an attorney who satisfies the standards of eligibility established by the State Court Administrator under ORS 151.430. The State Court Administrator shall determine and allow fair compensation for counsel appointed under this subsection and the reasonable expenses of the person in respect to the hearing. Compensation payable to appointed counsel shall not be less than $30 an hour. The compensation and expenses so allowed shall be paid by the administrator from funds available for the purpose. If appointed counsel is under contract to provide services for the proceeding under ORS 151.460, compensation shall be as provided by the contract.

(12) The Attorney General may represent the state at contested hearings before the board unless the district attorney of the county from which the person was committed elects to represent the state. The district attorney of the county from which the person was committed shall cooperate with the Attorney General in securing the material necessary for presenting a contested hearing before the board. If the district attorney elects to represent the state, the district attorney shall give timely written notice of such election to the Attorney General, the board and the attorney representing the person. [1977 c.380 §15 (enacted in lieu of 161.345); 1979 c.867 §6; 1979 c.885 §5; 1981 c.711 §7; 1981 s.s c.3 §130; 1983 c.430 §1; 1985 c.502 §23; 1987 c.803 §19; 1991 c.827 §3]

Note: The amendments to 161.346 by section 40, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

161.346. (1) The Psychiatric Security Review Board shall conduct hearings upon any application for discharge, conditional release, commitment or modification filed pursuant to ORS 161.336, 161.341 or 161.351 and as otherwise required by ORS 161.336 to 161.351 and shall make findings on the issues before it which may include:

(a) If the board finds that the person is no longer affected by mental disease or defect, or, if so affected, no longer presents a substantial danger to others, the board shall order the person discharged from commitment or from conditional release.

(b) If the board finds that the person is still affected by a mental disease or defect and is a substantial danger to others, but can be controlled adequately if conditionally released with treatment as a condition of release, the board shall order the person conditionally released as provided in ORS 161.336.

(c) If the board finds that the person has not recovered from the mental disease or defect and is a substantial danger to others and cannot adequately be controlled if conditionally released on supervision, the board shall order the person committed to, or retained in, a state hospital designated by the Department of Human Services for care, custody and treatment.

(2) At any time, the board may appoint a psychiatrist or licensed psychologist to examine the person and to submit a report to the board. Reports filed with the board pursuant to the examination shall include, but need not be limited to; an opinion as to the mental condition of the person and whether the person presents a substantial danger to others, and whether the person could be adequately controlled with treatment as a condition of release. To facilitate the examination of the person, the board may order the person placed in the temporary custody of any state hospital or other suitable facility.

(3) The board may make the determination regarding discharge or conditional release based upon the written reports submitted pursuant to this section. If any member of the board desires further information from the examining psychiatrist or licensed psychologist who submitted the report, these persons shall be summoned by the board to give testimony. The board shall consider all evidence available to it which is material, relevant and reliable regarding the issues before the board. Such evidence may include but is not limited to the record of trial, the information supplied by the attorney representing the state or by any other interested party, including the person, and information concerning the person's mental condition and the entire psychiatric and criminal history of the person. All evidence of a type commonly relied upon by reasonably prudent persons in the conduct of their serious affairs shall be admissible at hearings. Testimony shall be taken upon oath or affirmation of the witness from whom received. The officer presiding at the hearing shall administer oaths or affirmations to witnesses.

(4) The board shall furnish to the person about whom the hearing is being conducted, the attorney representing the person, the Attorney General, the district attorney and the court or department of the county from which the person was committed written notice of any hearing pending under this section within a reasonable time prior to the hearing. The notice shall include:

(a) The time, place and location of the hearing.

(b) The nature of the hearing and the specific action for which a hearing has been requested, the issues to be considered at the hearing and a reference to the particular sections of the statutes and rules involved.

(c) A statement of the authority and jurisdiction under which the hearing is to be held.

(d) A statement of all rights under subsection (6) of this section.

(5) Prior to the commencement of a hearing, the board or presiding officer shall inform each party as provided in ORS 183.413 (2).

(6) At the hearing, the person about whom the hearing is being held shall have the right:

(a) To appear at all proceedings held pursuant to this section, except board deliberations.

(b) To cross-examine all witnesses appearing to testify at the hearing.

(c) To subpoena witnesses and documents as provided in ORS 161.395.

(d) To be represented by suitable legal counsel possessing skills and experience commensurate with the nature and complexity of the case, to consult with counsel prior to the hearing and, if financially eligible, to have suitable counsel appointed at state expense.

(e) To examine all information, documents and reports which the board considers. If then available to the board, the information, documents and reports shall be disclosed to the person so as to allow examination prior to the hearing.

(7) A record shall be kept of all hearings before the board, except board deliberations.

(8) Upon request of any party before the board, or on its own motion, the board may continue a hearing for a reasonable period not to exceed 60 days to obtain additional information or testimony or for other good cause shown.

(9) Within 15 days following the conclusion of the hearing, the board shall provide to the person, the attorney representing the person, the Attorney General or other attorney representing the state, if any, written notice of the board's decision.

(10) The burden of proof on all issues at hearings of the board shall be by a preponderance of the evidence.

(11) If the board determines that the person about whom the hearing is being held is financially eligible, the board shall appoint suitable counsel to represent the person. Counsel so appointed shall be an attorney who satisfies the professional qualification standards established by the Public Defense Services Commission under ORS 151.216. The public defense services executive director shall determine and allow fair compensation for counsel appointed under this subsection and the reasonable expenses of the person in respect to the hearing. Compensation payable to appointed counsel shall not be less than the applicable compensation level established under ORS 151.216. The compensation and expenses so allowed shall be paid by the public defense services executive director from funds available for the purpose.

(12) The Attorney General may represent the state at contested hearings before the board unless the district attorney of the county from which the person was committed elects to represent the state. The district attorney of the county from which the person was committed shall cooperate with the Attorney General in securing the material necessary for presenting a contested hearing before the board. If the district attorney elects to represent the state, the district attorney shall give timely written notice of such election to the Attorney General, the board and the attorney representing the person.

161.350 [1971 c.743 §49; 1975 c.380 §3; repealed by 1977 c.380 §16 (161.351 enacted in lieu of 161.350)]

161.351 Discharge of person under jurisdiction of board; periodic review of status. (1) Any person placed under the jurisdiction of the Psychiatric Security Review Board pursuant to ORS 161.336 or 161.341 shall be discharged at such time as the board, upon a hearing, shall find by a preponderance of the evidence that the person is no longer affected by mental disease or defect or, if so affected, no longer presents a substantial danger to others which requires regular medical care, medication, supervision or treatment.

(2) For purposes of this section, a person affected by a mental disease or defect in a state of remission is considered to have a mental disease or defect. A person whose mental disease or defect may, with reasonable medical probability, occasionally become active and when it becomes active will render the person a danger to others, shall not be discharged. The person shall continue under such supervision and treatment as the board deems necessary to protect the person and others.

(3) Any person who has been placed under the jurisdiction of the board and who has spent five years on conditional release shall be brought before the board for hearing within 30 days of the expiration of the five-year period. The board shall review the person's status and determine whether the person should be discharged from the jurisdiction of the board. [1977 c.380 §17 (enacted in lieu of 161.350); 1981 c.711 §13; 1985 c.192 §4; 1989 c.49 §1]

161.360 Mental disease or defect excluding fitness to proceed. (1) If, before or during the trial in any criminal case, the court has reason to doubt the defendant's fitness to proceed by reason of incapacity, the court may order an examination in the manner provided in ORS 161.365.

(2) A defendant may be found incapacitated if, as a result of mental disease or defect, the defendant is unable:

(a) To understand the nature of the proceedings against the defendant; or

(b) To assist and cooperate with the counsel of the defendant; or

(c) To participate in the defense of the defendant. [1971 c.743 §50; 1993 c.238 §1]

161.365 Procedure for determining issue of fitness to proceed. (1) Whenever the court has reason to doubt the defendant's fitness to proceed by reason of incapacity as defined in ORS 161.360, the court may call to its assistance in reaching its decision any witness and may appoint a psychiatrist or psychologist to examine the defendant and advise the court.

(2) If the court determines the assistance of a psychiatrist or psychologist would be helpful, the court may order the defendant to be committed to a state mental hospital designated by the Department of Human Services for the purpose of an examination for a period not exceeding 30 days. The report of each examination shall include, but is not necessarily limited to, the following:

(a) A description of the nature of the examination;

(b) A statement of the mental condition of the defendant; and

(c) If the defendant suffers from a mental disease or defect, an opinion as to whether the defendant is incapacitated within the definition set out in ORS 161.360.

(3) Except where the defendant and the court both request to the contrary, the report shall not contain any findings or conclusions as to whether the defendant as a result of mental disease or defect was subject to the provisions of ORS 161.295 or 161.300 at the time of the criminal act charged.

(4) If the examination by the psychiatrist or psychologist cannot be conducted by reason of the unwillingness of the defendant to participate therein, the report shall so state and shall include, if possible, an opinion as to whether such unwillingness of the defendant was the result of mental disease or defect affecting capacity to proceed.

(5) The report of the examination shall be filed in triplicate with the clerk of the court, who shall cause copies to be delivered to the district attorney and to counsel for defendant.

(6) When upon motion of the court or indigent defendant, the court has ordered a psychiatric or psychological examination of the indigent defendant, a justice court shall order the county to pay, and a circuit court shall order the State Court Administrator to pay from funds available for the purpose:

(a) A reasonable fee if the examination of the defendant is conducted by a psychiatrist or psychologist in private practice; and

(b) All costs including transportation of the defendant if the examination is conducted by a psychiatrist or psychologist in the employ of the Department of Human Services or a community mental health and developmental disabilities program established under ORS 430.610 to 430.670.

(7) When such an examination is ordered at the request or with the acquiescence of a defendant who is determined not to be indigent, the examination shall be performed at the defendant's expense. When such an examination is ordered at the request of the prosecution, the county shall pay for the expense of the examination. [1971 c.743 §51; 1975 c.380 §4; 1981 s.s. c.3 §131; 1983 c.800 §11; 1987 c.803 §18; 1993 c.238 §2]

Note: The amendments to 161.365 by section 90, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

161.365. (1) Whenever the court has reason to doubt the defendant's fitness to proceed by reason of incapacity as defined in ORS 161.360, the court may call to its assistance in reaching its decision any witness and may appoint a psychiatrist or psychologist to examine the defendant and advise the court.

(2) If the court determines the assistance of a psychiatrist or psychologist would be helpful, the court may order the defendant to be committed to a state mental hospital designated by the Department of Human Services for the purpose of an examination for a period not exceeding 30 days. The report of each examination shall include, but is not necessarily limited to, the following:

(a) A description of the nature of the examination;

(b) A statement of the mental condition of the defendant; and

(c) If the defendant suffers from a mental disease or defect, an opinion as to whether the defendant is incapacitated within the definition set out in ORS 161.360.

(3) Except where the defendant and the court both request to the contrary, the report shall not contain any findings or conclusions as to whether the defendant as a result of mental disease or defect was subject to the provisions of ORS 161.295 or 161.300 at the time of the criminal act charged.

(4) If the examination by the psychiatrist or psychologist cannot be conducted by reason of the unwillingness of the defendant to participate therein, the report shall so state and shall include, if possible, an opinion as to whether such unwillingness of the defendant was the result of mental disease or defect affecting capacity to proceed.

(5) The report of the examination shall be filed in triplicate with the clerk of the court, who shall cause copies to be delivered to the district attorney and to counsel for defendant.

(6) When upon motion of the court or a financially eligible defendant, the court has ordered a psychiatric or psychological examination of the defendant, a county or justice court shall order the county to pay, and a circuit court shall order the public defense services executive director to pay from funds available for the purpose:

(a) A reasonable fee if the examination of the defendant is conducted by a psychiatrist or psychologist in private practice; and

(b) All costs including transportation of the defendant if the examination is conducted by a psychiatrist or psychologist in the employ of the Department of Human Services or a community mental health and developmental disabilities program established under ORS 430.610 to 430.670.

(7) When such an examination is ordered at the request or with the acquiescence of a defendant who is determined not to be financially eligible, the examination shall be performed at the defendant's expense. When such an examination is ordered at the request of the prosecution, the county shall pay for the expense of the examination.

161.370 Determination of fitness; effect of finding of unfitness; proceedings if fitness regained; pretrial objections by defense counsel. (1) When the defendant's fitness to proceed is drawn in question, the issue shall be determined by the court. If neither the prosecuting attorney nor counsel for the defendant contests the finding of the report filed by a psychiatrist or psychologist under ORS 161.365, the court may make the determination on the basis of such report. If the finding is contested, the court shall hold a hearing on the issue. If the report is received in evidence upon such hearing, the

party who contests the finding thereof shall have the right to summon and to cross-examine any psychiatrist or psychologist who submitted the report and to offer evidence upon the issue. Other evidence regarding the defendant's fitness to proceed may be introduced by either party.

(2) If the court determines that the defendant lacks fitness to proceed, the proceeding against the defendant shall be suspended, except as provided in subsection (12) of this section, and the court shall commit the defendant to the custody of the superintendent of a state mental hospital designated by the Department of Human Services or shall release the defendant on supervision for so long as such unfitness shall endure. The court may release the defendant on supervision if it determines that care other than commitment for incapacity to stand trial would better serve the defendant and the community. It may place conditions which it deems appropriate on the release, including the requirement that the defendant regularly report to the Department of Human Services or a community mental health and developmental disabilities program for examination to determine if the defendant has regained capacity to stand trial. When the court, on its own motion or upon the application of the superintendent of the hospital in which the defendant is committed, a person examining the defendant as a condition of release on supervision, or either party, determines, after a hearing, if a hearing is requested, that the defendant has regained fitness to proceed, the proceeding shall be resumed. If, however, the court is of the view that so much time has elapsed since the commitment or release of the defendant on supervision that it would be unjust to resume the criminal proceeding, the court on motion of either party may dismiss the charge and may order the defendant to be discharged or cause a proceeding to be commenced forthwith under ORS 426.070 to 426.170 or 427.235 to 427.290.

(3) The superintendent shall cause the defendant to be evaluated within 60 days from the defendant's delivery into the superintendent's custody, for the purpose of determining whether there is a substantial probability that, in the foreseeable future, the defendant will have the capacity to stand trial.

(4) In addition, the superintendent shall:

(a) Immediately notify the committing court if the defendant, at any time, gains or regains the capacity to stand trial or will never have the capacity to stand trial.

(b) Within 90 days of the defendant's delivery into the superintendent's custody, notify the committing court that:

(A) The defendant has the present capacity to stand trial;

(B) There is no substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial; or

(C) There is a substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial. If such a probability exists, the superintendent shall give the court an estimate of the time in which the defendant, with appropriate treatment, is expected to gain or regain capacity.

(5) If the superintendent determines that there is a substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial, unless the court otherwise orders, the defendant shall remain in the superintendent's custody where the defendant shall receive treatment designed for the purpose of enabling the defendant to gain or regain capacity. In keeping with the notice requirement under subsection (4)(b) of this section, the superintendent shall, for the duration of the defendant's period of commitment, submit a progress report to the committing court, concerning the defendant's capacity or incapacity, at least once every 180 days as measured from the date of the defendant's delivery into the superintendent's custody.

(6) A defendant who remains committed under subsection (5) of this section shall be discharged within a period of time that is reasonable for making a determination concerning whether or not, and when, the defendant may gain or regain capacity. However, regardless of the number of charges with which the defendant is accused, in no event shall the defendant be committed for longer than whichever of the following, measured from the defendant's initial custody date, is shorter:

(a) Three years; or

(b) A period of time equal to the maximum sentence the court could have imposed if the defendant had been convicted.

(7) The superintendent shall notify the committing court of the defendant's impending discharge 30 days before the date on which the superintendent is required to discharge the defendant under subsection (6) of this section.

(8) When the committing court receives a notice from the superintendent under either subsection (4) or (7) of this section concerning the defendant's progress or lack thereof, the committing court shall determine after a hearing, if a hearing is requested, whether the defendant presently has the capacity to stand trial.

(9) If under subsection (8) of this section the court determines that the defendant lacks the capacity to stand trial, the court shall further determine whether there is a substantial probability that the defendant, in the foreseeable future, will gain or regain the capacity to stand trial and whether the defendant is entitled to discharge under subsection (6) of this section. If the court determines that there is no substantial probability that the defendant, in the foreseeable future, will gain or regain the capacity to stand trial or that the defendant is entitled to discharge under subsection (6) of this section, the court shall dismiss, without prejudice, all charges against the defendant and:

(a) Order that the defendant be discharged; or

(b) Initiate commitment proceedings under ORS 426.070 or 427.235 to 427.290.

(10) All notices required under this section shall be filed with the clerk of the court and delivered to both the district attorney and the counsel for the defendant.

(11) If the defendant regains fitness to proceed, the term of any sentence received by the defendant for conviction of the crime charged shall be reduced by the amount of time the defendant was committed under this section to the custody of a state mental hospital designated by the Department of Human Services.

(12) The fact that the defendant is unfit to proceed does not preclude any objection through counsel and without the personal participation of the defendant on the grounds that the indictment is insufficient, that the statute of limitations has run, that double jeopardy principles apply or upon any other ground at the discretion of the court which the court deems susceptible of fair determination prior to trial.

(13) As used in this section, "superintendent" means the superintendent of the state mental hospital of the Department of Human Services to which the defendant has been committed. [1971 c.743 §52; 1975 c.380 §5; 1993 c.238 §3; 1999 c.931 §§1,2]

161.375 Escape of person placed at Oregon State Hospital; authority of superintendent to order arrest. (1) When a patient, who has been placed at the Oregon State Hospital for evaluation, care, custody and treatment under the jurisdiction of the Psychiatric Security Review Board or by court order under ORS 161.315, 161.365 or 161.370, has escaped or is absent without authorization from the Oregon State Hospital or from the custody of any person in whose charge the superintendent has placed the patient, the superintendent may order the arrest and detention of the patient.

(2) The superintendent may issue an order under this section based upon a reasonable belief that grounds exist for issuing the order. When reasonable, the superintendent shall investigate to ascertain whether such grounds exist.

(3) Any order issued by the superintendent as authorized by this section constitutes full authority for the arrest and detention of the patient and all laws applicable to warrant or arrest apply to the order. An order issued by the superintendent under this section expires 72 hours after being signed by the superintendent.

(4) As used in this section, "superintendent" means the superintendent of the Oregon State Hospital or the superintendent's authorized representative. [1997 c.423 §1]

Note: 161.375 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

161.380 [1971 c.743 §53; renumbered 161.290]

161.385 Psychiatric Security Review Board; composition, term, qualifications, compensation, appointment, confirmation and meetings; judicial review of orders. (1) There is hereby created a Psychiatric Security Review Board consisting of five members appointed by the Governor and subject to confirmation by the Senate under section 4, Article III of the Oregon Constitution.

(2) The membership of the board shall not include any district attorney, deputy district attorney or public defender, but, the membership shall be composed of:

(a) A psychiatrist experienced in the criminal justice system and not otherwise employed on a full-time basis by the Department of Human Services or a community mental health and developmental disabilities program;

(b) A licensed psychologist experienced in the criminal justice system and not otherwise employed on a full-time basis by the Department of Human Services or a community mental health and developmental disabilities program;

(c) A member with substantial experience in the processes of parole and probation;

(d) A member of the general public; and

(e) A lawyer with substantial experience in criminal trial practice.

(3) The term of office of each member is four years. The Governor at any time may remove any member for inefficiency, neglect of duty or malfeasance in office. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there

is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) A member of the board not otherwise employed full time by the state, shall be paid on a per diem basis an amount equal to $212, adjusted according to the executive pay plan for the biennium, for each day during which the member is engaged in the performance of official duties, including necessary travel time. In addition, subject to ORS 292.220 to 292.250 regulating travel and other expenses of state officers and employees, the member shall be reimbursed for actual and necessary travel and other expenses incurred in the performance of official duties.

(5) Subject to any applicable provision of the State Personnel Relations Law, the board may hire employees to aid it in performing its duties.

(6)(a) The board shall select one of its members as chairperson to serve for a one-year term with such duties and powers as the board determines.

(b) A majority of the voting members of the board constitutes a quorum for the transaction of business.

(7) The board shall meet at least twice every month, unless the chairperson determines that there is not sufficient business before the board to warrant a meeting at the scheduled time. The board shall also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(8)(a) When a person over whom the board exercises its jurisdiction is adversely affected or aggrieved by a final order of the board, the person is entitled to judicial review of the final order. The person shall be entitled on judicial review to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is indigent, suitable counsel shall be appointed by the reviewing court in the manner provided in ORS 138.500 (1). If the person is indigent, the reviewing court shall determine and allow, as provided in ORS 138.500, the cost of briefs, any other expenses of the person necessary to the review and compensation for counsel appointed for the person. The costs, expenses and compensation so allowed shall be paid as provided in ORS 138.500.

(b) The order and the proceedings underlying the order are subject to review by the Court of Appeals upon petition to that court filed within 60 days of the order for which review is sought. The board shall submit to the court the record of the proceeding or, if the person agrees, a shortened record. The record may include a certified true copy of a tape recording of the proceedings at a hearing in accordance with ORS 161.346. A copy of the record transmitted shall be delivered to the person by the board.

(c) The court may affirm, reverse or remand the order on the same basis as provided in ORS 183.482 (8).

(d) The filing of the petition shall not stay the board's order, but the board or the Court of Appeals may order a stay upon application on such terms as are deemed proper. [1977 c.380 §8; 1979 c.867 §7; 1979 c.885 §6; 1981 c.711 §15; 1981 s.s. c.3 §132; 1983 c.740 §26; 1983 c.800 §12; 1987 c.133 §1]

Note: The amendments to 161.385 by section 70, chapter 962, Oregon Laws 2001, become operative October 1, 2003. See section 15, chapter 962, Oregon Laws 2001. The text that is operative on and after October 1, 2003, is set forth for the user's convenience.

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(c) A member with substantial experience in the processes of parole and probation;

(d) A member of the general public; and

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(3) The term of office of each member is four years. The Governor at any time may remove any member for inefficiency, neglect of duty or malfeasance in office. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) A member of the board not otherwise employed full time by the state, shall be paid on a per diem basis an amount equal to $212, adjusted according to the executive pay plan for the biennium, for each day during which the member is engaged in the performance of official duties, including necessary travel time. In addition, subject to ORS 292.220 to 292.250 regulating travel and other expenses of state officers and employees, the member shall be reimbursed for actual and necessary travel and other expenses incurred in the performance of official duties.

(5) Subject to any applicable provision of the State Personnel Relations Law, the board may hire employees to aid it in performing its duties.

(6)(a) The board shall select one of its members as chairperson to serve for a one-year term with such duties and powers as the board determines.

(b) A majority of the voting members of the board constitutes a quorum for the transaction of business.

(7) The board shall meet at least twice every month, unless the chairperson determines that there is not sufficient business before the board to warrant a meeting at the scheduled time. The board shall also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(8)(a) When a person over whom the board exercises its jurisdiction is adversely affected or aggrieved by a final order of the board, the person is entitled to judicial review of the final order. The person is entitled on judicial review to suitable counsel possessing skills and experience commensurate with the nature and complexity of the case. If the person is financially eligible, suitable counsel shall be appointed by the reviewing court in the manner provided in ORS 138.500 (1). If the person is financially eligible, the public defense services executive director shall determine and pay, as provided in ORS 138.500, the cost of briefs, any other expenses of the person necessary to the review and compensation for counsel appointed for the person. The costs, expenses and compensation so allowed shall be paid as provided in ORS 138.500.

(b) The order and the proceedings underlying the order are subject to review by the Court of Appeals upon petition to that court filed within 60 days of the order for which review is sought. The board shall submit to the court the record of the proceeding or, if the person agrees, a shortened record. The record may include a certified true copy of a tape recording of the proceedings at a hearing in accordance with ORS 161.346. A copy of the record transmitted shall be delivered to the person by the board.

(c) The court may affirm, reverse or remand the order on the same basis as provided in ORS 183.482 (8).

(d) The filing of the petition shall not stay the board's order, but the board or the Court of Appeals may order a stay upon application on such terms as are deemed proper.

161.387 Board to implement policies; rulemaking; meetings not deliberative under public meeting requirements. (1) The Psychiatric Security Review Board, by rule pursuant to ORS 183.325 to 183.410 and not inconsistent with law, may implement its policies and set out its procedure and practice requirements and may promulgate such interpretive rules as the board deems necessary or appropriate to carry out its statutory responsibilities.

(2) Administrative meetings of the board and the evidentiary phase of board hearings are not deliberations for the purposes of ORS 192.690. [1981 c.711 §§10,11]

Note: See note under 161.326.

161.390 Rules for assignment of persons to state mental hospitals; release plan prepared by Department of Human Services. (1) The Department of Human Services shall promulgate rules for the assignment of persons to state mental hospitals under ORS 161.341, 161.365 and 161.370 and for establishing standards for evaluation and treatment of persons committed to a state hospital designated by the department or ordered to a community mental health and developmental disabilities program under ORS 161.315 to 161.351, 192.690 and 428.210.

(2) Whenever the Psychiatric Security Review Board requires the preparation of a predischarge or preconditional release plan before a hearing or as a condition of granting discharge or conditional release for a person committed under ORS 161.327 or 161.341 to a state hospital for custody, care and treatment, the Department of Human Services is responsible for and shall prepare the plan.

(3) In carrying out a conditional release plan prepared under subsection (2) of this section, the Department of Human Services may contract with a community mental health and developmental disabilities program, other public agency or private corporation or an individual to provide supervision and treatment for the conditionally released person. [1975 c.380 §7; 1977 c.380 §18; 1981 c.711 §14; 1993 c.680 §18]

161.395 Subpoena power of board. (1) Upon request of any party to a hearing before the board, the board or its designated representatives shall issue, or the board on its own motion may issue, subpoenas requiring the attendance and testimony of witnesses.

(2) Upon request of any party to the hearing before the board and upon a proper showing of the general relevance and reasonable scope of the documentary or physical evidence sought, the board or its designated representative shall issue, or the board on its own motion may issue, subpoenas duces tecum.

(3) Witnesses appearing under subpoenas, other than the parties or state officers or employees, shall receive fees and mileage as prescribed by law for witnesses in ORS 44.415 (2). If the board or its designated representative certifies that the testimony of a witness was relevant and material, any person who has paid fees and mileage to that witness shall be reimbursed by the board.

(4) If any person fails to comply with a subpoena issued under subsections (1) or (2) of this section or any party or witness refuses to testify regarding any matter on which the party or witness may be lawfully interrogated, the judge of the circuit court of any county, on the application of the board or its designated representative or of the party requesting the issuance of the subpoena, shall compel obedience by proceedings for contempt as in the case of disobedience of the requirements of a subpoena issued by the court.

(5) If any person, agency or facility fails to comply with an order of the board issued pursuant to subsection (2) of this section, the judge of a circuit court of any county, on application of the board or its designated representative, shall compel obedience by

proceedings for contempt as in the case of disobedience of the requirements of an order issued by the court. Contempt for disobedience of an order of the board shall be punishable by a fine of $100. [1977 c.380 §9; 1989 c.980 §8]

Note: 161.395 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

161.397 Psychiatric Security Review Board Account. The Psychiatric Security Review Board Account is established separate and distinct from the General Fund. All moneys received by the Psychiatric Security Review Board, other than appropriations from the General Fund, shall be deposited into the account and are continuously appropriated to the board to carry out the duties, functions and powers of the board. [2001 c.716 §3]

Note: 161.397 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 161 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

161.400 Leave of absence; notice to board. If, at any time after the commitment of a person to a state hospital under ORS 161.341 (1), the superintendent of the hospital is of the opinion that a leave of absence from the hospital would be therapeutic for the person and that such leave would pose no substantial danger to others, the superintendent may authorize such leave for up to 48 hours in accordance with rules adopted by the Psychiatric Security Review Board. However, the superintendent, before authorizing the leave of absence, shall first notify the board for the purposes of ORS 161.326 (2). [1981 c.711 §12]

161.403 [1983 c.800 §14; repealed by 1993 c.77 §1]

INCHOATE CRIMES

161.405 "Attempt" described. (1) A person is guilty of an attempt to commit a crime when the person intentionally engages in conduct which constitutes a substantial step toward commission of the crime.

(2) An attempt is a:

(a) Class A felony if the offense attempted is murder or treason.

(b) Class B felony if the offense attempted is a Class A felony.

(c) Class C felony if the offense attempted is a Class B felony.

(d) Class A misdemeanor if the offense attempted is a Class C felony or an unclassified felony.

(e) Class B misdemeanor if the offense attempted is a Class A misdemeanor.

(f) Class C misdemeanor if the offense attempted is a Class B misdemeanor.

(g) Violation if the offense attempted is a Class C misdemeanor or an unclassified misdemeanor. [1971 c.743 §54]

161.425 Impossibility not a defense. In a prosecution for an attempt, it is no defense that it was impossible to commit the crime which was the object of the attempt where the conduct engaged in by the actor would be a crime if the circumstances were as the actor believed them to be. [1971 c.743 §55]

161.430 Renunciation as a defense to attempt. (1) A person is not liable under ORS 161.405 if, under circumstances manifesting a voluntary and complete renunciation of the criminal intent of the person, the person avoids the commission of the crime attempted by abandoning the criminal effort and, if mere abandonment is insufficient to accomplish this avoidance, doing everything necessary to prevent the commission of the attempted crime.

(2) The defense of renunciation is an affirmative defense. [1971 c.743 §56]

161.435 "Solicitation" described. (1) A person commits the crime of solicitation if with the intent of causing another to engage in specific conduct constituting a crime punishable as a felony or as a Class A misdemeanor or an attempt to commit such felony or Class A misdemeanor the person commands or solicits such other person to engage in that conduct.

(2) Solicitation is a:

(a) Class A felony if the offense solicited is murder or treason.

(b) Class B felony if the offense solicited is a Class A felony.

(c) Class C felony if the offense solicited is a Class B felony.

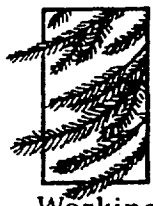
(d) Class A misdemeanor if the offense solicited is a Class C felony.

(e) Class B misdemeanor if the offense solicited is a Class A misdemeanor. [1971 c.743 §57]

161.440 Renunciation as defense to solicitation. (1) It is a defense to the crime of solicitation that the person soliciting the crime, after soliciting another person to commit a crime, persuaded the person solicited not to commit the crime or otherwise prevented the commission of the crime, under circumstances manifesting a complete and voluntary renunciation of the criminal intent.

(2) The defense of renunciation is an affirmative defense. [1971 c.743 §58]

RIGHTS OF THE MENTALLY ILL



OREGON ADVOCACY CENTER

Working for the Rights of Individuals with Disabilities

Rights of Persons with Mental Illness

Crisis Intervention Team Training
Portland, Oregon
November 14th, 2000

Janice Perciano and Jan Friedman
Oregon Advocacy Center

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WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

Mental Health--the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental illness--the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alteration in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems--patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

. . . . .

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**

- **A range of treatments exists for most mental disorders.**

. . . . .

Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment . Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

. . . . .

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable.

. . . . .

Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Excerpts from **U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of health, National Institute of Mental Health , 1999.**

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Persons with mental illness have the **same rights as everyone else**.

Why aren't persons with mental illness treated the same?

1. Stigma--shame, hidden subject, accepted to mistreat, make fun of persons with mental illness

2. Misconceptions

   A. Violent--studies show that persons with mental illness are no more likely to be violent than anyone else, but often are portrayed in the media as violent

   B. Stupid--persons with mental illness have the same ranges of intelligence as everyone else, sometimes persons with mental illness are confused with persons with retardation--not the same

   C. Incompetent--everyone is presumed competent unless shown otherwise--persons with mental illness are presumed competent to make decisions even if civilly committed--only under specific circumstances is a person determined to be incompetent (guardianship, conservatorship, outside consultant determination regarding medication of person on commitment)

   D. Delusional--only some persons with mental illness experience delusional thinking--and even for these persons the delusions occur only some of the time

3. Protection of the person with mental illness--social workers, family, care givers, police etc. often want to treat persons with mental illness in what is perceived to be the best interests of the person with mental illness--may be in conflict with what the individual chooses and may be patronizing

4. Protection of society/family from hardship and/ or danger--actions are taken against a person with mental illness to protect others

5. Ignorance and fear--belief by persons without mental illness that persons with mental illness are extremely different than themselves and that mental illness may "spread"

LAWS SPECIFICALLY AFFECTING PERSONS WITH MENTAL ILLNESSES

1. CIVIL COMMITMENT

WHAT IS CIVIL COMMITMENT?

Civil commitment is a process in which a judge decides whether a person who is alleged to be mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment. A person in the process of a commitment sometimes is called an Alleged Mentally Ill Person (AMIP). A civil commitment is not a criminal conviction and will not go on a criminal record.

When a civil commitment petition has been filed, an investigator from the community mental health program (CMHP) will investigate the need for the commitment. Depending on the investigator's decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a right to an attorney and to have witnesses testify. The judge then makes a decision whether the person should be committed. If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting. The maximum commitment period is 180 days, although a person can be ordered to stay hospitalized beyond the 180 days in recommitment proceedings.

WHO CAN BE COMMITTED

Oregon Revised Statutes (ORS) chapters 426 and 427 contain the law regarding civil commitment. A judge can commit a person for up to 180 days if the judge finds by clear and convincing evidence, that the person

> Has a mental disorder and, because of that mental disorder, is:
>
> Dangerous to self or others, or
>
> Unable to provide for basic needs (like health and safety).

Or, the judge can find that a person is:

> Diagnosed as having a major mental illness (such as chronic schizophrenia or manic- depression), and

Has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

ORS 426.005; ORS 426.130

HOW THE CIVIL COMMITMENT PROCESS BEGINS

1) The commitment process may be started by a county health officer, a judge, or any two persons filing papers in court. Or, the process may be started by a doctor or community mental health program director ordering a person to be held involuntarily in a hospital. ORS 426.070; ORS 426.228 through ORS 426.234.

2) When the papers are filed, the CMHP program must send out a mental health investigator to interview the person and others who know about the person. This investigator advises a judge whether or not to hold a court hearing. ORS 426.070; ORS 426.074.

WHERE THE PERSON STAYS BEFORE THE HEARING

A person against whom a civil commitment petition is filed may stay in the community unless the judge orders the person to be taken into custody or a doctor or CMHP director directs the person be in custody. The person can be in custody only if he or she is considered to be mentally ill and a danger to self or others. A person who is mentally ill and unable to provide for basic needs cannot be held in custody unless the person's inability to provide for basic needs is so extreme that the person is a danger to self. A person held before a hearing is on a precommitment hold or in precommitment detention. ORS 426.070; ORS 426.228; ORS 426.231; ORS 426.232; ORS 426.233.

If a person is held in custody on a precommitment hold, he or she cannot be held in jail unless he or she is charged with a crime or is a serious danger to hospital staff or property. ORS 426.140. The person may be held in a hospital or a nonhospital facility. A nonhospital facility is a facility approved by the Mental Health and Developmental Disability Services Division (MHDDSD) to provide adequate security, psychiatric, nursing and other services. ORS 426.005(e).

A person on a precommitment hold has the right to be held in a mental health facility providing care, custody and treatment required for mental and physical health and safety. In other words, the person can only be held in a place with staff trained to provide mental health treatment. ORS 426.072(2)(a); ORS 426.228.

LENGTH OF TIME A PERSON CAN BE HELD BEFORE A HEARING

A person cannot be held in custody on a precommitment hold longer than five working days without a court hearing. If five working days pass and there is no court hearing, a person is free to leave the hospital unless he or she has asked to postpone the hearing or has agreed to be hospitalized voluntarily under a diversion program. In other words, a person cannot be held longer than five working days unless a judge says so. ORS 426.095.

HOW LEGAL RIGHTS ARE AFFECTED BY COMMITMENT

In general, most legal rights are not affected by civil commitment. A person who is committed retains all legal and civil rights, including the right to vote and make contracts unless a court has found the person incompetent. ORS 426.385.

Some specific rights can be limited as a result of civil commitment:

Firearms - Persons who have been committed are forbidden from owning, buying, or possessing firearms. ORS 426.130(1)(D); ORS 166.250 (1)(D).

Future commitments - If a person is committed twice within the past three years, he or she can be committed more easily in the future. ORS 426.495.

Driving - Commitment can affect a person's ability to get or keep a driver's license. If a person has a mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle, the person cannot be licensed. ORS 807.090; ORS 807.700; ORS 809.410(16).

II. AMERICANS WITH DISABILITIES ACT (ADA)

The ADA protects persons with disabilities from discrimination in these areas:

1. Employment--This includes hiring, termination benefits, working conditions, etc.

2. Public Accommodations--This includes hotels, offices, shopping malls, restaurants, sports arenas, schools, zoos, hospitals, theaters, grocery stores, homeless shelters, libraries, etc.

3. Public Entities--This includes all local and state governmental services and programs.

4. Transportation--This includes buses, trains, lights rail must be accessible or

alternatives offered.

5. Telecommunications--This includes that telecommunication services must be made accessible for speech and/or hearing impaired persons.

Persons with mental illnesses are protected by the ADA if the mental illness substantially limits one or more of the major life activities of the person. Major life activities means activities such as working, learning, sleeping, thinking and walking. Persons who have a record of such an impairment or who are perceived to have such an impairment are also protected.

In addition to the ADA, which is federal law, Oregon has state laws prohibiting discrimination in employment and public accommodations.

III. FAIR HOUSING LAWS

The federal Fair Housing Act was passed in 1968 as part of the Civil Rights Act of 1968. The Fair Housing Act prohibited discrimination based on race, color, religion or national origin in the sale, rental or financing of housing. In 1974, Congress added a provision prohibiting housing discrimination based on sex.

In 1988, Congress added provisions prohibiting housing discrimination based on mental and/or physical disabilities. Under the law, landlords and sellers cannot discriminate against a person because the person has a mental illness and must make reasonable accommodations for a person disability. The law does not apply in some cases where the landlord or seller is acting with regard to his or her private house or small apartment building. The law also allows the rejection of any tenant or buyer who would directly threaten the health or safety of other individuals or would cause substantial physical damage to the property of others.

Oregon also has a state law prohibiting discrimination based on physical or mental disability in selling, leasing or renting of houses and apartments.

IV. RIGHTS IN THE COMMUNITY AND IN FACILITIES

STATUTORY AND CONSTITUTIONAL RIGHTS

Many people receive mental health services outside the state hospital. Even persons who are civilly committed often receive treatment in private hospitals that have contracts with the state. Additionally, more people are receiving services in facilities, group homes and independent residences rather than in hospitals.

A person who is receiving services outside the state hospital system has the same rights as any other person in the community. Some of the rights that all persons in the United States are the right to:

*Vote

*Exercise freedom of speech, freedom of association and freedom of religion.

*Have privacy, including the right to marry and have children.

*Be free from discrimination based on race, gender, color, national origin or disability.

In 1993, the legislature passed legislation that sets out some specific rights of persons receiving mental health or developmental disabilities services. A person who is receiving mental health or developmental disabilities services outside of the state hospital has the right to:

*Have a written treatment plan and participate in making the plan.

*Choose from available services and have those services provided in the least restrictive way.

*Receive only services to which a person gives informed, voluntary, written consent.

*Receive medication only for individual clinical needs.

*Not be involuntarily terminated or transferred from services without prior notice and the right to be notified of available sources for necessary services.

*Receive humane services, be protected from harm and have reasonable privacy.

*Be free from abuse and neglect.

*Report abuse and neglect without retaliation.

*Exercise religious freedom.

*Not be required to perform labor, except personal chores, without being paid.

*Visit with family, friends, advocates, legal and medical professionals.

*Be told about rights and how to report abuse.

*Assert grievances and have them considered in a fair, timely and impartial manner.

*Communicate with any rights program or advocate.

*Exercise these rights without any reprisal or punishment.

ORS 430.210.

V. ABUSE REPORTING

Since 1991, the law has required the reporting and investigating of abuse of persons with mental illness who are receiving mental health services in the community. Abuse is defined as:

*Any death caused by other than accidental or natural means.

*Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.

*Willful infliction of physical pain or injury.

*Sexual harassment or exploitation, including any sexual contact between an employee of a facility or community program and an adult who is receiving mental health services.

The law requires private and public officials to report abuse if they have reasonable cause to believe abuse occurred. This means that all doctors, nurses, aides, psychologists, employees of county mental health programs, employees of mental health services providers, clergy, attorneys, outreach workers, social workers, therapists, police and others must report abuse.

Abuse may be reported to the Mental Health and Developmental Disability Services Division (MHDDSD), the county mental health program or the police. The office that receives the abuse report must then conduct an investigation or make sure that an investigation is conducted. The person who may have been the victim of the abuse must be provided protective services if needed. The investigating office must complete a report of the investigation and send it to MHDDSD. ORS 430.735 through 430.765.

VI. INFORMED CONSENT TO TREATMENT

A person can receive mental health treatment, including medications, only if the person gives his or her informed consent. This means the person must be told what the benefits and risks of treatment are and must make a voluntary decision.

A person cannot be forced to take a particular medication just because everyone thinks it would be good for him or her. The exception is when a person has been civilly committed and two doctors have agreed that the person is unable to make decisions. In this case, if the proper procedures are followed, the person may be subjected to treatment that she or he does not want.

VII. GUARDIANSHIP

If a person is "incapacitated", a judge may appoint a guardian for her or him. A guardian can only be appointed by a judge. A parent does not have the powers of a guardian if the individual is 18 or over unless the judge has appointed the parent a s guardian.

TELEPHONE NUMBERS FOR ADVOCACY GROUPS AND LEGAL ASSISTANCE

American Civil Liberties Union	503-227-3186
Fair Housing Council	503-223-8295
Multnomah County Legal Aid	503-224-4086
National Alliance for the Mentally Ill	800-343-6264
Oregon Advocacy Center	503-243-2081
Toll-free	800-452-1694
TTY	503-323-9161
Toll-free TTY	800-556-5351
Oregon Legal Services	
Central Office	503-234-1534
Farm Workers' Office	503-981-5291
Hillsboro Office	503-648-7163
Native American Office	503-223-9483
Oregon State Bar	
Lawyer Referral Service	503-684-3763
Toll-free	800-452-7636
State Public Defender	503-378-3349
U.S. Office of Civil Rights	206-615-2290
Toll-free	800-362-1710

GOVERNMENT AGENCIES

Adult and Family Services Division	503-731-3111
Bureau of Labor and Industries	503-731-4200
Equal Employment Opportunity Commission	206-220-6883
Toll-free 800-669-4000	
TTY 206-220-6882	
Mental Health and Developmental Disability Services Division	503-945-9499
Office of Mental Health Services	503-945-9700
Office of Client Rights	503-945-9495
Psychiatric Security Review Board	503-229-5596
Senior and Disabled Services Division	503-945-5811
Toll-free 800-232-3020	
Social Security Administration	800-772-1213

ADVOCACY/CONSUMER GROUPS

Mind Empowered, Inc	503-231-4137
Oregon Advocacy Center	503-243-2081
Toll-free 800-452-1694	
TTY 503-323-9161	
Toll-free TTY	800-556-5351
Oregon Alliance for the Mentally Ill	503-370-7774
Recovery, Inc 503-231-1334	

Brief History of Treatment of Persons with Mental Illness in England and the United States

Early 1300s--English law categorized persons with mental disabilities as lunatics or idiots.

Pre-1600s--Persons with mental illness were cared for at home or sent to poorhouses, workhouses, jails.

1600s-- "Madhouses" created to confine persons with mental illness. The madhouses were unhealthy settings with harsh and punitive "treatment". Persons were chained, abused and publicly displayed.

1700s-- "Asylums" were developed to provide healthy environment and "moral treatment".

Mid-1700s--Persons with mental illness in England were placed in St. Mary of Bethlehem which became known as "Bedlam".

"Bethlehem--or Bedlam as it was called--was a favorite Sunday excursion spot for Londoners, who came to stare at the madmen through the iron gates. Should they survive the filthy conditions, the abominable food, the isolation and the darkness, and the brutality of their keepers, the patients of Bedlam were intitled to treatment--emetics, purgatives, bloodletting and various so-called harmless tortures provided by special paraphenalia." The History of Psychiatry, F.G. Alexander and S.T. Selesnick

1752--Pennsylvania Hospital opened with several cells for the "insane". The method of commitment was informal. A few words scribbled on a piece of paper were enough to get a person locked up.

1773--In Williamsburg, Virginia, the first US institution specialized for the "insane" opened.

Late 1800s--Large public institutions were filled with chronic patients receiving little treatment.

1883--Oregon State Insane Asylum opened in Salem (renamed Oregon State Hospital in 1907).

1900-1960--Hospitals emphasized treatment but no effective treatment was available. Institution populations continued to grow.

1907--Eastern Oregon Hospital opened in Pendleton.

> When we have a disturbed or noisy patient to deal with [prior to a lobotomy operation] in the University Hospital or Doctors Hospital we administer two, three or more electroshock treatments in rapid succession. Psychosurgery in the Treatment of Mental Disorders and Intractable Pain, Walter Freeman and James Watts, 1950.

1955--560,000 persons with mental illness were confined in hospitals (1/2 of all hospital beds).

1959--The average daily population in Oregon State Hospital and Eastern Oregon Hospital was 4909.

1960-1975--Deinstitutionalization resulted in the release of vast numbers of persons from institutions.

1961--Dammasch State Hospital opened in Wilsonville.

1975 to present--Communities recognized that deinstitutionalization could not succeed unless accompanied by adequate community support programs.

1977--Psychiatric Security Review Board created in Oregon to supervise persons found affected by mental disease or defect in criminal matters.

1990 to present--Managed care implemented for provision of mental health services.

Deaths at Dammasch State Hospital (DSH)--June 25, 1993 to October 8, 1993.

June 25, 1993--DC died at DSH--No medical examiner review but adequacy of medical treatment questioned.

August 29, 1993--JW died choking on pancakes. He was alone in his room, unmonitored despite swallowing problems.

August 29, 1993--LL died choking on pancakes. Staff called 911 but did not intubate LL or manually cut an airway.

September 19, 1993--KM died as a result of coronary arteriosclerosis. Staff had given her Haldol despite a diagnosis of mental retardation (IQ 54) and no diagnosis of mental illness. Staff found her lying on her bed. She had no pulse but was warm. Staff made a emergency request for a doctor. Thirteen minutes elapsed before a doctor arrived.

October 18, 1993--PG suffocated while being placed in physical restraints. A towel pulled over his mouth contributed to the death.

1995--Dammasch State Hospital closed.. Oregon State Hospital at Portland opened with capacity of 68.

1997--Current Oregon State Hospital capacity is for 727 beds, including hospital beds, residential beds, child and adolescent beds.

Section 3 - RESOURCES

- Family and Consumer
- Community Resources
- Medications

FAMILY AND CONSUMER

PERSPECTIVE

WHAT IT'S LIKE

Being crazy hurts. For one who has been there, the idea of going crazy out of moral weakness, because it is easier than "facing reality," is utterly bizarre.

The major mental illnesses, like most other illnesses, carry with them an early-appearing and almost ever-present feeling of "sickness" and exhaustion.

As it gets better and worse, there are times when you may be unable to function at all, perhaps being unable even to get out of bed.

At these times, investigation is needed to determine whether you are suffering extreme stress of real-work origin, suffering from a resurgence of mental illness symptoms, or whether there is some unrelated medical problem, such as an abscessed tooth or the flu.

Too often, these episodes are viewed as bouts of laziness and "lack of motivation," and treated with harassment or even termination from a treatment program.

Unless this phenomenon, and ways of coping with it, are explained to you, you too may come to believe you are lazy and good-for-nothing.

You become aware that your perceptions are unreliable, that you are having sensory experiences that others do not share.

As you struggle for some understanding of what is happening to you, you find yourself clutching at extreme and bizarre explanations.

When you try to talk to other people about your experiences, you discover there is no common language for them. You find yourself putting together an unsatisfactory and embarrassing patchwork of religious, occult, or scientific words.

When you do talk to people, they may lapse into shocked silence, change the subject, or reject your statements as weird and you as crazy.

If you are not aware the perceptions are different from those of other people, you are even more disabled. Whenever you try to do something or talk to someone, all sorts of things go wrong, which you do not understand.

Because you cannot predict whether your perceptions and interpretations of events are acceptable to others as "real," you begin to be afraid to talk about your feeling at all. If you have not yet felt there was something wrong/bad about you before, you do now. You become very lonely.

Since you gave no safe way to compare your "crazy ideas" with what normal people define as real, your ideas/delusions become more detailed, more organized, and more strongly held.

Extreme and uncontrollable emotions rush through you: fear, confusion, anger, despair.

The feelings are overwhelming. You see yourself doing things you cannot stop. It comes to you that you are no longer in control of your life. You are forced to depend on other people for some things, even if you do not want to.

You begin to fear that you may do something awful, something that will make people get rid of you forever.

You worry that whatever has happened to you may be permanent, that you may never be all right again.

Pain becomes very familiar. It comes to have form and texture like terrain.

If pain is fairly steady and continuous, you can sometimes almost tune it out. But if someone offers you more hurt, whether it be emotional battering or physical, you are suddenly desperate and hostile. You are tired, tired, tired, and do not have the energy to take any more. Sometimes you have to take it anyway.

At times the pain/craziness comes in overwhelming waves. Like most people, you think that pain will somehow never crush you. Somehow new reserves of strength will appear, effective treatments will be found, or, in the extreme, that you will simply pass out.

Then one day, you lose control of your mind, your body, everything. You'll lose your bowels and scream and scream and scream, like a little pig squirming in the dirt. And it does not stop.

Having broken, having been totally <u>helpless</u> forever after leaves you feeling fragile in a way that other people do not. In wonderment you watch "normal people" go about their lives, full of energy, confident, unknowing. There is an abyss between you.

If you hurt bad enough, you try anything to feel better: self-help books, religion, sex, drugs, alcohol, and anything you can think of.

Some things make you feel a little better, some do nothing, and many of them make you feel a lot worse.

In desperation, sometimes just drinking or drugging yourself into unconsciousness seems a worthy goal.

The risks of triggering further psychotic episodes and the risk of alcohol and drug addiction are substantial. It is hard to be interested in future consequences of things when you are not sure you have a future or want one.

If you get strung out on alcohol or drugs you will have another difficulty. The people who work with alcoholics and drug addicts do not want you because you are crazy. The people who work with the mentally ill do not want you because you are an alcoholic or an addict. You can only go to special, expensive, "dual diagnosis" programs. If you have three or more diagnoses, you are likely to end up in jail.

Seriously mentally ill people have a suicide rate of 20-30 times that of the normal population. At greatest risk are those who are too ill to have a normal life, and not sick enough to be unaware of it.

Hardly anyone wants to commit suicide.

As the years go by, you exhaust the treatment options open to you. Hospitals and doctors get tired of you because you never get better.

You drift away from your family. You cannot hold a job, or maintain a sexual relationship.

If you talk to others about your feelings, you come under pressure to shut up and act normal. Your desperation makes them uncomfortable.

You feel helpless, lonely, and as if you have nowhere you belong. You cannot stand being trapped in all that pain. All these are bad enough, but it is the crushing, never ending tiredness that ultimately gets you. You kill yourself because you have to.

What you would really like to hear is: "We know you are very tired, and you feel awful most of the time. We do not want you to go away. We want you to live.

"But if the time comes when you really cannot take anymore, and you have to die, we will be very sad, but we will understand.

"Whether you get better or not, and whether you live or not, we love you anyway."

Confused and frightened people tend to try to clamp tight control on whatever or whoever upsets them. It is rare to be given this recognition of your pain and permission to do whatever you have to do, but if you are, it is very comforting.

It tends to relieve some of your guilt feelings for being such a mess, and such a disappointment to your family and friends.

If you are like many seriously mentally ill people, you have known since sometime in childhood that there is something very wrong with you.

Functioning at school was very hard. You have less and less success in living up to the expectations of your family, and in being like other people.

Others' attempts to shape you up are sometimes drastic. You are likely to have the experience of being threatened, ridiculed, or punished for things that you do not understand, cannot do, or cannot stop doing.

Parents, teachers, school counselors, and pediatricians rarely are familiar with mental illness in children. Many professionals take the de facto stand that major mental illness and suicide virtually do not occur in young children, and that all such problems come from "labeling" and "bad parenting."

Your family withers under the implied or open accusation that they made you crazy. They become too intimidated to talk to you, out of fear that they will "say something wrong" and cause you to shatter in a million pieces.

Communication within your family is loaded with fear and guilt, and is further complicated by your thought or mood disorder.

Nobody will tell you what it going on. In loneliness and isolation your fears and crazy ideas grow.

Your parents are scapegoated by relatives, neighbors, and authorities. They begin exchanging recriminations themselves. They become more and more exhausted and discouraged.

You are torn between wanting to stay with your family because you hope you belong there, and wanting to leave because you caused them so much pain.

If your family breaks up or you withdraw from them and you do not find some other support system, you fall on the not so tender mercies of the state.

As you move out into the world, you find you are only comfortable with "social equals," people similarly ill or otherwise damaged, and those rare people who are willing to some extent to understand your experience and feel your pain.

Talking with straight people is nerve wracking. You can never be sure when something you say will come out all weird, and you will be recognized as a crazy person and gotten rid of.

Hungry for human contact, you approach other people, only to discover that they are afraid of you. They assume that if you are mentally ill, you are by definition suicidal and violent.

You had been so wrapped up in being afraid yourself, that it comes as a humiliating shock to find that <u>normal</u> people are afraid of <u>you</u>. Some of them will even take the position that if you are or ever have been crazy, you cannot be trusted with anything, ever.

When out in the community, you are anxiously self-conscious, aware that at any moment a mannerism, a social misstep, or something "inappropriate" will unmask you as a crazy and embarrass anyone you may be with.

You fear being stared at, made fun of, or even being attacked by street creeps always on the lookout for someone with a high victim profile.

If you are too sick to have a hope of concealing it, you can only wait to be hurt and try to keep on going.

Being disabled, you fall into the hands of caretakers.

Sometimes you feel like an abandoned ship, to be taken over by any normal person who wants to, as if they had some kind of salvage rights.

At times you spend a lot of energy fending off such people, trying to hold onto the right to run those parts of your life that you still can.

Caretakers come in various roles, with a variety of titles and letters after their names. Some are very skilled and genuinely helpful, a lot more manage to get by, and some are definitely part of the problem, not part of the solution.

You have no choice about being sick, and no choice about depending on caretakers at times. Even within a given type of service or a particular agency, you seldom have a choice. Your "case" is "assigned" to someone by a "catchment area," "admission rotation," or whatever.

Caretakers control access to medication, asylum (the hospital), money (welfare, SSI), and food (stamps). They decide whether to allow you the sick role, or whether to define you as bad, crazy, or stupid. They can invalidate what you say or do, and call upon the court to have you carted away.

Appeals from their decisions are costly, time consuming, difficult, or impossible. In no way is their relationship a voluntary one between equals.

For a caretaker to operate humanely in such an unequal relationship, a very high level of skill and integrity is required. When you have no choice, you need the best.

Paradoxically, the mental health system tends to assign the least experienced and lowest status workers to screening and to the seriously ill, and the most trained and highest status professionals to the less needy but "more interesting" (more likely to get better) clients.

Like all human beings, some mental healthers have their prejudices, some of which may have a major impact on your life. Some of these prejudices include that, if you are:

a. Poor--you are just trying to get free room and board;
b. Black--you have paranoid schizophrenia;
c. Old--you are hopelessly senile;
d. Male--you are violent;
e. Young and female--you are manipulative or seductive;
f. Young and male--you are a doper;
g. Admitted to a hospital from jail--you are faking;
h. Physically ill--it's all in your head;
i. Failing to get better--you are unmotivated.

In your dealings with mental health workers, you will encounter some common problems:

Mental healthers sometimes seem to see you as a kind of agent of insanity, and immediately start a power struggle over who is to be in control of the relationship.

They seem to fail to see that you have no desire to keep, much less propagate, your crazy ideas. You would get rid of them in a minute if you could only figure out how to do it.

They will frequently refuse to tell you your diagnosis and probable course of your illness. With no real information to go on, you are left to your imagination, which is often worse than anything a doctor could tell you.

What they tell you about the expected effects of your medications and possible side effects is commonly very sketchy. You sometimes have nasty surprises.

Although PRN (extra, as needed) medications are routinely prescribed in the hospital, you are rarely provided them outside. Somehow, life in the community is supposed to be much less stressful, and besides, you might "abuse" the medications.

You find yourself viewed with a general distrust. Everything you say or do is "evaluated" and subject to "clinical judgment," to determine its "real meaning." Yet basic investigative techniques, such as talking to everyone involved and cross-checking their stories, are omitted.

At times, this is due to lack of time or carelessness, but too often it comes from an ego trip wherein professionals feel that their qualifications enable them to discern deep truths virtually by remote control.

It is terribly frustrating to try to communicate with such people, because nothing you say is accepted at face value, but is changed into something unpredictably different.

Meanwhile, they want you to "develop a trust relationship" with them, but changes in staff and program priorities may come much faster than your ability to trust can handle.

You may have to cope with mental healthers who take basically useful approaches to problems and carry them to such lengths that they become problems themselves.

It is helpful to convey to you the expectation that you will get better, but not so helpful to fail to teach yourself care skills and work with the emotional problems that arise when it becomes clear that you are not improving.

Inventorying your symptoms and problems is a necessary beginning of a treatment plan, but concentrating only on what is wrong with you and ignoring the strengths and abilities you still have is not so useful.

Good general counseling skills and effective community organization are necessary to help you improve and maintain your quality of life. However, they do not eliminate the need for detailed knowledge of the symptoms, experiences, and problems which affect you as part of your mental illness, or as effects of your medications.

Anyone working with seriously ill people must be willing to take control at times when you are too disabled to carry on necessary life functions. Unfortunately, mental health work attracts numbers of people whose need to control others is so great that they tend to discourage your own sense of your own competence, and dampen any drive you may have toward free and self-reliant living.

This is a rip-off, because they imply that since you are incompetent, you may rely on them to meet your needs. The first time you get in trouble outside normal business hours or without an appointment, you may have a rude awakening.

You <u>have</u> no choice about learning to take care of yourself and your fellow crazy people as best you can. The response of the mental health system is often just too slow and unpredictable.

It is reasonable for mental health workers to hope for some emotional gratification from their work, but sometimes you are too sick, and have nothing to give in return. Sometimes, when you are not getting any better, your therapists get desperate and start "shot gunning" you with multiple medications and rapid, ill-thought-out changes in your treatment plan.

You may not be listened to when you try to explain what has worked for you in the past.

Since your records are usually following a hospital or an agency or two behind you, you may suddenly be taken off a regimen on which you had been stable, and which took months of experimenting to develop.

The principle seems to be "change something, whether it helps or not," rather than feel helpless.

Other times, some workers get frustrated and bitter, and put increasing pressure on you to "get well or get lost." This can be mutual: they cannot forgive you for not getting better, and you cannot forgive them for not getting you better.

If you are crazy, you can usually count on being poor.

If you are severely disabled, you will probably be on welfare, at least at first.

Your welfare grant is based on a fraction of what a study of local prices determines to be the minimum livable allotment.

Social Security (SSI) is somewhat more, but you are unlikely to successfully complete the complex application process without determined help from a case manager or a family member.

In either case, you will have a welfare medical card. Since there are restrictions on the services covered, and because the majority of local physicians do not take welfare patients, your medical care is likely to be poor and without continuity.

You will probably have bad teeth, as well. Dental care is only available for emergencies, and for a low dollar amount, resulting mostly in extractions.

Your clothing is likely to be poor, ill fitting and mismatched, coming from thrift stores, and sometimes carrying institutional marks.

Drifting in and out of hospitals, jails, and boarding houses, most of your possessions will have long since been lost or stolen. You may have little in the way of toilet articles, and you may smell.

Your status as a second class citizen, a loser, is displayed for all to see. In addition to the practical problems of poverty, there are the emotional effects. If you are one who has learned to count personal worth in terms of possessions, you are doubly poor.

There is a strong streak of Calvinism in our society: being poor is seen as evidence that you are also bad.

If you go into a nice store, clerks follow you around waiting for you to steal something. Some mental health workers dress especially well to avoid being mistaken for patients.

If you are unable to be productive, many feel you should be uncomfortable. It would be immoral, somehow contributing to your delinquency, to give you things you cannot earn.

You meet people who would obviously be willing to let you starve to death if it were their choice. To your humiliation is added an element of real fear.

You may find yourself begging and stealing, in violation of your own principles. You pack rat, assembling collections of junk, rather than have nothing at all.

Sometimes it is hard not to hate the caretakers around you, who have built a comfortable lifestyle upon your misfortune.

Sex is important to people, to sick people no less than to people who have the privilege of being healthy. Like everything else, mental illness messes it up.

When you are depressed, when you hurt so bad you have to be completely numb in order to function at all, the numbness itself becomes another kind of discomfort. You want to feel <u>something</u>, anything but more pain. You think of sex as a strong, good feeling, and try it. You run into a wall of pain and exhaustion. You cannot get aroused, you cannot tolerate intercourse. You experience one more crushing failure. Perhaps you are no longer a woman or a man anymore.

If you are high, in a manic state, you may be very sexually active. It may feel wonderful, or, if your high has reached an agitated, desperate stage, it may feel frenzied and out of control.

When you come down, it can be mortifying. You may have VD treatment, abortion, divorce papers, and new enemies waiting for you.

If you have a thought disorder, you may be too scattered to figure out what you need, or disorganized or fearful to effectively seek out a partner. If you find a partner, he or she is likely to be a "social equal." With both of you crazy things can get confusing.

Institutions do not make provisions for sexual privacy. Quite the contrary. Your sexual experiences are likely to take place in bushes or on the floors of out-of-the-way restrooms.

You risk a personal confrontation with the fact that many people, but especially high control institution types, do not feel crazy people are entitled to sex lives. They may also have reasonable concerns about competency to consent, and about civil liability.

If you are male, and your activities or choice of partner are not approved of, you may be written up in records as "sexually inappropriate with one of our sickest female patients" ("rapist").

If you are a female, you may be described in your chart as "sexually inappropriate with men" (presumably numerous, "whore").

If you are gay or lesbian, you are doubly disapproved of, and you risk having drastic action taken against you, especially premature discharge from treatment.

If you are young, and have homosexual experiences during prolonged institutionalization, which are common, you may have to keep it deeply secret afterward, and wrestle, usually alone, with the question of what your sexual orientation actually may be.

A complication of trying to have a sex life while under psychiatric treatment is that many psychotropic medications are sexually disabling in many people. You may find yourself unable to get aroused, or you may be aroused but unable to climax, or climax is long delayed.

You may be told about this when being instructed about your medications, but frequent not. If you can get up the nerve to raise the issue, often a reduction of dose or a change to another drug will take care of the problem.

If you cannot, you get more depressed at this additional evidence that your life is ruined.

When you are poor, crazy, and unwanted, you hunger for warmth and touching, on almost any terms. Sometimes you fall into the hands of cruel and exploitive people.

Sometimes you hope you will have a child, as a fulfillment of your identity as an adult human being, and in hopes of having someone to be with, who will love you. Frequently, this ends in tragedy, as you have children you cannot take care of, and they are taken away from you.

Because mentally ill people often are fairly helpless, they are frequent crime victims. Criminals often are aware that you may have no interested family or friends, and are easily discredited in court. Therefore, there is little risk of being prosecuted for any crime against you, short of murder.

The sword is two-edged: because you are "insane" you may receive no consequences for repeated antisocial acts. You risk developing habits of behavior that drive away your support system, and ultimately land you in the hospital or on Skid Row.

When you lose your mental health, you go through the same pattern of responses for any other major loss. Dr. Elizabeth Kubler-Ross's "Stages of Dying" is a fairly accurate model.

1. Shock. You never expect to go crazy, nor do you expect to find out one day that you have been crazy for a long time.

   You are stunned, confused, afraid. For a period of time, you are in shock and unable to do anything to help yourself.

2. Denial. You buy time to deal with overwhelming anxiety producing situations, by denying them. You try to go on living as if the problem did not exist, while your subconscious mind works on some way to cope with the problem.

   Other people, who are not sick, get frustrated and angry because you do not do whatever they think you should do about the situation.

   Since it is not their problem, they are not overwhelmed by anxiety, and they can view the whole affair more objectively.

   The crunch comes when they pressure you to "face this thing, right now!" and accuse you of "wanting to stay sick."

   The reason you are unwilling to do the things they demand, such as going to a clinic, taking medication, and giving up "unrealistic" life plans, is because you do not want to be sick. Therefore, you do not want anything to do with anything even remotely related to being crazy.

   Since your denial is basically driven by anxiety, the more you are harassed about "facing the facts," the more delayed as you're coming to terms with your situation.

3. Anger. When you realize that your life is going to be more painful and more limited than the lives of other people who are of no greater merit than yourself, you get mad.

   Since many people view the family as the source of all problems, you may direct, and be encouraged to direct, your anger at them. Often having strong guilt feelings themselves, they may agree that you are entitled to be angry at them.

   You may also vent your anger at mental health workers, whose very presence in your life is an undesirable reminder of how you have been cheated of a normal life.

   You may carry a powerful resentment against people who have the privilege of normalcy, who have jobs, friends, money, cars, and other things that you do not.

4. Bargaining. As it becomes clear that this insanity business is for real, and it shows no signs of going away, you want to make a deal.

   You try unusual diets, stranger religions, street drugs, anything that offers the faintest hope of making a difference.

You promise God that you will devote the rest of your life to medical research and serve to the poor, if only this cross will be taken from you.

Occasionally, someone recovers for no reason known to man. Not very often.

5. Depression. When you realize that no deals are being made, blaming people makes no difference, and the craziness is not going away. You are very, very sad.

   You have a right to be. Through no fault of your own, your life has been ruined. You may never have the job, children, a car, or even one day free of pain for the rest of your life. The temptation to give up and die is very great.

6. Acceptance. After a time, usually a long time, you find a way to accept yourself and what has happened, and to go on with your life.

   There are three things that you have to understand:

   a. You must take care of yourself and meet as many of your own needs as you can, either yourself or through relationships with other people which are mutual, equal and loving.

      By virtual biological law, people meet their own needs and those of their loved ones first. Only what is left over is offered to others.

      This is as true of mental health workers as anyone else. They provide specific services, and a measure of emotional support, but rarely as love as exchanged among equals.

   b. Blaming people, whether yourself, your family, or anyone else, is a waste of time.

      Too much psychodynamic, insight-oriented therapy is a thinly disguised search for someone to hold responsible.

      There is no way you can recover a piece of your life from someone, as if it were money damages. You may not be able to forgive or forget, but you have to withdraw your energy from the past, and go on.

   c. You have to find some reason, some mission in life to justify going on, in spite of the pain and lack of orderly success.

      If you are religious, it may be the faith that you are in this world to be tested, or to learn something essential for your spiritual development, and that your

Appendix

Some reasons mentally ill people contact crisis services are:

1. You may need help with a practical, real-world problem. If you spent a lot of your life being crazy, you may be missing whole areas of competence which are taken for granted by normal people, such as riding the bus, dealing with a traffic ticket, or returning defective merchandise to a store.

2. You may need help putting an idea in words, defining a problem clearly so that you can work on solving it, or communicating feelings to someone in a relationship. If you have a thought disorder, the most important area of communication in words can be extremely difficult.

3. You may need emotional support for a necessary decision not popular with your immediate support system. The people in your college psychology class may be delivering fulminating denunciations of psychotropic medications, but you have to stay on them, or end up in the hospital or dead.

4. You may have symptoms that relate to a developing medical problem, and you need help figuring out whether you need medical care, or whether these are just some new variations on your hallucinations and delusions.

5. You may be experiencing new or threatening psychiatric symptoms, such as prolonged sleep loss or command hallucinations ordering you to kill yourself. You may need help deciding how serious these are, and what to do about them.

6. You may need a perception check: does it seem likely that you are important enough for the FBI to bug your phone, or is that probably just a crazy idea?

7. You may need help finding specific local mental health or social services.

8. You may be without food, clothing, shelter, or essential medical care.

9. You may be in legal trouble, and need help conveying to those defending you, the nature of your illness and your disabilities.

suffering has a place in the overall cosmic picture. For others it may be the goal of someday writing a book, which you hope will help normal people understand the experiences and needs of the mentally ill.

For a few who have luck, brains, and a terrible determination, it may be possible to go back into the wilderness to try to lead a few brothers and sisters to freedom. They become mental health workers themselves.

It may be the love of family, fear of death, or even plain stubbornness, but there has to be a reason.

If the pain is futile, it is also intolerable.

COMMUNITY RESOURCES

NETWORK
Behavioral HealthCare, Inc.

Resume of Low-Income Housing Experience

Date of Inception	Project
March 1985	Tillicum Court Apartments

Under the corporate ownership of Southeast Network Housing Services, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing in studio and 1 bedroom apartments, as well as skills training and support services, are provided on-site. Additional psychiatric and clinical services are available through the Network's Rehabilitation and Community Services divisions.

March 1987 — 70th Street House

The Network provides residential care in a transitional group home setting to 12 individuals having mental illness. Twenty-four hour supervision, skills training, and counselor support are provided on-site as are meals, medication and money management. The facility is leased from the Housing Authority of Portland and operated by the Network. All residents are low income and supported by entitlement programs.

May 1988 — Nawikka Court Apartments

Under the corporate ownership of Southeast Network Housing Services II, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing is provided in 1 bedroom units with additional services provided as described for Tillicum Court.

ADMINISTRATION
5415 SE Milwaukie Avenue • Portland, Oregon 97202
(503)238-0769 • FAX(503)233-2801

January 1992

Pisgah Home/Harriet Court Apartments

The Network provides both residential care (Pisgah Home) and supported housing (Harriet Court) to individuals having mental illness at these co-located program sites. Fifteen Pisgah tenants receive twenty-four hour supervision, assistance with activities of daily living (hygiene, grooming, etc.), money, medication and crisis management; skills training and counseling. Fifteen Henry Court tenants live independently and receive skills training and support from on-site staff as appropriate to their needs. Tenants in either program reside in private rooms with private baths. Congregate meals are available. The Network owns and manages the facility in which it operates these programs. All tenants have incomes below 50% of median; many are supported by entitlements.

November 1993

Woodstock Court Apartments

The Network operates this nine (9) unit complex under lease from the Housing Authority of Portland, the project's co-developer (with Network). Eight studio units are rented to homeless individuals having mental illness. An on-site manager occupies a 9th unit. The Network provides skills training and support services including medication monitoring and a meal preparation skills program. The Network manages all aspects of this housing. All tenants have incomes below 50% of median, typically from entitlement payments.

May 1994

Lafayette Apartments

The Network owns and operates this thirty two (32) unit complex which provides supported independent living in studio and in one bedroom apartments to individuals having mental illness. On-site management and optional skills training and support services including medication monitoring and meal preparation training are provided. All tenants have incomes below 30% of median and are generally supported by entitlement programs.

October 1994

Kernlodge Home

Quint 26

The Network operates these two, five (5) unit homes under lease from The Housing Authority of Portland, the project's co-developer (with Network). Each home contains five SRO units (a private bedroom and bath), and shared space that includes kitchen, dining room, living room, laundry, and individual pantry/food storage areas. This shared housing affords its tenants privacy, security, and comfort in a small, group-oriented, neighborhood-friendly building. Tenants are low income persons having mental illness who are capable of living in an unsupervised setting. The buildings do not have live-in management, but are regularly monitored by the staff of Network Behavioral HealthCare, Inc. The Network provides the residents with skills training, case management, twenty-four hour emergency on-call psychiatric, health, vocational, socialization, recreational and medication monitoring services. All tenants have incomes below 50% of area median and are generally supported by entitlement payments.

January 1995

Lents Court

The Network operates this five (5) unit home under lease from The Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge and Quint 26 described above. All tenants are low income veterans who are clients of the VA Domaciliary Program. All support services are provided by the VA under a Letter of Understanding with Network.

January 1996

Tea Link Home

The Network operates this five (5) unit home under lease from the Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge, Quint 26 and Lents Court described above. All tenants are low income Asians. All support services are provided by the Chinese Mental Health Program.

March 1996

Hopewell Apartments

Under the corporate ownership of EcuNet Housing, Inc., a partnership between Network and Ecumenical Ministries of Oregon, Network operates this 8 one bedroom and 4 two bedroom HUD 811 apartment building. Hopewell offers low income people with HIV disease and psychiatric disabilities housing and a program of services to help them live as independently as possible. On-site management is available. Tenants pay about 30% of their income for rent and utilities and are required to meet HUD income eligibility requirements.

June 1996

Clinton Street Apartments

The Network owns and operates this 16 unit complex (15 studio apartments and 1 one bedroom apartment) to provide housing with linked support services for low income individuals with mental illness. The project has an on-site manager who provides skills training and support services including medication monitoring, case coordination, and recovery services. All tenants have incomes below 50% of area median and are generally supported by entitlement programs.

September 1996

Tabor House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. All six tenants are low income individuals who are capable of living in an unsupervised, supportive setting. Each has a private bedroom and shares use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

November 1996

75th Ave. Adult Foster Care

Network owns and operates this five resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 50% of area median and are supported by entitlement programs.

August 1998

Powell Blvd. Apartments

Under the ownership of Powell Boulevard Apartments, Inc., a not-for-profit corporation sponsored by REACH Community Development, Network operates this 20 unit HUD 811 project for the benefit of low income persons having co-existing mental illness and substance abuse disorders. Tenants occupy studio, 1 bedroom, and 2 bedroom units, and participate in a program of services designed to promote independence and sobriety. On-site management and supports are available to supplement psychiatric and addictions services provided through Network's Project STOP or other treatment providers. All tenants have incomes below 50% of area median and pay approximately 30% of their income for rent and utilities.

March 1999

Woodstock House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. The tenants are low income women who are capable of living in an unsupervised, supportive setting. The home is configured to allow the rental of individual bedrooms to single women or two bedroom suites to small families. Tenants share the use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

April 1999

Residential Intensive Treatment Services

The Network owns and manages this ten unit transitional housing program in which residential treatment is provided to individuals having mental illness and addictions issues. Tenants are referred by Multnomah County Community Corrections and receive twenty-four hour supervision, addictions treatment, assistance with activities of daily living, money, medication and crisis management; skills training and counseling. Tenants reside in private rooms with half baths during their three month stay. All tenants have incomes below 50% of median; many are supported by entitlements.

January 2000

Nadine Place

Network owns and operates this eight resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 30% of area median and are supported by entitlement programs

Tenants of these residential programs receive housing and on-site services as specified above. In addition, tenants are welcome to participate in the full range of community treatment and rehabilitation programs offered by The Network. These programs include case management; medical and psychiatric consultation; vocational, recreational and socialization services, substance abuse recovery services; psycho-social clubhouse; crisis/triage services; individual and group counseling; and medication management.

MEDICATIONS

MEDICATIONS AND THEIR SIDE EFFECTS

Psychiatric researchers believe that people suffering from many mental illnesses have imbalances in the way their brain metabolizes certain chemicals, called neurotransmitters. Because neurotransmitters are the messengers the nerve cells use to communicate with one another, these imbalances may result in the emotional, physical and intellectual problems that mentally ill people suffer. Psychiatric medications are like any other medicine a doctor would prescribe. They are formulated to treat specific conditions, and they must be monitored by a physician. All medicines have positive and negative effects. Whether or not a person will experience side effects cannot be predicted. Responses to medications are individual. Most medications psychiatrists prescribe may take a few days or a few weeks to become fully effective. The listed medications and their side effects are some of the most common but it is certainly not a complete list.

http://www.psych.org/public-infor/MEDS~1.HTM 7-15-99

MEDICATIONS AND THEIR SIDE EFFECTS

Antidepressents	Most Common Side Effects
Amitriptyline (Elavil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, worsening of heart disease, dizziness when first standing up
Amoxapine (Asendin)	Worsening of heart disease, sleepiness, agitation, insomnia, anxiety
Bupropion (Wellbutrin)	Agitation, dry mouth, insomia, headache, nausea, vomiting, constipation, tremor
Clomipramine (Anafranil)	Dry mouth, sleepiness, tremor, weight gain, sweating, dizziness when first standing up, blurred vision, constipation, trouble having orgasm, trouble urinating, nausea
Desipramine (Norpramin)	Dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, dizziness when first standing up
Doxepin (Sinequan)	Sleepiness, sweating, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, weight gain, dizziness when first standing up
Fluoxetine (Prozac)	Agitation, anxiety, insomnia, drowsiness, tremor, loss of appetite, nausea, diarrhea, headaches, dizziness, problems with orgasm
Imipramine (Tofranil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Maprotiline (Ludiomil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, weight gain
Nefazodone (Serzone)	Sleepiness, dizziness when first standing up, nausea, headache
Nortriptyline (Pamelor)	Sleepiness, dry mouth, trouble urinating, constipation, blurred vision, weight gain
Paroxetine (Paxil)	Nausea, sleepiness, fatigue, dizziness, insomnia, sweating, tremor, loss of appetite, anxiety, trouble having an orgasm
Protriptyline (Vivactil)	Dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, insomnia, anxiety
Sertraline (Zoloft)	Nausea, diarrhea, tremor, dizziness, insomnia, sleepiness, sweating, fry mouth, delay in having an orgasm
Trazodone (Desyrel)	Sleepiness, worsening of heart disease, dizziness when first standing up, nausea, vomiting
Trimipramine (Surmontil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Venlafaxine (Effexor)	Sedation, nausea, sweating, dry mouth, dizziness, weakness, constipation, decreased appetite, vomiting, anxiety, tremor, blurred vision, problems with orgasm, headache
Fluvoxamine (Luvox)	Sleepiness, insomnia, anxiety, tremor, nausea, loss of appetite, vomiting, sweating, delayed orgasm

http:noah.cuny.edu/illness/mentalhealth/cornell/medications/antidepsideff.html 7-15-99

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche" =the mind and "tropos" = turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics; that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially **highly addictive**, produce fairly **rapid tolerance** and are extremely **difficult to withdraw** from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal, as bad as it feels, is actually easier, quicker and safer than benzodiazapine withdrawal.

Common side effects are sedation, dry mouth, depression, and memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do **not produce tolerance**. The anti-depressants work to restore balance in the neurotransmitter systems, which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics
Elavil (amitriptyline)

Tofranil (imipramine)
Norpramine (desipramine)
Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

The second generation or "atypical" compounds
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)
Serzone (nefazadone)
Remeron (mirtazapine)

The SSRI's (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

The MAOs (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The **ANTI-MANICS (also referred to as mood stabilizers)** are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. **Non-addictive** and does not produce tolerance. Research has shown that these medications are also helpful in preventing the recurrence of severe mood swings.
Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The **ANTI-PSYCHOTICS** also called **Neuroleptics** are used to treat psychotic symptoms. As such they are believed to work by restoring balance in the neurotransmitter systems (primarily dopamine) which mediate thought processes, perception and mood. They are **non-addictive** and do not produce tolerance.
Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)
Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
The "new generation" anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Seroquel (quetiapine)
Orap (pimozide) used mainly for Tourette's Syndrome

The **Anti-Parkinson** medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The **ATTENTION DEFICIT DISORDER/HYPERACTIVITY** medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. These **medications can produce dependence and tolerance.** They are less often prescribed now as many of the **SSRI anti-depressants** and a

couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)
Adderol (contains both dextro and levo amphetamine)

There are probably newer medications in all the above classes since this has been written but this list is fairly inclusive.

Keep in mind that side effects can occur with any chemical you take in. Such things as aspirin and tylenol can be deadly. Side effects are reported when they occur in more than 2% of the population taking a particular medication. Most often they are dosage related or a sensitivity to a particular medication which can be substituted with one which is better tolerated. If you have a condition which warrants taking a psychotropic medication, odds are that you and loved ones around you suffer more from the condition than you ever will from a side effect.

ANTI-PSYCHOTIC DRUGS

ACETOPHENAZINE (TINDAL) MESORIDAZINE (SERENTIL) TRIFLUOPERAZINE (STELAZINE) THIOTHIXENE (NAVANE) RESPERIDONE (RISPERDAL) LOXATANE (LOXAPINE) CHLORPROMAZINE (THORAZINE) HALOPERIDOL (HALDOL) THIORAZINE (MELLARIL) PIMOZIDE (ORAP) MOLIDONE (MOBAN) CHLORPROTHIXENE (TARACTAN) FLUPHENAZINE (PROLIXIN) TRIFLUOPERAZINE (STELAZINE) PERPHENAZINE (TRILAFON) CLOZAPINE (CLOZARIL)	Side effects include dry mouth, blurred vision, constipation, and drowsiness. Some people taking the medications can experience a difficulty in urinating that ranges from mild problems beginning urination to complete inability to do so, a condition that requires prompt medical attention. Other side effects include greater risk for sunburn, changes in white blood cell count (with clozapine), low blood pressure when standing or sitting up, akathisia, dystonia, parkinsonism, and tardive dyskinesia. Tardive dyskinesia is one of the most serious side effects of anti-psychotic medications. This condition affects between 20 and 25 percent of persons taking antipsychotic drugs. Tardive dyskinesia causes involuntary muscular movements, and though it can affect any muscle group, it often affects facial muscles. There is no known cure for these involuntary movements (though some drugs, including reserpine and levodopa may help) and tardive dyskinesia may be permanent unless its onset is detected early.

Anti-psychotic drug list from Kay Peterson/Project Respond/Portland, Or. 7-15-1999

NOTES

PSYCHIATRIC MEDS BY TRADE NAME

CODES:

AA=anti-anxiety
AD=anti-depressant
AD/MAOI=anti-depressant (can be life threatening when mixed with tyramine, eg some alchols & cheeses)
AD/TCA=antidepressant (higher risk of fatal OD)
AP=anti-psychotic
ALZ=for Alzheimers disease
HYP=hypnotics, meds used for sleep
MR=muscle relaxants((not a psych med/may effectbehavior)
MS/AC=mood stabilizers; and /or anticonsulusant
NAR=narcotics,(for pain mgmt, may effect behavior)
SE= meds commonly used for side effects of anti-psychotics
STIM=stimulants

Adaptin	AD	doxepin
Adderall	STIM	dextroamphetamine
Akineton	SE	biperiden
Amytal	SLP	amobarbital
Anafranil	AD/TCA*	clomipramine
Antabuse	Etoh block	disulfiram
Aricept	ALZ	donepezil
Artane	SE	trihexyphenidyl
Ascendin	AD	amoxapine
Atarax	AA	hydroxyzine
Ativan	AA	lorazepam
Aventyl	AD/TCA*	nortriptyline
Benadryl	SE	diphenhydramine
Buspar	AA	buspirone
Centrax	AA	prazepam
Clozaril	AP	clozapine
Cogentin	SE	benztropine
Cognex	ALZ	tacrine
Cylert	STIM	pemoline
Dalmane	HYP	flurazepam
Darvocet	NAR	propoxyphene
Demerol	NAR	meperidine
Depakane	MS/AC	valproic acid
Depakote	MS/AC	valproic acid
Desyrel	AD	trazadone
Dilantin	AC	phenytoin
Dilaudid	NAR	hydromorphone
Effexor	AD	venlafaxine
Elavil	AD/TCA*	amitriptyline
Endep	AD/TCA*	amitriptyline
Equanil	AA	meprobamate
Eskalith	MS	lithium

Floricet	NAR	butalbital with aspirin
Florinal	NAR	butalbital with tylenol
Flexoril	MR	cyclobenzaprene
Halcion	HYP	triazolam
Haldol	AP	haloperidol
Inderal	SE/AA	propranolol
Isoptin	AA/MS	verapamil
Janimine	AD/TCA*	imipramine
Kemadrin	SE	procyclidine
Klonopin	AA	clonazepam
Librium	AA	chlordiazepoxide
Lioresal	MR	baclofen
Lithobid	MS	lithium
Loxitane	AP	loxapine
Ludiomil	AD	maprotiline
Lortabs	NAR	hydrocodone
Luvox	AD	fluvoxamine
Marplan	AD/MAOI	isocarboxazid
Mellaril	AP	thiorazine
Miltown	AA	meprobamate
Moban	AP	molidone
Mysoline	AC	primidone
Nardil	AD/MAOI	phenelzine
Navane	AP	thiothixene
Nembutal	HYP	pentobarbital
Noctec	HYP	chloral hydrate
Norpramin	AD/TCA*	desipramine
Orap	AP	pimozide
Pamelor	AD/TCA*	nortriptyline
paraldehyde	HYP	paraldehyde
Parnate	AD/MAOI	tranycypromine
Paxil	AD	paroxidine
Percocet	NAR	oxycodone with tylenol
Percodan	NAR	oxycodone with aspirin
Pertofrane	AD/TCA*	desipramine
Placidyl	HYP	ethchlorvynol
Prolixin	AP	fluphenazine
ProSom	HYP	estazolam
Prozac	AD	fluoxetine

Rela	MR	carisoprodol
Remeron	AD	mirtazapine
Restoril	HYP	temazepam
Risperdal	AP	resperidone
Ritalin	STIM	methyphenidate
Robaxin	MR	methocarbamol
Seconal	HYP	secobarbital
Serax	AA	oxazepam
Serentil	AP	mesoridazine
Serzone	AD	nefazodone
Seroquel	AP	quitiapine
Sinequan	AD/TCA*	doxepin
Soma	MR	carisoprodol
Stelazine	AP	trifluoperazine
Surmontil	AD/TCA*	trimipramine
Symmetrel	SE	amantadine
Taractan	AP	chlorprothixene
Tegretol	MS/AC	carbamazepine
Tenormin	SE	atenolol
Thorazine	AP	chlorpromazine
Tindal	AP	acetophenazine
Tofranil	AD/TCA*	imipramine
Tranxene	AA	clorazepate
Trilafon	AP	perphenazine
Tylenol/codeine	NAR	acetominophen with codeine
Tylox	NAR	oxycodone with aspirin
Valium	AA	diazepam
Vistaril	AA	hydroxyzine
Vivactil	AD/TCA*	proptriptyline
Wellbutrin	AD	bupropion
Xanax	AA	alprazolam
Zoloft	AD	sertraline
Zyban	AD	buproprion
Zyprexa	AP	olanzapine

GENERIC NAME	TRADE	TYPE
acetominophen with codeine	Tylenol/codeine	NAR
acetophenazine	Tindal	AP
alprazolam	Xanax	AA
amantadine	Symmetrel	SE
amitriptyline	Elavil	AD/TCA*
amitriptyline	Endep	AD/TCA*
amobarbital	Amytal	SLP
amoxapine	Ascendin	AD
atenolol	Tenormin	SE
baclofen	Lioresal	MR
benztropine	Cogentin	SE
biperiden	Akineton	S
bupropion	Wellbutrin	AD
buproprion	Zyban	AD
buspirone	Buspar	AA
butalbital with aspirin	Fioricet	NAR
butalbital with tylenol	Fiorinal	NAR
carbamazepine	Tegretol	MS/AC
carisoprodol	Rela	MR
carisoprodol	Soma	MR
chloral hydrate	Noctec	HYP
chlordiazepoxide	Librium	AA
chlorpromazine	Thorazine	AP
clomipramine	Anafranil	AD/TCA*
chlorprothixene	Taractan	AP
clozapine	Clozaril	AP
clorazepate	Tranxene	AA
clonazepam	Klonopin	AA
cyclobenzaprene	Flexoril	MR
desipramine	Norpramin	AD/TCA*
desipramine	Pertofrane	AD/TCA*
dextroamphetamine	Adderall	STIM
diazepam	Valium	AA
diphenhydramine	Benadryl	SE
disulfiram	Antabuse	Etoh block
donepezil	Aricept	ALZ
doxepin	Adaptin	AD
doxepin	Sinequan	AD/TCA*
estazolam	ProSom	HYP
ethchlorvynol	Placidyl	HYP
fluoxetine	Prozac	AD
fluphenazine	Prolixin	AP
flurazepam	Dalmane	HYP
fluvoxamine	Luvox	AD
haloperidol	Haldol	AP
hydrocodone	Lortabs	NAR
hydromorphone	Dilaudid	NAR
hydroxyzine	Atarax	AA

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAA
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MR
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAA
oxycodone with aspirin	Tylox	NAA
oxycodone with tylenol	Percocet	NAA
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAA
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

thiorazine	Mellaril	AP
thiothixene	Navane	AP
tranycypromine	Parnate	AD/MAOI
trazodone	Desyrel	AD
triazolam	Halcion	HYP
trifluoperazine	Stelazine	AP
trihexyphenidyl	Artane	SE
trimipramine	Surmontil	AD/TCA*
valproic acid	Depakane	MS/AC
valproic acid	Depakote	MS/AC
venlafaxine	Effexor	AD
verapamil	Isoptin	AA/MS

MEDICAL EMERGENCIES include but are not limited to:

Anti-psychotics (AP) may cause a syndrome with muscle rigidity, fever, fast pulse rate, high blood pressure, confusion.

Anti-psychotics (AP) may cause muscle stiffness and tightening, tremors, and effect swallowing.

Tricyclic anti-depressants (AD/TCA*) present a higher risk of lethal overdose, especially if combined with alcohol; if combined with cocaine can produce heart failure.

Antabuse (disulfiram) if combined with alcohol will cause flushing, sweating, headache,palpitations, difficulty breathing, rapid heart beat, drop in blood pressure, nausea & vomiting; may lead to serious drop in blood pressure and death.

Medication-related seizures , a situation which should be evaluated at the hospital.

Certain anti-depressants (AD/MAOI) if combined with alcohol , certain cheeses and other foods containing tyramine will cause blood pressure crisis.

Delirium is a medical emergency, which includes symptoms of irritability, significant distractability, hallucinations,

Meds such as anti-anxiety agents and hypnotics have a higher risk of lethal overdose particularly if combined with alcohol.

OTHER RISKS OF PSYCHIATRIC MEDICATIONS INCLUDE:

Susceptability to sunburn-particularly with certain antipsychotics.

Higher risk of dehydration- particularly with lithium.

Anti-cholinergic side effects , including dry mouth, blurred vision, constipation, difficulty urinating, impotence, constipation.

Many medications can cause allergic reactions as well as unexpected reactions with other medications, foods, alcohol, drugs.

Compiled by Project Respond for the Portland Police Department.

Portland Police Bureau

CRISIS INTERVENTION TEAM

MAKING A DIFFERENCE TOGETHER

CIT Training
May 20th - 24th, 2002
Portland, Oregon

Portland Police Bureau

Crisis Intervention Team

Instruction Manual

CIT Mission Statement:

"The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis."

Crisis Intervention Training

Day:	Monday Nov. 26th	Tuesday Nov. 27th	Wednesday Nov. 28th	Thursday Nov. 29th	Friday Nov. 30th
Location:	*Portland Adv./ Amp. D*	*Portland Adv./ Amp. C*	*Off Site*	*Portland Adv./ EdCenter. A*	*Portland Adv./ EdCenter. A*
0800-0900	Class Introduction	Review/ Civil Commitment,	Site Visits	Review/ MR/DD	Culture Panel
0900-1000	Childhood Disorders	P.S.R.B., and Consumer Rights	Site Visits	MR/DD	Scenarios
1000-1100	Overview of Mental Illness	Overview of M.H. System	Site Visits	Mental Status Exam	Scenarios
1100-1200	Overview of Mental Illness	Aging Services	Site Visits	BPLS/Violence Curve	Scenarios
1200-1300	Lunch	Lunch	Lunch	Lunch	Lunch-Move to SE Precinct
1300-1400	Overview of Mental Illness	Personality Disorders	Site Visits	Suicide Intervention	Officer Scenarios
1400-1500	"Voices"	Personality Disorders	Site Visits	Crisis Intervention	Officer Scenarios
1500-1600	Modeling Mental Illness	P.T.S.D.	Site Visits	Crisis Intervention	Officer Scenarios
1600-1700	Family and Consumer Panel	Alcohol & Drugs	Site Visits	Crisis Intervention	Graduation

Training will take place at Portland Adventist Hospital in the listed rooms. Except for Friday afternoon, when we will move to Southeast Precinct's Community Room to complete the training.

November 28, 2001:
Site Visitation Schedule

Time	Group A	Group B	Group C	Group D
0800-0900	Rennisance/ Clinic	Rennisance/Clinic	Ryles Center	Ryles Center
0920-1020	Ryles Center	Ryles Center	Rennisance/Clinic	Rennisance/Clinic
1040-1140	Faulkner Place	Port City	Comet Club	Hooper Detox
1140-1300	Lunch & Travel	Lunch & Travel	Lunch & Travel	Lunch & Travel
1300-1400	Port City	Royal Palm Hotel	Hooper Detox	New Mezz Connection
1420-1520	Bridgeview	Rainbow Adult Living	MCDC	MCDC
1540-1700	MCDC	MCDC	Bridgeview	Faulkner Place

Bridgeview: 707 NW Everett. Contact: Erin Fisher (Ph. 222-4906)

Comet Club: 5507 N. Lombard. Contact: Jessica Turner (Ph. 285-9871 ext. 315)

Faulkner Place: 13317 SE Powell Contact: Alan Wood (Ph. 760-9606)

Hooper Memorial Detox: 20 NE MLK Jr. Blvd. Contact: Jeanne Rivers (Ph. 238-2067)

MCDC: Meet in the Main Lobby, Contact: Kathy McCullough (Ph. 988-5230)

New Mezz Connection: 1122 SW Stark. (Enter through metal gate, then double glass doors, then into Day Treatment Center) Contact: Lorraine Vitkauskas (Ph. 552-5125)

Port City: 1847 E. Burnside. Contact: Brenda or Judy (Ph. 236-9515)

Rainbow Adult Living: 3701 SE Belmont. Contact: Greg Ruff (Ph. 231-1608)

Rennisance / Network Walk-in Clinic:

Royal Palm Hotel: 310 NW Flanders. Contact: Robin Hochtritt (Ph. 827-3949)

Ryles Center: 3339 SE Division. Contact: Kay Endres (Ph. 238-1477)

Section 1: Mental Illness

ASSESSMENT MODEL

RECOGNIZING PERSONS WITH MENTAL ILLNESS

The purpose of this activity is to provide officers with guidelines for identifying mentally ill persons. Emphasize that officers only have to be capable of identifying major behaviors indicative of a mental illness; they do not have to identify specific types of mental disorders. That is the function of a mental health professional. Whereas mental health professionals determine the type and severity of illness, officers only have to make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder.

Discussion Points

1. Generally, what is known about people with mental illnesses?

   - Depending on the severity of the disorder, mentally ill persons can be difficult to distinguish from persons not having a mental disorder.
   - Persons with a mental illness can be quite intelligent, perceptive, and articulate.
   - They can be employed and maintain familial relationships.
   - With the onset of their disorder, however, they become unable to deal realistically with the world.
   - Their thoughts and actions are not based on reality.
   - Their ability to think clearly is impaired.

2. What are the general characteristics that indicate a mental illness?

   - The behavior and mood of the person are inappropriate to the setting.
   - The behavior of the person tends to be inflexible.
   - The behavior of the person tends to be impulsive.

3. What are specific indicators of mental illness?

   - Sudden changes in lifestyle

     -can be both a cause and indicator of mental illness
     -involves an inability or unwillingness to fulfill one's expected role and responsibilities.

   - Major changes in behavior

     -behavior may have undergone sudden and drastic change
     -behavior may be marked by exaggerated mood swings
     -person may show lack of judgment regarding family, job, money, or property
     -person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic or fright

  -anxiety is intense and unfounded
  -person is in a state of panic or fright
  -person may have trembling hands, dry mouth, or sweaty palms
  -person may be "frozen" with fear

- Believes others are plotting against him

  -person has an unreal fear of being watched, talked about, followed, persecuted, or harmed (e.g. a large man believing a frail, elderly woman is trying to strangle him)
  -person cannot separate reality and imagination

- Hallucinations

  -person experience events that have no objective source, but that are nonetheless real to him or her
  -most common hallucinations are seeing or hearing things, but can involve any of the senses, such as:

    feel - most commonly of bugs crawling on the body
    smell - often of gas associated with death plots
    taste - usually of poisons in food
    hearing - voices telling the person to do something
    sight - visions of God, the dead, or horrible things.

  -hallucinations can also be induced by drug or alcohol abuse

- Delusions

  -personal beliefs that are not based on reality
  -can cause the person to view the world from a unique or peculiar perspective
  -often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person beliefs he or she is God, a saint, a famous person, or possesses a special talent or beauty)

- Depression

  -accompanies many mental disorders in varying degrees
  -often characterized by a persistent, general malaise
  -serious depression can involve withdrawal from family, job, and social involvement.

- Obsessions

  -recurrent thoughts, ideas, or images that the person cannot dismiss from mind usually involve behavior that the person finds unacceptable (e.g. a woman may believe

that every man she encounters is trying to seduce her)
-can cause tension and high level of anxiety

- Unexplained losses of memory

-not the normal forgetting of everyday things, but failing to remember the day, year, where one is, etc.
-not to be confused with loss of memory that often accompanies aging

- Confusion

-inability to focus on particular topic or interaction
-might be an indication that person has an obsession
-also caused by stroke, diabetic coma, intoxication, senility

- Impossible body ailments

-at first, symptoms are mild and may even fool doctors
-common beliefs are a body part growing, heart stopped, or chest filling with food

- Persons who suffer from mental illness must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are uncomfortable or annoying. Unlike hallucinations, these side effects are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize the presence of the side effects. Some of the major noticeable side effects include:

-minor stiffness, a rigid shuffling gait
-an at rest, hand jerk
-acute muscle spasms, tilted head
-a constant, fine, fast tremor
-blurry vision
-rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or-in severe cases-facial distortion

B Basic P Psychiatric L Life S Support

Portland Police Version

1. Goal

This summary is intended to provide police and other justice professionals with a basic outline of techniques for dealing with patients suffering from acute psychiatric disturbances. The emphasis is on an initial approach, urgent or emergent evaluation, and basics of intervention.

2. Introduction

Dealing with patients suffering from psychiatric disorders is often perceived as frightening by those infrequently exposed to these problems. The area of psychiatry itself may seem foreign for several reasons:

Psychiatry deals with biopsychosocial issues (1) that typically straddle multiple areas:

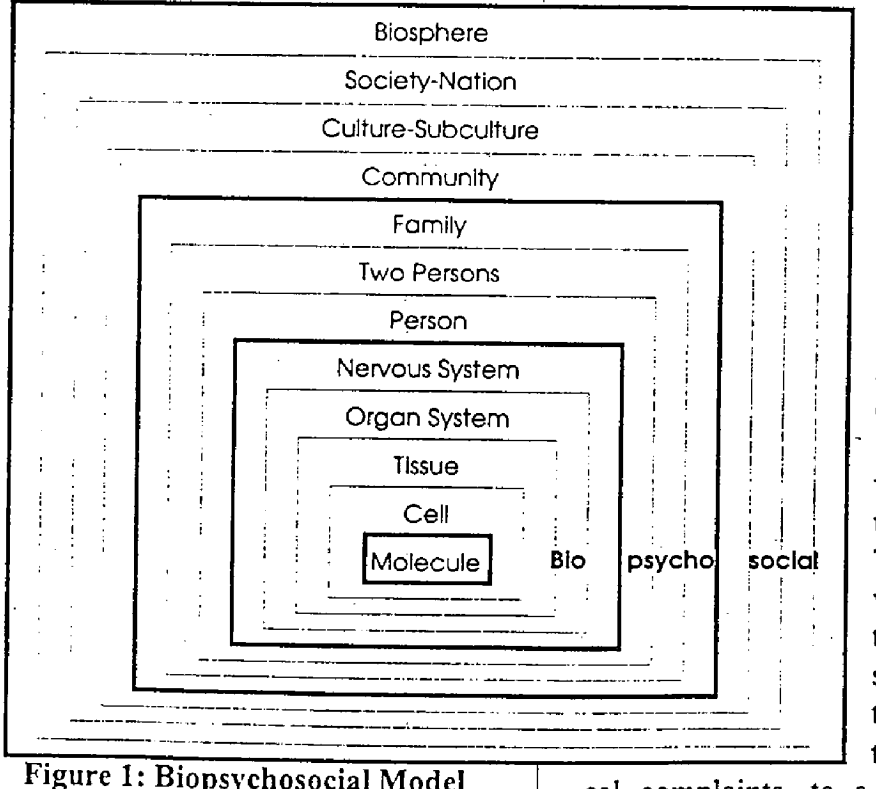


Figure 1: Biopsychosocial Model

There is no clear boundary between actions based on personal choice, social difficulties, psychological distress, or on a clearly biological disease. Multiple factors simultaneously influence the ultimate actions of an individual. Identifying and treating mental illness is complex, requires time, and may make the field appear diffuse and unclear.

Additionally, "gold standard tests" which would allow certain attribution of specific signs and symptoms to a specific disorder are generally not available. There is no X-Ray or blood test for bipolar disorder, for example. If a patient has signs of several disorders, multiple diagnoses must be considered, and frequently multiple diagnoses must be given. This may make the professionals operating in the field seem divided and without focus.

Finally, patients with psychiatric conditions often contact nonpsychiatric care providers first. They may adapt their complaints to match the specialty or "language" of the professional they are seeing. Thus, patients with similar ultimate diagnoses may present to a family doctor with physical complaints, to a mental health

professional with mental health complaints (2) (and likely to peace officers with safety concerns). Knowledge of mental illness can help the professional direct the patient safely into appropriate evaluation and treatment.

Top priority must be the professional's immediate physical safety.

The Basic Psychiatric Life Support model presented here is an attempt present the area of acute psychiatric practice in a way that is reductionistic, yet robust. The approach is generally algorithmic, similar to the Basic Cardiac Life Support course (3), which has brought emergency medical thinking to a broad audience. The structure of the algorithms here is determined by several factors which can be subsumed under the term "priority":

Severity: How bad is the disorder/injury?
Urgency: How fast must a response occur to be effective?
Remediability: How much difference will any response make?
Sequence: Does one step require a prior step?
Natural History: Balancing low frequency events with high morbidity against high frequency events with low morbidity.

3. Initial Triage

Even when it is clear that the appropriate or desired intervention is a psychiatric evaluation and/or treatment, attention must be given to its priority. (It is understood that here we are generally talking about noncatastrophic conditions in which the clinician has some realistic choices about how to proceed.)

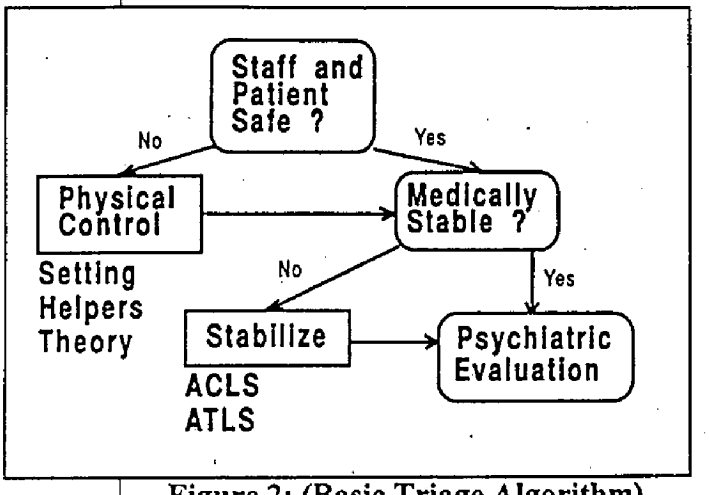


Figure 2: (Basic Triage Algorithm)

Top priority must be the clinician's immediate physical safety. What good can an injured or dead helper be? (Second priority is then the patient's own immediate physical safety.) If the clinician and patient are not physically safe, such safety must be provided for. Secondly, the patient must be medically stable to undergo psychiatric evaluation. If such medical stability is in question, immediate steps must be taken (after assuring physical safety) to intervene on this level. It is then the third priority to begin with a psychiatric evaluation, which will include the evaluation for suicide or homicide potential.

Also, attention must be given to the fact that a crisis represents the perception of an event or situation as intolerable, as an intolerable difficulty that exceeds the resources and coping mechanisms of the person defining the crisis. Such a concept must not be confused with that of an emergency,

which represents a sudden (and often distressing) event that may lead to serious psychological or physical consequences if there is no adequate response. This distinction is difficult, and at times one will need to proceed under the assumption of an emergency, even when it may ultimately prove that the problem is better identified as a crisis.

4. Physical Safety

That it is top priority to evaluate the potential of immediate harm to the professional and secondarily the patient comes as no surprise to police officers. This is their daily concern. We are looking for such basics as absence of weapons, a secure physical environment, and a patient that is reasonably able to modulate their behavior. The goal is to establish short term safety.

In essence, the concern is to identify and remain prepared for potential immediate violence, which represents a relatively rare event, but one with significant potential for injury or even death (4,5). It follows that attention must be given to issues of safety before they are needed. Protocols must be clear and well rehearsed.

4.1 Strategies:
To briefly review, the controllable variables can be grouped into three main categories: physical setting, personnel, and a theoretical model to guide the approach. Police safety techniques discuss these areas in detail, so here we will only list some areas of emphasis in the psychiatric arena for comparison.

4.1.1 Physical setting:
Structural requirements include the absence of dangerous or potentially dangerous objects, ideally access from multiple directions, monitoring and emergency communication systems, some provisions for confidentiality, and the opportunity to physically restrain a patient.

Each setting that the professional will work in should be rapidly reviewed a "worst case scenario" considerations in mind and steps should be taken to ensure as much safety in these settings as possible.

If physical restraint is used, sufficient help should be available to safely overwhelm the patient.

4.1.2 Personnel:
Just as the physical surroundings deserve attention, the professional must be completely aware of the help that is going to be available in an emergency. Specifically mental health trained, 24 hours per day, capability would be ideal. Such personnel should have an understanding of the medical model of overwhelming force. Police techniques that rely on verbal instructions or combative techniques (including pain holds) designed for persons with intact mental functioning can lead to difficulties. Patient injuries can occur in instances where the patient is incapable of understanding the purpose and context of police interventions due to a medical or psychiatric disorder. (See particularly the section on psychotic disorders.)

Medical (or paramedic) backup as well as collaboration with mental health professionals or outreach teams that might have some prior experience with the patient can also be very helpful. Such collaboration, however, re-

quires careful prior planning so that management at the scene of an incident can proceed smoothly.

Estimating the patient's control and deciding when the professional must assume control is key.

4.1.3 Theoretical Model:
Attempts at verbal intervention generally precede physical restraint. A clear model to decide when to switch modalities is necessary. One such model is presented here for comparison. It is intended as an ever-present scheme in the background of the evaluator's mind, while carrying out other tasks such as obtaining a history and performing a physical and/or mental status examination. It is again intended as an example only:

Patient's Response:	Staff Intervention:	My Response:
Aggression	Physical control	Fear
Hostility	Pseudochoice ("If...then...")	Anger
Anger	Real choices (Must be acceptable)	Anxiety
Anxiety	Support Encourage Ventilate Reassure "Extras"	Calm

Figure 3: (Interaction Grid)
(Adapted from: (6))

The figure represents an interaction grid: three segments (columns) are subdivided into four corresponding levels (rows) of interaction. The first column represents the patient's emotional response within the interaction, the third, the professional's emotional responses which are assumed to mirror the patient's. The key is that the clinician must gradually develop a sense for their own personal response to each of the patient's stages. In the column between are strategies for intervention.

Exceptions:
The model of gradual escalation through the various levels from anxious, to angry, to hostile, and ultimately to aggressive, can be obviated by a number of medical and psychiatric conditions. In particular, an organically disturbed (e.g.: intoxicated or delirious) patient may escalate abruptly from a seemingly calm or anxious state to an outright aggressive one. Similarly, psychosis, with the inherent lack of reality contact (and defining thought disorder or loose associations), may jump from one stage to the other with little or no warning. It is here that the professional's personal emotional response may be the only "early warning" that is possible. This means that in the example suggested in Figure 3, the professional entering a patient's room for the first time, finding a fear response developing abruptly, should immediately be prepared to provide for physical control and safety.

5. Medical Emergencies

In the context of the triage algorithm (figure 2), medical emergencies are considered those conditions which would require stabilization of the patient prior to a psychiatric interview.

Procedures for such interventions have generally already been established, and most professionals will be familiar with examples of them: BCLS and ACLS protocols for medical and ATLS for surgical emergencies. Vital signs should be obtained if at all possible and as early as possible. They should be considered a requirement prior to the end of any emergency psychiatric intervention. Beyond this, a brief medical history, review of systems, and physical evaluation is usually necessary to rule out immediate medical problems.

6. Basic Psychiatric Interviewing

Moving to psychiatric intervention, we can distinguish: Interview techniques, evaluation (process and content), assessment, and treatment.

Any interview consists of at least three phases, with attention to four simultaneous areas:

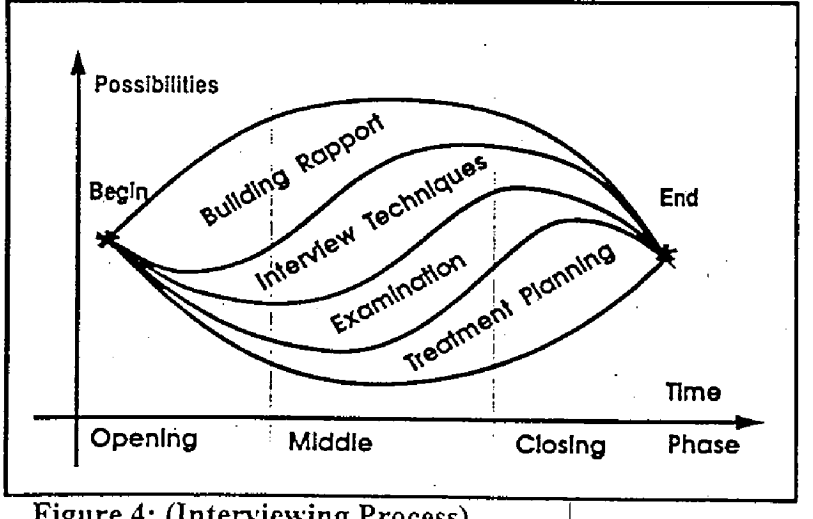


Figure 4: (Interviewing Process) (Adapted from: (7))

The beginning or opening phase of an interview emphasizes the establishment of rapport. The middle phase emphasizes the collection of information and the examination of the patient's current functioning. The closing phase emphasizes summarizing the information and communication of treatment decisions.

In the opening phase, questions will generally be open-ended, encouraging the patient to speak. Facilitative techniques, such as empathic statements, can be used to support this. In the middle phase, questions can frequently become more focused and steering techniques are used to direct the interview into content areas that are desired. Such steering techniques could be thought of as analogous to "back doors." For example, questions on the degree of depression can ultimately lead to questions of suicidality and specific suicidal plans:

„How depressed have you ever gotten?" „Have you ever been so depressed that you didn't want to live?" „Have you ever been so depressed that suicide started making sense?" „Have you ever planned or attempted suicide?" „How are things now?"

Similarly, questions about anger can lead to homicidal plans and questions regarding fear can lead to psychosis. While specific content areas need to be covered in the interview, attention to the process of the interaction will allow the professional to follow a nat-

In any interview the professionl's initial overriding concern is to develop solid rapport with the patient.

Knowing the relative importance of historical information can lead the interview.

ural „flow" of the conversation. Additional steering techniques can help when necessary topics don't come up naturally: „Now that we've talked about you, let's talk a little about your family." In the closing phase, the clinician may summarize and be speaking more (though frequently checking with the patient to be sure of understanding). The ultimate outcome of a successful interview should be an agreement about the next steps to be taken in a treatment plan.

7. Psychiatric Evaluation

The content of the evaluation generally includes a longitudinal (over time) component, the history, and a cross sectional (here and now) examination, typically, the mental status examination. This information leads to a diagnostic impression, which then guides the intervention strategy. While in an ideal case a relatively extensive history and thorough mental status examination will be obtained, the urgency of the moment may reduce this to current history with core mental status questions. Ultimately with a minimally cooperative patient, focus of the history should be to elicit a chief complaint and of the mental status examination to ask orientation questions.

7.1. Psychiatric History:

The history is usually obtained from the patient, though frequently outside corroborative information is needed. Generally this is done with, in emergencies without, the patient's permission. Depending on the urgency of the problem, intervention may need to occur before this information is complete or available. Obviously, no final disposition is possible until all of the information has been obtained and thoroughly considered.

The content is quite similar to that obtained in other areas of medicine. (In the following table(s) the asterisks identify the relative level of importance of the item). In emergencies, one would fall back on the most important items, clarifying these first.

Identifying Information
Chief Complaint (Suicide/Homicide?) ***
History of the Current Situation:**
Course Over Time**
Palliative and Provocative Factors
Review of Systems
Current Medications**
Current Drug Use Pattern**
Past Medical History*
Past Psychiatric History:
Hospital Admissions*
Biomedical Treatments (Medications)**
Suicide (Homicide) Attempts**
Past Alcohol and Drug Use*
Family History:
Genetic Risk Factors
Developmental History:
Family "Roles"
Defensive Mechanisms
Social History:
Current Level of Functioning
Prior Level of Functioning
Support System*

Table 1: History content

7.2. Mental Status Examination:

The mental status examination is intended to provide a cross sectional view of the patient's mental functioning at the current instant in time. It is a formalized method of obtaining and recording information on the higher cortical functions of the patient. To facilitate recall, four general areas can

be delineated: (Examples to serve as mnemonic devices are added in parentheses, and asterisks again denote the relative importance.)

1. General Inspection:
(Overview: "How does the patient look?")

Appearance: (Describing a "photograph") Height, weight, dress, grooming, etc.

Motor Behavior: (Describing the „silent movie") Movements, tics and mannerisms, level of activity, etc.

Speech: (Adding the "sound track") Rate, pressure, intonation, articulation, etc.

Attitude: (Putting it all together) Changes, relatedness with the interviewer, etc.

2. Emotions ("How does the patient feel?")

Mood: (The "climate") Depressed, happy, sad, irritable, etc. The patient describes the mood themselves. Their report will relate to a more extended period of time than the interviewer alone will have been able to observe.

Affect: (The "weather") Type: tearful, angry, etc.; Range: broad, full, narrow, flat, etc.; Stability: Labile, stable, etc. The interviewer attempts to describe the currently observed affective state of the patient in detail.

Congruence: The consistency between the observed emotions and reported mood with the context and content of the interview is observed. Loss of reality contact sometimes expresses itself here in lack of congruence.

3. Thoughts:** ("Software" analogy: "How does the patient think?")

Process:** This describes the logical flow of thoughts:

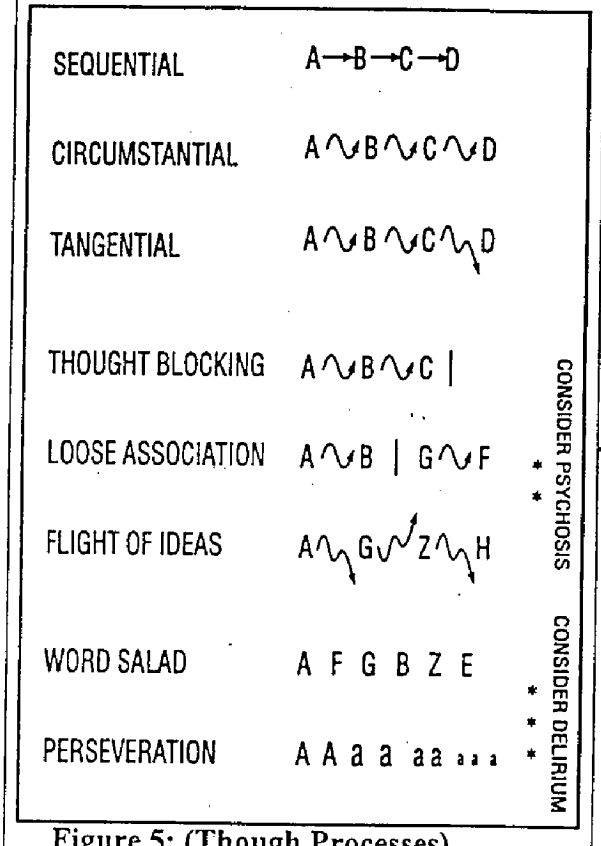


Figure 5: (Though Processes)

These can be considered to be on a spectrum from best organized to completely disorganized. On one end of the extreme, thoughts are expected to be sequential and concisely presented. At the other end of the extreme, no coherent thoughts can be discerned. There is literally word salad or perseveration. The most important stage*** is when loose associations (breaks in the logical flow) occur. They define psychosis. Tangential thinking may be dis-

When loose associations are present, consider psychosis; when there is word salad, consider delirium.

Orientation is the bedrock on which all other cognitive functions can be considered to rest.

tinguished from loose by the interviewers reaction: The thoughts: "What was my last question? How did we get onto this?" denote tangentiality. The thought: "Where did that come from?" denotes loose associations, and should be checked out. Worse disturbance generally indicates a worse disorder.

Content:** Here the thoughts themselves are grouped and unusual or important themes noted. In particular, any psychiatric interviewer will have to comment on suicidal*** or homicidal*** thoughts. These must be specifically sought out, as must be preoccupations and delusions* such as those indicating loss of reality contact, either in a non-bizarre or bizarre (completely impossible) context.

Perceptions:** How does the patient observe the world around them. Are illusions, hallucinations, auditory, visual, or tactile hallucinations**, depersonalization, derealization, ideas of reference, thought broadcasting, thought insertion, etc. present?

Using the computer analogy, thoughts can be considered to have disturbances that affect the logical order (poorly functioning program), abnormalities of content (database errors), and input errors.

4. Cognitive Evaluation*:** (Hardware analogy: "How is the machinery working?")

The following areas are all considered part of the cognitive function. In order to remember them, one might use the model of a familiar, reversible, toxic encephalopathy: alcohol intoxication. When one thinks of a person entering a bar and getting progressively intoxicated, ultimately to the point of coma, one can visualize the stages that they go through. Using this analogy, the extreme care needed to observe and document disturbances of orientation, attention, and concentration becomes clear.

Orientation: Time, place, and person.
Attention Concentration: Serial 7's, 3's, digit span, (usual is 7 digits forward, and 4 backward), spell "world" forward and backward.
Memory:
Registration: "Repeat after me"
Immediate Retention: 3 objects after 3' Recent Past: Events of the last few days Remote Past: Events several years ago
Abstraction: Ability to „get the big picture:"
Proverbs, similarities.
Intelligence: Fund of knowledge (consistent with the patient's education): vocabulary, presidents. general knowledge questions.
Judgment: Conceptualize outcomes: Stamped envelope, smoke in a theater scenarios.
Impulse Control: Ability to modulate impulses.
Insight: Awareness of illness.

Table 2: Cognitive Evaluation

The list is an attempt at such a hierarchical organization (using the above analogy) from the most severe to the least severe level of disturbance. If complete testing is not possible, it is useful to move to ever more basic cognitive tests.

8. Assessment

There are generally two parts to an assessment: 1) Organizing the information gathered in the history and mental status examination, and 2) Making a formal psychiatric diagnosis. Establishing a diagnosis may, however, be secondary to organizing the information in such a way that focuses attention on triage priorities. Broad diagnostic categories are considered first and allow stabilization and referral to more definitive evaluation and treatment. For our purposes, short range outcome is the major consideration.

Review of outcomes research shows that top priorities, which express themselves as variables affecting patient disposition, include:

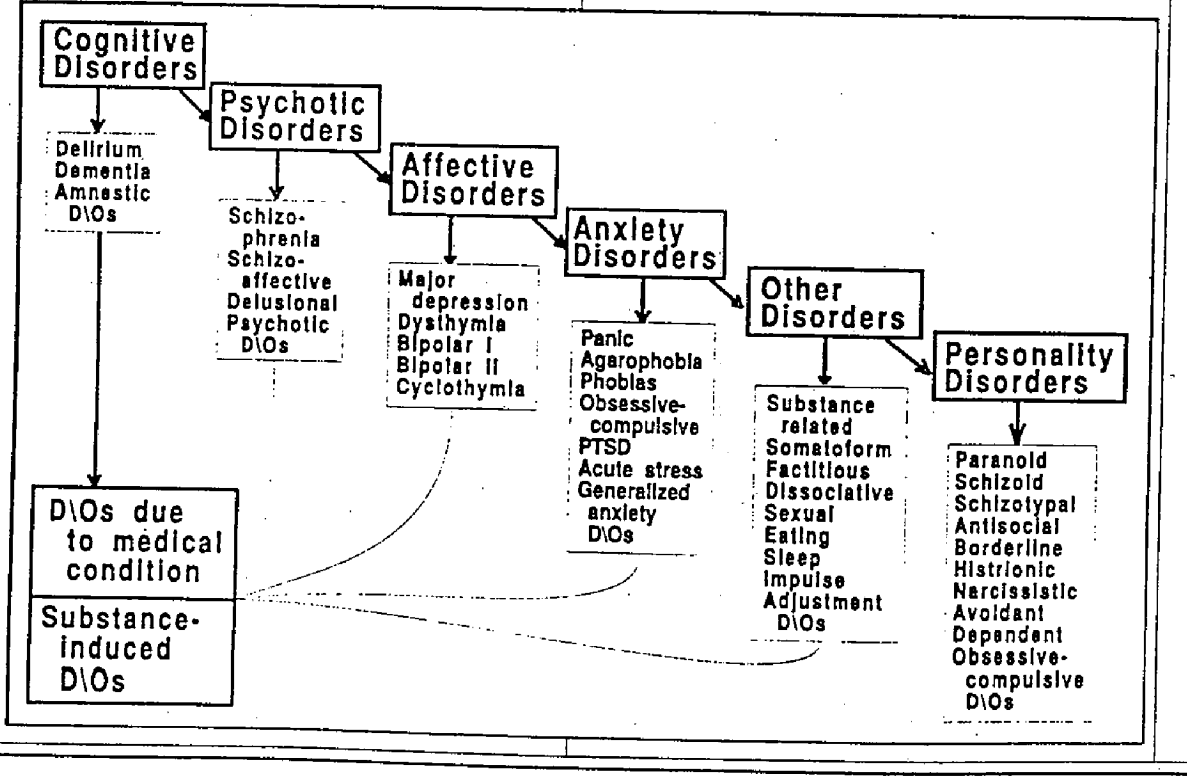
Dangerousness, prominence of symptoms (as clinical variables), clinical experience and knowledge of resources (as clinician variables), family members' support and desire for a specific outcome (as family variables), and referral source such as police, together with assessment of system options (3).

8.1 Impression:

Given the need for organization of diagnostic considerations, a clear idea about a diagnostic hierarchy is helpful. Which disorders take precedence over others? Why? Such a hierarchy is implicit in the DSM IV (8), producing a "cascade" of disorder groups. Generally, the hierarchy implies that treatment must be directed toward diagnoses higher in the model before treatment for lower priority diagnoses can be fully effective. Also, the more "biological" a disorder, the more likely it is to be found on the left; the more "psychological" a disorder, the more likely it is to be on the right.

Disorders induced by medical conditons or substances are listed with each group, but mut be considered first.

Figure 6: Differential Diagnostic Cascade



There are many medical emergency conditions that may initially present as a psychiatric disturbance.

Cognitive Disorders must be considered first. These are delirium (a medical emergency), dementia, and amnestic disorders. Problems where some outside influence causes what appears to be a psychiatric disorder are listed with each disorder group. Examples include substance intoxication, withdrawal, or medical illnesses. They must also be considered as the first priority. All of these disorders affect the brain's ability to function, and could be considered "machinery" or "hardware" problems. Treatment of these disorders will require attention to the underlying disorder. The most important is delirium***, characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention. This is heralded by disorientation and severely disorganized thought processes.

Psychotic Disorders*** must be considered next. These are illnesses. which affect the patient's ability to distinguish real from not real. They generally include major psychotic disorders such as Schizophrenia and are characterized by thought process (loosening of association or worse) or thought content (delusions) or perceptual disturbances (for example, auditory hallucinations). These can generally be considered "thinking problems." They are heralded by loose associations, delusions and or hallucinations. Treatment will usually involve the use of neuroleptics.

Affective Disorders are disorders that affect the mood. The mood may be depressed, elevated, or irritable. Major Depression and Bipolar Disorders (Manic Depressive Disorders) are the main illnesses. here. Both of these disorders can be accompanied by psychosis and when this is the case, the psychosis must be treated first. Treatments will often include medication such as antidepressants or mood stabilizers (thymoleptics).

Anxiety Disorders lead to excessive and inappropriate worry or panic. Examples include phobias, panic disorder, post traumatic stress disorder, the new acute stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. As implied by the hierarchy, removal of precipitants (such as Hyperthyroidism, psychosis or mood disorders) clearly takes precedence over symptom oriented treatment with, for example, Benzodiazepines.

Other Axis I disorder Groups follow in the diagnostic cascade.

Finally, toward the psychological side of the biopsychosocial diagnostic spectrum are Axis II Disorders:

Personality Disorders are problems with an individual's overall coping abilities. They should be considered if there is a long standing (since adolescence) pervasive (affecting all parts of an individual's life) pattern of maladaptive (causing personal distress or impairing functioning) behavior. In these patients the developmental "tool kit" might be thought of as not fully developed, frequently under the influence of traumatic disturbances in their childhood. DSM IV (8) generally distinguishes three groups: Cluster A (odd and eccentric), Cluster B (dra-

matic erratic and emotional) and Cluster C (anxious or fearful). Under stress, such individuals can display symptoms from any of the other diagnostic groups and a thorough evaluation, along with attention to the diagnostic hierarchy, is crucial prior to the diagnosis of a personality disorder. Treatment generally involves a carefully coordinated program of psychotherapeutic and social interventions. Since these conditions can mimic and coexist with many of the Axis I disorders, their identification and treatment take time and may be perceive as the most frustrating task for the professionals trying to help. Clear attention to who is responsible for what (interpersonal boundaries) is crucial to the management of these conditions.

In summary, it should be remembered that, many individuals suffer from several disorders simultaneously. One disorder does not generally exclude another, though if symptoms can be ascribed to a diagnosis further up in the hierarchy, then that diagnosis must be given. Thus, for example, a patient who is intoxicated, yet suffers from Schizophrenia, would likely show signs both of cognitive impairment and reality impairment, and would be given both diagnoses. Treatment must then also address both disorders.

8.2 Biopsychosocial Diagnosis:

In order to organize all of this information, the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) (8) has designed its multiaxial system of diagnosis. The diagnosis is recorded in five axes, whereby multiple diagnoses are encouraged when the criteria for the specific disorders are met.

Axis I: Psychiatric Clinical Syndrome ("Nature") Axis II: Personality Disorders or Traits ("Nurture") Axis III: Physical Disorders Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning (GAF Score).

Table 3: DSM IV Multiaxial System of Diagnosis

Many patient suffer from several disorders simultaneously that must all be identified.

9. Interventions

Beside the assurance of immediate physical safety outlined above, treatments will generally come in four major areas: general safety, biological treatments, psychological treatments, and social interventions.

Longer term safety issues are much more complex to evaluate. Generally the clinician is only able to identify broad groups of patients at risk for harm to self or others but cannot predict the future behavior with any reasonable certainty over more than a few hours or even days (4). One of the best and most important predictors is that of past behavior. Another key consideration is the presence of destabilizing factors such as intoxication.

9.1 Immediate Safety Interventions:

As outlined before, emergent intervention may require physical restraint. The principal behind the safe use of such restraint is overwhelming force. We cannot assume that a patient has

The clinician assumes the responsibility when there is significant danger or competence is low.

the mental capacity to recognize directions, physical cues (painful or nonpainful), and to respond appropriately. When a patient is physically restrained attention must be given to the legal framework (doctor's court hold or police officer hold, etc.). Also, the patient must then be observed very closely since this group of patients is at higher risk of having significant coexisting physical illnesses that can place them in danger, especially since the usual complaints of feeling ill may not occur. Once a professional has assumed responsibility for the patient they are responsible for the "whole" patient!

Similarly, chemical restraints can be used in some emergency conditions. Neuroleptics (Inapsine) or Benzodiazepines (Ativan) have been advocated and are often used in the medical setting.

9.2 General Safety:

Patients who present a danger to themselves or others are unable to care for themselves, or fail outpatient management, or require 24 hour observation for diagnostic assessment or ongoing round-the-clock medical treatment will require hospitalization. As long as such patients are willing to be hospitalized on a voluntary basis, there is little question as to how to proceed.

Involuntary Admission: In most states, if the patient represents a danger to himself or others due to a mental disorder, and/or is unable to care for their basic needs (grave disability), there is a process that allows emergent and urgent hospital admission on an involuntary basis. This is generally regulated in the Commitment Statutes. Difficulties arise when it is unclear how far the patient's rights of self determination go in comparison to the professional's ethical obligation to intervene in the face of a psychiatric disorder (right to competent treatment).

In this respect, a grid that plots danger against competency may be useful to the professional:

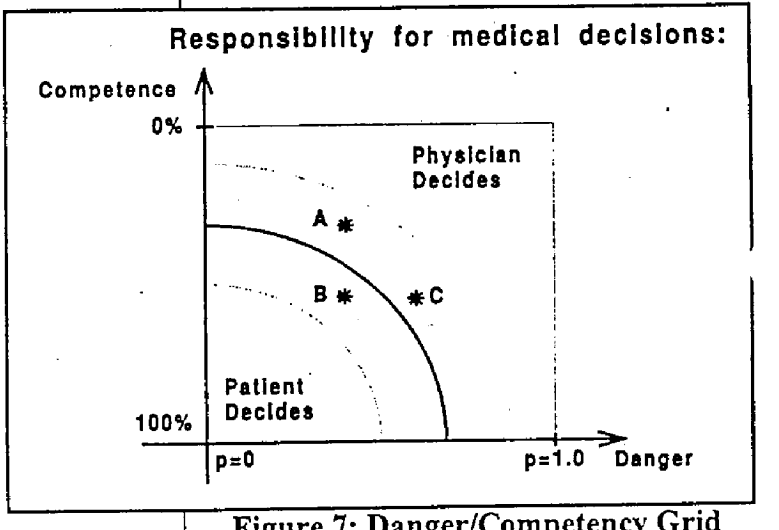


Figure 7: Danger/Competency Grid (Adapted from (10))

As outlined in this grid, competency is plotted against danger. In the lower left hand corner, patients who are in an area of low danger, yet have a high degree of competence, are clearly in charge of their treatment, irrespective of the clinician's preference. Simultaneously, patients that have either an extremely low level of competence (such as the severely disabled Alzheimer's patient wandering on the street) or are in an extreme degree of danger (such as an occluded airway)

must be treated by the clinician even against their will. Frequently, the situation is much less clear. Despite this, the law allows only for a dichotomous choice: One is asked to act as if the grid were bisected by a clean line. Nevertheless, it is quickly apparent that the gray band of mixed cases in the middle represents many cases and a significant clinical dilemma. For example, patients A, B, and C may differ only in some minor respects, yet patient A and C will be involuntarily admitted where B may not. Patient B may, for example, present with depression, suicidal ideations of several months' duration, and some poorly formulated thoughts of possibly taking an overdose. Patient C, similar in all ways, may, however, be contemplating the use of a firearm and has access to such. Clearly, patient C would require involuntary admission. Patient A, on the other hand, while in a situation just as B, may be intoxicated, lowering their level of competence. Clearly as well, here the clinician must intervene (even if only temporarily until competence is restored/intoxication resolved).

Involuntary admission in Oregon is regulated by the Oregon Revised Statutes (ORS 426). If a patient represents a danger to himself or others due to a mental disorder and is unable to agree to voluntary admission, the patient may be admitted against his/her will. The doctor's court hold (DCH) documents the belief of two licensed physicians or a physician and a qualified mental health professional that such a danger and mental illness exists. Outside of the hospital setting, the police or mental health program is needed to make such a determination. A police officer custody report (POCR) documents that a police officer has reason to believe that such danger and illness exists. A mental health program can also initiate such a police officer hold (Mental Health Director's Hold). When the mental disturbance does not rise to the level of danger but there is question about the individual's ability to care for themselves, any two interested persons may file a two party notice (TPN) with a county mental health agency. From the filing of all of these notices, a court investigation

The patient's safety for two weeks on their own may be key to deciding on potential danger.

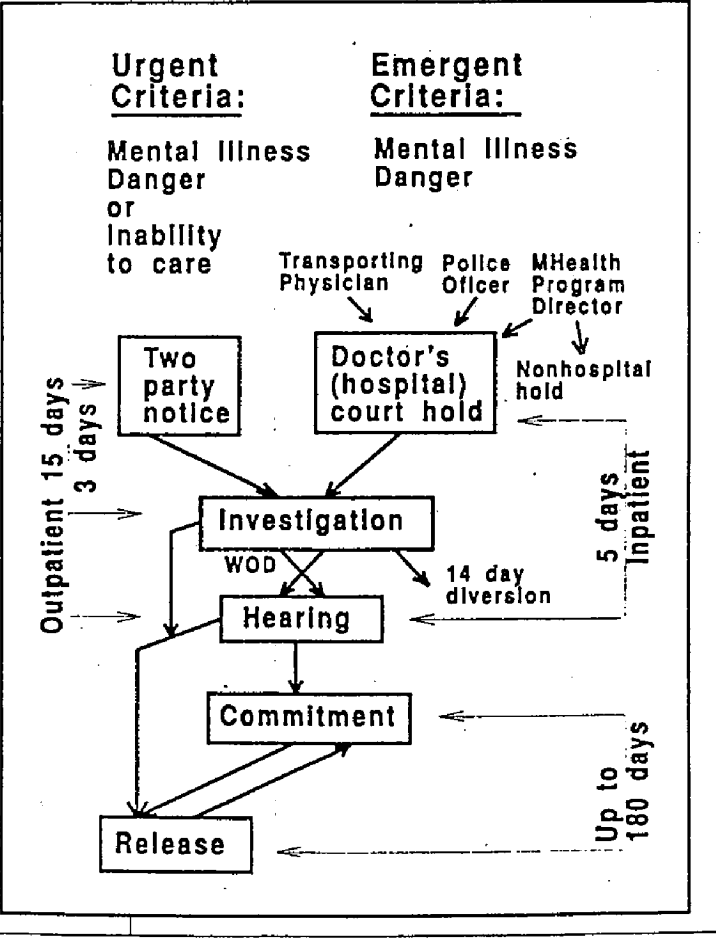


Figure 8: ORS 426

The patient should be treated in the least restrictive, yet safe, environment.

is initiated. This investigation may lead to a hearing (or to patient release). The hearing may lead to commitment. The main difference between the two routes in Oregon is that the emergent route (which includes only the criteria of mental illness and danger) requires that the patient be kept in the hospital and must not exceed five working days to the point of a hearing. The urgent route proceeds on an outpatient basis and 15 days may pass prior to a hearing. Therefore, frequently the question of danger must be phrased as: "Is this patient safe for 15 days in an outpatient setting?"

9.3 Biological Treatments:

In this area we generally think of the use of pharmacotherapeutic agents. Also, in general, one will have to consider psychiatric consultation in this context. Brief attention was given to the use of chemical (and physical) restraints earlier. An introduction into the basic psychopharmacology would clearly be beyond the scope of this brief review. Nevertheless, we should be clear that addressing an organic or cognitive mental disorder generally requires attention to or treatment of the underlying disorder. Thus, for example, treatment of hypo- or hyperthyroidism or delirium tremens would require the appropriate medical treatment for those conditions, not the psychopharmacologic treatment of the mental expressions of the illness (though there are exceptions where both becomes necessary). Psychotic disorders generally require antipsychotics (neuroleptics). Affective disorders will generally be treated with antidepressants and/or mood stabilizers, including Lithium, Tegretol, or Valproate. Anxiety disorders will frequently be treated with antianxiety agents, such as Benzodiazepines or Buspirone. As indicated by the differential diagnostic hierarchy, such agents must be used cautiously in combination.

From a psychiatric emergency viewpoint, it is extremely important to remember that treatment with neuroleptics, antidepressants, and mood stabilizers generally requires two to four weeks to be effective. Therefore, their initiation is frequently not part of an emergency, more triage-based intervention, no matter how badly one wants to help fast. Pharmacologic measures are generally very focused, directed at supporting a prior developed treatment plan and prescriptions are kept small. Careful coordination with outpatient treatment providers is crucial.

9.4 Psychological Treatments (Psychotherapy):

Similar to the section on pharmacotherapy, an introduction into psychotherapy is beyond the scope of this review. The emergency setting, as well as the realities of the treatment system, currently favor more focused, outcome oriented treatments that are frequently in the cognitive or behavioral realm. In many emergency settings general principles of crisis intervention apply: One attempts to restabilize the patient who has reached a point of instability and overload ("the straw that broke the camel's back") and support their process of reorganization through the phases of acute

decompensation, denial, anger, bargaining, grieving, and recovery. Such a hypothetical course of a crisis is outlined below:

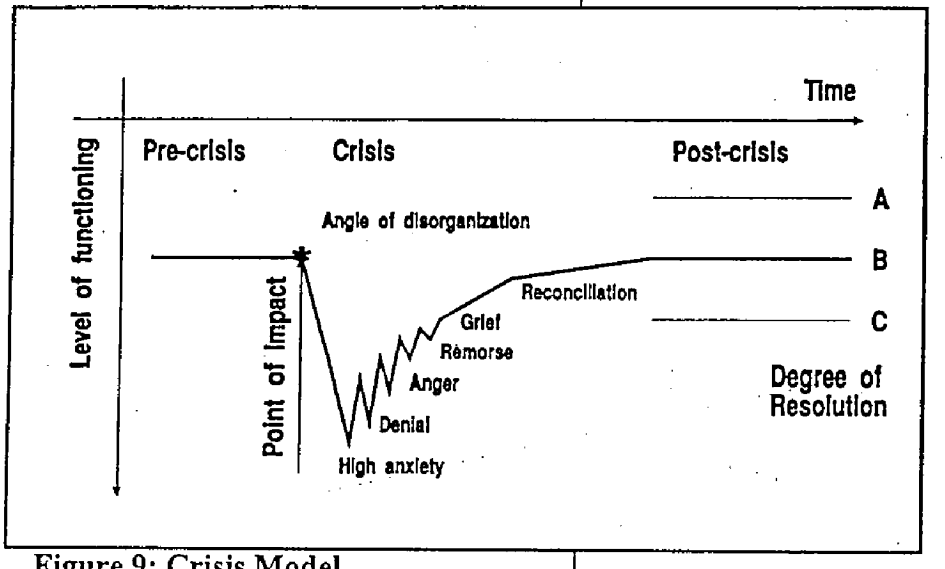


Figure 9: Crisis Model

Psychotherapeutic intervention could take on the following form: One assesses the biological, psychological and social realities that the patient brings to the situation. These are crucial for understanding the resiliency or stability of the patient's "system." Then focus on the balance between stressors and support system will allow a determination to be made on the severity and urgency of the current crisis. Stressors or supports are then manipulated where possible to help restabilize the patient.

Psychotherapeutic intervention using a debriefing model may also be appropriate. Such a model could be thought of as having four parts (see table 4). It may be used with individuals and groups. In the interaction, the four phases are explicitly separated. In the first phase facts are gathered from all participants. Statements about how one feels are excluded. (It is made clear that they are legitimate, but will be talked about separately). In the second phase, affects/feelings are clarified and discussed. Here the attempt is to collect a broad range of emotional responses, validating them. The disconnection from the facts and the legitimacy of the patient's own emotional response is emphasized. In the third phase the group is educated about what to expect (both in terms of future events and emotions); in the fourth,

Crisis intervention rebalances a percieved disparity between stressors and suuports.

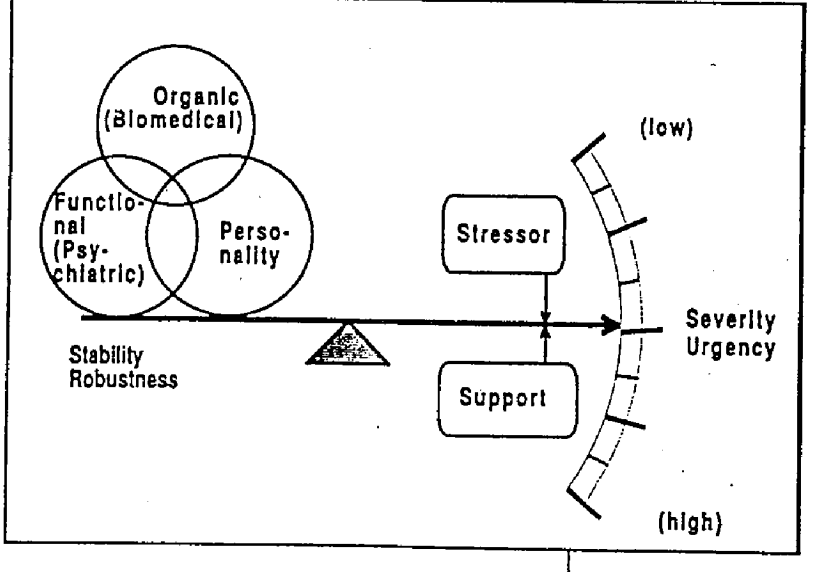


Figure 10: Crisis Intervention

The critical incident debriefing model may also be useful for the professional faced by trauma.

plans are made for any necessary follow-up.

1. Clarify the facts of the crisis ("What happened?").
2. Clarify the feelings ("How do you feel about this?").
3. Review the usual response to crises: (teaching phase).
   - Phase of Disbelief or Denial.
   - Phase of Shock or Confusion.
   - Phase of Anger.
   - Phase of Grief and Sadness.
   - Phase of Acceptance.
4. Problem solving or reopening the social world/contacts and ultimate resolution (reinforce adaptation and a plan for the future).

Table 4: Critical Incident Debriefing

In less formalized psychotherapeutic work three simple rules may help in the beginning:

1. When the patient presents a complaint, always validate it.
2. However, in doing so, acknowledge it in a way that will allow for reinterpreatation. Thus, it may be crucial to a psychotic patient to hear: "Oh, that sounds frightening," but it would be unwise to agree that the FBI may be indeed plotting.
3. Finally, offer a reinterpretation of the complaint that will direct the patient to action toward an useful goal. ("When you experience such voices, it may be a sign that you need to take a time out/take more medication.")

9.5 Social Interventions:

In this area, the realities of the patient's living are addressed. Clearly, attention must be given to food and shelter, as well as clothing. Where these are not immediate concerns, issues of disability may be the stated or covert objectives that should receive attention. While seeking psychiatric hospitalization in order to find shelter is understandable, it is clearly not the most efficient use of resources, and it would be the professional's task to support the legitimacy of such patient desires, yet to help the patient address their needs directly.

10. Summary

This outline is clearly intended as a forum for ongoing discussion and not as a finished document. It does, however, attempt to make explicit some of the core principles underlying emergency psychiatric evaluation and intervention. Since the subtleties of human interaction can clearly not be adequately addressed by such an approach, it is worth remembering that the experienced professional on the scene generally has access to significantly more information, including personal reactions, that can be crucial to accurately assessing the patient's situation. Pairing such clinical experience and "feel" for patients' needs with a clear diagnostic and therapeutic structure will hopefully provide some of the redundancy necessary to assure safe clinical interactions.

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Version: 7-10-95

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NOTES

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CRISIS INTERVENTION TEAM TRAINING
MAY 15, 2000

OVERVIEW OF MENTAL ILLNESS

WHAT IS MENTAL ILLNESS?

A biologically based brain disease characterized by

- perceptual disturbance
- mood lability
- lack of motivation
- and in extreme cases, suicidality.

Mental Illness can impact all areas of a person's functioning including

- **Social** — difficulty getting and/or maintaining necessities of life i.e. food, clothing, and shelter
- **Occupational** — difficulty acquiring and/or maintaining employment
- **Interpersonal** — difficulty maintaining relationships with friends, co-workers, partners, spouses, parents, children

Symptoms of mental illness may be exacerbated by environmental stressors including

- Poverty
- Homelessness
- Difficulty accessing medical care
- Poor nutrition
- Drug and alcohol addiction

Symptoms of mental illness may be alleviated by medicine and social supports including

Help in --

- keeping up an apartment
- shopping for food
- budgeting money
- attending to hygiene
- planning social activities
- making friends and maintaining relationships
- Easy access to mental health care that is affordable and tailored to the needs of the person

WHAT MENTAL ILLNESS IS NOT

- Mental illness is not a character flaw.
- Mental illness is not a guarantee that the person will be violent.
- Mental illness is not anyone's fault.
- Having a mental illness does not mean there is no hope.

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Thought Disorders

- Hallucinations that might cause people to see, hear, feel, taste or sense things that aren't there
- Talk to self
- disorganized thoughts
- Paranoia, delusions, or bizarre thoughts
- Minimal display of emotion
- Poor hygiene/malodorous
- May wear multiple layers of clothing or inappropriate clothes for the weather
- May have multiple bags filled with what might appear to be garbage

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Mania:

- Expansive irritable mood
- Decreased need for sleep
- Heightened self-esteem
- Grandiose ideas
- Pressured speech /inability to interrupt them
- Distractibility
- Poor impulse control (e.g. buying sprees, sexual indiscretions)
- Possible break with reality, i.e. psychosis

WHAT A PERSON WITH MENTAL ILLENSS MIGHT EXPERIENCE

People with major depressive disorder often do not act in a bizarre manner

Common symptoms of depression include:

- Depressed mood most of the day, nearly every day
- Loss of interest or pleasure in all or most activities of the day
- Significant weight loss or gain
- Difficulty sleeping or sleeping too much
- Fatigue or loss of energy
- Feelings of worthlessness
- Recurrent thoughts of death or thoughts of suicide

It is a myth that depression is a normal part of the aging process. It is important to remember that depression is an illness which can be successfully treated.

IF YOU HAVE TO TAKE THE PERSON INTO CUSTODY ON A HOLD SOMETIMES IT IS HELPFUL TO:

- Ask the person if they have ever been in handcuffs before
- Tell the person that you came to help them, not to hurt them
- Tell them they are not under arrest or in trouble
- Tell them you know that they are not a bad person
- Tell them your boss says you have to put them in handcuffs, it is the rule, it's nothing personal

ORGANIC AND PSYCHOTIC MENTAL ILLNESS

WHAT IS PSYCHOSIS

Psychosis is defined by a complex of symptoms that include:

Delusions (false beliefs in something that is so at odds with the prevailing societal consensus as to be recognized as ranging from the improbable to the bizarre).

Hallucinations (the experience of sensation in the absence of external stimulation, most commonly auditory, but in drug induced states or other organic states can include visual, olfactory, gustatory, and tactile sensations. That is hearing, seeing, smelling, tasting and feeling.)

Incoherence (unintelligible speech or speech which may make sense but conveys little or no information even though the person may talk a lot).

Loosening of Associations (the lack of connection in a person's flow of thought so that ideas seem to generate other ideas which have no logic to their sequence).

Catatonia (marked excitement or profound stupor and muteness to the degree that a person is at risk for life threatening exhaustion or is unable to carry out basic functions such as food seeking and feeding).

Gross Disorganization (marked difficulty in organizing behavior so that a person may be disoriented to time, place and identity, may be unable to respond to others or unable to respond in an understandable manner).

There is a range of conditions which may produce psychotic behavior. This may vary from; a brief reactive psychosis which is a response to excessively traumatic stress (for example: combat); to substance induced psychotic reactions; to psychosis due to a progressive brain deterioration such as in a dementia like Alzheimer's; and psychosis due to a chronic mental disorder such as schizophrenia or severe mood disorder as in psychotic depression or in psychotic mania.

The neurobiological basis of psychosis appears to stem largely, but not exclusively, from the disruption of dopamine transporting systems in the brain. This can be due to endogenous (internal) causes such as mental illness or dementia but also may be due to exogenous (external) causes such as head trauma or exposure to certain chemicals.

For our purposes, we are concerned with those chemicals which have reinforcing properties in the brain and are likely to be abused. Repeated use of

substances such as **alcohol, speed, crank, coke, crack, hallucinogenics, designer drugs,** increases the risk of developing a drug induced psychosis or "triggering" an existing condition such as schizophrenia or severe mood disorder. This appears to be due to the dopaminergic (dopamine stimulating) action of these substances in the brain.

The most common psychiatric symptom resulting from repeated or heavy use of any of the amphetamine type drugs is delusional thinking. Paranoid delusions of persecution and other bizarre or unusual explanations of events are frequently seen. Accompanying this paranoia can be agitation, anxiety and aggressive behavior so that persons in a drug induced psychotic state have much more potential for violent acts including homicide and suicide.

Think of the brain as an elaborate circuit board with very complex electrical interconnections which form our self-awareness, our experiences, our thoughts, our sensations, our perceptions, our memories. If you pour water on a circuit board it shorts out due to the water acting as an electrical conductor between parts of the circuits that weren't meant to be connected. Drugs act the same way in the brain except instead of water being the disruptive electrical conductor, they act on the neurotransmitters which conduct electrical activity. If the brain is no longer able to carry out established interconnected patterns of electrical activity and different pathways become involved, what the brain experiences is psychosis. What others see is that the psychotic person does not make sense and is responding to stimulation that is internal and not shared or understood by others.

Usually, if an individual abstains from drugs, **the psychotic symptoms will go away with time.** The symptoms generally go away within hours to days, although they can last several months and, for some unfortunate individuals, they may become permanent. **The population at highest risk for permanent damage is the one with an existing mental illness or mood disorder or, has a predisposition to develop a mental illness or mood disorder.**

At this time, the single most effective known treatment for psychotic disorders is the use of anti-psychotic medications. These are believed to have a stabilizing effect on the dopamine balance in the brain. These medications, however, are not 100% effective and they carry some risk of side effects. About 25% of people with psychotic symptoms do not obtain a favorable response to existing anti-psychotic medications. Hallucinations, confusion and disorganization generally respond to anti-psychotic medications but delusional thinking tends to be less responsive. Ideally however, treatment should combine medications with social therapies to be the most effective. There are some individuals who can recover without the use of medications but they are in a minority.

Denial is a major element making for great difficulty in the treatment of psychotic states that are either drug induced or due to chronic mental disorders. Frequently, the person experiencing the psychotic effects of drugs or of mental illness believes that what his senses are telling him is an accurate reflection of external reality. This is what we all believe and rely on to navigate through the world. When someone tells a psychotic individual that what they are experiencing is not "real", it is very difficult to make a convincing argument. What is going on in that person's brain is their reality so they must deny any challenges to that reality and refuse to accept any offers of treatment and refuse to believe that they might need treatment.

A common outcome is that a psychotic person comes to the attention of the police. A quick determination is made if the psychotic person poses some danger to themselves or others and is not willing to obtain voluntary treatment. The individual is transported to an emergency psychiatric facility where they can be detained against their will, for up to five court days. During this time an investigator must make a determination as to whether or not the person is to go to Civil Court before a judge and psychiatric examiners for an involuntary commitment hearing. The Civil Court has the authority to place the person under the care and custody of the Mental Health Division for a period not to exceed 180 days if they find the person continues to be mentally ill, a danger to self or others and is unable or unwilling to accept voluntary care. While under commitment and within the guidelines of the law, a person can be administered psychiatric medications against their will.

Go back now to the earlier statement that most drug induced psychotic states clear in a few hours to a few days. If a person in this condition is taken to a psychiatric emergency holding facility they are likely to be released without a commitment hearing. But, for the person whose symptoms persist, they stand a good chance of being committed and placed in a psychiatric hospital.

If a crime was committed at the time the person was picked up by the police, the person may have a detainer placed on them while in the hospital and then be transferred to jail once their symptoms have cleared. If the crime is serious enough, a mentally ill offender may go straight to jail and then quickly to court for a judge's order to be sent to Oregon State Hospital Forensic Unit for evaluation or treatment. Petty crimes committed while the person is psychotic are often dismissed if the court feels that the individual is getting the treatment they need. Repeat offenders are not as likely to be looked upon with such leniency particularly if they persist in denying they need treatment or do not follow through with treatment.

Mental illness is not a state of bliss. It can be a world filled with fear and confusion. Whether psychosis is drug induced or not doesn't make any

difference to your brain but **the choice to use or not use drugs of abuse will make a major difference in how your brain is going to function.**

Organic Disorders

a. Definition
    1. A class of conditions caused directly by abnormalities of brain structure or by alterations of brain neurochemistry or neurophysiology (e.g., delirium, dementia, amnesic syndrome, organic hallucinosis, organic delusional syndrome, organic mood syndrome, organic personality syndrome, etc.)

b. General symptoms
    1. Confusion, memory disturbance, disjointed speech, slow mentation, and substance abuse

    2. Physical signs
        a. Breath smells
        b. Blood shot eyes
        c. Runny nose
        d. Needle tracks
        e. Slurred speech
        f. Unsteady on feet
        g. Bizarre behavior and speech

    3. Head Trauma
        a. Permanent
        b. Slow mentation
        c. Impulsive
        d. Seizures
        e. Personality change

    4. Stroke
        a. Usually older person
        b. Paralysis
        c. Difficulty speaking

5. Dementia
    a. Older person
    b. Confused, especially about personal information
    c. Combative
    d. Often in a nursing home or has a specific care provider

6. Medical Causes
    a. Diabetic not taking insulin
    b. Drug overdose
    c. Delirium – fluctuating levels of consciousness
    d. Past seizures
    e. Off seizure medications
    f. Physical illness (sweating, nausea, vomiting)

Psychotic Disorders

a. Definition
   1. A disturbance of perception and thought process is a broad description of this category. The psychotic symptoms represent manifestations of disturbances in the flow, processing, and interpretation of information in the central nervous system. These symptoms can be mild to severe. (Mental Health : A Report of the Surgeon General)
   2. Hallucinations are the most common group of symptoms that result from this disordered processing and interpretation of sensory information. An example is the frequently described hallucination of hearing voices.
   3. Hallucinations may include:
      a. auditory
      b. smell
      c. feel
      d. visual
      e. physical
   4. Delusions are a more complex group of symptoms resulting from this disordered interpretation of information. A delusion is a false belief that an individual holds despite evidence to the contrary. A common example is paranoia, in which a person has delusional beliefs that others are trying to harm him. Any attempts to persuade the person that these beliefs are unfounded typically fail and may further entrench the delusional belief.
   5. Psychotic thought processes are characteristically loose, disorganized, illogical, or bizarre. These thought processes frequently produce bizarre observable patters of behavior that is also disorganized and bizarre.

Schizophrenia

a. The cause of schizophrenia has not yet been determined although research points to the interaction of genetic endowment and major environmental upheaval during the development of the brain. (Mental Health: A Report of the Surgeon General)
b. Part of the psychotic disorders schizophrenia frequently have marked disturbances in logical thought process.
c. Symptoms can include:
    1. Hallucinations
    2. Delusions
    3. Disorganized thoughts and behaviors
    4. Loose or illogical thoughts
    5. Agitation
    6. Flat or blunted affect
    7. Concrete thoughts
    8. Anhedonia (inability to experience pleasure
    9. Poor motivation, spontaneity, and initiative

MOOD DISORDERS

Mood Disorders

a. A group of clinical conditions characterized by a disturbance of mood, loss of that sense of control, and a subjective experience of great distress. This disturbance of mood can be manifested by either stained feeling or sustained elevation of mood. As with psychosis the disturbance of the mood occurs in a variety of patterns associated with different mental illnesses. (Mental Health: A Report of the Surgeon General)

Bipolar or Manic Depressive

a. Symptoms include mood swings from the lows of depression to the highs of mania. These episodes alternate and in some cases can be predicted. Severely affected people have a "rapid cycling" bipolar illness, in which the mood swings occur almost continuously.
b. Depression: symptoms include melancholy, sad, miserable most of the time. Loss of interest in life and pleasures. There can be a decreased energy level, fatigue, fits of weeping or constantly feeling like crying, and an unusually high degree of irritability. There is also a on going thoughts of suicide in severe cases.
c. Manic symptoms include a feeling of power, increased energy, seductive, elated, euphoric. Other symptoms include talks too fast, loud and without stopping. Thoughts race from one idea to the next in rapid succession without much logic. Stop eating, sleeping which in turn can change mood to irritability, anger, paranoia.

Major Depression

a. Ongoing feelings of melancholy, sad and miserable most of the time with loss of interest in life and pleasures. These episodes can also include decreased energy, fatigue, fits of weeping or constantly feeling like crying. Symptoms may

vary with individual, but are long lasting and affect the quality of life for the person.

b. The though process is constantly negative with hopelessness dominating present and future. Anxiety, dread can increased the individual's inability to function. Difficulty in concentration and making decisions; experience feelings of guilt, self-loathing, or worthlessness. Preoccupies with death and suicidal thoughts or attempts.
c. Physically individuals may experience disruptions in normal eating and sleeping patterns. Some are unable to sleep and others may sleep more hours than usual.
d. Behavior includes inability to get work done and difficulty in reading or studying. There is a great difficulty in accomplishing simply tasks such as washing, dressing, and eating. There may also be some restlessness and agitation. The characteristics include slowed thoughts, movements, and speech; walk stooped and shuffling gait

NOTES

NOTES

POST TRAUMATIC

STRESS DISORDER

Post Traumatic Stress Disorder

1.Symptoms develop following exposure to an extreme traumatic event that involves

- Direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to physical integrity of another person
- Witnessing an event as described above
- Learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate

2. The persons response involves intense fear, helplessness, or horror. In children this may be manifested by disorganized or agitated behavior.

3. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. In children this can include play where themes or aspects of the trauma are expressed
- Recurrent or distressing dreams of the event. In children there may be frightening dreams without recognizable content

Acting or felling that the traumatic event were recurring. Can include hallucinations and flashbacks

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity to internal or external cues that symbolize or resemble an aspect of the traumatic event

4. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness

- Efforts to avoid thoughts, feelings or conversation associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall important aspects of the trauma
- Diminished interest and participation in activities
- Feeling of detachment or estrangement from others
- Restricted range of affect
- Sense of a foreshortened future

5. Persistent symptoms of arousal

- Difficulty falling or staying asleep
- Irritability or anger outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

6. Prevalence rates for the general population range from 1% to 14%. Rates for at risk populations such as combat veterans, crime victims, ect. range from 3% to 58%

7. In about 50% of cases symptoms resolve within 3 months. In many cases symptoms persist longer than 12 months

8. Individuals with PTSD are at increased risk of developing a substance use disorder. Substance use exacerbated symptoms of PTSD

GUIDE TO ACCOMPANY

POST TRAUMATIC STRESS DISORDER

FEATURES OF PTSD

A. Traumatic event/significant stressor.

B. Re-experiencing of the traumatic event.

C. Numbing of responsiveness

D. Anxiety-based autonomic and cognitive symptoms.

DIAGNOSTIC CRITERIA FOR PTSD

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma by at least one of the following:

1. Recurrent and intrusive recollections of the event (nightmares).
2. Recurrent dreams of the event.
3. Sudden acting or feeling as if the traumatic event were re-occurring (flashbacks).

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

1. Marked diminished interest in one or more significant activities.
2. Feeling of detachment or estrangement from others.
3. Constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

1. Hyperalertness or exaggerated startle response.
2. Sleep disturbance.
3. Guilt about surviving when others have not, or about behavior required for survival.
4. Memory impairment or trouble concentrating.
5. Avoidance of activities that arouse recollection of the traumatic event.
6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.
7. Self-medication via alcohol/drug/pill abuse--chain smoking--overeating--anger mismanagement.

PTSD SUBTYPES

308.30 Post-traumatic Stress Disorder, Acute

- Onset of symptoms within six months of the trauma.
- Duration of symptoms less than six months.

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

- Duration of symptoms six months or more (Chronic)
- Onset of symptoms at least six months after the trauma (Delayed)

TRAUMATIC EVENTS THAT CAN PRECIPITATE PTSD

A. Rape

B. Natural Disaster

C. War--combat

PRECIPITATING TRAUMA & SIGNIFICANT STRESSORS OF COMBAT

- Exposure to death and mutilation of people and destruction and desolation of environment.

- Personal acts of violence, fighting, killing, and destroying.

- Danger and threat to life.

- Depersonalization and dehumanization of the military environment and the war experience.

- Discontinuity between war and non-war environment.

Additional Stressors of War

- Political and moral debate and controversy about combat, social and political divisiveness (draft evasion; marches, demonstrations, protests, and political debate). Creating a state of confusion and uncertainty; weakening morale; heightening vulnerability; diminishing social support and sanction; resulted in a homecoming by avoidance, rejection, and antagonism.

- System of rotation, limited tour of duty and periods of rest and recuperation with rapid individual entry and exit reduced morale and cohesiveness; rendered unit maneuvers more difficult and exposed participants to a more stressful transition.

- Restrictive policies (no plan to win the war; abandonment of captured territory; orders to request permission from higher authority before engaging the enemy) heightened danger, contributed to mistrust and lack of confidence in leadership.

Themes of "Post-Vietnam Syndrome."

- Guilt feelings and self-punishment.
- Feelings of being scapegoated.
- Rage and other violent impulses against indiscriminate targets.
- Combat brutality and it's attendant "psychic numbing."
- Alienation from one's own feelings and from other people.
- Doubt about ability to love and trust others.

TREATMENT OPTIONS FOR PTSD

A. Behavioral Techniques: Relocation, Desensitization

B. Education Techniques: Assertiveness, Relaxation

C. Supportive Techniques: Reflective Listening

D. Family Therapy

E. Hypno Therapy

F. Individual Therapy

G. Peer Group Therapy

H. Flooding, Abreactive Therapy

I. Gestalt Technique

J. Grief Psycho Therapy

K. Guilt and Regret Issues in Counseling

L. Anger and Stress Management

[Events]

VIETNAM: WHAT I REMEMBER

From "Patriotism Revisited," by David W. Powell, a memoir submitted last October to a creative writing class at the University of Arizona in Tucson. Powell served as a marine in Vietnam from 1965 to 1967.

The following events come to my conscious memory uninvited. I not only remember them vividly, I reexperience them with all my senses:

Froze with fright, standing up, the first time I was under fire

Watched two marines try to break open the skull of a dead Viet Cong with a large rock

Observed a marine intentionally shoot a girl four or six years of age

Watched the girl's grandfather carry her into our line of fire, sobbing

Had a lieutenant who delighted in sneaking up on me when I was on watch at night

Was offered a blood-soaked flak jacket and a helmet with a bullet hole through it as my first field equipment

Had my boots rot off during an operation in the field

Observed two captured nurses being beaten and raped by marines

Rifle-butted a girl of twelve in the face when she would not move away

Strangled a captured Viet Cong for refusing to talk to an interpreter

Discovered brain matter on barbed wire I was stretching out

Observed a marine laugh as he stepped on the chest of a dead Viet Cong and watched blood squirt out of the enemy's wounds

Awoke to find a buffalo leech on my leg

Was abandoned under fire when a roc jammed in my launcher

Was abandoned under fire when I was shot

Hit head and fell in open field. Watched my fellow marines run by me to seek cover for themselves

Received letter from wife telling me how much fun she and a girlfriend had on Friday nights when they went out to bars to dance

Watched fellow marine shoot himself in the foot to get evacuated

Heard same man cry in his sleep when he was returned to the company

Found marine boot with foot in it in a hedgerow

Almost run over by retreating U.S. tank

Saw Lt. Spivey hit a head-high booby trap

Nearly murdered villager for stealing my laundry

Watched Prestridge test his new M-16 by shooting a woman getting water from a nearby well

Identified Haas's remains

Exchanged letters with Haas's mother

Had an artillery canister fall six inches in front of my head

Was about to put on fresh boots when I discovered lice swimming in them

Saw seven-foot python climbing in ceilir. just above my head

Bullets sounding like bees digging up ground all around me

Nearly trapped in Da Nang village my last night in Vietnam

Robbed by marines while I slept in Okinawa after tour was over

Circled over El Toro air base for two hours so that President Johnson could land and be photographed greeting returning veterans

•

Since my return I have held eighteen different jobs and have been unemployed for several six-month periods. This is a direct result of my Post Traumatic Stress Disorder, specifically a disdain for being told to do tasks I do not want to do; an exaggerated startle response, which is terribly embarrassing to me; and a lack of control over emotional flooding.

I divorced my first wife two years after I got out of the service. I divorced my second wife in 1982. I separated from a four-year relationship in 1987. I have not had a significant relationship with a woman since then. I have no significant male or female friendships. I am aloof from my immediate family, who live in Tucson, Arizona.

PTSD SYMPTOMS

- MISTRUST
- DEPRESSION
- ISOLATION
- RAGE REACTIONS
- AVOIDANCE OF FEELINGS; ALIENATION
- GUILT/SHAME AND DOUBT
- ANXIETY REACTIONS
- SLEEP DISTURBANCE AND NIGHTMARES
- INTRUSIVE THOUGHTS

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HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
1120 S.W. THIRD AVENUE, 4TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3976

Dear Survivor:

This booklet is about the experience of being hurt on purpose by other people, and the changes in your life that it leaves behind.

You may wonder if what happened to you was bad enough to be called abuse. If you have to ask that question, it probably was. If you cannot remember large parts of your life, it almost certainly was.

I am sorry you are having to read this out of a book.... These things are better dealt with face-to-face. The effects of violence are best helped by different and more positive experiences with people. In a correctional institution, this is hard to do.

Take your time reading this. Use whatever parts seem helpful in your situation. Be patient with yourself. It will take time and work, but you <u>can</u> feel better.

Take care,

Joe Parker, RN

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Dear Colleagues,

In providing mental health care for corrections populations, management of Post Traumatic Stress Disorder has a central place.

Some clients come into the system as a result of acts in some way related to previous experiences of abuse. Many come as a result of self treatment of major symptoms by means of illegal drugs or alcohol.

Although psychotropic medications play an important role for many clients in controlling physical symptoms of the disorder, psychological treatment has proven to be very important in improving functioning and quality of life.

Since mental health resources are so limited in corrections, self-help educational materials must be used whenever possible. This booklet has been very helpful for our clients and staff, and we hope it will be helpful for your clients as well.

Permission is hereby granted to reproduce this material in any form and quantity necessary, for any use except for resale.

Sincerely,

Joe Parker, RN

POST TRAUMATIC STRESS DISORDER (PTSD)

WHAT DOES POST TRAUMATIC STRESS DISORDER MEAN?

Post is the Latin word for "after".

Trauma is the German word for "nightmare", but in English, it is used for any kind of injury, physical or psychological.

Stress is a force that changes the shape of things (including people).

Disorder refers to things that are a problem in a person's life now.

To understand PTSD, it is necessary to tell two stories.

> Once upon a time, several blind men wanted to understand about elephants.
>
> An elephant was brought to them, and they all approached it from different directions.
>
> One felt the tail, and said "an elephant is like a rope"!
>
> Another found a leg, and said, "no, an elephant is like a tree trunk".
>
> A third walked into the side of the elephant, and said, "really, an elephant is like a wall".
>
> Others found the ear, the trunk, a tusk, and each felt his part of the elephant was the real elephant.
>
> Each blind man was right about his part of the elephant, but none of them really understood about elephants.

The story of Post Traumatic Stress Disorder is similar.

PTSD was first recognized after the American Civil War.

Doctors noticed that some soldiers who had been in heavy combat complained of having attacks of fast heartbeat, chest pain, difficulty breathing, and fear that they were dying or going crazy.

The symptoms were similar to heart attacks. Not having the scientific equipment to investigate further, they assumed the attacks were a form of heart disease. They called it "soldiers' heart".

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We now know the attacks are not heart disease. They result from rushes of adrenalin, triggered by bad memories or nightmares.

A few years after the war, most people forgot about the problem, but the part of the elephant they had found was real.

World War I was the first time very large numbers of explosive shells were used in battle.

It was noticed that some combat veterans, afterward, had trouble with feeling somewhat dazed or confused, and with poor concentration and memory.

This seemed similar to what happened in many brain injuries. It was thought that the concussions of the shells caused tiny spots of bleeding in the brain. They called it "shell shock".

Eventually, a lot of autopsies were done on soldiers who had died of other causes, and no such bleeding was found. It was recognized that the symptoms resulted from extreme stress, not brain damage.

It should be remembered that many people with PTSD, especially from child abuse and domestic violence, have had damage from blows to the head. Both symptoms of brain injury and effects of overwhelming stress may be present in the same person.

A few years after the war, the matter was again dropped, but they had found another part of the elephant.

When World War II came, it took until June of 1944 to redevelop the treatment methods used in 1918.

In that war, they learned two important things. The severity of a person's symptoms was directly related to how much stress he or she had undergone, over how much time.

It was calculated that of 100 men in continuous combat, every single one would break down within 189 days. They called it "combat fatigue", or "combat exhaustion".

It also became clear that there is no such thing as a stress-proof person. Certainly some people break before others, but with enough stress and enough time, everybody breaks. They had another part of the elephant.

After World War II, it was assumed (never investigated, just assumed) that symptoms of traumatic stress went away in 6 months or a year, after the war was over.

Only after the Vietnam War did it become clear that PTSD symptoms could appear it any time, during or after the war. The symptoms could go on, better or worse from time-to-time, all of a person's life.

The severity of the symptoms is influenced by how much emotional support a person has available during and after trauma.

Veterans of an unpopular war, such as Vietnam, were clearly affected by the fact that nobody wanted to talk about it later.

Survivors of child abuse and domestic violence are more severely affected because family or friends, who normally would provide support, are the perpetrators of the violence.

In the late 1970's feminist writers began publicizing the fact that far more child abuse, sexual abuse, and domestic violence were occurring than previously admitted.

Studies began to reveal that domestic violence is a problem in about 25% of all families, regardless of race, religion, income or education. About 16% of all girls and 8% of all boys are sexually abused before the age of 18 years. Rapes reported to the authorities may represent less than 10% of those that actually occur. About 10% of the adult population is alcoholic. Inclusion of other abusable substances may raise the figure to double that.

Very few people are directly involved in wars, but most people have a family.

Unlike in times past, the feminists and Vietnam veterans have not shut up and gone away. Post Traumatic Stress Disorder is now an official diagnosis in the diagnostic and statistical manual.

Consciously or unconsciously, the brain remembers everything. Trauma really happens, and it changes who you are. You cannot seriously hurt human beings and expect them to forget it and be alright afterwards.

People who have Post-Traumatic Stress Disorder often worry about whether they are "crazy".

The word "psychotic" (or crazy) usually means experiencing or believing things that are not real: being "out of touch with reality".

People with PTSD's have essentially the opposite problem. They are in too much contact with reality, and in contact with realities that most people have the privilege of not knowing about.

It is just as possible to be sick from too much contact with reality, as from not enough.

That is the whole elephant.

The official definition of Post Traumatic Stress Disorder includes a combination of the following:

1. An extreme, painful experience, which would be severely stressful for almost anyone.

2. Continuing psychological "re-runs" of the events, including:

   a. frequent thoughts and memories about what happened, even when trying to avoid them.

   b. repeating nightmares about the trauma.

   c. suddenly feeling or acting as if the events were happening again (flashbacks).

   d. strong, painful feelings set off by things which are in some way related to what happened.

3. Ongoing attempts to avoid memories and feelings by:

   a. becoming generally numb to everything, by cutting off most feelings, both good and bad.

   b. avoiding activities or situations which may bring back memories and feelings.

   c. loss of large areas of memory about past life.

   d. loss of interest in things most other people care about, feeling different and cut off from other people.

   e. lack of any sense of having a future.

4. Continuous extreme physical alertness, including:

   a. constantly watching for signs of danger, with "startle responses", and trouble sleeping.

   b. trouble concentrating on business in the present world.

   c. irritability, outbursts of anger.

   d. physical reactions similar to what happened during past trauma (tremors, sweating, nausea etc.)

5. These symptoms continue for more than a month and can begin anytime from immediately to years after the trauma.

PSYCHOLOGICAL ABUSE

Children come into the world knowing nothing about themselves: whether they are smart or stupid, good or bad, lovable or unlovable. They can only learn these things from family, from people around them. If they are given "poison information", they have little choice but to believe it.

For the abuser psychological abuse has several advantages:

1. It leaves no physical marks. Unless the child becomes extremely depressed or psychotic there is no evidence to show in court.

2. It is safe. There is no risk of accidentally killing the child and being sent to prison. There is no problem with the child getting big enough to physically fight back or use a weapon.

3. It is easy. Psychological abuse can be kept up for years, wearing away at a child like rust. There is no great amount of energy or time involved.

Psychological abuse takes several forms. They are usually used together - it is rare for an abuser to use only one type.

1. Rejecting

   "I hate you, you ruined my life". "You are not my child" Nothing the child is or does is ever good enough.

2. Isolating

   Keeping the child away from any people other than abusers. This prevents the child from learning anything about him or herself except the "poison information" provided by the abusers.

3. Ignoring

   Not responding to anything the child is, says, or does. Psychologically/emotionally "not there" for the child.

4. Corrupting

   Involving the child in crimes, early alcohol/drug use, sexual activities, etc. that leaves the child unable to be part of normal society.

5. Terrorizing

   Keeping the child constantly in fear of being hurt, making the child watch others being hurt, keeping the child emotionally out of control most of the time.

PHYSICAL ABUSE

A large part of the "normal population" consider it legitimate to use physical force to discipline children. "Spanking" with an open hand is commonplace in our society. Abuse, fueled by uncontrolled anger or intoxication, goes far beyond ordinary discipline. Abusers almost always blame their violence on the child or spouse who is the victim. This is confusing to survivors, who need to know what level of violence qualifies as "abuse".

Abuse includes some combination of the following features:

1. Severity of injury. Cuts, bruises, broken bones, being strangled or knocked unconscious.....and sometimes death.

2. Weapons. Clubs, knives, guns and other instruments capable of causing severe injury or death. Life or death for the child depends totally on how well the abuser controls the weapon.

3. Use of pretexts. A child is punished for anything or nothing. The "rules" are made up as the abuser goes along, and change without warning. The child is never safe.

4. The abuser is out of control. Through alcohol/drugs, mental illness or personal choice, the abuser does not control amounts of force used. The child may be crippled or killed at any time.

It is sometimes useful, to understand the severity of a survivor's current symptoms, to put together a lifetime total assault history. Multiply the total number of each type of assault per day/week/month by the total amount of time exposed to the various abusers. Be sure to count both assaults in childhood and in adult life. The total number sometimes explains a lot about why you are having so many symptoms.

Finally, estimate the number of days on which the survivor could be sure of not being hurt. Sometimes this number is painfully small.

Adults who recognize their actions toward children as abusive often fear to tell anyone, out of fear they will go to jail or lose custody of their children. In reality, many social services agencies work with parents who have abused, or fear they may abuse their children, to learn to stop the violence and keep their children. Parents Anonymous is free and a good place to start.

SEXUAL ABUSE

Normal sexuality is the exchange of pleasure between two freely consenting people. Abuse is the wrongful use of a human being, as a thing, for the pleasure of another. Sexual abuse commonly involves:

1. Use of force or threat to control a person who is not consenting. The threats may be against the victim, ("Do what I want or I'll kill you...."), against others, (If I don't get what I want from you, I will just go after your little sister..."), or against the abuser himself, ("If you tell anyone, I will have to kill myself, and it will be all your fault...").

2. Use of lies to overcome resistance, ("I'm doing this to teach you, for your own good", "Everybody does this", "You want it, I know you do".). Lies can take the place of open violence.

3. Secrecy. Normal sexual relationships may go on in private, but they are not themselves secret. The demand for secrecy almost always indicates wrongdoing, and usually includes some kind of threat. ("You won't be by special girl anymore", "It would break your mother's heart", "You will be put in an institution".).

4. Betrayal of responsibility. Children have to depend on older people for protection, for food, clothing, shelter, and for truthful information about how to get along in the world. An adult who uses a child's natural needs in order to use the child's body, is committing a crime. Sometimes the betrayal hurts more than the fear, the isolation or the injuries.

The most basic drives of human beings, and of all animals, are to survive and to reproduce. The use of power to control a child is ultimately based on the threat to hurt, abandon, or kill. The child does whatever is necessary to survive. Energy that should go into growing up, is spent on trying to just get by, day by day.

Use of sex as a weapon strikes a child's basic ability to relate to, and trust, other human beings. It attacks a person's sense of being connected to other people, both in the present world, and to past and future generations.

Sexual abuse is like any other serious injury: some people survive and do well, some people only get by, and some end up not surviving at all. Good help and the right choices can make your life more nearly normal, and much happier than it might otherwise have been.

To be hurt, especially on purpose by other people, makes everyone sad and ashamed. In thinking about their lives and symptoms, most people tend to underestimate the severity of their experiences, and overestimate the amount of control they had over what happened.

HISTORY

The brain has mechanisms like "circuit breakers" which block out memories too bad to handle at a given time. The memory loss is usually "spotty", not complete, and gets better or worse depending on a person's stress level and how much help is available.

Trying to force the memory, by emotional pressure, drugs or hypnosis, often hurts rather than helps. If the brain needs to block out a memory, it usually has good reason. People tend to "face reality" as fast as they can. Pushing becomes just another form of violence.

It is common to have to work on plans for recovery with incomplete information. Often, some of the most important facts come out only quite late in the process.

Because the traumatic experience really happened, and really hurt, PTSD symptoms tend to continue, better at some times, worse at others, most of a person's life. Careful planning and use of recovery skills can greatly increase the amount of "good time" and make the bad times less frequent and less severe.

Putting together a written history of your life, and understanding the effect the traumatic parts had, usually helps make sense of many things that have happened in your life, during the abuse and after. It is very important in making plans for your recovery. Making the most complete possible history is a long term project. Memories come back in bits and pieces. Information from other people and from records also will come in bits and pieces. Some things may never be known.

This will be a stressful process, both in the effort spent in trying to remember, and in the energy needed to cope with what is remembered. Sadly, insight into what happened usually improves symptoms, but seldom completely removes them.

It helps to keep written notes, to avoid losing hard won information to the ups and downs of memory. Putting it in writing also seems to help keep things real, when so often they seem unreal, or even impossible.

1. Lay out a "life line", beginning with your birth. Put in any markers that will keep track of time: places you lived, where you went to school, births, marriages, deaths, institutions you were in, etc.

2. Talk to family, friends, teachers, ministers, neighbors and anyone else who may have information about your life.

   Keep in mind that some of these people truly did not know, some did not want to know, some knew but did nothing, and some may have profited in some way from what happened. (For example, as long as the violence was directed at you, it was not aimed at them.)

3. If you decide to talk with the perpetrator, be very careful of your safety. Many are still dangerous. Be clear about what you are trying to do. If you want the perpetrator to confirm memories you can barely believe yourself, be prepared to be called a liar, crazy, or to be told you wanted or deserved what happened. Try not to hope for too much: most perpetrators do not admit responsibility or say they are sorry.

   If your purpose is to confront the perpetrator with your anger and your knowledge that what was done was wrong, then, other than being careful for your safety, how the person reacts is not very important.

   If the perpetrator is confronted in the process of warning other family and friends about the danger he or she presents, be aware that some other people may react in much the same way as the perpetrator might.

   You cannot afford to attach your sense of self worth to the reactions of other people, because their responses have to do with who they are, not who you are.

4. Pay special attention to periods of time you cannot remember, or that others will not discuss with you. The more hurtful the experience, the more likely it will have been blocked out.

   Sometimes it is possible to work backward from things that are known: who was living with us at the time, who was drinking at that time etc.

5. Send for copies of any hospital or institution records that may be available. Although you have a right to see and copy most records pertaining to you, sometimes the help of an attorney or health care provider may be needed. Be aware that many professional people are careful not to ask questions they do not want to hear answers to. Some of the records may be in a sort of code, that is: "chaotic family life" may mean drunken violence on a daily basis, and "sexually molested" may cover rape, sodomy and torture.

Put your notes in a safe place. You may wish to add to them from time to time, as you find new information. Sometimes reviewing them will help you understand some new problem in your life.

LIFE CHANGES

Extremely hurtful experiences, ones that produce more fear, pain and anger then anyone can handle, leave behind four ongoing sets of behaviors. These are not so much "scars" as attempts to cope with trauma. Like any kind of treatment, if carried too far, they can become part of the problem, not part of the solution.

1. You begin intense, continuous study of the experience, trying to understand why those things happened, and how to keep them from happening again.

This involves constant thinking about the events, to the point it may interfere with other activities. You may have repetitive dreams about the events which may be so intense as to interfere with sleep and set off adrenalin reactions. The feelings can be so powerful that it can seem as if you are living in two different "movies" at the same time: the "bad old days" and "now".

Once you understand how the process works, you feel less disoriented, less out of control, and more able to cope.

Learning more information about trauma <u>does</u> help. You can take classes, read about it, and talk with others who have been through similar things.

2. You learn to constantly scan the environment for signs of danger. The scanning is compulsive - you cannot turn it off, so you have to plan for it.

Recognizing signs of threat may trigger strong reactions, sometimes as strong as the original events did. These reactions may be completely out of line with what is going on in the real world at the time.

Sometimes, you may well be aware of the connections between the present "trigger" and past experiences, even if you cannot control your reaction. At other times, the connection may be unconscious. You first become aware of your <u>reaction</u>, and may or may not later be able to connect it with the past.

The responses may be so intense as to feel like the trauma is actually happening again, that you are back in the bad old days. This is called a flashback. It can feel very crazy to find yourself feeling, saying, or doing things that do not relate to the present world.

To begin to control various kinds of flashbacks, it is important to map out your usual triggers, where they are likely to be encountered, and what your usual reactions are. Some triggers can be avoided almost completely, and should be. Others may be harder to avoid, or you may have good reason to take the chances involved in running into them.

Survival planning may include ways of minimizing exposure, arranging for support ahead of time, developing a "cool down" procedure, and concrete emergency plans in case of losing control.

3. Your body goes in chronic "red-alert", always ready to fight or run. Physical symptoms include extreme muscle tension ("the shakes"), headaches, high blood pressure, involuntary startle reactions and trouble sleeping. You feel afraid all the time, even when you have no present reason to.

It is in attempting to control <u>these</u> symptoms that so many people with PTSD get involved with alcohol and illegal drugs. Expert use of legitimate psychiatric and blood pressure medications can control most physical symptoms of PTSD. <u>They do not provide a high, are not addicting, are legal, and are much safer than street drugs</u>.

As survivors move forward in recovery, some may no longer need medication, others will need it only during bad times, and some may need it always.

Serious trauma can change the way a person's nervous system works, sometimes permanently. Even after allowing for the effects of brain damage and other injuries from violence, PTSD is a physical illness.

4. You are continually prepared to be hurt again, to lose again. The difference between the way life was supposed to be, and the way it turned out for you is a chronic stress.

You learn to avoid getting involved with other people for fear they will turn on you. You try not to care about people, animals or possessions, because sooner or later you expect them to be taken from you. You go so numb that you cannot feel anything, including good things. Being that numb <u>hurts</u>. Being cut off from good things, including people, makes you <u>sad</u>.

Emotions may swing like a pendulum, from overstimulated, hyperalert, fearful and angry, to depressed, numb and out of contact with the world around you. The extreme feelings often come and go in waves, and at times you actually may be out of control. Stabilizing this swing is a central goal of a recovery plan. Such a plan may include:

a. Mapping triggers and arranging your life to avoid recurring flashbacks.

b. Learning to recognize and avoid hurtful people.

c. Avoiding the use of drugs which temporarily improve symptoms, but make them worse on the "rebound". If needed, symptoms can be controlled with legitimate medications.

d. Reducing your exposure to new injury. (For instance, stay out of places that serve alcohol...)

e. Stopping current patterns of behavior which may be replays or reenactments of your own previous trauma, such as prostitution, fighting, child abuse.

f. Actions to make the real world safer are much more helpful than just trying to cope with your feelings about what might happen. Good locks and a dog are more helpful than lying in bed trying not to be afraid.

Extreme traumatic experiences, especially if they happened at a young age, can make you different from most other people. Of special interest are two groups of people who may seem very strange to you: predators and normal people.

DEALING WITH OTHER PEOPLE

A person's usual everyday approach to life and to other people is called a personality. A personality is made up of a person's biological inheritance (genes), the total set of things that have happened in the person's life, and the history of choices the person has made.

Every life is like a hand of cards. Some people play whatever they get well, others badly. Only a small number of people choose to hurt others. Even among people abused as children, 70% do not choose to hurt others.

Predators come in three forms:

A. Non-controllers:

All people have angry feelings, and all people have the impulse to hurt someone at times. Some choose not to control those impulses. Many choose to use alcohol and drugs, and let the chemicals block their impulse control. Others do whatever they feel like, sober or otherwise. Their attitude is: "I feel like shit, so somebody's going to pay..."

People who are loaded occasionally have the bad judgement to pick on somebody tougher than they are, but most, sober or not, are quite careful to act out their impulses on people who cannot effectively fight back.

B. Users:

Some people act as if they were the only real human being in the world, and other people are more like plants. If they want something, they simply take it, as if they were harvesting vegetables. Users have no sense of other people's rights and feelings, and do not consider that a problem.

It is not that they have something that other people do not. Rather, users are missing something most people have: a conscience, that is, internal personal limits on what they do. Any control of their behavior must be provided by others, and often by force.

C. Sadists:

People who enjoy humiliating and hurting others, and who do so while in full control of themselves., may make up as much as 10% of the population. They are found in all parts of society, with all levels of education and income. For some, other people's pain is sexually stimulating. Others like the feeling of power that comes with hurting people who cannot stop them.

The definition of sadism includes ongoing pattern of:

1. Using physical violence, threats or lies to control another person and inflict pain.

2. Humiliating and degrading a person in front of others.

3. Using a position of authority such as that of a parent to inflict unusually severe "discipline".

4. Being fascinated by violence, weapons, torture etc.

5. Finding the suffering of other people and animals funny, pleasurable or sexually stimulating.

Some sadistic people are very obvious. Others are so subtle that all you notice is that you feel bad when around them. Abuse survivors have had to learn to ignore their own feelings just to survive. Learning to recognize , and trust, your feelings and to take rapid action to protect yourself, sometimes takes a lot of work.

Cruel people often are quick to notice people who expect to lose, and will move in quickly. They avoid people who look like they know they have rights, and have people who love them, because they are likely to fight back.

It is necessary to learn to act like a person with value and rights, long before you can really feel it. In time, it will become real, not an act.

Normal people:

To deal with normal people, you must understand that the world they live in is very different from yours. They are not afraid all the time. They can feel many more things than pain, fear, and anger.

1. They have rarely felt so much pain that they have lost control of themselves, and certainly have not had that kind of pain caused intentionally by another person.

2. They do not assume they are at fault any time anything goes wrong.

3. They expect to be treated fairly, to be respected, and to love and be loved.

4. They can feel pleasure without drugs, they are depressed only occasionally, and do not know what being numb is about.

5. They expect to have a fair amount of control over their lives, and expect to live to be old.

With time and effort, you can learn to deal with people whose lives have been luckier than yours. One barrier will probably always remain: most normal people do not want to live in the world you know. Many will block you out so they can stay comfortable, not because you are doing something wrong. It is important not to reject all normal people, because there are always some who will work quite hard to understand how your life has been, even if they have had no similar experience themselves.

FINDING PEOPLE YOU CAN TALK TO

Think of how long it took you to put together the pieces of your history, make an accounting of how the abuse changed your life, and deal with your emotional reactions to that. You never had a choice about facing that because you had to live it.

Finding someone to talk to about it is not quick or simple. Some people will listen because they have had to live with abuse too. They may or may not be able to tolerate terrible stories at a given time. Listening to your story may bring up feelings they find too painful to deal with.

Others will listen because they are unusually committed to helping other people, or care a lot about you personally. Finding people who can listen is a key part of surviving. It involves several specific steps:

1. Talk with them about some part of your life that is fairly ordinary, and see if they really listen. If they listen poorly to the very ordinary, they certainly will not hear the really ugly. If they listen, then:

2. Choose a "medium bad" part of your story, one not too hard to handle if things go badly, and tell that. If they change the subject, turn mean, or drop a relationship, they probably are not worth any more effort.

   If they get panicky or go numb, you may have found another person with an abuse history. Keep in mind that they may or may not consciously recall the experience. Given plenty of time and personal space, these people may talk with you. Just as it was with you, pushing hurts rather than helps.

3. Once you know a person really well, you may choose to tell him or her the very worst things that happened, the ones that would really hurt if not handled with gentleness and respect. After you tell another person the very worst, and are met with kindness and respect, the memories never have quite the same power over you again.

4. Sometimes you will know people you care about, and very much would like to talk to, but you really feel they could not tolerate the ugly details. You may choose to tell them only some of the story, or even none.

   It is not fair that you should have to spend your energy to protect them from hearing about what you had to live, but occasionally it is necessary.

TRIGGERS

Human beings are creatures that learn, and keep on learning all of their lives, whether they want to or not.

They learn to recognize danger by noticing signs that were associated with past hurtful experiences. If the past experiences were severe, there may be a strong physical or emotional response, even if the conscious mind does not know what set it off.

These signs are called "triggers". People who have a good understanding of what situations set them off, can plan to avoid them, or to deal with the reactions. They come to feel much more in control of themselves.

Triggers can be internal, that is, can be a thought or a memory, as well as an outside event. Triggers take several forms:

1. Single Triggers: One sign alone is enough to set off a reaction. Examples: beer breath, body odor, being yelled at, seeing someone else hurt, violence or happy family situations shown on TV.

2. Compound Triggers: Several things, coming together, will set off a reaction, when each would not have been enough if it appeared alone. Examples: being touched, by someone who is angry, and has beer on his breath; or blood, on bed sheets, in the morning.

3. State-dependent triggers: One or several things which set off a reaction only when a person is tired, alone, in pain, intoxicated, etc. Without the changed mental and/or physical state, the particular signs are not enough to set off a reaction.

It is helpful to keep a log of what is happening around you, and what you were thinking about, just before your body and emotions "went off". Because of memory loss caused by stress, finding the trigger that set off a reaction can take time. Tracking down a trigger may also bring back lost memories. At other times, putting together more personal history will help identify triggers you had not recognized before.

FORGIVENESS

Abuse survivors often are pressed to "forgive" the perpetrator. The pressure may come from others, especially family members, or from the survivor's own beliefs about what should be done.

Forgiveness is a word for something that does not exist in the real world. There is no way to go back and act as if nothing ever happened, which is what most people want and most people think forgiveness means. People other then the survivor made bad choices, with terrible outcomes, and became worse people as a result.

The survivor may choose not to seek revenge, may choose to continue some contact with the abuser, and may try to support any positive change that the perpetrator may attempt, but there is no way the survivor can control what the abuser chose to do. If the survivor had been able to control other people's decisions, there would have been no abuse.

Children want very badly for their family to be good people, even in the face of strong evidence that they are not. They will blame themselves for things other people did. They will claim that they were somehow in control, rather than face the fact that they were helpless and that the bad choices were made by others. Survivors have nothing to be forgiven for, because they did not make the choices.

The abuser can choose to give up violence, take responsibility for the damage, and work toward rebuilding a family. Failing that, the survivor may have to piece together a family out of whatever is left, without the abuser.

A LAST WORD

A new family can be built out of the people who choose to be part of your life, whether or not they were born into it. A real family is something people do together, not something they are.

Building a new life may take terrible faith and courage. Some days it will seem easy, on other days, impossible. You go on living, with the unwanted knowledge of what evil people have done and can do, including what you yourself may have done and can do. Sometimes it takes all the courage you have just to get up and get dressed in the morning, knowing what can happen.

I wish you luck and courage on your journey. You will always have my respect.

Joe Parker, RN

THE PENDULUM SWING

REEXPERIENCING

- intrusive memories
- nightmares
- loss of sleep
- attacks of fear,
- flashbacks
- "startle" reactions
- increased need for alcohol/drugs

NUMBING

- feeling nothir
- loss of nor... interests
- detachment from others
- memory loss
- avoidance of reminders
- depression

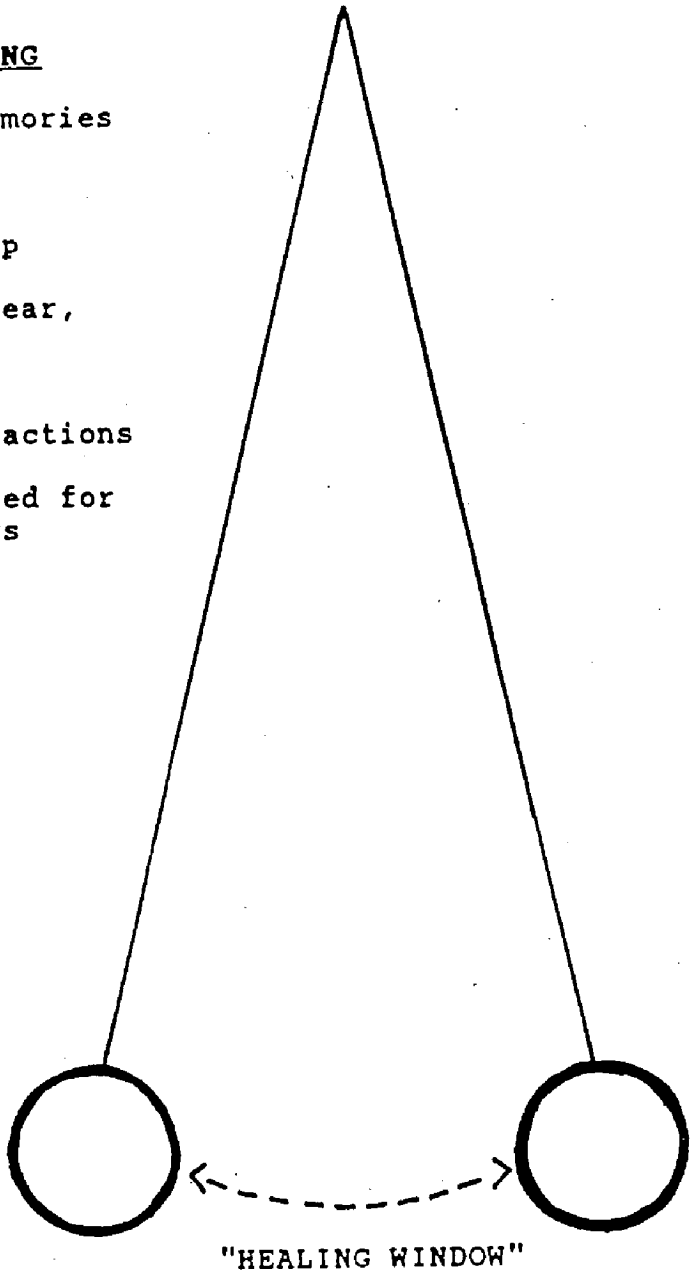
TOO AGITATED

TO WORK ON

PROBLEMS.

TOO MUCH

ENERGY.



UNABLE TO HOPE

FOR THINGS TO

GET BETTER.

NOT ENOUGH

ENERGY.

"HEALING WINDOW"

Enough energy to work on problems, and enough hope to want to.

NOTES

NOTES

ALCOHOL AND DRUGS

Alcohol, Drugs, and Chronic Mental Illness

1. Substance Abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period

- Recurrent use resulting in failure to fulfill major role obligations at work, home, or school
- Recurrent use in situations where it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

2. Substance Dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:

- Tolerance
- Withdrawal
- Substance taken in larger amounts or over a longer time than was intended
- Persistent desire or unsuccessful attempts to control use
- Great deal of time spent in obtaining, using, and recovering from the drug
- Important social, occupational, or recreational activities are given/ reduced due to use
- Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

3. Addiction is a chronic, progressive, terminal disease. Substance use result in changes in the brain which maintain addictive behavior

4. Incidence of substance abuse among individuals with chronic mental illness is higher than that of the general population.

ECA Studies:

Lifetime Prevalence	General Population	Dx. Of Schiz
Any SubstanceUse Disorder	16.7%	47.0%
Any Alcohol Disorder	13.5%	33.7%
Alcohol Dependence	7.9%	24.0%
Alcohol Abuse	5.6%	9.7%
Any Other Drug Disorder	6.1%	27.5%
Drug Dependence	3.5%	12.9%
Drug Abuse	2.6%	14.6%
Marijuana Depend/Abuse	4.3%	
Cocaine Depend/Abuse	0.2%	
Opiate Depend/Abuse	1.2%	
Amphetamine Depend/Abuse	1.7%	
Hallucinogen Depend/Abuse	0.3%	

5. Incidence of mental illness among individuals with a substance use disorder is greater than the general population

ECA Studies

Lifetime Prevalence	General Population	Alcohol Dx.	Drug Dx.
Any Mental Dx.	22.5%	36.6%	53.1%
Schizophrenia	0.7%	3.8%	6.8%
Any Affective	8.3%	13.4%	26.4%
Any Anxiety	14.6%	19.4%	28.3%

6. Reasons for use of substances by individuals with mental illness can include social, self medication, and addiction

Social:

- Means to behave like non-mentally ill peers
- Opportunities to be around others w/o high social demands
- Creates a sense of belonging to a social group

Self-Medication:

- Anxiety Reduction
- Improved ability to concentrate
- Improved energy level
- Increased sense of ability to function and well being
- Improved mood

Addiction:

- Physical and psychological dependence
- Altered brain function

7. Use of substance by individuals with chronic mental illness typically result in increases in symptoms of psychiatric disorders and reduced ability to function

8. Effective treatment involves simultaneous treatment of both the mental illness and substance use disorder

ALCOHOL AND DRUG

- WHAT TO LOOK FOR IN ASSESSING THE
- POTENTIAL FOR VIOLENT BEHAVIOR

- RISK FACTORS FOR HOMICIDE

- BLOOD ALCOHOL CONCENTRATION

- DEPRESSANTS
  - Alcohol
  - Opiates/Narcotics
  - Sedatives/Hypnotics/Anxiolytics

- ALCOHOL AND DRUG OVERVIEW

- INDICATORS OF DRUG USE

- OTHER DRUGS

- HALLUCINOGENS, PHENCYCLIDINE
- (PCP), AND RELATED SUBSTANCES

- INHALANTS

- DRUG PROBLEMS IN EMERGENCY
- ROOMS

ALCOHOL and DRUG (continued)

- RISK FACTORS FOR SUICIDE
- STIMULANTS
- SUBSTANCE ABUSE AND THE BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE.
- QUICK LIST OF SUBSTANCES AND THEIR SYMPTOMS

WHAT TO LOOK FOR IN ASSESSING THE POTENTIAL FOR VIOLENT BEHAVIOR

- A psychiatric diagnosis that includes violent or impulsive behavior among its criteria
- A previous history of violent behavior
- A history of substance abuse
- An injury to the head
- An injury to the central nervous system
- A previous history of physical abuse by others
- A previous history of suicidal behavior
- A previous history of delusions or hallucinations—particularly command hallucinations

Source: Lukas, S. (1993). Where to Start and What to Ask. New York: W. W. Norton & Co.

Risk Factors for Homicide

- Access to/ownership of guns
- Use of a weapon in prior abusive incidents
- Threats with weapon(s)
- Threats to kill
- Serious injury to victim(s) in prior abusive relationships
- Threats of suicide
- Drug or alcohol abuse
- History of forced sex with female partners
- Obsessiveness/extreme jealousy/extreme dominance

Blood Alcohol Concentration

Blood Alcohol Concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process

capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most states for drunkenness, which is 0.08 percent.

BAC can be measured by breath, blood, or urine vehicle tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury.

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are
impaired in most people long before they exhibit visible signs of drunkenness. While most states define legal intoxication for purposes of driving at a BAC of 0.08 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

The legal intoxication level in most states is 0.08 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.08 percent is reached.

Factors that will affect the BAC in a person:

- How much alcohol you drink.

- How fast you drink. The quicker you drink, the higher your peak BAC will be. The liver gets rid of alcohol at the average rate of one drink per hour (12 oz. beer, 5 oz. wine, 1 shot of distilled liquor). If a person drinks faster than this, the remainder will circulate in the blood stream until the liver can get rid of it.

- Body weight. Heavier people will be less affected by the same amount of alcohol than lighter people. They have more blood and water in their bodies in which to dilute the alcohol.

- Food in the stomach. When there is food in the stomach, alcohol is absorbed slower into the blood stream. The BAC rises more rapidly in those who drink on an empty stomach, because there is no food in which to dilute the alcohol.

- The type of alcohol you drink. The stronger a drink is (the higher the alcohol concentration, distilled alcohol first, wine second, beer third), the more quickly it is absorbed. This partially explains why hard liquor has more of an apparent " kick" than wine or beer.

- Type of mixer used. Water and fruit juices mixed with alcohol slow the absorption process, while carbonated beverages will speed it up. Carbon dioxide speeds the alcohol through the stomach and intestine into the bloodstream, creating a rapid rise in BAC.

- Temperature of the drink. Warm alcohol is absorbed quicker than cold alcohol.

- If you are male or female. Women reach higher BAC's faster because they have less water in their bodies and more adipose tissue (fat), which is not easily penetrated by alcohol. Therefore, a man and woman, with all other factors being equal, both drinking the same amount of alcohol will have different BAC levels. Hers will be higher. A woman's menstrual cycle will also affect her rate of absorption. They will experience their highest BAC's premenstrually. In addition, there is also evidence that a woman taking birth control pills, will absorb alcohol faster, resulting in higher BAC levels.

Depressants

Alcohol

- Most people do not think of alcohol as a drug

- Medical consequences usually show up after years of heavy drinking

- Has a profound effect on the chemistry of emotions

- Increases the hazards of other drugs when used in combination, to include: more severe side effects, more frequent adverse effects, and diminished effectiveness of the medication

- Remains in the body for four or more hours, depending on amount ingested

- Can result in respiratory depression, cardiac irregularities, coma. Using marijuana with alcohol inhibits vomiting and can increase the likelihood of overdose

- Other causes of serious injury or death can result from aspiration of vomitus, accidents from impaired judgment and coordination, fighting resulting from disinhibitory effects and increased aggressiveness, and suicide resulting from increased impulsivity/or depression.

- Medical complications include cirrhosis of the liver, brain damage and hypertension are common with high dose/long term use. Poor nutrition and self-care can be see with advanced alcoholism.

Appeal of the Drug:
- anxiety reduction
- social lubrication
- disinhibition

Specific Effects:
- rapid tolerance
- sedation
- impaired concentration
- impaired coordination
- rapidly fluctuating moods
- disinhibition

Signs of Use:
Slurred speech; uncoordinated movements; unsteady gait; nystagmus; flushed face; aggressive and/or disinhibited behavior; rapid mood shifts; impaired judgment and/or functioning.

Withdrawal Symptoms:
A hangover is the withdrawal syndrome from acute ingestion of alcohol. Nausea, vomiting, malaise, weakness, autonomic hyperactivity, anxiety, depression, irritability, transient hallucinations or illusions, headache, insomnia, and possible delirium may appear within 24 hours after use has stopped and last 3-10 days in the case of long-term alcohol dependence.

Withdrawal from alcohol can also include: convulsions; delirium tremens (DT's) and hallucinations. Withdrawal from alcohol can be medically dangerous and produce serious medical complications, and detoxification procedures must be monitored because abrupt withdrawal can be life-threatening. Withdrawal for the alcohol dependent person can last well beyond the time for which medical supervision is necessary. Symptoms can last for weeks or months.

Opiates /Narcotics

- Includes pain medications such as morphine, Demerol, Dilaudid, Darvon, Percodan, Vicodin, codeine, as well as heroin and methadone.

- It is theorized that many addicts and alcoholics have problems in their natural pain-regulating mechanisms that leave them vulnerable to addictive disease.

- Routes of administration can be oral, IV, intranasal, or through inhalation.

- Users are more likely to die from overdose than from withdrawal.

Appeal of the Drug:

- reduced sensitivity to pain
- "rush" of the initial effect (euphoria)
- tranquility
- reduced anxiety

Signs of Use:

- Pupillary constriction or dilation
- drowsiness
- slurred speech
- impairment in attention or memory behavior that suggests euphoria followed by apathy, dysphoria, psychomotor retardation, impaired judgment, or impaired functioning may also be signs of use

Specific Effects:

- rapid tolerance
- reduced sensitivity to pain
- sedation
- reduced anxiety
- excessive dryness (constipation
- sluggish muscle tone
- low blood pressure
- slowed pulse
- cough suppression
- shallow breathing
- slowed motor response
- inability to focus thoughts
- euphoria
- apathy

Sedatives/Hypnotics/Anxiolytics

Sedatives sedate or calm.

Hypnotics induce sleep.

Anxiolytics reduce ongoing anxiety.

The most commonly prescribed and abused are benzodiazepines. These include: Valium; Librium; Dalmane; Halcion; Ativan; Klonipin; and Xanax. The BZs are chosen for anxiety reduction and as sleep aids because they are safer and more effective than other sedatives. Overdose is virtually impossible if these drugs are not mixed with alcohol: however, withdrawal must be carefully monitored because abrupt withdrawal can be life threatening.

Signs of Use:
Slurred speech, uncoordinated movements, unsteady gait, impaired judgment.

Withdrawal Symptoms:
(Noted after prolonged use--usually 90 days at low doses.) Symptoms include anxiety, restlessness, dysphoria, and muscle twitches. Withdrawal from high doses can include severe anxiety, tremors, sweating, agitation, psychosis or seizure.

Alcohol and Drug Overview

The DSM-IV presents 12 classes of psychoactive substances that can cause organic impairment. These include:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opiods
- Phencyclidine & related substances
- Sedatives/Hypnotics/Anxiolytics
- Other/Unknown

1) Depressants

Alcohol, Opioids, Sedatives, Hypnotics, Anxiolytics

These psychoactive drugs have a primarily *sedative* effect and a strong potential to create dependence. The effects are experienced as reduction in tension, disinhibition, relief from anxiety, reduced stimulation, calmness or tranquility Their primary hazards include respiratory depression, coma, and death by injury due to accident.

2) Stimulants

Amphetamines, Cocaine, Caffeine, Nicotine

The primary effect of these drugs is *excitation* or *arousal.* They have a strong potential to create dependence because of the transient sense of pleasure and reward they provide. They are experienced as focused thought processes, euphoric mood and increased energy. Their primary hazards to life include: convulsive seizure, cardiac arrest or death by injury (due to wildly reckless driving, paranoia, agitation, aggression and/or psychotic behavior.

3) Other Drugs

Cannabis, Hallucinogens, Phencyclidine (PCP), Inhalants, Other/Unknown

These drugs cannot easily be grouped into a depressant or stimulant class as they have some characteristics of each. Hallucinogens and PCP are sometimes called *psychedelics.* They produce perceptual distortion in the form of sensory illusions or hallucinations and increased awareness of internal and external stimuli. Hallucinogens do not create physical dependence or high levels of physical toxicity, whereas this does not appear to be the case with PCP. These drugs may induce or contribute to *panic attacks.* They may cause death through *loss of reality testing* due to sensory distortion (e.g., not responding to pain, "flying" out a window). PCP can result in death due to overdose or to an accident caused by loss of motor control.

INDICATORS OF DRUG USE

- Neglect of significant personal concerns such as health, hygiene, personal appearance, housing needs or nutritional needs. Weight loss, poor appetite or obvious dental decay may be seen. Neglect is the result of drug seeking behavior and mental deterioration.

- Inexplicable sudden changes in personality, for example the sudden onset of aggression and/or paranoia.

- Acute changes in mental functioning, such as the onset of drowsiness, confusion or disorientation.

- Acute mood changes, including euphoria, depression or irritability.

- Recurring signs of drug withdrawal such as irritability, confusion, restlessness, tremor, sweating, cramps, and the complaint of 'aching bones.'

- Homelessness and itinerancy (frequent moving from place to place).

- Significant and repeated inconsistencies in statements to persons such as health care workers, and general lack of cooperation.

- The need to regularly take large amounts of benzodiazepine medication or other sedating medication.

- Attempts to manipulate health care workers with such talk as: "You know I need X and if I don't get X, I won't be able to control myself," etc.

- 'Track marks,' usually seen as longitudinal scars on the inside of the elbow areas, due to chronic intravenous drug use.

- Continued inability to provide identification.
- The complaint of insomnia, without obvious reason. Remember that marijuana abuse may be a possible cause of insomnia.
- 'Doctor shopping,' or the indiscriminate consultation of numerous doctors to obtain medication.
- Accusations of theft or confirmed involvement in crime to support a 'habit.'
- Denial of the problem may occur and should not be accepted if signs of drug use are present.

Other Drugs

Cannabis (Marijuana)

- Can be smoked in a pipe, rolled into cigarette paper or compressed into hashish or hashish oil.
- Comprised of about 400 chemicals, with the cannabinols (particularly delta-9 THC) and the cannabidiols creating the primary psychoactive effect.
- Potency is much higher than it was 10-20 years ago.
- Most of the marijuana in this country has a sedative effect and calms the user.
- Some users seek the dissociative effect of the drug—a feeling of distance from other people, which can make them feel safer in uncomfortable situations.
- The half-life of marijuana is eight days. It takes approximately two months to rid the body of all traces of the substance.
- Low doses result in impaired short-term memory.
- High doses result in: difficulty in concentration; difficulty managing emotions; amotivation; impaired ability to operate a car or other machinery; impaired job/school performance; distancing in relationships.

Appeal of the drug:

- dispels boredom
- narrows focus of concentration
- distorts time
- exaggerates the senses and emotions

- reduces anxiety
- dissociative effects

Specific Effects:
- decreases anxiety
- produces shifts in concentration
- produces a dissociative reaction
- alters perception of space and time
- alters judgment of speed and distance
- decreases motivation and concentration
- alters functioning of the hypothalamus and pituitary glands
- increases heart rate, decreases blood pressure
- lowers pressure within the eyes

Signs of Use:
Physical signs can include reddened eye, increased appetite, dry mouth, and rapid heart beat.

Withdrawal Symptoms:
Agitation, inability to concentrate, sleep problems, craving, decreased appetite, anxiety and discomfort around other people. Severity of symptoms depends upon the dose and length of use. For the average user, the symptoms are usually mild with a gradual onset because of the long-life of the drug. Users can rarely identify withdrawal symptoms due to marijuana because they often begin to occur several weeks after date of last use.

Hallucinogens, Phencyclidine (PCP), and Related Substance

- Primary effect involves changes in thought content, sensory perception and subjective emotional experience.

- Psychedelics cause intensified sensations, mixed-up sensations (synesthesia), illusions, delusions, hallucinations, stimulation, and impaired judgment and reasoning.

- The most commonly used psychedlics are: LSD, MDMA, PCP, peyote, and psilocybin mushrooms.

- PCP and Other Psychedelics: PCP, an animal tranquilizer causes mind-body distortions and a sensory deprived state.

- PCP has characteristics of depressants and stimulants.

- Easy and inexpensive to manufacture.

- Commonly mixed with other drugs and used as substitute for other chemicals without user's awareness.

- PCP is frequently found as adulterant for street drugs sold as LSD, Ecstasy, and/or THC.

- With repeated use the drug can be stored in the body for weeks or months beyond cessation of use.

- Higher doses can cause paralysis, loss of consciousness, amnesia, violence, and psychosis.

Appeal of the Drug:
- alters sensory input
- accentuates mood
- creates illusions
- synesthesia
- dissociative reaction
- loss of body and ego boundaries
- sense that mundane events aren't important
- sense of bonding and affiliation (ecstasy)

Specific Effects:
- tachycardia
- increased blood pressure
- increased body temperature
- pupil dilation
- visual illusions, perceptual changes
- emotional lability
- slowed time perception
- dissociative
- mild tolerance possible
-

Most Severe Hazards:
- panic reaction
- alters perception of time and space
- interferes with reflexes
- accidents common
- possible toxic psychosis
- drug-precipitated functional psychosis
- flashbacks

Signs of Use:

- Pupillary dilation; tachycardia; sweating; palpitations; blurred vision; tremors; uncoordinated movements
- Behaviors indicating marked depression or anxiety; ideas of reference; fear of "going crazy;" paranoid ideas; panic; impaired judgment and functioning
- Reports of perceptual changes: intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias, euphoria, mysticism or religiosity

Withdrawal Symptoms:
No physical dependence occurs with hallucinogens and no withdrawal syndrome has been documented, even after prolonged use of high doses.

Inhalants

- Includes volatile organic compounds such as: gasoline, glue, paint, cleaning agents, aerosol propellants, nitrous oxide (laughing gas) and amyl and butyl nitrate.

- Effects occur within 7-10 seconds and last no more than 30 minutes to one hour.

- Neurologic damage can include hearing and visual impairment, loss of coordination and memory, and learning disabilities. Mental impairment may be irreversible, though not usually progressive after abuse ceases.

- More users are preadolescents and young teens who do not have access to more "sophisticated" drugs, while others live in institutional settings or do not have enough money for other drugs.

- A common method of administration is to pour or spray the chemical onto a rag, place it over the nose and mouth, and inhale (huffing), or place in a plastic bag and inhale (bagging), or breathing in the inhalant directly from the container (sniffing).

Appeal of the drug:
- creates an intoxicated state
- effects are immediate and last from 5 to 45 minutes
- readily available through legal channels

Specific Effects (may vary depending on exact substance):
- mild intoxication
- possible hallucinations
- rapid onset of action
- create visual disturbances
- decrease appetite
- loss of memory

- unsteady gait

Most Severe Hazards:

- organ damage (including brain damage, liver damage, pancreatitis, kidney failure
- accidents, head trauma resulting from impaired judgment and coordination
- inflammation in joints, muscle weakness
- destroy red and white blood cells
- central nervous system depression or overstimulation
- cardiac arrhythmia (irregular heartbeat) and cardiac failure
- damage due to anoxia (lack of oxygen)

Signs of Use:

- rash around nose and mouth
- chemical breath, body odors
- residue
- red glassy watery eyes and dilated pupils
- slow, thick, slurred speech
- irritation of the throat/lungs/nose, nausea, headache
- dizziness
- nystagmus
- pains in chest and stomach
- fatigue
- staggering gait, disorientation, lack of coordination
- stupor
- euphoria
- belligerence
- assaultiveness
- impaired judgment and functioning

Reports of Drug Problems in Emergency Rooms (In many cases, more than one drug is found in incoming patients)	
DRUGS	**% of Patients Who Tested Positive**
1. Alcohol in combination with other drugs	32.6%
2. Cocaine	28.4%
3. Heroin/morphine, codeine, or other opioids	17.3%
4. Acetaminophen, aspirin, ibuprofen	13.9%
5. Benzodiazepines (Xanax, Valium, Ativan, Klonipin	10.4%
6. Antidepressants (Elavil, Prozac)	8.6%
7. Marijuana	8.6%
8. Methamphetamine/amphetamine	5.1%
9. Antihistamine	1.7%
10. OTC sleeping aids	1.3%

In some parts of the country, particularly San Francisco and on the West Coast, ER staff are seeing more and more Methamphetamine-Induced Psychosis.

Cocaine still causes the most deaths, although there has been an increase in deaths related to heroin overdose.

SUBSTANCE ABUSE AND BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE

Intoxication		Withdrawal States		Substance-Induced Paranoid Psychotic States	Substance-Induced Organic Brain Syndromes
High	Low	High	Low	High	High
Alcohol	Opiates	Alcohol	Opiates	Meth	Alcohol Withdrawal
PCP		Sedative		Cocaine	Sedative Withdrawal
Cocaine		Stimulants		PCP	PCP Intoxication
Meth					Inhalant Intoxication
Inhalants					Cocaine Intoxication
*LSD					Brain Injuries

Adapted from: Potter-Efron, R. & Potter-Efron, P. (eds.) 1990. Aggression, Family Violence and Chemical Dependency. New York: The Haworth Press.

Quick List - Substance Use Symptoms

SUBSTANCE	INTOXICATION SYMPTOMS	WITHDRAWAL SYMPTOMS
Depressants	slurred speech; incoordination; unsteady gait; impairment in attention or memory	nausea or vomiting; malaise or weakness; tachycardia; sweating; anxiety or irritablity; hypotension; coarse tremor of hands, tongue, and eyelids; insomnia; grand mal seizures
Stimulants	euphoria; grandiosity; hypervigilance; fighting; pupillary dilation; elevated blood pressure; perspiration or chills; nausea or vomiting	severe depression; irritablity; anxiety; fatigue; insomnia or hypersomnia; psychomotor agitation; intense craving for the substance
Opiates and Analgesics	initial euphoria followed by apathy, dysphoria, psychomotor retardation; impaired judgment; pupillary constriction; drowsiness; slurred speech; impaired attention or memory	cravings for opiates; all symptoms of severe influenza
Cannabinols (Marijuana)	euphoria; feeling of relaxation; sleepiness; heightened sexual arousal; anxiety; suspiciousness or paranoid ideation; sensation of slowed time; inappropriate laughter; social withdrawal; impaired judgment; bloodshot eyes; increased appetite ("junk" food); tachycardia; dry mouth	marked anxiety; emotional lability; depersonalization; possible persecutory delusions

Hallucinogens	illusions; hallucinations (visual); synesthesia; euphoria; mystical or religious experiences; pupillary dilation; tachycardia; sweating; palpitations; blurring of vision; tremors; incoordination; Bad Trip: anxiety and depression; ideas of reference; fear of losing one's mind; paranoid ideation	no apparent withdrawal symptoms; delusional disorder may develop; mood disorder may develop; post-hallucinogen perception disorder may develop ("flash back")
Solvents/Inhalants	euphoria; giddiness; light-headedness; slurred speech; lethargy; depressed reflexes; tremor; blurred vision; stupor or coma; belligerence; assaultiveness; apathy; impaired judgment; dizziness; nystagmus; eye irritation; irriation of throat, lungs, and nose	same as with the Depressants
PCP	belligerence; assaultiveness; impulsiveness; unpredictability; psychomotor agitation; vertical and horizontal nystagmus; increased blood pressure and heart rate; numbness or diminished responsiveness to pain; ataxia; muscle rigidity and seizures; bizarre and violent behavior; paranoid ideation	similar to Hallucinogens

adapted from: Fauman, M., (1994). Study Guide to DSM-IV. Washington D.C.: American Psychiatric Press, Inc.

NOTES

PERSONALITY DISORDERS

Personality Disorders Training
Crisis Intervention training
Portland Police
5/18/00

Outline

I. Overview

A. Definition: DMSIV A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adult, is stable over time and leads to distress or impairment.

B. Types:

1. Cluster A Paranoid, Schizoid, Schizotypal,
   - odd or eccentric

2. Cluster B: Antisocial, Borderline, Histrionic, Narcissitic,
   - dramatic, emotional or erratic

3. Cluster C: Avoident, Dependent, Obsessive Compulsive
   - anxious or fearful

II. Development of Personality Disorder

A. Stress / Coping Skill Relationship

B. Sense of Self

C. Impairments

1. self harm
2. self defeating behavior
3. relationships
4. abandonment issues

III. Management of Behavior

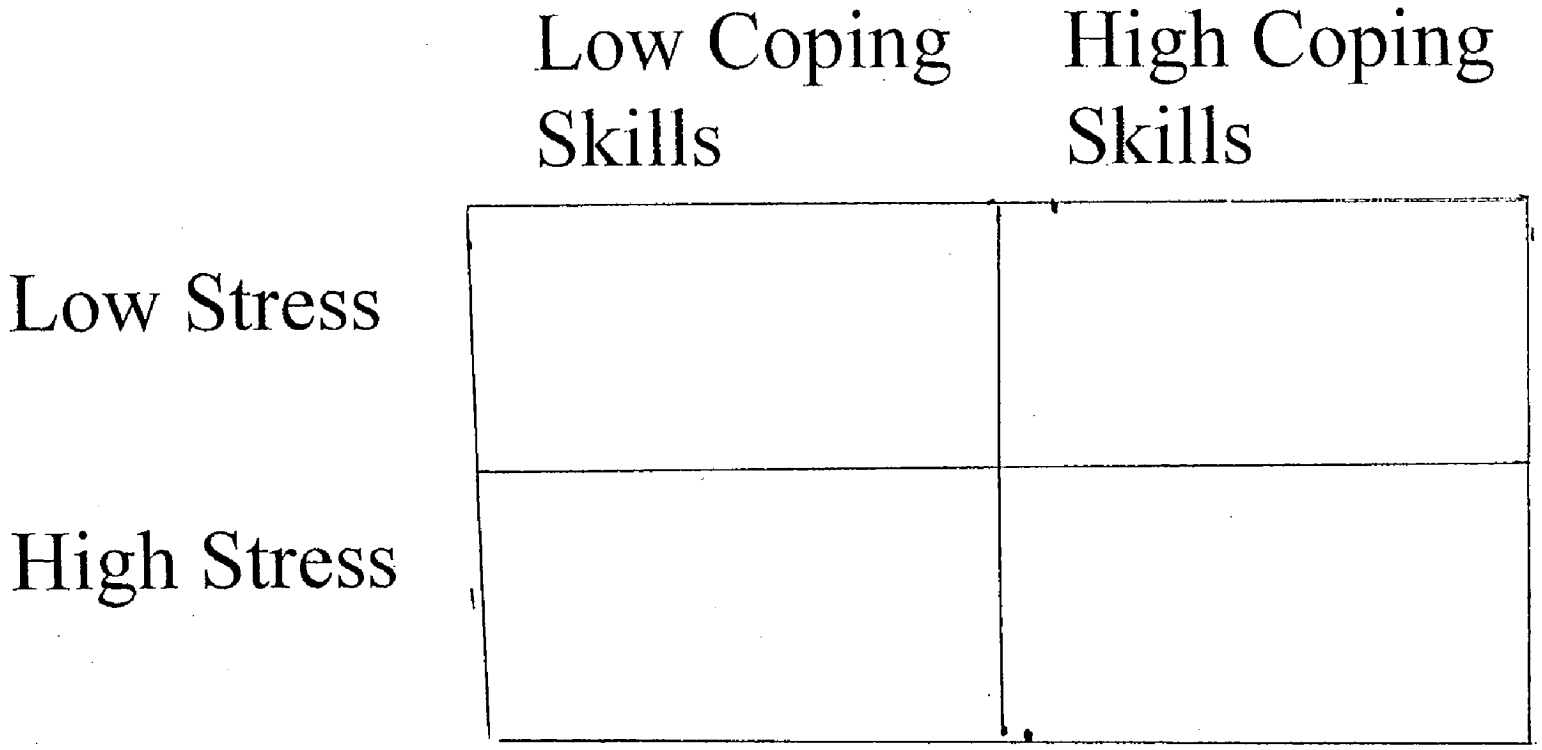
A. Neutrality

B. Clarifying Expectations

C. Setting limits

D. Supportive feedback

Stress/Coping Skill Relationship



NOTES

Section 2: Procedures

MENTAL STATUS EXAM

CIT Training -- The Mental Status Exam

Neil Falk, MD
May 9, 2000

A Mental Status Exam (MSE) is the mental health worker's equivalent of a medical provider's physical exam -- an examination of an individual to help determine if they have an illness. A very quick MSE can be performed quite easily, as many of the basics are common sense. The examination can even occur at a distance, and without the individual's participation -- a lot can be gained just by observation.

•Appearance

-- How is the individual dressed? Examples of dress which may indicate a mental illness include:

-- Inappropriate for weather (e.g. -- many layers in summer)
-- Inappropriate for context (e.g. -- pajamas in the street)
-- Odd or bizarre clothing
-- Very dirty/foul smelling/tattered clothing

-- How is the individual's hygiene? examples of hygiene which may indicate a mental illness include:

-- Very dirty/foul smelling clothing
-- Very dirty/foul smelling body
-- Poor dental condition

-- How is the individual behaving? Examples of behavior which may indicate a mental illness include:

-- Responding to internal stimuli (i.e. -- "talking to self")
-- Standing still/staring for prolonged periods (e.g. - catatonia)
-- Disorganized/non-goal directed actions
-- "Odd" actions, or interactions with others in the environment (e.g. -- bizarre mannerisms, posturing, agitated towards others, ignored by large group, being viewed with suspicion by group or vice versa)
-- Abnormally fast or slow movement pattern/energy level

• Thought Processes

The thought processes of the mentally ill are, by definition, disturbed. Mentally ill individuals may:

-- have disorganized thoughts (e.g. -- tangential thinking, loose associations, flight of ideas, etc.)
-- have "bizarre" thoughts (e.g. -- delusions of persecution, grandeur, conspiracies, etc.)
-- have blocked thoughts (i.e. -- long pauses during thinking)
-- persevere on one topic

• Speech

The speech of mentally ill individuals often is abnormal -- a reflection of their abnormal thought processes. Mentally ill individuals may:

-- speak abnormally fast or slow
-- use words abnormally (paraphasic errors)
-- use nonsense words
-- create words (neologisms)
-- be hard to interrupt (pressured speech)

•Miscellaneous

-- mood (how the person *says* he/she is feeling)
-- affect (how the person *appears* to be feeling)
-- suicidal/homicidal thoughts
    -- plan
    -- access to enact plan
    -- intent to carry out plan
    -- chronicity
-- hallucinations (usually auditory in the mentally ill)
-- cognitive abilities
    -- memory (short, intermediate, and long term)
    -- concentration/distractibility
    -- abstract thoughts (often mentally ill individuals cannot think abstractly)

•Generalities

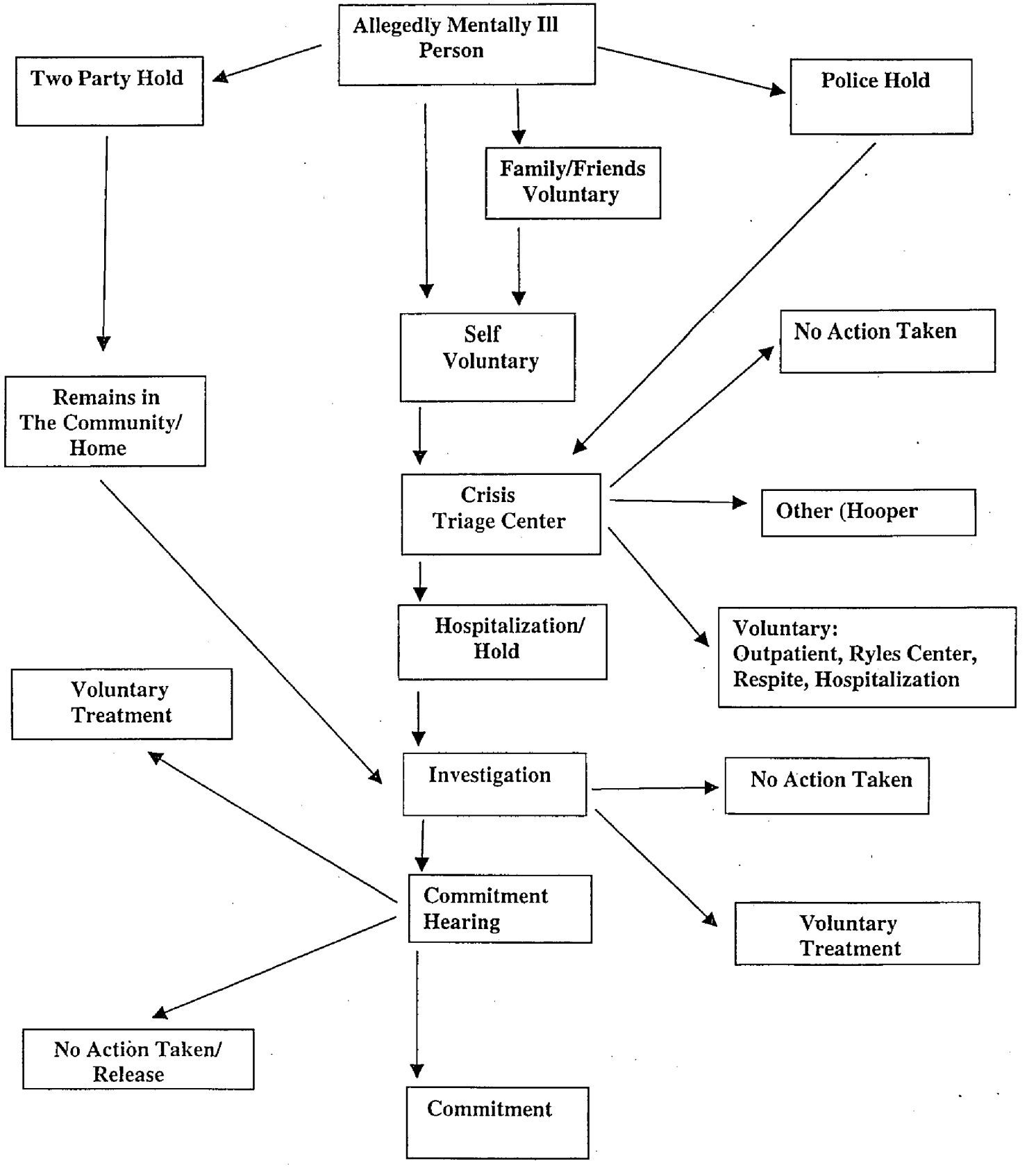
-- If it doesn't feel safe, don't do it!!
-- Mentally ill people are people, and deserve common respect.
-- Listen carefully.
-- Allow the individual to talk at length at least once.
-- Don't be afraid of silences. They often bring out symptoms.
-- Try to be an ally, not an adversary.

	Appearance	Thought Processes	Speech
Psychotic/Schizo-phrenic	Disheveled, Poor hygiene, Disorganized	Disorganized, Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to disheveled, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Intoxicated	Anything and everything	Anything and everything	Anything and everything

NOTES

COMMITMENT LAWS

THE COMMITMENT PROCESS



THE COMMITMENT PROCESS

THE DIFFERENCES BETWEEN A TWO-PARTY PETITION AND A HOSPITAL MEDICAL DOCTORS HOLD

TWO-PARTY PETITION

Used for issues of inability to care/deterioration of function.

Person remains in the community/home

Investigation completed within fourteen calendar days (two weeks)

Can be signed by any two-parties/people

HOSPITAL MEDICAL DOCTOR HOLD

Should be used only in cases of imminent danger to self or others

Person held in hospital

Investigation completed within five working days

Must be signed by two MD's or one MD and qualified health professional

THE COMMITMENT PROCESS

The Civil Commitment process is governed by the Oregon Revised Statutes 426 and the Administrative Rules (interpretation of the Statutes) from the Oregon Mental Health Division. The Statutes define what the legal definition of mental illness is. Legally, mentally ill means; a person because of a mental disorder, is one of the following:

A) Dangerous to self or others.

B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

C) A person who:

1) Is chronically mentally ill by the following definition (also known as "Expanded Criteria"):

a) Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility

AND

b) Is exhibiting symptoms or similar behavior to those that preceded or led to one or more of the hospitalizations or inpatient placements.

AND

c) Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Civil Commitment is a legal process not a clinical one. It has been designed as a legal procedure. At times, the logic of legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of family, significant others, or treatment providers.

The goals of the Mental Health Division in the Civil Commitment process:

A) To promote the well being of persons who are allegedly mentally ill and who are mentally ill and who are mentally ill during the involuntary care, custody, and treatment of mental illness pursuant to ORS 426.

B) To promote the protection of the civil rights of persons who are allegedly mentally ill or who are mentally ill.

C) To encourage the consistent application of ORS 426.

D) To encourage the provision of care, custody, and treatment of persons in the least restrictive environment that is available within existing resources.

THE COMMITMENT PROCESS

E) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through Civil Commitment, whenever possible.

F) To encourage that the Director (local community mental health system knowledgeable of the statues and administrative rules and provides leadership that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS. 426.

G) To provide for the safety of the community and the person when that person is dangerous to others or self as a result of a mental illness.

The Commitment process can be initiated, by giving Notice in writing (under oath) to the County Mental Health Program, by two persons, the County Health Officer, or any Magistrate. The Court will be immediately notified and the Community Mental Health Program will start (within 3 judicial days) An investigation to determine whether there is probable cause to believe the person is in fact mentally ill. Judicial days do not include weekends or Court holidays. The person is not usually in custody or detained during this process.

Emergency care, detention in a hospital and treatment can occur through the following ways:

A) A Peace Officer who has probable cause to believe a person is dangerous to self or to others and is in need of immediate care, custody of a person and remove them to the nearest hospital or approved non hospital facility, a physician will examine the person immediately. If the physician finds the person t be in need of emergency care or treatment for mental illness, the person to be in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the physician), otherwise the person shall be released from custody.

THE COMMITMENT PROCESS

B) A physician believes a person, who is at a hospital or approved non hospital, is dangerous to self or to others and is in need of emergency care or treatment for mental illness, can initiate a hospital hold and detain the person for emergency care. Under no circumstance shall any person be detained for more than 5 judicial days, following the signing of the hospital hold, without a Court Hearing.

C) A Designee of the Community Mental Health Program may, with probable cause that a person is dangerous to self or to others, or, additionally, (if the person is on a conditional release, outpatient commitment, trial visit) is unable to provide for personal needs, direct a Peace Officer to take custody and remove the person t o a hospital or approved non hospital facility for evaluation by a physician. This is called a "Director's Custody". If the physician finds the person is in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the Physician), otherwise the person shall be released from custody.

RIGHTS OF THE MENTALLY ILL

OREGON ADVOCACY CENTER
Working for the Rights of Individuals with Disabilities

Rights of Persons with Mental Illness

Crisis Intervention Team Training
Portland, Oregon
November 14th, 2000

Janice Perciano and Jan Friedman
Oregon Advocacy Center

Voice: 503-243-2081 • 1-800-452-1694 • TTY: 1-800-556-5351 • Fax: 503-243-1738
620 S.W. Fifth Avenue • 5th Floor • Portland, Oregon 97204-1428

WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

Mental Health--the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental illness--the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alteration in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems--patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

. . . . .

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**

- **A range of treatments exists for most mental disorders.**

. . . . .

Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment . Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

. . . . .

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable.

. . . . .

Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Excerpts from **U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of health, National Institute of Mental Health , 1999.**

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Persons with mental illness have the **same rights as everyone else**.

Why aren't persons with mental illness treated the same?

1. Stigma--shame, hidden subject, accepted to mistreat, make fun of persons with mental illness

2. Misconceptions

   A. Violent--studies show that persons with mental illness are no more likely to be violent than anyone else, but often are portrayed in the media as violent

   B. Stupid--persons with mental illness have the same ranges of intelligence as everyone else, sometimes persons with mental illness are confused with persons with retardation--not the same

   C. Incompetent--everyone is presumed competent unless shown otherwise--persons with mental illness are presumed competent to make decisions even if civilly committed--only under specific circumstances is a person determined to be incompetent (guardianship, conservatorship, outside consultant determination regarding medication of person on commitment)

   D. Delusional--only some persons with mental illness experience delusional thinking--and even for these persons the delusions occur only some of the time

3. Protection of the person with mental illness--social workers, family, care givers, police etc. often want to treat persons with mental illness in what is perceived to be the best interests of the person with mental illness--may be in conflict with what the individual chooses and may be patronizing

4. Protection of society/family from hardship and/ or danger--actions are taken against a person with mental illness to protect others

5. Ignorance and fear--belief by persons without mental illness that persons with mental illness are extremely different than themselves and that mental illness may "spread"

LAWS SPECIFICALLY AFFECTING PERSONS WITH MENTAL ILLNESSES

1. CIVIL COMMITMENT

WHAT IS CIVIL COMMITMENT?

Civil commitment is a process in which a judge decides whether a person who is alleged to be mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment. A person in the process of a commitment sometimes is called an Alleged Mentally Ill Person (AMIP). A civil commitment is not a criminal conviction and will not go on a criminal record.

When a civil commitment petition has been filed, an investigator from the community mental health program (CMHP) will investigate the need for the commitment. Depending on the investigator's decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a right to an attorney and to have witnesses testify. The judge then makes a decision whether the person should be committed. If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting. The maximum commitment period is 180 days, although a person can be ordered to stay hospitalized beyond the 180 days in recommitment proceedings.

WHO CAN BE COMMITTED

Oregon Revised Statutes (ORS) chapters 426 and 427 contain the law regarding civil commitment. A judge can commit a person for up to 180 days if the judge finds by clear and convincing evidence, that the person

> Has a mental disorder and, because of that mental disorder, is:
>
> Dangerous to self or others, or
>
> Unable to provide for basic needs (like health and safety).

Or, the judge can find that a person is:

> Diagnosed as having a major mental illness (such as chronic schizophrenia or manic- depression), and

Has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

ORS 426.005; ORS 426.130

HOW THE CIVIL COMMITMENT PROCESS BEGINS

1) The commitment process may be started by a county health officer, a judge, or any two persons filing papers in court. Or, the process may be started by a doctor or community mental health program director ordering a person to be held involuntarily in a hospital. ORS 426.070; ORS 426.228 through ORS 426.234.

2) When the papers are filed, the CMHP program must send out a mental health investigator to interview the person and others who know about the person. This investigator advises a judge whether or not to hold a court hearing. ORS 426.070; ORS 426.074.

WHERE THE PERSON STAYS BEFORE THE HEARING

A person against whom a civil commitment petition is filed may stay in the community unless the judge orders the person to be taken into custody or a doctor or CMHP director directs the person be in custody. The person can be in custody only if he or she is considered to be mentally ill and a danger to self or others. A person who is mentally ill and unable to provide for basic needs cannot be held in custody unless the person's inability to provide for basic needs is so extreme that the person is a danger to self. A person held before a hearing is on a precommitment hold or in precommitment detention. ORS 426.070; ORS 426.228; ORS 426.231; ORS 426.232; ORS 426.233.

If a person is held in custody on a precommitment hold, he or she cannot be held in jail unless he or she is charged with a crime or is a serious danger to hospital staff or property. ORS 426.140. The person may be held in a hospital or a nonhospital facility. A nonhospital facility is a facility approved by the Mental Health and Developmental Disability Services Division (MHDDSD) to provide adequate security, psychiatric, nursing and other services. ORS 426.005(e).

A person on a precommitment hold has the right to be held in a mental health facility providing care, custody and treatment required for mental and physical health and safety. In other words, the person can only be held in a place with staff trained to provide mental health treatment. ORS 426.072(2)(a); ORS 426.228.

LENGTH OF TIME A PERSON CAN BE HELD BEFORE A HEARING

A person cannot be held in custody on a precommitment hold longer than five working days without a court hearing. If five working days pass and there is no court hearing, a person is free to leave the hospital unless he or she has asked to postpone the hearing or has agreed to be hospitalized voluntarily under a diversion program. In other words, a person cannot be held longer than five working days unless a judge says so. ORS 426.095.

HOW LEGAL RIGHTS ARE AFFECTED BY COMMITMENT

In general, most legal rights are not affected by civil commitment. A person who is committed retains all legal and civil rights, including the right to vote and make contracts unless a court has found the person incompetent. ORS 426.385.

Some specific rights can be limited as a result of civil commitment:

Firearms - Persons who have been committed are forbidden from owning, buying, or possessing firearms. ORS 426.130(1)(D); ORS 166.250 (1)(D).

Future commitments - If a person is committed twice within the past three years, he or she can be committed more easily in the future. ORS 426.495.

Driving - Commitment can affect a person's ability to get or keep a driver's license. If a person has a mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle, the person cannot be licensed. ORS 807.090; ORS 807.700; ORS 809.410(16).

II. AMERICANS WITH DISABILITIES ACT (ADA)

The ADA protects persons with disabilities from discrimination in these areas:

1. Employment--This includes hiring, termination benefits, working conditions, etc.

2. Public Accommodations--This includes hotels, offices, shopping malls, restaurants, sports arenas, schools, zoos, hospitals, theaters, grocery stores, homeless shelters, libraries, etc.

3. Public Entities--This includes all local and state governmental services and programs.

4. Transportation--This includes buses, trains, lights rail must be accessible or

alternatives offered.

5. Telecommunications--This includes that telecommunication services must be made accessible for speech and/or hearing impaired persons.

Persons with mental illnesses are protected by the ADA if the mental illness substantially limits one or more of the major life activities of the person. Major life activities means activities such as working, learning, sleeping, thinking and walking. Persons who have a record of such an impairment or who are perceived to have such an impairment are also protected.

In addition to the ADA, which is federal law, Oregon has state laws prohibiting discrimination in employment and public accommodations.

III. FAIR HOUSING LAWS

The federal Fair Housing Act was passed in 1968 as part of the Civil Rights Act of 1968. The Fair Housing Act prohibited discrimination based on race, color, religion or national origin in the sale, rental or financing of housing. In 1974, Congress added a provision prohibiting housing discrimination based on sex.

In 1988, Congress added provisions prohibiting housing discrimination based on mental and/or physical disabilities. Under the law, landlords and sellers cannot discriminate against a person because the person has a mental illness and must make reasonable accommodations for a person disability. The law does not apply in some cases where the landlord or seller is acting with regard to his or her private house or small apartment building. The law also allows the rejection of any tenant or buyer who would directly threaten the health or safety of other individuals or would cause substantial physical damage to the property of others.

Oregon also has a state law prohibiting discrimination based on physical or mental disability in selling, leasing or renting of houses and apartments.

IV. RIGHTS IN THE COMMUNITY AND IN FACILITIES

STATUTORY AND CONSTITUTIONAL RIGHTS

Many people receive mental health services outside the state hospital. Even persons who are civilly committed often receive treatment in private hospitals that have contracts with the state. Additionally, more people are receiving services in facilities, group homes and independent residences rather than in hospitals.

A person who is receiving services outside the state hospital system has the same rights as any other person in the community. Some of the rights that all persons in the United States are the right to:

*Vote

*Exercise freedom of speech, freedom of association and freedom of religion.

*Have privacy, including the right to marry and have children.

*Be free from discrimination based on race, gender, color, national origin or disability.

In 1993, the legislature passed legislation that sets out some specific rights of persons receiving mental health or developmental disabilities services. A person who is receiving mental health or developmental disabilities services outside of the state hospital has the right to:

*Have a written treatment plan and participate in making the plan.

*Choose from available services and have those services provided in the least restrictive way.

*Receive only services to which a person gives informed, voluntary, written consent.

*Receive medication only for individual clinical needs.

*Not be involuntarily terminated or transferred from services without prior notice and the right to be notified of available sources for necessary services.

*Receive humane services, be protected from harm and have reasonable privacy.

*Be free from abuse and neglect.

*Report abuse and neglect without retaliation.

*Exercise religious freedom.

*Not be required to perform labor, except personal chores, without being paid.

*Visit with family, friends, advocates, legal and medical professionals.

*Be told about rights and how to report abuse.

*Assert grievances and have them considered in a fair, timely and impartial manner.

*Communicate with any rights program or advocate.

*Exercise these rights without any reprisal or punishment.

ORS 430.210.

V. ABUSE REPORTING

Since 1991, the law has required the reporting and investigating of abuse of persons with mental illness who are receiving mental health services in the community. Abuse is defined as:

*Any death caused by other than accidental or natural means.

*Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.

*Willful infliction of physical pain or injury.

*Sexual harassment or exploitation, including any sexual contact between an employee of a facility or community program and an adult who is receiving mental health services.

The law requires private and public officials to report abuse if they have reasonable cause to believe abuse occurred. This means that all doctors, nurses, aides, psychologists, employees of county mental health programs, employees of mental health services providers, clergy, attorneys, outreach workers, social workers, therapists, police and others must report abuse.

Abuse may be reported to the Mental Health and Developmental Disability Services Division (MHDDSD), the county mental health program or the police. The office that receives the abuse report must then conduct an investigation or make sure that an investigation is conducted. The person who may have been the victim of the abuse must be provided protective services if needed. The investigating office must complete a report of the investigation and send it to MHDDSD. ORS 430.735 through 430.765.

VI. INFORMED CONSENT TO TREATMENT

A person can receive mental health treatment, including medications, only if the person gives his or her informed consent. This means the person must be told what the benefits and risks of treatment are and must make a voluntary decision.

A person cannot be forced to take a particular medication just because everyone thinks it would be good for him or her. The exception is when a person has been civilly committed and two doctors have agreed that the person is unable to make decisions. In this case, if the proper procedures are followed, the person may be subjected to treatment that she or he does not want.

VII. GUARDIANSHIP

If a person is "incapacitated", a judge may appoint a guardian for her or him. A guardian can only be appointed by a judge. A parent does not have the powers of a guardian if the individual is 18 or over unless the judge has appointed the parent a s guardian.

TELEPHONE NUMBERS FOR ADVOCACY GROUPS AND LEGAL ASSISTANCE

American Civil Liberties Union	503-227-3186
Fair Housing Council	503-223-8295
Multnomah County Legal Aid	503-224-4086
National Alliance for the Mentally Ill	800-343-6264
Oregon Advocacy Center	503-243-2081
Toll-free	800-452-1694
TTY	503-323-9161
Toll-free TTY	800-556-5351
Oregon Legal Services	
Central Office	503-234-1534
Farm Workers' Office	503-981-5291
Hillsboro Office	503-648-7163
Native American Office	503-223-9483
Oregon State Bar	
Lawyer Referral Service	503-684-3763
Toll-free	800-452-7636
State Public Defender	503-378-3349
U.S. Office of Civil Rights	206-615-2290
Toll-free	800-362-1710

WORKING FOR THE RIGHTS OF INDIVIDUALS WITH DISABILITIES

GOVERNMENT AGENCIES

Adult and Family Services Division	503-731-3111
Bureau of Labor and Industries	503-731-4200
Equal Employment Opportunity Commission	206-220-6883
Toll-free 800-669-4000	
TTY 206-220-6882	
Mental Health and Developmental Disability Services Division	503-945-9499
Office of Mental Health Services	503-945-9700
Office of Client Rights	503-945-9495
Psychiatric Security Review Board	503-229-5596
Senior and Disabled Services Division	503-945-5811
Toll-free 800-232-3020	
Social Security Administration	800-772-1213

ADVOCACY/CONSUMER GROUPS

Mind Empowered, Inc	503-231-4137
Oregon Advocacy Center	503-243-2081
Toll-free 800-452-1694	
TTY 503-323-9161	
Toll-free TTY	800-556-5351
Oregon Alliance for the Mentally Ill	503-370-7774
Recovery, Inc 503-231-1334	

Brief History of Treatment of Persons with Mental Illness in England and the United States

Early 1300s--English law categorized persons with mental disabilities as lunatics or idiots.

Pre-1600s--Persons with mental illness were cared for at home or sent to poorhouses, workhouses, jails.

1600s-- "Madhouses" created to confine persons with mental illness. The madhouses were unhealthy settings with harsh and punitive "treatment". Persons were chained, abused and publicly displayed.

1700s-- "Asylums" were developed to provide healthy environment and "moral treatment".

Mid-1700s--Persons with mental illness in England were placed in St. Mary of Bethlehem which became known as "Bedlam".

"Bethlehem--or Bedlam as it was called--was a favorite Sunday excursion spot for Londoners, who came to stare at the madmen through the iron gates. Should they survive the filthy conditions, the abominable food, the isolation and the darkness, and the brutality of their keepers, the patients of Bedlam were intitled to treatment--emetics, purgatives, bloodletting and various so-called harmless tortures provided by special paraphenalia." The History of Psychiatry, F.G. Alexander and S.T. Selesnick

1752--Pennsylvania Hospital opened with several cells for the "insane". The method of commitment was informal. A few words scribbled on a piece of paper were enough to get a person locked up.

1773--In Williamsburg, Virginia, the first US institution specialized for the "insane" opened.

Late 1800s--Large public institutions were filled with chronic patients receiving little treatment.

1883--Oregon State Insane Asylum opened in Salem (renamed Oregon State Hospital in 1907).

1900-1960--Hospitals emphasized treatment but no effective treatment was available. Institution populations continued to grow.

1907--Eastern Oregon Hospital opened in Pendleton.

> When we have a disturbed or noisy patient to deal with [prior to a lobotomy operation] in the University Hospital or Doctors Hospital we administer two, three or more electroshock treatments in rapid succession. Psychosurgery in the Treatment of Mental Disorders and Intractable Pain, Walter Freeman and James Watts, 1950.

1955--560,000 persons with mental illness were confined in hospitals (1/2 of all hospital beds).

1959--The average daily population in Oregon State Hospital and Eastern Oregon Hospital was 4909.

1960-1975--Deinstitutionalization resulted in the release of vast numbers of persons from institutions.

1961--Dammasch State Hospital opened in Wilsonville.

1975 to present--Communities recognized that deinstitutionalization could not succeed unless accompanied by adequate community support programs.

1977--Psychiatric Security Review Board created in Oregon to supervise persons found affected by mental disease or defect in criminal matters.

1990 to present--Managed care implemented for provision of mental health services.

Deaths at Dammasch State Hospital (DSH)--June 25, 1993 to October 8, 1993.

June 25, 1993--DC died at DSH--No medical examiner review but adequacy of medical treatment questioned.

August 29, 1993--JW died choking on pancakes. He was alone in his room, unmonitored despite swallowing problems.

August 29, 1993--LL died choking on pancakes. Staff called 911 but did not intubate LL or manually cut an airway.

September 19, 1993--KM died as a result of coronary arteriosclerosis. Staff had given her Haldol despite a diagnosis of mental retardation (IQ 54) and no diagnosis of mental illness. Staff found her lying on her bed. She had no pulse but was warm. Staff made a emergency request for a doctor. Thirteen minutes elapsed before a doctor arrived.

October 18, 1993--PG suffocated while being placed in physical restraints. A towel pulled over his mouth contributed to the death.

1995--Dammasch State Hospital closed.. Oregon State Hospital at Portland opened with capacity of 68.

1997--Current Oregon State Hospital capacity is for 727 beds, including hospital beds, residential beds, child and adolescent beds.

Section 3: Resources

FAMILY AND CONSUMER PERSPECTIVE

WHAT IT'S LIKE

Being crazy hurts. For one who has been there, the idea of going crazy out of moral weakness, because it is easier than "facing reality," is utterly bizarre.

The major mental illnesses, like most other illnesses, carry with them an early-appearing and almost ever-present feeling of "sickness" and exhaustion.

As it gets better and worse, there are times when you may be unable to function at all, perhaps being unable even to get out of bed.

At these times, investigation is needed to determine whether you are suffering extreme stress of real-work origin, suffering from a resurgence of mental illness symptoms, or whether there is some unrelated medical problem, such as an abscessed tooth or the flu.

Too often, these episodes are viewed as bouts of laziness and "lack of motivation," and treated with harassment or even termination from a treatment program.

Unless this phenomenon, and ways of coping with it, are explained to you, you too may come to believe you are lazy and good-for-nothing.

You become aware that your perceptions are unreliable, that you are having sensory experiences that others do not share.

As you struggle for some understanding of what is happening to you, you find yourself clutching at extreme and bizarre explanations.

When you try to talk to other people about your experiences, you discover there is no common language for them. You find yourself putting together an unsatisfactory and embarrassing patchwork of religious, occult, or scientific words.

When you do talk to people, they may lapse into shocked silence, change the subject, or reject your statements as weird and you as crazy.

If you are not aware the perceptions are different from those of other people, you are even more disabled. Whenever you try to do something or talk to someone, all sorts of things go wrong, which you do not understand.

Because you cannot predict whether your perceptions and interpretations of events are acceptable to others as "real," you begin to be afraid to talk about your feeling at all. If you have not yet felt there was something wrong/bad about you before, you do now. You become very lonely.

Since you gave no safe way to compare your "crazy ideas" with what normal people define as real, your ideas/delusions become more detailed, more organized, and more strongly held.

Extreme and uncontrollable emotions rush through you: fear, confusion, anger, despair.

The feelings are overwhelming. You see yourself doing things you cannot stop. It comes to you that you are no longer in control of your life. You are forced to depend on other people for some things, even if you do not want to.

You begin to fear that you may do something awful, something that will make people get rid of you forever.

You worry that whatever has happened to you may be permanent, that you may never be all right again.

Pain becomes very familiar. It comes to have form and texture like terrain.

If pain is fairly steady and continuous, you can sometimes almost tune it out. But if someone offers you more hurt, whether it be emotional battering or physical, you are suddenly desperate and hostile. You are tired, tired, tired, and do not have the energy to take any more. Sometimes you have to take it anyway.

At times the pain/craziness comes in overwhelming waves. Like most people, you think that pain will somehow never crush you. Somehow new reserves of strength will appear, effective treatments will be found, or, in the extreme, that you will simply pass out.

Then one day, you lose control of your mind, your body, everything. You'll lose your bowels and scream and scream and scream, like a little pig squirming in the dirt. And it does not stop.

Having broken, having been totally <u>helpless</u> forever after leaves you feeling fragile in a way that other people do not. In wonderment you watch "normal people" go about their lives, full of energy, confident, unknowing. There is an abyss between you.

If you hurt bad enough, you try anything to feel better: self-help books, religion, sex, drugs, alcohol, and anything you can think of.

Some things make you feel a little better, some do nothing, and many of them make you feel a lot worse.

In desperation, sometimes just drinking or drugging yourself into unconsciousness seems a worthy goal.

The risks of triggering further psychotic episodes and the risk of alcohol and drug addiction are substantial. It is hard to be interested in future consequences of things when you are not sure you have a future or want one.

If you get strung out on alcohol or drugs you will have another difficulty. The people who work with alcoholics and drug addicts do not want you because you are crazy. The people who work with the mentally ill do not want you because you are an alcoholic or an addict. You can only go to special, expensive, "dual diagnosis" programs. If you have three or more diagnoses, you are likely to end up in jail.

Seriously mentally ill people have a suicide rate of 20-30 times that of the normal population. At greatest risk are those who are too ill to have a normal life, and not sick enough to be unaware of it.

Hardly anyone wants to commit suicide.

As the years go by, you exhaust the treatment options open to you. Hospitals and doctors get tired of you because you never get better.

You drift away from your family. You cannot hold a job, or maintain a sexual relationship.

If you talk to others about your feelings, you come under pressure to shut up and act normal. Your desperation makes them uncomfortable.

You feel helpless, lonely, and as if you have nowhere you belong. You cannot stand being trapped in all that pain. All these are bad enough, but it is the crushing, never ending tiredness that ultimately gets you. You kill yourself because you have to.

What you would really like to hear is: "We know you are very tired, and you feel awful most of the time. We do not want you to go away. We want you to live.

"But if the time comes when you really cannot take anymore, and you have to die, we will be very sad, but we will understand.

"Whether you get better or not, and whether you live or not, we love you anyway."

Confused and frightened people tend to try to clamp tight control on whatever or whoever upsets them. It is rare to be given this recognition of your pain and permission to do whatever you have to do, but if you are, it is very comforting.

It tends to relieve some of your guilt feelings for being such a mess, and such a disappointment to your family and friends.

If you are like many seriously mentally ill people, you have known since sometime in childhood that there is something very wrong with you.

Functioning at school was very hard. You have less and less success in living up to the expectations of your family, and in being like other people.

Others' attempts to shape you up are sometimes drastic. You are likely to have the experience of being threatened, ridiculed, or punished for things that you do not understand, cannot do, or cannot stop doing.

Parents, teachers, school counselors, and pediatricians rarely are familiar with mental illness in children. Many professionals take the de facto stand that major mental illness and suicide virtually do not occur in young children, and that all such problems come from "labeling" and "bad parenting."

Your family withers under the implied or open accusation that they made you crazy. They become too intimidated to talk to you, out of fear that they will "say something wrong" and cause you to shatter in a million pieces.

Communication within your family is loaded with fear and guilt, and is further complicated by your thought or mood disorder.

Nobody will tell you what it going on. In loneliness and isolation your fears and crazy ideas grow.

Your parents are scapegoated by relatives, neighbors, and authorities. They begin exchanging recriminations themselves. They become more and more exhausted and discouraged.

You are torn between wanting to stay with your family because you hope you belong there, and wanting to leave because you caused them so much pain.

If your family breaks up or you withdraw from them and you do not find some other support system, you fall on the not so tender mercies of the state.

As you move out into the world, you find you are only comfortable with "social equals," people similarly ill or otherwise damaged, and those rare people who are willing to some extent to understand your experience and feel your pain.

Talking with straight people is nerve wracking. You can never be sure when something you say will come out all weird, and you will be recognized as a crazy person and gotten rid of.

Hungry for human contact, you approach other people, only to discover that they are afraid of you. They assume that if you are mentally ill, you are by definition suicidal and violent.

You had been so wrapped up in being afraid yourself, that it comes as a humiliating shock to find that <u>normal</u> people are afraid of <u>you</u>. Some of them will even take the position that if you are or ever have been crazy, you cannot be trusted with anything, ever.

When out in the community, you are anxiously self-conscious, aware that at any moment a mannerism, a social misstep, or something "inappropriate" will unmask you as a crazy and embarrass anyone you may be with.

You fear being stared at, made fun of, or even being attacked by street creeps always on the lookout for someone with a high victim profile.

If you are too sick to have a hope of concealing it, you can only wait to be hurt and try to keep on going.

Being disabled, you fall into the hands of caretakers.

Sometimes you feel like an abandoned ship, to be taken over by any normal person who wants to, as if they had some kind of salvage rights.

At times you spend a lot of energy fending off such people, trying to hold onto the right to run those parts of your life that you still can.

Caretakers come in various roles, with a variety of titles and letters after their names. Some are very skilled and genuinely helpful, a lot more manage to get by, and some are definitely part of the problem, not part of the solution.

You have no choice about being sick, and no choice about depending on caretakers at times. Even within a given type of service or a particular agency, you seldom have a choice. Your "case" is "assigned" to someone by a "catchment area," "admission rotation," or whatever.

Caretakers control access to medication, asylum (the hospital), money (welfare, SSI), and food (stamps). They decide whether to allow you the sick role, or whether to define you as bad, crazy, or stupid. They can invalidate what you say or do, and call upon the court to have you carted away.

Appeals from their decisions are costly, time consuming, difficult, or impossible. In no way is their relationship a voluntary one between equals.

For a caretaker to operate humanely in such an unequal relationship, a very high level of skill and integrity is required. When you have no choice, you need the best.

Paradoxically, the mental health system tends to assign the least experienced and lowest status workers to screening and to the seriously ill, and the most trained and highest status professionals to the less needy but "more interesting" (more likely to get better) clients.

Like all human beings, some mental healthers have their prejudices, some of which may have a major impact on your life. Some of these prejudices include that, if you are:

a. Poor--you are just trying to get free room and board;
b. Black--you have paranoid schizophrenia;
c. Old--you are hopelessly senile;
d. Male--you are violent;
e. Young and female--you are manipulative or seductive;
f. Young and male--you are a doper;
g. Admitted to a hospital from jail--you are faking;
h. Physically ill--it's all in your head;
i. Failing to get better--you are unmotivated.

In your dealings with mental health workers, you will encounter some common problems:

Mental healthers sometimes seem to see you as a kind of agent of insanity, and immediately start a power struggle over who is to be in control of the relationship.

They seem to fail to see that you have no desire to keep, much less propagate, your crazy ideas. You would get rid of them in a minute if you could only figure out how to do it.

They will frequently refuse to tell you your diagnosis and probable course of your illness. With no real information to go on, you are left to your imagination, which is often worse than anything a doctor could tell you.

What they tell you about the expected effects of your medications and possible side effects is commonly very sketchy. You sometimes have nasty surprises.

Although PRN (extra, as needed) medications are routinely prescribed in the hospital, you are rarely provided them outside. Somehow, life in the community is supposed to be much less stressful, and besides, you might "abuse" the medications.

You find yourself viewed with a general distrust. Everything you say or do is "evaluated" and subject to "clinical judgment," to determine its "real meaning." Yet basic investigative techniques, such as talking to everyone involved and cross-checking their stories, are omitted.

At times, this is due to lack of time or carelessness, but too often it comes from an ego trip wherein professionals feel that their qualifications enable them to discern deep truths virtually by remote control.

It is terribly frustrating to try to communicate with such people, because nothing you say is accepted at face value, but is changed into something unpredictably different.

Meanwhile, they want you to "develop a trust relationship" with them, but changes in staff and program priorities may come much faster than your ability to trust can handle.

You may have to cope with mental healthers who take basically useful approaches to problems and carry them to such lengths that they become problems themselves.

It is helpful to convey to you the expectation that you will get better, but not so helpful to fail to teach yourself care skills and work with the emotional problems that arise when it becomes clear that you are not improving.

Inventorying your symptoms and problems is a necessary beginning of a treatment plan, but concentrating only on what is wrong with you and ignoring the strengths and abilities you still have is not so useful.

Good general counseling skills and effective community organization are necessary to help you improve and maintain your quality of life. However, they do not eliminate the need for detailed knowledge of the symptoms, experiences, and problems which affect you as part of your mental illness, or as effects of your medications.

Anyone working with seriously ill people must be willing to take control at times when you are too disabled to carry on necessary life functions. Unfortunately, mental health work attracts numbers of people whose need to control others is so great that they tend to discourage your own sense of your own competence, and dampen any drive you may have toward free and self-reliant living.

This is a rip-off, because they imply that since you are incompetent, you may rely on them to meet your needs. The first time you get in trouble outside normal business hours or without an appointment, you may have a rude awakening.

You <u>have</u> no choice about learning to take care of yourself and your fellow crazy people as best you can. The response of the mental health system is often just too slow and unpredictable.

It is reasonable for mental health workers to hope for some emotional gratification from their work, but sometimes you are too sick, and have nothing to give in return. Sometimes, when you are not getting any better, your therapists get desperate and start "shot gunning" you with multiple medications and rapid, ill-thought-out changes in your treatment plan.

You may not be listened to when you try to explain what has worked for you in the past.

Since your records are usually following a hospital or an agency or two behind you, you may suddenly be taken off a regimen on which you had been stable, and which took months of experimenting to develop.

The principle seems to be "change something, whether it helps or not," rather than feel helpless.

Other times, some workers get frustrated and bitter, and put increasing pressure on you to "get well or get lost." This can be mutual: they cannot forgive you for not getting better, and you cannot forgive them for not getting you better.

If you are crazy, you can usually count on being poor.

If you are severely disabled, you will probably be on welfare, at least at first.

Your welfare grant is based on a fraction of what a study of local prices determines to be the minimum livable allotment.

Social Security (SSI) is somewhat more, but you are unlikely to successfully complete the complex application process without determined help from a case manager or a family member.

In either case, you will have a welfare medical card. Since there are restrictions on the services covered, and because the majority of local physicians do not take welfare patients, your medical care is likely to be poor and without continuity.

You will probably have bad teeth, as well. Dental care is only available for emergencies, and for a low dollar amount, resulting mostly in extractions.

Your clothing is likely to be poor, ill fitting and mismatched, coming from thrift stores, and sometimes carrying institutional marks.

Drifting in and out of hospitals, jails, and boarding houses, most of your possessions will have long since been lost or stolen. You may have little in the way of toilet articles, and you may smell.

Your status as a second class citizen, a loser, is displayed for all to see. In addition to the practical problems of poverty, there are the emotional effects. If you are one who has learned to count personal worth in terms of possessions, you are doubly poor.

There is a strong streak of Calvinism in our society: being poor is seen as evidence that you are also bad.

If you go into a nice store, clerks follow you around waiting for you to steal something. Some mental health workers dress especially well to avoid being mistaken for patients.

If you are unable to be productive, many feel you should be uncomfortable. It would be immoral, somehow contributing to your delinquency, to give you things you cannot earn.

You meet people who would obviously be willing to let you starve to death if it were their choice. To your humiliation is added an element of real fear.

You may find yourself begging and stealing, in violation of your own principles. You pack rat, assembling collections of junk, rather than have nothing at all.

Sometimes it is hard not to hate the caretakers around you, who have built a comfortable lifestyle upon your misfortune.

Sex is important to people, to sick people no less than to people who have the privilege of being healthy. Like everything else, mental illness messes it up.

When you are depressed, when you hurt so bad you have to be completely numb in order to function at all, the numbness itself becomes another kind of discomfort. You want to feel <u>something</u>, anything but more pain. You think of sex as a strong, good feeling, and try it. You run into a wall of pain and exhaustion. You cannot get aroused, you cannot tolerate intercourse. You experience one more crushing failure. Perhaps you are no longer a woman or a man anymore.

If you are high, in a manic state, you may be very sexually active. It may feel wonderful, or, if your high has reached an agitated, desperate stage, it may feel frenzied and out of control.

When you come down, it can be mortifying. You may have VD treatment, abortion, divorce papers, and new enemies waiting for you.

If you have a thought disorder, you may be too scattered to figure out what you need, or disorganized or fearful to effectively seek out a partner. If you find a partner, he or she is likely to be a "social equal." With both of you crazy things can get confusing.

Institutions do not make provisions for sexual privacy. Quite the contrary. Your sexual experiences are likely to take place in bushes or on the floors of out-of-the-way restrooms.

You risk a personal confrontation with the fact that many people, but especially high control institution types, do not feel crazy people are entitled to sex lives. They may also have reasonable concerns about competency to consent, and about civil liability.

If you are male, and your activities or choice of partner are not approved of, you may be written up in records as "sexually inappropriate with one of our sickest female patients" ("rapist").

If you are a female, you may be described in your chart as "sexually inappropriate with men" (presumably numerous, "whore").

If you are gay or lesbian, you are doubly disapproved of, and you risk having drastic action taken against you, especially premature discharge from treatment.

If you are young, and have homosexual experiences during prolonged institutionalization, which are common, you may have to keep it deeply secret afterward, and wrestle, usually alone, with the question of what your sexual orientation actually may be.

A complication of trying to have a sex life while under psychiatric treatment is that many psychotropic medications are sexually disabling in many people. You may find yourself unable to get aroused, or you may be aroused but unable to climax, or climax is long delayed.

You may be told about this when being instructed about your medications, but frequent not. If you can get up the nerve to raise the issue, often a reduction of dose or a change to another drug will take care of the problem.

If you cannot, you get more depressed at this additional evidence that your life is ruined.

When you are poor, crazy, and unwanted, you hunger for warmth and touching, on almost any terms. Sometimes you fall into the hands of cruel and exploitive people.

Sometimes you hope you will have a child, as a fulfillment of your identity as an adult human being, and in hopes of having someone to be with, who will love you. Frequently, this ends in tragedy, as you have children you cannot take care of, and they are taken away from you.

Because mentally ill people often are fairly helpless, they are frequent crime victims. Criminals often are aware that you may have no interested family or friends, and are easily discredited in court. Therefore, there is little risk of being prosecuted for any crime against you, short of murder.

The sword is two-edged: because you are "insane" you may receive no consequences for repeated antisocial acts. You risk developing habits of behavior that drive away your support system, and ultimately land you in the hospital or on Skid Row.

When you lose your mental health, you go through the same pattern of responses for any other major loss. Dr. Elizabeth Kubler-Ross's "Stages of Dying" is a fairly accurate model.

1. Shock. You never expect to go crazy, nor do you expect to find out one day that you have been crazy for a long time.

   You are stunned, confused, afraid. For a period of time, you are in shock and unable to do anything to help yourself.

2. Denial. You buy time to deal with overwhelming anxiety producing situations, by denying them. You try to go on living as if the problem did not exist, while your subconscious mind works on some way to cope with the problem.

   Other people, who are not sick, get frustrated and angry because you do not do whatever they think you should do about the situation.

   Since it is not their problem, they are not overwhelmed by anxiety, and they can view the whole affair more objectively.

   The crunch comes when they pressure you to "face this thing, right now!" and accuse you of "wanting to stay sick."

   The reason you are unwilling to do the things they demand, such as going to a clinic, taking medication, and giving up "unrealistic" life plans, is because you do not want to be sick. Therefore, you do not want anything to do with anything even remotely related to being crazy.

   Since your denial is basically driven by anxiety, the more you are harassed about "facing the facts," the more delayed as you're coming to terms with your situation.

3. Anger. When you realize that your life is going to be more painful and more limited than the lives of other people who are of no greater merit than yourself, you get mad.

   Since many people view the family as the source of all problems, you may direct, and be encouraged to direct, your anger at them. Often having strong guilt feelings themselves, they may agree that you are entitled to be angry at them.

   You may also vent your anger at mental health workers, whose very presence in your life is an undesirable reminder of how you have been cheated of a normal life.

   You may carry a powerful resentment against people who have the privilege of normalcy, who have jobs, friends, money, cars, and other things that you do not.

4. Bargaining. As it becomes clear that this insanity business is for real, and it shows no signs of going away, you want to make a deal.

   You try unusual diets, stranger religions, street drugs, anything that offers the faintest hope of making a difference.

You promise God that you will devote the rest of your life to medical research and serve to the poor, if only this cross will be taken from you.

Occasionally, someone recovers for no reason known to man. Not very often.

5. Depression. When you realize that no deals are being made, blaming people makes no difference, and the craziness is not going away. You are very, very sad.

   You have a right to be. Through no fault of your own, your life has been ruined. You may never have the job, children, a car, or even one day free of pain for the rest of your life. The temptation to give up and die is very great.

6. Acceptance. After a time, usually a long time, you find a way to accept yourself and what has happened, and to go on with your life.

   There are three things that you have to understand:

   a. You must take care of yourself and meet as many of your own needs as you can, either yourself or through relationships with other people which are mutual, equal and loving.

      By virtual biological law, people meet their own needs and those of their loved ones first. Only what is left over is offered to others.

      This is as true of mental health workers as anyone else. They provide specific services, and a measure of emotional support, but rarely as love as exchanged among equals.

   b. Blaming people, whether yourself, your family, or anyone else, is a waste of time.

      Too much psychodynamic, insight-oriented therapy is a thinly disguised search for someone to hold responsible.

      There is no way you can recover a piece of your life from someone, as if it were money damages. You may not be able to forgive or forget, but you have to withdraw your energy from the past, and go on.

   c. You have to find some reason, some mission in life to justify going on, in spite of the pain and lack of orderly success.

      If you are religious, it may be the faith that you are in this world to be tested, or to learn something essential for your spiritual development, and that your

Appendix

Some reasons mentally ill people contact crisis services are:

1. You may need help with a practical, real-world problem. If you spent a lot of your life being crazy, you may be missing whole areas of competence which are taken for granted by normal people, such as riding the bus, dealing with a traffic ticket, or returning defective merchandise to a store.

2. You may need help putting an idea in words, defining a problem clearly so that you can work on solving it, or communicating feelings to someone in a relationship. If you have a thought disorder, the most important area of communication in words can be extremely difficult.

3. You may need emotional support for a necessary decision not popular with your immediate support system. The people in your college psychology class may be delivering fulminating denunciations of psychotropic medications, but you have to stay on them, or end up in the hospital or dead.

4. You may have symptoms that relate to a developing medical problem, and you need help figuring out whether you need medical care, or whether these are just some new variations on your hallucinations and delusions.

5. You may be experiencing new or threatening psychiatric symptoms, such as prolonged sleep loss or command hallucinations ordering you to kill yourself. You may need help deciding how serious these are, and what to do about them.

6. You may need a perception check: does it seem likely that you are important enough for the FBI to bug your phone, or is that probably just a crazy idea?

7. You may need help finding specific local mental health or social services.

8. You may be without food, clothing, shelter, or essential medical care.

9. You may be in legal trouble, and need help conveying to those defending you, the nature of your illness and your disabilities.

suffering has a place in the overall cosmic picture. For others it may be the goal of someday writing a book, which you hope will help normal people understand the experiences and needs of the mentally ill.

For a few who have luck, brains, and a terrible determination, it may be possible to go back into the wilderness to try to lead a few brothers and sisters to freedom. They become mental health workers themselves.

It may be the love of family, fear of death, or even plain stubbornness, but there has to be a reason.

If the pain is futile, it is also intolerable.

COMMUNITY RESOURCES

NETWORK
Behavioral HealthCare, Inc.

Resume of Low-Income Housing Experience

Date of Inception	Project
March 1985	Tillicum Court Apartments

Under the corporate ownership of Southeast Network Housing Services, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing in studio and 1 bedroom apartments, as well as skills training and support services, are provided on-site. Additional psychiatric and clinical services are available through the Network's Rehabilitation and Community Services divisions.

March 1987 — 70th Street House

The Network provides residential care in a transitional group home setting to 12 individuals having mental illness. Twenty-four hour supervision, skills training, and counselor support are provided on-site as are meals, medication and money management. The facility is leased from the Housing Authority of Portland and operated by the Network. All residents are low income and supported by entitlement programs.

May 1988 — Nawikka Court Apartments

Under the corporate ownership of Southeast Network Housing Services II, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing is provided in 1 bedroom units with additional services provided as described for Tillicum Court.

ADMINISTRATION
5415 SE Milwaukie Avenue • Portland, Oregon 97202
(503)238-0769 • FAX(503)233-2861

January 1992

Pisgah Home/Harriet Court Apartments

The Network provides both residential care (Pisgah Home) and supported housing (Harriet Court) to individuals having mental illness at these co-located program sites. Fifteen Pisgah tenants receive twenty-four hour supervision, assistance with activities of daily living (hygiene, grooming, etc.), money, medication and crisis management; skills training and counseling. Fifteen Henry Court tenants live independently and receive skills training and support from on-site staff as appropriate to their needs. Tenants in either program reside in private rooms with private baths. Congregate meals are available. The Network owns and manages the facility in which it operates these programs. All tenants have incomes below 50% of median; many are supported by entitlements.

November 1993

Woodstock Court Apartments

The Network operates this nine (9) unit complex under lease from the Housing Authority of Portland, the project's co-developer (with Network). Eight studio units are rented to homeless individuals having mental illness. An on-site manager occupies a 9th unit. The Network provides skills training and support services including medication monitoring and a meal preparation skills program. The Network manages all aspects of this housing. All tenants have incomes below 50% of median, typically from entitlement payments.

May 1994

Lafayette Apartments

The Network owns and operates this thirty two (32) unit complex which provides supported independent living in studio and in one bedroom apartments to individuals having mental illness. On-site management and optional skills training and support services including medication monitoring and meal preparation training are provided. All tenants have incomes below 30% of median and are generally supported by entitlement programs.

October 1994

Kernlodge Home

Quint 26

The Network operates these two, five (5) unit homes under lease from The Housing Authority of Portland, the project's co-developer (with Network). Each home contains five SRO units (a private bedroom and bath), and shared space that includes kitchen, dining room, living room, laundry, and individual pantry/food storage areas. This shared housing affords its tenants privacy, security, and comfort in a small, group-oriented, neighborhood-friendly building. Tenants are low income persons having mental illness who are capable of living in an unsupervised setting. The buildings do not have live-in management, but are regularly monitored by the staff of Network Behavioral HealthCare, Inc. The Network provides the residents with skills training, case management, twenty-four hour emergency on-call psychiatric, health, vocational, socialization, recreational and medication monitoring services. All tenants have incomes below 50% of area median and are generally supported by entitlement payments.

January 1995

Lents Court

The Network operates this five (5) unit home under lease from The Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge and Quint 26 described above. All tenants are low income veterans who are clients of the VA Domiciliary Program. All support services are provided by the VA under a Letter of Understanding with Network.

January 1996

Tea Link Home

The Network operates this five (5) unit home under lease from the Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge, Quint 26 and Lents Court described above. All tenants are low income Asians. All support services are provided by the Chinese Mental Health Program.

March 1996

Hopewell Apartments

Under the corporate ownership of EcuNet Housing, Inc., a partnership between Network and Ecumenical Ministries of Oregon, Network operates this 8 one bedroom and 4 two bedroom HUD 811 apartment building. Hopewell offers low income people with HIV disease and psychiatric disabilities housing and a program of services to help them live as independently as possible. On-site management is available. Tenants pay about 30% of their income for rent and utilities and are required to meet HUD income eligibility requirements.

June 1996

Clinton Street Apartments

The Network owns and operates this 16 unit complex (15 studio apartments and 1 one bedroom apartment) to provide housing with linked support services for low income individuals with mental illness. The project has an on-site manager who provides skills training and support services including medication monitoring, case coordination, and recovery services. All tenants have incomes below 50% of area median and are generally supported by entitlement programs.

September 1996

Tabor House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. All six tenants are low income individuals who are capable of living in an unsupervised, supportive setting. Each has a private bedroom and shares use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

November 1996

75th Ave. Adult Foster Care

Network owns and operates this five resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 50% of area median and are supported by entitlement programs.

August 1998

Powell Blvd. Apartments

Under the ownership of Powell Boulevard Apartments, Inc., a not-for-profit corporation sponsored by REACH Community Development, Network operates this 20 unit HUD 811 project for the benefit of low income persons having co-existing mental illness and substance abuse disorders. Tenants occupy studio, 1 bedroom, and 2 bedroom units, and participate in a program of services designed to promote independence and sobriety. On-site management and supports are available to supplement psychiatric and addictions services provided through Network's Project STOP or other treatment providers. All tenants have incomes below 50% of area median and pay approximately 30% of their income for rent and utilities.

March 1999

Woodstock House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. The tenants are low income women who are capable of living in an unsupervised, supportive setting. The home is configured to allow the rental of individual bedrooms to single women or two bedroom suites to small families. Tenants share the use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

April 1999

Residential Intensive Treatment Services

The Network owns and manages this ten unit transitional housing program in which residential treatment is provided to individuals having mental illness and addictions issues. Tenants are referred by Multnomah County Community Corrections and receive twenty-four hour supervision, addictions treatment, assistance with activities of daily living, money, medication and crisis management; skills training and counseling. Tenants reside in private rooms with half baths during their three month stay. All tenants have incomes below 50% of median; many are supported by entitlements.

January 2000

Nadine Place

Network owns and operates this eight resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 30% of area median and are supported by entitlement programs

Tenants of these residential programs receive housing and on-site services as specified above. In addition, tenants are welcome to participate in the full range of community treatment and rehabilitation programs offered by The Network. These programs include case management; medical and psychiatric consultation; vocational, recreational and socialization services, substance abuse recovery services; psycho-social clubhouse; crisis/triage services; individual and group counseling; and medication management.

MEDICATIONS

MEDICATIONS AND THEIR SIDE EFFECTS

Psychiatric researchers believe that people suffering from many mental illnesses have imbalances in the way their brain metabolizes certain chemicals, called neurotransmitters. Because neurotransmitters are the messengers the nerve cells use to communicate with one another, these imbalances may result in the emotional, physical and intellectual problems that mentally ill people suffer. Psychiatric medications are like any other medicine a doctor would prescribe. They are formulated to treat specific conditions, and they must be monitored by a physician. All medicines have positive and negative effects. Whether or not a person will experience side effects cannot be predicted. Responses to medications are individual. Most medications psychiatrists prescribe may take a few days or a few weeks to become fully effective. The listed medications and their side effects are some of the most common but it is certainly not a complete list.

MEDICATIONS AND THEIR SIDE EFFECTS

Antidepressents	Most Common Side Effects
Amitriptyline (Elavil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, worsening of heart disease, dizziness when first standing up
Amoxapine (Asendin)	Worsening of heart disease, sleepiness, agitation, insomnia, anxiety
Bupropion (Wellbutrin)	Agitation, dry mouth, insomia, headache, nausea, vomiting, constipation, tremor
Clomipramine (Anafranil)	Dry mouth, sleepiness, tremor, weight gain, sweating, dizziness when first standing up, blurred vision, constipation, trouble having orgasm, trouble urinating, nausea
Desipramine (Norpramin)	Dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, dizziness when first standing up
Doxepin (Sinequan)	Sleepiness, sweating, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, weight gain, dizziness when first standing up
Fluoxetine (Prozac)	Agitation, anxiety, insomnia, drowsiness, tremor, loss of appetite, nausea, diarrhea, headaches, dizziness, problems with orgasm
Imipramine (Tofranil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain sweating
Maprotiline (Ludiomil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, weight gain
Nefazodone (Serzone)	Sleepiness, dizziness when first standing up, nausea, headache
Nortriptyline (Pamelor)	Sleepiness, dry mouth, trouble urinating, constipation, blurred vision, weight gain
Paroxetine (Paxil)	Nausea, sleepiness, fatigue, dizziness, insomnia, sweating, tremor, loss of appetite, anxiety, trouble having an orgasm
Protriptyline (Vivactil)	Dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, insomnia, anxiety
Sertraline (Zoloft)	Nausea, diarrhea, tremor, dizziness, insomnia, sleepiness, sweating, fry mouth, delay in having an orgasm
Trazodone (Desyrel)	Sleepiness, worsening of heart disease, dizziness when first standing up, nausea, vomiting
Trimipramine (Surmontil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Venlafaxine (Effexor)	Sedation, nausea, sweating, dry mouth, dizziness, weakness, constipation, decreased appetite, vomiting, anxiety, tremor, blurred vision, problems with orgasm, headache
Fluvoxamine (Luvox)	Sleepiness, insomnia, anxiety, tremor, nausea, loss of appetite, vomiting sweating, delayed orgasm

http:noah.cuny.edu/illness/mentalhealth/cornell/medications/antidepsideff.html 7-15-99

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche" =the mind and "tropos" = turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics; that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially **highly addictive**, produce fairly **rapid tolerance** and are extremely **difficult to withdraw** from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal, as bad as it feels, is actually easier, quicker and safer than benzodiazapine withdrawal.

Common side effects are sedation, dry mouth, depression, and memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do **not produce tolerance.** The anti-depressants work to restore balance in the neurotransmitter systems, which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics
Elavil (amitriptyline)

Tofranil (imipramine)
Norpramine (desipramine)
Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

The second generation or "atypical" compounds
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)
Serzone (nefazadone)
Remeron (mirtazapine)

The SSRI's (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

The MAOs (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The ANTI-MANICS (also referred to as mood stabilizers) are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. Non-addictive and does not produce tolerance. Research has shown that these medications are also helpful in preventing the recurrence of severe mood swings.
Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The **ANTI-PSYCHOTICS** also called **Neuroleptics** are used to treat psychotic symptoms. As such they are believed to work by restoring balance in the neurotransmitter systems (primarily dopamine) which mediate thought processes, perception and mood. They are **non-addictive** and do not produce tolerance.
Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)
Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
The "new generation" anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Seroquel (quetiapine)
Orap (pimozide) used mainly for Tourette's Syndrome

The **Anti-Parkinson** medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The **ATTENTION DEFICIT DISORDER/HYPERACTIVITY** medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. **These medications can produce dependence and tolerance.** They are less often prescribed now as many of the SSRI anti-depressants and a

couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)
Adderol (contains both dextro and levo amphetamine)

There are probably newer medications in all the above classes since this has been written but this list is fairly inclusive.

Keep in mind that side effects can occur with any chemical you take in. Such things as aspirin and tylenol can be deadly. Side effects are reported when they occur in more than 2% of the population taking a particular medication. Most often they are dosage related or a sensitivity to a particular medication which can be substituted with one which is better tolerated. If you have a condition which warrants taking a psychotropic medication, odds are that you and loved ones around you suffer more from the condition than you ever will from a side effect.

ANTI-PSYCHOTIC DRUGS

ACETOPHENAZINE (TINDAL) MESORIDAZINE (SERENTIL) TRIFLUOPERAZINE (STELAZINE) THIOTHIXENE (NAVANE) RESPERIDONE (RISPERDAL) LOXATANE (LOXAPINE) CHLORPROMAZINE (THORAZINE) HALOPERIDOL (HALDOL) THIORAZINE (MELLARIL) PIMOZIDE (ORAP) MOLIDONE (MOBAN) CHLORPROTHIXENE (TARACTAN) FLUPHENAZINE (PROLIXIN) TRIFLUOPERAZINE (STELAZINE) PERPHENAZINE (TRILAFON) CLOZAPINE (CLOZARIL)	Side effects include dry mouth, blurred vision, constipation, and drowsiness. Some people taking the medications can experience a difficulty in urinating that ranges from mild problems beginning urination to complete inability to do so, a condition that requires prompt medical attention. Other side effects include greater risk for sunburn, changes in white blood cell count (with clozapine), low blood pressure when standing or sitting up, akathisia, dystonia, parkinsonism, and tardive dyskinesia. Tardive dyskinesia is one of the most serious side effects of anti-psychotic medications. This condition affects between 20 and 25 percent of persons taking antipsychotic drugs. Tardive dyskinesia causes involuntary muscular movements, and though it can affect any muscle group, it often affects facial muscles. There is no known cure for these involuntary movements (though some drugs, including reserpine and levodopa may help) and tardive dyskinesia may be permanent unless its onset is detected early.

Anti-psychotic drug list from Kay Peterson/Project Respond/Portland, Or. 7-15-1999

NOTES

PSYCHIATRIC MEDS BY TRADE NAME

CODES:

AA=anti-anxiety
AD=anti-depressant
AD/MAOI=anti-depressant (can be life threatening when mixed with tyramine, eg some alchols & cheeses)
AD/TCA=antidepressant (higher risk of fatal OD)
AP=anti-psychotic
ALZ=for Alzheimers disease
HYP=hypnotics, meds used for sleep
MR=muscle relaxants((not a psych med/may effectbehavior)
MS/AC=mood stabilizers; and /or anticonsulvsant
NAR=narcotics,(for pain mgmt, may effect behavior)
SE- meds commonly used for side effects of anti-psychotics
STIM=stimulants

Adaptin	AD	doxepin
Adderall	STIM	dextroamphetamine
Akineton	SE	biperiden
Amytal	SLP	amobarbital
Anafranil	AD/TCA*	clomipramine
Antabuse	Etoh block	disulfiram
Aricept	ALZ	donepezil
Artane	SE	trihexyphenidyl
Ascendin	AD	amoxapine
Atarax	AA	hydroxyzine
Ativan	AA	lorazepam
Aventyl	AD/TCA*	nortriptyline
Benadryl	SE	diphenhydramine
Buspar	AA	buspirone
Centrax	AA	prazepam
Clozaril	AP	clozapine
Cogentin	SE	benztropine
Cognex	ALZ	tacrine
Cylert	STIM	pemoline
Dalmane	HYP	flurazepam
Darvocet	NAR	propoxyphene
Demerol	NAR	meperidine
Depakane	MS/AC	valproic acid
Depakote	MS/AC	valproic acid
Desyrel	AD	trazadone
Dilantin	AC	phenytoin
Dilaudid	NAR	hydromorphone
Effexor	AD	venlafaxine
Elavil	AD/TCA*	amitriptyline
Endep	AD/TCA*	amitriptyline
Equanil	AA	meprobamate
Eskalith	MS	lithium

Floricet	NAA	butalbital with aspirin
Florinal	NAA	butalbital with tylenol
Flexoril	MA	cyclobenzaprene
Halcion	HYP	triazolam
Haldol	AP	haloperidol
Inderal	SE/AA	propranolol
Isoptin	AA/MS	verapamil
Janimine	AD/TCA*	imipramine
Kemadrin	SE	procyclidine
Klonopin	AA	clonazepam
Librium	AA	chlordiazepoxide
Lioresal	MA	baclofen
Lithobid	MS	lithium
Loxitane	AP	loxapine
Ludiomil	AD	maprotiline
Lortabs	NAA	hydrocodone
Luvox	AD	fluvoxamine
Marplan	AD/MAOI	isocarboxazid
Mellaril	AP	thioridazine
Miltown	AA	meprobamate
Moban	AP	molidone
Mysoline	AC	primidone
Nardil	AD/MAOI	phenelzine
Navane	AP	thiothixene
Nembutal	HYP	pentobarbital
Noctec	HYP	chloral hydrate
Norpramin	AD/TCA*	desipramine
Orap	AP	pimozide
Pamelor	AD/TCA*	nortriptyline
paraldehyde	HYP	paraldehyde
Parnate	AD/MAOI	tranycypromine
Paxil	AD	paroxidine
Percocet	NAA	oxycodone with tylenol
Percodan	NAA	oxycodone with aspirin
Pertofrane	AD/TCA*	desipramine
Placidyl	HYP	ethchlorvynol
Prolixin	AP	fluphenazine
ProSom	HYP	estazolam
Prozac	AD	fluoxetine

Rela	MR	carisoprodol
Remeron	AD	mirtazapine
Restoril	HYP	temazepam
Risperdal	AP	resperidone
Ritalin	STIM	methyphenidate
Robaxin	MR	methocarbamol
Seconal	HYP	secobarbital
Serax	AA	oxazepam
Serentil	AP	mesoridazine
Serzone	AD	nefazodone
Seroquel	AP	quitiapine
Sinequan	AD/TCA*	doxepin
Soma	MR	carisoprodol
Stelazine	AP	trifluoperazine
Surmontil	AD/TCA*	trimipramine
Symmetrel	SE	amantadine
Taractan	AP	chlorprothixene
Tegretol	MS/AC	carbamazepine
Tenormin	SE	atenolol
Thorazine	AP	chlorpromazine
Tindal	AP	acetophenazine
Tofranil	AD/TCA*	imipramine
Tranxene	AA	clorazepate
Trilafon	AP	perphenazine
Tylenol/codeine	NAA	acetominophen with codeine
Tylox	NAA	oxycodone with aspirin
Valium	AA	diazepam
Vistaril	AA	hydroxyzine
Vivactil	AD/TCA*	proptriptyline
Wellbutrin	AD	bupropion
Xanax	AA	alprazolam
Zoloft	AD	sertraline
Zyban	AD	buproprion
Zyprexa	AP	olanzapine

GENERIC NAME	TRADE	TYPE
acetominophen with codeine	Tylenol/codeine	NAR
acetophenazine	Tindal	AP
alprazolam	Xanax	AA
amantadine	Symmetrel	SE
amitriptyline	Elavil	AD/TCA*
amitriptyline	Endep	AD/TCA*
amobarbital	Amytal	SLP
amoxapine	Ascendin	AD
atenolol	Tenormin	SE
baclofen	Lioresal	MR
benztropine	Cogentin	SE
biperiden	Akineton	S
bupropion	Wellbutrin	AD
buproprion	Zyban	AD
buspirone	Buspar	AA
butalbital with aspirin	Fioricet	NAR
butalbital with tylenol	Fiorinal	NAR
carbamazepine	Tegretol	MS/AC
carisoprodol	Rela	MR
carisoprodol	Soma	MR
chloral hydrate	Noctec	HYP
chlordiazepoxide	Librium	AA
chlorpromazine	Thorazine	AP
clomipramine	Anafranil	AD/TCA*
chlorprothixene	Taractan	AP
clozapine	Clozaril	AP
clorazepate	Tranxene	AA
clonazepam	Klonopin	AA
cyclobenzaprene	Flexoril	MR
desipramine	Norpramin	AD/TCA*
desipramine	Pertofrane	AD/TCA*
dextroamphetamine	Adderall	STIM
diazepam	Valium	AA
diphenhydramine	Benadryl	SE
disulfiram	Antabuse	Etoh block
donepezil	Aricept	ALZ
doxepin	Adaptin	AD
doxepin	Sinequan	AD/TCA*
estazolam	ProSom	HYP
ethchlorvynol	Placidyl	HYP
fluoxetine	Prozac	AD
fluphenazine	Prolixin	AP
flurazepam	Dalmane	HYP
fluvoxamine	Luvox	AD
haloperidol	Haldol	AP
hydrocodone	Lortabs	NAR
hydromorphone	Dilaudid	NAR
hydroxyzine	Atarax	AA

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAR
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MR
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAR
oxycodone with aspirin	Tylox	NAR
oxycodone with tylenol	Percocet	NAR
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAR
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

thiorazine	Mellaril	AP
thiothixene	Navane	AP
tranycypromine	Parnate	AD/MAOI
trazodone	Desyrel	AD
triazolam	Halcion	HYP
trifluoperazine	Stelazine	AP
trihexyphenidyl	Artane	SE
trimipramine	Surmontil	AD/TCA*
valproic acid	Depakane	MS/AC
valproic acid	Depakote	MS/AC
venlafaxine	Effexor	AD
verapamil	Isoptin	AA/MS

MEDICAL EMERGENCIES include but are not limited to:

Anti-psychotics (AP) may cause a syndrome with muscle rigidity, fever, fast pulse rate, high blood pressure, confusion.

Anti-psychotics (AP) may cause muscle stiffness and tightening, tremors, and effect swallowing.

Tricyclic anti-depressants (AD/TCA*) present a higher risk of lethal overdose, especially if combined with alcohol; if combined with cocaine can produce heart failure.

Antabuse (disulfiram) if combined with alcohol will cause flushing, sweating, headache,palpitations, difficulty breathing, rapid heart beat, drop in blood pressure, nausea & vomiting; may lead to serious drop in blood pressure and death.

Medication-related seizures , a situation which should be evaluated at the hospital.

Certain anti-depressants (AD/MAOI) if combined with alcohol , certain cheeses and other foods containing tyramine will cause blood pressure crisis.

Delirium is a medical emergency, which includes symptoms of irritability, significant distractability, hallucinations,

Meds such as anti-anxiety agents and hypnotics have a higher risk of lethal overdose particularly if combined with alcohol.

OTHER RISKS OF PSYCHIATRIC MEDICATIONS INCLUDE:

Susceptability to sunburn-particularly with certain antipsychotics.

Higher risk of dehydration- particularly with lithium.

Anti-cholinergic side effects , including dry mouth, blurred vision, constipation, difficulty urinating, impotence, constipation.

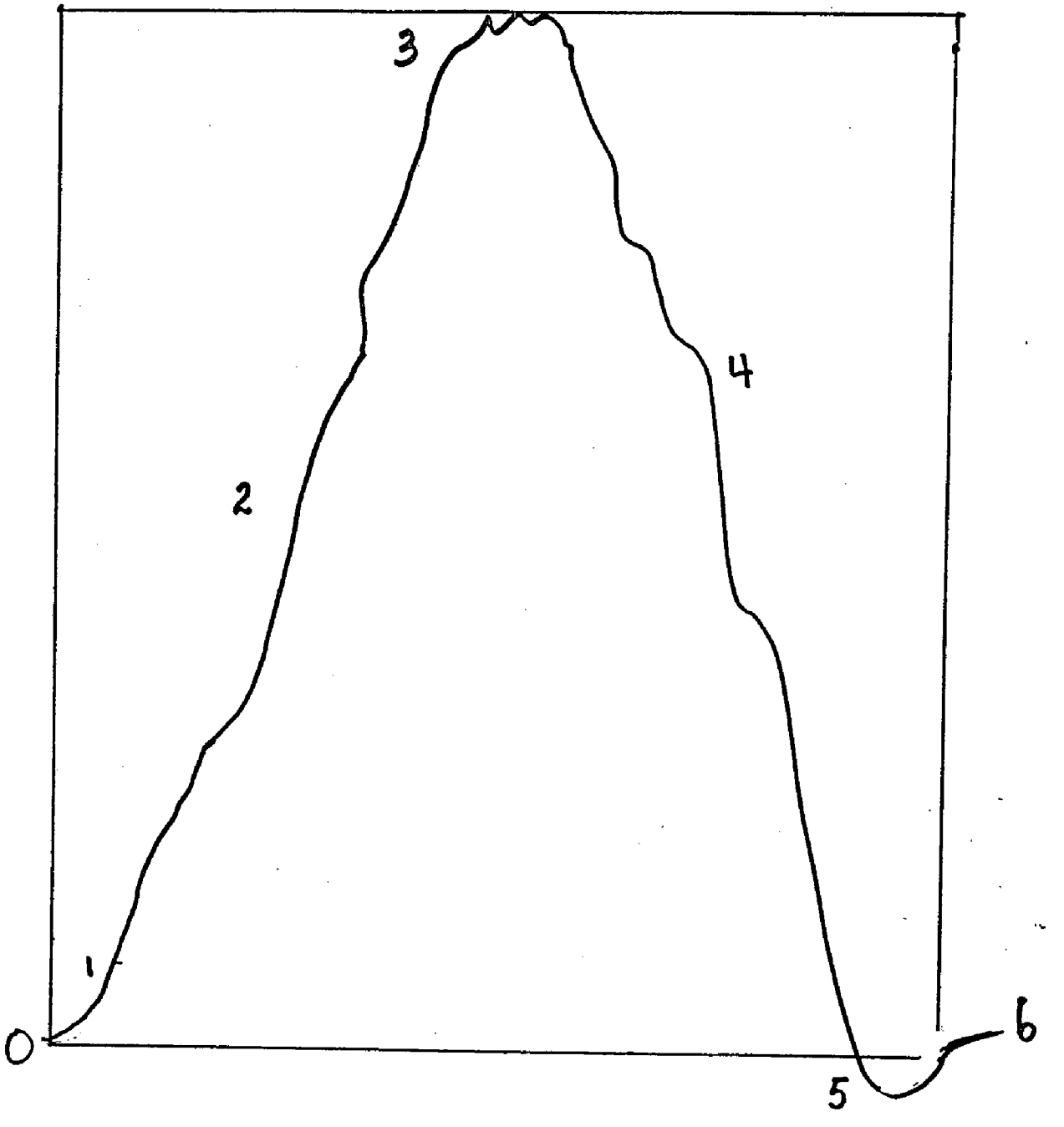
Many medications can cause allergic reactions as well as unexpected reactions with other medications, foods, alcohol, drugs.

Compiled by Project Respond for the Portland Police Department.

Section 4: Intervention

CRISIS CYCLE

The Crisis Cycle



0 - Normal State
1 - Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post crisis depletion
6. Stabilization

CRISIS CYCLE

0. Normal state.

1. Stimulation

Something has happened to cause the person to become:

Excited or
Active or
Upset or
Physically uncomfortable

Cause can be external or internal or both.

External
Something someone else said or did.
Environment: hot, cold, crowded.

Internal
Physical illness, injury or pain.
Emotional upset
Mental illness: mood disorders, hallucinations.

2. Escalation

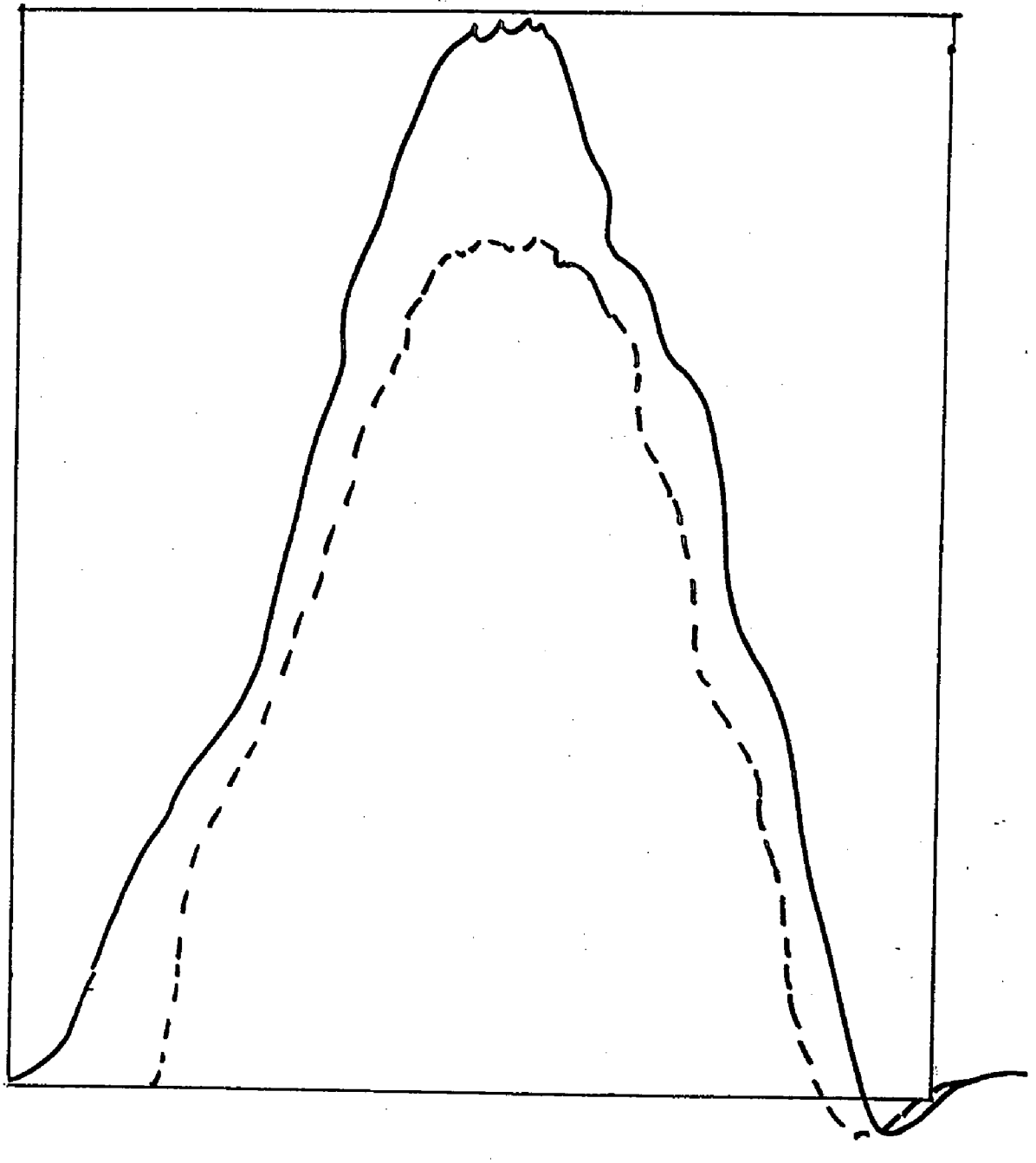
Obvious signs of distress.
Observable physical changes and changes in behavior. (if you don't know the person, it may be hard to know what is a change)

Examples:
Red face
Tense muscles (tight face, clenched fists)
Talking more or louder. (some get quiet/withdrawn)
-Increased activity : Pacing, rocking, etc.

3. Crisis

Out of control.
May scream, yell, curse.
May wave arms or stamp feet.
May assault.

Two crisis cycles juxtaposed



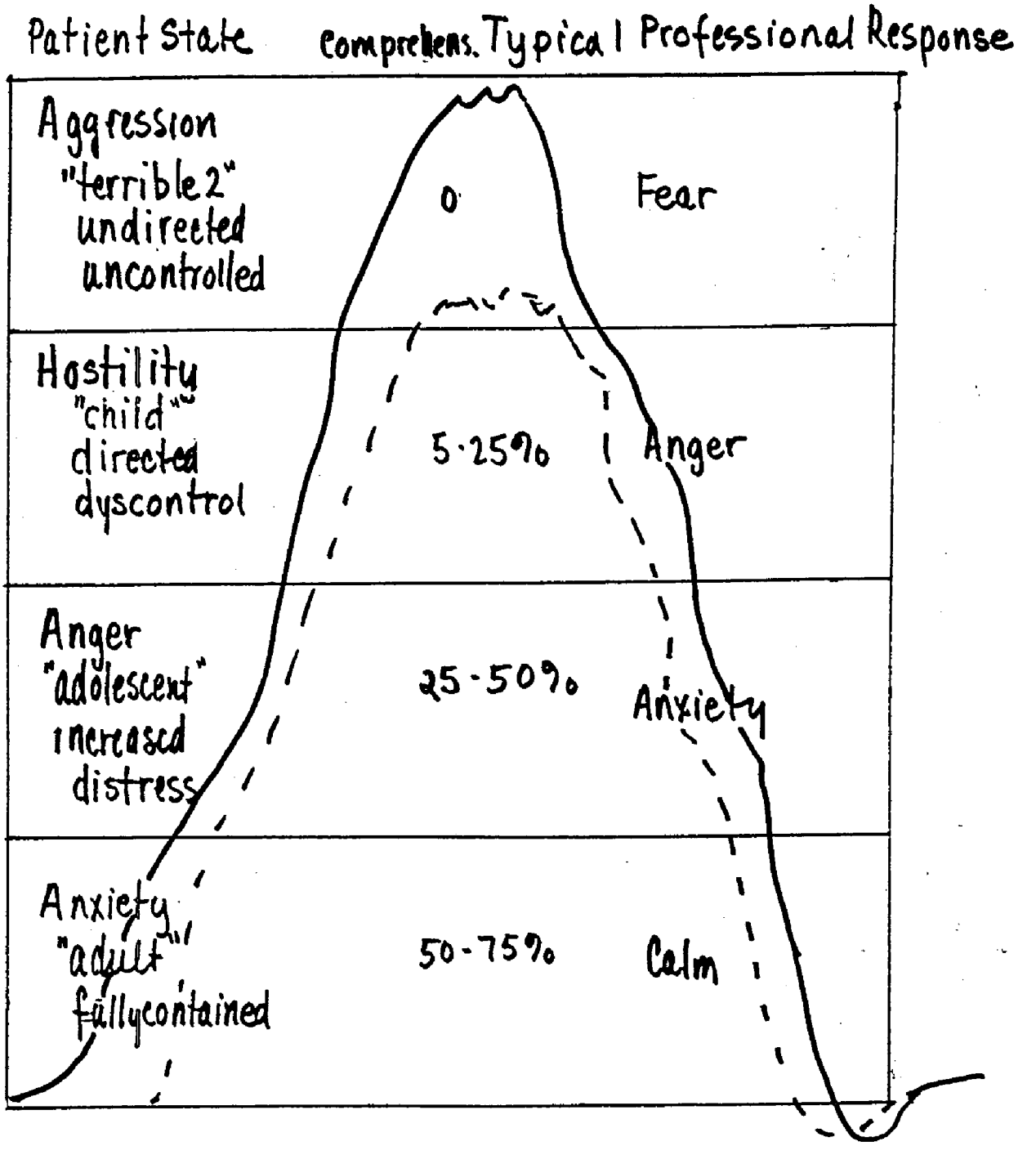
Basic Psychiatric Life Support Model

Patient State	Typical Professional Response
Aggression "terrible 2" undirected uncontrolled	Fear
Hostility "child" directed dyscontrol	Anger
Anger "adolescent" increased distress	Anxiety
Anxiety "adult" fullycontained	Calm

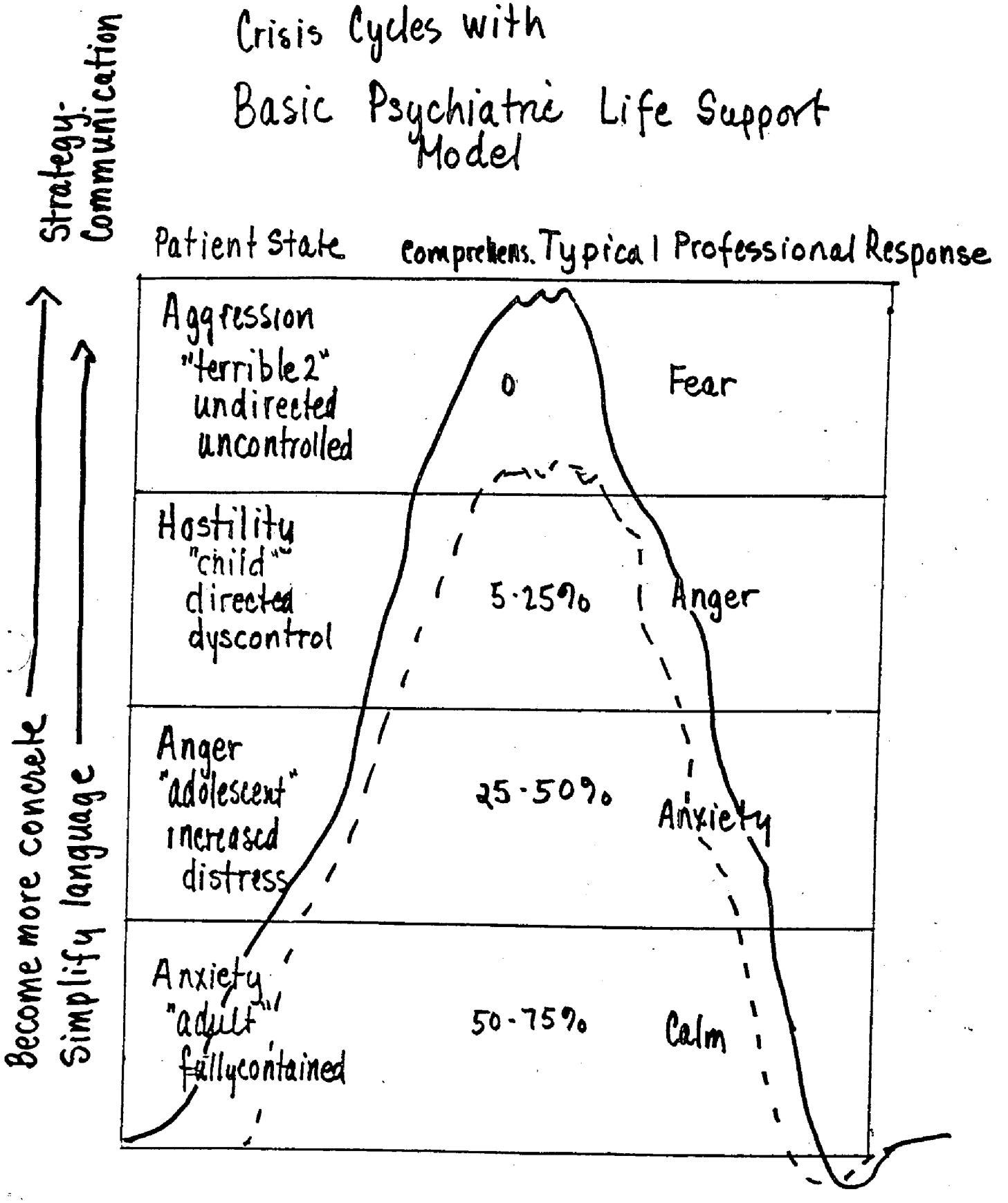
Basic Psychiatric Life Support Model

Patient State	% comprehension
Aggression "terrible 2" undirected uncontrolled	0-5%
Hostility "child" directed dyscontrol	5-25%
Anger "adolescent" increased distress	25-50%
Anxiety "adult" fully contained	50-75%

Crisis Cycles with Basic Psychiatric Life Support Model



Crisis Cycles with Basic Psychiatric Life Support Model



Course Title: Mental Retardation and Developmental Disabilities: Basics For Police Officers

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 3:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To familiarize officers with characteristics of individuals with developmental disabilities, and how these characteristics may affect officer interactions with individuals.

Performance Objectives:

The officer will demonstrate knowledge of what mental retardation is and distinguish it from mental illness

The officer will be able to identify some characteristics of persons with mental retardation in each of the following areas: communication, interaction, judgement/knowledge; performance abilities.

The officer will be able to list some implications of the above characteristics in managing interactions with victims, suspects, and witnesses.

The officer will demonstrate knowledge of how to identify paid or unpaid helpers of a person with a developmental disability.

Course Outline:

Definitions

1. Mental retardation
2. Developmental disability
3. Distinguishing mental retardation from mental illness
4. Other disabilities that affect cognitive functioning

Some characteristics of individuals with mental retardation

A. Recognition of disability/managing the encounter
B. Wide individual variation in each area.
   C. Communication issues
   D. Interaction issues
   E. Judgement/knowledge isssues
   F. Performance abilities

4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

Basic Psychiatric Life Support Model

Patient State

Aggression "terrible 2" undirected uncontrolled
Hostility "child" directed dyscontrol
Anger "adolescent" increased distress
Anxiety "adult" fullycontained

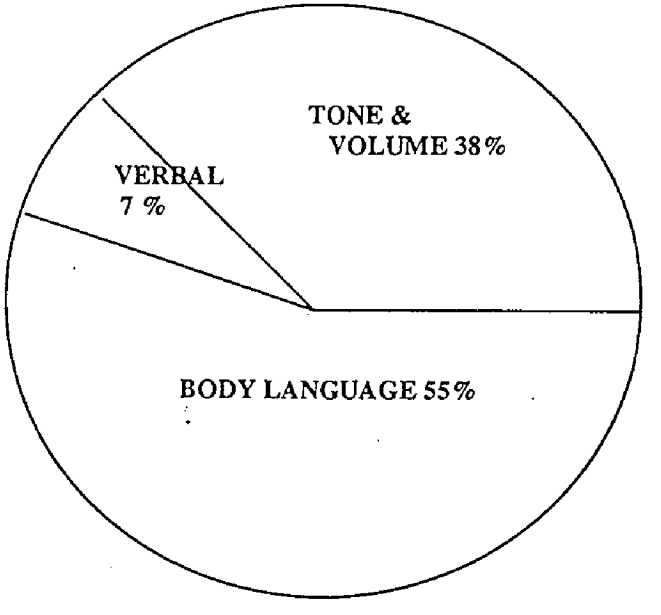
Managing Behavioral Emergencies

As trained crisis intervention specialists, your most likely subjects will be out of control chronically mentally ill persons, angry domestics, suicidal people in public places (bridge jumpers), barricaded individuals, and/or intoxicated persons displaying bizarre behaviors. What do these folks have in common? All will demonstrate some degree of serious impairment in their ability to communicate effectively. This presents a challenge to the police specialist who is attempting to negotiate an alternative to violent behaviors.

One of the few tools that mental health workers have available in dealing with agitated people is the ability to talk down potential assailants. Here are some useful ideas and techniques. The following focus will examine strategies in which you might maximize your ability to deal with agitated people. None of the material in itself is new. The objective for this presentation is to examine principles of applying effective communication techniques to de-escalate agitated persons when possible.

COMMUNICATION

When individuals are highly stressed, non-verbal communication becomes dominant.



Communication

Communication is a people process. It is an interactive phenomenon, which involves more than words. Messages are often the result of a combination of words, behaviors, and context. Parts of the message are:

Verbal Components

1. Content
2. Speech
   - Rate productivity
   - Tone
   - Volume
   - Congruency with other messages

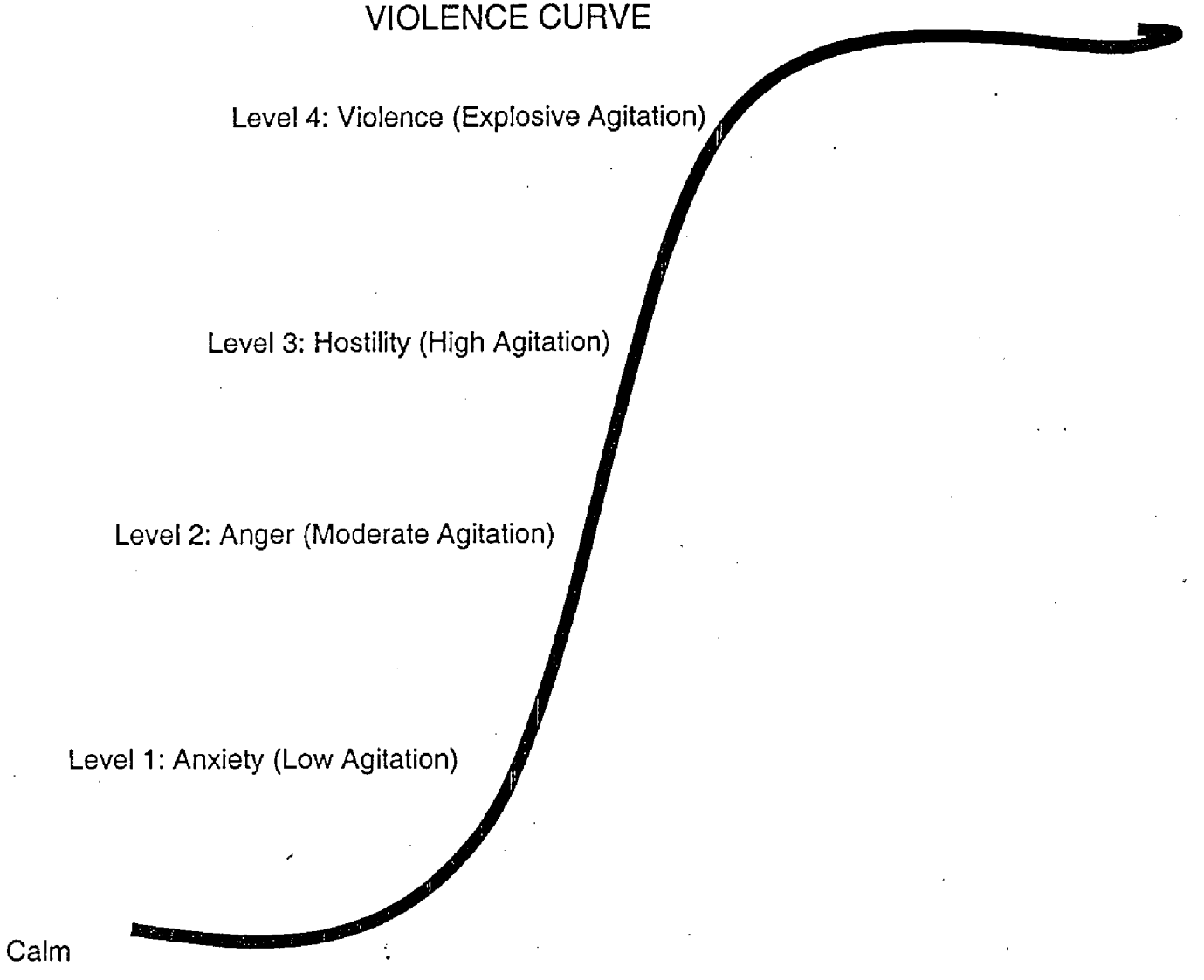
Nonverbal Components

1. Stance
2. Gestures – transient movements of the body or face
3. Eye movements
4. Facial expressions
5. Personal attire
6. Motor movements

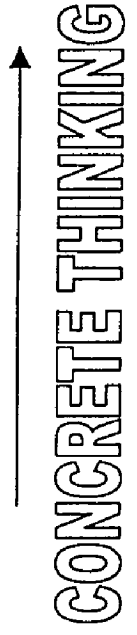
Factors that influence communication

1. Culture/ Religion
2. Sex roles
3. Social class
4. Perceptions or internal experiences
5. Values

VIOLENCE CURVE



The above violence curve does not take into consideration variables of acute mental illness or intoxicants or both. Behaviors of individuals so affected will be erratic and tend not to follow progressive patterns.



SUSPECT/ PERSON	CIT OFFICER RESPONSE
LEVEL 4: VIOLENCE	ANGER / FEAR
LEVEL 3: HOSTILITY	FEAR
LEVEL 2: ANGER	ANXIETY
LEVEL 1: ANXIETY	EMPATHY
CALM	SUPPORTIVE

Interaction

The escalation of violence chart describes the interaction and dynamic between the subject and officer. Both parties are human beings and are products of their upbringing, social norms, and survival instincts.

During the calm state of the violence chart, the subject is at ease. It is relatively easy to interact with such individuals even if they show perceptual distortions. When the subject shows anxiety as in level 1, it is not difficult to engage the person with a degree of sympathy or empathy. However, once the subject begins to exhibit symptoms of anger as in level 2, the CIT officer will normally experience symptoms of anxiety. When the subject is openly aggressive/abusive as in level 4, anger/fear may be the response.

The problem for both the subject and CIT officer is that as we move up the scale, the ability to effectively communicate diminishes. The subject's tunnel vision increases and thinking becomes more concrete as he/she gets more wound up. The officer likewise becomes more concrete as the stress level increases. The police officer has the additional disadvantage of needing to suspend emotions in order to perform well. Separating out feelings and increasing cerebral activity to

perform a technical function is common amongst emergency service workers. Unfortunately, this approach is counterproductive to the process of communication (which we described earlier as a people process interchange of ideas and feelings). The police officer must somehow bridge the paradox between suspending his/her emotions temporarily while listening for emotional cues in an effort to be effective.

The goal of the police officer in dealing with emotionally charged individuals is to pace and guide them into levels more conducive to mutual interchange. Communication skills for the police officer are like any other technical skill. Training and experience promote access to the skill — especially under emergent conditions.

Level 1: Anxiety
A subjective and uncomfortable emotion, which results from threats to the person. Accompanying feelings are dread and helplessness. The goal is to restore the person's sense of control by providing emotional support and negotiating an alternate action to the crisis.

Physical Attending Skills
- Facing the person squarely.
- Adopting an open posture.
- Leaning towards the person.
- Maintaining direct eye contact.
- Retaining a relaxed posture.
- Promoting a relaxing environment.

Responding Skills
- Emotional labeling
- Paraphrasing
- "I" statements
- Reflection / Mirroring
- Minimal reassurance
- Effective silence
- Open statements

Psychological Attending Skills
- What level of agitation did the patient display?
- What central theme concerned the patient?
- Was there evidence of drugs or alcohol that might interfere with predictability?

Intervention
- Negotiate through active listening

Level 2: Anger

Anger is a feeling state or emotion that serves to neutralize the helpless dread of anxiety. Anger can be functional in that the expression gives the person a sense of power. The danger is that anger can quickly escalate into physical expression or violence.

Angry people become less flexible in their ability to think. That is, they become more concrete as emotions rise. It is easier to understand that which can be touched or seen. Visual (nonverbal) messages become more important during stressful events. During stress periods, your verbal communication is required to be shorter, simpler, and more directive.

You goal is to keep the subject conversing with you and use time and your relationship to de-escalate the agitation.

Three Primary Techniques

1. Diffusing the adversarial emotion by acknowledging the anger. "I can see that you're very angry," or, "I'm sorry you're so upset." This has an impact when people become agitated and more concrete in their thinking because they automatically relate in terms of good or evil. That is, they may see themselves as victims and you as the aggressor. Acknowledging their concerns may serve to personalize and close this ever-increasing gap and provide you with a better chance of continuing an effective way of communicating. Remember, acknowledging the person's concern is not the same as agreeing with their position.

2. Advise giving or providing guidance in choosing a course of action or assuming a new role can help. Keep the advice very here and now, e.g. "you might be more safe on the sidewalk," or, "perhaps we could talk privately."

3. Provide choices. Offer a different course of action (A or B) or, one course of action that the person may choose to do or not (A or not A).

Remember that nonverbal interactions of posture, eye contact, tone, volume and pace are very important in the process of de-escalating the person.

Physical Attending Skills

- Facing the person at a 45-degree angle.
- Adopt an open posture
- Lean in to listen
- Maintain direct eye contact.
- Retain relaxed posture
- Promote a relaxing environment

Responding Skills

- Respect

- Empathy.
- Genuineness
- Speech Delivery
- Volume
- Calm Tone
- Productivity — keep dialogue simple.
- Content focus — keep immediate to the key issue.
- Pace speech to slow the person's agitated tempo.

Psychological Attending Skills

- Analysis
- What level of agitation.

Drugs and alcohol

- What central theme concerns the person?
- Can the anger issue be identified?
- What level did you leave the person?

Intervention

- Diffuse the adversarial momentum by affirming the anger.
- Advice giving. Directing to follow your good plan.
- Providing choices. Either A or B. A or –A.

Level 3: Hostility

Hostility is anger with a focused recipient. Hostile people are easy to detect. They are more openly irritable, demanding, argumentative, antagonistic or oppositional. Their voice volume can often be loud and threatening. This is the next stage to violence and must be dealt with caution given the potentially quick transition time. The subject is very concrete and more reliance is placed on the police officer's nonverbal and brief response. The goal is to obtain immediate control of the situation and diffuse to a less agitated (more manageable) stage.

The hostility stage is highly dynamic and the subject may move about displaying varying intensities. Each intervention episode should be less than 60 seconds in duration and often needs to be repeated before successfully diffusing the person/subject to the anger stage.

Four techniques in gaining control of the situation

1. Limit setting: Clearly state the boundaries of behavior that you will allow. "I need for you to lower your voice," "please step outside," "I need for you to leave," "please step back, I'm uncomfortable with you so close." The nonverbal approach is serious, professional, and authoritative. Hand signals are used to communicate. The verbal tone and volume are consistent with

the serious message. Sentences are less than 5 words and repeated rather than elaborated.

2. Diffuse the adversarial stance by acknowledging the anger: Timing is critical. Immediately (microseconds) following limit setting, or "punching a hole" in the defensive tirade. Affirm the individual by acknowledging his/her emotional state. This is a critical test point. If the subject/person accepts ("damn right I'm angry), then continue to dialogue using verbal and nonverbal skills to move to the more manageable Anger Stage. However, if the subject/person continues unabated despite repeated tries, be concerned that the escalation may result in violence.
3. Provide directives: Firmly tell the individual what you want him/her to do.
4. Give Warning: Clearly state as neutrally as possible the consequences of a given course of action.

The approach

1. Dealing with potentially violent people is frightening. You might be as charged as the subject. Try to maintain control by purposely taking deep breaths. Remember that you are going to try and regain control of the situation by communication. It isn't going to impress anyone if you squeak out your directives with residual air.
2. Approach the subject squarely from the side to avoid direct kicks. Keep an open posture (to avoid being perceived as attacking) and keep your hands out of your pockets.
3. Keep approximately two arm lengths distance from person.
4. Do not attempt to communicate by touch.
5. Maintain eye contact and an upright posture in an effort to convey control. Communication is continuous. The eyes coupled with facial gestures may provide advance warning of attack.

The Interaction

1. Do not engage in accusations, arguments, and demands for justification from the subject. This will result in a power struggle, which will prove futile. Winning arguments is not as important as fulfilling the job that you were called on to perform. Do not succumb to their baiting.
2. Work as a team, which may be part of a prearranged set of actions in dealing with emergent situations. Don't get maneuvered into being split apart as good guy, bad guy. "I can't talk to this cop. He's a jerk. I can see that you are a reasonable person. Can we privately discuss my request?"
3. Keep your verbalizations short and simple. Remember that the subject is operating very concretely and will only hear portions of what you will try to verbalize. Repeat your short request as opposed to paraphrasing.
4. Define clear expectations for the subject and communicate these positively and firmly.
5. Limit or address only those behaviors that clearly interfere with the client's welfare or the rights of others.

6. Confine the limits only to those that can be carried out. Empty limits only reinforce the patient's notion that you can not be relied upon. Likewise don't promise that which you cannot deliver. You will only be setting someone else up for potential violence.
7. Practice pat phrases and have them available. Under stress, it is more difficult to be creative. Timing your response is important in disarming an aggressor.

Physical Attending Skills

- Face the person squarely but approach at a 45-degree angle.
- Open posture. Keep your hands out of your pocket.
- Upright Posture. Denotes seriousness and control.
- Relaxed Posture. Denotes lack of intimidation.
- Do not communicate by touch.
- Maintain eye contact — look for advance warning of attack.
- If you point at an object or area, do not take your eyes off the subject.
- Remain two arm lengths away.

Responding Skills

- Genuineness
- Respect
- Speech Delivery
- Volume: Avoid shouting.
- Tone: Confident, assured and serious. Avoid challenging and condescending inflections.
- Rate: Purposely slow to de-escalate.
- Productivity: Keep sentences very short and simple.
- Repeat rather than elongate.
- Content: Here and now. Focus on your directive.
- Do not get "baited" into justifying or arguing.
- Avoid discussions leading to splitting. Confine warnings or promises to those that can be carried out.

Psychological Attending Skills

- Analysis
- What level of agitation?
- Have the person been using drugs and/or alcohol?
- What themes are being presented?
- Any "baiting or key words?
- What level did you leave the person?

Intervention

- Limit setting. Clearly state the boundaries of the behavior you will tolerate.
- Acknowledge the anger and focus.
- Provide directives. Firmly tell the individual what you want him/her to do.
- Warning. Clearly state as neutrally as possible the consequences of his/her behavior.

Level 4: Violence

Response Guidelines

Violence is aggression with a focus on destruction. Violence has injury as its goal. Violence may be verbal (if disruptive or hurtful enough) and/ or physical. The goal is to protect oneself. The goal is not to win but be useful at another time.

The Interaction

- Let your face drain of gestures
- Drop your shoulders indicating relinquishment
- Remain at 45-degrees to the person
- Don't make any sudden moves
- Don't take insults and taunting personally
- Don't be baited
- Do not take your eyes off the patient
- Clearly indicate to the aggressor that you intend to disengage and withdraw, e.g. "I quit, " or" "I'm out of here" messages
- Start moving away towards your escape
- Move slowly and methodically
- Continue your verbal and non-verbal communication to indicate retreat
- You can remain at bay waiting for reinforcements to arrive or totally withdraw.

Active Listening Concepts

Listening for Emotions

People communicate on two levels:

- Content — the simple facts
- Emotions — the emotional reaction to the facts

Train yourself to listen for the emotional message behind the content. Emotional reaction and subsequent behavior make the situation a crisis, not the fact of the situation. How a person feels about a situation will strongly influence what he/she does. Controlling the subject's emotions will help control the subject's behavior.

Listening for Values

- What people think are important
- What people prize

There may be a need to clarify the subject's values. Values influence behavior. The crux of the situation may be a value conflict.

Active Listening Skills

- Emotional labeling
- Paraphrasing
- Reflecting / Mirroring
- Effective pauses (silence)
- Minimal encouragers
- "I" Messages
- Open-ended Questions

Emotional Labeling

- The first active listening skill to be used in an incident.
- The intent of emotion labeling is to respond to the emotions heard in the subject's voice rather than content.
- Demonstrates that you are really listening and tuned into what the subject is emotionally experiencing.
- Do not tell a person how they are feeling, but rather how they *seem* or *sound* like they are feeling to you.
- Do not be afraid to label emotions incorrectly.
- Be aware of missing emotions.
- Listen for conflicts in the feelings expressed.
- Never hesitate: label every emotion you hear.
- Note when the emotions are inappropriate to the situation described.
- Be aware of your emotions and what the subject is hearing from you.
- Use throughout the negotiation / intervention whenever you hear emotions expressed.
- Do not use when you are being verbally attacked.

Emotional Labeling Examples

- You sound _____
- You seem _____
- I hear _____

Paraphrasing

- A summary in your words as to what you were just told.
- Demonstrates you are listening.

- Creates empathy and rapport because it demonstrates you have heard and understand.
- Creates empathy and support.
- Clarifies content, checks perception, and highlights issues.
- Obtains additional intelligence.

Paraphrasing Examples
- Are you telling me...
- Are you saying...

Reflecting / Mirroring
- Repeating back the last word or phrase the subject just said.
- Gives feedback that is very exact.
- Asks for more intelligence without guiding the direction.
- Gets intelligence when you do not have enough to ask a good question.

Effective Pauses (Silence)
- An effective pause is silence.
- Silence is effective if it serves your purpose.
- Most people are not comfortable with silence and will fill it with talk.

Uses of Silence
- When you are about to say something important.
- When you have just said something important.
- When the subject is trying to "psych" you out.

Minimal Encourages
- The sounds you make, especially on the telephone, to let the other person now you are present and listening.
- May be short questions such as: "really?", "Oh?", "When?"
- Does not interfere with the flow of the conversation.
- Lets the subject know you are present and listening.

Uses of Minimal Encouragers
- Helps build rapport.
- Encourages the subject to continue talking.

"I" Messages
- Enables us to let the subject know how they are making us feel, why we feel that way, and what they can do to remedy the situation.
- Conveys the above information in a non-threatening way and does not put the subject on the defensive.

Uses of an "I" Message

- When communication is difficult because of the intense emotions being directed at you.
- When the subject is making communication impossible.
- When you need to refocus the subject.
- When you are being verbally attacked.

Examples of "I" Messages

- I feel _____(emotion or feeling)
- When you_____(his/her behavior)
- Because _____(your reason)

Open-Ended Questions

- Questions that cannot be answered with a "yes" or a "no."
- To obtain information without asking a lot of questions.
- Usually begins with the words: how, what, when, where.

Uses of Open-Ended Questions

- To help a subject start talking.
- To elicit examples of specific behavior.
- To obtain additional intelligence.
- To focus on the subject's feelings.

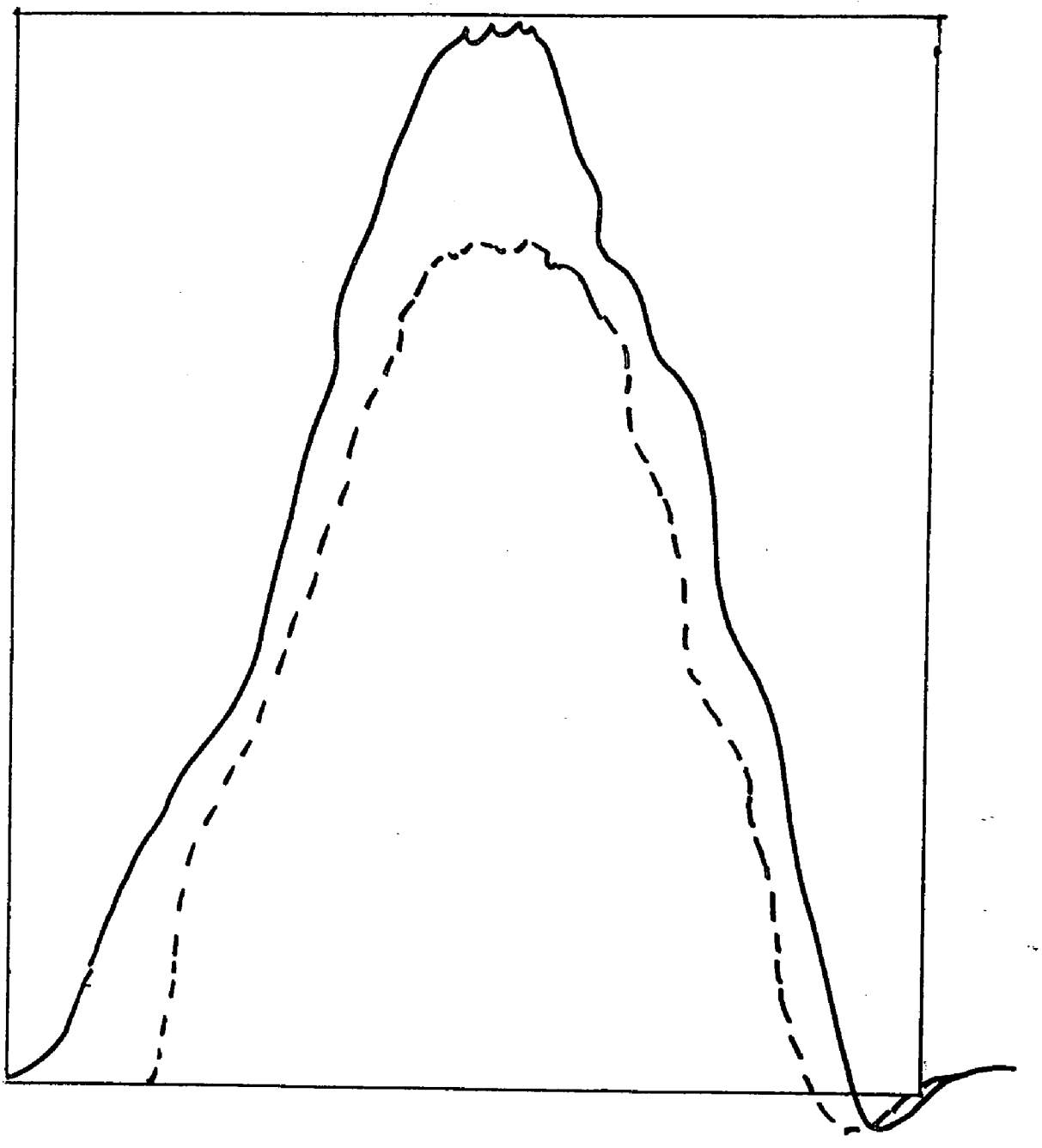
Problems Caused by Closed-Ended Questions

- Gives a feeling of interrogation, which makes rapport difficult to build.
- Causes you to work harder thinking up new questions.

NOTES

INTERVENTION IN THE CRISIS CYCLE

Two crisis cycles juxtaposed



4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

INTERVENTION

A. APPROACHING THE SCENE
   1. Calls
   2. Information before you arrive
   3. Monitor your own emotional state
   4. Leave prejudices/bias/predisposition behind

B. ON THE SCENE
   1. Assess the situation and stabilize, if necessary

C. CRISIS INTERVENTION
   1. Crisis cycle
      a. Intervention at each stage of the cycle
      b. Different levels of understanding, perception and development at each stage
         (1) Look at face, voice and posture for signs of what level
      c. Stages of cycle
         (1) Normal state
            (a) 100% perception and ability to reason
            (b) Acts as an adult
            (c) Person experiences no emotional content
            (d) Officer is calm
            (e) Can problem solve
         (2) Stimulation (internal/external)
            (a) 50-75% perception and ability to reason/understand
               1) Agitated behavior
            (b) Acts as a teenager
            (c) Person experiences anxiety
            (d) Officer is calm
            (e) Action officer should take
               1) Use simple sentences
               2) Use calming body language
               3) Keep voice low and calm
         (3) Escalation
            (a) 5-24% perception and ability to reason/understand
               1) Loud, aggressive, flushed
            (b) Acts as an 8-year old having a tantrum
            (c) Person experiences fear; frustration
            (d) Officer is anxious
            (e) Actions officer should take
               1) Use sentences of less than 5 words
               2) Make one immediate request
               3) Repeat continually
               4) Body language and voice firm but calm
         (4) Crisis
            (a) 0-5% perception and ability to reason/understand
               1) Out of control

(b) Acts like "terrible two's"
(c) Person experiences anger
(d) Officer is fearful/frustrated
(e) Actions officer should take
1) Use firm, one sentence commands
2) Repeat continually
3) Make decision regarding use of physical force

(5) De-escalation
(a) As consumer de-escalates, officer uses the same techniques down the de-escalation
(b) Consumer may suffer post-crisis depression
(c) Escalation can cycle up and down

(6) Things to remember
(a) Take your time
1) Person cannot remain in crisis state forever
(b) Constantly read feedback from consumer
(c) Stop doing anything that escalates the consumer
(d) Continue anything that de-escalates the consumer

(e) Have only one officer talk to the consumer at a time
1) Trade off if not effective

2. Communication skills

a. Verbal skills

(1) Tell person you are there to help
(2) Introduce self by first name
(3) Ask and use their name
(4) Do not involve yourself in their delusions; show you understand that they believe it is really happening
(5) Ask clarifying questions in terms of "I" statements
(a) "I don't understand this"
(b) "I'm afraid you'll hurt yourself"
(c) "I can't figure out why"
(6) Use personalized statements
(a) "Your holding that rock makes me nervous"
(7) Do not argue
(8) Actively listen
(a) Do not be afraid of silence
(b) Wait for responses
(c) Echo their feelings "You seem to be angry"
(9) Show concern and understanding
(a) Nod head while they are talking; indicate listening with "I see", "Uh, huh", etc.
(10) Treat person with respect
(11) Do not use offensive terms or sarcastic remarks
(12) Tell people what you are going to do
(a) Do not make promise you cannot keep
(13) If person becomes agitated, change subject

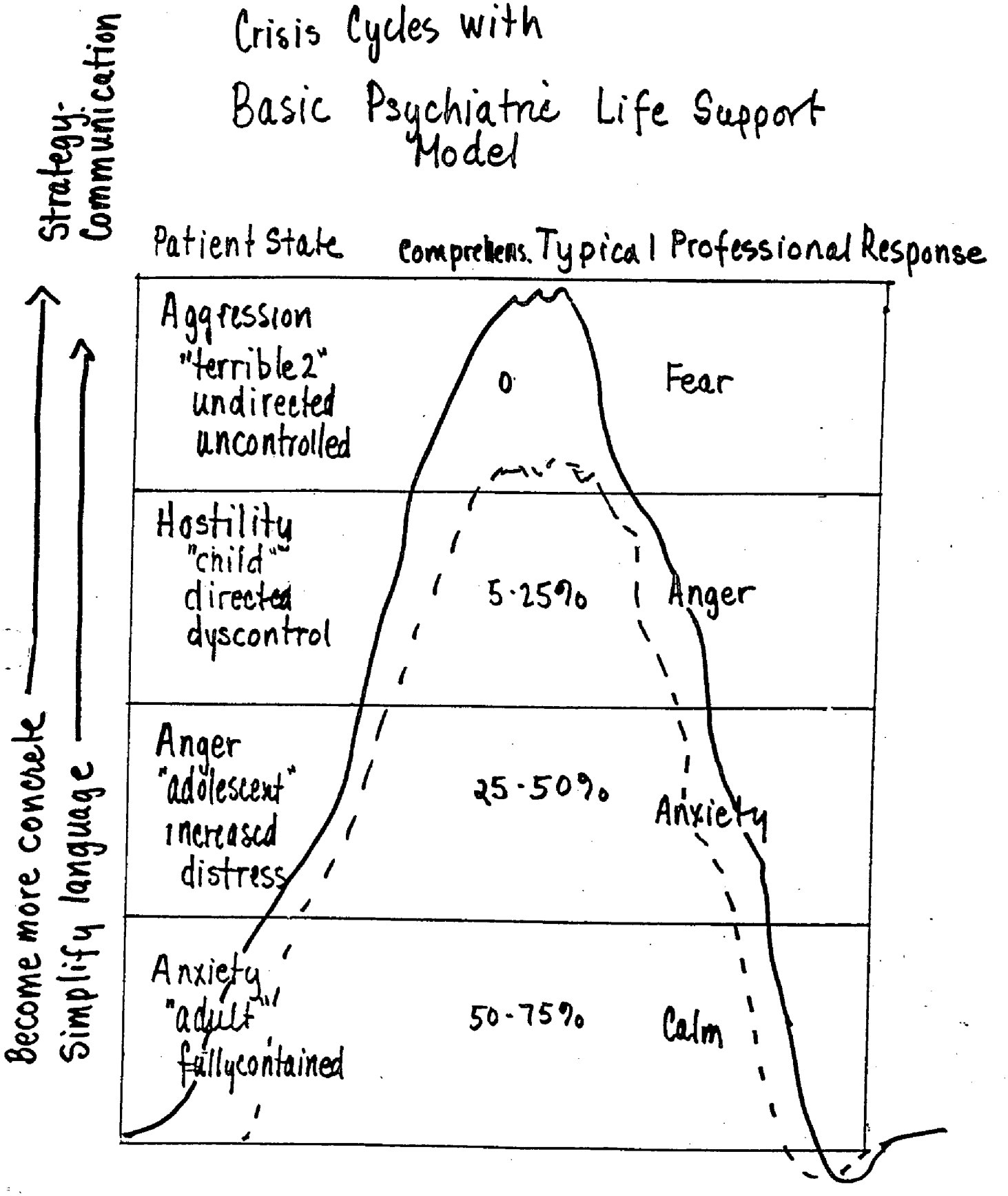
b. Non-verbal skills
   (1) Feedback loop
      (a) Watch reactions of consumer to you
      (b) Stop action if escalates consumer
   (2) Open body language
      (a) Rule of palms
         1) Palms open
      (b) Stand slightly to the side/bladed
      (c) Take safe, but not defensive stance
         1) More relaxed posture
         2) Head tilted
         3) Be ready/appear relaxed
      (d) Keep hands off paraphernalia
   (3) Eye contact
      (a) Try to make eye contact
         1) Some people like it as sign of personal contact
         2) May make some people nervous
      (b) Try to remain at eye level
   (4) Body space
      (a) Rule of 3
         1) Remain 3 arms length away at first contact
      (b) May need to move in to establish personal contact
   (5) Move slowly
      (a) Announce action to consumer

c. Questions to ask
   (1) Ask what is happening that caused crisis
   (2) Ask about past history
      (a) Case worker
      (b) Counselor
      (c) Treatment
   (3) Ask how they resolved similar situations in past
   (4) Ask what clinic they go to or where they go for treatment
   (5) Ask if they are taking medication(s)
   (6) Ask the names of their medication(s)
   (7) Ask if they would like to see a doctor
   (8) Ask if they are thinking of taking their own life
      (a) How
      (b) Do they have the means (gun, knife, pills)
      (c) Have they ever tried it before
   (9) Ask if they are hearing voices
      (a) Are they telling you to do something

d. Officer safety reminders
   (1) Never deny the possibility of violence
      (a) Persons with mental illness are not more violent than the "normal" population but may be more unpredictable
   (2) If hearing voices, ask what the voices are saying

(3) Keep relaxed approach, but not complacent
(4) Watch consumer's hands
(5) Upon transport, always handcuff even if this risks re-exciting the subject; tell the person what you are going to do and why

Crisis Cycles with Basic Psychiatric Life Support Model



Course Title: Mental Retardation and Developmental Disabilities: Basics For Police Officers

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 3:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To familiarize officers with characteristics of individuals with developmental disabilities, and how these characteristics may affect officer interactions with individuals.

Performance Objectives:

The officer will demonstrate knowledge of what mental retardation is and distinguish it from mental illness

The officer will be able to identify some characteristics of persons with mental retardation in each of the following areas: communication, interaction, judgement/knowledge; performance abilities.

The officer will be able to list some implications of the above characteristics in managing interactions with victims, suspects, and witnesses.

The officer will demonstrate knowledge of how to identify paid or unpaid helpers of a person with a developmental disability.

Course Outline:

Definitions

1. Mental retardation
2. Developmental disability
3. Distinguishing mental retardation from mental illness
4. Other disabilities that affect cognitive functioning

Some characteristics of individuals with mental retardation

A. Recognition of disability/managing the encounter
B. Wide individual variation in each area.
   C. Communication issues
   D. Interaction issues
   E. Judgement/knowledge isssues
   F. Performance abilities

4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

Basic Psychiatric Life Support Model

Patient State

Aggression "terrible 2" undirected uncontrolled
Hostility "child" directed dyscontrol
Anger "adolescent" increased distress
Anxiety "adult" fullycontained

Fear

A perceived need (sometimes irrational) to escape, defend against, or eliminate a perceived threat of personal injury.

Visual signals

Posture: Tense and prepared to defend, hide or run away.

Skin color: Pale or ashen.

Facial expression: Wide-eyed and fearful.

Auditory signals

Voice quality: Whining, pleading, gasping, bursts of speech, may be unable to speak.

Breathing: Rapid, shallow, irregular.

Confirming history

Personal history of abuse / victimization and/or withdrawal, sometimes punctuated by assaultive outbursts.

Crisis Intervention for: Fear

Goal: Threat Reduction

The basic assumption is that communication patterns that reduce the perceived threat will also reduce the probability that the assault will escalate to battery. Conversely, communication patterns that add to the perceived threat can be expected to increase the probability of battery. Here are some guidelines for reducing threat:

Posture: relaxed and open; hands in full view

Gestures: slow, palms-up

Position: slightly off to the side of the fearful client, and far enough away (8-10 feet, if possible) to make it clear that an attack on the client is not being planned.

- positions directly in front of, or any position behind a frightened person can be expected to increase the perceived threat
- positions at or below the eye level of the frightened person can be expected to reduce the perceived threat

Voice quality: firm, reassuring, confident

Speech content: logical, encouraging calm reflection; promising to help if possible, but not promising something that is not possible

Eye contact: if the frightened person seems to seek eye contact as an additional source of reassurance, it should be given freely; if the frightened person tries to avoid eye contact it should not be forced on them. There are many cultures that discourage or limit communication through eye contact.

Physical contact: some frightened people (particularly children) need to have reassurance communicated through touch. Touch should be "offered", not given without permission, and should be light with slow movements.

Frustration

An irrational attempt to gain control by physically attacking the source of frustration.

Visual signals

Posture: Tense and prepared to attack.

Skin color: Tones of purple or red; splotches.

Facial expression: Tense, focused, and angry.

Auditory signals

Voice quality: Menacing, aggressive, loud.

Breathing: Loud, deep, long, heavy.

Confirming history

History of low frustration tolerance, coupled with impulsiveness.

Crisis Intervention for: Frustration

Goal: Control

The basic assumption is that patterns of communication that demonstrate and "lend" control will contribute to the restoration of the internal control of the frustrated client. Conversely, communication that demonstrates loss of control will likely increase the probability that the frustrated person will lose their ability to control an impulse to attack. Here are some guidelines for exerting control:

Posture: self-confident, commanding

Gestures: firm, commanding, palms out or down

Position: directly in front of the frustrated client, and just outside of his/her striking range.

- A position within striking distance of a frustrated person communicates a challenge or a desire to fight.
- A position well outside of striking distance of a frustrated person communicates undue caution or fear, and unwittingly points out vulnerability and willingness to be a target for release of frustration.

Voice quality: quiet, firm, commanding in tones low enough to make the frustrated person strain to hear

Speech content: repetitive, confident commands without threat

Eye contact: direct and accompanied by facial expressions which indicate that a firm command is being given.

Physical contact: if physical contact is required to prevent the frustrated person from escalating from assault to battery, it should be made firmly but without excessive movement or pain that would indicate loss of control.

Manipulation

An indirect attempt to obtain or avoid something in exchange for not losing emotional control. Manipulation becomes dangerous when assault is used as a tool in the attempt. Remember: Beneath every manipulative demand there is a legitimate request. Manipulation can take a variety of forms, including:

The temper tantrum

In this case the manipulating person starts by making a calm, but unreasonable (given the circumstances) request. When the persons' requests / demands are not met, they threaten violence by appearing to lose control: yelling, banging, stomping, etc.

Playing the numbers

In this case the manipulating person attempts to "play" people against each other, hoping that in the confusion their request / demand will be met. Group care settings provide an abundance of opportunities for this form of manipulation.

Promoting confusion

In this case the manipulating person brings in related, but irrelevant, matters into the discussion, leaving the professional wondering what the client really wants, or how the issues being raised by the person relate to the request / demand being made.

Visual and auditory signals

Although the signals are often difficult to interpret at any particular moment, there is a definite and recognizable pattern :

- The initial set of signals often occur in a whining voice, usually with a "gimme" attached, and with the affect of a pitiable victim.
- If that doesn't work, the next step is a series of marginally related accusations, comparisons, and other trivia, uttered in more aggressive tones.
- If that doesn't work, the next step is threats and actions against property.
- Finally, when all else has failed, assault is attempted.

Confirming history

A history of losing control or attacking physically when feeling deprived or oppressed.

Crisis Intervention for: Manipulation

Goal: Detachment

The basic assumption is that communication patterns that tend to indicate refusal to become involved in manipulation will decrease the likelihood that the manipulative person will attempt to gain something through complete loss of control resulting in battery. Conversely, communication that indicates openness to the manipulative demand increases the belief that the demand will be met at the next higher level of loss of control. Here are some guidelines for detaching yourself from a manipulative game:

Posture: closed, relaxed

Gestures: idiosyncratic gestures of disapproval or mild irritation (toe or finger tapping, eye rolling, "disgusted" sighing and nodding, arm folding, etc.)

Position: close enough to physically intervene if necessary, but far enough away to show non-involvement (4-5 feet)

- turning slightly away to show non-involvement is appropriate, but do not turn your back

Voice quality: detached, mechanical, slightly bored

Speech content: quiet, repetitive, "broken record" commands

Eye contact: avoid eye contact by looking at the hairline, chin, shoulders, etc.

Physical contact: if physical contact with the person who is manipulating becomes necessary, it should be handled as quickly and unemotionally as possible. Try to make contact with clothing only, not flesh. Punitive and vengeful forcefulness should be avoided, since it will add to the belief that the manipulation could have been successful if it had been done differently.

Intimidation

A calculated attempt to get something in exchange for physical safety or freedom from the threat of injury. "Don't make me hurt you" is the flavor of the message you get from many of the people who intimidate.

Visual and auditory signals

Basically neutral or unremarkable, with the exception of a menacing voice quality and/or threatening words and posture. Often people who are attempting to intimidate use physical menacing / crowding (standing very close to or over the person being intimidated) as a way to threaten danger.

As in manipulation, there is a definite and recognizable pattern of change in signals:

- First, there is a clear and often strongly stated demand.
- If the demand isn't met, this is followed by a believable threat of physical injury coupled with a reminder that injury can be avoided by complying with the demand.
- Finally, refusal to comply or delay in complying is followed by the attempt to injure through assault.

While we often respond to attempts to manipulate with annoyance and irritation ("here we go again", or "give me a break"), we often respond to intimidation with fear and a belief that we might really get hurt!

Confirming history

A history of bullying, extortion, and other criminal assault.

Note: This form of assaultive behavior is often used by persons diagnosed as "anti-social personalities" or "sociopaths".

PRECAUTIONS (DON'TS)

REMEMBER, DON'T:

1. Deny the possibility of violence when early signs of agitation are first noticed.
2. Underestimate information given by others regarding behavioral clues.
3. Engage in behaviors that can be interpreted as aggressive.
4. Allow others to interact simultaneously while you are attempting to talk.
5. Make promise you can not keep.
6. Allow feelings of fear, anger, or hostility to interfere with self control and professional demeanor.
7. Argue, give orders, or disagree unless absolutely necessary.
8. Be placating by giving in and agreeing to all the real and imagined ills of the person.
9. Become condescending by using cynical, sarcastic, or satirical remarks.
10. Let your own importance be acted out in a know-it-all manner.
11. Raise your voice, put a sharp edge, or use threats to gain compliance.
12. Mumble, speak hesitantly, or use a tone so low that you can't be understood.
13. Argue over small points.
14. Attempt to reason with anyone under the influence of a mind altering substance.
15. Attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.
16. Allow a crowd to congregate.
17. Corner, or be cornered: give the person expanded space.
18. Ask why?
19. Deny the opportunity to save face.
20. Rush, be rushed, or lose your own cool!

RESOLVING CRISIS

02/09/95

1. INTRODUCE YOURSELF. PERSONALIZE CONTACT. "MY NAME IS JOHN. WHAT'S YOURS?"

2. USE A CALM VOICE.

3. UTILIZE RELAXED BODY LANGUAGE.

4. TELL PERSON YOU ARE THERE TO HELP THEM.

5. AVOID ARGUING.

6. SHOW GENUINE CONCERN BY ASKING MANY QUESTIONS.

7. ASK THE PERSON WHAT IS HAPPENING RIGHT NOW TO CAUSE THIS CRISIS.

8. ACTIVELY LISTEN. REPEAT BACK WHAT YOU HEAR THE PERSON COMMUNICATING ABOUT THEIR FEELINGS. REPORT BACK TO THE SUBJECT THE EMOTION YOU THINK THEY ARE FEELING. "YOU'RE FEELING ANGRY." "YOU'RE FEELING ANXIOUS." "YOU'RE FEELING FRIGHTENED."

9. ASK THE PERSON ABOUT HIS OR HER PAST HISTORY OF CRISIS.

10. ASK THE PERSON HOW THEY HAVE RESOLVED CRISIS IN THE PAST.

11. ASK ABOUT FRIENDS, RELATIVES, COUNSELORS, CASEWORKERS OR OTHER POSSIBLE SUPPORT PEOPLE.

12. OBSERVE THE SUBJECTS BODY LANGUAGE.

13. IF THE PERSON BECOMES MORE AGITATED CHANGE THE SUBJECT.

14. STATE CLARIFYING QUESTIONS IN TERMS OF THE OFFICER HAVING A PROBLEM:

"I DON'T UNDERSTAND THIS . . . "
"THAT ROCK IN YOUR HAND MAKES ME NERVOUS."
"I'M AFRAID YOU'LL HURT YOURSELF."
"I CAN'T FIGURE OUT WHY . . . "

15. GIVE INFORMATION. EXPLORE OPTIONS WITH SUBJECT.

16. TREAT PEOPLE WITH RESPECT.

17. TELL THE PERSON WHAT YOU ARE GOING TO DO TO HELP THEM.

18. ALWAYS KEEP YOUR WORD.

THE RULES

1- THE RULE OF TIME

2- THE RULE OF THREE

3- THE RULE OF FIVE

4- THE RULE OF PALMS

5- THE RULE OF ECHOS

6- THE RULE OF CALM

CRISIS INTERVENTION WITH PERSONS WITH DEVELOPMENTAL DISABILITY

NOTES

Course Title: The Crisis Cycle

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 4:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To introduce the crisis cycle as a model for understanding the stages of crisis. Implications for interventions will be discussed.

Performance Objectives:

1. The officer will be able to identify the stages that a person goes through when in crisis.

2. The officer will be able to identify and list typical emotional responses of officers intervening in crisis.

3. The officer will identify the language comprehension levels accompanying crisis stages and the implications for intervention.

Course Outline:

The Crisis Cycle: the emotional and behavioral stages people experience when in crisis (Oregon Intervention System model

0. Normal State
1. Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post-crisis depletion
6. Stabilization

The Escalation Grid (Basic Psychiatric Life Support Model)

1. Anxiety
2. Anger
3. Hostility
4. Aggression

How the Crisis Cycle and the Grid fit together

1. Emotional and behavioral interactions
2. Two crisis cycles juxtaposed
3. The Grid- typical responses of professional interveners

A. Anxiety- calm
B. Anger- anxiety
C. Hostility- anger
D. Aggression- fear

4. Recognizing your own responses
5. Setting aside your own responses

The effect of emotional state on communication

1. Comprehension decreases as control decreases
2. Implication for intervention strategies
   A. "adult", "adolescent", "child", "terrible 2"
   B. Simplify language
   C. Become more concrete

G. Effects of the system

Implications of characteristics

Finding out if there is someone who can help

1. Who are the players?
2. What questions can you ask to get useful information?

WHAT ARE MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES?

Definitions. There are many different definitions of mental retardation and developmental disabilities. Agencies typically have their own complex definitions, which may differ from agency to agency. The definitions below are "unofficial.

Mental Retardation. Intellectual functioning that is significantly below average, along with substantial limitations in adaptive behavior (for example, ability to independently perform activities of daily living or function in society.) Mental retardation originates during the developmental period (before 18 in most definitions) and is likely to be lifelong. Generally, a person who has an I.Q. score of 70 or lower is considered to have mental retardation.

Note about terminology: many people do not like to have the term "mental retardation" applied to them, because of unpleasant history or associations. Some prefer the term "developmental disability" or "cognitive disability". Some refer to themselves as "slow" or a "slow learner".

Developmental Disability. This is a broader term than mental retardation. A developmental disability is a disability caused by a neurological condition. It originates during the developmental period, it is likely to be lifelong, and it requires training and support similar to that needed by a person with mental retardation. Besides mental retardation, common causes of developmental disability are cerebral palsy, epilepsy, and autism. **Cerebral palsy** is a catchall term for a variety of disorders that affect a persons ability to move and to maintain posture and balance. Walking ability and speech are often affected. **Epilepsy**, also called seizure disorder, is a condition that causes seizures of various kinds. Some seizures cause a person to fall, lose consciousness, and have jerking movements of the whole body for several minutes. Others cause involuntary movements of a part of the body without loss of consciousness, and still others cause a brief loss of consciousness without falling. Mild forms of cerebral palsy or epilepsy are not considered developmental disabilities under the above definition. **Autism** is a severe developmental disability affecting communication, social interaction, and behavior.

Mental Illness vs. Mental Retardation. Mental retardation/ developmental disability is not the same as mental illness. Hallucinations and delusions are characteristic of some mental illnesses; they are not characteristic of MR/DD. Neither are mania or depression characteristic of mental retardation. A person with mental retardation can be expected to act rationally at their functional level. However, a person with mental retardation or another developmental disability may also have an additional disability such as a mental illness or a drug or alcohol addiction.

Other Disabilities. There are other disabilities and health conditions which affect cognitive (intellectual) functioning and which therefore may be confused with mental retardation. A disability from head injury to an adult is not mental retardation, nor is dementia from conditions such as Alzheimers or late stage alcoholism. A person who has recently had a seizure may have a short period of impaired functioning which may be mistaken for mental retardation.

Institutionalization. In the past, many individuals with developmental disabilities, even those with mild mental retardation were routinely institutionalized. Beginning in the late 1960's, it began to be generally understood that people with developmental disabilities had the right and the ability to live in the community. Programs such as group homes and semi-independent living programs were established to provide training and support in the community and people began coming out of institutions in increasing numbers. However, some people were discharged without appropriate

Do you want to call them now?
Is it OK if I call them?

If you are at a group home or foster home(or other situation in which someone seems to be in a staff role) in a crisis, and the staff seems to be unsure what to do:

Ask: Do you have someone you can call to help you in a crisis?
In a foster home there may not be anyone. In a group home or supported living situation, there should always be a way to contact administrators in an emergency.

SOME SUGGESTIONS FOR COMMUNICATING WITH A PERSON WHO HAS MENTAL RETARDATION

- Keep language simple, but not childish.
- Avoid abstractions or technicalities. Be concrete.
- Avoid yes/no questions, or questions that suggest the answer you expect.
- When you give instructions:
  - Give one at a time
  - Be clear and direct
  - Be sure the person understood. One way to do this is to ask them to repeat it back.
- Don't talk to others in front of the person, as if the person wasn't there.
- If the person has any reading/writing ability, write down simple reminders if they need to do something later. Ask if they have a calendar you can write it on.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

supports and others lost supports for budgetary or other reasons. The movement to "deinstitutionalize" people continues to the present. Today, Fairview and Eastern Oregon Training Centers are still in operation, but they are much smaller than they were in the past.

Being institutionalized affects people seriously. A history of being in an institution sometimes helps explain behaviors that are otherwise hard to understand. Usually the younger the person went into the institution, and the longer they remained, the more serious the effect. In an institution, people are deprived of the opportunity to learn what it's like to live in a regular family and community, and so it is much harder for them to develop appropriate social skills. They have limited opportunity to develop normal human relationships, and little modeling of how people act in normal situations. To survive, some people learned to comply with anyone who acted as if they were in a position of authority. The lack of privacy caused some not to have regard for their own privacy or that of others. For some, the lack of respect for their personal property taught them that if they valued something they needed to carry or wear it or it would be taken. People had few choices and little control over their own lives. Many people were sexually or physically abused by other residents or by staff, and they have the same kinds of problems other sexual abuse survivors have. These can include low self esteem, sexual acting out, lack of trust in others, Post Traumatic Stress Disorder and depression.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

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5/00

SOME CHARACTERISTICS OF INDIVIDUALS WITH MENTAL RETARDATION: IMPLICATIONS FOR LAW ENFORCEMENT

In order to successfully manage an encounter with a person with mental retardation, whether a victim, suspect, or witness, it is important for the officer to recognize the disability. Recognizing the disability and managing the encounter are often one and the same.

Each person with mental retardation is an individual. People with the same measured I.Q., whether they have mental retardation or not, vary widely in their skills, interests, personality and communication style. Listed below are some characteristics that may be more likely to occur in a person with mental retardation. There won't be anyone for whom all (or even most) of these factors apply. For some individuals with mental retardation few or none will apply.

Communication issues

- Does not communicate at the level of typical persons of the same age group
- Limited vocabulary or limited grammatical skills
- Speech defect
- Unable to read or write or limited ability
- Difficulty understanding questions
- Difficulty answering questions; may give "standard" or "parrotted" responses
- Appears to understand when they do not, may not want to admit lack of understanding
- Fails to comply with rules; this may be due to lack of understanding

Interaction issues

- An excessive desire to please others
- Behavior on a level below the person's age
- Crowding personal space when interacting with others
- Tendency to be overwhelmed by authority
- Becomes hostile or withdrawn rather than admit lack of understanding
- Low frustration tolerance

Judgement/knowledge issues

- Does not fully understand seriousness of situations
- Limited safety awareness; may be easily victimized
- Judgements regarding "friends" are the most difficult
- Easily persuaded or influenced by others
- Lack knowledge on how to protect themselves

Performance abilities. May be limited in some of these areas:

- Reading and writing
- Using the telephone
- Understanding finances
- Making change
- Understanding need to budget to cover living expenses
- May give away money or belongings
- Following complicated directions

- Telling time
- Keeping appointments
- Managing activities of daily living , such as hygiene, housekeeping, cooking

Effects of our culture (or system) and common attitudes about disabilities
These are often as limiting as the effects of the disability itself.

- Praised for compliance
- "Protected" by being "kept in"
- "Protected" by not being given sexual information
- Not taught about their rights
- Segregated from others; heavily dependent on caregivers
- Abuse may not be taken seriously
- Live in high risk environments

SOME IMPORTANT IMPLICATIONS OF THESE CHARACTERISTICS

The victim who has mental retardation:

- Higher risk of victimization, especially for sexual assault and robbery
- May be victimized by caregivers or "friends"
- May not understand that what has happened is a crime or that law enforcement can help

The suspect who has mental retardation:

- May admit to things he/she did not do, in order to comply or please
- May have been a follower or coerced by persons with higher abilities
- May not understand what you tell them about their rights (Miranda warnings)

Suspects, victims, and witnesses

- May tell you what they think is the "right answer"

FINDING OUT IF THERE IS SOMEONE WHO CAN HELP

This may also help you determine what the disability is.

Ask: Do you have a Case Manager?
Do you have their card?
(if no card) Who do they work for? Where is their office?

Ask: Is there someone who is paid to help you?(with money, making appointments, fixing meals,etc)
Do you have their card?
Do you have their phone number?
Would you like to call them now?
Is it OK if I call them?

Ask: Do you have a family member that helps you with things? A neighbor? Someone else?
Do you have their phone number?

Multnomah County Developmental Disabilities Services Division

"WHAT ARE ALL THESE PROGRAMS AND WHO'S IN CHARGE HERE ANYWAY?"

The Developmental Disabilities Services Divison (DDSD) is part of the Multnomah County Department of Community and Family Services. Until recently DDSD was called the "Developmental Disabilities Division" and before that, the "Developmental Disabilities Program". Offices are in the Commonwealth Building, 421 SW 6th, Suite 400, Portland, OR 97204, (503) 248-3658. Office hours are Monday through Friday 8:00 to 5:00 P.M.

The Division provides case management for eligible individuals. It also contracts with private providers (some non-profit and some for-profit) to provide residential and vocational services to some individuals. These residential and vocational services are funded mostly with state and federal money, and are under many state and federal regulations. The state and the county both have oversight responsibility for these programs.

Case Manager - Everyone served by the Division has one. This is the person in the Division who works directly with the individual, the family (especially for kids), and any residential, vocational, or other programs that the individual participates in. **This is who you should ask for when you need help for a particular individual.** The Division no longer calls case managers "case managers", but many other people do, so if you ask for the case manager, everyone will know who you're talking about. These people are now mostly called:

Family Consultant (for children)
Service Coordinator (for adults)

If a person urgently needs help and the case manager is not available, there is a **Backup Worker** available during business hours.

Protective Services Investigator - A specialized case manager who investigates allegations of abuse or neglect of adults served by the Division. (Services to Children and Families – SCF- investigates for children.) Police may deal with a Protective Services Investigator if the abuse or neglect involves criminal behavior. To make a Protective Services referral, report the suspected abuse to the individual's case manager (or the Backup Worker) and a Protective Services Investigator will be assigned.

Managers and supervisors - Every Service Coordinator/Family Consultant has one. You can ask for the supervisor if you can't get what you want from (or can't reach) the Service Coordinator/Family Consultant or the Backup Worker.

Division Manager - The person in charge of the Division.

RESIDENTIAL PROGRAMS

These are the programs that provide support in day to day living for some individuals with developmental disabilities. **Most individuals with developmental disabilities do not have any paid supports; they live by themselves or with friends or family.** There are many who need or want services which are not available due to funding constraints.

24-hour Residential ("Group homes")- These programs provide 24 hour staffing for support of individuals. The "typical" program is a 5- person group home. A few are larger. Some are "apartment model". In those, the staff will be present in the complex, but often not in the individual's apartment. **The people who work directly with individuals are generally called "direct care staff", although** in some agencies, they have other titles like "Community Support Specialist". Typically they work shifts and do not live in the home, although there are exceptions. **Group Homes typically have a house manager or site manager. The direct care staff should be able to reach the house manager or another administrative staff person by phone or beeper at all times, and you may want to ask them to do so if there's a problem.**

Semi-Independent Living Programs (SILP)- A program that provides support (typically 2-4 hours per week) to individuals who live in their own apartments. The individual has telephone access to a staff person in emergencies. If you think an individual may be in a SILP program, you may want to ask them if they have a staff person they can call.

Supported Living - A program that's more individualized than 24-hour residential programs but typically provides more support than SILP. There may be live in staff or "paid roommate", or direct care staff working shifts, or support workers dropping in. As in SILP, the individual has 24 hour access to staff by telephone, at any time staff is not with them.

The three kinds of programs listed above) are run by private agencies, under contract with the Division. All individuals served by these agencies are also served by and receive service payments through the Division (except for a very few individuals who pay privately). Agencies typically operate more than one home or site and several operate more than one program. Each agency has an **administrator** who may be called an Executive Director. The administrator or someone designated by the administrator should be available at all times in real emergencies

Adult Foster Care (AFC) - Adult foster care provides 24 hour care to individuals in private homes. **The provider is the person in charge**, who contracts to provide services. There may also be a **resident manager** and one or more **caregivers.** Typically either the provider or the resident manager lives in the home. Each Adult Foster home is licensed by the Multnomah County Adult Care Home Program, and then various agencies, including the Developmental Disabilities Services Division, arrange for service provision to individuals. Some individual make private pay arrangements for Adult Foster care, not through an agency.

Other kinds of residential supports - Individuals may have various kinds of **respite** (temporary) care, in group homes, in AFC, or with private individuals. Or they may have some paid supports in limited areas like money management. If they are elderly or physically disabled, they may receive foster care, personal care services, or other kinds of services from Senior and Disabled Services Division. If they have mental illness, they may receive help from a mental health agency.

Prepared by Lee Greer, Service Coordinator/Behavior Specialist
Multnomah County Developmental Disabilities Services Division
5/00

CHILD AND ADOLESCENT ASSESSMENT AND INTERVENTION

NOTES

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
    - I won't be here.
    - You won't have to deal with me.
    - You'd be better off without me.
    - Life is meaningless.
    - Death is probably a solution to my problems.
    - Would you miss me if something happened to me?
    - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
    - reckless driving, skating, bike-riding, swimming alone
    - drug-experimentation
    - sexual promiscuity
    - fighting, baiting others towards physical confrontation
    - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

NOTES

SUICIDE INTERVENTION

Suicide Prevention

- Develop your interview around a knowledge base and your questions will follow.
- Interviewing: The Basic Rule, "Always ask"
- Straightforward...Do you have thoughts of hurting or killing yourself? Ask the S word.

  How would you do it? Specificity.
  When and where would you do it? Specificity.
  Do you have the means to do it? Lethality.
  Why now? What is the final straw?
  Why *not* now? What are the protective factors?
  When and with what in the past? What was their impression of it?
  What level of control do you feel? How are your brakes?

- **Reasons for Suicide:**

#1. Person is in acute distress.
#2. Suicidal individuals are ambivalent: see choice as "life or death".
Engage in the "I win" game = If I live I win, if I die I win. Good example is the "Police assisted suicide"...drop the gun or we'll shoot.
#3. Person is cut off from outside support and therefore focus on relationships in the institutional setting.

In hospital studies (John Hopkins/Harvard Medical School) it was found that the symptoms prior to suicide included: Dysphoria (86%), Psychosis (50%), Somatic Anxiety (43%), Psychic Anxiety (93%), Agitation (79%), Lability (93%)

Farberow (1966) studied 218 suicide cases and found the predominant pre-suicide behaviors for the "active group" to be: restlessness, agitation, hyperactivity, pacing and sleep disturbance. For the "passive group" they were: severe depression, isolation, muteness, withdrawal, complaints about health and ambivalence about being in a hospital.

- **Risk Factors**: Sex, sexual orientation, age, alcohol/drug; plan, means (especially firearms), emotional upset, mood disorder, psychosis, physical health, incarceration, support system, recent loss or anniversary of loss, severe anxiety or turmoil, global insomnia, delusions of doom and gloom. Decrease the risk factors and you decrease the risk.

- **Highest Risk**: White, male, recent loss (job, spouse, financial support) alcohol on board. Risk increases with age after fifty. Has a realistic plan and the means to carry it out especially possession or access to a firearm.

- **High Risk**: Incarceration, alcohol or drugs on board, humiliation over arrest/charges (e.g. sex offense, particularly first arrest). Highest risk is during the first few hours of incarceration.

- **The Lethal Triad**: An upset person, with a firearm, with alcohol on board.

- **Important for jail and hospital settings**: Death by hanging is second only to firearms as the means of suicide. Approximately 17.2% of male suicides are by ligature and 14.3% of female suicides. (63.3% and 41.3% for males and females by firearm).

- Stats:
- Females threaten suicide more frequently than males by a factor of 3X.
- Males succeed at suicide more frequently than females by a factor of 3X.
- Incidence of female suicide is relatively stable.
- Rough guess is that there are around 25 attempts for every successful completion. This is an average as among the young there are about 100 attempts per success but among the elderly it may be about 4:1 to as high as 2:1.
- Elderly, white males have the highest incidence of successful suicide.
- 33% of elderly suicides saw their M.D.s the week of the suicide.
- People with a history of abuse as children have a 30 fold increase in risk.
- Oregon ranks 9th in the U.S in suicide rate.
- Suicide is the leading cause of death in people with bi-polar disorder:
  Major depression...20% BUT 98% of suicides are seriously depressed.
  Bi-Polar ... 25% to 50%
  General Population...1%
- In Schizophrenia, 20 to 40% attempt suicide while 10 to 15 % succeed.
- Nationally the rate is 12/100K/year
- This increases to 380/100K/year for people with untreated mental illness.
- Suicide ranks as the 9th leading cause of death in the U.S.
  3rd for fifteen to twenty-four year olds
  14th for elderly
- There has been a 200% increase in suicide rates among Black males.
- Successful suicide rates in the U.S. are: 8:2 male to female....9:1 white to non-white.....7:2 white males to white females.....8:2 non-white males to non-white females
- 2 to 6% of suicides occur in hospital settings (620 to 1800/year or 3/day or 1 per 8hr shift.
- In Oregon, the rate is 12 to 32 per year in hospital settings.
- Nationally, the rate of suicide on Medical/Surgical Units is 42/100K.
- On Psychiatric Units this increases to 90-150/100K. (In Finnish psych units the rate is 400/100K)

- Always take threats seriously even from those you believe are manipulating. Personality disordered individuals have been known to kill themselves just to prove they meant what they said ("I'll show you").

- One in ten with a diagnosis of Borderline Personality Disorder will eventually suicide.

- Look for sudden changes in mood, e.g. a depressed individual who suddenly seems to have "gotten over it". They may have made up their mind to proceed with a suicide.

- Look for **classical symptoms** of depression; ask about: appetite, sleep, energy, sexual drive-interest-performance, concentration, and mood. What you are looking for are **changes**, which may be sudden or have been occurring over the past few weeks.
- Most common: **Anergia**...loss of energy.
  Anhedonia...loss of enjoyment or capacity for pleasure.
  Loss of sexual drive, interest, response.
  Hypophagia...loss of appetite with accompanying weight loss.
  Hyperphagia...excessive eating with accompanying weight gain.
  Insomnia...difficulty falling or staying asleep.
  Hypersomnia...excessive sleeping with no sense of rest.
  Loss of concentration, short attention span.
  Low mood, tearfulness, irritability, hopelessness, and despair.
  Excessive guilt.

- Some people may not acknowledge being depressed but they may endorse many items on the list above.

- Suicidal individuals can hide it from you and carry out a successful suicide. You will be left wondering about what more you should have or could have done.

- **Substance Abuse and Suicide**: Lifetime risk 2 to 3% (Two to three times the national average). 15 to 25% of all suicides are by alcoholics. Intoxication is associated with 50% of all suicides.

- **Sobriety is essential.** Substance abuse increases lifetime risk of suicide by 2-3X. 15 to 20% of all suicides are by alcoholics. The highest risk in this group is a male with a long history of drinking who also has a co-morbid psychiatric disorder. Intoxication is associated with 50% of all suicides. Alcohol produces "alcohol myopia" which is the inability to perceive consequences of behavior.

- **Buffers, the "Wall of Resistance":** A strong religious prohibition against suicide. Clean and sober. Intact support system. Willingness to examine options and make a no-harm contract. For women, the best protector against suicide is a child. The more children, the lower the risk...ask "what will become of your children?". A job, a pet, a counselor or therapist. Duty to others. Medication compliance. Good health. Good friends. Job skills, job security. Safe environment and difficult access to means. At

the top of the list is hope. Anything that provides a glimmer of hope to a suicidal individual may be enough to prevent their suicide.

In the final analysis the final decision rests with the individual. However, most suicidal people do not want to die. They want to find a way to live and ambivalence exists right to the moment of death. Reduce risk factors and enhance protective factors and you reduce the risk of suicide.

Primary source of information comes from materials provided by AFSP, the American Foundation for Suicide Prevention

SUICIDAL BEHAVIOR

- Suicidal Behavior
- Suicide Plan
- History of Past Events
- The Persons Resources
- Recent Loss
- Physical Illness
- Drinking and other Substance Abuse
- Physical Isolation
- Dramatic Changes
- Mental Illness
- Suicide Prevention

Suicidal Behavior[2]

A common myth regarding suicide is that people who commit or attempt to commit suicide are mentally ill. Although people who are suicidal are usually in emotional turmoil and although suicide is often preceded by periods of depression, these conditions do not necessarily indicate mental illness. The mentally ill may attempt and commit suicide, but not all that attempt suicide are mentally ill.

Suicide in the United States is the 10th leading cause of death among adults and the second among adolescents. For every suicide there are 8 to 10 attempts, or about 300,000 attempts annually. Suicide knows no boundaries. It cuts across race, class, age, and sex, though its frequency varies with different groups. It is not an illness or an inherited disease as is sometimes believed but is usually a response to a life crisis that the person sees no other way of alleviating. Though many persons who commit suicide are in a temporary state of acute crisis, some are chronically self-destructive and continually attempt suicide.

Listed below are some of the major signs of suicidal behavior. A suicide can still occur without these signs being present, however. At the same time an officer should not hesitate to consider the person suicidal if on ly on e or two signs are apparent. It is impossible to predict suicide in any absolute sense, but inclusions of these signs and guidelines for officers will remove much of the guesswork associated with suicide assessment.

Suicide Plan

Many persons who attempt or commit suicide do so by design. The plan begins with the idea of suicide; suicidal people do not act on impulse but weigh the factors involved. The plan also involves the method of suicide and its lethality. A plan involving a gun will have more likelihood of being effective that will a plan involving tranquilizers. The availability of the means is also a factor. For example, if the person threatens to use a gun and he is a gun owner, the means is clearly available. The final element of a plan is its specificity — time, place, and circumstances. If a person indicates he will commit suicide within two days at a specific time and place, and he has the lethal means, he is a higher suicide risk than one without a plan. The more specific the plan, the higher the risk.

History of Past Attempts

The majority of people who commit suicide have made previous attempts.

The Person's Resources

The officer should assess two types of resources, internal and external. If the person feels life is worthless and that little hope for improvement exists, he or she is lacking internal resources and should be considered a high risk. Lack of

external resources, such as family or friends; or an inability to communicate with those persons is also an indication of high risk.

Recent Loss
Any recent personal loss or the threat of losing a life partner, parent, status, money, or job increases the person's risk of suicide.

Physical Illness
Having a serious illness, especially on that is terminal, that threatens one's values or status, or that is or likely to dramatically affect one's self image increases the risk of suicide.

Drinking and other Substance Abuse
Alcohol or drug abuse is often a sign of other problems, especially if the abuse is recent, and should be included in a suicide assessment. Also, use of alcohol or drugs often increases the risk of loss of control or an increase in impulsive behavior. Alcohol also increases the lethality of a drug overdose

Physical Isolation
The risk of suicide increases when a person is both physically and emotionally isolated. Isolation can cause people to feel they do not belong to a family or society and can increase feelings of worthlessness and other negative self-images. Even temporary isolation may be an impetus for suicide.

Dramatic Changes
A sudden, dramatic, or unexplainable change in lifestyle or behavior may be a clue to suicide contemplation. Change in one's social network and environment such as relocation or retirement can be very upsetting. Also, unexplained changes in behavior are often a symptom of a larger problem, which may in turn increase the risk of suicide.

Mental Illness
Persons who hear voices directing them to commit suicide are certainly in a high-risk situation. However, the number of persons who fall into this category is quite small. If a person indicates that other people, or voices, are controlling his or her behavior, those signs should not be ignored.

In an attempt to determine the existence of any of these signs, the officer must communicate with the person in a calm, direct, and matter of fact way. Talk about the finality of the act and use the terms "suicide," "death," "kill your self." Talking about suicide does not prompt the person to commit the act. The best way an officer can help the person is to discuss the person's problems, the suicide plan, and realistic alternatives. Communication with the person not only enables the officer to gather information regarding the risk, but it is also helpful for the suicidal person. Often the suicidal person has been lacking communication and the

offer's efforts tell him or her that someone is interested and concerned about finding an alternative solution.

[2] All the preceding information about suicide was copied with permission from: Improving the Police Response to the Mentally Disabled. Police Executive Research Forum, 1986.

Suicide Prevention

Suicidal Clues

- Verbal: "it doesn't matter anymore", "you won't be hearing from me again"
- Situational: hopeless and helpless.
- Behavioral: stripping of possessions or relationships, in appropriate calmness/flatness, past attempts.
- What is the Immediate Problem?
- What has happened in last 24 hours that makes you want to kill yourself?
- Identify the problems/situation.
- Identity the loss.
- Talk about it/ventilate feelings.

Identify Hook

- What is still important to the person?
- What still has value/meaning?
- Keep returning to the hook.

Determine Motivation

- What is objective/goal of suicide action?
- What is person hoping to accomplish?

Develop Non-Lethal Alternative Option

- To diffuse crisis state
- To accomplish objective/goal

Develop Specific Plan of Action

- Be realistic.
- Make a list.
- Go to next step.

Referral

- When appropriate.
- When crisis has ended.

Suicide Prevention

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Suggested Dialogue

- Look I can see you're really (label emotion) right now. I just want to talk with you for awhile.
- I really care about what happens to you. That's why I have this job.
- I know talking about this is really rough, but we can take it slow.
- I sense you're really down on yourself right now.

- Do you really want to die, or do you want to not hurt so much?

Finality of Death

- Once you're dead, you're not going to get another chance.
- You know if you kill yourself to get back at _____, all that's going to happen is that you'll be dead. We can't be sure of _____'s reaction. _____ may not care at all. Therefore _____ wins. You're dead and _____'s going to go on with their life.
- I guess right now you want to get away from the hurt, but dying (method) is pretty painful. Let's talk about some other way to get this pain out of your life.

Hooks

Parents

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

Children

- How do you think it will affect (name/'s) if you kill yourself?
- You know, if you kill yourself, you'll never see _____ grow up, graduate, get married. I can tell you care about them a lot.

Job, Career, Hobby

- You know, you've told me that you've made some pretty important breakthroughs in your job, if you killed yourself, you'll never have that satisfaction again.
- You were telling me about your (hobby), you're pretty proud of _____. What will happen to _____ if you die, will they just get tossed in the trash?

Pets

- What about _____? Who will take care of _____? I guess _____ will have to be destroyed.

Explore Plans / Thoughts

- What do you want to have happen? What would need to happen for you to feel better, feel like you could go on?
- What do you think (you/we) could do to make things not hurt so much?

PRACTICUM

Section 5: Other

COMMON ACRONYMS

(AMHSA) ADULT MENTAL HEALTH AND SUBSTANCE ABUSE
(AFS) ADULT AND FAMILY SERVICES
(ARC) ASSOCIATION OF RETARDED CITIZENS
(ADHD) ATTENTION DEFICIT HYPERACTIVITY DISORDER
(ADD) ATTENTION DEFICIT DISORDER
(BHD) BEHAVIORAL HEALTH DIVISION
(CMI) CHRONICALLY MENTALLY ILL
(CAMHSA) CHILD & ADOLESCENT MENTAL HEALTH AND SUBSTANCE ABUSE
(CCMH) CLACKAMAS COUNTY MENTAL HEALTH
(CIT) CRISIS INTERVENTION TEAM
(CRT) CRISIS RESPONSE TEAM
(CTC) CRISIS TRIAGE CENTER
(DCFS) DEPARTMENT OF COMMUNITY AND FAMILY SERVICES
(DSM4) DIAGNOSTIC AND STATISTICAL MANUAL
(DSO) DISABILITY SERVICES OFFICE
(EAP) EMPLOYEE ASSISTANCE PROGRAM
(ISP) INDIVIDUAL SERVICE PLAN
(MRDD) MENTALLY RETARDED DEVELOPMENTAL DISABILITY
(MHRC) METROPOLITAN HUMAN RIGHTS COMMISSION
(NAMI) NATIONAL ALLIANCE FOR THE MENTALLY ILL
(OAC) OREGON ADVOCACY CENTER
(PSRB) PSYCHIATRIC SECURITY REVIEW BOARD
(SDSD) SENIOR DISABLED SERVICES DIVISION
(SCF) SERVICES TO CHILDREN AND FAMILIES
(SSDI) SOCIAL SECURITY DISABILTIY
(SSI) SUPPLEMENTAL SECURITY DISABILITY

Notes

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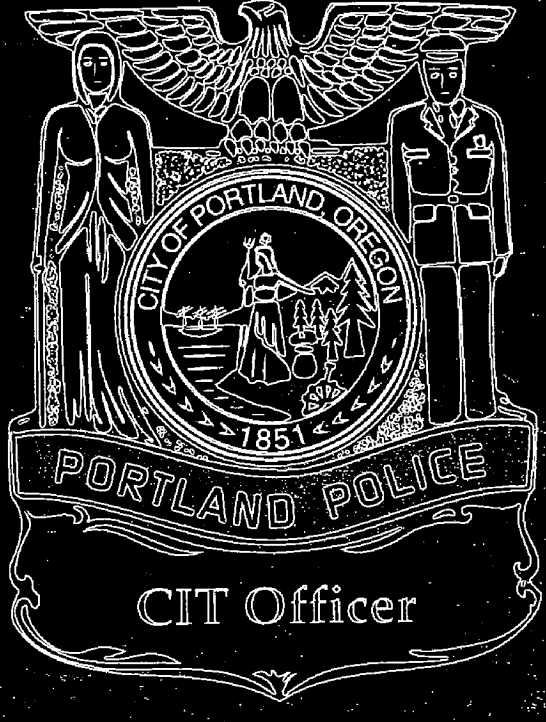
Portland Police Bureau

CRISIS INTERVENTION TEAM



MAKING A DIFFERENCE TOGETHER

CIT Training
November 26th - 30th, 2001
Portland, Oregon

2. **Oppositional-Defiant Disorder**
   - A disorder where children or adolescents display a pattern of openly uncooperative and negative, disobedient and hostile behavior.
   - More prevalent in males than females before puberty; rates equal after puberty.
   - Usually evident before age 8.
   - Symptoms
     1. Often loses temper.
     2. Often argues with adults.
     3. Often actively defies or refuse to comply with adult's request or rules.
     4. Often deliberately annoys people.
     5. Often blames others for his/her mistakes or misbehavior.
     6. Is often touchy or easily annoyed by others.
     7. Is often angry or resentful.
     8. Is often spiteful or vindictive.
   - Associated disorders or symptoms
     ADHD is common.
     Oppositional-defiant disorder can (but does not always) precede conduct disorder.
     Depression – low self-esteem.
     Substance abuse.

3. **Conduct Disorder**
   - A disorder in which there is a repetitive and persistent pattern of the violation of the basic rights of others OR major age appropriate roles.
   - More common in males than females.
   - May begin in childhood or adolescence.
   - Symptoms
     a. Aggression to people and animals
        1. Often bullies, threatens, intimidates others.
        2. Often initiates physical fights.
        3. Has used a weapon (e.g. bat, brick, broken bottle, knife, gun) that can cause serious physical harm.
        4. Has been physically cruel to people.
        5. Has been physical cruel to animals.
        6. Has stolen while confronting a victim (mugging, purse-snatching, extortion, bank robbery).
        7. Has forced someone into sexual activity.

Gold Award

A Model for Management and Treatment of Insanity Acquittees

Psychiatric Security Review Board, State of Oregon

In the mid 1970s, both the public and the mental health professions in Oregon were concerned about the threat to the public presented by persons found not guilty of crimes due to insanity who were released from psychiatric hospitals. In addition, the forensic unit of the state mental hospital was overcrowded with insanity acquittees, but there were few community programs to supervise or treat dangerous mentally ill offenders who might be released.

At the same time, increased attention to the rights of mentally ill patients in the 1960s and 1970s had led to due-process reforms that made it difficult to legally detain mentally ill persons. The state often used procedures for insanity acquittees similar to those used for civilly committed persons—short hospital stays with little or no community monitoring. Existing laws placed authority for disposition of insanity acquittees on the criminal courts, which often lacked the time, resources, or expertise to make informed judgments about an individual's clinical condition or dangerousness to others.

To address these problems, the state of Oregon in 1978 established the Psychiatric Security Review Board, an independent, interdisciplinary program for monitoring persons who are found guilty except for insanity and who are considered to present a substantial danger to others. In recognition of its commitment to improved integration of mental health services within the criminal justice system and its responsibility to community and societal values, the State of Oregon's Psychiatric Security Review Board was selected to receive the 1994 Gold Achievement Award from the Hospital and Community Psychiatry Service of the American Psychiatric Association. The award is presented each year to recognize outstanding programs for mentally ill and developmentally disabled persons. It includes a $10,000 prize made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals. The award was presented October 1 at the opening session of the 46th Institute on Hospital and Community Psychiatry in San Diego.

The primary purpose of the Psychiatric Security Review Board, which is the first program of its kind in the United States, is to protect society through the postadjudication management and treatment of insanity acquittees, almost all of whom are chronically mentally ill. The board assumes sole authority for determining whether persons assigned by the courts to its jurisdiction should be committed to the state hospital, granted conditional release or have conditional release revoked, or be discharged from the board's authority if they are no longer mentally ill and dangerous to others. Unless discharged early, an insanity acquittee remains under the board's jurisdiction for the maximum sentence that could have been received if the person had been convicted. The program's conditional release component provides a mechanism for reducing the number and length of costly inpatient stays.

The Psychiatric Security Review Board successfully bridges the mental health and criminal justice systems, while acting independently of both systems. Persons come under the jurisdiction of the board through the courts and are treated and supervised by staff from the mental health system. About 65 new persons are placed under the board's jurisdiction each year. Currently the board is responsible for about 500 people, 180 of whom are on conditional release. In a study of criminal recidivism among 366 subjects who were conditionally released between 1978 and 1986, only 15 percent were rearrested while on conditional release.

Oregon's Psychiatric Security Review Board has received highly favorable attention from national organizations, including the endorsements of the American Psychiatric Association and the National Alliance for the Mentally Ill. Two other states—Connecticut and Utah—have established review boards that substantially replicate the Oregon program. The board's continued vitality during a period of budget constraints, legal assaults on mental health systems, and public opinion favoring abolishment of the insanity defense attests to the confidence it has inspired among defense and prosecuting attorneys, judges, mental health professionals, and the citizens of Oregon.

Organization of the board

Oregon's Psychiatric Security Review Board functions independently of the court system and the Oregon Mental Health and Developmental Disability Services Division, although it closely coordinates its activities with the mental health division, which provides treatment to insanity acquittees.

The board effectively integrates the disciplines of law, psychiatry, psychology, and social work. By law, two of its five part-time members must be a psychiatrist and a psychologist experienced in the criminal justice system, one an experienced parole and probation officer, one an attorney experienced in criminal trial practice, and one a member of the general public. The psychiatrist and the psychologist cannot be employees of the state mental health division. The attorney cannot be a district attorney or public defender. The board members receive per diem expenses for their meetings.

Board members are appointed by the governor and confirmed by the state senate for four-year terms. The current members are George Saslow, M.D., Stephen Scherr, Ph.D., Kim Drake (parole and probation officer), Hilda Galaviz-Stoller, J.D., and Vern Faatz (public member).

The board has four staff positions—an executive director, two administrative assistants, and a secretary. Mary Claire Buckley, J.D., an attorney with mental health law experience in both civil and criminal commitments, serves as executive director. Staff duties include working with the staff of Oregon State Hospital in Salem, which provides inpatient services for persons under the board's jurisdiction; with members of the bar; with staff of community mental health agencies; and with victims and families of insanity acquittees.

The board operates on a biennial budget, with funds appropriated by the Oregon state legislature. Current funding, approved through mid-1995, for administrative costs associated with operation of the board is about $630,000 for the two-year period. The Oregon Mental Health and Developmental Disability Services Division provides the funds for community care of insanity acquittees on conditional release. The division contracts with public and private agencies to provide a range of mental health services.

The basic cost for community supervision of an insanity acquittee is about $5,000 per year. The cost for acquittees who need enhanced outpatient services is about $9,000 per year and for the few who need extensive residential placement services, about $33,000 per year. These totals compare with an annual cost of $60,130 for inpatient care.

The 1994 H&CP Achievement Award Winners

The American Psychiatric Association honored five outstanding mental health programs in an awards presentation on October 1 at the opening session of the 46th Institute on Hospital and Community Psychiatry in San Diego. The Psychiatric Security Review Board of the State of Oregon received the Gold Award and a $10,000 prize made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals.

Four programs received certificates of significant achievement. They are the Alternative Family Program of Gulf Coast Community Care in Clearwater, Florida, the Emory Autism Resource Center in Atlanta, Evolving Consumer Households of the Massachusetts Mental Health Center in Boston, and Independence Center in St. Louis.

The winning programs were chosen from among 52 applicants by the 1994 H&CP Achievement Awards board, which was chaired by Don R. Lipsett, M.D., of Cambridge, Massachusetts. The awards have been presented annually since 1949. Descriptions of this year's winning programs are included in this issue, beginning on page 1127.

Population served

Since the 1970s, the clinical characteristics of insanity acquittees have become increasingly homogeneous due to adoption of more restrictive definitions of the insanity defense. For example, in 1983 Oregon eliminated the insanity defense for people with a sole diagnosis of personality disorder. Most persons involved in a successful insanity defense have a diagnosis of a chronic mental illness, primarily schizophrenia or other psychosis, and have extensive past experience with both the mental health and the criminal justice systems. The persons for whom the board is responsible are often the sickest patients in the population of chronic mentally ill persons.

In a sample of 758 persons assigned to the jurisdiction of the Psychiatric Security Review Board between 1978 and 1986, almost 90 percent were men, and half were between the ages of 20 and 30. Most were white, in keeping with the ethnic distribution of Oregon's population. They were generally unemployed or underemployed and either lived alone, with family, or in protected settings.

More than three-quarters of the group had a previous state hospital stay. The group as a whole had a mean of 3.1 prior psychiatric hospitalizations, 59 percent of them involuntary. Psychosis accounted for 72 percent of diagnoses—60 percent of the group had a diagnosis of schizophrenia, and 7 percent had bipolar disorder. Eleven percent had a personality disorder, 8 percent had mental retardation, and 5 percent had organic mental disorders. Substance abuse disorders accounted for only 3 percent of primary diagnoses, but 27 percent of the group had substance abuse problems.

The group had extensive involvement with the criminal justice system—a mean of 5.5 police contacts per person—before being assigned to the board's jurisdiction. Seventy-seven percent of the sample had previously been charged with criminal offenses. Seventy-three percent were assigned to the board's jurisdiction after charges involving felonies, and 27 percent after misdemeanors. The most frequently occurring felonies were assaults, burglaries, and unauthorized use of motor vehicles. Harassment was the most frequently occurring misdemeanor. Cases resulting in death of another—murder or manslaughter—accounted for 4 percent of the crimes.

How the board operates

Board powers. The Psychiatric Security Review Board was created by 1977 legislation—Oregon Revised

Statutes, Sections 161.319–161.351, 161.385–161.395 (1977)—which transferred legal responsibility for insanity acquittees from the trial courts to the board as of January 1, 1978. The statute specifies that the primary concern of the board is protection of the public and gives the board sole authority for determining the placement of persons assigned to its jurisdiction.

To counterbalance these stipulations, the law provided substantial legal safeguards to persons under the board's jurisdiction, including rights to periodic hearings, legal representation at all hearings, cross-examination, subpoena power, independent professional evaluation before hearings, and appeal of the board's decisions to the Oregon appellate courts.

A key innovation is development of a well-supervised conditional release for insanity acquittees that covers both the individual's readiness for release and the availability of supervision and treatment in the community. The system allows for protection of the civil liberty interests of insanity acquittees by developing treatment in the least restrictive setting that is appropriate for each acquittee. The board may promptly revoke conditional release if it receives reports that the individual has violated the release conditions or that the individual's mental status has deteriorated. However, once a person is discharged from the board's jurisdiction, neither the trial court nor the board has any continuing authority over that person.

The board is a state agency administratively located within the Department of Administrative Services. Because authority over insanity acquittees is centralized in the board, which has specialized knowledge of the patient population and the care available for them, the state's interest in consistent application of rules and resources can be more easily accommodated than when decisions are made by a diverse group of trial court judges.

Commitment to the board's jurisdiction. Insanity defense cases in Oregon use a standard to define insanity that is based on the American Law Institute test. In 1983 the state changed the name of the plea used for insanity defense cases from "not responsible due to mental disease or defect" to "guilty except for insanity." A successful insanity defense initiates the Psychiatric Security Review Board's procedures for managing insanity acquittees.

After a finding of guilty except for insanity, the trial judge decides if the evidence shows that the defendant continues to be affected by a mental disease or defect and if the person presents a substantial danger to others. If the answer to either question is no, the state's jurisdiction terminates and the defendant is discharged; however, this outcome is relatively rare. The vast majority are not set free but are subject to management by the Psychiatric Security Review Board, which includes the probability of confinement and close supervision for an extended period of time.

> Most persons involved in a successful insanity defense have a diagnosis of a chronic mental illness and extensive past experience with both the mental health and the criminal justice systems.

The trial court judge determines the maximum length of this period based on the sentence the individual would have received if found criminally responsible for the offense. This time period is known in Oregon as the "insanity sentence," which ranges from year for a misdemeanor to a lifetime for murder. The court may assign individuals with multiple charges to the board's jurisdiction for longer periods reflecting consecutive sentencing.

The trial judge also determines whether there is a victim of the defendant's crime and whether the victim wishes to be notified if the board decides that the insanity acquittee will be conditionally released or discharged or if the acquittee escapes from supervision. If so, the board must make reasonable efforts to notify the victim of these events. Finally, the trial court judge determines whether the insanity acquittee will be initially placed in the forensic unit of the state hospital or in the community on conditional release.

Hearings. Insanity acquittees serve their "insanity sentence" within the mental health system either in the state hospital or in the community in a monitored conditional release program. The Oregon statutes require the Psychiatric Security Review Board to conduct periodic hearings for each individual it supervises. Each person is eligible for a hearing every six months. Insanity acquittees, hospital staff, and staff of community monitoring agencies may also request hearings. The board conducts about 300 full hearings each year.

Hearings are held once a week at Oregon State Hospital. Relaxed rules of evidence provide a less stringent burden of proof than in civil commitment hearings and allow board members to consider proceedings of the acquittee's trial, information submitted by interested parties, and the acquittee's entire psychiatric and criminal history.

During the days before the hearings, the board's staff compiles and provides to board members documents about the case, which may consists of several hundred pages. Over the last five years, the board has become more efficient in conducting hearings by employing a case summary coordinator to computerize records and then to index them for board members.

At least three board members must be present for a hearing. The state is represented by an assistant attorney general or local district attorney. The insanity acquittee has a right to legal counsel, and indigent persons are provided counsel without cost. Psychiatrists, social workers, and psychologists from the state hospital staff testify regarding the acquittee's mental health status and progress. The acquittee is present and can subpoena and cross-examine witnesses. All hearings are recorded,

and the transcript constitutes the record if the person decides to appeal the board's decision to the appellate court.

The burden of proof on all issues is by a preponderance of the evidence. The state bears the burden of persuasion in all hearings except those held to consider an acquittee's application for change of status, in which the person must prove his or her suitability for release or discharge.

All three board members must vote unanimously for a decision to be made at the hearing. If a consensus decision cannot be reached, the case file and transcript of the hearing are referred to the two board members who were not present and three of the five members must concur. At the conclusion of the hearing, the board's chair or acting chair gives the insanity acquittee and the attorney written notification advising of the right to appeal an adverse decision within 60 days from the date an order is signed. The board must provide a written order within 15 days of the hearing.

The board also conducts administrative hearings in which an insanity acquittee's conditional release or treatment plan is reviewed or modified. The acquittee does not have to be present for such hearings.

Hospitalization, conditional release, and discharge. Hospital care for insanity acquittees is provided at the Oregon State Hospital forensic unit in Salem. Almost 325 of the 700 beds at the state hospital are devoted to patients under the board's jurisdiction. The patient's treatment plan is developed by hospital staff, but major alterations in the plan, such as off-campus passes, must be approved by the Psychiatric Security Review Board.

Some patients who are assigned to the board's jurisdiction cannot be released into the community under any foreseeable conditions. But for others, conditional release is a reasonable prospect, provided they are closely monitored and supervised by mental health programs in the community. Community programs for insanity acquittees have been influenced by many of the major reforms that took place in community mental health in general in the late 1970s and early 1980s, particularly a refocusing on the needs of chronic mentally ill patients who were being discharged from state mental hospitals. In 1981 Oregon legislation recognized chronic mentally ill people as the population with the highest priority for public mental health services and reorganized community mental health programs to emphasize support services for them. Within this reorganization, a separate component for community services for released insanity acquittees was created.

The patient, the patient's attorney, or hospital staff members may file a request for conditional release. A patient may request a hearing for the board to consider conditional release every six months. The board then has 60 days within which to set that hearing. Hospital staff may submit a request for conditional release of a patient at any time. Those hearings are set as soon as possible.

At the board's request, a community program conducts a thorough evaluation of each insanity acquittee being considered for release. State law prohibits conditional release until the community program, in cooperation with the board, develops a plan to provide adequate supervision and treatment. The conditional release plan constitutes an agreement among the board, the Mental Health and Developmental Disability Services Division, the community program, and the insanity acquittee. The plan includes provisions for living arrangements, mental health aftercare, and case management.

The plan may specify that the acquittee reside in a specific group home and not change residence without approval of the case manager. He or she may be required to take medication under observation of group home staff, to attend a day treatment program, and to submit to drug screening and medical monitoring. The plan may also stipulate additional conditions; for example, the person may be prohibited from driving, using alcohol or other drugs, or contacting certain persons.

The board designates a particular person, usually the case manager, to monitor the insanity acquittee's progress and make reports to the board monthly or at any time the conditions of the release are violated or the acquittee's mental status changes. In addition, any police contact with the conditionally released person, even if he or she is a victim of a crime, is immediately reported to the board via the law enforcement data system computer. The community program usually reports to the board by telephone if a problem arises requiring prompt board action. On receipt of such a report, the board or its chairperson may immediately issue a written order revoking conditional release. This order constitutes a sufficient warrant for the police to take the person into custody. The person may not be jailed, but must be transported to the state hospital.

The entire process from report to rehospitalization may be accomplished within a few hours. The board must then hold a hearing within 20 days to decide if the person should remain committed to the hospital, return to conditional release, or be discharged. Data on persons under the board's jurisdiction before 1986 showed that although more than half of those on conditional release had their release revoked within a year, only a few revocations were due to new criminal charges. Most occurred because of violations of conditions of release such as a requirement to take medication or refrain from using alcohol or because of deteriorating mental health.

Persons may be discharged from the board's jurisdiction while in the hospital or on conditional release. At any hearing, the board must discharge a person found to be no longer affected by mental disorder or no longer presenting a substantial danger to others. Thus both criteria—mental disease or defect and dangerousness—must be met for the board to retain jurisdiction. A person is automatically discharged after having been under the board's jurisdiction for the duration of the "insanity sentence." At the end of the insanity sentence, the state has the option of instituting civil commitment procedures to retain custody of a person believed to meet criteria for civil commitment.

Research on outcomes

The Psychiatric Security Review Board monitors its own performance as well as that of the insanity acquittees it supervises. Quality improvement mechanisms include a full financial audit done by the Secretary of State's audit division every four years and an internal quarterly review using a productivity matrix developed by the board's staff. Performance measures (and their averages since 1992) include percentage of hearings held within statutory time limits (85.7 percent), percentage of conditional releases maintained per month (95.7 percent), and percentage of revocations based on new felonies (1.7 percent).

The board's centralized record keeping system has provided opportunities for extensive research on the characteristics of the forensic population and on service outcomes. Joseph Bloom, M.D., professor and chairman of the department of psychiatry at Oregon Health Sciences University, and his colleagues Douglas A. Bigelow, Ph.D., Bentson H. McFarland, M.D., Ph.D., Jeffrey Rogers, J.D., and Mary H. Williams, M.S., J.D., have studied various aspects of the Psychiatric Security Review Board's operation since its inception. A study funded by the National Institute of Mental Health developed in-depth information about a cohort of 758 persons assigned to the board's jurisdiction between 1978 and 1986, including data on their management while under the board's jurisdiction and on their involvement with the mental health and criminal justice systems after discharge.

The results showed that the system tended to use conditional release conservatively, in keeping with its mandate to protect the public; 68 percent of the study sample spent their entire insanity sentence or the entire study period in the hospital. Women were more likely than men to be conditionally released, as were subjects with fewer past contacts with the mental health and criminal justice systems and less serious crimes leading to board jurisdiction. Subjects whose conditional release was revoked tended to be younger, to have more extensive histories of substance abuse and of contact with the mental health and criminal justice systems, and to have spent more time in the hospital before conditional release. Follow-up an average of 53 months after subjects were discharged from the board's jurisdiction showed a significant decrease in the number of criminal justice contacts per year compared with the period before subjects became the board's responsibility. Among subjects who were arrested after discharge from the board's jurisdiction, there was an overall decrease in the number of felonies and an increase in the number of misdemeanors, compared with the period before board jurisdiction.

Plans for the future

The Psychiatric Security Review Board intends to continue to seek ways to increase its efficiency without jeopardizing its effectiveness. Current plans include training in administrative law procedure for board members and advanced training in computer technology for staff.

Staff of the Psychiatric Security Review Board also plan to increase efforts to fight state budget cuts that may threaten the board's existence. Adequate funding for the program beyond 1995 is not assured, as the final phase of a state initiative limiting the use of property tax revenue for government operations will go into effect that year. Staff plan to work with community organizations such as the Friends of Forensic, consisting of people with relatives and friends under supervision of the board, and the National Alliance for the Mentally Ill to mobilize support for continuing the board's mission of protecting public safety while promoting cost-effective supervision and treatment of mentally ill persons who commit crimes.

For more information, contact Mary Claire Buckley, J.D., Executive Director, Psychiatric Security Review Board, 620 Southwest Fifth, Number 907, Portland, Oregon 97204; telephone, 503-229-5596.

Applications for 1995 Achievement Awards

The Hospital and Community Psychiatry Service of the American Psychiatric Association is now accepting applications for the 1995 Achievement Awards. The awards will be presented at the Institute on Psychiatric Services (the new name for the Institute on Hospital and Community Psychiatry), to be held October 6–10, 1995, in Boston. The deadline for receipt of applications is January 6, 1995.

The American Psychiatric Association presents the awards each year to recognize programs that have made an outstanding contribution to the mental health field, that provide a model for other programs, and that have met challenges presented by limited financial or staff resources or other significant obstacles.

The winner of the first prize, the Gold Award, receives a $10,000 grant from Roerig, a division of Pfizer Pharmaceuticals. If more than one program is chosen as a Gold Award winner, the programs share the grant. The winner of the Gold Award also receives a plaque, and the winners of Significant Achievement Awards receive certificates.

Applicants should submit six copies (including the original) of a completed application form and a program description. Each program that applies will be visited by a representative of the local district branch of the American Psychiatric Association. The site visitor's evaluation will assist the Achievement Awards board in selecting the winning programs.

Ricardo P. Mendoza, M.D., of Torrance, California, is chair of the 1995 Achievement Awards board. To receive an application form or additional information, write Achievement Awards, APA, 1400 K Street, N.W., Washington, D.C. 20005, or telephone 202-682-6174.

PSRB EPR ENTRY

0028 05/04/01 11:08 (54MF) ** PAGE 01 **

REUR 0027 LEDS
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*** NOT A WARRANT ***
PSYC SECURITY REVIEW BD-COND'L RELEASE (BASED ON LNU)
EPR OR026035C NAM/A_____ ,J_____ L.___ .M.W. .05-09-1960
HGT/508 WGT/145 EYE/BLU HAI/BRO
OCA/82-515
FBI/_____ SID/_____ SOC/_____
OLN/ .OR.2000
OFF/1399 OFN/ATT ASSAULT I RTP/PCR DOE/03-26-2008
MIS/---NOTIFY PRB OF ALL INQUIRIES BY AM MSG---OR CALL LOCAL MENTAL HEALTH
WORKER L____ C_____ AT 541-7__-2___ X592
ENT: 09-25-1998 AT 1625 FROM MF BY/PSYC SECURITY REVIEW BOARD (PRB)
UPD: 04-27-2001 AT 1008 FROM PRB1
LNU/W093003945

-- IF ENFORCEMENT ACTION IS TAKEN AGAINST THIS PERSON SEND A MESSAGE TO 'PRB'

** NO MORE PAGES **

PSRB ORDER OF REVOCATION (EIP ENTRY) - RESPONSE TO WARRANTS CHECK

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0014 05/04/01 10:47  (54MF)    ** PAGE 01 **

REUR  0013  LEDS
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NO CRIMINAL WARRANT

PSYCHIATRIC SECURITY REVIEW BOARD ORDER FOR MANDATORY RETURN TO
OREGON STATE HOSPITAL.  AUTHORITY ORS 161.336 (5)

 (BASED ON DOB,NAM)
EIP  OR026035C   NAM/TEST,PSRB                        .F.W.OR.01-01-1940
 HGT/600  WGT/200  EYE/BRO  HAI/BRO
 OCA/01-TEST
 DOR/05-07-2001 RTP/PRB
 MIS/TEST ØNLY--HIT CØNFIRMATIØN 503-945-2800--TAKE TØ ØREGØN STATE HØSPITAL
    2600 CENTER ST NE SALEM
 ENT: 05-04-2001 AT 1045 FROM PRB1  BY/PSYC SECURITY REVIEW BØARD (PRB)
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PSRB MESSAGE SENT TO LAW ENFORCEMENT DISPATCH

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0022 PRB  OR026035C 05/04/01 10:55 (54MF)
OR PSYCHIATRIC RV BD


THE PSYCHIATRIC SECURITY REVIEW BOARD HAS ISSUED AN ORDER OF REVOCATION
AS FOLLOWS:

PSYCHIATRIC SECURITY REVIEW BOARD ORDER FOR MANDATORY RETURN TO
OREGON STATE HOSPITAL.  AUTHORITY ORS 161.336 (5)

 (BASED ON LNU)
EIP  OR026035C   NAM/TEST,PSRB                        .F.W.OR.01-01-1940
 HGT/600  WGT/200  EYE/BRO  HAI/BRO
 OCA/01-TEST
 DOR/05-07-2001 RTP/PRB
 MIS/TEST ØNLY--HIT CØNFIRMATIØN 503-945-2800--TAKE TØ ØREGØN STATE HØSPITAL
    2600 CENTER ST NE SALEM
 ENT: 05-04-2001 AT 1045 FROM PRB1  BY/PSYC SECURITY REVIEW BØARD (PRB)
LNU/W033426754

PLEASE ATTEMPT TO TAKE THE SUBJECT INTO CUSTODY AT 123 S.E. FOURTH, PORTLAND,
THE FOURTH STREET GROUP HOME.  THE STAFF TELEPHONE NUMBER AT THE GROUP HOME
IS 503-222-3333.  THE SUBJECT'S MENTAL HEALTH CASE MANAGER AT NETWORK IS
JOHN DOE (503-111-5555).  THE SUBJECT MUST BE TRANSPORTED TO OREGON STATE
HOSPITAL, 2600 CENTER ST NE, SALEM, PER THE ABOVE ENTRY.

MARY CLAIRE BUCKLEY
PSYCHIATRIC SECURITY REVIEW BOARD
503-229-5596 (8AM-5PM WEEKDAYS) -- FOR AFTER HOURS HIT CONFIRMATION CALL
                                   OREGON STATE HOSPITAL AT 503-945-2800

EOT *** *** ***
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Oregon
John A. Kitzhaber, M.D., Governor

Psychiatric Security Review Board
620 SW Fifth, Suite 907
Portland, OR 97204
(503) 229-5596
FAX (503) 229-5085
E-mail psrb@OregonVOS.net

HISTORY AND FUNCTIONING

OF THE

PSYCHIATRIC SECURITY REVIEW BOARD

I. Oregon's "Not Guilty by Reason of Insanity" Defense prior to the Psychiatric Security Review Board

A. Prior to 1971 Legislature:

A person who pled not guilty to a crime due to mental disease or defect in Oregon (NGI-not guilty by reason of insanity), had the burden of proving by a preponderance of the evidence that he/she was unable to distinguish right from wrong as a consequence of mental disease or defect. (Modified M'Naughton Rule)

B. 1971-1975:

In 1971, the Oregon Legislature passed a new "NGI" statute which used the American Law Institute Model Penal Code (ALI) view of criminal responsibility. The accused was found not responsible if suffering from a mental disease or defect and lacking the substantial ability to understand the nature of the act or to conform the conduct to the requirements of the law. The trial court then had three alternatives: The court could commit the person found "NGI" to the Mental Health Division for care, custody and treatment at the Oregon State Hospital; the court could oversee the supervision of the person in a manner similar to court probation; or the person could be released from supervision by the court.

When the court committed the "NGI" person to the Mental Health Division, the person remained at the state hospital until such time as the superintendent recommended to the trial court that the person was ready for release. The trial court then would hold a hearing and, where appropriate, the court could release the "NGI" person subject to conditions. When release was not appropriate, the court issued a new order of commitment. In no case was an "NGI" case to go longer than five years without a hearing for review.

By 1975, in response to concerns voiced by mental health professionals and trial judges, two task forces were appointed to investigate Oregon's criminal responsibility law and the impact of this law on the mental health system and the corrections system. A legislative package which became Oregon House Bill 2382 was compiled with the aim of solving some of the problems inherent in the 1971 statute.

II. 1977: Creation of the Psychiatric Security Review Board

Prior to the enactment of House Bill 2382 (ORS Chapter 161) by the 1977 Legislature, the trial court had the mandate to continue supervising "NGI" persons after sentencing. The court had neither the funds available nor adequate personnel to provide the needed supervision. Judges quickly discovered that they were unable to spend the time necessary to track "NGI" persons who were in the community, while attempting to carry a trial judge's case load. This was clearly evident by the difficulty in obtaining and locating persons under the Board's jurisdiction once the law went into effect in January, 1978.

As of January 1, 1978, supervision of all currently adjudicated "NGI" persons was transferred from the court to the Board. Insanity defense cases in which the court found the person suffered from mental disease or defect and presented a substantial danger were put under the jurisdiction of the Psychiatric Security Review Board (PSRB). The Board works cooperatively with, but independently of, the judicial and mental health systems. The Board's jurisdiction over persons using the insanity defense runs from the day of sentencing and, unless terminated early, continues for the maximum period of time the person could have been sentenced had the person been found guilty of the crime charged. Sentencing guidelines do not apply to these cases. Jurisdiction would be terminated early if the client no longer suffered from a mental disease or defect or no longer presented a substantial danger to others. An individual under the Board's jurisdiction receives credit for time served pursuant to the charge; time spent on unauthorized leave from the state hospital is added on to the jurisdictional maximum.

III. Legislative Changes to the Insanity Defense Since Inception

A. 1981 Legislation:

1. The major change to the statute was the deletion of persons from the Board who were classified solely a "danger to self."

2. Also built into the original statute was a "sunset" provision which stated that unless the Legislature in the 1981 session took affirmative action, the PSRB would cease to function on July 1, 1981, and its responsibilities and jurisdiction in insanity cases would revert to the committing judges. The Board was continued by the 1981 Legislature.

B. 1983 Legislation:

Major changes were proposed to the insanity defense and although a few were made none altered the basic functioning of the Board. The following changes were made:

1. The nomenclature was changed from "not responsible due to mental disease or defect" to "guilty except for insanity." The name change did not affect the insanity defense itself.

2. The definition of mental disease or defect in ORS 161.295(2) presently does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, and the Legislature added "nor do they include any abnormality constituting solely a personality disorder."

3. ORS 162.155(1)(d) was amended to allow for extradition of a person under the jurisdiction of the Psychiatric Security Review Board who leaves the state without authorization of the Board.

4. Jury instructions were developed on the issue of insanity.

5. The district attorney of each county would submit to the state court administrator statistical records containing information relating to the assertion and trial of mental disease or defect defenses under ORS 161.295 and 161.305.

C. 1985 Legislation:

1. A person on conditional release who leaves the state without authorization may be prosecuted for escape in the second degree. This provision expands the scope of prosecution for the crime of escape in the second degree to those persons on conditional release.

2. If it has been more than two years since a person under the Board's jurisdiction has had a hearing in which the burden of proof was on the state, then the burden shall be on the state. Thus, persons who regularly request hearings will not be penalized for exercising their statutory rights.

D. 1987 Legislation:

1. The Board members' per diem was increased to $212 with adjustments according to the executive pay plan. It is currently $283.55.

2. The timing of a revocation hearing was changed to 20 days from the date the person is returned to the custody of the Mental Health Division. It had been 20 days from the date of the revocation order.

E. 1989 Legislation:

The five-year hearing for persons in the custody of the Mental Health Division was eliminated. Persons on conditional release continue to receive this statutory hearing. Individuals in the state hospital have a statutory hearing every two years.

F. 1991 Legislation:

The time period within which the Attorney General has to review a conditional release plan drafted by hospital and community staff for those PSRB clients seeking release from the hospital was shortened from not less than 30 days to not less than 20 days prior to PSRB hearing.

G. 1993 Legislation:

Sex offender registration requirements were expanded to include persons found guilty except for insanity of certain enumerated sex offenses. When a Psychiatric Security Review Board client is discharged or placed on conditional release, Board staff shall enter the person's name and description, the description of the methodology of the offense and the address where the person expects to reside into the Law Enforcement Data System (LEDS).

H. 1995 Legislation:

The time period within which a person found guilty except for insanity may file a notice of appeal of the trial court's determination was extended from 30 days to 90 days after the order is entered in the register.

I. 2001 Legislation:

The timing of the transport by local law enforcement of a revoked PSRB client to Oregon State Hospital in Salem was changed from "immediate" to "as soon as practicable" when the revocation of conditional release is initiated by a designated authority other than the Board at night or on a weekend. This amendment brings the particular subsection into conformity with the timing statutorily mandated when the revocation is initiated by the Board.

IV. Functioning of the Psychiatric Security Review Board

A. Membership of Board and Staff:

By statute, the membership of the PSRB consists of a psychiatrist and a psychologist experienced in the criminal justice system, an experienced parole and probation officer, an attorney experienced in criminal trial practice, and a member of the general public. The five Board positions are appointed by the governor and confirmed by the Senate for four-year terms. A chair is elected for a one-year term.

The Board's staff consists of an Executive Director, two administrative assistants and a secretary. The Executive Director oversees the day-to-day operations of the staff, including the monitoring of PSRB clients on conditional release, preparing orders resulting from Board hearings and affidavits and orders for revocation of conditional release. Preparation and presentation of the budget and legislative matters are performed by the director. She serves as agency spokesperson, maintaining a professional dialogue with persons in the mental health and corrections systems.

B. Board Hearings:

When the Board conducts a hearing, the person appearing before the Board has the right to be represented by an attorney. If the person cannot afford counsel, an attorney will be appointed. Currently, there is an attorney under contract with the State Court Administrator's Office to handle these cases as most persons under the Board's jurisdiction are indigent. After hearing testimony and reviewing exhibits, the Board must determine by a preponderance of the evidence whether or not the person continues to be affected by a mental disease or defect and whether the person presents a substantial danger to others. The Board also considers whether the person is appropriate for conditional release and whether an adequate and verified conditional release plan is available.

The Board meets in panels of three on a weekly basis. Prior to the hearing day, voluminous exhibit files are sent to panel members for review. There are generally eight to twelve cases set per hearing day, which take an average of 30 minutes per hearing. In addition, the Board considers an average of four administrative matters. A typical day will include several initial hearings of new patients, several patient requests for discharge or conditional release, a revocation hearing and perhaps an outpatient supervisor or hospital request for hearing. There are also mandatory two- and five-year hearings.

C. Commitment and Timing of Hearings:

If the record and testimony sustain findings that the person continues to be affected by a mental disease or defect and presents a substantial danger to others the person is committed to a state hospital designated by the Mental Health Division for care, custody and treatment. If a client can be adequately controlled and treated and there is a

placement available, the client can be conditionally released to the community. After the initial hearing, which must be held within 90 days of hospitalization, the person may petition for release every six months. Board staff then has sixty days to schedule the hearing. Hospital staff may petition for a hearing request for discharge or conditional release at any time.

D. **Conditional Release and Revocation**:

When release is appropriate and a verified plan is approved by the Board, the person is ordered released from the state hospital subject to the Board's specific conditions. These Board conditions include:

1. An appropriate housing situation;

2. Mental health treatment and supervision;

3. The designation of a person who agrees to report monthly to the Board concerning the released person's progress and who also agrees to notify the Board's director immediately of any violations of the release conditions; and

4. Any other special conditions such as taking of Antabuse, abstaining from alcohol and drugs, or submitting to random drug screen tests.

Once the Board staff receives information indicating a violation of the conditional release plan or change in mental status, the chairperson or a member of the Board reviews the record and recommends revocation. In the case of an extreme emergency, the executive director may execute a revocation, verifying it with a Board member within 72 hours. A revocation consists of a "warrant" which orders the person's release revoked and further orders any peace officer within the state to serve the warrant and transport the person back to the Forensic Psychiatric Programs at Oregon State Hospital. Pursuant to ORS 161.336(5), the Board then conducts a due process hearing within 20 days of the person's return to the custody of the Mental Health Division. At the hearing the Board makes findings on the appropriateness of the revocation and whether conditional release should be continued after hearing the testimony of psychiatric experts and considering all of the evidence on the record.

Typical reasons for a revocation include: discontinuance of medications, failure to come in for mental health appointments, experiencing an uncontrollable change in mental health status, use of nonprescribed drugs or alcohol.

E. **Appeals**:

When the person believes that the court erred in placing the person under the jurisdiction of the Board, the person may appeal from the court's order within 90 days of the court's entering of the judgment order. The court's judgment order is a "final" order for purposes of appeal.

A person under the jurisdiction of the Board may also petition the Court of Appeals for judicial review of the Board's findings within 60 days of the entering of the Board's order following a hearing.

F. **Cost**:

The Psychiatric Security Review Board is a State agency and the Legislature funds both the functioning of the Board and the funding of the mental health treatment and supervision of the patients in the community. The cost of the Oregon system involves a budget for the 2001-03 biennium of $738,229 for Board functioning, hearings and staff.

The 2001-03 biennium legislative allotment for community treatment and supervision of PSRB patients on conditional release is approximately $3.1 million.

G. **Statistics**:

The Board is required by statute to maintain extensive records on each patient. Currently the Board has approximately 580 clients; 238 individuals reside in the community on conditional release. Close to 85% of the Board's clients are male. Seventy-five percent of placements under the Board are for felonies; primarily assaults and burglaries.

V. Summary

The Psychiatric Security Review Board has been the focus of international attention and study. An NBC white paper on "Crime and Insanity" shown on television in April 1983 focused on Oregon as a model system. In addition, the American Psychiatric Association statement on the insanity defense in December 1983 recommends the model system presently in operation in the State of Oregon under the aegis of the Psychiatric Security Review Board. The APA was impressed that:

> *Confinement and release decisions for acquittals are made by an experienced body that is not naive about the nature of violent behavior committed by mental patients and that allows a quasi-criminal approach for managing such persons. Psychiatrists participate in the work of the Oregon Board, but they do not have primary responsibility. The Association believes that this is as it should be since*

the decision to confine and release persons who have done violence to society involves more than psychiatric considerations. The interest of society, the interest of the criminal justice system and the interest of those who have been or might be victimized by violence must also be addressed in confinement and release decisions.

A report of the National Commission on the Insanity Defense issued in March 1983 and entitled "Myths and Realities", sponsored by the National Mental Health Association, recommends the adoption of a special statute to address the disposition of the acquittees after a finding of not responsible by reason of insanity of a violent crime. In that report, the National Commission also discusses the Oregon code creating the Psychiatric Security Review Board.

In 1989 the National Alliance for the Mentally Ill set goals and priorities which included the passing of statutes which provide improved systems for insanity acquittees, citing the Oregon Psychiatric Security Review Board as a model for such a statute.

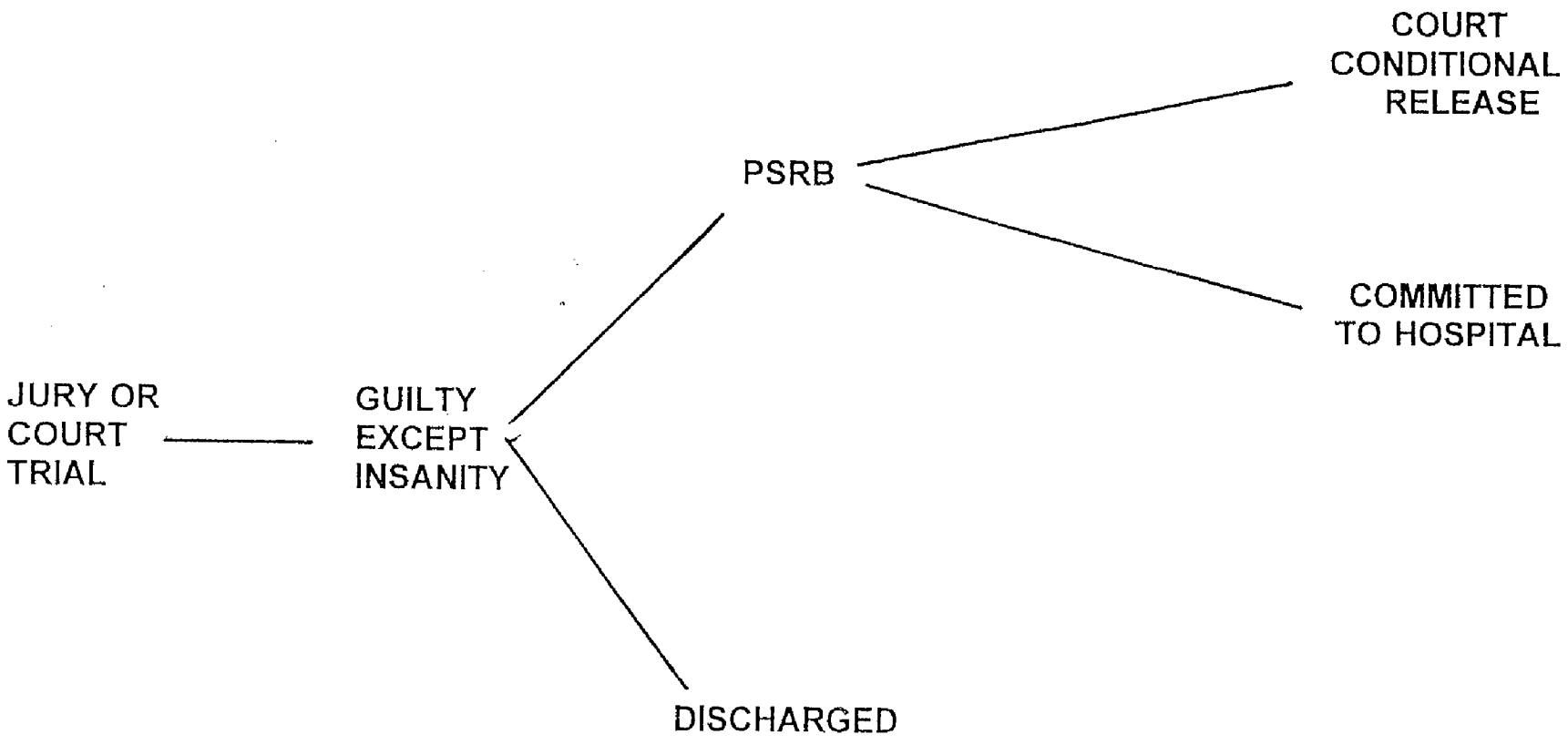
Most recently, the Psychiatric Security Review Board was named the APA's Hospital and Community Psychiatry's 1994 Gold Achievement Award winner. The award was given in recognition of the program's commitment to improved integration of mental health services within the criminal justice system and its responsibility to individual, community and societal values.

Oregon remains one of the states currently in the forefront of legal process in this area. Connecticut and Arizona have adopted the Oregon model. Other states, including Florida, Kentucky, Michigan, New Hampshire, and South Carolina have expressed an interest in this successful approach.

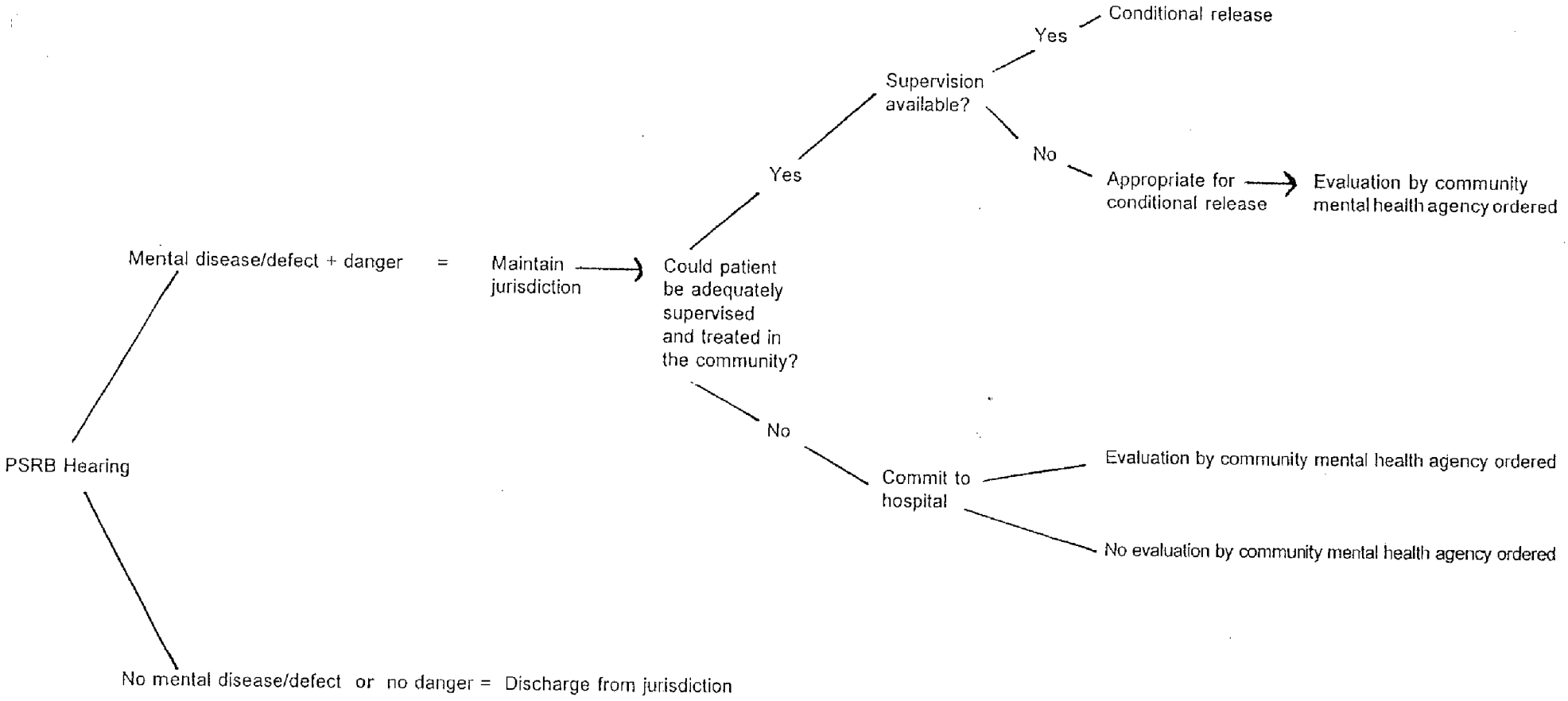
The insanity defense population will continue to be a part of our society. Oregon has chosen a unique approach by creating the Psychiatric Security Review Board which offers a multidisciplinary way of decision making. The Board's primary concern by statute is the protection of society. The system works well because of the ability of the Board to respond quickly to community emergencies and because the system balances the public's concern for safety, the treatment of persons in the community and the rights of the patients.

REVISED 10/01

COURT PROCESS - GUILTY EXCEPT INSANITY



PSRB HEARINGS PROCESS



Commitment to hospital - no further action until patient's next hearing
Evaluation - community mental health agency interviews patient to determine willingness to supervise
Appropriate for conditional release - could be adequately controlled and treated but need to put plan together
Conditional release - released to live in the community under close supervision

ORS 161.336(6)

The community mental health and developmental disabilities program director, the director of the facility providing treatment to a person on conditional release, any peace officer or any person responsible for the supervision of a person on conditional release may take a person on conditional release into custody or request that the person be taken into custody if there is reasonable cause to believe the person is a substantial danger to others because of mental disease or defect and that the person is in need of immediate care, custody or treatment. Any person taken into custody pursuant to this subsection shall immediately be transported to a state hospital designated by the Mental Health and Developmental Disability Services Division. A person taken into custody under this subsection shall have the same rights as any person appearing before the board pursuant to ORS 161.346.

Portland Police Bureau

Crisis Intervention Team

Instruction Manual

CIT Mission Statement:

"The mission of the Crisis Intervention Team is to use understanding and skills gained through specific training to identify and provide the most effective and compassionate response possible to police situations involving people in a mental health crisis."

Crisis Intervention Training

Day:	Monday Nov. 26th	Tuesday Nov. 27th	Wednesday Nov. 28th	Thursday Nov. 29th	Friday Nov. 30th
Location:	*Portland Adv./ Amp. D*	*Portland Adv./ Amp. C*	*Off Site*	*Portland Adv./ EdCenter. A*	*Portland Adv./ EdCenter. A*
0800-0900	Class Introduction	Review/ Civil Commitment,	Site Visits	Review/ MR/DD	Culture Panel
0900-1000	Childhood Disorders	P.S.R.B., and Consumer Rights	Site Visits	MR/DD	Scenarios
1000-1100	Overview of Mental Illness	Overview of M.H. System	Site Visits	Mental Status Exam	Scenarios
1100-1200	Overview of Mental Illness	Aging Services	Site Visits	BPLS/Violence Curve	Scenarios
1200-1300	Lunch	Lunch	Lunch	Lunch	Lunch-Move to SE Precinct
1300-1400	Overview of Mental Illness	Personality Disorders	Site Visits	Suicide Intervention	Officer Scenarios
1400-1500	"Voices"	Personality Disorders	Site Visits	Crisis Intervention	Officer Scenarios
1500-1600	Modeling Mental Illness	P.T.S.D.	Site Visits	Crisis Intervention	Officer Scenarios
1600-1700	Family and Consumer Panel	Alcohol & Drugs	Site Visits	Crisis Intervention	Graduation

Training will take place at Portland Adventist Hospital in the listed rooms. Except for Friday afternoon, when we will move to Southeast Precinct's Community Room to complete the training.

November 28, 2001:
Site Visitation Schedule

Time	Group A	Group B	Group C	Group D
0800-0900	Rennisance/ Clinic	Rennisance/Clinic	Ryles Center	Ryles Center
0920-1020	Ryles Center	Ryles Center	Rennisance/Clinic	Rennisance/Clinic
1040-1140	Faulkner Place	Port City	Comet Club	Hooper Detox
1140-1300	Lunch & Travel	Lunch & Travel	Lunch & Travel	Lunch & Travel
1300-1400	Port City	Royal Palm Hotel	Hooper Detox	New Mezz Connection
1420-1520	Bridgeview	Rainbow Adult Living	MCDC	MCDC
1540-1700	MCDC	MCDC	Bridgeview	Faulkner Place

Bridgeview: 707 NW Everett. Contact: Erin Fisher (Ph. 222-4906)

Comet Club: 5507 N. Lombard. Contact: Jessica Turner (Ph. 285-9871 ext. 315)

Faulkner Place: 13317 SE Powell Contact: Alan Wood (Ph. 760-9606)

Hooper Memorial Detox: 20 NE MLK Jr. Blvd. Contact: Jeanne Rivers (Ph. 238-2067)

MCDC: Meet in the Main Lobby, Contact: Kathy McCullough (Ph. 988-5230)

New Mezz Connection: 1122 SW Stark. (Enter through metal gate, then double glass doors, then into Day Treatment Center) Contact: Lorraine Vitkauskas (Ph. 552-5125)

Port City: 1847 E. Burnside. Contact: Brenda or Judy (Ph. 236-9515)

Rainbow Adult Living: 3701 SE Belmont. Contact: Greg Ruff (Ph. 231-1608)

Rennisance / Network Walk-in Clinic:

Royal Palm Hotel: 310 NW Flanders. Contact: Robin Hochtritt (Ph. 827-3949)

Ryles Center: 3339 SE Division. Contact: Kay Endres (Ph. 238-1477)

If you are going to meet with Greg Ruf at Rainbow Adult Living Center: Go to 510 SE 29th!

Section 1 - MENTAL ILLNESS

- Assessment
- Organic Mental Illness
- Mood Disorders
- PTSD
- Alcohol and Drugs
- Personality Disorders

ASSESSMENT MODEL

RECOGNIZING PERSONS WITH MENTAL ILLNESS

The purpose of this activity is to provide officers with guidelines for identifying mentally ill persons. Emphasize that officers only have to be capable of identifying major behaviors indicative of a mental illness; they do not have to identify specific types of mental disorders. That is the function of a mental health professional. Whereas mental health professionals determine the type and severity of illness, officers only have to make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder.

Discussion Points

1. Generally, what is known about people with mental illnesses?

   - Depending on the severity of the disorder, mentally ill persons can be difficult to distinguish from persons not having a mental disorder.
   - Persons with a mental illness can be quite intelligent, perceptive, and articulate.
   - They can be employed and maintain familial relationships.
   - With the onset of their disorder, however, they become unable to deal realistically with the world.
   - Their thoughts and actions are not based on reality.
   - Their ability to think clearly is impaired.

2. What are the general characteristics that indicate a mental illness?

   - The behavior and mood of the person are inappropriate to the setting.
   - The behavior of the person tends to be inflexible.
   - The behavior of the person tends to be impulsive.

3. What are specific indicators of mental illness?

   - Sudden changes in lifestyle

     -can be both a cause and indicator of mental illness
     -involves an inability or unwillingness to fulfill one's expected role and responsibilities.

   - Major changes in behavior

     -behavior may have undergone sudden and drastic change
     -behavior may be marked by exaggerated mood swings
     -person may show lack of judgment regarding family, job, money, or property
     -person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic or fright

  -anxiety is intense and unfounded
  -person is in a state of panic or fright
  -person may have trembling hands, dry mouth, or sweaty palms
  -person may be "frozen" with fear

- Believes others are plotting against him

  -person has an unreal fear of being watched, talked about, followed, persecuted, or harmed (e.g. a large man believing a frail, elderly woman is trying to strangle him)
  -person cannot separate reality and imagination

- Hallucinations

  -person experience events that have no objective source, but that are nonetheless real to him or her
  -most common hallucinations are seeing or hearing things, but can involve any of the senses, such as:

    feel - most commonly of bugs crawling on the body
    smell - often of gas associated with death plots
    taste - usually of poisons in food
    hearing - voices telling the person to do something
    sight - visions of God, the dead, or horrible things.

  -hallucinations can also be induced by drug or alcohol abuse

- Delusions

  -personal beliefs that are not based on reality
  -can cause the person to view the world from a unique or peculiar perspective
  -often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person beliefs he or she is God, a saint, a famous person, or possesses a special talent or beauty)

- Depression

  -accompanies many mental disorders in varying degrees
  -often characterized by a persistent, general malaise
  -serious depression can involve withdrawal from family, job, and social involvement.

- Obsessions

  -recurrent thoughts, ideas, or images that the person cannot dismiss from mind
  usually involve behavior that the person finds unacceptable (e.g. a woman may believe

that every man she encounters is trying to seduce her)
-can cause tension and high level of anxiety

- Unexplained losses of memory

-not the normal forgetting of everyday things, but failing to remember the day, year, where one is, etc.
-not to be confused with loss of memory that often accompanies aging

- Confusion

-inability to focus on particular topic or interaction
-might be an indication that person has an obsession
-also caused by stroke, diabetic coma, intoxication, senility

- Impossible body ailments

-at first, symptoms are mild and may even fool doctors
-common beliefs are a body part growing, heart stopped, or chest filling with food

- Persons who suffer from mental illness must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are uncomfortable or annoying. Unlike hallucinations, these side effects are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize the presence of the side effects. Some of the major noticeable side effects include:

-minor stiffness, a rigid shuffling gait
-an at rest, hand jerk
-acute muscle spasms, tilted head
-a constant, fine, fast tremor
-blurry vision
-rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or-in severe cases-facial distortion

B

Basic

P

Psychiatric

L

Life

S

Support

Portland
Police Version

1. Goal

This summary is intended to provide police and other justice professionals with a basic outline of techniques for dealing with patients suffering from acute psychiatric disturbances. The emphasis is on an initial approach, urgent or emergent evaluation, and basics of intervention.

2. Introduction

Dealing with patients suffering from psychiatric disorders is often perceived as frightening by those infrequently exposed to these problems. The area of psychiatry itself may seem foreign for several reasons:

Psychiatry deals with biopsychosocial issues (1) that typically straddle multiple areas:

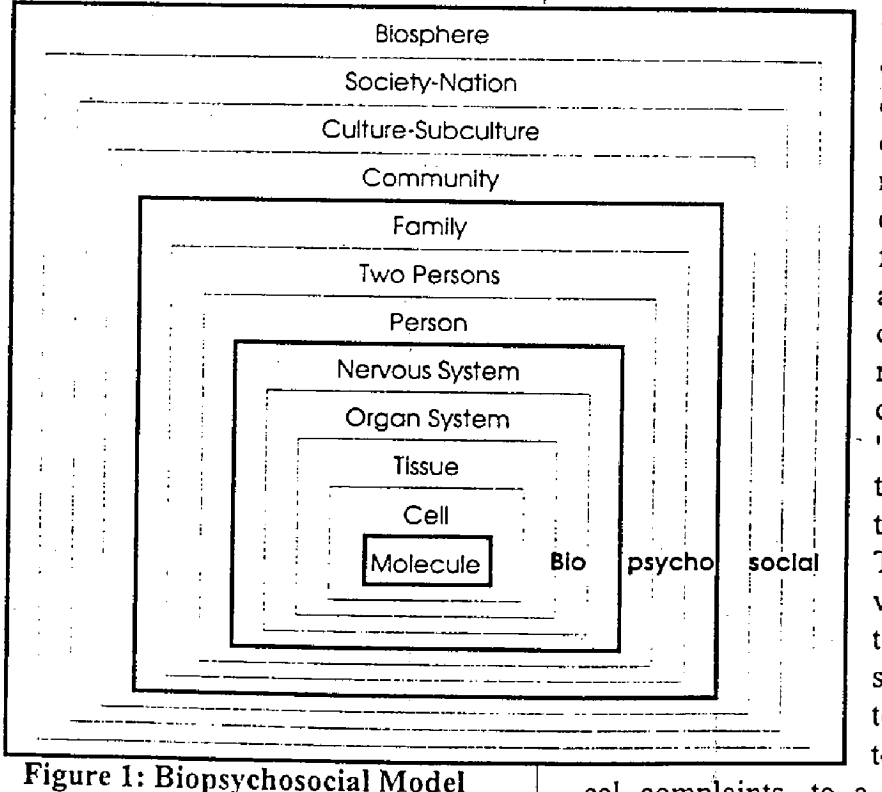


Figure 1: Biopsychosocial Model

There is no clear boundary between actions based on personal choice, social difficulties, psychological distress, or on a clearly biological disease. Multiple factors simultaneously influence the ultimate actions of an individual. Identifying and treating mental illness is complex, requires time, and may make the field appear diffuse and unclear.

Additionally, "gold standard tests" which would allow certain attribution of specific signs and symptoms to a specific disorder are generally not available. There is no X-Ray or blood test for bipolar disorder, for example. If a patient has signs of several disorders, multiple diagnoses must be considered, and frequently multiple diagnoses must be given. This may make the professionals operating in the field seem divided and without focus.

Finally, patients with psychiatric conditions often contact nonpsychiatric care providers first. They may adapt their complaints to match the specialty or "language" of the professional they are seeing. Thus, patients with similar ultimate diagnoses may present to a family doctor with physical complaints, to a mental health

professional with mental health complaints (2) (and likely to peace officers with safety concerns). Knowledge of mental illness can help the professional direct the patient safely into appropriate evaluation and treatment.

Top priority must be the professional's immediate physical safety.

The Basic Psychiatric Life Support model presented here is an attempt present the area of acute psychiatric practice in a way that is reductionistic, yet robust. The approach is generally algorithmic, similar to the Basic Cardiac Life Support course (3), which has brought emergency medical thinking to a broad audience. The structure of the algorithms here is determined by several factors which can be subsumed under the term "priority":

Severity: How bad is the disorder/injury?
Urgency: How fast must a response occur to be effective?
Remediability: How much difference will any response make?
Sequence: Does one step require a prior step?
Natural History: Balancing low frequency events with high morbidity against high frequency events with low morbidity.

3. Initial Triage

Even when it is clear that the appropriate or desired intervention is a psychiatric evaluation and/or treatment, attention must be given to its priority. (It is understood that here we are generally talking about noncatastrophic conditions in which the clinician has some realistic choices about how to proceed.)

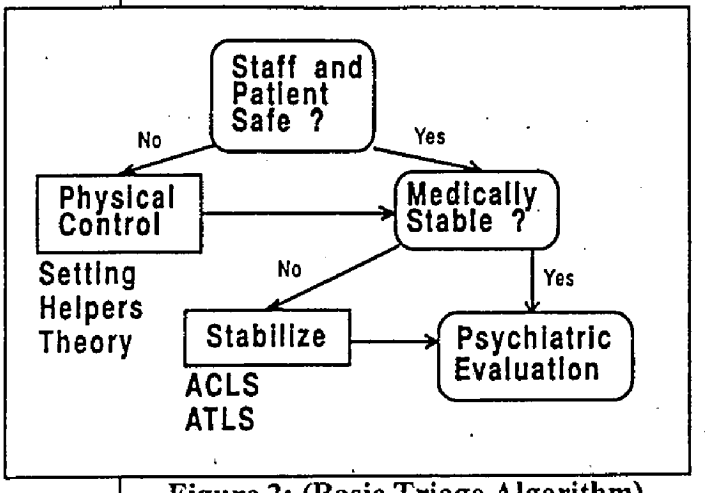


Figure 2: (Basic Triage Algorithm)

Top priority must be the clinician's immediate physical safety. What good can an injured or dead helper be? (Second priority is then the patient's own immediate physical safety.) If the clinician and patient are not physically safe, such safety must be provided for. Secondly, the patient must be medically stable to undergo psychiatric evaluation. If such medical stability is in question, immediate steps must be taken (after assuring physical safety) to intervene on this level. It is then the third priority to begin with a psychiatric evaluation, which will include the evaluation for suicide or homicide potential.

Also, attention must be given to the fact that a crisis represents the perception of an event or situation as intolerable, as an intolerable difficulty that exceeds the resources and coping mechanisms of the person defining the crisis. Such a concept must not be confused with that of an emergency,

which represents a sudden (and often distressing) event that may lead to serious psychological or physical consequences if there is no adequate response. This distinction is difficult, and at times one will need to proceed under the assumption of an emergency, even when it may ultimately prove that the problem is better identified as a crisis.

4. Physical Safety

That it is top priority to evaluate the potential of immediate harm to the professional and secondarily the patient comes as no surprise to police officers. This is their daily concern. We are looking for such basics as absence of weapons, a secure physical environment, and a patient that is reasonably able to modulate their behavior. The goal is to establish short term safety.

In essence, the concern is to identify and remain prepared for potential immediate violence, which represents a relatively rare event, but one with significant potential for injury or even death (4,5). It follows that attention must be given to issues of safety before they are needed. Protocols must be clear and well rehearsed.

4.1 Strategies:
To briefly review, the controllable variables can be grouped into three main categories: physical setting, personnel, and a theoretical model to guide the approach. Police safety techniques discuss these areas in detail, so here we will only list some areas of emphasis in the psychiatric arena for comparison.

4.1.1 Physical setting:
Structural requirements include the absence of dangerous or potentially dangerous objects, ideally access from multiple directions, monitoring and emergency communication systems, some provisions for confidentiality, and the opportunity to physically restrain a patient.

Each setting that the professional will work in should be rapidly reviewed a "worst case scenario" considerations in mind and steps should be taken to ensure as much safety in these settings as possible.

4.1.2 Personnel:
Just as the physical surroundings deserve attention, the professional must be completely aware of the help that is going to be available in an emergency. Specifically mental health trained, 24 hours per day, capability would be ideal. Such personnel should have an understanding of the medical model of overwhelming force. Police techniques that rely on verbal instructions or combative techniques (including pain holds) designed for persons with intact mental functioning can lead to difficulties. Patient injuries can occur in instances where the patient is incapable of understanding the purpose and context of police interventions due to a medical or psychiatric disorder. (See particularly the section on psychotic disorders.)

Medical (or paramedic) backup as well as collaboration with mental health professionals or outreach teams that might have some prior experience with the patient can also be very helpful. Such collaboration, however, re-

If physical restraint is used, sufficient help should be available to safely overwhelm the patient.

quires careful prior planning so that management at the scene of an incident can proceed smoothly.

Estimating the patient's control and deciding when the professional must assume control is key.

4.1.3 Theoretical Model:
Attempts at verbal intervention generally precede physical restraint. A clear model to decide when to switch modalities is necessary. One such model is presented here for comparison. It is intended as an ever-present scheme in the background of the evaluator's mind, while carrying out other tasks such as obtaining a history and performing a physical and/or mental status examination. It is again intended as an example only:

Patient's Response:	Staff Intervention:	My Response:
Aggression	Physical control	Fear
Hostility	Pseudochoice ("If...then...")	Anger
Anger	Real choices (Must be acceptable)	Anxiety
Anxiety	Support Encourage Ventilate Reassure "Extras"	Calm

Figure 3: (Interaction Grid) (Adapted from: (6))

The figure represents an interaction grid: three segments (columns) are subdivided into four corresponding levels (rows) of interaction. The first column represents the patient's emotional response within the interaction, the third, the professional's emotional responses which are assumed to mirror the patient's. The key is that the clinician must gradually develop a sense for their own personal response to each of the patient's stages. In the column between are strategies for intervention.

Exceptions:
The model of gradual escalation through the various levels from anxious, to angry, to hostile, and ultimately to aggressive, can be obviated by a number of medical and psychiatric conditions. In particular, an organically disturbed (e.g.: intoxicated or delirious) patient may escalate abruptly from a seemingly calm or anxious state to an outright aggressive one. Similarly, psychosis, with the inherent lack of reality contact (and defining thought disorder or loose associations), may jump from one stage to the other with little or no warning. It is here that the professional's personal emotional response may be the only "early warning" that is possible. This means that in the example suggested in Figure 3, the professional entering a patient's room for the first time, finding a fear response developing abruptly, should immediately be prepared to provide for physical control and safety.

5. Medical Emergencies

In the context of the triage algorithm (figure 2), medical emergencies are considered those conditions which would require stabilization of the patient prior to a psychiatric interview.

Procedures for such interventions have generally already been established, and most professionals will be familiar with examples of them: BCLS and ACLS protocols for medical and ATLS for surgical emergencies. Vital signs should be obtained if at all possible and as early as possible. They should be considered a requirement prior to the end of any emergency psychiatric intervention. Beyond this, a brief medical history, review of systems, and physical evaluation is usually necessary to rule out immediate medical problems.

6. Basic Psychiatric Interviewing

Moving to psychiatric intervention, we can distinguish: Interview techniques, evaluation (process and content), assessment, and treatment.

Any interview consists of at least three phases, with attention to four simultaneous areas:

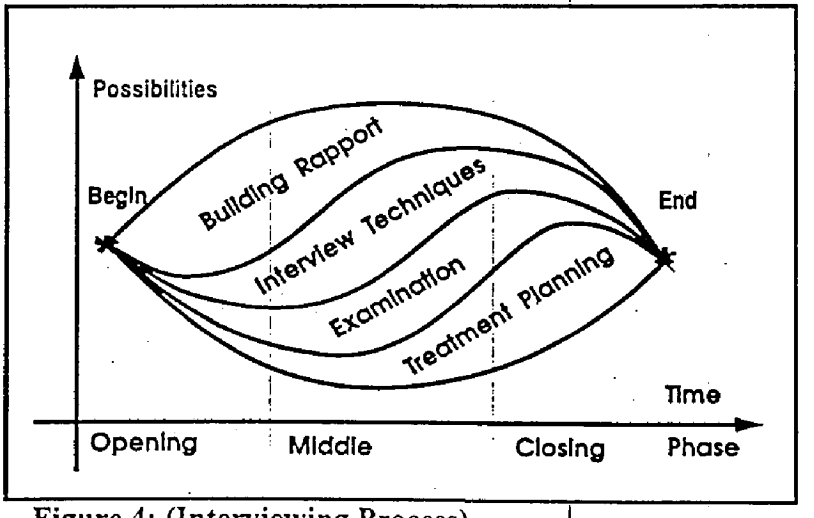


Figure 4: (Interviewing Process) (Adapted from: (7))

The beginning or opening phase of an interview emphasizes the establishment of rapport. The middle phase emphasizes the collection of information and the examination of the patient's current functioning. The closing phase emphasizes summarizing the information and communication of treatment decisions.

In the opening phase, questions will generally be open-ended, encouraging the patient to speak. Facilitative techniques, such as empathic statements, can be used to support this. In the middle phase, questions can frequently become more focused and steering techniques are used to direct the interview into content areas that are desired. Such steering techniques could be thought of as analogous to "back doors." For example, questions on the degree of depression can ultimately lead to questions of suicidality and specific suicidal plans:

„How depressed have you ever gotten?" „Have you ever been so depressed that you didn't want to live?" „Have you ever been so depressed that suicide started making sense?" „Have you ever planned or attempted suicide?" „How are things now?"

Similarly, questions about anger can lead to homicidal plans and questions regarding fear can lead to psychosis. While specific content areas need to be covered in the interview, attention to the process of the interaction will allow the professional to follow a nat-

In any interview the professionl's initial overriding concern is to develop solid rapport with the patient.

ural „flow" of the conversation. Additional steering techniques can help when necessary topics don't come up naturally: „Now that we've talked about you, let's talk a little about your family." In the closing phase, the clinician may summarize and be speaking more (though frequently checking with the patient to be sure of understanding). The ultimate outcome of a successful interview should be an agreement about the next steps to be taken in a treatment plan.

Knowing the relative importance of historical information can lead the interview.

7. Psychiatric Evaluation

The content of the evaluation generally includes a longitudinal (over time) component, the history, and a cross sectional (here and now) examination, typically, the mental status examination. This information leads to a diagnostic impression, which then guides the intervention strategy. While in an ideal case a relatively extensive history and thorough mental status examination will be obtained, the urgency of the moment may reduce this to current history with core mental status questions. Ultimately with a minimally cooperative patient, focus of the history should be to elicit a chief complaint and of the mental status examination to ask orientation questions.

7.1. Psychiatric History:

The history is usually obtained from the patient, though frequently outside corroborative information is needed. Generally this is done with, in emergencies without, the patient's permission. Depending on the urgency of the problem, intervention may need to occur before this information is complete or available. Obviously, no final disposition is possible until all of the information has been obtained and thoroughly considered.

The content is quite similar to that obtained in other areas of medicine. (In the following table(s) the asterisks identify the relative level of importance of the item). In emergencies, one would fall back on the most important items, clarifying these first.

Identifying Information
Chief Complaint (Suicide/Homicide?) ***
History of the Current Situation:**
Course Over Time**
Palliative and Provocative Factors
Review of Systems
Current Medications**
Current Drug Use Pattern**
Past Medical History*
Past Psychiatric History:
Hospital Admissions*
Biomedical Treatments (Medications)**
Suicide (Homicide) Attempts**
Past Alcohol and Drug Use*
Family History:
Genetic Risk Factors
Developmental History:
Family "Roles"
Defensive Mechanisms
Social History:
Current Level of Functioning
Prior Level of Functioning
Support System*

Table 1: History content

7.2. Mental Status Examination:

The mental status examination is intended to provide a cross sectional view of the patient's mental functioning at the current instant in time. It is a formalized method of obtaining and recording information on the higher cortical functions of the patient. To facilitate recall, four general areas can

be delineated: (Examples to serve as mnemonic devices are added in parentheses, and asterisks again denote the relative importance.)

1. General Inspection:
(Overview: "How does the patient look?")

Appearance: (Describing a "photograph") Height, weight, dress, grooming, etc.

Motor Behavior: (Describing the „silent movie") Movements, tics and mannerisms, level of activity, etc.

Speech: (Adding the "sound track") Rate, pressure, intonation, articulation, etc.

Attitude: (Putting it all together) Changes, relatedness with the interviewer, etc.

2. Emotions ("How does the patient feel?")

Mood: (The "climate") Depressed, happy, sad, irritable, etc. The patient describes the mood themselves. Their report will relate to a more extended period of time than the interviewer alone will have been able to observe.

Affect: (The "weather") Type: tearful, angry, etc.; Range: broad, full, narrow, flat, etc.; Stability: Labile, stable, etc. The interviewer attempts to describe the currently observed affective state of the patient in detail.

Congruence: The consistency between the observed emotions and reported mood with the context and content of the interview is observed. Loss of reality contact sometimes expresses itself here in lack of congruence.

3. Thoughts:** ("Software" analogy: "How does the patient think?")

Process:** This describes the logical flow of thoughts:

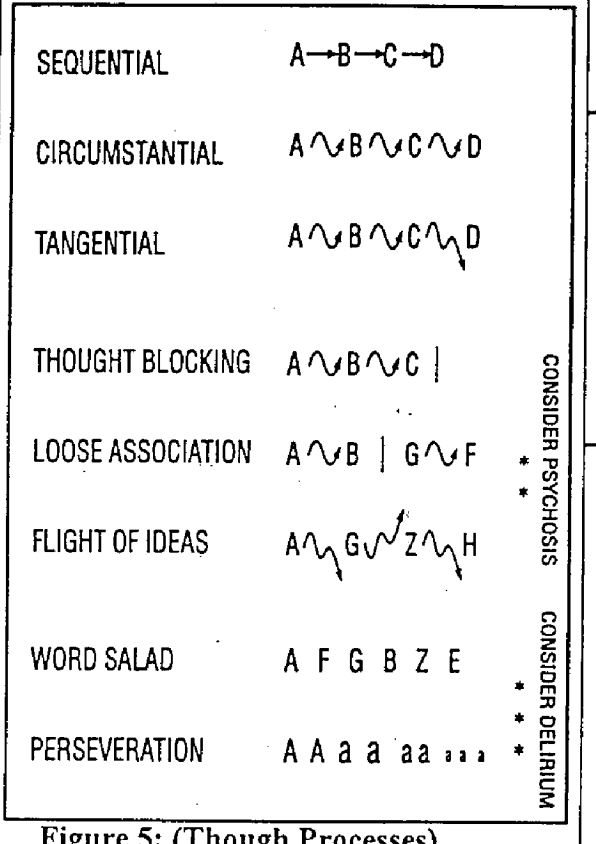


Figure 5: (Though Processes)

These can be considered to be on a spectrum from best organized to completely disorganized. On one end of the extreme, thoughts are expected to be sequential and concisely presented. At the other end of the extreme, no coherent thoughts can be discerned. There is literally word salad or perseveration. The most important stage*** is when loose associations (breaks in the logical flow) occur. They define psychosis. Tangential thinking may be dis-

When loose associations are present, consider psychosis; when there is word salad, consider delirium.

Orientation is the bedrock on which all other cognitive functions can be considered to rest.

tinguished from loose by the interviewers reaction: The thoughts: "What was my last question? How did we get onto this?" denote tangentiality. The thought: "Where did that come from?" denotes loose associations, and should be checked out. Worse disturbance generally indicates a worse disorder.

Content:** Here the thoughts themselves are grouped and unusual or important themes noted. In particular, any psychiatric interviewer will have to comment on suicidal*** or homicidal*** thoughts. These must be specifically sought out, as must be preoccupations and delusions* such as those indicating loss of reality contact, either in a non-bizarre or bizarre (completely impossible) context.

Perceptions:** How does the patient observe the world around them. Are illusions, hallucinations, auditory, visual, or tactile hallucinations**, depersonalization, derealization, ideas of reference, thought broadcasting, thought insertion, etc. present?

Using the computer analogy, thoughts can be considered to have disturbances that affect the logical order (poorly functioning program), abnormalities of content (database errors), and input errors.

4. Cognitive Evaluation*:** (Hardware analogy: "How is the machinery working?")

The following areas are all considered part of the cognitive function. In order to remember them, one might use the model of a familiar, reversible, toxic encephalopathy: alcohol intoxication. When one thinks of a person entering a bar and getting progressively intoxicated, ultimately to the point of coma, one can visualize the stages that they go through. Using this analogy, the extreme care needed to observe and document disturbances of orientation, attention, and concentration becomes clear.

Orientation: Time, place, and person.
Attention Concentration: Serial 7's, 3's, digit span, (usual is 7 digits forward, and 4 backward), spell "world" forward and backward.
Memory:
Registration: "Repeat after me"
Immediate Retention: 3 objects after 3' Recent Past: Events of the last few days Remote Past: Events several years ago
Abstraction: Ability to „get the big picture:"
Proverbs, similarities.
Intelligence: Fund of knowledge (consistent with the patient's education): vocabulary, presidents. general knowledge questions.
Judgment: Conceptualize outcomes: Stamped envelope, smoke in a theater scenarios.
Impulse Control: Ability to modulate impulses.
Insight: Awareness of illness.

Table 2: Cognitive Evaluation

The list is an attempt at such a hierarchical organization (using the above analogy) from the most severe to the least severe level of disturbance. If complete testing is not possible, it is useful to move to ever more basic cognitive tests.

8. Assessment

There are generally two parts to an assessment: 1) Organizing the information gathered in the history and mental status examination, and 2) Making a formal psychiatric diagnosis. Establishing a diagnosis may, however, be secondary to organizing the information in such a way that focuses attention on triage priorities. Broad diagnostic categories are considered first and allow stabilization and referral to more definitive evaluation and treatment. For our purposes, short range outcome is the major consideration.

Review of outcomes research shows that top priorities, which express themselves as variables affecting patient disposition, include:

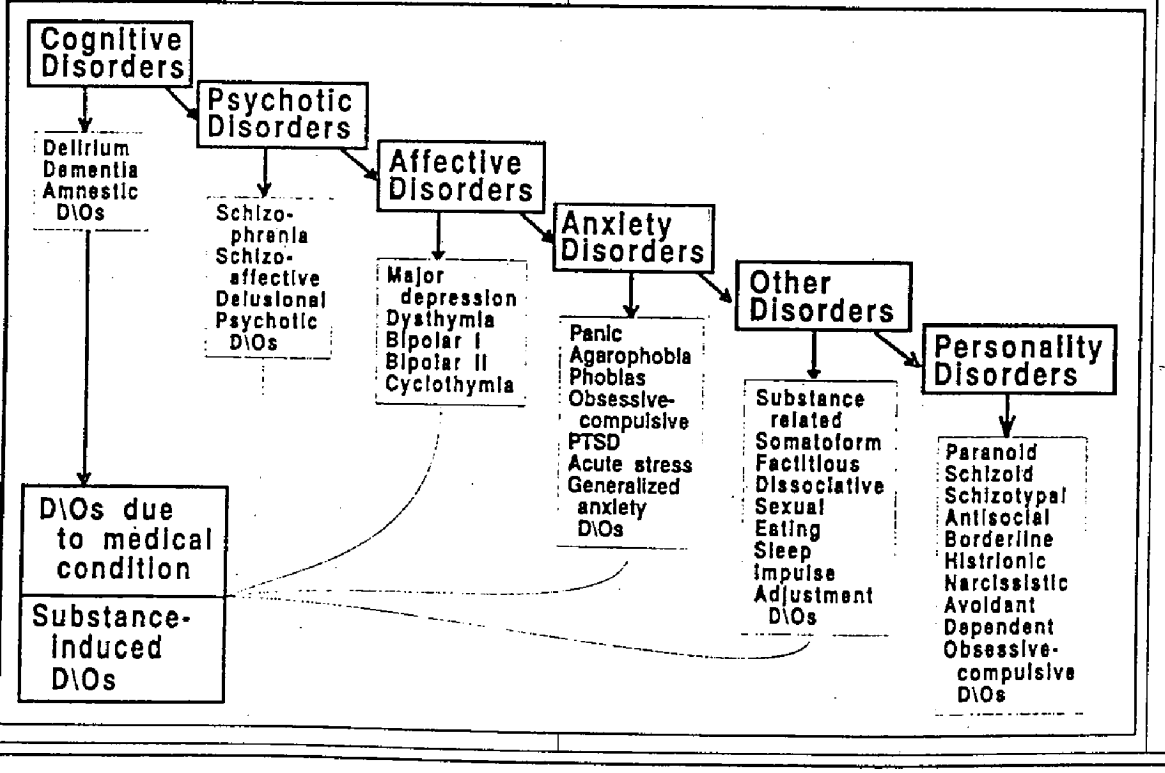
Dangerousness, prominence of symptoms (as clinical variables), clinical experience and knowledge of resources (as clinician variables), family members' support and desire for a specific outcome (as family variables), and referral source such as police, together with assessment of system options (3).

8.1 Impression:

Given the need for organization of diagnostic considerations, a clear idea about a diagnostic hierarchy is helpful. Which disorders take precedence over others? Why? Such a hierarchy is implicit in the DSM IV (8), producing a "cascade" of disorder groups. Generally, the hierarchy implies that treatment must be directed toward diagnoses higher in the model before treatment for lower priority diagnoses can be fully effective. Also, the more "biological" a disorder, the more likely it is to be found on the left; the more "psychological" a disorder, the more likely it is to be on the right.

Disorders induced by medical conditons or substances are listed with each group, but mut be considered first.

Figure 6: Differential Diagnostic Cascade



There are many medical emergency conditions that may initially present as a psychiatric disturbance.

Cognitive Disorders must be considered first. These are delirium (a medical emergency), dementia, and amnestic disorders. Problems where some outside influence causes what appears to be a psychiatric disorder are listed with each disorder group. Examples include substance intoxication, withdrawal, or medical illnesses. They must also be considered as the first priority. All of these disorders affect the brain's ability to function, and could be considered "machinery" or "hardware" problems. Treatment of these disorders will require attention to the underlying disorder. The most important is delirium***, characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention. This is heralded by disorientation and severely disorganized thought processes.

Psychotic Disorders*** must be considered next. These are illnesses. which affect the patient's ability to distinguish real from not real. They generally include major psychotic disorders such as Schizophrenia and are characterized by thought process (loosening of association or worse) or thought content (delusions) or perceptual disturbances (for example, auditory hallucinations). These can generally be considered "thinking problems." They are heralded by loose associations, delusions and or hallucinations. Treatment will usually involve the use of neuroleptics.

Affective Disorders are disorders that affect the mood. The mood may be depressed, elevated, or irritable. Major Depression and Bipolar Disorders (Manic Depressive Disorders) are the main illnesses. here. Both of these disorders can be accompanied by psychosis and when this is the case, the psychosis must be treated first. Treatments will often include medication such as antidepressants or mood stabilizers (thymoleptics).

Anxiety Disorders lead to excessive and inappropriate worry or panic. Examples include phobias, panic disorder, post traumatic stress disorder, the new acute stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. As implied by the hierarchy, removal of precipitants (such as Hyperthyroidism, psychosis or mood disorders) clearly takes precedence over symptom oriented treatment with, for example, Benzodiazepines.

Other Axis I disorder Groups follow in the diagnostic cascade.

Finally, toward the psychological side of the biopsychosocial diagnostic spectrum are Axis II Disorders:

Personality Disorders are problems with an individual's overall coping abilities. They should be considered if there is a long standing (since adolescence) pervasive (affecting all parts of an individual's life) pattern of maladaptive (causing personal distress or impairing functioning) behavior. In these patients the developmental "tool kit" might be thought of as not fully developed, frequently under the influence of traumatic disturbances in their childhood. DSM IV (8) generally distinguishes three groups: Cluster A (odd and eccentric), Cluster B (dra-

matic erratic and emotional) and Cluster C (anxious or fearful). Under stress, such individuals can display symptoms from any of the other diagnostic groups and a thorough evaluation, along with attention to the diagnostic hierarchy, is crucial prior to the diagnosis of a personality disorder. Treatment generally involves a carefully coordinated program of psychotherapeutic and social interventions. Since these conditions can mimic and coexist with many of the Axis I disorders, their identification and treatment take time and may be perceive as the most frustrating task for the professionals trying to help. Clear attention to who is responsible for what (interpersonal boundaries) is crucial to the management of these conditions.

In summary, it should be remembered that, many individuals suffer from several disorders simultaneously. One disorder does not generally exclude another, though if symptoms can be ascribed to a diagnosis further up in the hierarchy, then that diagnosis must be given. Thus, for example, a patient who is intoxicated, yet suffers from Schizophrenia, would likely show signs both of cognitive impairment and reality impairment, and would be given both diagnoses. Treatment must then also address both disorders.

8.2 Biopsychosocial Diagnosis:

In order to organize all of this information, the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) (8) has designed its multiaxial system of diagnosis. The diagnosis is recorded in five axes, whereby multiple diagnoses are encouraged when the criteria for the specific disorders are met.

Axis I: Psychiatric Clinical Syndrome ("Nature") Axis II: Personality Disorders or Traits ("Nurture") Axis III: Physical Disorders Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning (GAF Score).

Table 3: DSM IV Multiaxial System of Diagnosis

Many patient suffer from several disorders simultaneously that must all be identified.

9. Interventions

Beside the assurance of immediate physical safety outlined above, treatments will generally come in four major areas: general safety, biological treatments, psychological treatments, and social interventions.

Longer term safety issues are much more complex to evaluate. Generally the clinician is only able to identify broad groups of patients at risk for harm to self or others but cannot predict the future behavior with any reasonable certainty over more than a few hours or even days (4). One of the best and most important predictors is that of past behavior. Another key consideration is the presence of destabilizing factors such as intoxication.

9.1 Immediate Safety Interventions:

As outlined before, emergent intervention may require physical restraint. The principal behind the safe use of such restraint is overwhelming force. We cannot assume that a patient has

The clinician assumes the responsibility when there is significant danger or competence is low.

the mental capacity to recognize directions, physical cues (painful or nonpainful), and to respond appropriately. When a patient is physically restrained attention must be given to the legal framework (doctor's court hold or police officer hold, etc.). Also, the patient must then be observed very closely since this group of patients is at higher risk of having significant coexisting physical illnesses that can place them in danger, especially since the usual complaints of feeling ill may not occur. Once a professional has assumed responsibility for the patient they are responsible for the "whole" patient!

Similarly, chemical restraints can be used in some emergency conditions. Neuroleptics (Inapsine) or Benzodiazepines (Ativan) have been advocated and are often used in the medical setting.

9.2 General Safety:

Patients who present a danger to themselves or others are unable to care for themselves, or fail outpatient management, or require 24 hour observation for diagnostic assessment or ongoing round-the-clock medical treatment will require hospitalization. As long as such patients are willing to be hospitalized on a voluntary basis, there is little question as to how to proceed.

Involuntary Admission: In most states, if the patient represents a danger to himself or others due to a mental disorder, and/or is unable to care for their basic needs (grave disability), there is a process that allows emergent and urgent hospital admission on an involuntary basis. This is generally regulated in the Commitment Statutes. Difficulties arise when it is unclear how far the patient's rights of self determination go in comparison to the professional's ethical obligation to intervene in the face of a psychiatric disorder (right to competent treatment).

In this respect, a grid that plots danger against competency may be useful to the professional:

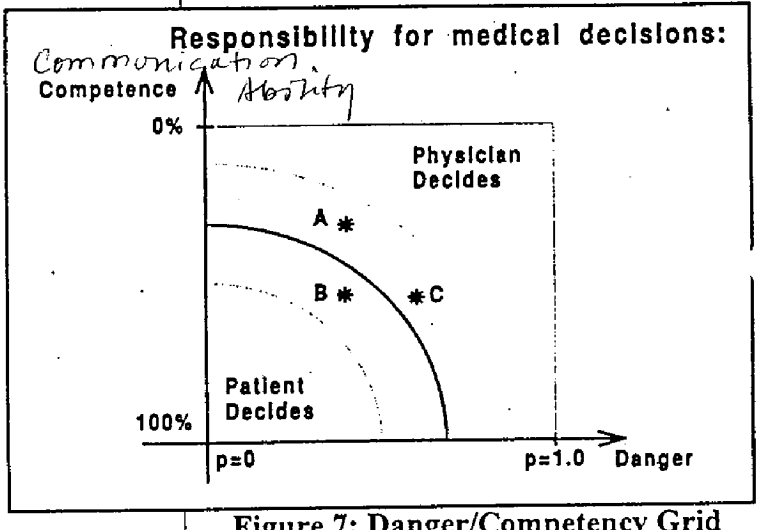


Figure 7: Danger/Competency Grid (Adapted from (10))

As outlined in this grid, competency is plotted against danger. In the lower left hand corner, patients who are in an area of low danger, yet have a high degree of competence, are clearly in charge of their treatment, irrespective of the clinician's preference. Simultaneously, patients that have either an extremely low level of competence (such as the severely disabled Alzheimer's patient wandering on the street) or are in an extreme degree of danger (such as an occluded airway)

must be treated by the clinician even against their will. Frequently, the situation is much less clear. Despite this, the law allows only for a dichotomous choice: One is asked to act as if the grid were bisected by a clean line. Nevertheless, it is quickly apparent that the gray band of mixed cases in the middle represents many cases and a significant clinical dilemma. For example, patients A, B, and C may differ only in some minor respects, yet patient A and C will be involuntarily admitted where B may not. Patient B may, for example, present with depression, suicidal ideations of several months' duration, and some poorly formulated thoughts of possibly taking an overdose. Patient C, similar in all ways, may, however, be contemplating the use of a firearm and has access to such. Clearly, patient C would require involuntary admission. Patient A, on the other hand, while in a situation just as B, may be intoxicated, lowering their level of competence. Clearly as well, here the clinician must intervene (even if only temporarily until competence is restored/intoxication resolved).

Involuntary admission in Oregon is regulated by the Oregon Revised Statutes (ORS 426). If a patient represents a danger to himself or others due to a mental disorder and is unable to agree to voluntary admission, the patient may be admitted against his/her will. The doctor's court hold (DCH) documents the belief of two licensed physicians or a physician and a qualified mental health professional that such a danger and mental illness exists. Outside of the hospital setting, the police or mental health program is needed to make such a determination. A police officer custody report (POCR) documents that a police officer has reason to believe that such danger and illness exists. A mental health program can also initiate such a police officer hold (Mental Health Director's Hold). When the mental disturbance does not rise to the level of danger but there is question about the individual's ability to care for themselves, any two interested persons may file a two party notice (TPN) with a county mental health agency. From the filing of all of these notices, a court investigation

The patient's safety for two weeks on their own may be key to deciding on potential danger.

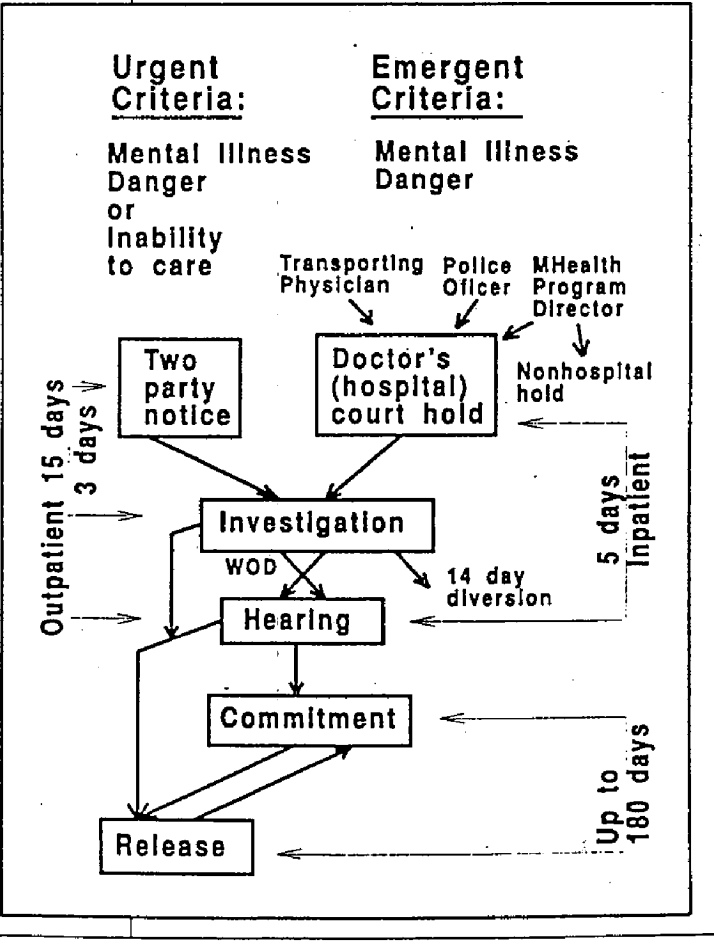


Figure 8: ORS 426

The patient should be treated in the least restrictive, yet safe, environment.

is initiated. This investigation may lead to a hearing (or to patient release). The hearing may lead to commitment. The main difference between the two routes in Oregon is that the emergent route (which includes only the criteria of mental illness and danger) requires that the patient be kept in the hospital and must not exceed five working days to the point of a hearing. The urgent route proceeds on an outpatient basis and 15 days may pass prior to a hearing. Therefore, frequently the question of danger must be phrased as: "Is this patient safe for 15 days in an outpatient setting?"

9.3 Biological Treatments:

In this area we generally think of the use of pharmacotherapeutic agents. Also, in general, one will have to consider psychiatric consultation in this context. Brief attention was given to the use of chemical (and physical) restraints earlier. An introduction into the basic psychopharmacology would clearly be beyond the scope of this brief review. Nevertheless, we should be clear that addressing an organic or cognitive mental disorder generally requires attention to or treatment of the underlying disorder. Thus, for example, treatment of hypo- or hyperthyroidism or delirium tremens would require the appropriate medical treatment for those conditions, not the psychopharmacologic treatment of the mental expressions of the illness (though there are exceptions where both becomes necessary). Psychotic disorders generally require antipsychotics (neuroleptics). Affective disorders will generally be treated with antidepressants and/or mood stabilizers, including Lithium, Tegretol, or Valproate. Anxiety disorders will frequently be treated with antianxiety agents, such as Benzodiazepines or Buspirone. As indicated by the differential diagnostic hierarchy, such agents must be used cautiously in combination.

From a psychiatric emergency viewpoint, it is extremely important to remember that treatment with neuroleptics, antidepressants, and mood stabilizers generally requires two to four weeks to be effective. Therefore, their initiation is frequently not part of an emergency, more triage-based intervention, no matter how badly one wants to help fast. Pharmacologic measures are generally very focused, directed at supporting a prior developed treatment plan and prescriptions are kept small. Careful coordination with outpatient treatment providers is crucial.

9.4 Psychological Treatments (Psychotherapy):

Similar to the section on pharmacotherapy, an introduction into psychotherapy is beyond the scope of this review. The emergency setting, as well as the realities of the treatment system, currently favor more focused, outcome oriented treatments that are frequently in the cognitive or behavioral realm. In many emergency settings general principles of crisis intervention apply: One attempts to restabilize the patient who has reached a point of instability and overload ("the straw that broke the camel's back") and support their process of reorganization through the phases of acute

decompensation, denial, anger, bargaining, grieving, and recovery. Such a hypothetical course of a crisis is outlined below:

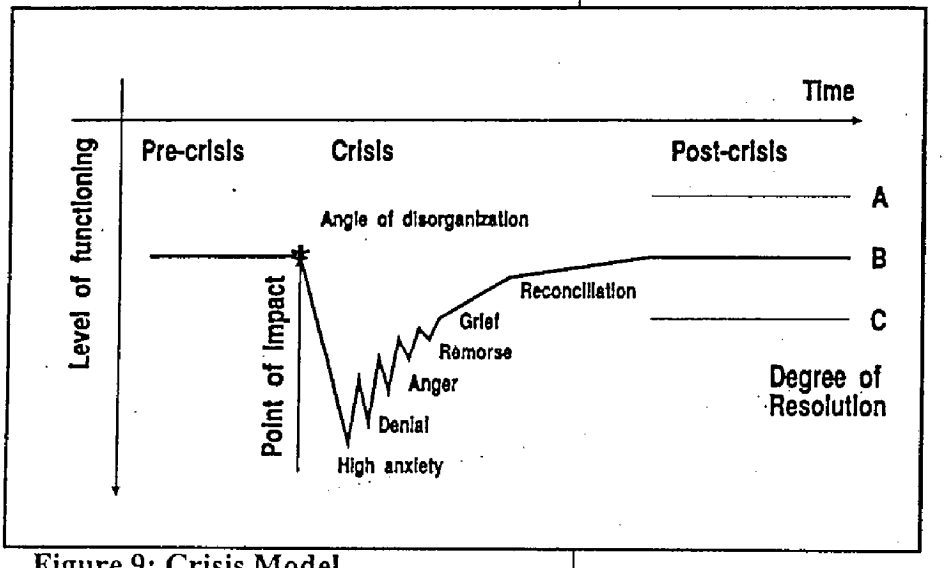


Figure 9: Crisis Model

Psychotherapeutic intervention could take on the following form: One assesses the biological, psychological and social realities that the patient brings to the situation. These are crucial for understanding the resiliency or stability of the patient's "system." Then focus on the balance between stressors and support system will allow a determination to be made on the severity and urgency of the current crisis. Stressors or supports are then manipulated where possible to help restabilize the patient.

Psychotherapeutic intervention using a debriefing model may also be appropriate. Such a model could be thought of as having four parts (see table 4). It may be used with individuals and groups. In the interaction, the four phases are explicitly separated. In the first phase facts are gathered from all participants. Statements about how one feels are excluded. (It is made clear that they are legitimate, but will be talked about separately). In the second phase, affects/feelings are clarified and discussed. Here the attempt is to collect a broad range of emotional responses, validating them. The disconnection from the facts and the legitimacy of the patient's own emotional response is emphasized. In the third phase the group is educated about what to expect (both in terms of future events and emotions); in the fourth,

Crisis intervention rebalances a percieved disparity between stressors and suuports.

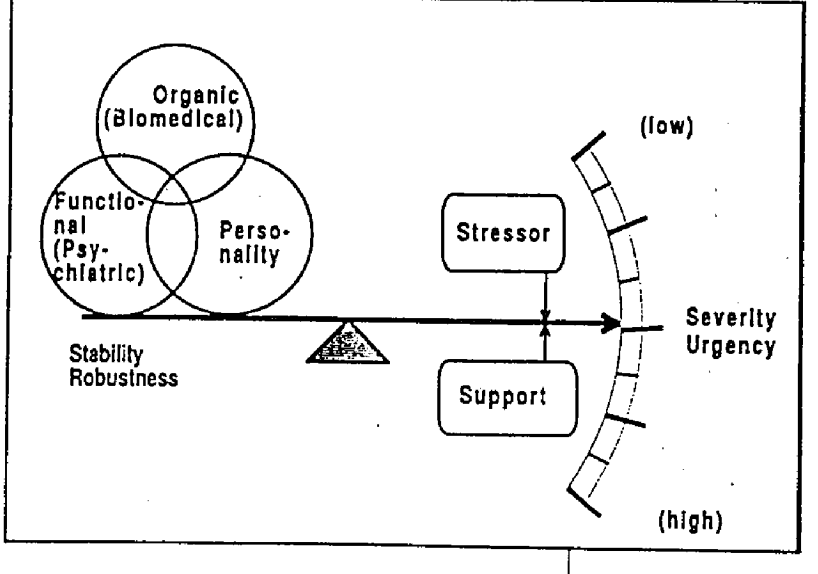


Figure 10: Crisis Intervention

The critical incident debriefing model may also be useful for the professional faced by trauma.

plans are made for any necessary follow-up.

1. Clarify the facts of the crisis ("What happened?").
2. Clarify the feelings ("How do you feel about this?").
3. Review the usual response to crises: (teaching phase).
   - Phase of Disbelief or Denial.
   - Phase of Shock or Confusion.
   - Phase of Anger.
   - Phase of Grief and Sadness.
   - Phase of Acceptance.
4. Problem solving or reopening the social world/contacts and ultimate resolution (reinforce adaptation and a plan for the future).

Table 4: Critical Incident Debriefing

In less formalized psychotherapeutic work three simple rules may help in the beginning:

1. When the patient presents a complaint, always validate it.
2. However, in doing so, acknowledge it in a way that will allow for reinterpreatation. Thus, it may be crucial to a psychotic patient to hear: "Oh, that sounds frightening," but it would be unwise to agree that the FBI may be indeed plotting.
3. Finally, offer a reinterpretation of the complaint that will direct the patient to action toward an useful goal. ("When you experience such voices, it may be a sign that you need to take a time out/take more medication.")

9.5 Social Interventions:

In this area, the realities of the patient's living are addressed. Clearly, attention must be given to food and shelter, as well as clothing. Where these are not immediate concerns, issues of disability may be the stated or covert objectives that should receive attention. While seeking psychiatric hospitalization in order to find shelter is understandable, it is clearly not the most efficient use of resources, and it would be the professional's task to support the legitimacy of such patient desires, yet to help the patient address their needs directly.

10. Summary

This outline is clearly intended as a forum for ongoing discussion and not as a finished document. It does, however, attempt to make explicit some of the core principles underlying emergency psychiatric evaluation and intervention. Since the subtleties of human interaction can clearly not be adequately addressed by such an approach, it is worth remembering that the experienced professional on the scene generally has access to significantly more information, including personal reactions, that can be crucial to accurately assessing the patient's situation. Pairing such clinical experience and "feel" for patients' needs with a clear diagnostic and therapeutic structure will hopefully provide some of the redundancy necessary to assure safe clinical interactions.

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NOTES

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NOTES

CRISIS INTERVENTION TEAM TRAINING
MAY 15, 2000

OVERVIEW OF MENTAL ILLNESS

WHAT IS MENTAL ILLNESS?

A biologically based brain disease characterized by

- perceptual disturbance
- mood lability
- lack of motivation
- and in extreme cases, suicidality.

Mental Illness can impact all areas of a person's functioning including

- **Social** — difficulty getting and/or maintaining necessities of life i.e. food, clothing, and shelter
- **Occupational** — difficulty acquiring and/or maintaining employment
- **Interpersonal** — difficulty maintaining relationships with friends, co-workers, partners, spouses, parents, children

Symptoms of mental illness may be exacerbated by environmental stressors including

- Poverty
- Homelessness
- Difficulty accessing medical care
- Poor nutrition
- Drug and alcohol addiction

Symptoms of mental illness may be alleviated by medicine and social supports including

Help in --

- keeping up an apartment
- shopping for food
- budgeting money
- attending to hygiene
- planning social activities
- making friends and maintaining relationships
- Easy access to mental health care that is affordable and tailored to the needs of the person

WHAT MENTAL ILLNESS IS NOT

- Mental illness is not a character flaw.
- Mental illness is not a guarantee that the person will be violent.
- Mental illness is not anyone's fault.
- Having a mental illness does not mean there is no hope.

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Thought Disorders

- Hallucinations that might cause people to see, hear, feel, taste or sense things that aren't there
- Talk to self
- disorganized thoughts
- Paranoia, delusions, or bizarre thoughts
- Minimal display of emotion
- Poor hygiene/malodorous
- May wear multiple layers of clothing or inappropriate clothes for the weather
- May have multiple bags filled with what might appear to be garbage

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Mania:

- Expansive irritable mood
- Decreased need for sleep
- Heightened self-esteem
- Grandiose ideas
- Pressured speech /inability to interrupt them
- Distractibility
- Poor impulse control (e.g. buying sprees, sexual indiscretions)
- Possible break with reality, i.e. psychosis

WHAT A PERSON WITH MENTAL ILLENSS MIGHT EXPERIENCE

People with major depressive disorder often do not act in a bizarre manner

Common symptoms of depression include:

- Depressed mood most of the day, nearly every day
- Loss of interest or pleasure in all or most activities of the day
- Significant weight loss or gain
- Difficulty sleeping or sleeping too much
- Fatigue or loss of energy
- Feelings of worthlessness
- Recurrent thoughts of death or thoughts of suicide

It is a myth that depression is a normal part of the aging process. It is important to remember that depression is an illness which can be successfully treated.

IF YOU HAVE TO TAKE THE PERSON INTO CUSTODY ON A HOLD SOMETIMES IT IS HELPFUL TO:

- Ask the person if they have ever been in handcuffs before
- Tell the person that you came to help them, not to hurt them
- Tell them they are not under arrest or in trouble
- Tell them you know that they are not a bad person
- Tell them your boss says you have to put them in handcuffs, it is the rule, it's nothing personal

ORGANIC AND PSYCHOTIC MENTAL ILLNESS

WHAT IS PSYCHOSIS

Psychosis is defined by a complex of symptoms that include:

Delusions (false beliefs in something that is so at odds with the prevailing societal consensus as to be recognized as ranging from the improbable to the bizarre).

Hallucinations (the experience of sensation in the absence of external stimulation, most commonly auditory, but in drug induced states or other organic states can include visual, olfactory, gustatory, and tactile sensations. That is hearing, seeing, smelling, tasting and feeling.)

Incoherence (unintelligible speech or speech which may make sense but conveys little or no information even though the person may talk a lot).

Loosening of Associations (the lack of connection in a person's flow of thought so that ideas seem to generate other ideas which have no logic to their sequence).

Catatonia (marked excitement or profound stupor and muteness to the degree that a person is at risk for life threatening exhaustion or is unable to carry out basic functions such as food seeking and feeding).

Gross Disorganization (marked difficulty in organizing behavior so that a person may be disoriented to time, place and identity, may be unable to respond to others or unable to respond in an understandable manner).

There is a range of conditions which may produce psychotic behavior. This may vary from; a brief reactive psychosis which is a response to excessively traumatic stress (for example: combat); to substance induced psychotic reactions; to psychosis due to a progressive brain deterioration such as in a dementia like Alzheimer's; and psychosis due to a chronic mental disorder such as schizophrenia or severe mood disorder as in psychotic depression or in psychotic mania.

The neurobiological basis of psychosis appears to stem largely, but not exclusively, from the disruption of dopamine transporting systems in the brain. This can be due to endogenous (internal) causes such as mental illness or dementia but also may be due to exogenous (external) causes such as head trauma or exposure to certain chemicals.

For our purposes, we are concerned with those chemicals which have reinforcing properties in the brain and are likely to be abused. Repeated use of

substances such as **alcohol, speed, crank, coke, crack, hallucinogenics, designer drugs**, increases the risk of developing a drug induced psychosis or "triggering" an existing condition such as schizophrenia or severe mood disorder. This appears to be due to the dopaminergic (dopamine stimulating) action of these substances in the brain.

The most common psychiatric symptom resulting from repeated or heavy use of any of the amphetamine type drugs is delusional thinking. Paranoid delusions of persecution and other bizarre or unusual explanations of events are frequently seen. Accompanying this paranoia can be agitation, anxiety and aggressive behavior so that persons in a drug induced psychotic state have much more potential for violent acts including homicide and suicide.

Think of the brain as an elaborate circuit board with very complex electrical interconnections which form our self-awareness, our experiences, our thoughts, our sensations, our perceptions, our memories. If you pour water on a circuit board it shorts out due to the water acting as an electrical conductor between parts of the circuits that weren't meant to be connected. Drugs act the same way in the brain except instead of water being the disruptive electrical conductor, they act on the neurotransmitters which conduct electrical activity. If the brain is no longer able to carry out established interconnected patterns of electrical activity and different pathways become involved, what the brain experiences is psychosis. What others see is that the psychotic person does not make sense and is responding to stimulation that is internal and not shared or understood by others.

Usually, if an individual abstains from drugs, **the psychotic symptoms will go away with time.** The symptoms generally go away within hours to days, although they can last several months and, for some unfortunate individuals, they may become permanent. **The population at highest risk for permanent damage is the one with an existing mental illness or mood disorder or, has a predisposition to develop a mental illness or mood disorder.**

At this time, the single most effective known treatment for psychotic disorders is the use of anti-psychotic medications. These are believed to have a stabilizing effect on the dopamine balance in the brain. These medications, however, are not 100% effective and they carry some risk of side effects. About 25% of people with psychotic symptoms do not obtain a favorable response to existing anti-psychotic medications. Hallucinations, confusion and disorganization generally respond to anti-psychotic medications but delusional thinking tends to be less responsive. Ideally however, treatment should combine medications with social therapies to be the most effective. There are some individuals who can recover without the use of medications but they are in a minority.

Denial is a major element making for great difficulty in the treatment of psychotic states that are either drug induced or due to chronic mental disorders. Frequently, the person experiencing the psychotic effects of drugs or of mental illness believes that what his senses are telling him is an accurate reflection of external reality. This is what we all believe and rely on to navigate through the world. When someone tells a psychotic individual that what they are experiencing is not "real", it is very difficult to make a convincing argument. What is going on in that person's brain is their reality so they must deny any challenges to that reality and refuse to accept any offers of treatment and refuse to believe that they might need treatment.

A common outcome is that a psychotic person comes to the attention of the police. A quick determination is made if the psychotic person poses some danger to themselves or others and is not willing to obtain voluntary treatment. The individual is transported to an emergency psychiatric facility where they can be detained against their will, for up to five court days. During this time an investigator must make a determination as to whether or not the person is to go to Civil Court before a judge and psychiatric examiners for an involuntary commitment hearing. The Civil Court has the authority to place the person under the care and custody of the Mental Health Division for a period not to exceed 180 days if they find the person continues to be mentally ill, a danger to self or others and is unable or unwilling to accept voluntary care. While under commitment and within the guidelines of the law, a person can be administered psychiatric medications against their will.

Go back now to the earlier statement that most drug induced psychotic states clear in a few hours to a few days. If a person in this condition is taken to a psychiatric emergency holding facility they are likely to be released without a commitment hearing. But, for the person whose symptoms persist, they stand a good chance of being committed and placed in a psychiatric hospital.

If a crime was committed at the time the person was picked up by the police, the person may have a detainer placed on them while in the hospital and then be transferred to jail once their symptoms have cleared. If the crime is serious enough, a mentally ill offender may go straight to jail and then quickly to court for a judge's order to be sent to Oregon State Hospital Forensic Unit for evaluation or treatment. Petty crimes committed while the person is psychotic are often dismissed if the court feels that the individual is getting the treatment they need. Repeat offenders are not as likely to be looked upon with such leniency particularly if they persist in denying they need treatment or do not follow through with treatment.

Mental illness is not a state of bliss. It can be a world filled with fear and confusion. Whether psychosis is drug induced or not doesn't make any

difference to your brain but **the choice to use or not use drugs of abuse will make a major difference in how your brain is going to function.**

Organic Disorders

a. Definition
    1. A class of conditions caused directly by abnormalities of brain structure or by alterations of brain neurochemistry or neurophysiology (e.g., delirium, dementia, amnesic syndrome, organic hallucinosis, organic delusional syndrome, organic mood syndrome, organic personality syndrome, etc.)

b. General symptoms
    1. Confusion, memory disturbance, disjointed speech, slow mentation, and substance abuse

    2. Physical signs
        a. Breath smells
        b. Blood shot eyes
        c. Runny nose
        d. Needle tracks
        e. Slurred speech
        f. Unsteady on feet
        g. Bizarre behavior and speech

    3. Head Trauma
        a. Permanent
        b. Slow mentation
        c. Impulsive
        d. Seizures
        e. Personality change

    4. Stroke
        a. Usually older person
        b. Paralysis
        c. Difficulty speaking

5. Dementia
    a. Older person
    b. Confused, especially about personal information
    c. Combative
    d. Often in a nursing home or has a specific care provider

6. Medical Causes
    a. Diabetic not taking insulin
    b. Drug overdose
    c. Delirium – fluctuating levels of consciousness
    d. Past seizures
    e. Off seizure medications
    f. Physical illness (sweating, nausea, vomiting)

Psychotic Disorders

a. Definition
   1. A disturbance of perception and thought process is a broad description of this category. The psychotic symptoms represent manifestations of disturbances in the flow, processing, and interpretation of information in the central nervous system. These symptoms can be mild to severe. (Mental Health : A Report of the Surgeon General)
   2. Hallucinations are the most common group of symptoms that result from this disordered processing and interpretation of sensory information. An example is the frequently described hallucination of hearing voices.
   3. Hallucinations may include:
      a. auditory
      b. smell
      c. feel
      d. visual
      e. physical
   4. Delusions are a more complex group of symptoms resulting from this disordered interpretation of information. A delusion is a false belief that an individual holds despite evidence to the contrary. A common example is paranoia, in which a person has delusional beliefs that others are trying to harm him. Any attempts to persuade the person that these beliefs are unfounded typically fail and may further entrench the delusional belief.
   5. Psychotic thought processes are characteristically loose, disorganized, illogical, or bizarre. These thought processes frequently produce bizarre observable patters of behavior that is also disorganized and bizarre.

Schizophrenia

a. The cause of schizophrenia has not yet been determined although research points to the interaction of genetic endowment and major environmental upheaval during the development of the brain. (Mental Health: A Report of the Surgeon General)
b. Part of the psychotic disorders schizophrenia frequently have marked disturbances in logical thought process.
c. Symptoms can include:
    1. Hallucinations
    2. Delusions
    3. Disorganized thoughts and behaviors
    4. Loose or illogical thoughts
    5. Agitation
    6. Flat or blunted affect
    7. Concrete thoughts
    8. Anhedonia (inability to experience pleasure
    9. Poor motivation, spontaneity, and initiative

MOOD DISORDERS

Mood Disorders

a. A group of clinical conditions characterized by a disturbance of mood, loss of that sense of control, and a subjective experience of great distress. This disturbance of mood can be manifested by either stained feeling or sustained elevation of mood. As with psychosis the disturbance of the mood occurs in a variety of patterns associated with different mental illnesses. (Mental Health: A Report of the Surgeon General)

Bipolar or Manic Depressive

a. Symptoms include mood swings from the lows of depression to the highs of mania. These episodes alternate and in some cases can be predicted. Severely affected people have a "rapid cycling" bipolar illness, in which the mood swings occur almost continuously.
b. Depression: symptoms include melancholy, sad, miserable most of the time. Loss of interest in life and pleasures. There can be a decreased energy level, fatigue, fits of weeping or constantly feeling like crying, and an unusually high degree of irritability. There is also a on going thoughts of suicide in severe cases.
c. Manic symptoms include a feeling of power, increased energy, seductive, elated, euphoric. Other symptoms include talks too fast, loud and without stopping. Thoughts race from one idea to the next in rapid succession without much logic. Stop eating, sleeping which in turn can change mood to irritability, anger, paranoia.

Major Depression

a. Ongoing feelings of melancholy, sad and miserable most of the time with loss of interest in life and pleasures. These episodes can also include decreased energy, fatigue, fits of weeping or constantly feeling like crying. Symptoms may

vary with individual, but are long lasting and affect the quality of life for the person.

b. The though process is constantly negative with hopelessness dominating present and future. Anxiety, dread can increased the individual's inability to function. Difficulty in concentration and making decisions; experience feelings of guilt, self-loathing, or worthlessness. Preoccupies with death and suicidal thoughts or attempts.
c. Physically individuals may experience disruptions in normal eating and sleeping patterns. Some are unable to sleep and others may sleep more hours than usual.
d. Behavior includes inability to get work done and difficulty in reading or studying. There is a great difficulty in accomplishing simply tasks such as washing, dressing, and eating. There may also be some restlessness and agitation. The characteristics include slowed thoughts, movements, and speech; walk stooped and shuffling gait

NOTES

NOTES

POST TRAUMATIC

STRESS DISORDER

Post Traumatic Stress Disorder

1.Symptoms develop following exposure to an extreme traumatic event that involves

- Direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to physical integrity of another person
- Witnessing an event as described above
- Learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate

2. The persons response involves intense fear, helplessness, or horror. In children this may be manifested by disorganized or agitated behavior.

3. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. In children this can include play where themes or aspects of the trauma are expressed
- Recurrent or distressing dreams of the event. In children there may be frightening dreams without recognizable content

Acting or felling that the traumatic event were recurring. Can include hallucinations and flashbacks

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity to internal or external cues that symbolize or resemble an aspect of the traumatic event

4. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness

- Efforts to avoid thoughts, feelings or conversation associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall important aspects of the trauma
- Diminished interest and participation in activities
- Feeling of detachment or estrangement from others
- Restricted range of affect
- Sense of a foreshortened future

5. Persistent symptoms of arousal

- Difficulty falling or staying asleep
- Irritability or anger outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

6. Prevalence rates for the general population range from 1% to 14%. Rates for at risk populations such as combat veterans, crime victims, ect. range from 3% to 58%

7. In about 50% of cases symptoms resolve within 3 months. In many cases symptoms persist longer than 12 months

8. Individuals with PTSD are at increased risk of developing a substance use disorder. Substance use exacerbated symptoms of PTSD

GUIDE TO ACCOMPANY

POST TRAUMATIC STRESS DISORDER

FEATURES OF PTSD

A. Traumatic event/significant stressor.

B. Re-experiencing of the traumatic event.

C. Numbing of responsiveness

D. Anxiety-based autonomic and cognitive symptoms.

DIAGNOSTIC CRITERIA FOR PTSD

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma by at least one of the following:

1. Recurrent and intrusive recollections of the event (nightmares).
2. Recurrent dreams of the event.
3. Sudden acting or feeling as if the traumatic event were re-occurring (flashbacks).

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

1. Marked diminished interest in one or more significant activities.
2. Feeling of detachment or estrangement from others.
3. Constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

1. Hyperalertness or exaggerated startle response.
2. Sleep disturbance.
3. Guilt about surviving when others have not, or about behavior required for survival.
4. Memory impairment or trouble concentrating.
5. Avoidance of activities that arouse recollection of the traumatic event.
6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.
7. Self-medication via alcohol/drug/pill abuse--chain smoking--overeating--anger mismanagement.

PTSD SUBTYPES

308.30 Post-traumatic Stress Disorder, Acute

- Onset of symptoms within six months of the trauma.
- Duration of symptoms less than six months.

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

- Duration of symptoms six months or more (Chronic)
- Onset of symptoms at least six months after the trauma (Delayed)

TRAUMATIC EVENTS THAT CAN PRECIPITATE PTSD

A. Rape

B. Natural Disaster

C. War--combat

PRECIPITATING TRAUMA & SIGNIFICANT STRESSORS OF COMBAT

- Exposure to death and mutilation of people and destruction and desolation of environment.

- Personal acts of violence, fighting, killing, and destroying.

- Danger and threat to life.

- Depersonalization and dehumanization of the military environment and the war experience.

- Discontinuity between war and non-war environment.

<u>Additional Stressors of War</u>

- Political and moral debate and controversy about combat, social and political divisiveness (draft evasion; marches, demonstrations, protests, and political debate). Creating a state of confusion and uncertainty; weakening morale; heightening vulnerability; diminishing social support and sanction; resulted in a homecoming by avoidance, rejection, and antagonism.

- System of rotation, limited tour of duty and periods of rest and recuperation with rapid individual entry and exit reduced morale and cohesiveness; rendered unit maneuvers more difficult and exposed participants to a more stressful transition.

- Restrictive policies (no plan to win the war; abandonment of captured territory; orders to request permission from higher authority before engaging the enemy) heightened danger, contributed to mistrust and lack of confidence in leadership.

Themes of "Post-Vietnam Syndrome."

- Guilt feelings and self-punishment.
- Feelings of being scapegoated.
- Rage and other violent impulses against indiscriminate targets.
- Combat brutality and it's attendant "psychic numbing."
- Alienation from one's own feelings and from other people.
- Doubt about ability to love and trust others.

TREATMENT OPTIONS FOR PTSD

A. Behavioral Techniques: Relocation, Desensitization

B. Education Techniques: Assertiveness, Relaxation

C. Supportive Techniques: Reflective Listening

D. Family Therapy

E. Hypno Therapy

F. Individual Therapy

G. Peer Group Therapy

H. Flooding, Abreactive Therapy

I. Gestalt Technique

J. Grief Psycho Therapy

K. Guilt and Regret Issues in Counseling

L. Anger and Stress Management

[Events]

VIETNAM: WHAT I REMEMBER

From "Patriotism Revisited," by David W. Powell, a memoir submitted last October to a creative writing class at the University of Arizona in Tucson. Powell served as a marine in Vietnam from 1965 to 1967.

The following events come to my conscious memory uninvited. I not only remember them vividly, I reexperience them with all my senses:

Froze with fright, standing up, the first time I was under fire

Watched two marines try to break open the skull of a dead Viet Cong with a large rock

Observed a marine intentionally shoot a girl four or six years of age

Watched the girl's grandfather carry her into our line of fire, sobbing

Had a lieutenant who delighted in sneaking up on me when I was on watch at night

Was offered a blood-soaked flak jacket and a helmet with a bullet hole through it as my first field equipment

Had my boots rot off during an operation in the field

Observed two captured nurses being beaten and raped by marines

Rifle-butted a girl of twelve in the face when she would not move away

Strangled a captured Viet Cong for refusing to talk to an interpreter

Discovered brain matter on barbed wire I was stretching out

Observed a marine laugh as he stepped on the chest of a dead Viet Cong and watched blood squirt out of the enemy's wounds

Awoke to find a buffalo leech on my leg

Was abandoned under fire when a roc jammed in my launcher

Was abandoned under fire when I was shot

Hit head and fell in open field. Watched my fellow marines run by me to seek cover for themselves

Received letter from wife telling me how much fun she and a girlfriend had on Friday nights when they went out to bars to dance

Watched fellow marine shoot himself in the foot to get evacuated

Heard same man cry in his sleep when he was returned to the company

Found marine boot with foot in it in a hedgerow

Almost run over by retreating U.S. tank

Saw Lt. Spivey hit a head-high booby trap

Nearly murdered villager for stealing my laundry

Watched Prestridge test his new M-16 by shooting a woman getting water from a nearby well

Identified Haas's remains

Exchanged letters with Haas's mother

Had an artillery canister fall six inches in front of my head

Was about to put on fresh boots when I discovered lice swimming in them

Saw seven-foot python climbing in ceilir. just above my head

Bullets sounding like bees digging up ground all around me

Nearly trapped in Da Nang village my last night in Vietnam

Robbed by marines while I slept in Okinawa after tour was over

Circled over El Toro air base for two hours so that President Johnson could land and be photographed greeting returning veterans

•

Since my return I have held eighteen different jobs and have been unemployed for several six-month periods. This is a direct result of my Post Traumatic Stress Disorder, specifically a disdain for being told to do tasks I do not want to do; an exaggerated startle response, which is terribly embarrassing to me; and a lack of control over emotional flooding.

I divorced my first wife two years after I got out of the service. I divorced my second wife in 1982. I separated from a four-year relationship in 1987. I have not had a significant relationship with a woman since then. I have no significant male or female friendships. I am aloof from my immediate family, who live in Tucson, Arizona.

PTSD SYMPTOMS

- MISTRUST
- DEPRESSION
- ISOLATION
- RAGE REACTIONS
- AVOIDANCE OF FEELINGS; ALIENATION
- GUILT/SHAME AND DOUBT
- ANXIETY REACTIONS
- SLEEP DISTURBANCE AND NIGHTMARES
- INTRUSIVE THOUGHTS

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MULTNOMAH COUNTY OREGON

DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
1120 S.W. THIRD AVENUE, 4TH FLOOR
PORTLAND, OREGON 97204
(503) 248-3976

Dear Survivor:

This booklet is about the experience of being hurt on purpose by other people, and the changes in your life that it leaves behind.

You may wonder if what happened to you was bad enough to be called abuse. If you have to ask that question, it probably was. If you cannot remember large parts of your life, it almost certainly was.

I am sorry you are having to read this out of a book.... These things are better dealt with face-to-face. The effects of violence are best helped by different and more positive experiences with people. In a correctional institution, this is hard to do.

Take your time reading this. Use whatever parts seem helpful in your situation. Be patient with yourself. It will take time and work, but you <u>can</u> feel better.

Take care,

Joe Parker, RN

MULTNOMAH COUNTY OREGON

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Dear Colleagues,

In providing mental health care for corrections populations, management of Post Traumatic Stress Disorder has a central place.

Some clients come into the system as a result of acts in some way related to previous experiences of abuse. Many come as a result of self treatment of major symptoms by means of illegal drugs or alcohol.

Although psychotropic medications play an important role for many clients in controlling physical symptoms of the disorder, psychological treatment has proven to be very important in improving functioning and quality of life.

Since mental health resources are so limited in corrections, self-help educational materials must be used whenever possible. This booklet has been very helpful for our clients and staff, and we hope it will be helpful for your clients as well.

Permission is hereby granted to reproduce this material in any form and quantity necessary, for any use except for resale.

Sincerely,

Joe Parker

Joe Parker, RN

POST TRAUMATIC STRESS DISORDER (PTSD)

WHAT DOES POST TRAUMATIC STRESS DISORDER MEAN?

Post is the Latin word for "after".

Trauma is the German word for "nightmare", but in English, it is used for any kind of injury, physical or psychological.

Stress is a force that changes the shape of things (including people).

Disorder refers to things that are a problem in a person's life now.

To understand PTSD, it is necessary to tell two stories.

> Once upon a time, several blind men wanted to understand about elephants.
>
> An elephant was brought to them, and they all approached it from different directions.
>
> One felt the tail, and said "an elephant is like a rope"!
>
> Another found a leg, and said, "no, an elephant is like a tree trunk".
>
> A third walked into the side of the elephant, and said, "really, an elephant is like a wall".
>
> Others found the ear, the trunk, a tusk, and each felt his part of the elephant was the real elephant.
>
> Each blind man was right about his part of the elephant, but none of them really understood about elephants.

The story of Post Traumatic Stress Disorder is similar.

PTSD was first recognized after the American Civil War.

Doctors noticed that some soldiers who had been in heavy combat complained of having attacks of fast heartbeat, chest pain, difficulty breathing, and fear that they were dying or going crazy.

The symptoms were similar to heart attacks. Not having the scientific equipment to investigate further, they assumed the attacks were a form of heart disease. They called it "soldiers' heart".

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We now know the attacks are not heart disease. They result from rushes of adrenalin, triggered by bad memories or nightmares.

A few years after the war, most people forgot about the problem, but the part of the elephant they had found was real.

World War I was the first time very large numbers of explosive shells were used in battle.

It was noticed that some combat veterans, afterward, had trouble with feeling somewhat dazed or confused, and with poor concentration and memory.

This seemed similar to what happened in many brain injuries. It was thought that the concussions of the shells caused tiny spots of bleeding in the brain. They called it "shell shock".

Eventually, a lot of autopsies were done on soldiers who had died of other causes, and no such bleeding was found. It was recognized that the symptoms resulted from extreme stress, not brain damage.

It should be remembered that many people with PTSD, especially from child abuse and domestic violence, have had damage from blows to the head. Both symptoms of brain injury and effects of overwhelming stress may be present in the same person.

A few years after the war, the matter was again dropped, but they had found another part of the elephant.

When World War II came, it took until June of 1944 to redevelop the treatment methods used in 1918.

In that war, they learned two important things. The severity of a person's symptoms was directly related to how much stress he or she had undergone, over how much time.

It was calculated that of 100 men in continuous combat, every single one would break down within 189 days. They called it "combat fatigue", or "combat exhaustion".

It also became clear that there is no such thing as a stress-proof person. Certainly some people break before others, but with enough stress and enough time, everybody breaks. They had another part of the elephant.

After World War II, it was assumed (never investigated, just assumed) that symptoms of traumatic stress went away in 6 months or a year, after the war was over.

Only after the Vietnam War did it become clear that PTSD symptoms could appear it any time, during or after the war. The symptoms could go on, better or worse from time-to-time, all of a person's life.

The severity of the symptoms is influenced by how much emotional support a person has available during and after trauma.

Veterans of an unpopular war, such as Vietnam, were clearly affected by the fact that nobody wanted to talk about it later.

Survivors of child abuse and domestic violence are more severely affected because family or friends, who normally would provide support, are the perpetrators of the violence.

In the late 1970's feminist writers began publicizing the fact that far more child abuse, sexual abuse, and domestic violence were occurring than previously admitted.

Studies began to reveal that domestic violence is a problem in about 25% of all families, regardless of race, religion, income or education. About 16% of all girls and 8% of all boys are sexually abused before the age of 18 years. Rapes reported to the authorities may represent less than 10% of those that actually occur. About 10% of the adult population is alcoholic. Inclusion of other abusable substances may raise the figure to double that.

Very few people are directly involved in wars, but most people have a family.

Unlike in times past, the feminists and Vietnam veterans have not shut up and gone away. Post Traumatic Stress Disorder is now an official diagnosis in the diagnostic and statistical manual.

Consciously or unconsciously, the brain remembers everything. Trauma really happens, and it changes who you are. You cannot seriously hurt human beings and expect them to forget it and be alright afterwards.

People who have Post-Traumatic Stress Disorder often worry about whether they are "crazy".

The word "psychotic" (or crazy) usually means experiencing or believing things that are not real: being "out of touch with reality".

People with PTSD's have essentially the opposite problem. They are in too much contact with reality, and in contact with realities that most people have the privilege of not knowing about.

It is just as possible to be sick from too much contact with reality, as from not enough.

That is the whole elephant.

The official definition of Post Traumatic Stress Disorder includes a combination of the following:

1. An extreme, painful experience, which would be severely stressful for almost anyone.

2. Continuing psychological "re-runs" of the events, including:

   a. frequent thoughts and memories about what happened, even when trying to avoid them.

   b. repeating nightmares about the trauma.

   c. suddenly feeling or acting as if the events were happening again (flashbacks).

   d. strong, painful feelings set off by things which are in some way related to what happened.

3. Ongoing attempts to avoid memories and feelings by:

   a. becoming generally numb to everything, by cutting off most feelings, both good and bad.

   b. avoiding activities or situations which may bring back memories and feelings.

   c. loss of large areas of memory about past life.

   d. loss of interest in things most other people care about, feeling different and cut off from other people.

   e. lack of any sense of having a future.

4. Continuous extreme physical alertness, including:

   a. constantly watching for signs of danger, with "startle responses", and trouble sleeping.

   b. trouble concentrating on business in the present world.

   c. irritability, outbursts of anger.

   d. physical reactions similar to what happened during past trauma (tremors, sweating, nausea etc.)

5. These symptoms continue for more than a month and can begin anytime from immediately to years after the trauma.

PSYCHOLOGICAL ABUSE

Children come into the world knowing nothing about themselves: whether they are smart or stupid, good or bad, lovable or unlovable. They can only learn these things from family, from people around them. If they are given "poison information", they have little choice but to believe it.

For the abuser psychological abuse has several advantages:

1. It leaves no physical marks. Unless the child becomes extremely depressed or psychotic there is no evidence to show in court.

2. It is safe. There is no risk of accidentally killing the child and being sent to prison. There is no problem with the child getting big enough to physically fight back or use a weapon.

3. It is easy. Psychological abuse can be kept up for years, wearing away at a child like rust. There is no great amount of energy or time involved.

Psychological abuse takes several forms. They are usually used together - it is rare for an abuser to use only one type.

1. Rejecting

   "I hate you, you ruined my life". "You are not my child" Nothing the child is or does is ever good enough.

2. Isolating

   Keeping the child away from any people other than abusers. This prevents the child from learning anything about him or herself except the "poison information" provided by the abusers.

3. Ignoring

   Not responding to anything the child is, says, or does. Psychologically/emotionally "not there" for the child.

4. Corrupting

   Involving the child in crimes, early alcohol/drug use, sexual activities, etc. that leaves the child unable to be part of normal society.

5. Terrorizing

   Keeping the child constantly in fear of being hurt, making the child watch others being hurt, keeping the child emotionally out of control most of the time.

PHYSICAL ABUSE

A large part of the "normal population" consider it legitimate to use physical force to discipline children. "Spanking" with an open hand is commonplace in our society. Abuse, fueled by uncontrolled anger or intoxication, goes far beyond ordinary discipline. Abusers almost always blame their violence on the child or spouse who is the victim. This is confusing to survivors, who need to know what level of violence qualifies as "abuse".

Abuse includes some combination of the following features:

1. Severity of injury. Cuts, bruises, broken bones, being strangled or knocked unconscious.....and sometimes death.

2. Weapons. Clubs, knives, guns and other instruments capable of causing severe injury or death. Life or death for the child depends totally on how well the abuser controls the weapon.

3. Use of pretexts. A child is punished for anything or nothing. The "rules" are made up as the abuser goes along, and change without warning. The child is never safe.

4. The abuser is out of control. Through alcohol/drugs, mental illness or personal choice, the abuser does not control amounts of force used. The child may be crippled or killed at any time.

It is sometimes useful, to understand the severity of a survivor's current symptoms, to put together a lifetime total assault history. Multiply the total number of each type of assault per day/week/month by the total amount of time exposed to the various abusers. Be sure to count both assaults in childhood and in adult life. The total number sometimes explains a lot about why you are having so many symptoms.

Finally, estimate the number of days on which the survivor could be sure of not being hurt. Sometimes this number is painfully small.

Adults who recognize their actions toward children as abusive often fear to tell anyone, out of fear they will go to jail or lose custody of their children. In reality, many social services agencies work with parents who have abused, or fear they may abuse their children, to learn to stop the violence and keep their children. Parents Anonymous is free and a good place to start.

SEXUAL ABUSE

Normal sexuality is the exchange of pleasure between two freely consenting people. Abuse is the wrongful use of a human being, as a thing, for the pleasure of another. Sexual abuse commonly involves:

1. Use of force or threat to control a person who is not consenting. The threats may be against the victim, ("Do what I want or I'll kill you...."), against others, (If I don't get what I want from you, I will just go after your little sister..."), or against the abuser himself, ("If you tell anyone, I will have to kill myself, and it will be all your fault...").

2. Use of lies to overcome resistance, ("I'm doing this to teach you, for your own good", "Everybody does this", "You want it, I know you do".). Lies can take the place of open violence.

3. Secrecy. Normal sexual relationships may go on in private, but they are not themselves secret. The demand for secrecy almost always indicates wrongdoing, and usually includes some kind of threat. ("You won't be by special girl anymore", "It would break your mother's heart", "You will be put in an institution".).

4. Betrayal of responsibility. Children have to depend on older people for protection, for food, clothing, shelter, and for truthful information about how to get along in the world. An adult who uses a child's natural needs in order to use the child's body, is committing a crime. Sometimes the betrayal hurts more than the fear, the isolation or the injuries.

The most basic drives of human beings, and of all animals, are to survive and to reproduce. The use of power to control a child is ultimately based on the threat to hurt, abandon, or kill. The child does whatever is necessary to survive. Energy that should go into growing up, is spent on trying to just get by, day by day.

Use of sex as a weapon strikes a child's basic ability to relate to, and trust, other human beings. It attacks a person's sense of being connected to other people, both in the present world, and to past and future generations.

Sexual abuse is like any other serious injury: some people survive and do well, some people only get by, and some end up not surviving at all. Good help and the right choices can make your life more nearly normal, and much happier than it might otherwise have been.

To be hurt, especially on purpose by other people, makes everyone sad and ashamed. In thinking about their lives and symptoms, most people tend to underestimate the severity of their experiences, and overestimate the amount of control they had over what happened.

HISTORY

The brain has mechanisms like "circuit breakers" which block out memories too bad to handle at a given time. The memory loss is usually "spotty", not complete, and gets better or worse depending on a person's stress level and how much help is available.

Trying to force the memory, by emotional pressure, drugs or hypnosis, often hurts rather than helps. If the brain needs to block out a memory, it usually has good reason. People tend to "face reality" as fast as they can. Pushing becomes just another form of violence.

It is common to have to work on plans for recovery with incomplete information. Often, some of the most important facts come out only quite late in the process.

Because the traumatic experience really happened, and really hurt, PTSD symptoms tend to continue, better at some times, worse at others, most of a person's life. Careful planning and use of recovery skills can greatly increase the amount of "good time" and make the bad times less frequent and less severe.

Putting together a written history of your life, and understanding the effect the traumatic parts had, usually helps make sense of many things that have happened in your life, during the abuse and after. It is very important in making plans for your recovery. Making the most complete possible history is a long term project. Memories come back in bits and pieces. Information from other people and from records also will come in bits and pieces. Some things may never be known.

This will be a stressful process, both in the effort spent in trying to remember, and in the energy needed to cope with what is remembered. Sadly, insight into what happened usually improves symptoms, but seldom completely removes them.

It helps to keep written notes, to avoid losing hard won information to the ups and downs of memory. Putting it in writing also seems to help keep things real, when so often they seem unreal, or even impossible.

1. Lay out a "life line", beginning with your birth. Put in any markers that will keep track of time: places you lived, where you went to school, births, marriages, deaths, institutions you were in, etc.

2. Talk to family, friends, teachers, ministers, neighbors and anyone else who may have information about your life.

   Keep in mind that some of these people truly did not know, some did not want to know, some knew but did nothing, and some may have profited in some way from what happened. (For example, as long as the violence was directed at you, it was not aimed at them.)

3. If you decide to talk with the perpetrator, be very careful of your safety. Many are still dangerous. Be clear about what you are trying to do. If you want the perpetrator to confirm memories you can barely believe yourself, be prepared to be called a liar, crazy, or to be told you wanted or deserved what happened. Try not to hope for too much: most perpetrators do not admit responsibility or say they are sorry.

   If your purpose is to confront the perpetrator with your anger and your knowledge that what was done was wrong, then, other than being careful for your safety, how the person reacts is not very important.

   If the perpetrator is confronted in the process of warning other family and friends about the danger he or she presents, be aware that some other people may react in much the same way as the perpetrator might.

   You cannot afford to attach your sense of self worth to the reactions of other people, because their responses have to do with who they are, not who you are.

4. Pay special attention to periods of time you cannot remember, or that others will not discuss with you. The more hurtful the experience, the more likely it will have been blocked out.

   Sometimes it is possible to work backward from things that are known: who was living with us at the time, who was drinking at that time etc.

5. Send for copies of any hospital or institution records that may be available. Although you have a right to see and copy most records pertaining to you, sometimes the help of an attorney or health care provider may be needed. Be aware that many professional people are careful not to ask questions they do not want to hear answers to. Some of the records may be in a sort of code, that is: "chaotic family life" may mean drunken violence on a daily basis, and "sexually molested" may cover rape, sodomy and torture.

Put your notes in a safe place. You may wish to add to them from time to time, as you find new information. Sometimes reviewing them will help you understand some new problem in your life.

LIFE CHANGES

Extremely hurtful experiences, ones that produce more fear, pain and anger then anyone can handle, leave behind four ongoing sets of behaviors. These are not so much "scars" as attempts to cope with trauma. Like any kind of treatment, if carried too far, they can become part of the problem, not part of the solution.

1. You begin intense, continuous study of the experience, trying to understand why those things happened, and how to keep them from happening again.

This involves constant thinking about the events, to the point it may interfere with other activities. You may have repetitive dreams about the events which may be so intense as to interfere with sleep and set off adrenalin reactions. The feelings can be so powerful that it can seem as if you are living in two different "movies" at the same time: the "bad old days" and "now".

Once you understand how the process works, you feel less disoriented, less out of control, and more able to cope.

Learning more information about trauma <u>does</u> help. You can take classes, read about it, and talk with others who have been through similar things.

2. You learn to constantly scan the environment for signs of danger. The scanning is compulsive - you cannot turn it off, so you have to plan for it.

Recognizing signs of threat may trigger strong reactions, sometimes as strong as the original events did. These reactions may be completely out of line with what is going on in the real world at the time.

Sometimes, you may well be aware of the connections between the present "trigger" and past experiences, even if you cannot control your reaction. At other times, the connection may be unconscious. You first become aware of your <u>reaction</u>, and may or may not later be able to connect it with the past.

The responses may be so intense as to feel like the trauma is actually happening again, that you are back in the bad old days. This is called a flashback. It can feel very crazy to find yourself feeling, saying, or doing things that do not relate to the present world.

To begin to control various kinds of flashbacks, it is important to map out your usual triggers, where they are likely to be encountered, and what your usual reactions are. Some triggers can be avoided almost completely, and should be. Others may be harder to avoid, or you may have good reason to take the chances involved in running into them.

Survival planning may include ways of minimizing exposure, arranging for support ahead of time, developing a "cool down" procedure, and concrete emergency plans in case of losing control.

3. Your body goes in chronic "red-alert", always ready to fight or run. Physical symptoms include extreme muscle tension ("the shakes"), headaches, high blood pressure, involuntary startle reactions and trouble sleeping. You feel afraid all the time, even when you have no present reason to.

It is in attempting to control these symptoms that so many people with PTSD get involved with alcohol and illegal drugs. Expert use of legitimate psychiatric and blood pressure medications can control most physical symptoms of PTSD. They do not provide a high, are not addicting, are legal, and are much safer than street drugs.

As survivors move forward in recovery, some may no longer need medication, others will need it only during bad times, and some may need it always.

Serious trauma can change the way a person's nervous system works, sometimes permanently. Even after allowing for the effects of brain damage and other injuries from violence, PTSD is a physical illness.

4. You are continually prepared to be hurt again, to lose again. The difference between the way life was supposed to be, and the way it turned out for you is a chronic stress.

You learn to avoid getting involved with other people for fear they will turn on you. You try not to care about people, animals or possessions, because sooner or later you expect them to be taken from you. You go so numb that you cannot feel anything, including good things. Being that numb hurts. Being cut off from good things, including people, makes you sad.

Emotions may swing like a pendulum, from overstimulated, hyperalert, fearful and angry, to depressed, numb and out of contact with the world around you. The extreme feelings often come and go in waves, and at times you actually may be out of control. Stabilizing this swing is a central goal of a recovery plan. Such a plan may include:

a. Mapping triggers and arranging your life to avoid recurring flashbacks.

b. Learning to recognize and avoid hurtful people.

c. Avoiding the use of drugs which temporarily improve symptoms, but make them worse on the "rebound". If needed, symptoms can be controlled with legitimate medications.

d. Reducing your exposure to new injury. (For instance, stay out of places that serve alcohol...)

e. Stopping current patterns of behavior which may be replays or reenactments of your own previous trauma, such as prostitution, fighting, child abuse.

f. Actions to make the real world safer are much more helpful than just trying to cope with your feelings about what might happen. Good locks and a dog are more helpful than lying in bed trying not to be afraid.

Extreme traumatic experiences, especially if they happened at a young age, can make you different from most other people. Of special interest are two groups of people who may seem very strange to you: predators and normal people.

DEALING WITH OTHER PEOPLE

A person's usual everyday approach to life and to other people is called a personality. A personality is made up of a person's biological inheritance (genes), the total set of things that have happened in the person's life, and the history of choices the person has made.

Every life is like a hand of cards. Some people play whatever they get well, others badly. Only a small number of people choose to hurt others. Even among people abused as children, 70% do not choose to hurt others.

Predators come in three forms:

A. Non-controllers:

All people have angry feelings, and all people have the impulse to hurt someone at times. Some choose not to control those impulses. Many choose to use alcohol and drugs, and let the chemicals block their impulse control. Others do whatever they feel like, sober or otherwise. Their attitude is: "I feel like shit, so somebody's going to pay..."

People who are loaded occasionally have the bad judgement to pick on somebody tougher than they are, but most, sober or not, are quite careful to act out their impulses on people who cannot effectively fight back.

B. Users:

Some people act as if they were the only real human being in the world, and other people are more like plants. If they want something, they simply take it, as if they were harvesting vegetables. Users have no sense of other people's rights and feelings, and do not consider that a problem.

It is not that they have something that other people do not. Rather, users are missing something most people have: a conscience, that is, internal personal limits on what they do. Any control of their behavior must be provided by others, and often by force.

C. Sadists:

People who enjoy humiliating and hurting others, and who do so while in full control of themselves., may make up as much as 10% of the population. They are found in all parts of society, with all levels of education and income. For some, other people's pain is sexually stimulating. Others like the feeling of power that comes with hurting people who cannot stop them.

The definition of sadism includes ongoing pattern of:

1. Using physical violence, threats or lies to control another person and inflict pain.

2. Humiliating and degrading a person in front of others.

3. Using a position of authority such as that of a parent to inflict unusually severe "discipline".

4. Being fascinated by violence, weapons, torture etc.

5. Finding the suffering of other people and animals funny, pleasurable or sexually stimulating.

Some sadistic people are very obvious. Others are so subtle that all you notice is that you feel bad when around them. Abuse survivors have had to learn to ignore their own feelings just to survive. Learning to recognize , and trust, your feelings and to take rapid action to protect yourself, sometimes takes a lot of work.

Cruel people often are quick to notice people who expect to lose, and will move in quickly. They avoid people who look like they know they have rights, and have people who love them, because they are likely to fight back.

It is necessary to learn to act like a person with value and rights, long before you can really feel it. In time, it will become real, not an act.

Normal people:

To deal with normal people, you must understand that the world they live in is very different from yours. They are not afraid all the time. They can feel many more things than pain, fear, and anger.

1. They have rarely felt so much pain that they have lost control of themselves, and certainly have not had that kind of pain caused intentionally by another person.

2. They do not assume they are at fault any time anything goes wrong.

3. They expect to be treated fairly, to be respected, and to love and be loved.

4. They can feel pleasure without drugs, they are depressed only occasionally, and do not know what being numb is about.

5. They expect to have a fair amount of control over their lives, and expect to live to be old.

With time and effort, you can learn to deal with people whose lives have been luckier than yours. One barrier will probably always remain: most normal people do not want to live in the world you know. Many will block you out so they can stay comfortable, not because you are doing something wrong. It is important not to reject all normal people, because there are always some who will work quite hard to understand how your life has been, even if they have had no similar experience themselves.

FINDING PEOPLE YOU CAN TALK TO

Think of how long it took you to put together the pieces of your history, make an accounting of how the abuse changed your life, and deal with your emotional reactions to that. You never had a choice about facing that because you had to live it.

Finding someone to talk to about it is not quick or simple. Some people will listen because they have had to live with abuse too. They may or may not be able to tolerate terrible stories at a given time. Listening to your story may bring up feelings they find too painful to deal with.

Others will listen because they are unusually committed to helping other people, or care a lot about you personally. Finding people who can listen is a key part of surviving. It involves several specific steps:

1. Talk with them about some part of your life that is fairly ordinary, and see if they really listen. If they listen poorly to the very ordinary, they certainly will not hear the really ugly. If they listen, then:

2. Choose a "medium bad" part of your story, one not too hard to handle if things go badly, and tell that. If they change the subject, turn mean, or drop a relationship, they probably are not worth any more effort.

   If they get panicky or go numb, you may have found another person with an abuse history. Keep in mind that they may or may not consciously recall the experience. Given plenty of time and personal space, these people may talk with you. Just as it was with you, pushing hurts rather than helps.

3. Once you know a person really well, you may choose to tell him or her the very worst things that happened, the ones that would really hurt if not handled with gentleness and respect. After you tell another person the very worst, and are met with kindness and respect, the memories never have quite the same power over you again.

4. Sometimes you will know people you care about, and very much would like to talk to, but you really feel they could not tolerate the ugly details. You may choose to tell them only some of the story, or even none.

   It is not fair that you should have to spend your energy to protect them from hearing about what you had to live, but occasionally it is necessary.

TRIGGERS

Human beings are creatures that learn, and keep on learning all of their lives, whether they want to or not.

They learn to recognize danger by noticing signs that were associated with past hurtful experiences. If the past experiences were severe, there may be a strong physical or emotional response, even if the conscious mind does not know what set it off.

These signs are called "triggers". People who have a good understanding of what situations set them off, can plan to avoid them, or to deal with the reactions. They come to feel much more in control of themselves.

Triggers can be <u>internal</u>, that is, can be a thought or a memory, as well as an outside event. Triggers take several forms:

1. Single Triggers: One sign alone is enough to set off a reaction. Examples: beer breath, body odor, being yelled at, seeing someone else hurt, violence or happy family situations shown on TV.

2. Compound Triggers: Several things, coming together, will set off a reaction, when each would not have been enough if it appeared alone. Examples: being touched, by someone who is angry, and has beer on his breath; or blood, on bed sheets, in the morning.

3. State-dependent triggers: One or several things which set off a reaction only when a person is tired, alone, in pain, intoxicated, etc. Without the changed mental and/or physical state, the particular signs are not enough to set off a reaction.

It is helpful to keep a log of what is happening around you, and what you were thinking about, just before your body and emotions "went off". Because of memory loss caused by stress, finding the trigger that set off a reaction can take time. Tracking down a trigger may also bring back lost memories. At other times, putting together more personal history will help identify triggers you had not recognized before.

FORGIVENESS

Abuse survivors often are pressed to "forgive" the perpetrator. The pressure may come from others, especially family members, or from the survivor's own beliefs about what should be done.

Forgiveness is a word for something that does not exist in the real world. There is no way to go back and act as if nothing ever happened, which is what most people want and most people think forgiveness means. People other then the survivor made bad choices, with terrible outcomes, and became worse people as a result.

The survivor may choose not to seek revenge, may choose to continue some contact with the abuser, and may try to support any positive change that the perpetrator may attempt, but there is no way the survivor can control what the abuser chose to do. If the survivor had been able to control other people's decisions, there would have been no abuse.

Children want very badly for their family to be good people, even in the face of strong evidence that they are not. They will blame themselves for things other people did. They will claim that they were somehow in control, rather than face the fact that they were helpless and that the bad choices were made by others. Survivors have nothing to be forgiven for, because they did not make the choices.

The abuser can choose to give up violence, take responsibility for the damage, and work toward rebuilding a family. Failing that, the survivor may have to piece together a family out of whatever is left, without the abuser.

A LAST WORD

A new family can be built out of the people who choose to be part of your life, whether or not they were born into it. A real family is something people do together, not something they are.

Building a new life may take terrible faith and courage. Some days it will seem easy, on other days, impossible. You go on living, with the unwanted knowledge of what evil people have done and can do, including what you yourself may have done and can do. Sometimes it takes all the courage you have just to get up and get dressed in the morning, knowing what can happen.

I wish you luck and courage on your journey. You will always have my respect.

Joe Parker, RN

THE PENDULUM SWING

REEXPERIENCING

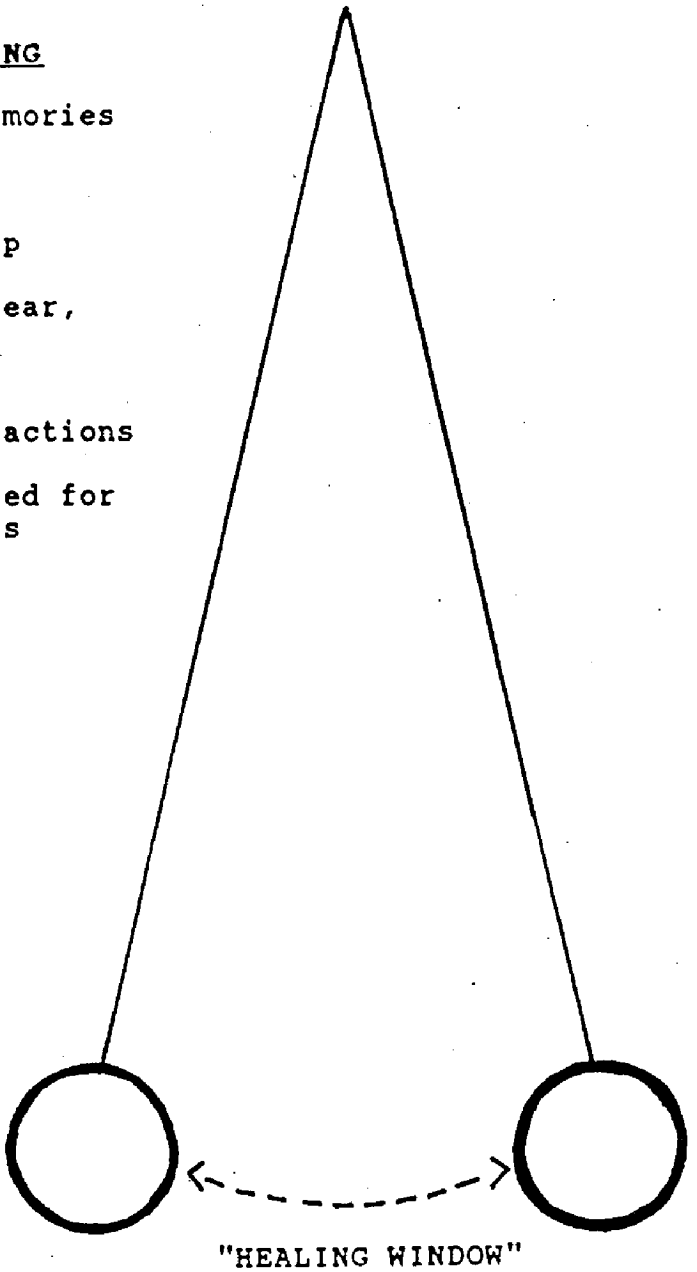
- intrusive memories
- nightmares
- loss of sleep
- attacks of fear,
- flashbacks
- "startle" reactions
- increased need for alcohol/drugs

NUMBING

- feeling nothi
- loss of nor... interests
- detachment from others
- memory loss
- avoidance of reminders
- depression

TOO AGITATED TO WORK ON PROBLEMS.

TOO MUCH ENERGY.



UNABLE TO HOPE FOR THINGS TO GET BETTER.

NOT ENOUGH ENERGY.

"HEALING WINDOW"

Enough energy to work on problems, and enough hope to want to.

NOTES

NOTES

ALCOHOL AND DRUGS

Alcohol, Drugs, and Chronic Mental Illness

1. Substance Abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period

- Recurrent use resulting in failure to fulfill major role obligations at work, home, or school
- Recurrent use in situations where it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

2. Substance Dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:

- Tolerance
- Withdrawal
- Substance taken in larger amounts or over a longer time than was intended
- Persistent desire or unsuccessful attempts to control use
- Great deal of time spent in obtaining, using, and recovering from the drug
- Important social, occupational, or recreational activities are given/ reduced due to use
- Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

3. Addiction is a chronic, progressive, terminal disease. Substance use result in changes in the brain which maintain addictive behavior

4. Incidence of substance abuse among individuals with chronic mental illness is higher than that of the general population.

ECA Studies:
Lifetime Prevalence

	General Population	Dx. Of Schiz
Any SubstanceUse Disorder	16.7%	47.0%
Any Alcohol Disorder	13.5%	33.7%
Alcohol Dependence	7.9%	24.0%
Alcohol Abuse	5.6%	9.7%
Any Other Drug Disorder	6.1%	27.5%
Drug Dependence	3.5%	12.9%
Drug Abuse	2.6%	14.6%
Marijuana Depend/Abuse	4.3%	
Cocaine Depend/Abuse	0.2%	
Opiate Depend/Abuse	1.2%	
Amphetamine Depend/Abuse	1.7%	
Hallucinogen Depend/Abuse	0.3%	

5. Incidence of mental illness among individuals with a substance use disorder is greater than the general population

ECA Studies Lifetime Prevalence	General Population	Alcohol Dx.	Drug Dx.
Any Mental Dx.	22.5%	36.6%	53.1%
Schizophrenia	0.7%	3.8%	6.8%
Any Affective	8.3%	13.4%	26.4%
Any Anxiety	14.6%	19.4%	28.3%

6. Reasons for use of substances by individuals with mental illness can include social, self medication, and addiction

Social:

- Means to behave like non-mentally ill peers
- Opportunities to be around others w/o high social demands
- Creates a sense of belonging to a social group

Self-Medication:

- Anxiety Reduction
- Improved ability to concentrate
- Improved energy level
- Increased sense of ability to function and well being
- Improved mood

Addiction:

- Physical and psychological dependence
- Altered brain function

7. Use of substance by individuals with chronic mental illness typically result in increases in symptoms of psychiatric disorders and reduced ability to function

8. Effective treatment involves simultaneous treatment of both the mental illness and substance use disorder

ALCOHOL AND DRUG

- WHAT TO LOOK FOR IN ASSESSING THE
- POTENTIAL FOR VIOLENT BEHAVIOR

- RISK FACTORS FOR HOMICIDE

- BLOOD ALCOHOL CONCENTRATION

- DEPRESSANTS
  - Alcohol
  - Opiates/Narcotics
  - Sedatives/Hypnotics/Anxiolytics

- ALCOHOL AND DRUG OVERVIEW

- INDICATORS OF DRUG USE

- OTHER DRUGS

- HALLUCINOGENS, PHENCYCLIDINE
- (PCP), AND RELATED SUBSTANCES

- INHALANTS

- DRUG PROBLEMS IN EMERGENCY
- ROOMS

ALCOHOL and DRUG (continued)

- RISK FACTORS FOR SUICIDE
- STIMULANTS
- SUBSTANCE ABUSE AND THE BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE.
- QUICK LIST OF SUBSTANCES AND THEIR SYMPTOMS

WHAT TO LOOK FOR IN ASSESSING THE POTENTIAL FOR VIOLENT BEHAVIOR

- A psychiatric diagnosis that includes violent or impulsive behavior among its criteria
- A previous history of violent behavior
- A history of substance abuse
- An injury to the head
- An injury to the central nervous system
- A previous history of physical abuse by others
- A previous history of suicidal behavior
- A previous history of delusions or hallucinations—particularly command hallucinations

Source: Lukas, S. (1993). Where to Start and What to Ask. New York: W. W. Norton & Co.

Risk Factors for Homicide

- Access to/ownership of guns
- Use of a weapon in prior abusive incidents
- Threats with weapon(s)
- Threats to kill
- Serious injury to victim(s) in prior abusive relationships
- Threats of suicide
- Drug or alcohol abuse
- History of forced sex with female partners
- Obsessiveness/extreme jealousy/extreme dominance

Blood Alcohol Concentration

Blood Alcohol Concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process

capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most states for drunkenness, which is 0.08 percent.

BAC can be measured by breath, blood, or urine vehicle tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury.

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are
impaired in most people long before they exhibit visible signs of drunkenness. While most states define legal intoxication for purposes of driving at a BAC of 0.08 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

The legal intoxication level in most states is 0.08 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.08 percent is reached.

Factors that will affect the BAC in a person:

- How much alcohol you drink.

- How fast you drink. The quicker you drink, the higher your peak BAC will be. The liver gets rid of alcohol at the average rate of one drink per hour (12 oz. beer, 5 oz. wine, 1 shot of distilled liquor). If a person drinks faster than this, the remainder will circulate in the blood stream until the liver can get rid of it.

- Body weight. Heavier people will be less affected by the same amount of alcohol than lighter people. They have more blood and water in their bodies in which to dilute the alcohol.

- Food in the stomach. When there is food in the stomach, alcohol is absorbed slower into the blood stream. The BAC rises more rapidly in those who drink on an empty stomach, because there is no food in which to dilute the alcohol.

- The type of alcohol you drink. The stronger a drink is (the higher the alcohol concentration, distilled alcohol first, wine second, beer third), the more quickly it is absorbed. This partially explains why hard liquor has more of an apparent " kick" than wine or beer.

- Type of mixer used. Water and fruit juices mixed with alcohol slow the absorption process, while carbonated beverages will speed it up. Carbon dioxide speeds the alcohol through the stomach and intestine into the bloodstream, creating a rapid rise in BAC.

- Temperature of the drink. Warm alcohol is absorbed quicker than cold alcohol.

- If you are male or female. Women reach higher BAC's faster because they have less water in their bodies and more adipose tissue (fat), which is not easily penetrated by alcohol. Therefore, a man and woman, with all other factors being equal, both drinking the same amount of alcohol will have different BAC levels. Hers will be higher. A woman's menstrual cycle will also affect her rate of absorption. They will experience their highest BAC's premenstrually. In addition, there is also evidence that a woman taking birth control pills, will absorb alcohol faster, resulting in higher BAC levels.

Depressants

Alcohol

- Most people do not think of alcohol as a drug

- Medical consequences usually show up after years of heavy drinking

- Has a profound effect on the chemistry of emotions

- Increases the hazards of other drugs when used in combination, to include: more severe side effects, more frequent adverse effects, and diminished effectiveness of the medication

- Remains in the body for four or more hours, depending on amount ingested

- Can result in respiratory depression, cardiac irregularities, coma. Using marijuana with alcohol inhibits vomiting and can increase the likelihood of overdose

- Other causes of serious injury or death can result from aspiration of vomitus, accidents from impaired judgment and coordination, fighting resulting from disinhibitory effects and increased aggressiveness, and suicide resulting from increased impulsivity/or depression.

- Medical complications include cirrhosis of the liver, brain damage and hypertension are common with high dose/long term use. Poor nutrition and self-care can be see with advanced alcoholism.

Appeal of the Drug:
- anxiety reduction
- social lubrication
- disinhibition

Specific Effects:
- rapid tolerance
- sedation
- impaired concentration
- impaired coordination
- rapidly fluctuating moods
- disinhibition

Signs of Use:
Slurred speech; uncoordinated movements; unsteady gait; nystagmus; flushed face; aggressive and/or disinhibited behavior; rapid mood shifts; impaired judgment and/or functioning.

Withdrawal Symptoms:
A hangover is the withdrawal syndrome from acute ingestion of alcohol. Nausea, vomiting, malaise, weakness, autonomic hyperactivity, anxiety, depression, irritability, transient hallucinations or illusions, headache, insomnia, and possible delirium may appear within 24 hours after use has stopped and last 3-10 days in the case of long-term alcohol dependence.

Withdrawal from alcohol can also include: convulsions; delirium tremens (DT's) and hallucinations. Withdrawal from alcohol can be medically dangerous and produce serious medical complications, and detoxification procedures must be monitored because abrupt withdrawal can be life-threatening. Withdrawal for the alcohol dependent person can last well beyond the time for which medical supervision is necessary. Symptoms can last for weeks or months.

Opiates /Narcotics

- Includes pain medications such as morphine, Demerol, Dilaudid, Darvon, Percodan, Vicodin, codeine, as well as heroin and methadone.

- It is theorized that many addicts and alcoholics have problems in their natural pain-regulating mechanisms that leave them vulnerable to addictive disease.

- Routes of administration can be oral, IV, intranasal, or through inhalation.

- Users are more likely to die from overdose than from withdrawal.

Appeal of the Drug:

- reduced sensitivity to pain
- "rush" of the initial effect (euphoria)
- tranquility
- reduced anxiety

Signs of Use:

- Pupillary constriction or dilation
- drowsiness
- slurred speech
- impairment in attention or memory behavior that suggests euphoria followed by apathy, dysphoria, psychomotor retardation, impaired judgment, or impaired functioning may also be signs of use

Specific Effects:

- rapid tolerance
- reduced sensitivity to pain
- sedation
- reduced anxiety
- excessive dryness (constipation
- sluggish muscle tone
- low blood pressure
- slowed pulse
- cough suppression
- shallow breathing
- slowed motor response
- inability to focus thoughts
- euphoria
- apathy

Sedatives/Hypnotics/Anxiolytics

Sedatives sedate or calm.

Hypnotics induce sleep.

Anxiolytics reduce ongoing anxiety.

The most commonly prescribed and abused are benzodiazepines. These include: Valium; Librium; Dalmane; Halcion; Ativan; Klonipin; and Xanax. The BZs are chosen for anxiety reduction and as sleep aids because they are safer and more effective than other sedatives. Overdose is virtually impossible if these drugs are not mixed with alcohol: however, withdrawal must be carefully monitored because abrupt withdrawal can be life threatening.

Signs of Use:
Slurred speech, uncoordinated movements, unsteady gait, impaired judgment.

Withdrawal Symptoms:
(Noted after prolonged use--usually 90 days at low doses.) Symptoms include anxiety, restlessness, dysphoria, and muscle twitches. Withdrawal from high doses can include severe anxiety, tremors, sweating, agitation, psychosis or seizure.

Alcohol and Drug Overview

The DSM-IV presents 12 classes of psychoactive substances that can cause organic impairment. These include:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opiods
- Phencyclidine & related substances
- Sedatives/Hypnotics/Anxiolytics
- Other/Unknown

1) Depressants

Alcohol, Opioids, Sedatives, Hypnotics, Anxiolytics

These psychoactive drugs have a primarily *sedative* effect and a strong potential to create dependence. The effects are experienced as reduction in tension, disinhibition, relief from anxiety, reduced stimulation, calmness or tranquility Their primary hazards include respiratory depression, coma, and death by injury due to accident.

2) Stimulants

Amphetamines, Cocaine, Caffeine, Nicotine

The primary effect of these drugs is *excitation* or *arousal.* They have a strong potential to create dependence because of the transient sense of pleasure and reward they provide. They are experienced as focused thought processes, euphoric mood and increased energy. Their primary hazards to life include: convulsive seizure, cardiac arrest or death by injury (due to wildly reckless driving, paranoia, agitation, aggression and/or psychotic behavior.

3) Other Drugs

Cannabis, Hallucinogens, Phencyclidine (PCP), Inhalants, Other/Unknown

These drugs cannot easily be grouped into a depressant or stimulant class as they have some characteristics of each. Hallucinogens and PCP are sometimes called *psychedelics*. They produce perceptual distortion in the form of sensory illusions or hallucinations and increased awareness of internal and external stimuli. Hallucinogens do not create physical dependence or high levels of physical toxicity, whereas this does not appear to be the case with PCP. These drugs may induce or contribute to *panic attacks*. They may cause death through *loss of reality testing* due to sensory distortion (e.g., not responding to pain, "flying" out a window). PCP can result in death due to overdose or to an accident caused by loss of motor control.

INDICATORS OF DRUG USE

- Neglect of significant personal concerns such as health, hygiene, personal appearance, housing needs or nutritional needs. Weight loss, poor appetite or obvious dental decay may be seen. Neglect is the result of drug seeking behavior and mental deterioration.

- Inexplicable sudden changes in personality, for example the sudden onset of aggression and/or paranoia.

- Acute changes in mental functioning, such as the onset of drowsiness, confusion or disorientation.

- Acute mood changes, including euphoria, depression or irritability.

- Recurring signs of drug withdrawal such as irritability, confusion, restlessness, tremor, sweating, cramps, and the complaint of 'aching bones.'

- Homelessness and itinerancy (frequent moving from place to place).

- Significant and repeated inconsistencies in statements to persons such as health care workers, and general lack of cooperation.

- The need to regularly take large amounts of benzodiazepine medication or other sedating medication.

- Attempts to manipulate health care workers with such talk as: "You know I need X and if I don't get X, I won't be able to control myself," etc.

- 'Track marks,' usually seen as longitudinal scars on the inside of the elbow areas, due to chronic intravenous drug use.

- Continued inability to provide identification.
- The complaint of insomnia, without obvious reason. Remember that marijuana abuse may be a possible cause of insomnia.
- 'Doctor shopping,' or the indiscriminate consultation of numerous doctors to obtain medication.
- Accusations of theft or confirmed involvement in crime to support a 'habit.'
- Denial of the problem may occur and should not be accepted if signs of drug use are present.

Other Drugs

Cannabis (Marijuana)

- Can be smoked in a pipe, rolled into cigarette paper or compressed into hashish or hashish oil.
- Comprised of about 400 chemicals, with the cannabinols (particularly delta-9 THC) and the cannabidiols creating the primary psychoactive effect.
- Potency is much higher than it was 10-20 years ago.
- Most of the marijuana in this country has a sedative effect and calms the user.
- Some users seek the dissociative effect of the drug—a feeling of distance from other people, which can make them feel safer in uncomfortable situations.
- The half-life of marijuana is eight days. It takes approximately two months to rid the body of all traces of the substance.
- Low doses result in impaired short-term memory.
- High doses result in: difficulty in concentration; difficulty managing emotions; amotivation; impaired ability to operate a car or other machinery; impaired job/school performance; distancing in relationships.

Appeal of the drug:

- dispels boredom
- narrows focus of concentration
- distorts time
- exaggerates the senses and emotions

- reduces anxiety
- dissociative effects

Specific Effects:
- decreases anxiety
- produces shifts in concentration
- produces a dissociative reaction
- alters perception of space and time
- alters judgment of speed and distance
- decreases motivation and concentration
- alters functioning of the hypothalamus and pituitary glands
- increases heart rate, decreases blood pressure
- lowers pressure within the eyes

Signs of Use:
Physical signs can include reddened eye, increased appetite, dry mouth, and rapid heart beat.

Withdrawal Symptoms:
Agitation, inability to concentrate, sleep problems, craving, decreased appetite, anxiety and discomfort around other people. Severity of symptoms depends upon the dose and length of use. For the average user, the symptoms are usually mild with a gradual onset because of the long-life of the drug. Users can rarely identify withdrawal symptoms due to marijuana because they often begin to occur several weeks after date of last use.

Hallucinogens, Phencyclidine (PCP), and Related Substance

- Primary effect involves changes in thought content, sensory perception and subjective emotional experience.

- Psychedelics cause intensified sensations, mixed-up sensations (synesthesia), illusions, delusions, hallucinations, stimulation, and impaired judgment and reasoning.

- The most commonly used psychedlics are: LSD, MDMA, PCP, peyote, and psilocybin mushrooms.

- PCP and Other Psychedelics: PCP, an animal tranquilizer causes mind-body distortions and a sensory deprived state.

- PCP has characteristics of depressants and stimulants.

- Easy and inexpensive to manufacture.

- Commonly mixed with other drugs and used as substitute for other chemicals without user's awareness.

- PCP is frequently found as adulterant for street drugs sold as LSD, Ecstasy, and/or THC.

- With repeated use the drug can be stored in the body for weeks or months beyond cessation of use.

- Higher doses can cause paralysis, loss of consciousness, amnesia, violence, and psychosis.

Appeal of the Drug:
- alters sensory input
- accentuates mood
- creates illusions
- synesthesia
- dissociative reaction
- loss of body and ego boundaries
- sense that mundane events aren't important
- sense of bonding and affiliation (ecstasy)

Specific Effects:
- tachycardia
- increased blood pressure
- increased body temperature
- pupil dilation
- visual illusions, perceptual changes
- emotional lability
- slowed time perception
- dissociative
- mild tolerance possible
-

Most Severe Hazards:
- panic reaction
- alters perception of time and space
- interferes with reflexes
- accidents common
- possible toxic psychosis
- drug-precipitated functional psychosis
- flashbacks

Signs of Use:

- Pupillary dilation; tachycardia; sweating; palpitations; blurred vision; tremors; uncoordinated movements
- Behaviors indicating marked depression or anxiety; ideas of reference; fear of "going crazy;" paranoid ideas; panic; impaired judgment and functioning
- Reports of perceptual changes: intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias, euphoria, mysticism or religiosity

Withdrawal Symptoms:
No physical dependence occurs with hallucinogens and no withdrawal syndrome has been documented, even after prolonged use of high doses.

Inhalants

- Includes volatile organic compounds such as: gasoline, glue, paint, cleaning agents, aerosol propellants, nitrous oxide (laughing gas) and amyl and butyl nitrate.

- Effects occur within 7-10 seconds and last no more than 30 minutes to one hour.

- Neurologic damage can include hearing and visual impairment, loss of coordination and memory, and learning disabilities. Mental impairment may be irreversible, though not usually progressive after abuse ceases.

- More users are preadolescents and young teens who do not have access to more "sophisticated" drugs, while others live in institutional settings or do not have enough money for other drugs.

- A common method of administration is to pour or spray the chemical onto a rag, place it over the nose and mouth, and inhale (huffing), or place in a plastic bag and inhale (bagging), or breathing in the inhalant directly from the container (sniffing).

Appeal of the drug:
- creates an intoxicated state
- effects are immediate and last from 5 to 45 minutes
- readily available through legal channels

Specific Effects (may vary depending on exact substance):
- mild intoxication
- possible hallucinations
- rapid onset of action
- create visual disturbances
- decrease appetite
- loss of memory

- unsteady gait

Most Severe Hazards:

- organ damage (including brain damage, liver damage, pancreatitis, kidney failure
- accidents, head trauma resulting from impaired judgment and coordination
- inflammation in joints, muscle weakness
- destroy red and white blood cells
- central nervous system depression or overstimulation
- cardiac arrhythmia (irregular heartbeat) and cardiac failure
- damage due to anoxia (lack of oxygen)

Signs of Use:

- rash around nose and mouth
- chemical breath, body odors
- residue
- red glassy watery eyes and dilated pupils
- slow, thick, slurred speech
- irritation of the throat/lungs/nose, nausea, headache
- dizziness
- nystagmus
- pains in chest and stomach
- fatigue
- staggering gait, disorientation, lack of coordination
- stupor
- euphoria
- belligerence
- assaultiveness
- impaired judgment and functioning

Reports of Drug Problems in Emergency Rooms (In many cases, more than one drug is found in incoming patients)	
DRUGS	**% of Patients Who Tested Positive**
1. Alcohol in combination with other drugs	32.6%
2. Cocaine	28.4%
3. Heroin/morphine, codeine, or other opioids	17.3%
4. Acetaminophen, aspirin, ibuprofen	13.9%
5. Benzodiazepines (Xanax, Valium, Ativan, Klonipin	10.4%
6. Antidepressants (Elavil, Prozac)	8.6%
7. Marijuana	8.6%
8. Methamphetamine/amphetamine	5.1%
9. Antihistamine	1.7%
10. OTC sleeping aids	1.3%

In some parts of the country, particularly San Francisco and on the West Coast, ER staff are seeing more and more Methamphetamine-Induced Psychosis.

Cocaine still causes the most deaths, although there has been an increase in deaths related to heroin overdose.

SUBSTANCE ABUSE AND BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE

Intoxication		Withdrawal States		Substance-Induced Paranoid Psychotic States	Substance-Induced Organic Brain Syndromes
High	Low	High	Low	High	High
Alcohol	Opiates	Alcohol	Opiates	Meth	Alcohol Withdrawal
PCP	[redacted]	Sedative	[redacted]	Cocaine	Sedative Withdrawal
Cocaine	[redacted]	Stimulants	[redacted]	PCP	PCP Intoxication
Meth	[redacted]	[redacted]	[redacted]	[redacted]	Inhalant Intoxication
Inhalants	[redacted]	[redacted]	[redacted]	[redacted]	Cocaine Intoxication
*LSD	[redacted]	[redacted]	[redacted]	[redacted]	Brain Injuries
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Adapted from: Potter-Efron, R. & Potter-Efron, P. (eds.) 1990. Aggression, Family Violence and Chemical Dependency. New York: The Haworth Press.

Quick List - Substance Use Symptoms

SUBSTANCE	INTOXICATION SYMPTOMS	WITHDRAWAL SYMPTOMS
Depressants	slurred speech; incoordination; unsteady gait; impairment in attention or memory	nausea or vomiting; malaise or weakness; tachycardia; sweating; anxiety or irritablity; hypotension; coarse tremor of hands, tongue, and eyelids; insomnia; grand mal seizures
Stimulants	euphoria; grandiosity; hypervigilance; fighting; pupillary dilation; elevated blood pressure; perspiration or chills; nausea or vomiting	severe depression; irritablity; anxiety; fatigue; insomnia or hypersomnia; psychomotor agitation; intense craving for the substance
Opiates and Analgesics	initial euphoria followed by apathy, dysphoria, psychomotor retardation; impaired judgment; pupillary constriction; drowsiness; slurred speech; impaired attention or memory	cravings for opiates; all symptoms of severe influenza
Cannabinols (Marijuana)	euphoria; feeling of relaxation; sleepiness; heightened sexual arousal; anxiety; suspiciousness or paranoid ideation; sensation of slowed time; inappropriate laughter; social withdrawal; impaired judgment; bloodshot eyes; increased appetite ("junk" food); tachycardia; dry mouth	marked anxiety; emotional lability; depersonalization; possible persecutory delusions

Hallucinogens	illusions; hallucinations (visual) synesthesia; euphoria; mystical or religious experiences; pupillary dilation; tachycardia; sweating; palpitations; blurring of vision; tremors; incoordination; Bad Trip: anxiety and depression; ideas of reference; fear of losing one's mind; paranoid ideation	no apparent withdrawal symptoms; delusional disorder may develop; mood disorder may develop; post-hallucinogen perception disorder may develop ("flash back")
Solvents/Inhalants	euphoria; giddiness; light-headedness; slurred speech; lethargy; depressed reflexes; tremor; blurred vision; stupor or coma; belligerence; assaultiveness; apathy; impaired judgment; dizziness; nystagmus; eye irritation; irriation of throat, lungs, and nose	same as with the Depressants
PCP	belligerence; assaultiveness; impulsiveness; unpredictability; psychomotor agitation; vertical and horizontal nystagmus; increased blood pressure and heart rate; numbness or diminished responsiveness to pain; ataxia; muscle rigidity and seizures; bizarre and violent behavior; paranoid ideation	similar to Hallucinogens

adapted from: Fauman, M., (1994). Study Guide to DSM-IV. Washington D.C.: American Psychiatric Press, Inc.

NOTES

PERSONALITY DISORDERS

Personality Disorders Training
Crisis Intervention training
Portland Police
5/18/00

Outline

I. Overview

A. Definition: DMSIV A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adult, is stable over time and leads to distress or impairment.

B. Types:

1. Cluster A Paranoid, Schizoid, Schizotypal,
   - odd or eccentric

2. Cluster B: Antisocial, Borderline, Histrionic, Narcissitic,
   - dramatic, emotional or erratic

3. Cluster C: Avoident, Dependent, Obsessive Compulsive
   - anxious or fearful

II. Development of Personality Disorder

A. Stress / Coping Skill Relationship

B. Sense of Self

C. Impairments

1. self harm
2. self defeating behavior
3. relationships
4. abandonment issues

III. Management of Behavior

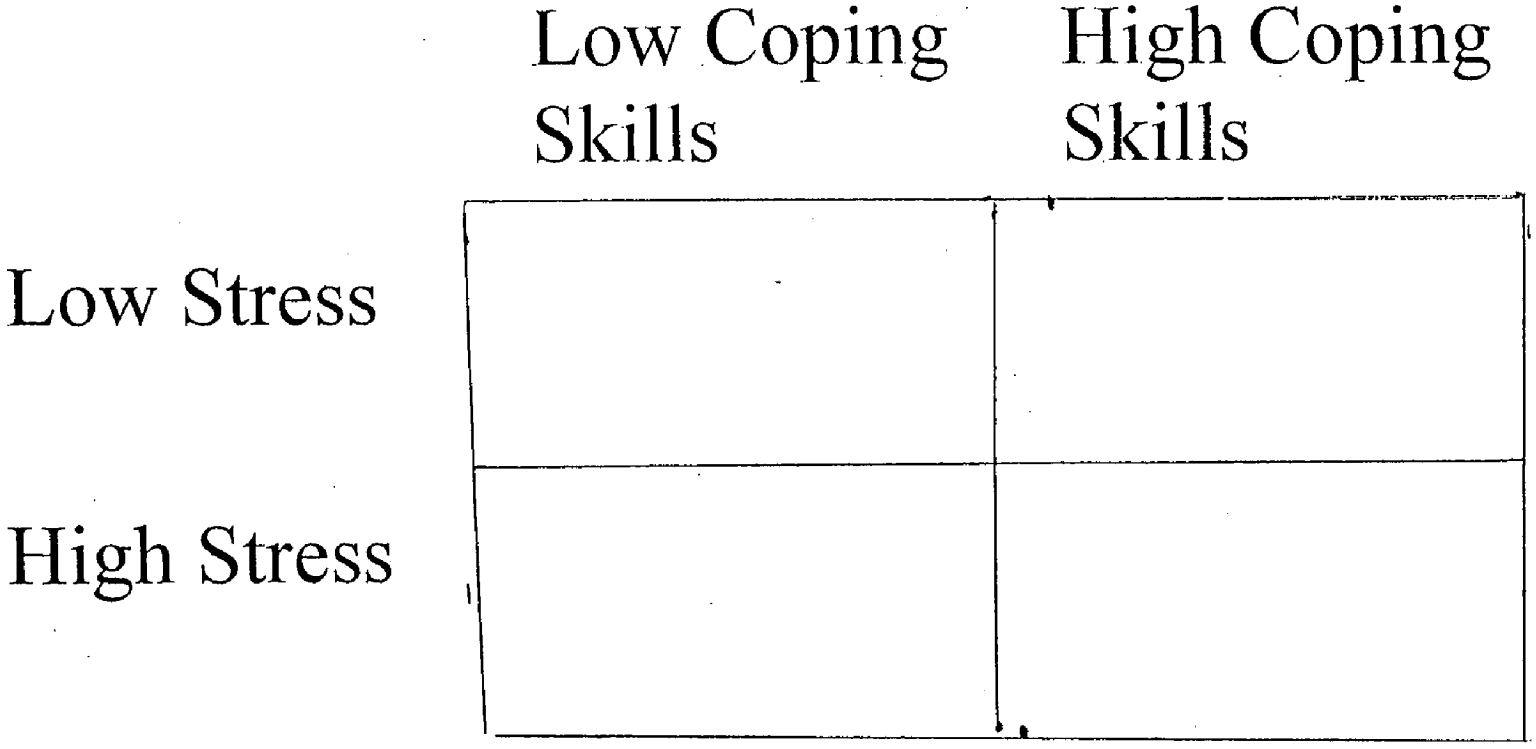
A. Neutrality

B. Clarifying Expectations

C. Setting limits

D. Supportive feedback

Stress/Coping Skill Relationship



NOTES

Section 2 - PROCEDURES

- Mental Status Exam
- Committment Laws
- Rights of the Mentally Ill

MENTAL STATUS EXAM

CIT Training -- The Mental Status Exam

Neil Falk, MD
May 9, 2000

A Mental Status Exam (MSE) is the mental health worker's equivalent of a medical provider's physical exam -- an examination of an individual to help determine if they have an illness. A very quick MSE can be performed quite easily, as many of the basics are common sense. The examination can even occur at a distance, and without the individual's participation -- a lot can be gained just by observation.

- Appearance

-- How is the individual dressed? Examples of dress which may indicate a mental illness include:

-- Inappropriate for weather (e.g. -- many layers in summer)
-- Inappropriate for context (e.g. -- pajamas in the street)
-- Odd or bizarre clothing
-- Very dirty/foul smelling/tattered clothing

-- How is the individual's hygiene? examples of hygiene which may indicate a mental illness include:

-- Very dirty/foul smelling clothing
-- Very dirty/foul smelling body
-- Poor dental condition

-- How is the individual behaving? Examples of behavior which may indicate a mental illness include:

-- Responding to internal stimuli (i.e. -- "talking to self")
-- Standing still/staring for prolonged periods (e.g. - catatonia)
-- Disorganized/non-goal directed actions
-- "Odd" actions, or interactions with others in the environment (e.g. -- bizarre mannerisms, posturing, agitated towards others, ignored by large group, being viewed with suspicion by group or vice versa)
-- Abnormally fast or slow movement pattern/energy level

• Thought Processes

The thought processes of the mentally ill are, by definition, disturbed. Mentally ill individuals may:

-- have disorganized thoughts (e.g. -- tangential thinking, loose associations, flight of ideas, etc.)
-- have "bizarre" thoughts (e.g. -- delusions of persecution, grandeur, conspiracies, etc.)
-- have blocked thoughts (i.e. -- long pauses during thinking)
-- persevere on one topic

• Speech

The speech of mentally ill individuals often is abnormal -- a reflection of their abnormal thought processes. Mentally ill individuals may:

-- speak abnormally fast or slow
-- use words abnormally (paraphasic errors)
-- use nonsense words
-- create words (neologisms)
-- be hard to interrupt (pressured speech)

•Miscellaneous

-- mood (how the person *says* he/she is feeling)
-- affect (how the person *appears* to be feeling)
-- suicidal/homicidal thoughts
    -- plan
    -- access to enact plan
    -- intent to carry out plan
    -- chronicity
-- hallucinations (usually auditory in the mentally ill)
-- cognitive abilities
    -- memory (short, intermediate, and long term)
    -- concentration/distractibility
    -- abstract thoughts (often mentally ill individuals cannot think abstractly)

•Generalities

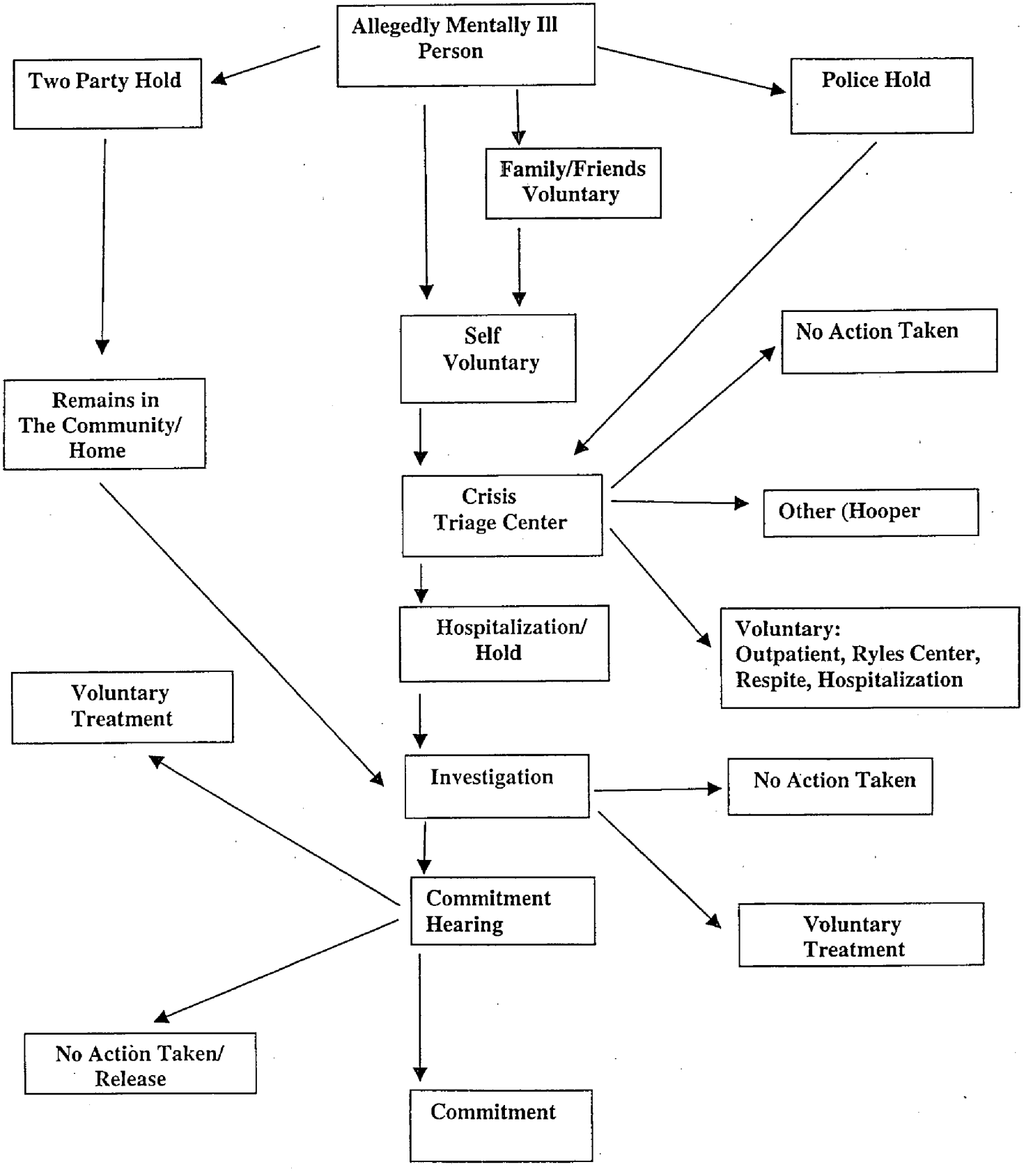
-- If it doesn't feel safe, don't do it!!
-- Mentally ill people are people, and deserve common respect.
-- Listen carefully.
-- Allow the individual to talk at length at least once.
-- Don't be afraid of silences. They often bring out symptoms.
-- Try to be an ally, not an adversary.

	Appearance	Thought Processes	Speech
Psychotic/Schizo-phrenic	Disheveled, Poor hygiene, Disorganized	Disorganized, Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to disheveled, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Intoxicated	Anything and everything	Anything and everything	Anything and everything

NOTES

COMMITMENT LAWS

THE COMMITMENT PROCESS



THE COMMITMENT PROCESS

THE DIFFERENCES BETWEEN A TWO-PARTY PETITION AND A HOSPITAL MEDICAL DOCTORS HOLD

TWO-PARTY PETITION

Used for issues of inability to care/deterioration of function.

Person remains in the community/home

Investigation completed within fourteen calendar days (two weeks)

Can be signed by any two-parties/people

HOSPITAL MEDICAL DOCTOR HOLD

Should be used only in cases of imminent danger to self or others

Person held in hospital

Investigation completed within five working days

Must be signed by two MD's or one MD and qualified health professional

THE COMMITMENT PROCESS

The Civil Commitment process is governed by the Oregon Revised Statutes 426 and the Administrative Rules (interpretation of the Statutes) from the Oregon Mental Health Division. The Statutes define what the legal definition of mental illness is. Legally, mentally ill means; a person because of a mental disorder, is one of the following:

A) Dangerous to self or others.

B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

C) A person who:

1) Is chronically mentally ill by the following definition (also known as "Expanded Criteria"):

   a) Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility
   AND
   b) Is exhibiting symptoms or similar behavior to those that preceded or led to one or more of the hospitalizations or inpatient placements.
   AND
   c) Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Civil Commitment is a legal process not a clinical one. It has been designed as a legal procedure. At times, the logic of legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of family, significant others, or treatment providers.

The goals of the Mental Health Division in the Civil Commitment process:

A) To promote the well being of persons who are allegedly mentally ill and who are mentally ill and who are mentally ill during the involuntary care, custody, and treatment of mental illness pursuant to ORS 426.

B) To promote the protection of the civil rights of persons who are allegedly mentally ill or who are mentally ill.

C) To encourage the consistent application of ORS 426.

D) To encourage the provision of care, custody, and treatment of persons in the least restrictive environment that is available within existing resources.

THE COMMITMENT PROCESS

E) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through Civil Commitment, whenever possible.

F) To encourage that the Director (local community mental health system knowledgeable of the statues and administrative rules and provides leadership that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS. 426.

G) To provide for the safety of the community and the person when that person is dangerous to others or self as a result of a mental illness.

The Commitment process can be initiated, by giving Notice in writing (under oath) to the County Mental Health Program, by two persons, the County Health Officer, or any Magistrate. The Court will be immediately notified and the Community Mental Health Program will start (within 3 judicial days) An investigation to determine whether there is probable cause to believe the person is in fact mentally ill. Judicial days do not include weekends or Court holidays. The person is not usually in custody or detained during this process.

Emergency care, detention in a hospital and treatment can occur through the following ways:

A) A Peace Officer who has probable cause to believe a person is dangerous to self or to others and is in need of immediate care, custody of a person and remove them to the nearest hospital or approved non hospital facility, a physician will examine the person immediately. If the physician finds the person t be in need of emergency care or treatment for mental illness, the person to be in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the physician), otherwise the person shall be released from custody.

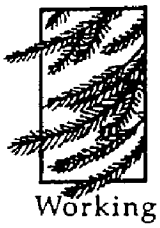
THE COMMITMENT PROCESS

B) A physician believes a person, who is at a hospital or approved non hospital, is dangerous to self or to others and is in need of emergency care or treatment for mental illness, can initiate a hospital hold and detain the person for emergency care. Under no circumstance shall any person be detained for more than 5 judicial days, following the signing of the hospital hold, without a Court Hearing.

C) A Designee of the Community Mental Health Program may, with probable cause that a person is dangerous to self or to others, or, additionally, (if the person is on a conditional release, outpatient commitment, trial visit) is unable to provide for personal needs, direct a Peace Officer to take custody and remove the person t o a hospital or approved non hospital facility for evaluation by a physician. This is called a "Director's Custody". If the physician finds the person is in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the Physician), otherwise the person shall be released from custody.

RIGHTS OF THE MENTALLY ILL

NOTES



OREGON ADVOCACY CENTER
Working for the Rights of Individuals with Disabilities

Rights of Persons with Mental Illness

Crisis Intervention Team Training
Portland, Oregon
November 14th, 2000

Janice Perciano and Jan Friedman
Oregon Advocacy Center

Voice: 503-243-2081 • 1-800-452-1694 • TTY: 1-800-556-5351 • Fax: 503-243-1738
620 S.W. Fifth Avenue • 5th Floor • Portland, Oregon 97204-1428

WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

Mental Health--the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental illness--the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alteration in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems--patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

. . . . .

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**

- **A range of treatments exists for most mental disorders.**

. . . . .

Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment . Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

. . . . .

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable.

. . . . .

Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Excerpts from **U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of health, National Institute of Mental Health , 1999.**

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Persons with mental illness have the **same rights as everyone else**.

Why aren't persons with mental illness treated the same?

1. Stigma--shame, hidden subject, accepted to mistreat, make fun of persons with mental illness

2. Misconceptions

   A. Violent--studies show that persons with mental illness are no more likely to be violent than anyone else, but often are portrayed in the media as violent

   B. Stupid--persons with mental illness have the same ranges of intelligence as everyone else, sometimes persons with mental illness are confused with persons with retardation--not the same

   C. Incompetent--everyone is presumed competent unless shown otherwise--persons with mental illness are presumed competent to make decisions even if civilly committed--only under specific circumstances is a person determined to be incompetent (guardianship, conservatorship, outside consultant determination regarding medication of person on commitment)

   D. Delusional--only some persons with mental illness experience delusional thinking--and even for these persons the delusions occur only some of the time

3. Protection of the person with mental illness--social workers, family, care givers, police etc. often want to treat persons with mental illness in what is perceived to be the best interests of the person with mental illness--may be in conflict with what the individual chooses and may be patronizing

4. Protection of society/family from hardship and/ or danger--actions are taken against a person with mental illness to protect others

5. Ignorance and fear--belief by persons without mental illness that persons with mental illness are extremely different than themselves and that mental illness may "spread"

LAWS SPECIFICALLY AFFECTING PERSONS WITH MENTAL ILLNESSES

1. CIVIL COMMITMENT

WHAT IS CIVIL COMMITMENT?

Civil commitment is a process in which a judge decides whether a person who is alleged to be mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment. A person in the process of a commitment sometimes is called an Alleged Mentally Ill Person (AMIP). A civil commitment is not a criminal conviction and will not go on a criminal record.

When a civil commitment petition has been filed, an investigator from the community mental health program (CMHP) will investigate the need for the commitment. Depending on the investigator's decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a right to an attorney and to have witnesses testify. The judge then makes a decision whether the person should be committed. If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting. The maximum commitment period is 180 days, although a person can be ordered to stay hospitalized beyond the 180 days in recommitment proceedings.

WHO CAN BE COMMITTED

Oregon Revised Statutes (ORS) chapters 426 and 427 contain the law regarding civil commitment. A judge can commit a person for up to 180 days if the judge finds by clear and convincing evidence, that the person

> Has a mental disorder and, because of that mental disorder, is:
>
> Dangerous to self or others, or
>
> Unable to provide for basic needs (like health and safety).

Or, the judge can find that a person is:

> Diagnosed as having a major mental illness (such as chronic schizophrenia or manic- depression), and

Has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

ORS 426.005; ORS 426.130

HOW THE CIVIL COMMITMENT PROCESS BEGINS

1) The commitment process may be started by a county health officer, a judge, or any two persons filing papers in court. Or, the process may be started by a doctor or community mental health program director ordering a person to be held involuntarily in a hospital. ORS 426.070; ORS 426.228 through ORS 426.234.

2) When the papers are filed, the CMHP program must send out a mental health investigator to interview the person and others who know about the person. This investigator advises a judge whether or not to hold a court hearing. ORS 426.070; ORS 426.074.

WHERE THE PERSON STAYS BEFORE THE HEARING

A person against whom a civil commitment petition is filed may stay in the community unless the judge orders the person to be taken into custody or a doctor or CMHP director directs the person be in custody. The person can be in custody only if he or she is considered to be mentally ill and a danger to self or others. A person who is mentally ill and unable to provide for basic needs cannot be held in custody unless the person's inability to provide for basic needs is so extreme that the person is a danger to self. A person held before a hearing is on a precommitment hold or in precommitment detention. ORS 426.070; ORS 426.228; ORS 426.231; ORS 426.232; ORS 426.233.

If a person is held in custody on a precommitment hold, he or she cannot be held in jail unless he or she is charged with a crime or is a serious danger to hospital staff or property. ORS 426.140. The person may be held in a hospital or a nonhospital facility. A nonhospital facility is a facility approved by the Mental Health and Developmental Disability Services Division (MHDDSD) to provide adequate security, psychiatric, nursing and other services. ORS 426.005(e).

A person on a precommitment hold has the right to be held in a mental health facility providing care, custody and treatment required for mental and physical health and safety. In other words, the person can only be held in a place with staff trained to provide mental health treatment. ORS 426.072(2)(a); ORS 426.228.

LENGTH OF TIME A PERSON CAN BE HELD BEFORE A HEARING
A person cannot be held in custody on a precommitment hold longer than five working days without a court hearing. If five working days pass and there is no court hearing, a person is free to leave the hospital unless he or she has asked to postpone the hearing or has agreed to be hospitalized voluntarily under a diversion program. In other words, a person cannot be held longer than five working days unless a judge says so. ORS 426.095.

HOW LEGAL RIGHTS ARE AFFECTED BY COMMITMENT
In general, most legal rights are not affected by civil commitment. A person who is committed retains all legal and civil rights, including the right to vote and make contracts unless a court has found the person incompetent. ORS 426.385.

Some specific rights can be limited as a result of civil commitment:

Firearms - Persons who have been committed are forbidden from owning, buying, or possessing firearms. ORS 426.130(1)(D); ORS 166.250 (1)(D).

Future commitments - If a person is committed twice within the past three years, he or she can be committed more easily in the future. ORS 426.495.

Driving - Commitment can affect a person's ability to get or keep a driver's license. If a person has a mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle, the person cannot be licensed. ORS 807.090; ORS 807.700; ORS 809.410(16).

II. AMERICANS WITH DISABILITIES ACT (ADA)

The ADA protects persons with disabilities from discrimination in these areas:

1. Employment--This includes hiring, termination benefits, working conditions, etc.

2. Public Accommodations--This includes hotels, offices, shopping malls, restaurants, sports arenas, schools, zoos, hospitals, theaters, grocery stores, homeless shelters, libraries, etc.

3. Public Entities--This includes all local and state governmental services and programs.

4. Transportation--This includes buses, trains, lights rail must be accessible or

alternatives offered.

5. Telecommunications--This includes that telecommunication services must be made accessible for speech and/or hearing impaired persons.

Persons with mental illnesses are protected by the ADA if the mental illness substantially limits one or more of the major life activities of the person. Major life activities means activities such as working, learning, sleeping, thinking and walking. Persons who have a record of such an impairment or who are perceived to have such an impairment are also protected.

In addition to the ADA, which is federal law, Oregon has state laws prohibiting discrimination in employment and public accommodations.

III. FAIR HOUSING LAWS

The federal Fair Housing Act was passed in 1968 as part of the Civil Rights Act of 1968. The Fair Housing Act prohibited discrimination based on race, color, religion or national origin in the sale, rental or financing of housing. In 1974, Congress added a provision prohibiting housing discrimination based on sex.

In 1988, Congress added provisions prohibiting housing discrimination based on mental and/or physical disabilities. Under the law, landlords and sellers cannot discriminate against a person because the person has a mental illness and must make reasonable accommodations for a person disability. The law does not apply in some cases where the landlord or seller is acting with regard to his or her private house or small apartment building. The law also allows the rejection of any tenant or buyer who would directly threaten the health or safety of other individuals or would cause substantial physical damage to the property of others.

Oregon also has a state law prohibiting discrimination based on physical or mental disability in selling, leasing or renting of houses and apartments.

IV. RIGHTS IN THE COMMUNITY AND IN FACILITIES

STATUTORY AND CONSTITUTIONAL RIGHTS

Many people receive mental health services outside the state hospital. Even persons who are civilly committed often receive treatment in private hospitals that have contracts with the state. Additionally, more people are receiving services in facilities, group homes and independent residences rather than in hospitals.

A person who is receiving services outside the state hospital system has the same rights as any other person in the community. Some of the rights that all persons in the United States are the right to:

*Vote

*Exercise freedom of speech, freedom of association and freedom of religion.

*Have privacy, including the right to marry and have children.

*Be free from discrimination based on race, gender, color, national origin or disability.

In 1993, the legislature passed legislation that sets out some specific rights of persons receiving mental health or developmental disabilities services. A person who is receiving mental health or developmental disabilities services outside of the state hospital has the right to:

*Have a written treatment plan and participate in making the plan.

*Choose from available services and have those services provided in the least restrictive way.

*Receive only services to which a person gives informed, voluntary, written consent.

*Receive medication only for individual clinical needs.

*Not be involuntarily terminated or transferred from services without prior notice and the right to be notified of available sources for necessary services.

*Receive humane services, be protected from harm and have reasonable privacy.

*Be free from abuse and neglect.

*Report abuse and neglect without retaliation.

*Exercise religious freedom.

*Not be required to perform labor, except personal chores, without being paid.

*Visit with family, friends, advocates, legal and medical professionals.

*Be told about rights and how to report abuse.

*Assert grievances and have them considered in a fair, timely and impartial manner.

*Communicate with any rights program or advocate.

*Exercise these rights without any reprisal or punishment.

ORS 430.210.

V. ABUSE REPORTING

Since 1991, the law has required the reporting and investigating of abuse of persons with mental illness who are receiving mental health services in the community. Abuse is defined as:

*Any death caused by other than accidental or natural means.

*Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.

*Willful infliction of physical pain or injury.

*Sexual harassment or exploitation, including any sexual contact between an employee of a facility or community program and an adult who is receiving mental health services.

The law requires private and public officials to report abuse if they have reasonable cause to believe abuse occurred. This means that all doctors, nurses, aides, psychologists, employees of county mental health programs, employees of mental health services providers, clergy, attorneys, outreach workers, social workers, therapists, police and others must report abuse.

Abuse may be reported to the Mental Health and Developmental Disability Services Division (MHDDSD), the county mental health program or the police. The office that receives the abuse report must then conduct an investigation or make sure that an investigation is conducted. The person who may have been the victim of the abuse must be provided protective services if needed. The investigating office must complete a report of the investigation and send it to MHDDSD. ORS 430.735 through 430.765.

VI. INFORMED CONSENT TO TREATMENT

A person can receive mental health treatment, including medications, only if the person gives his or her informed consent. This means the person must be told what the benefits and risks of treatment are and must make a voluntary decision.

A person cannot be forced to take a particular medication just because everyone thinks it would be good for him or her. The exception is when a person has been civilly committed and two doctors have agreed that the person is unable to make decisions. In this case, if the proper procedures are followed, the person may be subjected to treatment that she or he does not want.

VII. GUARDIANSHIP

If a person is "incapacitated", a judge may appoint a guardian for her or him. A guardian can only be appointed by a judge. A parent does not have the powers of a guardian if the individual is 18 or over unless the judge has appointed the parent a s guardian.

TELEPHONE NUMBERS FOR ADVOCACY GROUPS AND LEGAL ASSISTANCE

American Civil Liberties Union	503-227-3186
Fair Housing Council	503-223-8295
Multnomah County Legal Aid	503-224-4086
National Alliance for the Mentally Ill	800-343-6264
Oregon Advocacy Center	503-243-2081
Toll-free	800-452-1694
TTY	503-323-9161
Toll-free TTY	800-556-5351
Oregon Legal Services	
Central Office	503-234-1534
Farm Workers' Office	503-981-5291
Hillsboro Office	503-648-7163
Native American Office	503-223-9483
Oregon State Bar	
Lawyer Referral Service	503-684-3763
Toll-free	800-452-7636
State Public Defender	503-378-3349
U.S. Office of Civil Rights	206-615-2290
Toll-free	800-362-1710

WORKING FOR THE RIGHTS OF INDIVIDUALS WITH DISABILITIES

GOVERNMENT AGENCIES

Adult and Family Services Division	503-731-3111
Bureau of Labor and Industries	503-731-4200
Equal Employment Opportunity Commission	206-220-6883
Toll-free 800-669-4000	
TTY 206-220-6882	
Mental Health and Developmental Disability Services Division	503-945-9499
Office of Mental Health Services	503-945-9700
Office of Client Rights	503-945-9495
Psychiatric Security Review Board	503-229-5596
Senior and Disabled Services Division	503-945-5811
Toll-free 800-232-3020	
Social Security Administration	800-772-1213

ADVOCACY/CONSUMER GROUPS

Mind Empowered, Inc	503-231-4137
Oregon Advocacy Center	503-243-2081
Toll-free 800-452-1694	
TTY 503-323-9161	
Toll-free TTY	800-556-5351
Oregon Alliance for the Mentally Ill	503-370-7774
Recovery, Inc 503-231-1334	

Brief History of Treatment of Persons with Mental Illness in England and the United States

Early 1300s--English law categorized persons with mental disabilities as lunatics or idiots.

Pre-1600s--Persons with mental illness were cared for at home or sent to poorhouses, workhouses, jails.

1600s-- "Madhouses" created to confine persons with mental illness. The madhouses were unhealthy settings with harsh and punitive "treatment". Persons were chained, abused and publicly displayed.

1700s-- "Asylums" were developed to provide healthy environment and "moral treatment".

Mid-1700s--Persons with mental illness in England were placed in St. Mary of Bethlehem which became known as "Bedlam".

"Bethlehem--or Bedlam as it was called--was a favorite Sunday excursion spot for Londoners, who came to stare at the madmen through the iron gates. Should they survive the filthy conditions, the abominable food, the isolation and the darkness, and the brutality of their keepers, the patients of Bedlam were intitled to treatment--emetics, purgatives, bloodletting and various so-called harmless tortures provided by special paraphenalia." The History of Psychiatry, F.G. Alexander and S.T. Selesnick

1752--Pennsylvania Hospital opened with several cells for the "insane". The method of commitment was informal. A few words scribbled on a piece of paper were enough to get a person locked up.

1773--In Williamsburg, Virginia, the first US institution specialized for the "insane" opened.

Late 1800s--Large public institutions were filled with chronic patients receiving little treatment.

1883--Oregon State Insane Asylum opened in Salem (renamed Oregon State Hospital in 1907).

1900-1960--Hospitals emphasized treatment but no effective treatment was available. Institution populations continued to grow.

1907--Eastern Oregon Hospital opened in Pendleton.

> When we have a disturbed or noisy patient to deal with [prior to a lobotomy operation] in the University Hospital or Doctors Hospital we administer two, three or more electroshock treatments in rapid succession. Psychosurgery in the Treatment of Mental Disorders and Intractable Pain, Walter Freeman and James Watts, 1950.

1955--560,000 persons with mental illness were confined in hospitals (1/2 of all hospital beds).

1959--The average daily population in Oregon State Hospital and Eastern Oregon Hospital was 4909.

1960-1975--Deinstitutionalization resulted in the release of vast numbers of persons from institutions.

1961--Dammasch State Hospital opened in Wilsonville.

1975 to present--Communities recognized that deinstitutionalization could not succeed unless accompanied by adequate community support programs.

1977--Psychiatric Security Review Board created in Oregon to supervise persons found affected by mental disease or defect in criminal matters.

1990 to present--Managed care implemented for provision of mental health services.

Deaths at Dammasch State Hospital (DSH)--June 25, 1993 to October 8, 1993.

June 25, 1993--DC died at DSH--No medical examiner review but adequacy of medical treatment questioned.

August 29, 1993--JW died choking on pancakes. He was alone in his room, unmonitored despite swallowing problems.

August 29, 1993--LL died choking on pancakes. Staff called 911 but did not intubate LL or manually cut an airway.

September 19, 1993--KM died as a result of coronary arteriosclerosis. Staff had given her Haldol despite a diagnosis of mental retardation (IQ 54) and no diagnosis of mental illness. Staff found her lying on her bed. She had no pulse but was warm. Staff made a emergency request for a doctor. Thirteen minutes elapsed before a doctor arrived.

October 18, 1993--PG suffocated while being placed in physical restraints. A towel pulled over his mouth contributed to the death.

1995--Dammasch State Hospital closed.. Oregon State Hospital at Portland opened with capacity of 68.

1997--Current Oregon State Hospital capacity is for 727 beds, including hospital beds, residential beds, child and adolescent beds.

Section 3 - RESOURCES

- Family and Consumer
- Community Resources
- Medications

FAMILY AND CONSUMER PERSPECTIVE

WHAT IT'S LIKE

Being crazy hurts. For one who has been there, the idea of going crazy out of moral weakness, because it is easier than "facing reality," is utterly bizarre.

The major mental illnesses, like most other illnesses, carry with them an early-appearing and almost ever-present feeling of "sickness" and exhaustion.

As it gets better and worse, there are times when you may be unable to function at all, perhaps being unable even to get out of bed.

At these times, investigation is needed to determine whether you are suffering extreme stress of real-work origin, suffering from a resurgence of mental illness symptoms, or whether there is some unrelated medical problem, such as an abscessed tooth or the flu.

Too often, these episodes are viewed as bouts of laziness and "lack of motivation," and treated with harassment or even termination from a treatment program.

Unless this phenomenon, and ways of coping with it, are explained to you, you too may come to believe you are lazy and good-for-nothing.

You become aware that your perceptions are unreliable, that you are having sensory experiences that others do not share.

As you struggle for some understanding of what is happening to you, you find yourself clutching at extreme and bizarre explanations.

When you try to talk to other people about your experiences, you discover there is no common language for them. You find yourself putting together an unsatisfactory and embarrassing patchwork of religious, occult, or scientific words.

When you do talk to people, they may lapse into shocked silence, change the subject, or reject your statements as weird and you as crazy.

If you are not aware the perceptions are different from those of other people, you are even more disabled. Whenever you try to do something or talk to someone, all sorts of things go wrong, which you do not understand.

Because you cannot predict whether your perceptions and interpretations of events are acceptable to others as "real," you begin to be afraid to talk about your feeling at all. If you have not yet felt there was something wrong/bad about you before, you do now. You become very lonely.

Since you gave no safe way to compare your "crazy ideas" with what normal people define as real, your ideas/delusions become more detailed, more organized, and more strongly held.

Extreme and uncontrollable emotions rush through you: fear, confusion, anger, despair.

The feelings are overwhelming. You see yourself doing things you cannot stop. It comes to you that you are no longer in control of your life. You are forced to depend on other people for some things, even if you do not want to.

You begin to fear that you may do something awful, something that will make people get rid of you forever.

You worry that whatever has happened to you may be permanent, that you may never be all right again.

Pain becomes very familiar. It comes to have form and texture like terrain.

If pain is fairly steady and continuous, you can sometimes almost tune it out. But if someone offers you more hurt, whether it be emotional battering or physical, you are suddenly desperate and hostile. You are tired, tired, tired, and do not have the energy to take any more. Sometimes you have to take it anyway.

At times the pain/craziness comes in overwhelming waves. Like most people, you think that pain will somehow never crush you. Somehow new reserves of strength will appear, effective treatments will be found, or, in the extreme, that you will simply pass out.

Then one day, you lose control of your mind, your body, everything. You'll lose your bowels and scream and scream and scream, like a little pig squirming in the dirt. And it does not stop.

Having broken, having been totally <u>helpless</u> forever after leaves you feeling fragile in a way that other people do not. In wonderment you watch "normal people" go about their lives, full of energy, confident, unknowing. There is an abyss between you.

If you hurt bad enough, you try anything to feel better: self-help books, religion, sex, drugs, alcohol, and anything you can think of.

Some things make you feel a little better, some do nothing, and many of them make you feel a lot worse.

In desperation, sometimes just drinking or drugging yourself into unconsciousness seems a worthy goal.

The risks of triggering further psychotic episodes and the risk of alcohol and drug addiction are substantial. It is hard to be interested in future consequences of things when you are not sure you have a future or want one.

If you get strung out on alcohol or drugs you will have another difficulty. The people who work with alcoholics and drug addicts do not want you because you are crazy. The people who work with the mentally ill do not want you because you are an alcoholic or an addict. You can only go to special, expensive, "dual diagnosis" programs. If you have three or more diagnoses, you are likely to end up in jail.

Seriously mentally ill people have a suicide rate of 20-30 times that of the normal population. At greatest risk are those who are too ill to have a normal life, and not sick enough to be unaware of it.

Hardly anyone <u>wants</u> to commit suicide.

As the years go by, you exhaust the treatment options open to you. Hospitals and doctors get tired of you because you never get better.

You drift away from your family. You cannot hold a job, or maintain a sexual relationship.

If you talk to others about your feelings, you come under pressure to shut up and act normal. Your desperation makes <u>them</u> uncomfortable.

You feel helpless, lonely, and as if you have nowhere you belong. You cannot stand being trapped in all that pain. All these are bad enough, but it is the crushing, never ending <u>tiredness</u> that ultimately gets you. You kill yourself because you <u>have</u> to.

What you would really like to hear is: "We know you are very tired, and you feel awful most of the time. We do not want you to go away. We want you to live.

"But if the time comes when you really cannot take anymore, and you have to die, we will be very sad, but we will understand.

"Whether you get better or not, and whether you live or not, we love you anyway."

Confused and frightened people tend to try to clamp tight control on whatever or whoever upsets them. It is rare to be given this recognition of your pain and permission to do whatever you have to do, but if you are, it is very comforting.

It tends to relieve some of your guilt feelings for being such a mess, and such a disappointment to your family and friends.

If you are like many seriously mentally ill people, you have known since sometime in childhood that there is something very wrong with you.

Functioning at school was very hard. You have less and less success in living up to the expectations of your family, and in being like other people.

Others' attempts to shape you up are sometimes drastic. You are likely to have the experience of being threatened, ridiculed, or punished for things that you do not understand, cannot do, or cannot stop doing.

Parents, teachers, school counselors, and pediatricians rarely are familiar with mental illness in children. Many professionals take the de facto stand that major mental illness and suicide virtually do not occur in young children, and that all such problems come from "labeling" and "bad parenting."

Your family withers under the implied or open accusation that they made you crazy. They become too intimidated to talk to you, out of fear that they will "say something wrong" and cause you to shatter in a million pieces.

Communication within your family is loaded with fear and guilt, and is further complicated by your thought or mood disorder.

Nobody will tell you what it going on. In loneliness and isolation your fears and crazy ideas grow.

Your parents are scapegoated by relatives, neighbors, and authorities. They begin exchanging recriminations themselves. They become more and more exhausted and discouraged.

You are torn between wanting to stay with your family because you hope you belong there, and wanting to leave because you caused them so much pain.

If your family breaks up or you withdraw from them and you do not find some other support system, you fall on the not so tender mercies of the state.

As you move out into the world, you find you are only comfortable with "social equals," people similarly ill or otherwise damaged, and those rare people who are willing to some extent to understand your experience and feel your pain.

Talking with straight people is nerve wracking. You can never be sure when something you say will come out all weird, and you will be recognized as a crazy person and gotten rid of.

Hungry for human contact, you approach other people, only to discover that they are afraid of you. They assume that if you are mentally ill, you are by definition suicidal and violent.

You had been so wrapped up in being afraid yourself, that it comes as a humiliating shock to find that <u>normal</u> people are afraid of <u>you</u>. Some of them will even take the position that if you are or ever have been crazy, you cannot be trusted with anything, ever.

When out in the community, you are anxiously self-conscious, aware that at any moment a mannerism, a social misstep, or something "inappropriate" will unmask you as a crazy and embarrass anyone you may be with.

You fear being stared at, made fun of, or even being attacked by street creeps always on the lookout for someone with a high victim profile.

If you are too sick to have a hope of concealing it, you can only wait to be hurt and try to keep on going.

Being disabled, you fall into the hands of caretakers.

Sometimes you feel like an abandoned ship, to be taken over by any normal person who wants to, as if they had some kind of salvage rights.

At times you spend a lot of energy fending off such people, trying to hold onto the right to run those parts of your life that you still can.

Caretakers come in various roles, with a variety of titles and letters after their names. Some are very skilled and genuinely helpful, a lot more manage to get by, and some are definitely part of the problem, not part of the solution.

You have no choice about being sick, and no choice about depending on caretakers at times. Even within a given type of service or a particular agency, you seldom have a choice. Your "case" is "assigned" to someone by a "catchment area," "admission rotation," or whatever.

Caretakers control access to medication, asylum (the hospital), money (welfare, SSI), and food (stamps). They decide whether to allow you the sick role, or whether to define you as bad, crazy, or stupid. They can invalidate what you say or do, and call upon the court to have you carted away.

Appeals from their decisions are costly, time consuming, difficult, or impossible. In no way is their relationship a voluntary one between equals.

For a caretaker to operate humanely in such an unequal relationship, a very high level of skill and integrity is required. When you have no choice, you need the best.

Paradoxically, the mental health system tends to assign the least experienced and lowest status workers to screening and to the seriously ill, and the most trained and highest status professionals to the less needy but "more interesting" (more likely to get better) clients.

Like all human beings, some mental healthers have their prejudices, some of which may have a major impact on your life. Some of these prejudices include that, if you are:

a. Poor--you are just trying to get free room and board;
b. Black--you have paranoid schizophrenia;
c. Old--you are hopelessly senile;
d. Male--you are violent;
e. Young and female--you are manipulative or seductive;
f. Young and male--you are a doper;
g. Admitted to a hospital from jail--you are faking;
h. Physically ill--it's all in your head;
i. Failing to get better--you are unmotivated.

In your dealings with mental health workers, you will encounter some common problems:

Mental healthers sometimes seem to see you as a kind of agent of insanity, and immediately start a power struggle over who is to be in control of the relationship.

They seem to fail to see that you have no desire to keep, much less propagate, your crazy ideas. You would get rid of them in a minute if you could only figure out how to do it.

They will frequently refuse to tell you your diagnosis and probable course of your illness. With no real information to go on, you are left to your imagination, which is often worse than anything a doctor could tell you.

What they tell you about the expected effects of your medications and possible side effects is commonly very sketchy. You sometimes have nasty surprises.

Although PRN (extra, as needed) medications are routinely prescribed in the hospital, you are rarely provided them outside. Somehow, life in the community is supposed to be much less stressful, and besides, you might "abuse" the medications.

You find yourself viewed with a general distrust. Everything you say or do is "evaluated" and subject to "clinical judgment," to determine its "real meaning." Yet basic investigative techniques, such as talking to everyone involved and cross-checking their stories, are omitted.

At times, this is due to lack of time or carelessness, but too often it comes from an ego trip wherein professionals feel that their qualifications enable them to discern deep truths virtually by remote control.

It is terribly frustrating to try to communicate with such people, because nothing you say is accepted at face value, but is changed into something unpredictably different.

Meanwhile, they want you to "develop a trust relationship" with them, but changes in staff and program priorities may come much faster than your ability to trust can handle.

You may have to cope with mental healthers who take basically useful approaches to problems and carry them to such lengths that they become problems themselves.

It is helpful to convey to you the expectation that you will get better, but not so helpful to fail to teach yourself care skills and work with the emotional problems that arise when it becomes clear that you are not improving.

Inventorying your symptoms and problems is a necessary beginning of a treatment plan, but concentrating only on what is wrong with you and ignoring the strengths and abilities you still have is not so useful.

Good general counseling skills and effective community organization are necessary to help you improve and maintain your quality of life. However, they do not eliminate the need for detailed knowledge of the symptoms, experiences, and problems which affect you as part of your mental illness, or as effects of your medications.

Anyone working with seriously ill people must be willing to take control at times when you are too disabled to carry on necessary life functions. Unfortunately, mental health work attracts numbers of people whose need to control others is so great that they tend to discourage your own sense of your own competence, and dampen any drive you may have toward free and self-reliant living.

This is a rip-off, because they imply that since you are incompetent, you may rely on them to meet your needs. The first time you get in trouble outside normal business hours or without an appointment, you may have a rude awakening.

You <u>have</u> no choice about learning to take care of yourself and your fellow crazy people as best you can. The response of the mental health system is often just too slow and unpredictable.

It is reasonable for mental health workers to hope for some emotional gratification from their work, but sometimes you are too sick, and have nothing to give in return. Sometimes, when you are not getting any better, your therapists get desperate and start "shot gunning" you with multiple medications and rapid, ill-thought-out changes in your treatment plan.

You may not be listened to when you try to explain what has worked for you in the past.

Since your records are usually following a hospital or an agency or two behind you, you may suddenly be taken off a regimen on which you had been stable, and which took months of experimenting to develop.

The principle seems to be "change something, whether it helps or not," rather than feel helpless.

Other times, some workers get frustrated and bitter, and put increasing pressure on you to "get well or get lost." This can be mutual: they cannot forgive you for not getting better, and you cannot forgive them for not getting you better.

If you are crazy, you can usually count on being poor.

If you are severely disabled, you will probably be on welfare, at least at first.

Your welfare grant is based on a fraction of what a study of local prices determines to be the minimum livable allotment.

Social Security (SSI) is somewhat more, but you are unlikely to successfully complete the complex application process without determined help from a case manager or a family member.

In either case, you will have a welfare medical card. Since there are restrictions on the services covered, and because the majority of local physicians do not take welfare patients, your medical care is likely to be poor and without continuity.

You will probably have bad teeth, as well. Dental care is only available for emergencies, and for a low dollar amount, resulting mostly in extractions.

Your clothing is likely to be poor, ill fitting and mismatched, coming from thrift stores, and sometimes carrying institutional marks.

Drifting in and out of hospitals, jails, and boarding houses, most of your possessions will have long since been lost or stolen. You may have little in the way of toilet articles, and you may smell.

Your status as a second class citizen, a loser, is displayed for all to see. In addition to the practical problems of poverty, there are the emotional effects. If you are one who has learned to count personal worth in terms of possessions, you are doubly poor.

There is a strong streak of Calvinism in our society: being poor is seen as evidence that you are also bad.

If you go into a nice store, clerks follow you around waiting for you to steal something. Some mental health workers dress especially well to avoid being mistaken for patients.

If you are unable to be productive, many feel you should be uncomfortable. It would be immoral, somehow contributing to your delinquency, to give you things you cannot earn.

You meet people who would obviously be willing to let you starve to death if it were their choice. To your humiliation is added an element of real fear.

You may find yourself begging and stealing, in violation of your own principles. You pack rat, assembling collections of junk, rather than have nothing at all.

Sometimes it is hard not to hate the caretakers around you, who have built a comfortable lifestyle upon your misfortune.

Sex is important to people, to sick people no less than to people who have the privilege of being healthy. Like everything else, mental illness messes it up.

When you are depressed, when you hurt so bad you have to be completely numb in order to function at all, the numbness itself becomes another kind of discomfort. You want to feel <u>something</u>, anything but more pain. You think of sex as a strong, good feeling, and try it. You run into a wall of pain and exhaustion. You cannot get aroused, you cannot tolerate intercourse. You experience one more crushing failure. Perhaps you are no longer a woman or a man anymore.

If you are high, in a manic state, you may be very sexually active. It may feel wonderful, or, if your high has reached an agitated, desperate stage, it may feel frenzied and out of control.

When you come down, it can be mortifying. You may have VD treatment, abortion, divorce papers, and new enemies waiting for you.

If you have a thought disorder, you may be too scattered to figure out what you need, or disorganized or fearful to effectively seek out a partner. If you find a partner, he or she is likely to be a "social equal." With both of you crazy things can get confusing.

Institutions do not make provisions for sexual privacy. Quite the contrary. Your sexual experiences are likely to take place in bushes or on the floors of out-of-the-way restrooms.

You risk a personal confrontation with the fact that many people, but especially high control institution types, do not feel crazy people are entitled to sex lives. They may also have reasonable concerns about competency to consent, and about civil liability.

If you are male, and your activities or choice of partner are not approved of, you may be written up in records as "sexually inappropriate with one of our sickest female patients" ("rapist").

If you are a female, you may be described in your chart as "sexually inappropriate with men" (presumably numerous, "whore").

If you are gay or lesbian, you are doubly disapproved of, and you risk having drastic action taken against you, especially premature discharge from treatment.

If you are young, and have homosexual experiences during prolonged institutionalization, which are common, you may have to keep it deeply secret afterward, and wrestle, usually alone, with the question of what your sexual orientation actually may be.

A complication of trying to have a sex life while under psychiatric treatment is that many psychotropic medications are sexually disabling in many people. You may find yourself unable to get aroused, or you may be aroused but unable to climax, or climax is long delayed.

You may be told about this when being instructed about your medications, but frequent not. If you can get up the nerve to raise the issue, often a reduction of dose or a change to another drug will take care of the problem.

If you cannot, you get more depressed at this additional evidence that your life is ruined.

When you are poor, crazy, and unwanted, you hunger for warmth and touching, on almost any terms. Sometimes you fall into the hands of cruel and exploitive people.

Sometimes you hope you will have a child, as a fulfillment of your identity as an adult human being, and in hopes of having someone to be with, who will love you. Frequently, this ends in tragedy, as you have children you cannot take care of, and they are taken away from you.

Because mentally ill people often are fairly helpless, they are frequent crime victims. Criminals often are aware that you may have no interested family or friends, and are easily discredited in court. Therefore, there is little risk of being prosecuted for any crime against you, short of murder.

The sword is two-edged: because you are "insane" you may receive no consequences for repeated antisocial acts. You risk developing habits of behavior that drive away your support system, and ultimately land you in the hospital or on Skid Row.

When you lose your mental health, you go through the same pattern of responses for any other major loss. Dr. Elizabeth Kubler-Ross's "Stages of Dying" is a fairly accurate model.

1. Shock. You never expect to go crazy, nor do you expect to find out one day that you have been crazy for a long time.

   You are stunned, confused, afraid. For a period of time, you are in shock and unable to do anything to help yourself.

2. Denial. You buy time to deal with overwhelming anxiety producing situations, by denying them. You try to go on living as if the problem did not exist, while your subconscious mind works on some way to cope with the problem.

   Other people, who are not sick, get frustrated and angry because you do not do whatever they think you should do about the situation.

   Since it is not their problem, they are not overwhelmed by anxiety, and they can view the whole affair more objectively.

   The crunch comes when they pressure you to "face this thing, right now!" and accuse you of "wanting to stay sick."

   The reason you are unwilling to do the things they demand, such as going to a clinic, taking medication, and giving up "unrealistic" life plans, is because you do not want to be sick. Therefore, you do not want anything to do with anything even remotely related to being crazy.

   Since your denial is basically driven by anxiety, the more you are harassed about "facing the facts," the more delayed as you're coming to terms with your situation.

3. Anger. When you realize that your life is going to be more painful and more limited than the lives of other people who are of no greater merit than yourself, you get mad.

   Since many people view the family as the source of all problems, you may direct, and be encouraged to direct, your anger at them. Often having strong guilt feelings themselves, they may agree that you are entitled to be angry at them.

   You may also vent your anger at mental health workers, whose very presence in your life is an undesirable reminder of how you have been cheated of a normal life.

   You may carry a powerful resentment against people who have the privilege of normalcy, who have jobs, friends, money, cars, and other things that you do not.

4. Bargaining. As it becomes clear that this insanity business is for real, and it shows no signs of going away, you want to make a deal.

   You try unusual diets, stranger religions, street drugs, anything that offers the faintest hope of making a difference.

You promise God that you will devote the rest of your life to medical research and serve to the poor, if only this cross will be taken from you.

Occasionally, someone recovers for no reason known to man. Not very often.

5. Depression. When you realize that no deals are being made, blaming people makes no difference, and the craziness is not going away. You are very, very sad.

   You have a right to be. Through no fault of your own, your life has been ruined. You may never have the job, children, a car, or even one day free of pain for the rest of your life. The temptation to give up and die is very great.

6. Acceptance. After a time, usually a long time, you find a way to accept yourself and what has happened, and to go on with your life.

   There are three things that you have to understand:

   a. You must take care of yourself and meet as many of your own needs as you can, either yourself or through relationships with other people which are mutual, equal and loving.

      By virtual biological law, people meet their own needs and those of their loved ones first. Only what is left over is offered to others.

      This is as true of mental health workers as anyone else. They provide specific services, and a measure of emotional support, but rarely as love as exchanged among equals.

   b. Blaming people, whether yourself, your family, or anyone else, is a waste of time.

      Too much psychodynamic, insight-oriented therapy is a thinly disguised search for someone to hold responsible.

      There is no way you can recover a piece of your life from someone, as if it were money damages. You may not be able to forgive or forget, but you have to withdraw your energy from the past, and go on.

   c. You have to find some reason, some mission in life to justify going on, in spite of the pain and lack of orderly success.

      If you are religious, it may be the faith that you are in this world to be tested, or to learn something essential for your spiritual development, and that your

Appendix

Some reasons mentally ill people contact crisis services are:

1. You may need help with a practical, real-world problem. If you spent a lot of your life being crazy, you may be missing whole areas of competence which are taken for granted by normal people, such as riding the bus, dealing with a traffic ticket, or returning defective merchandise to a store.

2. You may need help putting an idea in words, defining a problem clearly so that you can work on solving it, or communicating feelings to someone in a relationship. If you have a thought disorder, the most important area of communication in words can be extremely difficult.

3. You may need emotional support for a necessary decision not popular with your immediate support system. The people in your college psychology class may be delivering fulminating denunciations of psychotropic medications, but you have to stay on them, or end up in the hospital or dead.

4. You may have symptoms that relate to a developing medical problem, and you need help figuring out whether you need medical care, or whether these are just some new variations on your hallucinations and delusions.

5. You may be experiencing new or threatening psychiatric symptoms, such as prolonged sleep loss or command hallucinations ordering you to kill yourself. You may need help deciding how serious these are, and what to do about them.

6. You may need a perception check: does it seem likely that you are important enough for the FBI to bug your phone, or is that probably just a crazy idea?

7. You may need help finding specific local mental health or social services.

8. You may be without food, clothing, shelter, or essential medical care.

9. You may be in legal trouble, and need help conveying to those defending you, the nature of your illness and your disabilities.

suffering has a place in the overall cosmic picture. For others it may be the goal of someday writing a book, which you hope will help normal people understand the experiences and needs of the mentally ill.

For a few who have luck, brains, and a terrible determination, it may be possible to go back into the wilderness to try to lead a few brothers and sisters to freedom. They become mental health workers themselves.

It may be the love of family, fear of death, or even plain stubbornness, but there has to be a reason.

If the pain is futile, it is also intolerable.

COMMUNITY RESOURCES

NETWORK
Behavioral HealthCare, Inc.

Resume of Low-Income Housing Experience

Date of Inception	Project
March 1985	Tillicum Court Apartments

Under the corporate ownership of Southeast Network Housing Services, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing in studio and 1 bedroom apartments, as well as skills training and support services, are provided on-site. Additional psychiatric and clinical services are available through the Network's Rehabilitation and Community Services divisions.

March 1987 — 70th Street House

The Network provides residential care in a transitional group home setting to 12 individuals having mental illness. Twenty-four hour supervision, skills training, and counselor support are provided on-site as are meals, medication and money management. The facility is leased from the Housing Authority of Portland and operated by the Network. All residents are low income and supported by entitlement programs.

May 1988 — Nawikka Court Apartments

Under the corporate ownership of Southeast Network Housing Services II, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing is provided in 1 bedroom units with additional services provided as described for Tillicum Court.

ADMINISTRATION
5415 SE Milwaukie Avenue • Portland, Oregon 97202
(503)238-0769 • FAX(503)233-2861

January 1992

Pisgah Home/Harriet Court Apartments

The Network provides both residential care (Pisgah Home) and supported housing (Harriet Court) to individuals having mental illness at these co-located program sites. Fifteen Pisgah tenants receive twenty-four hour supervision, assistance with activities of daily living (hygiene, grooming, etc.), money, medication and crisis management; skills training and counseling. Fifteen Henry Court tenants live independently and receive skills training and support from on-site staff as appropriate to their needs. Tenants in either program reside in private rooms with private baths. Congregate meals are available. The Network owns and manages the facility in which it operates these programs. All tenants have incomes below 50% of median; many are supported by entitlements.

November 1993

Woodstock Court Apartments

The Network operates this nine (9) unit complex under lease from the Housing Authority of Portland, the project's co-developer (with Network). Eight studio units are rented to homeless individuals having mental illness. An on-site manager occupies a 9th unit. The Network provides skills training and support services including medication monitoring and a meal preparation skills program. The Network manages all aspects of this housing. All tenants have incomes below 50% of median, typically from entitlement payments.

May 1994

Lafayette Apartments

The Network owns and operates this thirty two (32) unit complex which provides supported independent living in studio and in one bedroom apartments to individuals having mental illness. On-site management and optional skills training and support services including medication monitoring and meal preparation training are provided. All tenants have incomes below 30% of median and are generally supported by entitlement programs.

October 1994

Kernlodge Home

Quint 26

The Network operates these two, five (5) unit homes under lease from The Housing Authority of Portland, the project's co-developer (with Network). Each home contains five SRO units (a private bedroom and bath), and shared space that includes kitchen, dining room, living room, laundry, and individual pantry/food storage areas. This shared housing affords its tenants privacy, security, and comfort in a small, group-oriented, neighborhood-friendly building. Tenants are low income persons having mental illness who are capable of living in an unsupervised setting. The buildings do not have live-in management, but are regularly monitored by the staff of Network Behavioral HealthCare, Inc. The Network provides the residents with skills training, case management, twenty-four hour emergency on-call psychiatric, health, vocational, socialization, recreational and medication monitoring services. All tenants have incomes below 50% of area median and are generally supported by entitlement payments.

January 1995

Lents Court

The Network operates this five (5) unit home under lease from The Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge and Quint 26 described above. All tenants are low income veterans who are clients of the VA Domaciliary Program. All support services are provided by the VA under a Letter of Understanding with Network.

January 1996

Tea Link Home

The Network operates this five (5) unit home under lease from the Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge, Quint 26 and Lents Court described above. All tenants are low income Asians. All support services are provided by the Chinese Mental Health Program.

March 1996

Hopewell Apartments

Under the corporate ownership of EcuNet Housing, Inc., a partnership between Network and Ecumenical Ministries of Oregon, Network operates this 8 one bedroom and 4 two bedroom HUD 811 apartment building. Hopewell offers low income people with HIV disease and psychiatric disabilities housing and a program of services to help them live as independently as possible. On-site management is available. Tenants pay about 30% of their income for rent and utilities and are required to meet HUD income eligibility requirements.

June 1996

Clinton Street Apartments

The Network owns and operates this 16 unit complex (15 studio apartments and 1 one bedroom apartment) to provide housing with linked support services for low income individuals with mental illness. The project has an on-site manager who provides skills training and support services including medication monitoring, case coordination, and recovery services. All tenants have incomes below 50% of area median and are generally supported by entitlement programs.

September 1996

Tabor House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. All six tenants are low income individuals who are capable of living in an unsupervised, supportive setting. Each has a private bedroom and shares use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

November 1996

75th Ave. Adult Foster Care

Network owns and operates this five resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 50% of area median and are supported by entitlement programs.

August 1998

Powell Blvd. Apartments

Under the ownership of Powell Boulevard Apartments, Inc., a not-for-profit corporation sponsored by REACH Community Development, Network operates this 20 unit HUD 811 project for the benefit of low income persons having co-existing mental illness and substance abuse disorders. Tenants occupy studio, 1 bedroom, and 2 bedroom units, and participate in a program of services designed to promote independence and sobriety. On-site management and supports are available to supplement psychiatric and addictions services provided through Network's Project STOP or other treatment providers. All tenants have incomes below 50% of area median and pay approximately 30% of their income for rent and utilities.

March 1999

Woodstock House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. The tenants are low income women who are capable of living in an unsupervised, supportive setting. The home is configured to allow the rental of individual bedrooms to single women or two bedroom suites to small families. Tenants share the use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

April 1999

Residential Intensive Treatment Services

The Network owns and manages this ten unit transitional housing program in which residential treatment is provided to individuals having mental illness and addictions issues. Tenants are referred by Multnomah County Community Corrections and receive twenty-four hour supervision, addictions treatment, assistance with activities of daily living, money, medication and crisis management; skills training and counseling. Tenants reside in private rooms with half baths during their three month stay. All tenants have incomes below 50% of median; many are supported by entitlements.

January 2000

Nadine Place

Network owns and operates this eight resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 30% of area median and are supported by entitlement programs

Tenants of these residential programs receive housing and on-site services as specified above. In addition, tenants are welcome to participate in the full range of community treatment and rehabilitation programs offered by The Network. These programs include case management; medical and psychiatric consultation; vocational, recreational and socialization services, substance abuse recovery services; psycho-social clubhouse; crisis/triage services; individual and group counseling; and medication management.

MEDICATIONS

MEDICATIONS AND THEIR SIDE EFFECTS

Psychiatric researchers believe that people suffering from many mental illnesses have imbalances in the way their brain metabolizes certain chemicals, called neurotransmitters. Because neurotransmitters are the messengers the nerve cells use to communicate with one another, these imbalances may result in the emotional, physical and intellectual problems that mentally ill people suffer. Psychiatric medications are like any other medicine a doctor would prescribe. They are formulated to treat specific conditions, and they must be monitored by a physician. All medicines have positive and negative effects. Whether or not a person will experience side effects cannot be predicted. Responses to medications are individual. Most medications psychiatrists prescribe may take a few days or a few weeks to become fully effective. The listed medications and their side effects are some of the most common but it is certainly not a complete list.

MEDICATIONS AND THEIR SIDE EFFECTS

Antidepressents	Most Common Side Effects
Amitriptyline (Elavil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, worsening of heart disease, dizziness when first standing up
Amoxapine (Asendin)	Worsening of heart disease, sleepiness, agitation, insomnia, anxiety
Bupropion (Wellbutrin)	Agitation, dry mouth, insomia, headache, nausea, vomiting, constipation, tremor
Clomipramine (Anafranil)	Dry mouth, sleepiness, tremor, weight gain, sweating, dizziness when first standing up, blurred vision, constipation, trouble having orgasm, trouble urinating, nausea
Desipramine (Norpramin)	Dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, dizziness when first standing up
Doxepin (Sinequan)	Sleepiness, sweating, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, weight gain, dizziness when first standing up
Fluoxetine (Prozac)	Agitation, anxiety, insomnia, drowsiness, tremor, loss of appetite, nausea, diarrhea, headaches, dizziness, problems with orgasm
Imipramine (Tofranil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain sweating
Maprotiline (Ludiomil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, weight gain
Nefazodone (Serzone)	Sleepiness, dizziness when first standing up, nausea, headache
Nortriptyline (Pamelor)	Sleepiness, dry mouth, trouble urinating, constipation, blurred vision, weight gain
Paroxetine (Paxil)	Nausea, sleepiness, fatigue, dizziness, insomnia, sweating, tremor, loss of appetite, anxiety, trouble having an orgasm
Protriptyline (Vivactil)	Dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, insomnia, anxiety
Sertraline (Zoloft)	Nausea, diarrhea, tremor, dizziness, insomnia, sleepiness, sweating, fry mouth, delay in having an orgasm
Trazodone (Desyrel)	Sleepiness, worsening of heart disease, dizziness when first standing up, nausea, vomiting
Trimipramine (Surmontil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Venlafaxine (Effexor)	Sedation, nausea, sweating, dry mouth, dizziness, weakness, constipation, decreased appetite, vomiting, anxiety, tremor, blurred vision, problems with orgasm, headache
Fluvoxamine (Luvox)	Sleepiness, insomnia, anxiety, tremor, nausea, loss of appetite, vomiting sweating, delayed orgasm

http:noah.cuny.edu/illness/mentalhealth/cornell/medications/antidepsideff.html 7-15-99

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche" =the mind and "tropos" = turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics; that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially **highly addictive**, produce fairly **rapid tolerance** and are extremely **difficult to withdraw** from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal, as bad as it feels, is actually easier, quicker and safer than benzodiazapine withdrawal.

Common side effects are sedation, dry mouth, depression, and memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do **not produce tolerance.** The anti-depressants work to restore balance in the neurotransmitter systems, which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics

Elavil (amitriptyline)

Tofranil (imipramine)
Norpramine (desipramine)
Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

The **second generation or "atypical" compounds**
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)
Serzone (nefazadone)
Remeron (mirtazapine)

The **SSRI's** (serotonin-specific reuptake inhibitors)
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

The **MAOs** (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The **ANTI-MANICS (also referred to as mood stabilizers)** are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. **Non-addictive** and does not produce tolerance. Research has shown that these medications are also helpful in preventing the recurrence of severe mood swings.
Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The **ANTI-PSYCHOTICS** also called **Neuroleptics** are used to treat psychotic symptoms. As such they are believed to work by restoring balance in the neurotransmitter systems (primarily dopamine) which mediate thought processes, perception and mood. They are **non-addictive** and do not produce tolerance.
Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)
Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
The "new generation" anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Seroquel (quetiapine)
Orap (pimozide) used mainly for Tourette's Syndrome

The **Anti-Parkinson** medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The **ATTENTION DEFICIT DISORDER/HYPERACTIVITY** medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. **These medications can produce dependence and tolerance.** They are less often prescribed now as many of the **SSRI** anti-depressants and a

couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)
Adderol (contains both dextro and levo amphetamine)

There are probably newer medications in all the above classes since this has been written but this list is fairly inclusive.

Keep in mind that side effects can occur with any chemical you take in. Such things as aspirin and tylenol can be deadly. Side effects are reported when they occur in more than 2% of the population taking a particular medication. Most often they are dosage related or a sensitivity to a particular medication which can be substituted with one which is better tolerated. If you have a condition which warrants taking a psychotropic medication, odds are that you and loved ones around you suffer more from the condition than you ever will from a side effect.

ANTI-PSYCHOTIC DRUGS

ACETOPHENAZINE (TINDAL) MESORIDAZINE (SERENTIL) TRIFLUOPERAZINE (STELAZINE) THIOTHIXENE (NAVANE) RESPERIDONE (RISPERDAL) LOXATANE (LOXAPINE) CHLORPROMAZINE (THORAZINE) HALOPERIDOL (HALDOL) THIORAZINE (MELLARIL) PIMOZIDE (ORAP) MOLIDONE (MOBAN) CHLORPROTHIXENE (TARACTAN) FLUPHENAZINE (PROLIXIN) TRIFLUOPERAZINE (STELAZINE) PERPHENAZINE (TRILAFON) CLOZAPINE (CLOZARIL)	Side effects include dry mouth, blurred vision, constipation, and drowsiness. Some people taking the medications can experience a difficulty in urinating that ranges from mild problems beginning urination to complete inability to do so, a condition that requires prompt medical attention. Other side effects include greater risk for sunburn, changes in white blood cell count (with clozapine), low blood pressure when standing or sitting up, akathisia, dystonia, parkinsonism, and tardive dyskinesia. Tardive dyskinesia is one of the most serious side effects of anti-psychotic medications. This condition affects between 20 and 25 percent of persons taking antipsychotic drugs. Tardive dyskinesia causes involuntary muscular movements, and though it can affect any muscle group, it often affects facial muscles. There is no known cure for these involuntary movements (though some drugs, including reserpine and levodopa may help) and tardive dyskinesia may be permanent unless its onset is detected early.

Anti-psychotic drug list from Kay Peterson/Project Respond/Portland, Or. 7-15-1999

NOTES

PSYCHIATRIC MEDS BY TRADE NAME

CODES:

AA=anti-anxiety
AD=anti-depressant
AD/MAOI=anti-depressant (can be life threatening when mixed with tyramine, eg some alchols & cheeses)
AD/TCA=antidepressant (higher risk of fatal OD)
AP=anti-psychotic
ALZ=for Alzheimers disease
HYP=hypnotics, meds used for sleep
MR=muscle relaxants((not a psych med/may effectbehavior)
MS/AC=mood stabilizers; and /or anticonsulusant
NAR=narcotics,(for pain mgmt, may effect behavior)
SE= meds commonly used for side effects of anti-psychotics
STIM=stimulants

Adaptin	AD	doxepin
Adderall	STIM	dextroamphetamine
Akineton	SE	biperiden
Amytal	SLP	amobarbital
Anafranil	AD/TCA*	clomipramine
Antabuse	Etoh block	disulfiram
Aricept	ALZ	donepezil
Artane	SE	trihexyphenidyl
Ascendin	AD	amoxapine
Atarax	AA	hydroxyzine
Ativan	AA	lorazepam
Aventyl	AD/TCA*	nortriptyline
Benadryl	SE	diphenhydramine
Buspar	AA	buspirone
Centrax	AA	prazepam
Clozaril	AP	clozapine
Cogentin	SE	benztropine
Cognex	ALZ	tacrine
Cylert	STIM	pemoline
Dalmane	HYP	flurazepam
Darvocet	NAR	propoxyphene
Demerol	NAR	meperidine
Depakane	MS/AC	valproic acid
Depakote	MS/AC	valproic acid
Desyrel	AD	trazadone
Dilantin	AC	phenytoin
Dilaudid	NAR	hydromorphone
Effexor	AD	venlafaxine
Elavil	AD/TCA*	amitriptyline
Endep	AD/TCA*	amitriptyline
Equanil	AA	meprobamate
Eskalith	MS	lithium

Fioricet	NAR	butalbital with aspirin
Florinal	NAR	butalbital with tylenol
Flexoril	MR	cyclobenzaprene
Halcion	HYP	triazolam
Haldol	AP	haloperidol
Inderal	SE/AA	propranolol
Isoptin	AA/MS	verapamil
Janimine	AD/TCA*	imipramine
Kemadrin	SE	procyclidine
Klonopin	AA	clonazepam
Librium	AA	chlordiazepoxide
Lioresal	MR	baclofen
Lithobid	MS	lithium
Loxitane	AP	loxapine
Ludiomil	AD	maprotiline
Lortabs	NAR	hydrocodone
Luvox	AD	fluvoxamine
Marplan	AD/MAOI	isocarboxazid
Mellaril	AP	thiorazine
Miltown	AA	meprobamate
Moban	AP	molidone
Mysoline	AC	primidone
Nardil	AD/MAOI	phenelzine
Navane	AP	thiothixene
Nembutal	HYP	pentobarbital
Noctec	HYP	chloral hydrate
Norpramin	AD/TCA*	desipramine
Orap	AP	pimozide
Pamelor	AD/TCA*	nortriptyline
paraldehyde	HYP	paraldehyde
Parnate	AD/MAOI	tranycypromine
Paxil	AD	paroxidine
Percocet	NAR	oxycodone with tylenol
Percodan	NAR	oxycodone with aspirin
Pertofrane	AD/TCA*	desipramine
Placidyl	HYP	ethchlorvynol
Prolixin	AP	fluphenazine
ProSom	HYP	estazolam
Prozac	AD	fluoxetine

Rela	MR	carisoprodol
Remeron	AD	mirtazapine
Restoril	HYP	temazepam
Risperdal	AP	resperidone
Ritalin	STIM	methyphenidate
Robaxin	MR	methocarbamol
Seconal	HYP	secobarbital
Serax	AA	oxazepam
Serentil	AP	mesoridazine
Serzone	AD	nefazodone
Seroquel	AP	quitiapine
Sinequan	AD/TCA*	doxepin
Soma	MR	carisoprodol
Stelazine	AP	trifluoperazine
Surmontil	AD/TCA*	trimipramine
Symmetrel	SE	amantadine
Taractan	AP	chlorprothixene
Tegretol	MS/AC	carbamazepine
Tenormin	SE	atenolol
Thorazine	AP	chlorpromazine
Tindal	AP	acetophenazine
Tofranil	AD/TCA*	imipramine
Tranxene	AA	clorazepate
Trilafon	AP	perphenazine
Tylenol/codeine	NAA	acetominophen with codeine
Tylox	NAA	oxycodone with aspirin
Valium	AA	diazepam
Vistaril	AA	hydroxyzine
Vivactil	AD/TCA*	proptriptyline
Wellbutrin	AD	bupropion
Xanax	AA	alprazolam
Zoloft	AD	sertraline
Zyban	AD	buproprion
Zyprexa	AP	olanzapine

GENERIC NAME	TRADE	TYPE
acetominophen with codeine	Tylenol/codeine	NAR
acetophenazine	Tindal	AP
alprazolam	Kanax	AA
amantadine	Symmetrel	SE
amitriptyline	Elavil	AD/TCA*
amitriptyline	Endep	AD/TCA*
amobarbital	Amytal	SLP
amoxapine	Ascendin	AD
atenolol	Tenormin	SE
baclofen	Lioresal	MR
benztropine	Cogentin	SE
biperiden	Akineton	S
bupropion	Wellbutrin	AD
buproprion	Zyban	AD
buspirone	Buspar	AA
butalbital with aspirin	Fioricet	NAR
butalbital with tylenol	Fiorinal	NAR
carbamazepine	Tegretol	MS/AC
carisoprodol	Rela	MR
carisoprodol	Soma	MR
chloral hydrate	Noctec	HYP
chlordiazepoxide	Librium	AA
chlorpromazine	Thorazine	AP
clomipramine	Anafranil	AD/TCA*
chlorprothixene	Taractan	AP
clozapine	Clozaril	AP
clorazepate	Tranxene	AA
clonazepam	Klonopin	AA
cyclobenzaprene	Flexoril	MR
desipramine	Norpramin	AD/TCA*
desipramine	Pertofrane	AD/TCA*
dextroamphetamine	Adderall	STIM
diazepam	Valium	AA
diphenhydramine	Benadryl	SE
disulfiram	Antabuse	Etoh block
donepezil	Aricept	ALZ
doxepin	Adaptin	AD
doxepin	Sinequan	AD/TCA*
estazolam	ProSom	HYP
ethchlorvynol	Placidyl	HYP
fluoxetine	Prozac	AD
fluphenazine	Prolixin	AP
flurazepam	Dalmane	HYP
fluvoxamine	Luvox	AD
haloperidol	Haldol	AP
hydrocodone	Lortabs	NAR
hydromorphone	Dilaudid	NAR
hydroxyzine	Atarax	AA

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAA
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MR
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAA
oxycodone with aspirin	Tylox	NAA
oxycodone with tylenol	Percocet	NAA
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAA
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

thiorazine	Mellaril	AP
thiothixene	Navane	AP
tranycypromine	Parnate	AD/MAOI
trazodone	Desyrel	AD
triazolam	Halcion	HYP
trifluoperazine	Stelazine	AP
trihexyphenidyl	Artane	SE
trimipramine	Surmontil	AD/TCA*
valproic acid	Depakane	MS/AC
valproic acid	Depakote	MS/AC
venlafaxine	Effexor	AD
verapamil	Isoptin	AA/MS

MEDICAL EMERGENCIES include but are not limited to:

Anti-psychotics (AP) may cause a syndrome with muscle rigidity, fever, fast pulse rate, high blood pressure, confusion.

Anti-psychotics (AP) may cause muscle stiffness and tightening, tremors, and effect swallowing.

Tricyclic anti-depressants (AD/TCA*) present a higher risk of lethal overdose, especially if combined with alcohol; if combined with cocaine can produce heart failure.

Antabuse (disulfiram) if combined with alcohol will cause flushing, sweating, headache,palpitations, difficulty breathing, rapid heart beat, drop in blood pressure, nausea & vomiting; may lead to serious drop in blood pressure and death.

Medication-related seizures , a situation which should be evaluated at the hospital.

Certain anti-depressants (AD/MAOI) if combined with alcohol , certain cheeses and other foods containing tyramine will cause blood pressure crisis.

Delirium is a medical emergency, which includes symptoms of irritability, significant distractability, hallucinations.

Meds such as anti-anxiety agents and hypnotics have a higher risk of lethal overdose particularly if combined with alcohol.

OTHER RISKS OF PSYCHIATRIC MEDICATIONS INCLUDE:

Susceptability to sunburn-particularly with certain antipsychotics.

Higher risk of dehydration- particularly with lithium.

Anti-cholinergic side effects , including dry mouth, blurred vision, constipation, difficulty urinating, impotence, constipation.

Many medications can cause allergic reactions as well as unexpected reactions with other medications, foods, alcohol, drugs.

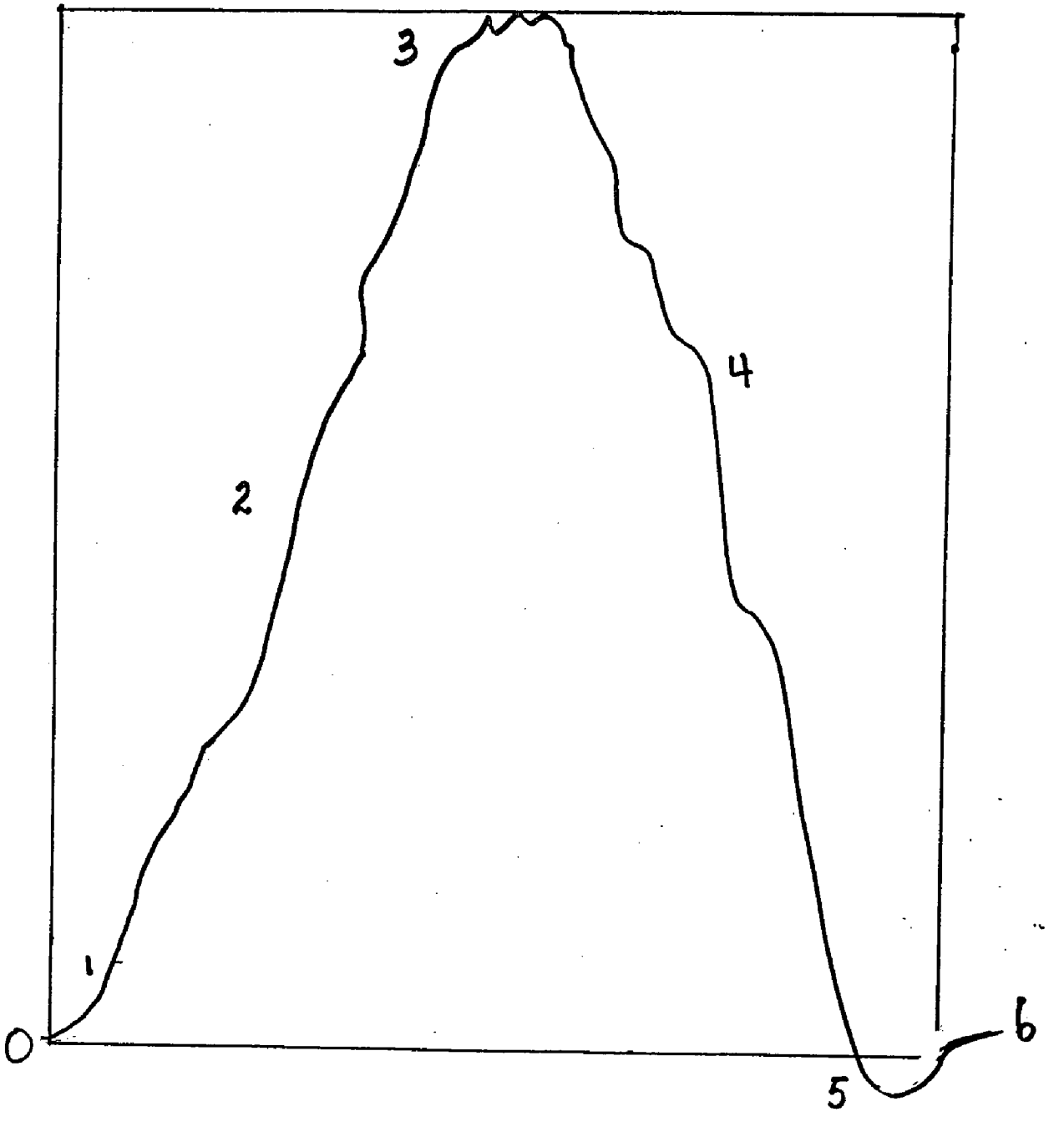
Compiled by Project Respond for the Portland Police Department.

Section 4 - INTERVENTION

- Crisis Cycle
- Intervention in the Crisis Cycle
- Crisis Intervention with Persons with Developmental Disability
- Child and Adolescent Assessment and Intervention
- Suicide Intervention
- Practicum

CRISIS CYCLE

The Crisis Cycle



0 - Normal State
1 - Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post crisis depletion
6. Stabilization

CRISIS CYCLE

0. Normal state.

1. Stimulation

Something has happened to cause the person to become:

Excited or
Active or
Upset or
Physically uncomfortable

Cause can be external or internal or both.

External
Something someone else said or did.
Environment: hot, cold, crowded.

Internal
Physical illness, injury or pain.
Emotional upset
Mental illness: mood disorders, hallucinations.

2. Escalation

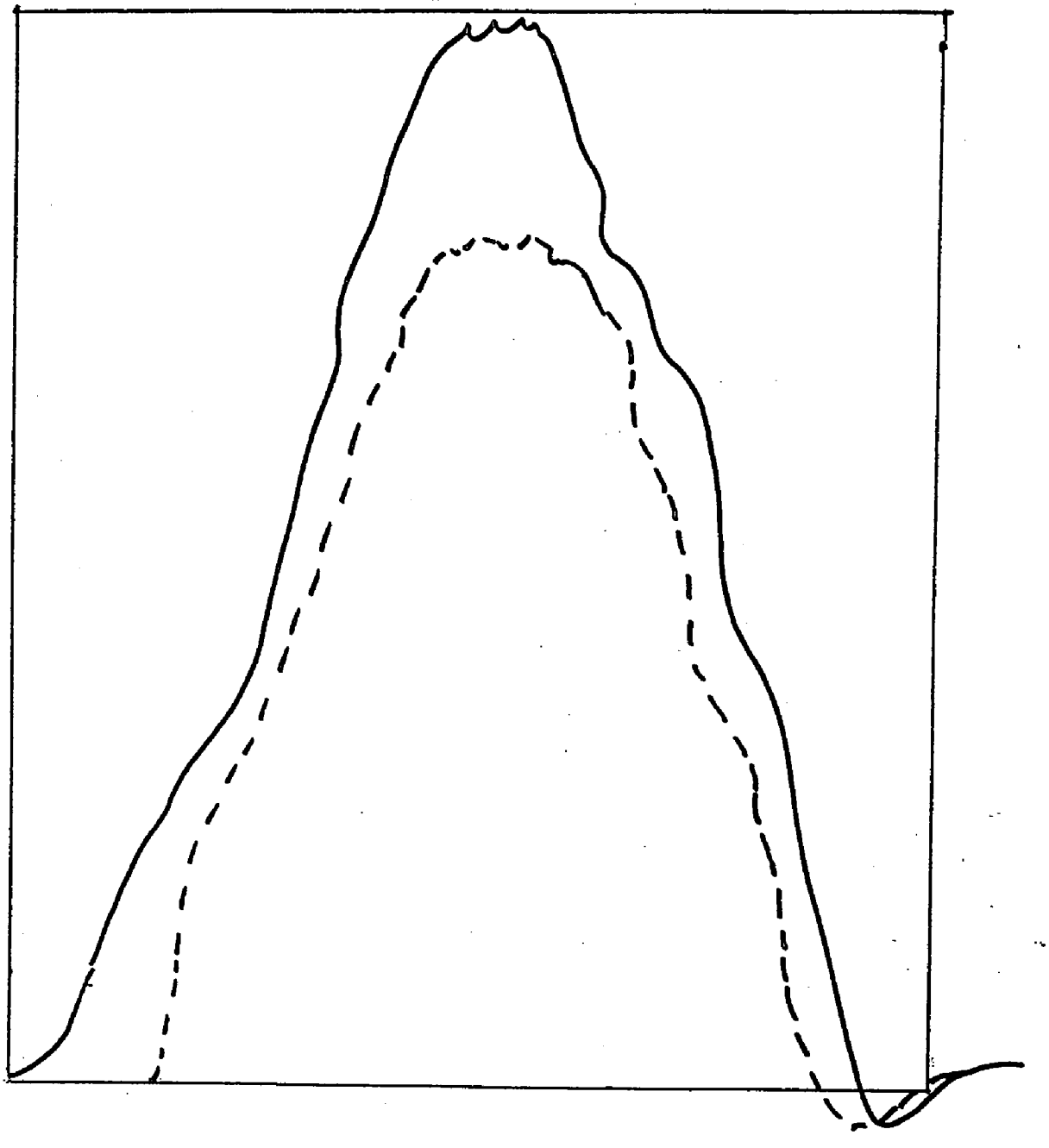
Obvious signs of distress.
Observable physical changes and changes in behavior. (if you don't know the person, it may be hard to know what is a change)

Examples:
Red face
Tense muscles (tight face, clenched fists)
Talking more or louder. (some get quiet/withdrawn)
-Increased activity : Pacing, rocking, etc.

3. Crisis

Out of control.
May scream, yell, curse.
May wave arms or stamp feet.
May assault.

Two crisis cycles juxtaposed



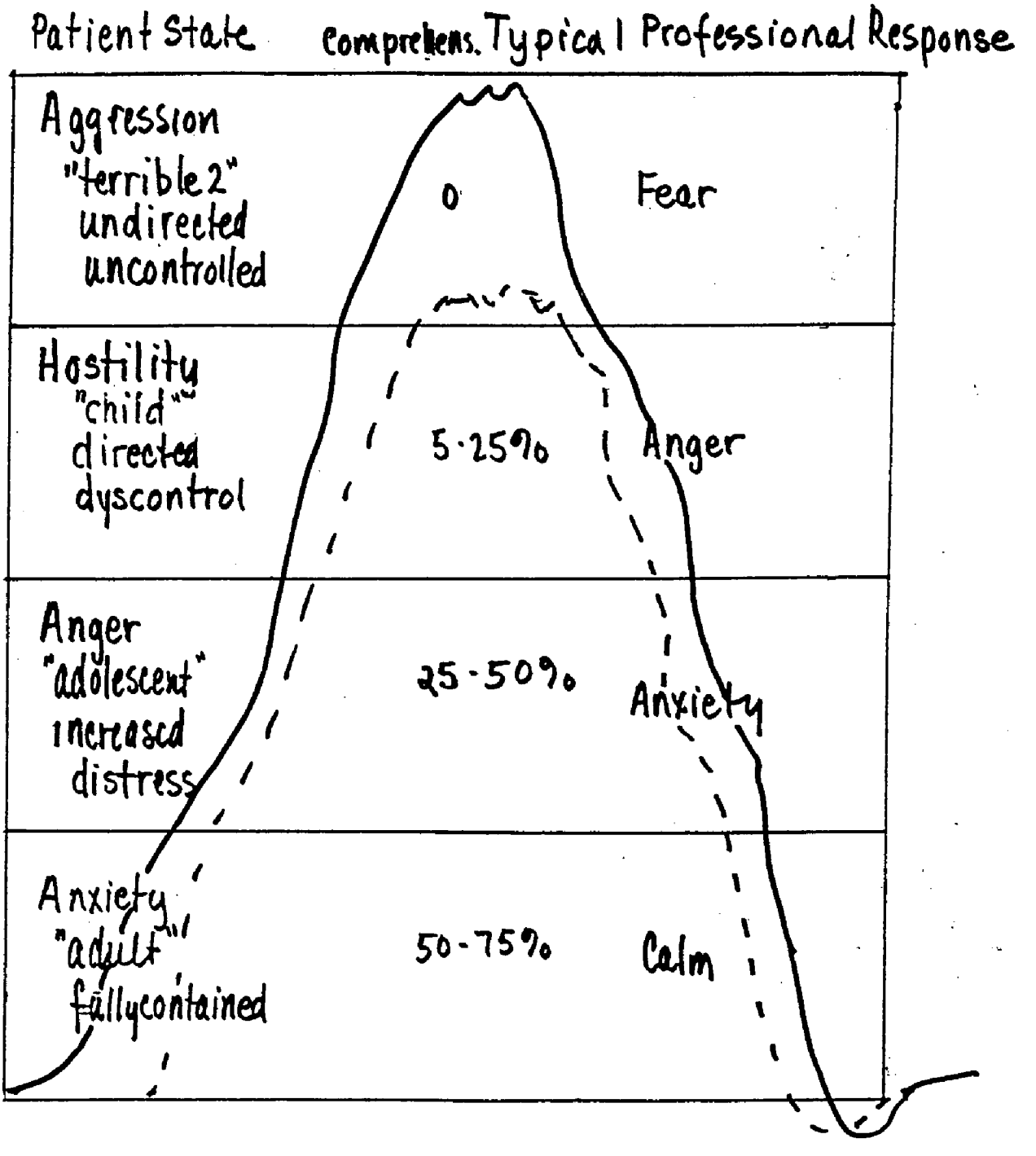
Basic Psychiatric Life Support Model

Patient State	Typical Professional Response
Aggression "terrible 2" undirected uncontrolled	Fear
Hostility "child" directed dyscontrol	Anger
Anger "adolescent" increased distress	Anxiety
Anxiety "adult" fully contained	Calm

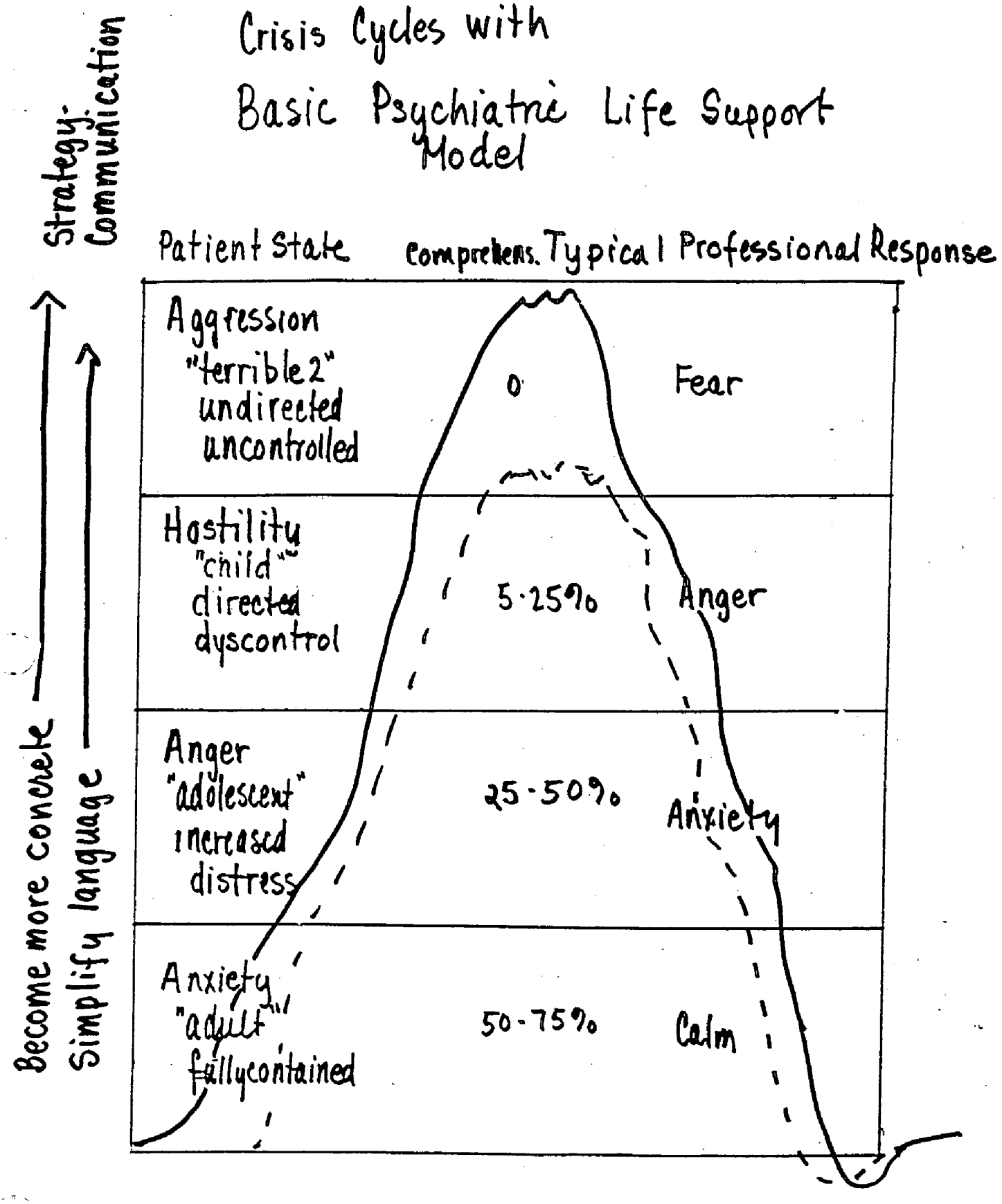
Basic Psychiatric Life Support Model

Patient State	% comprehension
Aggression "terrible 2" undirected uncontrolled	0-5%
Hostility "child" directed dyscontrol	5-25%
Anger "adolescent" increased distress	25-50%
Anxiety "adult" fully contained	50-75%

Crisis Cycles with Basic Psychiatric Life Support Model



Crisis Cycles with Basic Psychiatric Life Support Model



Course Title: Mental Retardation and Developmental Disabilities: Basics For Police Officers

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 3:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To familiarize officers with characteristics of individuals with developmental disabilities, and how these characteristics may affect officer interactions with individuals.

Performance Objectives:

The officer will demonstrate knowledge of what mental retardation is and distinguish it from mental illness

The officer will be able to identify some characteristics of persons with mental retardation in each of the following areas: communication, interaction, judgement/knowledge; performance abilities.

The officer will be able to list some implications of the above characteristics in managing interactions with victims, suspects, and witnesses.

The officer will demonstrate knowledge of how to identify paid or unpaid helpers of a person with a developmental disability.

Course Outline:

Definitions

1. Mental retardation
2. Developmental disability
3. Distinguishing mental retardation from mental illness
4. Other disabilities that affect cognitive functioning

Some characteristics of individuals with mental retardation

A. Recognition of disability/managing the encounter
B. Wide individual variation in each area.
   C. Communication issues
   D. Interaction issues
   E. Judgement/knowledge isssues
   F. Performance abilities

4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

Basic Psychiatric Life Support Model

Patient State

Aggression "terrible 2" undirected uncontrolled
Hostility "child" directed dyscontrol
Anger "adolescent" increased distress
Anxiety "adult" fully contained

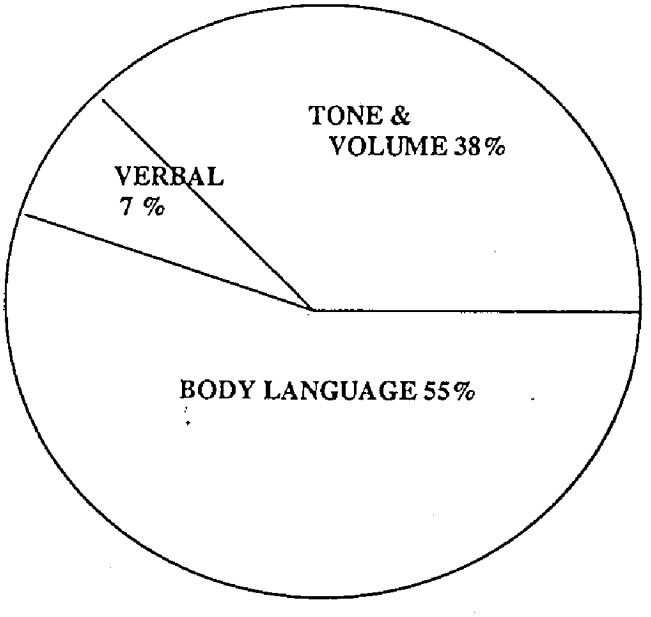
Managing Behavioral Emergencies

As trained crisis intervention specialists, your most likely subjects will be out of control chronically mentally ill persons, angry domestics, suicidal people in public places (bridge jumpers), barricaded individuals, and/or intoxicated persons displaying bizarre behaviors. What do these folks have in common? All will demonstrate some degree of serious impairment in their ability to communicate effectively. This presents a challenge to the police specialist who is attempting to negotiate an alternative to violent behaviors.

One of the few tools that mental health workers have available in dealing with agitated people is the ability to talk down potential assailants. Here are some useful ideas and techniques. The following focus will examine strategies in which you might maximize your ability to deal with agitated people. None of the material in itself is new. The objective for this presentation is to examine principles of applying effective communication techniques to de-escalate agitated persons when possible.

COMMUNICATION

When individuals are highly stressed, non-verbal communication becomes dominant.



Communication

Communication is a people process. It is an interactive phenomenon, which involves more than words. Messages are often the result of a combination of words, behaviors, and context. Parts of the message are:

Verbal Components

1. Content
2. Speech
   - Rate productivity
   - Tone
   - Volume
   - Congruency with other messages

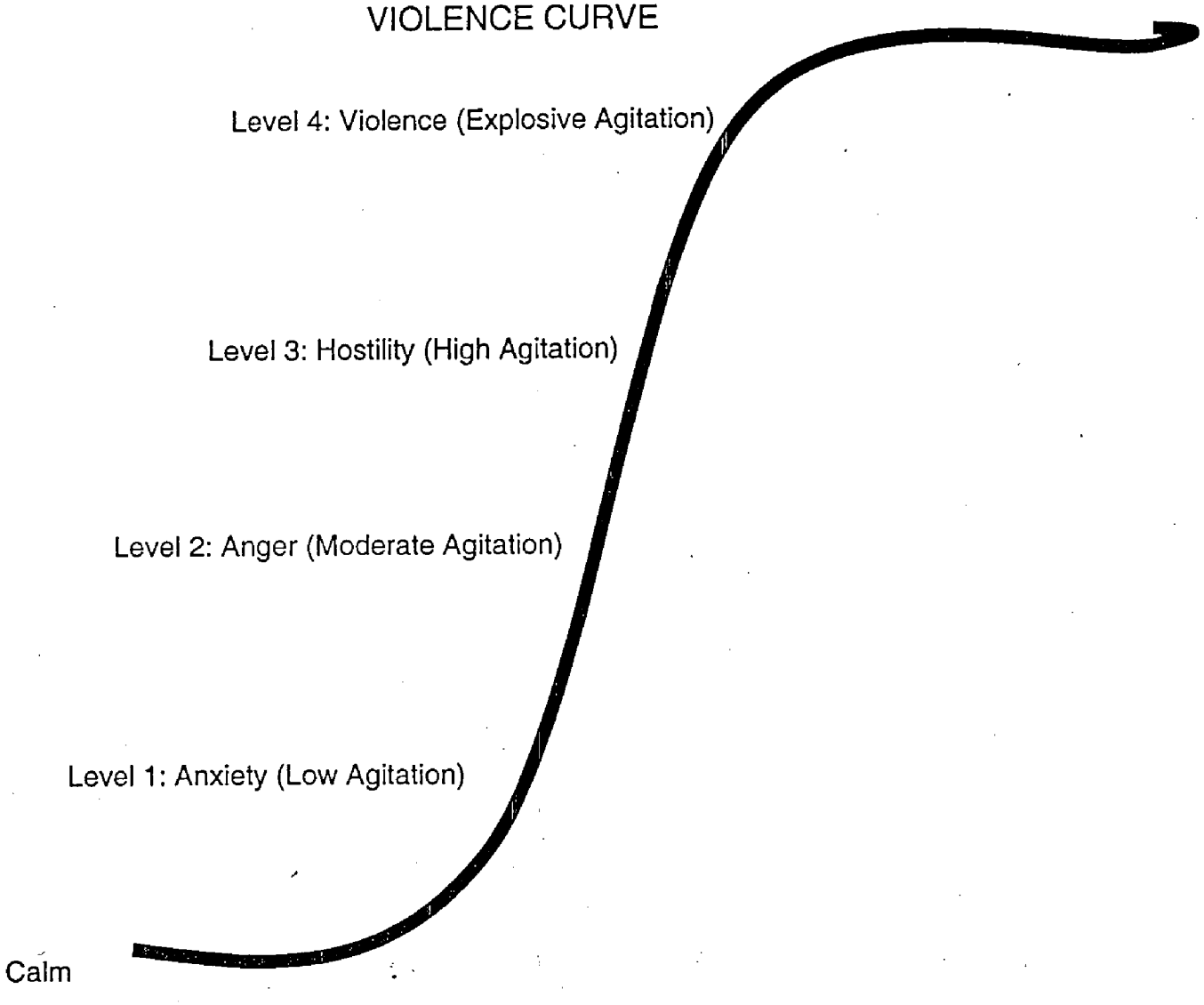
Nonverbal Components

1. Stance
2. Gestures – transient movements of the body or face
3. Eye movements
4. Facial expressions
5. Personal attire
6. Motor movements

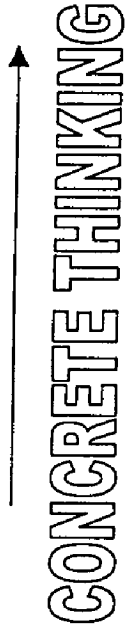
Factors that influence communication

1. Culture/ Religion
2. Sex roles
3. Social class
4. Perceptions or internal experiences
5. Values

VIOLENCE CURVE



The above violence curve does not take into consideration variables of acute mental illness or intoxicants or both. Behaviors of individuals so affected will be erratic and tend not to follow progressive patterns.



SUSPECT/ PERSON	CIT OFFICER RESPONSE
LEVEL 4: VIOLENCE	ANGER / FEAR
LEVEL 3: HOSTILITY	FEAR
LEVEL 2: ANGER	ANXIETY
LEVEL 1: ANXIETY	EMPATHY
CALM	SUPPORTIVE

Interaction

The escalation of violence chart describes the interaction and dynamic between the subject and officer. Both parties are human beings and are products of their upbringing, social norms, and survival instincts.

During the calm state of the violence chart, the subject is at ease. It is relatively easy to interact with such individuals even if they show perceptual distortions. When the subject shows anxiety as in level 1, it is not difficult to engage the person with a degree of sympathy or empathy. However, once the subject begins to exhibit symptoms of anger as in level 2, the CIT officer will normally experience symptoms of anxiety. When the subject is openly aggressive/abusive as in level 4, anger/fear may be the response.

The problem for both the subject and CIT officer is that as we move up the scale, the ability to effectively communicate diminishes. The subject's tunnel vision increases and thinking becomes more concrete as he/she gets more wound up. The officer likewise becomes more concrete as the stress level increases. The police officer has the additional disadvantage of needing to suspend emotions in order to perform well. Separating out feelings and increasing cerebral activity to

perform a technical function is common amongst emergency service workers. Unfortunately, this approach is counterproductive to the process of communication (which we described earlier as a people process interchange of ideas and feelings). The police officer must somehow bridge the paradox between suspending his/her emotions temporarily while listening for emotional cues in an effort to be effective.

The goal of the police officer in dealing with emotionally charged individuals is to pace and guide them into levels more conducive to mutual interchange. Communication skills for the police officer are like any other technical skill. Training and experience promote access to the skill — especially under emergent conditions.

Level 1: Anxiety
A subjective and uncomfortable emotion, which results from threats to the person. Accompanying feelings are dread and helplessness. The goal is to restore the person's sense of control by providing emotional support and negotiating an alternate action to the crisis.

Physical Attending Skills
- Facing the person squarely.
- Adopting an open posture.
- Leaning towards the person.
- Maintaining direct eye contact.
- Retaining a relaxed posture.
- Promoting a relaxing environment.

Responding Skills
- Emotional labeling
- Paraphrasing
- "I" statements
- Reflection / Mirroring
- Minimal reassurance
- Effective silence
- Open statements

Psychological Attending Skills
- What level of agitation did the patient display?
- What central theme concerned the patient?
- Was there evidence of drugs or alcohol that might interfere with predictability?

Intervention
- Negotiate through active listening

Level 2: Anger

Anger is a feeling state or emotion that serves to neutralize the helpless dread of anxiety. Anger can be functional in that the expression gives the person a sense of power. The danger is that anger can quickly escalate into physical expression or violence.

Angry people become less flexible in their ability to think. That is, they become more concrete as emotions rise. It is easier to understand that which can be touched or seen. Visual (nonverbal) messages become more important during stressful events. During stress periods, your verbal communication is required to be shorter, simpler, and more directive.

You goal is to keep the subject conversing with you and use time and your relationship to de-escalate the agitation.

Three Primary Techniques

1. Diffusing the adversarial emotion by acknowledging the anger. "I can see that you're very angry," or, "I'm sorry you're so upset." This has an impact when people become agitated and more concrete in their thinking because they automatically relate in terms of good or evil. That is, they may see themselves as victims and you as the aggressor. Acknowledging their concerns may serve to personalize and close this ever-increasing gap and provide you with a better chance of continuing an effective way of communicating. Remember, acknowledging the person's concern is not the same as agreeing with their position.

2. Advise giving or providing guidance in choosing a course of action or assuming a new role can help. Keep the advice very here and now, e.g. "you might be more safe on the sidewalk," or, "perhaps we could talk privately."

3. Provide choices. Offer a different course of action (A or B) or, one course of action that the person may choose to do or not (A or not A).

Remember that nonverbal interactions of posture, eye contact, tone, volume and pace are very important in the process of de-escalating the person.

Physical Attending Skills

- Facing the person at a 45-degree angle.
- Adopt an open posture
- Lean in to listen
- Maintain direct eye contact.
- Retain relaxed posture
- Promote a relaxing environment

Responding Skills

- Respect

- Empathy
- Genuineness
- Speech Delivery
- Volume
- Calm Tone
- Productivity — keep dialogue simple.
- Content focus — keep immediate to the key issue.
- Pace speech to slow the person's agitated tempo.

Psychological Attending Skills

- Analysis
- What level of agitation.

Drugs and alcohol

- What central theme concerns the person?
- Can the anger issue be identified?
- What level did you leave the person?

Intervention

- Diffuse the adversarial momentum by affirming the anger.
- Advice giving. Directing to follow your good plan.
- Providing choices. Either A or B. A or –A.

Level 3: Hostility

Hostility is anger with a focused recipient. Hostile people are easy to detect. They are more openly irritable, demanding, argumentative, antagonistic or oppositional. Their voice volume can often be loud and threatening. This is the next stage to violence and must be dealt with caution given the potentially quick transition time. The subject is very concrete and more reliance is placed on the police officer's nonverbal and brief response. The goal is to obtain immediate control of the situation and diffuse to a less agitated (more manageable) stage.

The hostility stage is highly dynamic and the subject may move about displaying varying intensities. Each intervention episode should be less than 60 seconds in duration and often needs to be repeated before successfully diffusing the person/subject to the anger stage.

Four techniques in gaining control of the situation

1. Limit setting: Clearly state the boundaries of behavior that you will allow. "I need for you to lower your voice," "please step outside," "I need for you to leave," "please step back, I'm uncomfortable with you so close." The nonverbal approach is serious, professional, and authoritative. Hand signals are used to communicate. The verbal tone and volume are consistent with

the serious message. Sentences are less than 5 words and repeated rather than elaborated.
2. Diffuse the adversarial stance by acknowledging the anger: Timing is critical. Immediately (microseconds) following limit setting, or "punching a hole" in the defensive tirade. Affirm the individual by acknowledging his/her emotional state. This is a critical test point. If the subject/person accepts ("damn right I'm angry), then continue to dialogue using verbal and nonverbal skills to move to the more manageable Anger Stage. However, if the subject/person continues unabated despite repeated tries, be concerned that the escalation may result in violence.
3. Provide directives: Firmly tell the individual what you want him/her to do.

4. Give Warning: Clearly state as neutrally as possible the consequences of a given course of action.

The approach

1. Dealing with potentially violent people is frightening. You might be as charged as the subject. Try to maintain control by purposely taking deep breaths. Remember that you are going to try and regain control of the situation by communication. It isn't going to impress anyone if you squeak out your directives with residual air.
2. Approach the subject squarely from the side to avoid direct kicks. Keep an open posture (to avoid being perceived as attacking) and keep your hands out of your pockets.
3. Keep approximately two arm lengths distance from person.
4. Do not attempt to communicate by touch.
5. Maintain eye contact and an upright posture in an effort to convey control. Communication is continuous. The eyes coupled with facial gestures may provide advance warning of attack.

The Interaction

1. Do not engage in accusations, arguments, and demands for justification from the subject. This will result in a power struggle, which will prove futile. Winning arguments is not as important as fulfilling the job that you were called on to perform. Do not succumb to their baiting.
2. Work as a team, which may be part of a prearranged set of actions in dealing with emergent situations. Don't get maneuvered into being split apart as good guy, bad guy. "I can't talk to this cop. He's a jerk. I can see that you are a reasonable person. Can we privately discuss my request?"
3. Keep your verbalizations short and simple. Remember that the subject is operating very concretely and will only hear portions of what you will try to verbalize. Repeat your short request as opposed to paraphrasing.
4. Define clear expectations for the subject and communicate these positively and firmly.
5. Limit or address only those behaviors that clearly interfere with the client's welfare or the rights of others.

6. Confine the limits only to those that can be carried out. Empty limits only reinforce the patient's notion that you can not be relied upon. Likewise don't promise that which you cannot deliver. You will only be setting someone else up for potential violence.
7. Practice pat phrases and have them available. Under stress, it is more difficult to be creative. Timing your response is important in disarming an aggressor.

Physical Attending Skills

- Face the person squarely but approach at a 45-degree angle.
- Open posture. Keep your hands out of your pocket.
- Upright Posture. Denotes seriousness and control.
- Relaxed Posture. Denotes lack of intimidation.
- Do not communicate by touch.
- Maintain eye contact — look for advance warning of attack.
- If you point at an object or area, do not take your eyes off the subject.
- Remain two arm lengths away.

Responding Skills

- Genuineness
- Respect
- Speech Delivery
- Volume: Avoid shouting.
- Tone: Confident, assured and serious. Avoid challenging and condescending inflections.
- Rate: Purposely slow to de-escalate.
- Productivity: Keep sentences very short and simple.
- Repeat rather than elongate.
- Content: Here and now. Focus on your directive.
- Do not get "baited" into justifying or arguing.
- Avoid discussions leading to splitting. Confine warnings or promises to those that can be carried out.

Psychological Attending Skills

- Analysis
- What level of agitation?
- Have the person been using drugs and/or alcohol?
- What themes are being presented?
- Any "baiting or key words?
- What level did you leave the person?

Intervention

- Limit setting. Clearly state the boundaries of the behavior you will tolerate.
- Acknowledge the anger and focus.
- Provide directives. Firmly tell the individual what you want him/her to do.
- Warning. Clearly state as neutrally as possible the consequences of his/her behavior.

Level 4: Violence

Response Guidelines

Violence is aggression with a focus on destruction. Violence has injury as its goal. Violence may be verbal (if disruptive or hurtful enough) and/ or physical. The goal is to protect oneself. The goal is not to win but be useful at another time.

The Interaction

- Let your face drain of gestures
- Drop your shoulders indicating relinquishment
- Remain at 45-degrees to the person
- Don't make any sudden moves
- Don't take insults and taunting personally
- Don't be baited
- Do not take your eyes off the patient
- Clearly indicate to the aggressor that you intend to disengage and withdraw, e.g. "I quit, " or" "I'm out of here" messages
- Start moving away towards your escape
- Move slowly and methodically
- Continue your verbal and non-verbal communication to indicate retreat
- You can remain at bay waiting for reinforcements to arrive or totally withdraw.

Active Listening Concepts

Listening for Emotions

People communicate on two levels:

- Content — the simple facts
- Emotions — the emotional reaction to the facts

Train yourself to listen for the emotional message behind the content. Emotional reaction and subsequent behavior make the situation a crisis, not the fact of the situation. How a person feels about a situation will strongly influence what he/she does. Controlling the subject's emotions will help control the subject's behavior.

Listening for Values

- What people think are important
- What people prize

There may be a need to clarify the subject's values. Values influence behavior. The crux of the situation may be a value conflict.

Active Listening Skills

- Emotional labeling
- Paraphrasing
- Reflecting / Mirroring
- Effective pauses (silence)
- Minimal encouragers
- "I" Messages
- Open-ended Questions

Emotional Labeling

- The first active listening skill to be used in an incident.
- The intent of emotion labeling is to respond to the emotions heard in the subject's voice rather than content.
- Demonstrates that you are really listening and tuned into what the subject is emotionally experiencing.
- Do not tell a person how they are feeling, but rather how they *seem* or *sound* like they are feeling to you.
- Do not be afraid to label emotions incorrectly.
- Be aware of missing emotions.
- Listen for conflicts in the feelings expressed.
- Never hesitate: label every emotion you hear.
- Note when the emotions are inappropriate to the situation described.
- Be aware of your emotions and what the subject is hearing from you.
- Use throughout the negotiation / intervention whenever you hear emotions expressed.
- Do not use when you are being verbally attacked.

Emotional Labeling Examples

- You sound _____
- You seem _____
- I hear _____

Paraphrasing

- A summary in your words as to what you were just told.
- Demonstrates you are listening.

- Creates empathy and rapport because it demonstrates you have heard and understand.
- Creates empathy and support.
- Clarifies content, checks perception, and highlights issues.
- Obtains additional intelligence.

Paraphrasing Examples
- Are you telling me...
- Are you saying...

Reflecting / Mirroring
- Repeating back the last word or phrase the subject just said.
- Gives feedback that is very exact.
- Asks for more intelligence without guiding the direction.
- Gets intelligence when you do not have enough to ask a good question.

Effective Pauses (Silence)
- An effective pause is silence.
- Silence is effective if it serves your purpose.
- Most people are not comfortable with silence and will fill it with talk.

Uses of Silence
- When you are about to say something important.
- When you have just said something important.
- When the subject is trying to "psych" you out.

Minimal Encourages
- The sounds you make, especially on the telephone, to let the other person now you are present and listening.
- May be short questions such as: "really?", "Oh?", "When?"
- Does not interfere with the flow of the conversation.
- Lets the subject know you are present and listening.

Uses of Minimal Encouragers
- Helps build rapport.
- Encourages the subject to continue talking.

"I" Messages
- Enables us to let the subject know how they are making us feel, why we feel that way, and what they can do to remedy the situation.
- Conveys the above information in a non-threatening way and does not put the subject on the defensive.

Uses of an "I" Message

- When communication is difficult because of the intense emotions being directed at you.
- When the subject is making communication impossible.
- When you need to refocus the subject.
- When you are being verbally attacked.

Examples of "I" Messages

- I feel _____(emotion or feeling)
- When you_____(his/her behavior)
- Because _____(your reason)

Open-Ended Questions

- Questions that cannot be answered with a "yes" or a "no."
- To obtain information without asking a lot of questions.
- Usually begins with the words: how, what, when, where.

Uses of Open-Ended Questions

- To help a subject start talking.
- To elicit examples of specific behavior.
- To obtain additional intelligence.
- To focus on the subject's feelings.

Problems Caused by Closed-Ended Questions

- Gives a feeling of interrogation, which makes rapport difficult to build.
- Causes you to work harder thinking up new questions.

NOTES

INTERVENTION IN THE CRISIS CYCLE

INTERVENTION

A. APPROACHING THE SCENE
   1. Calls
   2. Information before you arrive
   3. Monitor your own emotional state
   4. Leave prejudices/bias/predisposition behind

B. ON THE SCENE
   1. Assess the situation and stabilize, if necessary

C. CRISIS INTERVENTION
   1. Crisis cycle
      a. Intervention at each stage of the cycle
      b. Different levels of understanding, perception and development at each stage
         (1) Look at face, voice and posture for signs of what level
      c. Stages of cycle
         (1) Normal state
            (a) 100% perception and ability to reason
            (b) Acts as an adult
            (c) Person experiences no emotional content
            (d) Officer is calm
            (e) Can problem solve
         (2) Stimulation (internal/external)
            (a) 50-75% perception and ability to reason/understand
               1) Agitated behavior
            (b) Acts as a teenager
            (c) Person experiences anxiety
            (d) Officer is calm
            (e) Action officer should take
               1) Use simple sentences
               2) Use calming body language
               3) Keep voice low and calm
         (3) Escalation
            (a) 5-24% perception and ability to reason/understand
               1) Loud, aggressive, flushed
            (b) Acts as an 8-year old having a tantrum
            (c) Person experiences fear; frustration
            (d) Officer is anxious
            (e) Actions officer should take
               1) Use sentences of less than 5 words
               2) Make one immediate request
               3) Repeat continually
               4) Body language and voice firm but calm
         (4) Crisis
            (a) 0-5% perception and ability to reason/understand
               1) Out of control

(b) Acts like "terrible two's"
(c) Person experiences anger
(d) Officer is fearful/frustrated
(e) Actions officer should take
1) Use firm, one sentence commands
2) Repeat continually
3) Make decision regarding use of physical force

(5) De-escalation
(a) As consumer de-escalates, officer uses the same techniques down the de-escalation
(b) Consumer may suffer post-crisis depression
(c) Escalation can cycle up and down

(6) Things to remember
(a) Take your time
1) Person cannot remain in crisis state forever
(b) Constantly read feedback from consumer
(c) Stop doing anything that escalates the consumer
(d) Continue anything that de-escalates the consumer

(e) Have only one officer talk to the consumer at a time
1) Trade off if not effective

2. Communication skills

a. Verbal skills

(1) Tell person you are there to help
(2) Introduce self by first name
(3) Ask and use their name
(4) Do not involve yourself in their delusions; show you understand that they believe it is really happening
(5) Ask clarifying questions in terms of "I" statements
(a) "I don't understand this"
(b) "I'm afraid you'll hurt yourself"
(c) "I can't figure out why"
(6) Use personalized statements
(a) "Your holding that rock makes me nervous"
(7) Do not argue
(8) Actively listen
(a) Do not be afraid of silence
(b) Wait for responses
(c) Echo their feelings "You seem to be angry"
(9) Show concern and understanding
(a) Nod head while they are talking; indicate listening with "I see", "Uh, huh", etc.
(10) Treat person with respect
(11) Do not use offensive terms or sarcastic remarks
(12) Tell people what you are going to do
(a) Do not make promise you cannot keep
(13) If person becomes agitated, change subject

b. Non-verbal skills
   (1) Feedback loop
      (a) Watch reactions of consumer to you
      (b) Stop action if escalates consumer
   (2) Open body language
      (a) Rule of palms
         1) Palms open
      (b) Stand slightly to the side/bladed
      (c) Take safe, but not defensive stance
         1) More relaxed posture
         2) Head tilted
         3) Be ready/appear relaxed
      (d) Keep hands off paraphernalia
   (3) Eye contact
      (a) Try to make eye contact
         1) Some people like it as sign of personal contact
         2) May make some people nervous
      (b) Try to remain at eye level
   (4) Body space
      (a) Rule of 3
         1) Remain 3 arms length away at first contact
      (b) May need to move in to establish personal contact
   (5) Move slowly
      (a) Announce action to consumer
c. Questions to ask
   (1) Ask what is happening that caused crisis
   (2) Ask about past history
      (a) Case worker
      (b) Counselor
      (c) Treatment
   (3) Ask how they resolved similar situations in past
   (4) Ask what clinic they go to or where they go for treatment
   (5) Ask if they are taking medication(s)
   (6) Ask the names of their medication(s)
   (7) Ask if they would like to see a doctor
   (8) Ask if they are thinking of taking their own life
      (a) How
      (b) Do they have the means (gun, knife, pills)
      (c) Have they ever tried it before
   (9) Ask if they are hearing voices
      (a) Are they telling you to do something
d. Officer safety reminders
   (1) Never deny the possibility of violence
      (a) Persons with mental illness are not more violent than the "normal" population but may be more unpredictable
   (2) If hearing voices, ask what the voices are saying

(3) Keep relaxed approach, but not complacent
(4) Watch consumer's hands
(5) Upon transport, always handcuff even if this risks re-exciting the subject; tell the person what you are going to do and why

Fear

A perceived need (sometimes irrational) to escape, defend against, or eliminate a perceived threat of personal injury.

Visual signals

Posture: Tense and prepared to defend, hide or run away.

Skin color: Pale or ashen.

Facial expression: Wide-eyed and fearful.

Auditory signals

Voice quality: Whining, pleading, gasping, bursts of speech, may be unable to speak.

Breathing: Rapid, shallow, irregular.

Confirming history

Personal history of abuse / victimization and/or withdrawal, sometimes punctuated by assaultive outbursts.

Crisis Intervention for: Fear

Goal: Threat Reduction

The basic assumption is that communication patterns that reduce the perceived threat will also reduce the probability that the assault will escalate to battery. Conversely, communication patterns that add to the perceived threat can be expected to increase the probability of battery. Here are some guidelines for reducing threat:

Posture: relaxed and open; hands in full view

Gestures: slow, palms-up

Position: slightly off to the side of the fearful client, and far enough away (8-10 feet, if possible) to make it clear that an attack on the client is not being planned.

- positions directly in front of, or any position behind a frightened person can be expected to increase the perceived threat
- positions at or below the eye level of the frightened person can be expected to reduce the perceived threat

Voice quality: firm, reassuring, confident

Speech content: logical, encouraging calm reflection; promising to help if possible, but not promising something that is not possible

Eye contact: if the frightened person seems to seek eye contact as an additional source of reassurance, it should be given freely; if the frightened person tries to avoid eye contact it should not be forced on them. There are many cultures that discourage or limit communication through eye contact.

Physical contact: some frightened people (particularly children) need to have reassurance communicated through touch. Touch should be "offered", not given without permission, and should be light with slow movements.

Frustration

An irrational attempt to gain control by physically attacking the source of frustration.

Visual signals

Posture: Tense and prepared to attack.

Skin color: Tones of purple or red; splotches.

Facial expression: Tense, focused, and angry.

Auditory signals

Voice quality: Menacing, aggressive, loud.

Breathing: Loud, deep, long, heavy.

Confirming history

History of low frustration tolerance, coupled with impulsiveness.

Crisis Intervention for: Frustration

Goal: Control

The basic assumption is that patterns of communication that demonstrate and "lend" control will contribute to the restoration of the internal control of the frustrated client. Conversely, communication that demonstrates loss of control will likely increase the probability that the frustrated person will lose their ability to control an impulse to attack. Here are some guidelines for exerting control:

Posture: self-confident, commanding

Gestures: firm, commanding, palms out or down

Position: directly in front of the frustrated client, and just outside of his/her striking range.

- A position within striking distance of a frustrated person communicates a challenge or a desire to fight.
- A position well outside of striking distance of a frustrated person communicates undue caution or fear, and unwittingly points out vulnerability and willingness to be a target for release of frustration.

Voice quality: quiet, firm, commanding in tones low enough to make the frustrated person strain to hear

Speech content: repetitive, confident commands without threat

Eye contact: direct and accompanied by facial expressions which indicate that a firm command is being given.

Physical contact: if physical contact is required to prevent the frustrated person from escalating from assault to battery, it should be made firmly but without excessive movement or pain that would indicate loss of control.

Manipulation

An indirect attempt to obtain or avoid something in exchange for not losing emotional control. Manipulation becomes dangerous when assault is used as a tool in the attempt. Remember: Beneath every manipulative demand there is a legitimate request. Manipulation can take a variety of forms, including:

The temper tantrum

In this case the manipulating person starts by making a calm, but unreasonable (given the circumstances) request. When the persons' requests / demands are not met, they threaten violence by appearing to lose control: yelling, banging, stomping, etc.

Playing the numbers

In this case the manipulating person attempts to "play" people against each other, hoping that in the confusion their request / demand will be met. Group care settings provide an abundance of opportunities for this form of manipulation.

Promoting confusion

In this case the manipulating person brings in related, but irrelevant, matters into the discussion, leaving the professional wondering what the client really wants, or how the issues being raised by the person relate to the request / demand being made.

Visual and auditory signals

Although the signals are often difficult to interpret at any particular moment, there is a definite and recognizable pattern :

- The initial set of signals often occur in a whining voice, usually with a "gimme" attached, and with the affect of a pitiable victim.

- If that doesn't work, the next step is a series of marginally related accusations, comparisons, and other trivia, uttered in more aggressive tones.

- If that doesn't work, the next step is threats and actions against property.

- Finally, when all else has failed, assault is attempted.

Confirming history

A history of losing control or attacking physically when feeling deprived or oppressed.

Crisis Intervention for: Manipulation

Goal: Detachment

The basic assumption is that communication patterns that tend to indicate refusal to become involved in manipulation will decrease the likelihood that the manipulative person will attempt to gain something through complete loss of control resulting in battery. Conversely, communication that indicates openness to the manipulative demand increases the belief that the demand will be met at the next higher level of loss of control. Here are some guidelines for detaching yourself from a manipulative game:

Posture: closed, relaxed

Gestures: idiosyncratic gestures of disapproval or mild irritation (toe or finger tapping, eye rolling, "disgusted" sighing and nodding, arm folding, etc.)

Position: close enough to physically intervene if necessary, but far enough away to show non-involvement (4-5 feet)

- turning slightly away to show non-involvement is appropriate, but do not turn your back

Voice quality: detached, mechanical, slightly bored

Speech content: quiet, repetitive, "broken record" commands

Eye contact: avoid eye contact by looking at the hairline, chin, shoulders, etc.

Physical contact: if physical contact with the person who is manipulating becomes necessary, it should be handled as quickly and unemotionally as possible. Try to make contact with clothing only, not flesh. Punitive and vengeful forcefulness should be avoided, since it will add to the belief that the manipulation could have been successful if it had been done differently.

Intimidation

A calculated attempt to get something in exchange for physical safety or freedom from the threat of injury. "Don't make me hurt you" is the flavor of the message you get from many of the people who intimidate.

Visual and auditory signals

Basically neutral or unremarkable, with the exception of a menacing voice quality and/or threatening words and posture. Often people who are attempting to intimidate use physical menacing / crowding (standing very close to or over the person being intimidated) as a way to threaten danger.

As in manipulation, there is a definite and recognizable pattern of change in signals:

- First, there is a clear and often strongly stated demand.
- If the demand isn't met, this is followed by a believable threat of physical injury coupled with a reminder that injury can be avoided by complying with the demand.
- Finally, refusal to comply or delay in complying is followed by the attempt to injure through assault.

While we often respond to attempts to manipulate with annoyance and irritation ("here we go again", or "give me a break"), we often respond to intimidation with fear and a belief that we might really get hurt!

Confirming history

A history of bullying, extortion, and other criminal assault.

Note: This form of assaultive behavior is often used by persons diagnosed as "anti-social personalities" or "sociopaths".

PRECAUTIONS (DON'TS)

REMEMBER, DON'T:

1. Deny the possibility of violence when early signs of agitation are first noticed.
2. Underestimate information given by others regarding behavioral clues.
3. Engage in behaviors that can be interpreted as aggressive.
4. Allow others to interact simultaneously while you are attempting to talk.
5. Make promise you can not keep.
6. Allow feelings of fear, anger, or hostility to interfere with self control and professional demeanor.
7. Argue, give orders, or disagree unless absolutely necessary.
8. Be placating by giving in and agreeing to all the real and imagined ills of the person.
9. Become condescending by using cynical, sarcastic, or satirical remarks.
10. Let your own importance be acted out in a know-it-all manner.
11. Raise your voice, put a sharp edge, or use threats to gain compliance.
12. Mumble, speak hesitantly, or use a tone so low that you can't be understood.
13. Argue over small points.
14. Attempt to reason with anyone under the influence of a mind altering substance.
15. Attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.
16. Allow a crowd to congregate.
17. Corner, or be cornered: give the person expanded space.
18. Ask why?
19. Deny the opportunity to save face.
20. Rush, be rushed, or lose your own cool!

RESOLVING CRISIS

02/09/95

1. INTRODUCE YOURSELF. PERSONALIZE CONTACT. "MY NAME IS JOHN. WHAT'S YOURS?"

2. USE A CALM VOICE.

3. UTILIZE RELAXED BODY LANGUAGE.

4. TELL PERSON YOU ARE THERE TO HELP THEM.

5. AVOID ARGUING.

6. SHOW GENUINE CONCERN BY ASKING MANY QUESTIONS.

7. ASK THE PERSON WHAT IS HAPPENING RIGHT NOW TO CAUSE THIS CRISIS.

8. ACTIVELY LISTEN. REPEAT BACK WHAT YOU HEAR THE PERSON COMMUNICATING ABOUT THEIR FEELINGS. REPORT BACK TO THE SUBJECT THE EMOTION YOU THINK THEY ARE FEELING. "YOU'RE FEELING ANGRY." "YOU'RE FEELING ANXIOUS." "YOU'RE FEELING FRIGHTENED."

9. ASK THE PERSON ABOUT HIS OR HER PAST HISTORY OF CRISIS.

10. ASK THE PERSON HOW THEY HAVE RESOLVED CRISIS IN THE PAST.

11. ASK ABOUT FRIENDS, RELATIVES, COUNSELORS, CASEWORKERS OR OTHER POSSIBLE SUPPORT PEOPLE.

12. OBSERVE THE SUBJECTS BODY LANGUAGE.

13. IF THE PERSON BECOMES MORE AGITATED CHANGE THE SUBJECT.

14. STATE CLARIFYING QUESTIONS IN TERMS OF THE OFFICER HAVING A PROBLEM:

"I DON'T UNDERSTAND THIS . . . "
"THAT ROCK IN YOUR HAND MAKES ME NERVOUS."
"I'M AFRAID YOU'LL HURT YOURSELF."
"I CAN'T FIGURE OUT WHY . . . "

15. GIVE INFORMATION. EXPLORE OPTIONS WITH SUBJECT.

16. TREAT PEOPLE WITH RESPECT.

17. TELL THE PERSON WHAT YOU ARE GOING TO DO TO HELP THEM.

18. ALWAYS KEEP YOUR WORD.

THE RULES

1- THE RULE OF TIME

2- THE RULE OF THREE

3- THE RULE OF FIVE

4- THE RULE OF PALMS

5- THE RULE OF ECHOS

6- THE RULE OF CALM

CRISIS INTERVENTION WITH PERSONS WITH DEVELOPMENTAL DISABILITY

NOTES

Course Title: The Crisis Cycle

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 4:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To introduce the crisis cycle as a model for understanding the stages of crisis. Implications for interventions will be discussed.

Performance Objectives:

1. The officer will be able to identify the stages that a person goes through when in crisis.

2. The officer will be able to identify and list typical emotional responses of officers intervening in crisis.

3. The officer will identify the language comprehension levels accompanying crisis stages and the implications for intervention.

Course Outline:

The Crisis Cycle: the emotional and behavioral stages people experience when in crisis (Oregon Intervention System model

0. Normal State
1. Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post-crisis depletion
6. Stabilization

The Escalation Grid (Basic Psychiatric Life Support Model)

1. Anxiety
2. Anger
3. Hostility
4. Aggression

How the Crisis Cycle and the Grid fit together

1. Emotional and behavioral interactions
2. Two crisis cycles juxtaposed
3. The Grid- typical responses of professional interveners

A. Anxiety- calm
B. Anger- anxiety
C. Hostility- anger
D. Aggression- fear

4. Recognizing your own responses
5. Setting aside your own responses

The effect of emotional state on communication

1. Comprehension decreases as control decreases
2. Implication for intervention strategies
   A. "adult", "adolescent", "child", "terrible 2"
   B. Simplify language
   C. Become more concrete

G. Effects of the system

Implications of characteristics

Finding out if there is someone who can help

1. Who are the players?
2. What questions can you ask to get useful information?

WHAT ARE MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES?

Definitions. There are many different definitions of mental retardation and developmental disabilities. Agencies typically have their own complex definitions, which may differ from agency to agency. The definitions below are "unofficial.

Mental Retardation. Intellectual functioning that is significantly below average, along with substantial limitations in adaptive behavior (for example, ability to independently perform activities of daily living or function in society.) Mental retardation originates during the developmental period (before 18 in most definitions) and is likely to be lifelong. Generally, a person who has an I.Q. score of 70 or lower is considered to have mental retardation.

Note about terminology: many people do not like to have the term "mental retardation" applied to them, because of unpleasant history or associations. Some prefer the term "developmental disability" or "cognitive disability". Some refer to themselves as "slow" or a "slow learner".

Developmental Disability. This is a broader term than mental retardation. A developmental disability is a disability caused by a neurological condition. It originates during the developmental period, it is likely to be lifelong, and it requires training and support similar to that needed by a person with mental retardation. Besides mental retardation, common causes of developmental disability are cerebral palsy, epilepsy, and autism. **Cerebral palsy** is a catchall term for a variety of disorders that affect a persons ability to move and to maintain posture and balance. Walking ability and speech are often affected. **Epilepsy**, also called seizure disorder, is a condition that causes seizures of various kinds. Some seizures cause a person to fall, lose consciousness, and have jerking movements of the whole body for several minutes. Others cause involuntary movements of a part of the body without loss of consciousness, and still others cause a brief loss of consciousness without falling. Mild forms of cerebral palsy or epilepsy are not considered developmental disabilities under the above definition. **Autism** is a severe developmental disability affecting communication, social interaction, and behavior.

Mental Illness vs. Mental Retardation. Mental retardation/ developmental disability is not the same as mental illness. Hallucinations and delusions are characteristic of some mental illnesses; they are not characteristic of MR/DD. Neither are mania or depression characteristic of mental retardation. A person with mental retardation can be expected to act rationally at their functional level. However, a person with mental retardation or another developmental disability may also have an additional disability such as a mental illness or a drug or alcohol addiction.

Other Disabilities. There are other disabilities and health conditions which affect cognitive (intellectual) functioning and which therefore may be confused with mental retardation. A disability from head injury to an adult is not mental retardation, nor is dementia from conditions such as Alzhēimers or late stage alcoholism. A person who has recently had a seizure may have a short period of impaired functioning which may be mistaken for mental retardation.

Institutionalization. In the past, many individuals with developmental disabilities, even those with mild mental retardation were routinely institutionalized. Beginning in the late 1960's, it began to be generally understood that people with developmental disabilities had the right and the ability to live in the community. Programs such as group homes and semi-independent living programs were established to provide training and support in the community and people began coming out of institutions in increasing numbers. However, some people were discharged without appropriate

Do you want to call them now?
Is it OK if I call them?

If you are at a group home or foster home(or other situation in which someone seems to be in a staff role) in a crisis, and the staff seems to be unsure what to do:

Ask: Do you have someone you can call to help you in a crisis?
In a foster home there may not be anyone. In a group home or supported living situation, there should always be a way to contact administrators in an emergency.

SOME SUGGESTIONS FOR COMMUNICATING WITH A PERSON WHO HAS MENTAL RETARDATION

- Keep language simple, but not childish.
- Avoid abstractions or technicalities. Be concrete.
- Avoid yes/no questions, or questions that suggest the answer you expect.
- When you give instructions:
  - Give one at a time
  - Be clear and direct
  - Be sure the person understood. One way to do this is to ask them to repeat it back.
- Don't talk to others in front of the person, as if the person wasn't there.
- If the person has any reading/writing ability, write down simple reminders if they need to do something later. Ask if they have a calendar you can write it on.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

supports and others lost supports for budgetary or other reasons. The movement to "deinstitutionalize" people continues to the present. Today, Fairview and Eastern Oregon Training Centers are still in operation, but they are much smaller than they were in the past.

Being institutionalized affects people seriously. A history of being in an institution sometimes helps explain behaviors that are otherwise hard to understand. Usually the younger the person went into the institution, and the longer they remained, the more serious the effect. In an institution, people are deprived of the opportunity to learn what it's like to live in a regular family and community, and so it is much harder for them to develop appropriate social skills. They have limited opportunity to develop normal human relationships, and little modeling of how people act in normal situations. To survive, some people learned to comply with anyone who acted as if they were in a position of authority. The lack of privacy caused some not to have regard for their own privacy or that of others. For some, the lack of respect for their personal property taught them that if they valued something they needed to carry or wear it or it would be taken. People had few choices and little control over their own lives. Many people were sexually or physically abused by other residents or by staff, and they have the same kinds of problems other sexual abuse survivors have. These can include low self esteem, sexual acting out, lack of trust in others, Post Traumatic Stress Disorder and depression.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

SOME CHARACTERISTICS OF INDIVIDUALS WITH MENTAL RETARDATION: IMPLICATIONS FOR LAW ENFORCEMENT

In order to successfully manage an encounter with a person with mental retardation, whether a victim, suspect, or witness, it is important for the officer to recognize the disability. Recognizing the disability and managing the encounter are often one and the same.

Each person with mental retardation is an individual. People with the same measured I.Q., whether they have mental retardation or not, vary widely in their skills, interests, personality and communication style. Listed below are some characteristics that may be more likely to occur in a person with mental retardation. There won't be anyone for whom all (or even most) of these factors apply. For some individuals with mental retardation few or none will apply.

Communication issues

- Does not communicate at the level of typical persons of the same age group
- Limited vocabulary or limited grammatical skills
- Speech defect
- Unable to read or write or limited ability
- Difficulty understanding questions
- Difficulty answering questions; may give "standard" or "parrotted" responses
- Appears to understand when they do not, may not want to admit lack of understanding
- Fails to comply with rules; this may be due to lack of understanding

Interaction issues

- An excessive desire to please others
- Behavior on a level below the person's age
- Crowding personal space when interacting with others
- Tendency to be overwhelmed by authority
- Becomes hostile or withdrawn rather than admit lack of understanding
- Low frustration tolerance

Judgement/knowledge issues

- Does not fully understand seriousness of situations
- Limited safety awareness; may be easily victimized
- Judgements regarding "friends" are the most difficult
- Easily persuaded or influenced by others
- Lack knowledge on how to protect themselves

Performance abilities. May be limited in some of these areas:

- Reading and writing
- Using the telephone
- Understanding finances
- Making change
- Understanding need to budget to cover living expenses
- May give away money or belongings
- Following complicated directions

- Telling time
- Keeping appointments
- Managing activities of daily living , such as hygiene, housekeeping, cooking

Effects of our culture (or system) and common attitudes about disabilities.
These are often as limiting as the effects of the disability itself.

- Praised for compliance
- "Protected" by being "kept in"
- "Protected" by not being given sexual information
- Not taught about their rights
- Segregated from others; heavily dependent on caregivers
- Abuse may not be taken seriously
- Live in high risk environments

SOME IMPORTANT IMPLICATIONS OF THESE CHARACTERISTICS

The victim who has mental retardation:

- Higher risk of victimization, especially for sexual assault and robbery
- May be victimized by caregivers or "friends"
- May not understand that what has happened is a crime or that law enforcement can help

The suspect who has mental retardation:

- May admit to things he/she did not do, in order to comply or please
- May have been a follower or coerced by persons with higher abilities
- May not understand what you tell them about their rights (Miranda warnings)

Suspects, victims, and witnesses

- May tell you what they think is the "right answer"

FINDING OUT IF THERE IS SOMEONE WHO CAN HELP

This may also help you determine what the disability is.

Ask: Do you have a Case Manager?
Do you have their card?
(if no card) Who do they work for? Where is their office?

Ask: Is there someone who is paid to help you?(with money, making appointments, fixing meals,etc)
Do you have their card?
Do you have their phone number?
Would you like to call them now?
Is it OK if I call them?

Ask: Do you have a family member that helps you with things? A neighbor? Someone else?
Do you have their phone number?

Multnomah County Developmental Disabilities Services Division

"WHAT ARE ALL THESE PROGRAMS AND WHO'S IN CHARGE HERE ANYWAY?"

The Developmental Disabilities Services Divison (DDSD) is part of the Multnomah County Department of Community and Family Services. Until recently DDSD was called the "Developmental Disabilities Division" and before that, the "Developmental Disabilities Program". Offices are in the Commonwealth Building, 421 SW 6th, Suite 400, Portland, OR 97204, (503) 248-3658. Office hours are Monday through Friday 8:00 to 5:00 P.M.

The Division provides case management for eligible individuals. It also contracts with private providers (some non-profit and some for-profit) to provide residential and vocational services to some individuals. These residential and vocational services are funded mostly with state and federal money, and are under many state and federal regulations. The state and the county both have oversight responsibility for these programs.

Case Manager - Everyone served by the Division has one. This is the person in the Division who works directly with the individual, the family (especially for kids), and any residential, vocational, or other programs that the individual participates in. **This is who you should ask for when you need help for a particular individual.** The Division no longer calls case managers "case managers", but many other people do, so if you ask for the case manager, everyone will know who you're talking about. These people are now mostly called:

Family Consultant (for children)
Service Coordinator (for adults)

If a person urgently needs help and the case manager is not available, there is a **Backup Worker** available during business hours.

Protective Services Investigator - A specialized case manager who investigates allegations of abuse or neglect of adults served by the Division. (Services to Children and Families – SCF- investigates for children.) Police may deal with a Protective Services Investigator if the abuse or neglect involves criminal behavior. To make a Protective Services referral, report the suspected abuse to the individual's case manager (or the Backup Worker) and a Protective Services Investigator will be assigned.

Managers and supervisors - Every Service Coordinator/Family Consultant has one. You can ask for the supervisor if you can't get what you want from (or can't reach) the Service Coordinator/Family Consultant or the Backup Worker.

Division Manager - The person in charge of the Division.

RESIDENTIAL PROGRAMS

These are the programs that provide support in day to day living for some individuals with developmental disabilities. **Most individuals with developmental disabilities do not have any paid supports; they live by themselves or with friends or family.** There are many who need or want services which are not available due to funding constraints.

24-hour Residential ("Group homes")- These programs provide 24 hour staffing for support of individuals. The "typical" program is a 5- person group home. A few are larger. Some are "apartment model". In those, the staff will be present in the complex, but often not in the individual's apartment. **The people who work directly with individuals are generally called "direct care staff", although** in some agencies, they have other titles like "Community Support Specialist". Typically they work shifts and do not live in the home, although there are exceptions. **Group Homes typically have a house manager or site manager. The direct care staff should be able to reach the house manager or another administrative staff person by phone or beeper at all times, and you may want to ask them to do so if there's a problem.**

Semi-Independent Living Programs (SILP)- A program that provides support (typically 2-4 hours per week) to individuals who live in their own apartments. The individual has telephone access to a staff person in emergencies. If you think an individual may be in a SILP program, you may want to ask them if they have a staff person they can call.

Supported Living - A program that's more individualized than 24-hour residential programs but typically provides more support than SILP. There may be live in staff or "paid roommate", or direct care staff working shifts, or support workers dropping in. As in SILP, the individual has 24 hour access to staff by telephone, at any time staff is not with them.

The three kinds of programs listed above) are run by private agencies, under contract with the Division. All individuals served by these agencies are also served by and receive service payments through the Division (except for a very few individuals who pay privately). Agencies typically operate more than one home or site and several operate more than one program. Each agency has an **administrator** who may be called an Executive Director. The administrator or someone designated by the administrator should be available at all times in real emergencies

Adult Foster Care (AFC) - Adult foster care provides 24 hour care to individuals in private homes. **The provider is the person in charge**, who contracts to provide services. There may also be a **resident manager** and one or more **caregivers.** Typically either the provider or the resident manager lives in the home. Each Adult Foster home is licensed by the Multnomah County Adult Care Home Program, and then various agencies, including the Developmental Disabilities Services Division, arrange for service provision to individuals. Some individual make private pay arrangements for Adult Foster care, not through an agency.

Other kinds of residential supports - Individuals may have various kinds of **respite** (temporary) care, in group homes, in AFC, or with private individuals. Or they may have some paid supports in limited areas like money management. If they are elderly or physically disabled, they may receive foster care, personal care services, or other kinds of services from Senior and Disabled Services Division. If they have mental illness, they may receive help from a mental health agency.

Prepared by Lee Greer, Service Coordinator/Behavior Specialist
Multnomah County Developmental Disabilities Services Division
5/00

CHILD AND ADOLESCENT ASSESSMENT AND INTERVENTION

NOTES

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
    - I won't be here.
    - You won't have to deal with me.
    - You'd be better off without me.
    - Life is meaningless.
    - Death is probably a solution to my problems.
    - Would you miss me if something happened to me?
    - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
    - reckless driving, skating, bike-riding, swimming alone
    - drug-experimentation
    - sexual promiscuity
    - fighting, baiting others towards physical confrontation
    - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

NOTES

SUICIDE INTERVENTION

Suicide Prevention

- Develop your interview around a knowledge base and your questions will follow.
- Interviewing: The Basic Rule, "Always ask"
- Straightforward...Do you have thoughts of hurting or killing yourself? Ask the S word.

  How would you do it? Specificity.
  When and where would you do it? Specificity.
  Do you have the means to do it? Lethality.
  Why now? What is the final straw?
  Why *not* now? What are the protective factors?
  When and with what in the past? What was their impression of it?
  What level of control do you feel? How are your brakes?

- **Reasons for Suicide:**

#1. Person is in acute distress.
#2. Suicidal individuals are ambivalent: see choice as "life or death".
Engage in the "I win" game = If I live I win, if I die I win. Good example is the "Police assisted suicide"...drop the gun or we'll shoot.
#3. Person is cut off from outside support and therefore focus on relationships in the institutional setting.

In hospital studies (John Hopkins/Harvard Medical School) it was found that the symptoms prior to suicide included: Dysphoria (86%), Psychosis (50%), Somatic Anxiety (43%), Psychic Anxiety (93%), Agitation (79%), Lability (93%)

Farberow (1966) studied 218 suicide cases and found the predominant pre-suicide behaviors for the "active group" to be: restlessness, agitation, hyperactivity, pacing and sleep disturbance. For the "passive group" they were: severe depression, isolation, muteness, withdrawal, complaints about health and ambivalence about being in a hospital.

- **Risk Factors**: Sex, sexual orientation, age, alcohol/drug, plan, means (especially firearms), emotional upset, mood disorder, psychosis, physical health, incarceration, support system, recent loss or anniversary of loss, severe anxiety or turmoil, global insomnia, delusions of doom and gloom. Decrease the risk factors and you decrease the risk.

- **Highest Risk**: White, male, recent loss (job, spouse, financial support) alcohol on board. Risk increases with age after fifty. Has a realistic plan and the means to carry it out especially possession or access to a firearm.

- **High Risk**: Incarceration, alcohol or drugs on board, humiliation over arrest/charges (e.g. sex offense, particularly first arrest). Highest risk is during the first few hours of incarceration.

- **The Lethal Triad**: An upset person, with a firearm, with alcohol on board.

- **Important for jail and hospital settings**: Death by hanging is second only to firearms as the means of suicide. Approximately 17.2% of male suicides are by ligature and 14.3% of female suicides. (63.3% and 41.3% for males and females by firearm).

- Stats:
- Females threaten suicide more frequently than males by a factor of 3X.
- Males succeed at suicide more frequently than females by a factor of 3X.
- Incidence of female suicide is relatively stable.
- Rough guess is that there are around 25 attempts for every successful completion. This is an average as among the young there are about 100 attempts per success but among the elderly it may be about 4:1 to as high as 2:1.
- Elderly, white males have the highest incidence of successful suicide.
- 33% of elderly suicides saw their M.D.s the week of the suicide.
- People with a history of abuse as children have a 30 fold increase in risk.
- Oregon ranks 9th in the U.S in suicide rate.
- Suicide is the leading cause of death in people with bi-polar disorder:
  Major depression...20% BUT 98% of suicides are seriously depressed.
  Bi-Polar ... 25% to 50%
  General Population...1%
- In Schizophrenia, 20 to 40% attempt suicide while 10 to 15 % succeed.
- Nationally the rate is 12/100K/year
- This increases to 380/100K/year for people with untreated mental illness.
- Suicide ranks as the 9th leading cause of death in the U.S.
  3rd for fifteen to twenty-four year olds
  14th for elderly
- There has been a 200% increase in suicide rates among Black males.
- Successful suicide rates in the U.S. are: 8:2 male to female....9:1 white to non-white.....7:2 white males to white females.....8:2 non-white males to non-white females
- 2 to 6% of suicides occur in hospital settings (620 to 1800/year or 3/day or 1 per 8hr shift.
- In Oregon, the rate is 12 to 32 per year in hospital settings.
- Nationally, the rate of suicide on Medical/Surgical Units is 42/100K.
- On Psychiatric Units this increases to 90-150/100K. (In Finnish psych units the rate is 400/100K)

- Always take threats seriously even from those you believe are manipulating. Personality disordered individuals have been known to kill themselves just to prove they meant what they said ("I'll show you").

- One in ten with a diagnosis of Borderline Personality Disorder will eventually suicide.

- Look for sudden changes in mood, e.g. a depressed individual who suddenly seems to have "gotten over it". They may have made up their mind to proceed with a suicide.

- Look for **classical symptoms** of depression; ask about: appetite, sleep, energy, sexual drive-interest-performance, concentration, and mood. What you are looking for are **changes**, which may be sudden or have been occurring over the past few weeks.
- Most common: **Anergia**...loss of energy.
  Anhedonia...loss of enjoyment or capacity for pleasure.
  Loss of sexual drive, interest, response.
  Hypophagia...loss of appetite with accompanying weight loss.
  Hyperphagia...excessive eating with accompanying weight gain.
  Insomnia...difficulty falling or staying asleep.
  Hypersomnia...excessive sleeping with no sense of rest.
  Loss of concentration, short attention span.
  Low mood, tearfulness, irritability, hopelessness, and despair.
  Excessive guilt.

- Some people may not acknowledge being depressed but they may endorse many items on the list above.

- Suicidal individuals can hide it from you and carry out a successful suicide. You will be left wondering about what more you should have or could have done.

- **Substance Abuse and Suicide:** Lifetime risk 2 to 3% (Two to three times the national average). 15 to 25% of all suicides are by alcoholics. Intoxication is associated with 50% of all suicides.

- **Sobriety is essential.** Substance abuse increases lifetime risk of suicide by 2-3X. 15 to 20% of all suicides are by alcoholics. The highest risk in this group is a male with a long history of drinking who also has a co-morbid psychiatric disorder. Intoxication is associated with 50% of all suicides. Alcohol produces "alcohol myopia" which is the inability to perceive consequences of behavior.

- **Buffers, the "Wall of Resistance":** A strong religious prohibition against suicide. Clean and sober. Intact support system. Willingness to examine options and make a no-harm contract. For women, the best protector against suicide is a child. The more children, the lower the risk...ask "what will become of your children?". A job, a pet, a counselor or therapist. Duty to others. Medication compliance. Good health. Good friends. Job skills, job security. Safe environment and difficult access to means. At

the top of the list is hope. Anything that provides a glimmer of hope to a suicidal individual may be enough to prevent their suicide.

In the final analysis the final decision rests with the individual. However, most suicidal people do not want to die. They want to find a way to live and ambivalence exists right to the moment of death. Reduce risk factors and enhance protective factors and you reduce the risk of suicide.

Primary source of information comes from materials provided by AFSP, the American Foundation for Suicide Prevention

SUICIDAL BEHAVIOR

- Suicidal Behavior
- Suicide Plan
- History of Past Events
- The Persons Resources
- Recent Loss
- Physical Illness
- Drinking and other Substance Abuse
- Physical Isolation
- Dramatic Changes
- Mental Illness
- Suicide Prevention

Suicidal Behavior[2]

A common myth regarding suicide is that people who commit or attempt to commit suicide are mentally ill. Although people who are suicidal are usually in emotional turmoil and although suicide is often preceded by periods of depression, these conditions do not necessarily indicate mental illness. The mentally ill may attempt and commit suicide, but not all that attempt suicide are mentally ill.

Suicide in the United States is the 10th leading cause of death among adults and the second among adolescents. For every suicide there are 8 to 10 attempts, or about 300,000 attempts annually. Suicide knows no boundaries. It cuts across race, class, age, and sex, though its frequency varies with different groups. It is not an illness or an inherited disease as is sometimes believed but is usually a response to a life crisis that the person sees no other way of alleviating. Though many persons who commit suicide are in a temporary state of acute crisis, some are chronically self-destructive and continually attempt suicide.

Listed below are some of the major signs of suicidal behavior. A suicide can still occur without these signs being present, however. At the same time an officer should not hesitate to consider the person suicidal if on ly on e or two signs are apparent. It is impossible to predict suicide in any absolute sense, but inclusions of these signs and guidelines for officers will remove much of the guesswork associated with suicide assessment.

Suicide Plan

Many persons who attempt or commit suicide do so by design. The plan begins with the idea of suicide; suicidal people do not act on impulse but weigh the factors involved. The plan also involves the method of suicide and its lethality. A plan involving a gun will have more likelihood of being effective that will a plan involving tranquilizers. The availability of the means is also a factor. For example, if the person threatens to use a gun and he is a gun owner, the means is clearly available. The final element of a plan is its specificity — time, place, and circumstances. If a person indicates he will commit suicide within two days at a specific time and place, and he has the lethal means, he is a higher suicide risk than one without a plan. The more specific the plan, the higher the risk.

History of Past Attempts

The majority of people who commit suicide have made previous attempts.

The Person's Resources

The officer should assess two types of resources, internal and external. If the person feels life is worthless and that little hope for improvement exists, he or she is lacking internal resources and should be considered a high risk. Lack of

external resources, such as family or friends, or an inability to communicate with those persons is also an indication of high risk.

Recent Loss
Any recent personal loss or the threat of losing a life partner, parent, status, money, or job increases the person's risk of suicide.

Physical Illness
Having a serious illness, especially on that is terminal, that threatens one's values or status, or that is or likely to dramatically affect one's self image increases the risk of suicide.

Drinking and other Substance Abuse
Alcohol or drug abuse is often a sign of other problems, especially if the abuse is recent, and should be included in a suicide assessment. Also, use of alcohol or drugs often increases the risk of loss of control or an increase in impulsive behavior. Alcohol also increases the lethality of a drug overdose

Physical Isolation
The risk of suicide increases when a person is both physically and emotionally isolated. Isolation can cause people to feel they do not belong to a family or society and can increase feelings of worthlessness and other negative self-images. Even temporary isolation may be an impetus for suicide.

Dramatic Changes
A sudden, dramatic, or unexplainable change in lifestyle or behavior may be a clue to suicide contemplation. Change in one's social network and environment such as relocation or retirement can be very upsetting. Also, unexplained changes in behavior are often a symptom of a larger problem, which may in turn increase the risk of suicide.

Mental Illness
Persons who hear voices directing them to commit suicide are certainly in a high-risk situation. However, the number of persons who fall into this category is quite small. If a person indicates that other people, or voices, are controlling his or her behavior, those signs should not be ignored.

In an attempt to determine the existence of any of these signs, the officer must communicate with the person in a calm, direct, and matter of fact way. Talk about the finality of the act and use the terms "suicide," "death," "kill your self." Talking about suicide does not prompt the person to commit the act. The best way an officer can help the person is to discuss the person's problems, the suicide plan, and realistic alternatives. Communication with the person not only enables the officer to gather information regarding the risk, but it is also helpful for the suicidal person. Often the suicidal person has been lacking communication and the

offer's efforts tell him or her that someone is interested and concerned about finding an alternative solution.

[2] All the preceding information about suicide was copied with permission from: Improving the Police Response to the Mentally Disabled. Police Executive Research Forum, 1986.

Suicide Prevention

Suicidal Clues

- Verbal: "it doesn't matter anymore", "you won't be hearing from me again"
- Situational: hopeless and helpless.
- Behavioral: stripping of possessions or relationships, in appropriate calmness/flatness, past attempts.
- What is the Immediate Problem?
- What has happened in last 24 hours that makes you want to kill yourself?
- Identify the problems/situation.
- Identity the loss.
- Talk about it/ventilate feelings.

Identify Hook

- What is still important to the person?
- What still has value/meaning?
- Keep returning to the hook.

Determine Motivation

- What is objective/goal of suicide action?
- What is person hoping to accomplish?

Develop Non-Lethal Alternative Option

- To diffuse crisis state
- To accomplish objective/goal

Develop Specific Plan of Action

- Be realistic.
- Make a list.
- Go to next step.

Referral

- When appropriate.
- When crisis has ended.

Suicide Prevention

Suicidal Clues

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- Make a list.
- Go to next step.

Referral

- When appropriate.
- When crisis has ended.

Suggested Dialogue

- Look I can see you're really (label emotion) right now. I just want to talk with you for awhile.
- I really care about what happens to you. That's why I have this job.
- I know talking about this is really rough, but we can take it slow.
- I sense you're really down on yourself right now.

- Do you really want to die, or do you want to not hurt so much?

Finality of Death

- Once you're dead, you're not going to get another chance.
- You know if you kill yourself to get back at _____, all that's going to happen is that you'll be dead. We can't be sure of _____'s reaction. _____ may not care at all. Therefore _____ wins. You're dead and _____'s going to go on with their life.
- I guess right now you want to get away from the hurt, but dying (method) is pretty painful. Let's talk about some other way to get this pain out of your life.

Hooks

Parents

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

Children

- How do you think it will affect (name/'s) if you kill yourself?
- You know, if you kill yourself, you'll never see _____ grow up, graduate, get married. I can tell you care about them a lot.

Job, Career, Hobby

- You know, you've told me that you've made some pretty important breakthroughs in your job, if you killed yourself, you'll never have that satisfaction again.
- You were telling me about your (hobby), you're pretty proud of _____. What will happen to _____ if you die, will they just get tossed in the trash?

Pets

- What about _____? Who will take care of _____? I guess _____ will have to be destroyed.

Explore Plans / Thoughts

- What do you want to have happen? What would need to happen for you to feel better, feel like you could go on?
- What do you think (you/we) could do to make things not hurt so much?

PRACTICUM

Section 5 - OTHER

COMMON ACRONYMS

(AMHSA) ADULT MENTAL HEALTH AND SUBSTANCE ABUSE
(AFS) ADULT AND FAMILY SERVICES
(ARC) ASSOCIATION OF RETARDED CITIZENS
(ADHD) ATTENTION DEFICIT HYPERACTIVITY DISORDER
(ADD) ATTENTION DEFICIT DISORDER
(BHD) BEHAVIORAL HEALTH DIVISION
(CMI) CHRONICALLY MENTALLY ILL
(CAMHSA) CHILD & ADOLESCENT MENTAL HEALTH AND SUBSTANCE ABUSE
(CCMH) CLACKAMAS COUNTY MENTAL HEALTH
(CIT) CRISIS INTERVENTION TEAM
(CRT) CRISIS RESPONSE TEAM
(CTC) CRISIS TRIAGE CENTER
(DCFS) DEPARTMENT OF COMMUNITY AND FAMILY SERVICES
(DSM4) DIAGNOSTIC AND STATISTICAL MANUAL
(DSO) DISABILITY SERVICES OFFICE
(EAP) EMPLOYEE ASSISTANCE PROGRAM
(ISP) INDIVIDUAL SERVICE PLAN
(MRDD) MENTALLY RETARDED DEVELOPMENTAL DISABILITY
(MHRC) METROPOLITAN HUMAN RIGHTS COMMISSION
(NAMI) NATIONAL ALLIANCE FOR THE MENTALLY ILL
(OAC) OREGON ADVOCACY CENTER
(PSRB) PSYCHIATRIC SECURITY REVIEW BOARD
(SDSD) SENIOR DISABLED SERVICES DIVISION
(SCF) SERVICES TO CHILDREN AND FAMILIES
(SSDI) SOCIAL SECURITY DISABILTIY
(SSI) SUPPLEMENTAL SECURITY DISABILITY

Notes

NOTES

NOTES

NOTES

Portland Police Bureau

CRISIS INTERVENTION TEAM

CIT Officer

MAKING A DIFFERENCE TOGETHER

CIT Training
November 13th - 17th, 2000
Portland, Oregon

Portland Police Bureau

Crisis Intervention Team Instruction

Crisis Intervention Training
November 13th to 17th, 2000

Day:	Monday Nov. 13th	Tuesday Nov. 14th	Wednesday Nov. 15th	Thursday Nov. 16th	Friday Nov. 17th
Location	Portland Adventist: T.B.A.	Portland Adventist: T.B.A	Off Site See handouts.	Portland Adventist: T.B.A	Portland Adventist: T.B.A.
0800-0900	Introduction	Personality Disorders	Site Visits	~~Medications~~	Scenarios
0900-1000	Overview of Mental Illness	"Voices"	Site Visits	Modeling of Mental Illnesses	Scenarios
1000-1100	Overview of Mental Illness	PTSD & A/D	Site Visits	Mental Status Exam	Scenarios
1100-1200	Children's Disorders	PTSD & A/D	Site Visits	Crisis Cycle	Scenarios
1200-1300	Lunch	Lunch	Lunch	Lunch	Lunch
1300-1400	Family & Consumer Panel	Rights of the Mentally Ill	Site Visits	Suicide Intervention	Officer Scenarios
1400-1500	Community Resource Panel	Commitment Law & PSRB	Site Visits	Crisis Intervention	Officer Scenarios
1500-1600	Community Resource Panel	~~Developmental Disabilities~~	Site Visits	Crisis Intervention	Officer Scenarios
1600-1700	Community Resource Panel	~~Developmental Disabilities~~ MEDICATIONS	Site Visits	Crisis Intervention	Graduation

All classroom sessions will be held at Portland Adventist Medical Center: 10000 SE Main St. Please park in the main parking area, and enter the front lobby. CIT training signs will be available to direct you once inside.

Except; On Friday afternoon, 1300 to 1700, we will meet at the Midland Library. 805 SE 122nd Ave. This is due to the early closing of Portland Adventist for religious observances.

November 15th, 2000:
Site Visitation Schedule

Time	Group A	Group B	Group C	Group D
0800-0900	CTC	CTC	Ryles Center	Ryles Center
0920-1020	Ryles Center	Ryles Center	CTC	CTC
1040-1140	Faulkner Place	Port City	Comet Club	Hooper Detox
1140-1300	Lunch & Travel	Lunch & Travel	Lunch & Travel	Lunch & Travel
1300-1400	Port City	Royal Palm Hotel	Hooper Detox	New Mezz Connection
1420-1520	Bridgeview	Rainbow Adult Living	MCDC	MCDC
1540-1700	MCDC	MCDC	Bridgeview	Faulkner Place

Bridgeview: 707 NW Everett. Contact: Erin Fisher (Ph. 222-4906)

Comet Club: 5507 N. Lombard. Contact: Jessica Turner (Ph. 285-9871 ext. 315)

Crisis Triage Center (CTC): 5228 NE Hoyt. Contact: Johanna Niemitz (Ph. 215-1534)

Faulkner Place: 13317 SE Powell Contact: Alan Wood (Ph. 760-9606)

Hooper Memorial Detox: 20 NE MLK Jr. Blvd. Contact: Jeanne Rivers (Ph. 238-2067)

MCDC: Meet in the Main Lobby, Contact: Kathy McCullogh (Ph. 988-5230)

New Mezz Connection: 1122 SW Stark. (Enter through metal gate, then double glass doors, then into Day Treatment Center) Contact: Lorraine Vitkauskas (Ph. 552-5125)

Port City: 1847 E. Burnside. Contact: Brenda or Judy (Ph. 236-9515)

Rainbow Adult Living: 3701 SE Belmont. Contact: Greg Ruff (Ph. 231-1608)

Royal Palm Hotel: 310 NW Flanders. Contact: Robin Hochtritt (Ph. 827-3949)

Ryles Center: 3339 SE Division. Contact: Deb Allison (Ph. 238-1477)

Section 1 - MENTAL ILLNESS

- Assessment
- Organic Mental Illness
- Mood Disorders
- PTSD
- Alcohol and Drugs
- Personality Disorders

ASSESSMENT MODEL

RECOGNIZING PERSONS WITH MENTAL ILLNESS

The purpose of this activity is to provide officers with guidelines for identifying mentally ill persons. Emphasize that officers only have to be capable of identifying major behaviors indicative of a mental illness; they do not have to identify specific types of mental disorders. That is the function of a mental health professional. Whereas mental health professionals determine the type and severity of illness, officers only have to make a yes-or-no determination as to whether there is reason to believe the subject has a mental disorder.

Discussion Points

1. Generally, what is known about people with mental illnesses?

   - Depending on the severity of the disorder, mentally ill persons can be difficult to distinguish from persons not having a mental disorder.
   - Persons with a mental illness can be quite intelligent, perceptive, and articulate.
   - They can be employed and maintain familial relationships.
   - With the onset of their disorder, however, they become unable to deal realistically with the world.
   - Their thoughts and actions are not based on reality.
   - Their ability to think clearly is impaired.

2. What are the general characteristics that indicate a mental illness?

   - The behavior and mood of the person are inappropriate to the setting.
   - The behavior of the person tends to be inflexible.
   - The behavior of the person tends to be impulsive.

3. What are specific indicators of mental illness?

   - Sudden changes in lifestyle

     -can be both a cause and indicator of mental illness
     -involves an inability or unwillingness to fulfill one's expected role and responsibilities.

   - Major changes in behavior

     -behavior may have undergone sudden and drastic change
     -behavior may be marked by exaggerated mood swings
     -person may show lack of judgment regarding family, job, money, or property
     -person may dress flamboyantly, exhibit inappropriate sexual behavior, or go without sleeping or eating

- Extreme anxiety, panic or fright

  -anxiety is intense and unfounded
  -person is in a state of panic or fright
  -person may have trembling hands, dry mouth, or sweaty palms
  -person may be "frozen" with fear

- Believes others are plotting against him

  -person has an unreal fear of being watched, talked about, followed, persecuted, or harmed (e.g. a large man believing a frail, elderly woman is trying to strangle him)
  -person cannot separate reality and imagination

- Hallucinations

  -person experience events that have no objective source, but that are nonetheless real to him or her
  -most common hallucinations are seeing or hearing things, but can involve any of the senses, such as:

  feel - most commonly of bugs crawling on the body
  smell - often of gas associated with death plots
  taste - usually of poisons in food
  hearing - voices telling the person to do something
  sight - visions of God, the dead, or horrible things.

  -hallucinations can also be induced by drug or alcohol abuse

- Delusions

  -personal beliefs that are not based on reality
  -can cause the person to view the world from a unique or peculiar perspective
  -often focus on persecution (e.g. believes others are trying to harm him or her) or grandeur (person beliefs he or she is God, a saint, a famous person, or possesses a special talent or beauty)

- Depression

  -accompanies many mental disorders in varying degrees
  -often characterized by a persistent, general malaise
  -serious depression can involve withdrawal from family, job, and social involvement.

- Obsessions

  -recurrent thoughts, ideas, or images that the person cannot dismiss from mind
  usually involve behavior that the person finds unacceptable (e.g. a woman may believe

that every man she encounters is trying to seduce her)
-can cause tension and high level of anxiety

- Unexplained losses of memory

-not the normal forgetting of everyday things, but failing to remember the day, year, where one is, etc.
-not to be confused with loss of memory that often accompanies aging

- Confusion

-inability to focus on particular topic or interaction
-might be an indication that person has an obsession
-also caused by stroke, diabetic coma, intoxication, senility

- Impossible body ailments

-at first, symptoms are mild and may even fool doctors
-common beliefs are a body part growing, heart stopped, or chest filling with food

- Persons who suffer from mental illness must often take medication to counteract a chemical imbalance that may be causing the mental illness. Many medications, however, can cause side effects that are uncomfortable or annoying. Unlike hallucinations, these side effects are real. But, like hallucinations, the person has no control over them. Moreover, the person may not realize the presence of the side effects. Some of the major noticeable side effects include:

-minor stiffness, a rigid shuffling gait
-an at rest, hand jerk
-acute muscle spasms, tilted head
-a constant, fine, fast tremor
-blurry vision
-rhythmic motion of the jaw or lips, a clucking of the tongue, smacking of lips or-in severe cases-facial distortion

B

Basic

P

Psychiatric

L

Life

S

Support

Portland
Police Version

1. Goal

This summary is intended to provide police and other justice professionals with a basic outline of techniques for dealing with patients suffering from acute psychiatric disturbances. The emphasis is on an initial approach, urgent or emergent evaluation, and basics of intervention.

2. Introduction

Dealing with patients suffering from psychiatric disorders is often perceived as frightening by those infrequently exposed to these problems. The area of psychiatry itself may seem foreign for several reasons:

Psychiatry deals with biopsychosocial issues (1) that typically straddle multiple areas:

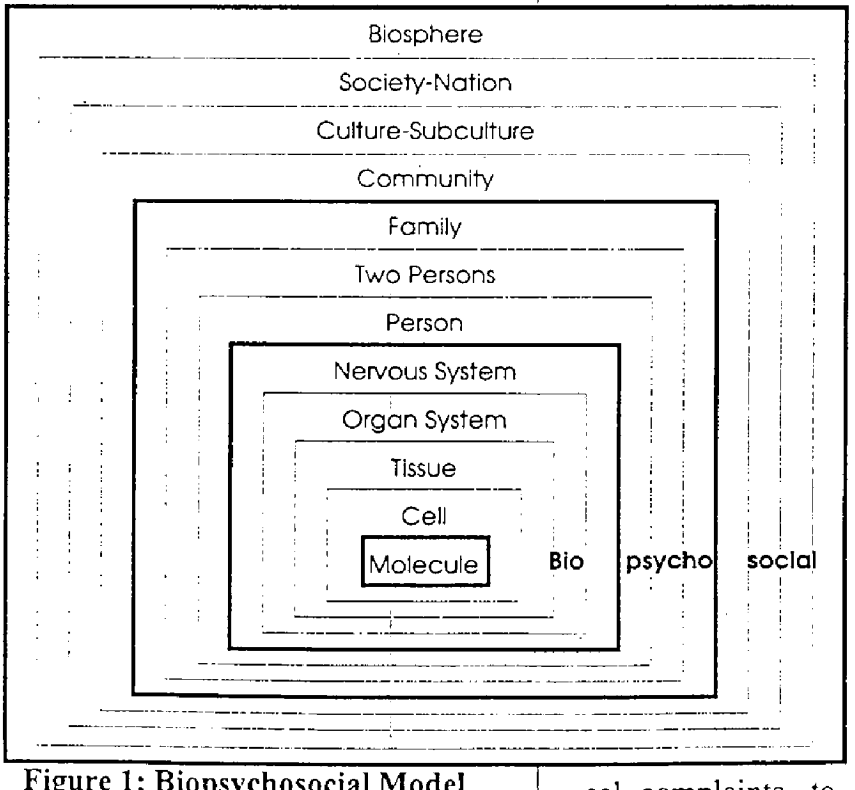


Figure 1: Biopsychosocial Model

There is no clear boundary between actions based on personal choice, social difficulties, psychological distress, or on a clearly biological disease. Multiple factors simultaneously influence the ultimate actions of an individual. Identifying and treating mental illness is complex, requires time, and may make the field appear diffuse and unclear.

Additionally, "gold standard tests" which would allow certain attribution of specific signs and symptoms to a specific disorder are generally not available. There is no X-Ray or blood test for bipolar disorder, for example. If a patient has signs of several disorders, multiple diagnoses must be considered, and frequently multiple diagnoses must be given. This may make the professionals operating in the field seem divided and without focus.

Finally, patients with psychiatric conditions often contact nonpsychiatric care providers first. They may adapt their complaints to match the specialty or "language" of the professional they are seeing. Thus, patients with similar ultimate diagnoses may present to a family doctor with physical complaints, to a mental health

professional with mental health complaints (2) (and likely to peace officers with safety concerns). Knowledge of mental illness can help the professional direct the patient safely into appropriate evaluation and treatment.

*Top priority must be the **professional's** immediate physical safety.*

The Basic Psychiatric Life Support model presented here is an attempt present the area of acute psychiatric practice in a way that is reductionistic, yet robust. The approach is generally algorithmic, similar to the Basic Cardiac Life Support course (3), which has brought emergency medical thinking to a broad audience. The structure of the algorithms here is determined by several factors which can be subsumed under the term "priority":

Severity: How bad is the disorder/injury?

Urgency: How fast must a response occur to be effective?

Remediability: How much difference will any response make?

Sequence: Does one step require a prior step?

Natural History: Balancing low frequency events with high morbidity against high frequency events with low morbidity.

3. Initial Triage

Even when it is clear that the appropriate or desired intervention is a psychiatric evaluation and/or treatment, attention must be given to its priority. (It is understood that here we are generally talking about noncatastrophic conditions in which the clinician has some realistic choices about how to proceed.)

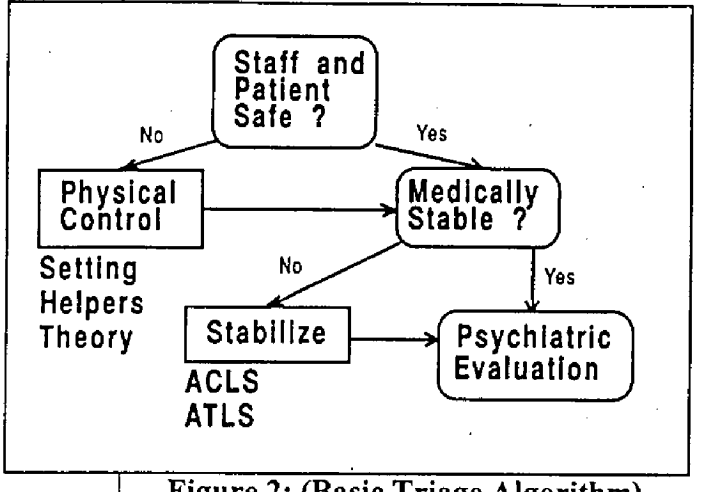


Figure 2: (Basic Triage Algorithm)

Top priority must be the clinician's immediate physical safety. What good can an injured or dead helper be? (Second priority is then the patient's own immediate physical safety.) If the clinician and patient are not physically safe, such safety must be provided for. Secondly, the patient must be medically stable to undergo psychiatric evaluation. If such medical stability is in question, immediate steps must be taken (after assuring physical safety) to intervene on this level. It is then the third priority to begin with a psychiatric evaluation, which will include the evaluation for suicide or homicide potential.

Also, attention must be given to the fact that a crisis represents the perception of an event or situation as intolerable, as an intolerable difficulty that exceeds the resources and coping mechanisms of the person defining the crisis. Such a concept must not be confused with that of an emergency,

which represents a sudden (and often distressing) event that may lead to serious psychological or physical consequences if there is no adequate response. This distinction is difficult, and at times one will need to proceed under the assumption of an emergency, even when it may ultimately prove that the problem is better identified as a crisis.

4. Physical Safety

That it is top priority to evaluate the potential of immediate harm to the professional and secondarily the patient comes as no surprise to police officers. This is their daily concern. We are looking for such basics as absence of weapons, a secure physical environment, and a patient that is reasonably able to modulate their behavior. The goal is to establish short term safety.

In essence, the concern is to identify and remain prepared for potential immediate violence, which represents a relatively rare event, but one with significant potential for injury or even death (4,5). It follows that attention must be given to issues of safety before they are needed. Protocols must be clear and well rehearsed.

4.1 Strategies:

To briefly review, the controllable variables can be grouped into three main categories: physical setting, personnel, and a theoretical model to guide the approach. Police safety techniques discuss these areas in detail, so here we will only list some areas of emphasis in the psychiatric arena for comparison.

4.1.1 Physical setting:

Structural requirements include the absence of dangerous or potentially dangerous objects, ideally access from multiple directions, monitoring and emergency communication systems, some provisions for confidentiality, and the opportunity to physically restrain a patient.

Each setting that the professional will work in should be rapidly reviewed a "worst case scenario" considerations in mind and steps should be taken to ensure as much safety in these settings as possible.

If physical restraint is used, sufficient help should be available to safely overwhelm the patient.

4.1.2 Personnel:

Just as the physical surroundings deserve attention, the professional must be completely aware of the help that is going to be available in an emergency. Specifically mental health trained, 24 hours per day, capability would be ideal. Such personnel should have an understanding of the medical model of overwhelming force. Police techniques that rely on verbal instructions or combative techniques (including pain holds) designed for persons with intact mental functioning can lead to difficulties. Patient injuries can occur in instances where the patient is incapable of understanding the purpose and context of police interventions due to a medical or psychiatric disorder. (See particularly the section on psychotic disorders.)

Medical (or paramedic) backup as well as collaboration with mental health professionals or outreach teams that might have some prior experience with the patient can also be very helpful. Such collaboration, however, re-

quires careful prior planning so that management at the scene of an incident can proceed smoothly.

4.1.3 Theoretical Model:
Attempts at verbal intervention generally precede physical restraint. A clear model to decide when to switch modalities is necessary. One such model is presented here for comparison. It is intended as an ever-present scheme in the background of the evaluator's mind, while carrying out other tasks such as obtaining a history and performing a physical and/or mental status examination. It is again intended as an example only:

Estimating the patient's control and deciding when the professional must assume control is key.

Patient's Response:	Staff Intervention:	My Response:
Aggression	Physical control	Fear
Hostility	Pseudochoice ("if...then...")	Anger
Anger	Real choices (Must be acceptable)	Anxiety
Anxiety	Support Encourage Ventilate Reassure "Extras"	Calm

Figure 3: (Interaction Grid) (Adapted from: (6))

The figure represents an interaction grid: three segments (columns) are subdivided into four corresponding levels (rows) of interaction. The first column represents the patient's emotional response within the interaction, the third, the professional's emotional responses which are assumed to mirror the patient's. The key is that the clinician must gradually develop a sense for their own personal response to each of the patient's stages. In the column between are strategies for intervention.

Exceptions:
The model of gradual escalation through the various levels from anxious, to angry, to hostile, and ultimately to aggressive, can be obviated by a number of medical and psychiatric conditions. In particular, an organically disturbed (e.g.: intoxicated or delirious) patient may escalate abruptly from a seemingly calm or anxious state to an outright aggressive one. Similarly, psychosis, with the inherent lack of reality contact (and defining thought disorder or loose associations), may jump from one stage to the other with little or no warning. It is here that the professional's personal emotional response may be the only "early warning" that is possible. This means that in the example suggested in Figure 3, the professional entering a patient's room for the first time, finding a fear response developing abruptly, should immediately be prepared to provide for physical control and safety.

5. Medical Emergencies

In the context of the triage algorithm (figure 2), medical emergencies are considered those conditions which would require stabilization of the patient prior to a psychiatric interview.

Procedures for such interventions have generally already been established, and most professionals will be familiar with examples of them: BCLS and ACLS protocols for medical and ATLS for surgical emergencies. Vital signs should be obtained if at all possible and as early as possible. They should be considered a requirement prior to the end of any emergency psychiatric intervention. Beyond this, a brief medical history, review of systems, and physical evaluation is usually necessary to rule out immediate medical problems.

6. Basic Psychiatric Interviewing

Moving to psychiatric intervention, we can distinguish: Interview techniques, evaluation (process and content), assessment, and treatment.

Any interview consists of at least three phases, with attention to four simultaneous areas:

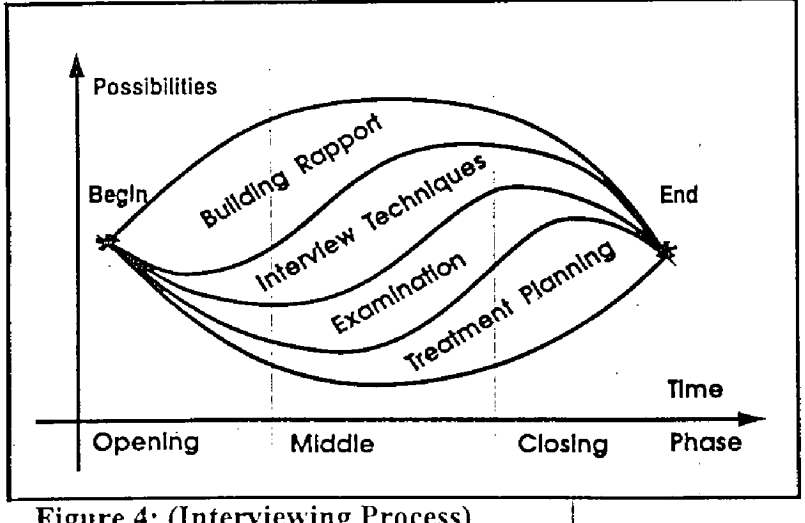


Figure 4: (Interviewing Process) (Adapted from: (7))

The beginning or opening phase of an interview emphasizes the establishment of rapport. The middle phase emphasizes the collection of information and the examination of the patient's current functioning. The closing phase emphasizes summarizing the information and communication of treatment decisions.

In any interview the professionl's initial overriding concern is to develop solid rapport with the patient.

In the opening phase, questions will generally be open-ended, encouraging the patient to speak. Facilitative techniques, such as empathic statements, can be used to support this. In the middle phase, questions can frequently become more focused and steering techniques are used to direct the interview into content areas that are desired. Such steering techniques could be thought of as analogous to "back doors." For example, questions on the degree of depression can ultimately lead to questions of suicidality and specific suicidal plans:

„How depressed have you ever gotten?" „Have you ever been so depressed that you didn't want to live?" „Have you ever been so depressed that suicide started making sense?" „Have you ever planned or attempted suicide?" „How are things now?"

Similarly, questions about anger can lead to homicidal plans and questions regarding fear can lead to psychosis. While specific content areas need to be covered in the interview, attention to the process of the interaction will allow the professional to follow a nat-

Knowing the relative importance of historical information can lead the interview.

ural „flow" of the conversation. Additional steering techniques can help when necessary topics don't come up naturally: „Now that we've talked about you, let's talk a little about your family." In the closing phase, the clinician may summarize and be speaking more (though frequently checking with the patient to be sure of understanding). The ultimate outcome of a successful interview should be an agreement about the next steps to be taken in a treatment plan.

7. Psychiatric Evaluation

The content of the evaluation generally includes a longitudinal (over time) component, the history, and a cross sectional (here and now) examination, typically, the mental status examination. This information leads to a diagnostic impression, which then guides the intervention strategy. While in an ideal case a relatively extensive history and thorough mental status examination will be obtained, the urgency of the moment may reduce this to current history with core mental status questions. Ultimately with a minimally cooperative patient, focus of the history should be to elicit a chief complaint and of the mental status examination to ask orientation questions.

7.1. Psychiatric History:
The history is usually obtained from the patient, though frequently outside corroborative information is needed. Generally this is done with, in emergencies without, the patient's permission. Depending on the urgency of the problem, intervention may need to occur before this information is complete or available. Obviously, no final disposition is possible until all of the information has been obtained and thoroughly considered.

The content is quite similar to that obtained in other areas of medicine. (In the following table(s) the asterisks identify the relative level of importance of the item). In emergencies, one would fall back on the most important items, clarifying these first.

Identifying Information
Chief Complaint (Suicide/Homicide?) ***
History of the Current Situation:**
Course Over Time**
Palliative and Provocative Factors
Review of Systems
Current Medications**
Current Drug Use Pattern**
Past Medical History*
Past Psychiatric History:
Hospital Admissions*
Biomedical Treatments (Medications)**
Suicide (Homicide) Attempts**
Past Alcohol and Drug Use*
Family History:
Genetic Risk Factors
Developmental History:
Family "Roles"
Defensive Mechanisms
Social History:
Current Level of Functioning
Prior Level of Functioning
Support System*

Table 1: History content

7.2. Mental Status Examination:
The mental status examination is intended to provide a cross sectional view of the patient's mental functioning at the current instant in time. It is a formalized method of obtaining and recording information on the higher cortical functions of the patient. To facilitate recall, four general areas can

be delineated: (Examples to serve as mnemonic devices are added in parentheses, and asterisks again denote the relative importance.)

1. General Inspection:
(Overview: "How does the patient look?")

Appearance: (Describing a "photograph") Height, weight, dress, grooming, etc.

Motor Behavior: (Describing the „silent movie") Movements, tics and mannerisms, level of activity, etc.

Speech: (Adding the "sound track") Rate, pressure, intonation, articulation, etc.

Attitude: (Putting it all together) Changes, relatedness with the interviewer, etc.

2. Emotions ("How does the patient feel?")

Mood: (The "climate") Depressed, happy, sad, irritable, etc. The patient describes the mood themselves. Their report will relate to a more extended period of time than the interviewer alone will have been able to observe.

Affect: (The "weather") Type: tearful, angry, etc.; Range: broad, full, narrow, flat, etc.; Stability: Labile, stable, etc. The interviewer attempts to describe the currently observed affective state of the patient in detail.

Congruence: The consistency between the observed emotions and reported mood with the context and content of the interview is observed. Loss of reality contact sometimes expresses itself here in lack of congruence.

3. Thoughts:** ("Software" analogy: "How does the patient think?")

Process:** This describes the logical flow of thoughts:

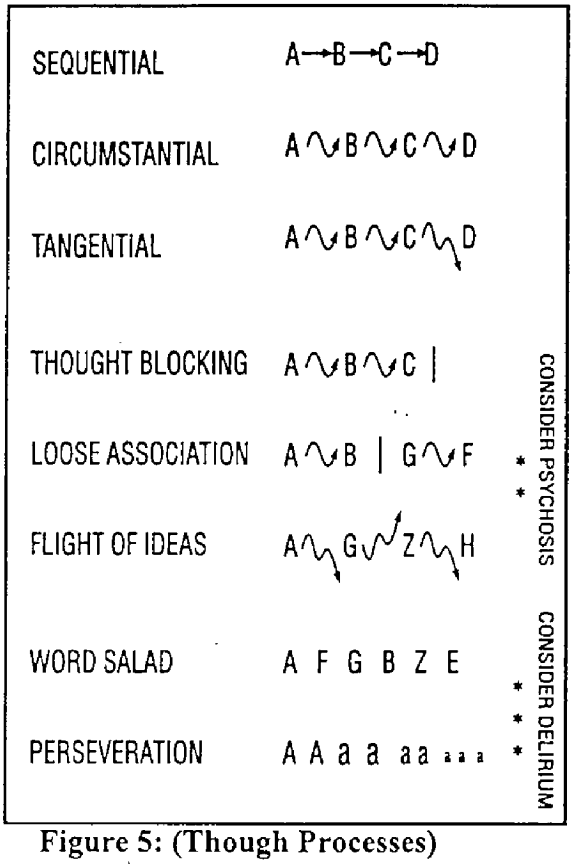


Figure 5: (Though Processes)

These can be considered to be on a spectrum from best organized to completely disorganized. On one end of the extreme, thoughts are expected to be sequential and concisely presented. At the other end of the extreme, no coherent thoughts can be discerned. There is literally word salad or perseveration. The most important stage*** is when loose associations (breaks in the logical flow) occur. They define psychosis. Tangential thinking may be dis-

When loose associations are present, consider psychosis; when there is word salad, consider delirium.

Orientation is the bedrock on which all other cognitive functions can be considered to rest.

tinguished from loose by the interviewers reaction: The thoughts: "What was my last question? How did we get onto this?" denote tangentiality. The thought: "Where did that come from?" denotes loose associations, and should be checked out. Worse disturbance generally indicates a worse disorder.

Content:** Here the thoughts themselves are grouped and unusual or important themes noted. In particular, any psychiatric interviewer will have to comment on suicidal*** or homicidal*** thoughts. These must be specifically sought out, as must be preoccupations and delusions* such as those indicating loss of reality contact, either in a nonbizarre or bizarre (completely impossible) context.

Perceptions:** How does the patient observe the world around them. Are illusions, hallucinations, auditory, visual, or tactile hallucinations**, depersonalization, derealization, ideas of reference, thought broadcasting, thought insertion, etc. present?

Using the computer analogy, thoughts can be considered to have disturbances that affect the logical order (poorly functioning program), abnormalities of content (database errors), and input errors.

4. Cognitive Evaluation*:** (Hardware analogy: "How is the machinery working?")

The following areas are all considered part of the cognitive function. In order to remember them, one might use the model of a familiar, reversible, toxic encephalopathy: alcohol intoxication. When one thinks of a person entering a bar and getting progressively intoxicated, ultimately to the point of coma, one can visualize the stages that they go through. Using this analogy, the extreme care needed to observe and document disturbances of orientation, attention, and concentration becomes clear.

Orientation: Time, place, and person.
Attention Concentration: Serial 7's, 3's, digit
span, (usual is 7 digits forward, and 4 backward), spell "world" forward and backward.
Memory:
Registration: "Repeat after me"
Immediate Retention: 3 objects after 3' Recent Past: Events of the last few days Remote Past: Events several years ago
Abstraction: Ability to „get the big picture:"
Proverbs, similarities.
Intelligence: Fund of knowledge (consistent
with the patient's education): vocabulary, presidents. general knowledge questions.
Judgment: Conceptualize outcomes: Stamped
envelope, smoke in a theater scenarios.
Impulse Control: Ability to modulate impulses.
Insight: Awareness of illness.

Table 2: Cognitive Evaluation

The list is an attempt at such a hierarchical organization (using the above analogy) from the most severe to the least severe level of disturbance. If complete testing is not possible, it is useful to move to ever more basic cognitive tests.

8. Assessment

There are generally two parts to an assessment: 1) Organizing the information gathered in the history and mental status examination, and 2) Making a formal psychiatric diagnosis. Establishing a diagnosis may, however, be secondary to organizing the information in such a way that focuses attention on triage priorities. Broad diagnostic categories are considered first and allow stabilization and referral to more definitive evaluation and treatment. For our purposes, short range outcome is the major consideration.

Review of outcomes research shows that top priorities, which express themselves as variables affecting patient disposition, include:

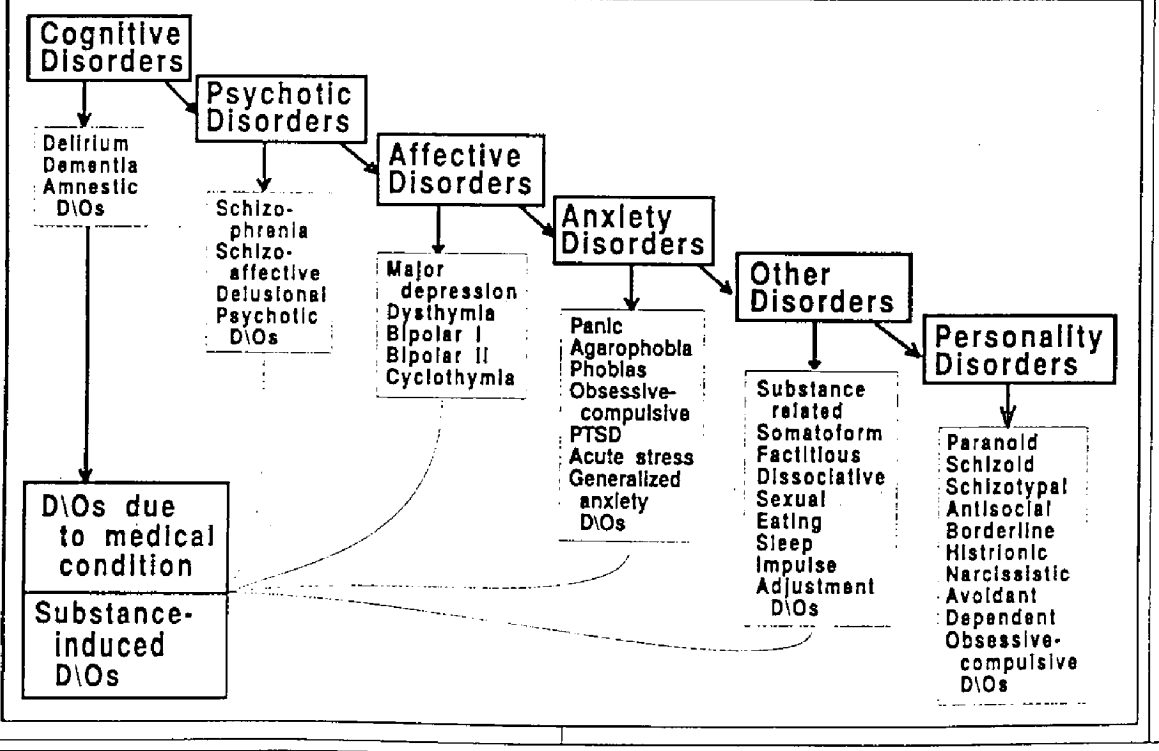
Dangerousness, prominence of symptoms (as clinical variables), clinical experience and knowledge of resources (as clinician variables), family members' support and desire for a specific outcome (as family variables), and referral source such as police, together with assessment of system options (3).

8.1 Impression:

Given the need for organization of diagnostic considerations, a clear idea about a diagnostic hierarchy is helpful. Which disorders take precedence over others? Why? Such a hierarchy is implicit in the DSM IV (8), producing a "cascade" of disorder groups. Generally, the hierarchy implies that treatment must be directed toward diagnoses higher in the model before treatment for lower priority diagnoses can be fully effective. Also, the more "biological" a disorder, the more likely it is to be found on the left; the more "psychological" a disorder, the more likely it is to be on the right.

Disorders induced by medical conditons or substances are listed with each group, but mut be considered first.

Figure 6: Differential Diagnostic Cascade



There are many medical emergency conditions that may initially present as a psychiatric disturbance.

Cognitive Disorders must be considered first. These are delirium (a medical emergency), dementia, and amnestic disorders. Problems where some outside influence causes what appears to be a psychiatric disorder are listed with each disorder group. Examples include substance intoxication, withdrawal, or medical illnesses. They must also be considered as the first priority. All of these disorders affect the brain's ability to function, and could be considered "machinery" or "hardware" problems. Treatment of these disorders will require attention to the underlying disorder. The most important is delirium***, characterized by rapid onset and fluctuation of global cognitive impairment with an inability to focus attention. This is heralded by disorientation and severely disorganized thought processes.

Psychotic Disorders*** must be considered next. These are illnesses. which affect the patient's ability to distinguish real from not real. They generally include major psychotic disorders such as Schizophrenia and are characterized by thought process (loosening of association or worse) or thought content (delusions) or perceptual disturbances (for example, auditory hallucinations). These can generally be considered "thinking problems." They are heralded by loose associations, delusions and or hallucinations. Treatment will usually involve the use of neuroleptics.

Affective Disorders are disorders that affect the mood. The mood may be depressed, elevated, or irritable. Major Depression and Bipolar Disorders (Manic Depressive Disorders) are the main illnesses. here. Both of these disorders can be accompanied by psychosis and when this is the case, the psychosis must be treated first. Treatments will often include medication such as antidepressants or mood stabilizers (thymoleptics).

Anxiety Disorders lead to excessive and inappropriate worry or panic. Examples include phobias, panic disorder, post traumatic stress disorder, the new acute stress disorder, obsessive compulsive disorder, and generalized anxiety disorders. As implied by the hierarchy, removal of precipitants (such as Hyperthyroidism, psychosis or mood disorders) clearly takes precedence over symptom oriented treatment with, for example, Benzodiazepines.

Other Axis I disorder Groups follow in the diagnostic cascade.

Finally, toward the psychological side of the biopsychosocial diagnostic spectrum are Axis II Disorders:

Personality Disorders are problems with an individual's overall coping abilities. They should be considered if there is a long standing (since adolescence) pervasive (affecting all parts of an individual's life) pattern of maladaptive (causing personal distress or impairing functioning) behavior. In these patients the developmental "tool kit" might be thought of as not fully developed, frequently under the influence of traumatic disturbances in their childhood. DSM IV (8) generally distinguishes three groups: Cluster A (odd and eccentric), Cluster B (dra-

matic erratic and emotional) and Cluster C (anxious or fearful). Under stress, such individuals can display symptoms from any of the other diagnostic groups and a thorough evaluation, along with attention to the diagnostic hierarchy, is crucial prior to the diagnosis of a personality disorder. Treatment generally involves a carefully coordinated program of psychotherapeutic and social interventions. Since these conditions can mimic and coexist with many of the Axis I disorders, their identification and treatment take time and may be perceive as the most frustrating task for the professionals trying to help. Clear attention to who is responsible for what (interpersonal boundaries) is crucial to the management of these conditions.

In summary, it should be remembered that, many individuals suffer from several disorders simultaneously. One disorder does not generally exclude another, though if symptoms can be ascribed to a diagnosis further up in the hierarchy, then that diagnosis must be given. Thus, for example, a patient who is intoxicated, yet suffers from Schizophrenia, would likely show signs both of cognitive impairment and reality impairment, and would be given both diagnoses. Treatment must then also address both disorders.

8.2 Biopsychosocial Diagnosis:

In order to organize all of this information, the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) (8) has designed its multiaxial system of diagnosis. The diagnosis is recorded in five axes, whereby multiple diagnoses are encouraged when the criteria for the specific disorders are met.

Axis I: Psychiatric Clinical Syndrome ("Nature") Axis II: Personality Disorders or Traits ("Nurture") Axis III: Physical Disorders Axis IV: Psychosocial and Environmental Problems Axis V: Global Assessment of Functioning (GAF Score).

Table 3: DSM IV Multiaxial System of Diagnosis

Many patient suffer from several disorders simultaneously that must all be identified.

9. Interventions

Beside the assurance of immediate physical safety outlined above, treatments will generally come in four major areas: general safety, biological treatments, psychological treatments, and social interventions.

Longer term safety issues are much more complex to evaluate. Generally the clinician is only able to identify broad groups of patients at risk for harm to self or others but cannot predict the future behavior with any reasonable certainty over more than a few hours or even days (4). One of the best and most important predictors is that of past behavior. Another key consideration is the presence of destabilizing factors such as intoxication.

9.1 Immediate Safety Interventions:

As outlined before, emergent intervention may require physical restraint. The principal behind the safe use of such restraint is overwhelming force. We cannot assume that a patient has

The clinician assumes the responsibility when there is significant danger or competence is low.

the mental capacity to recognize directions, physical cues (painful or nonpainful), and to respond appropriately. When a patient is physically restrained attention must be given to the legal framework (doctor's court hold or police officer hold, etc.). Also, the patient must then be observed very closely since this group of patients is at higher risk of having significant coexisting physical illnesses that can place them in danger, especially since the usual complaints of feeling ill may not occur. Once a professional has assumed responsibility for the patient they are responsible for the "whole" patient!

Similarly, chemical restraints can be used in some emergency conditions. Neuroleptics (Inapsine) or Benzodiazepines (Ativan) have been advocated and are often used in the medical setting.

9.2 General Safety:

Patients who present a danger to themselves or others are unable to care for themselves, or fail outpatient management, or require 24 hour observation for diagnostic assessment or ongoing round-the-clock medical treatment will require hospitalization. As long as such patients are willing to be hospitalized on a voluntary basis, there is little question as to how to proceed.

Involuntary Admission: In most states, if the patient represents a danger to himself or others due to a mental disorder, and/or is unable to care for their basic needs (grave disability), there is a process that allows emergent and urgent hospital admission on an involuntary basis. This is generally regulated in the Commitment Statutes. Difficulties arise when it is unclear how far the patient's rights of self determination go in comparison to the professional's ethical obligation to intervene in the face of a psychiatric disorder (right to competent treatment).

In this respect, a grid that plots danger against competency may be useful to the professional:

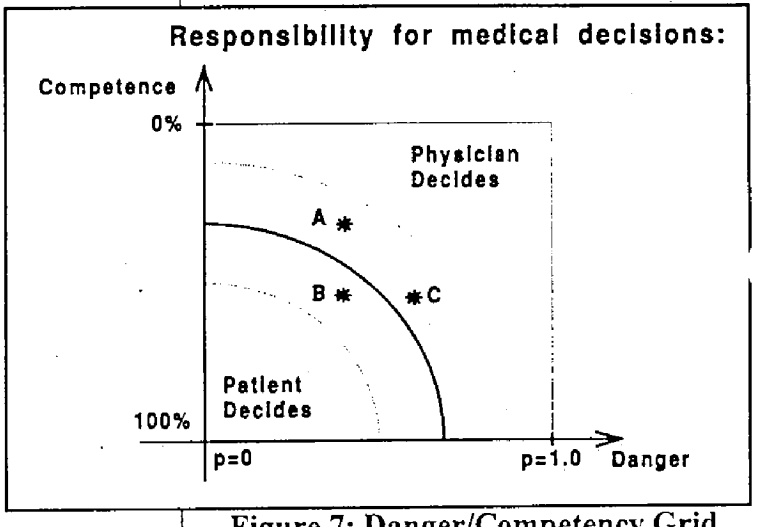


Figure 7: Danger/Competency Grid (Adapted from (10))

As outlined in this grid, competency is plotted against danger. In the lower left hand corner, patients who are in an area of low danger, yet have a high degree of competence, are clearly in charge of their treatment, irrespective of the clinician's preference. Simultaneously, patients that have either an extremely low level of competence (such as the severely disabled Alzheimer's patient wandering on the street) or are in an extreme degree of danger (such as an occluded airway)

must be treated by the clinician even against their will. Frequently, the situation is much less clear. Despite this, the law allows only for a dichotomous choice: One is asked to act as if the grid were bisected by a clean line. Nevertheless, it is quickly apparent that the gray band of mixed cases in the middle represents many cases and a significant clinical dilemma. For example, patients A, B, and C may differ only in some minor respects, yet patient A and C will be involuntarily admitted where B may not. Patient B may, for example, present with depression, suicidal ideations of several months' duration, and some poorly formulated thoughts of possibly taking an overdose. Patient C, similar in all ways, may, however, be contemplating the use of a firearm and has access to such. Clearly, patient C would require involuntary admission. Patient A, on the other hand, while in a situation just as B, may be intoxicated, lowering their level of competence. Clearly as well, here the clinician must intervene (even if only temporarily until competence is restored/intoxication resolved).

Involuntary admission in Oregon is regulated by the Oregon Revised Statutes (ORS 426). If a patient represents a danger to himself or others due to a mental disorder and is unable to agree to voluntary admission, the patient may be admitted against his/her will. The doctor's court hold (DCH) documents the belief of two licensed physicians or a physician and a qualified mental health professional that such a danger and mental illness exists. Outside of the hospital setting, the police or mental health program is needed to make such a determination. A police officer custody report (POCR) documents that a police officer has reason to believe that such danger and illness exists. A mental health program can also initiate such a police officer hold (Mental Health Director's Hold). When the mental disturbance does not rise to the level of danger but there is question about the individual's ability to care for themselves, any two interested persons may file a two party notice (TPN) with a county mental health agency. From the filing of all of these notices, a court investigation

The patient's safety for two weeks on their own may be key to deciding on potential danger.

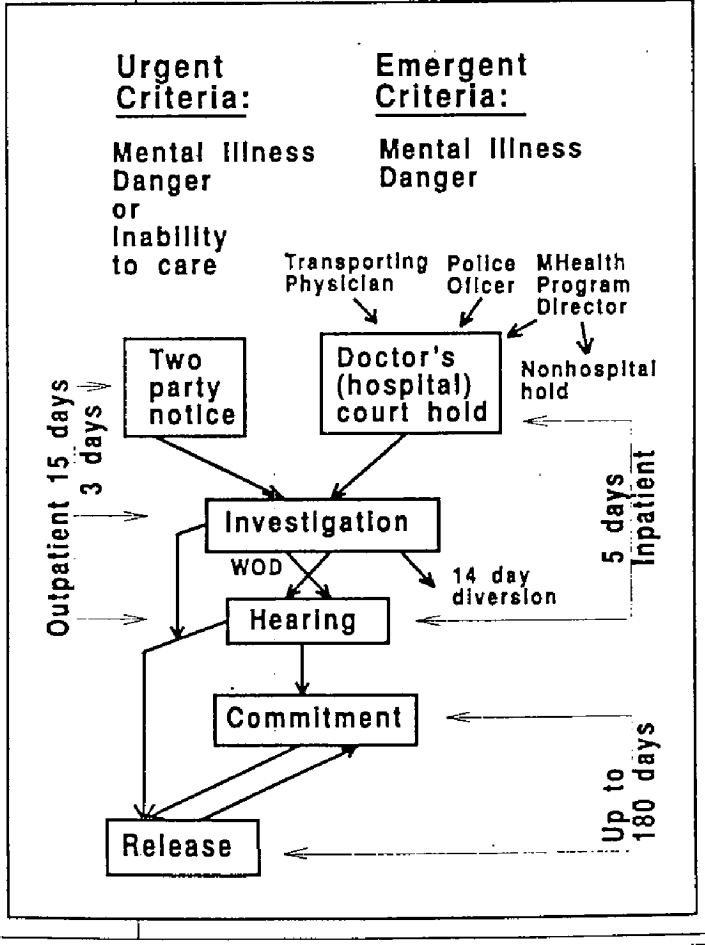


Figure 8: ORS 426

The patient should be treated in the least restrictive, yet safe, environment.

is initiated. This investigation may lead to a hearing (or to patient release). The hearing may lead to commitment. The main difference between the two routes in Oregon is that the emergent route (which includes only the criteria of mental illness and danger) requires that the patient be kept in the hospital and must not exceed five working days to the point of a hearing. The urgent route proceeds on an outpatient basis and 15 days may pass prior to a hearing. Therefore, frequently the question of danger must be phrased as: "Is this patient safe for 15 days in an outpatient setting?"

9.3 Biological Treatments:

In this area we generally think of the use of pharmacotherapeutic agents. Also, in general, one will have to consider psychiatric consultation in this context. Brief attention was given to the use of chemical (and physical) restraints earlier. An introduction into the basic psychopharmacology would clearly be beyond the scope of this brief review. Nevertheless, we should be clear that addressing an organic or cognitive mental disorder generally requires attention to or treatment of the underlying disorder. Thus, for example, treatment of hypo- or hyperthyroidism or delirium tremens would require the appropriate medical treatment for those conditions, not the psychopharmacologic treatment of the mental expressions of the illness (though there are exceptions where both becomes necessary). Psychotic disorders generally require antipsychotics (neuroleptics). Affective disorders will generally be treated with antidepressants and/or mood stabilizers, including Lithium, Tegretol, or Valproate. Anxiety disorders will frequently be treated with antianxiety agents, such as Benzodiazepines or Buspirone. As indicated by the differential diagnostic hierarchy, such agents must be used cautiously in combination.

From a psychiatric emergency viewpoint, it is extremely important to remember that treatment with neuroleptics, antidepressants, and mood stabilizers generally requires two to four weeks to be effective. Therefore, their initiation is frequently not part of an emergency, more triage-based intervention, no matter how badly one wants to help fast. Pharmacologic measures are generally very focused, directed at supporting a prior developed treatment plan and prescriptions are kept small. Careful coordination with outpatient treatment providers is crucial.

9.4 Psychological Treatments (Psychotherapy):

Similar to the section on pharmacotherapy, an introduction into psychotherapy is beyond the scope of this review. The emergency setting, as well as the realities of the treatment system, currently favor more focused, outcome oriented treatments that are frequently in the cognitive or behavioral realm. In many emergency settings general principles of crisis intervention apply: One attempts to restabilize the patient who has reached a point of instability and overload ("the straw that broke the camel's back") and support their process of reorganization through the phases of acute

decompensation, denial, anger, bargaining, grieving, and recovery. Such a hypothetical course of a crisis is outlined below:

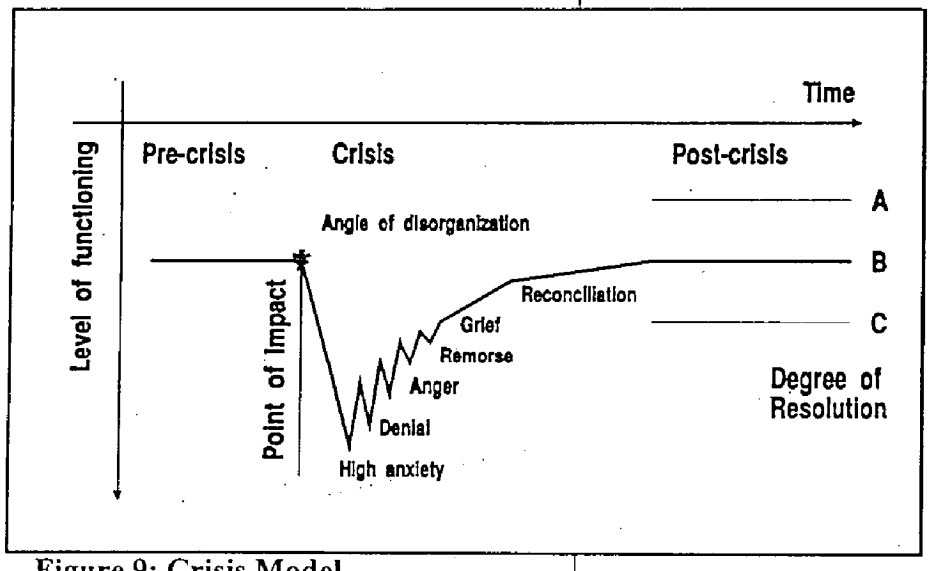


Figure 9: Crisis Model

Psychotherapeutic intervention could take on the following form: One assesses the biological, psychological and social realities that the patient brings to the situation. These are crucial for understanding the resiliency or stability of the patient's "system." Then focus on the balance between stressors and support system will allow a determination to be made on the severity and urgency of the current crisis. Stressors or supports are then manipulated where possible to help restabilize the patient.

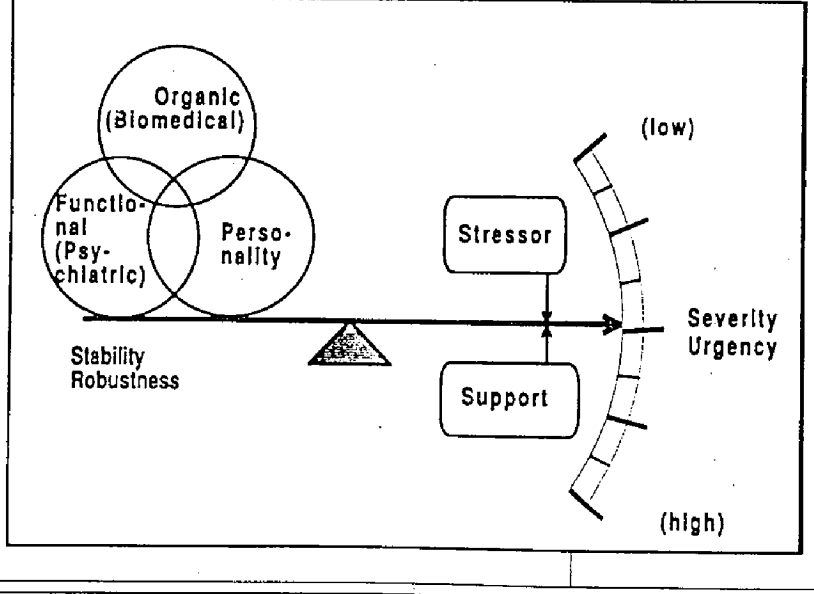


Figure 10: Crisis Intervention

Psychotherapeutic intervention using a debriefing model may also be appropriate. Such a model could be thought of as having four parts (see table 4). It may be used with individuals and groups. In the interaction, the four phases are explicitly separated. In the first phase facts are gathered from all participants. Statements about how one feels are excluded. (It is made clear that they are legitimate, but will be talked about separately). In the second phase, affects/feelings are clarified and discussed. Here the attempt is to collect a broad range of emotional responses, validating them. The disconnection from the facts and the legitimacy of the patient's own emotional response is emphasized. In the third phase the group is educated about what to expect (both in terms of future events and emotions); in the fourth,

Crisis intervention rebalances a percieved disparity between stressors and suuports.

The critical incident debriefing model may also be useful for the professional faced by trauma.

plans are made for any necessary follow-up.

1. Clarify the facts of the crisis ("What happened?").
2. Clarify the feelings ("How do you feel about this?").
3. Review the usual response to crises: (teaching phase).
   - Phase of Disbelief or Denial.
   - Phase of Shock or Confusion.
   - Phase of Anger.
   - Phase of Grief and Sadness.
   - Phase of Acceptance.
4. Problem solving or reopening the social world/contacts and ultimate resolution (reinforce adaptation and a plan for the future).

Table 4: Critical Incident Debriefing

In less formalized psychotherapeutic work three simple rules may help in the beginning:

1. When the patient presents a complaint, always validate it.
2. However, in doing so, acknowledge it in a way that will allow for reinterpreatation. Thus, it may be crucial to a psychotic patient to hear: "Oh, that sounds frightening," but it would be unwise to agree that the FBI may be indeed plotting.
3. Finally, offer a reinterpretation of the complaint that will direct the patient to action toward an useful goal. ("When you experience such voices, it may be a sign that you need to take a time out/take more medication.")

9.5 Social Interventions:

In this area, the realities of the patient's living are addressed. Clearly, attention must be given to food and shelter, as well as clothing. Where these are not immediate concerns, issues of disability may be the stated or covert objectives that should receive attention. While seeking psychiatric hospitalization in order to find shelter is understandable, it is clearly not the most efficient use of resources, and it would be the professional's task to support the legitimacy of such patient desires, yet to help the patient address their needs directly.

10. Summary

This outline is clearly intended as a forum for ongoing discussion and not as a finished document. It does, however, attempt to make explicit some of the core principles underlying emergency psychiatric evaluation and intervention. Since the subtleties of human interaction can clearly not be adequately addressed by such an approach, it is worth remembering that the experienced professional on the scene generally has access to significantly more information, including personal reactions, that can be crucial to accurately assessing the patient's situation. Pairing such clinical experience and "feel" for patients' needs with a clear diagnostic and therapeutic structure will hopefully provide some of the redundancy necessary to assure safe clinical interactions.

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NOTES

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NOTES

CRISIS INTERVENTION TEAM TRAINING
MAY 15, 2000

OVERVIEW OF MENTAL ILLNESS

WHAT IS MENTAL ILLNESS?

A biologically based brain disease characterized by

- perceptual disturbance
- mood lability
- lack of motivation
- and in extreme cases, suicidality.

Mental Illness can impact all areas of a person's functioning including

- **Social** — difficulty getting and/or maintaining necessities of life i.e. food, clothing, and shelter
- **Occupational** — difficulty acquiring and/or maintaining employment
- **Interpersonal** — difficulty maintaining relationships with friends, co-workers, partners, spouses, parents, children

Symptoms of mental illness may be exacerbated by environmental stressors including

- Poverty
- Homelessness
- Difficulty accessing medical care
- Poor nutrition
- Drug and alcohol addiction

Symptoms of mental illness may be alleviated by medicine and social supports including

Help in --

- keeping up an apartment
- shopping for food
- budgeting money
- attending to hygiene
- planning social activities
- making friends and maintaining relationships
- Easy access to mental health care that is affordable and tailored to the needs of the person

WHAT MENTAL ILLNESS IS NOT

- Mental illness is not a character flaw.
- Mental illness is not a guarantee that the person will be violent.
- Mental illness is not anyone's fault.
- Having a mental illness does not mean there is no hope.

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Thought Disorders

- Hallucinations that might cause people to see, hear, feel, taste or sense things that aren't there
- Talk to self
- disorganized thoughts
- Paranoia, delusions, or bizarre thoughts
- Minimal display of emotion
- Poor hygiene/malodorous
- May wear multiple layers of clothing or inappropriate clothes for the weather
- May have multiple bags filled with what might appear to be garbage

WHAT A PERSON WITH MENTAL ILLNESS MIGHT EXPERIENCE

Some Symptoms of Mania:

- Expansive irritable mood
- Decreased need for sleep
- Heightened self-esteem
- Grandiose ideas
- Pressured speech /inability to interrupt them
- Distractibility
- Poor impulse control (e.g. buying sprees, sexual indiscretions)
- Possible break with reality, i.e. psychosis

WHAT A PERSON WITH MENTAL ILLENSS MIGHT EXPERIENCE

People with major depressive disorder often do not act in a bizarre manner

Common symptoms of depression include:

- Depressed mood most of the day, nearly every day
- Loss of interest or pleasure in all or most activities of the day
- Significant weight loss or gain
- Difficulty sleeping or sleeping too much
- Fatigue or loss of energy
- Feelings of worthlessness
- Recurrent thoughts of death or thoughts of suicide

It is a myth that depression is a normal part of the aging process. It is important to remember that depression is an illness which can be successfully treated.

IF YOU HAVE TO TAKE THE PERSON INTO CUSTODY ON A HOLD SOMETIMES IT IS HELPFUL TO:

- Ask the person if they have ever been in handcuffs before
- Tell the person that you came to help them, not to hurt them
- Tell them they are not under arrest or in trouble
- Tell them you know that they are not a bad person
- Tell them your boss says you have to put them in handcuffs, it is the rule, it's nothing personal

ORGANIC AND PSYCHOTIC

MENTAL ILLNESS

WHAT IS PSYCHOSIS

Psychosis is defined by a complex of symptoms that include:

Delusions (false beliefs in something that is so at odds with the prevailing societal consensus as to be recognized as ranging from the improbable to the bizarre).

Hallucinations (the experience of sensation in the absence of external stimulation, most commonly auditory, but in drug induced states or other organic states can include visual, olfactory, gustatory, and tactile sensations. That is hearing, seeing, smelling, tasting and feeling.)

Incoherence (unintelligible speech or speech which may make sense but conveys little or no information even though the person may talk a lot).

Loosening of Associations (the lack of connection in a person's flow of thought so that ideas seem to generate other ideas which have no logic to their sequence).

Catatonia (marked excitement or profound stupor and muteness to the degree that a person is at risk for life threatening exhaustion or is unable to carry out basic functions such as food seeking and feeding).

Gross Disorganization (marked difficulty in organizing behavior so that a person may be disoriented to time, place and identity, may be unable to respond to others or unable to respond in an understandable manner).

There is a range of conditions which may produce psychotic behavior. This may vary from; a brief reactive psychosis which is a response to excessively traumatic stress (for example: combat); to substance induced psychotic reactions; to psychosis due to a progressive brain deterioration such as in a dementia like Alzheimer's; and psychosis due to a chronic mental disorder such as schizophrenia or severe mood disorder as in psychotic depression or in psychotic mania.

The neurobiological basis of psychosis appears to stem largely, but not exclusively, from the disruption of dopamine transporting systems in the brain. This can be due to endogenous (internal) causes such as mental illness or dementia but also may be due to exogenous (external) causes such as head trauma or exposure to certain chemicals.

For our purposes, **we are concerned with those chemicals which have reinforcing properties in the brain and are likely to be abused.** Repeated use of

substances such as **alcohol, speed, crank, coke, crack, hallucinogenics, designer drugs**, increases the risk of developing a drug induced psychosis or "triggering" an existing condition such as schizophrenia or severe mood disorder. This appears to be due to the dopaminergic (dopamine stimulating) action of these substances in the brain.

The most common psychiatric symptom resulting from repeated or heavy use of any of the amphetamine type drugs is delusional thinking. Paranoid delusions of persecution and other bizarre or unusual explanations of events are frequently seen. Accompanying this paranoia can be agitation, anxiety and aggressive behavior so that persons in a drug induced psychotic state have much more potential for violent acts including homicide and suicide.

Think of the brain as an elaborate circuit board with very complex electrical interconnections which form our self-awareness, our experiences, our thoughts, our sensations, our perceptions, our memories. If you pour water on a circuit board it shorts out due to the water acting as an electrical conductor between parts of the circuits that weren't meant to be connected. Drugs act the same way in the brain except instead of water being the disruptive electrical conductor, they act on the neurotransmitters which conduct electrical activity. If the brain is no longer able to carry out established interconnected patterns of electrical activity and different pathways become involved, what the brain experiences is psychosis. What others see is that the psychotic person does not make sense and is responding to stimulation that is internal and not shared or understood by others.

Usually, if an individual abstains from drugs, **the psychotic symptoms will go away with time.** The symptoms generally go away within hours to days, although they can last several months and, for some unfortunate individuals, they may become permanent. **The population at highest risk for permanent damage is the one with an existing mental illness or mood disorder or, has a predisposition to develop a mental illness or mood disorder.**

At this time, the single most effective known treatment for psychotic disorders is the use of anti-psychotic medications. These are believed to have a stabilizing effect on the dopamine balance in the brain. These medications, however, are not 100% effective and they carry some risk of side effects. About 25% of people with psychotic symptoms do not obtain a favorable response to existing anti-psychotic medications. Hallucinations, confusion and disorganization generally respond to anti-psychotic medications but delusional thinking tends to be less responsive. Ideally however, treatment should combine medications with social therapies to be the most effective. There are some individuals who can recover without the use of medications but they are in a minority.

Denial is a major element making for great difficulty in the treatment of psychotic states that are either drug induced or due to chronic mental disorders. Frequently, the person experiencing the psychotic effects of drugs or of mental illness believes that what his senses are telling him is an accurate reflection of external reality. This is what we all believe and rely on to navigate through the world. When someone tells a psychotic individual that what they are experiencing is not "real", it is very difficult to make a convincing argument. What is going on in that person's brain is their reality so they must deny any challenges to that reality and refuse to accept any offers of treatment and refuse to believe that they might need treatment.

A common outcome is that a psychotic person comes to the attention of the police. A quick determination is made if the psychotic person poses some danger to themselves or others and is not willing to obtain voluntary treatment. **The individual is transported to an emergency psychiatric facility where they can be detained against their will, for up to five court days.** During this time an investigator must make a determination as to whether or not the person is to go to Civil Court before a judge and psychiatric examiners for an involuntary commitment hearing. **The Civil Court has the authority to place the person under the care and custody of the Mental Health Division for a period not to exceed 180 days if they find the person continues to be mentally ill, a danger to self or others and is unable or unwilling to accept voluntary care. While under commitment and within the guidelines of the law, a person can be administered psychiatric medications against their will.**

Go back now to the earlier statement that most drug induced psychotic states clear in a few hours to a few days. If a person in this condition is taken to a psychiatric emergency holding facility they are likely to be released without a commitment hearing. **But, for the person whose symptoms persist, they stand a good chance of being committed and placed in a psychiatric hospital.**

If a crime was committed at the time the person was picked up by the police, the person may have a **detainer** placed on them while in the hospital and then be transferred to jail once their symptoms have cleared. If the crime is serious enough, a mentally ill offender may go straight to jail and then quickly to court for a judge's order to be sent to Oregon State Hospital Forensic Unit for evaluation or treatment. **Petty crimes** committed while the person is psychotic are often dismissed if the court feels that the individual is getting the treatment they need. Repeat offenders are not as likely to be looked upon with such leniency particularly if they persist in denying they need treatment or do not follow through with treatment.

Mental illness is not a state of bliss. It can be a world filled with fear and confusion. Whether psychosis is drug induced or not doesn't make any

difference to your brain but **the choice to use or not use drugs of abuse will make a major difference in how your brain is going to function.**

Organic Disorders

a. Definition
    1. A class of conditions caused directly by abnormalities of brain structure or by alterations of brain neurochemistry or neurophysiology (e.g., delirium, dementia, amnesic syndrome, organic hallucinosis, organic delusional syndrome, organic mood syndrome, organic personality syndrome, etc.)

b. General symptoms
    1. Confusion, memory disturbance, disjointed speech, slow mentation, and substance abuse

    2. Physical signs
        a. Breath smells
        b. Blood shot eyes
        c. Runny nose
        d. Needle tracks
        e. Slurred speech
        f. Unsteady on feet
        g. Bizarre behavior and speech

    3. Head Trauma
        a. Permanent
        b. Slow mentation
        c. Impulsive
        d. Seizures
        e. Personality change

    4. Stroke
        a. Usually older person
        b. Paralysis
        c. Difficulty speaking

5. Dementia
    a. Older person
    b. Confused, especially about personal information
    c. Combative
    d. Often in a nursing home or has a specific care provider

6. Medical Causes
    a. Diabetic not taking insulin
    b. Drug overdose
    c. Delirium – fluctuating levels of consciousness
    d. Past seizures
    e. Off seizure medications
    f. Physical illness (sweating, nausea, vomiting)

Psychotic Disorders

a. Definition
   1. A disturbance of perception and thought process is a broad description of this category. The psychotic symptoms represent manifestations of disturbances in the flow, processing, and interpretation of information in the central nervous system. These symptoms can be mild to severe. (Mental Health : A Report of the Surgeon General)
   2. Hallucinations are the most common group of symptoms that result from this disordered processing and interpretation of sensory information. An example is the frequently described hallucination of hearing voices.
   3. Hallucinations may include:
      a. auditory
      b. smell
      c. feel
      d. visual
      e. physical
   4. Delusions are a more complex group of symptoms resulting from this disordered interpretation of information. A delusion is a false belief that an individual holds despite evidence to the contrary. A common example is paranoia, in which a person has delusional beliefs that others are trying to harm him. Any attempts to persuade the person that these beliefs are unfounded typically fail and may further entrench the delusional belief.
   5. Psychotic thought processes are characteristically loose, disorganized, illogical, or bizarre. These thought processes frequently produce bizarre observable patters of behavior that is also disorganized and bizarre.

Schizophrenia

a. The cause of schizophrenia has not yet been determined although research points to the interaction of genetic endowment and major environmental upheaval during the development of the brain. (Mental Health: A Report of the Surgeon General)
b. Part of the psychotic disorders schizophrenia frequently have marked disturbances in logical thought process.
c. Symptoms can include:
    1. Hallucinations
    2. Delusions
    3. Disorganized thoughts and behaviors
    4. Loose or illogical thoughts
    5. Agitation
    6. Flat or blunted affect
    7. Concrete thoughts
    8. Anhedonia (inability to experience pleasure
    9. Poor motivation, spontaneity, and initiative

MOOD DISORDERS

Mood Disorders

a. A group of clinical conditions characterized by a disturbance of mood, loss of that sense of control, and a subjective experience of great distress. This disturbance of mood can be manifested by either stained feeling or sustained elevation of mood. As with psychosis the disturbance of the mood occurs in a variety of patterns associated with different mental illnesses. (Mental Health: A Report of the Surgeon General)

Bipolar or Manic Depressive

a. Symptoms include mood swings from the lows of depression to the highs of mania. These episodes alternate and in some cases can be predicted. Severely affected people have a "rapid cycling" bipolar illness, in which the mood swings occur almost continuously.
b. Depression: symptoms include melancholy, sad, miserable most of the time. Loss of interest in life and pleasures. There can be a decreased energy level, fatigue, fits of weeping or constantly feeling like crying, and an unusually high degree of irritability. There is also a on going thoughts of suicide in severe cases.
c. Manic symptoms include a feeling of power, increased energy, seductive, elated, euphoric. Other symptoms include talks too fast, loud and without stopping. Thoughts race from one idea to the next in rapid succession without much logic. Stop eating, sleeping which in turn can change mood to irritability, anger, paranoia.

Major Depression

a. Ongoing feelings of melancholy, sad and miserable most of the time with loss of interest in life and pleasures. These episodes can also include decreased energy, fatigue, fits of weeping or constantly feeling like crying. Symptoms may

vary with individual, but are long lasting and affect the quality of life for the person.

b. The though process is constantly negative with hopelessness dominating present and future. Anxiety, dread can increased the individual's inability to function. Difficulty in concentration and making decisions; experience feelings of guilt, self-loathing, or worthlessness. Preoccupies with death and suicidal thoughts or attempts.
c. Physically individuais may experience disruptions in normal eating and sleeping patterns. Some are unable to sleep and others may sleep more hours than usual.
d. Behavior includes inability to get work done and diffjculty in reading or studying. There is a great difficulty in accomplishing simply tasks such as washing, dressing, and eating. There may also be some restlessness and agitation. The characteristics include slowed thoughts, movements, and speech; walk stooped and shuffling gait

POST TRAUMATIC

STRESS DISORDER

Post Traumatic Stress Disorder

1.Symptoms develop following exposure to an extreme traumatic event that involves

- Direct personal experience of an event that involves actual or threatened death, serious injury, or other threat to physical integrity of another person
- Witnessing an event as described above
- Learning about unexpected or violent death, serious harm, or threat of death or injury by a family member or other close associate

2. The persons response involves intense fear, helplessness, or horror. In children this may be manifested by disorganized or agitated behavior.

3. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. In children this can include play where themes or aspects of the trauma are expressed
- Recurrent or distressing dreams of the event. In children there may be frightening dreams without recognizable content

Acting or felling that the traumatic event were recurring. Can include hallucinations and flashbacks

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity to internal or external cues that symbolize or resemble an aspect of the traumatic event

4. Persistent avoidance of stimuli associated with the trauma and numbing of generalized responsiveness

- Efforts to avoid thoughts, feelings or conversation associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall important aspects of the trauma
- Diminished interest and participation in activities
- Feeling of detachment or estrangement from others
- Restricted range of affect – FLAT PERSONALITY
- Sense of a foreshortened future

5. Persistent symptoms of arousal

- Difficulty falling or staying asleep
- Irritability or anger outbursts
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

6. Prevalence rates for the general population range from 1% to 14%. Rates for at risk populations such as combat veterans, crime victims, ect. range from 3% to 58%

7. In about 50% of cases symptoms resolve within 3 months. In many cases symptoms persist longer than 12 months

8. Individuals with PTSD are at increased risk of developing a substance use disorder. Substance use exacerbated symptoms of PTSD

GUIDE TO ACCOMPANY

POST TRAUMATIC STRESS DISORDER

FEATURES OF PTSD

A. Traumatic event/significant stressor.

B. Re-experiencing of the traumatic event.

C. Numbing of responsiveness

D. Anxiety-based autonomic and cognitive symptoms.

DIAGNOSTIC CRITERIA FOR PTSD

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Re-experiencing of the trauma by at least one of the following:

1. Recurrent and intrusive recollections of the event (nightmares).
2. Recurrent dreams of the event.
3. Sudden acting or feeling as if the traumatic event were re-occurring (flashbacks).

C. Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

1. Marked diminished interest in one or more significant activities.
2. Feeling of detachment or estrangement from others.
3. Constricted affect.

D. At least two of the following symptoms that were not present before the trauma:

1. Hyperalertness or exaggerated startle response.
2. Sleep disturbance.
3. Guilt about surviving when others have not, or about behavior required for survival.
4. Memory impairment or trouble concentrating.
5. Avoidance of activities that arouse recollection of the traumatic event.
6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.
7. Self-medication via alcohol/drug/pill abuse--chain smoking--overeating--anger mismanagement.

PTSD SUBTYPES

308.30 Post-traumatic Stress Disorder, Acute

- Onset of symptoms within six months of the trauma.
- Duration of symptoms less than six months.

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

- Duration of symptoms six months or more (Chronic)
- Onset of symptoms at least six months after the trauma (Delayed)

TRAUMATIC EVENTS THAT CAN PRECIPITATE PTSD

A. Rape

B. Natural Disaster

C. War--combat

PRECIPITATING TRAUMA & SIGNIFICANT STRESSORS OF COMBAT

- Exposure to death and mutilation of people and destruction and desolation of environment.

- Personal acts of violence, fighting, killing, and destroying.

- Danger and threat to life.

- Depersonalization and dehumanization of the military environment and the war experience.

- Discontinuity between war and non-war environment.

Additional Stressors of War

- Political and moral debate and controversy about combat, social and political divisiveness (draft evasion; marches, demonstrations, protests, and political debate). Creating a state of confusion and uncertainty; weakening morale; heightening vulnerability; diminishing social support and sanction; resulted in a homecoming by avoidance, rejection, and antagonism.

- System of rotation, limited tour of duty and periods of rest and recuperation with rapid individual entry and exit reduced morale and cohesiveness; rendered unit maneuvers more difficult and exposed participants to a more stressful transition.

- Restrictive policies (no plan to win the war; abandonment of captured territory; orders to request permission from higher authority before engaging the enemy) heightened danger, contributed to mistrust and lack of confidence in leadership.

Themes of "Post-Vietnam Syndrome."

- Guilt feelings and self-punishment.
- Feelings of being scapegoated.
- Rage and other violent impulses against indiscriminate targets.
- Combat brutality and it's attendant "psychic numbing."
- Alienation from one's own feelings and from other people.
- Doubt about ability to love and trust others.

TREATMENT OPTIONS FOR PTSD

A. Behavioral Techniques: Relocation, Desensitization

B. Education Techniques: Assertiveness, Relaxation

C. Supportive Techniques: Reflective Listening

D. Family Therapy

E. Hypno Therapy

F. Individual Therapy

G. Peer Group Therapy

H. Flooding, Abreactive Therapy

I. Gestalt Technique

J. Grief Psycho Therapy

K. Guilt and Regret Issues in Counseling

L. Anger and Stress Management

[Events]

VIETNAM: WHAT I REMEMBER

From "Patriotism Revisited," by David W. Powell, a memoir submitted last October to a creative writing class at the University of Arizona in Tucson. Powell served as a marine in Vietnam from 1965 to 1967.

The following events come to my conscious memory uninvited. I not only remember them vividly, I reexperience them with all my senses:

Froze with fright, standing up, the first time I was under fire

Watched two marines try to break open the skull of a dead Viet Cong with a large rock

Observed a marine intentionally shoot a girl four or six years of age

Watched the girl's grandfather carry her into our line of fire, sobbing

Had a lieutenant who delighted in sneaking up on me when I was on watch at night

Was offered a blood-soaked flak jacket and a helmet with a bullet hole through it as my first field equipment

Had my boots rot off during an operation in the field

Observed two captured nurses being beaten and raped by marines

Rifle-butted a girl of twelve in the face when she would not move away

Strangled a captured Viet Cong for refusing to talk to an interpreter

Discovered brain matter on barbed wire I was stretching out

Observed a marine laugh as he stepped on the chest of a dead Viet Cong and watched blood squirt out of the enemy's wounds

Awoke to find a buffalo leech on my leg

Was abandoned under fire when a rocker jammed in my launcher

Was abandoned under fire when I was shot

Hit head and fell in open field. Watched my fellow marines run by me to seek cover for themselves

Received letter from wife telling me how much fun she and a girlfriend had on Friday nights when they went out to bars to dance

Watched fellow marine shoot himself in the foot to get evacuated

Heard same man cry in his sleep when he was returned to the company

Found marine boot with foot in it in a hedgerow

Almost run over by retreating U.S. tank

Saw Lt. Spivey hit a head-high booby trap

Nearly murdered villager for stealing my laundry

Watched Prestridge test his new M-16 by shooting a woman getting water from a nearby well

Identified Haas's remains

Exchanged letters with Haas's mother

Had an artillery canister fall six inches in front of my head

Was about to put on fresh boots when I discovered lice swimming in them

Saw seven-foot python climbing in ceiling just above my head

Bullets sounding like bees digging up ground all around me

Nearly trapped in Da Nang village my last night in Vietnam

Robbed by marines while I slept in Okinawa after tour was over

Circled over El Toro air base for two hours so that President Johnson could land and be photographed greeting returning veterans

•

Since my return I have held eighteen different jobs and have been unemployed for several six-month periods. This is a direct result of my Post Traumatic Stress Disorder, specifically a disdain for being told to do tasks I do not want to do; an exaggerated startle response, which is terribly embarrassing to me; and a lack of control over emotional flooding.

I divorced my first wife two years after I got out of the service. I divorced my second wife in 1982. I separated from a four-year relationship in 1987. I have not had a significant relationship with a woman since then. I have no significant male or female friendships. I am aloof from my immediate family, who live in Tucson, Arizona.

PTSD SYMPTOMS

- MISTRUST
- DEPRESSION
- ISOLATION
- RAGE REACTIONS
- AVOIDANCE OF FEELINGS; ALIENATION
- GUILT/SHAME AND DOUBT
- ANXIETY REACTIONS
- SLEEP DISTURBANCE AND NIGHTMARES
- INTRUSIVE THOUGHTS

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HEALTH DIVISION
DETENTION CENTER, CORRECTIONS HEALTH
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(503) 248-3976

Dear Survivor:

This booklet is about the experience of being hurt on purpose by other people, and the changes in your life that it leaves behind.

You may wonder if what happened to you was bad enough to be called abuse. If you have to ask that question, it probably was. If you cannot remember large parts of your life, it almost certainly was.

I am sorry you are having to read this out of a book.... These things are better dealt with face-to-face. The effects of violence are best helped by different and more positive experiences with people. In a correctional institution, this is hard to do.

Take your time reading this. Use whatever parts seem helpful in your situation. Be patient with yourself. It will take time and work, but you <u>can</u> feel better.

Take care,

Joe Parker RN

Joe Parker, RN

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Dear Colleagues,

In providing mental health care for corrections populations, management of Post Traumatic Stress Disorder has a central place.

Some clients come into the system as a result of acts in some way related to previous experiences of abuse. Many come as a result of self treatment of major symptoms by means of illegal drugs or alcohol.

Although psychotropic medications play an important role for many clients in controlling physical symptoms of the disorder, psychological treatment has proven to be very important in improving functioning and quality of life.

Since mental health resources are so limited in corrections, self-help educational materials must be used whenever possible. This booklet has been very helpful for our clients and staff, and we hope it will be helpful for your clients as well.

Sincerely,

Joe Parker

Joe Parker, RN

POST TRAUMATIC STRESS DISORDER (PTSD)

WHAT DOES POST TRAUMATIC STRESS DISORDER MEAN?

Post is the Latin word for "after".

Trauma is the German word for "nightmare", but in English, it is used for any kind of injury, physical or psychological.

Stress is a force that changes the shape of things (including people).

Disorder refers to things that are a problem in a person's life now.

To understand PTSD, it is necessary to tell two stories.

> Once upon a time, several blind men wanted to understand about elephants.
>
> An elephant was brought to them, and they all approached it from different directions.
>
> One felt the tail, and said "an elephant is like a rope"!
>
> Another found a leg, and said, "no, an elephant is like a tree trunk".
>
> A third walked into the side of the elephant, and said, "really, an elephant is like a wall".
>
> Others found the ear, the trunk, a tusk, and each felt his part of the elephant was the real elephant.
>
> Each blind man was right about his part of the elephant, but none of them really understood about elephants.

The story of Post Traumatic Stress Disorder is similar.

PTSD was first recognized after the American Civil War.

Doctors noticed that some soldiers who had been in heavy combat complained of having attacks of fast heartbeat, chest pain, difficulty breathing, and fear that they were dying or going crazy.

The symptoms were similar to heart attacks. Not having the scientific equipment to investigate further, they assumed the attacks were a form of heart disease. They called it "soldiers' heart".

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We now know the attacks are not heart disease. They result from rushes of adrenalin, triggered by bad memories or nightmares.

A few years after the war, most people forgot about the problem, but the part of the elephant they had found was real.

World War I was the first time very large numbers of explosive shells were used in battle.

It was noticed that some combat veterans, afterward, had trouble with feeling somewhat dazed or confused, and with poor concentration and memory.

This seemed similar to what happened in many brain injuries. It was thought that the concussions of the shells caused tiny spots of bleeding in the brain. They called it "shell shock".

Eventually, a lot of autopsies were done on soldiers who had died of other causes, and no such bleeding was found. It was recognized that the symptoms resulted from extreme stress, not brain damage.

It should be remembered that many people with PTSD, especially from child abuse and domestic violence, have had damage from blows to the head. Both symptoms of brain injury and effects of overwhelming stress may be present in the same person.

A few years after the war, the matter was again dropped, but they had found another part of the elephant.

When World War II came, it took until June of 1944 to redevelop the treatment methods used in 1918.

In that war, they learned two important things. The severity of a person's symptoms was directly related to how much stress he or she had undergone, over how much time.

It was calculated that of 100 men in continuous combat, every single one would break down within 189 days. They called it "combat fatigue", or "combat exhaustion".

It also became clear that there is no such thing as a stress-proof person. Certainly some people break before others, but with enough stress and enough time, everybody breaks. They had another part of the elephant.

After World War II, it was assumed (never investigated, just assumed) that symptoms of traumatic stress went away in 6 months or a year, after the war was over.

Only after the Vietnam War did it become clear that PTSD symptoms could appear it any time, during or after the war. The symptoms could go on, better or worse from time-to-time, all of a person's life.

The severity of the symptoms is influenced by how much emotional support a person has available during and after trauma.

Veterans of an unpopular war, such as Vietnam, were clearly affected by the fact that nobody wanted to talk about it later.

Survivors of child abuse and domestic violence are more severely affected because family or friends, who normally would provide support, are the perpetrators of the violence.

In the late 1970's feminist writers began publicizing the fact that far more child abuse, sexual abuse, and domestic violence were occurring than previously admitted.

Studies began to reveal that domestic violence is a problem in about 25% of all families, regardless of race, religion, income or education. About 16% of all girls and 8% of all boys are sexually abused before the age of 18 years. Rapes reported to the authorities may represent less than 10% of those that actually occur. About 10% of the adult population is alcoholic. Inclusion of other abusable substances may raise the figure to double that.

Very few people are directly involved in wars, but most people have a family.

Unlike in times past, the feminists and Vietnam veterans have not shut up and gone away. Post Traumatic Stress Disorder is now an official diagnosis in the diagnostic and statistical manual.

Consciously or unconsciously, the brain remembers everything. Trauma really happens, and it changes who you are. You cannot seriously hurt human beings and expect them to forget it and be alright afterwards.

People who have Post-Traumatic Stress Disorder often worry about whether they are "crazy".

The word "psychotic" (or crazy) usually means experiencing or believing things that are not real: being "out of touch with reality".

People with PTSD's have essentially the opposite problem. They are in too much contact with reality, and in contact with realities that most people have the privilege of not knowing about.

It is just as possible to be sick from too much contact with reality, as from not enough.

That is the whole elephant.

The official definition of Post Traumatic Stress Disorder includes a combination of the following:

1. An extreme, painful experience, which would be severely stressful for almost anyone.

2. Continuing psychological "re-runs" of the events, including:

   a. frequent thoughts and memories about what happened, even when trying to avoid them.

   b. repeating nightmares about the trauma.

   c. suddenly feeling or acting as if the events were happening again (flashbacks).

   d. strong, painful feelings set off by things which are in some way related to what happened.

3. Ongoing attempts to avoid memories and feelings by:

   a. becoming generally numb to everything, by cutting off most feelings, both good and bad.

   b. avoiding activities or situations which may bring back memories and feelings.

   c. loss of large areas of memory about past life.

   d. loss of interest in things most other people care about, feeling different and cut off from other people.

   e. lack of any sense of having a future.

4. Continuous extreme physical alertness, including:

   a. constantly watching for signs of danger, with "startle responses", and trouble sleeping.

   b. trouble concentrating on business in the present world.

   c. irritability, outbursts of anger.

   d. physical reactions similar to what happened during past trauma (tremors, sweating, nausea etc.)

5. These symptoms continue for more than a month and can begin anytime from immediately to years after the trauma.

PSYCHOLOGICAL ABUSE

Children come into the world knowing nothing about themselves: whether they are smart or stupid, good or bad, lovable or unlovable. They can only learn these things from family, from people around them. If they are given "poison information", they have little choice but to believe it.

For the abuser psychological abuse has several advantages:

1. It leaves no physical marks. Unless the child becomes extremely depressed or psychotic there is no evidence to show in court.

2. It is safe. There is no risk of accidentally killing the child and being sent to prison. There is no problem with the child getting big enough to physically fight back or use a weapon.

3. It is easy. Psychological abuse can be kept up for years, wearing away at a child like rust. There is no great amount of energy or time involved.

Psychological abuse takes several forms. They are usually used together - it is rare for an abuser to use only one type.

1. Rejecting

   "I hate you, you ruined my life". "You are not my child" Nothing the child is or does is ever good enough.

2. Isolating

   Keeping the child away from any people other than abusers. This prevents the child from learning anything about him or herself except the "poison information" provided by the abusers.

3. Ignoring

   Not responding to anything the child is, says, or does. Psychologically/emotionally "not there" for the child.

4. Corrupting

   Involving the child in crimes, early alcohol/drug use, sexual activities, etc. that leaves the child unable to be part of normal society.

5. Terrorizing

   Keeping the child constantly in fear of being hurt, making the child watch others being hurt, keeping the child emotionally out of control most of the time.

PHYSICAL ABUSE

A large part of the "normal population" consider it legitimate to use physical force to discipline children. "Spanking" with an open hand is commonplace in our society. Abuse, fueled by uncontrolled anger or intoxication, goes far beyond ordinary discipline. Abusers almost always blame their violence on the child or spouse who is the victim. This is confusing to survivors, who need to know what level of violence qualifies as "abuse".

Abuse includes some combination of the following features:

1. Severity of injury. Cuts, bruises, broken bones, being strangled or knocked unconscious.....and sometimes death.

2. Weapons. Clubs, knives, guns and other instruments capable of causing severe injury or death. Life or death for the child depends totally on how well the abuser controls the weapon.

3. Use of pretexts. A child is punished for anything or nothing. The "rules" are made up as the abuser goes along, and change without warning. The child is never safe.

4. The abuser is out of control. Through alcohol/drugs, mental illness or personal choice, the abuser does not control amounts of force used. The child may be crippled or killed at any time.

It is sometimes useful, to understand the severity of a survivor's current symptoms, to put together a lifetime total assault history. Multiply the total number of each type of assault per day/week/month by the total amount of time exposed to the various abusers. Be sure to count both assaults in childhood and in adult life. The total number sometimes explains a lot about why you are having so many symptoms.

Finally, estimate the number of days on which the survivor could be sure of not being hurt. Sometimes this number is painfully small.

Adults who recognize their actions toward children as abusive often fear to tell anyone, out of fear they will go to jail or lose custody of their children. In reality, many social services agencies work with parents who have abused, or fear they may abuse their children, to learn to stop the violence and keep their children. Parents Anonymous is free and a good place to start.

SEXUAL ABUSE

Normal sexuality is the exchange of pleasure between two freely consenting people. Abuse is the wrongful use of a human being, as a thing, for the pleasure of another. Sexual abuse commonly involves:

1. Use of force or threat to control a person who is not consenting. The threats may be against the victim, ("Do what I want or I'll kill you...."), against others, (If I don't get what I want from you, I will just go after your little sister..."), or against the abuser himself, ("If you tell anyone, I will have to kill myself, and it will be all your fault...").

2. Use of lies to overcome resistance, ("I'm doing this to teach you, for your own good", "Everybody does this", "You want it, I know you do".). Lies can take the place of open violence.

3. Secrecy. Normal sexual relationships may go on in private, but they are not themselves secret. The demand for secrecy almost always indicates wrongdoing, and usually includes some kind of threat. ("You won't be by special girl anymore", "It would break your mother's heart", "You will be put in an institution".).

4. Betrayal of responsibility. Children have to depend on older people for protection, for food, clothing, shelter, and for truthful information about how to get along in the world. An adult who uses a child's natural needs in order to use the child's body, is committing a crime. Sometimes the betrayal hurts more than the fear, the isolation or the injuries.

The most basic drives of human beings, and of all animals, are to survive and to reproduce. The use of power to control a child is ultimately based on the threat to hurt, abandon, or kill. The child does whatever is necessary to survive. Energy that should go into growing up, is spent on trying to just get by, day by day.

Use of sex as a weapon strikes a child's basic ability to relate to, and trust, other human beings. It attacks a person's sense of being connected to other people, both in the present world, and to past and future generations.

Sexual abuse is like any other serious injury: some people survive and do well, some people only get by, and some end up not surviving at all. Good help and the right choices can make your life more nearly normal, and much happier than it might otherwise have been.

To be hurt, especially on purpose by other people, makes everyone sad and ashamed. In thinking about their lives and symptoms, most people tend to underestimate the severity of their experiences, and overestimate the amount of control they had over what happened.

HISTORY

The brain has mechanisms like "circuit breakers" which block out memories too bad to handle at a given time. The memory loss is usually "spotty", not complete, and gets better or worse depending on a person's stress level and how much help is available.

Trying to force the memory, by emotional pressure, drugs or hypnosis, often hurts rather than helps. If the brain needs to block out a memory, it usually has good reason. People tend to "face reality" as fast as they can. Pushing becomes just another form of violence.

It is common to have to work on plans for recovery with incomplete information. Often, some of the most important facts come out only quite late in the process.

Because the traumatic experience really happened, and really hurt, PTSD symptoms tend to continue, better at some times, worse at others, most of a person's life. Careful planning and use of recovery skills can greatly increase the amount of "good time" and make the bad times less frequent and less severe.

Putting together a written history of your life, and understanding the effect the traumatic parts had, usually helps make sense of many things that have happened in your life, during the abuse and after. It is very important in making plans for your recovery. Making the most complete possible history is a long term project. Memories come back in bits and pieces. Information from other people and from records also will come in bits and pieces. Some things may never be known.

This will be a stressful process, both in the effort spent in trying to remember, and in the energy needed to cope with what is remembered. Sadly, insight into what happened usually improves symptoms, but seldom completely removes them.

It helps to keep written notes, to avoid losing hard won information to the ups and downs of memory. Putting it in writing also seems to help keep things real, when so often they seem unreal, or even impossible.

1. Lay out a "life line", beginning with your birth. Put in any markers that will keep track of time: places you lived, where you went to school, births, marriages, deaths, institutions you were in, etc.

2. Talk to family, friends, teachers, ministers, neighbors and anyone else who may have information about your life.

   Keep in mind that some of these people truly did not know, some did not want to know, some knew but did nothing, and some may have profited in some way from what happened. (For example, as long as the violence was directed at you, it was not aimed at them.)

3. If you decide to talk with the perpetrator, be very careful of your safety. Many are still dangerous. Be clear about what you are trying to do. If you want the perpetrator to confirm memories you can barely believe yourself, be prepared to be called a liar, crazy, or to be told you wanted or deserved what happened. Try not to hope for too much: most perpetrators do not admit responsibility or say they are sorry.

   If your purpose is to confront the perpetrator with your anger and your knowledge that what was done was wrong, then, other than being careful for your safety, how the person reacts is not very important.

   If the perpetrator is confronted in the process of warning other family and friends about the danger he or she presents, be aware that some other people may react in much the same way as the perpetrator might.

   You cannot afford to attach your sense of self worth to the reactions of other people, because their responses have to do with who they are, not who you are.

4. Pay special attention to periods of time you cannot remember, or that others will not discuss with you. The more hurtful the experience, the more likely it will have been blocked out.

   Sometimes it is possible to work backward from things that are known: who was living with us at the time, who was drinking at that time etc.

5. Send for copies of any hospital or institution records that may be available. Although you have a right to see and copy most records pertaining to you, sometimes the help of an attorney or health care provider may be needed. Be aware that many professional people are careful not to ask questions they do not want to hear answers to. Some of the records may be in a sort of code, that is: "chaotic family life" may mean drunken violence on a daily basis, and "sexually molested" may cover rape, sodomy and torture.

Put your notes in a safe place. You may wish to add to them from time to time, as you find new information. Sometimes reviewing them will help you understand some new problem in your life.

LIFE CHANGES

Extremely hurtful experiences, ones that produce more fear, pain and anger then anyone can handle, leave behind four ongoing sets of behaviors. These are not so much "scars" as attempts to cope with trauma. Like any kind of treatment, if carried too far, they can become part of the problem, not part of the solution.

1. You begin intense, continuous study of the experience, trying to understand why those things happened, and how to keep them from happening again.

This involves constant thinking about the events, to the point it may interfere with other activities. You may have repetitive dreams about the events which may be so intense as to interfere with sleep and set off adrenalin reactions. The feelings can be so powerful that it can seem as if you are living in two different "movies" at the same time: the "bad old days" and "now".

Once you understand how the process works, you feel less disoriented, less out of control, and more able to cope.

Learning more information about trauma <u>does</u> help. You can take classes, read about it, and talk with others who have been through similar things.

2. You learn to constantly scan the environment for signs of danger. The scanning is compulsive - you cannot turn it off, so you have to plan for it.

Recognizing signs of threat may trigger strong reactions, sometimes as strong as the original events did. These reactions may be completely out of line with what is going on in the real world at the time.

Sometimes, you may well be aware of the connections between the present "trigger" and past experiences, even if you cannot control your reaction. At other times, the connection may be unconscious. You first become aware of your <u>reaction</u>, and may or may not later be able to connect it with the past.

The responses may be so intense as to feel like the trauma is actually happening again, that you are back in the bad old days. This is called a flashback. It can feel very crazy to find yourself feeling, saying, or doing things that do not relate to the present world.

To begin to control various kinds of flashbacks, it is important to map out your usual triggers, where they are likely to be encountered, and what your usual reactions are. Some triggers can be avoided almost completely, and should be. Others may be harder to avoid, or you may have good reason to take the chances involved in running into them.

Survival planning may include ways of minimizing exposure, arranging for support ahead of time, developing a "cool down" procedure, and concrete emergency plans in case of losing control.

3. Your body goes in chronic "red-alert", always ready to fight or run. Physical symptoms include extreme muscle tension ("the shakes"), headaches, high blood pressure, involuntary startle reactions and trouble sleeping. You feel afraid all the time, even when you have no present reason to.

It is in attempting to control these symptoms that so many people with PTSD get involved with alcohol and illegal drugs. Expert use of legitimate psychiatric and blood pressure medications can control most physical symptoms of PTSD. They do not provide a high, are not addicting, are legal, and are much safer than street drugs.

As survivors move forward in recovery, some may no longer need medication, others will need it only during bad times, and some may need it always.

Serious trauma can change the way a person's nervous system works, sometimes permanently. Even after allowing for the effects of brain damage and other injuries from violence, PTSD is a physical illness.

4. You are continually prepared to be hurt again, to lose again. The difference between the way life was supposed to be, and the way it turned out for you is a chronic stress.

You learn to avoid getting involved with other people for fear they will turn on you. You try not to care about people, animals or possessions, because sooner or later you expect them to be taken from you. You go so numb that you cannot feel anything, including good things. Being that numb hurts. Being cut off from good things, including people, makes you sad.

Emotions may swing like a pendulum, from overstimulated, hyperalert, fearful and angry, to depressed, numb and out of contact with the world around you. The extreme feelings often come and go in waves, and at times you actually may be out of control. Stabilizing this swing is a central goal of a recovery plan. Such a plan may include:

a. Mapping triggers and arranging your life to avoid recurring flashbacks.

b. Learning to recognize and avoid hurtful people.

c. Avoiding the use of drugs which temporarily improve symptoms, but make them worse on the "rebound". If needed, symptoms can be controlled with legitimate medications.

d. Reducing your exposure to new injury. (For instance, stay out of places that serve alcohol...)

e. Stopping current patterns of behavior which may be replays or reenactments of your own previous trauma, such as prostitution, fighting, child abuse.

f. Actions to make the real world safer are much more helpful than just trying to cope with your feelings about what might happen. Good locks and a dog are more helpful than lying in bed trying not to be afraid.

Extreme traumatic experiences, especially if they happened at a young age, can make you different from most other people. Of special interest are two groups of people who may seem very strange to you: predators and normal people.

DEALING WITH OTHER PEOPLE

A person's usual everyday approach to life and to other people is called a personality. A personality is made up of a person's biological inheritance (genes), the total set of things that have happened in the person's life, and the history of choices the person has made.

Every life is like a hand of cards. Some people play whatever they get well, others badly. Only a small number of people choose to hurt others. Even among people abused as children, 70% do not choose to hurt others.

Predators come in three forms:

A. Non-controllers:

All people have angry feelings, and all people have the impulse to hurt someone at times. Some choose not to control those impulses. Many choose to use alcohol and drugs, and let the chemicals block their impulse control. Others do whatever they feel like, sober or otherwise. Their attitude is: "I feel like shit, so somebody's going to pay..."

People who are loaded occasionally have the bad judgement to pick on somebody tougher than they are, but most, sober or not, are quite careful to act out their impulses on people who cannot effectively fight back.

B. Users:

Some people act as if they were the only real human being in the world, and other people are more like plants. If they want something, they simply take it, as if they were harvesting vegetables. Users have no sense of other people's rights and feelings, and do not consider that a problem.

It is not that they have something that other people do not. Rather, users are missing something most people have: a conscience, that is, internal personal limits on what they do. Any control of their behavior must be provided by others, and often by force.

C. Sadists:

People who enjoy humiliating and hurting others, and who do so while in full control of themselves., may make up as much as 10% of the population. They are found in all parts of society, with all levels of education and income. For some, other people's pain is sexually stimulating. Others like the feeling of power that comes with hurting people who cannot stop them.

The definition of sadism includes ongoing pattern of:

1. Using physical violence, threats or lies to control another person and inflict pain.

2. Humiliating and degrading a person in front of others.

3. Using a position of authority such as that of a parent to inflict unusually severe "discipline".

4. Being fascinated by violence, weapons, torture etc.

5. Finding the suffering of other people and animals funny, pleasurable or sexually stimulating.

Some sadistic people are very obvious. Others are so subtle that all you notice is that you feel bad when around them. Abuse survivors have had to learn to ignore their own feelings just to survive. Learning to recognize , and trust, your feelings and to take rapid action to protect yourself, sometimes takes a lot of work.

Cruel people often are quick to notice people who expect to lose, and will move in quickly. They avoid people who look like they know they have rights, and have people who love them, because they are likely to fight back.

It is necessary to learn to act like a person with value and rights, long before you can really feel it. In time, it will become real, not an act.

Normal people:

To deal with normal people, you must understand that the world they live in is very different from yours. They are not afraid all the time. They can feel many more things than pain, fear, and anger.

1. They have rarely felt so much pain that they have lost control of themselves, and certainly have not had that kind of pain caused intentionally by another person.

2. They do not assume they are at fault any time anything goes wrong.

3. They expect to be treated fairly, to be respected, and to love and be loved.

4. They can feel pleasure without drugs, they are depressed only occasionally, and do not know what being numb is about.

5. They expect to have a fair amount of control over their lives, and expect to live to be old.

With time and effort, you can learn to deal with people whose lives have been luckier than yours. One barrier will probably always remain: most normal people do not want to live in the world you know. Many will block you out so they can stay comfortable, not because you are doing something wrong. It is important not to reject all normal people, because there are always some who will work quite hard to understand how your life has been, even if they have had no similar experience themselves.

FINDING PEOPLE YOU CAN TALK TO

Think of how long it took you to put together the pieces of your history, make an accounting of how the abuse changed your life, and deal with your emotional reactions to that. You never had a choice about facing that because you had to live it.

Finding someone to talk to about it is not quick or simple. Some people will listen because they have had to live with abuse too. They may or may not be able to tolerate terrible stories at a given time. Listening to your story may bring up feelings they find too painful to deal with.

Others will listen because they are unusually committed to helping other people, or care a lot about you personally. Finding people who can listen is a key part of surviving. It involves several specific steps:

1. Talk with them about some part of your life that is fairly ordinary, and see if they really listen. If they listen poorly to the very ordinary, they certainly will not hear the really ugly. If they listen, then:

2. Choose a "medium bad" part of your story, one not too hard to handle if things go badly, and tell that. If they change the subject, turn mean, or drop a relationship, they probably are not worth any more effort.

   If they get panicky or go numb, you may have found another person with an abuse history. Keep in mind that they may or may not consciously recall the experience. Given plenty of time and personal space, these people may talk with you. Just as it was with you, pushing hurts rather than helps.

3. Once you know a person really well, you may choose to tell him or her the very worst things that happened, the ones that would really hurt if not handled with gentleness and respect. After you tell another person the very worst, and are met with kindness and respect, the memories never have quite the same power over you again.

4. Sometimes you will know people you care about, and very much would like to talk to, but you really feel they could not tolerate the ugly details. You may choose to tell them only some of the story, or even none.

   It is not fair that you should have to spend your energy to protect them from hearing about what you had to live, but occasionally it is necessary.

TRIGGERS

Human beings are creatures that learn, and keep on learning all of their lives, whether they want to or not.

They learn to recognize danger by noticing signs that were associated with past hurtful experiences. If the past experiences were severe, there may be a strong physical or emotional response, even if the conscious mind does not know what set it off.

These signs are called "triggers". People who have a good understanding of what situations set them off, can plan to avoid them, or to deal with the reactions. They come to feel much more in control of themselves.

Triggers can be internal, that is, can be a thought or a memory, as well as an outside event. Triggers take several forms:

1. Single Triggers: One sign alone is enough to set off a reaction. Examples: beer breath, body odor, being yelled at, seeing someone else hurt, violence or happy family situations shown on TV.

2. Compound Triggers: Several things, coming together, will set off a reaction, when each would not have been enough if it appeared alone. Examples: being touched, by someone who is angry, and has beer on his breath; or blood, on bed sheets, in the morning.

3. State-dependent triggers: One or several things which set off a reaction only when a person is tired, alone, in pain, intoxicated, etc. Without the changed mental and/or physical state, the particular signs are not enough to set off a reaction.

It is helpful to keep a log of what is happening around you, and what you were thinking about, just before your body and emotions "went off". Because of memory loss caused by stress, finding the trigger that set off a reaction can take time. Tracking down a trigger may also bring back lost memories. At other times, putting together more personal history will help identify triggers you had not recognized before.

FORGIVENESS

Abuse survivors often are pressed to "forgive" the perpetrator. The pressure may come from others, especially family members, or from the survivor's own beliefs about what should be done.

Forgiveness is a word for something that does not exist in the real world. There is no way to go back and act as if nothing ever happened, which is what most people want and most people think forgiveness means. People other then the survivor made bad choices, with terrible outcomes, and became worse people as a result.

The survivor may choose not to seek revenge, may choose to continue some contact with the abuser, and may try to support any positive change that the perpetrator may attempt, but there is no way the survivor can control what the abuser chose to do. If the survivor had been able to control other people's decisions, there would have been no abuse.

Children want very badly for their family to be good people, even in the face of strong evidence that they are not. They will blame themselves for things other people did. They will claim that they were somehow in control, rather than face the fact that they were helpless and that the bad choices were made by others. Survivors have nothing to be forgiven for, because they did not make the choices.

The abuser can choose to give up violence, take responsibility for the damage, and work toward rebuilding a family. Failing that, the survivor may have to piece together a family out of whatever is left, without the abuser.

A LAST WORD

A new family can be built out of the people who choose to be part of your life, whether or not they were born into it. A real family is something people do together, not something they are.

Building a new life may take terrible faith and courage. Some days it will seem easy, on other days, impossible. You go on living, with the unwanted knowledge of what evil people have done and can do, including what you yourself may have done and can do. Sometimes it takes all the courage you have just to get up and get dressed in the morning, knowing what can happen.

I wish you luck and courage on your journey. You will always have my respect.

Joe Parker

Joe Parker, RN

THE PENDULUM SWING

REEXPERIENCING

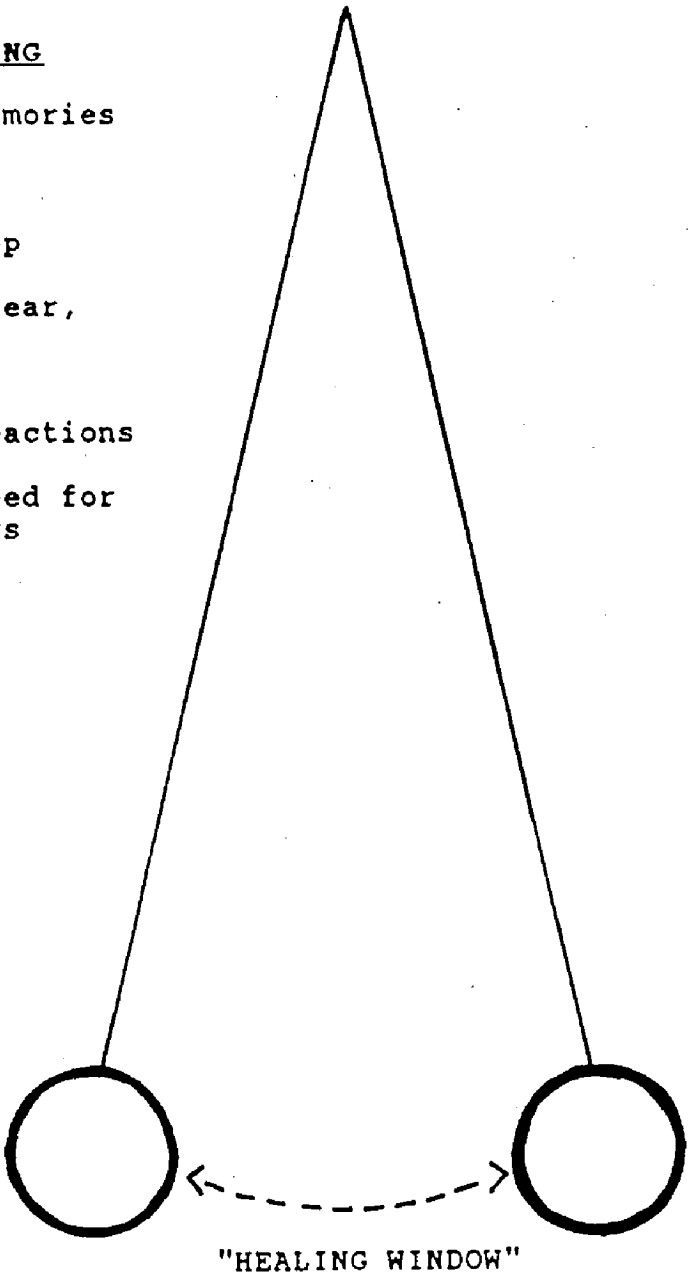
- intrusive memories
- nightmares
- loss of sleep
- attacks of fear,
- flashbacks
- "startle" reactions
- increased need for alcohol/drugs

NUMBING

- feeling nothing
- loss of not... interests
- detachment from others
- memory loss
- avoidance of reminders
- depression

TOO AGITATED TO WORK ON PROBLEMS.

TOO MUCH ENERGY.



UNABLE TO HOPE FOR THINGS TO GET BETTER.

NOT ENOUGH ENERGY.

"HEALING WINDOW"

Enough energy to work on problems, and enough hope to want to.

NOTES

NOTES

ALCOHOL AND DRUGS

Alcohol, Drugs, and Chronic Mental Illness

1. Substance Abuse is a maladaptive pattern of use manifested by one or more of the following symptoms in a 12 month period
- Recurrent use resulting in failure to fulfill major role obligations at work, home, or school
- Recurrent use in situations where it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

2. Substance Dependence is a pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following, occurring at any time during a 12 month period:
- Tolerance
- Withdrawal
- Substance taken in larger amounts or over a longer time than was intended
- Persistent desire or unsuccessful attempts to control use
- Great deal of time spent in obtaining, using, and recovering from the drug
- Important social, occupational, or recreational activities are given/ reduced due to use
- Use is continued despite knowledge of persistent physical or psychological problems caused or exacerbated by substance use

TEST Q

3. Addiction is a chronic, progressive, terminal disease. Substance use result in changes in the brain which maintain addictive behavior

4. Incidence of substance abuse among individuals with chronic mental illness is higher than that of the general population.

ECA Studies:
Lifetime Prevalence

	General Population	Dx. Of Schiz
Any SubstanceUse Disorder	16.7%	47.0%
Any Alcohol Disorder	13.5%	33.7%
Alcohol Dependence	7.9%	24.0%
Alcohol Abuse	5.6%	9.7%
Any Other Drug Disorder	6.1%	27.5%
Drug Dependence	3.5%	12.9%
Drug Abuse	2.6%	14.6%
Marijuana Depend/Abuse	4.3%	
Cocaine Depend/Abuse	0.2%	
Opiate Depend/Abuse	1.2%	
Amphetamine Depend/Abuse	1.7%	
Hallucinogen Depend/Abuse	0.3%	

5. Incidence of mental illness among individuals with a substance use disorder is greater than the general population

ECA Studies

Lifetime Prevalence	General Population	Alcohol Dx.	Drug Dx.
Any Mental Dx.	22.5%	36.6%	53.1%
Schizophrenia	0.7%	3.8%	6.8%
Any Affective	8.3%	13.4%	26.4%
Any Anxiety	14.6%	19.4%	28.3%

6. Reasons for use of substances by individuals with mental illness can include social, self medication, and addiction

TEST Q Social:

Means to behave like non-mentally ill peers
Opportunities to be around others w/o high social demands
Creates a sense of belonging to a social group

Self-Medication:

Anxiety Reduction
Improved ability to concentrate
Improved energy level
Increased sense of ability to function and well being
Improved mood

Addiction:

Physical and psychological dependence
Altered brain function

7. Use of substance by individuals with chronic mental illness typically result in increases in symptoms of psychiatric disorders and reduced ability to function

8. Effective treatment involves simultaneous treatment of both the mental illness and substance use disorder

ALCOHOL AND DRUG

- WHAT TO LOOK FOR IN ASSESSING THE
- POTENTIAL FOR VIOLENT BEHAVIOR

- RISK FACTORS FOR HOMICIDE

- BLOOD ALCOHOL CONCENTRATION

- DEPRESSANTS
  - Alcohol
  - Opiates/Narcotics
  - Sedatives/Hypnotics/Anxiolytics

- ALCOHOL AND DRUG OVERVIEW

- INDICATORS OF DRUG USE

- OTHER DRUGS

- HALLUCINOGENS, PHENCYCLIDINE
- (PCP), AND RELATED SUBSTANCES

- INHALANTS

- DRUG PROBLEMS IN EMERGENCY
- ROOMS

ALCOHOL and DRUG (continued)

- RISK FACTORS FOR SUICIDE
- STIMULANTS
- SUBSTANCE ABUSE AND THE BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE.
- QUICK LIST OF SUBSTANCES AND THEIR SYMPTOMS

WHAT TO LOOK FOR IN ASSESSING THE POTENTIAL FOR VIOLENT BEHAVIOR

- A psychiatric diagnosis that includes violent or impulsive behavior among its criteria
- A previous history of violent behavior
- A history of substance abuse
- An injury to the head
- An injury to the central nervous system
- A previous history of physical abuse by others
- A previous history of suicidal behavior
- A previous history of delusions or hallucinations—particularly command hallucinations

Source: Lukas, S. (1993). Where to Start and What to Ask. New York: W. W. Norton & Co.

Risk Factors for Homicide

- Access to/ownership of guns
- Use of a weapon in prior abusive incidents
- Threats with weapon(s)
- Threats to kill
- Serious injury to victim(s) in prior abusive relationships
- Threats of suicide
- Drug or alcohol abuse
- History of forced sex with female partners
- Obsessiveness/extreme jealousy/extreme dominance

Blood Alcohol Concentration

Blood Alcohol Concentration (BAC) is the amount of alcohol in the bloodstream. It is measured in percentages. For instance, having a BAC of 0.10 percent means that a person has 1 part alcohol per 1,000 parts blood in the body.

In a review of studies of alcohol-related crashes, reaction time, tracking ability, concentrated attention ability, divided attention performance, information process

capability, visual functions, perceptions, and psycho-motor performance, impairment in all these areas was significant at blood concentrations of 0.05 percent. Impairment first appeared in many of these important areas of performance at blood alcohol concentrations of 0.02 percent, substantially below the legal standard in most states for drunkenness, which is 0.08 percent.

BAC can be measured by breath, blood, or urine vehicle tests. BAC measurement is especially important for determining the role of alcohol in crashes, falls, fires, crime, family violence, suicide, and other forms of intentional and unintentional injury.

The public most commonly associates BAC with drunk driving. However, it is more accurate to refer to alcohol-impaired driving because one does not have to be drunk (intoxicated) to be demonstrably impaired. Driving skills, especially judgment, are
impaired in most people long before they exhibit visible signs of drunkenness. While most states define legal intoxication for purposes of driving at a BAC of 0.08 percent or higher, alcohol may cause deterioration in driving skills at 0.05 percent or even lower. Deterioration progresses rapidly with rising BAC.

The legal intoxication level in most states is 0.08 percent blood alcohol concentration (BAC). But alcohol depresses the central nervous system, causing slowed reactions, and one's ability to drive is affected long before a BAC of 0.08 percent is reached.

Factors that will affect the BAC in a person:

- How much alcohol you drink.

- How fast you drink. The quicker you drink, the higher your peak BAC will be. The liver gets rid of alcohol at the average rate of one drink per hour (12 oz. beer, 5 oz. wine, 1 shot of distilled liquor). If a person drinks faster than this, the remainder will circulate in the blood stream until the liver can get rid of it.

- Body weight. Heavier people will be less affected by the same amount of alcohol than lighter people. They have more blood and water in their bodies in which to dilute the alcohol.

- Food in the stomach. When there is food in the stomach, alcohol is absorbed slower into the blood stream. The BAC rises more rapidly in those who drink on an empty stomach, because there is no food in which to dilute the alcohol.

- The type of alcohol you drink. The stronger a drink is (the higher the alcohol concentration, distilled alcohol first, wine second, beer third), the more quickly it is absorbed. This partially explains why hard liquor has more of an apparent " kick" than wine or beer.

- Type of mixer used. Water and fruit juices mixed with alcohol slow the absorption process, while carbonated beverages will speed it up. Carbon dioxide speeds the alcohol through the stomach and intestine into the bloodstream, creating a rapid rise in BAC.

- Temperature of the drink. Warm alcohol is absorbed quicker than cold alcohol.

- If you are male or female. Women reach higher BAC's faster because they have less water in their bodies and more adipose tissue (fat), which is not easily penetrated by alcohol. Therefore, a man and woman, with all other factors being equal, both drinking the same amount of alcohol will have different BAC levels. Hers will be higher. A woman's menstrual cycle will also affect her rate of absorption. They will experience their highest BAC's premenstrually. In addition, there is also evidence that a woman taking birth control pills, will absorb alcohol faster, resulting in higher BAC levels.

Depressants

Alcohol

- Most people do not think of alcohol as a drug

- Medical consequences usually show up after years of heavy drinking

- Has a profound effect on the chemistry of emotions

- Increases the hazards of other drugs when used in combination, to include: more severe side effects, more frequent adverse effects, and diminished effectiveness of the medication

- Remains in the body for four or more hours, depending on amount ingested

- Can result in respiratory depression, cardiac irregularities, coma. Using marijuana with alcohol inhibits vomiting and can increase the likelihood of overdose

- Other causes of serious injury or death can result from aspiration of vomitus, accidents from impaired judgment and coordination, fighting resulting from disinhibitory effects and increased aggressiveness, and suicide resulting from increased impulsivity/or depression.

- Medical complications include cirrhosis of the liver, brain damage and hypertension are common with high dose/long term use. Poor nutrition and self-care can be see with advanced alcoholism.

Appeal of the Drug:
- anxiety reduction
- social lubrication
- disinhibition

Specific Effects:
- rapid tolerance
- sedation
- impaired concentration
- impaired coordination
- rapidly fluctuating moods
- disinhibition

Signs of Use:
Slurred speech; uncoordinated movements; unsteady gait; nystagmus; flushed face; aggressive and/or disinhibited behavior; rapid mood shifts; impaired judgment and/or functioning.

Withdrawal Symptoms:
A hangover is the withdrawal syndrome from acute ingestion of alcohol. Nausea, vomiting, malaise, weakness, autonomic hyperactivity, anxiety, depression, irritability, transient hallucinations or illusions, headache, insomnia, and possible delirium may appear within 24 hours after use has stopped and last 3-10 days in the case of long-term alcohol dependence.

Withdrawal from alcohol can also include: convulsions; delirium tremens (DT's) and hallucinations. Withdrawal from alcohol can be medically dangerous and produce serious medical complications, and detoxification procedures must be monitored because abrupt withdrawal can be life-threatening. Withdrawal for the alcohol dependent person can last well beyond the time for which medical supervision is necessary. Symptoms can last for weeks or months.

Opiates /Narcotics

- Includes pain medications such as morphine, Demerol, Dilaudid, Darvon, Percodan, Vicodin, codeine, as well as heroin and methadone.

- It is theorized that many addicts and alcoholics have problems in their natural pain-regulating mechanisms that leave them vulnerable to addictive disease.

- Routes of administration can be oral, IV, intranasal, or through inhalation.

- Users are more likely to die from overdose than from withdrawal.

Appeal of the Drug:

- reduced sensitivity to pain
- "rush" of the initial effect (euphoria)
- tranquility
- reduced anxiety

Signs of Use:

- Pupillary constriction or dilation
- drowsiness
- slurred speech
- impairment in attention or memory behavior that suggests euphoria followed by apathy, dysphoria, psychomotor retardation, impaired judgment, or impaired functioning may also be signs of use

Specific Effects:

- rapid tolerance
- reduced sensitivity to pain
- sedation
- reduced anxiety
- excessive dryness (constipation
- sluggish muscle tone
- low blood pressure
- slowed pulse
- cough suppression
- shallow breathing
- slowed motor response
- inability to focus thoughts
- euphoria
- apathy

Sedatives/Hypnotics/Anxiolytics

Sedatives sedate or calm.

Hypnotics induce sleep.

Anxiolytics reduce ongoing anxiety.

The most commonly prescribed and abused are benzodiazepines. These include: Valium; Librium; Dalmane; Halcion; Ativan; Klonipin; and Xanax. The BZs are chosen for anxiety reduction and as sleep aids because they are safer and more effective than other sedatives. Overdose is virtually impossible if these drugs are not mixed with alcohol: however, withdrawal must be carefully monitored because abrupt withdrawal can be life threatening.

Signs of Use:
Slurred speech, uncoordinated movements, unsteady gait, impaired judgment.

Withdrawal Symptoms:
(Noted after prolonged use--usually 90 days at low doses.) Symptoms include anxiety, restlessness, dysphoria, and muscle twitches. Withdrawal from high doses can include severe anxiety, tremors, sweating, agitation, psychosis or seizure.

Alcohol and Drug Overview

The DSM-IV presents 12 classes of psychoactive substances that can cause organic impairment. These include:

- Alcohol
- Amphetamines
- Caffeine
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Nicotine
- Opiods
- Phencyclidine & related substances
- Sedatives/Hypnotics/Anxiolytics
- Other/Unknown

1) Depressants

Alcohol, Opioids, Sedatives, Hypnotics, Anxiolytics

These psychoactive drugs have a primarily *sedative* effect and a strong potential to create dependence. The effects are experienced as reduction in tension, disinhibition, relief from anxiety, reduced stimulation, calmness or tranquility Their primary hazards include respiratory depression, coma, and death by injury due to accident.

2) Stimulants

Amphetamines, Cocaine, Caffeine, Nicotine

The primary effect of these drugs is *excitation* or *arousal.* They have a strong potential to create dependence because of the transient sense of pleasure and reward they provide. They are experienced as focused thought processes, euphoric mood and increased energy. Their primary hazards to life include: convulsive seizure, cardiac arrest or death by injury (due to wildly reckless driving, paranoia, agitation, aggression and/or psychotic behavior.

3) Other Drugs

Cannabis, Hallucinogens, Phencyclidine (PCP), Inhalants, Other/Unknown

These drugs cannot easily be grouped into a depressant or stimulant class as they have some characteristics of each. Hallucinogens and PCP are sometimes called *psychedelics*. They produce perceptual distortion in the form of sensory illusions or hallucinations and increased awareness of internal and external stimuli. Hallucinogens do not create physical dependence or high levels of physical toxicity, whereas this does not appear to be the case with PCP. These drugs may induce or contribute to *panic attacks*. They may cause death through *loss of reality testing* due to sensory distortion (e.g., not responding to pain, "flying" out a window). PCP can result in death due to overdose or to an accident caused by loss of motor control.

INDICATORS OF DRUG USE

- Neglect of significant personal concerns such as health, hygiene, personal appearance, housing needs or nutritional needs. Weight loss, poor appetite or obvious dental decay may be seen. Neglect is the result of drug seeking behavior and mental deterioration.

- Inexplicable sudden changes in personality, for example the sudden onset of aggression and/or paranoia.

- Acute changes in mental functioning, such as the onset of drowsiness, confusion or disorientation.

- Acute mood changes, including euphoria, depression or irritability.

- Recurring signs of drug withdrawal such as irritability, confusion, restlessness, tremor, sweating, cramps, and the complaint of 'aching bones.'

- Homelessness and itinerancy (frequent moving from place to place).

- Significant and repeated inconsistencies in statements to persons such as health care workers, and general lack of cooperation.

- The need to regularly take large amounts of benzodiazepine medication or other sedating medication.

- Attempts to manipulate health care workers with such talk as: "You know I need X and if I don't get X, I won't be able to control myself," etc.

- 'Track marks,' usually seen as longitudinal scars on the inside of the elbow areas, due to chronic intravenous drug use.

- Continued inability to provide identification.
- The complaint of insomnia, without obvious reason. Remember that marijuana abuse may be a possible cause of insomnia.
- 'Doctor shopping,' or the indiscriminate consultation of numerous doctors to obtain medication.
- Accusations of theft or confirmed involvement in crime to support a 'habit.'
- Denial of the problem may occur and should not be accepted if signs of drug use are present.

Other Drugs

Cannabis (Marijuana)

- Can be smoked in a pipe, rolled into cigarette paper or compressed into hashish or hashish oil.
- Comprised of about 400 chemicals, with the cannabinols (particularly delta-9 THC) and the cannabidiols creating the primary psychoactive effect.
- Potency is much higher than it was 10-20 years ago.
- Most of the marijuana in this country has a sedative effect and calms the user.
- Some users seek the dissociative effect of the drug—a feeling of distance from other people, which can make them feel safer in uncomfortable situations.
- The half-life of marijuana is eight days. It takes approximately two months to rid the body of all traces of the substance.
- Low doses result in impaired short-term memory.
- High doses result in: difficulty in concentration; difficulty managing emotions; amotivation; impaired ability to operate a car or other machinery; impaired job/school performance; distancing in relationships.

Appeal of the drug:

- dispels boredom
- narrows focus of concentration
- distorts time
- exaggerates the senses and emotions

- reduces anxiety
- dissociative effects

Specific Effects:
- decreases anxiety
- produces shifts in concentration
- produces a dissociative reaction
- alters perception of space and time
- alters judgment of speed and distance
- decreases motivation and concentration
- alters functioning of the hypothalamus and pituitary glands
- increases heart rate, decreases blood pressure
- lowers pressure within the eyes

Signs of Use:
Physical signs can include reddened eye, increased appetite, dry mouth, and rapid heart beat.

Withdrawal Symptoms:
Agitation, inability to concentrate, sleep problems, craving, decreased appetite, anxiety and discomfort around other people. Severity of symptoms depends upon the dose and length of use. For the average user, the symptoms are usually mild with a gradual onset because of the long-life of the drug. Users can rarely identify withdrawal symptoms due to marijuana because they often begin to occur several weeks after date of last use.

Hallucinogens, Phencyclidine (PCP), and Related Substance

- Primary effect involves changes in thought content, sensory perception and subjective emotional experience.

- Psychedelics cause intensified sensations, mixed-up sensations (synesthesia), illusions, delusions, hallucinations, stimulation, and impaired judgment and reasoning.

- The most commonly used psychedlics are: LSD, MDMA, PCP, peyote, and psilocybin mushrooms.

- PCP and Other Psychedelics: PCP, an animal tranquilizer causes mind-body distortions and a sensory deprived state.

- PCP has characteristics of depressants and stimulants.

- Easy and inexpensive to manufacture.

- Commonly mixed with other drugs and used as substitute for other chemicals without user's awareness.

- PCP is frequently found as adulterant for street drugs sold as LSD, Ecstasy, and/or THC.

- With repeated use the drug can be stored in the body for weeks or months beyond cessation of use.

- Higher doses can cause paralysis, loss of consciousness, amnesia, violence, and psychosis.

Appeal of the Drug:
- alters sensory input
- accentuates mood
- creates illusions
- synesthesia
- dissociative reaction
- loss of body and ego boundaries
- sense that mundane events aren't important
- sense of bonding and affiliation (ecstasy)

Specific Effects:
- tachycardia
- increased blood pressure
- increased body temperature
- pupil dilation
- visual illusions, perceptual changes
- emotional lability
- slowed time perception
- dissociative
- mild tolerance possible
-

Most Severe Hazards:
- panic reaction
- alters perception of time and space
- interferes with reflexes
- accidents common
- possible toxic psychosis
- drug-precipitated functional psychosis
- flashbacks

Signs of Use:

- Pupillary dilation; tachycardia; sweating; palpitations; blurred vision; tremors; uncoordinated movements
- Behaviors indicating marked depression or anxiety; ideas of reference; fear of "going crazy;" paranoid ideas; panic; impaired judgment and functioning
- Reports of perceptual changes: intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias, euphoria, mysticism or religiosity

Withdrawal Symptoms:
No physical dependence occurs with hallucinogens and no withdrawal syndrome has been documented, even after prolonged use of high doses.

Inhalants

- Includes volatile organic compounds such as: gasoline, glue, paint, cleaning agents, aerosol propellants, nitrous oxide (laughing gas) and amyl and butyl nitrate.

- Effects occur within 7-10 seconds and last no more than 30 minutes to one hour.

- Neurologic damage can include hearing and visual impairment, loss of coordination and memory, and learning disabilities. Mental impairment may be irreversible, though not usually progressive after abuse ceases.

- More users are preadolescents and young teens who do not have access to more "sophisticated" drugs, while others live in institutional settings or do not have enough money for other drugs.

- A common method of administration is to pour or spray the chemical onto a rag, place it over the nose and mouth, and inhale (huffing), or place in a plastic bag and inhale (bagging), or breathing in the inhalant directly from the container (sniffing).

Appeal of the drug:
- creates an intoxicated state
- effects are immediate and last from 5 to 45 minutes
- readily available through legal channels

Specific Effects (may vary depending on exact substance):
- mild intoxication
- possible hallucinations
- rapid onset of action
- create visual disturbances
- decrease appetite
- loss of memory

- unsteady gait

Most Severe Hazards:

- organ damage (including brain damage, liver damage, pancreatitis, kidney failure
- accidents, head trauma resulting from impaired judgment and coordination
- inflammation in joints, muscle weakness
- destroy red and white blood cells
- central nervous system depression or overstimulation
- cardiac arrhythmia (irregular heartbeat) and cardiac failure
- damage due to anoxia (lack of oxygen)

Signs of Use:

- rash around nose and mouth
- chemical breath, body odors
- residue
- red glassy watery eyes and dilated pupils
- slow, thick, slurred speech
- irritation of the throat/lungs/nose, nausea, headache
- dizziness
- nystagmus
- pains in chest and stomach
- fatigue
- staggering gait, disorientation, lack of coordination
- stupor
- euphoria
- belligerence
- assaultiveness
- impaired judgment and functioning

Reports of Drug Problems in Emergency Rooms (In many cases, more than one drug is found in incoming patients)	
DRUGS	**% of Patients Who Tested Positive**
1. Alcohol in combination with other drugs	32.6%
2. Cocaine	28.4%
3. Heroin/morphine, codeine, or other opioids	17.3%
4. Acetaminophen, aspirin, ibuprofen	13.9%
5. Benzodiazepines (Xanax, Valium, Ativan, Klonipin	10.4%
6. Antidepressants (Elavil, Prozac)	8.6%
7. Marijuana	8.6%
8. Methamphetamine/amphetamine	5.1%
9. Antihistamine	1.7%
10. OTC sleeping aids	1.3%

In some parts of the country, particularly San Francisco and on the West Coast, ER staff are seeing more and more Methamphetamine-Induced Psychosis.

Cocaine still causes the most deaths, although there has been an increase in deaths related to heroin overdose.

SUBSTANCE ABUSE AND BEHAVIORAL STATES OF AGGRESSION AND VIOLENCE

Intoxication		Withdrawal States		Substance-Induced Paranoid Psychotic States	Substance-Induced Organic Brain Syndromes
High	Low	High	Low	High	High
Alcohol	Opiates	Alcohol	Opiates	Meth	Alcohol Withdrawal
PCP	[redacted]	Sedative	[redacted]	Cocaine	Sedative Withdrawal
Cocaine	[redacted]	Stimulants	[redacted]	PCP	PCP Intoxication
Meth	[redacted]	[redacted]	[redacted]	[redacted]	Inhalant Intoxication
Inhalants	[redacted]	[redacted]	[redacted]	[redacted]	Cocaine Intoxication
*LSD	[redacted]	[redacted]	[redacted]	[redacted]	Brain Injuries
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Adapted from: Potter-Efron, R. & Potter-Efron, P. (eds.) 1990. Aggression, Family Violence and Chemical Dependency. New York: The Haworth Press.

Quick List - Substance Use Symptoms

SUBSTANCE	INTOXICATION SYMPTOMS	WITHDRAWAL SYMPTOMS
Depressants	slurred speech; incoordination; unsteady gait; impairment in attention or memory	nausea or vomiting; malaise or weakness; tachycardia; sweating; anxiety or irritablity; hypotension; coarse tremor of hands, tongue, and eyelids; insomnia; grand mal seizures
Stimulants	euphoria; grandiosity; hypervigilance; fighting; pupillary dilation; elevated blood pressure; perspiration or chills; nausea or vomiting	severe depression; irritablity; anxiety; fatigue; insomnia or hypersomnia; psychomotor agitation; intense craving for the substance
Opiates and Analgesics	initial euphoria followed by apathy, dysphoria, psychomotor retardation; impaired judgment; pupillary constriction; drowsiness; slurred speech; impaired attention or memory	cravings for opiates; all symptoms of severe influenza
Cannabinols (Marijuana)	euphoria; feeling of relaxation; sleepiness; heightened sexual arousal; anxiety; suspiciousness or paranoid ideation; sensation of slowed time; inappropriate laughter; social withdrawal; impaired judgment; bloodshot eyes; increased appetite ("junk" food); tachycardia; dry mouth	marked anxiety; emotional lability; depersonalization; possible persecutory delusions

Hallucinogens	illusions; hallucinations (visual) synesthesia; euphoria; mystical or religious experiences; pupillary dilation; tachycardia; sweating; palpitations; blurring of vision; tremors; incoordination; Bad Trip: anxiety and depression; ideas of reference; fear of losing one's mind; paranoid ideation	no apparent withdrawal symptoms; delusional disorder may develop; mood disorder may develop; post-hallucinogen perception disorder may develop ("flash back")
Solvents/Inhalants	euphoria; giddiness; light-headedness; slurred speech; lethargy; depressed reflexes; tremor; blurred vision; stupor or coma; belligerence; assaultiveness; apathy; impaired judgment; dizziness; nystagmus; eye irritation; irriation of throat, lungs, and nose	same as with the Depressants
PCP	belligerence; assaultiveness; impulsiveness; unpredictability; psychomotor agitation; vertical and horizontal nystagmus; increased blood pressure and heart rate; numbness or diminished responsiveness to pain; ataxia; muscle rigidity and seizures; bizarre and violent behavior; paranoid ideation	similar to Hallucinogens

adapted from: Fauman, M., (1994). Study Guide to DSM-IV. Washington D.C.: American Psychiatric Press, Inc.

NOTES

PERSONALITY DISORDERS

Personality Disorders Training
Crisis Intervention training
Portland Police
~~5/18/00~~ 11-14-00

Outline

I. Overview

A. Definition: DMSIV A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture, is pervasive and inflexible, has an onset in adolescence or early adult, is stable over time and leads to distress or impairment. - DEFICIT IN COPING

B. Types: TED KYSINSKI

1. Cluster A Paranoid, Schizoid, Schizotypal, - MAGICAL THINKING
   - odd or eccentric
2. Cluster B: Antisocial, Borderline, Histrionic, Narcissitic, (SELF HARM) (WHAT'S W IT FOR ME?)
   - dramatic, emotional or erratic
3. Cluster C: Avoident, Dependent, Obsessive Compulsive (EAGER TO PLEASE)
   - anxious or fearful

II. Development of Personality Disorder

A. Stress / Coping Skill Relationship

B. Sense of Self

C. Impairments

1. self harm
2. self defeating behavior
3. relationships
4. abandonment issues

(BORDERLINE)
SPLITTING -
- TRYING TO PLEASE MORE THAN 1 PERSON
- WILL TRY TO MANIPULATE PEOPLE

III. Management of Behavior

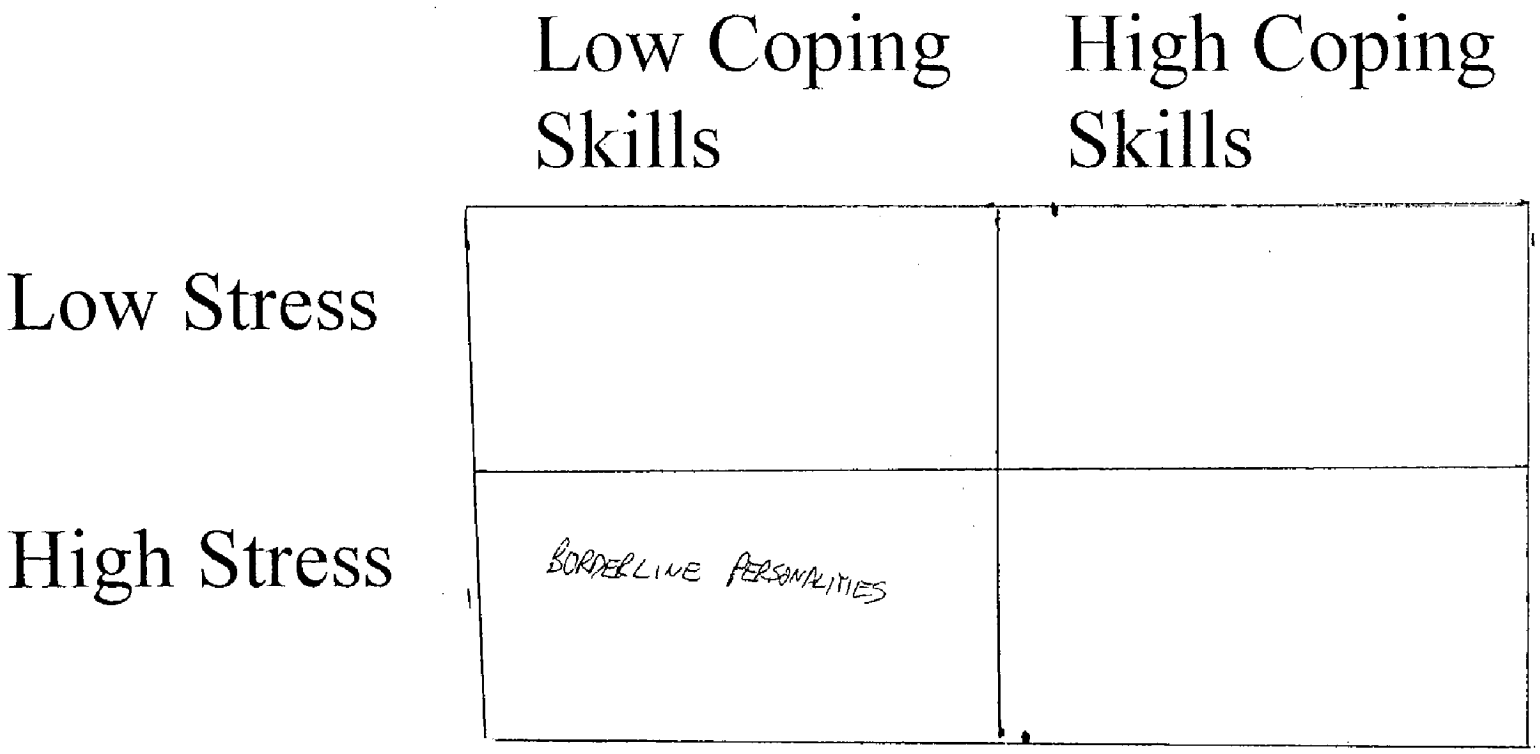
A. Neutrality

B. Clarifying Expectations

C. Setting limits

D. Supportive feedback

Stress/Coping Skill Relationship



Section 2 - PROCEDURES

- Mental Status Exam
- Committment Laws
- Rights of the Mentally Ill

MENTAL STATUS EXAM

CIT Training -- The Mental Status Exam

Neil Falk, MD
May 9, 2000

A Mental Status Exam (MSE) is the mental health worker's equivalent of a medical provider's physical exam -- an examination of an individual to help determine if they have an illness. A very quick MSE can be performed quite easily, as many of the basics are common sense. The examination can even occur at a distance, and without the individual's participation -- a lot can be gained just by observation.

•Appearance

-- How is the individual dressed? Examples of dress which may indicate a mental illness include:

-- Inappropriate for weather (e.g. -- many layers in summer)
-- Inappropriate for context (e.g. -- pajamas in the street)
-- Odd or bizarre clothing
-- Very dirty/foul smelling/tattered clothing

-- How is the individual's hygiene? examples of hygiene which may indicate a mental illness include:

-- Very dirty/foul smelling clothing
-- Very dirty/foul smelling body
-- Poor dental condition

-- How is the individual behaving? Examples of behavior which may indicate a mental illness include:

-- Responding to internal stimuli (i.e. -- "talking to self")
-- Standing still/staring for prolonged periods (e.g. - catatonia)
-- Disorganized/non-goal directed actions
-- "Odd" actions, or interactions with others in the environment (e.g. -- bizarre mannerisms, posturing, agitated towards others, ignored by large group, being viewed with suspicion by group or vice versa)
-- Abnormally fast or slow movement pattern/energy level

• Thought Processes

The thought processes of the mentally ill are, by definition, disturbed. Mentally ill individuals may:

-- have disorganized thoughts (e.g. -- tangential thinking, loose associations, flight of ideas, etc.)
-- have "bizarre" thoughts (e.g. -- delusions of persecution, grandeur, conspiracies, etc.)
-- have blocked thoughts (i.e. -- long pauses during thinking)
-- persevere on one topic

• Speech

The speech of mentally ill individuals often is abnormal -- a reflection of their abnormal thought processes. Mentally ill individuals may:

-- speak abnormally fast or slow
-- use words abnormally (paraphasic errors)
-- use nonsense words
-- create words (neologisms)
-- be hard to interrupt (pressured speech)

•Miscellaneous

-- mood (how the person *says* he/she is feeling)
-- affect (how the person *appears* to be feeling)
-- suicidal/homicidal thoughts
    -- plan
    -- access to enact plan
    -- intent to carry out plan
    -- chronicity
-- hallucinations (usually auditory in the mentally ill)
-- cognitive abilities
    -- memory (short, intermediate, and long term)
    -- concentration/distractibility
    -- abstract thoughts (often mentally ill individuals cannot think abstractly)

•Generalities

-- If it doesn't feel safe, don't do it!!
-- Mentally ill people are people, and deserve common respect.
-- Listen carefully.
-- Allow the individual to talk at length at least once.
-- Don't be afraid of silences. They often bring out symptoms.
-- Try to be an ally, not an adversary.

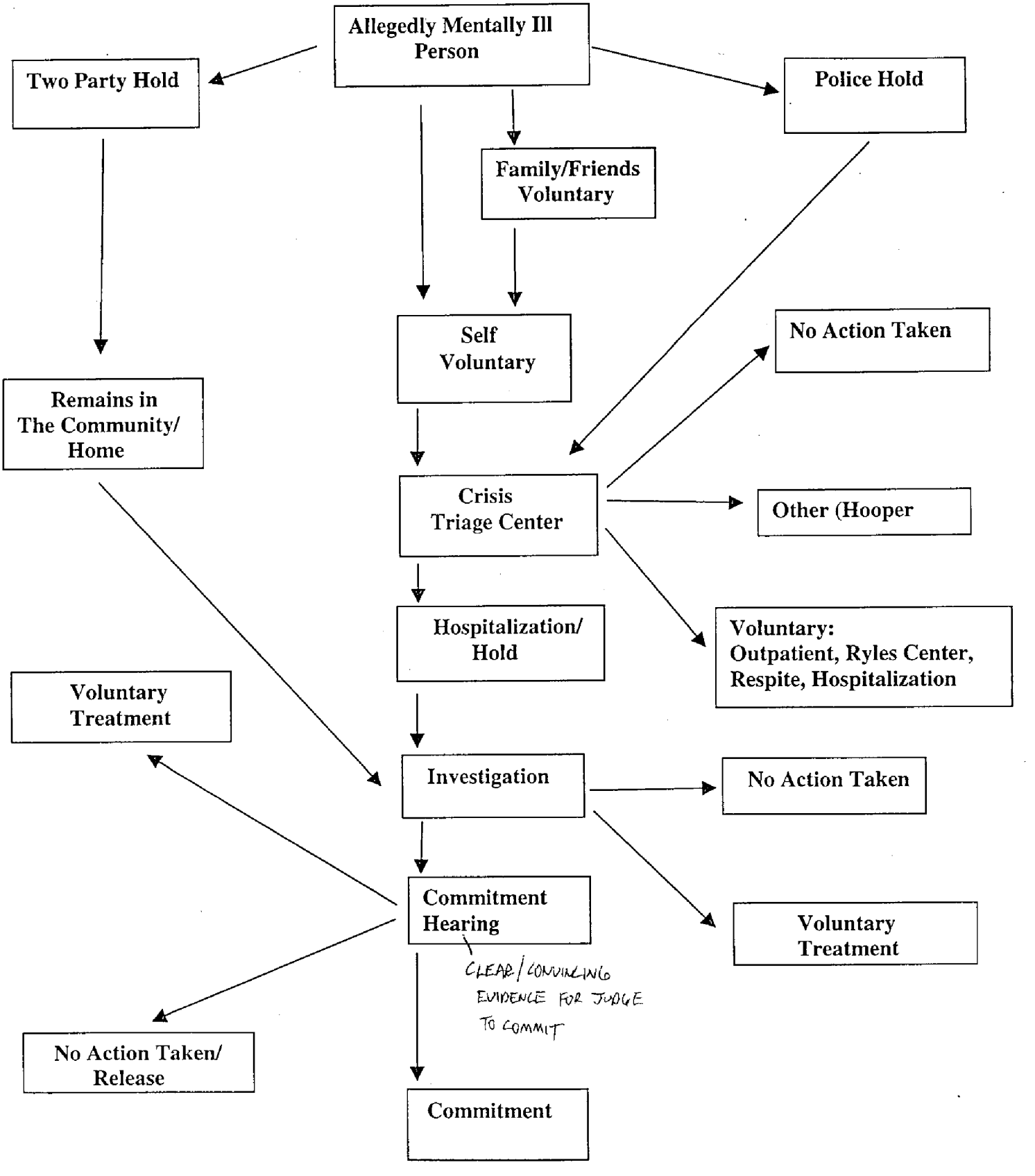
	Appearance	Thought Processes	Speech
Psychotic/Schizo-phrenic	Disheveled, Poor hygiene, Disorganized	Disorganized, Delusional, May be nonsensical or impoverished	Variable
Manic	Normal groom and dress to flashy, Rapid behavior	Rapid changes of topic, Grandiose, Delusional	Rapid and pressured
Depressed	Normal groom and dress to disheveled, slowed behavior	Slowed, impoverished sad themes	Slowed, often with thought blocking
Intoxicated	Anything and everything	Anything and everything	Anything and everything

NOTES

COMMITMENT LAWS

UP TO 5 JUDICAL DAYS

THE COMMITMENT PROCESS



THE COMMITMENT PROCESS

THE DIFFERENCES BETWEEN A TWO-PARTY PETITION AND A HOSPITAL MEDICAL DOCTORS HOLD

TWO-PARTY PETITION

Used for issues of inability to care/deterioration of function.

Person remains in the community/home

Investigation completed within fourteen calendar days (two weeks)

Can be signed by any two-parties/people

HOSPITAL MEDICAL DOCTOR HOLD

Should be used only in cases of imminent danger to self or others

Person held in hospital

Investigation completed within five working days

Must be signed by two MD's or one MD and qualified health professional

THE COMMITMENT PROCESS

The Civil Commitment process is governed by the Oregon Revised Statutes 426 and the Administrative Rules (interpretation of the Statutes) from the Oregon Mental Health Division. The Statutes define what the legal definition of mental illness is. Legally, mentally ill means; a person because of a mental disorder, is one of the following:

A) Dangerous to self or others.

B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.

C) A person who:

1) Is chronically mentally ill by the following definition (also known as "Expanded Criteria"):

a) Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility

AND

b) Is exhibiting symptoms or similar behavior to those that preceded or led to one or more of the hospitalizations or inpatient placements.

AND

c) Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Civil Commitment is a legal process not a clinical one. It has been designed as a legal procedure. At times, the logic of legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of family, significant others, or treatment providers.

The goals of the Mental Health Division in the Civil Commitment process:

A) To promote the well being of persons who are allegedly mentally ill and who are mentally ill and who are mentally ill during the involuntary care, custody, and treatment of mental illness pursuant to ORS 426.

B) To promote the protection of the civil rights of persons who are allegedly mentally ill or who are mentally ill.

C) To encourage the consistent application of ORS 426.

D) To encourage the provision of care, custody, and treatment of persons in the least restrictive environment that is available within existing resources.

THE COMMITMENT PROCESS

E) To encourage voluntary enrollment of persons in available mental health service in lieu of pursuing involuntary treatment through Civil Commitment, whenever possible.

F) To encourage that the Director (local community mental health system knowledgeable of the statues and administrative rules and provides leadership that persons being held are afforded their civil rights and are treated with dignity in the implementation of ORS. 426.

G) To provide for the safety of the community and the person when that person is dangerous to others or self as a result of a mental illness.

The Commitment process can be initiated, by giving Notice in writing (under oath) to the County Mental Health Program, by two persons, the County Health Officer, or any Magistrate. The Court will be immediately notified and the Community Mental Health Program will start (within 3 judicial days) An investigation to determine whether there is probable cause to believe the person is in fact mentally ill. Judicial days do not include weekends or Court holidays. The person is not usually in custody or detained during this process.

Emergency care, detention in a hospital and treatment can occur through the following ways:

A) A Peace Officer who has probable cause to believe a person is dangerous to self or to others and is in need of immediate care, custody of a person and remove them to the nearest hospital or approved non hospital facility, a physician will examine the person immediately. If the physician finds the person t be in need of emergency care or treatment for mental illness, the person to be in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the physician), otherwise the person shall be released from custody.

THE COMMITMENT PROCESS

B) A physician believes a person, who is at a hospital or approved non hospital, is dangerous to self or to others and is in need of emergency care or treatment for mental illness, can initiate a hospital hold and detain the person for emergency care. Under no circumstance shall any person be detained for more than 5 judicial days, following the signing of the hospital hold, without a Court Hearing.

C) A Designee of the Community Mental Health Program may, with probable cause that a person is dangerous to self or to others, or, additionally, (if the person is on a conditional release, outpatient commitment, trial visit) is unable to provide for personal needs, direct a Peace Officer to take custody and remove the person t o a hospital or approved non hospital facility for evaluation by a physician. This is called a "Director's Custody". If the physician finds the person is in need of emergency care or treatment for mental illness, the person can be detained in custody (a hospital hold will be signed by the Physician), otherwise the person shall be released from custody.

RIGHTS OF THE MENTALLY ILL

NOTES

OREGON ADVOCACY CENTER
Working for the Rights of Individuals with Disabilities

Rights of Persons with Mental Illness

Crisis Intervention Team Training
Portland, Oregon
November 14th, 2000

Janice Perciano and Jan Friedman
Oregon Advocacy Center

Voice: 503-243-2081 • 1-800-452-1694 • TTY: 1-800-556-5351 • Fax: 503-243-1738
620 S.W. Fifth Avenue • 5th Floor • Portland, Oregon 97204-1428

WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

Mental Health--the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.

Mental illness--the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alteration in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems--patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

. . . . .

The review of research supports two main findings:

- **The efficacy of mental health treatments is well documented, and**

- **A range of treatments exists for most mental disorders**.

. . . . .

Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment . Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

. . . . .

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable.

. . . . .

Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Excerpts from **U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of health, National Institute of Mental Health , 1999.**

RIGHTS OF PERSONS WITH MENTAL ILLNESS

Persons with mental illness have the **same rights as everyone else**.

Why aren't persons with mental illness treated the same?

1. Stigma--shame, hidden subject, accepted to mistreat, make fun of persons with mental illness

2. Misconceptions

   A. Violent--studies show that persons with mental illness are no more likely to be violent than anyone else, but often are portrayed in the media as violent

   B. Stupid--persons with mental illness have the same ranges of intelligence as everyone else, sometimes persons with mental illness are confused with persons with retardation--not the same

   C. Incompetent--everyone is presumed competent unless shown otherwise--persons with mental illness are presumed competent to make decisions even if civilly committed--only under specific circumstances is a person determined to be incompetent (guardianship, conservatorship, outside consultant determination regarding medication of person on commitment)

   D. Delusional--only some persons with mental illness experience delusional thinking--and even for these persons the delusions occur only some of the time

3. Protection of the person with mental illness--social workers, family, care givers, police etc. often want to treat persons with mental illness in what is perceived to be the best interests of the person with mental illness--may be in conflict with what the individual chooses and may be patronizing

4. Protection of society/family from hardship and/ or danger--actions are taken against a person with mental illness to protect others

5. Ignorance and fear--belief by persons without mental illness that persons with mental illness are extremely different than themselves and that mental illness may "spread"

LAWS SPECIFICALLY AFFECTING PERSONS WITH MENTAL ILLNESSES

1. CIVIL COMMITMENT

WHAT IS CIVIL COMMITMENT?

Civil commitment is a process in which a judge decides whether a person who is alleged to be mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment. A person in the process of a commitment sometimes is called an Alleged Mentally Ill Person (AMIP). A civil commitment is not a criminal conviction and will not go on a criminal record.

When a civil commitment petition has been filed, an investigator from the community mental health program (CMHP) will investigate the need for the commitment. Depending on the investigator's decision, the case may be dismissed without a hearing, the person may go into a diversion program or a hearing may be held. If a hearing is held, the person has a right to an attorney and to have witnesses testify. The judge then makes a decision whether the person should be committed. If the person is committed, the person may be hospitalized or may be required to undergo treatment in some other setting. The maximum commitment period is 180 days, although a person can be ordered to stay hospitalized beyond the 180 days in recommitment proceedings.

WHO CAN BE COMMITTED

Oregon Revised Statutes (ORS) chapters 426 and 427 contain the law regarding civil commitment. A judge can commit a person for up to 180 days if the judge finds by clear and convincing evidence, that the person

> Has a mental disorder and, because of that mental disorder, is:
>
> Dangerous to self or others, or
>
> Unable to provide for basic needs (like health and safety).

Or, the judge can find that a person is:

> Diagnosed as having a major mental illness (such as chronic schizophrenia or manic- depression), and

Has been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs.

ORS 426.005; ORS 426.130

HOW THE CIVIL COMMITMENT PROCESS BEGINS

1) The commitment process may be started by a county health officer, a judge, or any two persons filing papers in court. Or, the process may be started by a doctor or community mental health program director ordering a person to be held involuntarily in a hospital. ORS 426.070; ORS 426.228 through ORS 426.234.

2) When the papers are filed, the CMHP program must send out a mental health investigator to interview the person and others who know about the person. This investigator advises a judge whether or not to hold a court hearing. ORS 426.070; ORS 426.074.

WHERE THE PERSON STAYS BEFORE THE HEARING

A person against whom a civil commitment petition is filed may stay in the community unless the judge orders the person to be taken into custody or a doctor or CMHP director directs the person be in custody. The person can be in custody only if he or she is considered to be mentally ill and a danger to self or others. A person who is mentally ill and unable to provide for basic needs cannot be held in custody unless the person's inability to provide for basic needs is so extreme that the person is a danger to self. A person held before a hearing is on a precommitment hold or in precommitment detention. ORS 426.070; ORS 426.228; ORS 426.231; ORS 426.232; ORS 426.233.

If a person is held in custody on a precommitment hold, he or she cannot be held in jail unless he or she is charged with a crime or is a serious danger to hospital staff or property. ORS 426.140. The person may be held in a hospital or a nonhospital facility. A nonhospital facility is a facility approved by the Mental Health and Developmental Disability Services Division (MHDDSD) to provide adequate security, psychiatric, nursing and other services. ORS 426.005(e).

A person on a precommitment hold has the right to be held in a mental health facility providing care, custody and treatment required for mental and physical health and safety. In other words, the person can only be held in a place with staff trained to provide mental health treatment. ORS 426.072(2)(a); ORS 426.228.

"QMEN"

LENGTH OF TIME A PERSON CAN BE HELD BEFORE A HEARING

A person cannot be held in custody on a precommitment hold longer than five working days without a court hearing. If five working days pass and there is no court hearing, a person is free to leave the hospital unless he or she has asked to postpone the hearing or has agreed to be hospitalized voluntarily under a diversion program. In other words, a person cannot be held longer than five working days unless a judge says so. ORS 426.095.

HOW LEGAL RIGHTS ARE AFFECTED BY COMMITMENT

In general, most legal rights are not affected by civil commitment. A person who is committed retains all legal and civil rights, including the right to vote and make contracts unless a court has found the person incompetent. ORS 426.385.

Some specific rights can be limited as a result of civil commitment:

Firearms - Persons who have been committed are forbidden from owning, buying, or possessing firearms. ORS 426.130(1)(D); ORS 166.250 (1)(D).

Future commitments - If a person is committed twice within the past three years, he or she can be committed more easily in the future. ORS 426.495.

Driving - Commitment can affect a person's ability to get or keep a driver's license. If a person has a mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle, the person cannot be licensed. ORS 807.090; ORS 807.700; ORS 809.410(16).

II. AMERICANS WITH DISABILITIES ACT (ADA)

The ADA protects persons with disabilities from discrimination in these areas:

1. Employment--This includes hiring, termination benefits, working conditions, etc.

2. Public Accommodations--This includes hotels, offices, shopping malls, restaurants, sports arenas, schools, zoos, hospitals, theaters, grocery stores, homeless shelters, libraries, etc.

3. Public Entities--This includes all local and state governmental services and programs.

4. Transportation--This includes buses, trains, lights rail must be accessible or

alternatives offered.

5. Telecommunications--This includes that telecommunication services must be made accessible for speech and/or hearing impaired persons.

Persons with mental illnesses are protected by the ADA if the mental illness substantially limits one or more of the major life activities of the person. Major life activities means activities such as working, learning, sleeping, thinking and walking. Persons who have a record of such an impairment or who are perceived to have such an impairment are also protected.

In addition to the ADA, which is federal law, Oregon has state laws prohibiting discrimination in employment and public accommodations.

III. FAIR HOUSING LAWS

The federal Fair Housing Act was passed in 1968 as part of the Civil Rights Act of 1968. The Fair Housing Act prohibited discrimination based on race, color, religion or national origin in the sale, rental or financing of housing. In 1974, Congress added a provision prohibiting housing discrimination based on sex.

In 1988, Congress added provisions prohibiting housing discrimination based on mental and/or physical disabilities. Under the law, landlords and sellers cannot discriminate against a person because the person has a mental illness and must make reasonable accommodations for a person disability. The law does not apply in some cases where the landlord or seller is acting with regard to his or her private house or small apartment building. The law also allows the rejection of any tenant or buyer who would directly threaten the health or safety of other individuals or would cause substantial physical damage to the property of others.

Oregon also has a state law prohibiting discrimination based on physical or mental disability in selling, leasing or renting of houses and apartments.

IV. RIGHTS IN THE COMMUNITY AND IN FACILITIES

STATUTORY AND CONSTITUTIONAL RIGHTS

Many people receive mental health services outside the state hospital. Even persons who are civilly committed often receive treatment in private hospitals that have contracts with the state. Additionally, more people are receiving services in facilities, group homes and independent residences rather than in hospitals.

A person who is receiving services outside the state hospital system has the same rights as any other person in the community. Some of the rights that all persons in the United States are the right to:

*Vote

*Exercise freedom of speech, freedom of association and freedom of religion.

*Have privacy, including the right to marry and have children.

*Be free from discrimination based on race, gender, color, national origin or disability.

In 1993, the legislature passed legislation that sets out some specific rights of persons receiving mental health or developmental disabilities services. A person who is receiving mental health or developmental disabilities services outside of the state hospital has the right to:

*Have a written treatment plan and participate in making the plan.

*Choose from available services and have those services provided in the least restrictive way.

*Receive only services to which a person gives informed, voluntary, written consent.

*Receive medication only for individual clinical needs.

*Not be involuntarily terminated or transferred from services without prior notice and the right to be notified of available sources for necessary services.

*Receive humane services, be protected from harm and have reasonable privacy.

*Be free from abuse and neglect.

*Report abuse and neglect without retaliation.

*Exercise religious freedom.

*Not be required to perform labor, except personal chores, without being paid.

*Visit with family, friends, advocates, legal and medical professionals.

*Be told about rights and how to report abuse.

*Assert grievances and have them considered in a fair, timely and impartial manner.

*Communicate with any rights program or advocate.

*Exercise these rights without any reprisal or punishment.

ORS 430.210.

V. ABUSE REPORTING

Since 1991, the law has required the reporting and investigating of abuse of persons with mental illness who are receiving mental health services in the community. Abuse is defined as:

*Any death caused by other than accidental or natural means.

*Any physical injury caused by other than accidental means or that appears to be at variance with the explanation given of the injury.

*Willful infliction of physical pain or injury.

*Sexual harassment or exploitation, including any sexual contact between an employee of a facility or community program and an adult who is receiving mental health services.

The law requires private and public officials to report abuse if they have reasonable cause to believe abuse occurred. This means that all doctors, nurses, aides, psychologists, employees of county mental health programs, employees of mental health services providers, clergy, attorneys, outreach workers, social workers, therapists, police and others must report abuse.

Abuse may be reported to the Mental Health and Developmental Disability Services Division (MHDDSD), the county mental health program or the police. The office that receives the abuse report must then conduct an investigation or make sure that an investigation is conducted. The person who may have been the victim of the abuse must be provided protective services if needed. The investigating office must complete a report of the investigation and send it to MHDDSD. ORS 430.735 through 430.765.

VI. INFORMED CONSENT TO TREATMENT

A person can receive mental health treatment, including medications, only if the person gives his or her informed consent. This means the person must be told what the benefits and risks of treatment are and must make a voluntary decision.

A person cannot be forced to take a particular medication just because everyone thinks it would be good for him or her. The exception is when a person has been civilly committed and two doctors have agreed that the person is unable to make decisions. In this case, if the proper procedures are followed, the person may be subjected to treatment that she or he does not want.

VII. GUARDIANSHIP

If a person is "incapacitated", a judge may appoint a guardian for her or him. A guardian can only be appointed by a judge. A parent does not have the powers of a guardian if the individual is 18 or over unless the judge has appointed the parent a s guardian.

TELEPHONE NUMBERS FOR ADVOCACY GROUPS AND LEGAL ASSISTANCE

American Civil Liberties Union	503-227-3186
Fair Housing Council	503-223-8295
Multnomah County Legal Aid	503-224-4086
National Alliance for the Mentally Ill	800-343-6264
Oregon Advocacy Center	503-243-2081
Toll-free	800-452-1694
TTY	503-323-9161
Toll-free TTY	800-556-5351
Oregon Legal Services	
Central Office	503-234-1534
Farm Workers' Office	503-981-5291
Hillsboro Office	503-648-7163
Native American Office	503-223-9483
Oregon State Bar	
Lawyer Referral Service	503-684-3763
Toll-free	800-452-7636
State Public Defender	503-378-3349
U.S. Office of Civil Rights	206-615-2290
Toll-free	800-362-1710

GOVERNMENT AGENCIES

Adult and Family Services Division	503-731-3111
Bureau of Labor and Industries	503-731-4200
Equal Employment Opportunity Commission	206-220-6883
Toll-free 800-669-4000	
TTY 206-220-6882	
Mental Health and Developmental Disability Services Division	503-945-9499
Office of Mental Health Services	503-945-9700
Office of Client Rights	503-945-9495
Psychiatric Security Review Board	503-229-5596
Senior and Disabled Services Division	503-945-5811
Toll-free 800-232-3020	
Social Security Administration	800-772-1213

ADVOCACY/CONSUMER GROUPS

Mind Empowered, Inc	503-231-4137
Oregon Advocacy Center	503-243-2081
Toll-free 800-452-1694	
TTY 503-323-9161	
Toll-free TTY	800-556-5351
Oregon Alliance for the Mentally Ill	503-370-7774
Recovery, Inc 503-231-1334	

Brief History of Treatment of Persons with Mental Illness in England and the United States

Early 1300s--English law categorized persons with mental disabilities as lunatics or idiots.

Pre-1600s--Persons with mental illness were cared for at home or sent to poorhouses, workhouses, jails.

1600s-- "Madhouses" created to confine persons with mental illness. The madhouses were unhealthy settings with harsh and punitive "treatment". Persons were chained, abused and publicly displayed.

1700s-- "Asylums" were developed to provide healthy environment and "moral treatment".

Mid-1700s--Persons with mental illness in England were placed in St. Mary of Bethlehem which became known as "Bedlam".

"Bethlehem--or Bedlam as it was called--was a favorite Sunday excursion spot for Londoners, who came to stare at the madmen through the iron gates. Should they survive the filthy conditions, the abominable food, the isolation and the darkness, and the brutality of their keepers, the patients of Bedlam were intitled to treatment--emetics, purgatives, bloodletting and various so-called harmless tortures provided by special paraphenalia." The History of Psychiatry, F.G. Alexander and S.T. Selesnick

1752--Pennsylvania Hospital opened with several cells for the "insane". The method of commitment was informal. A few words scribbled on a piece of paper were enough to get a person locked up.

1773--In Williamsburg, Virginia, the first US institution specialized for the "insane" opened.

Late 1800s--Large public institutions were filled with chronic patients receiving little treatment.

1883--Oregon State Insane Asylum opened in Salem (renamed Oregon State Hospital in 1907).

1900-1960--Hospitals emphasized treatment but no effective treatment was available. Institution populations continued to grow.

1907--Eastern Oregon Hospital opened in Pendleton.

> When we have a disturbed or noisy patient to deal with [prior to a lobotomy operation] in the University Hospital or Doctors Hospital we administer two, three or more electroshock treatments in rapid succession. Psychosurgery in the Treatment of Mental Disorders and Intractable Pain, Walter Freeman and James Watts, 1950.

1955--560,000 persons with mental illness were confined in hospitals (1/2 of all hospital beds).

1959--The average daily population in Oregon State Hospital and Eastern Oregon Hospital was 4909.

1960-1975--Deinstitutionalization resulted in the release of vast numbers of persons from institutions.

1961--Dammasch State Hospital opened in Wilsonville.

1975 to present--Communities recognized that deinstitutionalization could not succeed unless accompanied by adequate community support programs.

1977--Psychiatric Security Review Board created in Oregon to supervise persons found affected by mental disease or defect in criminal matters.

1990 to present--Managed care implemented for provision of mental health services.

Deaths at Dammasch State Hospital (DSH)--June 25, 1993 to October 8, 1993.

June 25, 1993--DC died at DSH--No medical examiner review but adequacy of medical treatment questioned.

August 29, 1993--JW died choking on pancakes. He was alone in his room, unmonitored despite swallowing problems.

August 29, 1993--LL died choking on pancakes. Staff called 911 but did not intubate LL or manually cut an airway.

September 19, 1993--KM died as a result of coronary arteriosclerosis. Staff had given her Haldol despite a diagnosis of mental retardation (IQ 54) and no diagnosis of mental illness. Staff found her lying on her bed. She had no pulse but was warm. Staff made a emergency request for a doctor. Thirteen minutes elapsed before a doctor arrived.

October 18, 1993--PG suffocated while being placed in physical restraints. A towel pulled over his mouth contributed to the death.

1995--Dammasch State Hospital closed.. Oregon State Hospital at Portland opened with capacity of 68.

1997--Current Oregon State Hospital capacity is for 727 beds, including hospital beds, residential beds, child and adolescent beds.

Section 3 - RESOURCES

- Family and Consumer
- Community Resources
- Medications

FAMILY AND CONSUMER

PERSPECTIVE

WHAT IT'S LIKE

Being crazy hurts. For one who has been there, the idea of going crazy out of moral weakness, because it is easier than "facing reality," is utterly bizarre.

The major mental illnesses, like most other illnesses, carry with them an early-appearing and almost ever-present feeling of "sickness" and exhaustion.

As it gets better and worse, there are times when you may be unable to function at all, perhaps being unable even to get out of bed.

At these times, investigation is needed to determine whether you are suffering extreme stress of real-work origin, suffering from a resurgence of mental illness symptoms, or whether there is some unrelated medical problem, such as an abscessed tooth or the flu.

Too often, these episodes are viewed as bouts of laziness and "lack of motivation," and treated with harassment or even termination from a treatment program.

Unless this phenomenon, and ways of coping with it, are explained to you, you too may come to believe you are lazy and good-for-nothing.

You become aware that your perceptions are unreliable, that you are having sensory experiences that others do not share.

As you struggle for some understanding of what is happening to you, you find yourself clutching at extreme and bizarre explanations.

When you try to talk to other people about your experiences, you discover there is no common language for them. You find yourself putting together an unsatisfactory and embarrassing patchwork of religious, occult, or scientific words.

When you do talk to people, they may lapse into shocked silence, change the subject, or reject your statements as weird and you as crazy.

If you are not aware the perceptions are different from those of other people, you are even more disabled. Whenever you try to do something or talk to someone, all sorts of things go wrong, which you do not understand.

Because you cannot predict whether your perceptions and interpretations of events are acceptable to others as "real," you begin to be afraid to talk about your feeling at all. If you have not yet felt there was something wrong/bad about you before, you do now. You become very lonely.

Since you gave no safe way to compare your "crazy ideas" with what normal people define as real, your ideas/delusions become more detailed, more organized, and more strongly held.

Extreme and uncontrollable emotions rush through you: fear, confusion, anger, despair.

The feelings are overwhelming. You see yourself doing things you cannot stop. It comes to you that you are no longer in control of your life. You are forced to depend on other people for some things, even if you do not want to.

You begin to fear that you may do something awful, something that will make people get rid of you forever.

You worry that whatever has happened to you may be permanent, that you may never be all right again.

Pain becomes very familiar. It comes to have form and texture like terrain.

If pain is fairly steady and continuous, you can sometimes almost tune it out. But if someone offers you more hurt, whether it be emotional battering or physical, you are suddenly desperate and hostile. You are tired, tired, tired, and do not have the energy to take any more. Sometimes you have to take it anyway.

At times the pain/craziness comes in overwhelming waves. Like most people, you think that pain will somehow never crush you. Somehow new reserves of strength will appear, effective treatments will be found, or, in the extreme, that you will simply pass out.

Then one day, you lose control of your mind, your body, everything. You'll lose your bowels and scream and scream and scream, like a little pig squirming in the dirt. And it does not stop.

Having broken, having been totally <u>helpless</u> forever after leaves you feeling fragile in a way that other people do not. In wonderment you watch "normal people" go about their lives, full of energy, confident, unknowing. There is an abyss between you.

If you hurt bad enough, you try anything to feel better: self-help books, religion, sex, drugs, alcohol, and anything you can think of.

Some things make you feel a little better, some do nothing, and many of them make you feel a lot worse.

In desperation, sometimes just drinking or drugging yourself into unconsciousness seems a worthy goal.

The risks of triggering further psychotic episodes and the risk of alcohol and drug addiction are substantial. It is hard to be interested in future consequences of things when you are not sure you have a future or want one.

If you get strung out on alcohol or drugs you will have another difficulty. The people who work with alcoholics and drug addicts do not want you because you are crazy. The people who work with the mentally ill do not want you because you are an alcoholic or an addict. You can only go to special, expensive, "dual diagnosis" programs. If you have three or more diagnoses, you are likely to end up in jail.

Seriously mentally ill people have a suicide rate of 20-30 times that of the normal population. At greatest risk are those who are too ill to have a normal life, and not sick enough to be unaware of it.

Hardly anyone wants to commit suicide.

As the years go by, you exhaust the treatment options open to you. Hospitals and doctors get tired of you because you never get better.

You drift away from your family. You cannot hold a job, or maintain a sexual relationship.

If you talk to others about your feelings, you come under pressure to shut up and act normal. Your desperation makes them uncomfortable.

You feel helpless, lonely, and as if you have nowhere you belong. You cannot stand being trapped in all that pain. All these are bad enough, but it is the crushing, never ending tiredness that ultimately gets you. You kill yourself because you have to.

What you would really like to hear is: "We know you are very tired, and you feel awful most of the time. We do not want you to go away. We want you to live.

"But if the time comes when you really cannot take anymore, and you have to die, we will be very sad, but we will understand.

"Whether you get better or not, and whether you live or not, we love you anyway."

Confused and frightened people tend to try to clamp tight control on whatever or whoever upsets them. It is rare to be given this recognition of your pain and permission to do whatever you have to do, but if you are, it is very comforting.

It tends to relieve some of your guilt feelings for being such a mess, and such a disappointment to your family and friends.

If you are like many seriously mentally ill people, you have known since sometime in childhood that there is something very wrong with you.

Functioning at school was very hard. You have less and less success in living up to the expectations of your family, and in being like other people.

Others' attempts to shape you up are sometimes drastic. You are likely to have the experience of being threatened, ridiculed, or punished for things that you do not understand, cannot do, or cannot stop doing.

Parents, teachers, school counselors, and pediatricians rarely are familiar with mental illness in children. Many professionals take the de facto stand that major mental illness and suicide virtually do not occur in young children, and that all such problems come from "labeling" and "bad parenting."

Your family withers under the implied or open accusation that they made you crazy. They become too intimidated to talk to you, out of fear that they will "say something wrong" and cause you to shatter in a million pieces.

Communication within your family is loaded with fear and guilt, and is further complicated by your thought or mood disorder.

Nobody will tell you what it going on. In loneliness and isolation your fears and crazy ideas grow.

Your parents are scapegoated by relatives, neighbors, and authorities. They begin exchanging recriminations themselves. They become more and more exhausted and discouraged.

You are torn between wanting to stay with your family because you hope you belong there, and wanting to leave because you caused them so much pain.

If your family breaks up or you withdraw from them and you do not find some other support system, you fall on the not so tender mercies of the state.

As you move out into the world, you find you are only comfortable with "social equals," people similarly ill or otherwise damaged, and those rare people who are willing to some extent to understand your experience and feel your pain.

Talking with straight people is nerve wracking. You can never be sure when something you say will come out all weird, and you will be recognized as a crazy person and gotten rid of.

Hungry for human contact, you approach other people, only to discover that they are afraid of you. They assume that if you are mentally ill, you are by definition suicidal and violent.

You had been so wrapped up in being afraid yourself, that it comes as a humiliating shock to find that <u>normal</u> people are afraid of <u>you</u>. Some of them will even take the position that if you are or ever have been crazy, you cannot be trusted with anything, ever.

When out in the community, you are anxiously self-conscious, aware that at any moment a mannerism, a social misstep, or something "inappropriate" will unmask you as a crazy and embarrass anyone you may be with.

You fear being stared at, made fun of, or even being attacked by street creeps always on the lookout for someone with a high victim profile.

If you are too sick to have a hope of concealing it, you can only wait to be hurt and try to keep on going.

Being disabled, you fall into the hands of caretakers.

Sometimes you feel like an abandoned ship, to be taken over by any normal person who wants to, as if they had some kind of salvage rights.

At times you spend a lot of energy fending off such people, trying to hold onto the right to run those parts of your life that you still can.

Caretakers come in various roles, with a variety of titles and letters after their names. Some are very skilled and genuinely helpful, a lot more manage to get by, and some are definitely part of the problem, not part of the solution.

You have no choice about being sick, and no choice about depending on caretakers at times. Even within a given type of service or a particular agency, you seldom have a choice. Your "case" is "assigned" to someone by a "catchment area," "admission rotation," or whatever.

Caretakers control access to medication, asylum (the hospital), money (welfare, SSI), and food (stamps). They decide whether to allow you the sick role, or whether to define you as bad, crazy, or stupid. They can invalidate what you say or do, and call upon the court to have you carted away.

Appeals from their decisions are costly, time consuming, difficult, or impossible. In no way is their relationship a voluntary one between equals.

For a caretaker to operate humanely in such an unequal relationship, a very high level of skill and integrity is required. When you have no choice, you need the best.

Paradoxically, the mental health system tends to assign the least experienced and lowest status workers to screening and to the seriously ill, and the most trained and highest status professionals to the less needy but "more interesting" (more likely to get better) clients.

Like all human beings, some mental healthers have their prejudices, some of which may have a major impact on your life. Some of these prejudices include that, if you are:

a. Poor--you are just trying to get free room and board;
b. Black--you have paranoid schizophrenia;
c. Old--you are hopelessly senile;
d. Male--you are violent;
e. Young and female--you are manipulative or seductive;
f. Young and male--you are a doper;
g. Admitted to a hospital from jail--you are faking;
h. Physically ill--it's all in your head;
i. Failing to get better--you are unmotivated.

In your dealings with mental health workers, you will encounter some common problems:

Mental healthers sometimes seem to see you as a kind of agent of insanity, and immediately start a power struggle over who is to be in control of the relationship.

They seem to fail to see that you have no desire to keep, much less propagate, your crazy ideas. You would get rid of them in a minute if you could only figure out how to do it.

They will frequently refuse to tell you your diagnosis and probable course of your illness. With no real information to go on, you are left to your imagination, which is often worse than anything a doctor could tell you.

What they tell you about the expected effects of your medications and possible side effects is commonly very sketchy. You sometimes have nasty surprises.

Although PRN (extra, as needed) medications are routinely prescribed in the hospital, you are rarely provided them outside. Somehow, life in the community is supposed to be much less stressful, and besides, you might "abuse" the medications.

You find yourself viewed with a general distrust. Everything you say or do is "evaluated" and subject to "clinical judgment," to determine its "real meaning." Yet basic investigative techniques, such as talking to everyone involved and cross-checking their stories, are omitted.

At times, this is due to lack of time or carelessness, but too often it comes from an ego trip wherein professionals feel that their qualifications enable them to discern deep truths virtually by remote control.

It is terribly frustrating to try to communicate with such people, because nothing you say is accepted at face value, but is changed into something unpredictably different.

Meanwhile, they want you to "develop a trust relationship" with them, but changes in staff and program priorities may come much faster than your ability to trust can handle.

You may have to cope with mental healthers who take basically useful approaches to problems and carry them to such lengths that they become problems themselves.

It is helpful to convey to you the expectation that you will get better, but not so helpful to fail to teach yourself care skills and work with the emotional problems that arise when it becomes clear that you are not improving.

Inventorying your symptoms and problems is a necessary beginning of a treatment plan, but concentrating only on what is wrong with you and ignoring the strengths and abilities you still have is not so useful.

Good general counseling skills and effective community organization are necessary to help you improve and maintain your quality of life. However, they do not eliminate the need for detailed knowledge of the symptoms, experiences, and problems which affect you as part of your mental illness, or as effects of your medications.

Anyone working with seriously ill people must be willing to take control at times when you are too disabled to carry on necessary life functions. Unfortunately, mental health work attracts numbers of people whose need to control others is so great that they tend to discourage your own sense of your own competence, and dampen any drive you may have toward free and self-reliant living.

This is a rip-off, because they imply that since you are incompetent, you may rely on them to meet your needs. The first time you get in trouble outside normal business hours or without an appointment, you may have a rude awakening.

You <u>have</u> no choice about learning to take care of yourself and your fellow crazy people as best you can. The response of the mental health system is often just too slow and unpredictable.

It is reasonable for mental health workers to hope for some emotional gratification from their work, but sometimes you are too sick, and have nothing to give in return. Sometimes, when you are not getting any better, your therapists get desperate and start "shot gunning" you with multiple medications and rapid, ill-thought-out changes in your treatment plan.

You may not be listened to when you try to explain what has worked for you in the past.

Since your records are usually following a hospital or an agency or two behind you, you may suddenly be taken off a regimen on which you had been stable, and which took months of experimenting to develop.

The principle seems to be "change something, whether it helps or not," rather than feel helpless.

Other times, some workers get frustrated and bitter, and put increasing pressure on you to "get well or get lost." This can be mutual: they cannot forgive you for not getting better, and you cannot forgive them for not getting you better.

If you are crazy, you can usually count on being poor.

If you are severely disabled, you will probably be on welfare, at least at first.

Your welfare grant is based on a fraction of what a study of local prices determines to be the minimum livable allotment.

Social Security (SSI) is somewhat more, but you are unlikely to successfully complete the complex application process without determined help from a case manager or a family member.

In either case, you will have a welfare medical card. Since there are restrictions on the services covered, and because the majority of local physicians do not take welfare patients, your medical care is likely to be poor and without continuity.

You will probably have bad teeth, as well. Dental care is only available for emergencies, and for a low dollar amount, resulting mostly in extractions.

Your clothing is likely to be poor, ill fitting and mismatched, coming from thrift stores, and sometimes carrying institutional marks.

Drifting in and out of hospitals, jails, and boarding houses, most of your possessions will have long since been lost or stolen. You may have little in the way of toilet articles, and you may smell.

Your status as a second class citizen, a loser, is displayed for all to see. In addition to the practical problems of poverty, there are the emotional effects. If you are one who has learned to count personal worth in terms of possessions, you are doubly poor.

There is a strong streak of Calvinism in our society: being poor is seen as evidence that you are also bad.

If you go into a nice store, clerks follow you around waiting for you to steal something. Some mental health workers dress especially well to avoid being mistaken for patients.

If you are unable to be productive, many feel you should be uncomfortable. It would be immoral, somehow contributing to your delinquency, to give you things you cannot earn.

You meet people who would obviously be willing to let you starve to death if it were their choice. To your humiliation is added an element of real fear.

You may find yourself begging and stealing, in violation of your own principles. You pack rat, assembling collections of junk, rather than have nothing at all.

Sometimes it is hard not to hate the caretakers around you, who have built a comfortable lifestyle upon your misfortune.

Sex is important to people, to sick people no less than to people who have the privilege of being healthy. Like everything else, mental illness messes it up.

When you are depressed, when you hurt so bad you have to be completely numb in order to function at all, the numbness itself becomes another kind of discomfort. You want to feel <u>something</u>, anything but more pain. You think of sex as a strong, good feeling, and try it. You run into a wall of pain and exhaustion. You cannot get aroused, you cannot tolerate intercourse. You experience one more crushing failure. Perhaps you are no longer a woman or a man anymore.

If you are high, in a manic state, you may be very sexually active. It may feel wonderful, or, if your high has reached an agitated, desperate stage, it may feel frenzied and out of control.

When you come down, it can be mortifying. You may have VD treatment, abortion, divorce papers, and new enemies waiting for you.

If you have a thought disorder, you may be too scattered to figure out what you need, or disorganized or fearful to effectively seek out a partner. If you find a partner, he or she is likely to be a "social equal." With both of you crazy things can get confusing.

Institutions do not make provisions for sexual privacy. Quite the contrary. Your sexual experiences are likely to take place in bushes or on the floors of out-of-the-way restrooms.

You risk a personal confrontation with the fact that many people, but especially high control institution types, do not feel crazy people are entitled to sex lives. They may also have reasonable concerns about competency to consent, and about civil liability.

If you are male, and your activities or choice of partner are not approved of, you may be written up in records as "sexually inappropriate with one of our sickest female patients" ("rapist").

If you are a female, you may be described in your chart as "sexually inappropriate with men" (presumably numerous, "whore").

If you are gay or lesbian, you are doubly disapproved of, and you risk having drastic action taken against you, especially premature discharge from treatment.

If you are young, and have homosexual experiences during prolonged institutionalization, which are common, you may have to keep it deeply secret afterward, and wrestle, usually alone, with the question of what your sexual orientation actually may be.

A complication of trying to have a sex life while under psychiatric treatment is that many psychotropic medications are sexually disabling in many people. You may find yourself unable to get aroused, or you may be aroused but unable to climax, or climax is long delayed.

You may be told about this when being instructed about your medications, but frequent not. If you can get up the nerve to raise the issue, often a reduction of dose or a change to another drug will take care of the problem.

If you cannot, you get more depressed at this additional evidence that your life is ruined.

When you are poor, crazy, and unwanted, you hunger for warmth and touching, on almost any terms. Sometimes you fall into the hands of cruel and exploitive people.

Sometimes you hope you will have a child, as a fulfillment of your identity as an adult human being, and in hopes of having someone to be with, who will love you. Frequently, this ends in tragedy, as you have children you cannot take care of, and they are taken away from you.

Because mentally ill people often are fairly helpless, they are frequent crime victims. Criminals often are aware that you may have no interested family or friends, and are easily discredited in court. Therefore, there is little risk of being prosecuted for any crime against you, short of murder.

The sword is two-edged: because you are "insane" you may receive no consequences for repeated antisocial acts. You risk developing habits of behavior that drive away your support system, and ultimately land you in the hospital or on Skid Row.

When you lose your mental health, you go through the same pattern of responses for any other major loss. Dr. Elizabeth Kubler-Ross's "Stages of Dying" is a fairly accurate model.

1. Shock. You never expect to go crazy, nor do you expect to find out one day that you have been crazy for a long time.

   You are stunned, confused, afraid. For a period of time, you are in shock and unable to do anything to help yourself.

2. Denial. You buy time to deal with overwhelming anxiety producing situations, by denying them. You try to go on living as if the problem did not exist, while your subconscious mind works on some way to cope with the problem.

   Other people, who are not sick, get frustrated and angry because you do not do whatever they think you should do about the situation.

   Since it is not their problem, they are not overwhelmed by anxiety, and they can view the whole affair more objectively.

   The crunch comes when they pressure you to "face this thing, right now!" and accuse you of "wanting to stay sick."

   The reason you are unwilling to do the things they demand, such as going to a clinic, taking medication, and giving up "unrealistic" life plans, is because you do not want to be sick. Therefore, you do not want anything to do with anything even remotely related to being crazy.

   Since your denial is basically driven by anxiety, the more you are harassed about "facing the facts," the more delayed as you're coming to terms with your situation.

3. Anger. When you realize that your life is going to be more painful and more limited than the lives of other people who are of no greater merit than yourself, you get mad.

   Since many people view the family as the source of all problems, you may direct, and be encouraged to direct, your anger at them. Often having strong guilt feelings themselves, they may agree that you are entitled to be angry at them.

   You may also vent your anger at mental health workers, whose very presence in your life is an undesirable reminder of how you have been cheated of a normal life.

   You may carry a powerful resentment against people who have the privilege of normalcy, who have jobs, friends, money, cars, and other things that you do not.

4. Bargaining. As it becomes clear that this insanity business is for real, and it shows no signs of going away, you want to make a deal.

   You try unusual diets, stranger religions, street drugs, anything that offers the faintest hope of making a difference.

You promise God that you will devote the rest of your life to medical research and serve to the poor, if only this cross will be taken from you.

Occasionally, someone recovers for no reason known to man. Not very often.

5. Depression. When you realize that no deals are being made, blaming people makes no difference, and the craziness is not going away. You are very, very sad.

   You have a right to be. Through no fault of your own, your life has been ruined. You may never have the job, children, a car, or even one day free of pain for the rest of your life. The temptation to give up and die is very great.

6. Acceptance. After a time, usually a long time, you find a way to accept yourself and what has happened, and to go on with your life.

   There are three things that you have to understand:

   a. You must take care of yourself and meet as many of your own needs as you can, either yourself or through relationships with other people which are mutual, equal and loving.

      By virtual biological law, people meet their own needs and those of their loved ones first. Only what is left over is offered to others.

      This is as true of mental health workers as anyone else. They provide specific services, and a measure of emotional support, but rarely as love as exchanged among equals.

   b. Blaming people, whether yourself, your family, or anyone else, is a waste of time.

      Too much psychodynamic, insight-oriented therapy is a thinly disguised search for someone to hold responsible.

      There is no way you can recover a piece of your life from someone, as if it were money damages. You may not be able to forgive or forget, but you have to withdraw your energy from the past, and go on.

   c. You have to find some reason, some mission in life to justify going on, in spite of the pain and lack of orderly success.

      If you are religious, it may be the faith that you are in this world to be tested, or to learn something essential for your spiritual development, and that your

Appendix

Some reasons mentally ill people contact crisis services are:

1. You may need help with a practical, real-world problem. If you spent a lot of your life being crazy, you may be missing whole areas of competence which are taken for granted by normal people, such as riding the bus, dealing with a traffic ticket, or returning defective merchandise to a store.

2. You may need help putting an idea in words, defining a problem clearly so that you can work on solving it, or communicating feelings to someone in a relationship. If you have a thought disorder, the most important area of communication in words can be extremely difficult.

3. You may need emotional support for a necessary decision not popular with your immediate support system. The people in your college psychology class may be delivering fulminating denunciations of psychotropic medications, but you have to stay on them, or end up in the hospital or dead.

4. You may have symptoms that relate to a developing medical problem, and you need help figuring out whether you need medical care, or whether these are just some new variations on your hallucinations and delusions.

5. You may be experiencing new or threatening psychiatric symptoms, such as prolonged sleep loss or command hallucinations ordering you to kill yourself. You may need help deciding how serious these are, and what to do about them.

6. You may need a perception check: does it seem likely that you are important enough for the FBI to bug your phone, or is that probably just a crazy idea?

7. You may need help finding specific local mental health or social services.

8. You may be without food, clothing, shelter, or essential medical care.

9. You may be in legal trouble, and need help conveying to those defending you, the nature of your illness and your disabilities.

suffering has a place in the overall cosmic picture. For others it may be the goal of someday writing a book, which you hope will help normal people understand the experiences and needs of the mentally ill.

For a few who have luck, brains, and a terrible determination, it may be possible to go back into the wilderness to try to lead a few brothers and sisters to freedom. They become mental health workers themselves.

It may be the love of family, fear of death, or even plain stubbornness, but there has to be a reason.

If the pain is futile, it is also intolerable.

COMMUNITY RESOURCES

NETWORK
Behavioral HealthCare, Inc.

Resume of Low-Income Housing Experience

Date of Inception	Project
March 1985	Tillicum Court Apartments

Under the corporate ownership of Southeast Network Housing Services, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing in studio and 1 bedroom apartments, as well as skills training and support services, are provided on-site. Additional psychiatric and clinical services are available through the Network's Rehabilitation and Community Services divisions.

March 1987 — 70th Street House

The Network provides residential care in a transitional group home setting to 12 individuals having mental illness. Twenty-four hour supervision, skills training, and counselor support are provided on-site as are meals, medication and money management. The facility is leased from the Housing Authority of Portland and operated by the Network. All residents are low income and supported by entitlement programs.

May 1988 — Nawikka Court Apartments

Under the corporate ownership of Southeast Network Housing Services II, the Network operates this 16 unit HUD 202 project (15 tenant units plus manager) for the benefit of low income persons having mental illness. Housing is provided in 1 bedroom units with additional services provided as described for Tillicum Court.

ADMINISTRATION
5415 SE Milwaukie Avenue • Portland, Oregon 97202
(503)238-0769 • FAX(503)233-2661

January 1992

Pisgah Home/Harriet Court Apartments

The Network provides both residential care (Pisgah Home) and supported housing (Harriet Court) to individuals having mental illness at these co-located program sites. Fifteen Pisgah tenants receive twenty-four hour supervision, assistance with activities of daily living (hygiene, grooming, etc.), money, medication and crisis management; skills training and counseling. Fifteen Henry Court tenants live independently and receive skills training and support from on-site staff as appropriate to their needs. Tenants in either program reside in private rooms with private baths. Congregate meals are available. The Network owns and manages the facility in which it operates these programs. All tenants have incomes below 50% of median; many are supported by entitlements.

November 1993

Woodstock Court Apartments

The Network operates this nine (9) unit complex under lease from the Housing Authority of Portland, the project's co-developer (with Network). Eight studio units are rented to homeless individuals having mental illness. An on-site manager occupies a 9th unit. The Network provides skills training and support services including medication monitoring and a meal preparation skills program. The Network manages all aspects of this housing. All tenants have incomes below 50% of median, typically from entitlement payments.

May 1994

Lafayette Apartments

The Network owns and operates this thirty two (32) unit complex which provides supported independent living in studio and in one bedroom apartments to individuals having mental illness. On-site management and optional skills training and support services including medication monitoring and meal preparation training are provided. All tenants have incomes below 30% of median and are generally supported by entitlement programs.

October 1994

Kernlodge Home

Quint 26

The Network operates these two, five (5) unit homes under lease from The Housing Authority of Portland, the project's co-developer (with Network). Each home contains five SRO units (a private bedroom and bath), and shared space that includes kitchen, dining room, living room, laundry, and individual pantry/food storage areas. This shared housing affords its tenants privacy, security, and comfort in a small, group-oriented, neighborhood-friendly building. Tenants are low income persons having mental illness who are capable of living in an unsupervised setting. The buildings do not have live-in management, but are regularly monitored by the staff of Network Behavioral HealthCare, Inc. The Network provides the residents with skills training, case management, twenty-four hour emergency on-call psychiatric, health, vocational, socialization, recreational and medication monitoring services. All tenants have incomes below 50% of area median and are generally supported by entitlement payments.

January 1995

Lents Court

The Network operates this five (5) unit home under lease from The Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge and Quint 26 described above. All tenants are low income veterans who are clients of the VA Domaciliary Program. All support services are provided by the VA under a Letter of Understanding with Network.

January 1996

Tea Link Home

The Network operates this five (5) unit home under lease from the Housing Authority of Portland, the project's developer and owner. The building is identical to Kernlodge, Quint 26 and Lents Court described above. All tenants are low income Asians. All support services are provided by the Chinese Mental Health Program.

March 1996

Hopewell Apartments

Under the corporate ownership of EcuNet Housing, Inc., a partnership between Network and Ecumenical Ministries of Oregon, Network operates this 8 one bedroom and 4 two bedroom HUD 811 apartment building. Hopewell offers low income people with HIV disease and psychiatric disabilities housing and a program of services to help them live as independently as possible. On-site management is available. Tenants pay about 30% of their income for rent and utilities and are required to meet HUD income eligibility requirements.

June 1996

Clinton Street Apartments

The Network owns and operates this 16 unit complex (15 studio apartments and 1 one bedroom apartment) to provide housing with linked support services for low income individuals with mental illness. The project has an on-site manager who provides skills training and support services including medication monitoring, case coordination, and recovery services. All tenants have incomes below 50% of area median and are generally supported by entitlement programs.

September 1996

Tabor House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. All six tenants are low income individuals who are capable of living in an unsupervised, supportive setting. Each has a private bedroom and shares use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

November 1996

75th Ave. Adult Foster Care

Network owns and operates this five resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 50% of area median and are supported by entitlement programs.

August 1998

Powell Blvd. Apartments

Under the ownership of Powell Boulevard Apartments, Inc., a not-for-profit corporation sponsored by REACH Community Development, Network operates this 20 unit HUD 811 project for the benefit of low income persons having co-existing mental illness and substance abuse disorders. Tenants occupy studio, 1 bedroom, and 2 bedroom units, and participate in a program of services designed to promote independence and sobriety. On-site management and supports are available to supplement psychiatric and addictions services provided through Network's Project STOP or other treatment providers. All tenants have incomes below 50% of area median and pay approximately 30% of their income for rent and utilities.

March 1999

Woodstock House

Network operates this six bedroom home under lease from Rose Community Development. Network Project Stop provides drug and alcohol free permanent housing and supports to individuals in recovery. The tenants are low income women who are capable of living in an unsupervised, supportive setting. The home is configured to allow the rental of individual bedrooms to single women or two bedroom suites to small families. Tenants share the use of, and responsibility for the other areas of the home. Network provides skills training and support services on site as needed.

April 1999

Residential Intensive Treatment Services

The Network owns and manages this ten unit transitional housing program in which residential treatment is provided to individuals having mental illness and addictions issues. Tenants are referred by Multnomah County Community Corrections and receive twenty-four hour supervision, addictions treatment, assistance with activities of daily living, money, medication and crisis management; skills training and counseling. Tenants reside in private rooms with half baths during their three month stay. All tenants have incomes below 50% of median; many are supported by entitlements.

January 2000

Nadine Place

Network owns and operates this eight resident home for low income individuals having mental illness. Tenants receive 24 hour supervision, skills training, counseling, meals, medication, money management, and assistance with activities of daily living. All tenants have income below 30% of area median and are supported by entitlement programs

Tenants of these residential programs receive housing and on-site services as specified above. In addition, tenants are welcome to participate in the full range of community treatment and rehabilitation programs offered by The Network. These programs include case management; medical and psychiatric consultation; vocational, recreational and socialization services, substance abuse recovery services; psycho-social clubhouse; crisis/triage services; individual and group counseling; and medication management.

MEDICATIONS

MEDICATIONS AND THEIR SIDE EFFECTS

Psychiatric researchers believe that people suffering from many mental illnesses have imbalances in the way their brain metabolizes certain chemicals, called neurotransmitters. Because neurotransmitters are the messengers the nerve cells use to communicate with one another, these imbalances may result in the emotional, physical and intellectual problems that mentally ill people suffer. Psychiatric medications are like any other medicine a doctor would prescribe. They are formulated to treat specific conditions, and they must be monitored by a physician. All medicines have positive and negative effects. Whether or not a person will experience side effects cannot be predicted. Responses to medications are individual. Most medications psychiatrists prescribe may take a few days or a few weeks to become fully effective. The listed medications and their side effects are some of the most common but it is certainly not a complete list.

MEDICATIONS AND THEIR SIDE EFFECTS

Antidepressents	Most Common Side Effects
Amitriptyline (Elavil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, worsening of heart disease, dizziness when first standing up
Amoxapine (Asendin)	Worsening of heart disease, sleepiness, agitation, insomnia, anxiety
Bupropion (Wellbutrin)	Agitation, dry mouth, insomia, headache, nausea, vomiting, constipation, tremor
Clomipramine (Anafranil)	Dry mouth, sleepiness, tremor, weight gain, sweating, dizziness when first standing up, blurred vision, constipation, trouble having orgasm, trouble urinating, nausea
Desipramine (Norpramin)	Dry mouth, blurred vision, constipation, trouble urinating, weight gain, sweating, dizziness when first standing up
Doxepin (Sinequan)	Sleepiness, sweating, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, weight gain, dizziness when first standing up
Fluoxetine (Prozac)	Agitation, anxiety, insomnia, drowsiness, tremor, loss of appetite, nausea, diarrhea, headaches, dizziness, problems with orgasm
Imipramine (Tofranil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Maprotiline (Ludiomil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, weight gain
Nefazodone (Serzone)	Sleepiness, dizziness when first standing up, nausea, headache
Nortriptyline (Pamelor)	Sleepiness, dry mouth, trouble urinating, constipation, blurred vision, weight gain
Paroxetine (Paxil)	Nausea, sleepiness, fatigue, dizziness, insomnia, sweating, tremor, loss of appetite, anxiety, trouble having an orgasm
Protriptyline (Vivactil)	Dry mouth, blurred vision, constipation, trouble urinating, worsening of heart disease, dizziness when first standing up, insomnia, anxiety
Sertraline (Zoloft)	Nausea, diarrhea, tremor, dizziness, insomnia, sleepiness, sweating, fry mouth, delay in having an orgasm
Trazodone (Desyrel)	Sleepiness, worsening of heart disease, dizziness when first standing up, nausea, vomiting
Trimipramine (Surmontil)	Sleepiness, dry mouth, blurred vision, constipation, trouble urinating, dizziness when first standing up, worsening of heart disease, weight gain, sweating
Venlafaxine (Effexor)	Sedation, nausea, sweating, dry mouth, dizziness, weakness, constipation, decreased appetite, vomiting, anxiety, tremor, blurred vision, problems with orgasm, headache
Fluvoxamine (Luvox)	Sleepiness, insomnia, anxiety, tremor, nausea, loss of appetite, vomiting, sweating, delayed orgasm

http:noah.cuny.edu/illness/mentalhealth/cornell/medications/antidepsideff.html 7-15-99

A SHORT COURSE ON COMMONLY PRESCRIBED PSYCHOTROPIC* MEDICATIONS

Donlon G. McGovern, Ph.D.

*from the Greek words "psyche" =the mind and "tropos" = turning toward

The **BENZODIAZEPINES**

These medications referred to as "anxiolytics" that is, their target symptom is anxiety. Some are also used to treat seizure disorders. They are sedative-hypnotics; that is, they induce sedation and sleep but eventually interfere with sleep. They do not bring an abnormal neurotransmitter system back into balance but depress or "tune down" the central nervous system. The "benzos" are potentially **highly addictive**, produce fairly **rapid tolerance** and are extremely **difficult to withdraw** from. Withdrawal from benzodiazapines is similar to withdrawal from alcohol or barbiturates and can produce seizures and even death. Heroin withdrawal, as bad as it feels, is actually easier, quicker and safer than benzodiazapine withdrawal.

Common side effects are sedation, dry mouth, depression, and memory disturbances.

Trade name with generic name in parentheses.

Valium (diazepam)
Klonopin (clonazepam)
Xanax (alprazolam)
Halcion (triazolam)
Dalmane (flurazepam)
Centrax (prazepam)
Restoril (temazepam)
Tranxene (clorazepate)
Librium (chlordiazopoxide)
Equanil/Miltown (meprobamate)
BuSpar (buspirone) is included since it is an anxiolytic though it is not a benzodiazapine and does not appear to have addictive potential.

The **ANTIDEPRESSANTS:** used for treating the target symptoms of chronic depression such as sleep disorder, appetite disorder, anxiety, distractibility, agitation and dysphoric mood. The anti-depressants are **non-addictive** and do **not produce tolerance**. The anti-depressants work to restore balance in the neurotransmitter systems, which mediate mood, sleep, energy and the capacity for pleasure. Side effects can include dry mouth, constipation, difficulty urinating, difficulty ejaculating or reduced orgasmic response, difficulty with erection, agitation and headache.

the tricyclics
Elavil (amitriptyline)

Tofranil (imipramine)
Norpramine (desipramine)
Pamelor/Aventyl (nortriptyline)
Surmontil (trimipramine)
Vivactil (protriptyline)
Anafranil (clomipramine) mainly used for obsessive-compulsive disorder
Sinequan/Adapin (doxepin)

The **second generation or "atypical" compounds**
Ascendin (amoxapine)
Ludiomil (maprotiline)
Desyrel (trazadone)
Wellbutrin (buproprion)
Serzone (nefazadone)
Remeron (mirtazapine)

The **SSRI's** (serotonin-specific reuptake inhibitors) - CANNOT O.D. ON
Prozac (fluoxetine)
Paxil (paroxetine)
Zoloft (sertraline)
Effexor (venlafaxine) seems to have both tricyclic and SSRI properties
Luvox (fluvoxamine) used mainly to treat obsessive-compulsive disorder

The **MAOs** (monoamine oxidase inhibitors). These have to be used carefully as they can react to certain foods, high in the substance tyramine, such as red wines, aged cheeses and certain preserved meats, to produce a rapid and extreme rise in blood pressure. People taking MAO's follow some dietary restrictions and are taught what to watch for in their diet.
Nardil (phenelzine)
Marplan (isocarboxazid)
Parnate (trancyclopromine)

The **ANTI-MANICS (also referred to as mood stabilizers)** are used for treating mania, the hyperactive, excitable stage of bipolar mood disorder. **Non-addictive** and does not produce tolerance. Research has shown that these medications are also helpful in preventing the recurrence of severe mood swings.
Side effects can include: diarrhea, nausea, dry mouth, excessive thirst, tremor, loss of muscular coordination.
Lithobid/Eskalith (lithium carbonate)
Tegretol (carbamazapine)
Depakote (valproic acid)

The **ANTI-PSYCHOTICS** also called **Neuroleptics** are used to treat psychotic symptoms. As such they are believed to work by restoring balance in the neurotransmitter systems (primarily dopamine) which mediate thought processes, perception and mood. They are **non-addictive** and do not produce tolerance.
Side effects may include sedation, abnormal movement disorders (tardive dyskinesia, akathesia), bone marrow suppression, hormonal disturbances, dry mouth, constipation.
Thorazine (chlorpromazine)
Stelazine (trifluoperazine)
Mellaril (thioridazine)
Serentil (mesoridazine)
Trilafon (perphenazine)
Navane (thiothixene)
Moban (molindone)
Loxitane (loxapine)
Prolixin (fluphenazine)
Haldol (haloperidol)
Inapsine (droperidol)
The **"new generation"** anti-psychotics include:
Zyprexa (olanzapine)
Clozaril (clozapine)
Serlect (sertindole)
Risperdal (risperidone)
Seroquel (quetiapine)
Orap (pimozide) used mainly for Tourette's Syndrome

The **Anti-Parkinson** medications, for side effects from Anti-Psychotics. Most common side effect is dry mouth.
Cogentin (benztropine)
Artane (trihexyphenadyl)
Benadryl (diphenhydramine)
Inderal (propranalol) also used to treat Lithium caused tremors

The **ATTENTION DEFICIT DISORDER/HYPERACTIVITY** medications are used to reduce distractibility, improve concentration and attention and to reduce non goal-directed movement. Their action appears to be to improve neural activity in relay centers which "alert" the cerebral cortex to "pay attention" to relevant stimulation and to "tune out" irrelevant or distracting stimulation. The most common side effects are suppression of appetite and insomnia but can also include irritability. **These medications can produce dependence and tolerance. They are less often prescribed now as many of the SSRI anti-depressants and a**

couple of the tricyclic anti-depressants have been shown to be as effective with no risk of addiction or tolerance.
Cylert (pemoline)
Ritalin (methylphenidate)
Dexedrine (dextroamphetamine sulfate)
Adderol (contains both dextro and levo amphetamine)

There are probably newer medications in all the above classes since this has been written but this list is fairly inclusive.

Keep in mind that side effects can occur with any chemical you take in. Such things as aspirin and tylenol can be deadly. Side effects are reported when they occur in more than 2% of the population taking a particular medication. Most often they are dosage related or a sensitivity to a particular medication which can be substituted with one which is better tolerated. If you have a condition which warrants taking a psychotropic medication, odds are that you and loved ones around you suffer more from the condition than you ever will from a side effect.

ANTI-PSYCHOTIC DRUGS

ACETOPHENAZINE (TINDAL)		
MESORIDAZINE (SERENTIL)		Side effects include dry mouth, blurred vision, constipation, and drowsiness. Some people taking the medications can experience a difficulty in urinating that ranges from mild problems beginning urination to complete inability to do so, a condition that requires prompt medical attention.
TRIFLUOPERAZINE (STELAZINE)		
THIOTHIXENE (NAVANE)		
RESPERIDONE (RISPERDAL)		
LOXATANE (LOXAPINE)		
CHLORPROMAZINE (THORAZINE)		
HALOPERIDOL (HALDOL)		
THIORAZINE (MELLARIL)		Other side effects include greater risk for sunburn, changes in white blood cell count (with clozapine), low blood pressure when standing or sitting up, akathisia, dystonia, parkinsonism, and tardive dyskinesia.
PIMOZIDE (ORAP)		
MOLIDONE (MOBAN)		
CHLORPROTHIXENE (TARACTAN)		Tardive dyskinesia is one of the most serious side effects of anti-psychotic medications. This condition affects between 20 and 25 percent of persons taking antipsychotic drugs. Tardive dyskinesia causes involuntary muscular movements, and though it can affect any muscle group, it often affects facial muscles. There is no known cure for these involuntary movements (though some drugs, including reserpine and levodopa may help) and tardive dyskinesia may be permanent unless its onset is detected early.
FLUPHENAZINE (PROLIXIN)		
TRIFLUOPERAZINE (STELAZINE)		
PERPHENAZINE (TRILAFON)		
CLOZAPINE (CLOZARIL)		

Anti-psychotic drug list from Kay Peterson/Project Respond/Portland, Or. 7-15-1999

NOTES

PSYCHIATRIC MEDS BY TRADE NAME

CODES:

AA=anti-anxiety
AD=anti-depressant
AD/MAOI=anti-depressant (can be life threatening when mixed with tyramine, eg some alchols & cheeses)
AD/TCA=antidepressant (higher risk of fatal OD)
AP=anti-psychotic
ALZ=for Alzheimers disease
HYP=hypnotics, meds used for sleep
MR=muscle relaxants((not a psych med/may effectbehavior)
MS/AC=mood stabilizers; and /or anticonsulusant
NAR=narcotics,(for pain mgmt, may effect behavior)
SE= meds commonly used for side effects of anti-psychotics
STIM=stimulants

Adaptin	AD	doxepin
Adderall	STIM	dextroamphetamine
Akineton	SE	biperiden
Amytal	SLP	amobarbital
Anafranil	AD/TCA*	clomipramine
Antabuse	Etoh block	disulfiram
Aricept	ALZ	donepezil
Artane	SE	trihexyphenidyl
Ascendin	AD	amoxapine
Atarax	AA	hydroxyzine
Ativan	AA	lorazepam
Aventyl	AD/TCA*	nortriptyline
Benadryl	SE	diphenhydramine
Buspar	AA	buspirone
Centrax	AA	prazepam
Clozaril	AP	clozapine
Cogentin	SE	benztropine
Cognex	ALZ	tacrine
Cylert	STIM	pemoline
Dalmane	HYP	flurazepam
Darvocet	NAR	propoxyphene
Demerol	NAR	meperidine
Depakane	MS/AC	valproic acid
Depakote	MS/AC	valproic acid
Desyrel	AD	trazadone
Dilantin	AC	phenytoin
Dilaudid	NAR	hydromorphone
Effexor	AD	venlafaxine
Elavil	AD/TCA*	amitriptyline
Endep	AD/TCA*	amitriptyline
Equanil	AA	meprobamate
Eskalith	MS	lithium

Floricet	NAR	butalbital with aspirin
Florinal	NAR	butalbital with tylenol
Flexoril	MR	cyclobenzaprene
Halcion	HYP	triazolam
Haldol	AP	haloperidol
Inderal	SE/AA	propranolol
Isoptin	AA/MS	verapamil
Janimine	AD/TCA*	imipramine
Kemadrin	SE	procyclidine
Klonopin	AA	clonazepam
Librium	AA	chlordiazepoxide
Lioresal	MR	baclofen
Lithobid	MS	lithium
Loxitane	AP	loxapine
Ludiomil	AD	maprotiline
Lortabs	NAR	hydrocodone
Luvox	AD	fluvoxamine
Marplan	AD/MAOI	isocarboxazid
Mellaril	AP	thiorazine
Miltown	AA	meprobamate
Moban	AP	molidone
Mysoline	AC	primidone
Nardil	AD/MAOI	phenelzine
Navane	AP	thiothixene
Nembutal	HYP	pentobarbital
Noctec	HYP	chloral hydrate
Norpramin	AD/TCA*	desipramine
Orap	AP	pimozide
Pamelor	AD/TCA*	nortriptyline
paraldehyde	HYP	paraldehyde
Parnate	AD/MAOI	tranycypromine
Paxil	AD	paroxidine *
Percocet	NAR	oxycodone with tylenol
Percodan	NAR	oxycodone with aspirin
Pertofrane	AD/TCA*	desipramine
Placidyl	HYP	ethchlorvynol
Prolixin	AP	fluphenazine
ProSom	HYP	estazolam
Prozac	AD	fluoxetine

Rela	MR	carisoprodol
Remeron	AD	mirtazapine
Restoril	HYP	temazepam
Risperdal	AP	resperidone
Ritalin	STIM	methyphenidate
Robaxin	MR	methocarbamol
Seconal	HYP	secobarbital
Serax	AA	oxazepam
Serentil	AP	mesoridazine
Serzone	AD	nefazodone
Seroquel	AP	quitiapine
Sinequan	AD/TCA*	doxepin
Soma	MR	carisoprodol
Stelazine	AP	trifluoperazine
Surmontil	AD/TCA*	trimipramine
Symmetrel	SE	amantadine
Taractan	AP	chlorprothixene
Tegretol	MS/AC	carbamazepine
Tenormin	SE	atenolol
Thorazine	AP	chlorpromazine
Tindal	AP	acetophenazine
Tofranil	AD/TCA*	imipramine
Tranxene	AA	clorazepate
Trilafon	AP	perphenazine
Tylenol/codeine	NAA	acetominophen with codeine
Tylox	NAA	oxycodone with aspirin
Valium	AA	diazepam
Vistaril	AA	hydroxyzine
Vivactil	AD/TCA*	proptriptyline
Wellbutrin	AD	bupropion
Xanax	AA	alprazolam
Zoloft	AD	sertraline
Zyban	AD	buproprion
Zyprexa	AP	olanzapine

GENERIC NAME	TRADE	TYPE
acetominophen with codeine	Tylenol/codeine	NAR
acetophenazine	Tindal	AP
alprazolam	Xanax	AA
amantadine	Symmetrel	SE
amitriptyline	Elavil	AD/TCA*
amitriptyline	Endep	AD/TCA*
amobarbital	Amytal	SLP
amoxapine	Ascendin	AD
atenolol	Tenormin	SE
baclofen	Lioresal	MR
benztropine	Cogentin	SE
biperiden	Akineton	S
bupropion	Wellbutrin	AD
buproprion	Zyban	AD
buspirone	Buspar	AA
butalbital with aspirin	Fioricet	NAR
butalbital with tylenol	Fiorinal	NAR
carbamazepine	Tegretol	MS/AC
carisoprodol	Rela	MR
carisoprodol	Soma	MR
chloral hydrate	Noctec	HYP
chlordiazepoxide	Librium	AA
chlorpromazine	Thorazine	AP
clomipramine	Anafranil	AD/TCA*
chlorprothixene	Taractan	AP
clozapine	Clozaril	AP
clorazepate	Tranxene	AA
clonazepam	Klonopin	AA
cyclobenzaprene	Flexoril	MR
desipramine	Norpramin	AD/TCA*
desipramine	Pertofrane	AD/TCA*
dextroamphetamine	Adderall	STIM
diazepam	Valium	AA
diphenhydramine	Benadryl	SE
disulfiram	Antabuse	Etoh block
donepezil	Aricept	ALZ
doxepin	Adaptin	AD
doxepin	Sinequan	AD/TCA*
estazolam	ProSom	HYP
ethchlorvynol	Placidyl	HYP
fluoxetine	Prozac	AD
fluphenazine	Prolixin	AP
flurazepam	Dalmane	HYP
fluvoxamine	Luvox	AD
haloperidol	Haldol	AP
hydrocodone	Lortabs	NAR
hydromorphone	Dilaudid	NAR
hydroxyzine	Atarax	AA

hydroxyzine	Vistaril	AA
imipramine	Janimine	AD/TCA*
imipramine	Tofranil	AD/TCA*
isocarboxazid	Marplan	AD/MAOI
lithium	Eskalith	MS
lithium	Lithobid	MS
lorazepam	Ativan	AA
loxapine	Loxitane	AP
maprotiline	Ludiomil	AD
meperidine	Demerol	NAA
meprobamate	Equanil	AA
meprobamate	Miltown	AA
mesoridazine	Serentil	AP
methocarbamol	Robaxin	MA
methyphenidate	Ritalin	STIM
molidone	Moban	AP
mirtazapine	Remeron	AD
nefazodone	Serzone	AD
nortriptyline	Aventyl	AD/TCA*
nortriptyline	Pamelor	AD/TCA*
olanzapine	Zyprexa	AP
oxazepam	Serax	AA
oxycodone with aspirin	Percodan	NAA
oxycodone with aspirin	Tylox	NAA
oxycodone with tylenol	Percocet	NAA
paraldehyde	paraldehyde	HYP
paroxidine	Paxil	AD*
pemoline	Cylert	STIM
pentobarbital	Nembutal	HYP
perphenazine	Trilafon	AP
phenelzine	Nardil	AD/MAOI
phenytoin	Dilantin	AC
pimozide	Orap	AP
prazepam	Centrax	AA
primidone	Mysoline	AC
procyclidine	Kemadrin	SE
propranolol	Inderal	SE/AA
proptriptyline	Vivactil	AD/TCA*
propoxyphene	Darvocet	NAA
quitiapine	Seroquel	AP
risperidone	Risperdal	AP
secobarbital	Seconal	HYP
sertraline	Zoloft	AD
tacrine	Cognex	ALZ
temazepam	Restoril	HYP

thiorazine	Mellaril	AP
thiothixene	Navane	AP
tranycypromine	Parnate	AD/MAOI
trazodone	Desyrel	AD
triazolam	Halcion	HYP
trifluoperazine	Stelazine	AP
trihexyphenidyl	Artane	SE
trimipramine	Surmontil	AD/TCA*
valproic acid	Depakane	MS/AC
valproic acid	Depakote	MS/AC
venlafaxine	Effexor	AD
verapamil	Isoptin	AA/MS

MEDICAL EMERGENCIES include but are not limited to:

Anti-psychotics (AP) may cause a syndrome with muscle rigidity, fever, fast pulse rate, high blood pressure, confusion.

Anti-psychotics (AP) may cause muscle stiffness and tightening, tremors, and effect swallowing.

Tricyclic anti-depressants (AD/TCA*) present a higher risk of lethal overdose, especially if combined with alcohol; if combined with cocaine can produce heart failure.

Antabuse (disulfiram) if combined with alcohol will cause flushing, sweating, headache,palpitations, difficulty breathing, rapid heart beat, drop in blood pressure, nausea & vomiting; may lead to serious drop in blood pressure and death.

Medication-related seizures , a situation which should be evaluated at the hospital.

Certain anti-depressants (AD/MAOI) if combined with alcohol , certain cheeses and other foods containing tyramine will cause blood pressure crisis.

Delirium is a medical emergency, which includes symptoms of irritability, significant distractability, hallucinations,

Meds such as anti-anxiety agents and hypnotics have a higher risk of lethal overdose particularly if combined with alcohol.

OTHER RISKS OF PSYCHIATRIC MEDICATIONS INCLUDE:

Susceptability to sunburn-particularly with certain antipsychotics.

Higher risk of dehydration- particularly with lithium.

Anti-cholinergic side effects , including dry mouth, blurred vision, constipation, difficulty urinating, impotence, constipation.

Many medications can cause allergic reactions as well as unexpected reactions with other medications, foods, alcohol, drugs.

Compiled by Project Respond for the Portland Police Department.

Section 4 - INTERVENTION

- Crisis Cycle
- Intervention in the Crisis Cycle
- Crisis Intervention with Persons with Developmental Disability
- Child and Adolescent Assessment and Intervention
- Suicide Intervention
- Practicum

CRISIS CYCLE

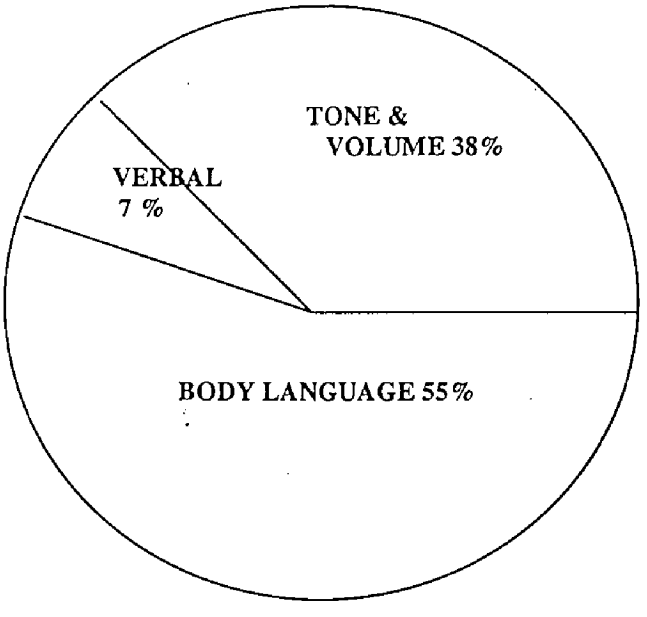
Managing Behavioral Emergencies

As trained crisis intervention specialists, your most likely subjects will be out of control chronically mentally ill persons, angry domestics, suicidal people in public places (bridge jumpers), barricaded individuals, and/or intoxicated persons displaying bizarre behaviors. What do these folks have in common? All will demonstrate some degree of serious impairment in their ability to communicate effectively. This presents a challenge to the police specialist who is attempting to negotiate an alternative to violent behaviors.

One of the few tools that mental health workers have available in dealing with agitated people is the ability to talk down potential assailants. Here are some useful ideas and techniques. The following focus will examine strategies in which you might maximize your ability to deal with agitated people. None of the material in itself is new. The objective for this presentation is to examine principles of applying effective communication techniques to de-escalate agitated persons when possible.

COMMUNICATION

When individuals are highly stressed, non-verbal communication becomes dominant.

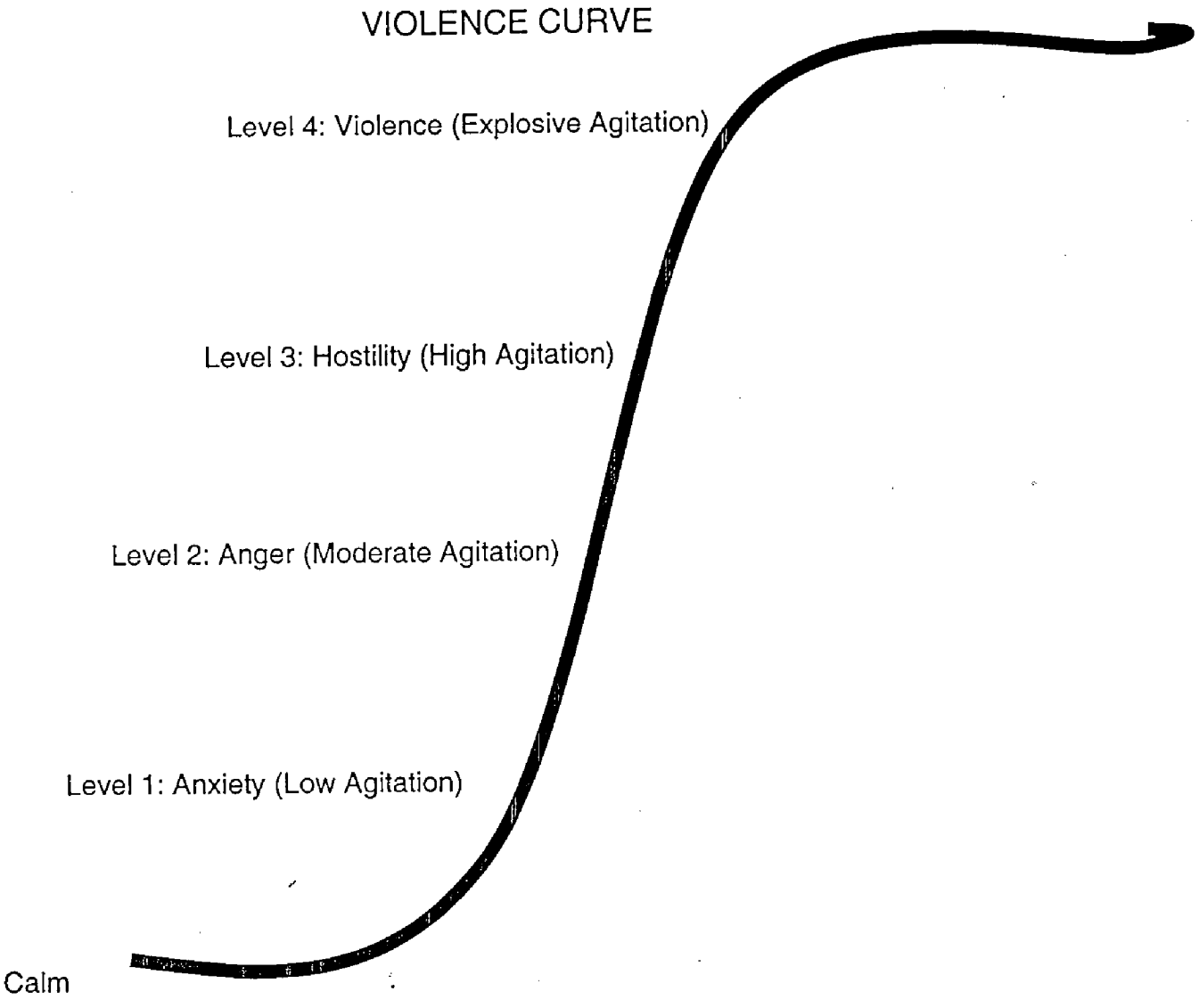


Communication
Communication is a people process. It is an interactive phenomenon, which involves more than words. Messages are often the result of a combination of words, behaviors, and context. Parts of the message are:

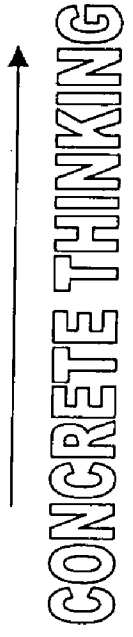
Verbal Components
1. Content
2. Speech
   - Rate productivity
   - Tone
   - Volume
   - Congruency with other messages

Nonverbal Components
1. Stance
2. Gestures – transient movements of the body or face
3. Eye movements
4. Facial expressions
5. Personal attire
6. Motor movements

Factors that influence communication
1. Culture/ Religion
2. Sex roles
3. Social class
4. Perceptions or internal experiences
5. Values



The above violence curve does not take into consideration variables of acute mental illness or intoxicants or both. Behaviors of individuals so affected will be erratic and tend not to follow progressive patterns.



SUSPECT/ PERSON	CIT OFFICER RESPONSE
LEVEL 4: VIOLENCE	ANGER / FEAR
LEVEL 3: HOSTILITY	FEAR
LEVEL 2: ANGER	ANXIETY
LEVEL 1: ANXIETY	EMPATHY
CALM	SUPPORTIVE

Interaction

The escalation of violence chart describes the interaction and dynamic between the subject and officer. Both parties are human beings and are products of their upbringing, social norms, and survival instincts.

During the calm state of the violence chart, the subject is at ease. It is relatively easy to interact with such individuals even if they show perceptual distortions. When the subject shows anxiety as in level 1, it is not difficult to engage the person with a degree of sympathy or empathy. However, once the subject begins to exhibit symptoms of anger as in level 2, the CIT officer will normally experience symptoms of anxiety. When the subject is openly aggressive/abusive as in level 4, anger/fear may be the response.

The problem for both the subject and CIT officer is that as we move up the scale, the ability to effectively communicate diminishes. The subject's tunnel vision increases and thinking becomes more concrete as he/she gets more wound up. The officer likewise becomes more concrete as the stress level increases. The police officer has the additional disadvantage of needing to suspend emotions in order to perform well. Separating out feelings and increasing cerebral activity to

perform a technical function is common amongst emergency service workers. Unfortunately, this approach is counterproductive to the process of communication (which we described earlier as a people process interchange of ideas and feelings). The police officer must somehow bridge the paradox between suspending his/her emotions temporarily while listening for emotional cues in an effort to be effective.

The goal of the police officer in dealing with emotionally charged individuals is to pace and guide them into levels more conducive to mutual interchange. Communication skills for the police officer are like any other technical skill. Training and experience promote access to the skill — especially under emergent conditions.

Level 1: Anxiety
A subjective and uncomfortable emotion, which results from threats to the person. Accompanying feelings are dread and helplessness. The goal is to restore the person's sense of control by providing emotional support and negotiating an alternate action to the crisis.

Physical Attending Skills
- Facing the person squarely.
- Adopting an open posture.
- Leaning towards the person.
- Maintaining direct eye contact.
- Retaining a relaxed posture.
- Promoting a relaxing environment.

Responding Skills
- Emotional labeling
- Paraphrasing
- "I" statements
- Reflection / Mirroring
- Minimal reassurance
- Effective silence
- Open statements

Psychological Attending Skills
- What level of agitation did the patient display?
- What central theme concerned the patient?
- Was there evidence of drugs or alcohol that might interfere with predictability?

Intervention
- Negotiate through active listening

Level 2: Anger

Anger is a feeling state or emotion that serves to neutralize the helpless dread of anxiety. Anger can be functional in that the expression gives the person a sense of power. The danger is that anger can quickly escalate into physical expression or violence.

Angry people become less flexible in their ability to think. That is, they become more concrete as emotions rise. It is easier to understand that which can be touched or seen. Visual (nonverbal) messages become more important during stressful events. During stress periods, your verbal communication is required to be shorter, simpler, and more directive.

You goal is to keep the subject conversing with you and use time and your relationship to de-escalate the agitation.

Three Primary Techniques

1. Diffusing the adversarial emotion by acknowledging the anger. "I can see that you're very angry," or, "I'm sorry you're so upset." This has an impact when people become agitated and more concrete in their thinking because they automatically relate in terms of good or evil. That is, they may see themselves as victims and you as the aggressor. Acknowledging their concerns may serve to personalize and close this ever-increasing gap and provide you with a better chance of continuing an effective way of communicating. Remember, acknowledging the person's concern is not the same as agreeing with their position.

2. Advise giving or providing guidance in choosing a course of action or assuming a new role can help. Keep the advice very here and now, e.g. "you might be more safe on the sidewalk," or, "perhaps we could talk privately."

3. Provide choices. Offer a different course of action (A or B) or, one course of action that the person may choose to do or not (A or not A).

Remember that nonverbal interactions of posture, eye contact, tone, volume and pace are very important in the process of de-escalating the person.

Physical Attending Skills

- Facing the person at a 45-degree angle.
- Adopt an open posture
- Lean in to listen
- Maintain direct eye contact.
- Retain relaxed posture
- Promote a relaxing environment

Responding Skills

- Respect

- Empathy
- Genuineness
- Speech Delivery
- Volume
- Calm Tone
- Productivity — keep dialogue simple.
- Content focus — keep immediate to the key issue.
- Pace speech to slow the person's agitated tempo.

Psychological Attending Skills

- Analysis
- What level of agitation.

Drugs and alcohol

- What central theme concerns the person?
- Can the anger issue be identified?
- What level did you leave the person?

Intervention

- Diffuse the adversarial momentum by affirming the anger.
- Advice giving. Directing to follow your good plan.
- Providing choices. Either A or B. A or –A.

Level 3: Hostility

Hostility is anger with a focused recipient. Hostile people are easy to detect. They are more openly irritable, demanding, argumentative, antagonistic or oppositional. Their voice volume can often be loud and threatening. This is the next stage to violence and must be dealt with caution given the potentially quick transition time. The subject is very concrete and more reliance is placed on the police officer's nonverbal and brief response. The goal is to obtain immediate control of the situation and diffuse to a less agitated (more manageable) stage.

The hostility stage is highly dynamic and the subject may move about displaying varying intensities. Each intervention episode should be less than 60 seconds in duration and often needs to be repeated before successfully diffusing the person/subject to the anger stage.

Four techniques in gaining control of the situation

1. Limit setting: Clearly state the boundaries of behavior that you will allow. "I need for you to lower your voice," "please step outside," "I need for you to leave," "please step back, I'm uncomfortable with you so close." The nonverbal approach is serious, professional, and authoritative. Hand signals are used to communicate. The verbal tone and volume are consistent with

the serious message. Sentences are less than 5 words and repeated rather than elaborated.

2. Diffuse the adversarial stance by acknowledging the anger: Timing is critical. Immediately (microseconds) following limit setting, or "punching a hole" in the defensive tirade. Affirm the individual by acknowledging his/her emotional state. This is a critical test point. If the subject/person accepts ("damn right I'm angry), then continue to dialogue using verbal and nonverbal skills to move to the more manageable Anger Stage. However, if the subject/person continues unabated despite repeated tries, be concerned that the escalation may result in violence.
3. Provide directives: Firmly tell the individual what you want him/her to do.

4. Give Warning: Clearly state as neutrally as possible the consequences of a given course of action.

The approach

1. Dealing with potentially violent people is frightening. You might be as charged as the subject. Try to maintain control by purposely taking deep breaths. Remember that you are going to try and regain control of the situation by communication. It isn't going to impress anyone if you squeak out your directives with residual air.
2. Approach the subject squarely from the side to avoid direct kicks. Keep an open posture (to avoid being perceived as attacking) and keep your hands out of your pockets.
3. Keep approximately two arm lengths distance from person.
4. Do not attempt to communicate by touch.
5. Maintain eye contact and an upright posture in an effort to convey control. Communication is continuous. The eyes coupled with facial gestures may provide advance warning of attack.

The Interaction

1. Do not engage in accusations, arguments, and demands for justification from the subject. This will result in a power struggle, which will prove futile. Winning arguments is not as important as fulfilling the job that you were called on to perform. Do not succumb to their baiting.
2. Work as a team, which may be part of a prearranged set of actions in dealing with emergent situations. Don't get maneuvered into being split apart as good guy, bad guy. "I can't talk to this cop. He's a jerk. I can see that you are a reasonable person. Can we privately discuss my request?"
3. Keep your verbalizations short and simple. Remember that the subject is operating very concretely and will only hear portions of what you will try to verbalize. Repeat your short request as opposed to paraphrasing.
4. Define clear expectations for the subject and communicate these positively and firmly.
5. Limit or address only those behaviors that clearly interfere with the client's welfare or the rights of others.

6. Confine the limits only to those that can be carried out. Empty limits only reinforce the patient's notion that you can not be relied upon. Likewise don't promise that which you cannot deliver. You will only be setting someone else up for potential violence.
7. Practice pat phrases and have them available. Under stress, it is more difficult to be creative. Timing your response is important in disarming an aggressor.

Physical Attending Skills

- Face the person squarely but approach at a 45-degree angle.
- Open posture. Keep your hands out of your pocket.
- Upright Posture. Denotes seriousness and control.
- Relaxed Posture. Denotes lack of intimidation.
- Do not communicate by touch.
- Maintain eye contact — look for advance warning of attack.
- If you point at an object or area, do not take your eyes off the subject.
- Remain two arm lengths away.

Responding Skills

- Genuineness
- Respect
- Speech Delivery
- Volume: Avoid shouting.
- Tone: Confident, assured and serious. Avoid challenging and condescending inflections.
- Rate: Purposely slow to de-escalate.
- Productivity: Keep sentences very short and simple.
- Repeat rather than elongate.
- Content: Here and now. Focus on your directive.
- Do not get "baited" into justifying or arguing.
- Avoid discussions leading to splitting. Confine warnings or promises to those that can be carried out.

Psychological Attending Skills

- Analysis
- What level of agitation?
- Have the person been using drugs and/or alcohol?
- What themes are being presented?
- Any "baiting or key words?
- What level did you leave the person?

Intervention

- Limit setting. Clearly state the boundaries of the behavior you will tolerate.
- Acknowledge the anger and focus.
- Provide directives. Firmly tell the individual what you want him/her to do.
- Warning. Clearly state as neutrally as possible the consequences of his/her behavior.

Level 4: Violence

Response Guidelines

Violence is aggression with a focus on destruction. Violence has injury as its goal. Violence may be verbal (if disruptive or hurtful enough) and/ or physical. The goal is to protect oneself. The goal is not to win but be useful at another time.

The Interaction

- Let your face drain of gestures
- Drop your shoulders indicating relinquishment
- Remain at 45-degrees to the person
- Don't make any sudden moves
- Don't take insults and taunting personally
- Don't be baited
- Do not take your eyes off the patient
- Clearly indicate to the aggressor that you intend to disengage and withdraw, e.g. "I quit, " or" "I'm out of here" messages
- Start moving away towards your escape
- Move slowly and methodically
- Continue your verbal and non-verbal communication to indicate retreat
- You can remain at bay waiting for reinforcements to arrive or totally withdraw.

Active Listening Concepts

Listening for Emotions

People communicate on two levels:

- Content — the simple facts
- Emotions — the emotional reaction to the facts

Train yourself to listen for the emotional message behind the content. Emotional reaction and subsequent behavior make the situation a crisis, not the fact of the situation. How a person feels about a situation will strongly influence what he/she does. Controlling the subject's emotions will help control the subject's behavior.

Listening for Values

- What people think are important
- What people prize

There may be a need to clarify the subject's values. Values influence behavior. The crux of the situation may be a value conflict.

Active Listening Skills

- Emotional labeling
- Paraphrasing
- Reflecting / Mirroring
- Effective pauses (silence)
- Minimal encouragers
- "I" Messages
- Open-ended Questions

Emotional Labeling

- The first active listening skill to be used in an incident.
- The intent of emotion labeling is to respond to the emotions heard in the subject's voice rather than content.
- Demonstrates that you are really listening and tuned into what the subject is emotionally experiencing.
- Do not tell a person how they are feeling, but rather how they *seem* or *sound* like they are feeling to you.
- Do not be afraid to label emotions incorrectly.
- Be aware of missing emotions.
- Listen for conflicts in the feelings expressed.
- Never hesitate: label every emotion you hear.
- Note when the emotions are inappropriate to the situation described.
- Be aware of your emotions and what the subject is hearing from you.
- Use throughout the negotiation / intervention whenever you hear emotions expressed.
- Do not use when you are being verbally attacked.

Emotional Labeling Examples

- You sound _____
- You seem _____
- I hear _____

Paraphrasing

- A summary in your words as to what you were just told.
- Demonstrates you are listening.

- Creates empathy and rapport because it demonstrates you have heard and understand.
- Creates empathy and support.
- Clarifies content, checks perception, and highlights issues.
- Obtains additional intelligence.

Paraphrasing Examples
- Are you telling me...
- Are you saying...

Reflecting / Mirroring
- Repeating back the last word or phrase the subject just said.
- Gives feedback that is very exact.
- Asks for more intelligence without guiding the direction.
- Gets intelligence when you do not have enough to ask a good question.

Effective Pauses (Silence)
- An effective pause is silence.
- Silence is effective if it serves your purpose.
- Most people are not comfortable with silence and will fill it with talk.

Uses of Silence
- When you are about to say something important.
- When you have just said something important.
- When the subject is trying to "psych" you out.

Minimal Encourages
- The sounds you make, especially on the telephone, to let the other person now you are present and listening.
- May be short questions such as: "really?", "Oh?", "When?"
- Does not interfere with the flow of the conversation.
- Lets the subject know you are present and listening.

Uses of Minimal Encouragers
- Helps build rapport.
- Encourages the subject to continue talking.

"I" Messages
- Enables us to let the subject know how they are making us feel, why we feel that way, and what they can do to remedy the situation.
- Conveys the above information in a non-threatening way and does not put the subject on the defensive.

Uses of an "I" Message

- When communication is difficult because of the intense emotions being directed at you.
- When the subject is making communication impossible.
- When you need to refocus the subject.
- When you are being verbally attacked.

Examples of "I" Messages

- I feel _____(emotion or feeling)
- When you_____(his/her behavior)
- Because _____(your reason)

Open-Ended Questions

- Questions that cannot be answered with a "yes" or a "no."
- To obtain information without asking a lot of questions.
- Usually begins with the words: how, what, when, where.

Uses of Open-Ended Questions

- To help a subject start talking.
- To elicit examples of specific behavior.
- To obtain additional intelligence.
- To focus on the subject's feelings.

Problems Caused by Closed-Ended Questions

- Gives a feeling of interrogation, which makes rapport difficult to build.
- Causes you to work harder thinking up new questions.

NOTES

INTERVENTION IN THE CRISIS CYCLE

INTERVENTION

A. APPROACHING THE SCENE

1. Calls
2. Information before you arrive
3. Monitor your own emotional state
4. Leave prejudices/bias/predisposition behind

B. ON THE SCENE

1. Assess the situation and stabilize, if necessary

C. CRISIS INTERVENTION

1. Crisis cycle
   - a. Intervention at each stage of the cycle
   - b. Different levels of understanding, perception and development at each stage
     - (1) Look at face, voice and posture for signs of what level
   - c. Stages of cycle
     - (1) Normal state
       - (a) 100% perception and ability to reason
       - (b) Acts as an adult
       - (c) Person experiences no emotional content
       - (d) Officer is calm
       - (e) Can problem solve
     - (2) Stimulation (internal/external)
       - (a) 50-75% perception and ability to reason/understand
         - 1) Agitated behavior
       - (b) Acts as a teenager
       - (c) Person experiences anxiety
       - (d) Officer is calm
       - (e) Action officer should take
         - 1) Use simple sentences
         - 2) Use calming body language
         - 3) Keep voice low and calm
     - (3) Escalation
       - (a) 5-24% perception and ability to reason/understand
         - 1) Loud, aggressive, flushed
       - (b) Acts as an 8-year old having a tantrum
       - (c) Person experiences fear; frustration
       - (d) Officer is anxious
       - (e) Actions officer should take
         - 1) Use sentences of less than 5 words
         - 2) Make one immediate request
         - 3) Repeat continually
         - 4) Body language and voice firm but calm
     - (4) Crisis
       - (a) 0-5% perception and ability to reason/understand
         - 1) Out of control

(b) Acts like "terrible two's"
(c) Person experiences anger
(d) Officer is fearful/frustrated
(e) Actions officer should take
1) Use firm, one sentence commands
2) Repeat continually
3) Make decision regarding use of physical force

(5) De-escalation
(a) As consumer de-escalates, officer uses the same techniques down the de-escalation
(b) Consumer may suffer post-crisis depression
(c) Escalation can cycle up and down

(6) Things to remember
(a) Take your time
1) Person cannot remain in crisis state forever
(b) Constantly read feedback from consumer
(c) Stop doing anything that escalates the consumer
(d) Continue anything that de-escalates the consumer

(e) Have only one officer talk to the consumer at a time
1) Trade off if not effective

2. Communication skills

a. Verbal skills

(1) Tell person you are there to help
(2) Introduce self by first name
(3) Ask and use their name
(4) Do not involve yourself in their delusions; show you understand that they believe it is really happening
(5) Ask clarifying questions in terms of "I" statements
(a) "I don't understand this"
(b) "I'm afraid you'll hurt yourself"
(c) "I can't figure out why"

(6) Use personalized statements
(a) "Your holding that rock makes me nervous"

(7) Do not argue
(8) Actively listen
(a) Do not be afraid of silence
(b) Wait for responses
(c) Echo their feelings "You seem to be angry"

(9) Show concern and understanding
(a) Nod head while they are talking; indicate listening with "I see", "Uh, huh", etc.

(10) Treat person with respect
(11) Do not use offensive terms or sarcastic remarks
(12) Tell people what you are going to do
(a) Do not make promise you cannot keep

(13) If person becomes agitated, change subject

b. Non-verbal skills
    (1) Feedback loop
        (a) Watch reactions of consumer to you
        (b) Stop action if escalates consumer
    (2) Open body language
        (a) Rule of palms
            1) Palms open
        (b) Stand slightly to the side/bladed
        (c) Take safe, but not defensive stance
            1) More relaxed posture
            2) Head tilted
            3) Be ready/appear relaxed
        (d) Keep hands off paraphernalia
    (3) Eye contact
        (a) Try to make eye contact
            1) Some people like it as sign of personal contact
            2) May make some people nervous
        (b) Try to remain at eye level
    (4) Body space
        (a) Rule of 3
            1) Remain 3 arms length away at first contact
        (b) May need to move in to establish personal contact
    (5) Move slowly
        (a) Announce action to consumer
c. Questions to ask
    (1) Ask what is happening that caused crisis
    (2) Ask about past history
        (a) Case worker
        (b) Counselor
        (c) Treatment
    (3) Ask how they resolved similar situations in past
    (4) Ask what clinic they go to or where they go for treatment
    (5) Ask if they are taking medication(s)
    (6) Ask the names of their medication(s)
    (7) Ask if they would like to see a doctor
    (8) Ask if they are thinking of taking their own life
        (a) How
        (b) Do they have the means (gun, knife, pills)
        (c) Have they ever tried it before
    (9) Ask if they are hearing voices
        (a) Are they telling you to do something
d. Officer safety reminders
    (1) Never deny the possibility of violence
        (a) Persons with mental illness are not more violent than the "normal" population but may be more unpredictable
    (2) If hearing voices, ask what the voices are saying

(3) Keep relaxed approach, but not complacent
(4) Watch consumer's hands
(5) Upon transport, always handcuff even if this risks re-exciting the subject; tell the person what you are going to do and why

Fear

A perceived need (sometimes irrational) to escape, defend against, or eliminate a perceived threat of personal injury.

Visual signals

Posture: Tense and prepared to defend, hide or run away.

Skin color: Pale or ashen.

Facial expression: Wide-eyed and fearful.

Auditory signals

Voice quality: Whining, pleading, gasping, bursts of speech, may be unable to speak.

Breathing: Rapid, shallow, irregular.

Confirming history

Personal history of abuse / victimization and/or withdrawal, sometimes punctuated by assaultive outbursts.

Crisis Intervention for: Fear

Goal: **Threat Reduction**

The basic assumption is that communication patterns that reduce the perceived threat will also reduce the probability that the assault will escalate to battery. Conversely, communication patterns that add to the perceived threat can be expected to increase the probability of battery. Here are some guidelines for reducing threat:

Posture: relaxed and open; hands in full view

Gestures: slow, palms-up

Position: slightly off to the side of the fearful client, and far enough away (8-10 feet, if possible) to make it clear that an attack on the client is not being planned.

- positions directly in front of, or any position behind a frightened person can be expected to increase the perceived threat
- positions at or below the eye level of the frightened person can be expected to reduce the perceived threat

Voice quality: firm, reassuring, confident

Speech content: logical, encouraging calm reflection; promising to help if possible, but not promising something that is not possible

Eye contact: if the frightened person seems to seek eye contact as an additional source of reassurance, it should be given freely; if the frightened person tries to avoid eye contact it should not be forced on them. There are many cultures that discourage or limit communication through eye contact.

Physical contact: some frightened people (particularly children) need to have reassurance communicated through touch. Touch should be "offered", not given without permission, and should be light with slow movements.

Frustration

An irrational attempt to gain control by physically attacking the source of frustration.

Visual signals

Posture: Tense and prepared to attack.

Skin color: Tones of purple or red; splotches.

Facial expression: Tense, focused, and angry.

Auditory signals

Voice quality: Menacing, aggressive, loud.

Breathing: Loud, deep, long, heavy.

Confirming history

History of low frustration tolerance, coupled with impulsiveness.

Crisis Intervention for: Frustration

Goal: Control

The basic assumption is that patterns of communication that demonstrate and "lend" control will contribute to the restoration of the internal control of the frustrated client. Conversely, communication that demonstrates loss of control will likely increase the probability that the frustrated person will lose their ability to control an impulse to attack. Here are some guidelines for exerting control:

Posture: self-confident, commanding

Gestures: firm, commanding, palms out or down

Position: directly in front of the frustrated client, and just outside of his/her striking range.

- A position within striking distance of a frustrated person communicates a challenge or a desire to fight.
- A position well outside of striking distance of a frustrated person communicates undue caution or fear, and unwittingly points out vulnerability and willingness to be a target for release of frustration.

Voice quality: quiet, firm, commanding in tones low enough to make the frustrated person strain to hear

Speech content: repetitive, confident commands without threat

Eye contact: direct and accompanied by facial expressions which indicate that a firm command is being given.

Physical contact: if physical contact is required to prevent the frustrated person from escalating from assault to battery, it should be made firmly but without excessive movement or pain that would indicate loss of control.

Manipulation

An indirect attempt to obtain or avoid something in exchange for not losing emotional control. Manipulation becomes dangerous when assault is used as a tool in the attempt. Remember: Beneath every manipulative demand there is a legitimate request. Manipulation can take a variety of forms, including:

The temper tantrum

In this case the manipulating person starts by making a calm, but unreasonable (given the circumstances) request. When the persons' requests / demands are not met, they threaten violence by appearing to lose control: yelling, banging, stomping, etc.

Playing the numbers

In this case the manipulating person attempts to "play" people against each other, hoping that in the confusion their request / demand will be met. Group care settings provide an abundance of opportunities for this form of manipulation.

Promoting confusion

In this case the manipulating person brings in related, but irrelevant, matters into the discussion, leaving the professional wondering what the client really wants, or how the issues being raised by the person relate to the request / demand being made.

Visual and auditory signals

Although the signals are often difficult to interpret at any particular moment, there is a definite and recognizable pattern :

- The initial set of signals often occur in a whining voice, usually with a "gimme" attached, and with the affect of a pitiable victim.
- If that doesn't work, the next step is a series of marginally related accusations, comparisons, and other trivia, uttered in more aggressive tones.
- If that doesn't work, the next step is threats and actions against property.
- Finally, when all else has failed, assault is attempted.

Confirming history

A history of losing control or attacking physically when feeling deprived or oppressed.

Crisis Intervention for: Manipulation

Goal: Detachment

The basic assumption is that communication patterns that tend to indicate refusal to become involved in manipulation will decrease the likelihood that the manipulative person will attempt to gain something through complete loss of control resulting in battery. Conversely, communication that indicates openness to the manipulative demand increases the belief that the demand will be met at the next higher level of loss of control. Here are some guidelines for detaching yourself from a manipulative game:

Posture: closed, relaxed

Gestures: idiosyncratic gestures of disapproval or mild irritation (toe or finger tapping, eye rolling, "disgusted" sighing and nodding, arm folding, etc.)

Position: close enough to physically intervene if necessary, but far enough away to show non-involvement (4-5 feet)

- turning slightly away to show non-involvement is appropriate, but do not turn your back

Voice quality: detached, mechanical, slightly bored

Speech content: quiet, repetitive, "broken record" commands

Eye contact: avoid eye contact by looking at the hairline, chin, shoulders, etc.

Physical contact: if physical contact with the person who is manipulating becomes necessary, it should be handled as quickly and unemotionally as possible. Try to make contact with clothing only, not flesh. Punitive and vengeful forcefulness should be avoided, since it will add to the belief that the manipulation could have been successful if it had been done differently.

Intimidation

A calculated attempt to get something in exchange for physical safety or freedom from the threat of injury. "Don't make me hurt you" is the flavor of the message you get from many of the people who intimidate.

Visual and auditory signals

Basically neutral or unremarkable, with the exception of a menacing voice quality and/or threatening words and posture. Often people who are attempting to intimidate use physical menacing / crowding (standing very close to or over the person being intimidated) as a way to threaten danger.

As in manipulation, there is a definite and recognizable pattern of change in signals:

- First, there is a clear and often strongly stated demand.
- If the demand isn't met, this is followed by a believable threat of physical injury coupled with a reminder that injury can be avoided by complying with the demand.
- Finally, refusal to comply or delay in complying is followed by the attempt to injure through assault.

While we often respond to attempts to manipulate with annoyance and irritation ("here we go again", or "give me a break"), we often respond to intimidation with fear and a belief that we might really get hurt!

Confirming history

A history of bullying, extortion, and other criminal assault.

Note: This form of assaultive behavior is often used by persons diagnosed as "anti-social personalities" or "sociopaths".

PRECAUTIONS (DON'TS)

REMEMBER, DON'T:

1. Deny the possibility of violence when early signs of agitation are first noticed.
2. Underestimate information given by others regarding behavioral clues.
3. Engage in behaviors that can be interpreted as aggressive.
4. Allow others to interact simultaneously while you are attempting to talk.
5. Make promise you can not keep.
6. Allow feelings of fear, anger, or hostility to interfere with self control and professional demeanor.
7. Argue, give orders, or disagree unless absolutely necessary.
8. Be placating by giving in and agreeing to all the real and imagined ills of the person.
9. Become condescending by using cynical, sarcastic, or satirical remarks.
10. Let your own importance be acted out in a know-it-all manner.
11. Raise your voice, put a sharp edge, or use threats to gain compliance.
12. Mumble, speak hesitantly, or use a tone so low that you can't be understood.
13. Argue over small points.
14. Attempt to reason with anyone under the influence of a mind altering substance.
15. Attempt to gain compliance based on the assumption that the person is as reasonable about things as you are.
16. Allow a crowd to congregate.
17. Corner, or be cornered: give the person expanded space.
18. Ask why?
19. Deny the opportunity to save face.
20. Rush, be rushed, or lose your own cool!

RESOLVING CRISIS

02/09/95

1. INTRODUCE YOURSELF. PERSONALIZE CONTACT. "MY NAME IS JOHN. WHAT'S YOURS?"

2. USE A CALM VOICE.

3. UTILIZE RELAXED BODY LANGUAGE.

4. TELL PERSON YOU ARE THERE TO HELP THEM.

5. AVOID ARGUING.

6. SHOW GENUINE CONCERN BY ASKING MANY QUESTIONS.

7. ASK THE PERSON WHAT IS HAPPENING RIGHT NOW TO CAUSE THIS CRISIS.

8. ACTIVELY LISTEN. REPEAT BACK WHAT YOU HEAR THE PERSON COMMUNICATING ABOUT THEIR FEELINGS. REPORT BACK TO THE SUBJECT THE EMOTION YOU THINK THEY ARE FEELING. "YOU'RE FEELING ANGRY." "YOU'RE FEELING ANXIOUS." "YOU'RE FEELING FRIGHTENED."

9. ASK THE PERSON ABOUT HIS OR HER PAST HISTORY OF CRISIS.

10. ASK THE PERSON HOW THEY HAVE RESOLVED CRISIS IN THE PAST.

11. ASK ABOUT FRIENDS, RELATIVES, COUNSELORS, CASEWORKERS OR OTHER POSSIBLE SUPPORT PEOPLE.

12. OBSERVE THE SUBJECTS BODY LANGUAGE.

13. IF THE PERSON BECOMES MORE AGITATED CHANGE THE SUBJECT.

14. STATE CLARIFYING QUESTIONS IN TERMS OF THE OFFICER HAVING A PROBLEM:

"I DON'T UNDERSTAND THIS . . . "
"THAT ROCK IN YOUR HAND MAKES ME NERVOUS."
"I'M AFRAID YOU'LL HURT YOURSELF."
"I CAN'T FIGURE OUT WHY . . . "

15. GIVE INFORMATION. EXPLORE OPTIONS WITH SUBJECT.

16. TREAT PEOPLE WITH RESPECT.

17. TELL THE PERSON WHAT YOU ARE GOING TO DO TO HELP THEM.

18. ALWAYS KEEP YOUR WORD.

THE RULES

1- THE RULE OF TIME

2- THE RULE OF THREE

3- THE RULE OF FIVE

4- THE RULE OF PALMS

5- THE RULE OF ECHOS

6- THE RULE OF CALM

CRISIS INTERVENTION WITH PERSONS WITH DEVELOPMENTAL DISABILITY

NOTES

Course Title: The Crisis Cycle

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 4:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To introduce the crisis cycle as a model for understanding the stages of crisis. Implications for interventions will be discussed.

Performance Objectives:

1. The officer will be able to identify the stages that a person goes through when in crisis.

2. The officer will be able to identify and list typical emotional responses of officers intervening in crisis.

3. The officer will identify the language comprehension levels accompanying crisis stages and the implications for intervention.

Course Outline:

The Crisis Cycle: the emotional and behavioral stages people experience when in crisis (Oregon Intervention System model

0. Normal State
1. Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post-crisis depletion
6. Stabilization

The Escalation Grid (Basic Psychiatric Life Support Model)

1. Anxiety
2. Anger
3. Hostility
4. Aggression

How the Crisis Cycle and the Grid fit together

1. Emotional and behavioral interactions
2. Two crisis cycles juxtaposed
3. The Grid- typical responses of professional interveners

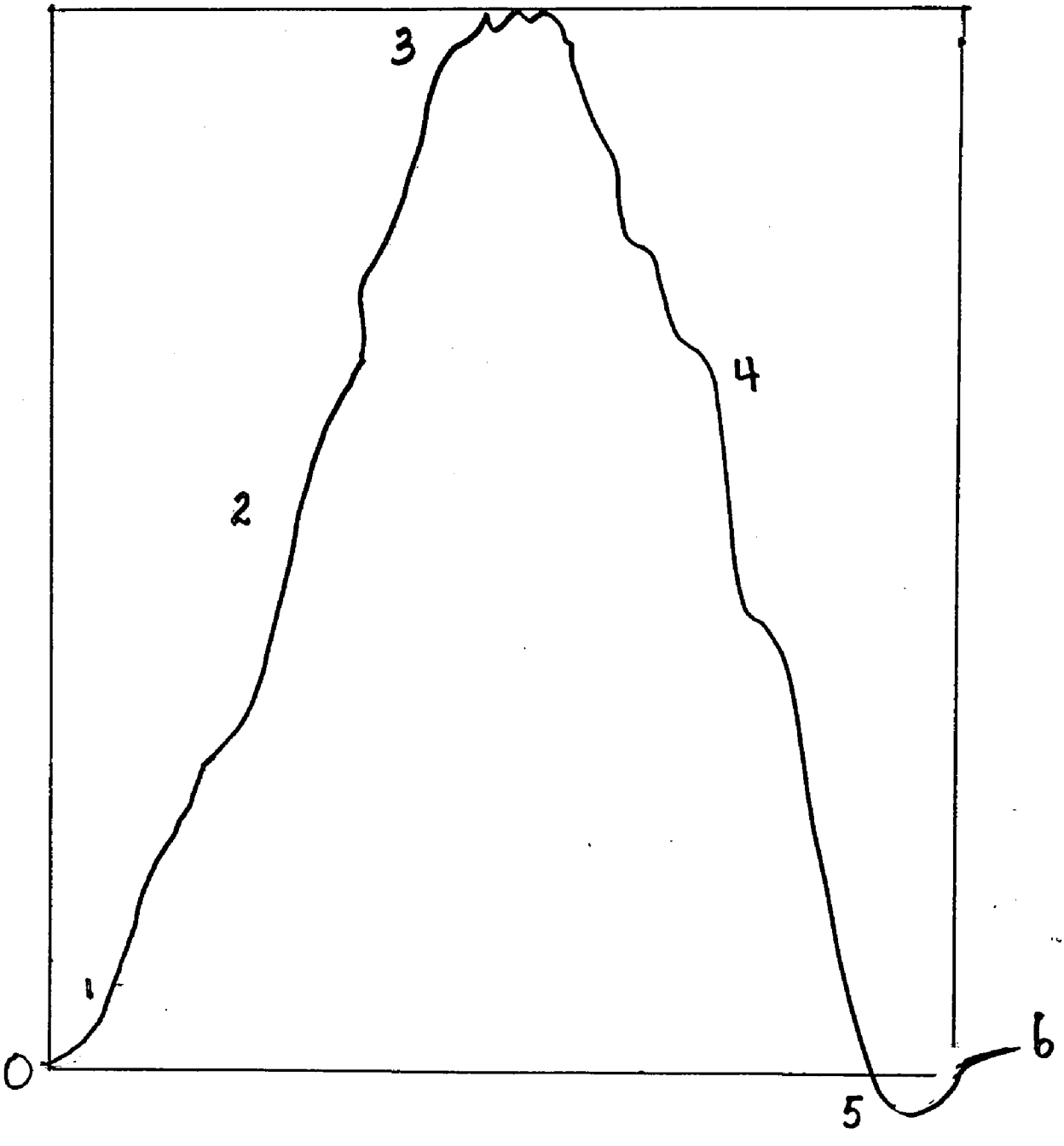
A. Anxiety- calm
B. Anger- anxiety
C. Hostility- anger
D. Aggression- fear

4. Recognizing your own responses
5. Setting aside your own responses

The effect of emotional state on communication

1. Comprehension decreases as control decreases
2. Implication for intervention strategies
   A. "adult", "adolescent", "child", "terrible 2"
   B. Simplify language
   C. Become more concrete

The Crisis Cycle



0 - Normal State
1 - Stimulation
2. Escalation
3. Crisis
4. De-escalation
5. Post crisis depletion
6. Stabilization

CRISIS CYCLE

0. Normal state.

1. Stimulation

Something has happened to cause the person to become:

Excited or
Active or
Upset or
Physically uncomfortable

Cause can be external or internal or both.

External
Something someone else said or did.
Environment: hot, cold, crowded.

Internal
Physical illness, injury or pain.
Emotional upset
Mental illness: mood disorders, hallucinations.

2. Escalation

Obvious signs of distress.
Observable physical changes and changes in behavior. (if you don't know the person, it may be hard to know what is a change)

Examples:
Red face
Tense muscles (tight face, clenched fists)
Talking more or louder. (some get quiet/withdrawn)
-Increased activity : Pacing, rocking, etc.

3. Crisis

Out of control.
May scream, yell, curse.
May wave arms or stamp feet.
May assault.

4. De- escalation

Gradual decrease in crisis behavior.
Still tense.
If provoked, can go back into Crisis.

5. Stabilization.

Back to normal behavior.
Under control.

6. Post-crisis drain.

May drop below normal level.
More likely if Crisis phase long or physical.
Quiet, withdrawn, tired.
May express regret of actions, may cry.

EVERYONE GOES THROUGH CYCLE WHEN UPSET.

NOT EVERYONE GOES ALL THE WAY UP.

YOU MAY COME INTO A PERSON'S CRISIS CYCLE AT ANY PHASE

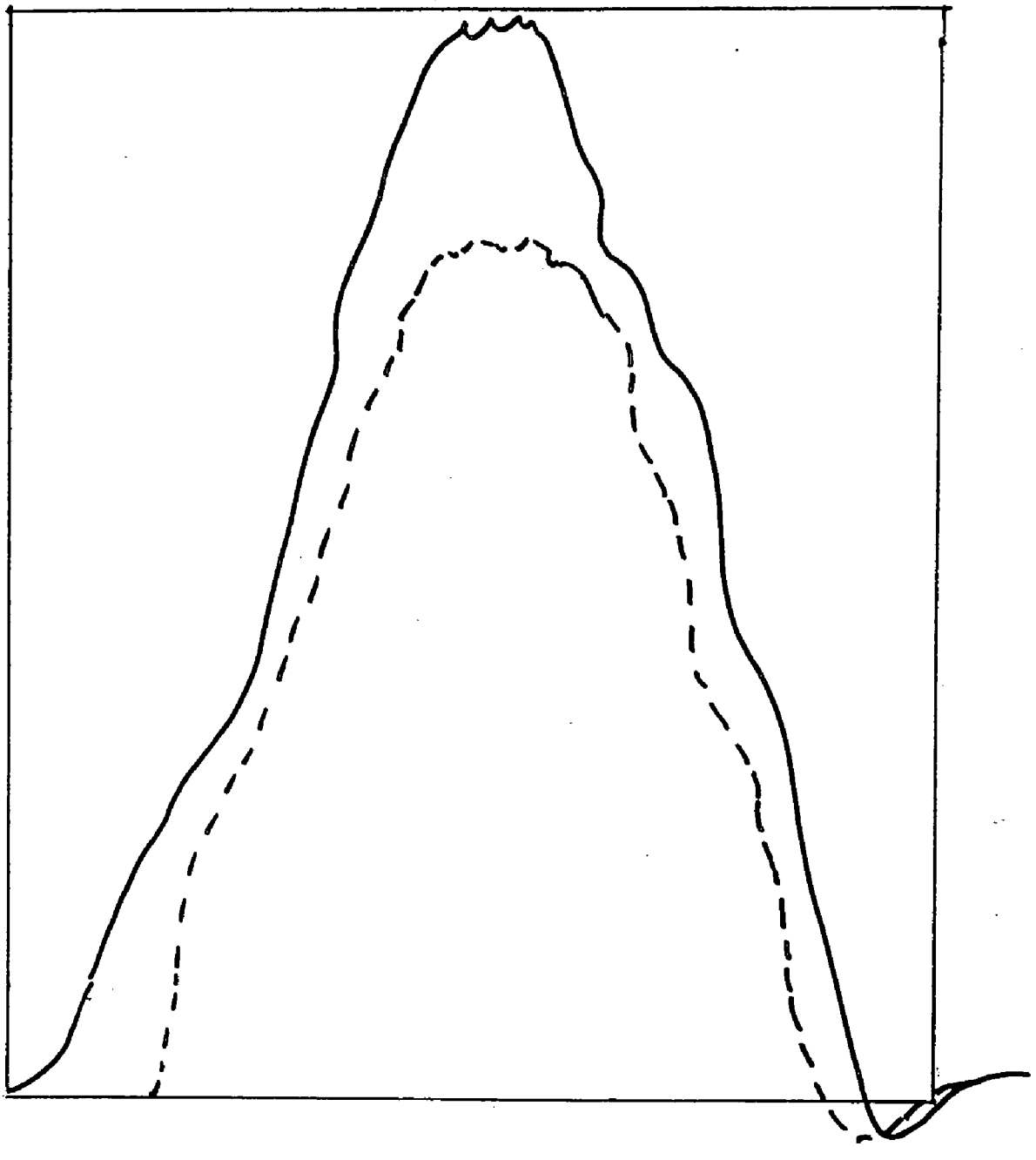
CYCLE CAN VARY IN LENGTH/INTENSITY/DETAILS.

Basic Psychiatric Life Support Model

Patient State

Aggression "terrible 2" undirected uncontrolled
Hostility "child" directed dyscontrol
Anger "adolescent" increased distress
Anxiety "adult" fullycontained

Two crisis cycles juxtaposed



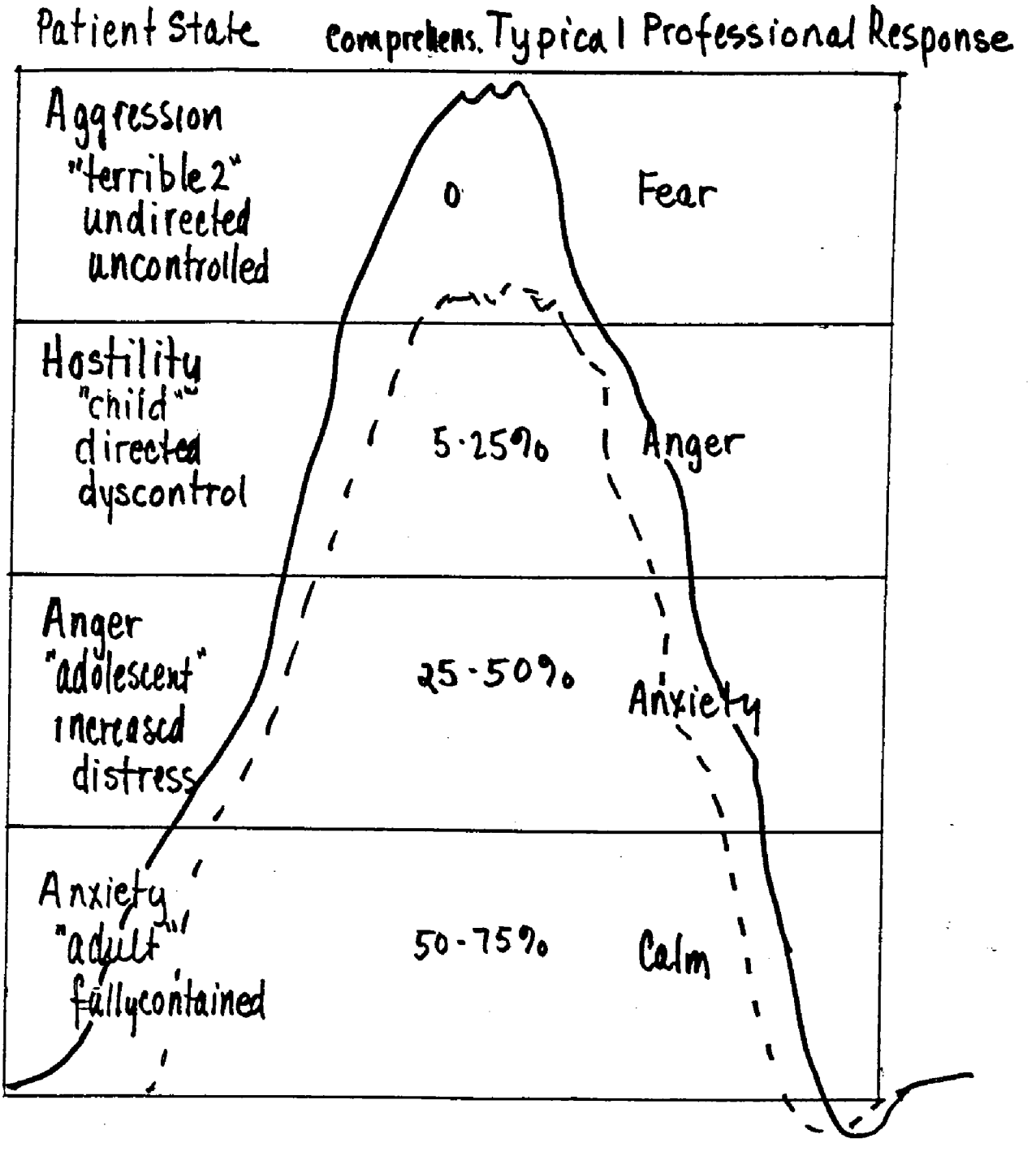
Basic Psychiatric Life Support Model

Patient State	Typical Professional Response
Aggression "terrible 2" undirected uncontrolled	Fear
Hostility "child" directed dyscontrol	Anger
Anger "adolescent" increased distress	Anxiety
Anxiety "adult" fully contained	Calm

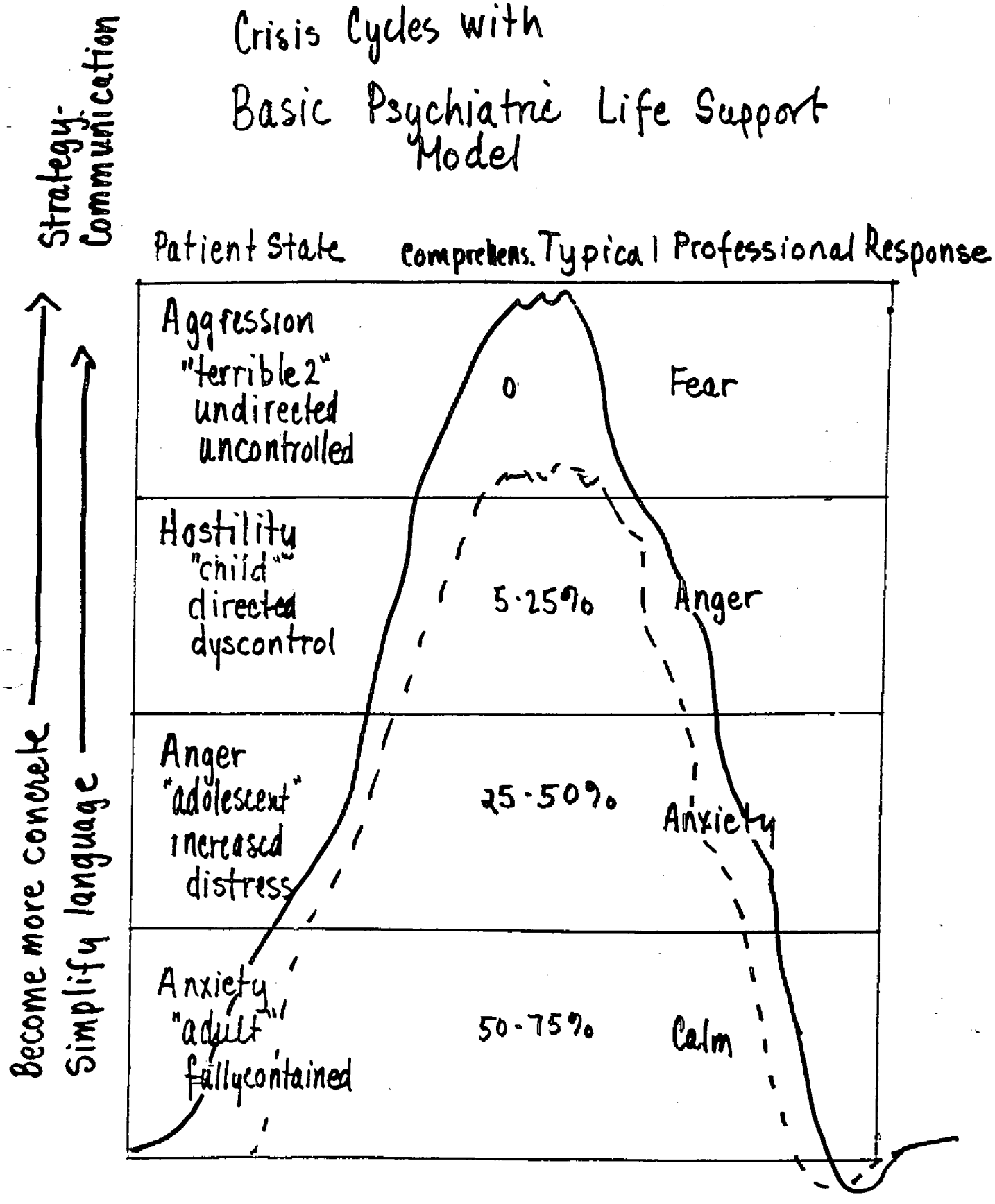
Basic Psychiatric Life Support Model

Patient State	% comprehension
Aggression "terrible 2" undirected uncontrolled	0-5%
Hostility "child" directed dyscontrol	5-25%
Anger "adolescent" increased distress	25-50%
Anxiety "adult" fully contained	50-75%

Crisis Cycles with Basic Psychiatric Life Support Model



Crisis Cycles with Basic Psychiatric Life Support Model



Course Title: Mental Retardation and Developmental Disabilities: Basics For Police Officers

Instructor: Lee Greer, Case Manager/Behavior Specialist
Multnomah County Developmental Disabilities Services Division

Date/Time: May 15, 2000, 3:00 PM

Audience: Crisis Intervention Team Officers

Course Goals: To familiarize officers with characteristics of individuals with developmental disabilities, and how these characteristics may affect officer interactions with individuals.

Performance Objectives:

The officer will demonstrate knowledge of what mental retardation is and distinguish it from mental illness

The officer will be able to identify some characteristics of persons with mental retardation in each of the following areas: communication, interaction, judgement/knowledge; performance abilities.

The officer will be able to list some implications of the above characteristics in managing interactions with victims, suspects, and witnesses.

The officer will demonstrate knowledge of how to identify paid or unpaid helpers of a person with a developmental disability.

Course Outline:

Definitions

1. Mental retardation
2. Developmental disability
3. Distinguishing mental retardation from mental illness
4. Other disabilities that affect cognitive functioning

Some characteristics of individuals with mental retardation

A. Recognition of disability/managing the encounter
B. Wide individual variation in each area.
   C. Communication issues
   D. Interaction issues
   E. Judgement/knowledge isssues
   F. Performance abilities

G. Effects of the system

Implications of characteristics

Finding out if there is someone who can help

1. Who are the players?
2. What questions can you ask to get useful information?

WHAT ARE MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES?

Definitions. There are many different definitions of mental retardation and developmental disabilities. Agencies typically have their own complex definitions, which may differ from agency to agency. The definitions below are "unofficial.

Mental Retardation. Intellectual functioning that is significantly below average, along with substantial limitations in adaptive behavior (for example, ability to independently perform activities of daily living or function in society.) Mental retardation originates during the developmental period (before 18 in most definitions) and is likely to be lifelong. Generally, a person who has an I.Q. score of 70 or lower is considered to have mental retardation.

Note about terminology: many people do not like to have the term "mental retardation" applied to them, because of unpleasant history or associations. Some prefer the term "developmental disability" or "cognitive disability". Some refer to themselves as "slow" or a "slow learner".

Developmental Disability. This is a broader term than mental retardation. A developmental disability is a disability caused by a neurological condition. It originates during the developmental period, it is likely to be lifelong, and it requires training and support similar to that needed by a person with mental retardation. Besides mental retardation, common causes of developmental disability are cerebral palsy, epilepsy, and autism. **Cerebral palsy** is a catchall term for a variety of disorders that affect a persons ability to move and to maintain posture and balance. Walking ability and speech are often affected. **Epilepsy**, also called seizure disorder, is a condition that causes seizures of various kinds. Some seizures cause a person to fall, lose consciousness, and have jerking movements of the whole body for several minutes. Others cause involuntary movements of a part of the body without loss of consciousness, and still others cause a brief loss of consciousness without falling. Mild forms of cerebral palsy or epilepsy are not considered developmental disabilities under the above definition. **Autism** is a severe developmental disability affecting communication, social interaction, and behavior.

Mental Illness vs. Mental Retardation. Mental retardation/ developmental disability is not the same as mental illness. Hallucinations and delusions are characteristic of some mental illnesses; they are not characteristic of MR/DD. Neither are mania or depression characteristic of mental retardation. A person with mental retardation can be expected to act rationally at their functional level. However, a person with mental retardation or another developmental disability may also have an additional disability such as a mental illness or a drug or alcohol addiction.

Other Disabilities. There are other disabilities and health conditions which affect cognitive (intellectual) functioning and which therefore may be confused with mental retardation. A disability from head injury to an adult is not mental retardation, nor is dementia from conditions such as Alzheimers or late stage alcoholism. A person who has recently had a seizure may have a short period of impaired functioning which may be mistaken for mental retardation.

Institutionalization. In the past, many individuals with developmental disabilities, even those with mild mental retardation were routinely institutionalized. Beginning in the late 1960's, it began to be generally understood that people with developmental disabilities had the right and the ability to live in the community. Programs such as group homes and semi-independent living programs were established to provide training and support in the community and people began coming out of institutions in increasing numbers. However, some people were discharged without appropriate

Do you want to call them now?
Is it OK if I call them?

If you are at a group home or foster home(or other situation in which someone seems to be in a staff role) in a crisis, and the staff seems to be unsure what to do:

Ask: Do you have someone you can call to help you in a crisis?
In a foster home there may not be anyone. In a group home or supported living situation, there should always be a way to contact administrators in an emergency.

SOME SUGGESTIONS FOR COMMUNICATING WITH A PERSON WHO HAS MENTAL RETARDATION

- Keep language simple, but not childish.
- Avoid abstractions or technicalities. Be concrete.
- Avoid yes/no questions, or questions that suggest the answer you expect.
- When you give instructions:
  - Give one at a time
  - Be clear and direct
  - Be sure the person understood. One way to do this is to ask them to repeat it back.
- Don't talk to others in front of the person, as if the person wasn't there.
- If the person has any reading/writing ability, write down simple reminders if they need to do something later. Ask if they have a calendar you can write it on.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

supports and others lost supports for budgetary or other reasons. The movement to "deinstitutionalize" people continues to the present. Today, Fairview and Eastern Oregon Training Centers are still in operation, but they are much smaller than they were in the past.

Being institutionalized affects people seriously. A history of being in an institution sometimes helps explain behaviors that are otherwise hard to understand. Usually the younger the person went into the institution, and the longer they remained, the more serious the effect. In an institution, people are deprived of the opportunity to learn what it's like to live in a regular family and community, and so it is much harder for them to develop appropriate social skills. They have limited opportunity to develop normal human relationships, and little modeling of how people act in normal situations. To survive, some people learned to comply with anyone who acted as if they were in a position of authority. The lack of privacy caused some not to have regard for their own privacy or that of others. For some, the lack of respect for their personal property taught them that if they valued something they needed to carry or wear it or it would be taken. People had few choices and little control over their own lives. Many people were sexually or physically abused by other residents or by staff, and they have the same kinds of problems other sexual abuse survivors have. These can include low self esteem, sexual acting out, lack of trust in others, Post Traumatic Stress Disorder and depression.

Some of the above materials were adapted from training materials developed by the Multnomah County Police/DD Committee for the Portland Police Bureau.

Materials Prepared by
Lee Greer
Multnomah County Developmental Disabilities Services Division
5/00

SOME CHARACTERISTICS OF INDIVIDUALS WITH MENTAL RETARDATION: IMPLICATIONS FOR LAW ENFORCEMENT

In order to successfully manage an encounter with a person with mental retardation, whether a victim, suspect, or witness, it is important for the officer to recognize the disability. Recognizing the disability and managing the encounter are often one and the same.

Each person with mental retardation is an individual. People with the same measured I.Q., whether they have mental retardation or not, vary widely in their skills, interests, personality and communication style. Listed below are some characteristics that may be more likely to occur in a person with mental retardation. There won't be anyone for whom all (or even most) of these factors apply. For some individuals with mental retardation few or none will apply.

Communication issues

- Does not communicate at the level of typical persons of the same age group
- Limited vocabulary or limited grammatical skills
- Speech defect
- Unable to read or write or limited ability
- Difficulty understanding questions
- Difficulty answering questions; may give "standard" or "parrotted" responses
- Appears to understand when they do not, may not want to admit lack of understanding
- Fails to comply with rules; this may be due to lack of understanding

Interaction issues

- An excessive desire to please others
- Behavior on a level below the person's age
- Crowding personal space when interacting with others
- Tendency to be overwhelmed by authority
- Becomes hostile or withdrawn rather than admit lack of understanding
- Low frustration tolerance

Judgement/knowledge issues

- Does not fully understand seriousness of situations
- Limited safety awareness; may be easily victimized
- Judgements regarding "friends" are the most difficult
- Easily persuaded or influenced by others
- Lack knowledge on how to protect themselves

Performance abilities. May be limited in some of these areas:

- Reading and writing
- Using the telephone
- Understanding finances
- Making change
- Understanding need to budget to cover living expenses
- May give away money or belongings
- Following complicated directions

- Telling time
- Keeping appointments
- Managing activities of daily living , such as hygiene, housekeeping, cooking

Effects of our culture (or system) and common attitudes about disabilities
These are often as limiting as the effects of the disability itself.

- Praised for compliance
- "Protected" by being "kept in"
- "Protected" by not being given sexual information
- Not taught about their rights
- Segregated from others; heavily dependent on caregivers
- Abuse may not be taken seriously
- Live in high risk environments

SOME IMPORTANT IMPLICATIONS OF THESE CHARACTERISTICS
The victim who has mental retardation:

- Higher risk of victimization, especially for sexual assault and robbery
- May be victimized by caregivers or "friends"
- May not understand that what has happened is a crime or that law enforcement can help

The suspect who has mental retardation:

- May admit to things he/she did not do, in order to comply or please
- May have been a follower or coerced by persons with higher abilities
- May not understand what you tell them about their rights (Miranda warnings)

Suspects, victims, and witnesses

- May tell you what they think is the "right answer"

FINDING OUT IF THERE IS SOMEONE WHO CAN HELP
This may also help you determine what the disability is.

Ask: Do you have a Case Manager?
Do you have their card?
(if no card) Who do they work for? Where is their office?

Ask: Is there someone who is paid to help you?(with money, making appointments, fixing meals,etc)
Do you have their card?
Do you have their phone number?
Would you like to call them now?
Is it OK if I call them?

Ask: Do you have a family member that helps you with things? A neighbor? Someone else?
Do you have their phone number?

Multnomah County Developmental Disabilities Services Division

"WHAT ARE ALL THESE PROGRAMS AND WHO'S IN CHARGE HERE ANYWAY?"

The Developmental Disabilities Services Divison (DDSD) is part of the Multnomah County Department of Community and Family Services. Until recently DDSD was called the "Developmental Disabilities Division" and before that, the "Developmental Disabilities Program". Offices are in the Commonwealth Building, 421 SW 6th, Suite 400, Portland, OR 97204, (503) 248-3658. Office hours are Monday through Friday 8:00 to 5:00 P.M.

The Division provides case management for eligible individuals. It also contracts with private providers (some non-profit and some for-profit) to provide residential and vocational services to some individuals. These residential and vocational services are funded mostly with state and federal money, and are under many state and federal regulations. The state and the county both have oversight responsibility for these programs.

Case Manager - Everyone served by the Division has one. This is the person in the Division who works directly with the individual, the family (especially for kids), and any residential, vocational, or other programs that the individual participates in. **This is who you should ask for when you need help for a particular individual.** The Division no longer calls case managers "case managers", but many other people do, so if you ask for the case manager, everyone will know who you're talking about. These people are now mostly called:

Family Consultant (for children)
Service Coordinator (for adults)

If a person urgently needs help and the case manager is not available, there is a **Backup Worker** available during business hours.

Protective Services Investigator - A specialized case manager who investigates allegations of abuse or neglect of adults served by the Division. (Services to Children and Families – SCF- investigates for children.) Police may deal with a Protective Services Investigator if the abuse or neglect involves criminal behavior. To make a Protective Services referral, report the suspected abuse to the individual's case manager (or the Backup Worker) and a Protective Services Investigator will be assigned.

Managers and supervisors - Every Service Coordinator/Family Consultant has one. You can ask for the supervisor if you can't get what you want from (or can't reach) the Service Coordinator/Family Consultant or the Backup Worker.

Division Manager - The person in charge of the Division.

RESIDENTIAL PROGRAMS

These are the programs that provide support in day to day living for some individuals with developmental disabilities. **Most individuals with developmental disabilities do not have any paid supports; they live by themselves or with friends or family.** There are many who need or want services which are not available due to funding constraints.

24-hour Residential ("Group homes")- These programs provide 24 hour staffing for support of individuals. The "typical" program is a 5- person group home. A few are larger. Some are "apartment model". In those, the staff will be present in the complex, but often not in the individual's apartment. **The people who work directly with individuals are generally called "direct care staff", although** in some agencies, they have other titles like "Community Support Specialist". Typically they work shifts and do not live in the home, although there are exceptions. **Group Homes typically have a house manager or site manager. The direct care staff should be able to reach the house manager or another administrative staff person by phone or beeper at all times, and you may want to ask them to do so if there's a problem.**

Semi-Independent Living Programs (SILP)- A program that provides support (typically 2-4 hours per week) to individuals who live in their own apartments. The individual has telephone access to a staff person in emergencies. If you think an individual may be in a SILP program, you may want to ask them if they have a staff person they can call.

Supported Living - A program that's more individualized than 24-hour residential programs but typically provides more support than SILP. There may be live in staff or "paid roommate", or direct care staff working shifts, or support workers dropping in. As in SILP, the individual has 24 hour access to staff by telephone, at any time staff is not with them.

The three kinds of programs listed above) are run by private agencies, under contract with the Division. All individuals served by these agencies are also served by and receive service payments through the Division (except for a very few individuals who pay privately). Agencies typically operate more than one home or site and several operate more than one program. Each agency has an **administrator** who may be called an Executive Director. The administrator or someone designated by the administrator should be available at all times in real emergencies

Adult Foster Care (AFC) - Adult foster care provides 24 hour care to individuals in private homes. **The provider is the person in charge**, who contracts to provide services. There may also be a **resident manager** and one or more **caregivers.** Typically either the provider or the resident manager lives in the home. Each Adult Foster home is licensed by the Multnomah County Adult Care Home Program, and then various agencies, including the Developmental Disabilities Services Division, arrange for service provision to individuals. Some individual make private pay arrangements for Adult Foster care, not through an agency.

Other kinds of residential supports - Individuals may have various kinds of **respite** (temporary) care, in group homes, in AFC, or with private individuals. Or they may have some paid supports in limited areas like money management. If they are elderly or physically disabled, they may receive foster care, personal care services, or other kinds of services from Senior and Disabled Services Division. If they have mental illness, they may receive help from a mental health agency.

Prepared by Lee Greer, Service Coordinator/Behavior Specialist
Multnomah County Developmental Disabilities Services Division
5/00

CHILD AND ADOLESCENT ASSESSMENT AND INTERVENTION

NOTES

Signs of Depression in Teens

- Sudden change in eating habits.
- Sudden change in sleeping habits.
- Giving away possessions or making a will (aka the "Dead Giveaway").
- Sudden mood swings.
- Sudden changes in appearance (clothing/hair style, lack of hygiene).
- Tendency to isolate self for extended periods, resenting requests to come out of isolation.
- Withdrawal from friends and other close relationships, including family members.
- Sudden changes in communication patterns.
- Uncustomary passivity, lack of emotional response, or "lashing out" inappropriately.
- Suddenly limiting interaction to one particular friend -- probably the "sounding board" for your child's feelings and emotions-- make contact with this person and insist that he or she disclose whether your child has mentioned hurting or killing himself. Ask this person if she/he thinks your child needs help. Unwillingness or reluctance to discuss the future.
- Saying things like
    - I won't be here.
    - You won't have to deal with me.
    - You'd be better off without me.
    - Life is meaningless.
    - Death is probably a solution to my problems.
    - Would you miss me if something happened to me?
    - I think I might be crazy/insane.
- Romanticizing death.
- Listening exclusively to death-related, depressing music.
- Lack of interest in usually enjoyable activities.
- Resentment, belligerence, or disdain toward optimistic outlooks (happy music, happy endings)
- Inability to compromise or see alternative (i.e., more optimistic) viewpoints.
- Decline in grades not attributable to any particular reason.
- Decline in physical activity or frantic, compulsive behavior.
- Sleeplessness and irritability.
- Headaches, stomach-aches, and other "vague" physical discomforts.
- Inability to concentrate.
- Generalized anxiety or despondency.
- Onset of "risky" behaviors, such as
    - reckless driving, skating, bike-riding, swimming alone
    - drug-experimentation
    - sexual promiscuity
    - fighting, baiting others towards physical confrontation
    - self-mutilation

- fascination with guns, knives, fire, death.

Other risk factors include:

Parents divorce
Parental Alcohol/Drug abuse
Prolonged illness (mental or physical) of a parent or sibling
Death in the family
Uprooting during adolescence (changing custodial parent, moving, etc.)
ADD and Learning Disorders
Lack of faith (not any particular religion, but lack of faith in a higher, benevolent power)
Low self-esteem, poor self-image
Trouble making and/or keeping friends
Compulsion to succeed (be perfect)
First born/middle born
Child does not handle rejection/criticism well
Child easily frustrated
History of depression/suicide (attempts or completions) in family

Understanding Serious Emotional Disturbances & Brain Disorders in Children and Adolescents

Which term should I use?
Many terms are used in reference to emotional and behavioral disorders. "Serious Emotional Disturbance" is the term used by the Individuals with Disabilities Education Act (IDEA). Some advocates prefer to use the term Brain Disorder to emphasize the biological basis of many disorders. Another commonly used term is Psychiatric Disability. Mental Illness is a term used more commonly with adults than with children and adolescents.

Anxiety Disorders
Anxiety Disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety Disorders include:

- Phobias
- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)

Attention Deficit/Hyperactivity Disorder (AD/HD)
AD/HD is a neurobiological disability. Young people with attention-deficit/hyperactivity disorder exhibit inattentiveness, impulsivity and sometimes hyperactivity. Many have trouble sitting still and tend to be accident-prone. There are three types of AD/HD:

- Inattentive
- Hyperactive-impulsive
- Combined

Bipolar Disorder (previously known as Manic-Depression) Bipolar disorder is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). A period of moderate mood may occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Conduct Disorder Children with conduct disorder repeatedly violate the personal or property rights of others and the basic expectations of society. A diagnosis of conduct disorder is likely if the behavior continues for a period of 6 months or longer. Oppositional defiant disorder often occurs before conduct disorder and may be an early sign of conduct disorder. Oppositional defiant disorder is diagnosed when a child's behavior is hostile and defiant for 6 months or longer.

Major Depression
Major depression affects a young person's behavior, thoughts, feelings, and body. Major depression in children and adolescents is serious; it is more than 'the blues.' Young people with depression may have a hard time coping with everyday activities and responsibilities, have difficulty getting along with others, and suffer from low self-esteem. Signs of depression include the following: sadness that won't go away;

hopelessness; irritability; loss of interest in pleasurable activities and changes in eating or sleeping habits. Older children can also be negative, restless, grouchy, aggressive, or feel that no one understands them.

Schizophrenia
Young people with schizophrenia have psychotic periods. They may also have hallucinations (sensing things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia occurs in approximately 3 out of 1000 adolescents.

Autistic Disorder (Autism)
Autism usually develops within the first 3 years of a child's life. Children and adolescents with autism can experience difficulty interacting normally with other people. Autism can affect many aspects of development. The symptoms range in severity from mild to very severe. Typical symptoms include the following: difficulty communicating with others; exhibiting repetitious behaviors such as rocking; limited range of interests and activities and becoming upset at the slightest change in environment or daily routine.

NOTES

SUICIDE INTERVENTION

Suicide Prevention

- Develop your interview around a knowledge base and your questions will follow.
- Interviewing: The Basic Rule, "Always ask"
- Straightforward...Do you have thoughts of hurting or killing yourself? Ask the S word.

  How would you do it? Specificity.
  When and where would you do it? Specificity.
  Do you have the means to do it? Lethality.
  Why now? What is the final straw?
  Why *not* now? What are the protective factors?
  When and with what in the past? What was their impression of it?
  What level of control do you feel? How are your brakes?

- **Reasons for Suicide:**

#1. Person is in acute distress.
#2. Suicidal individuals are ambivalent: see choice as "life or death".
Engage in the "I win" game = If I live I win, if I die I win. Good example is the "Police assisted suicide"...drop the gun or we'll shoot.
#3. Person is cut off from outside support and therefore focus on relationships in the institutional setting.

In hospital studies (John Hopkins/Harvard Medical School) it was found that the symptoms prior to suicide included: Dysphoria (86%), Psychosis (50%), Somatic Anxiety (43%), Psychic Anxiety (93%), Agitation (79%), Lability (93%)

Farberow (1966) studied 218 suicide cases and found the predominant pre-suicide behaviors for the "active group" to be: restlessness, agitation, hyperactivity, pacing and sleep disturbance. For the "passive group" they were: severe depression, isolation, muteness, withdrawal, complaints about health and ambivalence about being in a hospital.

- **Risk Factors**: Sex, sexual orientation, age, alcohol/drug, plan, means (especially firearms), emotional upset, mood disorder, psychosis, physical health, incarceration, support system, recent loss or anniversary of loss, severe anxiety or turmoil, global insomnia, delusions of doom and gloom. Decrease the risk factors and you decrease the risk.

- **Highest Risk**: White, male, recent loss (job, spouse, financial support) alcohol on board. Risk increases with age after fifty. Has a realistic plan and the means to carry it out especially possession or access to a firearm.

- **High Risk**: Incarceration, alcohol or drugs on board, humiliation over arrest/charges (e.g. sex offense, particularly first arrest). Highest risk is during the first few hours of incarceration.

- **The Lethal Triad**: An upset person, with a firearm, with alcohol on board.

- **Important for jail and hospital settings**: Death by hanging is second only to firearms as the means of suicide. Approximately 17.2% of male suicides are by ligature and 14.3% of female suicides. (63.3% and 41.3% for males and females by firearm).

- **Stats**:
- Females threaten suicide more frequently than males by a factor of 3X.
- Males succeed at suicide more frequently than females by a factor of 3X.
- Incidence of female suicide is relatively stable.
- Rough guess is that there are around 25 attempts for every successful completion. This is an average as among the young there are about 100 attempts per success but among the elderly it may be about 4:1 to as high as 2:1.
- Elderly, white males have the highest incidence of successful suicide.
- 33% of elderly suicides saw their M.D.s the week of the suicide.
- People with a history of abuse as children have a 30 fold increase in risk.
- Oregon ranks 9th in the U.S in suicide rate.
- Suicide is the leading cause of death in people with bi-polar disorder:
  Major depression...20% BUT 98% of suicides are seriously depressed.
  Bi-Polar ... 25% to 50%
  General Population...1%
- In Schizophrenia, 20 to 40% attempt suicide while 10 to 15 % succeed.
- Nationally the rate is 12/100K/year
- This increases to 380/100K/year for people with untreated mental illness.
- Suicide ranks as the 9th leading cause of death in the U.S.
  3rd for fifteen to twenty-four year olds
  14th for elderly
- There has been a 200% increase in suicide rates among Black males.
- Successful suicide rates in the U.S. are: 8:2 male to female....9:1 white to non-white.....7:2 white males to white females.....8:2 non-white males to non-white females
- 2 to 6% of suicides occur in hospital settings (620 to 1800/year or 3/day or 1 per 8hr shift.
- In Oregon, the rate is 12 to 32 per year in hospital settings.
- Nationally, the rate of suicide on Medical/Surgical Units is 42/100K.
- On Psychiatric Units this increases to 90-150/100K. (In Finnish psych units the rate is 400/100K)

- Always take threats seriously even from those you believe are manipulating. Personality disordered individuals have been known to kill themselves just to prove they meant what they said ("I'll show you").

- One in ten with a diagnosis of Borderline Personality Disorder will eventually suicide.

- Look for sudden changes in mood, e.g. a depressed individual who suddenly seems to have "gotten over it". They may have made up their mind to proceed with a suicide.

- Look for **classical symptoms** of depression; ask about: appetite, sleep, energy, sexual drive-interest-performance, concentration, and mood. What you are looking for are **changes**, which may be sudden or have been occurring over the past few weeks.
- Most common: **Anergia**...loss of energy.
  Anhedonia...loss of enjoyment or capacity for pleasure.
  Loss of sexual drive, interest, response.
  Hypophagia...loss of appetite with accompanying weight loss.
  Hyperphagia...excessive eating with accompanying weight gain.
  Insomnia...difficulty falling or staying asleep.
  Hypersomnia...excessive sleeping with no sense of rest.
  Loss of concentration, short attention span.
  Low mood, tearfulness, irritability, hopelessness, and despair.
  Excessive guilt.

- Some people may not acknowledge being depressed but they may endorse many items on the list above.

- Suicidal individuals can hide it from you and carry out a successful suicide. You will be left wondering about what more you should have or could have done.

- **Substance Abuse and Suicide**: Lifetime risk 2 to 3% (Two to three times the national average). 15 to 25% of all suicides are by alcoholics. Intoxication is associated with 50% of all suicides.

- **Sobriety is essential.** Substance abuse increases lifetime risk of suicide by 2-3X. 15 to 20% of all suicides are by alcoholics. The highest risk in this group is a male with a long history of drinking who also has a co-morbid psychiatric disorder. Intoxication is associated with 50% of all suicides. Alcohol produces "alcohol myopia" which is the inability to perceive consequences of behavior.

- **Buffers, the "Wall of Resistance"**: A strong religious prohibition against suicide. Clean and sober. Intact support system. Willingness to examine options and make a no-harm contract. For women, the best protector against suicide is a child. The more children, the lower the risk...ask "what will become of your children?". A job, a pet, a counselor or therapist. Duty to others. Medication compliance. Good health. Good friends. Job skills, job security. Safe environment and difficult access to means. At

the top of the list is hope. Anything that provides a glimmer of hope to a suicidal individual may be enough to prevent their suicide.

In the final analysis the final decision rests with the individual. However, most suicidal people do not want to die. They want to find a way to live and ambivalence exists right to the moment of death. Reduce risk factors and enhance protective factors and you reduce the risk of suicide.

Primary source of information comes from materials provided by AFSP, the American Foundation for Suicide Prevention

SUICIDAL BEHAVIOR

- Suicidal Behavior
- Suicide Plan
- History of Past Events
- The Persons Resources
- Recent Loss
- Physical Illness
- Drinking and other Substance Abuse
- Physical Isolation
- Dramatic Changes
- Mental Illness
- Suicide Prevention

Suicidal Behavior[2]

A common myth regarding suicide is that people who commit or attempt to commit suicide are mentally ill. Although people who are suicidal are usually in emotional turmoil and although suicide is often preceded by periods of depression, these conditions do not necessarily indicate mental illness. The mentally ill may attempt and commit suicide, but not all that attempt suicide are mentally ill.

Suicide in the United States is the 10th leading cause of death among adults and the second among adolescents. For every suicide there are 8 to 10 attempts, or about 300,000 attempts annually. Suicide knows no boundaries. It cuts across race, class, age, and sex, though its frequency varies with different groups. It is not an illness or an inherited disease as is sometimes believed but is usually a response to a life crisis that the person sees no other way of alleviating. Though many persons who commit suicide are in a temporary state of acute crisis, some are chronically self-destructive and continually attempt suicide.

Listed below are some of the major signs of suicidal behavior. A suicide can still occur without these signs being present, however. At the same time an officer should not hesitate to consider the person suicidal if on ly on e or two signs are apparent. It is impossible to predict suicide in any absolute sense, but inclusions of these signs and guidelines for officers will remove much of the guesswork associated with suicide assessment.

Suicide Plan
Many persons who attempt or commit suicide do so by design. The plan begins with the idea of suicide; suicidal people do not act on impulse but weigh the factors involved. The plan also involves the method of suicide and its lethality. A plan involving a gun will have more likelihood of being effective that will a plan involving tranquilizers. The availability of the means is also a factor. For example, if the person threatens to use a gun and he is a gun owner, the means is clearly available. The final element of a plan is its specificity — time, place, and circumstances. If a person indicates he will commit suicide within two days at a specific time and place, and he has the lethal means, he is a higher suicide risk than one without a plan. The more specific the plan, the higher the risk.

History of Past Attempts
The majority of people who commit suicide have made previous attempts.

The Person's Resources
The officer should assess two types of resources, internal and external. If the person feels life is worthless and that little hope for improvement exists, he or she is lacking internal resources and should be considered a high risk. Lack of

external resources, such as family or friends, or an inability to communicate with those persons is also an indication of high risk.

Recent Loss
Any recent personal loss or the threat of losing a life partner, parent, status, money, or job increases the person's risk of suicide.

Physical Illness
Having a serious illness, especially on that is terminal, that threatens one's values or status, or that is or likely to dramatically affect one's self image increases the risk of suicide.

Drinking and other Substance Abuse
Alcohol or drug abuse is often a sign of other problems, especially if the abuse is recent, and should be included in a suicide assessment. Also, use of alcohol or drugs often increases the risk of loss of control or an increase in impulsive behavior. Alcohol also increases the lethality of a drug overdose

Physical Isolation
The risk of suicide increases when a person is both physically and emotionally isolated. Isolation can cause people to feel they do not belong to a family or society and can increase feelings of worthlessness and other negative self-images. Even temporary isolation may be an impetus for suicide.

Dramatic Changes
A sudden, dramatic, or unexplainable change in lifestyle or behavior may be a clue to suicide contemplation. Change in one's social network and environment such as relocation or retirement can be very upsetting. Also, unexplained changes in behavior are often a symptom of a larger problem, which may in turn increase the risk of suicide.

Mental Illness
Persons who hear voices directing them to commit suicide are certainly in a high-risk situation. However, the number of persons who fall into this category is quite small. If a person indicates that other people, or voices, are controlling his or her behavior, those signs should not be ignored.

In an attempt to determine the existence of any of these signs, the officer must communicate with the person in a calm, direct, and matter of fact way. Talk about the finality of the act and use the terms "suicide," "death," "kill your self." Talking about suicide does not prompt the person to commit the act. The best way an officer can help the person is to discuss the person's problems, the suicide plan, and realistic alternatives. Communication with the person not only enables the officer to gather information regarding the risk, but it is also helpful for the suicidal person. Often the suicidal person has been lacking communication and the

offer's efforts tell him or her that someone is interested and concerned about finding an alternative solution.

[2] All the preceding information about suicide was copied with permission from: Improving the Police Response to the Mentally Disabled. Police Executive Research Forum, 1986.

Suicide Prevention

Suicidal Clues

- Verbal: "it doesn't matter anymore", "you won't be hearing from me again"
- Situational: hopeless and helpless.
- Behavioral: stripping of possessions or relationships, in appropriate calmness/flatness, past attempts.
- What is the Immediate Problem?
- What has happened in last 24 hours that makes you want to kill yourself?
- Identify the problems/situation.
- Identity the loss.
- Talk about it/ventilate feelings.

Identify Hook

- What is still important to the person?
- What still has value/meaning?
- Keep returning to the hook.

Determine Motivation

- What is objective/goal of suicide action?
- What is person hoping to accomplish?

Develop Non-Lethal Alternative Option

- To diffuse crisis state
- To accomplish objective/goal

Develop Specific Plan of Action

- Be realistic.
- Make a list.
- Go to next step.

Referral

- When appropriate.
- When crisis has ended.

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Suggested Dialogue

- Look I can see you're really (label emotion) right now. I just want to talk with you for awhile.
- I really care about what happens to you. That's why I have this job.
- I know talking about this is really rough, but we can take it slow.
- I sense you're really down on yourself right now.

- Do you really want to die, or do you want to not hurt so much?

Finality of Death

- Once you're dead, you're not going to get another chance.
- You know if you kill yourself to get back at _____, all that's going to happen is that you'll be dead. We can't be sure of _____'s reaction. _____ may not care at all. Therefore _____ wins. You're dead and _____'s going to go on with their life.
- I guess right now you want to get away from the hurt, but dying (method) is pretty painful. Let's talk about some other way to get this pain out of your life.

Hooks

Parents

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

Children

- How do you think it will affect (name/'s) if you kill yourself?
- You know, if you kill yourself, you'll never see _____ grow up, graduate, get married. I can tell you care about them a lot.

Job, Career, Hobby

- You know, you've told me that you've made some pretty important breakthroughs in your job, if you killed yourself, you'll never have that satisfaction again.
- You were telling me about your (hobby), you're pretty proud of _____. What will happen to _____ if you die, will they just get tossed in the trash?

Pets

- What about _____? Who will take care of _____? I guess _____ will have to be destroyed.

Explore Plans / Thoughts

- What do you want to have happen? What would need to happen for you to feel better, feel like you could go on?
- What do you think (you/we) could do to make things not hurt so much?

PRACTICUM

Section 5 - OTHER

COMMON ACRONYMS

(AMHSA) ADULT MENTAL HEALTH AND SUBSTANCE ABUSE
(AFS) ADULT AND FAMILY SERVICES
(ARC) ASSOCIATION OF RETARDED CITIZENS
(ADHD) ATTENTION DEFICIT HYPERACTIVITY DISORDER
(ADD) ATTENTION DEFICIT DISORDER
(BHD) BEHAVIORAL HEALTH DIVISION
(CMI) CHRONICALLY MENTALLY ILL
(CAMHSA) CHILD & ADOLESCENT MENTAL HEALTH AND SUBSTANCE ABUSE
(CCMH) CLACKAMAS COUNTY MENTAL HEALTH
(CIT) CRISIS INTERVENTION TEAM
(CRT) CRISIS RESPONSE TEAM
(CTC) CRISIS TRIAGE CENTER
(DCFS) DEPARTMENT OF COMMUNITY AND FAMILY SERVICES
(DSM4) DIAGNOSTIC AND STATISTICAL MANUAL
(DSO) DISABILITY SERVICES OFFICE
(EAP) EMPLOYEE ASSISTANCE PROGRAM
(ISP) INDIVIDUAL SERVICE PLAN
(MRDD) MENTALLY RETARDED DEVELOPMENTAL DISABILITY
(MHRC) METROPOLITAN HUMAN RIGHTS COMMISSION
(NAMI) NATIONAL ALLIANCE FOR THE MENTALLY ILL
(OAC) OREGON ADVOCACY CENTER
(PSRB) PSYCHIATRIC SECURITY REVIEW BOARD
(SDSD) SENIOR DISABLED SERVICES DIVISION
(SCF) SERVICES TO CHILDREN AND FAMILIES
(SSDI) SOCIAL SECURITY DISABILTIY
(SSI) SUPPLEMENTAL SECURITY DISABILITY

Notes

11-13-00

0800 – DORIS MENARD, NATL. ALLIANCE FOR MENTALLY ILL (NAMI) 1-800-

5 MAJOR ILLNESS

40-60 % OF M.I. LIVE WITH PARENT'S - PARENT'S GETTING OLDER

TOO MUCH DOPAMIN - SCHIZOPHRENIA

0830 – SGT. STEVE MORRO - (I.A.D)

RULE OF 5 - 5 FT. FROM SUBJECT

SHORT SENTENCES - LESS THAN 5 WORD'S

REPEAT ~~OR~~ 5 TIMES

0900 – DR. KEITH CHENG, M.D.

CLINICAL ASST. PROF.; PSYCHIATRY

OHSU

- WHAT IS MENTAL@ ILLNESS - 20% OF POPULATION
- MENTALLY ILL IN PRISON, IN SCHOOLS
- SCHIZOPHRENIA - ONE IN A HUNDRED
- COMMON MENTAL ILLNESS
  - -DEPRESSION
  - -SCHIZOPHRENIA
  - -SUBSTANCE ABUSE
  - -PTSD
  - -BORDERLINE PERSONALITY DISORDER

1000 – INTERVIEW W/ A PATIENT - "MIKE" M/W

FROM OREGON CITY, SCHIZ. DISORDER?

- DISORGANIZED THINKING
- LOOSE ASSOCIATIONS
- DELUSIONS (MERCURY PROJECT)
- BIPOLAR - (DEPAKOAT)

AGE 14 - CAN SIGN THEMSELVES IN TO CTC FOR ALCOHOL / DRUG TREATMENT

NOTES

AGE 15 - MEDICAL/DENTAL TREATMENT

1100 - DR. MELISSA ESHELMAN (CHILDHOOD DISORDERS)

ADHD - SYMPTOMS BEFORE AGE 7 / MORE THAN JUST 1 SETTING

OPOSITIONAL / [redacted] DEFFIANT DISORDER - ONSET BY AGE 8 (VERBAL)

CONDUCT DISORDER - MORE PHYSICAL CRUELTY

1130 - PHIL DIXON - SCF (SCREENING SUPERVISOR)

MANDATORY REPORTING

LUNCH

1300 - JASON RENAUD (NAMI - OREGON) 228-5692

1400 - PAUL IARRABINO - GATEKEEPER PROGRAM 988-3620

WENDY HILLMAN - PROTECTIVE SERVICE 988-5460

GINNIE CHURCHILL - M.COUNTY

ELDERLY ABUSE

1500 - NETWORK MENTAL HEALTH 43 AD + DIVISION / 238-0780 SUSAN DALCAMO

231-3050 (STREET KIDS)

"TARASOFT" - NOTIFYING THE INTENDED TARGET OF VIOLENCE

1600 - NETWORK BHC

UNITY

MT. HOOD MENTAL HEALTH

NOTES

NOTES

DAY 2

0800- MARY ELLEN WARREN
PERSONALITY DISORDERS

0900- GARY SJOLANDER - "VOICES"

FORMER MENTAL PATIENT THAT WORKS IN A FORENSIC'S OHSU UNIT

GROUP EXERCISE - TWO PEOPLE TALKING IN YOUR EAR WHILE YOUR ~~ASKING~~ ANSWERING QUESTIONS

ASK SIMPLE QUESTIONS

"PWN" PRESCRIBED WHEN NEEDED

1000- GLENN MAYNARD PTSD & A/

~~TEST~~
ID REASON
3 REASONS FOR SUBS. ABUSE
IMPACT OF A/D ON ~~MENTA~~ CHRONIC MENTALLY ILL

PTSD-

1300- RIGHT'S OF THE MENTALLY ILL
JAN ~~FREEMAN~~ FRIEDMAN
JANICE PERCIANO
STEPHAN ~~MATTHEWS~~ MATHIEN

1400- COMMITMENT LAW & PSRB
SHAWN KHAN
MARY CLAIRE BUCKLEY
COMMITMENT - 5 JUDICIAL DAYS

2800 INVESTIGATIONS BY MULT. COUNTY
11 INVESTIGATORS
10% GO TO COM. HEARING
70% GET COMMITTED

1500 - DR. ELIZABETH BIRECREE - ATTENDING AT PORTLAND CAMPUS
OREGON STATE HOSPITAL

"MEDICATIONS & MODELING"

- LOOK FOR: APPEARANCE
BEHAVIOR
GROOMING
MOVEMENTS
SPEECH - (RATE/RYTHYM)
THOUGHTS
CONTENT PROCESS

MOOD
AFFECT
SI/HI
COGNITION

MEDICATIONS
(USE)

MOOD STABILIZERS
LITHIUM
TEGRETOL
DEPAKOTE
NEURONTIN

ANTI-DEPRESSANTS

ANTI-PSYCHOTICS

ANXIOLYTICS
(ADDICTIVE)

DAY 3
SITE VISIT's

DAY 4

0800) DEVELOPMENTAL DISABILITIES - LEE GREER
MENTALLY RETARDATION

ROLE PLAYING

1000) MENTAL STATUS EXAM - DR. NEIL FAULK, MD

1100) CRISIS CYCLE - SGT. CARL McDADE, MORTH

M.C. COMMITMENT SERVICES

NOTES

1300 - DAN KAMADA "SUICIDE INTERVENTION & CRISIS INTERVENTION"

SUICIDE ASSESMENT

1. IDEATION / FLGS - INTENSITY
2. PLAN - DETAILS / OTHER
3. MEANS
4. INTENT
5. HISTORY

NOTES

NOTES

CITY OF
PORTLAND, OREGON
BUREAU OF POLICE

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Crisis Intervention Team Training Evaluation:

*Class Date:*_____

*Class Title:*_____

*Instructor:*_____

Please Circle One Response:

	Excellent	Above Average	Average	Fair	Poor
Class Content:	5	4	3	2	1
Organization of Material:	5	4	3	2	1
Presentation of Material:	5	4	3	2	1
Instructor Knowledge of Subject:	5	4	3	2	1
Overall Presentation:	5	4	3	2	1

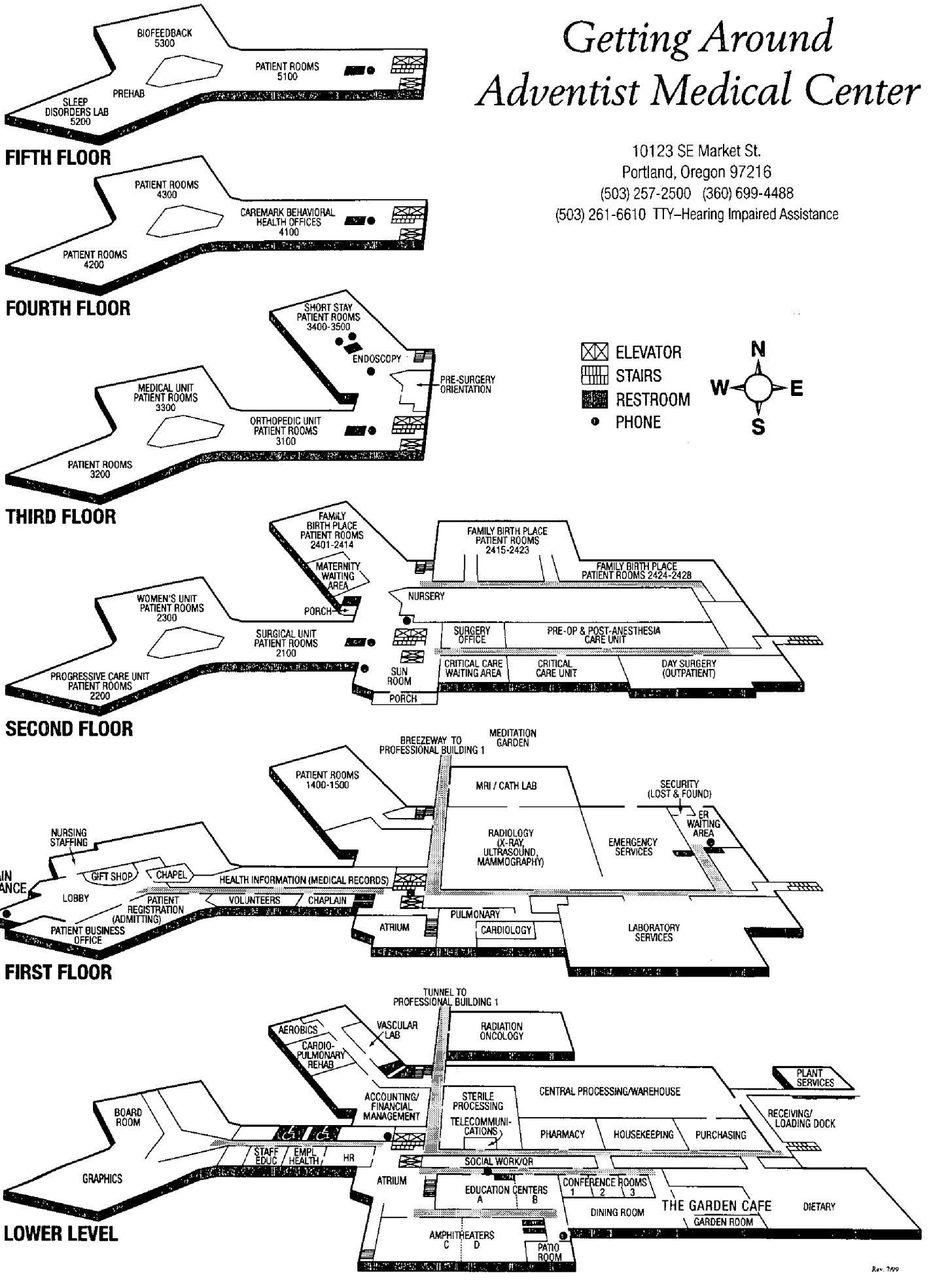
What portion of the material, if any, did you find to be most informative and beneficial?

List any changes that you would recommend to make this course more informative, beneficial, or would improve overall presentation.

Other comments?

Getting Around Adventist Medical Center

10123 SE Market St.
Portland, Oregon 97216
(503) 257-2500 (360) 699-4488
(503) 261-6610 TTY–Hearing Impaired Assistance



Rev. 7/99

Adventist Health

Getting to Adventist Medical Center

From I-84

Take the I-205 south exit (Salem). Stay in the right lane and watch for the immediate Glisan/ Stark exit. Take the exit. Follow the green road signs directing toward Mall 205. This will take you across Glisan and Stark, left onto Washington, and right onto 99th. (The blue "H" signs will also help direct you.) Stay on 99th past Mall 205 and follow the signs to the hospital.

From I-205

Take the Glisan/Stark exit (if traveling southbound) or the Stark/Washington exit (if traveling northbound). Follow the green "Mall 205" and blue "H" road signs directing you onto Washington and then right onto 99th. Stay on 99th past Mall 205 and follow the signs to the hospital.

From Division

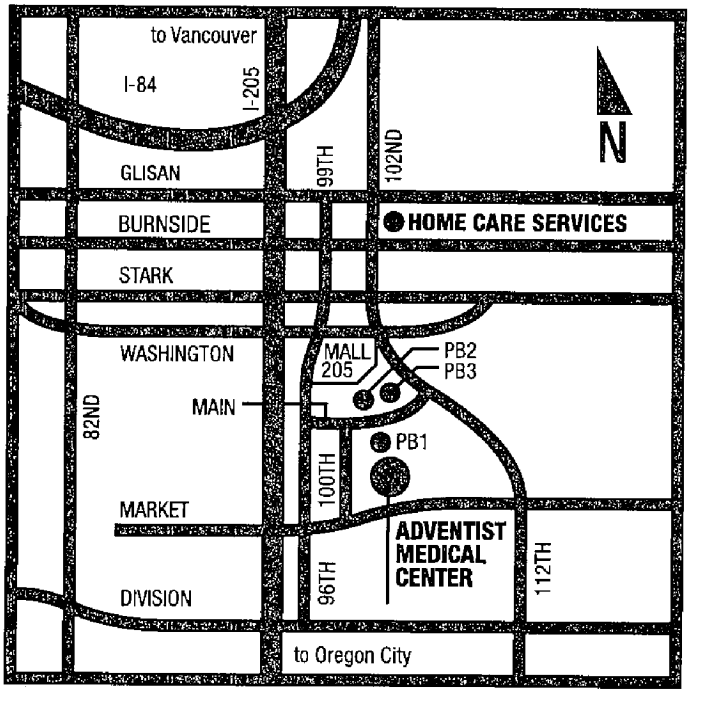
Turn north onto 96th Avenue. Proceed on 96th to the four-way stop on Market. Turn right onto Market; follow signs to hospital.

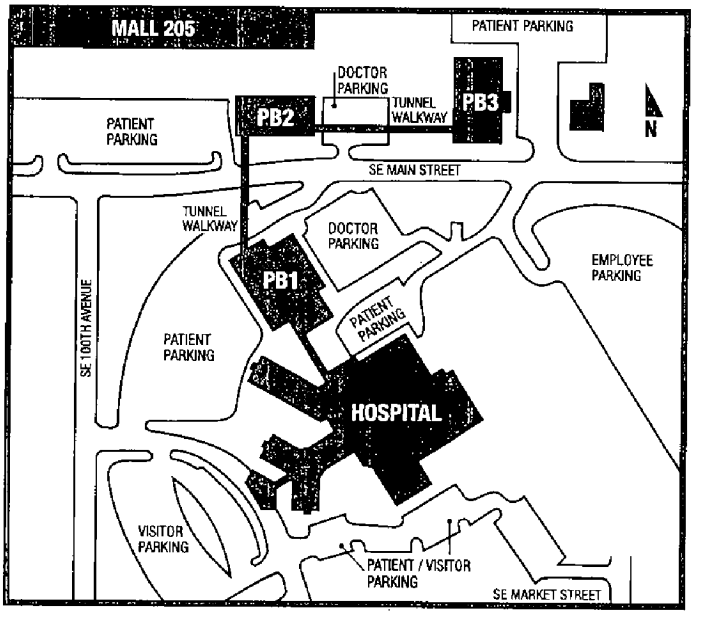
From Stark/Washington

Turn south onto 99th Avenue. Stay on 99th past Mall 205 and follow signs to the hospital.

By Bus and/or Light Rail

The hospital is served directly by Tri-Met buses #15 and #27 (Market-Main), which connects with the Gateway Transit Center. For more information, call Tri-Met at 238-RIDE (7433).





86-0374-8 12/99

V. POLICE ENCOUNTERS WITH INDIVIDUALS WITH MENTAL ILLNESS OR SUICIDAL IDEATION

Our review included six instances in which members of the PPB encountered individuals with mental illness or persons actively pursuing suicide. In some of those cases the subjects' mental illness or suicidal ideation was known to the officers beforehand, sometimes it was not. In every case, however, that illness added a heightened level of unpredictability and associated risk to the encounter. What each actor brings to an encounter between a police officer and a person suffering mental illness will differ. On the side of the police officer, there will be wide variations in age, experience, maturity, culture, training, attitudes toward those with mental illness, and opportunities to exercise skills developed in training. On the side of the individual confronted, there too will be the same wide variations in background, including attitudes or assumptions about the police, and varying capacities to understand and assimilate instructions and to bring themselves into self-control. These are not easy cases from any perspective.

Many law enforcement agencies — including Portland — have the capacity to provide a specialist response to incidents involving individuals with mental illness. In the PPB, this specialist response is provided by Crisis Intervention Team (CIT) officers. CIT officers receive specialized training in dealing with individuals with mental illness or suicidal ideation, and learn to slow down and de-escalate incidents, negotiate with subjects, and respond more flexibly. According to the PPB's CIT Coordinator, 193 PPB officers have received CIT training since it was introduced in 1995, and approximately 25 percent of patrol officers are currently CIT-trained.

Portland's CIT model was patterned after the one used by the Memphis Police Department, which is often-cited as an example of best practice in the area.[219] In November 2000, *The Journal of the American Academy of Psychiatry and the Law*

[219] Memphis is a city of approximately 630,000 residents, and its police department employees some 900 uniform patrol officers. Of that, the Department of Justice reported that 213 have received critical incident training. *Bureau of Justice Assistance Bulletin from the Field Practitioner Perspectives,* July 2000.

published a study of Memphis's CIT model.[220] As in Portland, the Memphis CIT training takes 40 hours and "focused on scenarios developed from actual incidents. These scenarios allowed for the illustration of crisis de-escalation principles and included intensive feedback from fellow officers and mental health professionals."[221] Four distinct benefits flowed from implementation of a CIT model in Memphis where, because over 25 percent of all uniformed patrol officers had been trained, there were CIT-trained officers available on every shift in every precinct:[222]

1. *Timely response.* In 100 randomly selected cases, a Memphis CIT officer arrived in fewer than ten minutes, "with the great majority of those calls responded to in under five minutes."
2. *Decreased need for SERT or SWAT teams.* De-escalation training in Memphis decreased the need for such teams. The more instances in which CIT was used, the fewer instances when Memphis's SWAT team was called out.
3. *Decreased Officer Injuries.* In Memphis, officer injuries in encounters with persons with mental illness dropped by more than half following implementation of CIT and, based on anecdotal evidence, so did injuries to the involved individuals with mental illness.
4. *Reduced Criminalization of Mental Illness Events.* The arrest rate of persons with mental illness dropped after introduction of CIT to approximately two percent as contrasted to a national average of 20 percent. "The Memphis CIT officers have increased their department's involvement in mental illness events and referrals to the health care system. This increase has happened while they have maintained an extremely low rate of

[220] Dupont, R. and Cochran, S., "Police Response to Mental Health Emergencies — Barriers to Change," *J Am Acad Psychiatry Law* 28:338-44, 2000.

[221] *Id.* at 339.

[222] *Id.* at 340.

arrest for those with mental illness, while at the same time significantly reducing their own injury rate."[223]

It is not possible to determine from the small sample of relevant cases we reviewed whether Portland's version of the Memphis CIT program has achieved similar results.[224] Nor can we say whether the subjects in the relevant cases we reviewed would have been responsive to even letter-perfect application of CIT techniques. However, our review did identify some CIT-related areas of concern to which the PPB should pay close attention:

A. Use of de-escalation techniques

We were concerned by what appeared to have been missed opportunities to attempt de-escalation in two cases involving subjects with mental illness. Although this is a small number, these cases represent one third of the officer-involved shootings and in-custody death incidents we reviewed involving persons with mental illness and suicidal ideation. Moreover, de-escalation is an elementary technique for dealing with aggressive subjects suffering from mental illness, and any failures to attempt the technique should be considered as significant omissions.

B. Failure to deploy CIT officers

We were also concerned that CIT officers did not appear to have been deployed in one of the two incidents where the PPB had a prior indication that such a deployment

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[223] It should also be noted that a police response team is not the only model currently being employed in the United States. Another model involves the police department's hiring of mental health professionals who are not sworn officers to provide "on-site and telephone consultations to officers in the field." Borum, R., Improving High Risk Encounters Between People with Mental Illness and the Police," *J Am Acad Psychiatry Law* 28:332-37, *at 334*, 2000. A third model involves "partnerships or cooperative agreements . . . between police and mobile mental health crisis teams that exist as part of the local community mental health services system and operate independently of the police department." *Ibid.*

[224] Aside from the difficulties of drawing firm conclusions on the basis of a small sample of cases, our ability to comment on CIT issues is constrained by the scant documentation of CIT considerations in the files we reviewed.

would be appropriate. Moreover, we noted that in one case a CIT officer apparently did not attempt any specialist CIT techniques, despite being present at the scene of an incident involving an individual with mental illness.

The deployment omission we identified may indicate that the CIT arrangements in place during our review period were insufficient to ensure the consistent application of CIT skills to incidents involving subjects with mental illness. In order to realize the benefits of its CIT program, the PPB must work to ensure that its deployment of CIT officers is sufficient to create a CIT response whenever the need arises, that CIT-type incidents are assigned to CIT officers whenever feasible, and that CIT officers are diligent in following their training when they attend such incidents.

Although we lack sufficient information to make overall judgments in respect to these issues in relation to the period covered by our review, we were concerned by a relatively current indication that the PPB does not provide as comprehensive a CIT service as it might: According to the May/June 2003 edition of the PPB's CIT newsletter, CIT officers were available to deal with just one third of the CIT-related calls the Bureau received during the first three months of 2003. This figure suggests that there is room for improvement in the Bureau's deployment practices. The PPB's goal should be to deploy a CIT officer to every call where such an officer's presence could be beneficial.

Recommendation 7.22: The PPB should ensure that CIT officers consistently exercise their specialist skills when dealing with CIT-related incidents.

Recommendation 7.23: We encourage the Bureau to examine its current practices in order to identify means of improving deployment rates of, and better capitalizing on the skills possessed by, its pool of CIT officers.

Recommendation 7.20: The PPB should provide all operational personnel with a radio earpiece.

Recommendation 7.21: The PPB should establish a helicopter unit.

Recommendation 7.22: The PPB should ensure that CIT officers consistently exercise their specialist skills when dealing with CIT-related incidents.

Recommendation 7.23: The PPB should examine its current CIT deployment practices in order to identify means of maximizing the rate at which appropriately skilled officers attend CIT-related incidents.

Recommendation 7.24: The PPB should ensure that officers consistently follow the Bureau's training and policy in relation to sudden death syndrome and associated prisoner restraint issues.

Recommendation 7.19: The PPB should monitor and evaluate the effectiveness of all its less-lethal hardware, and should tailor the availability and deployment of that hardware to ensure officers' access to effective and appropriate force options.

PPB Response: *Officers are required to write a report outlining the use of less-lethal force. The report is submitted to their supervisors. The supervisors, after reviewing the incident, author an after-action report and forward it through channels to the branch assistant chief for review. The original report written by the officer is submitted to the Records Division.*

The Training Division reviews all applications of less-lethal by reading all reports of incidents in which less-lethal force is used. The review assists in determining training needs and concerns. In the future the Training Division would like to design and maintain a database to track all deployments of less-lethal weapons.
Fiscal Impact: Minimal

Recommendation 7.20: The PPB should provide all operational personnel with a radio earpiece.

PPB Response: *Agree. The Bureau strives to provide officers the equipment necessary to attain maximum officer safety.*

Fiscal Impact: Significant.

Recommendation 7.21: The PPB should establish a helicopter unit.

PPB Response: *Agree in concept. The Bureau would like to identify and implement a dedicated flight team, establish a full time air unit, and share the cost, staffing and benefits with agencies in the Portland Metropolitan area.*

Fiscal Impact: Extremely significant.

Recommendation 7.22: The PPB should ensure that CIT officers consistently exercise their specialist skills when dealing with CIT-related incidents.

PPB Response: *Agree. The Bureaus purpose of establishing the program was to ensure better response to incidents involving mentally ill individuals, to reduce the risk to officers and citizens, and to ensure mentally ill individuals received proper treatment whether it come through the criminal justice system or mental health treatment. Study to expand program.*

Fiscal Impact: Yes

Recommendation 7.23: The PPB should examine its current CIT deployment practices in order to identify means of maximizing the rate at which appropriately skilled officers attend CIT-related incidents.

PPB Response: *Agree. See response to recommendation 7.22*

Fiscal Impact: Yes

Recommendation 7.24: The PPB should ensure that officers consistently follow the Bureau's training and policy in relation to sudden death syndrome and associated prisoner restraint issues.

PPB Response: *Agree. Extensive training and Bureau policy are current. Consistent policy enforcement by management and refresher training will be reviewed.*

Fiscal Impact: Yes

Recommendation 8.1: The PPB should proactively study its data on officer-involved shooting and in-custody-death incidents, to assist its efforts to prevent avoidable shootings and deaths.

PPB Response: *PPB agrees that data collection is an invaluable tool, not only for a historical perspective, but also for the development of training, policy and procedures.*

Fiscal Impact: Yes

Recommendation 8.2: The PPB should develop procedures and systems to accurately and completely capture and aggregate data on officer-involved shooting and in-custody death incidents, in a manner that facilitates analysis of those data.

PPB Response: *Agree. See response to recommendation 8.1*

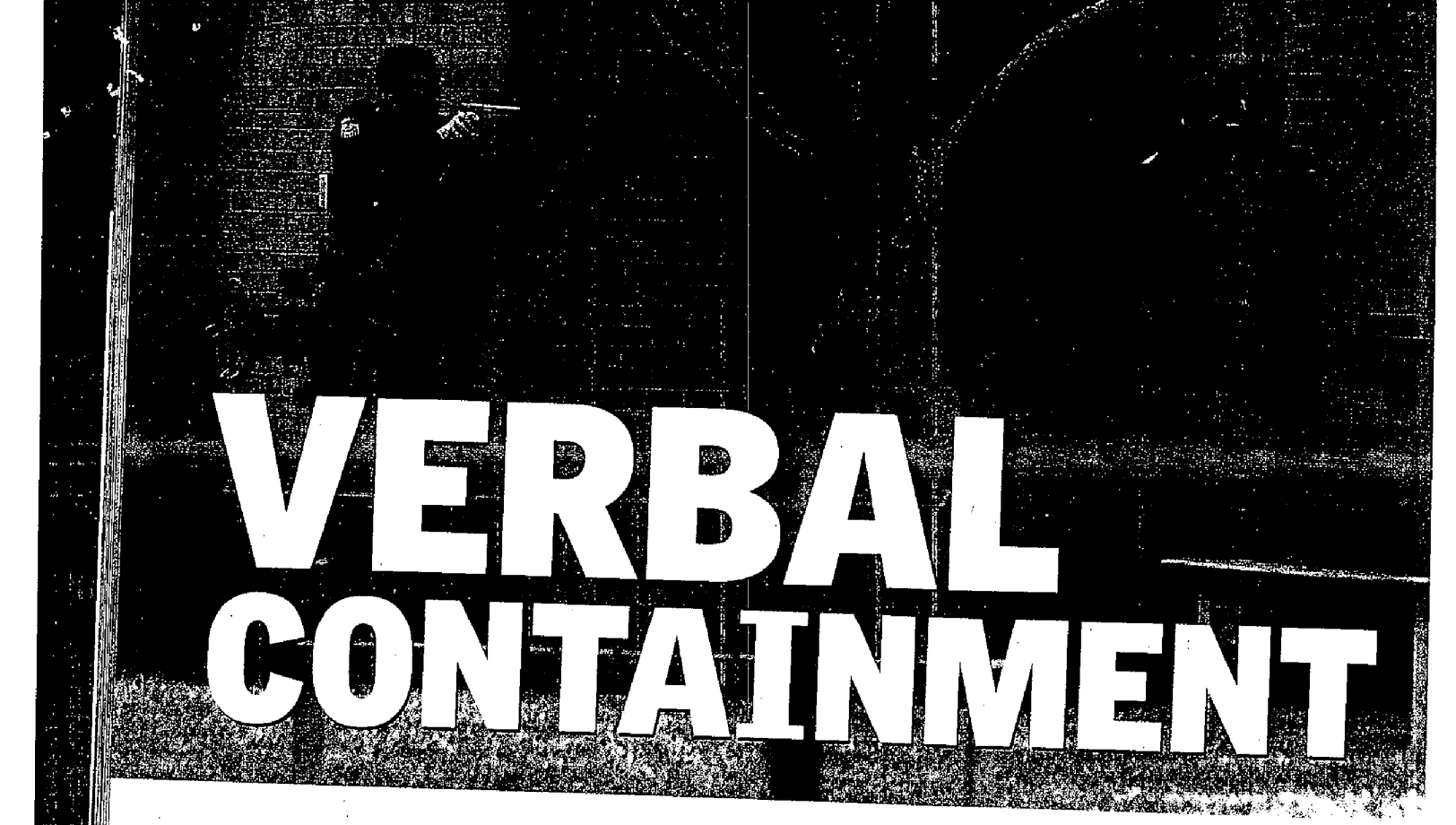
Fiscal Impact: Yes

Recommendation 8.3: The PBB should retain all records related to officer-involved shooting and in-custody death incidents for 25 years. Any otherwise applicable provision that requires longer retention than the period set for officer-involved shooting and in-custody death records should continue to be controlling.

PPB Response: *Agree. The Bureau will review recommendation with City Auditor and make necessary modifications.*

Fiscal Impact: Yes

Recommendation 8.4: The PPB should create procedures and systems that allow it to locate whatever records it possesses.



VERBAL CONTAINMENT

NEGOTIATION SKILLS FOR THE FIRST-RESPONDING OFFICER

BY SCOTTIE R. FRIER

You've done everything right so far. You inquired from dispatch about prior call history and whether weapons are involved. You parked a couple of houses from the residence. You made a cautious approach, listening intently as you neared the home.

As you approach, you hear an argument in the back yard. As you step through the gate, it all seems to start moving in slow motion. The estranged husband, startled by your presence and armed with a pistol, grabs his wife by the hair. He begins stepping towards the back door, using the wife as a shield and holding the gun to her head. You don't have a shot, and you're forced to get to cover. The husband drags the wife into the house. It gets worse, as you now hear children inside crying and begging, "Please don't hurt my mommy!" As the door slams, he screams, "I swear I'll kill them all if you try to come in!"

You call it in: "Headquarters, I've got an armed subject who has barricaded himself inside the residence. The subject has multiple hostages. Advise the watch commander, and respond negotiators with the SWAT team ASAP!"

The deployment and response of SWAT officers and negotiators often takes up to an hour and a half to two hours. So what now?

While some agencies encourage delaying the initial contact with the subject until the arrival of specialized units, my advice, as an experienced negotiator and instructor, is for first responders to make contact as soon as possible. Stephen J. Romano, former chief negotiator for the FBI and an expert in crisis negotiations, is also an avid proponent of early initial contact into a crisis site in order to promote verbal containment.

This article will address two main issues. First, it will identify and explain the concepts and tactical benefits behind the verbal-containment objective. Second, it will provide first-responding officers with some basic communication skills they can use to not only maintain the situation, but also gather beneficial information and intelligence.

Understand the Objective

The main objective of verbal containment is to reduce the likelihood of further violence. Quickly beginning some form of communication with the hostage taker or barricaded individual allows you to occupy the subject's attention in order to prevent them from harming hostages or committing other acts of violence. This will also allow you to project a poised and professional police demeanor in hopes of calming the subject, thereby providing a sense of order. Major John Ferrarro, commander of the South Carolina Department of Corrections' Situation Control unit, also advocates prompt initial contact. Ferraro explains that other benefits

<< Columbus and Whitehall, Ohio, police stand near the east doors of the Safe Auto Insurance Co. office in Whitehall on March 23, 2005. A gunman held a woman hostage in the building for six hours before fatally shooting himself.

PHOTO AP/COLUMBUS DISPATCH, JAMES D. DECAMP

include the ability to distract the subject from further fortifying the crisis site or formulating plans to attack officers.

Setting a realistic goal from the onset is critical for a first responder. Avoid becoming preoccupied with "talking the subject out." Understand that most successfully negotiated situations will take several hours to unfold. An initial chaos or confusion stage will hopefully evolve into a negotiation process and then finally a resolution. As a first responder, success in this situation comes with the ability to begin communication, reduce further violence and gather critical intel. I truly believe the officer or negotiator who can first convince the hostage taker or barricaded subject to communicate deserves as much credit for a successful resolution as the negotiator who worked the surrender.

First Contact

First responding officers who attempt to communicate with subjects in these situations must understand that they must use different communication skills than they might employ in most of their day-to-day duties. The majority of law enforcement communication is often very aggressive, impersonal and intrusive. This often works in our "just the facts" mode, but it can create barriers and cause defensiveness. Hostage takers and barricaded subjects are in a crisis state. They are emotional, irrational and often very scared.

Successful communications during these situations will require an ability on your part to empathize with the subject. The objective here is to communicate in such a way as to build rapport, gain trust and instill a sense of worth to the subject's issues and to the negotiation process.

When contact with the subject is made, identify yourself by first name without stating a rank or title. ("Hello my name is Scottie, and I'm with the sheriff's department. How are you doing in there?") Begin asking open-ended questions that will enable the subject to let you know what is happening. ("What happened today that caused this?" "What's going on in there?") Ask about the hostages. ("Is everyone in there with you OK?") If you know the name or relationship of the hostages, use this to personalize them. ("How are your wife and children doing in there?") Allow the subject to talk as much as he will without interruption. Listen intently—everything he says will help explain what's happening and why. And even more importantly, while he's talking to you, it takes his focus away from the hostages.

Prepare yourself for the fact that most of the initial communication with the subject will likely involve yelling, screaming, profanities and threats. This is known as a venting phase and can prove very intimidating and unsettling for the first responder. There is, however, an upside: The venting phase allows the subject to get things off his chest. It will also begin to provide you with tremendous insight into the issues, so really focus on what he says despite the way he's saying it.

The venting phase is also physically draining and should take some toll on the subject, which will hopefully cause him to begin to settle somewhat. During this time, let the subject know you are doing everything you can outside to control this situation. Encourage him to work with you by getting everything inside settled and under control.

Active Listening Skills

Trained crisis negotiators use communication tools referred to as active listening skills. These skills are designed to deal with the emotional mindset of someone in crisis.

One of the most important skills that you should try to understand and master is emotion labeling. Is the subject mad, worried, depressed, afraid or angry? What's causing their emotion?

Your ability to show the subject that you recognize how he feels will allow you to move into the critical rapport-building phase. *Example:* You ask, "What happened today?" He responds with, "She served papers on me; I think she has a new boyfriend. I'm going to lose my wife and my kids and I just can't have that." A good response here would be, "You really seem to be afraid that you're going to lose your family." Work hard to recognize what emotion is in play and the root cause. Tell him what you are hearing: "You seem to love your wife and you don't want to lose her." The subject believing that you get it will prove very beneficial at this point.

Two other skills that somewhat run hand in hand are paraphrasing and mirroring/reflecting. Paraphrasing refers to simply restating, in your own words, what the subject has been saying to you. This skill displays attentiveness on your part and can help clarify issues. For example, say the subject tells you, "I can't lose my wife; I must be with my children." Paraphrase this statement to sound something like this: "It sounds like your family is →→

Success Story

PHOTO SCOTTIE FRIER

ON MAY 9, FIRST-RESPONDER SERGEANT CALEB BLACK of the Lexington County (S.C.) Sheriff's Department negotiated the surrender of an armed rape suspect who was threatening to harm officers and commit suicide.

Using information provided by the victim, Black made phone contact with the suspect. While Black was speaking with the suspect on the phone, the shift lieutenant spotted the suspect's vehicle. The suspect began making threats to either harm officers or kill himself. He then began playing a cat-and-mouse game—stopping, making threats and then driving away.

The suspect drove for several miles before a police road block forced him to stop. Black then began first-responder negotiations with the suspect. The suspect, armed with a shotgun, made threats against officers and passing cars, forcing deputies to shut down all traffic on the interstate. Black negotiated with him, without the benefit of a coach, for several hours. Black was able to convince the suspect to throw the weapon out of the vehicle and surrender to the SWAT team.

important to you and that you love them very much." Mirroring statements repeat back to the subject his last words. *Example:* The subject says, "I might want to come out later, but all those SWAT guys are making me nervous." You respond with, "So, those SWAT guys are making you nervous?"

These skills will help you build a rapport with the subject; he will recognize that you are listening to what he has to say. Remember, your goal here is to project empathy towards the subject and his situation. This is not weakness on your part, or sympathy. You don't have to agree with him, but you can talk to him in a way that projects recognition of his perceptions and concerns.

Perception is reality. That is, the subject's perception of this situation is the reality you must deal with. Show the subject you're trying to understand his plight. This is not always easy—persons in crisis sometimes seem to have lost a sense of reality. Understanding this point can prove crucial when dealing with emotionally disturbed or mentally ill individuals.

"That leads me to a touchy subject. If you hear or recognize suicidal thoughts or ideology, ask the subject point blank if he's planning to commit suicide. Don't be afraid to ask this question outright—you aren't going to talk someone *into* committing suicide. You must recognize what options the subject is considering. If he says, "Maybe I should just end it all, that way I won't have to hurt anymore," ask this question: "Are you telling me you're thinking about committing suicide today?" Suggest that you and he try to work together on other possible solutions to the problem.

Demands & Deadlines

Pay close attention to demands or ultimatums made by the subject. What does he want? What does he think he needs? Be careful to avoid making offers or suggesting demands.

Demands made by the subject will provide negotiators a huge amount of insight into his thought process. Are his demands reasonable? Do they show some intent on his part to work through this situation? We must know that demands made by the subject reflect his mindset and are not simply thoughts or ideas that were prompted by our suggestions.

Should the subject begin threatening deadlines with demands, use stalling tactics. If, for instance, the subject threatens to hurt someone in 20 minutes if he can't have something, buy some time by telling him you must first get permission from your bosses. Explain it may take some time and effort to locate the item and get it to the scene. Let him know you're working on getting that item for him, but that it may take awhile.

Important: Be honest and realistic with the subject. If he asks for something completely unreasonable, such as "a case of whiskey, a pistol and a fully fueled jet so I can fly to Sweden," inform the subject that you don't think your bosses would ever give approval for something like that. Avoid simply telling the subject what you think he wants to hear. Think about it: An unrealistic demand may be his way of testing whether you will be truthful during

this process. Getting caught in a lie or making a promise you can't fulfill will seriously jeopardize any trust you may have gained up to this point.

Tactical Assessment

As communications with the subject continue, constantly assess tactical concerns and officer safety issues. Are you in a safe position with adequate cover? Have you notified responding officers and perimeter units of your exact position?

SWAT teams or tactical units will want as much intelligence as possible upon their arrival. Thomas Hamilton, deputy commander of the Lexington County (S.C.) Sheriff's Department SWAT team, suggests that first responders assess some of the following particulars if possible:

- What's the approximate location of the subject within the crisis site?
- Is he moving around, or does he seem localized?
- Did you hear any evidence of the subject barricading entry points or attempting to fortify his position?
- What types of weapons does he appear to have access to?
- Is he familiar with these weapons, or were they just available to him within the crisis site?
- Does he have military or police training?

Not only will this information assist the tactical units, it will also provide negotiators with additional clues regarding the subject's mindset and intentions.

One last thought: Don't simply look at your role in this situation as a temporary fix. If you've established a solid rapport and the subject is comfortable communicating with you, the negotiation commander arriving on scene will likely want to use this to their advantage. First responders are often asked to continue with communications while a trained negotiator serves as their coach. If the situation warrants introducing a new negotiator, use the rapport you have established in order to give credibility to this individual and the ongoing negotiation process.

Conclusion

Our ability to safely resolve or diffuse a crisis without using physical force can greatly enrich the confidence bestowed upon our profession by the citizens we are sworn to protect. The critical need for operational guidelines, policies and training that promotes and encourages a non-violent response to crisis situations becomes apparent when issues regarding public safety, public perception, liability and officer safety are examined or reviewed.

First responders who establish productive preliminary contact into a crisis site greatly enhance the odds of a successful and non-violent resolution. Never underestimate the importance of your role and the influence you may have in these situations. LOM

SCOTTIE FRIER is a lieutenant in the Violent Crimes Unit with the Lexington County (S.C.) Sheriff's Department. Frier also serves as the co-commander of the Crisis Negotiations Unit. He is a past president and current board member of the South Carolina Crisis Negotiators Association, which will hold its annual training conference in Myrtle Beach, S.C., on Oct. 16–18 (for more info, visit www.sccna.com). Contact Frier at 803/785-8611 or sfrier@lex-co.com.

Tips and Techniques

Portland Police Bureau

VOL. XL No. 14 July 19, 2004

Use of Force Report

The following needs to be reviewed carefully by all sworn and nonsworn Police Bureau members who will write or process the new Use of Force Report:

On August 1, 2004, the Police Bureau will adopt the new Use of Force Report. The report has been developed and will be implemented because of the continued review of Police Bureau policies and practices and because it brings the Police Bureau inline with many other law enforcement organizations around the country that already require this type of reporting.

The Use of Force Report will allow the Police Bureau to count, report and track the various uses of force by Police Bureau members during the course of their duties. The data will enable the Training Division to evaluate training and to recommend changes to training and policy, and will also aid in the continuing efforts of the Police Bureau to be accountable to the community - a critical element of community policing.

The majority of the report is a series of checking boxes and filling in lines to collect data and statistics. On the back, lower portion, of the report there is a section for a narrative. It is important that each Use of Force Report contain a complete and thorough narrative explaining the use of force and its justification. **Note:** You may write the narrative in another report such as a Custody or Investigative Report and refer to it in your Use of Force Report.

Every Bureau member who uses force, as defined in Directive 1010.20, and/or points a firearm, Taser or impact munitions at a person, shall use the Use of Force Report in addition to any other report currently required by Bureau policy. However, when more than one officer points a firearm or impact munitions at a person during an incident, only one officer is required to complete the Use of Force Report and document the pointing of weapons by other officers at the scene. The Use of Force Report condenses many other reports that are already used by Police Bureau members, including the Taser and Less Lethal (typically beanbag) reports. Members may discontinue use of those reports, but again, a narrative is still required.

Questions related to the completion of a Use of Force report should be directed to a supervisor.

The following are three scenarios that should help clarify the Bureau's policy on using the Use of Force Report:

Example #1: Officer Smith is a cover officer for Officer Jones at a verbal disturbance in a downtown nightclub. Upon arriving, Officer Smith applies a control hold on one of the subjects and escorts him out of the area to be interviewed. The force used by Officer Smith is not "...readily capable of causing injury."[1] Officer Smith subsequently releases the subject, without arresting him, uninjured. No Use of Force report is required for the control hold used in this incident.

[1] Ref. Directive 1010.20

Example #2: Officer Debry responds to SW 6th/Yamhill to a report of a man with a knife. Officer Debry parks a block away and waits for cover officers. However, before cover can arrive, the suspect approaches Officer Debry. From a distance of about 30 feet Officer Debry draws her pistol, points it at the suspect and orders him to drop the knife and lie on the ground. The suspect immediately complies and is taken into custody when cover officers arrive. Officer Debry must complete a Use of Force Report for pointing a firearm at a person - this is in addition to any other reports that she writes as a result of this incident. However, if the cover officers pointed firearms at the suspect, Officer Debry can document their involvement (pointing of a firearm) on the Use of Force Report and in her narrative report without the necessity of the covering officers completing a Use of Force Report.

Example #3: Officer Peel responds to a fight and briefly handcuffs one of the combatants, searches her and places her in his police car. After some investigation, it is determined that the subject in Officer Peel's car will be released. Officer Peel does so, but is required to complete a Use of Force Report to document the handcuffing of a subject, consistent with Bureau policy.

The following are step-by-step instructions to complete the Use of Force Report. There is also an example of a Use of Force Report attached to aid the user.

Introductory Section

Self explanatory; complete as you would other Police Bureau reports.

Conditions

Lighting Conditions:

This refers to the lighting conditions **where the use of force occurred**. It may refer to lighting conditions outdoors or the lighting conditions found inside a building, dwelling or other location. Therefore, an officer may report the lighting conditions as "low light" on a bright sunny afternoon because the use of force occurred in a dimly lit basement. Conversely, an officer might report the lighting conditions as "bright" on a dark rainy night because the use of force occurred in a brightly lit residence.

Applicable Suspect Conditions:

01 Actually armed: Checking this box means the suspect was actually armed with a weapon, whether or not the weapon was used. This includes: firearms, knives, clubs, brass knuckles or other devices that have been manufactured or modified or other items that can be used as weapons.

02 Reported to be armed: Checking this box means the suspect was reported to be armed. This information can be conveyed via police radio or by information gained by officers by some other means.

03 Assaulted officer: Self-explanatory

04 Assaulted citizen: Self-explanatory

05 History of violence: Checking this box means the officer knew of the suspect's history of violence **prior** to using force.

06 Failure to comply: Checking this means that the suspect is not actively physically resisting a police action, but is failing to comply. In certain situations an officer may be able to articulate that, in addition to failing to comply, the suspect is also indicating an "intent to engage in physical resistance" by means of clenching his/her fists, tensing muscles, etc. that could prompt an officer to check this box and box #07.

07 Engaged in or indicated the intent to engage in physical resistance: Checking this box means that the suspect is engaging in or intends to engage in behaviors that may necessitate the use of physical control by officers to control the suspect's actions.

08 Engaged in or indicated the intent to engage in aggressive physical resistance: Checking this box means that the suspect is engaging or intending to engage in behaviors that may necessitate the use of impact weapons to control the suspect's actions.

09 Other: This would be conditions not specifically referred to in #'s 1-8.

Under the Influence: Self-explanatory

Event Conditions

01 High-Risk Incident: Checking this box means the use of force arose out of a high-risk incident that could include high-risk vehicle stops, maintaining a perimeter on a location containing a suspected burglar, etc.

02 Search Warrant: Self-explanatory

03 Other: Many incidents cannot be easily categorized and will fall into the "other" category. These could include a foot pursuit, a domestic violence call, or a call to a report of an intoxicated individual.

Use of Force/Control Necessary to:

This requires that officers evaluate and check every box that applies. If a suspect engages in behaviors not listed in one of the eight categories, officers should write in the applicable conditions in either box #06 or #07.

Warning Given Before Deployment:

Self-explanatory

Control

Officers need to address every category even if it is only to check the "not applicable" box.

Physical Control: Check all that apply

Impact weapons: Check all that apply

Pepper Spray: Record the distance and number of sprays.

Pointing of Firearm or Impact Munitions: Officers will complete this section when they point a firearm or impact munitions directly at a person, to include depressed or low ready. This does not include firearms or impact munitions that are drawn for purposes of a building search, perimeter, or other high-risk situations where the weapon is not pointed at a person. Officers engaged in approved training are exempt from this requirement. When officers are involved in situations where more than one officer points a firearm or impact munitions at a person during a single incident, only one officer is required to complete the Use of Force Report. However, the reporting officer shall list how many officers pointed a weapon and shall identify the officers by name and DPSST # in the narrative section of the report. Officers shall also note the number of subjects at whom officers pointed firearms or impact munitions.

Discharge of Firearms

Officers shall complete this section most frequently when a firearm is discharged at an animal. In situations where officers discharge a firearm at a person, the report shall be completed by the detective investigating the incident.

Impact Munitions

Officers employing less lethal impact munitions shall complete this section of the report and shall report impact areas on the diagram on page 2 of the report.

Taser

Officers who deploy the Taser, including pointing the Taser at a person, shall complete this section of the form and report impact areas on the diagram below it.

Injuries

Injuries sustained by either the suspect or officer as a result of the use of force shall be reported in this section.

Checked by medical: This section needs to be completed in every instance in which force is used.

Taken to Hospital: Self-explanatory

Notification:

Indicate if a supervisor was notified and if he or she responded to the scene.

Narrative:

Except for very few situations, it is anticipated that the majority of use of force reports officers write will require continuation pages to be attached. Officers are encouraged to write as much as necessary to fully document the use of force.

DERRICK FOXWORTH
Chief of Police

Portland Police Bureau

USE OF FORCE REPORT

PAGE/OF 1-3

Sample Sample Sample

Case No.	Refer Case No.	Classification

Date/Time Reported	Date/Time Occurred	Location of Occurrence
7-15-04/2100	7-15-04/2100	SW 6th and Yamhill

	Name of Subject	CRN	Sex	Race	DOB
UF	DOE, Frank E.		M	W	01-01-77

Address	Hgt	Wgt	Hair	Eyes
1111 SW 2nd Ave., Portland, OR 97204	6'8"	225	Brown	Blue

Case No.

Conditions

Lighting Conditions: ☐ 01 DARK ☒ 02 LOW LIGHT ☐ 03 BRIGHT

Copies: ☐ Dets ☐ Cent ☐ East ☐ North ☐ NE ☐ SE ☐ PLM ☐ Trng ☐ Traf ☐ TOD

Applicable Suspect Conditions (Check all that apply)

- ☒ 01 Actually armed
- ☒ 02 Reported to be armed
- ☐ 03 Assaulted officer
- ☐ 04 Assaulted citizen
- ☐ 05 History of violence
- ☐ 06 Failure to comply
- ☐ 07 Engaged in or indicated the intent to engage in physical resistance
- ☒ 08 Engaged in or indicated the intent to engage in aggressive physical resistance
- ☐ 09 Other _____

Under the Influence (Check all that apply)

- ☐ 01 Alcohol
- ☐ 02 Drugs
- ☐ 03 Mental Illness
- ☒ 04 None apparent
- ☐ 05 Other (explain) _____

Event Conditions: ☒ 01 High risk incident ☐ 02 Search warrant ☐ 03 Other _____

Use of Force / Control Necessary to:

- ☒ 01 Defend self
- ☐ 02 Defend another
- ☒ 03 Make arrest
- ☐ 04 Prevent escape
- ☐ 05 Civil hold
- ☐ 06 Accomplish official purpose (explain) _____
- ☐ 07 Other _____

Warning Given Before Deployment: ☐ YES ☐ NO ☒ Not feasible

Control

Physical Control: ☐ 01 Pressure points ☒ 03 Control holds ☐ 05 Hobble ☐ 06 Not applicable
☒ 02 Handcuffing ☐ 04 Takedowns **Effective?** ☒ YES ☐ NO

Impact Weapons: ☐ 01 Hands/Feet ☐ 03 Flashlight ☐ 05 Other _____
☐ 02 Baton ☒ 04 Not applicable **Effective?** ☐ YES ☐ NO

Pepper Spray: Distance (Feet) ☐ 01 1-3' ☐ 02 4-7' ☐ 03 7'+ ☒ 04 Not applicable
Duration (Seconds) 1st _____ 2nd _____ 3rd _____ **Effective?** ☐ YES ☐ NO

Pointing of Firearm: # of Officers 1 # of Subjects 1
☒ 01 Handgun Distance (feet) 30 ☐ 03 AR-15 Distance (feet) _____ ☐ 05 Not applicable
☐ 02 Shotgun Distance (feet) _____ ☐ 04 Impact Munitions Distance (feet) _____

Discharge of Firearm ☒ Not applicable

Weapon	Subject	Result
☐ 01 Handgun (Primary) ☐ 03 Shotgun	☐ 01 Person ☐ 03 Other	☐ 01 Death ☐ 03 Missed
☐ 02 Handgun (Secondary) ☐ 04 AR-15	☐ 02 Animal _____	☐ 02 Injury

Impact Munitions ☒ Not applicable

Type/Distance

- ☐ 01 Bean bag _____ Feet
- ☐ 02 Stingers _____ Feet
- ☐ 03 Sage _____ Feet
- ☐ 04 Other _____ Feet _____

Effective? ☐ YES ☐ NO If not, why?

- ☐ 01 Clothing
- ☐ 02 Missed
- ☐ 03 Malfunction
- ☐ 04 No physical effect
- ☐ 05 Other _____

Rounds Fired _____ **Hits** _____

COMPUTER ENTRY Person _____ Entry _____

Reporting Officer	DPSST	Prec/Div	Rlf/Shift	Assn/Dist	Supervisor's Signature
S. Debry	1234	C	A	830	

Case No. Sample

Use of Force Report

Sample

Taser

☒ Not applicable

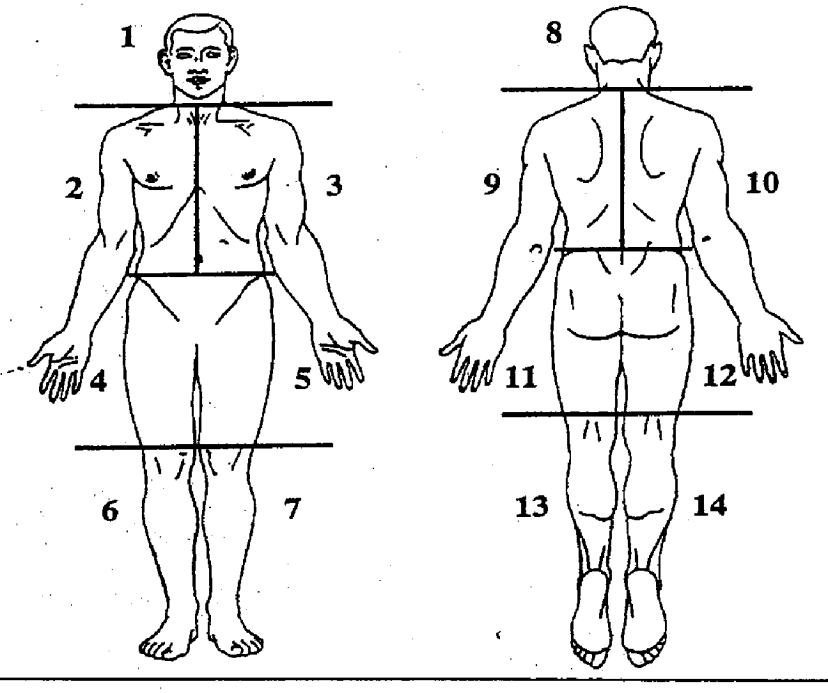
Application	Cycles	Distance (Feet)
☐ 01 Probe	☐ 1 ☐ 4	☐ 01 0-5' ☐ 03 11-15'
☐ 02 Drive stun	☐ 2 ☐ 5	☐ 02 6-10' ☐ 04 16-21'
☐ 03 Laser only	☐ 3 ☐ OTHER _____	

Did Probes Penetrate the Skin? ☐ YES ☐ NO

Effective? ☐ YES ☐ NO If not, why?

- ☐ 01 Heavy clothing
- ☐ 02 Close probe strikes
- ☐ 03 Low muscle mass
- ☐ 04 Subject moved
- ☐ 05 Missed
- ☐ 06 Malfunction
- ☐ 07 One probe
- ☐ 08 Other _____

Taser Serial # _____ **Cartridge #** _____



A = Drive Stun B = Probes C = Munitions D = Pepper Spray E = Impact Weapons

Injuries

	Officer	Suspect
01 None	☒	☒
02 Bruises	☐	☐
03 Abrasions	☐	☐
04 Lacerations	☐	☐
05 Broken bones	☐	☐
06 Other	☐	☐

_____

Checked by Medical

Officer	☐ YES	☒ NO
Suspect	☐ YES	☒ NO

Taken to Hospital — Where

Officer	☐ YES	☒ NO	_____
Suspect	☐ YES	☒ NO	_____

Notification: Superv. Notified: ☒ YES ☐ NO At Scene: ☐ YES ☒ NO Name / DPSST R. Jones / 4567

Narrative: 6. Officer J. Smith DPSST #789

8. On 7-15-04, 2100 hours, I was dispatched to SW 6th and Yamhill on a man with a Knife. Upon arrival, I parked my patrol vehicle on Morrison just west of 6th Avenue. I exited the patrol vehicle and walked to the corner of SW 6th and Morrison to see if I could see the subject with the Knife. Upon doing so, I observed a subject,

PORTLAND POLICE BUREAU

CONTINUATION REPORT Sample

PAGE/OF 3/3

CASE NO. SAMPLE | CLASSIFICATION

TYPE OF CONTINUATION ☐ INCIDENT ☐ TRAFFIC ACCIDENT ☐ CUSTODY ☐ SPECIAL

SUBJECT'S NAME: DOE, Frank E. | CRN | SEX: M | RACE: W | DOB: 01-01-77

LOCATION OF OCCURRENCE: SW 6th and Yamhill

CASE NO.

NARRATIVE–The order of appearance for additional information will be:
ITEM 1: ADDITIONAL PERSON INFO–List additional people (not suspects) and identify their involvement with the appropriate code. Additional person info includes contacts.
ITEM 2: ADDITIONAL SUSPECT INFO–Report all suspect info on additional incident reports. Each suspect must have coded crime analysis descriptors. Detail in the narrative only suspect info not covered in the boxes.
ITEM 3: ADDITIONAL VEHICLE INFO–List additional vehicles in the same fashion as reported in the vehicle section. Include the identifying code.
ITEM 4: ADDITIONAL WORTHLESS DOCUMENTS–Record multiple worthless documents on a multiple worthless document form and attach as additional pages. Record in the narrative the number of worthless documents written.
ITEM 5: ADDITIONAL PROPERTY–Record no more than four additional items of property in the narrative–and/or use a special report and attach as additional pages.
ITEM 6: ADDITIONAL OFFICERS–List all officers present and identify their involvement with the incident being reported.
ITEM 7: SUMMARY–A short summary is necessary if the narrative is more than one full page in length.
ITEM 8: NARRATIVE–List in chronological order all of the relevant details in the incident and/or elements of the crime or violation.

ITEM	CODE	
		later identified as DOE, walking directly towards me with a knife in his hand (30 feet away). DOE stated to me, "I am going to kill you." I immediately pointed my handgun at him and directed him to drop the knife. He complied. I then ordered him into the prone handcuffing position. He complied. Seconds later Officer J. Smith (DPSST #789) arrived and handcuffed DOE without incident. For further details, see the Custody Report.

REPORTING OFFICER(S)	BPST	PREC/DIV	RLF/SHFT	ASSN/DIST	SUPERVISOR'S SIGNATURE
S. Derby	1234	C	A	830	

PPB–CR–9/84

267 (9/96)

Tips & Techniques
Portland Police Bureau

VOL. MMI, No. 20 October 4, 2001

MOBILE CRISIS TEAM (MCT)
(Mobile Mental Health Response)

WHAT IS THE MCT? Three mental health agencies and the County are collaborating to provide mobile crisis response services County-wide. The MCT will be comprised of master's level clinicians, working either singly or in pairs, depending on the needs of each specific request.

IS THIS DIFFERENT FROM PROJECT RESPOND? For Central Precinct officers who have been working with Project Respond, the Project Respond team will continue to function as it always has, providing crisis response and outreach services in the downtown core and west side. The MCT will be comprised of additional staff to provide crisis response services through the other areas of the County.

WHAT SERVICES WILL MCT PROVIDE? Similar to Project Respond in the downtown and Westside area, the MCT will provide field-based (on-site) mental health consultation to law enforcement and the community. Services will include, but are not limited to, assessment for hospitalization, alternative plans to avoid hospitalization in cases where it is not clinically required, referrals to other social services, and short-term follow-up.

WHEN SHOULD YOU CALL FOR MCT? Any time that you believe that a mental health professional might be of help, including: possible hospitalizations, thorough mental health assessment (in those "gray" cases), or calls where citizens are particularly distraught (i.e., victims of crime, etc.).

WHEN SHOULD YOU NOT CALL MCT? In cases where the primary problem is acute intoxication, MCT will not be of much help. In those cases, however (particularly those where you may be receiving multiple calls to the same home), you are welcome to contact the team at a later time to consult about possible intervention or follow-up.

Calls Involving Children under the Age of 14: Mental health providers cannot speak to children under the age of 14 without the permission of the child's parent or legal guardian. The only exception to this is in situations where mental health intervention is needed to address a life-threatening situation; in these cases, the child would most probably be transported to an emergency room. Therefore, we will only be able to respond to calls involving children under 14 in the following situations:

- The parent/legal guardian is on scene and will give permission for us to meet with the child.
- The child is in SCF or OYA custody, and SCF/OYA staff have requested our presence.

- You have spoken directly with the parent or guardian and they have given you permission to have us come to the scene (you may have to testify that you were given permission).
- An equally reliable professional source (teacher, school counselor, etc.) will confirm that they have been given parental permission (again, they would need to be sure enough to testify on that issue).

HOW DO YOU REACH THE MCT? We have developed a protocol with BOEC to contact the Mobile Crisis Teams through our phone center (where staff will be tracking the availability and location of all MCT staff on shift, allowing them to provide BOEC with availability, ETA, etc.). Please make your request for MCT through BOEC. You will be asked to provide the following information:

- Name/DOB (if available) of the person for whom you are requesting help (to allow us to search our records before coming out)
- Location
- Your name/badge no.
- Cell phone number (if available)
- Brief summary of the situation and the service you are requesting

For officers who may have use of a cell phone, you will be given the option of providing BOEC with a callback number, so that you can speak directly with the MCT that will be responding to your call.

WHAT WILL HAPPEN WHEN THE MCT ARRIVES ON SCENE? MCT staff will consult with you prior to meeting with the client (whenever possible) to get your input on the situation, and to ask what you would like the Team to accomplish during our contact.

WHAT ARE THE HOURS OF THE MCT? MCT will be available 24 hours a day, seven days a week.

WHEN DOES THE SERVICE START? The MCT started the expanded service to the east side September 1st. Although the MCT will have staff on each of the three shifts, the MCT management is still in the process of filling all of the positions. Please request MCT assistance in any and all cases that you wish. The staffing levels of the program will be directly determined by the requests for service; accordingly, the more requests for service received, the sooner staffing levels will be increased to meet the needs of the community.

HOW MANY MCT STAFF ARE THERE? Five staff members are currently dedicated to the east side response teams. A single staff member will be working the overnight shifts; accordingly, during those overnight shifts (10pm - 8am) the MCT member will only be providing mobile response services to law enforcement, and to the emergency rooms. MCT is continuing to hire for the team, and will keep law enforcement agencies posted on a monthly basis about our staffing levels.

WHO TO CALL IF YOU HAVE PROBLEMS, CONCERNS, SUGGESTIONS? CIT Coordinator at (503) 823-0183.

Mark A. Kroeker
Chief of Police

Tips & Techniques

Portland Police Bureau

VOL. MMI No. 18 *October 2, 2001*

Distraction Principle

The majority of arrests performed by officers are uneventful. Usually the person being taken into custody is cooperative and offers no resistance. On occasion an officer will have to take into custody and handcuff a person who is uncooperative, physically resistant, and even combative in response to the efforts of the officer(s).

The Police Bureau's Training Division provides officers with numerous arrest techniques to take a person into custody. These techniques are designed to provide a margin of safety for the officers, while placing the person being taken into custody at a disadvantage. These techniques also contribute to minimizing injuries to officers and suspects. Regardless of the arrest techniques that officers choose, they should be aware of the option of **distracting** a subject just prior to, or while taking the subject into custody. As a reminder, the Training Division's Defensive Tactics Program teaches the following **Principle** which states:

> ***"In times of stress or concentration, the mind focuses on the most important element of the situation. Any sudden act of significant magnitude will break the concentration, causing the mind to momentarily focus on the distraction."***

This principle, when correctly applied, allows police officers to gain or maintain control of a subject by refocusing his or her concentration. Specific distractions are too numerous to list, but can be categorized into verbal and physical distractions. Physical distractions can include, but are not limited to, pressure point controls, control holds and hand gestures. Verbal distractions can include comments and commands designed to cause a person to momentarily look away while the officer initiates the custody.

However, when a person engages in aggressive physical resistance, or is combative, thus threatening the officer's safety, the officer is authorized to use whatever force is reasonable and necessary in accordance with the Police Bureau's training and use of force policy. Nothing in this Bulletin is intended to limit an officer's use of force

that is reasonable under the circumstances to maintain officer safety, to effect an arrest, or to conduct other official action.

Bureau members are aware that punches, knee strikes, elbow strikes and kicks are defined as Impact Weapons on PPB's Levels of Control and are considered a use of physical force as covered in the Use of Force G.O. 1010.20.

Officers will not use the phrase "distraction techniques" in written reports or testimony. Rather, officers will specifically detail the subject's behavior and other factors that led up to the decision to use that force they believe reasonable and necessary to control the person. Officers must document any type of force used to overcome physical and/or combative resistance. Officers should also list any safety concerns for themselves, the subject or others that they identified during the arresting process.

Officers will include in their reports any injuries known to have been incurred or claimed by the subject before and during the arrest process. Officer's injuries should also be documented in reports.

It is important for officers to remember that their actions must be reasonable given a subject's behavior, and if feasible, the subject should be given the opportunity to comply with the officer's commands.

Any questions regarding this bulletin can be directed to the Training Division.

Mark C. Kroeker

MARK A. KROEKER
Chief of Police

01-18
Submitted by Training Division

TRAINING BULLETIN
PORTLAND POLICE BUREAU

VOL. XXXIV, No. 1 *Revision #2: January 12, 1998*

WHAT IS THE "SUDDEN DEATH SYNDROME" (SDS)?

Officers are frequently called upon to assist in subduing subjects who are involved in extremely bizarre and violent behavior. Occasionally, the subject may be displaying symptoms of SUDDEN DEATH SYNDROME and could die while in the officer's custody.

SDS is a category of deaths which has no apparent detectable anatomical cause, which can occur while, or shortly after, a person is taken into custody. Generally, SDS has been associated with positional asphyxia, drug-induced excited delirium, cocaine psychosis, and/or neuroleptic malignant syndrome.

In the past several years there have been numerous deaths nation-wide which have occurred during custody or shortly after a police encounter. In the majority of these cases the autopsies did not reveal any basis for anatomical death--a "negative autopsy." Since there was no anatomical cause of death, many of the deaths were initially listed as being a result of police practices (e.g., oleoresin capsicum (OC) aerosol exposure, carotid restraint, and/or positional asphyxia). **Fortunately the autopsies, and the concurrent investigations, did identify several signs which preceded the unexplainable deaths of the individuals.** Some of these warning signs are:

* **Bizarre Behaviors**--including paranoia (e.g., hiding behind bushes, trees, or cars), hallucinations, hearing voices, extreme aggression toward objects (particularly glass), violent resistance/struggling, inappropriate nudity, hyperactivity prior to and during police contact, and/or self-inflicted injuries.

* **Bizarre Communications**--including talking incoherently, screaming, and yelling.

* **Physical Symptoms**--including hyperthermia (excessive body temperature), profuse sweating, seizures, foaming at the mouth, dilated pupils, uncontrollable shaking, inability to breathe, and extraordinary strength.

* **Officers' Actions** in encountering a SDS person often requires several officers and usually involves a strenuous confrontation, as the person displays abnormal strength. Several of these encounters have resulted in officers using carotid restraints, OC, and/or hogtying.

This Training Bulletin indicates to an officer what (s)he will do when (s)he comes into contact, while in the line of duty, with a person who is exhibiting behavior which would indicate a likelihood of suffering from "Sudden Death Syndrome" (SDS).

1. **Definitions**
   a. **Asphyxia** is a person's inability to move air in and out of his/her lungs which results in death due to a lack of adequate oxygenation (suffocation).
   b. **Cocaine Psychosis** is excited delirium that is induced by cocaine ingestion.
   c. **Sudden Death Syndrome (SDS)** is a category of deaths which has no apparent detectable anatomical cause and which occurs while, or shortly after, a person is taken into custody. SDS has been associated with positional asphyxia, drug-induced excited delirium, cocaine psychosis, and/or neuroleptic malignant syndrome, as noted in G.O. 870.20 (Handcuffing, Searching, and Transportation) on page 5, line 25.
   d. **Excited Delirium** "is an acute mental disorder characterized by impaired thinking, disorientation, visual hallucination and illusions."
   e. **Maximum Restraint Position** means to connect a person's bound hands with the person's bound feet with some form of restraint.
   f. **Neuroleptic Malignant Syndrome (NMS)** is similar to drug-induced excited delirium and is a recognized cause of sudden death. NMS generally occurs in psychiatric patients who are taking antipsychotic medications. However, NMS can also occur in individuals who are not taking antipsychotic medications.
   g. **Positional Asphyxia (Suffocation)** "occurs when body position interferes with respiration, resulting in asphyxia." Positional asphyxia is the result of interference with the muscular or mechanical components of respiration. When a person is suffering from positional asphyxia there is usually one or more contributing factors that restrict the person's ability to correct the problem causing the respiratory deficiency. The contributing factors can include alcohol and/or drug intoxication, head injury, entrapment, restraint, and/or some other physical disability. Positional asphyxia can be caused by:
      (1) confined space,
      (2) obesity and/or a large stomach can interfere with respiration when placed in a prone position,
      (3) contour of a vehicle's floor--if the person's abdomen is pressed against the floor or the drive shaft hump of a vehicle,
      (4) maximum restraint in the prone (face-down) position.

2. **Sudden Death Syndrome (SDS) Assessment Factors**--the following factors will only be considered if KNOWN (observed) by the officer or described by witnesses AND if NOT APPROPRIATE to the totality of the circumstances:
   a. **Primary SDS Assessment Factors:**
      (1) bizarre behaviors:
         (a) removal of clothing,
         (b) extreme aggression toward objects--particularly glass,
         (c) self-inflicted injuries, and/or
         (d) violent resistance or physical struggling with officers;
      (2) bizarre communications:
         (a) incoherent screaming/yelling;
      (3) physical observations (observed by, or reported to, the officer):
         (a) uncontrollable shaking,
         (b) skin tone and coloration,
         (c) extraordinary strength,
         (d) inability to breathe,
         (e) seizures and/or,
         (f) unconsciousness.
   b. **Secondary SDS Assessment Factors:**
      (1) bizarre behaviors:
         (a) paranoia (hiding behind bushes, trees, cars, etc.),
         (b) hallucinations,
         (c) hearing voices, and/or
         (d) hyperactivity prior to officer contact;
      (2) bizarre communications:
         (a) talking incoherently and/or
         (b) speaking to imaginary people and/or things;
      (3) physical symptoms:
         (a) hyperthermia (excessive body temperature),
         (b) profuse sweating,
         (c) foaming at the mouth, and/or
         (d) dilated pupils.

      Note: Likely SDS Suspect, for purposes of this bulletin, is a person whom an officer has observed to be exhibiting at least two of the Primary SDS Assessment Factors, or one Primary and two Secondary SDS Assessment Factors.

3. **When An Officer Observes Sufficient SDS Assessment Factors to Believe That the Person Observed is Likely to Suffer SDS (S)he Should Attempt the Following:**
   a. **During the Confrontation**--when reasonable and tactically sound, an officer should attempt to limit the type and duration of physical exertion by the SDS candidate. The longer the physical exertion continues, the greater likelihood of the person being consumed by the SDS.
   b. **After the SDS Person is Controlled (voluntarily or involuntarily) the Officer Should:**
      (1) attempt to calm the person--as reasonable time and circumstances permit;
      (2) place the person in a position that does not knowingly and significantly restrict breathing, e.g., place the person on his/her side, seat the person in an upright position, etc.;
      (3) closely monitor the person's apparent, or suspected, medical needs (within the officer's medical training and experience) as reasonable circumstances permit.

c. **Medical Attention** (the principal objectives of this section are to arrange for a likely SDS sufferer to be assisted by emergency medical personnel and to arrange for the person to be transported to an emergency medical facility as soon as practicable). An officer shall:
   (1) arrange for EMT response to aid the person likely to be suffering SDS--this medical attention will be requested, summoned, and/or provided as soon as reasonable after the officer observes the SDS Assessment Factors,
   (2) arrange for the person to be transported by ambulance to an emergency medical center--this can include requesting an ambulance when emergency medical personnel are requested,
   (3) inform the medical personnel of your concerns and observations as soon as practicable after the medical personnel make contact with the SDS sufferer.

d. **If the SDS Subject is Transported by Officers**--the subject shall be transported by two (2) officers. The second officer will closely observe the subject and be aware of:
   (1) uncontrollable shaking,
   (2) skin tone and coloration,
   (3) extraordinary strength,
   (4) inability to breathe,
   (5) seizures,
   (6) unconsciousness,
   (7) hyperthermia (excessive body temperature),
   (8) profuse sweating,
   (9) foaming at the mouth, and/or
   (10) dilated pupils.

e. **Report**--all officers involved with a probable SDS sufferer will prepare a detailed written report of the incident within a reasonable time after the encounter--this report may be combined with a routine incident report, and a copy of the report will be sent to the Police Liability Manager. In addition to routine incident details, this report will include:
   (1) the officer's observations and assessment of the SDS Assessment Factors,
   (2) the officer's actions in attempting to reasonably limit the confrontation and its duration,
   (3) the officer's actions in attempting to restrain and/or in restraining the person (including all force levels used in detail),
   (4) the officer's actions while waiting for medical personnel to arrive,
   (5) the officer's statements to medical personnel regarding his/her SDS Assessment Factors.

f. **Notification**--a supervisor shall be notified if an officer utilizes the maximum restraint position or is involved with a probable SDS sufferer.

Refer: G.O. 870.20

98-1
Information taken from *Legal Defense Manual*, Brief #95-1, pp. 13-17.
Submitted by Officer Rich Austria and PLM Roger Haven
Original Issue Date: October 6, 1995
Original Number: VOL. XXXI, No. 11

TRAINING BULLETIN
PORTLAND POLICE BUREAU

VOL. XXXIV, No. 1 *Revision #2: January 12, 1998*

WHAT IS THE "SUDDEN DEATH SYNDROME" (SDS)?

Officers are frequently called upon to assist in subduing subjects who are involved in extremely bizarre and violent behavior. Occasionally, the subject may be displaying symptoms of SUDDEN DEATH SYNDROME and could die while in the officer's custody.

SDS is a category of deaths which has no apparent detectable anatomical cause, which can occur while, or shortly after, a person is taken into custody. Generally, SDS has been associated with positional asphyxia, drug-induced excited delirium, cocaine psychosis, and/or neuroleptic malignant syndrome.

In the past several years there have been numerous deaths nation-wide which have occurred during custody or shortly after a police encounter. In the majority of these cases the autopsies did not reveal any basis for anatomical death--a "negative autopsy." Since there was no anatomical cause of death, many of the deaths were initially listed as being a result of police practices (e.g., oleoresin capsicum (OC) aerosol exposure, carotid restraint, and/or positional asphyxia). **Fortunately the autopsies, and the concurrent investigations, did identify several signs which preceded the unexplainable deaths of the individuals.** Some of these warning signs are:

* **Bizarre Behaviors**--including paranoia (e.g., hiding behind bushes, trees, or cars), hallucinations, hearing voices, extreme aggression toward objects (particularly glass), violent resistance/struggling, inappropriate nudity, hyperactivity prior to and during police contact, and/or self-inflicted injuries.

* **Bizarre Communications**--including talking incoherently, screaming, and yelling.

* **Physical Symptoms**--including hyperthermia (excessive body temperature), profuse sweating, seizures, foaming at the mouth, dilated pupils, uncontrollable shaking, inability to breathe, and extraordinary strength.

* **Officers' Actions** in encountering a SDS person often requires several officers and usually involves a strenuous confrontation, as the person displays abnormal strength. Several of these encounters have resulted in officers using carotid restraints, OC, and/or hogtying.

This Training Bulletin indicates to an officer what (s)he will do when (s)he comes into contact, while in the line of duty, with a person who is exhibiting behavior which would indicate a likelihood of suffering from "Sudden Death Syndrome" (SDS).

1. **Definitions**
   a. **Asphyxia** is a person's inability to move air in and out of his/her lungs which results in death due to a lack of adequate oxygenation (suffocation).
   b. **Cocaine Psychosis** is excited delirium that is induced by cocaine ingestion.
   c. **Sudden Death Syndrome (SDS)** is a category of deaths which has no apparent detectable anatomical cause and which occurs while, or shortly after, a person is taken into custody. SDS has been associated with positional asphyxia, drug-induced excited delirium, cocaine psychosis, and/or neuroleptic malignant syndrome, as noted in G.O. 870.20 (Handcuffing, Searching, and Transportation) on page 5, line 25.
   d. **Excited Delirium** "is an acute mental disorder characterized by impaired thinking, disorientation, visual hallucination and illusions."
   e. **Maximum Restraint Position** means to connect a person's bound hands with the person's bound feet with some form of restraint.
   f. **Neuroleptic Malignant Syndrome (NMS)** is similar to drug-induced excited delirium and is a recognized cause of sudden death. NMS generally occurs in psychiatric patients who are taking antipsychotic medications. However, NMS can also occur in individuals who are not taking antipsychotic medications.
   g. **Positional Asphyxia (Suffocation)** "occurs when body position interferes with respiration, resulting in asphyxia." Positional asphyxia is the result of interference with the muscular or mechanical components of respiration. When a person is suffering from positional asphyxia there is usually one or more contributing factors that restrict the person's ability to correct the problem causing the respiratory deficiency. The contributing factors can include alcohol and/or drug intoxication, head injury, entrapment, restraint, and/or some other physical disability. Positional asphyxia can be caused by:
      (1) confined space,
      (2) obesity and/or a large stomach can interfere with respiration when placed in a prone position,
      (3) contour of a vehicle's floor--if the person's abdomen is pressed against the floor or the drive shaft hump of a vehicle,
      (4) maximum restraint in the prone (face-down) position.

2. **Sudden Death Syndrome (SDS) Assessment Factors**--the following factors will only be considered if KNOWN (observed) by the officer or described by witnesses AND if NOT APPROPRIATE to the totality of the circumstances:
   a. **Primary SDS Assessment Factors:**
      (1) bizarre behaviors:
         (a) removal of clothing,
         (b) extreme aggression toward objects--particularly glass,
         (c) self-inflicted injuries, and/or
         (d) violent resistance or physical struggling with officers;
      (2) bizarre communications:
         (a) incoherent screaming/yelling;
      (3) physical observations (observed by, or reported to, the officer):
         (a) uncontrollable shaking,
         (b) skin tone and coloration,
         (c) extraordinary strength,
         (d) inability to breathe,
         (e) seizures and/or,
         (f) unconsciousness.
   b. **Secondary SDS Assessment Factors:**
      (1) bizarre behaviors:
         (a) paranoia (hiding behind bushes, trees, cars, etc.),
         (b) hallucinations,
         (c) hearing voices, and/or
         (d) hyperactivity prior to officer contact;
      (2) bizarre communications:
         (a) talking incoherently and/or
         (b) speaking to imaginary people and/or things;
      (3) physical symptoms:
         (a) hyperthermia (excessive body temperature),
         (b) profuse sweating,
         (c) foaming at the mouth, and/or
         (d) dilated pupils.

      Note: Likely SDS Suspect, for purposes of this bulletin, is a person whom an officer has observed to be exhibiting at least two of the Primary SDS Assessment Factors, or one Primary and two Secondary SDS Assessment Factors.

3. **When An Officer Observes Sufficient SDS Assessment Factors to Believe That the Person Observed is Likely to Suffer SDS (S)he Should Attempt the Following:**
   a. **During the Confrontation**--when reasonable and tactically sound, an officer should attempt to limit the type and duration of physical exertion by the SDS candidate. The longer the physical exertion continues, the greater likelihood of the person being consumed by the SDS.
   b. **After the SDS Person is Controlled (voluntarily or involuntarily) the Officer Should:**
      (1) attempt to calm the person--as reasonable time and circumstances permit;
      (2) place the person in a position that does not knowingly and significantly restrict breathing, e.g., place the person on his/her side, seat the person in an upright position, etc.;
      (3) closely monitor the person's apparent, or suspected, medical needs (within the officer's medical training and experience) as reasonable circumstances permit.

c. **Medical Attention** (the principal objectives of this section are to arrange for a likely SDS sufferer to be assisted by emergency medical personnel and to arrange for the person to be transported to an emergency medical facility as soon as practicable). An officer shall:
   (1) arrange for EMT response to aid the person likely to be suffering SDS--this medical attention will be requested, summoned, and/or provided as soon as reasonable after the officer observes the SDS Assessment Factors,
   (2) arrange for the person to be transported by ambulance to an emergency medical center--this can include requesting an ambulance when emergency medical personnel are requested,
   (3) inform the medical personnel of your concerns and observations as soon as practicable after the medical personnel make contact with the SDS sufferer.

d. **If the SDS Subject is Transported by Officers**--the subject shall be transported by two (2) officers. The second officer will closely observe the subject and be aware of:
   (1) uncontrollable shaking,
   (2) skin tone and coloration,
   (3) extraordinary strength,
   (4) inability to breathe,
   (5) seizures,
   (6) unconsciousness,
   (7) hyperthermia (excessive body temperature),
   (8) profuse sweating,
   (9) foaming at the mouth, and/or
   (10) dilated pupils.

e. **Report**--all officers involved with a probable SDS sufferer will prepare a detailed written report of the incident within a reasonable time after the encounter--this report may be combined with a routine incident report, and a copy of the report will be sent to the Police Liability Manager. In addition to routine incident details, this report will include:
   (1) the officer's observations and assessment of the SDS Assessment Factors,
   (2) the officer's actions in attempting to reasonably limit the confrontation and its duration,
   (3) the officer's actions in attempting to restrain and/or in restraining the person (including all force levels used in detail),
   (4) the officer's actions while waiting for medical personnel to arrive,
   (5) the officer's statements to medical personnel regarding his/her SDS Assessment Factors.

f. **Notification**--a supervisor shall be notified if an officer utilizes the maximum restraint position or is involved with a probable SDS sufferer.

Refer: G.O. 870.20

98-1
Information taken from *Legal Defense Manual*, Brief #95-1, pp. 13-17.
Submitted by Officer Rich Austria and PLM Roger Haven
Original Issue Date: October 6, 1995
Original Number: VOL. XXXI, No. 11

Tips and Techniques

Portland Police Bureau

VOL. XLIII No. 8 October 29, 2007

Force Data Collection Report

The following, in conjunction with the roll call video, needs to be reviewed carefully by all sworn and non-sworn Police Bureau members who will write or process the new Force Data Collection Report. The new Force Data Collection Report contains significant changes to when and how the report will be completed.

On November 5, 2007, the Police Bureau will adopt the new Force Data Collection Report. This report was developed based on review of the old Use of Force Report and will be implemented because of the continued review of Police Bureau policies and practices. The proper tracking of data will help the Training Division to continually review effectiveness of training and bureau equipment, and to recommend changes to training and policy.

The majority of the report is in a check-a-box format for ease of use. The back of the report now contains a larger narrative section for bureau members to use to ensure a complete and thorough narrative documenting the use of force and the justification for the application of force. You still may write the narrative in another report such as a Custody or Investigative Report and refer to it in your Force Data Collection Report.

The Force Data Collection Report is categorized in sections. In order to instruct the manner in which to fill out the report properly, each section will be described thoroughly to establish new requirements and to distinguish requirements that have stayed the same.

Step-by-step instructions:

Top Section

Complete this section as you would other Police Bureau reports.

Perceived Suspect Conditions

Simply check the boxes that apply to this incident; more than one box can be checked.

01 Actually/Perceived Armed: Checking this box means the subject was actually armed or you perceived the subject to be armed with a weapon. This includes deadly weapons, dangerous weapons, or any other object that can be used as a weapon.

02 Reported to be Armed: Checking this box means the subject was reported to be armed. This information can become available to members from a variety of sources.

Submitted by: Sergeant Mike Marshman, Chief's Office
Original Issue Date: October 29, 2007
Original Number: Vol. XLIII, No. 08

03 Assaulted Officer: Self-explanatory

04 Assaulted Citizen: Self-explanatory

05 History of Violence: Checking this box means the information received about the subject's violent history became known **prior** to **this** incident and prior to contact with the subject.

06 Failure to Comply: Checking this box means the subject did not obey or comply with officers' demands or commands. Failing to comply does not mean actively physically resisting.

07 Engaged in or Indicated the Intent to Engage in Physical Resistance: Checking this box means that the subject is engaging in or intends to engage in behaviors that may cause the officer(s) to use physical control.

08 Engaged in or Indicated the Intent to Engage in Aggressive Physical Resistance: Checking this box means that the subject is engaging in or intends to engage in behaviors that may cause the officer(s) to use physical force.

09 High Risk Incident/Custody: Checking this box means the subject was engaged in activity that caused the officer(s) to utilize a more dynamic tactical doctrine; for example, a felony car stop or a warrant entry on a residence.

10 Alcohol (under the influence of): Self-explanatory

11 Drugs (under the influence of): Self-explanatory

12 Mental Illness: Self-explanatory

13 None Apparent: Self-explanatory

14 Other: Self-explanatory but if this box is checked, the details need to be documented in the narrative section of the report.

Use of Force/Control Necessary to

This section is self-explanatory. Check all of the boxes that apply, more than one box can be checked. If box, 06 other, is checked, note the details in the narrative section of the report.

Officer Activity Immediately Prior to Force Response

This section denotes what activity the officer was doing immediately prior to a force response from the officer. Most of the options listed are self-explanatory. Box 06 Transporting in Vehicle may need clarification based on the new reporting guidelines. It is possible to have a handcuffed prisoner in a patrol vehicle in transit to jail where the method used to gain custody of the prisoner did not require the Force Data Collection Report to be written. While in route to jail, it might be necessary to use maximum restraints on the prisoner based on their actions in the patrol vehicle. In this rare instance, box 06, Transporting in Vehicle would be checked.

Subject Was Injured

Boxes 01 through 04 are self-explanatory.
Note: If the subject was not injured, leave this section blank and check *none* in the next section for subject injuries.

Injuries

Checking these boxes indicate the injuries that the officer and/or the suspect received **during this incident**. If the suspect was injured prior to this incident, box 01 of the previous section (Subject Was Injured) should be checked with the appropriate documentation noted in the narrative section of the report.

Force Options Used

If one or more of the force options boxes are checked, the member needs to check if the force option was effective; yes or no. If the force option box was not checked, there is no need to check the effective box.

01 Control Holds Causing Injury: Checking this box means the control hold applied caused a **substantial degree of pain** that lasted for a **substantial duration of time**. Injury is more than substantial pain as defined by ORS. Without the substantial degree of pain in conjunction with a substantial duration of time, the criteria of causing injury has not been met and this box need not be checked. The basis for a substantial duration of time is a period lasting fifteen (15) minutes or longer. A control hold that causes a substantial degree of pain for less than fifteen minutes does not meet the reporting criteria for this report. Pain that lasts for less than fifteen minutes has been termed a fleeting sensation.

02 Takedowns: Checking this box means the officer took a subject to the ground by utilizing their own strength to move the subject to the ground. It is not a takedown if the officer used a control hold combined with verbal commands to successfully persuade the subject to go to the ground under the subjects own power.

03 Hobble: Self-explanatory

04 Hands/Feet: Checking this box means the officer used a part of their body to strike a subject to gain compliance. This box also applies to knees, elbows, etc.

05 Baton: Self-explanatory

06 Pepper Spray: Checking this box simply means you used pepper spray on the subject regardless of how many sprays and for what duration.

07 Taser: Checking this box means the member deployed the taser in the drive stun and/or probes manner. If the member only pointed the taser at a subject, regardless if the laser was activated or not, this box should **not** be checked and therefore a report is not required.

08 Bean Bag Round(s): Checking this box means a member fired less than lethal impact munitions at a subject. If a member only pointed impact munitions weapons at a subject, this box should **not** be checked.

09 Point Firearm: Checking this box means a member pointed their duty weapon at a subject. A duty weapon is the member's handgun, shotgun, and/or AR-15.

Treatment Received

The treatment received section describes the medical treatment received by the officer and/or the suspect. This section is self-explanatory and as stated, more than one box can be checked

Notification

This section of the report is self-explanatory.

Narrative

It is expected that most Force Data Collection Reports will not be stand-alone reports. Bureau members are expected to write complete and thorough reports to fully document the circumstances for the amount and type of force used for each incident.

Rosanne M. Sizer
By Acting Chief B. Martinek

ROSANNE M. SIZER
Chief of Police

Portland Police Bureau

FORCE DATA COLLECTION REPORT

PAGE/OF 1/

Case No. | Refer Case No. | Classification

Original Report Date/Time | This Report Date/Time | Location of Occurrence

UF | Name of Subject | CRN | Sex | Race | DOB

Address | Hgt | Wgt | Hair | Eyes

Home Phone | Mobile Phone | Work/Message Phone

Case No.

Copies
- Dets
- Cent
- East
- North
- NE
- SE
- Traf
- PLM
- Tmg

Perceived Subject Conditions (Check All That Apply)

- 1 Actually/Perceived Armed
- 2 Reported to be Armed
- 3 Assaulted Officer
- 4 Assaulted Citizen
- 5 History of Violence
- 6 Failure to Comply
- 7 Engaged in or Indicated the Intent to Engage in Physical Resistance
- 8 Engaged in or Indicated the Intent to Engage in Aggressive Physical Resistance
- 9 High Risk Incident/Custody
- 10 Alcohol (under the influence of)
- 11 Drugs (under the influence of)
- 12 Mental Illness
- 13 None Apparent
- 14 Other

Use of Force/Control Necessary to (Check All That Apply)

- 1 Defend Self
- 2 Defend Another
- 3 Make Arrest
- 4 Prevent Escape
- 5 Civil Hold
- 6 Other

Officer Activity Immediately Prior To Force Response (Check All That Apply)

- 1 Foot Pursuit
- 2 Subject Escort
- 3 Person Search (Cuffed)
- 4 Person Search (Not Cuffed)
- 5 Handcuffing
- 6 Transporting in Vehicle
- 7 Interview Interrogation
- 8 Other

Subject Was Injured (Check All That Apply)

- 1 Prior to Police Involvement
- 2 During Arrest
- 3 In Custody
- 4 Other

Injuries (Check All That Apply)

	1 None	2 Bruises	3 Abrasions	4 Lacerations	5 Broken Bones	6 Other Injuries
Officer	☐	☐	☐	☐	☐	☐
Subject	☐	☐	☐	☐	☐	☐

Force Options Used (Check All That Apply)

1 Control Holds Causing Injury	Effective:	☐ Yes	☐ No
2 Takedowns	Effective:	☐ Yes	☐ No
3 Hobble	Effective:	☐ Yes	☐ No
4 Hands/Feet	Effective:	☐ Yes	☐ No
5 Baton	Effective:	☐ Yes	☐ No
6 Pepper Spray	Effective:	☐ Yes	☐ No
7 Taser	Effective:	☐ Yes	☐ No
8 Bean Bag Round(s)	Effective:	☐ Yes	☐ No
9 Point Firearm	Effective:	☐ Yes	☐ No

Treatment Received (Check All That Apply)

	Officer	Subject
1 EMS at Scene	☐	☐
2 EMS at Precinct	☐	☐
3 Hospital/Admitted	☐	☐
4 Hospital/Released	☐	☐
5 Treatment Refused		☐
6 Self Treatment		☐
7 Mental Health Admission		☐

Computer Entry Person

Entry

Notification

Supervisor Notified: ☐ Yes ☐ No **At Scene:** ☐ Yes ☐ No **Name/DPSST:**

Reporting Officer	DPSST	Prec/Div	Rlf/Shift	Assn/Dist	Supervisor's Signature

Portland Police Bureau	FORCE DATA COLLECTION CONTINUATION REPORT	PAGE/OF
Case No.	Name of Subject	CRN

797 (11/07) v1

attend

You are registered for this Class.
To remove yourself from this Class click here.

Dir 1010.20 Phys. Forc.: Sup. Resp.#080458

10/22/2008

Instructor: City Attorney Dave Worboril; Ellen Osoinach	**Contact Phone:** 503-823-0600
Wednesday	10/22/2008 // 09:00 - 11:00
	Justice Center, 14th Floor Wayne Sullivan Room

This course counts as "LEADERSHIP" at DPSST

NOTE: Leadership can double for OTHER if an officer does not have a supervisory certificate.

Full Title: Directive 1010.20 Physical Force: Supervisor Responsibilities

PPB's legal advisors will review court cases and legal principles with the class to determine where the courts are drawing the lines on use of force, how force issues play out in litigation, and what kind of force thinking works best both on the street and in court. There will be a constructive conversation about the ideal PPB use of force culture. The class will discuss what supervisors want to see in their officers' thinking, force decision making and reporting. The presenters will also describe how the force review process works and the experience of supervisors and officers during reviews. By the end of this course, supervisors should be well-prepared to participate meaningfully in PPB's ongoing discussion about force policy and practice and will be able to review an officer's report for accuracy and completeness, determine whether an officer's force was justified under PPB's directive, and prepare proposed findings in misconduct investigations.

Tips and Techniques

Portland Police Bureau

VOL. XLIV No.8 July 29, 2008

Recommendations for Response to Excited Delirium Calls

Recent research has revealed insight into the cause and effect of excited delirium syndrome. While there are a number of causes to explain this syndrome, police officers must recognize warning signs and develop strategies to effectively resolve the incident.

All Portland Police officers have been introduced to many of the signs of excited delirium syndrome: removing clothing, breaking glass and mirrors and an affinity to water. This is not a complete list, and not all signs are present at every occurrence.

Incidents involving individuals suffering from excited delirium are often very chaotic; officer and citizen safety is our primary responsibility. Although the subject may have engaged in criminal conduct, **it is important to remember that the subject's condition is truly a medical emergency and should be handled as such.**

Here are suggestions to help officers have the best chance of success:

1. While en-route, if there is any information that suggests an excited delirium situation, get EMS started immediately. Don't wait to get there and assess the situation. Time is critical and can mean the difference between life and death.

2. Wait for cover and put a plan together to control the individual as quickly as possible. Prolonged struggles should be avoided. Overwhelming numbers may mean a quicker stop to the fight. The use of Taser may be appropriate also.

3. Medical response should be part of the initial planning. Have medical personnel start treatment as soon as it is safe for them to approach the subject. EMS has a medical protocol for excited delirium situations.

4. Directive 630.45 states, " Members **will not** transport subjects who appear to be seriously injured, seriously ill, or unconscious **unless** an on-scene evaluation by EMS determines the subject is cleared for officer transport. This includes, but is not limited to any subject who:
    a. Appears to be suffering from excited delirium..."

A coordinated effort between police and EMS personnel gives us the best possible chance of a positive outcome for these tumultuous situations.

ROSANNE M. SIZER
CHIEF OF POLICE

Submitted by: Sergeant Scott Montgomery, NE Precinct
Original Issue Date: July 29, 2008
Original Number: Vol. XLIV, No. 8

1 In-Service 2005-06

- Portland Police Bureau
- Training Division
- Foot Pursuits

2 Foot Pursuit Defined

- Foot Pursuit:
- A pursuit on foot by officer(s) where constant visual contact is maintained at all times, and the suspect is readily capable of being apprehended by the pursuing officer(s)

3 Tactical Apprehension Strategies

[redacted]

4 Looking Back

5 Looking Back…Targeting

[redacted]

6 Change in Stride

[redacted]

7 ▣ Hand and Arm Movement

8 ▣ Arm Movement

9 ▣ Guarding

10 ▣ Examples of Guarding

11 ▣ Examples of Guarding

12 ▣ Pursuit Transition

- When transitioning from foot pursuit to tactical apprehension strategies:

13 ▣ Information

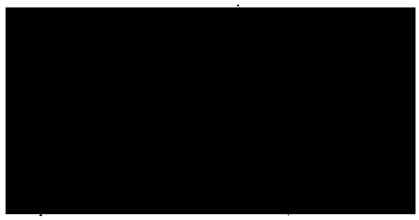
- When tactically feasible you should broadcast information on the following:

- Direction of Travel
- Suspect description
- Any changes in circumstances
- Suspect behavior

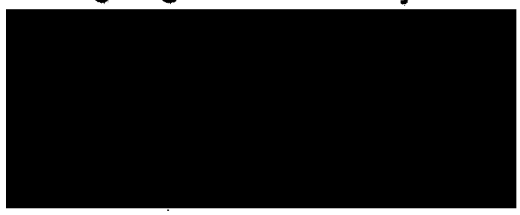
14 Corners

15 Pursuit Termination

- Foot pursuit should end when:



16 Losing Sight of the Subject



17 Physical Termination

- Use the correct technique
- Use correct custody procedures
- Avoid the "pile"

18 Subject Surrenders

- Possible assault tactic by the subject
- It's not over yet…stay in control
- Wait for assistance

19 Pursuit Restrictions

- Armed Suspects

- Pursuing with your weapon out
- Danger versus Public Safety

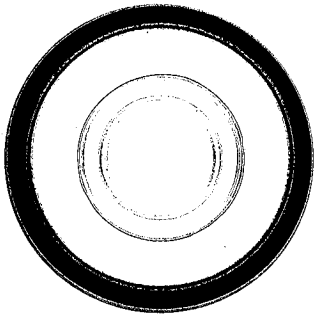
20 

In-Service 2005-06

- Portland Police Bureau
- Training Division
- Foot Pursuits

Roll Call Training

Portland Police Bureau



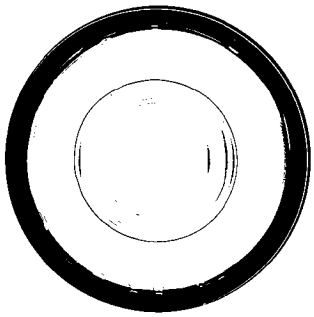
August 2008

1. Emergency Medical Transport Directive 8:28

2. Child Abuse Team 6:38

Roll Call Training

Portland Police Bureau

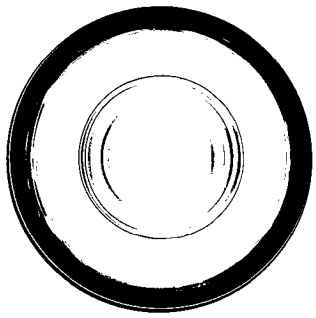


July
2007

1. Hobble Review / Excited Delirium
10.00

Roll Call Training

Portland Police Bureau



July
2009

1. Hobble Review / Excited Delirium
   10:00
2. Submitting Currency to Property
   Evidence Division 1:33