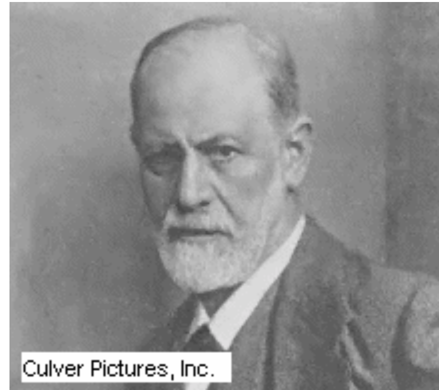
Principals – Considerations
In Substance/Mental Health Treatment

Perspective on Mental Illness



Notes:

They are Us

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

"THEY" are "US!"

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

Consider These Examples

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

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

Consider These Examples:

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

	"US" ***Normal or sub-clinical*** ***"Withdrawn"***	***"THEM" "Social Phobia"***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

OR . . .

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

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

OR . . .

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

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

OR . . .

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

	"US" ***Normal or sub-clinical*** ***"Cautious, Territorial"***	***"THEM"*** ***"Delusional"***
Intensity	We may believe and defend ideas that are totally false and even refuse to listen to evidence refuting our point of view. At times, particularly in situations in which our livelihood or economic well being is threatened, we may believe that others are conspiring to take advantage of us.	They become fixated on beliefs that are not only untrue, but, at times, bizarre or paranoid. Persons with paranoid delusions believe that persons or organizations are following them, or conspiring to cause them harm. They are extremely dangerous when they feel threatened, as they become assaultive to protect themselves or to escape.
Frequency	Situational, 2-3 times per year	Daily
Duration	Usually episodic with no specific duration	Prolonged… for years

- They are US . . . except that it is not happening to us . .
- ***Now or Yet***

	Prevalence	**Lifetime Prevalence**	**Probability**
Depression	7%	20%	1 in 5
Post Traumatic Stress Disorder	1-3%	8%	
Panic Disorder	2%	10%	1 in 10
Chemical Abuse	14%	20%	2 in 10

According to Epidemiological Study cited in the *Harvard Mental Health Letter.*

Increasing Prevalence of Police Encounters with Persons with Mental Illness

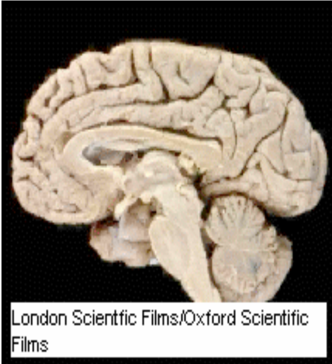
This chart illustrates the percentage of people in the United States who experience a particular mental illness at some point during their lives. The figures are derived from the National Co-morbidity Survey, in which researchers interviewed more than 8000 people aged 15 to 54 years. Homeless people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

Disorder	Percentage
Schizophrenia and Related Disorders	3% [1]
Mania	2.5%
Panic Disorder	4%
Antisocial Personality Disorder	4%
Post Traumatic Stress Disorder	8%
Simple Phobia	11%
Social Phobia	12.5%
Major Depression	17%

1 Including schizoaffective, schizophreniform delusional disorder, and atypical psychosis

The Brain, Social Systems, and Stress

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


London Scientfic Films/Oxford Scientific Films

They are us because we all have a brain…

Potential to Inherit Mental Illness

Chemical Disorder (Neurotransmitters)

Neurological (Circuitry) Disorder

- Neuronal activity,
- (Utilization of Neurotransmitters)

and a mind…

Thoughts	Emotions
Beliefs	Behaviors
Values	

we all live within a Social System…

Job	Family
Relationships	Discrimination
Poverty	Laws (Justice)
Injustice	

and we all experience Stress

The Common Denominator!

- Which can cause, contribute to, or exacerbate mental disorders (or lead to trauma).

The Myth of Schizophrenia and Violence

Schizophrenia is one of the most misunderstood diseases on the planet. Many people think it means having a *split personality,* a belief that has its roots in old Hollywood movies.

Schizophrenia is not splitting of the personality into different pa1ts-as portrayed in *Dr. Jekyll and Mr. Hyde,* or *The Three Faces of Eve.* In fact, the thought processes of persons with severe schizophrenia are so disordered that they barely cope with the requirements of daily existence, never mind *multiple* existences. The phenomenon of multiple personalities is extremely rare, and is not a form of schizophrenia. Addition- ally, the picture of a person with schizophrenia as a "violent madman," is a legacy of popular fiction. Many persons with this condition are extremely timid and afraid, and become hostile only when they are not taking their medicine, or when they feel threatened.

Discussion

The Diagnostic Statistical Manual of Psychiatric Disorders, *Fourth Edition*

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

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

A brief (maybe not brief enough) note about the
Diagnostic Statistical Manual of Psychiatric Disorders-Fourth Edition
more popularly known as the… DSM-IV

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

Cultural, Spiritual, and Religious Considerations

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

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

Persons who are obsessed and say-do repetitious things…
…repetitious things
…repetitious things
…repetitious things

Persons Who Act Obsessed, and Say-Do Repetitious Things

Common Features

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

Persons who are obsessed and say-do repetitious things

Typical· EXAMPLE STATEMENTS

- I have to check, find, call, wash, clean, count, etc., or…
- I must check, find, call, wash, clean, count, etc., or …
- If I don't check, find, call, wash, clean, count, etc., *then* …
- I will lose________ if I don't check, find, call, wash, clean, count, etc.

Possible Diagnoses-see DSM-IV

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

Considerations/Related Topics

No matter how trivial the obsessions an individual with this pathology may present, the fear and anxiety they feel when faced with the prospect of being unable to accomplish their particular mission(s), can result in acts of violence or attempts to escape at all cost.

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

Common Features

- Statements reflecting:

  Loose Associations

  + Expression of ideas or words that have no relationship, as if they do

  Flight of Ideas

  + Expression of incomplete ideas, wandering from topic to topic, with vague or no relationships

  Word Salad

  + Incomprehensible combinations of words at random

  Clanging

  + Rhyming words with each other and manufactured words

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

Loose Associations

+ "I had no idea that the people with long sleeved shirts on the porch at the home had *all* of the aluminum recycling business, in fact Elvis told us that."

Flight of Ideas

+ "I have to go to the doctor but of course the bus driver I met yesterday is probably still mad and I have nothing proper to wear."

Word Salad

+ "Biscuits with no wheels are not of any proprietary means to me unless Pic tells us to do it!"

Clanging

+ "The bang on the tang is lang bang hang!"

Possible Diagnoses see DSM-IV

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

Considerations/Related Topics

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

Individuals who make paranoid statements and are extremely suspicious of everyone and everything

Common Features

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

Individuals who make paranoid statements and are extremely suspicious of everyone and everything

Typical Example Statements

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

Possible Diagnoses-see DSM-IV

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

Considerations/Related Topics

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

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

Common Features

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

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

Typical Example Statements

- Statements would resemble normal speech patterns for the individual involved, though speech *content* would most likely be extremely disorganized, paranoid, delusional.

  – "Look out!" "Watch it!" (Avoiding collision or encounter with object/persons not visible to others)

  – Statements that sound like responses to questions when no one has asked anything: "No!" "I can't right now." Will you help me do it?"

    "I told Mr. Harry that I can't go with him now." (with no other person present)

    "Tell Mr. Harry I am busy." (with no one else present)

    "Mr. Harry told me I should just kill myself."

    "Aliens are broadcasting instructions to me."

    "The FBI tells me what to do through voices in my head."

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

Possible Diagnoses-see DSM-IV

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

Considerations/Related Topics

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

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

Common Features

- Exaggerated Angel Excessive Response regarding some problem, injustice, or perceived personal slight
- Rapid, erratic physical movement
- Pacing
- Breathlessness
- Excessive perspiration
- Repetitious statements regarding some injustice or perceived slight
- Rapid, pressured speech
- Topics of speech change rapidly with little or no coherent relationship between topics
- Slapping or hitting her or himself in a frustrated manner
- Hair pulling
- Spitting
- Cursing

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

Typical Example Statements

- "I'm gonna kill somebody if they don't get outta my way!"
- "He told me I was crazy... I am crazy... I'll show who is crazy... I am... That's who!!"
- "I told them not to let me catch them together and then I saw him wearing my shirt... well… I ran that before… I mean I been there... She can't come back now... I mean it!"
- "Those are my food stamps and they can't take em away... I will get my food stamps back if I have to kick some @#$%to do it!"
- "Mr. Harry told me... I mean he ***told me*** to kick their #$%A& so I am gonna do it."

Possible Diagnoses-see DSM-IV

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

Considerations/Related Topics

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

A Word about Psychotropic Medications

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

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

Psychotropic medication and compliance with prescribed medication are then, central to they ability of a person diagnosed with mental illness to function adaptively in the community. Individuals who threaten suicide, who display bizarre behavior, or who disturb those around them are, most likely, not taking prescribed medications as directed by a psychiatrist.

Medication Non-Compliance

- Return of Symptoms – Decompensation
- Hospitalization
- Arrest
- Homelessness
- Episodes of Violence
- Suicide-Suicide Attempts
- Loss of Previous Stabilization

Suicide

Persons who appear depressed and are, therefore, potentially suicidal

Notes:

Common Features

- Excessive sleep
- Loss of appetite
- Weight loss
- Loss of energy-Lethargy
- Lapse in usual self care (appearance-hygiene)
- Giving away personal possessions
- Writing farewell letters or despondent journal entries
- Refusal to interact with others-social isolation
- Listening to music repetitiously emphasizing suicidality or hopelessness
- Preoccupation with symbols/artistic representations of death
- Hostility toward others without apparent reason

Typicall example Statements

" I am so tired of living." "I can't seem to do anything." "Why can't I just die?"

" I wish I had never been born" " Why am I alive?"

" I don't want to kill myself, but I wish something or someone would do it for me."

"Who cares?" or "I don't care about anything."

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

Persons who appear depressed and are, therefore, potentially suicidal

Possible Diagnoses-see DSM-IV

Major Depression; Bipolar Affective Disorder; Schizoaffective Disorder, Depressed Type or Bipolar Type-Depressed;

Psychotic Disorders; Most Substance Related Disorders

Considerations/Related Topics

Suicidality

Baker Act

Involuntary Admission to a Psychiatric Facility

Use the SLAP Model to Assess an Individual's Suicide Plan

Specific details of the plan

What is the individual planning to do?

Lethality of the plan

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

Availability of the method

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

Proximity of assistance or help

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

Suicide Assessment

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

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

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

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

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

Developing a Suicide Contract

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

CONTRACT

I, ______________________, promise not to harm myself between today and _______________.
name day/date

I will call the emergency or crisis mental health line at ________________ and discuss my feelings
Telephone number

if I feel I want to break this contract.

I promise to make and keep an appointment with _______________________________________
psychiatrist/therapist/friend/family member/professional

____________________________________ on _______________ ________________________.
day date

Other Agreements/Conditions

____

____

____

____

____

____

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____

____

Signed: ______________________________
name

Date: ______________________________
date

Table: Relationships between Drug and Alcohol Abuse and Mental Illness

Feature/Symptoms	Mental Disorder	Substance Related Disorder
Depression Suicidality	Major Depression Bipolar disorder Schizoaffective disorder	Alcohol Intoxication, Abuse or Dependence Intoxication, Abuse or Dependence on any Depressant Drugs Drug and/or Alcohol Withdrawal
Mania	Bipolar Affective disorder Cyclothymia Schizoaffective disorder	Cocaine Intoxication, Abuse or Dependence Amphetamine Abuse or Dependence
Psychosis	Schizophrenia Other psychotic disorders	Cocaine Intoxication, Abuse, Dependence, or Psychosis Alcohol Hallucinosis Delirium Tremens Certain Drug withdrawals
Delusions	Schizophrenia Other psychotic disorders	Cocaine Intoxication, Abuse, Dependence Amphetamine Intoxication, Abuse, Dependence, or Psychosis
Hallucinations	Schizophrenia Other psychotic disorders	Delirium Tremens Other forms of drug withdrawal Hallucinogen intoxication
Obsessions	Obsessive Compulsive disorder Obsessive Compulsive personality disorder	Cocaine Intoxication
Paranoia	Schizophrenia Other psychotic disorders Paranoid personality disorder	Cocaine Intoxication, Abuse, Dependence, or Psychosis
Panic	Panic attacks	Drug and/or alcohol withdrawal Cocaine Intoxication, Abuse, Dependence, or Psychosis Amphetamine Intoxication, Abuse, Dependence, or Psychosis

Typical Behaviors and Statements of Persons Experiencing Substance Related Disorders

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

Practical Interventions to Manage Difficult Encounters with the Mentally Ill

Notes:

Priorities for Verbal De-escalation or Intervention

The safety of all persons present, including YOU!

The safety of the individual presenting the problem

Property

Assessing Who is dangerous?

Persons who are paranoid

Persons experiencing command hallucinations (voices telling them to do things)

Individuals who are agitated

Individuals expressing rage or extreme anger

People who ***say*** they are dangerous

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

Always remain calm and use a non-confrontational approach

Do not

- Argue
- Threaten
- Command

Do

- Placate–agree
- Reassure
- Distract
- Detach emotionally
- Use authority positively

Components of the Assessment

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

Verbal Characteristics

– The content and quality of speech, style, volume, pitch, inflection, mimicry, accent

Behavioral Characteristics

– Posture, body language, gestures, facial expression, eye movement, hand position, tremors-shaking, clothing

Environmental Factors

– Those items that the person has surrounded themselves with and used to create their environment, strange decorations or trimmings, the inappropriate use of aluminum foil or any other object, clutter.

General Guidelines for Physical Behavior during Verbal Interventions

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

Avoid aggressive or confrontational eye contact-use intermittent contact.

Move slowly.

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

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

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

Maintain open body posture.

Essential Verbal Behavior

Use a calm voice.

Maintain volume that is less than that of an aggressor.

Reflect or paraphrase their concerns—

– "I understand that you are concerned about your wife."

Reflect and validate their affect—

– … " I can see that you are extremely upset."

Use descriptive statements with "I" references.

Further Guidelines for Intervention

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

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

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

Announce all of your actions before initiating them. Answer all ***"why?"*** questions.

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

What to Do

Stay calm… avoid overreacting… be helpful.

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

Speak slowly and in unambiguous terms.

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

Understand that it may ***not*** be possible to have a rational discussion.

Use the CAF Problem Solving -Conflict Resolution Model

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

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

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

Questions to ask the troubled Individual

What is your name?

Where do you live or sleep?

Do you know where you are right now?

Do you know what day it is?

Do you know what is happening right now?

What kind of problem are you having?

Questions to ask the Family Members, By-standers, and other Involved Parties

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

Acted in a violent manner or threatened anyone recently or in the past?

Threatened or attempted to hurt her or himself recently or in the past?

Been using any alcohol or illicit drugs today or has s/he in the past?

Been taking any medications for a mental disorder or for anything else?

Ever been in treatment or seen a psychiatrist for a mental disorder?

Ever been a veteran that has seen active combat duty?

Ever had a history of unusual behavior?

Been neglecting her or his personal care or hygiene recently?

Crisis Intervention [3]

Do not react quickly.

Take time to assess the situation. Time is a tool.

Attempt to de-escalate or calm the individual, as well as others involved.

Urge them to discard any potentially lethal instruments (guns, pills, knives, etc.)

Do ***not*** show surprise or discouragement… ***stay calm!***

Offer hope without reassurances that may be meaningless.

Ask them for an agreement not to act on their intentions ***now***… bargain for a delay.

Urge them to put off the decision or the act until they have discussed all of the options available to them.

Perform a Baker Act (BA-52) ***after*** the situation has been stabilized.

[3] It is common for the interventionist to experience emotions when encountering a suicidal person. Sometimes annoyance and resentments are felt. These reactions are normal! Try to put yourself at ease, do the best you can. There is, often, no perfect or ideal method to manage this extremely taxing situation!

The Baker Act

Voluntary or Involuntary Admission to an Inpatient Psychiatric Receiving Facility

Criteria for voluntary admission

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

Mental illness is defined in the Baker Act as:

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

Voluntary admission

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

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

Assisting Persons with Mental Illness and/or Substance Abuse Problems, to Access Professional Help and Community Resources

Notes:

Goals and Methods

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

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

How can law enforcement officers, mental health services providers, and members of the community cooperate to overcome the traditional system?

To improve services

To reduce stress

To minimize or eliminate problems

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

All parties can establish structured agreements.

All parties can regularly review agreements for efficacy and appropriateness.

The SARA Model of Assessment and Decision Making

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

Utilization of the SARA model to collect "just the facts" eliminates or at least minimizes the influence of misperception, misconception, and prejudgment:

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

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

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

Assess the results or likelihood of success of your plan; return to step one if you are not satisfied with your initial plan or to make adjustments.

Mental Status Exam Lexicon of Terms and Descriptors

Physical Appearance			
Complexion	0 Blushed 0 Jaundiced	0 Pale 0 Ruddy	0 Swarthy 0 Tan
Dress	0 Bizarre 0 Business Attire 0 Casual 0 Disheveled	0 Eccentric 0 Formal 0 Inappropriate 0 Meticulous	0 Neat 0 Unkempt 0 Unusual
Eyes	0 Avoids eye contact 0 Blinking 0 Bright/Sparkling 0 Closed	0 Downcast 0 Gazing 0 Questioning 0 Tearful	0 Shifting 0 Squinting 0 Staring 0 Wincing
Facial Expression	0 Alert 0 Bewildered 0 Calm 0 Worried	0 Confused 0 Dazed 0 Happy	0 Perplexed 0 Sad 0 Tense
Hygiene	0 Clean 0 Dirty	0 Incontinent 0 Odorous	
Mannerisms	0 Exaggerated swallowing 0 Frowning 0 Hair pulling/twisting 0 Lip biting	0 Lip smacking 0 Nail biting 0 Pill rolling 0 Puckering	0 Scratching 0 Skin picking 0 Skin rubbing 0 Teeth grinding
Posture	0 Peculiar	0 Rigid	0 Slouching
Skin Discoloration	0 Bruises 0 Burns 0 Cuts	0 Dry 0 Edema 0 Insect Bites 0 Lesions	0 Moist 0 Rash 0 Tattoos

Interview Behavior		
0 Abusive	0 Guarded	0 Naïve
0 Angry	0 Histrionic	0 Negative
0 Aggressive	0 Hostile	0 Passive
0 Apathetic	0 Impulsive	0 Sarcastic
0 Arrogant	0 Indifferent	0 Seductive
0 Assertive	0 Initiates	0 Sensitive
0 Cooperative	0 Interested	0 Silly
0 Dependent	0 Introverted	0 Suspicious
0 Disinterested	0 Intrusive	0 Threatening
0 Dramatic	0 Irritable	0 Uncooperative
0 Evasive	0 Lethargic	0 Unresponsive
0 Extraverted	0 Manipulative	0 Withdrawn
0 Grandiose	0 Menacing	

Psychomotor Activity		
0 Agitation	0 Repetitious	0 Tremulous
0 Compulsivity	0 Restless	0 Tics
0 Hyperactivity	0 Retardation	0 Unusual gait
0 Impulsivity	0 Ritualistic	

Speech		
0 Aphasic	0 Mute	0 Slurs
0 Deliberate	0 Muttering	0 Spontaneous
0 Excessive	0 Paucity	0 Stammering
0 Halting	0 Pressured	0 Stuttering
0 Indistinct	0 Rapid	0 Talkative
0 Loud	0 Soft	
0 Mumbling	0 Slow	

Mood/Emotions/Affects		
0 Ambivalent 0 Angry 0 Anxious 0 Blunted 0 Constricted 0 Depressed 0 Despondent 0 Distressed	0 Elated 0 Elevated 0 Euphoric 0 Excited 0 Expressionless 0 Fearful 0 Flat 0 Hypomanic	0 Irritable 0 Labile 0 Nervous 0 Panicky 0 Phobic 0 Sad 0 Rage

Thought Flow		
0 Blocking 0 Circumstantial 0 Clang 0 Echolalia	0 Flight of ideas 0 Fragmentary 0 Loose Association 0 Neologism	0 Perseveration 0 Rambling 0 Tangential 0 Word Salad

Thought Content		
0 Antisocial 0 Assaultive Delusions: 0 Grandeur 0 Persecution 0 Religious 0 Guilt	0 Homicidal 0 Hopelessness 0 Hypochondriacal (Somatic) 0 Ideas of reference 0 Obscene 0 Obsessive	0 Paranoid 0 Religiosity 0 Sexual preoccupation 0 Suicidal 0 Suspiciousness 0 Worthlessness

Sensorium/Perception		
0 Amnesia 0 Confabulation 0 Delirium 0 Depersonalization 0 Derealization 0 Distracted 0 Dissociation	Hallucinations: 0 Auditory 0 Visual 0 Kinetic 0 Olfactory 0 Gustatorial Impaired orientation to: 0 Person, place, time	Memory: 0 Recent 0 Intermediate 0 Remote 0 Poor Concentration 0 Sedated 0 Stuporous 0 Unconscious

Intellect		
0 Above Average 0 Average	0 Below Average 0 Paucity of knowledge	0 Paucity of vocabulary 0 Poor abstraction

Judgement/Insight	
0 Denial of degree / severity of their condition 0 Doesn't know why they are here 0 Insight is impaired	0 Judgement is impaired 0 Unmotivated for treatment 0 Unrealistic expectations for treatment outcome

Least Restrictive

Community Resources for Persons who are Mentally Ill

Situation	Police Action	Community Resource
Onset of illness Initial behavioral disruption Mild psychosis Onset of initial depression	Usually none Possible mediation	Psychiatric Evaluation Medication Management
Relapse of symptoms or severe onset of illness	Mediation Verbal Intervention Possible physical intervention	Medication Management Case Management
Progression of Severity Episodes of disruption, self ne- glect, medication non-compliance.	Mediation Verbal Intervention Possible Physical Intervention	Medication Management Case Management Day Treatment Program
Beginning of Chronicity More severe disruption, medica- tion non compliance, more severe symptoms, misdemeanor criminal acts	Verbal Intervention Physical Intervention	Medication Management Case Management Outpatient Treatment Program
Acute Stage Criminal Acts, Suicide Attempts, Assaults, Severe Self Neglect	Verbal Intervention Physical Intervention	Medication Management Case Management Intensive Treatment Pro- gram or Partial Hospitalization Program
Crisis Stage	Verbal Intervention Physical Intervention Baker Act	Psychiatric Hospitaliza- tion or Inpatient Program
Chronic Stage	None	State Hospitalization