

San Jose Police Department
Managing and Resolving Crisis-CIT Course
40 Hours
CCN: 2560-20770
Rev. 5/1/2022

Course Goal: The CIT Course objective is to train Police Officers to recognize people suffering from mental illness and aide them in providing a safe and humane response for those suffering a crisis.

Course Purpose: The CIT Course is a collaborative effort on the part of the San Jose Police Department (SJPD), the National Alliance for the Mentally Ill (NAMI) and Santa Clara County Behavioral Health Department.

The CIT Course strives to provide Officers with professional and trauma informed training to assist them in the recognition of community members struggling with mental illness. To provide Officers with additional tools and resources to better respond to those in crisis and direct them more appropriate levels of care. Finally, in the spirit of 21st Century Policing Officers are provided information and resources to manage critical incident stress to develop healthy coping skills throughout their careers.

Topics:

1. Introduction (history of mental health)
2. Mood Disorders
3. Community organization presentations- Recovery Center, Mobile Crisis Response Team (MCRT) .
4. Civil Commitment /legal issues
5. Schizophrenia/psychosis
6. Personality disorders/Dual Diagnosis/ common medications
7. Excited Delirium
8. Autism
9. Suicide By Cop
10. Post-Traumatic Stress Disorder/veterans issues (PTSD)
11. Traumatic Brain Injury (TBI)
12. Critical Incident Stress Management
13. Video Debriefing/De-escalation/Communication
14. NAMI Panel Presentation (National Alliance on Mental Illness)
15. Intellectual Disabilities
16. Child & Adolescent Intervention & juvenile Resources
17. Alzheimer's
18. Case studies
19. Managing Substance Abuse-Critical Incident Self Care
20. Site Visits
21. Responding Persons in a Mental Health Crisis- Video scenarios and simulation
22. Communication ICE -Officer Wellness

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Student Learning Activities and Methods of Evaluation:

Students will be taught through several methods including PowerPoint presentation, class discussion, video de-briefing and video simulation. An Interactive Video Simulator will be used to put the officers in simulated interactions with people in crisis. The class will be evaluated on their responses and provided immediate feedback on decisions and outcomes.

- I. **Introduction**
 - A. CIT introduction
 1. Instructor and Student Introductions
 2. POST roster
 3. Class Expectations
 4. Pre-Test
- II. **Trauma and PTSD**
 - A. Recognizing Trauma in Law Enforcement Officers
 1. Acute
 2. Chronic
 3. Complex Secondary/Vicarious
 4. Traumas effect on the human body
 - a. Sleep Disturbance
 - b. Headache
 - c. Fatigue
 - d. Digestive
 - e. Chronic Health Conditions
 - B. Traumas effect on the human brain
 1. Anger
 2. Fear
 3. Sadness
 4. Anxiety
 5. Shame
 6. Nightmares
 - C. How to Process Trauma
 1. Connect with Others
 2. Talk with supportive persons
 3. Movement/Exercise
 4. Mindfulness
 5. Rest and Sleep
 6. Volunteer
 7. Avoid Alcohol and Drugs
 8. Know when to ask for help

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- D. Unhealthy Processing
 - 1. Alcohol and Drugs
 - 2. Gambling
 - 3. Isolating
 - 4. Anger and Aggression
 - 5. Risk taking
- E. Caring for yourself on Duty
 - 1. Talk about it
 - 2. Get moving
 - 3. 5-4-3-2-1
 - 4. Sleep
 - 5. Exercise
- F. EMDR
 - 1. Eye Movement Desensitization and Reprocessing
 - 2. Treatment for PTSD
 - 3. Bilateral stimulations
- G. Support
 - 1. LEOS
 - 2. Confidential
 - 3. Spouse support
 - 4. "Magic Trick"
 - 5. Emotional first aid

III. Intellectual Disabilities

- A. Introduction
 - 1. Frequency of Intellectual Disabilities
 - 2. Causes
 - 3. San Andreas Regional Center
- B. The Lanterman Act
 - 1. Disabilities Act
 - 2. Rights of people with ID
 - a. Right to live normal and independent
 - b. Treated with dignity, privacy and humane
 - c. Right to education
- C. Victim-offender relationship
 - 1. Higher percentage of violence against persons with disabilities
 - 2. Committed by persons victim knew
 - 3. Lower percentage of violence by strangers
 - 4. People with ID are 7x more likely to be assaulted than non-disabled
 - 5. 80% of women with ID have been sexually assaulted, 30% of men
- D. Regional Center Services

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1. Referrals
 2. Assessment
 3. Counseling
 4. Outreach
 5. Advocacy
 6. Funding
 7. Placements
 8. Family Support
 9. Training
- E. Definition of Intellectual Disability**
1. Diagnosed before 18
 2. IQ below 70
 3. Has diagnosis of developmental disability
 4. Substantial impairment of 3 or more areas of adaptive behavior
 - a. Self-care
 - b. Mobility
 - c. Self-Direction
 - d. Learning
 - e. Living Skills
 - f. Economic
 - g. Expressive Language
 - h. Receptive Language
- F. Types of Intellectual Disabilities**
1. Mental Retardation
 2. Seizure Disorder
 3. Cerebral Palsy
 4. Autism
 5. Other
- G. Components of Intellectual Disabilities**
1. Poorly developed living skills
 2. May not understand consequences
 3. Short attention span
 4. Memory deficits
 5. Developmentally young
 6. Impaired language
- H. Types of Calls**
1. Medical emergencies
 2. Victim of abuse/neglect
 3. Domestic Violence
 4. Missing person
 5. Suspicious person
 6. Under the influence
 7. Hostile Behavior

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- 8. Indecent exposers
- I. Hints for Officers
 - 1. Med bracelets
 - 2. Medicare/Medical card
 - 3. SARC card
 - 4. Conservator?
 - 5. SSI, SSA
 - 6. Lack of eye contact
 - 7. May mask disability
 - 8. Speak slowly, hand gestures
 - 9. Allow more time for response
- J. Key communication concepts
 - 1. Speak directly to person
 - 2. Treat as adult
 - 3. Gain trust
 - 4. Simple words
 - 5. Short sentences
 - 6. Open ended questions
 - 7. Validate answers
 - 8. Check for understanding
- K. Case Studies
 - 1. Case study #1 Male, 50s
 - 2. Case Study #2 Young male, Downtown
- L. Resources
 - 1. 24-7

IV. Case Study

- A. Class Objectives
 - 1. Timeline
 - 2. Pre-planning
 - 3. Tactical Response-Tactical Conduct
 - 4. Documentation
 - 5. Red-Flags "suicide by cop"
 - 6. Lessons learned
- B. Subject
 - 1. Name
 - 2. History
 - 3. Diagnosis (self-admitted)
 - a. PTSD
 - b. Mood disorder
 - c. Depression
 - d. Schizophrenic
 - e. Bi-Polar
- C. Prior Contacts

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1. CPS
 2. Suspicious circumstances
 3. 5150
 4. 911-crying
 5. Covered in blood
 6. 261 PC
 7. 415 PC
 8. Suicide threats
 9. Welfare Check
 10. Sexual Battery
- D. Tactics/Response/De-escalation**
1. Radio/CAD
 2. Cover/Concealment/Distance
 3. CIT officer?
 4. Lethal Force
 5. Less Lethal
 6. Physical Contact/Hands
 7. Staging FIRE/EMS
 8. Pre-planned multi-response
- E. Follow-up**
1. Emails sent to crisis management
 2. LE Liaison -John Costa
 3. SJPD Intel Unit
 4. Extensive G.O
- F. Suicide by Law Enforcement**
1. UCLA study
 2. 36% of OIS
 3. LASD study
 4. 11% of OIS were SBC
 5. 98% were male
 6. 39% DV history
 7. Abused alcohol and/or drugs
 8. Prior history of suicide
 9. 50% of weapons were loaded
 10. 17% replica
- G. Lessons Learned**
1. Pre-plan, pre-arrival
 2. CIT
 3. Arrest/Hands officers
 4. Less lethal
 5. Stage medical
 6. Stick to roles
 7. Broadcast
 8. Establish "core" transaction

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9. Discuss, Execute, Document, Follow-up, Debrief

V. **Autism Spectrum Disorders and Law Enforcement**

A. Topics

1. Autism Facts
2. Social
3. Communication
4. Repetitive Interests/Activates
5. Global Impact
6. Associated Symptoms/Diagnosis
7. Possible emergencies/Suggestions

B. Facts

1. Increase in ASD
2. 1 in 59 children
3. New cases rising
4. What is a spectrum disorder?
5. Boys 4-5x more likely

C. Social Domain

1. Do not learn hidden curriculum
2. Unable to anticipate change
3. Motivation
4. Perception

D. Results of Social Deficit

1. Social norms
2. Misinterpret
3. Awkward or "rude"
4. Social hierarchies

E. Communication

1. Difficulty in conversation
2. Failure to respond
3. One-sided conversation
4. Repetitive
5. Style of speaking
6. Auditory
7. Putting words together
8. Comprehension of verbal and nonverbal commands

F. Result of Communication Deficit

1. Lack of accurate information
2. Seem impulsive
3. Slow to understand

G. Repetitive/Restricted Interests

1. Attention issues
2. Unusual interests

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3. Body movements
4. Preoccupations
5. Memory for details
6. Attachments
7. Need to engage in repetitive behaviors
- H. Results of Restricted Interest
 1. Single minded focus
 2. Need to hold objects
 3. Little interest in others
- I. Executive Functioning and Deficit Results
 1. Use past experience to inform current events
 2. Ability to anticipate
 3. Flexible and understand rules
 4. Inhibit responses
 5. Do not learn from mistakes
 6. Unable to choose alternate path
 7. Lack ability to make connections
- J. Associated Symptoms/Diagnosis
 1. Hyperactivity
 2. Impulsivity
 3. Anxiety
 4. Aggression
 5. ADHD
 6. Depression
 7. 60-80% have impairments
 8. Seizure
 9. Hypersensitive
 10. Pain threshold
 11. Sensory issues
 - a. May run from officer
 - b. May flee from sirens or lights
 12. Attracted to shiny objects
 - a. Badge
 - b. Belt
 - c. Weapons
 13. Public Safety Emergencies
 - a. May wander
 - b. Go to water
 - c. Stealing
 - d. Tantrums
 - e. Trespassing
 - f. Aggression
 - g. Suspicious behavior
 - h. May display rocking, moaning, head banging

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- i. May fight against medical procedures or restraints
- 14. Suggestions**
 - a. Safe distance
 - b. Allow time
 - c. Armed?
 - d. Be aware of impulsivity
 - e. Talk softly and calmly
 - f. Narrate actions
 - g. Speak short and direct
 - h. Avoid slang
 - i. Use pictures
 - j. Get to know autism community
 - k. Avoid rapid pointing or waving
 - l. Examine med alert bracelet
 - m. Model calming body language
 - n. Be aware of possible seizures
 - o. Minimize sensory overload
- 15. Interviewing techniques**
 - a. Will take time
 - b. May not be able to provide personal info
 - c. May repeat words or questions
 - d. False confessions

VI. Joshua's Gift

- A.** Training for Police to learn how to respond to individuals and families living with Autism
- B.** Inspiration behind Joshua's Gift
 - 1. Son diagnosed with Autism
 - 2. Family thoughts
 - 3. Advocate
 - 4. Resilience
 - 5. Love
 - 6. Compassion
- C.** About the foundation
 - 1. Non-profit
 - 2. Financial contribution, services to families
 - 3. Promote development
 - 4. Acceptance
 - 5. Educating
 - 6. Training
 - 7. First Responders
 - 8. Approach and Interact
- D.** Autism and the need for Police training

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1. Manage individuals and families
 2. 1 in 54
 3. 20% of youth with autism have had police contact
 4. Training requirements by state
 5. Autism Spectrum Disorder
 6. No medical test
 7. Understand how disabilities effect compliance
- E. How can you help?
1. Brief, simple instructions
 2. Safety, dignity and respect
 3. Approach
 4. De-escalate
 5. Rights of the individual
 6. Mitigate risk
 7. Force response
- F. How can we help?
1. Code Joshua
 2. Create to assist families
 3. To notify first responders
 4. Safe response
 5. Identifies calls from autism community
- G. Sensory Overload
1. Sirens
 2. Lights
 3. Negative reaction
 4. Escalated
 5. Self-protective action
 6. Fight or flight
- H. F. Our Desire
1. Accept
 2. Respect
 3. Include

VII. **De-escalation/Video Debriefing/Communication**

A. De-escalation defined

1. To decrease in extent, volume, or scope
2. Verbal De-Escalation is an intervention for use with people who are at risk for aggression. It is basically using calm language, along with other communication techniques, to diffuse, re-direct, or de-escalate a conflict situation.

B. De-escalation Techniques: Actions used by officers, when safe and feasible without compromising law-enforcement priorities, that seek to minimize the likelihood of the need to use force during an incident and increase the likelihood of gaining voluntary compliance from a subject.

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C. Importance of de-escalation

1. Peace officers must recognize that, while many force encounters involve circumstances that are tense, uncertain, and rapidly evolving, they will be expected to identify circumstances that allow for attempts to de-escalate the situation and minimize their reliance on physical force.
2. Allows for the tactical “slowing down” of an incident in a manner that increases the potential for resolving the situation with minimum use of force.
3. Increases officer safety and reduces the likelihood of officer or suspect injury.
4. Reduces community complaints and improves Police Legitimacy and perception.
5. Should be used when police action is not IMMEDIATELY necessary to protect the officer or others from physical harm.

D. Stages of escalation

1. Calm
2. Trigger
3. Agitation
4. Acceleration
5. Peak
6. De-escalation
7. Recovery

E. Signs of agitation

1. Raised voice
2. Rapid speech
3. Pacing
4. Excessive sweating
5. Balled fists
6. Erratic movements
7. Fidgeting
8. Aggressive muscle tension

F. Aspects of communication

1. Body language
2. Tone
3. Word choice

G. LEAP

1. Listen: listen with the goal of understanding.
2. Empathize: consider their point of view
3. Agree: reflect, agree to disagree
4. Partner: finding a goal to work on together

H. Tactical Conduct

1. Hayes v. County of San Diego
2. Core transaction

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3. Level of urgency
4. Threat assessment (information gathering)
5. Cover, concealment, distance, time
6. Crisis Intervention Team

VIII. **Alzheimer's and Related Dementias: Law Enforcement Encounters**

A. Alzheimer's & Related Dementias

1. Dementia definition
2. Alzheimer's disease (AD)
3. Other causes

B. Stages of Alzheimer's Disease

1. No impairment
2. Very Mild Decline
3. Mild Decline
4. Moderate Decline
5. Moderately severe decline
6. Severe decline
7. Severe decline

C. Cause & Cure

1. No known cause or cure.

D. Statistics

1. State
2. National

E. Tips to Recognize & Manage Persons with Dementia

1. Identification for affected person
2. Recognize signs, symptoms, and possible problems.

F. Situations Involving Persons with Alzheimer's

1. Auto Accidents/Traffic violations
2. Wandering
3. Possible Crimes
4. Abuse/Domestic Violence
5. Homicide/Suicide
6. Scams/Financial Abuse

G. Communicating with a Confused Individual

1. Identify yourself
2. Slow and clear verbal communication
3. Repeat if necessary
4. Maintain eye contact
5. Remove environmental stressors or use of restraints
6. ACT

IX. **The "5150": 72-Hour Holds for Mental Health Evaluation**

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- A. Stigma
- B. Tools to Reduce Stigma
 1. Pay Attention to language
 2. See yourself as the individual
 3. Educate yourself
- C. Scenario
 1. Why is this problematic?
 2. How can you respond?
- D. Implicit Bias
 1. Definition: refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.
- E. Characteristics of Implicit Bias
 1. Implicit biases are **pervasive**. Everyone possesses them.
 2. Implicit and explicit biases are related but **distinct** mental constructs.
 3. The implicit association we hold **do not align with our declared beliefs** or even reflect stances we would explicitly endorse.
 4. We generally tend to hold implicit biases that **favor our own ingroup**, though research has shown that we can still hold implicit biases against our group.
 5. Implicit biases are **malleable**. The implicit associations that we have formed can be gradually unlearned through a variety of debiasing techniques.
- F. Why Should I Pay Attention to Our Implicit Biases?
 1. Biased Attitudes
 2. Act of Bias
 3. Discrimination
 4. Bias Motivated Violence
 5. Genocide
- G. Training Roadmap
 1. What is a “5150”?
 - a. Purpose of a 72-Hour Hold
 - b. 72-Hour Hold Process
 2. When May a 5150 Be Written?
 - a. Mental Health Disorder
 - b. Grave disability/Danger to Self/Danger to Others
 - c. Probable Cause
- H. What is a “5150”?
 1. Purpose of a 72-Hour Hold
 - a. 72-hour hold allowed a person: to be taken... into custody for a period of up to 72 hours”

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- b. “for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment”
 - c. **“in a facility designated by the county** for evaluation and treatment.”
2. 72-Hour Hold Timeline
- a. 72-hour clock starts
 - b. Immediate transport to designated facility
 - c. Person evaluated at designated facility
 - d. Before 72 hours: Person is discharged from facility or remains in facility (voluntarily on 14-day hold)
3. Designated Facilities Permitted to Receive 72-Hour Holds for Evaluation
- a. Emergency Psychiatric Services (EPS)
 - b. Uplift Crisis Stabilization Unit (minors)
 - c. Good Samaritan Hospital
 - d. El Camino Hospital
 - e. Stanford Hospital
 - f. VA Palo Alto
 - g. Main Jail, 8A Unit
4. Who May Write a 72-Hour Hold?
- a. Peace Officers
 - b. Mental Health Professionals with County Authorization
5. Obligations the 5150 Writer
- a. Must take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the person.
 - b. Must provide oral advisements in language/modality understood by the person detained. If they do not understand an oral advisement, a written advisement must be given.
 - c. All information and records obtained in providing services related to a 72-hour hold “shall be confidential”
6. Your Advisement to Person Detained
- a. If a person is detained at their residence
7. Legal Requirements for 5150 Detentions
- a. A 5150 May Only Be Written If
 - a. There is probable cause to believe that a person is a danger to self/other, or gravely disabled as a result of a mental health disorder.
 - b. Standard of Proof: Probable Cause
 - a. State of facts known to you that would lead a person of ordinary care and prudence to believe or entertain a strong suspicion that person detained as a result of a mental health disorder meets one

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- of the three criteria (grave disability, danger to self, danger to others).
- b. What does probable cause look like for 72-hour hold?
 - c. “As a Result of a Mental Health Disorder”
 - a. Look for symptoms of severe mental illnesses such as Schizophrenia, Bipolar Disorder, and Depression.
 - b. 72-hour holds are not appropriate for detentions based on:
 - i. Intellectual or developmental disabilities
 - ii. Drug or alcohol abuse
 - iii. Medical issues
 - c. Scenario
 - d. Danger to Self, Danger to Others, and Grave Disability
 - a. In order to detain someone with a 72-hour hold, the person must be a danger to themselves or others, or gravely disabled.
 - b. A person may not be detained solely on the basis that they
 - i. Are not taking prescribed psychiatric medications,
 - ii. Could really benefit from mental health services, or
 - iii. Present a nuisance in the community.
 - c. A person must presently DS/DO/GD Criteria.
 - i. Example
 - ii. Example: Grave Disability
- 8.** What is “Danger to Self”
- a. Threats or actions which indicate the intent to commit suicide or inflict serious bodily harm on oneself, or actions which place the person in serious physical jeopardy, and which proceed from a mental disorder.
- 9.** What is “Danger to Others”
- a. Words or actions which indicate a serious intent to cause bodily harm to another person, and which owe to a mental disorder. IF the danger to others finding is based on the person’s threats rather than acts, the evaluator must believe it is likely that the person will carry out the threats.”
 - b. Scenarios: Danger to Self/Others
- 10.** Grave Disability
- a. A condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.”

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- b. Grave Disability: Minors
 - a. A minor is gravely disabled if “as a result of a mental disorder, [the minor] is unable to use the elements of life which as essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others.”
- c. Grave Disability: Incarcerated Persons
 - a. Unable to take advantage of the food, clothing, and shelter provided to them in custody.
 - b. In Santa Clara County Jails, authorized mental health professionals initiate 72-Hour holds. Persons in custody who are on 72-hour holds must be housed on Unit 8A.
 - c. Scenarios
 - d. Conservatorship of Smith
- d. Grave Disability: Third Party Assistance
 - a. In civilized society people do not live in a vacuum, completely independent of everyone and everything.
 - b. A person is not gravely disabled if the person “can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to provide for the person’s basic personal needs for food, clothing, or shelter.
 - c. Scenario
- 11. Probable Cause Considerations
 - a. Rational Inference: you can make logical conclusions or deductions based on facts presented.
 - b. Historical Course of Illness” ONLY IS the information is RELEVANT and has “REASONABLE BEARING” on whether the person meets 5150 criteria
 - c. Third Party Statements: Must have “REASONABLE BEARING” on 5150 criteria. Third parties are liable if the intentionally provide you with false information.
 - a. Scenarios
- 12. MHAP Services
 - a. Patient’s Rights Unit
 - b. Economic Rights Unit
 - c. Housing Rights Unit
 - d. Contact Info

X. **Child and Adolescent Crisis Intervention**

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- A. Trends- National**
 - 1. CDC Stats 2007-2015:
 - a. Gender differences
 - a. Girls 15 to 19 doubled
 - b. Boys 15 to 19 increased by 30%
 - b. Suicide by firearms 51% of suicides
 - c. Suicide by suffocation/hanging 25.9% of suicides
- B. Trends- Santa Clara County**
 - 1. Stats from 2003-2015, there were 229 youth from Santa Clara County that died as a result of suicide
 - 2. 46% of these deaths were from hanging/suffocation
 - 3. 21 of these deaths were from firearms
 - 4. 92.3% hold a triggering factor such as recent crisis, current and history mental health problem, and history of suicidal thoughts.
- C. Mental Health Disorders**
 - 1. Is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life's ordinary demands and routines.
 - 2. There are more than 200 classified forms of mental illness.
- D. Neurodevelopmental Disorders**
 - 1. Characterized by developmental deficits that usually show up early in a child's development (often before the child enters elementary school) and can last throughout the individual's lifetime.
- E. Mental Disorders vs. Neurodevelopmental Disorders vs. Typical Developmental Stage Issues**
 - 1. Young Children—tantrums, “me” focused, developmental thinking skills
 - 2. Middle School Age Children--strongly influenced by peers, “stuck” between childhood and adolescence, hormonal changes, mood changes, and physical changes.
 - 3. Adolescents--test limits, exploring identity and values, desire to be more independent, impulsivity.
 - 4. Judgment is last to develop
 - a. Chart
- F. Common Diagnoses for Youth in Crisis**
 - 1. Child-Specific Diagnosis
 - a. Reactive Attachment Disorder
 - b. Separation Anxiety Disorder
 - c. Conduct Disorder
 - d. Oppositional Defiant Disorder
 - e. Disruptive Mood Dysregulation Disorder
 - 2. Broad Diagnosis (not age specific)

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- a. Major Depressive Disorder
 - b. Anxiety Disorder
 - c. PTSD
 - d. Bipolar I & II
 - e. Adjustment Disorder
- G. Trauma & Brain Development**
- 1. Chart depicting the brain and trauma stress in the body
 - a. Adverse Childhood Experiences
 - b. Disrupted Neurodevelopment
 - c. Social, emotional, and cognitive impairment
 - d. Adoption of health-risk behaviors
 - e. Disease, disability and social problems
 - f. Early death
- H. 5150/5585**
- 1. Immediate concerns about safety
 - a. Due to a mental health issue
 - b. Probable cause (can include third party reports)
 - 2. Danger to Self
 - 3. Sanger to Others
 - 4. Grave Disability
- I. Biological Risk Factors**
- 1. Family History
 - 2. TBI
 - 3. Chronic Illness
- J. Psychological Risk Factors**
- 1. Previous Suicide Attempt
 - 2. No coping skills
 - 3. Trauma/Abuse History
 - 4. Mental Health Diagnosis
 - 5. Alcohol/Substance Use
- K. Environmental Risk Factors**
- 1. Recent loss
 - 2. Access to weapons
 - 3. Bullying
 - 4. Lack of social support
- L. Potential Warning Signs**
- 1. Wounds/Scars
 - 2. Access to sharps
 - 3. Frequent “accidents”
 - 4. Isolation/irritability
 - 5. Threats/statements of suicide
 - 6. Art depicting death/suicide
 - 7. Dramatic changes in appearance/personality
 - 8. Giving things away

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9. Drop in academic performance

10. Increase in sadness/irritability

M. Protective Factors

1. Internal

2. External

N. Self-Harming Behaviors

1. Intentional harm to self however, not intended to be lethal

2. A behavior not mental illness

3. Myths

4. Why do youths self-harm?

5. Suicide is an intentional act of ending one's life

6. Self-Harm is the intentional harm of self without the intent of dying

7. Self-Harm itself does not indicate hospitalization

8. Relationship between suicide and self-harm is complicated.

9. Assessing self-harming behaviors

O. Assessments Tips

1. Assessment Tools

2. Do's for Assessing and Rapport

3. Don'ts for Assessing and Rapport

4. 5150 Assessments for Youth Ages 5-9

5. 5150 Assessments for Youth Ages 10 +

a. Scaling questions

b. Direct questions about living, dying, plans, means, and intent

c. Ask about coping tools, supports and other resources

6. Quick Guide to Assessments

a. Build Rapport

b. Determine immediate issue

c. Evaluate Risk Factors

d. Decide if meets 5150 criteria

7. Scenarios

P. Resources

1. Uplift Family Services Crisis Continuum

a. Mobile Crisis Response

b. Crisis Stabilization Unit

c. Community Transition Services

XI. Traumatic Brain Injury (TBI)

A. Definition of TBI

1. Insult to the brain caused by an external physical force that results in impairment of cognitive abilities/physical functioning.

2. Can disturb behavioral or emotional functioning.

B. Definition of ABI (Acquired Brain Injury)

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1. Injury to the brain that has occurred after birth and is not hereditary, congenial or degenerative.

C. TBI

1. TBI is not used for a personal who is born with a brain injury.
2. Also not used for brain injuries that happen during birth.
3. Video Explanation

D. Acquired Brain Injury

1. Chart

E. Types of Head Injury

1. Two varieties of TBI
 - a. Open Head Injury
 - b. Closed Head Injury

F. Brain Injury

1. Highest among adolescents and young adults
2. Leading causes
 - a. Falls
 - b. Motor Vehicle Accidents

G. TBI the Signature of this War

1. Many soldiers experiencing blast exposures at greater frequencies
2. Blast wave significance not yet well understood
3. Memory, concentration, and problem-solving difficulties

H. Head Injuries Graded On

1. Mild
2. Moderate
3. Severe

I. Diagnosis

1. History of TBI
2. Length of unconsciousness/post traumatic amnesia
3. Physical Examination
4. Neuropsychology

J. Living with a TBI

1. Video

K. TBI Stats

1. Every 23 seconds someone is affected
2. 1.5-2 million individuals a year sustain a TBI
3. 5.3 million in the US with TBI
4. Shaken body Syndrome (SBS)
5. Persons w Brain Injuries commit crimes at a 7x higher rate
6. Minnesota Study
 - a. 83% of incarcerated individual have experienced one or more head injuries
7. Seattle Study
 - a. 87% of those incarcerated had a TBI

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8. Brain Functioning
- L. Symptoms of TBI
 1. Emotional
 2. Behavioral
 3. Social
 4. Cognitive
 5. Physical
- M. Emotional
 1. Depression
 2. Anxiety
 3. Hopelessness
 4. Reduced Confidence
 5. Apathy
 6. Emotional Numbness
 7. Intense Fear/PTSD
- N. Behavioral
 1. Impatience
 2. Anger
 3. Frustration
 4. Confrontational Behaviors
 5. Impulsivity
 6. Increased avoidance of uncomfortable situations or activities
 7. Withdrawal
- O. Physical
 1. Headaches
 2. Chronic Pain
 3. Fatigue
 4. Weakness or numbness
 5. Changes in vision
 6. Other sensory changes
 7. Changes in sleep
 8. Change sin appetite
 9. Vertigo
 10. Nausea
 11. Impairment in fine motor speed and coordination
 12. Changes in sexual functioning
- P. Cognitive
 1. Short/Long Term memory loss
 2. Slowed ability to process information
 3. Unable to multitask
 4. Changes in attention
 5. Confusion
 6. Word finding problems
 7. Disorientation and spatial disorientation

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8. Difficulty keeping up with a conversation
 9. Changes in decision making
 10. Alterations in judgement
 11. Changes in ability to plan/organize/initiate activities
- Q. Social**
- R.** Increased anxiety
 - S.** Depression and wild mood swings
 - T.** Impulsivity
 - U.** Isolation
 - V.** Egocentric behavior, inability to see how their actions might affect others
 - W.** Changes in relationships
 - X.** Change in ability to engage in hobbies and leisure activities
- Y.** Responding to People with Brain Injuries
- Z.** Signs to Identify A Possible TBI
1. Unsteady gait/balance problems
 2. Slurred Speech
 3. Slow/Delayed responses to questions
 4. Inability to maintain focus on conversation
 5. Cannot remember where they live/where they are at
 6. Easily agitated, sometimes volatile
 7. May have a notebook/PDA but unable to operate it under stress
 8. May have a medical alert bracelet
- AA.** Identifying Someone Who Has A Brain Injury (Clues)
1. Verbal Issues
 2. Social Issues
 3. Personality Issues
 4. Behavioral Issues
- BB.** Treatment Areas
1. Education/support for family
 2. Individual and group therapies
 3. Medication including symptom management
 4. Rehab
- CC.** Prevention Areas
1. Rest
 2. Education
 3. Neurometabolic changes and concussion
 4. Helmets
- DD.** Cognitive Rehabilitation
1. Restorative
 2. Compensatory
 3. Environmental
 4. Behavioral

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- EE.** Ways to Approach a Person with a TBI
 - 1. Ask
 - a. Results of TBI?
 - b. Do they have contact information for a caregiver
 - c. Do they know how to get home?
 - d. Reassure you are there to help
- FF.** Responding to a Person with TBI
 - 1. General Overall Management Approaches
 - a. Treat as an adult
 - b. Be patient
 - c. Be consistent
 - d. Keep it simple/concise
 - e. Calm/Controlled Behavior
 - f. Expect the unexpected
 - g. Redirect to keep on task
- GG.** Behavior Management Strategies
 - 1. Confusion
 - 2. Impaired ability to carry out a plan of action
 - 3. Impaired alertness and mental fatigue
- HH.** Head Injury 101
 - 1. The Cheat Sheet

XII. Understanding Schizophrenia, Mood Disorders and Psychosis

- A. Schizophrenia**
 - 1. Schizophrenia and Genetics
 - 2. Research and Schizophrenia
 - 3. How They May Look
 - 4. How they may be affected:
 - 5. Symptoms
- B. Delusions**
 - 1. Definition
 - 2. Types of Delusions
 - 3. Other negative symptoms
 - 4. Video
- C. Schizophrenia Treatment**
 - 1. Biological
 - 2. Medication Side Effects
 - 3. Psychological Treatment
- D. Supportive Help Organizations**
 - 1. Community Resources
 - 2. Family referrals
- E. Suggested Ways to Approach**
 - 1. Respect
 - 2. Do not disagree with their delusions

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3. Be curious
4. Listen
5. Provide resources
6. Evaluate for 5150

F. N.I.C.E Paton Blough

1. **N**ever undermine the delusion or the person
2. **I**gnore personal verbal attacks and threats as much as possible
3. **C**onnect on a personal/local level
4. **E**xtend friendship, kindness and compassion
5. Video- Things not to say

G. Major Depression

1. Video- Recognize the Signs
2. Depression Symptoms
3. Warning Signs for Suicide
4. Treatment for Depression

H. Bipolar Disorder

1. Diagnosis
2. Types of Bipolar Disorder
 - a. Manic (Bipolar 1)
 - a. Video
 - b. Depressed (Bipolar II)
 - a. Video
3. Basics of the Diagnosis
 - a. Pediatric bipolar disorder
 - b. Treatment options
4. Illegal Drug Use
 - a. 55% of bipolar patients have history of drug abuse

I. Psychosis

1. Could be a sign of substance abuse
2. Could be an early sign of schizophrenia
3. Could be a result of a reaction to medication
4. Video
5. Psychological Interventions include individual, family and group psychotherapies.
 - a. Goals of Treatment

XIII. Alcohol/Substance Abuse/Peer Support- (Critical Incident Self Care)

A. Employee Assistance Program

1. Coordinates and Manages
 - a. Critical Incident Response Team (CIRT)
 - b. Peer Support Program
 - c. Catastrophic Illness Program
 - d. Psychological Professionals (MHN)

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- e. Police Chaplains
- f. Stress Unit
- 2. Confidentiality
- 3. Law Enforcement Suicide a national problem
- B. Critical Incident Response Team (CIRT)**
 - 1. 24/7 SFPD support
 - 2. Psychological Support
 - 3. Debriefings for officers, dispatchers, family members, and others
- C. Peer Support Program**
 - 1. Trained in peer support techniques
 - 2. Confidentiality maintained
- D. Police Chaplains**
 - 1. Multi-denominational group
 - 2. Respond to on- or off duty critical incidents
 - 3. Grief, spiritual support and consultation
 - 4. Confidential
- E. Psychological Professionals Managed Health Network (MHN)**
 - 1. Outpatient mental health benefit
 - 2. Mental health professionals culturally competent in law enforcement issues
- F. Stress Unit, Alcohol/Chemical Dependency**
 - 1. Counseling, Information and Referrals for alcohol and chemical dependency.
 - 2. Assist members into treatment, provide transportation, coordinate financial assistance
 - 3. Voluntary Confidential Support
 - a. Recovery programs, 12-step programs, 24/7 availability
- G. Critical Incidents**
 - 1. An event which is outside the normal human experience
 - 2. Posttraumatic stress is a normal reaction to an abnormal situation
 - a. Psychological Effects
 - b. Cognitive Effects
 - c. Physical Effects
 - d. Emotional Effects
 - 3. Officer Involved Shooting
 - a. Behavioral Effects
 - 4. Possible Effects of Trauma Over Time
 - 5. Posttraumatic Stress Disorder (PTSD)
 - a. 25% of first responders suffer
 - b. "Injured in the line of duty"
 - a. PTSD Is defined as an injury.
 - c. Can cops get PTSD?

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H. Alcoholism

1. Disease model
2. Addiction Facts
3. Police Issues
4. Classifications
 - a. Low Risk Drinking
 - b. At Risk Drinking
5. Retirement & Alcoholism
6. C.A.G.E. Questionnaire
7. Observations

I. Opiate Dependency

1. Non-medical opiate pill abuse has reached epidemic proportions.

J. Suggested Reading

K. Self-Care Techniques

1. Exercise
2. See a therapist once a year!
3. Mindfulness & Relaxation
4. West Coast Post Trauma Retreat (WCPR)
5. COP Line 1-800-267-5463
6. Sergeant Art Howards 415-378-5082

XIV. Case Study

A. Common Traits:

1. Mental Health Subjects
2. Subjects Under the Influence
3. Intoxicated Subjects
 - a. What do these subjects have in common?
 - a. Altered thought process
 - b. Altered physical strength
 - c. Unpredictability

B. Responding to Calls for Service Involving Mental Health Subjects

1. This was the topic of discussion in the beginning of shift due to the high volume of calls for service involving mental health subjects.
 - a. Should we treat these like routine calls for service?
 - b. Is a traditional two officer response always adequate?
 - c. Why might we alter our response?

C. De-Escalation and Tactical Conduct

1. Violence involving mental health subjects are becoming more prevalent.
2. Police response and tactics should be altered in efforts to maximize peaceful resolution

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- a. Perhaps increase personnel and alternative de-escalation tactics could decrease injury and risk to all.
 - b. Scenario: SJPD Case Number 17-312-101
 - a. Day Watch Call for Service
 - b. Swing Watch Call for Service
 - i. Assignments
 - ii. Video
 - c. After Action
 - i. Ending
 - ii. Medical Treatment
 - iii. Explanation of actions of subject's mother
 - iv. Documentation (processing the scene/investigation)
 - v. Notifications
 - vi. De-brief
 - c. Why All the communication with the Reporting Person (R/P)?
 - a. Prepare the family for all possible outcomes (Mobile Crisis Response Team)
 - b. Make it very clear to ALL concerned parties what our INTENT was and how we PREPARED for the incident (Family, Subject involved, Internal Affairs, District Attorney and Jury)
- 3. Consent**
- a. Although consent may not be necessary, consider meeting with the RP:
 - b. Explain our goal is to seek a peaceful resolution at all costs.
- 4. All Available Resources**
- a. Select a staging location
 - b. Conduct and complete background check prior calls for service and criminal history to determine behavioral patterns and intelligence
 - c. Gather at staging location, review and brief the details of the call for service
 - d. Assignments
 - a. Verbal (CIT or Negotiator Mobile Crisis Response Team)
 - b. Less lethal
 - c. Lethal as last resort
 - d. Hands on officers
 - e. Supervisor should be present during briefing:
 - a. Clarify WHY we are there?
 - b. Should we walk away?

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- c. Reverse brief: play back the briefing to ensure understanding.
- d. Compromised Authority: What If's
- 5. Conclusion
 - a. Preparation starts well before the shift begins
 - b. Use adequate personnel and the experience at hand to maximize efforts for a peaceful resolution
 - c. Stage, gather intelligence, explore ALL options
 - d. Establish assignments, roles and expectations
 - e. Discuss What If's
 - f. Prepare the protective gear
 - g. Meet with R/P
 - h. Execute the mission with de-escalation and tactical conduct in mind
 - i. Consider when to walk away
 - j. Medical Personnel Staging area
 - k. Process Scene
 - l. Explain actions to R/P
 - m. Make proper notifications
 - n. Document
 - o. Review and approve reports
 - p. De-brief
- 6. Questions?

XV. **PTSD, TBI and Challenges for Returning Veterans**

- 1. Posttraumatic
- B. Stress Disorder- PTSD**
 - 1. John Van Allen, II
 - 2. Veteran Specific Issues?
 - 3. Old Thinking on Veterans and Criminality
- C. PTSD and Criminal Offending**
 - 1. Violent Offending and Domestic Violence
 - a. National statistics
 - 2. PTSD and Violence
 - a. PTSD increases the risk of weapon and assault charges
 - 3. Treatment
- D. Signs and Symptoms**
 - 1. Diagnosing PTSD
 - a. Avoidance & Numbing
 - b. Hyperarousal
 - c. Reexperiencing
 - 2. Service Connection Resources
- E. PTSD and Trauma**
- F. PTSD in OIF & OEF Veterans**

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- G. Prevalence of PTSD
- H. Recovery from PTSD
 - 1. Possible Triggers
 - 2. Grounding Technique
- I. Questions

XVI. **NAMI Panel Presentations**

- 1. Panel Presentation/ Consumer and Family Perspective
- B. Panel Presentation
 - 1. What is it like to live with mental illness?
 - 2. Encounters with police
 - a. Good and Bad
- C. Crisis Intervention Techniques when working with a personal who has mental illness
 - 1. Speaking calmly, slowly, and clearly
 - 2. Try to get them to focus
 - 3. Despite their behavior, they may be afraid
 - 4. Explain to the person what is going to happen
- D. Crisis intervention techniques when working with family members of consumers
 - 1. Acknowledge their difficulties and validate their feelings
 - a. Understand there may be negative feelings towards police.
 - 2. Offer appropriate assistance
 - 3. Explain what is going to happen

XVII. **Gun Violence Restraining Orders (GVROs)**

- A. What is it?
 - 1. An order that allows law enforcement to take guns and ammo from persons who are a danger to self/others. Requires party to relinquish weapons/ammo immediately.
- B. 3 Types:
 - 1. Temporary Emergency Order is for an immediate threat and is only for law enforcement.
 - 2. Temporary Ex-Parte is a formal application made in court by LEA or family/housemates
 - 3. Order after Notice/hearing is a one-year order after having a full hearing.
- C. Tips:
 - 1. If an imminent threat you can request GVRO over the phone, memorialize it on the emergency order.

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2. If no emergency request ex-parte order because it triggers a formal hearing, allowing the change for guns to be removed for a year or longer.
- D. Taking guns**
1. The order requires the party to relinquish the guns/ammo immediately to law enforcement. If they refuse you have a basis for a search warrant pursuant PC 1524(a)(14).
- E. For Help**
1. On-Call search warrant DDAs can assist with an emergency order or warrant.
- F. Chart for reference to assist in types of GVROs, who can apply, process, duration of GVRO and legal authority.**

XVIII. **Santa Clara County Mobile Crisis Response Team (MCRT/IHOT)**

- A. Mission:** provide effective and compassionate crisis intervention response to individuals who experience mental health crisis; as well as reduce hospitalizations and unnecessary incarcerations whenever possible.
- B. MCRT Goal**
1. Assist individuals and their families to de-escalate the crisis and connect them safely to mental health services to reduce risks to self/others, increase public safety, increase outreach and engagement services, and provide necessary resources.
- C. MCRT Hours of Operation**
1. Monday – Friday 8am to 8pm
 2. Contact info: 800-704-0900 opt 2
 3. Area Served: Santa Clara County
 4. Languages: English, Spanish, Vietnamese (others available via use of Language Line).
 5. When to call--someone is experiencing a mental health crisis, or when someone may be suicidal and requires a psychiatric evaluation.
 6. **For minors, call Uplift Mobile Crisis 408-379-9085**
- D. Who is MCRT?**
1. Mobile Crisis Response Team consist of culturally competent, trained clinicians in crisis intervention to intervene with adult individuals who are experiencing acute mental health crisis.
 2. MCRT Clinician's partner with Law Enforcement Agencies within Santa Clara County.

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3. Staffing: 12 clinicians (LCSW, ASW, LMFT, AMFT) and Law Enforcement Liaisons
- E. MCRT Services
1. Crisis screening
 2. Crisis assessment
 3. Crisis intervention
 4. Verbal de-escalation
 5. Linkage/referral and resources
- F. Questions?

XIX. **Communication ICE**

- A. Introduction to Instructors
- B. **I** mportant **C** are **E**valuate
1. Self-Management Intervention tool
 - a. Manage emotions in the present and plan for the future
 2. Control
 - a. Move from external to internal locus of control
 3. Value and Care
 - a. Focus on valuing yourself and caring for your emotions to enhance better decision making when faced with crisis.
 4. Emotion vs Logic
 - a. Move from an emotional management state to intellectual/analytical processing to assist in problem solving.
 5. I.C.E promotes personal ownership, self-awareness, de-escalation, recovery and evolution of self
- C. The Officer's Tax
- D. I am IMPOTANT right now
1. Positive self-talk: "I" messages → "I need" / "I feel"
 2. Identify inflamed emotions
 3. Value and acceptance
 4. Initiate positive thought to move towards positive action with purpose
 5. Take ownership of your thoughts
 6. Take ownership of your actions
 7. Take ownership of your feelings
 8. Thoughts, Actions, Feelings are fluent
- E. CARE for myself
1. Using healthy means
 2. Utilize things I have access to
 3. Positive self-talk
 4. Working out
 5. Going for a walk

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6. Venting
7. Taking space
8. Listening to music/audio

F. EVALUATE

1. Find the best options for solutions
2. Examine Psychological and environmental factors
3. Decide the best course of action
4. Implement actions based on thoughts and assessments
5. Make decisions that facilitate recovery and advancement.

G. Group Activity

1. Important: prioritize yourself, acknowledge your feelings, & Value all that is YOU.
2. Care” give yourself what you need- time, exercise, nutrition, mediation, connection, and wellness.
3. Evaluate: your situation, role, opportunity for growth, & what you can do moving forward.

H. Keep in Mind

1. If you skip steps when using ICE:
 - a. I & C with E = Burnout
 - b. I & E without C = Compassion fatigue
 - c. C & E without I = Numbing

I. Summary

1. Limbic System (flipping your lid)
2. Stressor – Resource = Threat
3. Shift Perspective from what is wrong with me to what happened to me
4. I am Important
5. Care for myself
6. Evaluate and recover

J. Questions

XX. Site Visits to Local Resources

A. Site Visit #1

1. Sobering Center: 151 W Mission St., San Jose

B. Site Visit #2

1. NAMI: 1150 S. Bascom Ave Suite #25, San Jose

C. Site Visit #3

1. Crisis Stabilization Unit: 51 Llewellyn Ave, Campbell

XXI. Suicide by Cop

A. Learning Points

1. What is Suicide by Cop (SBC)

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2. Phases of SBC
 3. How to recognize unfolding SBC event
 4. Response considerations to SBC event
 5. Strategies to try and diffuse an SBC event
 6. Officer safety after an SBC event
- B. Full Disclosure**
- C. What is Suicide by Cop?**
1. Is a suicide method in which someone deliberately acts in a threatening manner, either towards or in the presence of a law enforcement official, with the main goal of provoking a lethal response from an officer
- D. 5 Defining Criteria for SBS**
1. Subject states a wish to die and ask the police to kill jim.
 2. Subject understands the finality of the act
 3. Leaves evidence of suicidal communication
 4. Processes a lethal weapon, or one that appears to be
 5. Intentionally escalates the incident to provoke officers to shoot.
- E. Indicators**
1. Unusual or inappropriate actions to initiate contact
 2. Intentionally makes the officer believe s/he pose a lethal threat to officer or another.
 3. Asks officer to use lethal force (suicidal ideation)
 4. Escalates aggressive behavior (points gun at officers, charges officer, etc.) to force a lethal response.
- F. Why do we care?**
1. 60-754 of SBC precipitators have a confirmed or suspected mental illness
 2. Question: Are police more likely to use deadly force due to perceived or actual danger?
- G. A Phenomenon?**
1. In US 1400-1800 OIS occur annually (33% are fatal, 450-600)
 2. Researchers estimate 150-200 fatalities result from SBC
 - a. LA Study” for every SBC event, 60 attempted but have been de-escalated w/o use of lethal force.
- H. What RED FLAGS suggest SBC?**
1. Suicidal Intent
 - a. Verbal Cues: “kill me,” “no one will miss me,” etc.
 - b. Ask police to kill them
 - c. Appears depressed, agitated, or in a mental health crisis
 2. Illogical Behaviors
 - a. Action Cues
 - a. Often intoxicated or under influence

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- b. Abnormal criminal behavior (does not attempt to flee)
 - c. Brandishing for no reason, self-inflicting injury
 - d. Aggressive/ non-compliant, even after being shot
 - e. Usually armed with firearm or edged weapon
 - f. If armed with a gun- 5-% shot at police
3. Acute Stressors
- a. Historical Cutes
 - a. End of relationship
 - b. Hopelessness
 - c. Mental Illness/PTSD
 - d. Homelessness
4. Nature of Call Indicators
- a. 28% of 9-1-1 calls initially classified as 5150 subjects
 - b. 23% classified as “suicidal subjects”
 - a. Call takers should triage and relay these indicators to responding units.
- I. Suicide and SBC
1. 3 Steps for SBC precipitators:
- a. Pre-motivational
 - a. Risk factors present but not actually suicidal
 - b. Motivational
 - a. Suicidal ideation & plan formulation (intent & communication)
 - c. Volitional
 - a. Plan is underway
2. Most LEO contact occur during the motivational phase
3. This means there still many be opportunity to change course of events
4. SBC occurs when you reach the volitional phase
- J. What research shows
1. 2 Types of situations for SBC:
- a. Planned confrontations- precipitator initiated
 - a. Suicidal but unable to complete the act
 - b. Created the confrontation and immediately provokes lethal.
 - b. Spontaneous Response- Opportunistic
 - a. Not actively thinking about suicide but reacts to actions of officer
 - b. Example” in response to officer pointing firearm at the subject, s/he walks or runs at the officer brandishing knife.
- K. Demographic Indicators
1. Predominately male (83%)

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2. Trigger points include:
 - a. Stressful, adverse life changes
 - b. Terminal illness
 - c. Loss of job, lawsuit, etc.
 - d. Confirmed or suspected mental health diagnosis.
- L. Response to SBC Incidents
1. Listen to the nature of the call and look for “red flags”
 2. The majority of SBC calls, the subject does not have a firearm
 3. Look for suicidal vs homicidal behaviors and actions
 4. Pay attention to your safety but look for your opportunities to verbally de-escalate.
 5. Response 3 steps:
 - a. Assure your safety and the public’s safety
 - b. Pointing a gun at a potentially suicidal person will increase anxiety and exacerbate the situation
 - c. Communication is your most effective tool- pointing a gun at them while telling them “I’m here to help you” is not very credible.
 6. Step 1: Assure your safety and the public safety
 - a. If the subject has a firearm:
 - a. Options are limited
 - b. Take cover, use extreme caution, warn incoming units and bystanders.
 - b. If the subject has an edged weapon:
 - a. Maintain distance, use available cover as indicated
 - c. If the subject does not have an obvious weapon.
 - a. Do not bark orders (i.e. show me your hands)
 - b. Make requests one at a time—slow it down
 - d. Define contact and cover/containment assignments
 - e. Call for additional resources:
 - a. Supervisor
 - b. CIT (if available)
 - c. K-9, medical, less-lethal options, etc.
 7. Step 2: Pointing a gun at a potentially suicidal person can increase anxiety and exacerbate the situation
 - a. Unless the subject is armed with a firearm, time, distance, cover, and conversation are your best options
 - b. In SPONTANEOUS RESPONSE incidents, pointing a gun can actually trigger a SBC reaction
 - c. Depending on the weapon displayed, consider keeping your firearm unholstered and at “low ready” to minimize anxiety
 8. Step 3: Communication is your most effective tool

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- a. Recent LAPS studies indicate a large majority of SBC events are resolved without use of any force (81%)
 - b. 17% required less-lethal tools to de-escalate
 - c. 7% involved use of lethal force
 - d. "Talking to a suicidal person- establishing a personal connection and a relationship of trust- is the most effective way of defusing SBC incidents" – PERF (2019)
- 9. Prior to Arrival**
- a. If no imminent danger- take time to gather more information before arrival (tactical pause)
 - b. Consider calling the R/P and get information firsthand
 - a. Topics of the subject will respond positively to
 - b. Topics to avoid
 - c. Plan your response and establish assignments
- 10. Upon Arrival**
- a. Look to reduce the subject's anxiety & encourage communication
 - b. Suicidal individuals have a sense of urgency- don't add to it
 - c. SLOW THINGS DOWN!
 - a. Speak slowly, try to establish rapport & treat with respect
 - b. Listen to problems being expressed
 - c. Express your desire to help and use their ambivalence to divert negative thoughts on suicide.
 - d. Minimize tactical engagement unless there is no alternative
 - e. If practical- BACK OFF to minimize provocation
 - f. Your actions may increase the subject's aggressiveness
 - g. Watch for unexpected or inappropriate responses to the situation
 - h. Remember "good cop – bad cop"
- 11. The Emotional Toll**
- a. The importance of understanding the emotional toll of SBC cannot be understated
 - b. Duty to protect life is our greatest purpose
 - c. Extensive training to assure deadly force is used appropriately and in compliance within strict confines of the law
 - d. Officers involved in justified shootings suffer considerable stress at the time of the incident.
 - e. Stress extends far beyond the actual event.

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- a. Exhaustive joint criminal and administrative investigations
 - b. Intense media scrutiny
 - c. Community uproar
 - d. Personal moral evaluation
 - e. Potential career loss
 - f. Potential criminal prosecution
 - g. Potential financial hardship
 - h. Potential civil litigation
 - i. Alienation of friends and colleagues
 - j. Emotional doubts (could I have done it differently?)
 - f. PTSD is a common occurrence
 - a. Research shows 30-40% of officers impacted
 - b. Officer realizes s/he was manipulated as a means of killing another
 - g. Many officers do not recover from inflicted by SBC:
 - a. Leave the profession
 - b. Decompensate personally and professionally
 - c. Take their own life
- 12. The Bottom Line**
- a. If the behavior does not make sense, consider SBC
 - b. Trust your instincts and your training
 - c. Look for opportunity to intervene during the motivational phase
 - d. Consider backing off if public safety not in danger
 - e. Despite your best efforts, the precipitator's desire to die may leave you no other options
 - f. **STAY FOCUSED AND WATCH YOUR SAFETY**
- 13. Questions**

XXII. Sudden Death and Excited Delirium Syndrome (ExDS)

- A. Paradigm Shift**
 - 1. Struggling and resistance can indicate a medical emergency and not a criminal act (or in addition to)
- B. Video**
- C. History of Sudden Death**
 - 1. Chart
 - 2. Sudden death is not new
 - 3. Disappearance from medical reports in 1950's after development of psychotropic drugs
 - 4. History
 - a. Mental institutions closed in 70's & 80's
 - b. Cocaine craze in 70's & 80's

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- c. Crack cocaine in 80's & 90's
- d. Methamphetamine 90's to present
- e. New designer drugs
- 5. Although many reporters make sudden and/or in-custody deaths appear new, think back into the 1980's, 1990's, etc.
- 6. What defensive tools were "blamed"?
 - a. Carotid holds: 1970's
 - b. Restraint methods: 1980's
 - c. Pepper spray: 1990's
 - d. TASER ECDs: 21st century
- 7. Sudden Death defined by the World Health Organization as a cardio-respiratory collapse that occurs within 24 hours after the onset of symptoms.
- 8. Instantaneous Death is death that occurs within 5 minutes of the onset of symptoms.
- D. Drugs and Mental Illness**
 - 1. 2.6% of the U/S/ population over 18 years of age has bipolar disorder (> 5.7 million people)/
 - 2. 1.1% of U.S. population over 18 years of age has schizophrenia (> 2.4 million people)
 - 3. Un-diagnosed mental illness
 - 4. Developmental delays
 - 5. Significant event/unknown event... Broken Heart Syndrome
- E. Drug Abuse Warning Network (DAWN) 2011**
 - 1. Cocaine was involved in 505,224 ED visits
 - 2. Amphetamine and meth were involved in 172,792 ED visits
 - 3. PCP was involved in 75,538 ED visits
 - 4. MDMA was involved in 22,498 ED visits
 - 5. Mis. Hallucinogenic were involved in 8,043 ED visits
 - 6. Marijuana was involved in 445,668 (syn, 531) ED visits
 - 7. Heroin was involved in 258,483 ED visits
 - 8. Total illicit ED visits were 1,252,500
- F. Video on Salvia**
- G. Excited Delirium connection to Drugs and Alcohol**
 - 1. Cocaine increases temperature, heart rate, myocardial pressure contractibility and blood pressure
 - 2. Methamphetamine chronic use can lead to agitation, confusion, hallucinations, paranoia and aggressiveness
 - 3. PCP often causes agitation, delusions, and irrational behavior
 - 4. Alcohol is a recognized cause of a variety of ventricular arrhythmias and may increase a predisposed heart to have a fatal arrhythmia
 - 5. Psychotropic drugs; antidepressants, antipsychotics, etc.

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6. There is no such thing as a non-lethal dose of cocaine...Sensitization v Tolerance
 7. When alcohol is mixed with cocaine = coca ethylene, which increases incidence of sudden death
 8. Some people fail to take their prescribed neuroleptic medications, causing them to engage in bizarre behavior and exhibit excited delirium indicators
 9. A single cocaine overdose can cause COMA and seizures.
- H.** Video, Venture County Sheriff Department
1. Did you notice?
 - a. Sweating, core temp can be as high as 109 degrees
 - b. Removal of clothing
Yelling and screaming
 - c. No effect of High strength OC
 - d. No sense of pain
 - e. Delusional
 - f. Unintelligible
- I.** Tony's Cop Simplified Version
1. Norepinephrine over production
 2. Dopamine over production
 3. Think of it as super-charged fight or flight reaction where the normal process of relaxing or calming down has failed
 4. Now add chronic drug use or mental health issues
- J.** Let's Talk About Dopamine
1. Dopamine is the "feel good" chemical in the brain
 2. Parkinson's disease and drug addiction are opposite diseases, but both depend upon dopamine in the brain. Parkinson's patients don't have enough on it; drug addicts get too much of it
 3. Bipolar and Schizophrenia Dopamine levels
 4. Cocaine and amphetamines bind to dopamine transporter
 5. Dopamine reuptake
- K.** Mechanisms of Cocaine and Amphetamine DAT blocking
1. Functionality...Dopamine D2 receptors are decreased by addiction
 - a. Chart
 2. Dopamine Reuptake Chart
- L.** "Excited Delirium" Profile
1. 91-99% male
 2. Generally, between the ages of 35-44
 3. Person usually involved in a struggle
 4. Death generally follows bizarre behavior episode, and/or the use of illegal drugs
 5. Geographic residence not a factor

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6. These generalizations are based upon research, and does not preclude females, people who fail to take their prescription medication, and others, etc. from experiencing sudden death.

M. Focus of Training

1. You are NOT being trained to a make a clinical diagnosis
2. In contrast, you are being trained about behavioral cues that may permit you to identify the individual as a potential high-risk candidate for a sudden or an in-custody death

N. Key Terms & Definitions

1. Agitated delirium/mania is more accurate term for EXCITED delirium. This term is found in the medical and psychological literature and is classified as a diagnosis.
2. "Mania left untreated is often fatal"
3. Excited delirium is a descriptive phrase that historically has not been a recognized medical or psychiatric condition. According to Dr. Wetli, Dr. Fishbain is credited for first using the term.
4. Plaintiff's attorneys argue Excited Delirium is not medically recognized disease by AMA or in DSM V.
5. The American College of Emergency Physicians and the National Association of Medical Examiners have recently recognized Excited Delirium as a condition.

O. Agitated Chaotic Event

1. An officer describing suspect being in a state of excited delirium is technically a diagnosis
2. Medical, Psychological, Mental Health professionals along with forensic pathologists determine a diagnosis.
3. Officers should say/write "the person appeared to be in an Agitated Chaotic Event (ACE)", then describe observed identified behavioral cues.
 - a. Chart examples of ACE

P. Pre-disposing factors for Sudden Death

1. Obese, large belly
2. Under the influence of alcohol
3. Withdrawal from alcohol
4. Hot and humid weather
5. Dehydrated
6. Hypoglycemic (low blood sugar)
7. Head injury
8. Under the influence of stimulants
9. Prescription drugs: too much / too little
10. High blood pressure
11. Enlarged heart
12. Heart disease

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13. Pulmonary disease

Q. Physical Characteristics

1. Dilated pupils
2. High body temperature- hyperthermia
3. Sweating profusely
4. Skin discoloration
5. Dehydration
6. Head injury (past or present)

R. Behavioral Characteristics

1. Intense paranoia
2. Extremely agitated
3. Violent or bizarre behavior
4. Violence toward objects (i.e., glass)
5. Naked or stripping off clothing
6. Running wildly (e.g., into traffic)
7. Screaming for no apparent reason
8. Pressured, loud, incoherent speech
9. Psychotic in appearance
10. Rapid changes in emotions (cry, laugh)
11. Disoriented about time, place, him or herself
12. Superhuman strength
13. Muscle rigidity (may not be resisting)
14. Diminished sense of pain (OC doesn't work)
15. Hallucinating (hears voices)
16. Resists violently during control and restraint.
17. Resists violently after being restrained
18. Says "I can't breathe" during or after being restrained (may indicate breathing distress)
19. Lack of focus; easily distracted (unable to follow simple directions or orders)
20. Visions of grandeur (I'm Napoleon)
21. Depending on the situation, only 1 behavioral cue is needed to request EMS, back-up and a supervisor

S. Summary of Characteristics

1. **Confused**, disoriented about self
2. **Resists violently**, before, during, after restraint
3. **I can't breathe** (may indicate respiratory issues)
4. **Strips off clothing**; naked; **Sweating profusely**
5. Intense paranoia
6. **Superhuman strength**; **Seemingly unstoppable**; **Struggle**

T. Four Phases of "Excited Delirium"

1. Phase I: Hyperthermia (strips off clothing...naked usually)
2. Phase II: Delirium (incredible strength)

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3. Phase III: Respiratory Arrest (goes limp; AED will say “do not shock”)
 4. Phase IV: Cardiac Arrest (death)
- U. Response Model**
1. GET: more info (dispatch)
 2. SEND: EMS, more officers, supervisor
 3. DEVELOP: plan (if time & safe)
 4. DE-ESCALATE: if possible and safe to do so
 5. CAPTURE: (ECD, sooner than later)
 6. CONTROL: (officers)
 7. RESTRAIN: (restraint equipment)
 8. SEDATE: (Paramedic/ER)
 9. TRANSPORT: (ambulance—faceup; squad—sitting or on side)
- V. Transportation by Ambulance**
1. Ambulance transport is preferred
 2. Supine (face-up) on gurney, restrained or not
 3. Handcuff, officer rides in or behind the ambulance to assist in handcuff removal
- W. Transportation by Police Car**
1. Do not Hog-tie (Vrs Hobble)
 2. Sit the person upright in the back seat, and seat belt and shoulder harness him or her
 3. If unable to sit upright, position the person on his or side and then seat belt and/or shoulder harness
 4. Second officer sides in the back to monitor the individual (if practical)
 5. Go directly to the Hospital
- X. Response Model**
1. Plan
 2. Access
 3. Capture
 4. Control
 5. Restrain
 6. Sedate
 7. Transport
 8. Chart
- Y. Investigators and the Medical Examiners**
1. Co-develop a plan
 2. Harvest the brain
 3. Obtain hair samples
 4. Obtain core body temperature
 5. Photograph and video scene
 6. Psychological Autopsy

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- Z. Video, Mom Sues Police After Son Dies While in Custody
- AA. Appleton Police Department, Jefferson Street Incident
- BB. Resources
- CC. Video Crazy Salvia Trip
- DD. Bath Salts Video

XXIII. Santa Clara County Mental Health Resources and Scenarios: Interactive Video Simulation Training for San Jose PD

- A. Disclaimer
- B. IVST... What is It?
 - 1. Life sized, interactive, video projections
 - 2. First developed for force option training
 - 3. Video reacts to the decisions of the officer.
 - 4. Previously, no videos for specifically designed to train officers how to address the needs of the mentally ill in crisis.
- C. Training Goals – Same as CIT
 - 1. Reduce deaths and injuries to both officers and people with mental illness
 - 2. Reduce the need for the use of force by officers encountering a mentally ill person in crisis
 - 3. Increase access and engagement in services for people with mental illness
 - 4. Reduce unnecessary CFS, arrests and incarcerations that clog the CJS and create obstacles to recovery
- D. Purpose of IVST
 - 1. Decision-making skills they need to:
 - a. Recognize Mentally Ill people in Crisis
 - b. De-escalate Crisis Situations
 - c. Increase Referrals to Services
 - d. Improve Outcomes in a Culturally Diverse Environment
 - 2. How police respond to mentally ill individuals can have a tremendous impact on how these encounters will be resolved and what future these individuals can expect
 - 3. The Bottom Line...
 - a. The basic philosophy of any law enforcement officer should be to provide treatment that is:
 - a. Humane
 - b. Compassionate
 - c. Treat People with Dignity
- E. Who's in Charge?
 - 1. Gaining Control vs. Taking Control
 - a. Your Confidence
 - b. Your ability to remain calm
 - c. Speaking slowly, gently and clearly

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- d. Lowering your voice
 - e. Indicating a willingness to help and understand
- F. Steps to Leading to Behavioral Change
 - 1. Active Listening
 - 2. Empathy
 - 3. Rapport
 - 4. Influence
 - 5. Behavioral Change
- G. Interactions & Problem Solving
 - 1. Anxiety/Agitation
 - a. Ask the person to slow down
 - b. Don't demand behavior
 - c. Give the person enough personal space
 - d. Reassure person there is time to sort the situation out
 - e. Can you remove the source of agitation/anxiety?
 - 2. Aggressive Behavior
 - a. Set limits of behavior
 - b. Be aware of threatening statements and take them seriously
 - 3. Hallucinations Delusions
 - a. Do not argue with hallucinations or delusions
 - b. Accept that this is what the person believes or perceives
 - 4. Loss of Contact w/ Reality
 - a. Support reality-based statements
 - b. Do not encourage statements that are not real
 - c. Be careful with use of touch
 - 5. Slow Response
 - a. Allow person to formulate a response
 - b. Be patient
 - 6. Difficulty Establishing Directed Activity
 - a. Make expectations clear and concise
 - b. Help person identify meaningful task and break these down into doable tasks
 - 7. Difficulty Making Decisions
 - a. Limit number of decisions to be made
 - b. Take a directive stance that relate to a person's safety
 - 8. Exaggerated Response
 - a. Use clear concise questions and statements
 - 9. Depression, Frustration, Loneliness, Guilt
 - a. Allow person to vent
 - b. Allow person to cry
 - c. Help in problem solving and making changes in behavior that will have an impact on feelings
 - d. Help person set realistic goals

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- 10.** Disorganized, Illogical Thinking
 - a.** Word sentences in simple terms
 - b.** Ask one question at a time
 - c.** Allow person time to form an answer/response
- H.** De-escalation Techniques...Don't Do This
 - 1.** Express anger/irritation or shout
 - 2.** Mislead person
 - 3.** Assume they cannot hear you
 - 4.** Use inflammatory language
 - 5.** Force discussions
 - 6.** Move suddenly
 - 7.** Challenge delusions/hallucinations
 - 8.** Touch person unless needed for officer safety
 - 9.** It's NOT Personal
- I.** Final Thoughts and Suggestions...
 - 1.** Never promise things you cannot do
 - 2.** Develop a strategy
 - 3.** Keep your options open
 - 4.** Deal with me now...deal with me later!
- J.** Mental Health Problem Solving
 - 1.** Can you tell us what's going on here?
 - 2.** How can we help you today?
 - 3.** Are you a veteran?
 - 4.** Are you under the care of a doctor or case worker?
 - 5.** Are you taking meds? What meds? For what?
 - 6.** Do you know where you are? What day is it?
 - 7.** How do you get clothing, food and shelter?
 - 8.** Are you hearing voices? What are they saying?
 - 9.** Will you come with me to see someone who can help you?
- K.** Interactive Video Simulation Training (IVST)
 - 1.** Video simulations for officer training in responding to different mental health crises.