The University of Kansas

# Kansas Law Enforcement Training Center

Hutchinson, Kansas

## Course Title: Interactions with Special Populations

**Course Code: 09.02**

**Handout Title: Interactions with Special Populations**

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**LEARNING OBJECTIVES:**

1. **Define mental illness.**
2. **List various origins of mental illness.**
3. **Identify symptoms sometimes exhibited by a person with a mental illness including:**
	1. **Psychosis**
	2. **Paranoia**
4. **Identify some common diagnoses, including:**
	1. **Clinical depression**
	2. **Bipolar disease**
	3. **Anxiety disorders**
	4. **Schizophrenia**
	5. **Anti-social personality**
	6. **Dissociative disorders**
	7. **Impulse control disorders**
5. **List some of the mental illnesses first evident in childhood.**
6. **List medications frequently taken by those suffering from a mental illness.**
7. **List diseases or conditions which may be mistaken as mental illness.**
8. **Identify the proper approach and methods of establishing rapport with those suffering from a mental illness.**
9. **Identify effective ways to handle situations involving mentally disturbed or irrational persons.**
10. **Identify the differences between mental illness and mental retardation.**
11. **Identify signs that suggest that a person is mentally handicapped.**
12. **Identify issues concerning suicides.**
13. **Identify risk factors that may indicate that a person is suicidal.**
14. **Identify procedures for initial contact with a suicidal person.**
15. **Identify the phenomena of police assisted suicide.**
16. **Identify what role law enforcement may play in an involuntary commitment and legal requirements regarding emergency detention of a mentally ill person.**
17. **Identify procedures to take custody of and transport mentally impaired subjects.**
18. **Identify insanity as a defense for criminal activity according to Kansas law.**
19. **Identify concerns for law enforcement officers in dealing with an individual with Alzheimer’s Disease.**
20. **Identify common types and locations of elder abuse.**

##### **INTERACTING WITH SPECIAL POPULATION**S

Officers frequently encounter “Abnormal” behavior. Abnormal behavior may include any number of actions, statements or mannerisms, anything that is not expected or not natural. People you encounter may behave oddly or abnormally for many different reasons: to get attention, due to drug use, as a result of a trauma or accident, due to different cultural norms, or it may be due to some form of mental illness.

There are many different types of mental illness, and it is not uncommon for law enforcement to encounter someone who is mentally ill. The interaction can be challenging for someone who is not prepared. Today’s police officer needs to have a working knowledge of psychology. Although not expected to make a diagnosis, a general knowledge will be a benefit in the performance of law enforcement duties.

When faced with unpredictable behavior, an officer may react out of fear of the unknown, lack of knowledge or experience, or misconception. This could prompt rash, inappropriate and costly action. Citizens, even those acting abnormally, are entitled to full protection and rights under the law.

It is necessary for a law enforcement officer to be informed and professional, for the security of those he deals with, as well as, to protect the officer from physical harm and liability.

**MENTAL ILLNESS**

The Facts

* Mental illness is widespread, an estimated 54 million Americans suffer from mental illness in any given year. It affects 1 in 5 families.
* The mentally ill have a reputation of being dangerous, which is highlighted by the media. **In fact**, very few mentally ill persons pose a threat to the public. Only a very small percentage are violent towards others (although many more may harm themselves). Typically, people fear mentally ill persons because they are thought to be unpredictable.
* Unfortunately, there is still a stigma attached to being mentally ill.
* Some falsely perceive it as a character flaw or weakness, something that will go away if the person has enough strength or will. **But mental illness is a disease, like heart disease, cancer or diabetes.**
* Most mental illnesses can be successfully treated. The success rate for treatment is 60-80% (treatment for heart disease is only effective 41-52% of the time).
* *At least half of all individuals with serious mental illness also have substance abuse problems*.

**Mental Illness** is defined as 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.

* Mental illness is a general term that refers to a group of illnesses.
* There are more than **200** forms of mental illness.

**Origins/Causes of Mental Illness**

Most illnesses are caused by problems in the brains functioning. The brain is very complicated and there are still many areas that scientists don’t have answers for. The causes of mental illness can be as varied as the different forms. For some types of mental illness, the cause is still unknown.

Known causes include:

1. Genetic
2. Chemical/Biological/Neurological
3. Physical (injury/trauma)
4. Environmental stresses
5. Or a combination of these

**Physical conditions that can be mistaken for Mental Illness**

There are several diseases or conditions that may be mistaken for a mental illness. They may include the following:

* Low blood sugar/Diabetes
* Epilepsy
* High blood pressure
* Brain tumors
* Head injuries
* Severe infections
* Meningitis
* Pneumonia

Persons with these conditions may appear dazed and confused. They may wander or be violent, or appear to be in a stupor. It may appear they are having a panic attack or they may appear drunk. Conversely, sometimes a mental illness may be mistaken for another medical condition.

**Conditions of Mental Illness**

**Psychosis** (Psychotic episode)--“Out of touch with reality.”

* Someone having a psychotic episode perceives their world differently than normal. There are changes in the brain affecting thinking, emotion and/or behavior.
* Because of their distorted perception of reality, they may feel frightened, anxious or confused. Their behavior may also be very disturbing and frightening to others.
* They may be suffering from **hallucinations -** where they see, hear, smell, taste, or feel things that are not there.
* They may develop **delusions** - false beliefs, such as, beliefs that they are being persecuted, cheated, harassed, poisoned or conspired against. They may experience delusions of Grandeur where they believe they are a famous or important person.
* A psychotic person may have disorganized thinking--thoughts come and go rapidly. They cannot concentrate on one thought and they may be easily distracted. It may be *nearly impossible to communicate with them.*
* They may neglect their appearance, not changing clothes or bathing.
* They may appear excited or angry for no apparent reason. Or they may appear emotionless with no facial expression, speaking in a monotone voice, appearing apathetic.
* They may sit for hours not moving, or they may not be able to sit still.
* There may be drastic changes in their behavior. (Someone who is normally shy very outspoken.)

Psychosis may occur with many different conditions. It is most commonly associated with Schizophrenia, but may also occur with bi-polar, depression, head injuries and substance abuse.

**Paranoia** -- a suspiciousness that is either highly exaggerated or not warranted at all.

* Paranoia may be related to delusions.
* Paranoid individuals are often difficult for LEO’s to deal with. They are unable to trust anyone and are difficult to interview.
* Danger cannot always be predicted when dealing with people showing such a high degree of guardedness. Paranoid individuals may become aggressive and attempt injury to anyone trying to assist them.
* Paranoia may be a symptom of a mental illness, but anyone can develop paranoia given the right combination of peer pressure and repeated exposure to one viewpoint (militia and extremist groups).

# TYPES OF MENTAL ILLNESSES

**Affective disorders** (mood disorders)

**Depression**

* Depression is the most prevalent form of mental illness. There are 19 million Americans (10% of the population) who suffer from some type of depression every year, and over their lifetime 1 in 5 Americans will experience a major depression.
* It may be referred to as clinical depression, major depression, unipolar depression, or severe depression.
* Depression is a biological illness that affects behavior, thoughts, and feelings.
* Depression symptoms:
* Persistent, sad, anxious or empty mood.
* Sleeping too much or too little.
* Loss of interest or pleasure in activities that were once enjoyed.
* Significant change in appetite or body weight.
* Loss of energy or fatigue.
* Feelings of worthlessness or inappropriate guilt.
* Difficulty thinking, concentrating, remembering or making decisions.
* Recurrent thoughts of death or suicide.
* Depression can affect anyone at any age, gender, race, or income level. It affects nearly twice as many women (12%) as men (7%) per year. It affects up to 2.5% of children and 8.3% of adolescents in the U.S.
* Those suffering can’t just snap out of it, it is more than just the blues or a bad mood.
* It can be successfully treated, but up to 15% of those with major depression die by suicide.

**Bipolar disease** (formerly known as Manic-Depression)

* An affective (mood) disorder that is characterized by episodes of both depression and mania.
* Bipolar disorder affects 2.3 million Americans (1% of the population).
* The person cycles between the depressed state and the manic state, sometimes with a period in between of being well. The cycles recur and become more frequent over time.
* Mania symptoms:
* Excessive energy, activity, restlessness, racing thoughts and rapid talking.
* Denial that anything is wrong.
* Extreme “high” or euphoric feelings.
* Easily irritated or distracted.
* Decreased need for sleep.
* Unrealistic beliefs in one’s ability and powers.
* Uncharacteristically poor judgment.
* Sustained period of behavior that is different from usual.
* Unusual sex drive.
* Provocative, intrusive or aggressive behavior.
* Excessive involvement in risky behaviors or activities.
* Depression symptoms will be the same indicated earlier.
* Bipolar disorder occurs equally in men and women, however, more women experience *rapid cycling* in which there are 4 or more episodes within a 12-month period.
* Children can develop bipolar disorder, but often when it is seen in children it is more severe and may co-occur with disruptive behavior disorders, making diagnosis difficult.
* During either cycle, there may be psychotic episodes, including hallucination and delusions.
* Studies indicate that 80-90% of those who suffer from bipolar disorder have relatives with some form of depression. The illness is thought to be a biochemical imbalance, and it can be triggered by environmental factors.
* Without effective treatment, the illness can lead to suicide in nearly 20% of the cases.

## Anxiety Disorders

An anxiety disorder is an illness consisting of excessive and pervasive worry and concern leading to fear and panic with no clear cause and in situations that are not usually stressful or dangerous. There is enough distress that it is difficult for the person to function and the disorder can become debilitating.

There are 5 main categories:

1. **Panic Disorder**--attacks occurring with no logical cause triggering: pounding heart, chest pains, sweating, trembling, shortness of breath, dizziness, fear of dying. Many times people feel they are having a heart attack.
2. **Phobias**--deep-seated fear that is irrational, distressing, and disruptive to a person’s life. (Claustrophobia, agoraphobia, social phobia)
3. **Obsessive-Compulsive Disorder (OCD)-**a person is consumed by obsessions (repeated, upsetting thoughts and images) such as fears about dirt or germs or an overwhelming need to have things in a certain order. To combat these obsessions, the person engages in repetitive rituals (compulsions). The person may spend hours daily on the compulsions.
* Constant hand washing
* Checking and rechecking ritual (making sure doors are locked, or appliances are off)
* Counting or other rituals
* Hoarding
1. **Post-Traumatic Stress Disorder (PTSD)--**a person who survived a disaster or very traumatic experience are unable to clear the images from their mind. They have nightmares, flashbacks and may replay the event over and over in their mind. They may also feel the physical symptoms felt at the time of the incident.
2. **Generalized Anxiety Disorder (GAD)**--symptoms include 6 months or more of persistent feelings of exaggerated worry and tension that are unfounded or unrelenting. Individuals may worry constantly about their health, loved ones, finances, or jobs, even when there appears to be no reason to do so. They may experience a nameless worry about life in general.

**Psychotic Illnesses**

Psychotic illnesses are illnesses marked by psychotic episodes. The most common is Schizophrenia.

**Schizophrenia**—a chronic severe, and disabling brain disease which impairs a person’s ability to think clearly, manage his/her emotions, make decisions, and relate to others.

* It affects roughly 2 million Americans in their lifetime (1%).
* Most are not violent but withdrawn. Substance abuse can increase the rate of violence.
* Schizophrenia affects women and men equally, but in men the onset is usually earlier (late teens to early 20’s, compared to women who usually are affected in their20’s-30’s).
* It is **not** split personality.

**Personality Disorders**

The most widely recognized personality disorder is Antisocial Personality Disorder. **Antisocial Personality Disorder (APD)** is characterized by a pattern of disregarding and violating others’ rights and safety. Individuals with this disorder are sometimes called **psychopaths or sociopaths**.

To be diagnosed as antisocial:

* The person must be at least 18 years old.
* Since the age of 15 there have been at least three of the following:
* Repeated acts that could lead to arrest.
* Conning for pleasure or profit, repeated lying, or the use of aliases.
* Failure to plan ahead or being impulsive.
* Repeated assaults on others.
* Reckless when it comes to their or others safety.
* Poor work behavior or failure to honor financial obligations.
* Rationalizing the pain they inflict on others.

Approximately 3% of men and 1% of women in the population have antisocial personality disorder. But it is estimated that 70-80% of the prison population has APD.

Common symptoms include:

* Defiant
* Lack of remorse and guilt
* Lack of empathy
* Self-absorbed
* Irresponsible
* Deceitful
* Manipulative
* Superficial charm and wit
* Shallow emotions
* Egocentricity and grandiosity
* Irritable and aggressive
* Glibness and superficiality
* Lack of anxiety or emotion in situations that warrant such emotion

The psychopath’s beliefs, relationships and views may include:

* They do what they believe is right for them regardless of the impact on others.
* They are contemptuous of the customs, morals and ethics of society, and authority figures.
* They have a talent for pathological lying.
* They believe they are special and are driven by a need to prove their superiority.
* If they encounter evidence that they are only human, they will attempt to restore self-esteem by exerting power.
* They see others as weak and vulnerable and available for exploitation.
* They will victimize others by manipulating observed weaknesses and will, in turn, feign being a victim to absolve themselves of blame.
* They are callous about the pain and suffering of others.
* They are highly competitive, slick and calculating.

Those with APD are a concern for law enforcement because they can be very manipulative. Those who are very intelligent are especially dangerous and can manipulate interviews with officers and psychiatrists.

**Other Disorders**

**Impulse Control Disorders--**disorders in which a person acts on certain impulses, that are potentially harmful, but they cannot resist.

* Pyromania
* Kleptomania
* Pathological Gambling
* Intermittent Explosive Disorder

**Dissociative disorders**--disorders where the person is disconnected from full awareness of self, time, and/or external circumstances.

* Dissociative Amnesia
* Dissociative Identity Disorder (formerly Multiple Personality Disorder)

**Mental Illness in children**

It is estimated that over 7 million American children suffer from mental illness. Children suffer from some of the same illnesses as adults. Many children also suffer from emotional disorders and behavioral disorders. Often diagnosis is difficult because of multiple disorders, or mistaken behavioral problems. Depression is the most common illness, affecting 3-6 million youths. Everyday 14 young people commit suicide. Other common disorders include: Autism, ADHD, Anxiety disorders.

**Autism** is a developmental disorder that is first evident within the first three years of a child’s life. There is no cure. Autism strikes males about four times as often as females.

 Signs of autism:

* + - Impaired social interaction
		- Children may not react to their names
		- Have difficulty interpreting tones and facial expressions
		- Appear unaware of others feelings
		- Repetitive movements
		- Rocking
		- Hair twirling
		- Self-injurious activities
		- Biting
		- Head-banging
		- Abnormal responses to sounds, touch, or other sensory stimulation
		- Reduced sensitivity to pain
		- Extraordinarily sensitive to sounds, touch or other sensations

**Attention Deficit Hyperactivity Disorder (ADHD or ADD)** is a neurobehavioral disorder that interferes with one’s ability to pay attention, and may include hyperactivity and inability to control impulsive behavior. ADHD affects 3-5% of all children (2-3 times more boys than girls are affected) and it may also affect adults.

Attention deficit signs:

* **Inattention**
* Difficulty staying on task
* Easily distracted
* Forgetful in daily activities
* Does not seem to listen
* **Hyperactivity**
* Fidgets
* Talks excessively
* Can’t sit still
	+ **Impulsivity**
* Difficulty waiting their turn
* Often interrupts
* Says inappropriate things

**COMMON MENTAL ILLNESS MEDICATIONS**

The numbers of medications are as varied as the types of mental illnesses. Medications fall into many broad categories.

**1. Anti-depressants 2. Anti-psychotics**

Effexor Thorazine

Serzone Halodol/Haloperidol

Wellbutrin Clozaril/clozapine

Tricyclic anti-depressants Zyprexa

 Anafril Vesprin

 Elavil Serentil

 Vivactil Daxoline

Selective Serotonin Reuptake Inhibitors (SSRI’s)

 Prozaca.

 Luvox

 Paxil

 Zoloft

Monoamine Oxidase Inhibitors (MAOI’s)

 Parnate

 Marplan

**3**. **Anti-anxiety** **4.** **Anti-manic 5.** **Alzheimer’s 6. ADHD**

Valium/diazepam Lithium Aricept Ritalin

 Xanax Depakote Cognex Dexedrine

 Librium, Librax Tegretol Riminyl Cylert

 BuSpar

 Seraxp

It is important to point out that these products relieve the *symptoms* of the illness, but they do not cure it.

### **METHODS OF DEALING WITH A MENTALLY DISORDERED PERSON**

**Attempt to assess the person**.

When possible you should try to assess the mentally disturbed individual prior to contacting them. Consider their prior contact with police, and any prior acts of violence. If possible, try to speak with someone who has some information on the person or their behavior.

* Family member
* Neighbor
* Witnesses/complainant

If you are unable to assess the person before contact, you should quickly assess them at contact.

Appearance

* Visual search for possible weapons
* Strange clothing
* Dirty, disheveled

Behavior

* + Speech
* Illogical
* Very rapid
* Slurred
* Very loud or very quiet
* Irritated, angry, belligerent
* Body movement
* Agitated, pacing, abrupt, forceful
* Repetitive
* Slowed
	+ Body language
* Open
* Guarded
* Defensive
* Threatening

**Responding to a call involving an unstable person**

Your goal is to get the situation under control, and get the person help from a trained professional. You need to find a way to help without aggravating the situation.  **Do not respond alone**, if you know you are going to a call involving a mentally disturbed person. *Even if you have dealt with them before*, don’t make any assumptions about their behavior on this occasion, they can be very dangerous. Keep a safe distance. Remember that a person who is mentally ill or under the influence of drugs or alcohol, is very **unpredictable**, DO NOT assume they will react in the manner expected.

Time is your ally. Take as much time as you need, *unless the person is an immediate threat to themselves or others.*

* Take time to assess the individual and the environment.
* Take time to establish rapport.
* Try to find out what is going on. **Be a good listener**.
* Give the person time to quiet down.
* Encourage them to vent their feelings, sometimes ventilation alone will calm them down and make them less dangerous.
* Do not give the impression that there is not time for them.

Control the environment as much as possible.

* Provide a non-threatening environment.
* Reduce outside noises, crowds and influences as much as possible.

**Your Actions**

* Try to remain low-key. Often your words are not as important as your behavior. (A psychotic person may not understand any words or commands you give.) Your emotional reaction is critical; they will feed off of your emotions. If you become forceful and angry, they will usually react with more anger.
* **Do not be judgmental**. Remember mental illness is a disease and the person may have no conscious control over their thoughts and action.
* Do not take their anger personally.
* **Do not respond with aggression.**
* Do not deceive the person.
* Do not make assurances or promises.
* Do not agree with or condone delusions.
* Do not threaten, abuse, or make fun of them.
* Avoid behavior that may appear threatening.
* **BE ALERT**.

**Helpful hints:**

* Speak in a slower, quieter tone of voice.
* Look at the person. Get their attention first.
* **Do not expect rational discussion**.
* Avoid giving several instructions at once. Be brief, repeat if necessary.
* Allow time for the person to comprehend what you are saying.
* When giving instructions, try to do so in with a positive, firm voice and give the instructions in concrete, simple ways, avoiding excessive detail.
* Do not be fooled by a sudden return to reality. The subject may just as quickly return to crisis.

**If physical force becomes necessary:**

* Do not try to restrain alone. Disordered persons often have short bursts of extreme strength, and they may be impervious to pain.
* Try to apprehend in a way that is least likely to hurt the person.
* Know where your firearm is at all times.
* Think safety and treatment.
* Conduct a thorough search of the person for officer and patient safety, but do so with extreme caution.

**Transportation of an unstable person**

* Follow your department guidelines for transporting people with mental illness.
* If possible transport in a patrol wagon, transport van, or in a cruiser with Plexiglas or metal shielding, or use an ambulance.
* If you have access to them, use leather or Velcro restraints.
* The individual should be transported to a hospital or treatment facility for mental evaluation, rather than booked as a criminal.

**MENTALLY HANDICAPPED**

**General Information**

Mental retardation and other developmental disabilities are not mental illnesses, although there may be some similarities in appearance and behavior between the mentally ill and the mentally handicapped. Estimates are that there are 6 to 7.5 million people who are mentally retarded (2.5-3% of the population). A person with mental retardation has below normal intellectual functioning and impairments in some behavior. The onset is during childhood (before 18).

* These are permanent conditions.
* A mentally retarded person may appear alert, but intellectually function more like a child.
* There is a tremendous variety in skill levels, from mildly retarded to profoundly mentally retarded.
* It occurs in both men and women from all cultures and economic conditions.

**Indications of mental retardation**

* May be unable to formulate thoughts and answer questions readily.
* May have speech defects.
* May appear interested in children, as they can better understand what children are doing.
* May have slow responses similar to alcohol or drug abuse.
* Often they have poor judgment.
* Often inadequate in their personal relationships.
* Easily influenced by others, including authority figures.
* Often unable to foresee the consequences of an act.
* Socially immature.
* Resent unkind nicknames/teasing and may do something foolish because of it.
* May be aware they are different and very sensitive about things.
* Some may become aggressive to feel important.
* May be less tolerant to stress, feel inferior, or frustrated.

**Mental retardation and the Criminal Justice System**

* Studies indicate that there may be a relatively high level of persons who are mentally retarded in the criminal justice system.
* Often this may be because people with these disabilities are easily manipulated by others. They may be accomplices who are unaware of consequences of their actions.
* People with developmental disabilities have a 4 to 10 times higher risk of becoming a crime victim.

**Methods of dealing with a mentally retarded person**

* **Go Slowly** - rapid speech and questions may confuse or frighten the person.
* Practice patience.
* Rephrase questions into simpler language, so it is easy to comprehend.
* Minimize outside influences - noises, crowds - they may confuse the person.

**SUICIDE**

**The Facts**

The statistics about suicide are frightening. Suicide is the 8th leading cause of death in America. It is the 3rd leading cause of death of those 15-24 years of age (after injuries and homicide). The highest suicide rate is among the elderly.

More men die from suicide than women (4:1).

72% of all suicides are committed by white males.

There is no hard data on suicide attempts, but indications are that for every completion there are 8-25 attempts.

Suicide risk can be linked to drug and alcohol abuse.

The use of firearms is the most frequent means of death.

**Some risk factors may include:**

* Serious illness or death in the family
* Loss of health
* Emotional, physical, sexual abuse or domestic violence
* Divorce, separation or break up with boyfriend/girlfriend
* Psychiatric illness
* History of suicidal behavior
* Arrest or disciplinary crisis
* Loss of employment or other financial setback
* Entry into or finishing therapy

**Warning signs of suicide:**

* + - * Talking about death or suicide
			* Ending significant relationships
			* Making final arrangements
			* Giving away possessions
			* Taking unnecessary risks
			* Having a suicide plan

**Contact with a suicidal person**

Often law enforcement officers may have the first contact with a suicidal person. Dealing with a suicidal person is very dangerous. **Call for back up; do not handle the call alone.** Your behavior and attitude during the call can have a huge impact.Maintain a calm matter-of-fact demeanor. Do not become agitated or excited, stay low-key. Yelling will only make the situation worse and may force the person into action.

Try to gain rapport, refer to the person by name. Be sympathetic, and non-judgmental. As much as the situation allows, be patient. Take things slowly. Time is your ally. If there is no imminent danger, **LISTEN**. Let the person vent and unload despair, sometimes this alone can defuse the situation.

If possible, contact family and friends before contacting the suspect to get a history. It may not be a good idea to allow the person to talk to family members, they may say their last good-byes, and take action.

Most suicidal people are not certain that they want to die. They may not really want to kill themselves, they just want the emotional pain to stop. They see death as an escape.

Try to determine if the person has been drinking or using drugs. This may increase their likelihood of successfully committing suicide, since many suicides have a high correlation with substance abuse.

Listen for phrases such as “It doesn’t matter anymore”, “It’ll be over soon”, and “I am just so tired I can’t go on”.

Watch for sudden calming or ambivalence. Often when they make the final decision to die, they become calm.

If they tell you they are better, don’t believe them.

Crisis intervention can fail and injury or death may be the result. The officers involved in the call often feel responsible. It is important for the officer to have a support system, and to be assured that they are not at fault. People who kill themselves are responsible for their own actions.

**What to say to a suicidal person**

**Ask the person if they are planning to kill themselves.**

* **Do not be afraid to talk about suicide**. You are not going to put the idea into his/her head. You are showing that you take it seriously.
* Use the words “suicide”, “death” and “kill yourself”.

**If the answer is YES, ask the person:**

* **How they are going to do it?** This will indicate if they have a suicide plan, which means they may be more serious.
* **Do they have what they need?** Are the means available to carry out their plan?
* **Have they taken any action yet?** Sometimes by the time you have contact, they may have already taken pills or committed an action that has not yet proven lethal, but may if time is delayed.
* **Have they attempted suicide in the past?** People who have attempted in the past are at greater risk for committing suicide.
* **Ask the location of any weapons**, and try to separate them from the weapon.

Avoid problem solving, advice giving, belittling, arguments, and making the person feel they need to justify the suicidal feelings.

Things **not** to say:

* It will be better tomorrow
* Cheer up
* It is not so bad
* Avoid threats or aggression
* Avoid anything that trivializes their pain. They may have been battling the pain for years and it may *not* be better tomorrow.

\*\* **Always maintain your own safety**, and the safety of others. Remember a suicidal person can quickly become homicidal.

**Suicide-by-cop (police assisted suicide)**

Sometimes a person wants to kill him/herself, but will not be strong enough to do it, and may force an officer to use deadly force against them. This phenomenon, often referred to as suicide by cop, appears to be on the rise. If an officer is forced to take the life of someone, it can be devastating for the officer involved.

* Feelings of anger, resentment and disbelief are frequent.
* The officer does much second guessing of their actions, and may replay the incident over and over in their head, looking for a different solution.
* Post Traumatic Stress Disorder is common.

The officer must be constantly reminded that it was **not** their fault. Their options are limited, and they must protect themselves and/or third party.

**Police Officer Suicides**

Suicide is a very real threat for law enforcement officers. The combination of stress, alcoholism, depression, family conflicts, problems or discipline at work, etc., and with the fact that guns are readily available, put officers in great danger.

There are very few statistics on officer suicides. Often officers try to disguise their suicides.

Numbers do indicate that **cops are more likely to kill themselves than to be killed in the line of duty.**

Officers are extremely unlikely to seek help. Cops see themselves as someone who solves problems, not someone who is allowed to have problems. As is common in most cases, warning signs are usually present to indicate that an officer may commit suicide. A suicidal officer is a danger to the whole department and all citizens of that jurisdiction.

Intervention is the key to preventing suicide. The consequences of getting help are *never* as permanent as the consequences of suicide. Do not worry more about someone losing their gun than losing their life.

**LEGAL ISSUES SURROUNDING MENTAL ILLNESS**

Insanity defense

A defendant cannot be held criminally responsible for conduct if, *when he committed the act charged, his mind was so defective or diseased that he did not know the nature and quality of the act he was doing or if he did know its nature and quality, he did not know that the act was wrong.*

Emergency Detention Authority--K.S.A. 59-2946, 59-2953, 59-2954, 59-2957.

1. K.S.A. 59-2953. Investigation; emergency detention; authority and duty of law enforcement officers.

(a) Any law enforcement officer who has a **reasonable belief** formed upon investigation that a person is a mentally ill person and because of such person's mental illness **is likely to cause harm to self or others** if allowed to remain at liberty *may take the person into custody without a warrant*. The officer shall transport the person to a treatment facility where the person shall be examined by a physician or psychologist on duty at the treatment facility, except that no person shall be transported to a state psychiatric hospital for examination, unless a written statement from a qualified mental health professional authorizing such an evaluation at a state psychiatric hospital has been obtained. If no physician or psychologist is on duty at the time the person is transported to the treatment facility, the person shall be examined within a reasonable time not to exceed 17 hours. If a written statement is made by the physician or psychologist at the treatment facility that after preliminary examination the physician or psychologist believes the person likely to be a mentally ill person subject to involuntary commitment for care and treatment and because of the person's mental illness is likely to cause harm to self or others if allowed to remain at liberty, and if the treatment facility is willing to admit the person, the law enforcement officer shall present to the treatment facility the application provided for in subsection (b) of K.S.A. 2000 Supp. 59-2954 and amendments thereto. If the physician or psychologist on duty at the treatment facility does not believe the person likely to be a mentally ill person subject to involuntary commitment for care and treatment the law enforcement officer shall return the person to the place where the person was taken into custody and release the person at that place or at another place in the same community as requested by the person or if the law enforcement officer believes that it is not in the best interests of the person or the person's family or the general public for the person to be returned to the place the person was taken into custody, then the person shall be released at another place the law enforcement officer believes to be appropriate under the circumstances. The person may request to be released immediately after the examination, in which case the law enforcement officer shall immediately release the person, unless the law enforcement officer believes it is in the best interests of the person or the person's family or the general public that the person be taken elsewhere for release.

(b) If the physician or psychologist on duty at the treatment facility states that, in the physician's or psychologist's opinion, the person is likely to be a mentally ill person subject to involuntary commitment for care and treatment but the treatment facility is unwilling to admit the person, the treatment facility shall nevertheless provide a suitable place at which the person may be detained by the law enforcement officer. If a law enforcement officer detains a person pursuant to this subsection, the law enforcement officer shall file the petition provided for in subsection (a) of K.S.A. 2000 Supp. 59-2957 and amendments thereto, by the close of business of the first day that the district court is open for the transaction of business or shall release the person. No person shall be detained by a law enforcement officer pursuant to this subsection in a nonmedical facility used for the detention of persons charged with or convicted of a crime.

2. K.S.A. 59-2954

(a) A treatment facility may admit and detain any person for emergency observation and treatment upon an ex parte emergency custody order issued by a district court pursuant to K.S.A. 2000 Supp. 59-2958 and amendments thereto.

(b) A treatment facility may admit and detain any person presented for emergency observation and treatment upon written application of a law enforcement officer having custody of that person pursuant to K.S.A. 2000 Supp. 59-2953 and amendments thereto, except that a state psychiatric hospital shall not admit and detain any such person unless a written statement from a qualified mental health professional authorizing such admission to a state psychiatric hospital has been obtained. The application shall state:

      (1) The name and address of the person sought to be admitted, if known;

      (2) The name and address of the person's spouse or nearest relative, if known;

      (3) The officer's belief that the person may be a mentally ill person subject to involuntary commitment and because of the person's mental illness is likely to cause harm to self or others if not immediately detained;

      (4) The factual circumstances in support of that belief and the factual circumstances under which the person was taken into custody including any known pending criminal charges; and

      (5) The fact that the law enforcement officer will file the petition provided for in K.S.A. 2000 Supp. 59-2957 and amendments thereto, by the close of business of the first day thereafter that the district court is open for the transaction of business, or that the officer has been informed by a parent, legal guardian or other person that such parent, legal guardian or other person, whose name shall be stated in the application will file the petition provided for in K.S.A. 2000 Supp. 59-2957 and amendments thereto within that time.

**ELDER ISSUES**

The geriatric population is increasing rapidly as the baby boomers reach retirement age. Allcommunities have citizens who are elderly and there are certain issues that face law enforcement regarding their population.

**Elder Abuse**

Abuse of the elderly is a rapidly growing public health issue, which has an enormous impact on today’s society and on law enforcement. Types of abuse include:

1. **Physical abuse**--the use of physical force, which is willfully inflicted, that may result in bodily injury, pain, or impairment. It may include, but is not limited to: striking (with or without an object), beating, pushing, shoving, shaking, slapping, kicking, pinching, burning and sexual assault.
2. **Psychological/Emotional abuse**--the willful infliction of mental suffering, anguish, emotional pain or distress. It may include insults, threats, intimidation, instilling fear, humiliation, isolation, ignoring, and verbal assaults.
3. **Neglect**--the refusal or failure of a caretaker to provide for the needs of an elder. This may include not providing necessities such as food, water, shelter, clothing, personal hygiene needs, medicine, health care, and not providing for their personal safety.
4. **Financial abuse**--the illegal or improper use of an elder’s funds, property, or assets. Examples may include: cashing checks without authorization, forging a signature, stealing, and deceiving to gain assets.
5. **Abandonment**--the desertion of an elderly person by an individual who has assumed responsibility for providing care or has physical custody of an elder.
6. Also possible is **self-neglect**, in which an elder behaves in a way that threatens their own health and safety through inattention or apathy.

**Location of the victim**

* The victim may live in a nursing home or other institution.
* The victim may live in a private home and may have a caretaker, possibly a family member.

#### Recognizing Elder Abuse

Because of dementia or other barriers, the victim may not be able to assist in the investigation. These cases can be very difficult to investigate. Great attention should be given to the story the victim and others surrounding them give, to determine if the injury or condition fits the claim. Elderly patients may be very fragile, and unlike child abuse, a slight shove or a simple fall may provide enough force to shatter bones that are ravaged by osteoporosis. You may consider aggravated charges if a victim has been pushed or struck. Elder abuse, like many other forms of victimization, is very underreported. Be aware of trends and indicators.

Risk Factors for elder abuse:

* Substance abuse (either by the suspect or victim)
* Prior history of abuse
* Frailty, disability, or impairment of elder.
* Dependence
* Either the victim is dependent on the suspect, **or** the suspect dependent on the victim.
* Could be physical or financial dependence.

When investigating elder abuse there are several signs, which may **possibly** indicate abuse.

* **Physical abuse**
* Bruises, black eyes, cuts, welts, rope marks
* Broken bones
* Absence of hair and/or hemorrhaging below the scalp.
* An elders report of physical abuse or mistreatment.
* A caregiver’s refusal to allow visitors to see and elder alone.
* **Psychological/Emotional abuse**
* Fear
* Withdrawal
* Depression
* Hesitation to talk openly
* Confusion
* Elder’s report of verbal abuse
* **Neglect**
* Dehydration, malnutrition, untreated bedsores, poor personal hygiene
* Dirt, fecal/urine smell, or other health hazard
* Rashes, sores, lice
* Untreated medical conditions
* Elder’s report of neglect
* **Financial abuse**
* Unusual activity in bank account.
* Unexplained disappearance of funds or possessions.
* Recent changes in power of attorney, wills, or financial investments.
* Provision of services that are not necessary.
* Spending habits/care that are not in line with the estate.
* **Abandonment**
* Desertion of an elder at a hospital, nursing facility, shopping center or public location.
* Elder’s report of being abandoned.

###### Possible indicators of abuse from the caregiver

* Elder not given the opportunity to speak for him or herself or see others without the presence of the caregiver.
	+ - Attitudes of indifference or anger toward the dependant person.
		- Caregiver blames elder or is overly hostile.
		- Previous history of abuse to others.
		- Problems with drugs or alcohol.
		- Unwarranted defensiveness by caregiver.

**Who is likely to be the abuser?**

The sad fact is that most often the perpetrator of abuse, neglect or exploitation against an elderly person is someone who is close to them.

* + 47% of abusers are adult children
	+ 19% of abusers are spouses
	+ 24% of abusers are other relatives
	+ 10% of abusers are not related

**Barriers to an elder abuse investigation**

There are many things that become challenges when trying to investigate elder abuse. These are very difficult cases to investigate, and very hard to successfully prosecute, but these barriers can be overcome with a strong investigation.

* Isolation of the elder. Often the older victim may not have any contact with the outside world. They may no longer attend church, visit friends, or go into public for any reason. If they are confined to a basement or a room, there is little chance for others to know the abuse exists.
* Cultural barriers. It may be difficult for officers to relate with the victim do to cultural reasons.
* Race
* Gender
* Other
* Stereotyping. Often there are negative stereotypes of the elderly which hamper our investigation (we see them as senile and poor witnesses so we do not proceed). An older persons stereotyping of law enforcement may also have an impact.
* Victim barriers
* **Fear**—the victim does not want to be alone or be put in a nursing home.
* **Dementia**—the victim may be suffering from a disorder and may not be able to help in the investigation.
* They may feel guilty or stupid about something they did.
* They may protect the abuser or be ashamed that they raised or trusted a person capable of such actions.

## Investigating Elder Abuse

Separate the elder and question them without anyone else present. It is very important to keep the elder separate from others. If the elder can see or hear a potential suspect, they will very likely not disclose the abuse to you. Whenever you question an elder person try to do so away from others. Even if the other person present is not the abuser, the elder may not talk to you because they do not want others to know about the abuse.

Ask some questions to determine their level of functioning. You can make the questions very simple (what year is it, who is president, what room are we in). It is crucial to determine what the persons intellectual level is, **but do not quit investigating if the elder is irrational** **or incompetent**. Those who are more out of touch with reality, are more likely to be victimized.

Look for multiple types of abuse. If the elder is suffering from one type of abuse, they are likely also a victim of another type. Most victims who are physically abused are also psychologically abused, and there is a very high correlation between financial abuse and physical abuse.

There are many sources of information to consider in an elder abuse case. Beyond questioning the usual family, neighbors, friends, don’t forget others who may have knowledge about this elder’s special situation or relationships, including doctors, Adult Protective Services, clergy, attorneys, bank tellers, pharmacists, perhaps even hair stylists.

**Build an evidence-based case**. Your case should not rely on a victim’s testimony. By the time the case goes to trial months or years in the future, the victim may very well not be available or competent to give testimony.

* Take lots of photos. Take photos of the victim, any injuries, inadequate clothing, hazards, and the living conditions. Visually put the jury at the scene.
* Collect all documents and evidence. Document all medications, and any items related to elder care. Collect soiled bed linens, or consider taking cultures. Collect anything that may potentially be evidence. Unfortunately, often in financial cases the suspect may have control over documents, but if any bank statements, bills, or legal documents are present, seize them.
* **Obtain a copy of the 911 tape.** Often the 911 call contains valuable information and it is a frequently overlooked source of evidence. It is not unusual for the 911 call to be placed by the suspect or sometimes by the victim, either way the recording will be valuable in court.
* Look for evidence of addictions. Since there is a high correlation between substance abuse and elder abuse, signs of addiction become important.
* Contact a geriatric specialist if you have any specific questions. Often there are unique health and medical concerns with the elderly and information from a specialist will be invaluable.
* Get Adult Protective Services involved. They can provide a lot of assistance and resources to the victim. They may also be aware of prior abuse reports.

**ALZHEIMER’S**

**Alzheimer’s disease (AD)** is a progressive irreversible disease that attacks and destroys nerve cells in the brain. It is the most common dementing disorder. Symptoms of AD include:

* Gradual memory loss
* Decline in ability to perform routine tasks
* Disorientation in time and space
* Impairment of judgment
* Personality change
* Difficulty in learning
* Loss of language and communication skills

AD currently affects at least 4 million Americans, and it is estimated that by 2050 it will affect 14 million Americans. It is the 4th leading cause of death among adults (after heart disease, cancer and stroke).

* It affects both men and women of all racial and socioeconomic backgrounds.
* There is no cure and progression cannot be stopped or reversed.
* The rate of progression varies in each individual, but a person with AD will live from 3 to 20 years (with an average of 8 years) from the onset of symptoms.
* AD eventually leaves the victims unable to care for themselves.
* Seven out of 10 AD patients live at home.

**Signs that a person has Alzheimer’s include:**

* Confused or disoriented
* Appears to be lost or wandering
* Appears agitated, fearful, or angry
* Is unable to grasp or remember the present situation
* Has difficulty judging the passage of time
* Asks the same question over and over
* Gives inappropriate responses to questions
* Is dressed inappropriately for the occasion
* Has blank or inappropriate facial expressions
* Is delusional

**Possible law enforcement contacts with an Alzheimer’s patient**

Wandering

* You may either be called to take a report of a lost adult, or you may come into contact with a disoriented person.
* The AD patient may wander for different reasons (restlessness, fear, confusion, stress). Often once they are away from home they cannot find their way back.
* The Alzheimer’s Association has begun a nation wide Safe Return program which provides information to caregivers and identification bracelets or clothing labels.
* If searching for an AD patient who has wandered, look in neighborhoods that they used to live in, old workplaces and favorite spots.
* If you have contact with a person you suspect has wandered away:
* Approach them from the front.
* Assure them you are there to help.
* Check for injuries or exposure.
* Check for identification (often the AD patient will **not** be able to tell you what their current phone number or address is, and they may give you former information).
* Check missing persons files.
* Do not leave them alone, they may wander away again.

False reports

* AD patients may report prowlers, burglaries, thefts, and other crimes that did not actually occur.
* They may be delusional and have incorrect beliefs of victimization.
* They frequently accuse others, including family and friends, of stealing from them.
* They may not remember where they left a car or household item and report it as stolen.

Driving

* + Driving is a complex activity requiring quick reactions.
	+ AD patients who drive may become a safety issue.
	+ They may make poor decisions, drive inappropriate speeds, become angry and confused behind the wheel.
	+ They may be reported as a DUI or careless driver.

Shoplifting

* Memory loss and confusion may cause a person with AD to forget to pay for an item or in some cases they may not even know it is necessary to pay for items.
* They often become very confused about financial matters.
* They may deny that they took an item or that they were even in the store.
* Their intent is not criminal.

Indecent Exposure

* + The disease may cause repetitive movements and fidgeting such as playing with zippers and buttons.
	+ It may also cause loss of impulse control. A person may remove clothing because they are too warm and they may not understand that their behavior is inappropriate.

**Communicating with an AD patient**

* The person may not remember their address, phone number or even their name. Be aware that if they do give you information, it may be a previous address, not their current one.
* The person may not recognize a family member or spouse. They may vehemently deny knowing someone because due to the memory loss, they do not remember them.
* Sometimes an AD patient’s ability to communicate may be greatly diminished. They may not be able to remember simple words.
* They may give inappropriate answers.
* They may mix current events and happenings with things that have occurred many years in the past.
* They may change their answer each time you ask a question.
* Do not assume the person can understand you and comply with the information you give.
* Speak slowly and softly in a low-pitched voice.
* Give positive instructions. Instead of “don’t go there,” instead try “let’s go here”.
* Adopt a non-aggressive posture.
* Maintain eye contact.
* Keep the person away from crowds and noise.
* Avoid sudden movements.
* Ask only one question at a time and give only one direction at a time.
* Use short sentences and familiar words.
* Repeat information or questions using the same words.
* Ask questions that require a yes or no answer.
* Avoid restraints if at all possible; if they are necessary remember their bones may be very frail.

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