Albuquerque Police Department

Enhanced Crisis Intervention Team Training (eCIT)

New Mexico Department of Public Safety Accreditation NM16101L

Version 1.2

Response

In responding to an individual with a behavioral health disorder or in a behavioral health crisis, an officer will de-escalate and calm the situation until a supervisor or ECIT or MCT arrives to control the scene and direct operations.

- ECIT, MCT, or CIU will take the lead in interacting with individuals in a behavioral health crisis. If a supervisor has assumed responsibility for the scene, the supervisor will seek input from ECIT, MCT or CIU on strategies for de-escalating, calming and resolving the crisis, when it is safe.

- The responding officer will request a backup officer whenever the individual will be taken into custody (either for booking or for emergency mental health evaluation). If the responding officer is a CITO, the officer should specifically request an ECIT officer or MCT as backup.

- Officers should take steps to calm the situation. Where possible, eliminate emergency lights and sirens, disperse crowds, and assume a quiet non-threatening tone and manner when approaching or conversing with the individual. Where possible, avoid physical contact, and take time to assess the situation. Officers should operate with the understanding that time is an ally, and there is no need to rush or force the situation.

- Officers should move slowly and do not excite or agitate the person. Provide reassurance that the police are there to help and that the person will be provided with appropriate care, assistance and resources.

- Officers should communicate clearly and calmly. If possible, speak slowly and use a low tone of voice. Express concern for the person's feelings, and allow the person to share feelings without expressing judgment.

- Where possible, officers should gather information from acquaintances or family members. Attempt to find out what the nature of the crisis the individual is experiencing. Request professional assistance, if available and appropriate, to assist in communicating with and calming the person.

- Officers should not threaten the individual with arrest or physical harm, as this may create additional fright, stress, and potential aggression.

- Officers should avoid topics that seem to agitate the person, and guide the conversation away from areas that cause stress or agitation and towards topics that seem to ease the situation.

- Officers should always be truthful. If the person senses deception, he or she may withdraw in distrust, become hypersensitive, or retaliate in anger. If an individual is experiencing delusions and/or hallucinations and asks the officer to validate them, statements such as, "I am not seeing what you are seeing, but I believe that you are seeing them," are recommended. Validating and/or participating in the individual's delusion or hallucination is not advised.

Officers will complete an original incident report where required (e.g. there are charges filed, a CIU referral, or transport to the hospital). Regardless of whether an incident report is required, officers will complete a CIT contact sheet for any dispatch in which the subject's behavior indicates a behavioral health disorder or behavioral health crisis.

Assessing Risk

Not all people affected by a behavioral health disorder or who are in behavioral health crisis are dangerous, and some may present dangerous behavior only under certain circumstances or conditions. Officers should assess whether someone may be danger to himself or herself, the officer, or others, by considering the following:

- The person's availability to weapons.

- The person's statements, conduct, or inferences that suggest the person will commit a violent or dangerous act.

- The person's history. The person's history may be known to the Department, the officer, family, friends, and neighbor Indications that the person lacks self-control, particularly lack of physical and psychological control over rage, anger, fright, or agitation. Signs of lack of self-control include extreme agitation, inability to sit still or communicate effectively, wide eyes, and rambling incoherent thoughts and speech. Clutching oneself or other objects to maintain control, begging to be left alone, offering assurances that one is all right may also suggest that the individual is losing control.

- The volatility of the environment. Agitators who may upset the person, create a combustible environment, or incite violence should be carefully noted and controlled.

An individual affected by a behavioral health disorder or crisis may rapidly change his or her conduct or demeanor from calm and responsive to commands to physically active and agitated or non-responsive. This behavior change may result from an external trigger (such as an officer who states "I have to handcuff you now,") or from internal stimuli (such as delusions or hallucinations). Variations in a person's demeanor or conduct does not mean he or she will become violent or threatening. Officers should observe and be prepared at all times for a rapid change in behavior.

Non-engagement or Disengagement

After attempting contact and de-escalation techniques, if a supervisor, after consulting with **eCIT** if on-scene, determines that a person exhibiting behavioral health disorder or behavioral health crisis is not a threat to others and that further interaction with the individual will result in an undue safety risk to the person, the public, or officers, they should use disengagement. A supervisor will notify a lieutenant of this decision and will develop a plan to contact the person at a different time or under different circumstances. A police report and/or CIT contact sheet will be generated documenting the following elements:

a. Details of the call;
b. Reasons for disengagement;
c. Actions taken to deescalate the situation;
d. Actions taken to promote safety;
e. Follow-up plans and referrals made; and
f. Flagged address for a safety bulletin.

The word "**disengagement**" will be placed in the incident summary line of the report or CIT contact sheet. If the subject is barricaded, the officers will follow the additional procedures set forth in the Hostage, Suicidal/Barricaded Subject, and Tactical Threat Assessment SOP.

In limited circumstances, officers may be aware of the identity and behavior of an individual before making contact that indicates that the individual is not currently a threat to others, and that contact with law enforcement would not be helpful but only serve to escalate the situation. In these circumstances, a supervisor may approve non-engagement. The supervisor will report non-engagement decisions to a lieutenant. The non-engagement will be documented in the same manner as a disengagement with the word "non-engagement" placed in the incident summary line of the report or CIT contact sheet.

Disengagement Procedures

The supervisor on scene will ensure that every reasonable attempt is made to contact the subject. If the subject refuses to make contact with officers on scene and remains barricaded, the supervisor will:

- Ensure that an on-duty lieutenant responds to the scene, if the lieutenant is not already on scene.
- Ensure all available resources are utilized in order to safely resolve the situation
- The supervisor will not escalate or make forced entry into the location or close distance on the subject.
- The supervisor will ensure that the family members, friends, and subject are provided additional resources and services available to them. This will be documented by the on-body recording device. A list of these resources is available through the RTCC.
- The supervisor will document (via on-body recording device) advising the family, friends, or others involved of the dangers of contacting a barricaded or suicidal/barricaded subject.
- After reasonable attempts are made to contact the barricaded or suicidal/barricaded subject without resolution and the situation does not meet the criteria of 2-42-4-E, the incident commander will have officers withdraw from the area.
- When officers clear the call, officers cannot force the family, friends, or others involved to leave the area. The supervisor will ensure that any subject who lives at the location of the incident and cannot safely return, was offered a safe location to stay for the night. Additional basic needs should also be considered.
- If the subject has pending misdemeanor charges or misdemeanor warrant, officers will not make forced entry to effect the arrest. This does not prevent the officer from filing the appropriate criminal charges under state statute or city ordinance.
- The on scene supervisor will ensure that an original incident report includes: all supplemental reports, video or digital recordings, victim/witness statements, and any other pertinent documents related to the incident. Copies of all reports and statements will be forwarded to the Crisis Intervention Unit by the end of their shift.
- On scene supervisor will ensure a periodic watch is entered for each shift for a 24-hour period at the location. The watch is for area command information only not to be dispatched.

Pick up order/Certificates of Evaluation are civil orders. Mental health orders will not be used as a basis for forced entry to take the subject into custody.

Guide to Assessing Suicide Risk

Suicide is inherently difficult to predict. Many more people will show warning signs for possible suicide than will ever actually make an attempt. Not everyone who attempts suicide will fit a typical profile or communicate warning signs in advance. Warning signs for suicide can be obvious or so subtle as to be invisible. Signs may build up so gradually so that you don't notice them, or come on so quickly and intensely that you hardly have time to react. Faced with the difficulty of never being able to accurately know who is truly at significant risk of suicide and who is not, it is safest to assume that anyone who is showing any warning signs for suicide is at risk. Past behavior is the best predictor of future behavior. Therefore, anyone who has a history of past serious suicide attempts should be assumed to be a suicide risk now, particularly if any warning signs are present.

Mental health professionals tend to think about suicidal feelings and thoughts on a continuum (with high risk and imminent danger on one end, and low risk and little imminent danger on the other end). As a general rule, the level of danger suicidal people present to their own lives increases dramatically as they progress along the steps towards a suicidal act (as they move from suicidal thinking (ideation), to planning their suicide, to collecting the necessary equipment, to actually engaging in the act). The earlier that a person can be stopped during their progression of suicidal behaviors, the better.

S*uicidal thoughts, commonly known as suicidal ideation, are the most important and most common warning sign indicating suicide risk*. Although it cannot be known with certainty what others are thinking, anyone who regularly includes themes of suicide or death in conversation, writing, music or artwork (e.g., by talking about giving up on life, or how others would be better off without him or her) can be assumed to be sending out a warning sign that they are experiencing suicidal ideation.

If you suspect someone may be experiencing suicidal thoughts, **go to the person and ask directly if he or she is thinking about killing him or herself**. Don't beat around the bush. Don't be indirect. The topic of suicide is too important to risk remaining hidden. You're perhaps being nosy by asking such a direct and personal question, but you may also be the first person to notice the problem and be in a position to do something about it. Given the stakes involved with regard to suicidal behavior (i.e., a person's life!), it is better to be nosy than to be polite. It is far better to ask the question than to ignore your gut feelings and let a problem continue on to an unfortunate and lethal conclusion.

Take any suicidal talk (or any behavior that leads you to believe that someone is suicidal) seriously. You will find yourself overreacting at times when you do this. There will be "false positive" (incorrectly assuming people are truly suicidal when they are not) situations where

you take someone's suicide joke seriously and end up making much ado about nothing. However, if you fail to take all occasions of suicidal talk and behavior seriously, you run the risk of missing or ignoring clues and warning signs that are leading up to an actual suicide gesture. The danger associated with failing to react to a real warning sign of suicide is so great as to make it quite acceptable for you to end up with a high rate of false positives.

If you ask, "Are you suicidal? Are you thinking about harming yourself?", and the person tells you "yes, I am suicidal", then your next question should be, "Do you have a plan for killing yourself". This is the next logical question to ask because people who have a plan for killing themselves are at greater risk for actually harming themselves than people who doesn't. Further questions might be, "When are you planning to kill yourself?" and "Do you have access to the tools and equipment you need to kill yourself?" The sooner people intend to kill themselves, the more risk they present to themselves. If someone's risk is imminent (i.e., if he or she is ready to kill him or herself this evening) then get on the telephone with the emergency operator and do what you can to have this person hospitalized. It's better if you can talk the suicidal person into making the call, but if you can't do that, make the call anyway. Let a doctor or the police have the responsibility for keeping the suicidal person safe.

Some people think that bringing up the topic of suicide around people who are prone to such thoughts will encourage them to kill themselves. This isn't true. Your discussion of suicide will not trigger someone to act. Instead, you talking normally about the subject will convey your concern and may help cut through the shame that the person may have about talking about his or her suicidal feelings. Bringing up the subject of suicide is more likely to lessen the threat of actual suicide than to increase the likelihood of the event.

Other people avoid asking about suicide because they consider such talk an invasion of privacy. This might be true to some extent, but in this case, such privacy concerns are overrated. What good is privacy when someone is in danger of dying unnecessarily and before their time? Failing to ask about suicide out of some concern about embarrassing someone you care about might enable an unnecessary death, whereas asking about suicide could help save a life.

Brief Check List

- Past Suicide Attempts
- Currently giving away valuables
- Current thoughts of suicide
- A Plan
- Means or equipment to carry out the plan
- Time Line (are you thinking of doing this soon?)

Enhanced Crisis Intervention Team (eCIT) Training

Student Guide

De-Escalation
Active Listening Skills

Active Listening Skills

Safety, De-stigmatization, and Resources should be kept in mind when using Active Listening Skills. Keeping dignity and respect in mind will help with rapport building.

Definitions:

- A communication technique that a listener uses to show the speaker that they are paying attention and understand the message that is being relayed.

- Active listening is a communication technique used in counseling, training and conflict resolution, which require the listener to feed back what they hear to the speaker.

Why Active Listening:

Empathy vs Sympathy

- Empathy: Understanding what others are feeling and/or thinking because you have experienced it yourself or can put yourself in their shoes.

- Sympathy: Acknowledging another person's emotional hardships and providing comfort and assurance.

Using active listening skills and techniques can help the listener gain a better understanding of the situation that the speaker is going through. This helps relay to the speaker that the listener has empathy towards the situation. The listener gains more information by using skills and has the ability to retain the information more effectively. Rapport building in heightened emotional states is important because it can help you with gaining compliance through influence.

Clinical evidence and research suggest that active listening is an effective was to create behavioral change in others (Rogers, C., & Dymond, R., 1954). When listened to by another, individuals tend to evaluate their own feelings and thoughts, allowing them to have more clarity. This allows them to become better problem solvers and more accepting of someone else’s point of view. Showing empathy allows the individual to have less fear of being criticized and open up to a realistic appraisal of their own position (Noesner, G., & Webster, M., 1997).

The use of active listening skills helps create an empathic relationship between the officer and the subject. Building this empathy can help create rapport, which in time can be used to influence the person’s behavior. Using this approach in crisis intervention shows an effort in a short period of time to stabilize emotions and restores a subject’s ability to think more clearly.

Active listening- Physical Skills:

Active listening starts with your physical characteristics and approach when engaging someone. These skills may not work on everyone you spend time with but if you use them consistently they will reflect professionalism on all your encounters.

Creating a scene with empathy and respect will help an individual feel safe enough to consider other perspectives and become more receptive to the positive suggestion from law enforcement.

- Face the speaker
- Nod occasionally
- Maintain eye contact
- Minimize distractions
- Keep an open mind
- Open and inviting posture when safe

- Open hands while talking or listening
- Thinking position
- Sitting when safe
- Respond appropriately
- Smile and other facial expressions
- Talk to the person directly

Internal and External distractions:
Internal distractions are your own personal biases and emotions.

Emotions:

- Anger
- Frustration
- Irritation

Biases:

- Giving more attention to people who look like you
- Wealthy
- Attractive

Barriers to Active Listening:

- Arguing
- Patronizing
- Interrupting
- Moralizing
- Rescue trap
- Demeaning
- Intimidating
- Police Jargon- 10 code, statue numbers, etc.
- "Why" questions
- Quick Reassurances
- Advising
- Preaching
- Lecturing

Seven Active Listening Skills:

- Reflecting/Mirroring
- Open-Ended Questions
- Minimal Encouragers
- Emotion Labeling
- Paraphrasing
- "I" Messages
- Effective Pauses

Use these techniques to show the speaker that you are listening. It can be used to help continue or start a conversation, and some techniques can be used to help you gather more information. Using these techniques can help you retain more information from your conversation with an individual. These are designed to let someone who is speaking know that you are listening, resulting in better rapport and de-escalation.

Reflecting/Mirroring:

- This should be simple and short. You repeat key words or the last few spoken words that the speaker just said. This shows the speaker that the listeners is trying to understand and is using the speaker's terms as reference. This also helps indicate to the speaker that the listener wants them to continue the conversation and maybe talk more about what the listener reflected back.
    - "Gist" of a sentence
    - Repeating the last few words
    - Results in more intelligence
    - Voice inflection is important- Asking it in the annotation of a question

Example: “Ever since we broke up I want to die”- Speaker
“You want to die…”- Listener (Mirroring)
“You want the pain to go away…” –Listener (Reflecting)

Open Ended Questions:

- These are designed to encourage a full, meaningful answer using the subject’s own knowledge and/or feelings. It is the opposite of close-ended questions, which encourages a short or single-word answer.
- Using the acronym WHaT can help you create open-ended questions.
    - What
    - How
    - (and)
    - “Tell me more about…”

Minimal Encouragers:

- These are small signals that let the speaker know you are listening and understanding what they are saying.
- Examples:
    - “uh-huh”
    - “mmm”
    - “ok”
    - Head nodding

- *Note:* Be cautious using “ok” in certain situations. It can relay that you are approving of an inappropriate action.
    - *Example:* I am going to kill myself.”, and the listener responds “ok”.

Emotion Labeling:

- This is an important step in building rapport. It helps the speaker know that the listener is seeing and understanding the emotions of the situation or content.
- You let the speaker know that you are seeing or hearing an emotion that they are experiencing or have experienced.
- Don’t be afraid of labeling the emotions incorrect.
- Examples:
    - “This experience sounds horrifying to you.”
    - “You look deflated and sad.”
- See the emotion wheel/list later in this section.

Psychological research has classified six facial expressions which correspond to distinct universal emotions: disgust, sadness, happiness, fear, anger, surprise [Black,Yacoob,95]. It is interesting to note that four out of the six are negative emotions.

Paul Ekman’s initial research determined that there were six core emotions, which he termed *universal emotions*. These original universal emotions are:

1. Happiness - symbolized by raising of the mouth corners (an obvious smile) and tightening of the eyelids

2. Sadness - symbolized by lowering of the mouth corners, the eyebrows descending to the inner corners and the eyelids drooping
3. Surprise - symbolized by eyebrows arching, eyes opening wide and exposing more white, with the jaw dropping slightly
4. Fear - symbolized by the upper eyelids raising, eyes opening and the lips stretching horizontally
5. Disgust - symbolized by the upper lip raising, nose bridge wrinkling and cheeks raising
6. Anger - symbolized by eyebrows lowering, lips pressing firmly and eyes bulging

There is a seventh emotion that is sometimes considered universal.

7. Contempt - symbolized by half of the upper lip tightening up (using what is called the risorius muscle) and often the head is tilted slightly back.

Paraphrasing:

- You translate the conversation into your own words and let the speaker know.
- Let's the speaker know you are listening.
- Helps you gain more information and clarify the information you have been given.

"I" Statements:

- Used to convey your concerns in a manner that is non-threating and does not put the subject in an immediate defensive state.
- Helps to build rapport by establishing the listener as an individual and not a uniform.
- Example;
    - "I want to know what happened today but it is hard for me to focus on your words when you have a knife in your hand."

Effective Pauses:

- This is a break in conversation when you do not say anything.
- Used immediately before or after saying something meaningful.
- Silence is uncomfortable for most people.
- Gives you a chance to gather your thoughts.

S.A.F.E.R. Model

This model helps illustrate when active listening skills fail or when they should not be used. As professionals all situations are handled with dignity and respect, which should never be overlooked. The following are situations where active listening would not be utilized in law enforcement.

Security of Person and/or Property:
Always follow your officer safety training and SOP (standard operating policy) when handling situations involving the security of people and places. If you are on a scene where someone is being attacked you must react to the safety of the person (victim), this is not a time to attempted verbal de-escalation skills with the offender. If property is being destroyed or someone is trying to gain entry into a secure location active listening skills may not be affective when immediate action is required.

Attack
If you are being attacked protect yourself do not attempt to use active listening skills when your safety is at risk. Immediate safety for yourself and others should always trump active listening.

Flight
If during the course of an investigation the offender flees from custody, you must react to the situation and apprehend the offender. Active listening skills may not be useful in this situation but you may be required to give verbal commands.

Excessive Repetition
When voluntary compliance is not achieved after you have exhausted all verbal options, you must react. Some tips can be offering options and explaining what the recourse is for noncompliance.

Revised Priorities
If during a contact a more imminent calls comes out and you must take it, communication needs to end. If you are interviewing someone and over the air it comes out that they are wanted for a violent offense your technique needs to adjust towards taking the person into custody.

Article Review:

Livingston, J., Desmarais, S., Verdun-Jones, S., Parent, R., Michalak, E., & Brink, J. (2014). Perceptions and experiences of people with mental illness regarding their interactions with police. *International Journal of Law and Psychiatry*, 334-340.

This study examined perceptions and lived experiences of people with mental illness and their interaction with law enforcement. 60 people living with a mental illness who had contact with law enforcement in Vancouver, Canada were interviewed about their interaction and perceptions.

- 72% (almost three-quarters) were satisfied with how police officers handled their most recent interactions.
- 51% rated their previous contacts with the police as a positive experience.
- 32% rated their previous contacts with the police as a negative experience.

This study has quotes from people living with a mental illness about law enforcement interactions and here are a few:

On access to personal information

> "So they [the police] go into a situation and know how to handle the person, how to speak to the person, know a bit about his background, so the don't offend them or set them off, or how to get the situation under control."

On communicating effectively

> "Ask the person if they are under the care of a physician or psychiatrist. Are they on medication for a mood disorder? Be gentle, but ask questions… Ask if there is any help they need. Tell them we al need to be safe, treat them with dignity."

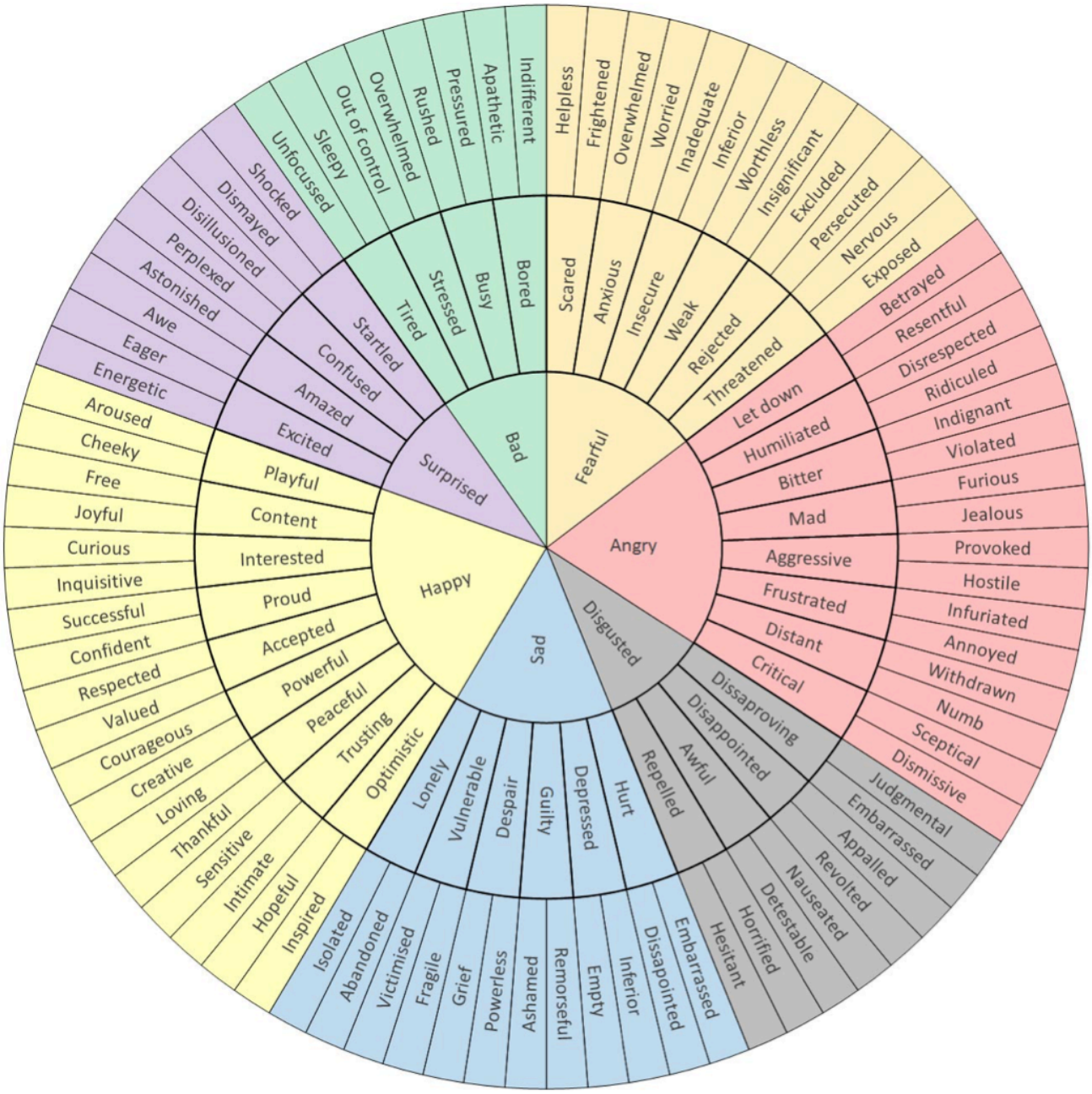
On treating people with compassion

> "Sometimes be more human, not so policy driven. And I don't just mean handcuffs, I mean sometimes I'm just transported and… I could have been a sack of flour. … It's all just by the book… and I'm just nothing, I'm not a human being"

On connecting with the community

> "Follow up with someone like me to see what I am like when I am well. Then they [the police] can learn more about mental illness and know how to handle people like me."

Emotion Labeling



Pleasant Feelings							
Open	Happy	Alive	Good	Love	Interested	Positive	Strong
Understanding	Great	Playful	Calm	Loving	Concerned	Eager	Impulsive
Confident	Gay	Courageous	Peaceful	Considerate	Affected	Keen	Free
Reliable	Joyous	Energetic	At Ease	Affectionate	Fascinated	Earned	Sure
Easy	Lucky	Liberated	Comfortable	Sensitive	Intrigued	Intent	Certain
Amazed	Fortunate	Optimistic	Pleased	Tender	Absorbed	Anxious	Rebellious
Free	Delighted	Provocative	Encouraged	Devoted	Inquisitive	Inspired	Unique
Sympathetic	Overjoyed	Impulsive	Clever	Attracted	Nosy	Determined	Dynamic
Interested	Gleeful	Free	Surprised	Passionate	Snoopy	Excited	Tenacious
Satisfied	Thankful	Frisky	Content	Admiration	Engrossed	Enthusiastic	Hardy
Receptive	Important	Animated	Quiet	Warm	Curious	Bold	Secure
Accepting	Festive	Spirited	Certain	Touched		Brave	
Kind	Ecstatic	Thrilled	Relaxed	Sympathy		Daring	
	Satisfied	Wonderful	Serene	Close		Challenged	
	Glad		Free and Easy	Loved		Optimistic	
	Cheerful		Bright	Comforted		Re-enforced	
	Sunny		Blessed	Drawn Toward		Confident	
	Merry		Reassured	Empathy		Hopeful	
	Elated					Earnest	
	Jubilant						
	Empowered						

Difficult/Unpleasant Feelings							
Angry	Depressed	Confused	Helpless	Indifferent	Afraid	Hurt	Sad
Irritated	Lousy	Upset	Incapable	Insensitive	Fearful	Crushed	Tearful
Enraged	Disappointed	Doubtful	Alone	Dull	Terrified	Tormented	Sorrowful
Hostile	Discouraged	Uncertain	Paralyzed	Nonchalant	Suspicious	Deprived	Pained
Insulting	Ashamed	Indecisive	Fatigued	Neutral	Anxious	Pained	Grief
Sore	Powerless	Perplexed	Useless	Reserved	Alarmed	Tortured	Anguish
Annoyed	Diminished	Embarrassed	Inferior	Weary	Panic	Dejected	Desolate
Upset	Guilty	Hesitant	Vulnerable	Bored	Nervous	Rejected	Desperate
Hateful	Dissatisfied	Shy	Empty	Preoccupied	Scared	Injured	Pessimistic
Unpleasant	Miserable	Stupefied	Forced	Cold	Worried	Offended	Unhappy
Offensive	Detestable	Disillusioned	Hesitant	Disinterested	Frightened	Afflicted	Lonely
Bitter	Repugnant	Unbelieving	Despair	Lifeless	Timid	Aching	Grieved
Aggressive	Despicable	Skeptical	Frustrated	Numb	Shaky	Victimized	Mournful
Resentful	Abominable	Distrustful	Distressed		Restless	Heartbroken	Dismayed
Inflamed	Terrible	Misgiving	Woeful		Doubtful	Agonized	
Provoked	In Despair	Lost	Pathetic		Threatened	Appalled	
Incensed	Sulky	Unsure	Tragic		Cowardly	Humiliated	
Infuriated	Bad	Uneasy	In a Stew		Quaking	Wronged	
Cross	A Sense of Loss	Pessimistic	Dominated		Menaced	Alienated	
Worked Up	Down	Tense	Worthless		Wary		
Boiling	Down n' out		Hopeless				
Fuming							
Aggitated							

If any editing or revisions need to be made to this document or if you would like to contribute new material please contact Matthew Tinney at mtinney@cabq.gov, 505-553-2229
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eCIT Training

De-escalation Tips and Techniques

Student Guide

De-Escalation

What is it?

- A variety of psychosocial techniques aimed at reducing violent and/or disruptive behavior.
- Skills used to reduce/eliminate the risk of violence during an escalation phase through verbal and non-verbal communications.
- Less authoritative, less controlling, less confrontational approach to gain more control.

Fight, Flight, or Freeze

Look at the following list of flight, fight freeze responses below, possible signs that someone is no longer feeling safe and might be at risk. This is not a complete list but may help to identify what you should be watching for:

Fight

- Crying
- Hands in fists, desire to punch, rip
- Flexed/tight jaw, grinding teeth, snarl
- Fight in eyes, glaring, fight in voice
- Desire to stomp, kick, smash with legs, feet
- Feelings of anger/rage
- Homicidal/suicidal feelings
- Knotted stomach/nausea, burning stomach
- Metaphors like bombs, volcanoes erupting

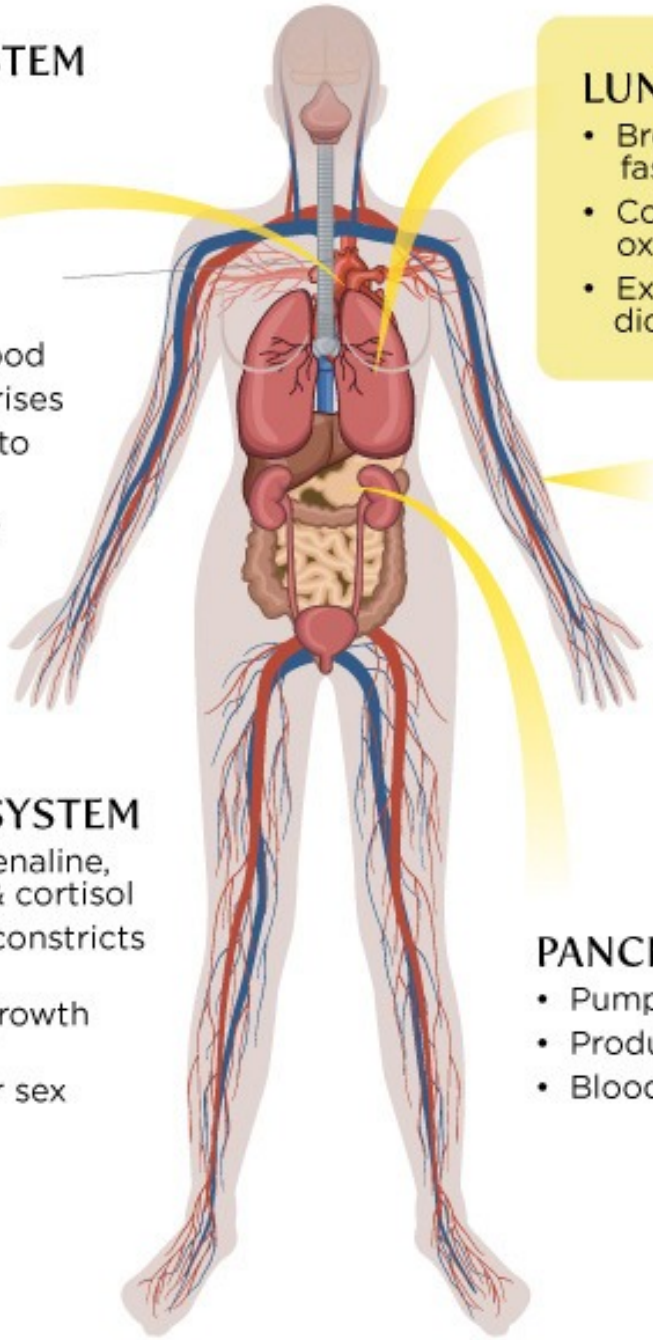
Flight

- Restless legs, feet /numbness in legs
- Anxiety/shallow breathing
- Big/darting eyes
- Leg/foot movement
- Reported or observed fidgety-ness, restlessness, feeling trapped, tense
- Sense of running in life- one activity-next
- Excessive exercise

Freeze

- Feeling stuck in some part of body
- Feeling cold/frozen, numb, pale skin
- Sense of stiffness, heaviness
- Holding breath/restricted breathing
- Sense of dread, heart pounding
- Decreased heart rate (can sometimes increase)
- Orientation to threat

Fight-or-Flight Response



IMMUNE SYSTEM
- Is repressed

HEART
- Beats faster
- Pumps more blood
- Blood pressure rises
- Blood increases to muscles
- Blood decreases to organs

LUNGS
- Breathing becomes faster & shallower
- Consume more oxygen
- Expel more carbon dioxide

SKIN
- Sweating begins

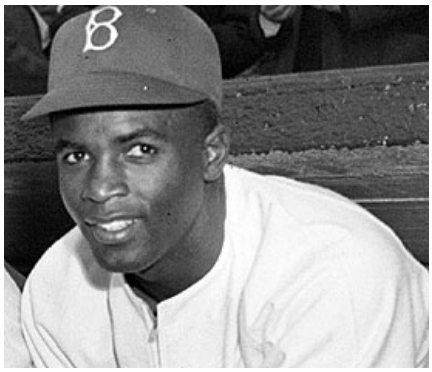
ENDOCRINE SYSTEM
- Pumps out adrenaline, noradrenaline & cortisol
- Noradrenaline constricts blood vessels
- Releases less growth hormone
- Produces fewer sex hormones

PANCREAS
- Pumps out glucagon
- Produces less insulin
- Blood sugar level rises

http://www.appliedbiofeedbacksolutions.com/fff.html

Respect & Dignity

"I'm not concerned with your liking or disliking me... All I ask is that you respect me as a human being."
Jackie Robinson



"Dignity does not consist in possessing honors, but in deserving them."
Aristotle

Respect

- a feeling of admiring someone or something that is good, valuable, important, etc.
- a feeling or understanding that someone or something is important, serious, etc., and should be treated in an appropriate way
- a particular way of thinking about or looking at something

Dignity

- a way of appearing or behaving that suggests seriousness and self-control
- the quality of being worthy of honor or respect

Merriam-Webster

Bias

Implicit Bias and Law Enforcement
By Tracey G. Gove, Captain, West Hartford, Connecticut, Police Department

The implicit bias phenomenon is being explored in many phases of the criminal justice system and is not limited to law enforcement. Specifically, implicit bias is being studied in judicial decision making (for example, jury selection, jury instruction, and sentencing decisions), as well as in hiring and promotion decisions within criminal justice agencies. Outside of the criminal justice field, the topic has been examined in the fields of education and medicine, as well as in CEO selection at Fortune 500 companies.

A discussion on implicit bias must start with a brief explanation of how the brain sorts, relates, and processes information. Much of the day-to-day processing is done at an unconscious level as the mind works through what Professor Kang calls schemas, which are "templates of knowledge that help us organize specific examples into broad categories. A stool, sofa, and office chair are all understood to be 'chairs.' Once our brain maps some item into that category, we know what to do with it—in this case . . . sit on it. Schemas exist not only for objects, but also for people. Automatically, we categorize individuals by age, gender, race, and role. Once an individual is mapped into that category, specific meanings associated with that category are immediately activated and influence our interaction with that individual."

When used to categorize people, these schemas are called stereotypes. Although the term stereotype carries a negative connotation, social scientists posit that stereotyping is simply the way the brain naturally sorts those we meet into recognizable groups. Attitudes, on the other hand, are the overall evaluative feelings, positive or negative, associated with these individuals or groups. That is to say, attitude is the tendency to like or dislike, or to act favorably or unfavorably, toward someone or something.

For example, "[I]f we think that a particular category of human beings is frail—such as the elderly—we will not raise our guard." Also, "[I]f we identify someone as having graduated from our beloved alma mater, we will feel more at ease." Lastly, when introduced to someone new, about whom nothing is known but who is reminiscent of an old, admired friend, one may instantly feel comfortable and at ease with that person.

It is said that implicit bias, then, includes both implicit stereotypes and implicit attitudes and is shaped by both *history* and *cultural influences* (for example, upbringing; life experiences; relationships; and all manner of media—books, movies, television, newspapers, and so on). Research has shown that a person's previous experiences (both positive and negative) leave a "memory record." Implicit biases encompass the myriad fears, feelings, perceptions, and stereotypes that lie deep within the subconscious; they act on those memory records and exist without an individual's permission or acknowledgement. In fact, implicit bias can be completely contradictory to an individual's stated beliefs—a form of conscious-unconscious divergence.

http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=2499&issue_id=102011

Verbal Judo

"Treat people well, regardless of their differences." – **Dr. George Thompson**

The Five Universal Truths

For the last thirty years of his eclectic life, George "Rhino" Thompson crisscrossed America with a message the world desperately needs to hear – a message of tolerance for other human beings and our outer differences and his last chapter and to find common ground with Five Universal Truths.

1. All people want to be treated with dignity and respect.
2. All people want to be asked rather than being told to do something.
3. All people want to be told why they are being asked to do something.
4. All people want to be given options rather than threats.
5. All people want a second chance when they make a mistake.

This global perspective promoting universal respect, tolerance and forgiveness can connect all people, everywhere. We need a vehicle to develop understanding, and using our words for a defined purpose can create the forward momentum toward an ultimate goal.

L.E.A.P.S.

- Listen: gives you more information on where the person is today
- Empathize: gives you information on where the person has been
- Ask: fact finding, general, direct, open ended questions, opinion seeking
- Paraphrase: their meaning in your words
- Summarize: reconnects communication when interrupted

verbaljudo.com
Address: PO BOX 1351 Auburn, NY 13021
Phone: 800.448.1042
Fax: 800.805.9572

Mental Health First Aid

Mental Health First Aid is an 8-hour course that teaches you how to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps someone identify, understand, and respond to signs of mental illnesses and substance use disorders.

The theme of the course is the de-escalation process broken down into 5 steps called **A.L.G.E.E.**

Mentalhealthfirstaid.org
info@mentalhealthfirstaid.org
202-684-7457

Assess for risk of suicide or harm

When helping a person going through a mental health crisis, it is important to look for signs of suicidal thoughts and behaviors, non-suicidal self-injury, or other harm. Some warning signs of suicide include:

- Threatening to hurt or kill oneself
- Seeking access to means to hurt or kill oneself
- Talking or writing about death, dying, or suicide
- Feeling hopeless
- Acting recklessly or engaging in risky activities
- Increased use of alcohol or drugs
- Withdrawing from family, friends, or society
- Appearing agitated or angry
- Having a dramatic change in mood

Mental Health First Aid

Listen nonjudgmentally

It may seem simple, but the ability to listen and have a meaningful conversation requires skill and patience. Listening is critical in helping an individual feel respected, accepted, and understood. Mental Health First Aid teaches you to use a set of verbal and nonverbal skills such as open body posture, comfortable eye contact, and other strategies to engage in appropriate conversation.

Give reassurance and Information

It is important to recognize that mental illnesses and addictions are real, treatable illnesses from which people can and do recover. When talking to someone you believe may be experiencing symptoms of a mental illness, approach the conversation with respect and dignity and don't blame the individual for his or her symptoms. Mental Health First Aid provides information and resources you can offer to someone to provide emotional support and practical help.

Encourage appropriate professional help

There are many professionals who can offer help when someone is in crisis or may be experiencing the signs and symptoms of a mental illness or addiction.

Types of Professionals

- Doctors (primary care physicians or psychiatrists)
- Social workers, counselors, and other mental health professionals
- Certified peer specialists

Types of Professional Help

- "Talk" therapies
- Medication

Other professional supports

Encourage self-help and other support strategies

Individuals with mental illness can contribute to their own recovery and wellness through:

- Exercise
- Relaxation and meditation
- Participating in peer support groups
- Self-help books based on cognitive behavioral therapy
- Engaging with family, friends, faith, and other social networks

De-Escalation

Four Encounter Types in Crisis Response

1. Loss of reality (LOR)
2. Loss of hope (LOH)
3. Loss of control (LOC)
4. Loss of perspective (LOP)

Loss of Reality

- Withdrawn
- False Beliefs
- Disorganized thinking
- Hearing/Seeing things
- Odd behaviors or mannerisms
- Suspicious/paranoia/fearful
- Highly distractible/disoriented

How can you inadvertently escalate a situation?

- Officer presence- Gun, Badge, Belt, Body Position, Use of Space Crowding
- Over-reliance on commands to get compliance – yelling, arguing, ordering
- Hands-on touching
- Lack of patience, empathy

Why confrontation does not ALWAYS work.

- Logic and ability to reason are compromised during a psychiatric crisis.
- Disorganized thinking causes difficulty in following simple requests
- Paranoid ideation causes mistrust of others, including officers
- Reasons for non-compliance are less about a power struggle (as they might be in a normal conflict) and more about the brain disorder that is mental illness.

CIT Paradox

By taking a less physical, less authoritative, less controlling, less confrontational, approach you will have more authority, more control over the person in a diminished capacity encounter.

Ground subject in the here and now.

Loss of Control

- Manipulation
- Impulsiveness
- Destructiveness
- Irritability/Hostility
- Anger/Argumentative
- Anti-social/oppositional

Listen, defuse, deflect

Loss of Hope

- Sad/Anguish
- Overwhelmed
- Emotional Pain
- Fatigue/helpless
- Suicidal talk/gestures
- Crying/deep despair

Instill Hope

Loss of Perspective

- Euphoric/Energetic
- Physical discomfort
- Restlessness/Pacing
- Verbal/rapid speech
- Apprehension/dread
- Grandiose/ambitious
- Anxiety/nervous/panic

Calm, Re-direct, Re-assure

In all four crisis situations the Goal is to CALM.

Three Phases of an Encounter

Engage:

- Establish rapport
- How you are presenting yourself
- Introduce yourself, ask the person's name
- State the reason you are there in a way that builds trust (make it about safety and empathy)
- Scene management – remove distractions, upsetting influences and disruptive people

Assess:

- Gather needed info
- Ruling in/out mental illness
- Medical or drug/alcohol issues
- Was a crime committed
- Assess lethality if suicide or depression is an issue
- Talk to others at the scene
- Trust the experts. Family members can be a great source of information

Resolve:

- Voluntary compliance
- Decide on course of action
- Forecast, tell the person what you are going to do. "I am going to put my hands in your jacket pocket to check for any weapons."
- Leading. Tell them what you expect and what you need form them.

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Enhanced Crisis Intervention Team (eCIT) Training

Student Guide

Assessment and Commitment

Assessment and Commitment

State Statutes Governing Psychiatric Intervention and Treatment in New Mexico

43-1-11. Commitment of adults for thirty-day period

A. Every adult client involuntarily admitted to an evaluation facility pursuant to Section 43-1-10 NMSA 1978 has the right to a hearing within seven days of admission unless waived after consultation with counsel. If a physician or evaluation facility decides to seek commitment of the client for evaluation and treatment, a petition shall be filed with the court within five days of admission requesting the commitment. The petition shall include a description of the specific behavior or symptoms of the client that evidence a likelihood of serious harm to the client or others and shall include an initial screening report by the evaluating physician individually or with the assistance of a mental health professional or, if a physician is not available, by a mental health professional acceptable to the court. The petition shall list the prospective witnesses for commitment and a summary of the matters to which they will testify. Copies of the petition shall be served on the client, the client's guardian, and treatment guardian if one has been appointed, and the client's attorney.

B. At the hearing, the client shall be represented by counsel and shall have the right to present evidence on the client's behalf, including testimony by an independent mental health professional of the client's own choosing, to cross-examine witnesses and to be present at the hearing. The presence of the client may be waived upon a showing to the court that the client knowingly and voluntarily waives the right to be present. A complete record of all proceedings shall be made.

C. A court-appointed guardian for an adult involved in an involuntary commitment proceeding shall have automatic standing to appear at all stages of the proceeding and shall be allowed to testify by telephone or through affidavit if circumstances make live testimony too burdensome.

D. The court shall include in its findings the guardian's opinion regarding the need for involuntary treatment or a statement detailing the efforts made to ascertain the guardian's opinion.

E. Upon completion of the hearing, the court may order a commitment for evaluation and treatment not to exceed thirty days if the court finds by clear and convincing evidence that:

(1) as a result of a mental disorder, the client presents a likelihood of serious harm to the client's own self or others;

(2) the client needs and is likely to benefit from the proposed treatment; and

(3) the proposed commitment is consistent with the treatment needs of the client and with the least drastic means principle.

F. Once the court has made the findings set forth in Subsection E of this section, the court shall hear further evidence as to whether the client is capable of informed consent. If the court determines that the client is incapable of informed consent, the court shall appoint for the client a treatment guardian who shall have only those powers enumerated in Section 43-1-15 NMSA 1978.

G. An interested person who reasonably believes that an adult is suffering from a mental disorder and presents a likelihood of serious harm to the adult's own self or others, but does not require emergency

care, may request the district attorney to investigate and determine whether reasonable grounds exist to commit the adult for a thirty-day period of evaluation and treatment. The applicant may present to the district attorney any medical reports or other evidence immediately available to the applicant, but shall not be required to obtain a medical report or other particular evidence in order to make a petition. The district attorney shall act on the petition within seventy-two hours. If the district attorney determines that reasonable grounds exist to commit the adult, the district attorney may petition the court for a hearing. The court may issue a summons to the proposed client to appear at the time designated for a hearing, which shall be not less than five days from the date the petition is served. If the proposed client is summoned and fails to appear at the proposed time and upon a finding of the court that the proposed client has failed to appear, or appears without having been evaluated, the court may order the proposed client to be detained for evaluation as provided for in Subsection C of Section 43-1-10 NMSA 1978.

H. Any hearing provided for pursuant to Subsection G of this section shall be conducted in conformance with the requirements of Subsection B of this section.

History: 1953 Comp., § 34-2A-10, enacted by Laws 1977, ch. 279, § 10; 1978, ch. 161, § 5; 1979, ch. 396, § 3; 1989, ch. 128, § 7; 2009, ch. 159, § 14.

43-1-10. Emergency mental health evaluation and care

A. **A peace officer may detain and transport a person for emergency mental health evaluation and care in the absence of a legally valid order from the court only if:**

(1) the person is otherwise subject to lawful arrest;
(2) the peace officer has reasonable grounds to believe the person has just attempted suicide;
(3) the peace officer, based upon the peace officer's own observation and investigation, has reasonable grounds to believe that the person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Immediately upon arrival at the evaluation facility, the peace officer shall be interviewed by the admitting physician or the admitting physician's designee; or

(4) a physician, a psychologist or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency has certified that the person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Such certification shall constitute authority to transport the person.

B. An emergency evaluation under this section shall be accomplished upon the request of a peace officer or jail or detention facility administrator or that person's designee or upon the certification of a physician, a psychologist or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency. A court order is not required under this section. If an application is made to a court, the court's power to act in furtherance of an emergency admission shall be limited to ordering that:

(1) the client be seen by a certified psychologist or psychiatrist prior to transport to an evaluation facility; and
(2) a peace officer transport the person to an evaluation facility.

C. An evaluation facility may accept for an emergency-based admission any person when a physician or certified psychologist certifies that such person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Such certification shall constitute authority to transport the person.

D. A person detained under this section shall, whenever possible, be taken immediately to an evaluation facility. Detention facilities shall be used as temporary shelter for such persons only in cases of extreme emergency for protective custody, and no person taken into custody under the provisions of the code shall remain in a detention facility longer than necessary and in no case longer than twenty-four hours. If use of a detention facility is necessary, the proposed client:

(1) shall not be held in a cell with prisoners;
(2) shall not be identified on records used to record custody of prisoners;
(3) shall be provided adequate protection from possible suicide attempts; and
(4) shall be treated with the respect and dignity due every citizen who is neither accused nor convicted of a crime.

E. The admitting physician or certified psychologist shall evaluate whether reasonable grounds exist to detain the proposed client for evaluation and treatment, and, if reasonable grounds are found, the proposed client shall be detained. If the admitting physician or certified psychologist determines that reasonable grounds do not exist to detain the proposed client for evaluation and treatment, the proposed client shall not be detained.

F. Upon arrival at an evaluation facility, the proposed client shall be informed orally and in writing by the evaluation facility of the purpose and possible consequences of the proceedings, the right to a hearing within seven days, the right to counsel and the right to communicate with an attorney and a mental health professional of the proposed client's own choosing and shall have the right to receive necessary and appropriate treatment.

G. A peace officer who transports a proposed client to an evaluation facility under the provisions of this section shall not require a court order to be reimbursed by the referring county.

History: 1953 Comp., § 34-2A-9, enacted by Laws 1977, ch. 279, § 9; 1978, ch. 161, § 4; 1979, ch. 396, § 2; 1989, ch. 128, § 6; 2013, ch. 39, § 2.

From:

http://public.nmcompcomm.us/nmpublic/gateway.dll/?f=templates&fn=default.htm

Criteria Considered for Inpatient Admission into Psychiatric Hospital:

- Psychiatric Illness
- Danger or self or others
- If the patient will benefit from treatment
- Medical staff must consider the least restrictive option

Goals of Hospitalization

- Safety
- Evaluation
- Stabilization
- Treatment (medication management and psychotherapy)

The goals for hospitalization parallel the reasons for commitment. There must be reasonable efforts to assure that hospitalization will improve the safety of the patient and those affected by the patient. The hospital will perform an evaluation to confirm a treatable illness, and stabilize that person by giving treatment for their illness.

Treatments and Interventions in the hospital

- Medical management
    - Treatment for chronic/acute illnesses that can be made worse by psychiatric problems
    - Treatment teams may include social workers, nurses, therapists, doctors, discharge planners and peer advocates
- Medications by mouth or injectable
- Psychotherapy: milieu, individual, group
    - Long term intensive talk therapy is not available in the hospital, which is often a misconception made by patients and families.
    - There will not be daily one hour one-on-one sessions with therapists to have in-depth psychoanalytic breakthroughs.
    - Instead, group therapy and other therapies offered such as AA meetings, Occupational and Physical Therapy
- Safe placements

NAMI MINNESOTA
National Alliance on Mental Illness

Fact Sheet

800 Transfer Road, Suite 31, St. Paul, MN 55114 Tel: 651-645-2948 or 888-NAMI-HELPS Fax: 651-645-7379 www.namihelps.org

Commonly Prescribed Psychotropic Medications

Antipsychotics (used in the treatment of schizophrenia and mania)	Anti-depressants	Anti-obsessive Agents
Typical Antipsychotics	**Tricyclics**	
Haldol (haloperidol)	*Anafranil (clomipramine)	Anafranil (clomipramine)
Loxitane (loxapine)	Asendin (amoxapine)	Luvox (fluvoxamine)
Mellaril (thioridazine)	Elavil (amitriptyline)	Paxil (paroxetine)
Moban (molindone)	Norpramin (desipramine)	Prozac (fluoxetine)
Navane (thiothixene)	Pamelor (nortriptyline)	Zoloft (sertraline)
Prolixin (fluphenazine)	Sinequan (doxepin)	
Serentil (mesoridazine)	Surmontil (trimipramine)	Antianxiety Agents
Stelazine (trifluoperazine)	Tofranil (imipramine)	Ativan (lorazepam)
Thorazine (chlorpromazine)	Vivactil (protiptyline)	BuSpar (buspirone)
Trilafon (perphenazine)		Centrax (prazepam)
	SSRIs	*Inderal (propranolol)
Atypical Antipsychotics	Celexa (citalopram)	*Klonopin (clonazepam)
Abilify (aripiprazole)	Lexapro (escitalopram)	Lexapro (escitalopram)
Clozaril (clozapine)	*Luvox (fluvoxamine)	Librium (chlordiazepoxide)
Risperdal (risperidone)	Paxil (paroxetine)	Serax (oxazepam)
Seroquel (quetiapine)	Prozac (fluoxetine)	*Tenormin (atenolol)
Zyprexa (olanzapine)	Zoloft (sertraline)	Tranxene (clorazepate)
		Valium (diazepam)
	MAOIs	Xanax (alprazolam)
Mood Stabilizers (used in the treatment of bipolar disorder)	Nardil (phenelzine) Parnate (tranylcypromine)	*Antidepressants, especially SSRIs, are also used in the treatment of anxiety.
Depakene (valproic acid)		
Depakote	**Others**	Stimulants
Eskalith	Desyrel (trazadone)	(used in the

Lithobid (lithium)
Lithonate
Lithotabs
*Lamictal (lamotrigine)
*Neurontin (gabapentin)
*Tegretol (carbamazepine)
*Topamax (topiramate)

Effexor (venlafaxine)
Remeron (mirtazapine)
Serzone (nefazodone)
Wellbutrin (bupropion)

Anti-Panic Agents
Klonopin (clonazepam)
Paxil (paroxetine)
Xanax (alprazolam)
Zoloft (sertraline)
*Antidepressants are also used in treatment of panic disorder.

treatment of ADHD)
Adderall (amphetamine and dextroamphetamine)
Cylert (pemoline)
Dexedrine (dextroamphetamine)
Ritalin (methylphenidate)
*Antidepressants with stimulant properties, such as Norpramin and Wellburtrin, are also used in the treatment of ADH

Listed above are the brand names, followed by the generic in parenthesis. A second chart below provides cross-referencing by generic name.

***Although this medication has been approved by the FDA for the treatment of other disorders, it has not been approved for this particular use. Some evidence of this medication's efficacy for such use does exist however. This type of medication use is referred to as "off label."**

Remember, always consult your doctor or pharmacist with any specific medication questions

Generic Name	Brand Name	Current Uses
alprazolam	Xanax	anxiety, panic
amitriptyline	Elavil, Endep	depression (tricyclic)
amoxapine	Asendin	psychotic depression
amphetamine	Adderall	ADD
aripiprazole	Abilify	schizophrenia (atypical)
buproprion	Wellbutrin	depression, ADD
buspirone	BuSpar	anxiety
carbamazepine	Tegretol	bipolar disorder
chloriazepoxide	Librium	anxiety
chlorpromazine	Thorazine	schizophrenia (typical)
citalopram hydrobromide	Celexa	depression (SSRI)
clomipramine	Anafranil	OCD, depression (tricyclic)
clonazepam	Klonopin	anxiety
clorazepate	Tranxene	anxiety
clozapine	Clozaril	schizophrenia (atypical)
desipramine	Norpramin	depression (tricyclic), ADD

dextroamphetamine	Adderall, Dexedrine	ADD
diazepam	Valium	anxiety
divalproex sodium	Depakote	bipolar disorder
doxepin	Adapin, Sinequan	depression (tricyclic)
escitalopram	Lexapro	depression (SSRI), anxiety
fluoxetine	Prozac	depression (SSRI), OCD, panic
fluphenazine	Prolixin, Prolixin Decanoate	schizophrenia (typical)
fluvoxamine	Luvox	OCD, depression (SSRI)
haloperidol	Haldol, Haldol Decanoate	schizophrenia (typical)
imipramine	Tofranil	depression (tricyclic), panic
lithium carbonate	Eskalith, Lithobid	bipolar disorder
lithium citrate	Cibalith S	bipolar disorder
lorazepam	Ativan	anxiety
loxapine	Loxitane	schiophrenia (typical)
maprotiline	Ludiomil	depression (tricyclic)
mesoridazine	Serentil	schiophrenia (typical)
methylphenidate	Ritalin	ADD
mirtazapine	Remeron	depression
molindone	Moban	schiophrenia (typical)
nefazodone	Serzone	depression
nortriptyline	Pamelor	depression (tricyclic)
olanzapine	Zyprexa	schizophrenia (atypical)
oxazepam	Serax	anxiety
paroxetine	Paxil	depression (SSRI), OCD, panic
pemoline	Cylert	ADD
perphenazine	Trilafon	schizophrenia (typical)
phenelzine	Nardil	depression (MAOI)
prazepam	Centrax	anxiety
prochlorperazine	Compazine	schizophrenia (typical)
protriptyline	Vivactil	depression (tricyclic)
quetiapine	Seroquel	schizophrenia (atypical)
risperidone	Risperdal	schizophrenia (atypical)
sertraline	Zoloft	depression (SSRI), ODC, panic
thioridazine	Mellaril	schizophrenia (typical)
thiothixene	Navane	schizophrenia (typical)
tranylcypromine sulfate	Prarnate	depression (MAOI)
trazodone	Desyrel	depression (tricyclic)
trifluoperazine	Stelazine, Vesprin	schizophrenia (typical)

trimipramine	Surmontil	depression (tricyclic)
valproic acid	Depakene	bipolar disorder
venlafaxine	Effexor	depression

Enhanced Crisis Intervention Team (eCIT) Training

Student Guide

Bipolar Disorder

Bipolar Disorder

Learning objectives for this section:

- Student will have a good base knowledge of bipolar disorder
- Student will have a basic understanding of and be able to name at least two different types of bipolar disorder
- Student will be able to demonstrate a basic knowledge of cyclothymic disorder
- Student will be able to identify some of the signs and symptoms of bipolar disorder
- Students will know some of the possible risk factors contributing to bipolar disorder
- Students will know some of the different types of treatments for bipolar disorder

What is bipolar disorder?

Bipolar disorder is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. People with bipolar disorder can have extreme mood swings. They can have long periods of depression, periods where they experience mania, and then other times where they have normal moods. It should be noted that the time in between the depressive and manic stages of bipolar vary from person to person. These moods swings are much more severe than normal up and down days that everyone goes through as part of life.

Types of bipolar:

Bipolar I Disorder

- Defined by manic or mixed episodes that last seven days, or by symptoms that are so severe that the person needs immediate hospital care. Usually, depressive episodes occur as well, typically lasting at least two weeks.

Bipolar II Disorder

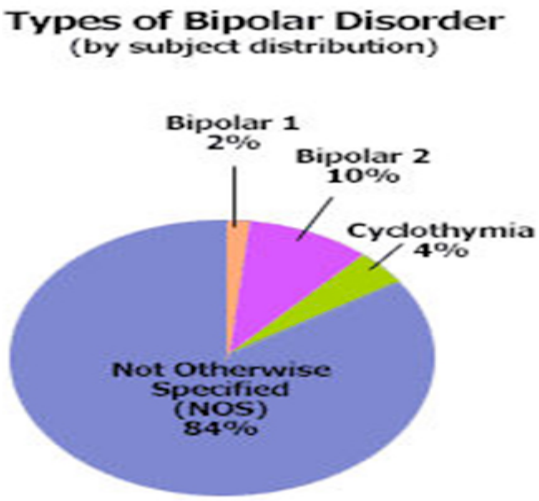
- Defined by a pattern of depressive episodes and hypomanic episodes, but no full blown manic or mixed episodes.

Unspecified Bipolar Disorder

- Diagnosed when symptoms of the illness exist but do not meet the diagnostic criteria for either bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.

Cyclothymic Disorder

- Can be thought of as a mild form of bipolar disorder. People living with cyclothymia spend at least half their lives in either a very good or very bad mood. Although these moods cause distress and impairment in functioning, they don't reach the severity of Bipolar I, Bipolar II, or major depression.



Symptoms of bipolar disorder:

- Elevated, expansive, or extremely irritable mood. This mood is persistent throughout the course of several days. (Not simply a few hours).
- Increased energy and over activity
- Lack of inhibitions
- Excessive involvement in potentially destructive behaviors (such as spending sprees, sexual indiscretions).
- Grandiose thinking and possibly grandiose delusions
- Need for less sleep
- Rapid thinking
- Increased talking, and possibly pressured speech
- Can be easily irritated and get angry when frustrated
- Increased planning and goal setting, usually unrealistic goals and plans.
- Easily distracted

Risk Factors for Bipolar Disorder:

Most scientists believe that there is not one single cause for bipolar disorder but instead there are many factors likely acting together that result in the illness or increased risk. These risk factors may include the following:

- Genetic – a family history of bipolar disorder is one of the strongest and most consistent risk factors for bipolar disorder. People with first degree relatives people with BPAD I have about ten times the risk of developing Bipolar themselves.
- Environmental – Bipolar disorder is associated with divorced, separated or widowed individuals. Bipolar is more prevalent in countries with higher incomes as opposed to lower income countries.

Treatments for Bipolar Disorder:

Prescribed Medications

- Mood stabilizer such as: Lithium,Lamictal (for bipolar depression),Tegretol, Zyprexa, and Depakote.
- Antipsychotics such as: Risperidone, Olanzapine, Quetiapine, Ziprasidone and Asenapine.
- Antidepressants, generally used simultaneously with mood stabilizers, such as: Trazodone, Zoloft, Paxil, and Wellbutrin.

Therapy

- Cognitive Behavioral Therapy
  - Patient learns to change harmful or negative thoughts or behaviors.
- Psychoeducation
  - Patient is educated on living with bipolar disorder and how it is treated. This education hopes to teach the patient how to recognize when they are headed toward an episode so that they can get help before things escalate.
- Family focused therapy
  - Patient and family members learn how to cope with and recognize signs an impending episode so that they can help work through together.
- Interpersonal and social rhythm therapy
  - Patient learns to manage their relationships and day to day living in an attempt to “normalize” their daily routine. This accompanied by a strong sleep schedule can help protect against manic episodes.

Famous People Living With Bipolar Disorder

Catherine Zeta-Jones

Russell Brand

Demi Lovato

In conclusion:

Officers are reminded to always think of safety when to helping a person living with bipolar disorder. Officers should take in all of the risk factors of a situation and try to deescalate the situation using any of the above information to build rapport.

Officers are reminded that people living with bipolar disorder often have to live with the stigma that has been placed on people living with mental illness. It is important that officers not perpetuate that cycle of stigmatization by utilizing the information that they have gained in this section to help link them resources.

Officers are reminded to use the many resources at their disposal to assist any of the people they come in contact with living with bipolar disorder. It is hoped that by linking them to resources their quality of life will improve while lessening their interaction with law enforcement.

Resources for Bipolar Disorder:

- NAMI Albuquerque www.nami.org 2501 San Pedro NE Suite 212, Albuquerque NM 87110 (505)256-0288
- The International Society for Bipolar Disorders isbd.org
- Depression and Bipolar Support Alliance DBSA dbsalliance.org
- St. Martin's Hospitality Center www.smhc-nm.org 1201 3rd ST NW, Albuquerque, NM 87102 (505)242-4399
- Depression Bipolar Support Alliance (DBSA) dbsaAlbuquerque.org

Enhanced Crisis Intervention Team (eCIT) Training

Student Guide

Developmental Disabilities

And

Autism Spectrum Disorder

Developmental Disabilities

Learning objectives for this section:

- Student will have a good base knowlegde about developmental disabilities
- Student will be able to list three of the different types of developmental disabilities
- Student will have a better understanding of the how person's with delopmental disabilites interact within the criminal justice system
- Student will know what researchers believe are possible causes for development disabilties

What are developmental disabilties?

Development disabilities are a group of conditions due to an impairment in physical, learning, language or behavior area. The Centers for Disease Control that about one in six children have one or more developmental disabilities or other developmental delays. These conditons begin during the developmental period, may impact day-today functioning, and usually last throughout a person's lifetime.

What are some of the different types of developmental disabilties?

- Intellectual disabilty(mental retardation)
    - Limits ability to learn(IQ below 70) and to function in daily life
    - Onset prior to age 18
    - The cause is 80% of cases is unknown and there are 300 possible factors in the other 20%
- Autism Spectrum Disorders(ASD)
- Genetic and chromosol disorders
    - Fragile X(most common form of inherited ID)
    - Down Syndrome
- Fetal alcohol disorders/effects
- Cerebral palsy

Common Traits for Persons living with Developmental Disabilities

- They area often picked on, victimized and humiliated
- They have a desire for approval and acceptance and often do what others tell them to
- They have very poor impulse control and diffuculty with long term thinking
- They have difficulty handling stress
- They have difficulty predicting consequences or resisting strong emotional responses.

Contact with Criminal Justice System

- Here are some useful facts about persons living with Development disabilities and their contacts with the criminal justice system.
- They are involved as victims or suspects more often than people not living with developmental disabilities
- They have a 4 to 10 time higher risk of becoming a victim of crime than people not living with developmental disabilties
- As children they are three times more likely to become abused and or neglected
- Persons living with Intellectual disabilities have a very high rate of violent victimization
- They are more likely to confess to crimes that they did not commit
- They are more likely to say what they think the police officer wants to hear
- They are more likely to agree with advise given to them by a lawyer even if it means a guilty plea for a crime they did not commit
- They are often co-defendants because they are followers and not leaders

Things to remember

Officers are reminded to always think of safety when contacting a person living with a developmental diasability. Officers should take in all the risk factors of a situation and try to de-escalate the situation using any of the information given to help build rapport.

Officers are reminded that people living with developmental disabilities often have to live with the stigma that has been placed on people with disabilities. It is important that officers recognize that stigma and try to break down those barriers so that they can help the person.

Officers are reminded to use the many resources available to help that person living with the disability get connected to the help they need. It is hoped that by linking them to services it will improve that person's quality of life as well as reduce their interaction with police.

Autism Spectrum Disorder

Learning objectives for this section:

- Student will have a basic understanding of Autism Spectrum Disorder(ASD)
- Student will know the typical signs and behaviors to look for to help identify someone living with Autism Spectrum Disorder(ASD)
- Students will know what risk factors are associated with causing Autism Spectrum Disorder(ASD)
- Students will know the basic guildlines for interaction with individuals with Autism Spectrum Disorder(ASD)

What is Autism Spectrum Disorder?

Autism Spectrum Disorder(ASD) is a brain disorder that impairs someones socialization and communication. Someone with ASD may have trouble developing and maintaining relationships as well as communicating both verbal and nonverbally. They are socially awkward and often make no eye contact. Someone with autism may not recognize safety hazards or perceive the existance of real threats. Moreover, they may not recognize social cues and customs in everyday life settings.

Visual and verbal cues for Autism Spectrum Disorder:

- Stimming which is characterized by hand-flapping, rocking back and forth, or twirling.

- Repetition which can be seen in actions such as lining up objects or verbally when a word or phrase is repeated over and over again.

- Delayed response when asked questions or given commands

- Unusual tone of voice which can be manifested as monotone with no showing of emotion

- Flat affect in that their facial expressions are fixed showing no emotion

- Lack of eye contact (not a show of disrespect)

- Unusual or unbalanced gait appear to be clumsy or unsteady

What are the causes of Autism Spectrum Disorder?

The exact cause of autism spectrum disorder is not currently known. It's a complex condition and may occur as a result of genetics or environmental factors.

Genes – some researchers believe that certain genes our inherited from their parents that could make them more vulnerable to developing Autism.

Environmental factors – Some researchers believe that a child born with a genetic vulnerabilty to austim will only develop the condition when exposed to certain environmental trigger.

Interaction Guidelines

- When you know their name use it
- When giving orders or directions be specific and to the point
- Remember to use simple language and speak slow and clear
- When feasible give them time to understand what you are trying to communicate
- Make your questions simple and easy to understand and give them time to respond
- Offering praise can help build rapport
- Use non-threatening body language and a calm voice remember that your uniform and presence may be intimidating
- Use caution and be prepared for unexpected outbursts

In conclusion

Officers are reminded to always think of safety when having to deal with a person who is living with Autism Spectrum disorder. Officers should take in all the risk factors of a situation and try to de-escalate the situation using any of the above information to build rapport.

Officers are reminded that people living with Autism Spectrum Disorder often live with the stigma that has been placed on people living with disabilities. It is important that officers use the information they have gained in this class to help break the cycle of stigmatization.

Officers are reminded to use the many resources at their disposal to assist people living with Autism Spectrum Disorder and their families. It can be a very difficult thing to live with this disorder and any help that can be given to the families will help with their quality of life.

Resources for people with developmental disabilities

- Center for Development and Disability
  - 2300 Menaul Blvd NE (505) 272-3000
- ARCA
  - Disabilty.gov (505)332-6700

Resources for Autism Spectrum Disorder

- Center for Development and Disability
  - 2300 Menaul Blvd NE (505)272-3000
- New mexico Autism Society
  - http://nmautismsociety.org/ (505)332-0306
- Autism Speaks
  - Autismspeaks.org

Enhance Crisis Intervention Team (CIT) Training

Student Guide

PTSD

PTSD

Overview:

Most people who experience a traumatic event will have reactions that may include shock, anger, nervousness, fear, and even guilt. These reactions are common; and for most people, they go away over time. For a person with PTSD, however, these feelings continue and even increase, becoming so strong that they keep the person from living a normal life. People with PTSD have symptoms for longer than one month and cannot function as well as before the event occurred.

PTSD is not a sign of weakness or moral failing, people living with PTSD include famous actors and comedians, athletes, and of course valiant war veterans.

1. http://www.webmd.com/mental-health/post-traumatic-stress-disorder

Key Concepts:

All people experience anxiety. Without the experience of anxiety, life would be even more dangerous, though it might be more fun. People wouldn't prepare for tests or work deadlines. People would take risks that are stupid, and they would become obnoxious and insensitive.

Police are witnesses to the effects of violence at rates much higher than almost any profession. This puts them into contact with people living with PTSD, and puts them at risk for developing PTSD.

Extreme trauma and PTSD teaches people to fear the world and to feel helpless. If you've been attacked by a bear, you will naturally feel very frightened every time you see reminders of bears. What if the bear is your abusing father and you're eight years old?

PTSD has very high rates of co-occurring with other psychiatric illnesses, increasing the risk of having another illness by 80%. Men are more likely than women to have co-occurring conduct disorder and substance use disorders, both of which are associated with increased risk of violence.

Be effective rather than right! Trying to convince people you're right about something, for example, the trauma wasn't that bad, can usually have the opposite of the desired effect. Arguments and the desire to be right diminish compassion and empathy.

Reference is the DSM-V

NORMAL STRESS RESPONSE vs. DISORDER

All people react to trauma. Most at minimum have some mild symptoms associated with PTSD such as hyper-vigilance, hyper-arousal, avoiding, numbing, and anger.

The DSM-V criteria require longer than a month, and like all disorders it must cause significant distress or impairment in the individual's social interactions, capacity to work, or other important areas of functioning.

Rambo, a movie from 1982, though dated, depicts a soldier who suffers from post traumatic stress disorder and has difficulty adjusting to normal life. He is shown to be prone to violence because of the torture he suffered at the hands of North Vietnamese soldiers in the Vietnam War. It's a good movie and can give a general sense of some PTSD symptoms such as a sense of being numb, as well as being prone to anger.

https://en.wikipedia.org/wiki/John_Rambo

How do people respond to stress?

When your sense of safety and trust are shattered by a traumatic event, it's normal for the mind and body to be in shock. It's common to have bad dreams, feel fearful, and find it difficult to stop thinking about what happened. For most people, these symptoms gradually lift over time. But this normal response to trauma becomes PTSD when the symptoms don't ease up and your nervous system gets "stuck" and fails to recover its equilibrium.

PTSD develops differently from person to person. While the symptoms of PTSD most commonly develop in the hours or days following the traumatic event, it can sometimes take weeks, months, or even years before they appear. There are three main types of symptoms and they can arise suddenly, gradually, or come and go over time:

1. Re-experiencing the traumatic event
2. Avoiding reminders of the trauma
3. Increased anxiety and emotional arousal

http://www.helpguide.org/articles/ptsd-trauma/post-traumatic-stress-disorder.htm

PTSD Symptoms:

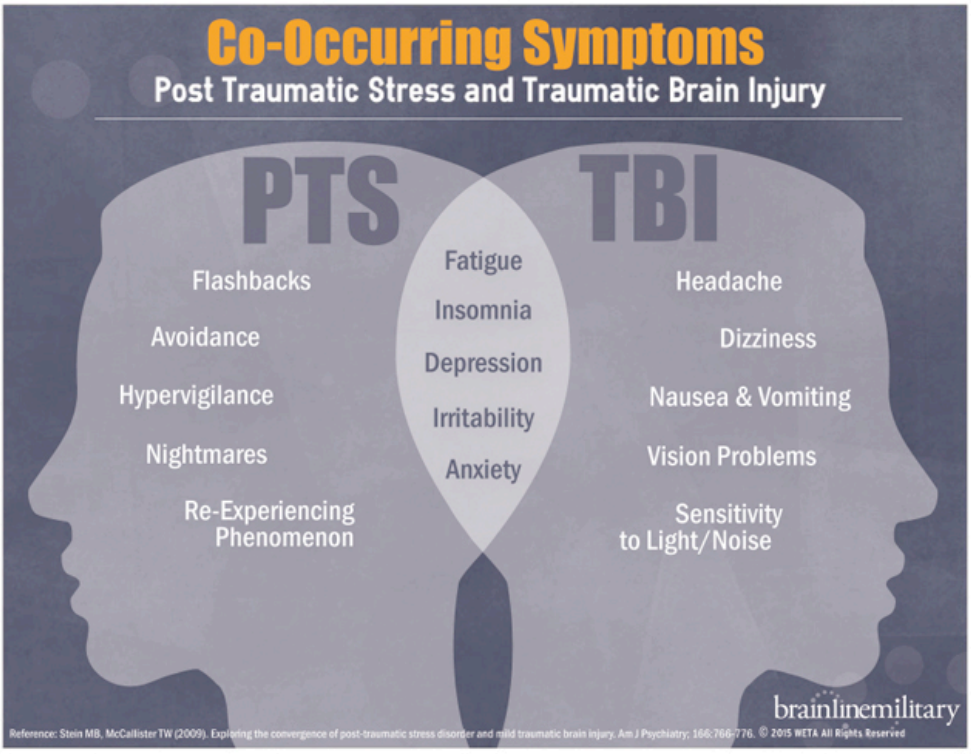
- History of significant trauma
- Persistent remembering, or "reliving" the stressor (intrusion symptoms)
  - "It just won't turn off…" (amped intensity)
  - Thoughts; memories; nightmares; re-enactment; flashbacks; physical, emotional distress at reminders (triggers)
- Avoidance
  - What you resist, persists
  - Efforts to avoid any and all reminders of the trauma, negative emotions (exception: ANGER often only "safe" emotion).
  - Many, many methods of avoidance
- Disruption in arousal, reactivity
  - "Can't be still, can't be calm…"
  - Irritability; sleep disturbance; exaggeration startle; self destructive or reckless behavior
  - Maxed out nervous system, faulty danger assessment
- Disruption in thinking, mood
  - "I'll get you before you get me…"
  - Some amnesia around traumatic event; negative beliefs about self, world; blame; negative emotions; alienation from others; restricted emotions

PTSD Prevalence

- Prevalence
  - **~ 9% lifetime** (men < women); **3.5% current**
  - Highest rates: Rape, child abuse, military combat/captivity, torture, genocide

PTSD Co-occurs frequently.

- ~ 80% more likely to have a (second) psych disorder than general population is of having one.
  - Depression, anxiety, substance abuse, personality disorders
  - Among Vets from Afghanistan and Iraq, co-occurrence of PTSD and mild TBI is 48%
  - Suicidality: trauma increases risk, PTSD increases it more
    - Veterans: highest risk is wounded combat vets; watch out for GUILT, ANGER, & IMPULSIVITY



PTSD in Special Populations

- PTSD in Women compared to men
  - Diagnosed more frequently
  - Diagnosis persists longer than in men.
  - Women have less symptoms of irritability and impulsivity than men
  - PTSD in Children
    - Kids may develop new onset nightmares
    - Dreams often without content specific to the trauma
    - Young children express re-experienceing through play.
- PTSD in Veterans (women are veterans, too!)
  - Current conflicts → high number of veterans with combat and other trauma
  - Use of guardsman & reservists, repeated deployments, urban/guerilla warfare

PTSD Treatment

- PTSD is treatable!
- Psychosocial
    - Cognitive behavioral treatments have strongest research support
- Medication: antidepressants, prazosin, antipsychotics
- Support groups
- Stress management
- Prevention: education and support

Keys for Law Enforcement:

- It's *not* all about you…
    - May not be deliberately uncooperative
    - Anger may be the only "safe" emotion

- Then again, it may not *not* be about you
    - Appearance (uniform, gender, race) may be a trigger
    - Prior contact with you or other law enforcement
    - Authority & hierarchy may be a trigger
        - Immigrants & "Secret Police", veterans victimized by superiors

De-Escalation Strategies

- DO NOT minimize the trauma
    - "It wasn't that bad…at least you survived…others had it worse…" etc.
- As best you can, empower the subject
    - People with PTSD may alternate between seeing you as rescuer, perpetrator
    - Only as safety/tactical allows: **be predictable**
    - Communicate what's going to happen
    - Allow the illusion of choice, face-saving measures
- Trust is very hard to come by; keep your promises!
- PTSD may not always be the driver, there are high rates of co-occurrence with PTSD.

- Substances, depression, etc.

❖ You may need to repeated yourself frequently

- Who you are, current setting, safety, intent to help, etc

❖ Time is generally on your side, so patience is a virtue

❖ Instill hope as best you can

Things to consider about instilling hope:

- It is a much more difficult task than you may expect.
- Try to give objective comforting information:
  - Examples:
    - "There are treatments for PTSD, and I've been taught that they really can work."
    - "The plan is that you'll go to your therapist tomorrow to talk about this."

A sense of safety is key

❖ Focus on, and use the word, "Safety." A loss of a sense of safety is a fundamental problem in PTSD.

But be careful not to moralize or minimize!

❖ Avoid statements like: "Why would you think about hurting yourself? Your wife loves you, you have so much to live for" Because he may believe his wife hates him, or maybe she actually does, either way, you'll get into an argument.

CIT Knowledge Network

The CIT Knowledge Network offers free training and exclusive membership for public safety!

The CIT Knowledge Network is a collaboration with UNM's Project ECHO, the Albuquerque Police Department, and Crisis Intervention Team Inc. to bring specialty online training, support, and real-time feedback to officers on cases involving individuals living with mental illness. Members of the Network have access to weekly meetings by using videoconferencing software Zoom. If you are interested in joining the CIT Knowledge Network or learning more about what we do, please contact Project Coordinator Jennifer Earheart at, jearheart@cabq.gov.

www.gocit.org/cit-knowledge-network
info@goCIT.org

Albuquerque Housing Authority
Resource Guide

ALBUQUERQUE HOUSING AUTHORITY

"Empowering people in our community through affordable housing and self sufficiency opportunities."

ADULT BASIC EDUCATION

ABC (Albuquerque Bernalillo County) Library
Main Library (505) 768-5141
See site for other locations
http://abclibrary.org/computerclasses

Albuquerque GED
419 Pennsylvania SE & 6900 Gonzales SW
(505) 907-9957

Albuquerque Hispano Chamber of Commerce
Computer, resume writing, & interviewing classes
(505) 842-9003

Catholic Charities
3301 Candelaria NE (505) 724-4670
GED, ESL, Computer Literacy, Citizenship Classes (all free)

CNM
525 Buena Vista SE (505) 224-3935
GED, ESL, Literacy

Encentro
714 4th St SW (505) 247-1023
ESL (English as a Second Language)

Reading Works
1113 Rhode Island St NE (505) 321-9620
Adult literacy

Southwestern Indian Polytechnic Institute
9169 Coors Blvd NW (505) 346-7728
GED (serves American Indian & Alaskan Native Students)

UNM
1836 Lomas Blvd NE (505) 925-8900
GED, ESL, Literacy

CHILDCARE / CHILDREN'S SERVICES

APS Title I Homeless Project
(505) 256-8239

Catholic Charities
Children's Learning Center, Daycare
2010 Bridge SW (505) 721-4643
Mon-Thurs 7AM-5:30PM; Fri 7AM-4:30PM
Low income families - 1-5 yrs of age

Child Support Enforcement Division
(800) 288-7207

Cuidando Los Ninos Daycare
1500 Walter SE (505) 843-6899
Mon-Fri 7AM-5:30PM; child care & therapy for homeless children

ECHO Inc.
300 Menaul Blvd NW (505) 242-6777
Food for income NM residents, pregnant, child under 12 months, children under 6 if no WIC

NM Family Network
(505) 265-0430
Advocacy & support to families with behavioral health challenges

New Mexico Kids
1634 University Blvd NE (505) 277-7900
Mon-Fri 9AM-4PM; child care referrals

PB&J Family Services
1101 Lopez Road SW (505) 877-7060
Support children developmental disabilities/mental illness; health education; nursing; teach safety middle/high school

State Child Care Assistance (CYFD)
3401 Pan American NE (800) 832-1321
Help low income families pay for day care (6 wk-13 yrs); parent education

CHILDCARE / CHILDREN'S SERVICES (CONT.)

St. Josephs Community Health
1516 5th St NW (505) 924-8000
Prenatal & up to 3 yrs; education for 1st time parents

Tres Manos
832 Buena Vista SE (505) 848-1310
Mon-Fri 9AM-5:30PM; child care
CNM students (3-5 yrs, must be potty-trained)

WIC (Women, Infants & Children)
2400 Wellesley Dr NE (505) 841-4173
300 San Mateo NE (505) 841-8929
1401 William St SE (505) 764-0271
Low income families pay for food, formula, diapers, etc

Young Children's Health Center at UNM
306 A San Pablo SE (505) 272-9242
1st Thurs each month; 1PM-7PM must live in 87108 or 87123 zip; medical care for infants to 18yr

CLOTHING SITES

Albuquerque Rescue Mission
525 2nd St SW (505) 346-4673
Mon-Fri 8AM-4:30PM & Sat 8AM-1PM,
1st 20 people

Bernalillo County Council of the PTA
1730 University SE (505) 344-7481
9AM-1PM (during school yr) Tues-Fri

Good Shepherd Center
218 Iron St SW (505) 243-2527
9AM-11:45AM & 12:45PM-1:45PM
Mon, Tues, Wed; only men's clothing

Immaculate Conception Church
619 Copper Ave NW (505) 247-4271
12:45PM-1:45PM Sun only

John Marshall Health & Social Services Center
1500 Walter SE (505) 848-1345
Call for appointment

Project Share
1515 Yale SE (505) 242-5677

Salvation Army
4301 Bryn Mawr NE (505) 881-4292

Storehouse – Rio Rancho
1030 Veranda Dr SE, Rio Rancho, NM
(505) 892-2077
Provides emergency food & clothing

St. Martin's Hospitality Center
1201 3rd St NW (505) 843-9405
8:30AM Mon, Tues, Thurs, Fri

St. Vicente de Paul
4120 Menaul Blvd NE (505) 346-1500
10AM-7PM Mon-Fri; 10AM-5PM Sat; low cost clothing (thrift store or voucher)

The Storehouse
106 Broadway SE (505) 842-6491
Provides emergency food & clothing

The ROCK at Noon Day
2400 2nd SW (505) 246-8001
9AM-11AM Tues-Fri

DISABILITIES

Adelante Development Center
(505) 341-2000
Adults w/ disabilities; assisted living
& home-based care

ARCA
11300 Lomas NE (505) 332-6700
Residential support systems for people with mental retardation & developmental disabilities

DISABILITIES (CONT.)

Casa Angelica
5629 Isleta Blvd SW (505) 877-5763
Intermediate care facility for developmentally disabled children (Canossian Daughters of Charity)

Center for Disabilities Information Hotline
(800) 552-8195

Cornucopia Adult Services
2002 Bridge Blvd SW (505) 877-1310

Division of Vocational Rehabilitation (DVR)
111 Lomas Blvd NW, #422 (505) 383-2500
Help w/ disabilities achieve a suitable employment outcome

Disability Rights New Mexico
1720 Louisiana Blvd NW, #204 (505) 256-3100
Protect, promote & expand the right of those w/ disabilities

HELP New Mexico
5101 Copper Ave NE (505) 265-3717
Special Needs Housing Initiative

Home New Mexico
2300 Menaul NE (505) 889-9486
Assist disabled home seekers with homeownership resources

Independent Living Resource
4665 Indian School, Ste 100 (505) 266-5022
Assists with housing for those with a disability

NM Aging & Disability Resource Center
(505) 476-4846 or (800)-432-2080

Transitional Living Services
4020 Central SE (505) 268-5295
Emergency, group & rehabilitation programs for severely disabled mentally ill adults

Transitional Living Services
5601 Domingo Rd NE (505) 323-3811
Short to long term housing services for those w/ mental disabilities

DOMESTIC VIOLENCE SHELTERS & SERVICES

Catholic Charities
2010 Bridge SW (505) 724-4651
Legal help for immigrants of domestic abuse

Central NM Immigrant Law Center
714 4th St SW (505) 247-1023
Legal help for immigrants of domestic abuse

Domestic Violence Helpline
(505) 243-4300 or (877) 974-3400

Domestic Violence Hotline
(800) 799-SAFE (7233)

Domestic Violence Resource Center
625 Silver Ave SW (505) 843-9123
Women/children support groups, counseling, legal/hospital advocacy, crime response

Enlace Comunitario
2425 Alamo Ave SE (505) 246-8972
Advocates for victims of domestic violence

Haven House
(505) 896-4869 or (800) 526-7157
Emergency shelter, crisis intervention & support services for victims of domestic violence

Family Advocacy Center (505) 243-2333
Victims of violence in interpersonal relationships, provides emergency medical staff, victim advocates, legal & financial assistance along with law enforcement

DOMESTIC VIOLENCE SHELTERS & SERVICES (CONT.)

Morning Star House
1410 San Pedro NE (505) 232-8299
Hot Line: (505) 507-7720
Provide safety, advocacy, education & support for victims of domestic violence in Albuquerque

PB&J Family Services (505) 877-7060

S.A.F.E. House (Domestic Violence)
(505) 247-4219 or (800) 773-3645 (24 hr toll free)
Emergency housing for domestic violence victims

UNM Police (505) 227-2241

Women's Community Association
(505) 884-8856 or (505) 247-4219
Shelter, safe house & services for victims of domestic violence

EMERGENCY / HOTLINE NUMBERS

Agora Crisis Center (Crisis & Suicide Hotline)
(505) 277-3013 – 9AM-midnight
(866) 435-7166 – 24 hrs

NM Crisis Line (855) 662-7474

United Way Resource Hotline
211 or (505) 245-1735

EMPLOYMENT ASSISTANCE & OPPORTUNITIES

Goodwill – Job Development (505) 881-6401

Goodwill – Gateway to Work (505) 881-6401

Goodwill – GoodSkills (505) 881-6401

Goodwill – Senior Community Service Employment Program (SCSEP)
(505) 881-6401

HELP New Mexico
5101 Copper Ave NE (505) 265-3717
Job placement & training

Job Corps – (800) 733-JOBS (5627)

Labor Ready – Lomas (505) 265-5148

Labor Ready – Central (505) 268-9040

Labor Ready – Montano (505) 344-8003

Labor Express – 2nd St (505) 344-4404

Labor Express – Jackson (505) 225-4383

Labor Express – Copper Ave (505) 766-5678

Labor Express – Central Ave (505) 831-2345

NM Dept of Labor (505) 222-4600

NM Works Career Link (505) 994-9219

FAMILY SERVICES

Adoption Assistance Agency (505) 263-5757

Adoption Plus
1111 Menaul Blvd NE, Ste 5
(505) 323-6002

All Faiths Receiving Home
1709 Moon St NE & 3001 Trelis Dr NW
(505) 271-0329
Daycare, therapy, child abuse prevention

American Red Cross
Various locations (505) 265-8514
Minor home repair for low income, education on safety & health, youth programs

Birthright of Albuquerque
3228 Candelaria NE (800) 550-4900
Support to pregnant women

FAMILY SERVICES (CONT.)

Desert Hills for Youth
5310 Sequoia Rd NW (505) 836-7330
Behavior mgt services, outpatient medication clinic, psychological services

Enlace Comunitario
2425 Alamo Ave SE (505) 246-8972
Child support, divorce, custody, restraining orders & other legal services

Hogares
1218 Griegos Rd NW (505) 345-8471
Youth & young adult (up to 24 yrs); counseling & more

New Mexico Human Services
4330 Cutler Ave NE (505) 222-9200
3280 Bridge Blvd SW (505) 841-2300
1711 Randolph Rd SE (505) 383-2600
1041 Lamberton Pl NE (505) 841-7700
Income support

Project Rachel
(505) 831-8238 or (888) 456-HOPE
Leave voice mail, post abortion healing

Samaritan Counseling Center
1101 Medical Arts Ave NE (505) 842-5300
Sliding scale payment services for family and/or relationship counseling

Saranam, LLC
1100 Eubank NE, Ste A (505) 299-6154

St. Joseph Fertility Care Center
4000 St. Josephs Pl NW (505) 831-8222
Natural Family Planning

Transitional Living Services
5601 Domingo Rd NE (505) 323-3811
Short to long term housing services for those w/ mental disabilities

Youth Development (YDI)
Various locations (505) 352-3469
Various programs for youth & families

FINANCIAL

Credit Rescue Now
2601 Wyoming Blvd NE, Ste. 117
(505) 792-7785

FOOD PANTRIES

Alamosa Food Pantry
6900 Gonzales Rd SW (505) 836-8800
Mon-Thurs / last week of month 9AM-4PM

Albuquerque Drop in Center
1007 San Mateo SE (505) 256-8289
Mon-Wed-Fri 10AM-12PM
Tue-Thur 1PM-3PM

Albuquerque Indian Center
105 Texas SW (505) 268-4418
Food bank on Tuesdays & Thursdays 1PM

Angels Acts of Kindness
3213 Montreal NE (505) 271-8622
Call for appointment

Casa de las Commundades
444 Chama SE (505) 247-1387
Thurs, Sat & Sun / 2:30PM

East Central Multi-Purpose Center
306-B San Pablo SE (505) 256-2070

ECHO Inc.
300 Menaul Blvd NW (505) 242-6777
Food pantry for families with children under 6 & seniors 60+

Emmanuel Metropolitan Community Church
341 Dallas NE (505) 268-0599
3rd Fri of month / 5:30PM-7PM

FOOD PANTRIES (CONT.)

Glory Christian Fellowship
2417 Wyoming NE (505) 275-9623
Tues & Thurs / 9:30AM-12PM

Faith Tabernacle Baptist (505) 255-6226

Grant Chapel
7920 Claremont NE (505) 293-1300
Tues-Thurs / 9:30AM-1PM

HELP New Mexico
5101 Copper Ave NE (505) 265-3717
Child & Adult Care Food Program

Holy Family Parish
562 Atrisco SW (505) 842-5426
Tues / 1PM

John Marshall Center
1500 Walter SE (505) 848-1345

Los Griegos Multi-Purpose Center
1231 Candelaria NW (505) 761-4050

Project Share
1515 Yale SE (505) 242-5677
1 box per 30 days / Mon, Tues, Thurs, Fri
12:30PM-3:30PM
Provides a hot, nutritious meal six evenings per week (closed Wednesday) from 5PM-6PM

Roadrunner Food Bank (505) 247-2052

Rio Grande Food Pantry
600 Coors Blvd NW (505) 831-3778
Food boxes for needy families; call for schedule

Storehouse – Albuquerque
106 Broadway SE (505) 842-6491
Provides emergency food & clothing

Storehouse – Rio Rancho
1030 Veranda Dr SE (505) 892-2077
Provides emergency food & clothing

SACM Food Pantry
3905 Las Vegas Dr SW (505) 877-1472
1st Tues of month / 9AM-12PM

Sacred Heart Parish
412 Stover SW (505) 242-0561

Salvation Army
4301 Bryn Mawr NE (505) 872-1171
Mon, Wed, Fri 9AM-11:30AM & 1PM-3:30PM

Sandia Church of the Nazarene
2801 Louisiana NE (505) 881-0267
Tues, Fri (2x/month) 9:30AM

St. John's Episcopal Cathedral
318 Silver SW (505) 247-1581
Tues 9AM-10AM; sign up Monday

SE Highland Food Pantry
417 Palomas SE (505) 256-1682
Tues & Thurs 2PM

Storehouse
106 Broadway SE (505) 842-6491
Tues-Sat

The Church
3021 Todos Santos NW (505) 836-4444
Sat mornings

New Mexico Veterans Integration Center
13032 Central Ave SE (505) 265-0512
Veteran food pantry Wed & Fri

Vision Unlimited
7701 Zuni SE (505) 856-7606
4th Sat of month

HEALTH & DENTAL

Albuquerque Healthcare for the Homeless, Inc
1217 1st St NW (505) 766-5197

Benefits Connection Center (505) 273-5222

HEALTH & DENTAL (CONT.)

Care Net Pregnancy Center (505) 880-8371

Children's Grief Center (505) 323-0478

First Choice Community Healthcare
Various locations (505) 873-7400 or 873-7451
Free wellness programs & confidential teen clinic, primarily low income; take people with no insurance

First Nations Community Healthsource
5608 Zuni Rd SE (505) 262-2481
Mon, Tues, Thurs, Fri / 8AM-9PM
Wed / 8AM-12PM & 5PM-9PM, Sat 9AM-1PM
People with American Indian blood

Healthcare for the Homeless-Medical Clinic
1st & Mountain NW (505) 242-4644
Mon, Tues, Fri, 8AM-12PM
Counseling, psychosocial analysis

Healthcare for the Homeless-Dental Clinic
1st & Mountain NW (505) 242-8288

Indian Health Services
801 Vassar Dr NE (505) 248-4000

New MexiKids (888) 997-2583

Medicaid
4330 Cutler Ave NE (505) 222-9200
Health insurance for children & pregnancy

People Helping People
Albuquerque & Rio Rancho (505) 892-1951
Immediate & medical emergencies

Pharmacy - UNM Hospital
2211 Lomas Blvd NE (505) 272-4110
Low cost prescriptions

Planned Parenthood – NE (505) 294-1577

Planned Parenthood – SE (505) 265-3722

Public Health Clinic (STD Info) (505) 841-4100

Rio Grande Geriatrics & Family Practice
8400 Menaul Blvd NE (505) 908-1171
Primary care, house calls; family nurse practitioner

Transitional Living Services
5601 Domingo Rd NE (505) 323-3811
Short to long term housing services for those w/ mental disabilities

UNM Care
2211 Lomas Blvd NE (505) 272-2521
Insurance at UNM for low income individuals; must qualify
WIC – North Valley (505) 272-2283

WIC – SE (505) 272-2283

University Center for Women's Health
(505) 272-8075

HOUSEHOLD ITEMS

From the Heart Foundation (505) 256-7664

Grace Free Store
420 San Lorenzo NW (505) 344-4152
Free household items to those in need.
Thurs & Sat 1-4PM

Goodwill Industries of NM
5000 San Mateo Blvd NE (505) 881-6401
Low cost clothing, furniture & household goods

Love INC (505) 268-4663

St. Vincent De Paul (505) 242-3434

HOUSING

Affordable Housing Hot Line (505) 768-3400
Affordable housing resources for rental, homeownership, homebuyer counseling, etc.

Affordable Rental Housing Hotline
(505) 232-6698

Barrett House Foundation Inc.
10300 Constitution Ave NE (505) 243-4887
Housing & Supportive Services

Bridges Supportive Housing (505) 246-0944
Supportive housing for homeless single women & homeless women with children, must be willing to work at least part time. Rent is 30% of income

Catholic Charities
1202 Pennsylvania NE (505) 724-4670
Transitional housing program to help move homeless families to permanent housing

City of Albuquerque Affordable Housing Hotline
(505) 768-3400
Information on City sponsored affordable housing developments

City of Albuquerque
Office of Neighborhood Revitalization
700 4th St SW, Ste A (505) 767-5825
Provides assistance for home repairs for low income homeowners

Consumer Credit Counseling Services-SW
2727 San Pedro NE, Ste 117 (505) 308-2227
Provides education in the appropriate use of credit & home buying

Habitat for Humanity – Greater Albuquerque
4900 Menaul Blvd NE (505) 265-0057
New home construction for low income families

Home New Mexico
3900 Osuna Rd NE (505) 889-9486
Assists disabled people with home purchase repair & information

Supportive Housing Coalition
625 Silver Ave SE, St 325 (505) 255-3643
Assists with housing, landlord-tenant issues

Greater Albuquerque Housing Partnership
539 Pennsylvania St SE (505) 244-1614
Developing affordable housing; provides counseling for first time low income homebuyers

Neighborhood Housing Services of Albuquerque
4605 4th St NW (505) 243-5511
Home rehabilitation loans for low income families in the Downtown, Sawmill & Wells Park neighborhoods

New Mexico Apartment Search
Affordable rental housing service
http://www.housingnm.org/secured/affordablerentals/search/homepagepublic.htm

New Mexico Mortgage Finance Authority (MFA)
344 4th St SW (505) 843-6880
Provides a variety of housing finance programs for low income New Mexicans

Sawmill Community Land Trust
904 19th St NW (505) 764-0359
Develops & builds permanently affordable, quality housing for persons with low to moderate income

St. Vincent De Paul Society
714 4th St SW (505) 346-1504
Rental assistance for person with eviction notices, along with other services

HOUSING SAFETY & RELATED

Housing Code Enforcement (City)
(505) 764-3954

Bernalillo County Environmental Health
(505) 314-0310

IMMIGRATION SERVICES

Catholic Charities
2010 Bridge SW (505) 724-4651
Mon-Fri / 8AM-5PM
Sliding scale payment legal services

Central NM Immigrant Law Center
714 4th St SW (505) 247-1023
Immigrant resource center (legal, ESL, DV)

Enlace Communitario (505) 246-8972
Visa & immigration issues

LEGAL ASSISTANCE

City of Albuquerque Human Rights Office
(505) 924-3380
Promotes awareness & practice for fair housing laws, investigates housing discrimination & complaints

District Court-2nd Judicial (505) 841-6737

Enlace Comunitario
2425 Alamo Ave SE (505) 246-8972
Child support, divorce, custody, restraining orders & other legal services

Law Access NM
(505) 998-4529 or (800) 340-9771, if out of City limits. Pro-bono basis to get help with Landlord / Tenant disputes, eviction rights, unsafe housing

Lawyer Referrals (505) 243-2615

Legal Help Line
(505) 998-4529 (Albuquerque)
(800) 340-9771 (State Wide)
Mon-Fri 8:45AM-12PM & 12:30PM-3:45PM
Free telephone legal advice for low income NM

Metro Court (505) 841-8100

New Mexico Legal Aid
301 Gold Ave SW (505) 243-7871
Contact if you had problems renting or buying a home because of your race, color, national origin, religion, gender, family status or disability

Pegasus Legal Services for Children
3201 4th St NW (505) 244-1101
Legal resource for children, caregivers, & community concerning the legal rights & needs of children & youth

Tenant Hotline
5121 Masthead NE (505) 998-4529
Mon-Fri / 9AM-3PM
Low income individuals with rental issues

MEAL SITES

Albuquerque Rescue Mission
525 2nd St SW (505) 346-4673
Mon-Sat / 6AM-7AM - Breakfast
5PM-6PM / Dinner

Bread & Blessings at
Immaculate Conception Church
619 Copper Ave NW (505) 247-4271
Sun only / 12:45PM-1:45PM

Cross Roads Café
1020 Coal SE (505) 242-0497
Wed only / 5PM-6:15PM

First Methodist Church
341 Lead SW (505) 243-5646
Mon only / 12PM

Good Shepherd Center
218 Iron St SW (505) 243-2527
Sat 11:30AM-12PM
Mon, Tues, Wed, Fri 3:15PM-4PM

International All Faith Center
3rd & Coal SW (505) 243-1789
Sun only / 3PM

MEAL SITES (CONT.)

Joy Junction
4500 2nd St SW (505) 877-6967
Everyday 5:30AM, 12PM, 5PM

The ROCK at Noon Day
2400 2nd SW (505) 246-8001
Tues-Fri 12PM-1PM; Sun 11AM

Project Share
1515 Yale SE (505) 242-5677
Mon, Tues, Thurs, Fri, Sat, Sun 5PM-6PM

Restoration Ministries
825 San Mateo SE (505) 255-7579
Every Saturday / 11:30AM-1PM

MEN

Albuquerque Opportunity Center
715 Candelaria NE (505) 344-4340
Men only

ESH Recovery Home
126 General Chennault NE (505) 332-8935
Men only; substance abuse, mental illness

NM Men's Recovery Academy (NMMRA)
1000 W. Main St, Los Lunas, NM (505) 866-0590
Full array of residential re-entry

Salvation Army men's residential rehab program
400 John St SE (505) 242-3112
Men 21 & up

MORTGAGE ASSISTANCE / HOME REPAIR

American Red Cross Emergency
Minor Home Repair (505) 265-8514 Ext. 33
Minor home repair for low to moderate income homeowners

Family Housing Development Corp
(505) 873-9638
Down payment & financing assistance for qualified first time homebuyers.

Mortgage Finance Authority (MFA)
344 4th St SW (505) 843-6880

Southwest Neighborhood Housing Services
(505) 243-5511
Homebuyers training, landlord/tenant counseling, budgeting classes, foreclosure avoidance, home rehabilitation program & help for refinancing existing loans for the Albuquerque area

United South Broadway Corp.
1500 Walter St SE (505) 764-8867
Foreclosure prevention and assistance services, HUD Certified Counseling Agency

RENTAL AND/OR UTILITY ASSISTANCE

Catholic Charities
3301 Candelaria NE (505) 724-4670

Century Link Telephone Assistance
Medicaid Only (800) 244-1111

John Marshall Health & Social Services Center
1500 Walter SE (505) 848-1345
First come, first serve

LIHEAP (505) 841-2128
Help with PNM bill

The ROCK at Noon Day
2400 2nd SW (505) 246-8001
Requires 4 days of volunteer time & documentation of eviction notice or utility late notice

Project Unite (505) 761-9818

RENTAL AND/OR UTILITY ASSISTANCE (CONT.)

Salvation Army
Broadway & Coal (505) 872-1171
Emergency rental assistance; requires eviction notice. PNM (all yr) & gas (winter)

Supportive Housing Coalition
625 Silver Ave SE, St 325 (505) 255-3643
Assists with housing, landlord-tenant issues

St. Vincent de Paul
4120 Menaul NE (505) 346-1500

SECTION 8 / PUBLIC HOUSING

Albuquerque Housing Authority
1840 University Blvd SE (505) 764-3920
Programs for affordable housing

Bernalillo County Housing
1900 Bridge SW (505) 314-0200
Programs for affordable housing

Town of Bernalillo Housing Authority
(505) 867-2792
Programs for affordable housing

Office of Native American Program - HUD
201 3rd St NW (505) 766-1372
Programs for affordable housing

SENIOR SERVICES

Aging & Long Term Care Services Department
(800) 432-2080

Catholic Charities - Senior Transportation
3301 Candelaria NE (505) 721-4634

City of Albuquerque Dept of Senior Affairs
714 7th St SW (505) 764-6400
Minor home repair & home chores for senior homeowners

Cornucopia Adult Services
2002 Bridge Blvd SW (505) 877-1310

ECHO Food Commodities
300 Menaul NW (505) 242-6777
Supplemental foods; seniors 60+

HELP New Mexico
5101 Copper Ave NE (505) 265-3717

Legal Resources for the Elderly (LREP)
5121 Masthead NE (505) 797-6005 or
(800) 876-6657
Free, statewide help for NM residents 55 & older, no income restrictions

Love Inc.
(505) 255-5683

NewLife Homes (505) 293-7553

NM Aging & Disability Resource Center
(505) 476-4846 or (800)-432-2080

Senior Citizens Law Office (60+)
4317 Lead Ave SE, Ste A (505) 265-2300
Mon-Fri 8:30AM-12PM & 1PM-5PM

Silver Horizons (60+)
1212 Candelaria NW (505) 884-3881 x 14
Utility assistance, home repairs, free flu shots, etc

St. Mary's Rest Home
205 7th St NW (505) 243-5888
Only Catholic rest home in Albuquerque

St. Vincent de Paul
4120 Menaul NE (505) 346-1500

United Way Resource Hotline
(505) 245-1735

SHELTERS

Albuquerque Opportunity Center
715 Candelaria NE (505) 344-4340
Men only

Albuquerque Rescue Mission
525 2nd SW (505) 346-4673
1:30PM Mon-Sat. Day & night shelters

Amistad Crisis Shelter
2929 Barcelona SW (505) 877-0371
Crisis shelter for youth aged 12-17

Barrett House Foundation Inc.
10300 Constitution Ave NE (505) 243-4887
Emergency Shelter for women and children

Emergency Winter Shelter (505) 346-4673

Family Promise of Albuquerque
(505) 268-0331

Good Shepherd Center
218 Iron St SW (505) 243-2527
Men only / opens 6PM daily

Joy Junction
4500 2nd St SW (505) 877-6967
Families, Men & Women
For ride, call 800-924-0569

Marie Amadea Shelter
708 Tijeras Ave NW (505) 242-1516
Shelter, counseling, transportation, education

Metropolitan Homelessness Project
715 Candelaria NE (505) 344-2323

The ROCK at Noon Day
2400 2nd SW (505) 246-8001
9AM-11AM / Tues-Fri, laundry, showers, phones, clothes

Salvation Army (505) 872-1171

Salvation Army (Rehab Center)
(505) 242-3112

Saranam, LLC (505) 299-6154

St. Martin's Hospitality Center
1201 3rd St NW (505) 843-9405
Day shelter, clothing exchange, supportive housing, motel lease assistance & other services

Trinity House, Catholic Worker House
1925 Five Points Rd SW (505) 242-0497
Meals, hospitality, transition housing
West Side Shelter
Sign up 3PM-8PM; meet at Rescue Mission, Men, Women, Children 10 & under only open from Nov 15-Mar 15

Women's Housing Coalition
3005 San Pedro NE (505) 884-8856
Single women with or without children; 2-year stay in program allowed. Thrift Store.

SHOWER SITES

St. Martin's Hospitality Center
1201 3rd St NW (505) 843-9405
8AM / Mail, ID's & phones

The ROCK at Noon Day
2400 2nd SW (505) 246-8001
Tues-Fri / 9AM-11AM

SUBSTANCE ABUSE & MENTAL HEALTH

Agora Crisis Center (505) 277-3013

Al-Anon
Various locations (505) 262-2177
Substance abuse recovery service

AA - Alcoholics Anonymous
1921 Alvarado NE (505) 266-1900

SUBSTANCE ABUSE & MENTAL HEALTH (CONT.)

Albuquerque Center for Hope & Recovery
1027 San Mateo SE (505) 256-8289
Mental health and/or substance abuse

Albuquerque Rape Crisis Center (505) 266-7711

Albuquerque Metro Central Intake (AMCI)
(505) 272-9033
Outpatient substance abuse counseling

Almas de Amistad
510 2nd St NW, Ste 101 (505) 246-9300
Substance abuse recovery service for women

Children's Grief Center (505) 323-0478

Cocaine Anonymous
Various locations (505) 344-9828

Crossroads (for women)
805 Tijeras Ave NW (505) 242-1010
Transition program for women w/ co-occurring addictive & mental health Issues

ESH Recovery Home
126 General Chennault NE (505) 332-8935
Men only; substance abuse, mental illness

Health Care for the Homeless
1217 1st NW (505) 848-7611
STARS provide short-term assessments & long-term case mgt for homeless w/ mental health and/or substance abuse, etc

MATS Detox
5901 Zuni Rd SE (505) 468-1555

Metropolitan Homelessness Project
715 Candelaria NE (505) 344-2323

Metamorphosis (Methadone & Suboxone)
111 Monroe St NE (505) 260-9917
Mental & substance abuse services

Methadone Treatment (866) 675-4912

MHC Crisis Line (Suicide) (505) 272-1121

NA (Narcotics Anonymous)
Various locations (505) 260-9889

NAMI (National Alliance for the Mentally Ill)
(505) 256-0288

NewLife Homes (505) 293-7553

NM Women's Recovery Academy
6000 Isleta Blvd SW (505) 873-2761
Pathways
2551 Coors NW (505) 338-3320
Mental health and/or substance abuse

Salvation Army men's residential rehab program
400 John St SE (505) 242-3112
Men 21 & up

Samaritan Counseling Center (505) 842-5300
Supportive Housing Coalition of NM
625 Silver Ave SE, St 325 (505) 255-3643
Behavior health issues

Susan's Legacy
11005 Spain NE (505) 843-8450
Co-occurring mental & addictive disorders.
Diagnosis of mental health and substance abuse for program entry

St. Martins - Chemical Dependency
1201 3rd NW (505) 764-8231
Individuals w/ co-occurring mental health & substance abuse issues

St. Martins - Mental Health
1201 3rd NW (505) 764-8231
Case mgt, medication mgt, psychiatric & nursing care, housing support

St. Martins - Mental Health
Intake & assessment for the homeless.
Coffee Shop inside facility @ 700 2nd St. NW

SUBSTANCE ABUSE & MENTAL HEALTH (CONT.)

Transitional Living Services
5601 Domingo Rd NE (505) 323-3811
Short to long term housing services for those w/ mental disabilities

Turquoise Lodge
6000 Isleta SW (505) 841-8978
Substance abuse services

UNM Addiction & Substance Abuse Program
2600 Yale SE (505) 944-7999
Youth & adults

UNM Mental Health Center
2600 Marble Ave NE (505) 272-2800
24 hr crisis line: (505) 272-2920
SHAC/Student Health & Counseling

UNM Children's Psychiatric Center
1001 Yale Blvd NE (505) 272-2890

WOMEN

A Peaceful Habitation
(505) 440-5937
Home & post prison aftercare ministry for women

Alas de Amistad
510 2nd St NW, Ste 101 (505) 246-9300
Substance abuse recovery service
for women only

Barrett House
10300 Constitution NE
(505) 246-9244 or (505) 243-4887
Women & Children

Bridges Supportive Housing
(505) 246-0944
Supportive housing for homeless single women & homeless women with children. Client must be willing to work at least part time. Rent is 30% of income

Casa Milagro
2818 Cuero NE (505) 883-8870
Women 35 yrs & up with chronic mental illness. Short term transitional housing in Bernalillo County

Crossroads for Women
805 Tijeras Ave NW (505) 242-1010
Transition program for women with co-occurring addictive & mental health issues

HELP New Mexico
5101 Copper Ave NE (505) 265-3717
Offers transitional housing for women

NM Women's Recovery Academy (NMWRA)
6000 Isleta Blvd SW (505) 873-2761
Full array of residential re-entry

Our Sister's Closet
YMCA of the Middle Rio Grande
210 Truman St NE, Ste A, (505) 254-9922
Business clothing, shoes & accessories at no cost for women going on job interviews/work

Proyecto La Cuz
Catholic Charities of Central NM
3301 Candelaria NE (505) 724-4670
Homeless women's & children's shelter

Susan's Legacy
11005 Spain NE (505) 843-8450
Co-occurring mental & addictive disorders. Diagnosis of mental health and substance abuse for program entry

TenderLove Community Center
3600 4th St NW
(505) 349-1795
Day shelter, job training

Women's Community Association
(505) 884-8856 or (505) 247-4219
Safe house; Coalition Against Domestic Violence

WOMEN (CONT.)

Women's Housing Coalition
3005 San Pedro NE (505) 884-8856
Single women with or without children; 2-year stay in program allowed; thrift store

Barrett House Foundation Inc.
10300 Constitution Ave NE
(505) 246-9244 or (505) 243-4887
Emergency Shelter for women and children

YOUTH

All Faiths Receiving Home
1709 Moon NE (505) 271-0329
Provide services to children & their families in a healthy environment which includes education, treatment, advocacy, food, clothing, affordable & safe housing

Amistad Runaway
1706 Centro Familiar SW (505) 877-0371
Teens 12-17

Big Brothers, Big Sisters (505) 837-9223

Boys & Girls Club (505) 247-1553

Casa Hermosa YDI- Youth Development Inc.
630-632 Chama St SE (505) 212-7470
Transitional living program for ages 16-21; 24 hr supervision for residents transitioning from homelessness into independent living; case management & counseling provided

CYFD (505) 841-4800

Early Head Start (505) 767-6500 or 764-3033

Haven of Love
4025 Isleta SW (505) 877-9915 or 873-3771
Emergency shelter, meals & clothing for homeless young men aged 18-21

HELP New Mexico
5101 Copper Ave NE (505) 265-3717
Youth Building Program

Life Options Academy (505) 841-4875

MCH Partnership in Parenting (505) 255-8740

New Day Youth & Family Services
2820 Ridgecrest SE (505) 260-9912 or 938-1060
Temporary shelter for runaway/homeless youth; crisis shelter with counseling & referral service

Outcomes, Inc (505) 243-2551

Parents Reaching Out (505) 247-0192

PB&J Family Services Inc. (505) 877-7060

Title I Child Homeless Project, APS
(505) 256-8239

UNM Addiction & Substance Abuse Program
2600 Yale SE (505) 944-7999
Youth & adults

Youth Development Inc
6301 Central NW (505) 831-6038
Transitional living programs for homeless families

Youth Development Inc. Headstart
(505) 244-0250

VETERANS

Goodwill – Homeless Veterans' Reintegration Program (HVRP) (505) 881-6401

Goodwill – Supportive Services for Veteran Families (SSVF) (505) 881-6401

New Mexico Veterans Integration Center
13032 Central Ave SE (505) 265-0512

Rehabilitation Services & Veterans Program
406 San Mateo NE, Ste 122 (505) 255-8440
Transitional housing for homeless veterans with other services offered

OTHER SERVICE PROVIDERS

Accion (505) 243-884
Micro-lending organization; Lending Record of over $1 million

American Red Cross
142 Monroe St NE (505) 265-8514

Amtrak (800) 872-7245

Goodwill Traumatic Brain Injury
5000 San Mateo NE (505) 881-6401
Assistance after a traumatic brain injury

Greyhound Bus Station
320 1st St SW (505) 243-4435

HELP New Mexico
5101 Copper Ave NE (505) 265-3717
Adult mentoring, leadership development, foster grandparent, income tax assistance

Albuquerque Indian Center (505) 268-4418

Animal Humane Association (505) 255-5523

Child/Adult Protective Services (505) 841-6100

Consumer Credit Counseling (505) 884-6601
Dept. of Community Services (505) 768-2860

Emergency Food Assistance Program (TEFAP)
(505) 841-2625
Federal program that helps supplement the diets of low-income Americans, including elderly people, by providing them with emergency food & nutrition assistance at no cost

Human Services Dept. (800) 432-6217

Motor Vehicle Division (888) MVD-INFO

New Mexico Dept of Health - Vital Statistics
Birth and Death Certificates
2400 Wellesley NE
(505) 827-0121 or (866) 534-0051

Oaks of Righteousness Transitional Living Program, East Central Ministries
134 Vermont St NE (505) 266-3590
Provides a subsidized & supportive living environment to make sustainable life changes

Social Security Office (505) 346-6694

United Way Resource Hotline
211 or (505) 245-1735

Love INC
(505) 255-5683 (option 1), share your story with a volunteer, list ALL your needs, receive a home visit to get information about places that can help

SUBSIDIZED HOUSING

The apartment complexes listed below have HUD-Insured and/or subsidized rental units that are privately owned. The manager of the individual complexes accepts applications for the rental units. HUD does not own the subsidized units/complexes; therefore cannot accept applications to any HUD office. It is the responsibility of the property owner or manager of each apartment complex to certify applicants and assign rental units. Any inquiries regarding your qualifications, your pending application, or whether a vacancy exists, should be addressed to the manager of the respective complex. Managers have information on current income limits and other eligibility criteria for participation in their specific subsidized rental program.

Each of HUD's subsidized rental programs has specific eligibility requirements relating to income, financial assets, family composition, and in some cases, other qualification criteria. It is the applicant's responsibility to furnish any information necessary to confirm eligibility. Failure to do so is a reason for owners or managers to refuse to provide a unit to any applicant for participation in one of HUD's rental assistant programs i.e., Section 8 and Section 236.

Section 202/811 HOUSING ASSISTANCE PROGRAM FOR ELDERLY AND DISABLED

These units are specifically developed for occupancy by Elderly persons (those 62 years of age and older) and/or physically or mentally challenged individuals. Challenged individuals must have a physical or mental impairment that meets all of the following criteria.

- The impairment is expected to be of long-continued and indefinite duration
- The impairment substantially impedes his/her ability to live independently
- The impairment is of such nature that ability to live independently could be improved by more suitable conditions. These conditions must be certified by a physician and the applicant must have an obvious physical disability

Occupancy by persons and families limited to those whose annual income at admission does not exceed the published maximum income limit established for the geographic area in which the complex is located. Participants are required to pay thirty-percent (30%) of their adjusted income for rental of these units.

Public Housing & Section 8 Tenant Based Assistance	
Albuquerque Housing Authority 1840 University Blvd SE Albuquerque, NM 87106 505-764-3920	Bernalillo County Housing 1900 Bridge Blvd SW Albuquerque, NM 87105 505-314-0200

*Note: Section 8 Housing Assistance Vouchers are only issued by local Public Housing Authorities and cannot be obtained directly from HUD.

If you have any questions, please call (505) 346-6463. If you are hearing or speech impaired, you may access this number via TTY by calling the Federal Information Relay Service at 1-800-927-9275. You may also reach us on the Internet at btto://www.hud.gov

Definition of Codes

D = Disabled E = Elderly F = Individual families

D	Agua Azul Apts	353 Camino Azul NW, 87121	831-7014
D	Center for Behavior, SVCS	12732 Singing Arrow SE, 87123	266-4013
D	Center For Behavioral Serv	3024 Sol de Vida NW, 87120	452-1553
D	Concha Ortiz y Pino De Kleven	4139-45 Mesa Verde NE, 87110	268-5295
D	El Paseo Village	420 Coal SE, 87102	842-1078
D	Gene Gilbert Manor	1001 Valencia SE, 87108	268-5295
D	Gray House	1105 Georgia NE, 87110	268-5295
D	New Life Homes 2	330 Airport SW, 87121	433-5111
D	Vern Jolly House	1600 Boatright NE, 87112	268-5295
E	AHEPA 501 Apartments	6800 Los Volcanes Rd NW, 87105	833-5602
E	AHEPA 501 II Apartments	6700 Los Volcanes Rd NW, 87105	833-3139
E	AHEPA 501 III Apartments	6620 Bluewater Rd NW, 87121	839-9487
E	Brentwood Gardens	6302 Harper Place NE, 87109	821-0818
E	David Spector Shalom	5500 Wyoming Blvd NE, 87109	823-1433
E	Edward Romero Terrace	8100 Central SE, 87108	232-1433
E	El Centro Familiar Apts	2210 Centro Familiar Blvd SW, 87105	314-0200
E	Encino House East	412 Alvarado SE, 87108	266-7736
E	Encino House Midtown	609 Encino Place NE, 87102	247-4185
E	Hibernian House Senior	624 Coal SW, 87102	489-7322
E	La Resolana Apts	1025 Chelwood Park Blvd NE, 87112	296-1425
E	Mesa Hills Apts	1000 Louisiana Blvd NE, 87112	255-0674
E	Ranchitos Village	6811 Ranchitos NE, 87109	822-9159
E	Rio Vista	770 Juan Tabo NE, 87123	293-5565
E	Salvation Army Silver Crest	4400 Pan American Fwy NE, 87107	883-1068
E	Solar Villas	1135 Texas NE, 87110	266-1976
F	Canyon Point	301 Western Skies Dr SE, 87123	294-3108
F	Canyon Ridge	200 Figueroa NE, 87123	299-8066
F	Lafayette Square	3901 Lafayette Square NE, 87107	881-7991
F	Montgomery Manor Apts	4301 Morris NE, 87111	296-9023
F	Mountain View II Apts	2323 Kathryn Ave SE, 87106	266-5455
F	Mountain View III Apts	1333 Columbia SE, 87106	266-5455
F	Plaza David Chavez	2821 Mountain NW, 87104	242-1361
F	Plaza Dorado	425 Western Skies Dr SE, 87123	296-8121
F	Saint Anthony Plaza	1750 Indian School Rd NW, 87104	766-5619
F	Sandia Vista	901 Tramway Blvd NE, 87123	298-4461
F	Sunny Acres	2821 Mountain Rd NW, 87104	242-1361
F	Sun Plaza	4400 Montgomery Blvd NE, 87109	881-4949
F	Villa Esperanza	3901 Lafayette NE, 87107	881-7991
F	Westwood Village	901 68th St NW, 87102	831-1177
	Redlands Apts	5901 Redlands NW, 87120	833-3531

Affordable Housing Program Rentals
The below are owned by the City of Albuquerque, Department of Family and Community Services (DFCS). Since these units are not funded by HUD, they are funded with local municipal tax revenue and income from rent paid by tenants. Since they are not funded by HUD, they are not part of the Albuquerque Housing Authority (AHA). They are not HUD funded Public Housing units.

Bluewater Village
6600 Bluewater Rd NW
(866) 491-5400

Santa Barbara (55 plus)
1420 Edith Blvd NE
(866) 295-9183

The Beach Apartments
2525 Tingley Dr SW
(505) 514-0492

Manzano Vista
1501 Tramway Blvd NE
(800) 581-7699

Candelaria Gardens
820 Candelaria NW
(866) 295-9823

Glorieta Apts
115 Glorieta NE
(866) 351-7650

Tucson Apartments
5401 & 5405 Tucson NW
(877) 222-0495

New Affordable Housing Complexes

Plaza Ciudana
310 Indian School Rd NE (505) 219-2163

Casitas de Colores
512 Lead Ave SW (505) 842-5644

Villa de San Felipe
601 Coal Ave SW (505) 244-1500

Plaza Feliz Multi-Family Apts
517 San Pablo St SE (505) 255-3030

Silver Moon Lodge
901 Park Ave SW (505) 362-3017

Extended Stay

University Village
1901 University Blvd SE (505) 835-5800

How To Get To AHA

By car: Take I-25 to Gibson Blvd SE, exit to eastbound Gibson, go east to University Blvd (traffic signal), then turn left and go north 1.5 blocks, to 1840 University Blvd SE. The AHA office is located on the east side of University Blvd, use the main entrance on the south side of the building.

By bus: The AHA office is served by two ABQ ride bus lines (route 16 and rush hour express route 217) and by Sun Van (para transit for the disabled).

Tips for First Responders

5th Edition

- Seniors
- People With Service Animals
- People With Mobility Impairments
- People With Autism
- People Who Are Deaf Or Hard Of Hearing
- People Who Are Blind Or Visually Impaired
- People With Cognitive Disabilities
- People With Multiple Chemical Sensitivities
- People Who Are Mentally Ill
- Childbearing Women and Newborns
- People With Seizure Disorders
- People With Brain Injuries

Additional copies of these tips sheets are available for purchase.

For information about prices, go to
http://cdd.unm.edu/products/tipsforfirstresponders.htm

For More Information:

Dr. Anthony Cahill
Center for Development and Disability
(505) 272-2990
acahill@salud.unm.edu

University of New Mexico

American Association on Health & Disability

RESEARCH AND TRAINING CENTER ON INDEPENDENT LIVING

University of Kansas

New Mexico Governor's Commission on Disability

New Mexico Department of Health

The opinions expressed in this material do not represent the official positions of these agencies.

Designed by Crick Design 505-296-8408

Seniors

Always ask the person how you can best assist them.

- Some elderly persons may respond more slowly to a crisis and may not fully understand the extent of the emergency. Repeat questions and answers if necessary. Be patient! Taking time to listen carefully or to explain again may take less time than dealing with a confused person who may be less willing to cooperate.
- Reassure the person that they will receive medical assistance without fear of being placed in a nursing home.
- Older people may fear being removed from their homes – be sympathetic and understanding and explain that this relocation is temporary.
- Before moving an elderly person, assess their ability to see and hear; adapt rescue techniques for sensory impairments.
- Seniors with a hearing loss may appear disoriented and confused when all that is really "wrong" is that they can't hear you. Determine if the person has a hearing aid. If they do, is it available and working? If it isn't, can you get a new battery to make it work?
  See the tip sheet for People Who Are Deaf Or Hard Of Hearing for more information.

- If the person has a vision loss, identify yourself and explain why you are there. Let the person hold your arm and then guide them to safety.
  See the tip sheet on People Who Are Blind or Visually Impaired for more information.

- If possible, gather all medications before evacuating. Ask the person what medications they are taking and where their medications are stored. Most people keep all their medications in one location in their homes.

- If the person has dementia, turn off emergency lights and sirens if possible. Identify yourself and explain why you are there. Speak slowly, using short words in a calm voice. Ask "yes" or "no" questions: repeat them if necessary. Maintain eye contact.

People with Service Animals

Traditionally, the term "service animal" referred to seeing-eye dogs. However, today there are many other types of service animals.

- Remember – a service animal is not a pet.
- Do not touch or give the animal food or treats without the permission of the owner.
- When a dog is wearing its harness, it is on duty. In the event you are asked to take the dog while assisting the individual, hold the leash and not the harness.
- Plan to evacuate the animal with the owner. Do not separate them!
- Service animals are not registered and there is no proof that the animal is a service animal. If the person tells you it is a service animal, treat it as such. However, if the animal is out of control or presents a threat to the individual or others, remove it from the site.

- A person is not required to give you proof of a disability that requires a service animal. You should accept the claim and treat the animal as a service animal. If you have doubts, wait until you arrive at your destination and address the issue with the supervisor in charge.

- The animal need not be specially trained as a service animal. People with psychiatric and emotional disabilities may have a companion animal. These are just as important to them as a service animal is to a person with a physical disability – please be understanding and treat the animal as a service animal.

- A service animal must be in a harness or on a leash, but need not be muzzled.

People with Mobility Impairments

- Always ask the person how you can help before beginning any assistance. Even though it may be important to evacuate quickly, respect their independence to the extent possible. Don't make assumptions about the person's abilities.
- Ask if they have limitations or problems that may affect their safety.
- Some people may need assistance getting out of bed or out of a chair, but CAN then proceed without assistance. Ask!
- Here are some other questions you may find helpful.
  - "Are you able to stand or walk without the help of a mobility device like a cane, walker or a wheelchair?"
  - "You might have to [stand] [walk] for quite awhile on your own. Will this be ok? Please be sure and tell someone if you think you need assistance."
  - "Do you have full use of your arms?"
- When carrying the person, avoid putting pressure on his or her arms, legs or chest. This may result in spasms, pain, and may even interfere with their ability to breathe.

- Avoid the "fireman's carry." Use the one or two person carry techniques.

Crutches, Canes or Other Mobility Devices

- A person using a mobility device may be able to negotiate stairs independently. One hand is used to grasp the handrail while the other hand is used for the crutch or cane. Do not interfere with the person's movement unless asked to do so, or the nature of the emergency is such that absolute speed is the primary concern. If this is the case, tell the person what you'll need to do and why.
- Ask if you can help by offering to carry the extra crutch.
- If the stairs are crowded, act as a buffer and run interference for the person.

Evacuating Wheelchair Users

- If the conversation will take more than a few minutes, sit or kneel to speak to the person at eye level.
- Wheelchair users are trained in special techniques to transfer from one chair to another. Depending on their upper body strength, they may be able to do much of the work themselves.
- Before you assume you need to help, or what that help should be, ask the person what help they need.

Carrying Techniques for Non-Motorized Wheelchairs

- The in-chair carry is the most desirable technique to use, if possible.
  - **One-person assist**
    - Grasp the pushing grips, if available.
    - Stand one step above and behind the wheelchair.
    - Tilt the wheelchair backward until a balance (fulcrum) is achieved.
    - Keep your center of gravity low.
    - Descend frontward.
    - Let the back wheels gradually lower to the next step.
  - **Two-person assist**
    - Position the second rescuer in front of the wheelchair and face the wheelchair.
    - Stand one, two, or three steps down (depending on the height of the other rescuer).
    - Grasp the frame of the wheelchair.
    - Push into the wheelchair.
    - Descend the stairs backwards.

Motorized Wheelchairs

- Motorized wheelchairs may weigh over 100 pounds unoccupied, and may be longer than manual wheelchairs. Lifting a motorized wheelchair and user up or down stairs requires two to four people.

- People in motorized wheelchairs probably know their equipment much better than you do! Before lifting, ask about heavy chair parts that can be temporarily detached, how you should position yourselves, where you should grab hold, and what, if any, angle to tip the chair backward.

- Turn the wheelchair's power off before lifting it.

- Most people who use motorized wheelchairs have limited arm and hand motion. Ask if they have any special requirements for being transported up or down the stairs.

People With Autism

Communication

- Speak calmly - use direct, concrete phrases with no more than one or two steps, or write brief instructions on a pad if the person can read.
- Allow extra time for the person to respond.
- The person may repeat what you have said, repeat the same phrase over and over, talk about topics unrelated to the situation, or have an unusual or monotone voice. This is their attempt to communicate, and is not meant to irritate you or be disrespectful.
- Avoid using phrases that have more than one meaning such as "spread eagle" "knock it off" or "cut it out".
- Visually check to see if there is a wrist or arm tattoo or bracelet that identifies the person as having an autism spectrum disorder.
- Some people with autism don't show indications of pain - check for injuries.

Social

- Approach the person in a calm manner. Try not to appear threatening.
- The person may not understand typical social rules, so may be dressed oddly, invade your space, prefer to be farther away from you than typical, or not make eye contact. It's best not to try and point out or change these behaviors unless it's absolutely necessary.

- The person may also look at you at an odd angle, laugh or giggle inappropriately, or not seem to take the situation seriously. Do not interpret these behaviors as deceit or disrespect.
- Because of the lack of social understanding, persons with autism spectrum disorders may display behaviors that are misinterpreted as evidence of drug abuse or psychosis, defiance or belligerence. Don't assume!

Sensory and Behavior

- If possible, turn off sirens, lights, and remove canine partners. Attempt to find a quiet location for the person, especially if you need to talk with them.
- Avoid touching the person. If possible, it's preferable to gesture or slowly guide the person.
- If the person is showing obsessive or repetitive behaviors, or is fixated on a topic or object, try to avoid stopping these behaviors or taking the object away from them, unless there is risk to self or others.
- Make sure that the person is away from potential hazards or dangers (busy streets, etc.) since they may not have a fear of danger.
- Be alert to the possibility of outbursts or impulsive, unexplained behavior. If the person is not harming themselves or others, wait until these behaviors subside.

People Who are Deaf or Hard of Hearing

- There is a difference between hard of hearing and deaf. People who are hearing impaired vary in the extent of hearing loss they experience. Some are completely deaf, while others can hear some sounds with hearing aids.
- Hearing aids do not guarantee that the person can hear and understand speech. They increase volume, not necessarily clarity.
- If possible, flick the lights when entering an area or room to get their attention.
- Establish eye contact with the individual, not with the interpreter, if one is present.
- Use facial expressions and hand gestures as visual cues.
- Check to see if you have been understood; repeat and rephrase if necessary.
- Offer pencil and paper. Write slowly and let the individual read as you write.
- Written communication may be especially important if you are unable to understand the person's speech.

- Speak slowly and clearly, but do not over-enunciate.
- Do not block your mouth with your hands or an object when speaking.
- Do not allow others to interrupt you while conveying emergency information.
- Be patient – the person may have difficulty understanding the urgency of your message.
- Provide the person with a flashlight to signal their location in the event they are separated from the rescue team. This will facilitate lip-reading or signing in the dark.
- Written communication will work for many people who are deaf. Keep instructions simple, in the present tense and use basic vocabulary. American Sign Language (ASL) is its own language and not a manual form of English. It has its own syntax and grammar. Native ASL users may read and write English as a second language.

People who are Visually Impaired

- There is a difference between visual impairment and blindness. Some people who are "legally blind" have some sight, while others are totally blind.
- Announce your presence and then enter the area.
- Speak naturally and directly to the individual.
- Do not shout.
- Don't be afraid to use words like "see," "look," or "blind."
- State the nature of the emergency and offer the person your arm. As you walk, advise them of any obstacles.
- Offer assistance but let the person explain what help is needed.
- Do not grab or attempt to guide them without first asking them.
- Let the person grasp your arm or shoulder lightly for guidance.

- They may choose to walk slightly behind you to gauge your body's reactions to obstacles.
- Be sure to mention stairs, doorways, narrow passages, ramps, etc. before you come to them.
- When guiding someone to a seat, place the person's hand on the back of the chair.
- If leading several individuals with visual impairments, ask them to guide the person behind them.
- Remember that you'll need to communicate any written information orally.
- When you have reached safety, orient the person to the location and ask if any further assistance is needed.
- If the person has a service animal, don't pet it unless the person says it is okay to do so. Service animals must be evacuated with the person.
  Refer to the tip sheet on People with Service Animals for more information.

People with Cognitive Disabilities

- **Say:**
  - My name is…. I'm here to help you, not hurt you.
  - I am a … (*name your job*)
  - I am here because … (*explain the situation)*
  - I look different than my picture on my badge because … (*for example, if you are wearing protective equipment)*
- **Show:**
  - Your picture identification badge (*as you say the above).*
  - That you are calm and competent.
- **Give:**
  - Extra time for the person to process what you are saying and to respond.
  - Respect for the dignity of the person as an equal and as an adult (*example: speak directly to the person).*
  - If needed, offer an arm to the person to hold as they walk, or an elbow for balance.
  - If possible, quiet time to rest (*as possible, to lower stress and fatigue).*

- **Use:**
  - Short sentences.
  - Simple, concrete words.
  - Accurate, honest information.
  - Pictures and objects to illustrate your words. Point to your ID picture as you say who you are, point to any protective equipment as you speak about it.
- **Predict:**
  - What will happen (*simply and concretely)?*
  - When events will happen (*tie to common events in addition to numbers and time, for example, "By lunch time…" "By the time the sun goes down…").*
  - How long this will last – when things will return to normal (*if you know).*
  - When the person can contact or rejoin loved ones (*for example: calls to family, re-uniting pets)*

- **Ask for/Look for:**
  - An identification bracelet with special health information.
  - Essential equipment and supplies (*for example: wheelchair, walker, oxygen, batteries, communication devices [head pointers, alphabet boards, speech synthesizers, etc.])*
  - Medication
  - Mobility aids (*for example, assistance or service animal)*
  - Special health instructions (*for example: allergies).*
  - Special communication information (*for example, is the person using sign language)?*
  - Contact information.
  - Signs of stress and/or confusion (*for example, the person might say he or she is stressed, look confused, withdraw or start rubbing their hands together).*
  - Conditions that people might misinterpret (*for example, someone might mistake Cerebral Palsy for drunkenness).*
- **Repeat:**
  - Reassurances (*for example, "You may feel afraid. That's ok. We're safe now.")*

- Encouragement (*for example, "Thanks for moving fast. You are doing great. Other people can look at you and know what to do").*
- Frequent updates on what's happening and what will happen next. Refer to what you predicted will happen, for example: "Just like I said before, we're getting into my car now. We'll go to… now".

- **Reduce:**
  - Distractions. For example: lower volume of radio, use flashing lights on vehicle only when necessary.

- **Explain:**
  - Any written material (*including signs)* in everyday language.
  - Public address system announcements in simple language.

- **Share:**
  - The information you've learned about the person with other workers who'll be assisting the person.

People With Multiple Chemical Sensitivities

- Reassure the person that you understand he or she is chemically sensitive and will work with him or her. Be sure to ask what the person is sensitive to, including his or her history of reactions to various drugs you may have to administer.
- Flag the person's chart or other written information that he or she is chemically sensitive.
- Whenever possible, take the person's own medical supplies and equipment with them, including oxygen mask and tubing, medications, food and water; bedding, clothing, and soap - he or she may be sensitive to these items if issued at a shelter or hospital.
- If you do administer drugs:
  - Administer low doses with caution.
  - Use IV fluid bottled in glass without dextrose if possible - many people react to corn-based dextrose.
  - Capsules are generally better than tablets - they have fewer binders, fillers and dyes.

- If administering anesthesia, use short-acting regional rather than general anesthesia whenever possible and try to avoid the use of halogenated gas anesthetics.

- If the person is taken to an emergency shelter or a hospital, help protect him or her from air pollution. Some suggestions:

  - Avoid placing the person in rooms with recent pesticide sprays, strong scented disinfectants or cleaners, new paint or carpet, or other recent remodeling.
  - Place a sign on the door stating that the person inside has chemical sensitivities.
  - Assign caregivers who are not wearing perfume or fabric softener on clothes and who are not smokers.
  - Allow the person to wear a mask or respirator, use an air filter, or open a window as needed.
  - Keep the door to the person's room closed, if possible.
  - Reduce time the person spends in other parts of the shelter or hospital.

People Who Are Mentally Ill

- You may not be able to tell if a person is mentally ill until you have begun the evacuation procedure.
- If a person begins to exhibit unusual behavior, ask if they have any mental health issues of which you need to be aware. However, be aware that they may or may not tell you. If you suspect someone has a mental health issue, use the following tips to help you through the situation.
- In an emergency, the person may become confused. Speak slowly and in a normal, calm speaking tone.
- If the person becomes agitated, help them find a quiet corner away from the confusion.
- Keep your communication simple, clear and brief.
- If they are confused, don't give multiple commands – ask or state one thing at a time.
- Be empathetic – show that you have heard them and care about what they have told you. Be reassuring.
- If the person is delusional, don't argue with them or try to "talk them out of it". Just let them know you are there to help them.
- Ask if there is any medication they should take with them.

- Try to avoid interrupting a person who might be disoriented or rambling – just let them know that you have to move quickly.
- Don't talk down to them, yell or shout.
- Have a forward leaning body position – this shows interest and concern.

Childbearing Women and Newborns

Tips for Childbearing Women

- Usually, pregnancy is not an emergency. In fact, if the pregnant woman is otherwise healthy, it's likely that she can be included in any plans for evacuation or sheltering for the general population.
- However, if the woman has had a cesarean section ("C-Section") at any time in the past, or if she has any of the following problems now or in the previous three hours, she is at higher risk.
  - Steady bleeding "like a period" from the vagina
  - Convulsion or a really bad (unusual) headache that will not go away with Tylenol
  - Constant strong belly or back pain with hardness in her pregnant belly
  - Strong pains and hardening belly that comes and goes every couple of minutes and a "due date" three weeks away or more
    - If she has had any of these problems, she should be taken to a hospital (if hospital access is available) or other health care facility for an assessment. If taking her to a facility is not possible, she should be helped to find a comfortable position and not be left alone.

- If she has not had these problems, the hospital is often not the best place to take pregnant women, women in labor or new mothers with newborns due to danger from infections or other exposures. Remember: a normal birth is not an illness.

- A woman who has one or more of the symptoms below may be in labor and about to give birth. Do not move her - it is better to have a birth where you are than on the way to somewhere else.
  - Making grunting sounds every one to three minutes.
  - She says "yes" if you ask "Is the baby pushing down?" or she says, "The baby's coming."
  - You see bulging out around the vagina when she grunts or bears down.
- Give pregnant women and new moms lots of fluids to drink (water or juice is best).
- Be as calming as possible; expectant mothers may be especially anxious in emergency situations. Reassure them you will do everything you can for them.
- Try not to separate expectant or newly delivered moms and their family, even if transporting.

- If you must transport a pregnant woman, regardless of whether she is in labor or not:
  - Transport her lying on her side, not flat on her back
  - Ask her if she has a copy of her pregnancy/prenatal records; if she does, make sure they are brought with her.

Tips for Just After a Baby has Been Born

- Dry and rub the baby gently to keep baby warm and to stimulate breathing.
- Place the naked baby on mother's skin between her breasts and cover both mom and baby.
- Cutting the cord is not an emergency. The cord should only be cut when you have sterile tools (scissor, knife blade, etc.). It's better to wait rather than cut the cord with a non-sterile blade.
- Usually, the placenta (afterbirth) will follow the baby on its own in about a half an hour or less. After it comes, it can be put in a plastic bag, wrapped with the baby or left behind, depending on the circumstances.

- Monitor bleeding from the vagina. Some bleeding is normal - like a heavy period. It should slow down to a trickle within 5 to 10 minutes. If it doesn't, the woman needs medical care.
- Encourage mom to put baby to breast. The baby's hands should be free to help find the breast. Point baby's nose toward mom's nipple and the baby's tummy toward mom's.
- If you need to transport a mother and her newly born baby:
  - Keep the mom and newborn together: baby in mom's arms or on her belly
  - Take diapers, baby clothes and formula and bottles (if mom is bottle feeding the baby) if they are available.

People with Seizure Disorders

- Some types of seizures have warning symptoms while others do not. Warning symptoms may include visual or auditory hallucinations, or the person notices a burning smell. If the person senses an upcoming seizure, suggest they lie down and provide help if asked.
- Stay calm - talk with the person softly, and rub the person's arm or back gently
- If possible, look at a watch or a clock to time the duration of the seizure. After the seizure is over, give this information to the person. If the seizure lasts more than five minutes or the person does not resume consciousness, call 911.
- Attempt to turn the individual on her/his side; preferably the left side to allow saliva or other substances to drain from the mouth and keep the airway open.
- Move any nearby objects away from the person that could lead to injury if the person hits the object, or see if the person can be moved if they are near hard objects too heavy to move. You may place a pillow, towel, coat or other soft object underneath the person's head to protect it.

- Loosen clothing around neck when jerking is over, remove glasses if the person wears them.

- If breathing stops, call 911 and start CPR. Please note that you must be certified to perform CPR.

- DO NOT restrain the person – the seizure will end naturally.

- DO NOT try to force the mouth open with any hard implement or fingers. A person cannot swallow their tongue. Efforts to hold the tongue down can injure the teeth or jaw.

People with Brain Injuries

- Brain injury is sometimes called the "hidden disability" as you may not be able to tell that a person has a brain injury during your initial contact with them. Most people with brain injuries will be able to tell you that this is their disability.
- Some people with brain injuries have memory lapses, become excited or have trouble concentrating, especially in places with lots of distractions. If you can, move with the person to a quiet location to talk with them.
- Approach the person in a calm manner, explaining your role in a non-threatening way.
- Use direct, concrete phrases. Avoid long, complicated sentences where possible, and allow extra time for the person to respond.
- Some people with brain injuries may need to have information repeated more than once.
- They may not be able to report events in a sequence. If you need to know what happened, ask them step-by-step questions. Ask "what was the first thing that happened?" and then "can you tell me what happened next?"

- Some people with brain injuries may not be able to tell you the names of medications they're taking. Ask them to describe the shape and color of the medication instead.

- You can also ask them if they have memory aids. Many people with brain injuries will recognize the phrases "i-map" (Individualized Medical Assistance Portfolio) or "Retrain My Brain" tool kit. These usually have medications and other information about the person written down in them.

- Some symptoms of brain injury can mimic behaviors associated with drug or alcohol abuse, such as balance problems, slurred speech, paranoia or even belligerence if the person becomes agitated. Don't assume!

- If possible, turn off sirens and lights if you're transporting someone with a brain injury, as these can provoke a seizure.

COMMONLY ASKED QUESTIONS
ABOUT THE AMERICANS WITH DISABILITIES ACT
AND LAW ENFORCEMENT

I. Introduction

Police officers, sheriff's deputies, and other law enforcement personnel have always interacted with persons with disabilities and, for many officers and deputies, the Americans with Disabilities Act (ADA) may mean few changes in the way they respond to the public. To respond to questions that may arise, this document offers common sense suggestions to assist law enforcement agencies in complying with the ADA. The examples presented are drawn from real-life situations as described by police officers or encountered by the Department of Justice in its enforcement of the ADA.

1. Q: What is the ADA?

A: The Americans with Disabilities Act (ADA) is a Federal civil rights law. It gives Federal civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in State and local government services, public accommodations, employment, transportation, and telecommunications.

2. Q: How does the ADA affect my law enforcement duties?

A: Title II of the ADA prohibits discrimination against people with disabilities in State and local governments' services, programs, and employment. Law enforcement agencies are covered because they are programs of State or local governments, regardless of whether they receive Federal grants or other Federal funds. The ADA affects virtually everything that officers and deputies do, for example:

- receiving citizen complaints;
- interrogating witnesses;
- arresting, booking, and holding suspects;
- operating telephone (911) emergency centers;
- providing emergency medical services;
- enforcing laws;
- and other duties.

3. Q: Who does the ADA protect?

A: The ADA covers a wide range of individuals with disabilities. An individual is considered to have a "disability" if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

Major life activities include such things as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. To be substantially limited means that such activities are restricted in the manner, condition, or duration in which they are performed in comparison with most people.

- The ADA also protects people who are discriminated against because of their association with a person with a disability.

Example: Police receive a call from a woman who complains that someone has broken into her residence. The police department keeps a list of dwellings where people with AIDS are known to reside. The woman's residence is on the list because her son has AIDS. Police fail to respond to her call, because they fear catching the HIV virus. The officers have discriminated against the woman on the basis of her association with an individual who has AIDS.

4. Q: What about someone who uses illegal drugs?

A: Nothing in the ADA prevents officers and deputies from enforcing criminal laws relating to an individuals current use or possession of illegal drugs.

II. Interacting with People with Disabilities

5. Q: What are some common problems that people with disabilities have with law enforcement?

A: Unexpected actions taken by some individuals with disabilities may be misconstrued by officers or deputies as suspicious or illegal activity or uncooperative behavior.

Example: An officer approaches a vehicle and asks the driver to step out of the car. The driver, who has a mobility disability, reaches behind the seat to retrieve her assistive device for walking. This appears suspicious to the officer.

- Individuals who are deaf or hard of hearing, or who have speech disabilities or mental retardation, or who are blind or visually impaired may not recognize or be able to respond to police directions. These individuals may erroneously be perceived as uncooperative.

Example: An officer yells "freeze" to an individual who is running from an area in which a crime has been reported. The individual, who is deaf, cannot hear the officer and continues to run. The officer mistakenly believes that the individual is fleeing from the scene. Similarly, ordering a suspect who is visually impaired to get over "there" is likely to lead to confusion and misunderstanding, because the suspect may have no idea where the officer is pointing.

- Some people with disabilities may have a staggering gait or slurred speech related to their disabilities or the medications they take. These characteristics, which can be associated with neurological disabilities, mental/emotional disturbance, or hypoglycemia, may be misperceived as intoxication.

Example: An officer observes a vehicle with one working headlight and pulls the vehicle over. When the driver hands the registration to the officer, the officer notices that the driver's hand is trembling and her speech is slurred. The officer concludes that the individual is under the influence of alcohol, when in fact the symptoms are caused by a neurological disability.

Example: A call comes in from a local restaurant that a customer is causing a disturbance. When the responding officer arrives at the scene, she discovers a 25-year-old man swaying on his feet and grimacing. He has pulled the table cloth from the table. The officer believes that the man has had too much to drink and is behaving aggressively, when in fact he is having a seizure.

What can be done to avoid these situations?

Training, sensitivity, and awareness will help to ensure equitable treatment of individuals with disabilities as well as effective law enforcement. For example:

- When approaching a car with visible signs that a person with a disability may be driving (such as a designated license plate or a hand control) , the police officer should be aware that the driver may reach for a mobility device.

- Using hand signals, or calling to people in a crowd to signal for a person to stop, may be effective ways for an officer to get the attention of a deaf individual.

- When speaking, enunciate clearly and slowly to ensure that the individual understands what is being said.

- Finally, typical tests for intoxication, such as walking a straight line, will be ineffective for individuals whose disabilities cause unsteady gait. Other tests, like breathalyzers, will provide more accurate results and reduce the possibility of false arrest.

6. Q: What if someone is demonstrating threatening behavior because of his or her disability?

A: Police officers may, of course, respond appropriately to real threats to health or safety, even if an individual's actions are a result of her or his disability. But it is important that police officers are trained to distinguish behaviors that pose a real risk from behaviors that do not, and to recognize when an individual, such as someone who is having a seizure or exhibiting signs of psychotic crisis, needs medical attention. It is also important that behaviors resulting from a disability not be criminalized where no crime has been committed. Avoid these scenarios:

- A store owner calls to report that an apparently homeless person has been in front of the store for an hour, and customers are complaining that he appears to be talking to himself. The individual, who has mental illness, is violating no loitering or panhandling laws. Officers arriving on the scene arrest him even though he is violating no laws.

- Police receive a call in the middle of the night about a teenager with mental illness who is beyond the control of her parents. All attempts to get services for the teenager at that hour fail, so the responding officer arrests her until he can get her into treatment. She ends up with a record, even though she committed no offense.

7. Q: What procedures should law enforcement officers follow to arrest and transport a person who uses a wheelchair?

A: Standard transport practices may be dangerous for many people with mobility disabilities. Officers should use caution not to harm an individual or damage his or her wheelchair. The best approach is to ask the person what type of transportation he or she can use, and how to lift or assist him or her in transferring into and out of the vehicle.

Example: An individual with a disability is removed from his wheelchair and placed on a bench in a paddy wagon. He is precariously strapped to the bench with his own belt. When the vehicle begins to move, he falls off of the bench and is thrown to the floor of the vehicle where he remains until arriving at the station.

- Some individuals who use assistive devices like crutches, braces, or even manual wheelchairs might be safely transported in patrol cars.

- Safe transport of other individuals who use manual or power wheelchairs might require departments to make minor modifications to existing cars or vans, or to use lift-equipped vans or buses. Police departments may consider other community resources, e.g., accessible taxi services.

8. Q: What steps should officers follow to communicate effectively with an individual who is blind or visually impaired?

A: It is important for officers to identify themselves and to state clearly and completely any directions or instructions -- including any information that is posted visually. Officers must read out loud in full any documents that a person who is blind or visually impaired needs to sign. Before taking photos or fingerprints, it is a good idea to describe the procedures in advance so that the individual will know what to expect.

9. Q: Do police personnel need to take special precautions when providing emergency medical services to someone who has HIV or AIDS?

A: Persons with HIV or AIDS should be treated just like any other person requiring medical attention. In fact, emergency medical service providers are required routinely to treat all persons as if they are infectious for HIV, Hepatitis B, or other blood borne pathogens, by practicing universal precautions. Many people do not know that they are infected with a blood borne pathogen, and there are special privacy considerations that may cause those who know they are infected not to disclose their infectious status.

- Universal precautions for emergency service providers include the wearing of gloves, a mask, and protective eyewear, and, where appropriate, the proper disinfection or disposal of contaminated medical equipment. Protective barriers like gloves should be used whenever service providers are exposed to blood.

Example: Police are called to a shopping mall to assist a teenager who has cut his hand and is bleeding profusely. As long as the attending officers wear protective gloves, they will not be at risk of acquiring HIV, Hepatitis B, or any other bloodborne pathogen, while treating the teenager.

- Refusing to provide medical assistance to a person because he or she has, or is suspected of having, HIV or AIDS is discrimination.

Example: Police are called to a shopping mall, where an individual is lying on the ground with chest pains. The responding officer asks the individual whether she is

currently taking any medications. She responds that she is taking AZT, a medication commonly prescribed for individuals who are HIV-positive or have AIDS. The officer announces to his colleagues that the individual has AIDS and refuses to provide care. This refusal violates the ADA.

III. Effective Communication

10. Q: Do police departments have to arrange for a sign language interpreter every time an officer interacts with a person who is deaf?

A: No. Police officers are required by the ADA to ensure effective communication with individuals who are deaf or hard of hearing. Whether a qualified sign language interpreter or other communication aid is required will depend on the nature of the communication and the needs of the requesting individual. For example, some people who are deaf do not use sign language for communication and may need to use a different communication aid or rely on lip-reading. In one-on-one communication with an individual who lip-reads, an officer should face the individual directly, and should ensure that the communication takes place in a well-lighted area.

- Examples of other communication aids, called "auxiliary aids and services" in the ADA, that assist people who are deaf or hard of hearing include the exchange of written notes, telecommunications devices for the deaf (TDD's) (also called text telephones (TT's) or teletypewriters (TTY's)), telephone handset amplifiers, assistive listening systems, and videotext displays.

- The ADA requires that the expressed choice of the individual with the disability, who is in the best position to know her or his needs, should be given primary consideration in determining which communication aid to provide. The ultimate decision is made by the police department. The department should honor the individual's choice unless it can demonstrate that another effective method of communication exists.

- Police officers should generally not rely on family members, who are frequently emotionally involved, to provide sign language interpreting.

Example: A deaf mother calls police to report a crime in which her hearing child was abused by the child's father. Because it is not in the best interests of the mother or the child for the child to hear all of the details of a very sensitive, emotional situation, the mother specifically requests that the police officers procure a qualified sign language interpreter to facilitate taking the report. Officers ignore her request and do not secure the services of an interpreter. They instead communicate with the hearing child, who then signs to the mother. The police department in this example has violated the ADA

because it ignored the mothers request an inappropriately relied on a family member to interpret.

- In some limited circumstances a family member may be relied upon to interpret.

Example: A family member may interpret in an emergency, when the safety or welfare of the public or the person with the disability is of paramount importance. For example, emergency personnel responding to a car accident may need to rely on a family member to interpret in order to evaluate the physical condition of an individual who is deaf. Likewise, it may be appropriate to rely on a family member to interpret when a deaf individual has been robbed and an officer in hot pursuit needs information about the suspect.

Example: A family member may interpret for the sake of convenience in circumstances where an interpreter is not required by the ADA, such as in situations where exchanging written notes would be effective. For example, it would be appropriate to rely on a passenger who is a family member to interpret when an individual who is deaf is asking an officer for traffic directions, or is stopped for a traffic violation.

11. Q: If the person uses sign language, what kinds of communication will require an interpreter?

A: The length, importance, or complexity of the communication will help determine whether an interpreter is necessary for effective communication.

- In a simple encounter, such as checking a driver's license or giving street directions, a notepad and pencil normally will be sufficient.

- During interrogations and arrests, a sign language interpreter will often be necessary to effectively communicate with an individual who uses sign language.

- If the legality of a conversation will be questioned in court, such as where Miranda warnings are issued, a sign language interpreter may be necessary. Police officers should be careful about miscommunication in the absence of a qualified interpreter -- a nod of the head may be an attempt to appear cooperative in the midst of misunderstanding, rather than consentor a confession of wrongdoing.

- In general, if an individual who does not have a hearing disability would be subject to police action without interrogation, then an interpreter will not be required, unless one is necessary to explain the action being taken.

Example: An officer clocks a car on the highway driving 15 miles above the speed limit. The driver, who is deaf, is pulled over and issued a noncriminal citation. The individual is able to understand the reasons for the citation, because the officer exchanges written notes with the individual and points to information on the citation. In this case, a sign language interpreter is not needed.

Example: An officer responds to an aggravated battery call and upon arriving at the scene observes a bleeding victim and an individual holding a weapon. Eyewitnesses observed the individual strike the victim. The individual with the weapon is deaf, but the officer has probable cause to make a felony arrest without an interrogation. In this case, an interpreter is not necessary to carry out the arrest.

12. Q: Do I have to take a sign language interpreter to a call about a violent crime in progress or a similar urgent situation involving a person who is deaf?

A: No. An officer's immediate priority is to stabilize the situation. If the person being arrested is deaf, the officer can make an arrest and call for an interpreter to be available later at the booking station.

13. Q: When a sign language interpreter is needed, where do I find one?

A: Your department should have one or more interpreters available on call. This is generally accomplished through a contract with a sign language interpreter service. Communicating through sign language will not be effective unless the interpreter is familiar with the vocabulary and terminology of law enforcement, so your department should ensure that the interpreters it uses are familiar with law enforcement terms.

14. Q: Is there any legal limit to how much my department must spend on communication aids like interpreters?

A: Yes. Your department is not required to take any step that would impose undue financial and administrative burdens. The "undue burden" standard is a high one. For example, whether an action would be an undue financial burden is determined by considering all of the resources available to the department. If providing a particular auxiliary aid or service would impose an undue burden, the department must seek alternatives that ensure effective communication to the maximum extent feasible.

15. Q: When would an officer use an assistive listening device as a communication aid?

A: Assistive listening systems and devices receive and amplify sound and are used for communicating in a group setting with individuals who are hard of hearing.

- At headquarters or a precinct building, if two or more officers are interrogating a witness who is hard of hearing, or in meetings that include an individual who is hard of hearing, an assistive listening device may be needed.

16. Q: What is a TDD and does every police station have to have one?

A: A telecommunications device for the deaf (TDD) is a device used by individuals with hearing or speech disabilities to communicate on the telephone. A TDD is a keyboard with a display for receiving typed text that can be attached to a telephone. The TDD user types a message that is received by another TDD at the other end of the line.

- Arrestees who are deaf or hard of hearing, or who have speech disabilities, may require a TDD for making outgoing calls. TDD's must be available to inmates with disabilities under the same terms and conditions as telephone privileges are offered to all inmates, and information indicating the availability of the TDD should be provided.

- TDDs typically cost $200-300 each and can be used with a standard telephone. It is unlikely that the cost of purchasing a TDD will be prohibitive. Still, a small department with limited resources could arrange to share a TDD with a local courthouse or other entity, so long as the TDD is immediately available as needed.

17. Q. What about "911" calls? How are those made accessible to people with speech or hearing disabilities?

A: Individuals with hearing and speech disabilities must have direct access to "911" or similar emergency telephone services, meaning that emergency response centers must be equipped to receive calls from TDD and computer modem users without relying on third parties or state relay services. It is important that operators are trained to use the TDD when the caller is silent, and not only when the operator recognizes the tones of a TDD at the other end of the line. For additional information, please refer to the Department of Justices publication, *Commonly Asked Questions Regarding Telephone Emergency Services*. For information about how to obtain this and other publications, see the resources section at the end of this document.

18. Q: Procedures at my office require citizens to fill out forms when reporting crimes. What if the person has a vision disability, a learning disability, mental retardation or some other disability that may prevent the person from filling out a form?

A: The simplest solution is to have an officer or clerk assist the person in reading and filling out the form. Police officers have probably been doing this for years. The form itself could also be provided in an alternative format. Providing a copy of the form in large print (which is usually as simple as using a copy machine or computer to increase type size) will make the form accessible to many individuals with moderate vision disabilities.

IV. Architectural Access

19. Q: Does the ADA require all police stations to be accessible to people with disabilities?

A: No. Individuals with disabilities must have equal access to law enforcement services, but the ADA is flexible in how to achieve that goal. The ADA requires programs to be accessible to individuals with disabilities, not necessarily each and every facility. Often, structural alterations to an existing police station or sheriffs office will be necessary to create effective access. In some situations, however, it may be as effective to use alternative methods, such as relocating a service to an accessible building, or providing an officer who goes directly to the individual with the disability. Whatever approach to achieving "program access" is taken, training of officers and deputies, well-developed policies, and clear public notice of the approach will be critical to ensuring successful ADA compliance.

Example: A police station in a small town is inaccessible to individuals with mobility disabilities. The department decides that it cannot alter all areas of the station because of insufficient funds. It decides to alter the lobby and restrooms so that the areas the public uses -- for filling out crime reports, obtaining copies of investigative reports for insurance purposes, or seeking referrals to shelter care -- are accessible. Arrangements are made to conduct victim and witness interviews with individuals with disabilities in a private conference room in the local library or other government building, and to use a neighboring department's accessible lock-up for detaining suspects with disabilities. These measures are consistent with the ADA's program accessibility requirements.

Example: An individual who uses a wheelchair calls to report a crime, and is told that the police station is inaccessible, but that the police department has a policy whereby a police officer will meet individuals with disabilities in the parking lot.

The individual arrives at the parking lot, waits there for three hours, becomes frustrated, and leaves. By neglecting to adequately train officers about its policy, the police department has failed in its obligation to provide equal access to police services, and has lost valuable information necessary for effective law enforcement.

20. Q: What about holding cells and jails that are not accessible?

A: An arrestee with a mobility disability must have access to the toilet facilities and other amenities provided at the lock-up or jail. A law enforcement agency must make structural changes, if necessary, or arrange to use a nearby accessible facility.

- Structural changes can be undertaken in a manner that ensures officer safety and general security. For example, grab bars in accessible restrooms can be secured so that they are not removable.

- If meeting and/or interrogation rooms are provided, those areas should also be accessible for use by arrestees, family members, or legal counsel who have mobility disabilities.

21. Q: Is there a limit to the amount of money my agency must spend to alter an existing police facility?

A: Yes. It is the same legal standard of "undue burden" discussed earlier with regard to the provision of communication aids. Your agency is not required to undertake alterations that would impose undue financial and administrative burdens. If an alteration would impose an "undue burden", the agency must choose an alternative that ensures access to its programs and services.

22. Q. We are building a new prison. Do we need to make it accessible?

A: Yes. All new buildings must be made fully accessible to, and usable by, individuals with disabilities. The ADA provides architectural standards that specify what must be done to create access.

- Either the Uniform Federal Accessibility Standards (UFAS) or the ADA Standards for Accessible Design (without the elevator exemption) (ADA Standards) may be used. UFAS has specific scoping requirements for prisons that require, among other things, that 5% of all cells be made accessible to individuals with mobility disabilities.

- Unlike modifications of existing facilities, there is no undue burden limitation for new construction.

- In addition, if an agency alters an existing facility for any reason -- including reasons unrelated to accessibility -- the altered areas must be made accessible to individuals with disabilities.

V. Modifications of Policies, Practices, and Procedures

23. Q: What types of modifications in law enforcement policies, practices, and procedures does the ADA require?

A: The ADA requires law enforcement agencies to make reasonable modifications in their policies, practices, and procedures that are necessary to ensure accessibility for individuals with disabilities, unless making such modifications would fundamentally alter the program or service involved. There are many ways in which a police or sheriffs department might need to modify its normal practices to accommodate a person with a disability.

Example: A department modifies a rule that prisoners or detainees are not permitted to have food in their cells excet at scheduled intervals, in order to accommodate an individual with diabetes who uses medication and needs access to carbohydrates or sugar to keep blood sugar at an appropriate level.

Example: A department modifies its enforcement of a law requiring a license to use motorized vehicles on the streets, in order to accommodate individuals who use scooters or motorized wheelchairs. Such individuals are pedestrians, but may need to use streets where curb cuts are unavailable.

Example: A department modifies its regular practice of handcuffing arrestees behind their backs, and instead handcuffs deaf individuals in front in order for the person to sign or write notes.

Example: A department modifies its practice of confiscating medications for the period of confinement, in order to permit inmates who have disabilities that require self-medication, such as cardiac conditions or epilepsy, to self-administer medications that do not have abuse potential.

Example: A department modifies the procedures for giving Miranda warnings when arresting an individual who has mental retardation. Law enforcement personnel use simple words and ask the individual to repeat each phrase of the warnings in her or his own words. The personnel also check for understanding, by asking the individual such questions as what a lawyer is and how a lawyer might help the individual, or asking the individual for an example of what a right is. Using simple language or pictures and symbols, speaking slowly and clearly, and asking concrete

questions, are all ways to communicate with individuals who have mental retardation.

- Informal practices may also need to be modified. Sometimes, because of the demand for police services, third party calls are treated less seriously. Police officers should keep in mind that calling through a third party may be the only option for individuals with certain types of disabilities.

VI. Resources

24. Q: It sounds like awareness and training are critical for effective interaction with individuals with disabilities. How can I find out more about the needs of my local disability community?

A: State and local government entities were required, by January 26, 1993, to conduct a "self-evaluation" reviewing their current services, policies, and practices for compliance with the ADA. Entities employing 50 or more persons were also to develop a "transition plan" identifying structural changes that needed to be made. As part of that process, the ADA encouraged entities to involve individuals with disabilities from their local communities. Continuing this process will promote access solutions that are reasonable and effective. Even though the deadlines for the self-evaluation, transition plan, and completion of structural changes have passed, compliance with the ADA is an ongoing obligation.

25. Q: Where can I turn for answers to other questions about the ADA?

A: The Department of Justice's toll-free ADA Information Line answers questions and offers free publications about the ADA. The telephone numbers are: 800-514-0301 (voice) or 800-514-0383 (TTY). Publications are also available from the ADA Website www.ada.gov.

U.S. Department of Justice
Civil Rights Division
Disability Rights Section

Instructor/Presenter Bios

Jennifer Earheart, MA

Jennifer is the Project Coordinator for the CIT Knowledge Network, a collaborative project launched in 2016 by APD, UNM's Department of Psychiatry and Behavioral Sciences, and Project ECHO. Jennifer received her Master's in Applied Anthropology from the University of Memphis in 2013 and has worked on several research studies since then. If you are interested in joining the CIT Knowledge Network please email her at jearheart@cabq.gov.

Sgt. John Gonzales

John has been with the Albuquerque Police department since 2004. He is the Sergeant for the Crisis Intervention Unit and the Crisis Outreach and Support Team, overseeing the Crisis Intervention Team program and training. He received his Bachelors of Arts in Criminology from the University of New Mexico. He has been part of APD training since 2007.

Celina Lopez

Celina has worked with the City Of Albuquerque since 1997 where she was a trainer for computer and job development skills plus was a family development specialist. She became a crisis specialist for APD when the Crisis Outreach and Support Team started in 2006.

Mark Oberman

Mark works for the Albuquerque Police Department Crisis Intervention Team as a Crisis Outreach Clinician. He is an independently licensed counselor in the state of New Mexico. Previously he worked with the University of New Mexico Psychiatric Hospital as a discharge planner on the adult psychiatric wards. Mark has a BA from Florida Atlantic University in Boca Raton, Florida in Organizational Change and Development and a Master's from Webster University in Counseling.

Nils Rosenbaum, MD

Nils has worked with the Albuquerque Police Department since 2007 and is clinical director for the CIU. He is a volunteer attending physician with UNM, a medical provider for High Dessert Family Services, and is a staff psychiatrist for Kaseman Hospital. He has won NAMI New Mexico's outstanding psychiatrist award.

Det. Lawrence Saavedra

Lawrence has spent 24 years in law enforcement. He has served as an Albuquerque Aviation Police Officer, Sandoval County Sheriff's Deputy, and is currently a Detective with the Albuquerque Police Department. In APD he has served as a patrol officer, a field training officer, a crisis intervention detective, a school resource officer, and was a primary negotiator on the crisis negotiation team. Lawrence has trained law enforcement officers in crisis intervention and crisis de-escalation since 2006

Detective Tasia Sullivan

Tasia has been with the Albuquerque Police Department since 2009. She is Basic and Advanced Crisis Intervention Certified, Basic Crisis Negotiations Certified and Mental Health First Aid Certified. Tasia received a Bachelor of Arts in Sociology and Criminology from University of New Mexico. She was a volunteer at the Agora Crisis Center during her time at UNM. She also spent 2 years as a Child Abuse Investigator for the NM Children, Youth and Families Department.

Detective Matthew Tinney

Matthew is a Detective with the Albuquerque Police Department's Crisis Intervention Unit and a primary negotiator for the Crisis Negotiations Team. He began his career with the City of Albuquerque in 2004, joining the police department in 2006. He has received the CIT Officer of the Year Award. Matthew holds master instructor certifications in crisis intervention, dispute intervention behavior management, barricaded hostage situations, and handling of the mentally ill.

Lt. Zachary L Wesley

Zachary began his career in Law Enforcement in 1999 with the North Little Rock Police Department. In 2001 he joined the Albuquerque Police Department. Zachary obtained a Bachelor of University Studies in 2002 from the University of New Mexico. He is the lieutenant for the Crisis Intervention Unit and the Crisis Outreach and Support Team, overseeing the Crisis Intervention Team program and training.