Interactions with Persons with Mental Impairments

Version: [NM260005]

INSTRUCTOR LESSON

Version: [NM260005]

Lesson Purpose: Provide the student with awareness of crisis management, including crisis intervention, confrontation, de-escalation practicum and proper interaction with persons with mental impairments.

Learning Objectives: During this lesson, students will receive information and instruction on how to do the following:

1. Identify and understand House Bill 93 and sections of the bill
2. Identify and understand crisis management and intervention
3. Identify proper interaction and de-escalation with persons with mental impairments
4. Identify how to gather critical information between dispatch and officers to maximize safety

Hours: 2

Instructional Methods: in-person

Required Materials, Aids & Equipment: computer

Videos: A&E. 2023. “Officers Reunite Special Needs Person with His Family | Nightwatch | A&E.” Video. *YouTube*. https://www.youtube.com/watch?v=vtTEVAGCgHM.

Autism Family. 2023. “Autistic Stimming Defined.” Video. *YouTube*. https://www.youtube.com/watch?v=_brSCemI6ZM.

Community Networks of Specialized Care. 2017. “Communicating Effectively with Individuals with Developmental Disabilities.” Video. *YouTube*. https://www.youtube.com/watch?v=Roc3_gOOHZ4.

InsideFWPD. 2018. “Autism Interaction Training Video (Final).” Video. *YouTube*. https://www.youtube.com/watch?v=QI4tz86QuZA.

National Autistic Society. 2016. “Autism TMI Virtual Reality Experience.” Video. *YouTube*. https://www.youtube.com/watch?v=DgDR_gYk_a8.

NBIA BC. 2015. “Police Responding to Persons with a Brain Injury.” Video. *YouTube*. https://www.youtube.com/watch?v=pWgkfthA8dw.

Sprouts. 2025. “Living with Bipolar Disorder: Signs, Symptoms & Everyday Life.” Video. *YouTube*. https://www.youtube.com/watch?v=MOkip7IamH0.

TMJ4 News. 2014. “A Closer Look at Treating PTSD in Kids.” Video. *YouTube*. https://www.youtube.com/watch?v=BLI4VI2FXY4.

WebMD. 2017a. “My Life with Bipolar – Bipolar Disorder: In Our Own Words | WebMD.” Video. *YouTube*. https://www.youtube.com/watch?v=qM5U7sFefi4.

WebMD. 2017b. “Living with Schizophrenia: Management, Support & Hope | WebMD.” Video. *YouTube*. https://www.youtube.com/watch?v=C7JI9_59tfY.

Testing Requirements: End-of-topic online test

References:

Behavior. (2021, April 12). 5 words to avoid when helping Students De-Escalate - Miss behavior. Miss Behavior. https://www.missbehaviorblog.com/5-words-to-avoid-when-helping-students/

Hutson, H., Anglin, D., Yarbrough, J., Hardaway, K., Russell, M., Strote, J., Canter, M., & Blum, B. (1998). Suicide by cop. Annals of Emergency Medicine, 32(6), 665–669. https://doi.org/10.1016/s0196-0644(98)70064-2

James, A. (2019, May 31). Police are our safety net for the mentally ill in crisis. Chicago Tribune.

https://www.chicagotribune.com/2018/04/10/police-are-our-safety-net-for-the-mentally-ill-in-crisis/

Khan, H., Miller, M., Barber, C., & Azrael, D. (2024). Fatal Police Shootings of Victims with Mental Health Crises: A Descriptive Analysis of Data from the 2014–2015 National Violent Death Reporting System. Journal of Urban Health, 101(2), 262–271. https://doi.org/10.1007/s11524-024-00833-3

Mental illness. (n.d.). National Institute of Mental Health (NIMH). https://www.nimh.nih.gov/health/statistics/mental-illness

[Authored / Revised / Reviewed] By:

[A scrolling list that archives **all** subject matter experts, legal reviewers, and other personnel who authored, reviewed, or revised the lesson by month and year.]
[Name]
[Title]
[Agency]
[Month Year]

I. Introduction

SLIDE: "Interactions with Persons with Mental Impairments"

This course fulfills the required minimum 2 hours of in-service training pursuant to section 29-7-7.5 NMSA 1978

A. Instructional goal

SLIDE: "Instructional Goal"

Provide the student with awareness of crisis management, including crisis intervention, confrontation, de-escalation practicum and proper interaction with persons with mental impairments.

B. Instructional Objectives

SLIDE: "Instructional Objectives"

Upon completion of this block of instruction the participant will:

1) Identify and understand House Bill 93 and sections of the bill
2) Identify and understand crisis management and intervention
3) Identify proper interaction and de-escalation with persons with mental impairments
4) Identify how to gather critical information between dispatch and officers to maximize safety

End-of-topic test questions for this lesson are directly related to learning objectives.

C. Crisis Management

SLIDE: "Crisis Management"

Involves understanding how to work with individuals who have mental, neurodevelopmental, or neurocognitive disabilities. This training will help you prepare for the tasks that are vital to achieving successful outcomes.

D. Crisis Intervention

SLIDE: "Crisis Intervention"

Crisis intervention plays a vital role in achieving successful outcomes when interacting with individuals who have mental impairments. Officers who can recognize and understand the communication needs of people with special needs can make a positive difference. By understanding the nuances of communicating with individuals with mental, neurodevelopmental, and neurocognitive impairments, officers are better positioned to provide effective assistance without escalating the situation.

E. History of House Bill 93

SLIDE: "History of HB 93"

This legislation (originally and specifically linked to SB 369 and HB 93 in 2011) aimed to improve police interactions with individuals experiencing mental health crises and reduce negative encounters, became effective 7/1/2011.

This legislative action is now officially called “Interaction with Persons with Mental Impairments”

The number of hours required for law enforcement training on dealing with the mentally impaired is an attempt to slow and lesson the number of negative interactions.

**Note - HB 93 is no longer related to Interaction with Persons with Mental Impairments. Referencing HB 93 in legal documents will cause confusion.

II. Body

A. Why are we here?

SLIDE: “Why are we Here”

Negative interactions between police and individuals with mental impairments are increasing, as is the media attention surrounding them.

* 1 in 5 people fatally shot by police have a mental illness

* 15% of all calls annually involve someone struggling with mental illness

In order to best serve our communities, we must continue to learn how to interact and assist people with mental impairments during daily interactions and in times of crisis.

1. Mental Health by the Numbers

SLIDE: “Mental Health by the Numbers”

It is estimated that more than one in five U.S. adults live with a mental illness (59.3 million in 2022; 23.1% of the U.S. adult population). Mental illnesses include many different conditions that vary in degree of severity, ranging from mild to moderate, to severe.

2. Police are our Safety Net

SLIDE: “Police are our Safety Net”

"For years, the mental health community has argued that police should not be the safety net for mental health crises. Years. And the response from decision-makers and elected officials has not been to increase mental health funding. Or to build a comprehensive mental health crisis system to handle such situations. Or to pour funding into college campuses where 25 percent of people first experience the onset of mental health conditions.

No, the response has been to pay for better police training.

Until we put money and effort and thought into building a better mental
health system, police officers will remain the safety net."

3. Law Enforcement Officer Response

SLIDE: "LEO Response"

Officers should follow a four-step process when responding to events that involve people with mental health, neurodevelopmental or neurocognitive disabilities.

STEP 1: Recognize behaviors

STEP 2: Assess risk and create a safe environment

STEP 3: Communicate effectively and use de-escalation strategies

STEP 4: Use external resources and social service referrals

B. Common Types of Mental Health Disabilities

SLIDE: "Common Types of Mental Health Disabilities"

1. Depression and Suicide
2. Anxiety
3. Post Traumatic Stress Disorder

4. Psychosis
5. Schizophrenia
6. Bipolar disorder

Slide 2: "Common Types if Mental Health Disabilities"

7. Autism
8. Alzheimer's
9. Dementia
10. Traumatic Brain Injury

Officers are not expected to diagnose specific mental impairments but should focus on recognizing the symptoms being displayed and responding appropriately to the individual's needs.

C. Depression

SLIDE: "Depression"

1. One of the most common mental health illnesses in the U.S. Approximately 21 million adults in the U.S. had at least one major depressive episode and they were highest among people 18-25 YOA.

2. For some people, depression can interfere with or limit one's ability to carry out major life activities. About 30% of people with depression attempt suicide.

SLIDE 2: "Depression"

3. One of the most significant signs and symptoms of depression officers deal with consistently is loss of hope. Loss of hope can lead to suicidal ideation (SI) and possibly homicidal ideation (HI).

Verbal indicators

- Soft, monotone, or slow speech with long pauses
- Impatient, irritation, frequent sighing
- Minimal verbal engagement with limited responses to questions or one-word answers
- Communicates overwhelming feelings of guilt and worthlessness
- Communicates feelings of hopelessness, despair, or suicidal thoughts
- Expresses no solution to their problems other than death, which they may view as a welcome relief

D. Suicide

SLIDE: "Suicide"

1. A leading cause of death in the U.S. that impacts all cultural and socioeconomic groups, but especially the following:

    - American Indians and non-Hispanic Whites
    - Men = nearly 80% of all suicides
    - People 85 years old and up
    - 46% had a mental illness

a) Suicide: Myth vs. Fact

SLIDE: "Suicide: Myth vs. Fact"

(1) **MYTH**: Suicide only affects people with mental health conditions. **Fact**: Not all people with mental health issues are suicidal, and not all suicidal people have mental health issues. Life stressors are also associated with suicidal thoughts or attempts.

(2) **MYTH:** Most suicides happen without warning. **Fact**: In reality, many suicidal people show warning signs to those closest to them, though those loved ones may not

recognize the signs. That is why it is important to learn signs and symptoms.

SLIDE 2: “Suicide: Myth vs. Fact”

(3) **MYTH**: Talking about suicide will encourage it or put it in someone’s mind or give them the idea to kill themselves. **Fact**: "Talking about suicide not only reduces the stigma, but also allows individuals to seek help, rethink their opinions, and share their story with others. We all need to talk more about suicide."

(4) **MYTH**: Young people who identify as heterosexual have a higher rate of suicidal thoughts and behavior compared to those who identify as LGBTQ. **Fact**: The LGBTQ community has a higher suicide rate than the heterosexual community.

b) Risk Assessment

SLIDE: “Risk Assessment”

Presence of three factors indicates increased risk of suicide and urgency:

- Thought (ideation) - Refers to the presence of suicidal thoughts. This can range from passive thoughts, such as "I wouldn't mind if I didn't wake up," to active thoughts, such as "I want to end my life".
- Plan - This involves an individual having a developed plan for how they would take their life. A detailed or fully worked-out plan indicates a higher risk.
- Means - This factor assesses whether the individual has access to the tools or means to carry out their suicide plan. For example, a person with a plan to use a gun and access to one is at a much higher and more immediate risk than someone who does not have access to their chosen method.

c) Suicide Warning Signs

SLIDE: “Suicide Warning Signs”

- Threatening to hurt or kill oneself
- Seeking access to means
- Talking, writing, or posting on social media about death, dying, or suicide
- Acting recklessly or engaging in risky activities
- Feeling hopeless, worthless or a lack of purpose
- Withdrawing from family, friends, or society
- Increasing alcohol or drug use
- Having a dramatic change in mood
- Giving away prized possessions
- Unusual paying off debts

d) Suicide by Law Enforcement

SLIDE: "Suicide by Law Enforcement"

- Evidence of suicidal intent and wanting officers to shoot
- Possessed a lethal weapon or what appeared to be a lethal weapon
- Intentionally escalated and provoked officers to shoot
- 98% were men from 18-54 YOA
- 48% had a firearm

e) LEO Response to Suicidal Subjects

SLIDE: "LEO Response to Suicidal Subjects"

What are the legal considerations?

- Responding to suicidal calls must be guided by both sound tactics and legal precedent. Case law has consistently reinforced that officers must operate within constitutional boundaries, even in the context of a mental health crisis.
- If no crime is being committed, officers do not have the authority to create jeopardy or escalate a situation into a use-of-force incident. In Kirby v. Duva (2008), the court held that it was excessive for officers to create circumstances leading to the use of force when the individual had not committed a crime and did not pose an immediate threat to others.
- Suicidal behavior alone does not constitute a criminal act, and Fourth Amendment protections apply fully. Officers

must balance their duty to protect life with constitutional limits on the use of force.

SLIDE 2: "LEO Response to Suicidal Subjects"

What information should you gather and consider before arriving on the scene?

- What is the individual saying? Are they making active threats of self-harm or suicidal intent?
- Does the individual have access to lethal means? (firearms, knives, medications, ligatures, etc.)
- Is the individual in a private residence, public space, or another location?
- Are they alone, or is another person present who may be in danger based on the current situation?
- Who placed the call? (subject, family member, third party, or mental health professional who can provide context)
- Does dispatch have any history or information regarding prior suicidal calls, known diagnoses, or behavioral health contacts?

SLIDE 3: "LEO Response to Suicidal Subjects"

How should you approach the scene and person?

- It is important to recognize that if an officer, based on the situation, is required to respond, the mere presence of uniformed law enforcement can naturally escalate a suicidal crisis, even without any verbal or physical action. This escalation occurs simply because officers represent authority and control, factors that may heighten distress for individuals already experiencing intense emotional turmoil or fear.
- Recognizing and intentionally reducing these natural escalation triggers can greatly improve the chances of a peaceful resolution.

SLIDE 4: "LEO Response to Suicidal Subjects"

How should you approach the scene and person?

To mitigate this, officers should:

- Approach quietly when safe to do so, minimizing lights and sirens.
- Maintain appropriate distance and cover while ensuring clear communication. Immediately maintain a safe distance if the person has a knife or other dangerous item; use extreme caution and take cover if the person has a firearm.
- Limit the visible number of officers when possible.
- Avoid making quick, sudden movements.
- Use calm, non-threatening body language and tone.
- Begin with reassurance, such as, “You’re not in trouble. We’re here because we care about you and want to help you.”

SLIDE 5: “LEO Response to Suicidal Subjects”

How should you assess risk and make decisions?

A structured decision-making process helps ensure consistency and defensibility in the field. Officers should document:

- What information was known at the time of response?
- The perceived level of risk to the individual, officers, and others.
- Steps taken to de-escalate and communicate, or resources offered.
- The rationale for any decisions made, including response to the scene vs. disengagement and mitigation over the telephone.

f) Suicide Intervention Strategies

SLIDE: “Suicide Intervention Strategies”

- Immediate and specific action is the key to effective intervention.
- Remove any means the person can use to commit suicide.
- DO NOT leave the person alone, even for a few seconds.

- Communicate calmly, openly, and directly with the person.
- Be patient, listen actively and validate feelings.
- Express support and concern.
- Do not argue or debate whether suicide is right or wrong.

SLIDE 2: "Suicide Intervention Strategies"

- Ask directly and clearly about suicide ("Do you have a plan for suicide?") and open-ended questions that encourage the person to share their feelings and perspective.
- "Please explain how you've been feeling lately?"
- "Who or what has been helpful to you in the past when you've felt like this?"
- "What do you wish people understood about what you're going through?"
- "What reasons do you have to live?"

E. Anxiety Disorders

SLIDE: Anxiety Disorders

Generalized Anxiety Disorders (GAD) and panic attacks are conditions where the person worries constantly about everyday issues and situations which can interfere with school, work, and relationships.

F. Post Traumatic Stress Disorder (PTSD)

SLIDE: Post Traumatic Stress Disorder

1. Post-Traumatic Stress Disorder (PTSD) is a mental health condition that can develop after "exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

    a) Directly experiencing the traumatic event(s)

b) Witnessing, in person, the event(s) as they occurred to others

c) Learning that traumatic events occurred to a close family member or close friend

d) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)"

e) It may impact individuals differently. The trauma event can be anything in a person's life, even if it is small to other individuals.

2. What are some PTSD symptoms for adults?

SLIDE: What are some PTSD symptoms for adults?

a) Replaying the experience repeatedly or having nightmares (e.g., flashbacks). The person may feel as if they are reliving the experience, including the time and place of the event.

b) Negative feelings towards themselves or others. Expresses guilt or shame, including survival guilt where the person survived a traumatic event and others did not.

c) Anxious or constant feelings of being in constant danger. May appear jittery, always looking out for the next threat, or may express difficulty sleeping or concentrating. Constant danger is a feeling of not being safe. It does not have to be a conscious feeling that the individual states.

3. What are some PTSD symptoms for children?

SLIDE: What are some PTSD symptoms for children?

a) Separation anxiety, trouble sleeping, or nightmares.

b) Reenacting the trauma through play, drawings, or stories.

c) Irritable or aggressive.

d) Avoiding school and problems completing schoolwork or making friends.

e) Depression, anxiousness, withdrawal, or participating in reckless behavior like substance abuse or running away.

4. Statistics for PTSD

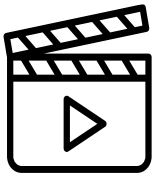
SLIDE: Statistics for PTSD

a) According to the Department of Veterans Affairs the statistics for the US population for PTSD are:

(1) 4 out of every 100 men will develop PTSD
(2) 8 out of every 100 women will develop PTSD

b) And according to "The Community Dispatch" magazine:

(1) 15 out of every 100 officers will develop PTSD



Video: "A Closer Look at Treating PTSD in Kids." (1:39)

Slide: Click to play the icon to show a 1:39 minute video, "A Closer Look at Treating PTSD in Kids."
https://www.youtube.com/watch?v=BLI4VI2FXY4.

G. Psychosis

Slide: Psychosis

1. Psychosis is not a specific mental illness, but a prominent symptom present in multiple mental health disorders. It is used for a collection of symptoms that happen when a

person has trouble telling the difference between what's real and what's not.

2. This disconnection from reality can occur for several reasons, including various mental and physical conditions.

Slide: Psychosis 2

3. What is the difference between a delusion and a hallucination?

    a) Delusions: Fixed, false beliefs and ideas that aren't based in reality, persisting despite contradictory evidence.

    b) Hallucination: Sensory experiences (seeing, hearing, feeling things not there).

    c) Hallucinations involve perceiving something unreal (e.g., hearing voices), whereas delusions involve believing something untrue (e.g., thinking you are a secret agent). Both are symptoms of psychosis, often occurring together in conditions like schizophrenia, but one is about senses, the other about ideas.

SLIDE: How should you interact with a person who is suffering from hallucinations?

4. How should you interact with a person who is suffering from hallucinations?

    a) Hallucinations to the person are just as real as things that people who are not hallucinating see or hear. This is important as it drives the conversation to have with them. People experiencing hallucinations can feel like outcasts and shame about what they are going through. Any conversation needs to include trust, believing the person and what they are saying, and being inclusive, not to isolate them.

b) Do the following when communicating with a person who is having hallucinations:

(1) Stay calm and create a safe environment. Speak in a calm, quiet tone and avoid sudden movements. Reduce stimuli like bright lights or loud noises. Don't invade their personal space or touch them without permission.

(2) Offer reassurance by saying things like, “You're safe and I am here to help.”

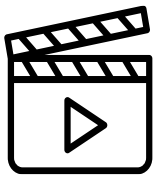
(3) Acknowledge their experience, but do not dismiss, argue with, or try to convince them what they are hearing/seeing is false. Acknowledge them by saying:
"I know that you see/hear something, but I don't see/hear it."
"I don't see the person/hear voices, but I believe that you do."

(4) Gently redirect their attention. Try distracting them by changing the subject, moving to a different room, or engaging in a simple activity they enjoy. For example, encourage them to focus on your voice or a specific object in the room.

H. Schizophrenia

SLIDE: Schizophrenia

Schizophrenia is a chronic and complex mental disorder characterized by a combination of symptoms” including psychosis. While not all cases of psychosis indicate schizophrenia, the presence of psychosis is a defining feature. Understanding this relationship is crucial for compassionate support for individuals navigating the complexities of psychosis and schizophrenia.



Video: “Living with Schizophrenia: Management, Support & Hope | WebMD.” (6:08)

Slide: Click to play the icon to show a 6:08 minute video, “Living with Schizophrenia: Management, Support & Hope | WebMD” https://youtu.be/C7JI9_59tfY?si=ODIpdKy7yli8ZErS.

SLIDE: Schizophrenia: How do we interact with someone with schizophrenia?

1. How do we interact with someone with schizophrenia?

    a) Remember that their beliefs and hallucinations are very real to them. Their eyes and ears are processing information the same way your eyes and ears are processing information right now.

    b) Don't try and tell them that you see or hear the same thing because when what they are seeing and hearing in changes and you do not see the change you will lose credibility and trust. Do not discredit what they're seeing. If you tell them that what they're seeing is wrong, you will lose their trust. Acknowledge that what they're seeing is real to them and it would be very scary to see and hear those things.

    c) Try and speak slowly, they might be hearing a lot of things and might have a hard time focusing on you. You can try to clap or even ask them if they hear your voice and can focus on what your voice sounds like.

    d) They might move around a lot, be vigilant for your safety, but also try and let them expel that extra energy by pacing or moving their arms if they are not posing a present danger.

SLIDE: Schizophrenia: What are some verbal indicators of schizophrenia?

2. What are some verbal indicators of schizophrenia?

    a) Disorganized, incoherent, nonsensical, or irrational speech.

b) Associations between ideas expressed are loose, and following the person's thought process may be challenging.

c) A lack of or very little actual content in the person's speech.

d) Memory loss such as their name or home address (although these may be signs of other physical ailments such as injury, dementia, or Alzheimer's disease).

e) Repeating the speech or behaviors of others.

SLIDE: Schizophrenia: What are some non-verbal indicators of schizophrenia?

3. What are some non-verbal indicators of schizophrenia?

a) Delusions, which are a belief in thoughts or ideas that are false, such as delusions of grandeur ("I am Jesus Christ") or paranoid delusions ("My neighbor tunneled pipes into my new house and installed cameras to spy on me").

b) Hallucinations in any of the five senses (e.g., hearing voices, feeling one's skin crawl, smelling strange odors, seeing things others cannot see).

c) Auditory hallucinations refer to the experience of having false perceptions of sounds–often of voices–that have no actual origin but are experienced as coming from outside the person's head. They are not thoughts or an individual just thinking out loud.

d) People with severe mental illnesses commonly experience auditory hallucinations. They’re the most common type of hallucination ..." and "are often associated with schizophrenia and other mental conditions, but they can happen for several other reasons, such as hearing loss and substance abuse.

Auditory hallucinations are not always a sign of a mental condition."

SLIDE 2: Schizophrenia: What are some non-verbal indicators of schizophrenia?

e) Voices may be positive, negative or neutral. Sometimes, hearing voices can be upsetting or distressing. They may command the person to do something that may cause harm to themselves or others.

f) It is important to note that hallucinations to the individual are as real as things that people who are not hallucinating see or hear. This is important as it drives the conversation with the individual. Oftentimes, people feel like outcasts and are ashamed of what they are experiencing.

g) People who do not see or hear what the individual sees and hears do not believe the person because it is not tangible to them.

h) The conversation with this individual needs to include trust, believing the person and what they are saying, and being inclusive to not isolate the individual.

i) Example statement: “I believe you see/hear these things though I do not. Many people experience the same thing and it’s okay. Can you tell me more about what you are seeing/hearing?”

SLIDE 3: Schizophrenia: What are some non-verbal indicators of schizophrenia?

j) Extreme agitation, aggressiveness, or emotional reactions inappropriate for the situation or circumstance.

k) For example, laughing hysterically or giggling for no apparent reason, shouting at random

passersby, or reacting with hostility without provocation.

l) False beliefs that one suffers from extraordinary physical ailments. For example, the person is convinced that their heart has stopped beating for extended periods.

m) Obsession with recurrent and uncontrolled thoughts, ideas, and images.

n) Extreme confusion, fright, or paranoia.

o) Feelings of invincibility.

I. Bipolar Disorder

SLIDE: Bipolar Disorder

1. Causes unusual or extreme shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks.

2. Moods range from periods of significantly ‘up,’ elated, irritable, or energized behavior (manic episodes) to very ‘down,’ sad, indifferent, or hopeless periods (depressive episodes).

3. It is important to note that this is not a switch that can be turned on or off. It is also not something that triggers within seconds. The shift in behavior does not have a specific timeline, and a person can remain in a particular state for an unknown period.

SLIDE: What are some verbal indicators of bipolar?

1. Talks very fast about a lot of different things, racing thoughts

2. Talks very slowly, feels like they have nothing to say

3. Trouble concentrating or making decisions

4. Forgetfulness

5. Statements that they are significant, talented, or powerful

6. Statements that they feel worthless or think about suicide or death

SLIDE: What are some non-verbal indicators of bipolar?

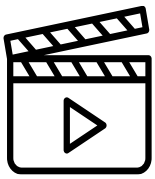
1. Excessive energy or constantly tired

2. Does not sleep or sleeps too much

3. Loss of appetite and weight loss or increased appetite and weight gain

4. Engages in impulsive or risky behaviors with little concern for consequences (e.g., overspending money, hyper-sexuality, or reduced inhibitions)

5. Believes they can do a lot of things at once; begins numerous projects that they have difficulty completing



Video: "Living with Bipolar Disorder: Signs, Symptoms & Everyday Life." (5:05)

Slide: Click to play the icon to show a 5:05 minute video, "Living with Bipolar Disorder: Signs, Symptoms & Everyday Life" https://www.youtube.com/watch?v=MOkip7IamH0&t=16s.

J. What conditions can mimic a mental illness?

SLIDE: What conditions can mimic a mental illness?

It's important for officers to understand the conditions that can mimic mental illness. Medical issues—such as diabetes, head injuries, or drug intoxication—can cause similar behaviors associated with psychosis,

depression, and general anxiety disorder. For example, symptoms of psychosis can be caused by cocaine or amphetamine use, and alcohol use can cause signs of depression.

1. Neurodevelopmental & Neurocognitive Disabilities (NND)

SLIDE: Neurodevelopmental & Neurocognitive Disabilities (NND)

NND's are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime. They generally begin anytime during the developmental period before birth but can happen after birth due to injury, infection, or other factors. They may involve dysfunction in attention, memory, perception, language, problem-solving, or social interaction. These disorders may be mild and easily manageable with behavioral and educational interventions, or they may be more severe, and affected individuals may require more support.

2. Neurodevelopmental & Neurocognitive Disabilities (NND)

SLIDE 2: Neurodevelopmental & Neurocognitive Disabilities (NND)

Officers must be trained to recognize people with an NND because they can have difficulty understanding instructions, communicating clearly, or responding appropriately under stress. Therefore, officers must be able to identify signs of NND's, adjust their communication style, and avoid escalating situations—ensuring interactions are safe, respectful, and aligned with professional policing standards.

They face tremendous challenges within the criminal justice system because they can lack the necessary skills to understand that their actions may be wrong, making them more susceptible to criminal behaviors, albeit unknowingly.

3. Neurodevelopmental Disabilities

SLIDE: Neurodevelopmental Disabilities

a) Neurodevelopmental disabilities are a group of conditions that affect the development of the brain and nervous system, leading to difficulties in various areas of functioning.

b) Types of Neurodevelopmental Disorders:

(1) Cognitive abilities: Intellectual disability, learning disorders

(2) Motor skills: Cerebral palsy, developmental coordination disorder

(3) Communication: Autism spectrum disorder, language disorders

(4) Social and emotional behavior: Attention-deficit/hyperactivity disorder (ADHD), anxiety disorders

4. Neurocognitive Disabilities

SLIDE: Neurocognitive Disabilities

a) Neurocognitive disorders are a group of conditions that affect cognitive functions, such as memory, attention, language, and problem-solving. They are caused by damage or dysfunction in the brain.

b) Types of Neurocognitive Disorders:

(1) Alzheimer's disease: The most common type, characterized by progressive memory loss, confusion, and changes in behavior.

(2) Dementia: Caused by damage to blood vessels in the brain and affects language, behavior, and personality, hallucinations, Parkinson's-like symptoms, and memory loss.

(3) Delirium: A sudden onset of confusion, agitation, and altered sleep patterns.

(4) Other neurocognitive disorders: Including Huntington's disease, multiple sclerosis, and traumatic brain injury.

5. Signs

Slide: Signs

a) Distinct facial features

b) Delayed physical development or small stature

c) Unusual gait, posture, or poor coordination

d) Difficulty communicating or a limited vocabulary

e) Difficulty understanding concepts of time

f) Problems with short-term memory

g) Challenges with social judgment

h) Difficulty understanding social cues

i) Difficulty regulating emotions and behavior

j) Difficulties with reasoning, problem-solving, planning, abstract thinking, and judgment

6. Sensory Issues

Slide: Sensory Issues

a) Can be overstimulated by what they see, smell, hear, touch, taste, or just by thinking it.

b) Sound - Loud and sudden noises that surprise the person can overstimulate.

c) Light - Some people with an NND are overstimulated by light, while others are attracted to it. People may try to avoid or shield themselves from flashing lights.

d) Touch - Some people with an NND may enjoy sensory input or be overstimulated by it. Examples include playing with water or striking oneself in the head or body.

K. Neurodevelopmental Disabilities – Autism Spectrum Disorder

SLIDE: Neurodevelopmental Disabilities – Autism Spectrum Disorder

1. Autism Spectrum Disorder is a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave.

2. Can be diagnosed at any age, but signs and symptoms generally appear in the first two years of life.

3. What are some common signs of Autism Spectrum Disorder?

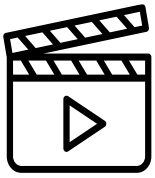
   a) Repetitive behaviors,

   b) motor difficulties,

   c) communication difficulties,

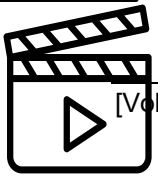
   d) social difficulties and

   e) sensitivity to change and stimulation.



Video: "Autism TMI Virtual Reality Experience." (2:06)

Slide: Click to play the icon to show a 2:06 minute video, "Autism TMI Virtual Reality Experience"
https://www.youtube.com/watch?v=DgDR_gYk_a8.



Video: "Autism interaction training video." (5:06)

Slide: Click to play the icon to show a 5:06 minute video, "Autism interaction training video" https://www.youtube.com/watch?v=QI4tz86QuZA.

Video: "Autistic Stimming Defined." (3:56)

Slide: Click to play the icon to show a 3:56 minute video, "Autistic Stimming Defined" https://www.youtube.com/watch?v=_brSCemI6ZM&t=26s.

SLIDE: Interacting with people with Autism Spectrum Disorder

1. Do not be condescending or patronizing
2. Avoid using slang and sarcasm because it can be confusing
3. Avoid forcing them to make eye contact because it can be uncomfortable
4. Take time to listen
5. Provide simple, direct, and specific instruction
6. When possible, avoid physically touching them and remain aware of physical proximity

L. Traumatic Brain Injury

Slide: Traumatic Brain Injury (TBI)

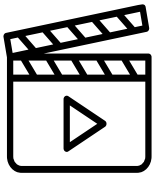
1. Affects how the brain works. It may be caused by a bump, blow, jolt or penetrating injury to the head.
2. What are some common signs and symptoms of a TBI?
3. What are some law enforcement considerations?

Video: "Police Responding to Persons With A Brain Injury." (9:26)

Slide: Click to play the icon to show a 9:26 minute video, "Police Responding to Persons With A Brain Injury" https://www.youtube.com/watch?v=_brSCemI6ZM&t=26s.

Slide: Responses to Officers

1. Feel overwhelmed by the officer's presence
2. Try to flee or become upset b/c they do not understand what is happening
3. Unable to comprehend or follow instructions
4. Difficulty describing details or actions
5. Provide answers they think the officer is looking for
6. May say 'yes' or 'no' to a question as a default response
7. Waive their Miranda rights, not understanding the consequences
8. Feel pressured to confess to a crime they did not commit (wants to cooperate)



Video: "Communicating Effectively with Individuals with Developmental Disabilities." (5:23)

Slide: Click to play the icon to show a 5:23 minute video, "Communicating Effectively with Individuals with Developmental Disabilities" https://www.youtube.com/watch?v=Roc3_gOOHZ4.

Slide: Communication

1. The inability of people with an NND to communicate effectively with officers can increase their vulnerability to arrest, and behavioral issues may intensify the situation. Each person can have their own unique ways of communicating.

    a) Full sentences and reciprocal conversation

b) One-word sentences

c) Sign language

d) Pictures

e) Texting or augmented devices

Slide 2: Communication

2. Treat adults as adults, regardless of their disability.

3. Speak directly with the person and frequently use their name.

4. Use a normal tone of voice and speech cadence.

5. Use simple language and short sentences.

6. Ask simple open-ended questions when seeking information without suggesting answers. If the person does not appear to understand a question, try asking it another way.

Slide 3: Communication

7. Avoid asking closed-ended questions with a “yes” or “no” answer.

8. Avoid asking abstract questions about the reasons for their behavior.

9. Ask questions that provide options for answers.

10. Be patient and wait up to 15 seconds for a response to any question.

11. If they seem unsure about something, ask them to repeat it in their own words.

M. Create Structure and Routine

SLIDE: Create Structure and Routine

1. People with an NND can thrive on structure and routine. The mere presence of law enforcement can disturb a person's routine and produce specific behaviors.

2. Explain what you are doing and how long it will take.

3. Use positive reinforcement.

4. Use timers and visual aids to set expectations.

N. Physical Aggression

SLIDE: Physical Aggression

1. If a person with a NND is physically aggressive, they are not generally doing this with malicious intent or trying to hurt another person. They are often looking to communicate their wants and needs, seeking affection, or trying to be playful, albeit inappropriately.

2. Can occur without warning or any precursor.

3. Move away or step back.

4. Ignoring the behavior may help de-escalate.

5. Avoid engaging in confined areas if they are nervous, agitated, or emotional.

O. Youth in Crisis

SLIDE: Youth in Crisis

We must remember that adolescents have an immature frontal lobe, this means that they aren’t able to see very far into the future for what the consequences of their actions could be. They aren’t easily able to restrain

themselves and often think of themselves as invincible. We also need to remember what a crisis could be for them, that might not be a crisis for us as adults.

1. Examples of a crisis for an adolescent:

    a. Romantic relationship ended

    b. Bad grades

    c. Being grounded – inability to hang out with friends

    d. Cyberbullying – or loss of "likes" or "shares" which could indicate loss of social status

2. Suicide is the second leading cause of death in youth ages 10-24, and over 60% with major depression do not receive services.

3. Especially among adolescents, the stigma of mental illness remains high. Kids are bullied and isolated for being perceived as "weak".

P. 5 Words to Avoid When Helping Students and Children De-Escalate

SLIDE: 5 Words to Avoid When Helping Students and Children De-Escalate

De-escalation is such a HARD process – and the language we use can become the reasons why a student calms, or a student escalates further. De-escalation language should always be non-judgmental, and the adult should try to listen more than they talk. So, if you are talking, here's 5 words to avoid when helping students de-escalate.

1. "But…" Whenever we use the word "but" in a sentence, we're going against what our conversation partner is saying. In de-escalation, it's all about affirming and listening, not trying to argue your point. Instead of interjecting what you want to say, try taking a deep breath and turning on your listening ears.

2. “Consequence” Talking about a child’s consequence or what will happen to them as a result of their behavior is a big NO if you’re working on calming the child down. If there are school policies that warrant specific next steps after all is said and done, let that be a discussion for much later. Right now, focus on emotional and physical safety for the child, and to ensure they’re feeling heard by you.

SLIDE 2: 5 Words to Avoid When Helping Students and Children De-Escalate

3. “Always/Never” When we speak in big generalizations about a person or a situation, it paints an unfair picture of the truth and doesn’t open up the conversation to feel safe for both communication partners. Try to not speak about the original problem but focus on how to help the child move from crisis to feeling safer and calmer. A debrief conversation, with safe and respectful words, can happen later.
4. “Why?” It’s in our nature to problem solve immediately and try to determine the cause of the crisis. During the crisis cycle, resist the urge to problem solve and probe. Our students' brains are physically not able to clearly problem solve and articulate needs when they’re in a crisis. Save this for a debrief later! When helping students de-escalate, we really need to practice patience.

5. Any kind of sarcasm. While some elements of distraction and humor can be helpful for SOME students, sarcasm is definitely off limits in this situation. Sarcasm would be a foreign language for a crisis-affected brain and will likely be interpreted as truth. Stick to empathetic responses and careful listening!

Q. Dispatchers and Callers

SLIDE: Dispatchers and Callers

1. Loss of Hope (LOH) is a deep depression, extreme sadness and feelings of being helpless and hopeless. The person usually has experienced a recent loss (or losses) that are

devastating to them. The goal of this negotiation is first to install some hope so that the person can be persuaded to talk to someone or seek help. A high number of callers that fall in this category are suicidal callers.

2. Loss of Reality (LOR) is the delusions (false beliefs) and hallucinations (hearing or seeing things). The goal of this negotiation is to cut through the fear and confusion caused by the psychosis and get the person to comply with an officer assist.

SLIDE 2: Dispatchers and Callers

3. Loss of Control (LOC) will be displayed with emotions as anger, hostility, and rising tensions. The goal of this negotiation is to calm the person through empathy using active listening skills. When dealing with this type of caller, it is important to not let the caller's emotion get to the dispatcher. Using de-escalation methods will have the potential to create a safer environment for not only the responding units, but all others that may be on scene along with the safety of the caller.

4. Loss of Perspective (LOP). This is when a person has feelings of anxiety, worry, or nervousness that can possibly escalate to the feeling of panic. The goal of this negotiation is to calm the person through empathy using active listening skills.

R. De-escalation: Rules of Body Language

SLIDE: De-escalation: Rules of Body Language

Be aware of your non-verbal communications. Ensure your tone, facial expressions, body language and gestures relay calm and empathy.

SLIDE: Good Body Language

1. Standing off to the side of the person and remaining relaxed but alert
2. Keeping your hands down, open and visible at all times

3. Using slow, deliberate movements
4. Maintaining a neutral and attentive facial expression

SLIDE: Bad Body Language

1. Standing rigidly directly in front of the person
2. Pointing your finger
3. Excessive gesturing or pacing
4. Faking a smile

S. De-escalation: Five Purposeful Actions

SLIDE: De-escalation: Five Purposeful Actions

Responses, tips and reminders to help stabilize tense situations.

1. Remain Calm. Use body language and verbal communication
   techniques to help stabilize tense or stressful situations.
2. Change the Setting. If possible, remove people from the area. This may involve parties to the conflict and onlookers.
3. Respect personal space. Maintain a safe distance and avoid touching the other person.
4. Listen. Give your full attention, nod and ask questions, and avoid changing the subject or interrupting.
5. Empathize. Present genuine concern and a willingness to understand without judging.

T. De-escalation: Verbal Communication

SLIDE: De-escalation: Verbal Communication

Remain respectful and courteous. Address the individual with civility and use phrases such as “please” and “thank you.”

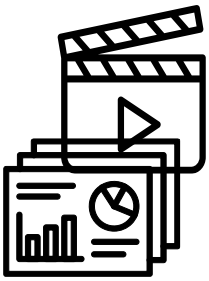
Tone + Volume + Rate of Speech + Inflection = Verbal De-escalation

1. Tone – speak calmly to demonstrate empathy.
2. Volume – monitor your volume and avoid raising your voice.
3. Rate of speech – speek slowly, though not too slowly, because it is soothing.

4. Inflection – be aware of emphasizing words or syllables because that can negatively affect the situation.

SLIDE: Verbal Communication

Instead of saying	Try
"Calm down."	"I can see that you are upset..."
"I can't help you."	"I want to help. What can I do?"
"I know how you feel."	"I understand that you feel..."
"Come with me."	"May I speak with you?"



Video: "Officers Reunite Special Needs Person With His Family | Nightwatch | A&E" (4:55)

Slide: Click to play the icon to show a 4:55 minute video, "Officers Reunite Special Needs Person With His Family | Nightwatch | A&E" https://www.youtube.com/watch?v=vtTEVAGCgHM&t=81s.

III. Conclusion

A. Summary

SLIDE: "Summary."

To effectively and appropriately interact with people who have mental health, neurodevelopmental or neurocognitive disabilities, officers should:

- Recognize behaviors
- Assess risk and create a safe environment
- Communicate effectively and use de-escalation strategies

This lesson provided information to help officers recognize behaviors indicative of mental health, neurodevelopmental and neurocognitive disabilities. It also covered best practices for using verbal de-escalation techniques when encountering a person in crisis.

B. Learning Objectives

SLIDE: "Learning Objectives." Facilitate a targeted review of the lesson using learning objective content. Emphasize to students that

end-of-topic test questions for this lesson and final state exam are directly related to learning objectives.

End-of-topic test questions for this lesson are directly related to learning objectives.

C. Closing Statement

SLIDE: "Closing Statement."

Effectively responding to people with mental health, neurodevelopmental or neurocognitive disabilities is not just about enforcing the law, it's about protecting life, dignity, and trust. Every calm word, patient pause, and de-escalation effort can prevent harm and create hope for someone in crisis. When officers respond with understanding and restraint, they demonstrate the heart of true policing – service, compassion, and professionalism. Through empathy and skill, officers can turn moments of vulnerability into opportunities for safety, connection, and respect.

SLIDE: "Resources"

SLIDE: End Notes

SLIDE: Quiz