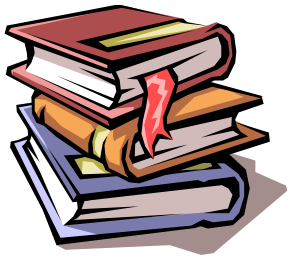
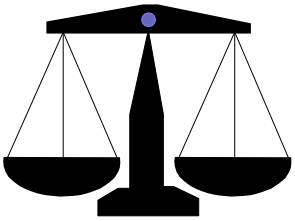


POLICE RESPONSE

TO THE

MENTALLY ILL



Curriculum prepared by:

National Alliance for the Mentally Ill
Maryland Chapter- Metropolitan Baltimore

Baltimore County Health Department
Bureau of Mental Health

The Baltimore County Police Department
Baltimore County, Maryland

Police Response to the Mentally Ill
Executive Summary

The Baltimore County Police Department has recognized a need to further enhance the abilities of law enforcement officers in their response and interactions with people in crisis. In 1995, the Baltimore County Police Department launched a week long training initiative to teach law enforcement officers strategies and skills to effectively respond, communicate and resolve issues related to mental health crises.

This training, which is updated annually, has been designed to provide insight into people who experience a mental illness and issues related to mental illness. There has been a realization that law enforcement officers serve as the front-line responders in the community. They frequently face situations that require a rapid, sensitive and skilled response.

If the person has mental illness, how will the officer know? How will they react? We have designed a curriculum to help officers recognize and respond to an individual who may have a mental illness. This curriculum contains pertinent information including summary sheets, handouts, lesson plans and objectives. This material is an excellent educational tool to help officers provide a better quality of life for the citizens to which they serve.

ACKNOWLEDGEMENTS

We wish to thank the National Alliance for the Mentally Ill (Maryland Chapter), and the Baltimore County Health Department Bureau of Mental Health as well as individual contributors listed in this booklet. We need to reach more officers and communities to educate them about mental illness. Thank you for doing your part to fulfill this mission.

LIST OF ADDITIONAL CONTRIBUTORS

Baltimore County Maryland Department of Aging
Baltimore Crisis Response Center, Inc.
Community College of Baltimore County
(Dr. Ann Kaiser Stearns)
Johns Hopkins University
Maryland Psychiatric Research Center
Mental Health Players of Maryland
Sheppard Pratt Health System

FOR MORE INFORMATION

If you would like more information about this training curriculum, please contact:

Behavioral Assessment Unit
Baltimore County Police Department
C/O PC09
700 E. Joppa Rd.
Towson, Md. 21286
410-931-2145

Captain Mel Blizzard
Baltimore County Police Department
700 E. Joppa Road
Towson, Md. 21286
410-887-7343

Sharon Lipford, LCSW-C
Baltimore County Health Department
6401 York Rd.
Baltimore, Md. 21212
410-887-2731

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Training Objectives

The *Police Response to the Mentally Ill* seminar has been designed primarily for the education of police officers, 911-call takers, and first responders of all levels of experience. The purpose of this training is to teach skills and strategies for those who interact with people in crisis or who are suffering with a mental illness.

Through the training, participants will accomplish the following:

- Become educated about the medical and behavioral aspects of mental illness.
- Identify situations where a person with mental illness, law enforcement and mental health providers might interact.
- Learn specific intervention techniques for managing a mentally ill person in crisis.
- Become familiar with NAMI and other resources available in the community.

SUMMARY SHEET

Introduction

Each session is opened with sharing the personal experience of a law enforcement officer from our own agency. The participants are able to put a face on the experiences of dealing with a family living with a mental illness and the frustration of navigating within the mental health system.

SUMMARY SHEET

Framing the Problem

Historically law enforcement personnel and mental health clinicians have not worked together in a collaborative manner. This is due primarily to different identified missions and goals (e.g. safety versus treatment, perpetrator versus client/patient). However, in reality, law enforcement and the mental health community interact on a routine basis. This presentation explores the commonalties between the two professions.

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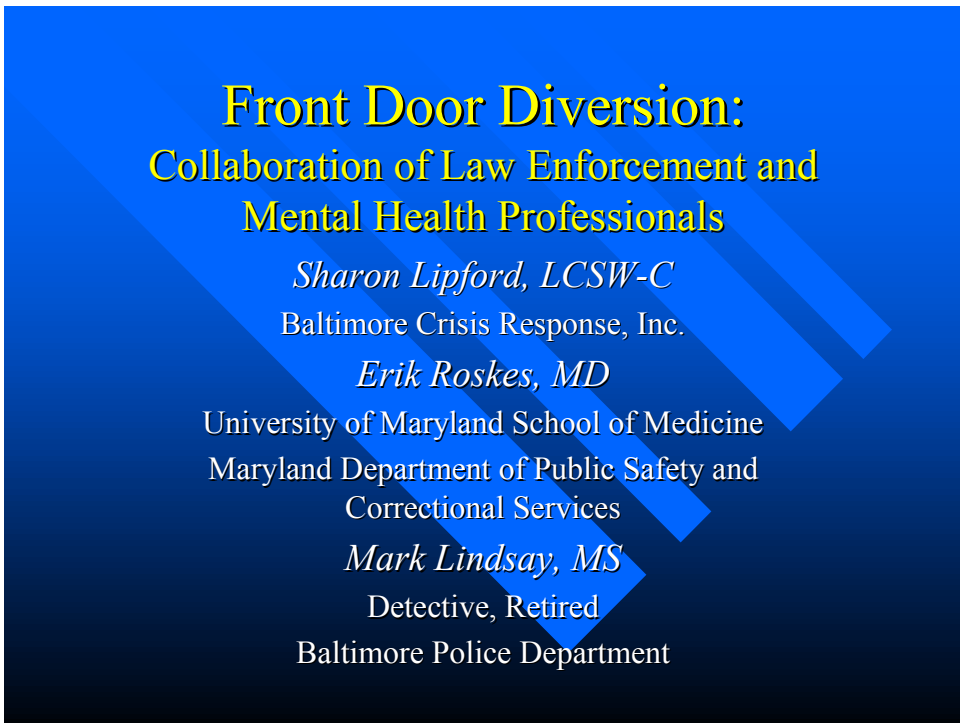

SUMMARY SHEET

Overview of Mental Illness

The complexities of mental illness are quite expansive. This presentation reviews the most common types of mental illness, those most likely to be encountered by law enforcement officers and emergency providers in the field, and describes the behaviors typically associated with the illness.

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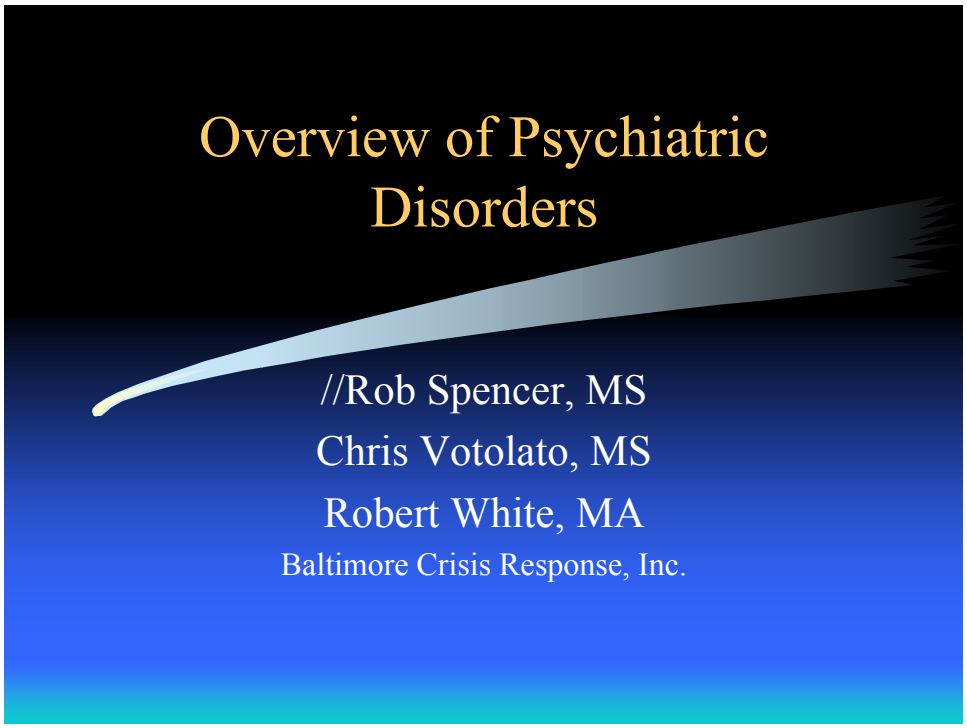

SUMMARY SHEET

Behavioral Response To Mental Illness

Based on the medical model, this presentation provides an overview of the different types of mental illnesses and the traditional behavioral methods of treatment. In addition, medications most commonly utilized by physicians for treating mental illnesses are discussed.

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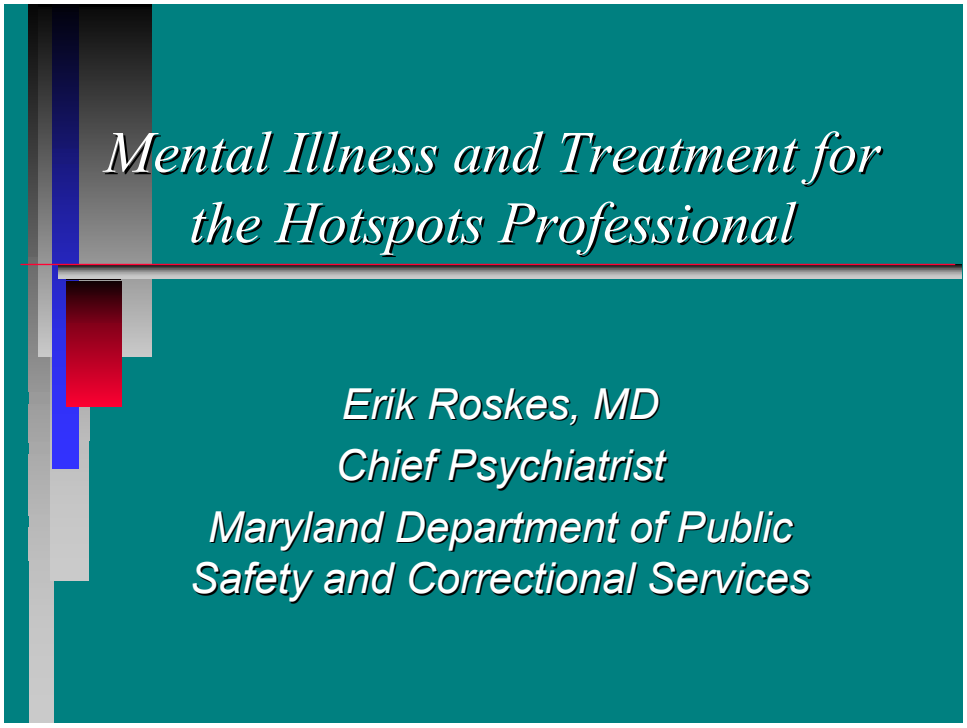


SUMMARY SHEET

Biological Basis of Mental Illness

This course of instruction allows the student to understand what schizophrenia is and who can get it. The symptoms are discussed as well as current research data on the illness.

SUMMARY SHEET

Aggressive Behavior

This worksheet imparts the effects of stigma and what is perceived by the consumer as suspicious or negative body language and physical posture.

At the conclusion of the class, the Officer should be able to:

- Describe the difficulty that psychotic subjects experiences in being able to pay attention to what is being said and in following directions
- State 3 reasons why psychiatric patients go off their medications
- Describe the five phases of the Aggressive cycle
- Define when to try to problem solving with a subject who has a mental illness, Vs when to give short specific directions.

- Discuss how patients with bipolar illness or Schizophrenia may need more physical space to cooperate with you
- Look at issue of judgement- the subject's and your own.
- What to say and how to say it
- When to keep quiet

SUMMARY SHEET

Crisis Intervention and Suicide

The way in which a professional communicated with a person-in-crisis can either escalate or de-escalate the situation. This segment educates the officers about the crisis intervention model, specific communication (de-escalation) techniques and reviews suicide risk factors.

WHAT IS A CRISIS?

DEFINITION: A crisis arises when an individual is confronted with a situation and is unable to achieve a balance (homeostasis) because their usual coping mechanisms are inadequate or unavailable. What does that mean? The person is unable to use their current support system or do what naturally has been helpful in the past during difficult times-e.g. gym, church/synagogue, friends, recreational supports (bowling club), crying, movies, reading, TV, etc.

WHAT HAPPENS DURING A CRISIS?

BEHAVIOR:

- Depression
- Anxiety
- Tries to reduce stress
- Seeks situational supports
- Perception changes

COPING/ IN BALANCE:
The person experiences a phenomenon called tunnel vision.

PERCEPTION OF THE EVENT: How does the person perceive the event? What meaning does it hold? How a person defined the event will cognitively shape his/her emotional reaction to it. EG. Divorce, loss of a job.

SITUATIONAL SUPPORTS: Does the person have and use a support system? Often times in a crisis, the person has either isolated him/herself or has few/no supports.

COPING MECHANISMS: Each of us has characteristic ways of coping with stress including psychological defenses such as denial,

rationalizations, projection, intellectualization; etc. We also utilize outside supports such as reading, playing, instrument, friends, etc. There are also maladaptive strategies: alcohol, drugs, working long hours, violence.

CHARACTERISTICS OF THE PERSON IN CRISIS:

1. Has difficulty maintaining usual activities
2. Feels that events are out of his/her control
3. Has difficulty concentrating
4. Experiences disturbances in eating and sleeping
5. Overwhelming feelings of helplessness, hopelessness, and fatigue
6. Difficulty making even simple decisions
7. May be irritable, cry frequently, depressed, angry
8. Experiences little or no enjoyment of things that are usually pleasurable- anhedonia
9. Pays little attention to personal grooming

SOME POSSIBLE SYMPTOMS THAT MAY INDICATE THE NEED FOR SHORT-TERM PSYSCHIATRIC INTERVENTION:

1. Alcohol and or drug use as a coping strategy
2. Significant weight gain/loss
3. Insomnia or excessive sleeping

4. Panic attacks
5. Unrealistic thinking
6. Suicidal/homicidal ideation
7. Compulsive behaviors
8. Self destructive behaviors (cutting on self)

SUICIDE

SUICIDE ASSESSMENT:
One of the most difficult problems a counselor or police officer will encounter is dealing with a suicidal person. Suicide can be presented in an obscure manner, vague or person can clearly state thoughts about suicide, which can be frightening.

It is important to view suicide as a process- people don't wake up and decide to attempt suicide. Most people entertain thoughts- feelings of hopelessness, helplessness, loneliness, anger, and depression.

It is a myth that suicidal people really want to die- most people can't imagine living in their current situation and they feel they have little control to change it. Suicidal people have tunnel vision. It is also a myth that if you ask about suicide that you are "planting" the seed.

Top 5 Indicators:

- ♦ Specific plan
- ♦ Availability of means
- ♦ Previous attempts
- ♦ Family completions
- ♦ Drug and alcohol use

Consider the following facts: 31,000 in U.S. per year suicide rate has been steady since the 1970's. More suicides than homicides.

Age: higher completion among elderly 65 and over and 15-24.
Gender: More attempts with females, more completions with males due to higher lethal means- 4x higher rate of completion- - 6,000 women and 24,000 men.
Race: American Indian, Caucasian and African American
Family Completions: makes suicide a viable option
Resources: may be a last resort
Previous attempts: increases personal risk- practice makes perfect
Specific plan and means: how much has person thought about idea?
Recent loss: job, death, divorce, accident, and health, respect

Emotional symptoms: depression increases likelihood-especially insomnia
Medical symptoms: do they have medical problems, chronic pain?
ETOH and drugs: dramatically increases impulsivity and decreases inhibitions, decreases ambivalence- not thinking clearly

CRISIS INTERVENTION

INTERVENTION STRATEGIES:
Your goal is to:

1. Build relationship.
2. Help the person identify the crisis.
3. Assess person's usual mechanisms for coping with stress.
4. Refer the person to counseling services e.g. mobile crisis team.

Closure
Problem solve
Identify problem- break down
Gather info. -ask concrete questions
Establish relationship

1. **ESTABLISH A RELATIONSHIP:**

Your main goal is to establish trust. The client needs to feel that you accept, respect and understand his feelings. The client also needs to develop confidence that you can be helpful. Your role is to be a helper/listener.

Reflect feelings	paraphrase
Minimal verbal response	summarize
Clarify	confront
Focus	inform
Silence	reframe

A. SUPPORTIVE LISTENING- let the person have the opportunity to express feelings freely. Receive info in a calm, nonjudgmental manner. Don't tell the client he shouldn't feel a certain way.

B. VALIDATE THE FEELINGS- Tell person it's all right to have those feelings. This helps to de-escalate.

C. IDENTIFY THE CLIENTS STRENGTHS- Point out strengths that

you observe in client- what are their values, what is important to them?

2. **GATHER INFO AND MAKE AN ASSESSMENT:** You begin to ask pertinent factual questions. Focus on the current situation (e.g. don't ask what it was like when client was 13). What's going on today? What happened? How do you take care of yourself?

3. **IDENTIFY PROBLEM:** Together with the client, you agree upon what is the most urgent problem. Prioritize.

4. **PROBLEM SOLVE:** Explore alternatives, identify options, anticipate obstacles, develop alternative plans, give resource information, support client's ability to carry out the plan
   This step is intended to help the person gain control of the situation and develop some confidence in managing the problem. It is very tempting to give advice- but DON'T. If you find yourself saying I think you should, If I were you... The clinician needs to reframe the comments to say- Have you considered, what do you think about...

5. **CLOSURE:** As the process ends, review with the client the actions they will take and the contingency plans.

MANAGING VIOLENT BEHAVIOR:

Some psychiatric emergency clients may be potentially violent. The astute officer or counselor will be knowledgeable about signs or impending violence and will be acquainted with the techniques for limiting the potential for danger.

HOW TO APPROACH THE AGITATED MENTALLY ILL PERSON:

There is a mnemonic devise that can help deal with a potentially violent person- called the CAT

1. Control behavior
2. Assess situation quickly
3. Treat specifically

SUMMARY SHEET

Personality Disorders

Personalities are complex components that make-up a person's unique and individual traits or style. When one or more traits become problematic, a person can be diagnosed with having a personality disorder. This presentation examines the different types of personality disorders and provides treatment recommendations when responding to a person with a personality disorder.

INTRODUCTION TO PERSONALITY DISORDERS

Presented by: Robert Spencer, MS

Introduction to Personality Disorders:

1. An individual's personality reflects the style in which he or she behaves, thinks, and expresses emotion.

2. Personality can range from adaptive to maladaptive. When one's personality is maladaptive and causes problems for the person it may be labeled "disordered." There are several official personality disorders, each of which corresponds to a specific maladaptive style of personality.

3. Different personality traits can be appropriate for different situations. For example, a person who craves attention might gravitate toward acting or running for political office. The desire to be the center of attention could serve to motivate the individual who opts for one of these professions. On the other hand, attention craving as a personality style might not be as suited for such professions as movie director or political speechwriter. It is likely that these "behind-the-scenes" occupations would leave the person feeling unfulfilled.

4. Personality and personality disorders develop due to many factors. Causal influences include biological factors, childhood experiences, and how the person copes with his or her environment.

5. Some personality disorders are more severe than others

are. Similarly, some personality disorders are more treatable than others are. Long-term psychotherapy (talk therapy) is generally the treatment of choice.

6. Individuals with personality disorders will not often seek treatment for their personality. More likely their impetus for seeking help is some sort of interpersonal crisis, mental illness, or out of control situation.

7. Often, the treatments offered to individuals with personality disorders are resisted by the individual. Before entering therapy, these individuals had spent years developing their personality styles. Facing the prospect of permanent personality change, for this individual, can often seem strange or even terrifying. For this reason, treatment appointments are "forgotten," medications are "lost", and the suggestions from the therapists are dismissed.

8. Individuals with personality disorders are particularly vulnerable to various crises. The nature of this crisis largely depends on the individual's specific personality style. For example, someone who is overly shy and anxious might react differently to criticism than would a person who is overly forceful.

AVOIDANT PERSONALITY DISORDER

1. These individuals tend to be shy and fear rejection.

2. They may view themselves as inadequate.

3. Most are only comfortable with a small circle of people, often consisting mostly of first-degree relatives.

SCHIZOID PERSONALITY DISORDER

1. Most of these individuals are interpersonally detached.

2. They display a restricted range of emotional expression.

3. Most will choose to do solitary activities in their free time.

DEPENDANT PERSONALITY DISORDER

1. They may cling to people whom they hope will care for them.

2. Many feel unable to care for themselves without constant support from others.

3. They often portray themselves as inept in order to obtain support from others.

HISTRIONIC PERSONALITY DISORDER

1. Many have an unrelenting need to be the center of attention.

2. They tend to make use of excessive emotional displays and outrageous style of dress to attract attention.

3. These individuals are often overly sexually provocative and seductive.

4. Emotions expressed by people with histrionic personality disorder are often times shallow and subject to rapid change.

PASSIVE-AGGRESSIVE PERSONALITY DISORDER

1. Many are perpetually malcontented, argumentative and irritable.

2. These individuals express envy incessantly, complain of personal misfortune, and feel unappreciated.

3. Attempts they make to feel better usually include passive-aggressive maneuvers and other covert (sneaky) tactics.

BORDERLINE PERSONALITY DISORDER

1. This disorder can be conceptualized as extreme versions of the Histrionic, Dependent, and/or Passive-Aggressive personal disorders.

2. They are on-guard against abandonment from close relation(whether the abandonment is real or simply imagined)

3. Unstable sense of identity, chronic sense of emptiness, and bursts of extreme rage are common.

4. These individuals may resort to extreme and manipulative behaviors during stress. Such behaviors include suicide attempts, temper tantrums, self-mutilating, and paranoid thinking.

5. Rapidly shifting moods and frequent suicidal behaviors are common to this disorder.

ANTISOCIAL PERSONALITY DISORDER

1. Childhood history of rule breaking, violating the rights of others, theft, or aggression is required for the diagnosis.

2. Some of these individuals are sadistic but many are more accurately described as being manipulative, selfish, and impulsive.

3. They have frequent contacts with law enforcement.

Diagnostic criteria for 301.83 Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self image, affects, and impulsivity beginning by early adulthood and present in a variety of contexts as indicated by five (or more) of the following.

1. Frantic efforts to avoid real or imagined abandonment. NOTE: Do not include suicidal or self- mutilating behavior covered in Criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identify disturbance markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). NOTE: Do not include suicidal or self-mutilating behavior covered in the Criterion 5.
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days.)
7. Chronic feelings of emptiness.
8. Inappropriate intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Diagnostic criteria for 301.7 Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by repeatedly performing acts that are grounds for arrest.

1. Failure to conform to social norms with respect to lawful behaviors as indicated repeatedly performing acts that are grounds to arrest.
2. Deceitfulness, as indicated by repeated lying, uses of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is an evidence of Conduct Disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

NARCISSISTIC PERSONALITY DISORDER

1. These individuals often have a sense of entitlement, self-importance, and arrogance.

2. Many have trouble empathizing with others.

3. They often expect recognition for their greatness even though they have not earned it through true ability or accomplishments.

OBSESSIVE COMPULSIVE PERSONALITY DISORDER

1. These individuals tend to be perfectionistic, dogmatic, and stubborn.

2. Most are overly concerned with details and rules.

3. Excessive devotion to work is common.

PARANOID PERSONALITY DISORDER

1. This disorder can be conceptualized as an extreme personality variant of Antisocial, Narcissistic, and/or Obsessive-Compulsive personality disorders.

2. They are perpetually on guard against being taken advantage of, humiliated, or duped.

3. As a defensive maneuver they tend to act in a gruff, aloof manner and avoid confiding in others for fear of disloyalty.

4. These individuals tend to bear grudges.

5. May frequently come to the attention of law enforcement.

SUMMARY SHEET

Abnormal Psychology

This is a specialized course for police officers, managers, and civilian police employees including 911 employees. It provides an overview of current concepts normality and abnormality. The primary focus is to diminish the stigma and eradicating many myths and misconceptions associated with mental illness.

THE COMMUNITY COLLEGE OF BALTIMORE COUNTY
(CCBC – Dundalk Campus)
with the
BALTIMORE COUNTY POLICE DEPARTMENT
Presents
PSYCHOLOGY 201 – "ABNORMAL PSYCHOLOGY"
With
Dr. Ann Kaiser Stearns

COURSE DESCRIPTION

A specialized course for police officers, managers and police department civilian employees, this course will provide an overview of current concepts of normality and abnormality. Some historical perspectives on mental health and mental illness issues of relevance to law enforcement professionals and counselors will be provided. A primary focus will be diminishing the stigma and eradicating many of the myths and misconception associated with mental disorders (such as depression, anxiety, and alcohol problems) seen commonly in the general public and among Police professionals.

LEARNING OBJECTIVES

STUDENTS WILL:

- Distinguish between characteristics and symptoms of mentally ill persons vs. traits and behavior of mentally well individuals, recognizing a frequent "overlap" of characteristics and behavior;

- Identify and examine the important role that drug abuse and stress often play to "trigger" and/or contribute to mood, anxiety and adjustment disorders, plus many other illnesses;

- Examine the complexity of causal factors and variety of viewpoints in understanding Abnormal Psychology;

- Identify and examine the signs, symptoms, and contributing factors associated with personality and substance- related disorders, the schizophrenia, sexual disorders, bipolar disorder, dementia, and disorders of childhood or adolescence;

- Develop an overview of the types of medications, therapies and other treatment methods associated with various mental illnesses and stressful circumstances;

- Apply the concepts of Abnormal Psychology to one's own life experience in order to recognize when help is needed and what help is available when a mental

disorder is present in one's self, a family member, a colleague, or another person in need of support, compassion or professional assistance;

- Identify certain infamous criminals and the severe mental disorders from which they may have suffered, contributing to their victimization of innocent people.

SUMMARY SHEET

Officer Safety Issues

This workshop provides basic awareness in self-defense methods, philosophies and tactics.

EMPLOYMENT AND BASIC TRAINING DIVISION

LESSON PLAN

COURSE: Dealing with the Mentally Ill
TOPIC: self-defense Tactics
PAGE: #1

I. Introduction

1. During the next hour we will cover the following information.

A. Basic S/D Tactics
B. Fundamental S/D Principles
C. Defensive Tactics and the Mentally Ill.
D. Some hands on Tactics.

II. Confrontational Principles

Note: If the opponent has both portions of this formula then it could spell disaster for the officer.

1. **Ability –** We cannot control.

a. Weapons
b. Training
c. Presence of Alcohol/Drugs
d. Mental Illness

2. **Opportunity –** That which we can control.

a. Awareness
b. Stance, position, balance
c. Basic Tactics- Contact and Cover
d. Communication Skills
e. Observations – Watching Hands
f. Training – Proficiency
g. Safety in Numbers
h. Cover/Concealment
i. Physical Fitness

III. Three questions we continually ask during any confrontation.

1. Am I Safe?

Demonstrate basic balanced interview position.

- Feet shoulder width
- Knees slightly bent
- Hands mid-drift
- 1 ½ Adversary arms length away
- Position of Advantage
- Awareness-Watch hands, etc.

Demonstrate Contact & Cover positions.

Contact Person

Makes initial and primarily all communications.
Issues Paperwork
Takes field notes, etc.

Cover Person

Protection of general area
Protection of Contact person
Accesses all threats
Accesses backdrop

Keeps weapon hand free.

Position for obtaining record checks, etc.

Basic communication skills & Body Language.

2. What do I have?

Nature/type of call

Felony

Misdemeanor- Still a threat!

Weapons Involved

Custody – Non-Custody Situation.

Type of individual I'm dealing with.

Three basic types of individuals.

- **Criminal-** Freedom
- **Crusader-** will sacrifice all to complete their objective
- **Mentally Ill-** Unknown

Note: What things do we or can we sometimes expect from a mentally ill individual.

- Unpredictability

- Medications
- Non-Rational
- Non-Empathetic
- Suppressed Morals
- Lower inhibitions

Note: What is the difference between Physical and Mental Illness?

Physical- can be measured, tested; you can see and get a grasp of it. It's concrete.

Mental- is abstract. It deals with the thought process which cannot be seen until it manifests itself into behavior. That's when they call us!

3. What can I do about it?

Good fundamental tactics
Awareness
Good handcuffing procedures
Expect the un-expected
Teamwork
Keep weapon hand free
Good communication skills
Isolate the situation

De-escalation skills
Calming voice
Don't buy into delusions, "I believe you hear voices, but I do not hear them now."
Empathetic Listening
Reflective Limits
Enforce Limits
Be aware of non-verbal communications
Be consistent

IV. Conclusion

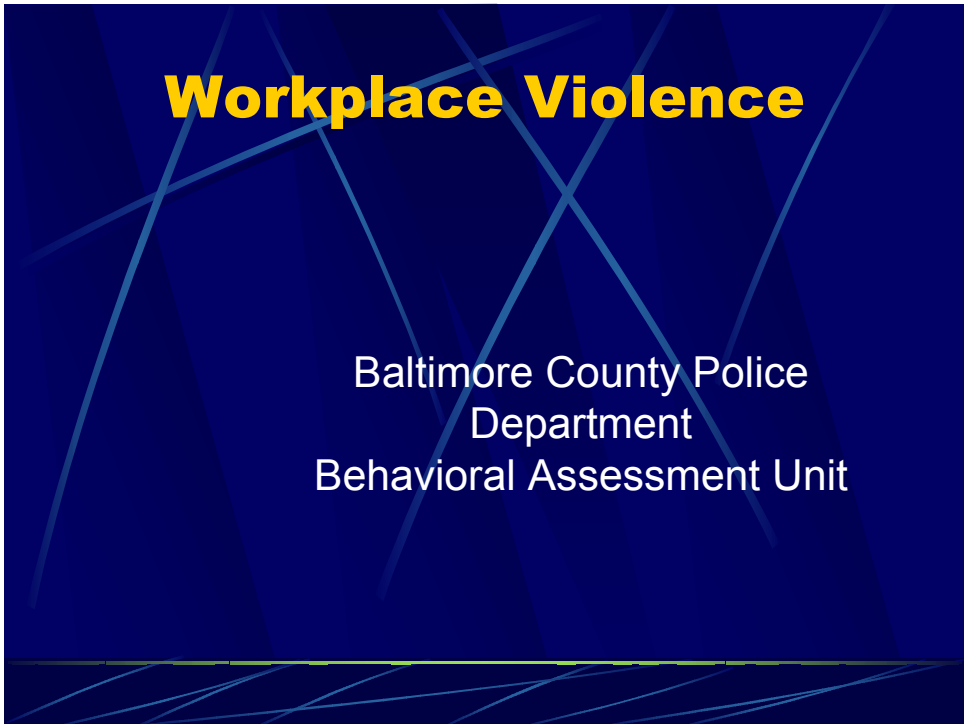
When dealing with the mentally ill we must have a good foundation of fundamental principals and skills. Good communication skills and polished defensive tactics are the keys to success when dealing with the Mentally Ill.

SUMMARY SHEET

Workplace Violence

This workshop is designed to heighten awareness of personal safety and security in the workplace. This topic addresses the various levels of violence and its indicators.

Power Point Presentation: Double click on slide to view.



Summary Sheet

Negotiations/Case Studies

This workshop allows the student to identify the skills and certain tactics used to effectively negotiate with an individual with mental illness. The primary goal is safety and the preservation of life. Actual case critiques are shared with the audience.

Hostage Negotiation Team
Power Point
Double click on slide to view.

SUMMARY SHEET

Vulnerable Adult Abuse

This workshop identifies local statutes protecting vulnerable adults. This topic identifies types of abuse; physical, sexual, psychological, financial, etc.

HOW TO COMMUNICATE WITH CONFUSED PERSONS

1. **Make sure that you have their attention.**
   Touch
   Look directly into eyes
   Hold hands (according to comfort level)

2. **Identify yourself.**
   I'm officer _____, I'm here to help.

3. **Make sure that you are heard.**
   Wait for response
   Talk slowly and clearly
   Repeat, if necessary
   Don't shout; if hearing impaired, speak slowly, face person directly and use only slightly increased volume

4. **Be clear about what you expect.**
   Use short, simple words
   Point to or show what you mean

5. **Give feeling that you know they can and will do what you expect.**
   Ask, do not demand
   Urge, do not push or pull
   Make one request at a time- if choice is involved

6. **Be truthful**
   Trust is important

7. **Other suggested protocol**
   Always speak to and communicate with the vulnerable adult. To alleviate fear with this person, it might be helpful if the officer:
   - Makes eye contact at same level of vulnerable adult
   - Remove hat (respect factor for older adults)

What to look for in Assessing Financial Abuse

1. What are the client's income sources, dollar amounts, and payment due dates?
2. Where are checks deposited?
3. How is cash obtained?
4. How are bills payed? Who writes and or signs the checks?
5. What is the amount of the monthly bills?
6. What debts exist?

7. Does the client have any credit cards or automated teller cards? Does he or she use them? Who else is listed on the accounts?
8. What is the total number of bank accounts? Where are they located? What is the approximated balance in each? What types of accounts are they? Is anyone else listed on the accounts?
9. Does the client have stocks or bonds? Where are they located? Does he or she have a brokerage account?
10. Does the client own a home, and is anyone else listed as a joint tenant? Who has the deeds to the property?
11. Does the client have any safe deposit boxes? Where are they located and who has the keys? Does anyone else have access to them?
12. Does the client have jewelry, expensive collections, art, or other valuables? Where are they kept?
13. Does the client have insurance policies? What kinds?
14. Is anyone using the client's residence or utilities without permission?
15. Have loans or gifts been made or given recently?
16. Has the client given power of attorney to anyone?
17. Does the client have a conservator or guardian?
18. Does the client have a lawyer or accountant?
19. Is there a will and where is it located?

20. Has the client signed any papers recently?
21. Is the client getting adequate food, clothing, etc?
22. Will any new forms of income become available soon?
23. What is the income of the client's supporters?
24. Does the client have any pets that may need to be cared for if the living arrangement changes?
25. Are other relatives available to help? Are they geographically and emotionally close to the client? Are they burdened with children or other concerns? Could they monitor someone else?
26. How often is the client in contact with this support system?

Signs of Adult Abuse

Individual signs by themselves are not enough; the key factor in identifying adult abuse is to look for a pattern of signs, symptoms, or events. The American Association of Retired Persons, in their brochure, *Domestic Mistreatment of the*

Elderly, Towards Prevention, Some Do's and Don'ts, identified several signs and symptoms:

- Withdrawn or timid
- Physically injured
- Longing for death
- Vague health problems
- Shopping for physicians
- Anxiety increasing depression
- Hostile
- Confused
- Unresponsive
- New Poverty
- Anxious to please
- New self-neglect
- Conflicting stories
- Mounting resentment
- Excusing failure
- Shifting blame
- Aggressive-defensive behavior
- Substance abuse
- Unusual fatigue
- New affluence
- New health problems
- Preoccupation with depression
- Withholding food or medication

Adult Abuse Quiz

1. Forty-two states in the United States have a mandatory reporting law for adult abuse in the community.
   True. The remaining eight states rely on voluntary reporting of elder abuse by professionals.

2. Adult Protective Services has the same legal powers to intervene as Child Protective Services.
   False. Competent adults have a right to remain in an abusive situation if they choose.

3. Maryland has a mandatory reporting law for adult abuse, which covers all professionals who deal with adults in the community.
   True. Under the law any health practitioner, police officer, or human service worker who has the reason to believe that a vulnerable adult is in danger is required to report the fact to the local

department of social services. Any concerned person many make such a report.

4. Physical abuse is the most prevalent form of adult abuse
   False. Neglect is the most common form of adult abuse.

5. In the law the types of risk which are investigated are: physical abuse, exploitation, and abuse by self or others.
   True. Only four types of risk are mentioned: physical abuse, exploitation, neglect by self, neglect by others.

6. Most care giving in the country is performed by nursing agencies in clients' homes.
   False. Most care giving (more than 90%) is provided by family members.

7. A Power of Attorney is usually limited to making financial decisions.
   True. However, in Maryland, an agent may be delegated by and individual to make health care decisions; a court appointed guardian of the person many do the same.

8. The federal government established nationwide definitions, detailing criteria and standards for elder abuse in the Older Americans Act.
   False. No national standards exist; policy and definitions are developed on a state by state basis.

9. Most victims of adult abuse are women over the age of 80.
   True. The 1998 National Incidence Study determined that the oldest old (i.e., over age 80) woman is at the highest risk of being victimized by elder abuse.

10. Spouses are the most frequent abusers of vulnerable adults.
   False. Adult children are the most frequent perpetrators.

Stories of Adult Abuse

Mildred

Mildred, 82, is tied to her bed while her brother is outside working on the farm. She cries a lot. Scars, mixed with open flesh wounds, mark her wrists. This is obviously not the first time that she has been tied to her bed. She is a victim of Alzheimer's disease and

her brother ties her to her bed because she wanders away from the house.

Louise

Louise, 74, wears sunglasses to hide the bruises on her face from the driver who delivers her noon meal. The driver notices a tear coming from under the glasses, "what's the matter, Louise"? She begins sobbing and closes the door. Louise supports her 52-year-old alcoholic son who lives with her. He regularly threatens her to put her in a nursing home if she doesn't give him the money. Although she feels trapped in her home, she can't make her own son move. Yesterday, in a drunken rage, he demanded money, then slapped her when she refused. She gave him the money.

John

John, 89, wakes up in an ambulance, the last thing he remembers is getting ready to cook lunch. The paperboy had called the police when John's paper began to pile up for 5 days. John becomes disoriented and loses consciousness when he does not take his medicine. His medications cost $440 a month, and his Social Security is only $510. Sure,

John has some savings, but he feels that he may need that some day.

Lillian

Lillian is 80 years old. She has some health problems and recently she has been having problems getting around. A year ago, her daughter Susan, 54, came to live with her. Things were going well until Susan lost her job. She has been unable to find another, and has been increasingly dependent on her mother. She started drinking excessively and spends hours in front of the TV. This angers Lillian and has led to arguments between the two women. Recently, the arguments have been getting physical, with Susan pushing and hitting Lillian. The other day, Lillian found out that Susan has been taking large sums of money out of their joint account. Lillian is upset and frightened that confronting Susan will make her more angry.

Anna

Anna and her husband used their savings to buy a duplex ten years ago, with an apartment for them and one for their married daughter, Sarah, and her family. Relations were amicable until Anna's husband died

two years ago. Anna is now 75 years old, with a heart condition. Since her father's death, Sarah has been going out a great deal and leaving the care of the children and the housework to Anna. She also insisted that Anna begin paying rent for her apartment, and that she buy expensive gifts for the children with her pension money. When Anna objected, Sarah instructed her children not to speak to her, and Anna was ignored for a week. Anna is unhappy with her treatment a, but fears rejection and abandonment is she does not comply.

Types of Abuse-
Definitions and Key Points

Physical Abuse
Sexual Abuse
Psychological Abuse
Financial Abuse
Active Neglect
Passive Neglect
Self- Neglect

PROFILES AND INDICATORS OF ABUSE

Physical abuse

Victims and abusers often live together

When spouses abuse, it may be a life long behavior, or it may begin in old age

Abusers may have mental health or substance abuse problems

Victims are often dependent on their abusers for care

Abusers are often dependent on victims for money or housing

Mental/emotional problems of victims may not be obvious

Medical personnel are often first to discover during a normal check-up

PHYSICAL INDICATORS

Bruises or welts

Burns

Abrasions on arms, legs, torso

Fractures, sprains, lacerations, abrasions

Disorientation, stupor

Internal injuries

History of similar injuries

Numerous or suspicious hospitalizations

BEHAVIORAL INDICATORS

THE VICTIM:

Is easily frightened or appears fearful

Exhibits denial

Is agitated or trembling

Is hesitant to talk openly

Offers implausible stories

Makes contradictory statements

Often recants accusations

Is willing to assume responsibility for whatever precipitated intervention

BEHAVIORAL INDICATORS

THE ABUSER:

Conceals the victim's injuries

Offers inconsistent or implausible explanations for the injuries

Threatens the victim

Has mental health or substance abuse problems

Is obstructive to investigation

Handles the victim inappropriately

Is unreasonable critical of social and health care providers and changes frequently

PROFILE OF SEXUAL ABUSE

Those who suffer from dementia or who are particularly nonverbal

Physical symptoms of sexual abuse will not be obvious

Physical indicators

Sexually transmitted disease(s)

Genital or anal infection, irritation, discharge, bleeding, itching, bruising, or pain

Painful urination and /or defecation, or retention

Difficulty walking or sitting

Torn, stained, or bloody underclothing

Behavioral indicators
THE VICTIM AND ABUSER:

Exhibit inappropriate, unusual, or aggressive sexual behavior

The victim exhibits extreme anxiety

The abuser appears to be overly protective or dominant

PROFILE OF PSYCHOLOGICAL ABUSE

Victims may appear to be relatively independent

Abusers often have histories of substance abuse and/or mental illness, and are often dependent on victims for money or housing

Victims and abusers are often living together

Physical and behavioral indicators of psychological abuse

THE VICTIM:

Exhibits sleeping, eating, or speech disorders

Is depressed

Expresses helplessness or hopelessness

Is isolated

Appears confused, fearful, agitated, or angry

Appears to have low self-esteem

Seeks attention and affection

THE ABUSER

Threatens and/or speaks poorly of the victim

Ignores the victim and his or her needs

PROFILE OF FINANCIAL ABUSE

Abusers: may live with the victim or have strong relationships with them. Seem to be motivated by financial gain rather than malice.

Victims: are often single and isolated, with a few social supports.

Physical indicators of financial abuse

Unusual volume or type of banking activity

Banking activity inconsistent with victim's ability

Non- payment of bills

Changes to legal documents

Unexplained withdrawals from or transfers between accounts

Along with other indicators, financial information no longer going to the person's home

The standard of living is not reflective of financial resources

Missing property

Suspicious signatures on checks or other documents

Absence of documentation about financial arrangements

The abuser may be living beyond obvious means

Behavioral indicators of financial abuse

THE VICTIM:

Gives implausible explanation about finances

Is unaware of or does not understand financial arrangements

THE ABUSER:

Expresses excessive concern about money

A recent acquaintance who:
Expresses interest in the person's finances, promises to provide assistance or care; ingratiates him- herself to the person

Gives implausible explanation about finances

Isolates the victim

Insists on lowering the cost of caregiving

Profile of Neglect

Physical indicators

Untreated bedsores

Skin disorders or rashes

Untreated injuries or medical problems

Poor hygiene

Hunger, malnutrition, or dehydration

Pallor, or sunken eyes or cheeks

Absence of basic necessities in home

Absence of needed prescribed medication

Lack of clean bedding or clothing

Unsuitable clothing

Unsanitary or unsafe living conditions

Absence of needed dentures, eyeglasses, hearing aids, walkers, wheelchairs, braces, or commodes

PROFILE OF SELF NEGLECT

The incidence increases with age

Many self- neglecting persons live alone

Many are depressed and/or confused

Some have a tendency to wander

Indicators of self- neglect

May resemble those of active and passive neglect by others

SUMMARY SHEET

Vulnerable Adults Assistance Network

V.A.A.N. is a local consortium of service providers that focus on a collaborative effort to provide the best possible service to vulnerable adults. Participants learn how to use the group as a resource.

The Vulnerable Adults Assistance Network
1999 Annual Report

The Vulnerable Adults Assistance Network (VAAN) is a committee comprised of representatives of various county agencies that encounter vulnerable adult County residents. In the past, each agency has attempted to resolve the residents' problems using only their own resources. VAAN has brought these agencies together for more effective problem solving and interagency coordination.

HISTORY

In 1994, George Washington University sponsored the Intergovernmental Health Policy Project. The goal of the project: to facilitate partnerships between the Department of Aging, Bureau of Mental Health, Alliance Inc. and Revisions Behavioral Health Systems, to help the elderly mentally ill client age in place. However, as various needs of the mentally ill aging client were identified, it was obvious that other Baltimore County agencies were needed to achieve this goal.

At this time, Baltimore County's Department of Aging, Department of Health (Adult Evaluation and Review Services and Bureau of Mental Health) and Department of Social Services (Adult Service Screening, Aging Intake Unit and the Aging/Continuing Unit) already had a collaborative relationship in place. These agencies decided to formalize a committee and expand the membership to include the Fire Department (Emergency Medical Services), Police Department (Precinct 3/Community Outreach Unit) and Health Department (Public Health Nursing Services and Substance Abuse.) On October 23, 1996 they met to plan a more effective way of providing care and services to geriatric residents of Baltimore County. Since then the membership has increased to include the Department of Social Services (Non-Aged Adult Unit), Police Department (Family Crimes Unit) and the Department of Permits and Development Management (Code Inspection and Enforcement).

MISSION STATEMENT

"To identify and remedy gaps in service delivery and enhance the quality of life to at risk, vulnerable adult County residents

through the facilitation of interagency education, consultation and cooperation among appropriate local government agencies. An at - risk vulnerable adult is considered to be a Baltimore County resident, eighteen years of age or older, who has a complex medical, psychological, or social problem.

OPERATION

VAAN meets monthly to consult on various cases, which are ongoing, not remedied and involve more than one agency. Since this is consultation and not supervision, there is no expectation that the presenter must follow the committee recommendations. However, presenters are requested to evaluate the committee's effectiveness and to update the committee on any progress made toward resolution of the problems within three months after the presentation. In addition to providing consultation, VAAN attempts to

identify barriers and gaps in service delivery related to the situation presented.

CLIENT CHARACTERISTICS

- Multiple medical and coexisting psychiatric concerns
- Medical and/or psychiatric follow-up is poor
- Income is limited to Social Security
- No assets
- Homeowner whose home is generally in substandard condition
- Limited to family involvement
- Multiple county agency involvement that includes the Police, Fire, Environmental, Code Enforcement and the Departments of Aging, Health and Social Services. On several occasions the County Executive's Office or County Councilmen were also involved.

REFERRAL PROCESS

To make a referral, the VAAN referral form is completed and sent to the Central Receiving Person. The referral will then be assessed and either a suggestion for an intervention will be offered or a date will be set to present at a VAAN committee meeting. The referring agency staff member is encouraged to invite other involved agencies to also attend the VAAN meeting.

OUTCOMES

VAAN has reviewed the work it has completed to date and has identified the following outcomes:

- Bridged gaps in service by fostering interagency cooperation and coordination.
- Clarified roles among agencies, which allowed for more realistic expectations about each agency's purpose.
- Implemented various educational training sessions, which have enhanced the committee's awareness of resources related to the vulnerable adult.

- Reduced duplication in service among agencies by developing systems approach to problems involving vulnerable adult.

The Vulnerable Adults Assistance Network has gained recognition for its efforts to identify and remedy gaps in service delivery and to enhance the quality of life to at risk vulnerable adult Baltimore County residents.

VAAN has been recognized as one of the recipients of the PERF Award- 1998 Herman Goldstein Excellence In Problem Oriented Policing Award. The Police Executive Research Forum (PERF) held their sixth annual conference in San Diego where VAAN was selected as one of 150 to present. PERF receives thousands of entries for the Herman Goldstein Award around the world. This clearly acknowledged VAAN as a model to be utilized in the resolution of issue involving vulnerable adults.

Techniques for Interviewing Victims

- Make the victim as comfortable as possible
- Tell the victim what to expect during the investigation
- Minimize the number of interviews
- Minimize the number of people present
- Allow the victim to describe the incident in his or her own words
- Be patient and reassuring. Some older people, particularly those in crises, may need time to collect their thoughts and may need to take frequent breaks. Avoid unnecessary pressure.
- Acknowledge the victim's anxiety and try to discern its cause. For example, you may say, "You seem anxious. Are you concerned that your son will find out that you have talked to me?"
- Keep it simple. Phrase questions in a clear, concise fashion.
- Keep questions short.
- Ask open-ended questions that encourage further investigation.
- Accept and use the victim's terminology and language for acts, body parts, etc.
- Avoid influencing the victim's account of the alleged offense.

- If you feel that the elder is having difficulty understanding or communicating, ask him or her if he or she has assistant devices or someone who can help.
- Ask the victim if he or she would like assistance. If so, ask how he or she would like to be assisted. Do not guess.
- Even if the victim appears to be somewhat confused, do not discount the information. Make every effort to obtain the fullest possible response before relying on information from others.
- If you need to have another person assist in communicating or providing information for the victim, conduct the conversation in the victim's presence and look for signs of corroboration from the victim (e.g., nodding in agreement). Do not discuss the victim as if he or she is not in the room.
- Do not argue with the victim.
- Assess the likelihood of retaliation. If a threat is present, arrange for protection. APS may be of assistance.
- Determine whom the victim first told about the abuse.
- Show the victim records or other documents that suggest abuse. Record his or her response to each one that is in dispute.

- Conclude the interview in such a fashion that the victim feels free to contact the investigator again. Endure that the victim is capable and has the means for contact. If not, take measures to facilitate follow-up with the victim.

SUMMARY SHEET

Classroom Avenger

This is a two-hour course of instruction presenting a profile of a hypothetical individual that has a potential to be violent towards peers or others. This individual's motive is personal vengeance. This course reviews 15 school/classroom-shooting incidents.
The behavioral-psychological profile of the classroom avenger is an effort to describe possible identifying characteristics of individuals at high risk for engaging in violent criminal acts in a school setting.

(Disseminate article, classroom avenger by Dr. James McGee and Caren De Bernardo)

SUMMARY SHEET

Virtual Voices

This experiential workshop includes a 45-minute segment in which participants are linked to an individual audiocassette recorder with earphones. People are assigned simple tasks, which they must perform while “hearing” auditory hallucinations. A mandatory briefing and debriefing session allows the audience to put this experience into context and to apply their interactions with persons with psychiatric disorders.

Virtual Voices

This experimental workshop includes a 45 minute segment in which participants are hooked up to individual audiocassette players with earphones and are assigned simple tasks which they must perform while "hearing" auditory hallucinations. A mandatory briefing and de-briefing allows the audience to put this experience into a context and to apply it to their interactions with persons with psychiatric disabilities. This workshop is not for persons hearing voices themselves or family members who might find it too upsetting.

Objectives: The participant will understand the day to day challenges that face people with psychiatric disabilities and to marvel at their strength and resilience. The participant will learn about the subjective experience of hearing voices that are distressing. The participant will become more empathetic toward people who hear distressing voices. The participant will change practices to better address the needs of people who hear distressing voices. (Law enforcement will learn why it is difficult to follow simple instructions or answer simple

questions if one is hearing auditory hallucinations, and will suggest changes in officer handling of certain types of interactions.)

Materials:

(1 for each participant)
Audiocassette players and 45 minute audiotapes; psychological mental health status tests; at least 5 community "tasks" on cards (at least 5 copies each);
Also:
Games and puzzles; toothpicks; waiting room magazines; signs for each workstation; easel and pad; pens and pencils; at least one volunteer role player for each of 4 stations and at least 1 more for the psyche evaluation for every 8 to 10 participants. Listings of NAMI programs and services. Videotape: A&E Investigative Report: The Shattered Mind.

DIRECTIONS TO VOLUNTEER PSYCHIATRISTS

1. During this workshop people will be listening to tape through headphones. The tape simulates the experience of hearing voices.

2. While listening to the tape the workshop participants will have to move through four different workstations. You are working at the workstation called "psychiatric emergency services."

3. When workshop participants come to your workstation, they will wait in an area that we call the "psychiatric emergency room waiting area." There will be lots of magazines on the table. People will wait for you to come and get them.

4. You are to role-play being a psychiatrist. Do not be too nice or empathetic with people. Your attitude should be very formal and

"professional." You must be very task-oriented and work fairly quickly with people. There is no time for nice talk, making people feel comfortable, etc. Just act like a psychiatrist who is simply " getting the job done" without much concern for the person.

5. The workshop instructor will show you the place where you will interview people. This is your "office."

6. The workshop instructor will give you a clipboard and pen. On the clipboard you will notice sheets of paper. There are the "emergency services evaluation forms". These evaluation forms contain the questions you will ask for.

7. As the stimulation begins you will notice people with headphones sitting in the waiting area around the magazines. Go out to the waiting area, pick any person and tell them they must come with you for an interview. Then take them back to your "office."

8. You will have approximately six minutes with each person.

9. When you have been seated take out your clipboard and ask the person for their name and social security number. Jot it down on the front of the page. Ask them what is bothering them. Then turn the page over. There are ten questions to ask the person. Get through as many questions as you can with the person in about six minutes. It's up to you to decide whether or not to write down the answers they give.

10. When approximately six minutes are up, tell the person you are done and ask them to move on to another workstation.

11. If the person says they have been to all the workstations, tell them to go back to the day treatment program. If their tape finishes while you are interviewing tell them *not* to rewind it. They are to wait for the discussion period to start in a few minutes.

SUMMARY SHEET

Mental Health Players

This workshop is presented by *The Mental Health Players,* a group of volunteer actors, that interact with the participants through role playing. Participants experience first hand, situations with someone in crisis and have the ability to critique their experience.

Mental Illness Scenarios
A
Practical Exercise

Presented by
Mental Health Players
Of
Maryland

1. Each group will participate in four scenarios.
2. The goal of the group is to resolve the problem in each scenario.
3. Two members from each group will actively participate in resolving the case.
4. All group members are encouraged to volunteer in at least one scenario.
5. You will have 15 minutes to resolve the case. Followed by discussion on the interventions used.

Scenarios

ROOM A. A tenant has reported that loud music has been occurring over the past 8 days from this apartment.

ROOM B. A 7/11 cashier has reported that a woman is in her store eating and stealing food. The cashier has tried to ask her to leave but the woman does not respond.

ROOM C. A barmaid has reported that a man is in the bar harassing other patrons. She is worried about a fight breaking out.

ROOM D. A bank manager has reported that a customer in her bank has been counting her money for the past 35 minutes. She has not responded to any bank employees.

SUMMARY SHEET

Consumer Experience

Consumers of mental health services present an interactive discussion about their experiences with Dark Days, Acceptance, Medications, Coping, Successes and Hope/Dreams. The presenters educate the audience about their treatment and recovery process in the mental health system and their interface with law enforcement.

Living With Mental Illness: Consumer Experience

Consumers of mental health services present this interactive workshop to various audiences (e.g., other consumers, family members, the general public, mental health staff and police.) The presenters reveal their experiences with Dark Days, Acceptance, Medications, Coping, Successes and Hopes and Dreams- educating the audience about the recovery process in the treatment of severe mental illness: what has helped, what has hurt. [For law enforcement audiences, the discussion is geared somewhat toward consumer interactions with police: what helps, what hurts.]

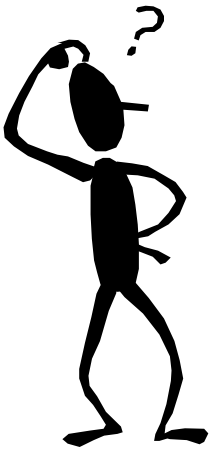
Objectives: The participant will recognize that consumers who have been very ill and in denial CAN experience success. The participant will recognize that consumers are useful resources for helpful suggestions about coping methods, medication issues, communicating with someone who is psychotic, etc. The participant will recognize that consumers can be effective team members for their own treatment and for other consumers. [Law enforcement participants will gain useful insights into consumer coping mechanisms and what has helped/hurt consumers in

interactions between consumers and law enforcement in the community.]

SUMMARY SHEET

Uncertain Journey

Families are frequently placed in the difficult position of providing treatment for their loved one who has a mental illness. As many as 65% of patients discharged from the hospital will return to live with their families. This presentation reviews the experiences families face while providing "treatment" for their relative and the need for supportive interventions with linkages to community resources.



Uncertain Journey

Families are frequently the treatment providers of last resort. As many as 65% of patients discharged from the hospital will go to live with their families and/or receive primary care and support from a family member. Families accept this role with no formal training and little support from the mental health community. [Law enforcement interacts with families in situations of crisis. Families and law enforcement are both the 24-7 crisis care providers. Each makes assumptions about the other group- what they can or should or won't do, what training they do or don't have, and why they will or won't do "more" or "better"]

Objectives:

The participant will recognize family members have experienced a traumatic event (the mental illness), are not to blame for the brain disorder, and have normative responses to that trauma.

The participant will recognize that families are useful resources for the treatment team. The participant will be able to identify what families of individuals with serious brain disorders need from providers of mental health services to be effective team members. [Law enforcement officers will recognize that families need referral to community resources and that such referral can reduce crisis calls.]

Materials: VCR and videotape: “Uncertain Journey” [will play only the first 15-20 minutes, depending on the time available.]

SUMMARY SHEET

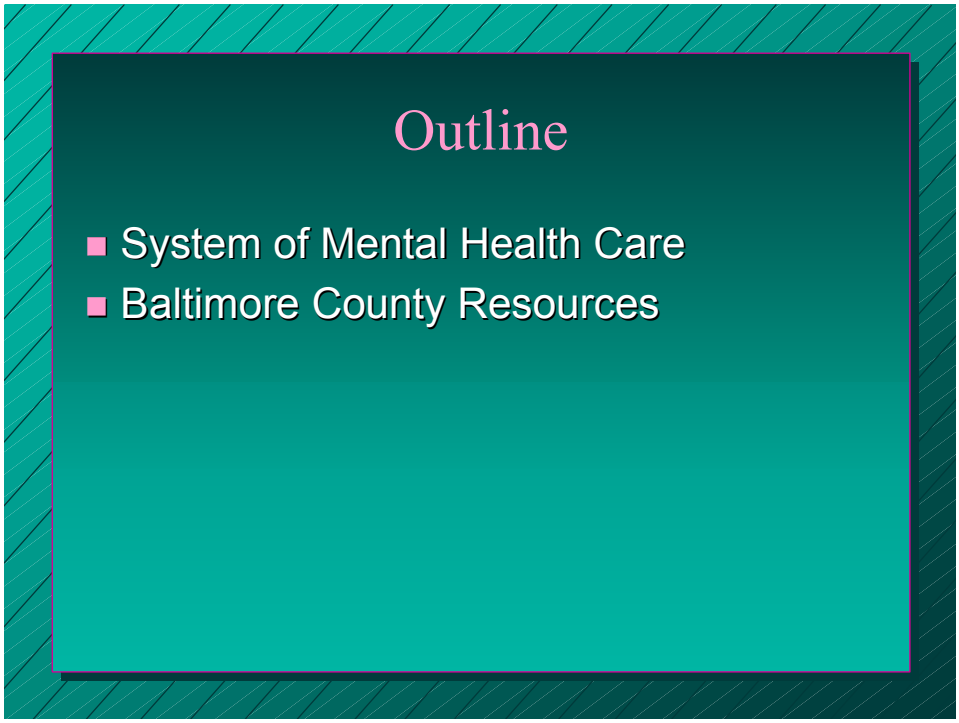
Resource Review

While a large portion of the training is dedicated to teaching skills and response strategies, it is important to also provide concrete tools to aid the first responder. These tools consist of a compilation of community resources. An overview of the local mental health system and community resources is discussed with the group. These resources can serve as a referral guide when the officer responds in the field to a person with a mental illness.

Power Point Presentation:

Mental Health Resources in Baltimore County

Double click on slide below to view contents.



BALTIMORE COUNTY DEPARTMENT OF HEALTH

BUREAU OF MENTAL HEALTH CORE SERVICE AGENCY

The Baltimore County Bureau of Mental Health is a unit of the Health Department that, in addition to receiving County funding for its operations, has been designated by the Maryland Mental Hygiene Administration as a Core Service Agency. This means that the Bureau functions as the mental health authority for the administration of state funded services to mentally ill persons residing in Baltimore County.

The Bureau of Mental Health/Core Service Agency is located the Drumcastle Center at 6401York Road in Towson. Program staff at this location administer publicly funded clinical, rehabilitative, and crisis mental health services within this jurisdiction. A complementary number of staff supports these administrative functions. The Bureau is open five days per week, Monday through Friday, from 8:30 am until 4:30 PM. Bureau personnel may be reached by phone at 410-887-2731 or by fax at 410-887-

4859.The Bureau's target population is Baltimore County's seriously and persistently mentally ill men, women and children who depend upon publicly funded services for their care. Approximately 2% of people nationwide are seriously and persistently mentally ill. This translates to about 14,600 people in Baltimore County.

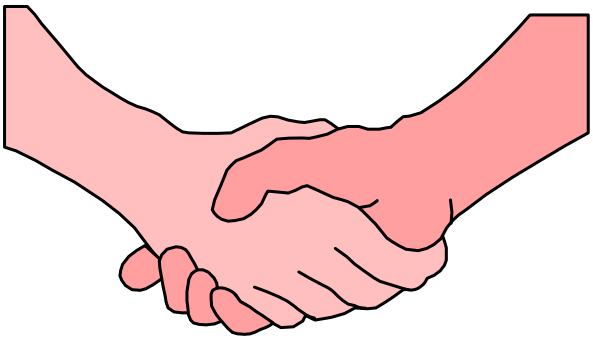
With the exception of three clinical case managers, all direct mental health services administered by the Bureau are provided by contracted nonprofit providers. The array of services available to Baltimore County citizens has broadened significantly over the past two years to include over 400 providers. These services include rehabilitation and residential programs, outpatient clinics, mobile treatment, case management, geriatric service teams, after school programs, respite services, crisis services, and homeless support services.

In fiscal year 1999, all of the Bureau's grant sponsored programs transitioned to a fee for service system within a managed care environment. Successful implementation of this change has produced a service system providing the most appropriate level and intensity of care to consumers, which in turn, produces the best clinical outcomes.

To access Mental Health Services in Baltimore County contact the Maryland Health Partners, the

State's Administrative Services Organization (ASO) for intake and referral at 1-800-888-1965.

COMMUNITY MENTAL HEALTH CENTERS



The Community Mental Health Centers provide Psychiatric Outpatient Treatment for children, adults and the elderly, including evaluation and assessment, treatment planning, individual, group and family therapy, and medication, when necessary. Other services may include daytime emergency intervention, case management, consultation and education services, after school programs, and specialized geriatric service teams.

Community Mental Health Centers

1. Key Point Health Systems at Southwestern
   10 Winters Lane
   Catonsville, MD 21228
   Director: Ted Fraker,MSW,PhD
   Phone: 410-521-7770

2. Sheppard Pratt at Northwestern
   Liberty Family Resource Center
   3525 Resource Center
   Randallstown, MD 21133
   Director: Carol Weber
   Phone: 410-521-7770

3. Sheppard Pratt at Towson, NORCOM
   6501 N. Charles Street
   Baltimore, MD 21285
   Director Nancy Ryder
   Phone: 410-560-5985

4. Franklin Square
   Eastern Community Mental Health Center
   9100 Franklin Square Drive
   Baltimore, MD 21237
   Director: Steve Pasko
   Phone: 410-780-2200

5. Key Point Health Services
   Southeastern Community Mental Health
   7702 Dunmanway
   Baltimore, MD 21222
   Director: Tessa Worsham
   Phone: 410-887-7167

Other licensed providers in Baltimore County

1. ReVisions Outpatient Mental Health Center
   22 Bloomsbury Road
   Catonsville, MD 21228
   Director: Denise Christopher
   Phone: 410-887-719-6740

2. Maryland Psychiatric Research Center
   P.O. Box 21247
   Baltimore, MD 21247
   Director: Dr.Robert Buchanon
   Phone: 410-402-7549

3. Villa Maria
   23090 Dulaney Valley Road
   Cockeysville, MD 21093
   Director: Nancy Ryder
   Phone:410-252-4700

PSYCHIATRIC REHABILTATION PROGRAM

The Bureau of Mental Health has several nonprofit agencies available to provide psychiatric rehabilitation services for adults with serious and persistent mental illness.

These programs include:

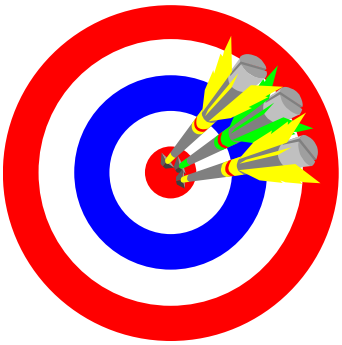
ReVisions, Inc.	Phone: 410-747-4492
Dulaney Station	Phone: 410-453-9533
Prologue, Inc.	Phone: 410-653-6190
The Alliance, Inc.	Phone: 410-574-7700
Key Point, Inc.	Phone: 410-282-2363

Each of these programs provide rehabilitation planning and services including:

- Assessment and individual rehabilitation plans
- Independent living skills training
- Recreation and social skills training
- Vocational skills training
- Supportive job placement

- Case management

The programs are generally open Monday through Friday from 9:00am to 5:00pm with expanded social and recreation services on evenings and weekends. Please contact the individual programs for specific hours of operation.



Targeted Case Management

The Baltimore County Bureau of Mental Health has contracted with Psychotherapeutic Community Services Association for targeted case management services. Services include assessment of needs, referrals to appropriate resources, monitoring the provision of services, assistance with entitlements and advocacy services.

Eligible adults must have a primary DSM-IV diagnosis of Schizophrenia, Mood Disorder, other Psychotic Disorders, Borderline Personality Disorder or Schizotypal Personality Disorder. Children and adolescents with a DSM-IV diagnosis indicating mental illness are generally eligible for services.

Services are provided in the community, in the client's home, in treatment programs, and other locations as needed in addition to the program offices.

The phone number for Psychotherapeutic Community Services Association is 410-823-7784.

MENTAL HEALTH SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES

Each of the Community Mental Health centers in Baltimore County provides specialized treatment services geared to the needs of children and adolescents who have severe emotional and behavioral problems. These services include individual, and family therapy, psychopharmacology when necessary; and school consultation for enrolled patients of the community mental health centers. Group therapy and school based clinics are available at some sites. In addition to general psychotherapeutic services, the Bureau has a number of specialized treatment programs for children and their families, including In-Home Intervention Teams and After School Programs.

After School Services

Located in Cockeysville and Lansdowne, the After School Programs provide a structured therapeutic treatment program for children (ages 6-11 at the Lansdowne site and ages 11-15 at the Cockeysville site). Each of the programs provides individual, family and group therapy, behavior modification, recreation therapy and tutoring. Day therapeutic summer programs are also provided.

To arrange for services, contact Maryland Health Partners at 1-800-888-1965.

Flexible Services

As a result of state grant funding, the Bureau of Mental Health has expanded capacity to provide a wide range of innovative, short term; community and home based services. These services include therapeutic recreation, respite care, transportation, in home aides, and other services not covered under the public mental health system.

Baltimore County children and adolescents who are severely emotionally disturbed and at risk for a more restrictive placement are eligible for these flexible services. Contact the Bureau of Mental Health, Child and Adolescent Services at 410-887-2731.

MOBILE TREATMENT SERVICES

The Bureau of Mental Health/Core Service Agency contracts with Russell House Associates to provide mobile treatment services.

Mobile Treatment Services include:

- Outreach mental health evaluation and treatment services in the client's home or other community settings
- Twenty-four hour on-call coverage for active patients
- Case management and advocacy
- Patient and family mental illness education

The purpose of mobile treatment is to reach out to clients with a severe mental illness and a history hospitalization with a goal of preventing rehospitalization. Services are providing Monday through Friday from 9:00am to 5:00pm and some

evenings, however the staff is available to active patients twenty four hours a day seven days a week.

Russell House Associates can be reached at 410-574-0306

EMERGENCY MENTAL HEALTH SERVICES

The Baltimore County Health Department has partnered with the Baltimore County Police Department to develop and implement a psychiatric Emergency Response System (ERS). The ERS operated by Affiliated Santé Group, addresses emergent psychiatric needs of the citizens of Baltimore County. The primary goal is to help the individual in crisis remain in the community by avoiding an unnecessary hospitalization or removal from the natural environment.

The Emergency Mental Health System serves as the central hub in the public mental health system.

- Operations Center, Telephone Triage and Crisis Hotline: 24-hour response line to help citizens, providers and emergency response personnel find appropriate information and resources for mental health services, general community resources, and crisis/suicide prevention hotline.

- Mobile Crisis Teams: From 10 AM - 1 AM, seven days per week, a team comprised of a mental health clinician and plain-clothed police officer are available to respond to persons in crisis, mental health providers, hospital emergency rooms, other agencies and the community at large. The mobile crisis team is available to respond to assess emergency mental health situation, stabilize a crisis situation and prevent unnecessary hospitalization. At this time the mobile crisis team is limited to respond to the Essex and Dundalk areas of Baltimore County.

- In-home Intervention Team: Specialized mental health professionals assist individual and families on an on-call and temporary basis. The service is designed to help stabilize less urgent crises and provide linkages to on-going services.

- Urgent Care Clinic: When an urgent mental health appointment is needed, a clinic is available from 6 PM - 10 PM, Monday - Friday and weekends.

- Non-Mental Health Emergency Housing: Temporary housing for those with a mental illness may be provided on a dad-to-day basis for those displaced in the community.

- Critical Incident Stress Management: Specialty trained clinicians are assembled to respond to community disasters and provide psychological intervention.

BRIEF PSYCHIATRIC ASSESMENT

1. Observations of Symptoms:
   a. Mood- happy, sad, agitated, rapid change
   b. Appearances- hygiene, speech, movements
   c. Hallucinations or Delusions- odd beliefs, unusual thinking style, hearing voices
   d. Awareness and Memory- concentration, oriented to person, place and time, alertness
   e. Insight and Judgement- do they see their own behavior as unusual

2. History:
   a. It may be helpful to use family members to obtain additional information.
   b. Inquire about past treatment experiences (psychiatric hospitalization, outpatient treatment)
   c. Ask about prior incidents of violence to self and others (inquire about arrests and convictions)
   d. Inquire about mental illness in other family members.

3. Medications:
   a. Learn basic medications (or carry a list in your wallet).

b. Ask about current and past medications.

4. Reasons for Non-compliance:
   a. Denial of illness
   b. Side effects
   c. Simple forgetfulness
   d. Mistrust of mental health professionals
   e. Medications do not work immediately
   f. No cure(medications may not completely rid person of symptoms e.g. person with schizophrenia may still hear voices)
   g. Lost medications
   h. Difficulty asking for help

MAJOR DEPRESSIVE DISORDER

Description: Major depressive disorder is a condition that affects up to 20% of Americans. Although it is found slightly more often among women and men, it is present in people of all ages, races, and income. People who suffer from major depressive disorder are at a great risk for self-harm. As many as 50% will attempt to end their lives with 15% completing suicide. Approximately 80% of those with depression can benefit from treatment with medications.

1. Assessment:
    a) Observation of Symptoms
        i) Mood: Usually depressed or irritable, loss of interests, recurrent thoughts of death/suicide.
        ii) Appearance: Appetite disturbance (eating more/less), weight loss, easily fatigued, complaints of backaches, sleep disturbances (more/less).
        iii) Hallucinations/delusions: Feelings of worthlessness or extreme guilt can be somewhat delusional
        iv) Awareness/Memory: Difficulty concentrating

v) Insight/Judgement: Many individuals with the above symptoms may not characterize themselves as “depressed”

b) History
   i) Ask about previous thoughts/acts of suicide as well as treatment experiences
   ii) From others inquire about the person’s impulsivity risk
   iii) Ask about family history of depression, suicide, and alcohol abuse

c) Medications
   i) Prozac, Zoloft, doxepin, Pacil, wellbutrin, trazodone, desipramine, etc.
   ii) Electro-convulsive therapy (ECT)

2. Intervention:
   a) Listening: People with major depressive disorder are often receptive to supportive listening. Due to poor concentration, the person may have a hard time formulating ideas or making decisions (be patient!).
   b) Information Gathering: Information presented is usually reliable, but problems may be minimized.

BIPOLAR DISORDER

Description: Bipolar disorder affects slightly more than 1% of Americans with a 10-20% rate of completed suicides. Persons with bipolar disorder experience periods of both extreme depression as well as periods of excessive energy and impassivity. About 70% of people with bipolar disorder can respond well to the proper medication treatment.

1. Assessment: (Mania)
   a) Observation of symptoms
      i) Mood: often an elevated or irritable
      ii) Appearance: Talkative, decreased need for sleep
      iii) Hallucinations/delusions: Thoughts are often racing (they sometimes jump from topic to topic), are frequently delusional (fixed/false belief)
      iv) Awareness/Memory: Distractible
      v) Insight/Judgement: Will not see own behavior as abnormal, many have an inflated sense of self worth

   b) History:

i) Impulsive crimes as well as risk taking behavior.
ii) When asking about past treatment experiences, inquire if the treatment was for depression or mania.
iii) Those suffering from bipolar disorder almost always have an immediate family member with a disorder.

c) Medications:
i) Depakote, lithium, Tegretol, Neurontin

2. Intervention:
a) Listening: Be patient, and ask direct questions.
b) Information Gathering: Make use of third parties, be sure to obtain a family history of mental illness and always ask about impulsive/violent behavior.

SCHIZOPHRENIA

Description: Schizophrenia is a mental illness characterized by an impaired perception of reality. This most often takes form of hallucinations, delusions or paranoia. People with schizophrenia usually do not relate well to others. Schizophrenia affects about 1% of the population.

1. Assessment
   a) Observation of symptoms
      i) Mood: often flat or deadened emotions.
      ii) Appearance: disorganized speech and behavior, and may be very disheveled and have poor hygiene.
      iii) Hallucinations/delusions: common, usually auditory hallucinations, may have very bizarre delusions.
      iv) Awareness and memory: May be very distracted by their hallucinations and therefore not aware of their surroundings (including you).
      v) Insight/judgement:poor

   b) History
      i) Prior treatment, and compliance with the treatment.

ii) Ask others who know the patient about his/her history, including history of impulsive violence.

c) Medications
   i) see list of antipsychotics and anticholinergics.

2. Intervention:
   a) Listening: Be respectful and professional. If the person is paranoid, being overly friendly may be viewed with suspicion. At times a "show of force" may be useful in avoiding impulsive violence.

   b) Information gathering: Depending on third party information, as the individual may have very poor insight and may not trust you.

ANXIETY DISORDERS-
PANIC DISORDER

Description: Panic disorder is a condition in which the individual experiences recurrent and unexpected panic or anxiety attacks. Although the symptoms of a panic attack usually last no longer than 30 minutes, the experience can be extremely frightening to the individual. Often, people with panic disorder will seclude themselves from others and remain at home, a condition called agoraphobia. When this is the case, it is usually done due to fear of having a panic attack in public.

1. Assessment:
    a) Observation of symptoms
        i) Mood: frightened or scared
        ii) Appearance: pounding heart, sweating, trembling, shortness of breath, chest pain, nausea, lightheaded
        iii) Hallucinations/delusions: May have a surreal or detached perception of their surroundings.
        iv) Awareness: may feel detached or "out of body"
        v) Insight/judgement: May have a fear of going crazy or of being about to die

b) History
   i) Prior treatment history
   ii) History of depression

c) Medications
   i) Ativan, Librium, Klonopin, Xanax, Valium
   ii) Prozac, Zoloft, Paxil, Celexa, Elavil, Pamelor

2. Intervention
   a) Listening: Be calm and supportive, as a calm voice may help to counter the agitation and sense of loss of control. Be patient and wait out the attack. Have a high suspicion of heart disease and a "heart attack".

   b) Information gathering: Try to assess if the person has had these attacks in the past and if so, if treatment has been obtained. Often, medical providers to not make the diagnosis correctly, and it is a very treatable disorder once diagnosed.

ANXIETY DISORDERS-
POST TRAUMATIC DISORDER

1. Assessment:
   a) Observation of symptoms:
      i) Mood: Emotions are usually deadened or restricted, often irritable
      ii) Appearance: Increased arousal, avoidance of things associated with the trauma. The person may experience frequent panic attacks.
      iii) Hallucinations/delusions: Sometimes have brief periods of hallucinations/delusions
      iv) Awareness/Memory: Difficulty concentrating, very alert to surroundings
      v) Insight/Judgement: Person may view self as being out of control

   b) History:
      i) Ask about a single trauma/event (i.e. rape) or a series of traumatic events (i.e. sexual abuse)
      ii) Ask about treatment history

c) Medications:
   i) Ativan, Librium, Valium, Xanax, Prosac, Zoloft, Paxil, Risperdal, Zyprexa, etc.
   ii) Counseling is primary treatment modality

2. Intervention:
   a) Listening: Be supportive, many victims blame themselves. Focus on building trust. Be supportive even if the victim is reluctant to press charges.

   b) Information Gathering: Keep in mind that it may be difficult for them to talk about the trauma.

RESOURCE LIST

B

Blankfeld, Robert MHS
Baltimore County Department of Health
6401 York Rd.
Baltimore, Md. 21212
Bus: 410-887-2731
Bus Fax: 410-887-4859
E-Mail: RBLANKFELD@CO.BA.MD.US

Behavioral Assessment Unit
Baltimore County Police Department
700 E. Joppa Rd.
Towson, Md. 21286
410-931-2145

Blizzard, Melvin Captain
Baltimore County Police
700 E. Joppa Rd.
Towson MD. 21286
Bus: 410-887-7343
E-Mail: MBLIZZARD@CO.BA.MD.US

Bull, Lisa
Mental Health Players
323 East 25th St.
Baltimore Md. 21218
Bus: 410-235-1178 x207
Bus Fax: 410-235-1180

C

Collins, Mary LCSW-C

PO Box 21247
Baltimore Md. 21228
Bus: 410-402-7619
Bus Fax: 410-402-7198
E-Mail: MCOLLINS@MPRC.UMARYLAND.EDU

D

DeBernardo, Caren Psy.D.
Forensic & Law Enforcement Services
1931 Greenspring Dr.
Timonium, Md. 21093
Bus: 410-560-5985

F

Farinholt, Katherine
NAMI
5210 York Rd.
Baltimore Md. 21212
Bus: 410-435-2600
Bus Fax: 410-435-0355
E-Mail: KFARINHOLT@YAHOO.COM

G

Greenberg, Sheldon Ph.D.
Johns Hopkins University
201 N. Charles St.
Baltimore Md. 21201
Bus: 410-516-0770
Bus Fax: 410-516-4869

H

Hancock, Stu BSW
Prologue Inc.
609 Baltimore Ave.
Towson Md. 21204
Bus: 410-825-0198

Hilliard, Deborah MSRN-CS
Sheppard and Enoch Pratt Health System
6501 N. Charles St.
Towson Md. 21204
Bus: 410-938-3520
Bus Fax: 410-938-3553
E-Mail: DHILLIARD@SHEPPARDPRATT.ORG

L

Lipford, Sharon LCSW-C
Baltimore County Department of Health
Bureau of Mental Health
6401 York Rd.
Baltimore, Md. 21212
Bus: 410-887-2731
Bus Fax: 410-887-4859
E-Mail: SLIPFORD@CO.BA.MD.US

P

Pascale, Katherine
State Attorney Generals Office
200 St. Paul Pl.
Baltimore Md. 21202

Bus: 410-576-6521
Bus Fax: 410-576-6314

R

Rapp, Charles Captain
Baltimore County Police Department
700 E. Joppa Rd.
Towson Md. 21204
Bus: 410-887-2201
E-Mail: CRAPP@CO.BA.MD.US

Rose, Sharon LCSW-C
Baltimore County Department of Aging
1 Investment Pl.
Towson Md. 21204
Bus: 410-853-3531
Bus Fax: 410-853-3599
E-Mail: SROSE@CO.BA.MD.US

Roskes, Eric MD.
Maryland Department of Corrections
Patuxent Institute
PO Box 700
Jessup Md. 20794
Bus: 410-799-8486
Bus Fax: 410-799-7457
E-Mail: EROSKES@JUNO.COM

S

Spencer, Rob MS
Baltimore Crisis Response Center
1105 Light St. 2nd Floor
Baltimore Md. 21030

Bus: 410-576-5097
Bus Fax: 410-576-9607
E-Mail: LUDITE1@STARPOWER.NET

Kaiser Sterns, Ann Ph.D.
614 Lake Dr.
Towson Md. 21286
Bus: 410-337-0897

Stewert, Bette
NAMI
Bus: 410-328-8747
Bus Fax: 410-328-0699

V

Votolato, Chris MS
Baltimore Crisis Response Center
1105 Light St. 2nd Floor
Baltimore Md. 21230
Bus: 410-576-5097
Bus Fax: 410-576-9607
E-Mail: CVOT1@STARPOWER.NET

W

White, Robert MA
Baltimore Crisis Response Center
1105 Light St. 2nd Floor
Baltimore Md. 21230
Bus: 410-576-5097
Bus Fax: 410-576-9607

Wiggins, Edgar MHS
Baltimore Crisis Response Center
1105 Light St. 2nd Floor

Baltimore Md. 21230
Bus: 410-576-5097
Bus Fax: 410-576-9607
E-Mail: RUNEDGAR@AOL.COM