



POLICE GUIDE

**For Responding to Youth
With Mental Health Needs**

Western New York Rural Mental Health Partnership
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Responding to Youth
With Mental Health Needs

DEDICATION

We dedicate this Guide to all police officers who serve and protect our homes, our communities, and our families. We honor your courage and praise your dedications. We salute your commitment to all members of society and we appreciate and thank you for your understanding and respectful treatment of our mentally troubled youth.

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ABOUT MENTAL ILLNESS

Mental illness can affect anyone. It is not a sign of weak character or lack of intelligence. Many well known people suffer with depression, bipolar disorder, or other mental health problems. Most mental illnesses are biological, caused in part by imbalanced brain chemicals. This can negatively effect behavior, judgment, perception, and other functions. It should not be assumed that youth with mental health disorders have been abused. In fact, many youth who have mental health disorders also have loving homes and devoted parents.



Sometimes a mental health need will emerge suddenly, but usually they develop over a period of time. Many young people go undiagnosed until their symptoms worsen in adolescence or young adulthood. **At any given time, one in every five youth suffer from a mental health problem. Two-thirds of them are not getting the help they need.**

When an officer encounters a youth with extreme behaviors the officer should consider the possibility of an undiagnosed mental health need and may need to refer the youth for a professional mental health evaluation.

All types of mental health conditions can be diagnosed and treated. Most youth with mental health needs lead fairly normal lives once their symptoms are controlled. Treatment and positive relationships with caring adults can allow them to live their lives much like their peers.

PARENTS AS ALLIES

Parents can be strong and effective allies to officers who are responding to a situation involving mentally troubled youth. Clear communication from the officer will help the parent to stay calm and be supportive as the officer interacts with the youth.

Additionally, the parent may have previously experienced similar situations with the youth and may be able to advise the officer about approaches that could defuse the situation, or conversely, provoke a negative or even hostile response.

In some cases, it may be unclear if a youth has a mental illness.

In these cases an alert and informed police officer can suggest to the parent that a professional mental health evaluation may be needed.

The officer can reassure and advise the parent, or when appropriate, assist in obtaining an evaluation by calling for a crisis team to intervene. Informed advice from a law enforcement professional can give a parent new insight into how to help the youth.

In particularly difficult situations, a parent may be frightened by a youth's aggressive or violent behavior, but is nevertheless, reluctant to call the police. The parent may fear a community's zero tolerance domestic violence policy, or assume that the officer will not understand the mental health problems and will arrest the youth. This is a valid fear.

Usually a parent needs reassurance that the officer's objective is not to arrest the youth, but to help.

PUBLIC SAFETY

Most young people with mental health needs are no more violent or dangerous than those in the general population. In fact, many are withdrawn, fearful and uncomfortable dealing with others. If they become aggressive it is usually because they feel frightened, confused, or hopeless. Sometimes youth who are severely ill do not realize it. This lack of perception can cause a severely mentally disturbed youth to be unable to accurately assess their surroundings or understand what is said to them.

Fear and confusion about where they are and what is happening can lead to unpredictable responses and may pose a threat to the personal safety of the troubled youth, the responding officer or others at the scene.

However most youth with mental health needs are not this severely affected.

Maintaining public safety may be especially challenging when a youth has never been diagnosed, has stopped taking prescribed medication, or has a dual diagnosis; that is, has a major mental health disorder and a co-occurring substance abuse problem.

Even if an officer feels no threat to his or her own safety, the officer must keep on guard to the possibility that a mentally troubled youth may try to hurt him

or herself, or react in a dramatic fashion to a perceived threat from the officer's presence, actions, the surroundings, or anything else.

In such cases, the responding officer may find modifying standard procedures to meet the needs of these young people works best.

ON-SCENE ASSESSMENT

It is not easy to distinguish between alcohol or substance intoxication, mental retardation, epilepsy, mental illness, and some other medical conditions. In fact, "self-medication" with alcohol or illegal drugs is a common complication found in adolescents with mental health problems. This makes it even more difficult for police to evaluate and properly respond to the conduct of the mentally troubled youth.

Important note: Involuntary behaviors such as impulsiveness and flawed thinking are recognized symptoms of mental illness, and are worsened by substance abuse. Law enforcement officers can augment their life saving function of stopping risky behaviors with an informed and compassionate approach.

The following observations may signal the presence of a mental health need:

- history of mental health problems, and/or possession of psychiatric medications
- a plain, emotionless facial expression and body language
- incoherent thoughts or speech
- inability to focus or concentrate
- bizarre appearance, movements or behaviors
- delusions of personal importance or identity; unrealistic over-confidence
- hallucinations or perceptions unrelated to reality
- agitation, often without clear reason
- pronounced feelings of hopelessness, sadness or guilt

DISPOSITION

Many non-dangerous calls involving youth with mental health needs are best handled by supporting the parent's wishes and encouraging professional mental health intervention.

If the youth is a danger to him/herself or a serious threat to others the officer must decide whether to arrest (if a crime has been committed) or initiate a mental health evaluation.

When an officer determines a professional mental health evaluation is needed the officer may choose (in accordance with local law enforcement policy) to consider one of the following options:

- Transport the youth to the local crisis team or ER in a police vehicle.
- Summon the local crisis team to the scene to evaluate the youth.
- Escort the parents as they transport their child to the crisis team or ER.
- Stay on the scene until an ambulance arrives and the EMS team is sufficiently informed to take charge of the situation.
- Leave the youth in the care of their parent or guardian.
- Some other appropriate action that complies with the local standard procedures.



A professional evaluation is often the first step for a youth to receive treatment. This is necessary to discover the underlying cause of the youth's behaviors and symptoms, and to determine what interventions will help most.

A treatment plan may include individual, group, and/or family therapy. Other therapy types include anger management, behavioral therapy, social skills training, and therapeutic recreation. The plan may also include intervention for a learning disability.

CLINICAL RECOMMENDATIONS

The following suggestions are from mental health professionals. A strategy that includes patience is more likely to defuse a tense situation with a troubled youth.

- Stay calm and don't overreact.
- Be friendly and accepting but remain firm and professional.
- Remove upsetting influences, distractions, and people from the scene.
- Gather information from family or bystanders.
- Indicate that you are trying to understand. Reassure the youth that you are there to help, not harm.
- Speak simply and briefly, and announce your actions before initiating them.
- Do not move suddenly, shout or give rapid orders.
- Avoid direct, continuous eye contact.
- If possible, do not touch the youth. Do not crowd his/her "comfort zone".
- Ask the youth for their cooperation, and allow them time to respond.
- Understand that you may not have a rational discussion, but try to keep conversation concrete by redirecting the topic when needed.
- Be aware that your police uniform and equipment may frighten the youth. Multiple officers may increase the youth's level of agitation.
- Do not express anger, impatience or irritation.
- Do not force discussion or assume that an unresponsive youth cannot hear you. They may not understand or may be unable to respond.
- Recognize that the youth may be overwhelmed by sensations, thoughts, surroundings, frightening beliefs, internal sounds or voices.
- Acknowledge that the youth's delusions are real to him or her.
- Do not argue with delusional statements, or mislead the youth to think that you feel or think the same way.
- Do not use inflammatory language, such as "wacko" or "psycho" in the youth's presence or in the nearby vicinity. Mental health disorders do not affect a youth's ability to hear.



POINTS TO REMEMBER

- A police officer's ability to recognize symptoms of mental illness can be invaluable when assessing a scene.
- Symptoms of mental illness often first appear during adolescence.
- Mental illness and bizarre behavior are not criminal.
- Failure to follow police instructions during a psychotic episode is most likely NOT a deliberate act of defiance.
- These youth heal with treatment, not jail. When incarcerated, illness often worsens, especially if psychiatric medications are withheld.
- Four out of every five runaway youth suffer from depression. (US Select Committee on Children, Youth & Families).
- Suicide is a serious concern. Suicide is the third leading cause of death for 15-24 year olds (approx. 5,000 youths each year) and the sixth leading cause of death for 5-15 year olds. Tragically, the rate of youth suicides has nearly tripled since 1960.
- Desperate parents can be guided to appropriate community resources by a knowledgeable officer.
- A sensitive intervention by a police officer can be a reassuring and steadying influence on a struggling youth, and can encourage the youth to cooperate. Police officers have a unique and phenomenal ability to "make things better".

MENTAL HEALTH DISORDERS

The growing complexities and increased pace of our society and culture have brought new pressures to bear, making childhood and adolescence a more complicated, confusing and dangerous experience than ever before. Research has shown that prolonged stress can create changes in the brain and its function. Mental illnesses are now being diagnosed more accurately (and frequently) in children as scientific understanding of the brain progresses. Using modern imaging technologies,

researchers have also discovered brain differences in some mentally ill youth. Some of the most commonly diagnosed mental health disorders are listed below.

ANXIETY DISORDERS

Anxiety disorders fall into several categories including panic disorder, general anxiety disorder, and phobias. These disorders may have a biological basis or be triggered by environmental causes.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (AD/HD, ADD, ADHD)

AD/HD youth find it hard to sit still, control their behavior, and pay attention. They may be disruptive, disorganized, have difficulty following instructions, and may “over-focus” on favorite activities. Youth with AD/HD often lack social skills and have trouble making and keeping friends. Law enforcement officers may encounter these youth when they act before they think. AD/HD youth have been known to run into traffic, reach into the kitchen blender, or climb too high, all without considering the consequences.

BIPOLAR DISORDER

Bipolar disorder, also known as manic depressive illness, is a serious but highly treatable brain disorder. A bipolar youth experiences highs and lows: periods of mania and depression with normal moods in between.

Law enforcement officers may encounter bipolar youth more often than those with other mental health disorders. Attention seeking behavior can sometimes become disorderly or aggressive. The youth may fall in with “the wrong crowd” or self-medicate (experiment with alcohol and drugs) since they are often unable to determine the consequences of their actions.

BORDERLINE PERSONALITY DISORDER (BPD)

Youth with BPD are impulsive and unstable in their moods, personal relationships, and self-image. They have dramatic mood swings with periods of depression, extreme irritability, anxiety, and uncontrolled anger.

CONDUCT DISORDER

More research is needed to better understand youth with this disorder, a complicated group who persistently disregard rules and violate other’s rights. Inappropriate and socially unacceptable behaviors often cause these youth to be viewed as delinquent rather than mentally ill. Their anger takes several forms including verbal and physical aggression. Common behaviors include: bullying,

threatening or intimidating, stealing, running away, lying, fire setting, truancy, breaking and entering, vandalism, cruelty to animals, fighting, and confrontation. Explosive anger is the primary maladaptive behavior and causes significant interference in social, academic, and occupational functioning.

DEPRESSION / MAJOR DEPRESSION

Clinical depression goes well beyond sadness, and is much more than having a bad day or coping with a major loss. Youth who suffer with depression cannot “snap-out-of-it” by trying hard. Symptoms include persistent sadness and hopelessness, withdrawal from friends or activities, and poor school attendance or declining academic performance. The youth may experience a distressing level of indecision, an inability to concentrate, excessive sleep, a change in eating habits, a feeling of numbed emotions, and frequent physical complaints. A youth who is attempting to escape their depression may try to self medicate with street drugs or alcohol. There may be thoughts of death or suicide.

Any attempt at suicide, even an apparently small gesture, should receive professional intervention, since they often represent “the tip of the iceberg”. Treatment usually includes a combination of counseling and antidepressant medications.

DISSOCIATIVE DISORDERS

This group of disorders is believed to be a response to trauma, as the effected individual attempts to distance themselves from something too awful to include in their view of themselves. Dissociative symptoms, or a full-blown Dissociative Disorder, can occur within another diagnosis especially the Anxiety Disorders, such as PTSD. Treatment of these disorders is similar to that of other disorders stemming from abuse or trauma.

EATING DISORDERS

The 3 main categories of eating disorders include compulsive overeating, anorexia, and bulimia.

NON-VERBAL LEARNING DISABILITY (NLD/NVLD)

NLD is a learning disability thought to result from differences in the “wiring” of the brain that influence perception and behavior.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

This disorder is characterized by repetitive, intrusive, and unwanted thoughts (obsessions) and/or rituals (compulsions) that seem impossible to control.

OPPOSITIONAL DEFIANT DISORDER (ODD)

ODD is a pattern of disobedient, hostile, and defiant rule breaking that lasts for an extended period and is longer than a typical child or adolescent “phase”. Many ODD youth also have co-occurring AD/HD, anxiety, depression, learning disabilities, or other mental health disorders.

SCHIZOPHRENIA

Schizophrenia is a very serious mental illness that usually emerges in late adolescence or young adulthood. The symptoms of schizophrenia are characterized as either positive or negative.

Positive symptoms include bizarre behavior and psychosis, which refers to hallucinations, delusions, thought disorders, and hearing voices. Negative symptoms include an emotionless expression, apathy, and withdrawal.

Thought disorders are the diminished ability to think clearly and logically. Language may sound garbled to them, or their own speech may be garbled. Delusions are false beliefs, such as thinking others can hear their thoughts. Paranoid delusions are false beliefs that an outside force threatens them. For example, they may believe that aliens or an enemy government are attempting to steal the thoughts from their head.

Hallucinations are false perceptions which may be heard, seen, or felt, and may be perceived as voices. The voices may warn of danger, tell the youth to take some action, or simply comment on life. Some youth hear multiple voices.

Schizophrenia differs from other mental health disorders in that it is rarely controlled without strong psychiatric medications. However, once the schizophrenic youth adheres to a program of regular medication and therapy, there is substantial hope for a normalized life, including education, employment, family and friends.

SELF-INJURING BEHAVIORS

Self-injuring behaviors are intentional, but non-life threatening, attempts to escape psychological pain by the self-infliction of physical pain. This is most often, but not exclusively, practiced by girls and is done solely for the self-injurer, not as an attempt to manipulate others.

SENSORY INTEGRATION DYSFUNCTION (SID)

These youth process sensations inaccurately, in a way that causes either over-sensitivity or under-sensitivity to stimulation. Youth who are under-responsive to a sensation may seem “wound up” and talk too loud, or touch others too much or too hard. They may even hurt themselves without noticing. Youth who are over-

responsive may react negatively to motion, loud or busy environments, bright light, touch, or food smells. They may react with aggression, withdrawal, or even nausea.

PSYCHIATRIC MEDICATIONS

Many very effective medications are available for the treatment of mental health disorders. Most youth who have a known diagnosis are prescribed medications; however, they may not be taking them as prescribed. Some psychiatric medications have side effects. Their effectiveness can be altered by the consumption of alcohol, caffeine, citrus, some herbal supplements and over the counter medications, or smoking cigarettes.

Some commonly prescribed medications are listed on the following pages, grouped in categories of illnesses they are used to treat. Many of them are used to treat more than one type of disorder. Each medication is listed by its brand name, followed by the generic name in parentheses.

CAUTION: This information is not complete and should not be used for diagnosis or treatment. For more complete drug information, see <http://www.nami.org/> or <http://www.medscape.com/> (free registration).

ANTI-DEPRESSANTS

Anafranil (clomipramine)
Celexa (citalopram)
Desyrel (Trazodone)
Elavil or Endep (amitriptyline)
Effexor (Venlafaxine)
Luvox (Fluvoxamine)
Marplan (isocarboxazid)
Manerix (moclobemide)
Nardil (phenelzine)
Norpramin (desipramine)
Pamelor or Aventyl (nortriptyline)
Parnate (tranylcypromine)
Paxil (Paroxetine)
Prozac (Fluoxetine)
Remeron (mirtazapine)

Serzone (Nefazodone)
Sinequan or Adapin (doxepin)
Tofranil (mipramine)
Triptil or Vivactil (protriptyline)
Wellbutrin (Bupropion)
Zoloft (Sertraline)

STIMULANTS - *Treats AD/HD*

Adderall (dextroamphetamine sulfate)
Concerta (methylphenidate hydrochloride)
Cylert (Pemoline)
Dexedrine (Dextroamphetamine)
Ritalin (Methylphenidate)

ANTI-ANXIETY AGENTS

Treats anxiety and panic disorders.

Ativan (lorazepam)
Buspar (buspirone)
Centrax (prazepam)
Inderal (propranolol)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Paxil (paroxetine)
Serax (oxazepam)
Tranzene (clorazepate)
Valium (diazepam)
Xanax (alprazolam)
Zoloft (Sertraline)

ANTI-OBSESSIVE AGENTS

Treats obsessive-compulsive disorder (OCD).

Anafranil (clomipramine)
Luvox (fluvoxamine)
Paxil (paroxetine)
Prozac (fluoxetine)
Zoloft (sertraline)

ANTI-PSYCHOTIC AGENTS

Clozaril (clozapine)
Haldol (haloperidol)
Loxitane (loxapine)
Mellaril (thioridazine)
Moban (molindone)
Navane (thiothixene)
Prolixin (fluphenazine)
Risperdal (risperidone)
Serentil (mesoridazine)
Seroquel (quetiapine)
Stelazine (trifluoperazine)
Thorazine (chlorpromazine)
Trilafon (perphenazine)
Zyprexa (olanzapine)

MOOD STABILIZERS

Used to treat bipolar disorder, aggression, and depression.

Depakote (valproic acid)
Eskalith, Lithobid, Lithonate, and Lithotabs (lithium)
Lamictal (Lamotrogine)
Neurontin (Gabapentin)
Tegretol (carbamazepine)
Topamax (Topiramate),

ANTI-AGGRESSION AGENTS

Catapress
Inderal

MEDICATIONS TO TREAT SUBSTANCE ABUSE

Antabuse (disulfiram) used in management of chronic alcoholism. Even small amounts of alcohol taken when this drug is in the body will make the patient ill, a severe reaction can be fatal.

Atarax, Vistaril (hydroxyzine)

This allergy drug is often used to treat nausea & vomiting, anxiety, and psychiatric emergencies including acute alcoholism.

Serentil (mesoridazine) - alcoholism

Catapress (Clonidine)- nicotine or opioid withdrawal symptoms

Dolophine, Methadose (methadone)

Treats narcotic withdrawal symptoms, can be habit-forming.

Trexan (naltrexone).

Also used to treat alcohol dependence.

NOTE: Alcohol withdrawal symptoms may also be treated with Librium (chlordiazepoxide)

Tranzene (clorazepate)

Valium (diazepam)

Serax (oxazepam)