Law Enforcement and Disability Training

by

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A dissertation submitted to the Graduate Faculty of
Auburn University
in partial fulfillment of the
requirements for the Degree of
Doctor of Philosophy

Auburn, Alabama
December 18, 2009

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Abstract

To further the body of knowledge which determines efficacy of academy police training in the area of disabilities, this study examines the content of law enforcement training curricula for information related to mental illness, mental retardation and pervasive developmental disorder. Seventeen states responded, representing all five regions of the United States and were representative of states with large urban industrialized areas, and relatively large populations, as well as states dominated by a rural agrarian economy and smaller populations. Each curriculum was critiqued using a code sheet containing predetermined criteria for each disability.

Acknowledgments

       I would like to begin by thanking my family. No words can express how much I love

you and appreciate your unwavering support. To my mom and dad: Thank you for always

having high expectations and unending support. I am truly blessed to have parents that not only

express their love through words but through actions! I know that I would not be the person I am

today with out you. To my sisters: I want you all to know that I count myself extremely lucky to

have three wonderful sisters. You are each beautiful, talented and I am a better person because

of each of you! To my Nongi and Paw: Thank you for always being a huge part of my life. Few

people have grandparents that are as big a part of their lives as you have been. To the Meade

family, I would like to extend my appreciation for your love and support not only to me but to

Benjamin when I was consumed with school and other responsibilities.

       I would like to thank each member of my committee. It is a huge commitment to oversee

a dissertation and your hard work and support are greatly appreciated. A special thank you is

extended to Dr. Daniel Clay for leading my committee and helping me complete this goal. I

would also like to thank Dr. Margaret Shippen for being a wonderful mentor.

       Lastly but certainly not least I would like to thank my husband Benjamin. You have

always and continue to "WOW" me in ways you don't even know. You have always supported

and fueled my dreams and desires even when it meant a hardship for our family. While it might

be silly, I also want to thank my "pack", Dozer, Riley, Sam and Alley. I RUFF you all!

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I. INTRODUCTION

Statement of the Problem

There are over 300 million people in the United States, of which nearly 274 million are

identified as having one or more disabilities of some type. With that in mind, the PEW Report

(2008) recently noted that the U.S. prison population nearly tripled between 1987 and 2007, and

nearly 1.6 million people are held in state or federal custody with an additional 724 thousand

serving time in local jails. These statistics equate to a startling fact: one in 100 individuals are

incarcerated and one in 31 are on probation or parole in the United States (PEW Report).

Assuming these statistics to be accurate, more than 2 million individuals with disabilities

identified or not, are currently incarcerated in U.S. prisons. In 2002, the National GAINS

Center, which is part of the United States Department of Health and Human Services, found that

nearly three-quarters of jail detainees with severe mental illnesses also had co-occurring

disorders and often had complicated histories of unemployment, homelessness, addiction,

victimization and inadequate health care.

A 2009 study conducted by Steadman found that 14.5% of males and 31% of females

recently admitted to jails have a serious mental illness. In many instances, law enforcement

officers serve as gatekeepers, deciding whether an individual will proceed into the criminal

justice system, the mental health system or simply be ignored (Wells & Schafer, 2006).

Accordingly, it becomes apparent that there should be a strong emphasis in law enforcement

training on recognition of disability and appropriate interaction between officers and individuals

who may be exhibiting symptoms of disability, particularly in situations of first contact. Whether police encounter the individual with disability as the perceived victim or perpetrator, the incident would be handled more efficiently and humanely if the officer on the scene were able to bring enhanced training in disabilities to bear on the situation.

Unfortunately, stories from across the U.S. point to the fact that many police officers can be unprepared to deal effectively with individuals who do not fall into the expected criminal mold. Gaps in police skills become apparent when they are faced with unfamiliar patterns of behavior in a perpetrator or victim. Consider the following accounts of interaction between police officers and persons with disabilities:

- In 1985, a young man with a diagnosis of autism suffered internal injuries, including the eventual loss of one kidney, after police forcibly subdued him because he ran when he saw a police car, thereby arousing suspicion. A ten million dollar damage claim was filed against the police (Debbault, 2002).

- A man with severe mental retardation suffocated when police officers sat on him to subdue him. His mother had called the police for assistance when her son became abusive. According to his sister's statements, the man had a vocabulary of only a few words and did not have the mental capacity to understand and follow the officers' orders (McKinley, 1989).

- In 1991, an individual who was deaf died after a struggle with police officers in Washington, D.C. Witnesses claimed that the man threatened police with a metal bar, but was unable to communicate that he could not breathe when officers held him down (Escobar & Castaneda, 1991).

With events such as these occurring in our nation, clearly more awareness and training is needed for frontline law enforcement. Each state has a governing body for law enforcement training identified as the Peace Officer Standards and Training Commission or Council. These governing organizations serve a common purpose in all 50 states and will be referred to as the Peace Officer Standards and Training Commission or POSTC in this paper. The POSTC designs and mandates basic training requirements for employed officers. Without proper training and awareness, citizens may not receive the most effective service from law enforcement personnel and the potential for mistreatment may increase.

<div align="center">The Criminal Justice System</div>

The Bureau of Justice Statistics (2004) found that in 2001 the federal, state and local governments in the United States spent $167 billion on police protection, judicial and legal services, and corrections. The three components of police, courts and corrections comprise the criminal justice system (Gaines and Miller, 2006). Crime control in a democratic society is complex because it must be achieved without abandoning the notion of justice; the rights of the individual must be balanced against the good of society at large (Hagan, 2008). A democratic society uses the "due process model" in which individuals are presumed innocent until proven guilty and as such, the individual's rights must be protected from the time of apprehension to conviction (Hagan).

This due process model operates under the assumption that it is better to err on the side of caution; a guilty person should go free before an innocent person is unjustly convicted. The due process model focuses on protecting constitutional rights at every stage of the criminal justice process. This is the reason why police, the first line of defense in criminal apprehension, must be aware of their responsibilities to serve wisely, with knowledge, efficiency and compassion in

every case (Gaines & Miller, 2006). The following section will outline how individuals with disabilities are identified by the medical and clinical professions.

Diagnostic and Statistical Manual of Mental Disorders

The need for a classification of mental disorders has been clear throughout the history of medicine (DSM-IV-TR, 2000). While the need for a classification system has been apparent, there has been little agreement on which disorders to include. In the United States, the initial motivation for developing a classification system was to collect statistical information. In an attempt to collect these data, the 1840 census questioned citizens about the single category of "idiocy," further described as "insanity." In the 1880 census, seven categories were included: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. In 1917, a "Committee on Statistics" became known as the American Psychiatric Association (APA) and, together with the National Commission on Mental Hygiene, formulated a plan for collecting uniform data in U.S. mental hospitals. The plan was accepted by the Bureau of the Census.

The United States Army adopted a broader version of the plan and the Veterans Administration later modified the plan to better incorporate the outpatient needs of World War II servicemen and veterans. Known as the International Classification of Diseases (ICD), the ICD was revised six times before a new variant became known as the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952. The 1952 DSM contained a glossary of descriptions of diagnostic categories and was the first official manual on mental disorders to focus on clinical unity (American Psychiatric Association, 2000). The DSM continued to be revised and is now in its sixth revision. The current Diagnostic and Statistical Manual is known and referred to as the DSM-IV-TR which indicates fourth version with text revisions.

The DSM-IV-TR provides a classification of mental disorders. While no single definition adequately specifies or operationally defines the boundaries of mental disorder, the DSM-IV-TR attempts to provide parameters for each classification included. In the DSM-IV-TR, each of the disorders is "conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with significantly increased risk of suffering death, pain, disability or an important loss of freedom" (2000, p. xxxi).

Included in the DSM-IV-TR are 18 major categories of disorders with 320 subheadings. The researcher acknowledges the volume of detail and the number of disorders included in the DSM-IV-TR, but for the purposes of this study only the categories of Schizophrenia, Bi-Polar Disorder, Mental Retardation and Pervasive Developmental Delay will be included. These are fairly broad categories, but still very limited in scope when it comes to the full range of human disability. Each is categorized by symptomology, such as lack of communication skills or inability to follow simple direction that are easily discerned as abnormal behavior by the general populace. Accordingly, law enforcement are not taxed to the point of needing diagnostic skills in order to recognize such disability, but still find value in information that enables them to deal effectively with a victim or perpetrator displaying such symptoms. Other disabilities are also worthy of consideration, but this study purposefully limits the range to disabilities with symptomology that may seem perplexing to law enforcement, particularly in a situation of first response.

In addition, the focus of this study has been narrowed to the aforementioned disabilities to add detail and depth to the studies conducted by Gerald Murphy (1986), and most recently James McAfee and Stephanie Musso (1995). To incorporate the input of McAfee and Musso

and to glean any additional information which might prove pertinent to the conduct of this study,

attempts were made to contact the authors. None of the attempts proved successful. Also,

Schizophrenia, Bi-Polar Disorder, Mental Retardation and Pervasive Developmental Delay are

disabilities that reflect the author's personal areas of interests. The author's interest is

substantiated by the fact that, within the United States population, schizophrenia alone affects up

three million people (Center for Disease Control, 2009). Bi-Polar Disorder, in one form or

another, affects 5.7 million Americans or 2.6% of the population and Mental Retardation affects

2-3% of the population. It is estimated that 3.4 of every 1000 children are diagnosed with a

Pervasive Developmental Delay (National Institute of Mental Health, 2009). In-depth

information about each area of disability will be provided in Chapter 2.

Individuals with Disabilities and Police Interaction

By the end of the nineteenth century, the placement of individuals into institutions was a

well established societal practice. While institutions were initially grounded in the ideals of

protection and training for those individuals unable to care for themselves, conditions quickly

deteriorated. Overcrowding and minimal staffing spiraled to even greater levels when financial

support waned and a destructive cycle of patient neglect ensued (Gargiulo & Kilgo, 2000).

Sanitation was poor and even individuals who entered the institution in good health often became

ill while living there. In many institutions, such as the Willowbrook State School in New York,

the rate of hepatitis contagion was 100%. As conditions worsened, society turned a blind eye,

preferring to keep the unpleasant facts hidden from the public conscience.

In the 1960s, civil rights and social reform became the themes of the era and society

began to change. President John F. Kennedy created the President's Committee on Mental

Retardation to investigate and recommend reforms in the institutional system. Finding the

current conditions "deplorable," Kennedy vowed to move individuals out of their

institutionalized surroundings and provide services in the "least restrictive setting possible"

(Murphy, 1986). The traditional treatment of long-term hospitalization or asylum care was

discarded in favor of treatment within the community (Murphy). In 1961, the Joint Commission

on Mental Illness and Health in the United States published a comprehensive review of research

across the span of five years. Titled "Action for Mental Health," the Joint Commission found

that individuals suffering from mental illness were not being effectively treated within

institutions. The Joint Commission findings and Kennedy's call for improvements led to the

Mental Retardation Facilities and the Mental Health Centers Construction Act of 1963. As a

result of increasing public awareness and government concern, affected individuals were now

moved closer to their families and became entitled to services in their home communities at local

mental health agencies (Fishley, 1992).

Patients' rights became an area of litigation that would also continue to influence the

movement to deinstitutionalize those with disabilities. Three cases contributed significantly to

the deinstitutionalization movement: Rouse v. Cameron (1966), Wyatt v. Stickey (1972), and

O'Connor v. Donaldson (1975). All three cases held that patients are entitled to release from

state hospitals if the hospitals fail to provide treatment. The cases of Wyatt and O'Connor

specifically held that non-dangerous patients cannot be kept in an institution if they are not

receiving treatment and can also survive safely outside the hospital environment (Murphy, 1986).

In addition, Rogers v. Okin (1980) and Rennie v. Klein (1981) confirmed the right of those

living with mental illness to live in the community without treatment. Table 1 lists and

summarizes these five cases introduced above.

Table 1

Deinstitutionalization Court Cases

Year	Court Case	State	Results/Findings
1966	Rouse v. Cameron	DC	Right to treatment while institutionalized
1972	Wyatt v. Stickney	AL	Partlow State School Was found to be a warehousing institution capable only of deterioration and debilitation of the residents
1975	O'Connor v. Donaldson	FL	Non-dangerous persons have a constitutional right to liberty
1980	Rogers v. Okin	MA	Patient's right to refuse medical treatment
1981	Rennie v. Klein	NJ	Patient's right to refuse medication

While the concept appeared quite reasonable in theory, deinstitutionalizing thousands of long-term patients proved to be difficult at best. In the late 1960s, large numbers of individuals diagnosed with mental illness and mental retardation were released into the community and into the care of families ill equipped to care for them (Earley, 2006). Mental health networks and social services were slow to develop and understaffed for a rapidly expanding caseload. Often, community-based social and mental health services offered inadequate programs and were not specifically designed to deal with individuals who had few social skills, limited financial resources and occasional aggressive tendencies towards themselves or others (Murphy, 1986). Delivery of services was often impeded by bureaucratic "red tape" or other obstacles, and often by the individual's right to refuse treatment (Murphy). State laws, such as California's

Lanterman-Petris-Short Act in 1969, imposed strict guidelines for involuntary commitment along with strict limits on the duration of such commitments (Murphy).

Now faced with a new group of individuals, many of whom were challenged by an inability to make sound judgments and take responsibility for themselves, yet legally required to do so, law enforcement became increasingly pressured by neighborhoods to "do something" with these individuals who often lived outside societal norms. Many individuals with mental health needs were homeless, adrift due to a lack of low-cost housing, recession, and cutbacks in federal subsidies and entitlement programs (Murphy, 1986). In the ranks of the young people with mental disabilities, alcohol and drug addiction often made illnesses such as schizophrenia harder to recognize. Law enforcement officers, few of whom had any knowledge or training in recognition of mental illness, were forced to make immediate decisions on the street to resolve urgent problems. In recognition of the fact that the immediate solution may do little to prevent future problematic reoccurrences, police officers had the option to refer individuals to mental health clinics or hospitals, but the admission paperwork was complicated and time consuming (Murphy). Very often, despite an officer's attempt to locate assistance, the individual with a mental disability refused treatment or other help. As a last resort, officers were instructed to contain an individual only when he appeared to be disoriented or agitated due to substance abuse, a danger to himself or others, in need of medical treatment, or gravely "disabled." Operating most frequently under a "contain first and ask questions later" philosophy (Murphy, 1986), such an unwritten policy has led some individuals to question how and with what content law enforcement officers are trained.

Law Enforcement Training

Improving the awareness and education of law enforcement officers has been an enduring feature of reform in the area of criminal justice. While the desire to employ professionally trained officers can be dated back to the 1930s, the notion did not receive full support until the advent of individuals such as August Vollumer and the publication of the Wickersham Commission Report (Sullivan, 2005). After World War II, a high school education became the basic minimum requirement for entry into the police force and a college degree became a desirable goal. In 1967, the work of the President's Commission on Law Enforcement and the Administration of Justice turned the goal of a college education into an official recommendation. The Law Education Program began offering incentives for officers who obtained a college degree. Currently, formal education of law enforcement officers occurs in two arenas: institutions of higher learning outside the realm of law enforcement and in police institutions/academies that refine judgment and skills to the specific responsibilities of law enforcement such as maintaining the public safety (Sullivan, 2005). Attendance in academies is deemed law enforcement training.

By 2000, 15% of local police departments required at least some college education, an increase over the 10% which required some higher education in 1990. In 2000, only 1% of departments required completion of a baccalaureate degree, but most departments required a degree for advancement and pay increases (Sullivan, 2005). A national sample survey conducted in 1990 showed that 85% of law enforcement officers had attended college, 28% had obtained a baccalaureate and 6% had at least some graduate or professional education beyond the basic four years. No specific information on training and awareness in disabilities was provided in this report (Sullivan).

Although there is descriptive information about the numbers of officers that attend college-level courses as part of their career preparation, little is known about the nature and quality of the courses being taken (Sullivan, 2005). The public generally supports the notion that police should be well educated, but the available body of research does not necessarily support any connection between higher learning and the ability to make quality judgments in urgent situations. Thought processes and communication skills, expert judgment, enhanced knowledge, tolerance and compassion may not always be the outcome of a generalized education in the college setting. The minimal research presently available measures officers' attitudes rather than performance. Shernock (1992) found that officers who are college graduates are less cynical, less punitive, less prejudiced and less inclined to be an authoritarian personality. Additional research by Shernock based on officers' official records found college educated law enforcement received fewer complaints and boasted a quicker response time. A study conducted in 1981 found that education was unrelated to the use of lethal force (Sullivan, 2005).

An area of law enforcement preparation that has been rarely researched and publicly critiqued is the training received by law enforcement officers at police academies or other institutions. Specifically, there is little research focused on the training received by officers in the realm of individuals with special needs. In 1986, Gerald Murphy published *Special Care: The Police Response to the Mentally Disabled*. This publication was the result of a year-long study that focused on the manner in which police and mental health agencies address the needs of individuals with mental illness. Murphy's data were collected via surveys of law enforcement policies, procedures and training. In addition, data were derived from interviews with police officers, managers and chiefs as well as mental health professionals. Information on training practices were collected from 38 police academies serving 172 law enforcement

agencies. Written information on police practices were obtained from 51 law enforcement agencies and telephone contacts were made to obtain additional information. The 51 agencies surveyed were located in 22 states and served 13% of the U.S. population. Murphy found that officers were in contact with individuals who were mentally ill or mentally distressed as often as they apprehended individuals for murder, all types of manslaughter, rape, robbery, aggravated assault and grand theft together.

A 1979 study by Janus et al. found that 16 hours of abnormal psychology training, with descriptions of psychiatric disorders and syndromes, improved the attitudes of officers toward those with mental illness and the mental health system. Despite this, Murphy found that the average length of time devoted to these topics in 1986 was 4.27 hours. The range was a low of 90 minutes to a high of 22 hours. Two of the departments surveyed by Murphy did not conduct any training on mental illness at all.

Almost ten years later, James McAfee and Stephanie Musso (1995) added to the body of research by again attempting to quantify the amount of training in mental illness and disabilities received by law enforcement officers. Mcafee and Musso's extensive review of the literature yielded the same difficulties as the current author has encountered: little to no sources on the topic of police training and disabilities. Police and criminal justice journals have yielded no material on this topic within the last 15 years. Only one source cited by McAfee and Musso, Problem-Oriented Policing by Goldstein in 1990, discussed police interaction with deinstitutionalized persons with mental illness. Additional information gleaned from the article consisted of a simple list of persons with disabilities, such as mental retardation, who are likely to be victimized or who may inadvertently commit criminal acts.

McAfee and Musso (1995) obtained phone numbers and addresses for law enforcement from the government section of state phone books. They reported that 42 of 50 states were contacted by telephone to discuss state mandated training; however, no mention was made of which state, or which agency within the state, was actually contacted. The caller requested a copy of appropriate written materials, but the study did not define what materials were deemed significant. Phone contact with the remaining eight states, again unnamed by the authors, was unsuccessful and a second attempted contact was made by written correspondence. Ultimately, some form of response was received from 49 of the 50 states. Results revealed that eight states do not require any formal training in the area of disabilities, thirty-six required new police officers to complete "some degree of training" and four remaining states were deemed to have "ambiguous training policies" in the area of individuals with disabilities.

Need for Further Research and Significance

McAfee and Musso (1995) do not define "persons with disabilities" or the manner in which information was clarified. Two attempts to contact the authors for additional information, including operational definitions, went unanswered. In an effort to extend and clarify the body of literature, a preliminary search of publicly available records was conducted on the World Wide Web. Of the 50 states, 14 states had websites which noted a minimum number of training hours set by a Peace Officer Standards and Training Commission . Of these 14 states, only two had mandated training on disabilities that was publicly accessible on their websites. No federal guidelines for training law enforcement in the area of individuals with disabilities could be located on the internet or in print.

In light of the fact that the National Institute on Mental Health (2008) estimates that 26.2 percent of Americans ages 18 and older suffer from a diagnosable mental disorder in any given

year, it is imperative that more information on police training and interventions in the cases of

individuals with disabilities be publicly available. Using statistics provided by the United States

Census, that percentage translates into almost 60 million people, or one in four adults. Teplin

(1984) suggests that the number of individuals with mental illness in the community has

increased due to 1) deinstitutionalization, 2) restrictive laws regarding civil commitment, and 3)

reduction in funding for community-based mental health programs. A 1997 survey found that

many officers were alarmed by the unpredictability of those with mental illness and expressed

frustration with the lack of options when it comes to approaching and dealing with those who

exhibit signs of mental illness (Green, 1997). When police come into contact with some of these

individuals, they must be aware that behaviors symptomatic of mental disorder are often

misinterpreted and approaches typically used by law enforcement may actually worsen an

already difficult situation, particularly in the heightened atmosphere of a first response.

Although individual police officers may be well meaning, the blame lies squarely on deficits in

training. Officers are trained to look for threatening or unreasonable behaviors that may be drug

and/or alcohol related and then to react accordingly. Those same interventions can be ineffective

or potentially injurious to the person who is simply exhibiting the symptomology of a mental

disorder that requires evaluation and treatment rather than incarceration.

In assuring that police officers have the necessary training to deal with individuals with

disabilities, the impact of funding allocations is of paramount importance. The cost of basic

training for police officers is high, both in terms of actual operating expense and the salaries paid

to recruits during their academy education (Sweeny, 2005). Costs escalate when additional

materials and instructors are added to the program. Some states have restrictions against passing

unfunded mandates, which means that if the state does not have the financial resources to

reimburse counties, cities and towns for additional training time, it cannot require expansion of existing curriculum (Sweeny).

It has been 22 years since Murphy's study and 13 years since McAfee and Musso's study, it is evident that there exists a paucity in the literature focusing on the nature and frequency of police training in the area of disabilities. The author believes that additional study is warranted and should be welcomed by police academies who strive to equip their graduates with information that is current and suited to meet the realistic needs of not only law enforcement, but the population they serve.

Overview of the Study

To further the body of knowledge which determines efficacy of academy police training in the area of disabilities, this study examines the content of police training curricula for information specifically related to mental illness, mental retardation and pervasive developmental disorder. Regarding mental illness, the curricula were searched for information such as definition, characteristics, treatment, medications, cognitive and behavior therapies, myths, the mention of any additional disorders and suggested methods of police interaction. Regarding mental retardation, the curricula were searched for definition, characteristics, cognitive levels, myths and suggested methods of police interaction. Finally, the curricula were similarly searched regarding pervasive developmental delay, or PDD, to see if definition, criteria for diagnosis, and suggested methods of police interaction were included. Because PDD may include several more defined disabilities such as Autism and Asperger's Syndrome, the curricula were examined to see if other developmental disorders were covered. Notations were made when specific state laws regarding the treatment of people with disabilities were included in the curricula. The purpose of this descriptive study is to examine the police academy curricula for

all responding states to determine the level of training being conducted in the area of the

designated disabilities.

II. LITERATURE REVIEW

The purpose of this chapter is to provide a brief overview of developmental disabilities (Pervasive Developmental Disorders-PDD and Mental Retardation-MR), mental illness (Schizophrenia and Bi-Polar Disorder), law enforcement structure and the current training standards. The author acknowledges that developmental disabilities and mental illness may encompass many diagnoses; however, for the purposes of this chapter the focus will be on the four conditions listed previously (DD/PDD, MR, Schizophrenia and Bi-Polar).

According to Debbaudt (2000) and illustrative of the need for state law enforcement to ensure that academies offer cadets training in human exceptionality, the following events occurred on a typical California afternoon in 1985. Law enforcement officer Shari Lohman was on patrol when she noted a teenaged male riding a bicycle along the road. Nothing about the young man raised suspicion or alerted Officer Lohman until the teenager glanced over his shoulder, jumped from the bike, and started running, guiding the bike as he went. Such action gave Officer Lohman cause to believe that the bike may be stolen, so she called the dispatcher for assistance and proceeded to follow the youth. Sergeant Jim Lowder heard the call and joined Lohman in pursuit. As Lohman caught up with the boy, he dropped the bike and continued to run. The officers could not understand why the boy was acting in such a strange way and came to the conclusion that he may be under the influence of a hallucinogenic drug. The chase finally ended when the boy entered a family garage.

At that point, the two law enforcement officers not only wanted to apprehend the suspect, but also avoid a location that potentially offered access to weapons or accomplices. To that end, they forcibly subdued the boy, Guido Rodriguez Jr., only to learn later that he had entered his own family's garage and that he had Autism. The incident gradually escalated into tragedy when it was found that Rodriguez suffered bruising, lacerations, and a damaged kidney that eventually required surgical removal. A ten million dollar lawsuit was subsequently filed against the Irvine California Police Department (Debbaudt, 2000), alleging these front line officers were unable to identify an individual with autistic characteristics, rather mistaking his actions for that of a potential criminal. Lack of proper police training caused this teenager serious physical injury and created cause for legal action against the entire department.

Unfortunately, similar incidents may be all too common. For example, in July, 2005, a nineteen-year old male became agitated, threw a microwave oven out of a window, ripped up a sofa, and then barricaded himself inside his residence. In spite of a medical alert card that identified the young man as an individual with Asperger's Disorder, a form of Autism, the law enforcement officers removed his clothes, placed him in a paper suit, and interrogated him without an appropriate adult present. The young man's mother responded, "The way he was treated was absolutely appalling. The whole system is flawed" (The Watchdog, 2008 p.1).

Largely because the behavior of individuals with autism dictates a strenuous adherence to rules and routine (Batshaw, Pellegrino, & Roizen, 2007), there is little evidence of any significant association between criminal offending and Autism (Debbaudt, 2002); however, there are cases where individuals with developmental disabilities are guilty of a crime. Often, however, the functional level of an individual with developmental delay (DD) is not taken into consideration at the time of prosecutorial filing and his or her attorney may face challenges in the

legal system. In 2002, a sixteen-year old male with DD in Sacramento, California, left his group

home with a knife and walked three miles to an area Starbucks where he attacked a woman. He

faced charges of attempted murder and, if convicted, incarceration in a state prison. The boy's

mother, Joan Maggi, said, "To hold David criminally responsible for what he did would not be

fair because he doesn't understand what he did." She believed that he needed treatment and

supervision, not a prison term, but the defense attorney's motion to move the case to juvenile

court was denied. The attorney, Bob Blasier, stated, "He's developmentally disabled… He's

borderline mentally retarded….All they see is the police report. They don't get the background

on David's disabilities until later" (Autism Today, 2008, p. 1). Obviously, the lack of

recognition of disability at the time of apprehension later presented the defense attorney a

challenge in negotiating a legal system unaware of the full ramifications of the case. While this

case involved an individual with autism, history has shown that this type of reaction by the

justice system has repeated itself. In 2006, Pete Earley wrote "In 1955, some 560,000

Americans were being treated for mental problems in state hospitals. Between 1955 and 2000,

our nation's population increased from 166 million to 276 million. If you took the patient-per-

capita ratio that existed in 1955 and extrapolated it on the basis of the new population, you would

expect to find 930,000 patients in state run hospitals. But there are fewer than 55,000 in them

today. Where are the others? Nearly 300,000 are in jails and prisons. Another half million are

on court-ordered probation."

    With the incidence of Autism on the rise (Center for Disease Control, 2008), it seems that

cases such as these can only increase. "Persons with Autism and other developmental

disabilities are estimated to have up to seven times more contacts with law enforcement agencies

during their lifetimes" (Debbault, Personal communication, 2008). It appears that law

enforcement officers may not understand that individuals with developmental disabilities often lack the cognitive and problem-solving skills to make decisions and communicate effectively. Further, these individuals may experience anxiety or agitation which can result in unusual or inappropriate behaviors that can be mistaken for criminal conduct or intent.

<div align="center">Categories of Pervasive Developmental Disorders</div>

Autism Spectrum Disorders

In 1943, Leo Kanner, a psychiatrist at Johns Hopkins Medical Center, noted that eleven of his patients displayed remarkably similar symptoms. Their lack of interest in people while exhibiting inordinate interest in inanimate aspects of their environment, as well as favoring absolute sameness in routine and environment, led Dr. Kanner to publish detailed observations that were later described as early infantile Autism. His work gained considerable interest and marked the beginning of serious research into this baffling disorder (Tidmarsh & Volkmar, 2003).

Autism is now called Autism Spectrum Disorder (ASD) and reflects the vast differences seen in each diagnosed individual (American Psychological Association, 2000). With symptoms ranging from mild to severe, people with Autism are unique; they exhibit behaviors and characteristics in different combinations and degrees. According to research compiled by the National Research Council (2001), boys were more consistently identified than girls (three to four boys per girl) and girls were more likely than boys to demonstrate decreased mental capabilities in conjunction with Autism.

Each person with Autism will have a different level of independence as well; some need a caregiver at all times while others live semi- or fully independent lives and are able to contribute to the community in various ways. Autism is recognized as a lifelong neurological

disorder affecting communication, socialization, and behavior (Wilczynski, 2007). Learning

difficulties may cause confusion, frustration, and anxiety for these individuals. Many individuals

with Autism express these emotions in a variety of ways such as withdrawing, engaging in

repetitive behaviors, aggression, or even self-injury. While symptoms may decrease with

therapy or intervention, Autism remains a life long disability (Debbaudt, 2002; Janzen, 1996).

Used by professionals when diagnosing ASD, The American Psychiatric Association's

(2000) Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition Text-Revision

(DSM-IV-TR), categorizes ASD under the broader heading of Pervasive Developmental

Disorder (PDD). Due to the pervasive delays in development, five developmental disorders are

contained in the PDD category. The categories include Autism Disorder, Rhett's Disorder,

Childhood Disintegrative Disorder, Asperser's Disorder, and Pervasive Developmental Delay-

Not Otherwise Specified (PDD-NOS) and each category is described below.

Autism Disorder

For an individual to receive a diagnosis of Autism Disorder, a predetermined number of

characteristics must be displayed in each of three categories: social interaction, communication,

and behavior (American Psychiatric Association, 2000). In the area of social interaction,

individuals must display two or more of the following: limited eye contact, limited facial

expression, unusual gestures or body posturing, lack of social interaction, and lack of social or

emotional reciprocity. In addition, those individuals with Autism are often described as aloof,

preferring to be alone rather than in the company of others. They infrequently use eye contact,

facial expression or body language as an interactive tool, and thus find it difficult to participate

in the reciprocity required in a social setting.

With regard to communication, an individual must display at least one or more of the following characteristics: lack or delay in development of verbal language with no attempt to gesture or mime, inability to initiate or sustain conversation, echolalia or stereotypical language, and lack of make-believe or imaginative play. Examples of this deficit are the inability to approach someone and initiate a request, repetition of words or phrases in inappropriate contexts, and the inability to play creatively (American Psychological Association, 2000; Batshaw, Pellegrino, & Roizen, 2007).

Behaviorally, an individual must demonstrate one of the following: restricted, repetitive, and stereotypical patterns of behavior, interests, and activities; preoccupation with one or more stereotypical and restricted patterns of interest that is abnormal in focus or intensity; inability to alter routines or schedules; persistent preoccupation; or repetitive motor mannerisms. Individuals with Autism Disorder are often resistant to changes in the environment, such as where they sit or what time an activity occurs. Some have difficulty with clothing textures or display preoccupation with a part of a toy rather than the entire toy or its appropriate use. At least one delay must originate before the age of three in order to identify an individual with the diagnosis of Autism Disorder (American Psychiatric Association, 2000; National Research Council, 2001).

Rhett's Disorder

Individuals diagnosed with Rhett's Disorder present normal prenatal and perinatal development with no apparent cause for concern during the first few months of life (Batshaw, Pellegrino, & Roizen, 2007). Through the first five months, there appears to be normal psychomotor development and brain growth demonstrated by measurement of normal head circumference. Somewhere between the ages of five months and forty-eight months, head

circumference begins to decrease. The child loses acquired hand skills between the ages of five

months and thirty months, and repetitive hand movements, such as hand-wringing, become

apparent. Individuals with Rhett's Disorder also display severe psychomotor retardation, e.g.

motor tics, loss of ability, or an inability to suck, drink, or turn side to side. These individuals

appear to have poorly coordinated gait or trunk movements. Children with Rhett's also have

severely impaired expressive and receptive language development. They also display a loss of

social engagement, which may or may not improve as they grow older (American Psychological

Association, 2000).

Childhood Disintegrative Disorder

For at least the first two years of life, individuals diagnosed with Childhood

Disintegrative Disorder (CDD) experience normal development in verbal and nonverbal

communication, social relationships, as well as play and adaptive behavior. It is between the

ages of two and a half and ten that CDD becomes apparent with a significant loss in at least two

of the following areas: expressive or receptive language, social skills or adaptive behavior, bowel

or bladder control, and play and/or motor skills (American Psychological Association, 2000;

Hendry, 2000).

Asperger's Disorder

Asperger's Disorder is hallmarked by a qualitative impairment in social interaction and

behavior. For diagnosis, an individual must display at least two of the following symptoms:

limited eye contact, facial expression, body postures or gestures; lack of peer relationships; lack

of spontaneous sharing of emotions, achievements, or objects; and lack of social or emotional

reciprocity. Asperger's Disorder is also characterized by repetitive and stereotypical patterns of

behavior that consist of at least one of the following: abnormal preoccupation with a person, item

or topic; strict adherence to patterns, rituals, or routine; repetitive mannerisms such as hand flapping or twisting; and intense preoccupation with parts of objects. Since there is no impairment in language, adaptive behavior or cognitive functioning, individuals with Asperger's Disorder must show social and behavioral impairments that significantly impact normal functionality in order to be diagnosed (American Psychiatric Association, 2000; Szatmari, 2000).

Pervasive Developmental Delay–Not Otherwise Specified (PDD–NOS)

Pervasive Developmental Delay–Not Otherwise Specified is a category under the umbrella of PDD, but symptomology lies outside the parameters for diagnosis set out in the other four categories. Individuals with PDD–NOS have severe and pervasive impairment in the development of reciprocal social interaction and verbal and nonverbal communication, as well as stereotypical behaviors, interests, and activities. "Atypical Autism," a type of Autism that does not meet the criteria for Autism Disorder due to late onset or atypical symptomatology, is included in this category (American Psychiatric Association, 2000).

Incidence and Prevalence of Autism Spectrum Disorder

The Center for Disease Control (CDC) defines incidence as the number of new cases of disease in a defined group of people over a specified time period. Prevalence, however, is defined as the number of existing disease cases in a defined group of people over a specified period of time. In the case of ASD, incidence is very difficult to establish because the exact time a person develops an ASD is hard to pinpoint. On the other hand, public health professionals use prevalence measures to track a condition over time and plan responses at local, regional, and national levels. The CDC Autism and Developmental Disabilities Monitoring (ADDM) Network released data in 2007 indicating that the ratio of eight-year-old children, in multiple areas of the United States, that were diagnosed with an ASD was about one in one hundred and fifty. Results

from the ADDM network showed the prevalence of ASD, among states participating in the project, to be 6.7 per 1000 children in 2000 (6 sites) and 6.6 per 1000 in 2002 (14 sites), or approximately one in one hundred and fifty children. Most sites identified between 5.2 and 7.6 per 1000 eight-year olds with ASD in 2000 and 2002. Since the ADDM sites do not indicate a nationally representative sample, the prevalence estimates should not be generalized to every community in the United States. Although accurate for the areas studied, rates could be higher or lower elsewhere. For example, in Brick Township, New Jersey, school officials reported a 900% increase in the number of school aged children diagnosed with Autism (Sack-Min, 2008). Nevertheless, such prevalence estimates, for planning and identification purposes, can help communities project how many children may be affected. Estimates can also be useful in the provision of more appropriate interventions for children with an ASD (Center for Disease Control, 2008).

Annually, on the first of December, the U.S. Department of Education mandates that every school system submit a "child count" of children with disabilities as part of the Individuals with Disabilities Education Act (IDEA). The data collected are stratified by age, state, disability, and category. According to Fighting Autism (2005), the incidence rate from 1992 to 2003 for individuals ages six to twenty-one years has increased 947%. In 1992, there were 126 individuals with Autism, ages 6–21 years, reported by the state of Alabama for child count; by 2003, that number had increased to 1,319. In the fifty states, DC, and Puerto Rico, the overall number of individuals with Autism in 1992 was 15,558. By 2003, that number had increased to 140,920, an 806% increase.

The Autism Society of America (2008) reported the incidence of Autism to be one in 10,000 births in 1992; by 2005, the incidence was reported to be one in 166. It is estimated that

there will be four million individuals with ASD in the next decade (Autism Society of America). In Autism, Advocates, and Law Enforcement Professionals (2002), Debbaudt asserts that without respect to racial or ethnic background, on a global basis, there are already twelve million individuals with Autism and the number is growing.

<div align="center">Diagnosis of Pervasive Developmental Disorders</div>

First Signs, Inc. is a national non-profit organization dedicated to educating parents and pediatric professionals about the early warning signs of Autism and other developmental disorders. Founded in 1988, First Signs, Inc. utilized policy statements issued by the American Academy of Neurology, the American Academy of Pediatrics, and the National Research Council to create a model for disseminating information about early warning signs, the need for routine screening and treatment options. First Signs, Inc. is endorsed by 13 professional medical groups, including multiple chapters of the American Academy of Pediatrics. According to First Signs, Inc. (2008), clinically, there are few "absolute indicators" that dictate childhood evaluation, but there are signs and symptoms that parents and family practitioners should know. As early as six months, infants should begin displaying big smiles or other joyful expressions. By nine months of age, they should begin to exchange sounds, smiles, and other facial expressions. Twelve-month old infants should begin to use reciprocal gestures such as pointing, showing, reaching and waving. As language begins to develop, families and physicians should be concerned if babbling does not appear by twelve months, simple words by 16 months, and two-word phrases by 24 months. An additional concern would be the loss of babbling, speech, or social skills at any age. Regression should be monitored very carefully by the appropriate professional. Once these symptoms appear, the child is often referred for diagnostic testing.

Diagnostic tests and other clinical evaluations help to determine the nature, scope, and intensity of the child's abilities and deficits.

The National Research Council (2001) recommends that all testing should be viewed through a developmental perspective. The first step in the diagnostic evaluation is a structured developmental interview. This interview is designed to detect a lack of developmental milestones in communication and social interaction while also noting repetitive or restrictive interests and/or behaviors. The second portion of the evaluative process is the ADOS, The Autism Diagnostic Observation Schedule (Lord et al., 2002). This tool is a semi-structured assessment designed to allow an examiner to observe the occurrence or non-occurrence of behaviors identified as important to the diagnosis of Autism, or other pervasive developmental disorders that span developmental levels and chronological ages. Planned social occasions, referred to as "presses" are created to stimulate the appearance of a particular type of behavior and to give the examiner an opportunity to assess communication, social interaction, and play or the imaginative use of materials. Using a diagnostic algorithm, overall ratings are computed to formulate a diagnosis. In short, the goal of the ADOS is to provide standardized contexts in which to observe the social/communicative behaviors of individuals across the life span in order to aid in the diagnosis of Autism and other Pervasive Developmental Disorders.

The ADOS (Lord et al., 2002) consists of four modules, each of which is appropriate for children and adults at different levels of development and language, from young children with no expressive or receptive language to verbally fluent adults. Module one consists of ten activities with 29 accompanying ratings; it is designed for use with children who have "pre-verbal or single word speech." For most activities in this module the focus is on the playful use of toys or other materials. Module two is designed for use with children who have "phrase speech."

Phrase speech is defined as regular production of non-echoed phrases made up of three independent units. Module three is designed for use with children who have "fluent" language skills. This module has four specific goals: (1) to observe spontaneous social-communicative behavior given a situation that provides a press to communicate or interact; (2) to assess the ability to behave appropriately, given the demands of particular situations (e.g. interaction with the examiner, pretend play, anticipation); (3) to evaluate creativity and conversation style; and (4) to provide a standard context for the collection of language and repetitive/stereotypic behavior samples. Module four is designed for use with verbally fluent adolescents and adults. The activities combine unstructured conversation with a series of structured situations and interview questions that offer a variety of activities for particular kinds of social and communicative behaviors. This module has four specific goals: (1) to observe spontaneous social-communicative behavior given a situation that provides a press to communicate or interact; (2) to assess the individual's ability to behave appropriately, given the demands of particular situations (e.g. telling a story, teaching a task); (3) to evaluate the individual's creativity and conversation style; and (4) to provide a standard context for the collection of language and repetitive/stereotypic behavior samples (Lord et al., 2002).

Table 2

ADOS Modules and Target Audience

Module	Language Level	Number of Activities	Age
One	Pre-Verbal or Single Words	10	All
Two	Phrase Speech	14	All
Three	Fluent Speech	14	Child/Adolescent
Four	Fluent Speech	15	Adolescent/Adult

Using the ADOS in conjunction with a structured interview, the diagnostician will compare obtained scores and milestones to the criteria of the DSM-IV-TR. A potential first step to educating law enforcement about Autism is to increase awareness about characteristics that are inherent to the disability.

Mental Retardation

Historical references to mental retardation can be found throughout the literature. The plight of those who are believed to be "defective" has been and still is dependent on the customs and beliefs of the culture. For example, in ancient Greece, in the city state of Sparta, neonates were examined by a group of elders. Those infants found to be "defective" were killed. Similarly in the Roman Empire, individuals with disabilities, including children, were frequently sold to be used as entertainment or as amusement (Ainsworth & Baker, 2004). During the Middle Ages, more humane forms of treatment began to appear with the formation of "foundling homes" and a decrease in infanticide. In the early 12th century, Henry II of England supported a law that designated those with mental retardation as wards of the state, thereby extending a level of protection to them (Ainsworth & Baker).

A cornerstone in the history of those with mental retardation is the work of Jean-Marc-Gaspard Itard. In 1800, Itard was hired to work with the "wild boy of Aveyron," a child who had lived his early life in primitive conditions with a pack of dogs in the woods of south France. Later named Victor, the boy was found to be both deaf and mute. After 5 years of training, Victor continued to have difficulties with language and social interaction, but had acquired more skills and knowledge than any of Itard's colleagues expected (Ainsworth & Baker, 2004).

In 1876 the Association of Medical Officers of American Institutions for Idiotic and Feeble Minded Person, later known as the American Association of Mental Retardation (AAMR), was formed by Edouard Seguin to support those individuals who at the time were considered to be "idiots, morons, or feeble minded." Recognizing that "retarded" held a pejorative connotation, the association opted to change their name in 2006 to the American Association on Intellectual and Developmental Disabilities (AAIDD, 2008).

The term "mental retardation" is defined by the DSM-IV-TR and has three specific criteria defined as "significantly sub-average general intellectual functioning (criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health and safety (criterion B) (Batshaw, Shapiro & Farber, 2007) and onset must occur before age 18 years (criterion C)" (American Psychological Association, 2000). Ainsworth and Baker (2004) defined mental retardation as "a syndrome of delay or disordered brain development evident before age 18 that results in difficulty learning information and skills needed to adapt quickly and adequately to environmental changes."

Diagnostic Criteria

According to the DSM-IV-TR (2000), the diagnostic criteria for the category of Mental Retardation does not include an exclusion criterion; therefore the diagnosis is made whenever the diagnostic criteria are met, regardless of the presence of another disability. Table 3 presents the criteria for diagnosis.

Table 3

Diagnostic Criteria for Mental Retardation (APA, 2000)

A. Significantly sub-average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly sub-average intellectual functioning).

B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standard expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

C. The onset is before age 18 years.

Note. From the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) by the American Psychiatric Association, 2000.

More than one possible cause is suggested in more than 50% of cases (Ainsworth & Baker, 2004). Mental retardation, like many disorders, cuts across racial, ethnic, educational, cultural, social, religious, and economic backgrounds. While this is true, some subsets of mental

retardation are linked to genetic factors, prenatal influence and environmental factors following birth. For 75% of children with mild symptoms and 30–40% of those with severe symptoms, no specific cause is apparent (Ainsworth & Baker).

Sub-average general intellectual functioning is defined by an intelligence quotient (IQ) of 70 or below (APA, 2006). This score is two standard deviations below the mean of 100. The IQ score must be obtained by assessment with one or more of the standardized, individually administered intelligence tests. It is recognized that there is a measurement error of approximately five points in assessing IQ, although this amount may vary from instrument to instrument (APA, 2006). The DSM-IV-TR outlines four degrees of severity that reflect the level of intellectual impairment: Mild, Moderate, Severe and Profound. These degrees of severity and their corresponding IQ levels are provided in Table 4.

Table 4

Degrees of Severity of Mental Retardation

Classification	IQ Range
Mild Mental Retardation	IQ level 50–55 to approximately 70
Moderate Mental Retardation	IQ level 35–40 to 50–55
Severe Mental Retardation	IQ level 20–25 to 35–40
Profound Mental Retardation	IQ level below 20–25

Note. From the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) by the American Psychiatric Association, 2000.

Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone their age (APA, 2000). In many cases, adaptive functioning can improve with skill specific instruction while IQ tends to remain a more stable attribute. Adaptive functioning is typically determined by gathering information from one or more reliable resources such as a parent, guardian or teacher. Information obtained includes medical history, developmental history, educational performance history and current skills. One of the more commonly published scales to obtain adaptive functioning levels is the Vineland Adaptive Behavior Scales. This scale provides a clinical cutoff score that is a composite of performance in a number of domains.

Prevalence of Mental Retardation

MR affects at least 1.4% of the United States population, or up to 2.5 million people (Ainsworth & Baker, 2004). Life expectancy for an individual with mental retardation is typically correlated with the severity of retardation. The death rate for children and adolescents under 19 years of age who have moderate MR is twice that of their peers without MR. Death rates for individuals with severe MR are even higher, approaching 7 to 31 times greater than their peers without MR (Ainsworth & Baker, 2004). However, with improved medical care, individuals with all forms of mental retardation who live through the critical first year are living longer lives. Ainsworth and Baker found that in 1998 there were 600,000 children ages 6–21 diagnosed with mental retardation in the nation's schools. This figure did not include any children that were counted in another category of disability even though they may also have a diagnosis of mental retardation.

Mental Illness

A review of history shows that individuals with disabilities have traditionally been placed into asylums, state hospitals, group homes, jails or other locations in which the public assumed "care" had been provided. The 1960s and 1970s were known for civil rights movements which encompassed expanded rights, increased social acceptance, fuller integration, and increased funds for programs (Martin, 2001). While the public assumed all movements were positive, those individuals forced out of institutions or state hospitals were faced with little to no assistance and "yo-yo effects" as politicians, parents, professionals and the public at large became locked in a bitter debate (Earley, 2006; Martin, 2001). Some questions arising in these debates included: Where do those who are mentally ill or disabled live? Where do they obtain medicines? Who has to pay for service? Historically, all individuals with disabilities were stereotypically viewed as mentally defective, regardless of category or type of disability.

In 1959, Dr. Birnbaum began studying public policy and mental illness as part of a post doctorate program at Harvard University. Eventually published in the American Bar Association Journal, Dr. Birnbaum's premise was that patients suffering from mental illness in state hospitals had a constitutional "right to treatment." At the time, most patients had been locked in state hospitals against their wills. Once placed in these facilities, they were told they could not be released until they demonstrated improvement, yet most state run programs had few medical or psychological programs in place (Earley, 2006). Birnbaum's "right to treatment" was viewed as revolutionary because patients' constitutional rights, as defined by the Fifth Amendment, were being denied. As media attention grew, patients began to contact Dr. Birnbaum, requesting that he publicize his views by representing them in court. While Birnbaum was not a lawyer, he agreed to represent Kenneth Donaldson, a mental health patient held in a state hospital despite

his desire to be released. While officials initially considered dismissing the case, they

reconsidered when the case became a landmark civil issue (Earley). As the movement continued

to grow, other suits were filed under Birnbaum's "right to treatment" theory.

In 1970, Alabama fired more than 100 employees at a state mental hospital in Tuscaloosa

to save money. In an effort to save these jobs, Attorney George Dean filed a lawsuit on behalf of

the patients, claiming that the loss of employees deprived patients of their right to treatment.

While Alabama officials were initially amused by the suit, Judge Bazelon scheduled the case for

trial. The Wyatt v. Stickney case grew into the country's first major civil rights battle for those

with mental illness.

Wyatt v. Stickney

In 1970, Bryce State Hospital in Tuscaloosa, AL, housed 5,200 patients. Montgomery

Advertiser editor and publisher, Hal Martin, equated the living conditions to a "Nazi

concentration camp" (ADAP, 2004). After losing 100 licensed professionals such as

psychologists, occupational therapists and nurses, conditions worsened. After the lay-offs, there

was one physician for every 350 patients, one nurse for every 250 patients and one psychiatrist

for every 1,700 patients.

The Department of Mental Health and Mental Retardation asserted that they had the

authority to hire and fire personnel as needed. While Judge Johnson agreed, he believed that a

federal question existed regarding the minimum standards required for treatment of those who

were involuntarily committed. In testimony, then 15-year old Ricky, a juvenile delinquent

sentenced to Bryce as a punishment, stated that he "slept on wet floors and was locked in a cell-

type room with the only light coming from the slats in the door."

Building on Morton Birnbaum's 1960 publication "The Right to Treatment," Judge Johnson ruled on March 12, 1971, that

> there can be no legal justification for the State of Alabama's failing to afford treatment and adequate treatment from a medical standpoint to the several thousand patients who have been civilly committed to Bryce for treatment purposes. To deprive any citizen of his or her liberty upon altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process. (ADAP, 2004)

Providing the state with six months to establish a 'right to treatment" plan, Judge Johnson stipulated that objective measures, such as number of professionals per patient and the creation of formal treatment plans, must be implemented. Despite the six month window to improve conditions, Bryce and the state failed to meet Johnson's criteria.

As a result of the Wyatt v. Stickney case, those with mental illness were now entitled to treatment; they were also afforded the right to refuse treatment. The question arose: If a state couldn't place an individual into medical care, and a family could not make treatment decisions for those of legal age, at what point could someone intervene? Patients who were too unstable to make treatment decisions were allowed to wander the streets. Often delusional, those with mental illness began coming into contact with law enforcement. While there are a number of disorders included under the much larger umbrella of mental illness, again this dissertation will focus on schizophrenia and bi-polar, which Early (2006) found to be the most commonly identified mental disorders of incarcerated individuals.

Schizophrenia

Schizophrenia is a psychiatric diagnosis that describes a mental disorder characterized by abnormalities in the perception or expression of reality (APA, 2000). It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganized speech and thinking with significant social or occupational dysfunction. Schizophrenia is one of nine disorders (Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder due to General Medical Condition, Substance Induced Psychotic Disorder, and Psychotic Disorder Not Otherwise Specified) included under the heading of Schizophrenia and Psychotic Disorders. While these disorders have been included under the same heading and may present with similar psychotic symptoms, the symptoms are not considered to be the fundamental feature of the disorder nor do the disorders in this category necessarily have the same etiology (APA, 2000).

The DSM-IV-TR (2000) outlines the essential features of schizophrenia as a "mixture of characteristic signs and symptoms that dominate for the predominance of a one month period with a significant portion of the signs and symptoms persisting at least 6 months." The signs and symptoms are associated with clear social and/or occupational dysfunction. The characteristic symptoms of schizophrenia are a range of cognitive and emotional dysfunctions that include perception, language and communication, inferential thinking, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive and attention.

Bi-Polar Disorder

Bipolar disorder is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated mood clinically referred

to as mania or, if milder, hypomania (Robb & Reber, 2007). Individuals who experience manic episodes also commonly experience depressive episodes or symptoms, or mixed episodes in which features of both mania and depression are present at the same time. These episodes are usually separated by periods of "normal" mood, but in some individuals, depression and mania may rapidly alternate, known as rapid cycling. The dictionary defines mood as "predominant feeling" but psychiatrists look at mood as the "state of optimism or pessimism, the feelings of contentedness or dissatisfaction, physical feelings such as how fatigued or robust one feels" (Mondimore, 1999). Extreme manic episodes can sometimes lead to psychotic symptoms such as delusions and hallucinations. The disorder has been subdivided into Bipolar I, Bipolar II, Cyclothymia and other types, based on the nature and severity of mood episodes experienced; the range is often described as the bipolar spectrum (APA, 2000).

Bipolar Disorder is considered a "chameleon" of psychiatric disorders, changing symptoms from one patient to the next and from one episode to the next even within the same patient. While depression and mania have been recorded in history and literature by Greeks and Persian physicians, several of whom believed the two conditions were linked, it was not until the early twentieth century that the German psychiatrist Emil Kraepelin presented that depression and mania could be linked in the same disorder. He coined the disorder "manic-depressive insanity" (Mondimore, 1999).

Mania

The manic state is the most extreme and dramatic symptom of the symptom cluster. In the manic state, the individual's mood switches into "high." This euphoric feeling usually starts gradually and may take up to two weeks to fully develop. As this euphoric feeling intensifies, the symptoms and behaviors increasingly become more unpleasant and more pathological. This

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state is considered the most dangerous and the most abnormal mood associated with mood disorders (Mondimore, 1999).

In this manic state, individuals begin to feel a false sense of heightened intellect and awareness. During this period, individuals can have grandiose delusions and hallucinations. Racing thoughts and pressured speech are common. Table 5 presents a list of moods and bodily symptoms most often associated with the state of mania (Mondimore, 1999). Often these behaviors lead to increased writing, which is not always decipherable after the episode. The manic state is also associated with a feeling of exuberance and overconfidence that manifests itself in the form of spending sprees, sexual promiscuity, overuse of alcohol and other intoxicating substances (Earley, 2006; Mondimre, 1999).

Table 5

Symptoms of Mania

Mood Symptoms	Bodily Symptoms
Irritable mood	Decreased need for sleep
Elated, euphoric mood	Increased energy level
Grandiosity	Erratic appetite
	Increased libido
Cognitive Symptoms	Symptoms of Psychosis
Feeling of heightened concentration	Grandiose delusions
Accelerated thinking	Hallucinations

Note. From *Bi-Polar Disorder: A Guide for Patients and Families*, by M. Montimore, 1999, Baltimore, MD: The Johns Hopkins University Press.

Depression

The depressive state felt by those diagnosed with bipolar disorder is different than the depressed mood typically felt by others. Individuals who suffer some type of loss or sadness feel "sad," but retain normal reactivity to mood (Mondimore, 1999). This reactivity to mood is what enables individuals to feel sadness at a funeral, yet once they leave, have the ability to dispel feelings of bereavement, isolation, or disappointment. Individuals diagnosed with bipolar and in a depressive state are unable to alter their thoughts. Their thinking can become dominated by a sense of grief, loss, hopelessness or guilt. Feelings of inadequacy and worthlessness are especially common while in the depressive state. Individuals who are depressed are unable to locate or engage in pleasurable activities and this inability to feel pleasure is referred to as anhedonia. Table 6 presents a list of moods and bodily symptoms most often associated with the state of depression (Mondimore, 1999).

Table 6

Symptoms of Depression

Mood Symptoms	Bodily Symptoms
Depressed mood	Sleep disturbances
Dysphoric mood	Appetite disturbance
Diurnal variation of mood	Loss of interest in sex
Guilty feelings	Fatigue
Anhedonia	Constipation
Social withdrawl	Headaches
Suicidal thoughts	Worsening of painful conditions

Table 6 (continued)

Cognitive Symptoms	Symptoms of Psychosis
Poor concentration	Delusional thinking
Poor memory	Hallucinations
Slowed thinking	Catatonic state

Note. From *Bi-Polar Disorder: A Guide for Patients and Families*, by M. Montimore, 1999,

Baltimore, MD: The Johns Hopkins University Press.

Prevalence of Bi-Polar Disorder

Mondimore (1999) estimated that 2% of the general population suffered from some form

of bipolar disorder. A survey of patients with bi-polar disorder and other mood disorders

completed by the National Depressive and Manic-Depressive Association in the early 1990's

found that 36% of those who responded to the questionnaire did not seek professional treatment

until more than ten years after their symptoms began (Mondimore, 1999). The same

questionnaire also found that patients had to see an average of 3.3 physicians prior to obtaining

an accurate diagnosis and 73% had received at least one inaccurate diagnosis. The DSM-IV-TR

(2000) indicates the average age of onset to be 20 years for both men and women. Bipolar I

Disorder is a recurrent disorder with more than 90% of individuals who have one manic episode

going on to have future episodes. Between 60–70% of manic episodes occur immediately

following a previous manic episode.

First-degree biological relatives of individuals with Bipolar I Disorder have higher

occurrence rates of the disorder. It has also been found that those with a first-degree relative are

more likely to have an earlier age onset (APA, 2000). Like many serious mental illnesses,

bipolar affects not only the individual diagnosed with the disease but family, friends, and colleagues as well. Mondimore's research showed that about 15% of those with bipolar disorder successfully commit suicide

Disabilities and Law Enforcement

In 1955, at the peak of institutionalization there were 559,000 individuals confined to state mental hospitals. After the deinstitualization movement, this number was down to fewer than 80,000 in 1999 (Kupers, 1999). Individuals with developmental disabilities and mental illness were increasingly more likely to come into contact with law enforcement officers because they are more likely to display behaviors deemed inappropriate or unusual. No longer institutionalized and in view of the public, unusual behavior often drew the attention of other citizens (Wells & Schafer, 2006). Provided with few options, law enforcement officers are often faced with informal responses such as releasing the individual, taking them into custody or attempting to locate mental health assistance. The following sections will review the structure of law enforcement and recruitment of personnel.

History and Structure of Law Enforcement

The concept of policing is barely two centuries old and became formalized with the rise of urbanization and industrialization in the Western world (Hagan, 2008). Predecessors in England were originally citizen groups that policed themselves. Later, a system of elected constables and sheriffs was created to enforce laws. The Metropolitan Police Act of England, passed in 1829, created the first salaried police to patrol London. They were known as "Bobbies", nicknamed for their creator, Robert Peel (Real Police, 2007). In the United States, Boston began its police department in 1838, followed by New York City in 1845. New York set the foundation for the modern police department by combining day and night watchmen under

the control of a single police chief. Other municipalities such as Baltimore, Chicago, Cincinnati, and New Orleans quickly followed. As a result of the California Gold Rush in 1848, some of the first federal police agencies were created. Some of the first were the Postal Inspectors, Border Patrol, the Secret Service, and what would later become the Federal Bureau of Investigation (Hagan, 2008).

The original police were heavily influenced by politics and the political "machine;" police positions were often obtained through appointment by political bosses (Hagan, 2008). The first anti-corruption measure, the Pendleton Act of 1883, focused on nepotism while increasing job security, but was not enforced until 1900. By 1902, professionalism became the focus and the Internal Association of Chiefs of Police (IACP) was formed (Hagan, 2008). Its first president, Richard Sylvester, chief of the Washington DC Police Department, was regarded as the father of police professionalism (Real Police, 2007). Sylvester advocated a citizen-soldier model and was responsible for many paramilitary aspects of policing. August Vollmer, Chief of the Berkley Police Department, would later become known as the patriarch of police professionalism. By 1918, he advocated for a scientific crime fighter model, and was responsible for introducing America to stop lights, police car radios, crime laboratories, lie detectors, fingerprint repositories, and uniform crime reporting (Gaines & Miller, 2006). Vollmer also created the "college cop" movement in which he advocated for the education of every police officer, preferably to the level of Bachelor's Degree. The movement was cut short by the demand for returning World War II veterans to be given hiring preference over those with better educational qualifications. Overall, Vollmer advocated for intelligent, hardworking individuals. One study, using the intelligence testing available at the time, found that police in the city of Detroit scored an average of 55 on intelligence testing, while Vollmer's department

scored an average of 147. Vollmer supported the policewoman movement as well, specifically

because he believed women to be of higher intelligence. To his credit, Vollmer also hired the

first African-American and advocated for equality and promotion within the department (Real

Police, 2007).

Vollmer helped to create the first real "criminology" department at the University of

California (UC) Berkley, and later served there as Dean of the school. UC Berkley's curriculum

focused on public speaking, sociology, psychology, abnormal psychology, and statistics (Hagan,

2008). As part of his work, Vollmer advocated for standardized training and modernization of

law enforcement. Herbert Hoover's appointment of the National Commission on Law

Observance and Enforcement resulted in the Wickersham Report. Named after its chairman,

George Wickersham, the report focused on two areas of law enforcement that needed reform:

police brutality and the corruptive influence of politics (Gaines & Miller, 2006). Vollmer found

that the report echoed many of his opinions and he subsequently presented the first set of

baseline standards for police accreditation as follows:

- Personnel standards — removal of employees, even the chief, "for cause"

- Communication and records — modern systems based on the Berkley model

- Salary and benefits schedule — fair schedule of pay and promotion by grade

- Separate units — for crimes involving juveniles and vice

- State information bureaus — crime data collection and analysis centers

- Training academies — creation of regional academies (Real Police, 2007).

Under the professional model of policing, chiefs who had little power over their

departments began to take more control. They reorganized departments and created midlevel

positions, known as assistant chiefs or majors, who were able to assist in the closer supervision

of individual officers. Police chiefs also asserted greater power by bringing large areas of the city under their control, thus limiting the power of the local politicians. With the reorganization of police departments, the creation of special units such as criminal investigation and traffic squads took jurisdiction-wide power. This cross-precinct power served to also decrease the political power of corrupt politicians (Hagan, 2008).

There are approximately 17,000 law enforcement agencies in the United States, employing about 750,000 officers (Hagan, 2008). Most policing is done by state and local agencies rather than federal agencies. Police agencies include local police, sheriffs' departments, and state police, as well as 50 federal law enforcement agencies. Department size varies according to the size of the municipality; the vast majority of police work occurs in small town departments with fewer than 30 officers, but cities such as New York boast over 38,000 in uniform (Hagan, 2008).

Local police departments run by municipalities are the most common law enforcement agencies; yet, local policing may also be done by sheriffs' departments and specialty units such as airport or campus police. State law and local ordinances are enforced by local police while sheriffs' units operate on a county level and enforce laws in areas not covered by the municipal police departments. Sheriffs more commonly operate county jails, serve court papers, and maintain order in courtrooms (Hagan, 2008). State police enforce state laws exclusively. There are approximately 80,000 fulltime state police employees, of which 70% are sworn officers (Albanese, 2005).

All state police are involved in highway traffic enforcement; yet, half are also involved in investigative work. There are 50 federal law enforcement agencies that employ approximately

88,000 federal agents, most of whom perform investigative functions. The two largest federal agencies are Homeland Security and the Department of Justice (Albanese, 2005).

Currently, there are three styles of policing or approaches to management. Identified in 1968 by James Q. Wilson, they are the watchman style, the legalistic style, and the service style (Hagan, 2008). The watchman style is a preventative approach and emphasizes the maintenance of order. In an effort to maintain public order, police use discretion to prevent disorder. To dissipate the causative factors vastly reduces the risk of public disturbance and the necessity for further intervention. For example, police may disperse noisy youth that have gathered on a street corner, negotiate neighborhood disputes, or detain and question suspicious persons. Minor law infractions might be ignored and disputes settled informally in the interest of preventing major disruptions. Watchman style departments tend to be common in large, older cities with large populations of poor or minorities. This style tends also to be more common in localities where politics still often control policing.

The legalistic style of management focuses on violations of the law and becomes more reactive than proactive; crime fighting is their hallmark. Police have the power and can arrest, detain, issue citations, search, and collect evidence of a crime. In this style, officers exercise discretion; believing that they cannot enforce every law to the letter, their decisions are influenced by factors such as the seriousness of the crime, victim preferences for arrest, demeanor, race, ethnicity, and social class. This type of policing is found in newer and more affluent communities. The focus is on "professional policing," enforcing the vice laws, and emphasizes arrest (Hagan, 2008).

The third management style is service. Departments using this approach emphasize officers as problem-solvers who address social difficulties and neighborhood concerns. Much of

the officer's time is spent involved in service projects such as providing directions, finding lost children, referring individuals to social service agencies, and transporting persons to the hospital. This style is most often found in small communities where the crime rate is so low that the officers have the luxury of pursuing local concerns in the attempt to generally improve the quality of life for everyone. This type of department believes that community relations are critical to good policing and solicits citizen involvement (Hagan, 2008).

While these three styles of policing are the most common, a new paradigm of community policing is beginning to emerge. Community policing reflects a philosophy that is foundationally good common sense; the police and the community should work in tandem for the good of the group. Many believe that community policing will:

- Strengthen the capacity of communities to resist and prevent crime and social disorder
- Create a more harmonious relationship between the police and the public, including some power sharing with respect to police policies and tactical priorities
- Restructure police service delivery by linking it with other municipal services
- Reform the police organizational model by creating larger and more complex roles for individual officers (Skinner, 2006, p. 12)

This new style of policing is geared toward producing more committed and empowered police officers who will support the community as peacekeepers with an emphasis on prevention (Ellison, 2006). Officers involved in community policing are instructed to spend designated quantities of time patrolling their areas on bicycles or on foot, interacting with the public and reinforcing their visibility. Many officers and departments have difficulty shifting from the traditional views of policing that focus on solving crimes, apprehending, and processing

offenders with little citizen involvement. Tradition views police officers as neutral, authoritative, detached professionals who respond to crime and "catch the bad guys" (FBI Law Bulletin, 2006, p. 12).

While many departments are now moving toward the community policing philosophy, some critics are quick to point out that this philosophy tends to be more successful in areas that are made up of homogeneous, low-crime, middle-class neighborhoods (Ellison, 2006). Communities that are more likely to be high-crime areas lack the open discussion between citizens and police, as well as the invitation for interaction that is essential for successful community policing. Without community support, policing necessarily reverts to a more authoritative style (Ellison, 2006).

Responsibilities of Law Enforcement

The goal of public law enforcement is to stop crime; but, stopping crime is not the only duty of a police officer. According to Gaines and Miller (2006), four basic responsibilities inherent in law enforcement are enumerated as follows: enforce the law, provide services, prevent crime, and preserve the peace. Commitment to these responsibilities serves as a basis for the police motto, "serve and protect" and is also inherent in the first line of the Law Enforcement Code of Ethics, "serve the community." Besides catching criminals, many officers spend a great deal of time responding to noise complaints, confiscating firecrackers, directing traffic, locating lost children, and completing paperwork (Gaines & Miller). Police officers, along with firefighters, are often the first emergency responders to arrive at the scene of a disaster. For example, when the World Trade Centers were attacked, New York City (NYC) police officers were immediately dispatched, and seventy-one subsequently lost their lives in the search for victims. The general public has the luxury of attending to their own business in public, but a

police officer's business is to remain ever alert to the out-of-ordinary, the suspicious, or the

overtly threatening persons or events surrounding him and the people who depend on him or her

for their protection. Whenever an officer can, he or she must thwart crime before it happens and

save lives before they are even threatened. Those that choose to become law enforcement

officers understand the life-long commitment to continued training and an occupation that can be

complicated and demanding.

Law Enforcement Recruitment

While policies and procedures for recruiting law enforcement officers change from one

department to another, basic requirements are: (a) one must be a United States citizen, (b) free

from felony conviction, (c) in possession of, or be eligible for, a driver's license in the state

where the department is located, and (d) be age twenty-one or older (Hagan, 2008). Beyond

these basics, most departments also require an extensive background check; drug testing; review

of educational, military, and driving records; credit checks; interviews with spouses,

acquaintances, previous employers; Federal Bureau of Investigation search; and polygraph test.

Each year, as many as 20% of the approximately 70,000 applicants are rejected because the

applicant lied during the rigorous screening process. Many departments also maintain guidelines

for physical attributes that must be achieved and maintained, such as the ability to pass a

physical fitness or agility test. The U.S. Department of Justice, Bureau of Justice Statistics

(2008), reported that there are 1,076,897 full-time personnel in law enforcement as of September

2004. This number is 5.6% higher than the 1,019,496 employed in 2000. As of June 2003, local

police departments had 580,749 full-time employees including 451,737 sworn personnel (US

Department of Labor, 2007).

These recruitment procedures and guidelines have not always been in place, and some are newer than one might imagine. Police recruitment policies began in 1829 when the Metropolitan Police of London began hiring officers; only in the last forty years have these procedures begun to change. In an effort to diversify police rolls and departments, most police forces have implemented new tests, screens, and procedures to attract and choose candidates. When August Vollmer began promoting the need for higher education requirements in the 1920s, few officers had attended college. By the 1990s, 65% of officers had some college credits and 25% were college graduates. Today, 83% of all departments require a high school diploma and 8% require at least a two-year college degree. College or university degrees are typically seen as an advantage when considered for hiring or promotions (Gaines & Miller, 2006). Aside from the changes in educational requirements, societal expectations and demands have afforded minorities and women equal access to jobs in law enforcement.

In 1964, the typical officer was a Caucasian male, with minority races and females vastly under-represented. In 1964, the Civil Rights Act, along with the accompanying 1972 amendments, started to open some doors. The Equal Employment Opportunity Act held departments liable for the recruitment and hiring of minorities and women, though long-standing politics slowed the progress. Finally, in 1968, the city of Indianapolis put two female patrol officers on the force. During the 1990s, the number of women in law enforcement grew only by 5.3%. But 2003 and 2004 actually saw four of the nation's largest cities — Boston, Detroit, Milwaukee, and San Francisco — name women to the post of Chief of Police. From 1987 to 2003, minority representation among local police officers increased from 14.6% to 23.6%. Minorities accounted for 18.8% of sheriffs' offices in 2003 compared to 13.4% in 1987 (Hagan,

2008). As shifts in personnel demographics change across the nation, each state is responsible for creating adequate training that seeks to include a diverse body of officers.

Law Enforcement Training

Law enforcement officers are the "front line" in controlling crime. Officers are responsible for keeping the peace, apprehending violators, combating crime, preventing crime and providing social services. As discussed in the previous section, individuals desiring a career in law enforcement must first apply and be accepted into a state training program. While each state in our nation has distinctive and separate training, a review of publicly available information on the World Wide Web revealed common themes among each training curriculum.

Those participating in law enforcement academies are often taught curricula containing the following topics: academics, driving, firearms, human relations, law and physical training. While these themes remain common among the states, the content of each topic varies greatly. This dissertation study will review the content of each state's curriculum standard as set forth by the POSTC.

Alabama Law Enforcement Training

Every state requires that police recruits complete two components of training, one in the police academy and one in the field. Alabama's commitment to training began in 1935 when the original 75 members of the highway patrol were employed. Over a ten-day period of time, at the Gay Teague Hotel in Montgomery, these men received training in criminal law, first aid, motorcycle operation, and basic firearms. After this initial group was trained, there was a brief period of time in which training was offered on the Maxwell Air Force Base at no expense to the trainees. It was in this location that the first formal session of the Alabama Police Academy was conducted in 1954 (APOSTC, 2008).

Today, police officers are trained at one of seven academies located around the state: the

Huntsville Police Academy, the Birmingham Police Academy, the Mobile Police Academy, the

Montgomery Police Academy, the Northeast Police Academy, the Southwest Police Academy,

and the APOSTC Law Enforcement Academy in Tuscaloosa. Sheriffs are trained at the

Jefferson County Law Enforcement Academy and state troopers access their final training at the

Alabama Criminal Justice Training Center (APOSTC, 2008). In communication with the

director of Alabama's POSTC, he was made aware of this study and the use of state materials in

the dissertation.

Every officer in the state of Alabama must be educated according to the guidelines set

forth by the APOSTC procedures, rules, and regulations. Effective June, 2007, the APOSTC

outlined a course of study that consisted of thirteen categories and 480 hours of course

instruction. These thirteen categories are presented in Table 7. A complete listing of all topics

covered can be found in Appendix A.

Table 7

Topics of Curriculum for Law Enforcement in Alabama

Curriculum Topic	Hours
Introduction to Law Enforcement	8
General Topics	95
Equipment	21
Criminal Investigations	50
Criminal Procedures and Laws of Evidence	32

(table continues)

Table 7 (continued)

Curriculum Topic	Hours
Juvenile Procedures	8
Courts	31
Patrol Techniques	16
Traffic Operations	34
Offensive and Defensive Tactics	109
Community / News Media Relations	3
Firearms Training	43
Examinations and Directors Time	30

In order to successfully complete the training, a trainee must achieve an overall score of 70% or greater on all written exams, pass the first aid exam with a minimum score of 70%, pass a written legal issue exam with a minimum of 70%, pass the physical agility exam and achieve a minimum score of 70 percent on two of three attempts on the firearms course. If any trainee fails to meet these standards, they are barred from employment as a law enforcement officer for a period of two years after which he or she may reapply (APOSTC, 2008).

Each police academy curriculum must meet the APOSTC minimum standards. Nevertheless, each academy may choose to require its trainees to complete additional hours in order to receive certification. For example, The Mobile Alabama Police Academy requires completion of 900 hours of course and field training prior to certification (Mobile Police Department, 2008). Although the APOSTC mandates the topics to be covered, each academy is responsible for compiling and implementing its own content. Such latitude on the part of the

academies could lead to inconsistencies in the recognition of citizens who fall outside the

officers' realm of expectations. For example, if the characteristics of Autism present themselves

in such a way that the police officer interprets them as a sign of guilt, it is not inconceivable that

the person with disabilities runs an increased risk of being mistakenly detained.

While conducting research on Autism and police training, the researcher discovered that

each police academy and department creates its own training materials. In many instances,

individuals from community-based agencies are invited by the police to create and present

material about a given topic. In one example, a police academy reported that the training

materials were provided by the presenter from a local mental health agency (personal

communication, December 15, 2007). In an effort to locate the minimum training standards for

Alabama, the Alabama Peace Officer Standards and Training Commission (APOSTC) was

contacted. The contact person reported that the APOSTC allots four hours to the general topics

category "Handling the Emotionally Disturbed" (Appendix B). The lesson plan, originally dated

September 12, 1992 and revised on January 1, 2007 set out the three lesson objectives (Appendix

C). The first was to equip law enforcement trainees with information needed to recognize

mentally disturbed persons encountered in police work. The second was to acquaint the law

enforcement trainee with behavioral factors that parallel mental illness, but are not. The last goal

was to educate law enforcement trainees on crisis intervention procedures. Based on the

available training materials, the commission focus during training is to prepare law enforcement

trainees to handle an encounter with individuals with mental illness. As defined by the training

materials, a mental illness is a "variety of mind altering disorders which cause abnormal

thoughts, feelings, perception, judgment and behaviors" (Handling the Emotionally Disturbed,

2004).

The training material begins with basic mental health statistics, stating facts such as "five in 100 adults have a personality disorder and six in every 100 adults have serious depression." The presentation contains 80 slides and there are 28 different disorders represented in those slides. Twenty-nine of the slides contain information about social perceptions, suspected causes and treatments. Eight of the slides address the recognition of mental illness and give tips on how to "deal with an angry person" and de-escalate a situation. A vast majority of the disorders are presented in a single slide with up to six bullet points each; however, the majority of the listings have only one to three bullet points of generalized information. For example, a slide entitled Mental Retardation (MR) contains two bullets: (1) "People with mental retardation have a below normal mental development." (2) "Often due to a brain condition that was present at birth." Three of the slides contain no information other than titles of disorders such as "Physical Illness", "Amnesia and Memory Loss", and "Mental Disorders in Old Age" (Handling the Emotionally Disturbed, 2004). While the CDC cites Autism as one of the fastest growing developmental disabilities, it is not mentioned in the training material (Appendix B).

Only two studies examining law enforcement training and disabilities are found in the literature (Mcafee & Musso, 1995; Murphy, 1986). Moreover, no federal training standards are in place for states (personal communication, 2008). Therefore, the purpose of this dissertation will be to expand and update the investigation of law enforcement training in the areas of awareness and interaction between law enforcement officers and citizens with disabilities.

METHOD

As stated in the previous chapter, the purpose of this dissertation is to expand and update the current body of knowledge by examining law enforcement training as it relates to individuals with disabilities. In the formulation of this study, the author reviewed the POSTC curriculum for the state of Alabama, as well as relevant literature. McAfee and Musso (1995) reviewed the training curricula from 48 states and concluded that 12 common themes emerged from the combined data. These 12 topics, along with the number and percentage of states providing training in each category, are presented in Table 8.

Table 8

McAfee and Musso: Training Topics Derived from 1995 Study of Curricula

Topic	Number	Percentage
Mentally Ill/ Mentally Disturbed/ Emotionally Disturbed	29	60
Crisis Intervention	15	31
Human Relations/Interpersonal Communication	14	29
Deaf/Hearing Impaired/Hard of Hearing	12	25
Mental Retardation	4	8
Americans with Disabilities Act	4	8
Developmental Disabilities	2	4

Table 8 (continued)

Topic	Number	Percentage
Referral Agencies	2	4
Physically Impaired/Wheelchair Users	2	4
Elderly/Alzheimer victims	2	4
Blind/Visually Impaired	1	2
Learning Disabled	1	2

Notes. From McAffe, J., & Musso, S. (1995). Training police officers about persons with

disabilities: A 50-state policy analysis. *Remedial and Special Education, 16*(1), 52–63.

The first column denotes the total number of responding states that included information

about the category of disability. The second column denotes the same information based

on a percentage calculation.

This current study has chosen to build upon the 1995 findings by examining the manner

in which Mental Illness, Mental Retardation, and Pervasive Developmental Disorders are

presented in police academy training materials across all responding states. Additionally, the

narrowed scope of this study reflects the personal interests of the author as well as recognition of

the prevalence of these three disabilities in the population of the United States.

Sample

Within the United States, each state has a governing law enforcement board known as the

Peace Officer Standards and Training Commission (POSTC). It is this body that is responsible

for establishing the minimum standards of training for law enforcement academies within their

borders, but individual academies can choose to require additional hours and can select the method by which content is delivered. Since there is limited information available in the body of literature on individual police academies, and for uniformity among the states, the governing commissions were selected to provide training curricula for the purposes of this study.

In each of the 50 states, the POSTC has contact information made public on the World Wide Web (See appendix D for the list of contacts). Additional contact information was located on http://www.iadlest.org/ , the web page for the International Association of Directors of Law Enforcement Standards and Training (Appendix H).

Procedure

The study began with an attempt to garner information concerning police academy training materials from all fifty states. Because individual academies have latitude in the use and presentation of materials, the author chose to contact each state POSTC to request materials which are mandated in cadet training. Using the publicly available Internet contact list, each POSTC was contacted via email with a letter, submitted on Auburn University letterhead, requesting a copy of all training materials (outlines, Power Points, handouts, lesson plans) pertinent to disabilities (Appendix G). Each contact was asked to provide an outline or listing of all course topics, total number of training hours required, and a breakdown of topics by hours allotted for instruction. Each contact was also provided assurance that privacy would be respected and no dissemination of state materials would be allowed. This letter was formulated by the author and presented to Chief Kenny Cullpepper, Cullman County Chief of Police in the state of Alabama, who reviewed the request for training materials to ensure face validity and clarity. Chief Cullpepper's signature added relevance to the letter and served as assurance that materials received from the states would be used only for the purposes intended.

After two weeks, there was no response; many of the emails were returned as undeliverable. The same letter, again on University letterhead, was then sent via the United States Postal Service to each contact on the available Internet list. An additional two weeks yielded responses from 5 states. At the suggestion of one respondent, the author accessed the website for the International Association of Directors of Law Enforcement Standards and Training (IDLEST), and then contacted the directors listed via telephone (Appendix H) using the available phone numbers. In some cases, these numbers proved to be a direct line, but in most cases the published number was not to the director, but to the agency. After introduction and a request to speak to the individual responsible for the formulation and/or oversight of police academy curriculum, the author was either transferred to the director or given additional contact numbers. In cases where there was no answer in the director's office, a phone message was left with the author's name and number, and short description of the nature of the call. For those who still did not respond within 7 business days, a second phone call was made. In the instances where the author made contact, but was referred to someone else, the same procedures were followed.

When the author made contact with an agency representative able to fulfill the request for academy training curriculum, introduction included the name of the affiliated University and a short description of the nature and purpose of the study. The author requested training materials relevant to disabilities and an academy overview to include course topics and hour requirements. Three of the states requested the email containing the letter as documentation of the study prior to release of the curricula. This email was sent, as requested, within 24 hours. A total of four state curricula were purchased by the author. Academy curricula for two states were purchased from on-line bookstores recommended by the states; one state curriculum was purchased directly

from the POSTC office while another was purchased from the state's law enforcement website, printed at a selected Kinkos and picked up by the author. The remaining 13 curricula were sent to the author by the POSTC contact.

Data Analysis

In this study, the author analyzed the POSTC curricula for three of the training topics that McAfee and Musso listed among their common themes: (a) Mentally Ill/Mentally Disturbed/ Emotionally Disturbed, (b) Mental Retardation, and (c) Developmental Disabilities. While the McAfee and Musso study in 1995 distilled these common topics from materials provided by academies in 48 states, their publication did not provide any definition or detail as to what was contained in each category. Attempts to contact the authors by phone or email for clarification, insights, or additional information were unsuccessful.

In the effort to provide a standard as curricula was being reviewed, the author designed a code list (Appendix E) to serve as point of reference for specific items being examined within the curricula of responding states. The code list, found in Appendix E, contained the DSM-IV-TR (2000) definitions for Mental Illness, Mental Retardation and Developmental Delay, as well as the DSM-IV-TR definitions for the specific disabilities contained in each category and included in this study: Bi-Polar Disorder, Schizophrenia, Mental Retardation, Autism, Asperger's Syndrome, Rhett's Disorder, Childhood Disintegrative Disorder and Pervasive Developmental Delay-Not Otherwise Specified.

The curricula from the responding states was read thoroughly by both the author and two reviewers, trained by the author to use the guidelines provided by the code list in examination of training materials. The first reviewer, a college graduate with a Bachelor of Science degree in Nursing and the second reviewer, a college graduate with a Master of Business Administration

degree, were also provided with a brief history of law enforcement, disability, and the nuances of the relationship between the two. Additionally, the author provided training that discussed each disability in terms of characteristics, treatment, and strategies for productive interaction and intervention. The reviewers were asked to review the training materials for 24 hours and were subsequently provided an opportunity to have any questions answered. The author and the reviewers then engaged in consensus building discussion as they coded one curriculum together using the created code list. At this point, it was determined that the author and reviewers needed a more concise way to meaningfully store a multiplicity of information and, using the code list as a guide, the code sheet found in Appendix F was created. The code sheet, created in Microsoft Excel as a table, also had the added value of more efficiently standardizing, between author and the reviewers, the data being retrieved from voluminous training materials. After the creation of the code sheet, the author and the reviewers again coded one curriculum together to cement the ability to find consensus.

Subsequently, both author and reviewers read and critiqued individually each submitted curriculum and filled in a code sheet accordingly. The three code sheets, in the form of Microsoft Office Excel files, were then merged to make one table. In order to protect privacy, each responding state was then randomly assigned a number and the name of the state was removed from the table. Any references to the training materials of a particular state are made with the use of this assigned number. Original curricula were stored in a secured location while author and the reviewers worked with copied material that did not contain identifying information.

Research Questions

Each of the obtained curriculums was analyzed using the following seven research questions:

1)   What is the total number of academy hours required by Peace Officer Standards and Training Commissions for cadet training in each state?

2)   What is the average number of academy hours required by Peace Officer Standards and Training Commissions across the country?

3)   What is the average number of academy hours required by Peace Officer Standards and Training Commission across the country in the area of disabilities?

4)   Does each state present a definition, based on referenced sources for mental illness, mental retardation and developmental disabilities?

5)   Does each state present characteristics, treatment options, myths, or suggested methods of interaction for mental illness, specifically Bi-Polar Disorder and Schizophrenia?

6)   Does each state present characteristics, cognitive levels, myths and suggested methods of interaction for those with mental retardation?

7)   Does each state include descriptions, criteria for diagnosis or suggested methods of interaction for any of the Autism Spectrum Disorders?

RESULTS

Analysis of Results

Seventeen of fifty states (Table 9) responded to written and/or telephone requests for

POSTC mandated training materials used in their police academies. While only 34% of states

responded, sampling size was counterbalanced by the fact that respondents were located in all 5

regions of the United States (Figure 1) and were representative of states with large urban

industrialized areas, and relatively large populations, as well as states dominated by a rural

agrarian economy and smaller populations.
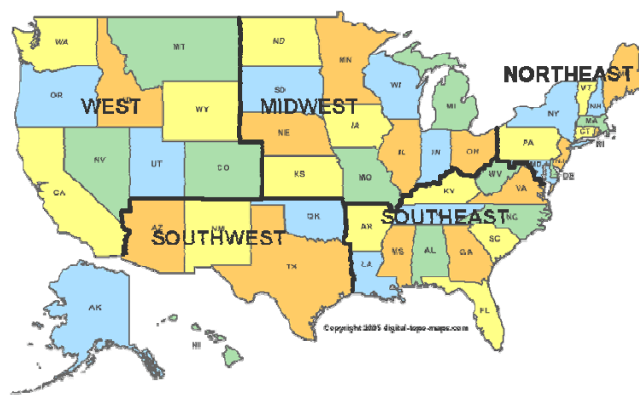
Figure 1. United States map depicting five regions.

Figure 2 displays the portion of the United States population that resides in each region.

The southeast is the most populous, containing 25% of the country's population. The midwest,

west and northeast each comprise about 20% of the nation's population. The southwest,

comprised of only four states, accounts for 12% of the population.
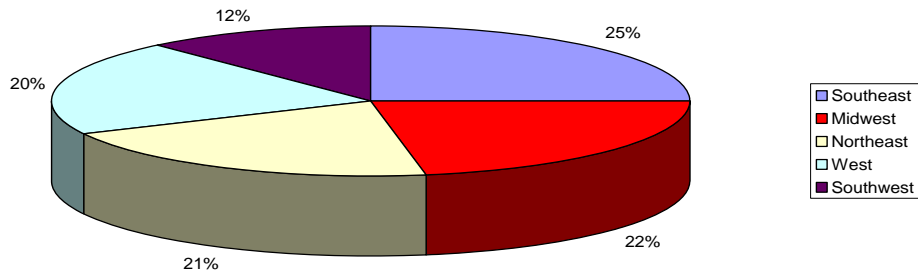
Figure 2. Percentage of US Population by Region

Respondents located in the Southeast were Alabama, Virginia, Tennessee, Florida, West Virginia and North Carolina. Also responding were two states in the Northeast: Massachusetts and Vermont. Five states from the Midwest responded: Illinois, Iowa, Minnesota, Ohio and Wisconsin. California, Alaska and Colorado responded from the Western portion of the United States while Texas responded from the Southwest. There are well acknowledged differences in culture from region to region, as characterized by the liberal "blue states" as opposed to the more conservative "red states" politically. The sampling contained states with these cultural differences, as well as states that are geographically widespread with enormous differences in population density.

The combined populations of responding states account for 20–25% of their regional population in the west, midwest, southwest and southeast. The combined populations of the responding states in the northeast represent only 4% of their regional population (Figure 3) and therefore pose a risk of bias.
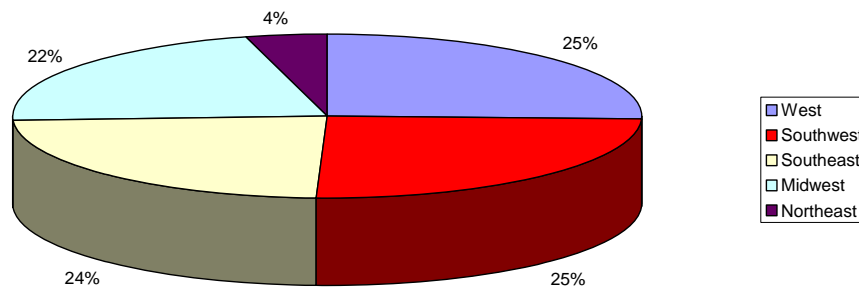
Figure 3. Percentage of Regional Population Represented by Responding States

While 100% participation is desirable in any study, training curricula does represent a

cross section of American states from the five geographical regions with all their implied

differences. The 17 states that have been reported as "responding" sent actual materials to be

used in this study, while the two states that reported materials to be unavailable were not counted

as respondents. In addition to the submitted training materials, the World Wide Web was used as

a source of publicly available information in the case of 37 states. Research questions posed at

the end of Chapter 3 guided the examination of training materials and enabled the researcher to

organize data for relevant discussion.

Table 9

States Providing Written Materials

Alabama	Ohio
Alaska	Tennessee
California	Florida
Colorado	Texas
Illinois	Vermont
Iowa	North Carolina
Virginia	Wisconsin
Massachusetts	West Virginia
Minnesota	

Utilizing publicly available information found on the World Wide Web for 37 states, it was determined that Peace Officers must participate in an average of 628 hours or 15.7 forty-hour weeks. Appendix I provides a list containing the publicly available total number of training hours required by each state. Of the 37 states for which training hours were available, Louisiana required the least amount of training with 400 hours, or 10 weeks, and Colorado required the most training with 1040 hours, or 26 weeks. The median training time was 600 hours with a range of 720 hours. Ten of the 50 state's websites also contained a breakdown of training hours and of these states, an average of 10 hours was dedicated to individuals with disabilities. Despite requests in writing and by telephone, only 5 of the 17 responding states provided a breakdown of training content by hours, and in all five cases, this was the same information available on their

Internet websites. A summary of these findings, which correspond to the first three research

questions can be found in Table 10

Table 10

Results of Research Questions One–Three

Research Question	n	Result
(1) What is the total number of academy hours required by the POSTC for cadet training in each state?	37	Median = 600 Minimum = 400 Maximum = 1040
(2) What is the average number of academy hours required by the POSTC across the country?	37	Mean = 628
(3) What is the average number of academy hours required by the POSTC across the country for training in disabilities?	10	Mean = 10 Minimum = 2 Maximum = 14

Note. n represents the number of states included in results.

Analysis of Respondents by Region

All five geographical regions of the United States have states that provided a definition of

mental illness; however, four of the five regions also contained states that provided no definition.

The only southwestern state that responded provided a general definition of mental illness for

law enforcement while recognizing DSM-IV-TR as a professional definition. All regions

contained at least one state that defined Bi-Polar Disorder, but other than the southwestern

region, less than half of the represented states within each region provided a definition.

Definitions of Schizophrenia were distributed across regions and within regions similarly

to definitions of Bi-Polar Disorder. Some states defined both but some states defined only one or

the other. Two thirds of responding states suggested methods of police interaction with persons

having mental illness. All regions were represented, with a range of 50% to 100% of states

within a region providing guidance to law enforcement trainees.

Those states that provided definitions of mental retardation represent all five regions and

also provided trainees with suggested methods of police interaction. However, only slightly

more than 50% of responding states addressed this issue. Less than 20% of responding states

provided law enforcement trainees with a definition of developmental disabilities. These three

states represented three of the geographical regions. Each state also provided the trainees with

suggested methods of interaction. One state in the northeast gave trainees suggestions for

dealing with persons with developmental disabilities, but failed to provide a definition or criteria.

Analysis of Respondents by Disability

Utilizing the Diagnostic and Statistical Manual: Fourth Edition Text Revised (DSM-IV-

TR; APA, 2000) as the standard for defining mental illness, the author determined that 9 of the

17 states provided a generalized definition of mental illness. Eight of these states included

characteristics of Bi-Polar Disorder and 9 included characteristics of Schizophrenia. Five states

included information about medication, one about cognitive therapy, four about hospitalization,

and two about behavioral therapies for individuals with mental illness. Counseling, referral to

community agencies, and the use of restraints were additional treatment topics discovered in at

least one curriculum. Four states included content about myths surrounding mental illness and

eleven states provided suggested methods of interaction between police officers and those displaying symptoms of mental illness.

The widely accepted definition of mental retardation is an individual with an IQ of 70 or below who displays deficits in self help skills such as personal care, community orientation, or daily functioning (APA, 2000; Ainsworth & Baker, 2004; Batshaw, Shapiro & Farber, 2007). It was this accepted definition which was used as the standard for reviewing each submitted curriculum. It was found that five of the 17 responding states provided a definition of mental retardation which cited decreased intellectual functioning and deficits in self-help skills. One state curriculum included information about cognitive levels and one state used the words "mild/moderate" and "severe/profound," but did not provide any detail or discussion that highlighted implied differences in cognitive level or functioning. Five states provided characteristics of mental retardation and/or behavioral examples. No states provided information regarding myths of mental retardation, but seven provided suggested methods for officer interactions with those individuals suspected of having mental retardation.

Only three of the 17 responding states contained information about developmental disabilities as they are defined by the DSM-IV-TR (APA, 2000). However six states included information specifically defining Autism. One of these also included information defining Asperger's Syndrome, but none of the other Autism Spectrum Disorders were included in any submitted curricula. Each of the six states which offered a definition of Autism also included suggested interactions for police officers when dealing with individuals displaying characteristics associated with Autism. A summary of these findings, which correlate to research questions four through seven, can be found in Table 11.

Table 11

Content of Responding States' Curriculum Standards as Set Forth by the POSTC

	Number	Percent
Mental Illness		
Definition		
Defined consistent with DSM-IV-TR	3	17.6%
Defined in some other manner	10	58.8%
No definition provided.	4	23.5%
Bipolar Disorder		
Characteristics properly identified	9	52.9%
Schizophrenia		
Characteristics properly identified	9	52.9%
Treatment information Recognized Medication	5	29.4%
Cognitive Therapy	1	5.9%
Hospitalization	3	17.6%
Behavior Therapy Others	2	11.8%
Myths presented	4	23.5%
Mental Retardation adequately defined	9	52.9%
Cognitive levels explained	1	5.9%
Characteristics explained	6	35.3%
Myths presented	0	0.0%
Suggested methods of police interaction presented	10	58.8%

Table 11 (continued)

	Number	Percent
Developmental Disabilities		
Adequately defined	4	23.5%
Disabilities under Pervasive Developmental Delay presented		
Autism	7	41.2%
Asperger's Disorder	1	5.9%
Rhett's Disorder	0	0.0%
PDD-NOS	1	5.9%
Childhood Disintegrative Disorder	0	0.0%
Other	4	23.5%
Criteria for diagnosis of each disorder presented	0	0.0%
Suggested methods of police interaction presented	6	35.3%

While this study focused on the topics of mental illness, specifically Bi-Polar Disorder, Schizophrenia, Mental Retardation, and Developmental Disabilities, several other disorders appeared in four or more of the submitted police training curriculums. As a mater of interest, these disabilities included: Post Traumatic Stress Disorder, Psychosis, Anxiety Disorders, Dementia/Alzheimer's and Epilepsy.

V. DISCUSSION

In 2008, the PEW Report found that the U.S. prison population nearly tripled between 1987 and 2007 with every one person out of 100 incarcerated. Additionally, one person out of every 31 is on probation or parole. Judge Charlotte Cooksey, who founded the mental health court in Baltimore, Maryland, stated "Our jails have become de facto psychiatric hospitals." Surveys conducted by Wells and Schafer (2006) found that officers report monthly encounters with individuals who have mental illness. Sixty percent of participants reported at least three encounters monthly, each lasting a minimum of two hours. Additionally, Engel and Silver (2001) found that 3.7% to 7.9% of all police encounters involve persons who are believed to be "mentally disordered."

Given the number of disabilities in the general population and the growing number of inmates held in U.S. prisons, law enforcement officers, by necessity must receive quality training on the recognition of disability in individuals displaying symptoms, and receive information which leads to appropriate interactions and positive outcomes. However, repeated incidents dating as far back as 25 years and continuing into the present would lead one to question whether this rationale receives practical support in terms of police training. In June 2009, an 18 year old with an IQ of 47, who lacked the ability to read, write or speak intelligibly was arrested, tried, and sentenced to 100 years in prison for child sex abuse. Texas Tech University law professor Daniel Benson called his sentence "absurd" because "repeat child molesters and rapists routinely receive lighter sentences" (Fox News, 2009). In another incident, as recently as July 2009, a

man with multiple disabilities locked himself into a store restroom because he felt ill. After he failed to open the door to pounding by police, he was tasered. When asked later, through signed interpretation, why he had failed to open the door, he replied that he thought it was "the devil" (Fox News, 2009).

In spite of the paradigm shift in American policing that occurred about a decade ago when law enforcement became less response-oriented and more community-based in their policing policies, increased community service activities have not always prepared officers to deal effectively with individuals with mental illness. The new emphasis on community-based policing should entail closer ties to community leaders and agencies, as well as a better working knowledge of community support systems such as shelters and mental health programs. However in some cases, the efforts of community resources and police officers to work in tandem toward a positive outcome are disjointed at best. Ninety-seven percent of one study's police respondents indicated that it "needs to be easier to get someone into the treatment facility" (Wells & Schafer, 2006, p. 580). Many of these same officers also anecdotally reported that "mental health providers say they cannot take them (person with mental illness).… When asked what to do, they say it's not their problem" (Wells & Schafer, p. 580).

In 2003, President George Bush formed the President's New Freedom Commission on Mental Health and directed its members to "study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements…." Subsequently, "The Commission found widespread fragmentation in the mental health delivery system and concluded that the system is not oriented toward the goal of recovery for the people it serves" (Massaro, 2004, p. 1). In recognition that inadequacies exist across the board, it is even more important that knowledgeable police officers be the first line of defense against injustice. They

must be perceptive enough to recognize behavior that may stem from disability rather than criminality. Law enforcement officers are often forced to make rapid decisions that impact lives, and their jobs can only be made easier when gaps in knowledge are closed with solid foundational information in the area of disabilities.

It follows that training in disabilities should become an integral part of academy curricula and the public should be assured that every facet of policing, including the involvement of law enforcement with individuals having special needs, is based on sound judgment seeded in current knowledge. When provided with training, Wells and Schafer (2006) found that officers were better able to identify an individual in crisis as having a mental illness. Prior to training, only 10% of the study participants felt that they could identify an individual with mental illness compared to the more than 50% who felt confident post training.

In 1986, Gerald Murphy published the results of a year-long study that focused on how the needs of those with mental illness were addressed by police and mental health agencies. Information for the study was obtained from academies and agencies located in 22 states. Murphy's research showed that agencies and academies offered from 90 minutes to 22 hours of training on mental illness, but the study selected academies and agencies at random rather than one homogeneous group that shared any commonalities. Almost ten years later, McAfee and Musso (1995) added to the research by attempting to quantify the amount of training in mental illness and disability received by law enforcement officers. While McAfee and Musso were fortunate to obtain information by telephone from 42 states, they did not define "person with disabilities," nor did they identify the types of agencies or academies contacted. Neither did they divulge in their study the specific questions used to elicit responses.

Summary

Individuals with mental illness, mental retardation and developmental disabilities are more likely to come into contact with law enforcement officers because they are more prone to display behaviors deemed inappropriate or suspicious by the general public. Although not empirically validated, Ruiz and Miller (2004) and Janik (1992) found law enforcement representatives reported seven to ten percent of citizen calls were due to requests for help regarding those who are potentially mentally ill. A later study in 2006 found that 40% of participating officers had at least two contacts with individuals suspected of having a mental illness and 60% of these officers reported three or more contacts. Behavior outside accepted social norms draws attention that often results in a call to police. It then falls to the responding police officer to gauge the behaviors of the offender and determine what kind of help is appropriate in terms of best serving the needs of offender and public alike. In many cases, individuals with disabilities are not readily identifiable by any type of obvious physical characteristics; there is nothing that would immediately alert an officer to the fact that an individual is disabled rather than intoxicated or drugged. Participants in Wells and Schafer's 2006 study responded to open ended questions with statements such as "I have problems being able to take the time to deal with these subjects appropriately during an overworked and understaffed shift" and "My biggest problem is identifying a subject with mental illness." Participants also reported, "I lack the knowledge of options we have when responding to persons with mental illness."

Mental Illness

A review of history shows that individuals with mental illness have traditionally been placed into asylums, state hospitals, group homes, jails or other locations where the public

assumed that they would receive adequate care unavailable elsewhere. The 1960s and 1970s

were a time of public awakening in terms of civil rights. Individuals with mental illness, many

of whom were long-time residents of various institutions, suddenly found themselves without

custodial support. The Wyatt v. Stickney (1970) case gave individuals with mental illness the

right to treatment, but also gave them the right to refuse treatment. Often unable to make such

decisions on their own, many ended up living on the streets or depending heavily on community

outreach for basic necessities. By virtue of delusional behavior deemed threatening by the public

and because they lacked the ability to communicate their needs effectively, displaced individuals

were often taken into custody by officers who did not otherwise know how to handle such

situations.

Though Early (2006) found that Schizophrenia and Bi-Polar Disorders were the most

commonly identified mental disorders within the incarcerated population, none of the 17 states

that responded to the request for training curricula cited specific mental illnesses within the

prison population. However, 14 of the 17 did include statements about mental illness; nine of

those presented a definition which included the same content as the professionally accepted

definition in the DSM-IV-TR. The remaining five did not use DSM-IV-TR guidelines and

simply included global statements such as "mental or emotional illness that affects the way a

person thinks, acts, feels and behaves" (State 5). For purposes of confidentiality, states were

randomly assigned numbers and will be referred to in such a manner. While the latter type of

definition is not grossly inaccurate, it does not clearly distinguish between a true mental illness

and the effects seen with drug or alcohol use, or even a temporary change in mood or behavior.

With this type of global definition, potentially ten minutes of road rage could be deemed

symptomatic of mental illness. All nine of the states whose definition of mental illness included

the DSM-IV-TR criteria also included a definition of Schizophrenia and eight included a definition of Bi-Polar Disorder.

Interestingly, 13 states included information pertaining to at least one additional area of disability with Post Traumatic Stress Disorder (PTSD) and Psychosis being the most common. The author speculates that the inclusion of PTSD may largely be due to the length of the current war and the number of tours of duty that soldiers have been required to complete with perhaps minimal time between assignments. In one state, the category of psychosis included generalized characteristics such as anxiety, inappropriate behavior, extreme rigidity, excitability, disorganized speech and depression, all of which could be symptomatic of a multitude of disorders.

Eleven of the states defining mental illness also included suggestions for police action which may enhance the chances for effective interaction with individuals exhibiting characteristics of mental illness. These included "assessing the situation" prior to approaching or interacting, "empathizing" and using "active listening" during which officers are taught to respond by paraphrasing and checking on the accuracy of an individual's concerns or fears. Unfortunately, one state curriculum included a recommendation for the use of "confinement" and "restraint" with handcuffs utilized as the primary treatment of choice (State 6). Another state recommended that officers "Go learn everything you can about mental illness" and elaborated by saying, "It's scary stuff to be around someone who is so disturbed" (State 5). Statements such as these parlay the responsibility for learning how to make appropriate judgments in challenging circumstances clearly upon the shoulders of police cadets. If the topic is of sufficient importance to be included in academy curriculum, then it should be of sufficient importance to be taught by trained instructors who present current information grounded in

knowledge rather than myth. Additionally, it is critical that law enforcement agents see individuals with disabilities in a compassionate light, as people deserving of care and treatment even while the dictates of the law are being upheld. Inciting statements in academy training literature can only serve to heighten anxiety for all concerned when police officers must respond to a potentially dangerous and stressful situation involving an individual with mental illness.

<div align="center">Mental Retardation</div>

The plight of those who are deemed "defective" has been, and still is, dependent on the customs and beliefs of the culture. In ancient Greece, neonates found "defective" were killed (Ainsworth & Baker, 2004). By the middle ages, "foundling homes" began to appear and Henry II of England supported law to make those with mental retardation wards of the state, thereby granting protection. While the term mental retardation was originally synonymous with derogatory terminology such as "idiot, feeble minded or moron" (AAIDD, 2008), the DSM-IV-TR defines the term as

> … significantly sub-average general intellectual functioning that is accompanied by significant limitations in adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health and safety with an onset prior to age 18. (APA, 2000; Batshaw, Shapiro & Farber, 2007)

Only five of the responding states met the DSM-IV-TR criteria when defining mental retardation in their academy curricula. While these five states included sub-average intellectual functioning, only one state elaborated to include information about the cognitive levels commonly regarded as mild, moderate, severe and profound. These five also included descriptors which elaborated the definition by providing common characteristics for those

individuals with mental retardation. For example, one of the five described those with mental retardation as "having poor communication skills, a shortened attention span, a poor sense of time, immature, overly compliant and a poor understanding of consequences" (State 5). While these five states presented accurate definitions and characteristics, several of the responding states also included statements such as, "The mentally retarded individual requires special handling. An individual may look like a grown-up but have the intelligence of a child" (State 6). State 6 offered a recommendation for interaction that directed the officer to be "patient, kind and understanding." While all officers should display such qualities, generalized information should be relegated to the lay public while law enforcement officers should be given the benefit of expert training grounded in professional knowledge.

Developmental Disabilities

While the term developmental disabilities includes a broad range of disorders that present hallmark systemic delays in growth and functioning, pervasive developmental disorders last into adulthood and specifically refer to the five disabilities known as Autism Spectrum Disorders (ASD). These disorders are Autism, Asperger's Syndrome, Rhett's Disorder, Childhood Disintegrative Disorder and Pervasive Developmental Delay, Not Otherwise Specified (PDD-NOS). In 2007, the Centers for Disease Control (CDC) conducted the first U.S. multi-site collaborative study to monitor the prevalence of ASD. Estimates, the first to come from multiple sites utilizing the same methodology for the same points in time, placed the incidence of ASD in the population at a ratio of one to 150. According to the CDC, these data represent the most comprehensive effort to obtain accurate figures for the prevalence of Autism Spectrum Disorders to date (CDC, 2008). Additionally, the CDC found the incidence of ASD to be increasing at an alarming rate (2008). Revisiting the total population figures for the United States (Census

Bureau, 2007) in terms of the CDC incidence rates for Autism Spectrum Disorders, there are almost 2 million people with this type of disability currently in the United States.

Because a prominent characteristic of Autism is an individual's aversion to loss of routine and strict adherence to rules and rituals (Batshaw, Pelligrino, & Roizen, 2007), there is little evidence of any significant association between Autism and criminal offending (Debbaudt, 2002). However, individuals with Autism continue to come into contact with law enforcement in much the same way that individuals with mental illness and mental retardation do. Behaviors that seem odd to the general public often attract attention and serve to summon calls for police intervention. Exacerbating an already perplexing situation for police officers, individuals with Autism often display an aversion to eye contact, a reluctance to be touched, repetitive and seemingly incomprehensible bodily movements, and a tendency to engage in self-soothing behaviors in an increasingly stressful situation. They often lack the ability to communicate or react in a socially acceptable manner, a situation which could be interpreted by authorities as obstinance or a willful refusal to cooperate. To safeguard the public and the law enforcement officers who serve them, and most of all those individuals with ASD who may be caught in a difficult situation not of their own making, it becomes imperative that law enforcement academies present students with quality information regarding the recognition and disposition of individuals with developmental disabilities.

Of the 17 responding states, three states had a curriculum that included the DSM-IV-TR definition for developmental disabilities; however, seven states included the DSM-IV-TR definition for Autism. Only one state included definitions for Asperger's Syndrome and PDD-NOS. While the differences in Autism Spectrum Disorders may seem minimal to the lay person, a basic understanding of the characteristics and differences can impact the expectations with

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which a law enforcement officer approaches a victim or perpetrator and how he chooses to interact with the individual displaying symptomology. Six of the seven states presenting information about Autism also included their recommendations for interaction. Many of the recommendations included "approach from the front and slowly, offer your hands as a greeting, respect personal space and use a supportive stance, make positive statements, use a calm, slow and low voice and keep directions short and simple" (State 10, 15, 21 and 35).

Limitations

Each state has a governing body for law enforcement training identified as the Peace Officer Standards and Training Commission (POSTC). The POSTC designs and mandates basic training requirements for employed officers throughout the state. While this study focused on the POSTC guidelines and curricula across all responding states, the author acknowledges that the POSTC is a state level agency and individual academies are free to interpret those guidelines and curriculum mandates with some flexibility. Therefore, this study is limited by the autonomy with which academies address training within the POSTC guidelines. Some may devote additional hours to a topic of disability, choosing to elaborate on particular points of interest, while others adhere to minimum training requirements and choose to treat the same topic in a more cursory fashion. Individual academies may provide additional specialized training on some aspect of disability by way of hiring presenters with acknowledged expertise, and if such ad hoc additions to the curriculum should exist in order to meet community need, there would be no way to consider it for purposes of this study. Some academies may simply adjust training according to feedback and the current challenges of their locale. For instance, if police officers are most challenged by the gang activity in a city, great emphasis may be placed on suggested methods of dealing with gang violence to the detriment of topics such as disability. It is not

possible in the present study to account for a fluid curriculum that may adjust within the confines of limited time and resources.

Additionally, presenters and instructors in some academies may be more, or less, qualified on the topic of disabilities than instructors in other academies. Academies located in cities with colleges and universities may be able to access a broader pool of current knowledge in the form of expert presenters. Examination of qualifications and experience of instructors was outside the scope of this study, as were preconceived ideas or biases that might affect the degree to which a cadet is willing or able to internalize instructional materials. The current descriptive study cannot effectively measure the outcome of instruction in terms of how much content was actually learned, or how the behavior or attitudes of a cadet were changed based on exposure to training materials.

There were only three areas of focus in the examination of state training curricula: Mental Illness, Mental Retardation and Developmental Disability. These are fairly broad categories, but still very limited in scope when it comes to the full range of human exceptionality. Accordingly, adherence to only three focus areas narrowed the scope of the study and could not account for other training materials that may prove valuable in cases where law enforcement encounters individuals with symptomology commonly associated with disability.

While the entire training curricula for six states were obtained, 11 states responded with only those materials used in training related to disabilities. In the cases of these eleven states, useful information on disabilities may have also been embedded in other topics and gone undetected. Conversely, within the scope of this study, it was not possible to determine whether something included in the written curriculum was actually presented in the classroom environment with appropriate care taken to actually insure the transfer of knowledge.

This study yielded a response rate of 17 out of 50 states; training materials from a higher number of respondents would lend more credibility to the study. However, the low sample size was counterbalanced by the fact that respondents were located across all 5 regions of the United States. Even so, the heaviest response came from the southeast (six states) and the midwest (five states), areas that are commonly considered more socially conservative, less populace and more rural. While it was beyond the scope of this study to search for any cultural bias which might affect the willingness of an academy to devote time and resources to training related to disabilities, no obvious patterns emerged that might indicate one region more willing than any other to include such instructional materials.

Finally, this study is descriptive in nature and necessarily subject to the interpretations of the author. In an effort to minimize variances in the examination of training materials across the 17 responding states, a code sheet was used to standardize the information in table format. In an effort to further control misinterpretation or bias on the part of the author or secondary reviewers, standardized definitions contained in the DSM-IV-TR were used to operationally define each disability included in the study.

<center>Future Directions</center>

To gain a more comprehensive overview of the disability related content being taught to law enforcement cadets during academy training, additional focus should be placed on expanding the number of responding states. Although every state was contacted, many states failed to return calls or letters. There were also states who indicated that their training materials were in the process of revision and were not currently available. These states were not included for the purposes of this study. Future research efforts may have a better success rate with the return of requested materials if contacts are made first at the academy level, and then moved up

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the chain of command one step at a time as deemed necessary. Of course, in such a scenario the homogenous nature of dealing with only state POSTC guidelines would be lost, and a study might be better focused on how POSTC standards are met and adhered to across the various academies responsible for implementation.

Another option would include a review of state legislation to determine which states support legislative mandates for disability training as part of law enforcement academy training. This type of research in conjunction with exploration of funding available in each state for training of law enforcement might shed light on how, or why, some states include the topic of disability in training curricula.

This study focused on three areas of disability and could easily be expanded to include others. It might prove interesting to note the quality and quantity of instruction presented on a particular topic in relationship to the prevalence of that disability in the population. A survey of lay people in the community might also highlight disparity or synchronicity with the priorities of law enforcement when it comes to allotting instructional time and resources to particular topics. For instance, perhaps the general public believes that officers should be better trained to interact with individuals with Mental Illness while the academy that prepares officers for work in that locale gives more priority to training in the area of Mental Retardation.

One must bear in mind, however, that presentation of training materials is only one half of the equation and that this study could be hugely expanded to measure adequacy of academy training in areas related to disability by actually testing cadets for their grasp of factual data before and after instruction. Surveys done before and after training could also assess cadet attitudes, perceptions, and personal confidence in the ability to recognize and affect a positive outcome for individuals with disability. A quantitative study that compares the two surveys

could shed light upon why or why not certain topics are of more importance than others and enable the academy to weight instructional time accordingly.

A future study might undertake a distillation of symptomology that is common to multiple disabilities and approach instruction in terms of how symptoms alone might dictate the course of action taken by law enforcement in first response situations. For instance, if an individual is unable to communicate, he may be affected by deafness, autism, mental retardation or a myriad of other conditions. Rather than trying to define the problem, the police officer could simply rely on his training for suggested methods of interaction with an individual lacking communication skills. An individual may be highly excitable, but instead of trying to decide whether the individual is high on drugs or simply experiencing the manic stage of Bi-Polar Disorder, the officer relies on training which has taught him how to interact with an individual who cannot be calmed. The conclusions of such a study could impact the approach that academies use when presenting future instruction on disability.

SEEDS Model

This study has shown that great variance exists in the overall training that law enforcement cadets receive in the area of disabilities. Not only do POSTC requirements differ from state to state (there are no federal guidelines or standards), but each academy is permitted untethered latitude in both the quantity and quality of topical instruction. Varying hours of classroom instruction, inconsistent levels of instructor expertise, course content developed from disparate definitions and lack of situational role-modeling result in wide variability in the amount of practical knowledge that officers take into the field after graduation. Even those with the best knowledge base may find themselves unprepared to apply that knowledge with an adequate level of expertise. In an attempt to consolidate knowledge about interaction with persons with

disabilities into an easily remembered and practical format, the author has formulated the SEEDS model for use by officers in the field. For officers facing a difficult situation, SEEDS provides an easy to remember, easy to follow, thought progression. The SEEDS model encompasses the five priority assessments that an officer must make swiftly and accurately:

1) SAFETY: Are there individuals, including police officers in this situation who are in immediate danger?

2) EVALUATE: Are there individuals who are exhibiting unexpected or extraordinary behaviors, and could these behavior be attributed to disability?

3) ENTRY: Has this individual been approached using a non-threatening stance, and with the intention to resolve any escalating behaviors?

4) DETERMINE: Is the individual able to communicate or follow concise directives, and does this situation require additional or specialized personnel?

5) STRATEGY: Has a plan of action been determined that will insure safety and resolution?

Law enforcement officers do not normally have the luxury of sifting through numerous alternatives to action: their responses must often be both immediate and correct. Foundational classroom training in various disabilities gives law enforcement officers valuable information, but emphasis must be placed on the ability of officers to recognize disability in a first response situation and to accordingly make procedural adjustments.

Just as officers improve firearm proficiency with range practice, proficiency in assessing and resolving stressful interactions can be improved by providing multi-linear pre-recorded scenarios that provide opportunities for the trainee to select the course of action. Making correct choices reinforces the cadet's confidence in his learning while incorrect choices provide

coaching opportunities and content review. Answering the SEEDS questions in order from one through five may give officers confidence that their assessments are accurate and that they have not missed important facets of the situation. It gives them a tool to take from the classroom to the street.

Conclusion

In conducting this study, the author examined the curricula provided by 17 Peace Officer Standards and Training Commission s from across the United States. In addition, publicly available material on law enforcement training from all 50 states was reviewed on the World Wide Web. By reviewing both sources of information, the author concisely answered the previously formulated research questions as follows:

1. What is the total number of academy hours required by the POSTC for cadet training in each state?

Nationally, these commissions require an average of 628 hours or 15.7 forty-hour weeks

2. What is the average number of academy hours required by Peace Officer Standards and Training Commission s from across the country?

Appendix I contains a list of states and their required number of training hours.

3. What is the average number of academy hours required by Peace Officer Standards and Training Commission s across the country in the area of disabilities?

Across the ten states for which disability training hours were available, an average of ten hours was dedicated to the topic of disabilities. Washington spent the least amount of time with only two hours and New York dedicated the most training time with 14 hours.

4. Does each state present a definition, based on referenced sources, for mental illness, mental retardation, and developmental disabilities?

No. Only nine of the participating states provided a definition based on the DSM-IV-TR standard for mental illness. Five states provided a definition that included accepted criteria for mental retardation and only three included a definition for developmental disabilities.

5. Does each state present characteristics, treatment options, myths or suggested methods of interaction for individuals with mental illness, specifically Bi-Polar Disorder and Schizophrenia?

No. Eight states provided a definition of Bi-Polar Disorder and nine provided a criteria-based definition of Schizophrenia. Of these states, five included information about medication, four about hospitalization, two about behavioral therapy and one about cognitive therapy. Four of the responding states presented myths associated with mental illness and 11 provided suggestions for interactions.

6. Does each state present cognitive levels, characteristics, myths and suggested methods of interaction for those with mental retardation?

No. Two states presented information about cognitive levels while five described characteristics. None presented myths and seven included recommendations for interaction.

7. Does each state include criteria for diagnosis or suggested methods of interaction for any of the Autism Spectrum Disorders?

No. Only one state presented information about diagnostic criteria and six state curricula contained recommendations for interaction.

Law enforcement officers find themselves in acutely stressful situations on a daily basis and must be vigilant to safeguard themselves, as well as the public, in the performance of their

duties. It is a job that requires the ability to make rapid decisions that seriously impact the lives

of those they have sworn to serve. Without federal standards, states are left to determine their

own curricula and individual academies are responsible for the implementation of those

standards. Law enforcement officers need and deserve training that enables them to do their jobs

in the most efficient and productive manner possible. Providing law enforcement with ample

training and practical tools such as the SEEDS Model will allow them to confidently recognize

and interact productively with individuals who are disabled and at the same time, ensure that

those individuals with special needs are treated in ways which will affect a positive outcome for

everyone involved. With incidence of disabilities such as Autism on the rise, any U.S. family

could be touched by preventable tragedy unless well prepared law enforcement officers are able

to make informed decisions.

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Appendix A

Alabama Peace Officers Standards and Training Commission
480 hour Minimum Standards Curriculum
Effective January 1, 2006

Subject	**Hours**
<u>Introduction To Law Enforcement</u>	<u>Total 8 Hours</u>
Opening Remarks and Orientation	2 hours
History of Law Enforcement	1 hour
Law Enforcement Ethics and Professionalism	4 hours
Title 36-21-40	1 hour
<u>General Topics</u>	<u>Total 95 Hours</u>
Notetaking & Notebook Construction	2 hours
Federal Law Enforcement Agencies	3 hours
State law Enforcement Agencies	2 hours
Introduction to Terrorism	4 hours
Police Communications (Radio)	2 hours
Records and Reports	4 hours
Effective Report Writing	8 hours
Explosives Act #1971/Recognizing Bombs and Explosives	3 hours
Handling the Emotionally Disturbed	4 hours
First Aid Includes C.P.R certification in accordance with American Heart Association or Red Cross Standards	8 hours
Stress	4 hours
Hazardous Materials	4 hours
Weapons of Mass Destruction	4 hours
Domestic Violence	4 hours
Public Utilities Enforcement Agencies	2 hours
Gangs, Sects, Cults and Deviant Movements	6 hours
Victims of Crime and Leniency	2 hours
Interpersonal Communications	4 hours
N.H.T.S.A. Standardized Field Sobriety Testing Course (Horizontal Gaze Nystagmus training)	24 hours
Project ICE	1 hour
<u>Equipment</u>	<u>Total 21 Hours</u>
Care and Use of Police Equipment	2 hours
Operation of Emergency Vehicles	3 hours
Police Defensive Driving	16 hours

Criminal Investigation	Total 50 Hours
Receiving and Handling Complaints	4 hours
Preserving the Crime Scene, Collecting and Preserving Evidence	8 hours
Building Searches	8 hours
Death Investigations	4 hours
Fingerprints	4 hours
Burglary Investigations	2 hours
Robbery Investigations	2 hours
Auto Theft	2 hours
Drug Enforcement and Vice Investigations (Drug Enforcement – 4 hours, Methamphetamine Lab – 2 hours, Prostitution – 1 hour, Gambling – 1 hour)	8 hours
Sex Crimes	4 hours
Search and Seizure/4th Amendment law	4 hours

Criminal Procedures & Laws of Evidence	Total 32 Hours
Laws of Arrest, State & Federal Criminal Procedure	8 hours
Searching & Transporting Prisoners	4 hours
Laws of Corrections & Custody	4 hours
Civil Process	2 hours
Interrogations & Confessions (5th & 6th Amendments)	4 hours
Alabama Rules of Evidence	4 hours
Criminal/Civil Liability & Civil Rights	4 hours
U.S. Constitution, Bill of Rights & Constitution Principles	2 hours

Juvenile Procedure	Total 8 Hours
Juvenile Laws, Detainment & Detention Procedures	4 hours
Exploitation of Children	4 hours

Courts	Total 31 Hours
Alabama Criminal Law, Title 13A	16 hours
State of Alabama Motor Vehicle Laws, Title 32,	4 hours
Title 15, Criminal Procedure	2 hours
Court Procedures	8 hours
Title VII: ADA/Sexual Harassment	1 hour
Patrol Techniques	Total 16 Hours
Patrol Techniques	12 hours
Officer/Violator Contact	2 hours
Traffic Direction and Control	2 hours

Traffic Operations	Total 34 Hours
Introduction to Accident Investigation	2 hours
Questioning Drivers & Witnesses	1 hour
Hit and Run Accidents	1 hour
Accident Reports and Safety Responsibility Laws	4 hours
Measurements & Diagrams (no scale diagramming)	10 hours
Marks on the Roadway	4 hours
Licenses & Registration and CDL	2 hours
Traffic Exam	1 hour
Traffic Exam Review	1 hour
Draeger	8 hours

Offensive & Defensive Tactics	Total 109 Hours
Defensive Tactics - PPCT	32 hours
Defensive Tactics - SSGT or Arcon	16 hours
Physical Training	33 hours
Officer Survival	24 hours
Physical Agility Exam	4 hours

Community/News Media Relations	Total 3 Hours
Community/News Media Relations	3 hours

Firearms Training	Total 43 hours
Firearms Qualification	27 hours
Close Combat/Night Firing	12 hours
Shotgun Familiarization	4 hours

Examinations and Directors Time	Total 30 Hours
Testing	
Evaluations	
Reviews	
Graduation	
Administrative Meetings	

Grand Total 480 Hours

APOSTC Disability Training

HANDLING THE
EMOTIONALLY DISTURBED

ALABAMA PEACE OFFICERS STANDARDS AND TRAINING COMMISSION
2004

OBJECTIVES

- Be able to define mental illness.
- Identify the types and classifications of mental illness
- Recognize signs of mental illness
- Discuss intervention strategies for handling the mentally ill and emotionally disturbed
- Identify how to deal with aggressive behavior
- Be familiar with the commitment law and procedure, and where to refer the mentally ill for assistance

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MENTAL ILLNESS

- Mental illness is defined as a variety of mind altering disorders, which cause abnormal thoughts, feelings, perception, judgment, and behaviors.

ATTITUDE AND PERCEPTION

- Mental illness has long carried a stigma.
- What we don't know or understand frightens or frustrates us.
- Some believe the individual:
  - Caused their own illness.
  - Can turn the illness off and on at will or when convenient.
  - Is weak and their mind is underdeveloped.
  - Pretends to be mentally ill to get attention or favor.

Mental Illness Facts

- 44 million Americans 18 or older experience a mental or substance related illness in a given year.
- 4.8 million Americans suffer from a severe and persistent mental illness in a given year.
- 5.2 million other Americans experience a mental illness that seriously impairs their ability to function successfully at work, home, and in their community.

Mental Illness Facts

- 9 to 13 percent of American children between the ages of 9 and 17 suffer from a severe emotional disturbance.
- An estimated 15 to 25 percent of elderly Americans suffer from serious symptoms of mental illness.

1

MENTAL ILLNESS FACTS

- Every 5 in 100 Adults have Personality Disorders
- Every 5 in 100 Adults have serious depression
- Every 1 in 100 Adults have Schizophrenia
- Every 1 in 100 adults have Alzheimer Disease
- Every 10 in 100 abuse drugs or alcohol
- 500,000 suicides committed each year
- 500,000 reported cases of rape
- 1.5 million cases of reported child abuse

COMMON TYPES OF MENTAL ILLNESS

- Some of the more common types of disorders which officers may encounter are:
  - Psychotic Disorders
  - Mood/Affective Disorders
  - Personality Disorders
  - Dissociative Disorders
  - Cognitive Disorders
  - Somatoform Disorders

PSYCHOTIC DISORDERS

- Individual loses contact with reality.
  - Schizophrenia
  - Schizo Affective Disorder

MOOD/AFFECTIVE DISORDER

- Individual experiences disturbed or unstable emotions
  - Depression
  - Bi-polar

PERSONALITY DISORDERS

- Individual experiences personal distress with significant impairment in work or social ability to function.
  - Post Traumatic Stress Disorder
  - Obsessive-compulsive Disorder

DISSOCIATIVE DISORDER

- Individual experiences disturbances in consciousness, memory, perception of the environment, or identity.
  - Amnesia (minus physical cause)
  - Dissociative identity disorder (multiple, distinct personalities)

2

100

COGNITIVE DISORDERS

- Individual experiences a significant loss of mental capacity to function.
  - Delirium
  - Dementia

SOMATOFORM DISORDERS

- Characterized by the presence of physical symptoms that can not be explained by a medical or psychiatric illness.
  - Hypochondria
  - Pain Disorder

IMPULSE CONTROL DISORDER

- Inability to control harmful or erratic behaviors.
  - Kleptomania
  - Pyromania

CAUSES OF MENTAL ILLNESS

- Four causation viewpoints:
  - Biological
  - Psychological
  - Cognitive
  - Sociocultural

Biological Perspective

- This viewpoint holds that some mental illnesses are related to bodily processes and levels of neurotransmitters (chemical substances that enable brain cells to communicate with each other and the body). Imbalances in chemical levels of neurotransmitters have been linked with some mental illnesses such as Schizophrenia, Depression and Anxiety.

Psychological Perspective

- This viewpoint emphasizes the effects that environment and upbringing has on one's mental health.

3

Cognitive Perspective

- The belief is that mental illness results from cognitive problems, related to how one reasons, perceives circumstances and resolves opposition. Depression, Anxiety, and Personality disorders are thought to result from the cognitive perspective.

Sociocultural Perspective

- Social, economic and cultural ills impact the condition of one's mental health. Research has proven that poor people and those who are misplaced experience mental illnesses at a higher rate than some other populations. Additionally, victims of disaster and certain crimes are at greater risk of experiencing a mental illness, especially depression, anxiety and post traumatic stress disorder.

Treatment

- Persons with a mental illness can receive treatment through some local hospitals, mental health centers, private physicians or private therapist.
- The two most common treatment methods for mental illness are:
  - Drug therapy and,
  - Psychotherapy.

Drug Therapy

- Drug therapy involves treating the person with regular doses of one of more of the following:
  - Anti-psychotic drugs (major tranquilizers) – used to treat symptoms of schizophrenia and other related disorders.
  - Anti-depressant drugs – used to treat symptoms of depression and other related disorders

Drug Therapy

  - Anti-anxiety drugs (minor tranquilizers) – used to treat anxiety and panic disorders.
  - Anti-manic drugs – used to treat the mania that corresponds with bi-polar.

Psychotherapy

- Incorporates a range of techniques and practices to help one identify and understand factors that contributed to their illness and teaches behavior modification.
- Another method referred to as behavioral therapy is particularly effective n treating some personality disorders such as phobias or obsessive-compulsive disorders.

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Support Groups

- National Alliance for the Mentally Ill (NAMI)

Symptoms

- Psychosis	- Withdrawn
- Hallucinations	- Motor abnormalities
- Delusions	- Lack of insight
- Affect	- Violence
- Mania	- Changes in emotional tone
- Paranoia	
- Thought disorder	- Strange memory loss
- Bizzare behavior	

SCHIZOPHRENIA

- Schizophrenia is a severe disorder characterized by delusions, inappropriate emotional responses, disorganized thinking, hallucinations, and deteriorated social functioning.

SCHIZOPHRENIA

- The age of onset is typically between the ages of 16-25.
- It is uncommon after 30 years of age.
- Rare after 40 years of age.
- Occurs in about 1% of individuals.
- 10 % of individuals with disease commit suicide.
- 10% of homeless have schizophrenia.

SCHIZOPHRENIA

- Can affect anyone at any point in their lives, but is more common in those persons who are genetically predisposed to the disease.
  - Chances of inheriting the disease:
    - 1% chance if neither parent had it
    - 13% if one parent has it
    - 35% if both parents have it

SCHIZOPHRENIA

- Schizophrenia occurs equally in men and women, however, it is a more serious disease in men than in women, primarily because men do not respond well to psychotropic medications. They have a higher relapse, and their long-term adjustment is not nearly as good as women.

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TYPES OF SCHIZOPHRENIA

- Hebephrenic
  - Disorganized thinking, shallow and inappropriate affect. Ex. Laughs and talks to themselves.
- Catatonic
  - Stupor, inhibition of movement, mute, withdrawal, statue immobility.

TYPES OF SCHIZOPHRENIA

- Paranoid
  - Delusions of persecution or grandeur, can be very suspicious.
- Chronic Undifferentiated
  - Symptoms are associated with one or more of the above.

Signs and Symptoms

- Moodiness
- Withdrawal
- Apathy
- Loss of Interest in personal appearance
- Belief that people are watching them
- Preoccupied with their body
- Vagueness in thought
- Delusions
- Hallucinations
- Affect
  - Flat, blunted affect, zombie

SCHIZOPHRENIA

- What Schizophrenia is not:
  - A split personality
  - Mental Retardation
  - Manic-depressive Psychosis
  - Borderline Personality Disorder
  - Street or Prescription Drug Psychosis

Treatment

- There is no cure for schizophrenia. However, by following a treatment routine, symptoms can be prevented from reoccurring. This can be achieved through:
  - Medication
  - Outpatient Clinical Services (e.g., mental health center)
  - Hospitalization
  - Community Case Management Services

BIPOLAR DISORDER

- It is also called manic-depressive illness.
- It is a mood disorder.
- Individuals can experience extreme shifts in mood, energy and behavior.
- Bipolar disorder is a brain disease. It can be attributed to abnormalities in the structure and/or activity of specific brain circuits.

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Bipolar Disorder

- The disease appears before age 20 in about 90% of the cases.
- It can also appear in childhood and as late as 50 years of age.
- 2.5 million people are affected each year.
- Individuals with bipolar disorder often die 9.2 years earlier than those individuals who don't have bipolar disorder.

Bipolar Disorder

- About 1 in 5 or 20% of the individuals with the disease commit suicide.
- The chance of inheriting the disease are:
  - 15-30% if one parent has the disease.
  - 50-75% if both parents have the disease.

Symptoms

- Symptoms of the disease include different episodes.
- An individual can have an episode and experience the symptoms of depression
- An individual can have an episode and experience the symptoms of mania
- An individual can experience a mixed episode that includes symptoms of depression and mania.

Symptoms

- During severe episodes, psychotic symptoms can be present with the mania of depression.
- An individual has rapid cycling bipolar disorder when 4 or more episodes occur in a 12 month period.
- Suicidal thoughts can be present
- Symptoms can worsen with the use of alcohol and/or drugs.

Treatment

- There is no cure for bipolar disorder. However, by following a treatment routine, symptoms can be prevented from reoccurring. This can be achieved through:
  - Medication
  - Outpatient Clinical Services (e.g., mental health center)
  - Hospitalization
  - Community Case Management Services

Special Conditions

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Mental Retardation

- People with mental retardation have a below normal mental development.
- Often due to a brain condition that was present at birth.

Physical Illness

Amnesia and Memory Loss

Mental Disorders in Old Age

ANXIETY DISORDERS

- Affects more than 19 million people each year.
- 5 categories of anxiety disorders
  - Panic Disorder
  - Obsessive-Compulsive Disorder
  - Post-Traumatic Stress disorder
  - Social Phobia
  - Generalized Anxiety Disorder

PANIC DISORDER

- Panic Disorder – Characterized by panic attacks, sudden feelings of terror that strike repeatedly and without warning.
- Physical symptoms include chest pain, heart palpitations, shortness of breath, dizziness, abdominal discomfort, feelings of unreality, and fear of dying.

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OBSESSIVE-COMPULSIVE DISORDER

- Affects 3.3 million Americans each year.
- People with obsessive-compulsive disorder suffer intensely from recurrent unwanted thoughts (obsessions) or rituals compulsions, which they feel they cannot control.
  - Hand washing
  - Counting
  - Cleaning

POST-TRAUMATIC STRESS DISORDER

- Persistent symptoms that occur after experiencing a traumatic event such as war, rape, child abuse, natural disasters, or being taken hostage.
- Symptoms may include nightmares, flashbacks, numbing of emotions, depression, and feeling angry, irritable, distracted and being easily startled are common.

SOCIAL PHOBIA

- Extreme, disabling and irrational fear of something that really poses little or no actual danger; the fear leads to avoidance of objects or situations and can cause people to limit their lives.

GENERALIZED-ANXIETY DISORDER

- Chronic, exaggerated worry about everyday routine life events and activities, lasting at least six months; almost always anticipating the worst even though there is little reason to expect it. Accompanied by physical symptoms, such as fatigue, trembling, muscle tension, headache, or nausea.

PSYCHOTIC ILLNESS

- Hallunicinations
- Delusions
- Thought disorder
- Bizarre behavior
- Withdrawal
- Motor abnormalities

PSYCHOSIS

- Thoughts and behavior are not reality based.

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HALLUCINATION

- Imagined sights, sounds, tastes, smells, touches.
  - Auditory – hears things that are not there.
  - Visual – sees things that are not there.

DELIRIUM

- Persons consciousness becomes clouded. They have problems concentrating, paying attention, and staying on the subject.

DELUSION

- False belief, irrational ideas, fixed beliefs. These beliefs are firmly implanted in the person's ideas and beliefs. There is no point in trying to tell then otherwise. If you argue or try to rationalize with them, you will get NO WHERE!
- 3 TYPES
  - Delusions of persecution
  - Delusions of Grandeur
  - Delusions of Reference

WITHDRAWAL

- Retreat from society and relationships with others.

DEPRESSION

- Affects 19 million Americans each year
- Depression causes people to lose pleasure from daily life, can complicate other medical conditions, and can even be serious enough to lead to suicide.

CAUSES OF DEPRESSION

- Biological
- Cognitive
- Gender
- Co-occurrence
- Medications
- Genetic
- Situational

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SYMPTOMS OF DEPRESSION

- Persistent sad, anxious or "empty" mood
- Sleeping too much or too little, middle of the night or early morning waking
- Reduced appetite and weight loss, or increased appetite and weight gain
- Loss of pleasure and interest in activities once enjoyed, including sex
- Restlessness, irritability

SYMPTOMS OF DEPRESSION

- Persistent physical symptoms that do not respond to treatment
- Difficulty concentrating, remembering or making decisions
- Fatigue or loss of energy
- Feeling guilty, hopeless or worthless
- Thoughts of suicide or death

DEMENTIA

- Decline of intellectual and other mental facilities. Total loss of reality, loses short-term memory, remembers the past but not the present. May be agitated, possibly violent.
  - Alzheimers

PSYCHIATRIC EMERGENCY

- A manifestation of acute mental symptoms of sufficient severity that the absences of immediate attention could place the mental or physical health of the individual or others in serious jeopardy.
- **Practical definition:** Any situation, which an individual or those around him/her, deem to be a psychiatric emergency.

RECOGNIZING MENTAL ILLNESS

- **Appearance:** may be normal or "out of place"
- **Behavior:** may be normal, odd, or "out of place"
- **Speech:** may be normal, non-sequential, very rapid or very slow
- **Emotion:** may be normal, excessive, inappropriate, or apparently absent
- **Thoughts:** may be normal, irrational, and hard to follow, or distorted

CRIMINALITY VS MALINGERING

- Aggressive behavior is not a diagnosis of mental illness, but some mentally ill people can be aggressive.
- The motive for specific behaviors in the mentally ill often rests in a distortion of reality rather than criminal intent.

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CRIMINALITY VS MALINGERING

- Faking psychotic behavior is rare; most people would rather be thought criminal than insane. (one exception; personality disorders, especially anti-social personality.)
- Why bother to distinguish mental illness from criminality? To avoid filling jails with the mentally ill and hospitals with criminals.

WHO ARE THE POTENTIALLY DANGEROUS PERSONS?

- Suicidal
- Psychotic (especially paranoid)
- Manic
- Intoxicated (particularly with cocaine, PCP, alcohol)
- Organically impaired (especially seizure disorder)

PREDICTING DANGEROUS BEHAVIOR

- There is no accurate method to predict violent or dangerous behavior.
- Previous history of violence is the best predictor available.
- Learn to trust you gut; if you feel unsafe, listen to that feeling.

SAFETY ISSUES

- You must feel safe before you can effectively deal with a psychiatric emergency
- Personal space
- Environmental barriers
- Weapons
- Show of force rather than show of aggression

INTERVENING WITH THE POTENTIALLY DANGEROUS MENTALLY ILL PERSON

- Safety first. Protect yourself and others
- Assemble adequate personnel
- Gather available information
- Enlist the help of friends or relatives if possible
- Maintain calm but firm tone of voice and body language
- Explain who you are and why you're there

INTERVENING WITH THE POTENTIALLY DANGEROUS MENTALLY ILL PERSON

- Provide truthful reassurance
- Resist provocation to anger (be aware of your own emotions)
- Set limits on dangerous behavior in a non-threatening manner
- Don't argue with delusions!
- Time is your ally in most circumstances

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INTERVENING WITH THE POTENTIALLY DANGEROUS MENTALLY ILL PERSON

- Carefully explain what you are going to be doing
- Make calm, deliberate motions only!
- Restrain as necessary to prevent injury to self or others

SPECIFIC CAUTIONS

- The suicidal person: watch for attempts by the individual to provoke an attack, thus aiding the suicide.
- The paranoid person: avoid an attitude of undue familiarity an overt friendliness, which the individual may interpret in a hostile fashion

SPECIFIC CAUTIONS

- The brain-injured person: inability to understand instructions or delay impulses due to cognitive deficits may appear to be deliberate opposition. Often the individual has lost the capacity to interpret body language and tone of voice.

DEALING WITH AN ANGRY PERSON

- Do not punish someone for being angry.
- Listen actively to what the person is saying and feeling.
- Help the individual to accept feeling angry and identify the real causes of the anger.
- You do not need to offer solutions or solve problems immediately

DEALING WITH AN ANGRY PERSON

- Enlist the individual's help in selecting an appropriate way to direct the anger.
- Do not ignore anger or calm someone down just to make you feel more comfortable.
- Do not take anger personally and become defensive.

DEALING WITH AN ANGRY PERSON

- Sometimes it is best to insist that an angry person regain control before you talk with them.
- Be aware of the early warning signs which indicate that an individual is having difficulty coping with unpleasant feelings.
- Intervene as soon as you feel something wrong.

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DEALING WITH AN ANGRY PERSON

- Attempt to make an angry situation a learning experience which generates constructive alternatives for handling unpleasant feelings.
- If you want to influence someone's behavior, change you reaction to it.

DEALING WITH AN ANGRY PERSON

- Avoid win-lose, right-wrong situations
- Do not corner someone physically or psychologically.
- **DO NOT MAKE PROMISES YOU CAN'T KEEP.**

Safety and De-escalation Principles

- Know the environment
  - Exits
  - Offensive and defensive weapons
  - Alarm systems
  - Position of furniture
  - Isolated areas
  - Emergency procedures

Safety and De-escalation Principles

- Know what you control
  - Movement/stance/breathing
  - Hand position
  - Physical distance from subject
  - Touching
  - Body language
  - Effect of your manner (hostile, authoritarian, overly helpful, professional concern).
  - Protect your back
  - Tone of voice
  - Eye contact
  - Dress

Safety and De-escalation Principles

- **Think** before you intervene
  - Remove cheerleaders
  - Get angry person alone, on neutral territory if possible
  - Sit down, lower voice, same height level
  - Do you need HELP?
  - Don't bring in outside force prematurely
  - Don't underestimate <u>any</u> angry person

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Appendix C

Alabama Peace Officer Standard & Training Commission Lesson Plan

DATE: SEP 18, 1992 REVISED

ALABAMA PEACE OFFICERS STANDARDS & TRAINING COMMISSION
LESSON PLAN COVER SHEET

LESSON TITLE: HANDLING THE EMOTIONALLY DISTURBED

TIME ALLOTTED: 2 HRS OF A 6 HR. BLOCK

METHOD: LECTURE/DISCUSSION

REFERENCES: POLICE RESPONSE TO SPECIAL POPULATIONS, U.S. DEPT. OF JUSTICE; 1987-

DE CUIR, WALTER "HANDLING THE MENTALLY ILL", F.B.I. LAW ENFORCEMENT BULLETIN, 1988

MURPHY, GERALD, SPECIAL CARE; IMPROVING THE POLICE RESPONSE TO THE MENTALLY DISABLED: DEPT. OF JUSTICE PUB. JULY 1985.

HANDOUTS/AIDS:

1. BASIC PSYCHOLOGY

2. MENTALLY ILL PERSONS (SIGNS AND SYMPTOMS)

3. DISTURBED OR VIOLENT PERSONS

4. WARNING SIGNS OF POTENTIAL SUICIDES

5. SPECIAL CONDITIONS ENCOUNTERED BY POLICE

6. THE MENTALLY RETARDED

7. PHYSICAL ILLNESS AND AMNESIA

8. DEPRESSED PERSONS

LESSON OBJECTIVES:

1. TO EQUIP THE STUDENTS WITH THE INFORMATION NEEDED TO RECOGNIZE MENTALLY DISTURBED PERSONS THAT WILL BE ENCOUNTERED IN POLICE WORK.

2. TO AQUAINT THE STUDENT WITH BEHAVIORIAL FACTORS AND ILLNESSES THAT PARALLEL MENTAL ILLNESS, BUT IS NOT.

3. TO EDUCATE THE STUDENTS ON CRISIS INTERVENTION PROCEDURES.

DEMONSTRATED LEARNING OBJECTIVES:

1. THE STUDENT WILL BE ABLE TO IDENTIFY THE FOLLOWING TYPE OF E.D.PIS.

   A. RETARDED PERSONS

   B. DISTURBED OR VIOLENT

   C. MENTAL ILLNESS

   D. PERSONS SUFFERING FROM HALLUCINATIONS

   E. SUICIDAL PERSONS

Appendix D

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IADLEST June 2007 Directory

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Appendix E

Law Enforcement and Disabilities Code Sheet

A. Mental Illness: defined as individuals who can appear delusional, paranoid, displaying significant deficits in social interaction or unusually disorganized speech (APA, 2000; Earley, 2006; Davis, 2005)

    1. Characteristics of Bi-polar Disorder
        a. DSM-IV-TR describes a category of mood disorders defined by the presence of one or more episodes of abnormal moods.
        b. Moods can be abnormally elevated, clinically referred to as mania and/or depressive episodes or symptoms of depression.
        c. Individuals may display mania, depression or a mixed episodes with periods of "normal" moods between episodes
    2. Characteristics of Schizophrenia
        a. DSM-IV-TR characterizes by abnormalities in perception or expression of reality
        b. Manifests as auditory hallucinations, paranoid or bizarre delusions, disorganized speech and thinking with significant social or occupational dysfunction
    3. Curriculum presents information additional disorders included under category of mental illness
    4. Curriculum presents information about medical treatments such as medication, cognitive therapy, hospitalization, and/or behavioral therapy
    5. Myths
    6. Police curricula suggested methods of interaction

B. Mental Retardation: defined as individual with an IQ of 70 and below who displays deficits in self-help skills such as personal care, community orientation, or daily functioning (APA, 2000; Ainsworth & Baker, 2004; Batshaw, Shapiro & Farber, 2007)

    1. Cognitive levels (IQ) associated with mental retardation
        a. 50/55-70 Mild MR
        b. 35/40- 50/55 Moderate MR
        c. 20/25- 35/40 Severe MR
        d. below 20/25 Profound MR
    2. Characteristics of mental retardation
        a. sub-average intellectual functioning (IQ of 70 and below) and
        b. impairments in at least two areas of adaptive functioning (communication, self-care, home living, interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health or safety)
    3. Myths
    4. Police curricula suggested methods of interaction

C. Developmental Disabilities: defined as an individual who has developmental delays across multiple areas of functioning, specifically those with deficits in communication, social interaction and behavior (APA, 2000; Janzen, 1996; Lord et al., 2002)

   1. Disabilities included under Pervasive Developmental Delay
        a. Autism
        b. Asperger's Disorder
        c. Rhett's Disorder
        d. Pervasive Developmental Delay- Not Otherwise Specified (PDDNOS)
        e. Childhood Disintegrative Disorder (CDD)
   2. Criteria for diagnosis for each disorder
        a. Autism: DSM-IV-TR designated number of deficits in each of three categories: social interaction, communication and behavior
        b. Asperger's Disorder: DSM-IV-TR designated number of deficits in social interactions and behavior
        c. Rhett's Disorder: Normal development prenatal and perinatal with a marked decrease in head circumference between the fifth and forty-eighth months. Characterized by the repetitive hand movements that resemble hand-wringing.
        d. PDD-NOS: Often referred to as Atypical Autism due to late onset or atypical symptomology. Still meets majority of DSM-IV-TR criteria for Autism.
        e. CDD: Characterized by a significant loss of expressive/receptive language, social skills, adaptive behavior, bowel or bladder control and play or motor skills between the ages of two and ten years.
   3. Police curricula suggested methods of interaction

Code Sheet -- Mental Illness

State	How is mental illness defined?	Are characteristics of Bipolar disorder identified?	Are character-istics of Schizophrenia identified?	Are additional disorders included in this category? List.	Is treatment information included?					Are myths presented?	Are suggested methods of police interaction presented?
					Medication	Cognitive therapy	Hospitali-zation	Behavior therapy	Other - List.		
1	A variety of mind altering disorders, which cause abnormal thoughts, feelings, perception, judgment and behaviors.	Yes	Yes	Anxiety disorders; panic disorders; OCD; PTSD; Social phobia; Generalized-Anxiety disorder; psychotic illness, including hallucinations, delusions, thought disorder, bizarre behavior, withdrawal, and motor abnormalities	Yes	No	Yes	Yes	Com-munity case manage-ment services	No	Yes
2	A term used to describe a broad range of mental or emotional problems that seriously interfere with the way a person is able to live his or her life.	No	Yes	Dementia; depression; anxiety disorders such as OCD; substance abuse	No	No	No	No	None	No	Yes
3											
4											

State	How is mental illness defined?	Are characteristics of Bipolar disorder identified?	Are character-istics of Schizophrenia identified?	Are additional disorders included in this category? List.	Is treatment information included?					Are myths presented?	Are suggested methods of police interaction presented?
					Medication	Cognitive therapy	Hospitali-zation	Behavior therapy	Other - List.		
5	A term used for a group of disorders causing severe disturbances in a person's thinking, feeling, and ability to relate to others. A person affected by a mental illness usually has a substantially diminished capacity for coping with the ordinary demands of life. Thought disorder is a condition where the person's thought process is disrupted causing the person to experience delusions or irrational fears, see visions or a number of other irrational behaviors. A mood disorder also referred to as an affective disorder, is a condition where the person experiences periodic disturbances in mood, concentration, sleep, activity, appetite or social behavior.	One specific statement made: "People who are affected by bipolar disorder may experience periods of excessive energy, feel no pain or feel they require little or no sleep.	no	General characteristics: fearfulness, inappropriate behavior, extreme rigidity, excitability, impaired self-care, hallucinations, delusions, disorganized speech, and depression are mentioned with definitions but not specific to disorders identified.	no	no	yes-Lanterman-Petris-Short Act: identifies criteria for involuntary commit-ment for 72 hours	no	none	no	no

State	How is mental illness defined?	Are characteristics of Bipolar disorder identified?	Are character-istics of Schizophrenia identified?	Are additional disorders included in this category? List.	Is treatment information included?					Are myths presented?	Are suggested methods of police interaction presented?
					Medication	Cognitive therapy	Hospitali-zation	Behavior therapy	Other - List.		
6	Can be marked by periods of extreme sadness (depression) or excitement (mania). Course outline only. Mentally ill part of "special populations."	No	No	Ability to describe and explain behavior of mentally ill is a specific performance outcome.	No	No	No	No	None	No	Officer is expected to be able to demon-strate and employ the threshold Assessment and Response Procedure (isolate, contain, assess, respond).
7											
8											
9	Mental or emotional illness affects the way a person thinks, acts, feels and behaves.	no	no	Psychosis, Psychotics, Psychopaths/Socio paths- (words are included and bolded with little to no clarification)	no	no	no	no	"Learn everything you can about mental illness. It's scary to be around someone who is so disturbed."	no	no
10											
11											

State	How is mental illness defined?	Are characteristics of Bipolar disorder identified?	Are character-istics of Schizophrenia identified?	Are additional disorders included in this category? List.	Is treatment information included?					Are myths presented?	Are suggested methods of police interaction presented?
					Medication	Cognitive therapy	Hospitali-zation	Behavior therapy	Other - List.		
12											
13	Psychotic disorders are disorders of psychogenetic origin with or without clearly defined anatomical brain irregularities. These include the types of mental disorders commonly referred to under the legal term "insanity." Hospitalization is frequently necessary… may be episodic, with periods of relative normalcy between.	Bi-polar is not identified but category called "affective reactions" is listed and defined as "reactions associated with disturbed emotions… the most common type of affective reaction is cyclical manic-depressive reaction… characterized by alternating and relatively prolonged periods of excitement (mania) and depression.	yes	Psychosomatic Disorders, Psychoneurotic Disorders, Personality disorders, Transient Situational Personality Disorders, Psychopathic Personality Disorders (Alcoholic, Drug and Sex Offenders)	no	no	no	no	Restraints-handcuffs, confine-ment	no	no
14											
15	No specific definition of mental illness that distinguishes it from developmental disabilities	Yes	Yes	Depression; manic-depressive; organic disorders such as dementia, brain atrophy, strokes	Yes	No	Yes	No	Depression	Yes	Yes
16											
17											

State	How is mental illness defined?	Are characteristics of Bipolar disorder identified?	Are character-istics of Schizophrenia identified?	Are additional disorders included in this category? List.	Is treatment information included?					Are myths presented?	Are suggested methods of police interaction presented?
					Medication	Cognitive therapy	Hospitali-zation	Behavior therapy	Other - List.		
18 19 20 21	DSM-IV	Yes	Yes	Major depressive episodes; Manic episodes; Dissociative disorders including fugue, amnesia and depersonalization; Personality disorders including passive-aggressive, schizoid, paranoid, inadequacy and antisocial	No	No	No	No	None	No	Yes
22 23	Has definitions for "categorical vulnerable adult" and "functional vulnerable adult."	No	No	No	No	No	No	No	None	No	Deals primarily with ADA and major areas of physical or mental disability requiring public sector accommodations.
24 25											

State	How is mental illness defined?	Are characteristics of Bipolar disorder identified?	Are characteristics of Schizophrenia identified?	Are additional disorders included in this category? List.	Is treatment information included?					Are myths presented?	Are suggested methods of police interaction presented?
					Medication	Cognitive therapy	Hospitali-zation	Behavior therapy	Other - List.		
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30											
31											
32											
33	"…term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress and /or impaired functioning."	Yes	Yes	PTSD	Yes	No	No	No	Counseling	No	Yes
34											
35	encompassing a number of distinct brain disorders such as manic-depressive illness, schizophrenia, depression, and severe anxiety that disrupts a person's mood, thought process, memory, sensory input, feelings and ability to reason and relate to others.	no	no	Alzheimer's Disease	no	no	no	no	None	no	yes
36											

State	How is mental illness defined?	Are characteristics of Bipolar disorder identified?	Are character-istics of Schizophrenia identified?	Are additional disorders included in this category? List.	Is treatment information included?					Are myths presented?	Are suggested methods of police interaction presented?
					Medication	Cognitive therapy	Hospitali-zation	Behavior therapy	Other - List.		
37											
38											
39											
40											
41											
42	Brain disorders that impair thinking, feeling and behavior; and disrupt ability to function in activities of daily living such as social interaction, employment, education and self-care.	Yes	Yes	Panic attack; PTSD; Depression; OCD; Personality disorder; conduct disorder; Generalized Anxiety Disorder	Yes	Yes	Only in co-occurrence with substance abuse	Yes	Social skills training; Case manage-ment; Psycho-social Rehabilita-tion; Peer-run srvcs	Yes	Yes
43	General definition: Illness, disease, or condition that either substantially impacts a person's thought, perception of reality, emotional process, or judgment, or grossly impairs a person's behavior, as manifest-ed by recent distur-bance behavior. Pro-fessional definition: DSM-IV	Yes	Yes	Personality disorders (paranoia, antisocial, borderline); mood disorders (depression and bipolar); anxiety disorders (including OCD and PTSD); psychosis; developmental disorders.	Yes	No	No	No		Yes	Yes; L.E.A.P.S. (Listen, empathize, ask paraphrase and summarize)
44	No specific definition of mental illness that distinguishes it from developmental disabilities	No	No	None	No	No	No	No	None	Yes	Yes

State	How is mental illness defined?	Are characteristics of Bipolar disorder identified?	Are character-istics of Schizophrenia identified?	Are additional disorders included in this category? List.	Is treatment information included?					Are myths presented?	Are suggested methods of police interaction presented?
					Medication	Cognitive therapy	Hospitali-zation	Behavior therapy	Other - List.		
45	No	No	No	Curricula module for Alzheimer's and Dementia training was provided.	No	No	No	No	None	No	No
46											
47	DSM-IV definition quoted. Also included state statute definition "Mental illness for purposes of involuntary commitment, means substantial disorder of though, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life but does not include alcoholism.	yes	yes	Depression, Anxiety Disorders (panic, OCD, phobias PTSD), Personality Disorders (Sociopaths), and People Exhibiting Medically Significant Behavior	no	no	yes	no	referral to community agency	no	yes
48	No detail about what is contained in the 4-hr block.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
49											
50											

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Code Sheet -- Mental Retardation

State	How is mental retardation defined?	Are cognitive levels explained?	Are characteristics explained?	Are myths presented?	Are suggested methods of police interaction presented?
1	Not defined	No, only defined as "below normal mental development."	minimally	No	co-occurring with mental illness
2	Not addressed	No	No	No	No
3					
4					
5	An individual with below average intellectual functioning or deficits in adaptive behavior. Individuals affected by MR have a limited capacity to learn which may be caused by a birth defect, deprivation in early childhood, disease, consumption of toxins or poisons, or numerous other reasons. MR is not the same as Mental Illness.	no	"behavioral indicators" are listed with examples. Areas included are poor communication skills, shortened attention span, poor sense of time, immature social relationships, overly compliant, difficulty with simple tasks, poor understanding of consequences	no	yes- broken into 7 categories with guideline examples: 1)initial contact, 2) instructions and commands 3) evaluation, 4) assessment, 5) questioning 6) information gathering, 7) resolution options
6	Not addressed	No	No	No	No
7					
8					
9	People who are mentally handicapped have below normal mental development due to a brain condition.	no	no	no	"Control your frustration, think of how the impaired person feels. Be patient, kind and understanding."
10					
11					
12					
13	The mentally retarded individual requires special handling. An individual may look like a grownup but have an intelligence no greater than that of a child.	no	no	no	"...officer should be patient, kind and understanding."
14					
15	Persons who have intellectual functioning which is below average. A decreased ability to learn.	No	No	No	Yes

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State	How is mental retardation defined?	Are cognitive levels explained?	Are characteristics explained?	Are myths presented?	Are suggested methods of police interaction presented?
16					
17					
18					
19					
20					
21	A genetic disorder in which a person has significantly sub-average general intellectual ability and is significantly limited in at least two of the following skill areas: communication, self-care, home living, interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health, or safety	No	Yes	No	Yes
22					
23	Not addressed	No	No	No	No
24					
25					
26					
27					
28					
29					
30					
31					
32					
33	Not addressed	No	No	No	No
34					

State	How is mental retardation defined?	Are cognitive levels explained?	Are characteristics explained?	Are myths presented?	Are suggested methods of police interaction presented?
35	MR is characterized both by a significantly below average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, and getting along in social situations and school activities. Mental retardation is sometimes referred to as a cognitive or intellectual disability. There are different degrees of mental retardation, ranging from mild to profound. A person's level of mental retardation can be defined by their intelligence quotient or by the types and amount of support they need. Mental retardation is an impairment affecting the brain and its ability to process information.	no	yes	no	yes
36					
37					
38					
39					
40					
41					
42	A life-long disability consisting of impaired intellectual functioning.	Single level identified with IQ <70-75	Only in how they co-occur with mental illness	No	Yes
43	MR refers to a range of substantial limitations in mental functioning manifested in persons before age of 18. Characteristics of MR are a below-average intellectual capacity plus limitations in two or more adaptive skill areas such as communication, self-care, home living, social skills, health, safety academic functioning, and work.	Yes	Yes	No	Yes
44	Down Syndrome presented.	No	Down Syndrome	No	No
45	no	no	no	no	no
46					

State	How is mental retardation defined?	Are cognitive levels explained?	Are characteristics explained?	Are myths presented?	Are suggested methods of police interaction presented?
47	Developmental disability means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related tomental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the affected individual. Developmental disability does not include senility which is primarily caused by the process of aging or the infirmities of aging. (defined in state statute)	mild/ moderate and severe/profound- examples given but no #s	yes	no	yes
48	No detail about what is contained in the 4-hr block.	n.a.	n.a.	n.a.	n.a.
49					
50					

Code Sheet – Pervasive Developmental Disabilities

State	How are developmental disabilities defined?	Are disabilities under Pervasive Developmental Delay presented?						Is the criteria for diagnosis for each disorder presented?	Are suggested methods of police interaction presented?	Note
		Autism	Asperger's Disorder	Rhett's Disorder	PDD-NOS	Childhood Disinte-grative Disorder (CDD)	Other — List.			
1	No specific definition	No	No	No	No	No	None	No	No	
2	Not addressed	No	No	No	No	No	None	No	No	
3										
4										
5	A DD is a disability which manifests before the age of 18, continues, or can be expected to continue indefinitely and constitutes a substantial disability for that individual	Yes- presented as a "severe disability in which all areas of functioning and interacting with others are affected"	no	no	no	no	MR, CP, Epilepsy, Neurological Disorders (Blind and/or Deaf)	no	Yes- broken into 6 categories with guideline examples: 1) initial contact, 2) evaluation, 3) assessment, 4) questioning, 5) information gathering, 6) resolution options	Lanterman Developmental Disabilities Service Act: written to establish CA's responsibility for and the coordination of services for people with DD. Services are coordinated statewide through regional centers.
6										
7										
8										
9	Not addressed	no	no	no	no	no	None	no	no	
10										
11										
12										
13	Not addressed	no	no	no	no	no	None	no	no	
14										

State	How are developmental disabilities defined?	Are disabilities under Pervasive Developmental Delay presented?						Is the criteria for diagnosis for each disorder presented?	Are suggested methods of police interaction presented?	Note
		Autism	Asperger's Disorder	Rhett's Disorder	PDD-NOS	Childhood Disinte-grative Disorder (CDD)	Other — List.			
15	Four components: mental or physical impairment, onset before age 22, continues indefinitely, and substantial functional limitations in three ore more of seven dimensions (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and capacity for self-sufficiency)	Yes	No	No	No	No	Brain injury; mental retardation; cerebral palsy; epilepsy	No	Yes	
16										
17										
18										
19										
20										
21	No specific definition	No	No	No	No	No	None	No	No	
22										
23	Not addressed		No	No	No	No	None	No	No	
24										
25										
26										
27										
28										
29										
30										
31										
32										

State	How are developmental disabilities defined?	Are disabilities under Pervasive Developmental Delay presented?						Is the criteria for diagnosis for each disorder presented?	Are suggested methods of police interaction presented?	Note
		Autism	Asperger's Disorder	Rhett's Disorder	PDD-NOS	Childhood Disinte-grative Disorder (CDD)	Other — List.			
33	No specific definition	Yes	Yes	No	Yes	No	None	Only autism	Yes	
34										
35	no	no	no	no	no	no	None	no	no	
36										
37										
38										
39										
40										
41										
42	No specific definition	Yes	No	No	No	No	None	No	No	
43	"…a severe, chronic disability of a person five years of age or older."	Yes	No	No	No	No	None	No	Yes	

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State	How are developmental disabilities defined?	Are disabilities under Pervasive Developmental Delay presented?						Is the criteria for diagnosis for each disorder presented?	Are suggested methods of police interaction presented?	Note
		Autism	Asperger's Disorder	Rhett's Disorder	PDD-NOS	Childhood Disinte-grative Disorder (CDD)	Other — List.			
44	No specific definition	Defined as a complex developmental disability that typically appears during the first 3 years of life, the result of a neurological disorder that affects the normal functioning of the brain impacting development in the areas of social interaction and communication skills.	No	No	No	No	MD; Alzheimer's; MS; cerebral palsy; paralysis; spina bifida;	No	Yes	
45	no	no	no	no	no	no	None	no	no	Alzheimer's or other Dementia separate unit
46										

State	How are developmental disabilities defined?	Are disabilities under Pervasive Developmental Delay presented?						Is the criteria for diagnosis for each disorder presented?	Are suggested methods of police interaction presented?	Note
		Autism	Asperger's Disorder	Rhett's Disorder	PDD-NOS	Childhood Disinte-grative Disorder (CDD)	Other — List.			
47	Developmental disability means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related tomental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the affected individual. Developmental disability does not include senility which is primarily caused by the process of aging or the infirmities of aging. (defined in state statute)	yes- detailed descriptors	no	no	no	no	CP, Epilepsy, TBI, Prader-Willi, and Fetal Alcohol Syndrome	no	yes	Alzheimer's or other Dementia separate unit
48	n.a.	No detail about what is contained in the 4-hr block.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	
49										
50										

Appendix G

Request Letter

AUBURN
UNIVERSITY

March 3, 2009

To Whom It May Concern:

Each year the number of individuals with significant disabilities increases. We hope to review each state's current standards and gain valuable insight into current training practices. In order to do so, we are contacting Police Officer Training and Standards Commissions across the country requesting their current training standards and requirements.

We know that the demands on your time are pressing, but if you are able to provide us with information about your academy training programs, we would very much appreciate your help. No individual state will be identified in the study and all received materials will be kept confidential. Examples of requested materials are as follows:

1. Overall course listings with titles and hours required for graduation
2. Content of any courses relating to all disabilities
3. Training materials such as:
   - Power Point presentations
   - Handouts
   - Lesson plans
   - Curriculum guides

We wish to thank you for any assistance that you can provide. Upon completion of the study, we would be happy to provide your state with a summary of the findings and information you may find helpful for future training. Thank you for your assistance.

Please mail all correspondence and questions to:
Whitney Meade
14907 Clovercrest Dr.
Huntsville, AL 35803
meadeww@auburn.edu

Sincerely,

Whitney Meade, M.A.

Kenny Culpepper
Cullman City Chief of Police

APPENDIX H

IADLEST STATE MEMBER DIRECTORY ON IADLEST WEBSITE

Alabama POST	Alan Benefield	334-242-4045
Alaska Police Stds Cncl	Terry Vrabec	907-465-4378
Arizona POST Board	Lyle Mann	602-223-2514
Arkansas Cmsn on LEST	Terry Bolton	870-574-1810
California POST	Paul Cappitelli	916-227-2802
Colorado POST	John Kammerzell	303-866-5692
Connecticut POST Cncl	Thomas Flaherty	203-238-6505
Delaware State Police	Ralph Davis	302-739-5903
District of Columbia	Maureen O'Connell	202-727-1516
Florida Dept of LE	Michael Crews	850-410-8600
Georgia POST	Ken Vance	770-732-5802
Honolulu Police Dept	Susan Ballard	808-529-3175
Idaho POST Academy	Jeffrey Black	208-884-7250
Illinois LE Trng & Stds Bd	Thomas Jurkanin	217-782-4540
Indiana LE Trng Board	Rusty K. Goodpaster	317-839-5191
Iowa LE Academy	E. A. "Penny" Westfall	515-242-5357
Kansas LE Trng Ctr	Steven R. Culp	620-694-1400
Kentucky Dept of CJ Trng	John W. Bizzack	859-622-6165
Louisiana POST	Judy Dubuy	225-925-4942
Maine CJ Academy	John B. Rogers	207-877-8000
Maryland Police & Corr Trng Cmsns	Raymond A. Franklin (acting)	410-875-3606
Massachusetts Mun Police Trng Cmte	Dolores Ford	781-437-0300
Michigan Cmsn on LE Stds		517-322-1417
Minnesota Bd of POST	Neil Melton	651-643-3060
Mississippi Bd on LEOST	Robert D. Davis	601-987-3065
Missouri Dept of Pub Safety	Jeremy S. Spratt	573-751-4819
Montana POST	Wayne C. Ternes	406-444-9976
Nebraska LE Trng Ctr	William J. Muldoon	308-385-6030
Nevada POST	Richard P. Clark	775-687-3318
New Hampshire POST	Donald L. Vittum	603-271-2133
New Jersey Police Trng Cmsn	Robert Melson	609-984-0960
New Mexico Dept of Pub Safety	Arthur D. Ortiz	505-827-9290
New York Div of CJ Svcs - Ofc of Pub Sfty	John Bilich	518-457-6101
North Carolina CJ Trng & Stds Div	Wayne Woodard	919-716-6470
North Carolina Sheriffs' Ed & Trng Stds Cmsn	Julia Lohman	919-716-6450
North Carolina Justice Academy	Peggy Schaefer	910-525-4151
North Dakota POST Bd	Mark Gilbertson	701-328-5500

Ohio Police Officer Trng Cmsn	Ron Ferrell	740-845-2700
Oklahoma Cncl on LE Ed & Trng	Larry Birney	405-239-5100
Oregon Dept of PSST	John Minnis	503-378-2043
Pennsylvania Mun PO Trng Cmsn	John Gallaher	717-346-4086
Rhode Island Mun Police Trng Academy	Anthony J. Silva	401-722-3360
South Carolina CJ Academy	Hubert F. Harrell	803-896-7779
South Dakota CJ Trng Ctr	Jon Bierne	605-773-3584
Tennessee LE Trng Academy	Brian Grisham	615-741-4448
Texas Cmsn on LEO Stds & Ed	Timothy A. Braaten	512-936-7700
Utah POST	Scott Stephenson	801-957-3211
Vermont CJ Trng Cncl	R. J. Elrick	802-483-6228
Virginia Dept of CJ Svcs	Ron Bessent	804-786-8001
Washington CJ Trng Cmsn	Michael Parsons	206-835-7347
West Virginia Div of CJ Svcs	Chuck Sadler	304-558-8814
Wisconsin Trng & Stds Bureau	Kenneth Hammond	608-266-9606
Wyoming POST	Betty Haukap	

APPENDIX I

TOTAL TRAINING HOURS BY STATE

State	Total Training Hours	Hours Dedicated to Disabilities
Alabama	480	4
Alaska		
Arizona	585	
Arkansas	480	
California	664	
Colorado	1040	
Connecticut	646	
Delaware	880	
Florida		
Georgia	416	
Hawaii		
Idaho	400	
Illinois		
Indiana	600	
Iowa	520	
Kansas	560	
Kentucky	768	
Louisiana	320	
Maine	720	11
Maryland	960	
Massachusetts	800	
Michigan	562	
Minnesota		
Mississippi	400	
Missouri	600	
Montana		
Nebraska	560	
Nevada	640	
New Hampshire	480	
New Jersey		
New Mexico	849.25	12
New York	635	14
North Carolina	618	8
North Dakota		
Ohio		
Oklahoma	576	
Oregon		
Pennsylvania	754	11
Rhode Island	671	
South Carolina		
South Dakota	480	
Tennessee	400	
Texas	618	24
Utah	600	
Vermont	903	10
Virginia		
Washington	720	2
Wisconsin	520	
West Virginia	825	4