

Date: July 30, 2015

To: Honorable Chairman Jean Monestime
and Members, Board of County Commissioners

From: Carlos A. Gimenez
Mayor 

Subject: Crisis Intervention Team Training - Directive 150071

The following information is provided in response to Resolution R-1150-14 adopted by the Board of County Commissioners (Board) December 2, 2014 directing the administration to analyze training protocols of the Miami-Dade Police Department (MDPD) for interaction with persons suffering from mental illness and to consult with local mental health experts to expand police training to improve the handling of people suffering from mental health illnesses.

MDPD staff, through the Miami-Dade Public Safety Training Institute (MDPSTI), began the mandatory training of patrol officers through a 40-hour Crisis Intervention Team (CIT) training course in 2005. This training addresses issues such as: The Florida Mental Health Law, Understanding Mental Illness, Medication, Substance Abuse, Suicide Assessment, Community Resources, etc. MDPD has approximately 1,200 sworn personnel assigned to patrol duties, with only 254 patrol officers in need of attending the aforementioned training.

MDPD is committed in continuing to train all remaining patrol personnel using the currently available 40-hour training curriculum. (Attachment #1). All officers and supervisors assigned to patrol duties have been mandated to attend this training. During the 2015 calendar year, training classes have been scheduled for: August 17-21, September 21-25, October 26-30 and November 30–December 4.

On September 25, 2014, MDPSTI staff met with the Honorable Judge Steve Leifman and Ms. Habsi W. Kaba, Miami-Dade County Crisis Intervention Team Program Coordinator, 11th Judicial Circuit Criminal Mental Health Project. At that meeting, it was suggested that, in light of the time it took to train approximately 1,200 officers, updated information related to CIT training be conducted via training notes and/or the MDPSTI's on-line training site. Those updates will be issued based on new legislation or new crisis intervention related matters.

MDPD already conducts a mandatory 16-hour CIT training for Police Complaint Officers and Police Dispatchers. The training course covers a collection of topics such as the Role of a CIT Call-Taker/Dispatcher, Effective Communication and de-Escalation Techniques, amongst others (Attachment #2). The number of MDPD Communications Bureau staff directly involved with CIT related calls is as follows: 115 Police Complaint Officers, 88 Police Dispatchers, 8 Police Complaint Supervisors and 6 Police Dispatcher Supervisors.

Honorable Chairman Jean Monestime
and Members, Board of County Commissioners
Page 2

As of June 2015, a total of 58 MDPD Police Dispatchers, Police Complaint Officers (911 Call-Taker), Police Dispatcher Supervisors and Police Complaint Supervisors, have been successfully trained. Due to staffing requirements, MDPD Communications personnel can only send 10 to 12 employees per class. Since January 2012, MDPSTI has trained a total of 294 Communications employees from various agencies. The final CIT training for MDPD Communications Bureau personnel will be conducted in early 2016.

MDPD is in the process of implementing a new electronic offense-incident reporting system. When the system is fully operational, patrol units will be able to automatically input crisis intervention statistics into a database.

Per Ordinance 14-65, this memorandum will be placed on the next available Board of County Commissioners meeting agenda.

Should you require additional information, please contact J.D. Patterson, Jr., Director, Miami-Dade Police Department at 305-471-3272, or me directly.

Attachments

Crisis Intervention Teach School Training
Crisis Intervention Team School of Training – 16 hour Training Manual for
Communications Personnel

c: Robert A. Cuevas, Jr., County Attorney
Russell Benford, Deputy Mayor, Office of the Mayor
J.D. Patterson, Jr., Director, Miami-Dade Police Department
Charles Anderson, Commission Auditor
Christopher Agrippa, Clerk of the Board
Eugene Love, Agenda Coordinator

ATTACHMENT #1



Circuit of Florida
Eleventh Judicial Circuit

Criminal Mental Health Project
Jail Diversion Program

CRISIS INTERVENTION TEAM SCHOOL OF TRAINING



Richard E. Gerstein Justice Building
1351 NW 12th Street Room #226
Miami, Florida 33125

Miami-Dade County CIT Program Coordinator/Liaison: Habsi W. Kaba MS MFT

TABLE OF CONTENTS

SECTION ONE

CIT Welcome and Overview
Miami-Dade County Mayor's Mental Health Task Force

SECTION TWO

Review of Major Psychiatric Illnesses
Signs & Symptoms of Schizophrenia
Signs & Symptoms of Bipolar Disorder
Differences between Mental Retardation and Mental Illness

SECTION THREE

Understanding and Helping the Suicidal Person
Tips for Befriending Suicidal People

SECTION FOUR

Co Occurring Disorders

SECTION FIVE

Mental Health & Substance Abuse Resources
Mobile Crisis Team Flyer
Critical Incident Stress Information Sheet

SECTION SIX

Verbal De-Escalation Techniques & Interventions
Role Play Preparation
Basic CIT Officer Guideline
Law Enforcement Mini-Mental Status Checklist

SECTION SEVEN

Post Traumatic Stress Disorder

SECTION EIGHT- MARCHMAN ACT

Florida Statute 397 – The Marchman Act
Report of Law Enforcement Officer Initiating Marchman Act
Marchman Act- Protective Custody Section 397.675 Procedure
Petition for Stabilization and Assessment Form
Petition for Involuntary Treatment Form
Exparte Order- Substance Abuse- Juvenile Form

SECTION NINE – BAKER ACT

Law Enforcement and the Baker Act Guide

FORMS

Report of Law Enforcement Officer Initiating Involuntary Examination
Transportation to Receiving Facility
Exparte Order for Involuntary Examination
Certificate of Professional Initiating Involuntary Examination

SECTION TEN - BAKER ACT RECEIVING FACILITIES/CRISIS STABILIZATION UNITS

Private/Public
Transportation Exception Plan (special population)
Adolescent/Children – Geriatric – Deaf or Hard of Hearing -Hospital Emergency Departments

SECTION ELEVEN

Pre-Trial Detention Center Tour Instructions
Power point – How Much Stress Can You Take
Final Evaluation

Crisis Intervention Team Training Miami-Dade County



SECTION ONE



Eleventh Judicial Circuit Criminal Mental Health Project

Crisis Intervention Team (CIT) Miami-Dade County



Welcome to the CIT 40-hour training program of the Eleventh Judicial Circuit Criminal Mental Health Project. Our purpose is to provide you with additional tools that will help you deal more effectively with people that experience mental health problems. You will gain a better understanding of different psychiatric disorders, how it affects individuals and your impact as a law enforcement officer.

Through this training you will be more equipped to recognize some of the symptoms that a person with mental illness may at times display and to assess whether or not he/she needs to be diverted to treatment rather than incarceration for a misdemeanor. We will also provide you with resources and information which will facilitate and enable you to do a more efficient job, while increasing your safety as well as theirs.

The CIT concept was first formed in 1983, by the local Memphis NAMI affiliate, a division of the National Alliance for the Mentally Ill. In September 1987, in the aftermath of a shooting episode in the Memphis area during which a mentally ill man was killed by law enforcement officers, a task force was established in Memphis to find ways to prevent such tragedies from re-occurring. A partnership was formed which became the Crisis Intervention Team, consisting of law enforcement agencies, emergency medical and psychiatric services, receiving hospitals, families of the mentally ill, and consumers. The CIT training program of Miami-Dade County is based on the Memphis training model.

Since the inception of the Jail Diversion program in 2004, of the Eleventh Judicial Circuit Criminal Mental Health Project has provided 40-hour CIT training to over 2500 law enforcement officers within 34 agencies in Miami-Dade County. Consequently, there have been less tragic incidents involving the police and individuals with mental illnesses. In addition, Miami-Dade County's CIT program is being recognized on a national and international level as an elite and respected team of skilled law enforcement specialist who make a difference in the lives of the mentally ill and the safety of law enforcement officers.

The goals of the Miami-Dade County Crisis Intervention Team program are:

- to provide training, information and mental health community resources to law enforcement officers and help them deal more effectively with mentally ill citizens in crisis.
- to reduce the rate of injury to officers and the mentally ill in their interactions.
- to divert mentally ill offenders from the criminal justice system by delivering proper care for the individual in crisis through a collaboration of mental health and criminal justice agencies.

We hope you will find this training beneficial as well as an enhancement to your law enforcement training. Please feel free to bring to our attention any concerns or anything we can do to improve the program. Your feedback, involvement and contribution are crucial to the success of this program.

MIAMI-DADE COUNTY MAYOR'S MENTAL HEALTH TASK FORCE

"Developing a model continuum of care for persons with mental illnesses"

Background: On January 11, 2005 the Miami-Dade County Grand Jury released a report detailing the crisis of people with untreated mental illnesses who become involved in the criminal justice system which concluded that these individuals are faced with a woefully inadequate system of community based care. Specific areas of need were outlined, as well as recommendations for improvements. The report cautioned that failure to adopt changes would likely result in continued financial and human costs with which Miami-Dade County is ill-prepared to contend.

Facts about Mental Illness in Miami-Dade County Revealed by the Grand Jury Report:

- An estimated **9.1%** of the general population (**210,000 individuals**) in Miami-Dade County experience mental illnesses. This represents largest percentage of people living with mental illnesses of any urban community in the United States.
- Because of a lack of access to care, **law enforcement, correctional facilities, and the courts** have increasingly become the **lone responders** to persons in crisis due to untreated mental illnesses.
- Law enforcement officers in Florida respond to more mental health calls than burglaries, assaults, or DUI cases.
- The City of Miami Police Department, alone, responds to **3,600 mental health calls annually**.
- On any given day, **the Miami-Dade County Jail houses between 800 and 1200 individuals with mental illnesses** (roughly **20%** of the total inmate population), and now exists as **the largest psychiatric facility in the State of Florida**.
- **One-third** of the inmate floors at the Pre-Trial Detention Center are now used to house people identified as requiring psychiatric treatment.
- People with mental illnesses remain in jail **8 times longer**, and at a cost **7 times greater** than persons without mental illnesses arrested for the exact same charge.
- Approximately **250** individuals from Miami-Dade County are committed to state forensic facilities every year, at an annual cost of **\$112,000 per person or \$28 million annually**.
- Without adequate access to treatment, many individuals cycle through this system for the majority of their adult lives.

Community Reaction:

In response to the Grand Jury's report, *Mayor Carlos Alvarez* has assembled the **Mayor's Mental Health Task Force**, co-chaired by *Judge Steve Leifman* of the 11th Judicial Circuit, *Ms. Silvia Quintana* from the Florida Department of Children and Families, and *Mr. Jack Lowell* of the Codina Group. This body, consisting of experts from the criminal justice, mental health, and social services communities, is charged with finding ways to implement the Grand Jury's recommendations.

Crisis Intervention Team Training Miami-Dade County



SECTION TWO



Eleventh Judicial Circuit Criminal Mental Health Project

REVIEW OF THE MAJOR PSYCHIATRIC ILLNESSES

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health
Project

MENTAL HEALTH DEFINED PEOPLES' ABILITY TO INTEGRATE THEMSELVES WITH THE WORLD AROUND THEM

- ❖ SOCIALLY
- ❖ OCCUPATIONALLY
- ❖ ACADEMICALLY
- ❖ WITH FAMILY & FRIENDS
- ❖ SUCCESSFULLY ADAPT TO STRESS

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health
Project

MENTAL ILLNESS DEFINED

❖ GROUP OF DISORDERS RELATED TO ALTERED BRAIN CHEMISTRY

❖ Mental illness" means an impairment of the mental or emotional processes (*serious thought or mood disorder*) that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health
Project

INCIDENCE OF MENTAL HEALTH DISORDERS

❖ ABOUT 1 IN 5 ADULTS SUFFER FROM SOME TYPE OF MENTAL HEALTH DISORDER (APPROXIMATELY 5 MILLION PEOPLE US)

- SCHIZOPHRENIA (2%)
- MOOD DISORDERS (DEPRESSION & BIPOLAR) (6%)
- ANXIETY DISORDER (8%)
- SUBSTANCE ABUSE (7%)
- ANTSOCIAL PERSONALITY DISORDER (2%)

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

CAUSES OF MENTAL ILLNESS

❖ SEVERAL CAUSES ARE SUGGESTED

- ❖ BIOLOGICAL (GENETICS)
- ❖ NEUROLOGICAL (BRAIN DAMAGE)
- ❖ BIOMEDICAL (MEDICAL CONDITIONS)
- ❖ ENVIRONMENTAL EXPOSURE

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

MENTAL ILLNESS VS. INTELLIGENCE

WHERE MENTAL ILLNESS BEGINS
DEVELOPMENT ENDS

**CHEMICALS IMPLICATED IN
PSYCHIATRIC ILLNESSES**

- ❖ DOPAMINE
- ❖ SEROTONIN
- ❖ NOREPINEPHRINE
- ❖ ACETYLCHOLINE
- ❖ ENDORPHINS
- ❖ GLUTAMATE

Eleventh Judicial Circuit Criminal Mental Health Project

**WHO CAN BE AFFECTED WITH
MENTAL ILLNESS?**

- ❖ MILLIONS OF PEOPLE WORLD WIDE
- ❖ AFFECTS ALL RACES, GENDER, ECONOMIC STATUS,
SOCIAL & CULTURAL GROUPS

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

**MENTAL ILLNESS IS TREATABLE
NOT CURABLE**

- ❖ MEDICATION
- ❖ THERAPY
- ❖ OTHER TREATMENTS

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

MEDICATION

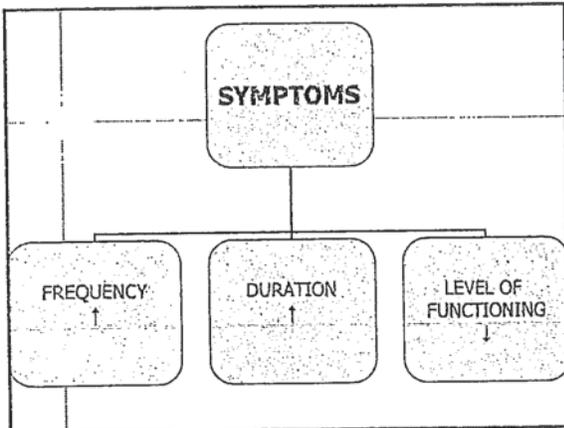
- The Common Cold
- Not like Tylenol
- Cocktails

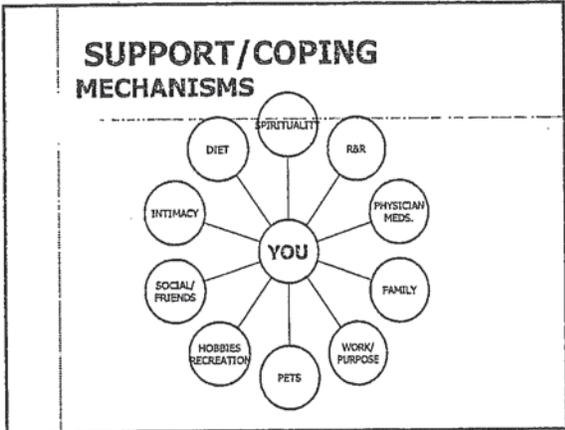
THE MOST SEVERE & PERSISTENT PSYCHIATRIC CONDITIONS

- ❖ SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS
- ❖ BIPOLAR DISORDERS
- ❖ MAJOR DEPRESSION
- ❖ ANXIETY DISORDERS
- ❖ DEMENTIA
- ❖ DISORDERS SPECIFIC TO CHILDREN
- ❖ SUBSTANCE ABUSE DISORDERS (CAN CO-EXIST WITH ANOTHER MENTAL ILLNESS)

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project





SCHIZOPHRENIA

- ❖ THOUGHT TO BE AN IMBALANCE OF DOPAMINE & SEROTONIN IN THE BRAIN
- ❖ IT IS THE MOST SEVERE FORM OF THOUGHT DISORDER
- ❖ EARLY SIGNS OF SCHIZOPHRENIA
 - ▣ PROBLEM FUNCTIONING BEGINNING IN ADOLESCENCE
 - ▣ SUSPICIOUS, INTROVERTED, WITHDRAWN
- ❖ THE MAIN FEATURE OF SCHIZOPHRENIA IS PSYCHOSIS

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

DISORGANIZED THOUGHTS/ SPEECH/BIZARRE BEHAVIORS

(THOUGHT PROCESSES)

- ❖ THE PERSON CANNOT ORGANIZE HIS THINKING IN A WAY THAT MAKES SENSE (LOOSE ASSOCIATIONS, MAGICAL THINKING, DISASSOCIATION)
- ❖ THE PERSON IS UNABLE TO GIVE A STRAIGHT ANSWER TO A SIMPLE QUESTION (CIRCUMSTANTIAL, FLIGHT OF IDEAS, RACING THOUGHTS)
- ❖ THE PERSON MAKE STATEMENTS THAT DON'T MAKE SENSE TO YOU THE LISTENER (WORD SALAD, NEOLOGISMS)
- ❖ THE PERSON SEEMS CONFUSED AND DISORGANIZED (POOR REALITY TESTING)
- ❖ THE PERSON MAY BE ABLE TO GIVE THE CORRECT DAY/DATE, LOCATION, READ & WRITE

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

WHAT IS PSYCHOSIS?

❖ THE PERSON HAS AN EXTREME BREAK FROM REALITY INVOLVING DELUSIONS, HALLUCINATIONS AND/OR BIZARRE BEHAVIORS

❖ THE RIGHT AND LEFT HEMISPHERES OF THE BRAIN FUNCTIONS OUT OF SEQUENCE. THE PERSON IS IN A DREAMLIKE STATE WHILE AWAKE

❖ THE PERSON HAS DISTURBANCES IN THINKING, FEELING AND BEHAVING/ RELATING

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

SYMPTOMS OF PSYCHOSIS

❖ HALLUCINATIONS

❖ DELUSIONS

❖ PARANOIA

❖ BIZARRE DISORGANIZED OR CATATONIC BEHAVIOR

❖ DISORGANIZED THOUGHT AND SPEECH

❖ FLAT AFFECT

❖ DETERIORATION OF SOCIAL, INTERPERSONAL AND SELF-CARE FUNCTIONING

❖ SUICIDE

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

HALLUCINATIONS

(FALSE EXTERNAL SENSORY PERCEPTION)

❖ THE PERSON EXPERIENCES THINGS THAT ARE NOT REALLY THERE BUT ARE REAL TO THEM

❖ SEEING (VISUAL) COMMON IN PATIENTS DIAGNOSED WITH SCHIZOPHRENIA

❖ HEARING (AUDITORY) COMMON IN PATIENTS WITH DRUG INTOXICATION

❖ SMELLING (OLFACTORY) MAY BE ASSOCIATED WITH SEIZURE

❖ TASTING (GUSTATORY) MAY BE RELATED TO NEUROLOGICAL PROBLEMS

❖ FEELING (TACTILE) USUALLY DUE TO ALCOHOL WITHDRAWAL AND OTHER DRUG ABUSE

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

TYPES OF AUDITORY HALLUCINATIONS

- COMFORTING
- CONDEMING
- CONTROLLING
- COMMANDS
- NOISE

TYPES OF AUDITORY HALLUCINATIONS



▪ COMFORTING

▪ CONDEMING





**CONTROLLING/
COMMAND**

BEHAVIORS ASSOCIATED WITH HALLUCINATIONS

- ❖ THE PERSON IS TALKING, LAUGHING OR CRYING TO THEMSELF
- ❖ COVERING EARS WITH HANDS, CLOTHING OR HEADPHONE
- ❖ MAY DUCK OR FEND OFF SOMETHING
- ❖ SITTING, STANDING MOTIONLESS OR ROCKING MOTION
- ❖ LOOKING IN THE DIRECTION WHERE THE VOICES ARE COMING FROM

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

**DELUSIONS
(THOUGHT CONTENT)**

- ❖ THE PERSON HAS A FIXED, FALSE BELIEF OR IDEA THAT HAS LITTLE OR NO BASE IN REALITY, CANNOT BE ACCOUNTED BY CULTURAL BACKGROUND, AND CANNOT BE ALTERED BY RATIONAL ARGUMENTS
- ❖ THE PERSON WITH PARANOID DELUSIONS IS POTENTIALLY MORE AGITATED AND VIOLENT

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

TYPES OF DELUSIONS

- ❖ **PARANOID TYPES:** IRRATIONAL BELIEF THAT ONE IS BEING PERSECUTED (BEING WATCHED BY THE CIA WHO TAPPED PHONE)
- ❖ **IDEAS OF REFERENCE:** BELIEF THAT SOME EVENT IS UNIQUELY RELATED TO THAT PERSON (JESUS IS SPEAKING TO THE PERSON THROUGH TV CHARACTERS)
- ❖ **THOUGHT BROADCASTING:** BELIEF THAT ONE'S THOUGHTS CAN BE HEARD BY OTHERS
- ❖ **DELUSIONS OF GRANDEUR:** BELIEF THAT ONE HAS SPECIAL POWERS BEYOND THOSE OF A NORMAL PERSON
- ❖ **DELUSIONS OF GUILT:** FALSE BELIEF THAT THAT ONE IS GUILTY OR RESPONSIBLE FOR SOMETHING (THE TSUNAMI IN ASIA AND AFRICA)

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

SYMPTOMS OF DELUSIONS

- ❖ THE PERSON BELIEVES HE IS AN IMPORTANT OR FAMOUS PERSON
- ❖ HE HAS SUPER POWERS AND CAN DO ANYTHING OR WAS SENT TO DO GREAT THINGS, OR DESTROY THINGS
- ❖ THE PERSON MAY TAKE ON A SPECIFIC IDENTITY WITH A SPECIFIC PURPOSE (HE IS JESUS CHRIST OR WAS SENT BY GOD TO ACCOMPLISH A TASK)
- ❖ THE PERSON BELIEVES THAT SOMEONE FAMOUS IS IN LOVE WITH THEM
- ❖ THE PERSON BELIEVES PEOPLE CAN READ AND OR CONTROL HIS MIND
- ❖ THE PERSON BELIEVES HE IS THE TARGET OF SECRET INVESTIGATION

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

SYMPTOMS OF DELUSIONS CONT'D

- ❖ THE PERSON IS CONVINCED THAT THE TV OR RADIO IS TALKING ABOUT HIM
- ❖ THE PERSON BELIEVES HE IS DEAD, NOT REAL, OR DOESN'T EXIST
- ❖ THE PERSON IS CONVINCED THAT THE FOOD IS POISONED
- ❖ THE PERSON MAY GIVE BIZARRE EXPLANATION OF CUTS & BRUISES, ABSENCE OF CLOTHES OR WHY THEY REFUSE TO DO CERTAIN ACTIVITIES

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

AFFECT AND MOOD
(FLAT, BLUNTED, LABILE, CONSTRICTED INAPPROPRIATE)

- ❖ THE PERSON'S EMOTION DOES NOT CORRESPOND WITH WHAT IS HAPPENING AROUND THEM AT THE MOMENT
- ❖ THE PERSON'S BEHAVIOR MAY OR MAY NOT SHOW WHAT OR HOW THEY ARE FEELING

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

BIPOLAR DISORDER
(MANIC DEPRESSIVE DISORDER)

- ❖ CHEMICAL IMBALANCE CAUSING ABNORMAL RANGE OF MOOD. FLUCTUATING BETWEEN EPISODES OF MANIA AND DEPRESSION (EXTREME HIGHS AND LOWS)
- ❖ DISTURBANCE IN MOOD, EMOTIONS, AND IMPULSE CONTROL (THE CHAMELEON DISEASE)
- ❖ MAY HAVE PSYCHOTIC FEATURES
- ❖ THE PERSON'S FUNCTIONING IS SEVERELY AFFECTED. MAY BE EXTREMELY VIOLENT

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

SYMPTOMS OF BIPOLAR DISORDER

- ❖ FEELINGS OF EUPHORIA
- ❖ RAPID SPEECH, NON STOP TALKING
- ❖ GRANDIOSE TYPE OF DELUSIONAL THINKING
- ❖ EXCESSIVE AMOUNT OF ENERGY
- ❖ DECREASED NEED FOR SLEEP
- ❖ INTRUSIVE, LACKS LIMITS AND BOUNDRIES
- ❖ REPETITIVE AND COMPULSIVE BEHAVIORS
- ❖ VERY ODD AND ECCENTRIC IN APPEARANCE
- ❖ EXCESSIVE AND DANGEROUS BEHAVIORS (DRINKING, DRUGGING, SEX, GAMBLING, SPENDING)
- ❖ UNABLE TO FOLLOW SIMPLE INSTRUCTIONS
- ❖ IRRITABLE, AGGRESSIVE, VIOLENT
- ❖ DEPRESSED, LABILE MOOD, SUICIDAL

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

MAJOR DEPRESSION

❖ MAJOR DEPRESSION MAY HAVE PSYCHOTIC FEATURES

❖ ABOUT TWO THIRD OF ALL DEPRESSED PATIENTS CONTEMPLATE SUICIDE AND 10-15% COMMIT SUICIDE

❖ ONLY HALF OF PATIENTS WITH MAJOR DEPRESSION EVER RECEIVE TREATMENT

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

SYMPTOMS OF MAJOR DEPRESSION

❖ LOSS OF ENERGY, PLEASURE OR INTEREST IN USUAL ACTIVITIES

❖ ANXIETY AND/OR IRRITABILITY

❖ FEELINGS ASSOCIATED WITH BEING TRAPPED, HOLE, DARK CLOUD HANGING, CARRYING HEAVY LOAD

❖ FEELINGS OF GUILT, HOPELESSNESS, HELPLESSNESS, WORTHLESSNESS, USELESSNESS

❖ DIFFICULTY PAYING ATTENTION AND CONCENTRATING

❖ OFTEN THINKS ABOUT DEATH AND/ SUICIDE

❖ DOESN'T EAT OR OVEREATS

❖ CANT SLEEP OR SLEEPING TOO MUCH

❖ NO DESIRE FOR INTIMACY

Eleventh Judicial Circuit Criminal Mental Health Project

ASSESSING DEPRESSION

S SLEEP (INCREASES/DECREASES)

I INTEREST/HOBBIES DECREASE

G GUILT/WORTHLESSNESS

E ENERGY DECREASES

C CONCENTRATION DECREASES

A APPETITE (INCREASES/DECREASES)

P PSYCHOMOTOR MOVEMENTS

S SUICIDE IDEATIONS/SEX (NO INTEREST)

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

STRESS & SYMPTOMS

- Triggers
- Structure
- Mental illness and a psychotic state

PREOCCUPATIONS

- Sexual
- Religious
- Political
- Lack of Insight and Denial

SUPPORT & COPING MECHANISMS



Assisted Living Facilities

- SSI Income
- SSA.com

ERIC

- Education
- Recognition
- Identification
- Coping Skills

PERSONALITY DISORDERS

- ❖ **PERSONALITY**
 - DISTINCTIVE SET OF STABLE & PREDICTABLE TRAITS, BEHAVIOR STYLES & PATTERNS
 - HOW WE PERCEIVE THE WORLD, OUR ATTITUDES, THOUGHTS & FEELINGS
 - HEALTHY PERSONALITIES ARE ABLE TO COPE WITH NORMAL STRESSES & HAVE NO TROUBLE FORMING RELATIONSHIPS WITH FAMILY, FRIENDS & CO-WORKERS
- ❖ **PERSONALITY DISORDER**
 - A DEEPLY INGRAINED, INFLEXIBLE PATTERN OF RELATING TO OTHERS THAT ARE MALADAPTIVE.
 - USUALLY RECOGNIZABLE BY ADOLESCENCE OR EARLIER
 - TEND TO BE INFLEXIBLE, RIGID, & UNABLE TO RESPOND TO THE CHANGES AND DEMANDS OF LIFE
 - FEELS THAT THEIR BEHAVIOR PATTERN ARE "NORMAL" OR "RIGHT" (EGO-SYSTONIC)
- ❖ **CAUSES**
 - GENERALLY OCCURRING IN EARLY CHILDHOOD
 - GENETICALLY PREDISPOSED
 - ENVIRONMENTAL FACTORS MAY CAUSE A PERSON WHO IS ALREADY VULNERABLE TO DEVELOP A PERSONALITY DISORDER

ANXIETY RELATED DISORDERS

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

GENERALIZED ANXIETY DISORDER

❖ CAN COEXIST WITH OTHER DISORDERS

❖ SYMPTOMS:

- UNREALISTIC WORRY
- PHYSICAL TENSION
- AUTOMATIC AROUSAL AND HYPERACTIVITY
- APPREHENSIVE EXPECTATION, VIGILANCE AND SCANNING OF ENVIRONMENT

❖ PHOBIAS

❖ IRRATIONAL FEARS

❖ SYMPTOMS:

- SPECIFIC PHOBIAS (ANIMALS, SPIDERS, DOGS)
- SOCIAL PHOBIA
- AGORAPHOBIA

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

PANIC DISORDER

❖ RECURRENT SEVERE PANIC ATTACKS CAUSED BY A SUDDEN UNPREDICTABLE ONSET OF INTENSE APPREHENSION, FEAR, TERROR AND SENSE OF IMPENDING DOOM; OCCORING AT LEAST ONCE A WEEK

❖ SYMPTOMS:

- PALPITATION
- TACHYCARDIA
- DYSPNIA, FAINTING AND DIZZINESS
- SWEATING, FLUSHES, CHILLS
- CHEST PAIN
- HYPERVENTILATION
- DEPERSONALIZATION, DEREALIZATION
- THE PERSON BELIEVES HE/SHE IS DYING AND FREQUENTLY UTILIZES EMERGENCY SERVICES

10/9/2013 Eleventh Judicial Circuit Criminal Mental Health Project

POSTTRAUMATIC STRESS DISORDER

❖ RESPONSES TO THE EXPERIENCE OF A TRAUMA OR CATASTROPHIC EVENT

❖ SYMPTOMS:

- NIGHTMARES
- FLASHBACKS (RE-EXPERIENCING THE TRAUMA)
- EXTREME ANXIETY
- FEELINGS OF DETACHMENT
- OUTBURST OF ANGER
- HYPER-VIGILANCE

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

OBSESSIVE COMPULSIVE DISORDER

❖ COMPULSION THAT INTERFERES WITH SOCIAL, OCCUPATIONAL, AND INTERPERSONAL FUNCTIONING

❖ UNWANTED REPEATITIVE AND UNCONTROLLED THOUGHTS, IMAGES OR IMPULSES

❖ SYMPTOMS:

- CLEANING
- WASHING
- CHECKING
- COUNTING
- REPEATING

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

SOMATOFORM DISORDERS (RELATING TO BODY)

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

HYPPOCHONDRIASIS

❖ PREOCCUPATION WITH, AND UNREALISTIC INTERPRETATION OF PHYSICAL SYMPTOMS AND SENSATION AS A SERIOUS DISEASE

❖ SYMPTOMS:

- PREOCCUPATION WITH HEALTH STATE DESPITE REASSURANCE
- THE PERSON IS NOT DELUSIONAL
- USUALLY FOCUS ON A PARTICULAR BODY ORGAN

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

DISSOCIATIVE DISORDER

❖ THE DISRUPTION OF THE USUALLY INTEGRATED FUNCTIONS OF CONSCIOUSNESS, MEMORY, IDENTITY, OR PERCEPTION OF THE ENVIRONMENT

❖ COMMON AREAS OF IMPAIRMENT INCLUDE:

- TEMPORARY MEMORY LOSS (AMNESIA)
- UNEXPECTED AND NON-DIRECTED TRAVELING(FUGUE)
- THE PRESENT OF TWO OR MORE SEPARATE, DISTINCT, PERSONALITIES (ALTERS)
- SENSATION OF NOT BEING REAL

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

ANTIDEPRESSANTS

- Celexa
- Effexor
- Paxil
- Prozac
- Serazone
- Wellbutrin
- Zoloft
- Lexapro



- Elavil
- Tofranil
- Anafranil

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

ANTIPSYCHOTICS

- Abilify
- Clozaril
- Geodon
- Zypreza
- Risperdal
- Seroquel
- Haldol
- Prolixin
- Stelazine
- Thorazine
- Trilafon

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

STIMULANT

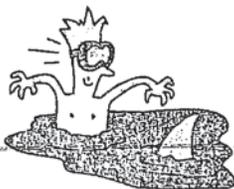


- Adderall
- Concerta
- Dexedrine
- Ritalin
- Strattera

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

ANXIOLYTIC



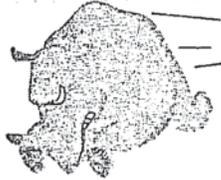
- Ativan
- Librium
- Valium
- Xanax

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

MOOD STABILIZER

- Depakote
- Lithium
- Lamictal
- Tegretol
- Topomax



10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

ANTIHISTAMINES AND ANTICHOLINERGICS

- Benadryl
- Vistaril/Atarax
- Cogentin



10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

REFERENCES:

■ Diagnostic & statistical manual of mental disorders (1994). (4th ed.). American psychiatric association. Washington, DC.

■ Houseman, C. (1998). Psychiatric certification review guide for the generalist, & clinical specialist in adult, child & adolescent psychiatric & mental health nursing. (2nd ed.). Health Leadership Associates, Inc. Potomac MD.

■ Kaplan, H.I., Sadock, B.J. (1998). Synopsis of psychiatry: Behavioral sciences/clinical psychiatry (8th ed.). Philadelphia, PA: Lippincott.

10/9/2013

Eleventh Judicial Circuit Criminal Mental Health Project

CIT Law Enforcement Guide to...

SIGNS & SYMPTOMS OF SCHIZOPHRENIA

(Symptoms may vary from person to person)

Individuals suffering from schizophrenia experience difficulty differentiating between real and unreal experience, thinking logically and displaying appropriate emotions and responses.

- **HALLUCINATIONS**- A false or distorted sensory experience that appears to be real.
 - visual
 - audio
 - tactile
 - gustatory
 - olfactory

- **DELUSIONS** – A false belief
 - Paranoid – belief that you are being followed, heard, watched etc.)
 - Erotomania -famous people are in love with you
 - Somatic – belief that you have a fatal disease
 - Grandeur- belief that you are much greater, more powerful and influential than your really are, unusual powers.

- **DISRUPTIVE THOUGHTS AND BEHAVIORS** –difficulty concentrating, staying focused and on topic, difficulty following directions.
- **DISORGANIZED SPEECH** - person does not make sense or words are out of order
- **CONTINUOUS VERBALIZATION**
- **UNUSUAL SENSITIVITY** – any of the senses can be affected
- **FLAT AFFECT** – a lack of emotional expression including voice, eyes, and face
- **HOSTILITY**
- **AGITATION**
- **DETERIORATION OF PERSONAL HYGIENE**
- **EMOTIONAL UNRESPONSIVENESS**
- **SOCIAL WITHDRAWAL**
- **SUICIDAL THOUGHTS, PLANS AND IDEATIONS**
- **PACING**
- **ROCKING**
- **ERRATIC MOVEMENT AND BEHAVIOR**
- **DARTING GLANCES**

CIT Law Enforcement Guide to...

SIGNS & SYMPTOMS OF BIPOLAR DISORDER

(Symptoms may vary from person to person)

Symptoms of bipolar disorder are disturbances or abnormalities in mood. Individuals who suffer from bipolar disorder are at risk of death either by dangerous behavior or in the manic state by suicide in a depressive state.

LOWS

FEELINGS OF:

SADNESS

ANXIOUSNESS

HOPLESSNESS

WORTHLESSNESS

PESSIMISM

GUILT

FATIGUED

LOSS OF INTEREST OR PLEASURE IN HOBBIES, ACTIVITIES ONCE ENJOYED

SUICIDAL THOUGHTS, IDEATION, ATTEMPTS

HIGHS

EUPHORIA – feeling high

AGITATION

INFLATED SELF ESTEEM, GRANDIOSITY, POOR JUDGEMENT

DELUSIONS

GRANDIOSE

MAGICAL THINKING

HALLUCINATIONS

EDGINESS

IRRITABILITY

RESTLESSNESS

RACING THOUGHTS

RAPID, CONTINUOUS SPEECH, VERY TALKATIVE

SHIFTING FROM ONE TOPIC TO ANOTHER

INCREASED ENERGY

SLEEPLESSNESS

RECKLESS SPENDING SPREES

AGGRESSIVE BEHAVIOR

DIFFICULTY CONCENTRATING

DRUG/ALCOHOL

DIFFERENCES BETWEEN MENTAL RETARDATION AND MENTAL ILLNESS

Many people make the common mistake of confusing people with mental retardation with those who have mental illnesses. However, it is most important to understand that these disorders are separate and distinct conditions. The following chart contrasts the two conditions.

MENTAL RETARDATION

- A. Refers to significantly below average intellectual functioning.
- B. Refers to impairment in social adaptation.
- C. Usually occurs during early development or is present at birth. However, a brain injury or toxemia may cause retardation at any age.
- D. Mental retardation is permanent, but can be compensated for through education and development chronic.
- E. A person with mental retardation can usually be expected to behave rationally at his operational level.

MENTAL ILLNESS

- A. Has nothing to do with intelligence.
- B. Characterized by disturbances in thinking, feeling and relating to others or the environment.
- C. Can strike anyone at anytime.
- D. Mental illness may be temporary or chronic. Episodes may ebb and flow.
- E. A person with a mental illness may vacillate between normal and irrational behavior. Some people with a mental illness may be erratic or even violent, especially when not undergoing treatment.

Crisis Intervention Team Training Miami-Dade County



SECTION THREE



Eleventh Judicial Circuit Criminal Mental Health Project

Understanding and Helping the Suicidal Person



Mental health experts differentiate between five types of behaviors. Knowing their appropriate definitions will help you better understand the behaviors.

- Suicidal ideation
- Attempted suicide
- Suicidal gesture
- Self-injurious behavior
- Completed suicide

Suicide Ideation

- Thoughts about suicide. This term generally refers to what people say about their ideas and intentions because it is not possible to know what a person is actually thinking
- Documenting these thoughts is vital information for mental health professionals when initiating an involuntary examination.

Attempted Suicide

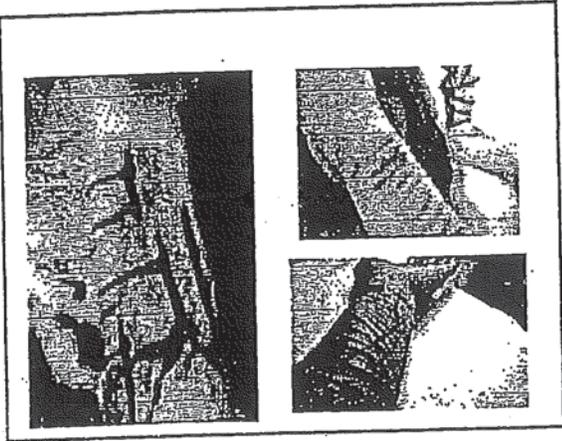
- A person tries to commit suicide or kill himself or herself but does not succeed because the method chosen was not lethal (e.g., small amount of drugs) or intervention prevented death; the person may or may not be injured.

Suicidal Gestures

- Often, a person will make what appears to be a suicide attempt, using means that are extremely unlikely to be lethal.
- Often, these gestures are dismissed as "manipulation." However, it is not uncommon for a person who has previously made a suicidal gesture subsequently to kill himself or herself.
- All suicidal gestures need to be taken seriously and assessed by a competent mental health professional.

Self-Injurious Behavior

- Sometimes, people harm themselves, such as cutting their arms, with no apparent intention to die. There is a great deal of speculation about why people hurt themselves in this way.
- For law enforcement, such actions should be treated as very seriously.



Self Injury vs. Suicide

- Some individuals who appear to be suicidal are actually displaying a behavior known as self-injury or self-mutilation.
- Description defines self-injury as: "deliberate, nonlife-threatening, socially unacceptable, self-inflicted harm to the body."

Self-Injury vs. Suicide

- This behavior may include cutting, scratching, burning, and even preventing wounds from healing and pulling out stitches.
- Self-injurers use the behavior as a way to release their intense emotions. It's a way of coping.

Be Aware of the Signs

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, out, seemingly without thinking
- Feeling trapped like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping too much
- Dramatic mood change
- No reason for living; no sense of purpose in life

Be Aware of the Facts

- Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems
- Most suicidal give definite warnings of their suicidal intentions, others are either unaware of the significance of these warnings or do not know how to respond to them.

Be Aware of the Facts

- Talking about suicide does not cause someone to be suicidal
- Suicide is the third leading death among young people ages 15 - 24 and it is the eighth leading cause of death among all persons.
- Youth (15 - 24) suicide rates increased more than 200% from the 1950's to the late 1970's, following the late 1970's, the rates for youth suicide have remained stable.

Be Aware of the Facts

- The suicide rate is higher among the elderly (over 65) than any other age group.
- Four times as many men kill themselves as compared to women, yet three times as many women attempt suicide as compared to men.
- Suicide cuts across all age, economic, social, and ethnic boundaries.

Be Aware of the Facts

- Firearms are currently the most utilized method of suicide by essentially all groups (male, female, young, old, white, non-white).
- Surviving family members not only suffer the trauma of losing a loved one to suicide, and may themselves be at higher risk for suicide and emotional problems.

You should be aware of three specific mental illness that make a person more likely to commit suicide.

- Depression
- Bi-Polar Disorder
- Schizophrenia

Depression

- Persons experiencing depression may commit suicide when their symptoms appear to be improving.
- This happens because depression often robs individuals of the energy and resolution to act forcefully.
- As they began to improve, the ability to act returns. They now have the will and the energy to carry out the suicide

Suicide

- For adults, suicide is usually *planned (rather than impulsive) act*
- For adolescents, suicide is often an impulsive act. However, especially in jail, where the person is often under extreme stress and possibly intoxicated, impulsive suicides are much more likely among all age groups.

High Risk Suicide

- Client discusses specific suicide plan:
 - time
 - method
 - place
 - means
 - cause
 - perceived benefit

L.E. MUST DOCUMENT

- T = Thoughts
- I = Intent
- P = Plan
- M = Means

Let Your Instincts Guide You...

- Did you feel "uncomfortable" or worried about the safety of the client?
- All you need is "A reason to believe"

Helping Someone Who is Threatening Suicide

- Show interest and support
- Ask if he/she is thinking about suicide
- Be direct. Talk openly and freely about suicide.
- Be willing to listen. Allow for expression of feelings. Accept feelings.
- Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life

Risk Assessment Questions

1. Have you been thinking of killing yourself?
2. What has happened that makes life not worth living?
3. How will you do it?

Risk Assessment Questions

4. How much do you want to die?
5. How much do you want to live?
6. How often do you have these thoughts?
7. When you think of suicide, how long do the thoughts stay with you?

Risk Assessment Questions

8. Have you ever attempted suicide?
9. Have you been drinking heavily lately or taking drugs?
10. Has anyone in your family committed or attempted suicide?
11. Is there anyone or anything to stop you?
12. On a scale of 1 to 10, what is the probability that you will kill yourself?

Helping Someone Who is Threatening Suicide

- Don't give advice by making decisions for someone else to tell them to behave differently.
- Don't ask "why", this encourages defensiveness.
- Offer empathy not sympathy.
- Don't act shocked, this creates distance.

Helping Someone Who is Threatening Suicide

- Don't be sworn to secrecy. Seek support
- Offer hope that alternatives are available, do not offer glib reassurance; it only proves that you don't understand.
- Take action! Remove means!

Be Aware of Feelings, Thoughts, and Behaviors.

People in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently they can't:

- Stop the pain
- Think clearly
- Make decisions
- See any way out
- Sleep, eat or work

**Be Aware of Feelings, Thoughts,
and Behaviors.**

People in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently they can't:

- Get out of the depression
- Make the sadness go away
- See the possibility of change
- See themselves as worthwhile
- Get someone's attention
- Seem to get control

**Guidelines for Good Listening in
Crisis Situations**

- Be prepared to listen
- Show interest
- Be aware of cultural preferences
- Respect the individual's situation
- Be aware of nonverbal communication
- Provide comfort
- Focus attention

**Guidelines for Good Listening in
Crisis Situations**

- Respect silences
- Listen carefully
- Avoid interrupting
- Allow expressions of emotion
- Tolerate repetition
- Ask simple and clear questions
- Be sure to understand

Guidelines for Good Listening in Crisis Situations

- Give hope
- "Be" with the person even if you can't fix it.

References

- American Red Cross (1982). Providing Red Cross disaster health services. ARC 3076
- Hafner, B.Q. & Frandsen, K.J. (1985). Psychological emergencies and crisis intervention. Englewood, CO: Modon Publishing company.
- Mitchell, J.T. & Bury, G. (1990). Emergency services stress: Guidelines for preserving the health and careers of emergency services personnel. Englewood Cliffs, NJ: Prentice Hall, Inc.
- Mitchell, J.T. & Resnick, H.L.P. (1981). Englewood Cliffs, NJ: Prentice Hall, Inc.
- Emergency response to crisis. Bowie, MD: Robert J. Brady, Co.
- Amini, L.M. & Zunin, F.S. (1991). The act of condolence: What to write, what to say, what to do at a time of loss. New York: Harper Collins Publishers.

Tips for Befriending Suicidal People

1. All befriending is played by ear. There are **NO FORMULAS**, just some safe guidelines.
2. You must **BE YOURSELF**. Anything else feels phony, sounds phony and won't be natural to you or the person who is talking with you. **BE REAL**.
3. You want to **MAKE A RELATIONSHIP** with the other person so they feel they can **TRUST** you enough to tell you what is really on their mind. You want them to be able to confide in you like a close friend.
4. What you say or don't say is not as important as **HOW YOU SAY IT**. If you can't find the right words, but feel genuinely concerned, your voice and manner will convey this.
5. Your job is to **LISTEN**.
6. Give your **FULL ATTENTION**. Listen for feelings, as well as facts. Listen for what is not said, as well as what is said, verbal and non-verbal. Allow the person to unburden without interruption.
7. **ACCEPT SILENCE**. Don't feel you have to say something every time there is a pause. Silence gives you both time to think. When you don't know what to say, say nothing.
8. **SHOW INTEREST**, and invite the person to continue without giving them the third degree. Simple direct questions ("What happened?" "What's the matter?") are less threatening than complicated, probing ones.
9. ~~**STEER TOWARD THE PAIN**, not away from it. The person~~
wants to tell you about the private, painful things that most other people don't want to hear. You may have to provide an opening—"You seem depressed. What's the matter?" **ACKNOWLEDGE THE PAIN**.

10. **DEAL WITH THE PERSON, NOT JUST “THE PROBLEM.”** If you try to act like a counselor or expert, or try to solve problems or give advice, it will probably be resented.
11. Give them **SUPPORT**. Let them know they are **NOT ALONE**.
12. Let them know you **VALUE** and **ACCEPT** them regardless of the situation they are in.
13. Talk as an **EQUAL**. Give up any roles, don't be an authority figure. Give them your **RESPECT**.
14. Try to **RELATE**, see and feel things from the other **PERSON'S POINT OF VIEW**.
15. **BE ON THEIR SIDE**. Don't side with the people they may be hurting, or the people who are hurting them.
16. **LET THE PERSON FIND THEIR OWN ANSWERS**, even if you see an “obvious” solution.
17. Many times there are **NO “ANSWERS”** and your role is simply to **BEAR WITNESS**, to **BE WITH THE PERSON** and **SHARE THE PAIN**. Giving your time, attention and concern may not seem like “doing enough,” but it is the best thing you can do. People in distress in seemingly hopeless situations can make you feel helpless and inadequate. Fortunately, we do not have to come up with solutions, change people's lives, or even save their lives. They will save themselves, make their own changes and decisions, etc. **TRUST THEM**.

Crisis Intervention Team Training Miami-Dade County



SECTION FOUR



Eleventh Judicial Circuit Criminal Mental Health Project

Co-occurring Disorders

Presented by Martha Fonseca, LCSW

Defining Co-occurring Disorders

- o People with co-occurring substance abuse disorders and mental disorders are:
 - ◆ Individuals who have at least one mental disorder, as well as, an alcohol or drug use disorder.
 - ◆ One disorder may prompt the emergence of the other or both disorders may exist independently.
 - ◆ At least one disorder of each type can be diagnosed independently.

Defining Co-occurring Disorders

- o Individuals with a mental illness have an increased risk for substance abuse; and individuals who abuse substances have an increased risk for mental disorders.
- o Individuals with dual disorders often require longer treatment, have more crises, and progress more gradually in treatment.

Understanding Co-occurring Disorders

- o Co-occurring substance abuse disorders and psychiatric disorders are both common and complex.
- o Children, adolescents, and older adults may experience co-occurring disorders.
- o According to a report published by the *Journal of the American Medical Association*, 37% of alcohol abusers and 53% of drug abusers also have at least one mental illness. Twenty-nine percent of people diagnosed with a mental illness abuse either alcohol or drugs.

Which develops first? Substance abuse or the psychiatric problem?

- o It depends. Often the psychiatric problem develops first. In an attempt to alleviate symptoms, a person with emotional symptoms may drink or use drugs. This is considered "self-medication". Frequent self-medication may lead to physical or psychological dependence on alcohol or drugs. If it does, the person then suffers from not just one problem, but two.

Which develops first? Substance abuse or the psychiatric problem?

- o On the other hand, a person whose substance abuse problem has become severe may develop symptoms of a psychiatric disorder (depression, hallucinations, suicide attempts).
- o In adolescents, drug or alcohol abuse may merge and continue into adulthood, which may contribute to the development of emotional problems.

Which develops first? Substance abuse or the psychiatric problem?

- o Persons with dual disorders often experience more severe and chronic medical, social, and emotional problems. Because they have two disorders, they are vulnerable to both substance abuse relapse and a worsening of the psychiatric disorder.

Defining Substance Abuse

- o Definition of use: use of a substance with no negative consequences.
- o According to DSM-IV:
 - o Abuse is defined as:
 - o 1) recurrent substance use resulting in failure to fulfill roles at work, school, or home
 - o 2) recurrent substance use in physically hazardous situations
 - o 3) recurrent substance-related legal problems
 - o 4) continued use despite interpersonal problems

...Defining Substance Abuse

- o Substance dependence is defined as (3 or more in a 12 month period):
 - o Increased tolerance
 - o Presence of withdrawal
 - o Using in larger amounts or over a longer period than intended
 - o Persistent desire/unsuccessful efforts to cut down or control use
 - o Spending a great deal of time obtaining, using, or recovering from effects of a substance
 - o Reduction of important/meaningful activities due to use
 - o Continued use despite negative consequences

Effect and Dangers: Alcohol

- o Alcohol first acts as a stimulant, and then it makes people feel relaxed and a bit sleepy.
- o Seriously affect a person's judgment
- o Coordination.
- o Slurred speech
- o Confusion
- o Depression
- o Short-term memory loss
- o Slow reaction times.
- o Black out

Effects and Dangers: Methamphetamines

- o Users feel a euphoric rush from methamphetamine, particularly if it is smoked or shot up. But they can develop tolerance quickly - and will use more meth for longer periods of time, resulting in sleeplessness, paranoia, and hallucinations.
- o Users sometimes have intense delusions such as believing that there are insects crawling under their skin.
- o Prolonged use may result in violent, aggressive behavior, psychosis, and brain damage.
- o The chemicals used to make methamphetamine can also be dangerous to both people and the environment.

Effects and Dangers: Amphetamines

- o Swallowed or snorted, these drugs hit users with a fast high, making them feel powerful, alert, and energized.
- o Uppers pump up heart rate, breathing, and blood pressure, and they can also cause sweating, shaking, headaches, sleeplessness, and blurred vision.
- o Prolonged use may cause hallucinations and intense paranoia.

Effects and Dangers: Cocaine

- o Cocaine is a stimulant that rocks the central nervous system, giving users a quick, intense feeling of power and energy. Snorting highs last between 15 and 30 minutes; smoking highs last between 5 and 10 minutes.
- o Cocaine also elevates heart rate, breathing rate, blood pressure, and body temperature.
- o Injecting cocaine can give you hepatitis or AIDS if you share needles with other users. Snorting can also put a hole inside the lining of your nose.
- o First-time users - even teens - of both cocaine and crack can stop breathing or have fatal heart attacks. Using either of these drugs even one time can kill you.

Effects & Dangers: "Bath Salts"

- o Also known as Vanilla Sky, Ivory Wave, White Rush, Bliss, White Lightning, and Hurricane Charlie
- o A designer drug; the active ingredient in bath salts is a chemical called MDPV which acts as a stimulant like amphetamines and cocaine
- o Usually snorted or smoked
- o Produces a meth-like high and sometimes violent behavior. Users have been observed anxious, combative, paranoid, and experiencing hallucinations and delusions.
- o Other effects include suicidality, impaired perception of reality, reduced motor control, and decreased ability to think clearly.
- o Bath salts can cause rapid heart rate, chest pains, nosebleeds, kidney failure, seizures, muscle damage and loss of bowel control

Effects and Dangers: Cough Medicine (DXM)

- o Street Names: triple C, candy, C-C-C, dex, DM, drex, red devils, robo, rojo, skittles, tussin, velvet, vitamin D
- o Small doses help suppress coughing, but larger doses can cause fever, confusion, impaired judgment, blurred vision, dizziness, paranoia, excessive sweating, slurred speech, nausea, vomiting, abdominal pain, irregular heartbeat, high blood pressure, headache, lethargy, numbness of fingers and toes, redness of face, dry and itchy skin, loss of consciousness, seizures, brain damage, and even death.
- o Sometimes users mistakenly take cough syrups that contain other medications in addition to dextromethorphan. High doses of these other medications can cause serious injury or death.

Effects & Dangers: Ecstasy (MDMA)

- This drug combines a hallucinogenic with a stimulant effect, making all emotions, both negative and positive, much more intense.
- Users feel a tingly skin sensation and an increased heart rate.
- Ecstasy can also cause dry mouth, cramps, blurred vision, chills, sweating, and nausea.
- Sometimes users clench their jaws while using. They may chew on something (like a pacifier) to relieve this symptom.
- Many users also experience depression, paranoia, anxiety, and confusion. There is some concern that these effects on the brain and emotion can become permanent with chronic use of ecstasy.
- Ecstasy also raises the temperature of the body. This increase can sometimes cause organ damage or even death.

Effects & Dangers: GHB

- GHB is a depressant drug that can cause both euphoric (high) and hallucinogenic effects.
- The drug has several dangerous side effects, including severe nausea, breathing problems, decreased heart rate, and seizures.
- GHB has been used for date rape because it is colorless and odorless and easy to slip into drinks.
- At high doses, users can lose consciousness within minutes. It's also easy to overdose! There is only a small difference between the dose used to get high and the amount that can cause an overdose.
- Overdosing GHB requires emergency care in a hospital right away. Within an hour GHB overdose can cause coma and stop someone's breathing, resulting in death.
- GHB (even at lower doses) mixed with alcohol is very dangerous - using it *even once* can kill you.

Effects and Dangers: Heroin

- Heroin gives you a burst of euphoric (high) feelings, especially if it's injected. This high is often followed by drowsiness, nausea, stomach cramps, and vomiting.
- Users feel the need to take more heroin as soon as possible just to feel good again.
- With long-term use, heroin ravages the body. It is associated with chronic constipation, dry skin, scarred veins, and breathing problems.
- Users who inject heroin often have collapsed veins and put themselves at risk of getting deadly infections such as HIV, hepatitis B or C, and bacterial endocarditis (inflammation of the lining of the heart) if they share needles with other users.

Effects and Dangers: Marijuana

- o **Effects & Dangers:**
- o Marijuana can affect mood and coordination. Users may experience mood swings that range from stimulated or happy to drowsy or depressed.
- o Marijuana also elevates heart rate and blood pressure. Some people get red eyes and feel very sleepy or hungry. The drug can also make some people paranoid or cause them to hallucinate.
- o Marijuana is as tough on the lungs as cigarettes - steady smokers suffer coughs, wheezing, and frequent colds.

Effects & Dangers: Spice

- o "Spice": A family of herbal mixtures containing dried, shredded plant material and chemical additives which create the psychoactive effects. Used as alternative to cannabis.
- o Also known as K2, fake marijuana, Yucatan Fire, Skunk, Moon Rocks
- o Spice users report experiences similar to those produced by marijuana, and regular users may experience withdrawal and addiction symptoms.
- o Spice mixtures are sold in many countries in head shops, gas stations, and via the Internet
- o Some Spice products are sold as "incense" but resemble potpourri (common forms include short cones or long, thin sticks). Like marijuana, Spice is abused mainly by smoking. Sometimes Spice is mixed with marijuana or is prepared as an herbal infusion for drinking.
- o A variety of mood and perceptual effects have been described, and patients who have been taken to Poison Control Centers report symptoms that include rapid heart rate, vomiting, agitation, confusion, and hallucinations.

Effects & Dangers: Ketamine

- o Ketamine hydrochloride is a quick-acting anesthetic that is legally used in both humans (as a sedative for minor surgery) and animals (as a tranquilizer). At high doses, it causes intoxication and hallucinations similar to LSD.
- o Users may become delirious, hallucinate, and lose their sense of time and reality. The trip - also called K-hole - that results from ketamine use lasts up to 2 hours.
- o Users may become nauseated or vomit, become delirious, and have problems with thinking or memory.
- o At higher doses, ketamine causes movement problems, body numbness, and slowed breathing.
- o Overdosing on ketamine can stop you from breathing - and kill you.

Effects & Dangers: Steroids

- o Most anabolic steroids are synthetic substances similar to the male sex hormone testosterone. They are taken orally or are injected.
- o Also known as Juice, gym candy, pumpers, stackers
- o Major effects of steroid abuse can include liver damage; jaundice; fluid retention; high blood pressure; increases in "bad" cholesterol.
- o Males may experience shrinking of the testicles, baldness, breast development, and infertility. Females may experience growth of facial hair, menstrual changes, male-pattern baldness, and deepened voice. Teens may experience permanently stunted height, accelerated puberty changes, and severe acne.
- o All users, but particularly those who inject the drug, are at risk of infectious diseases such as HIV/AIDS and hepatitis.

What kind of mental/emotional problems are seen in people with a co-occurring disorder?

- o Depressive disorders: depression and bipolar disorder
- o Anxiety disorders: generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and phobias
- o Other psychiatric disorders: Schizophrenia, Psychotic disorders, Personality Disorders

Mental illness or substance abuse?

Signs and symptoms of mental illness

CAN LOOK LIKE

Signs and symptoms of substance abuse

Behavioral signs and symptoms

- o Abnormally low mood
- o Sadness and hopelessness
- o Excessive feelings of guilt and worthlessness
- o Difficulty concentrating or making decisions
- o Fatigue
- o Reduction in self-esteem
- o Withdrawal from others
- o Suicidal thoughts, plans or attempts
- o Euphoria, feeling "high"
- o Agitation, edginess, irritability, restlessness
- o Racing thoughts, talking a lot
- o Increased energy, sleeplessness
- o Inflated self-esteem, grandiosity, poor judgment
- o Delusions or hallucinations (visual/auditory)

Behavioral signs and symptoms

- o Difficulty paying attention, forgetfulness
- o General lack of motivation, energy; "I don't care" attitude
- o Sudden oversensitivity, temper tantrums, or resentful behavior
- o Moodiness or nervousness
- o Silliness or giddiness
- o Excessive need for privacy, isolation
- o Secretive or suspicious behavior
- o Dishonesty, lying
- o Aggressive behavior
- o Extreme hyperactivity
- o Paranoia

Assessment

- o Sometimes it is impossible to tell the difference between mental illness or an acute drug induced episode.
- o If the subject does not have obvious drug/alcohol signs, assume you are dealing with a mentally ill individual.
- o Individuals who are exhibiting aberrant behavior from drug use may need emergency medical attention.

Assessment

- o Psychological/behavioral risks: Assess for Danger to self/others; violent behavior; psychotic symptoms (command hallucinations/delusions).
- o Biological Risks: Assess for life-threatening medical problems (substance- induced toxic states/withdrawal).

Resources

- o Mobile Crisis Team: available 24 hours; outreach service that provides evaluation and crisis intervention for individuals that may be at risk of harm to self/others or self-neglect; provides information about community mental health/substance abuse services. MCT can be contacted at (305)774-3616; (305)774-3617
- o Ex-parte Order
- o Marchman Act
- o Switchboard of Miami: provides resources, 24-hour hotline (305)358-HELP

Case Scenarios

- o Mother calls 911 regarding her daughter, a 50 year-old, white female, with a history of MH problems. She reports that she received a call from neighbor stating that daughter was verbally abusive towards him and other neighbors. Upon arrival, daughter is observed unkempt. In her apartment, a table is observed on its side on the floor, furniture looks like it was used as a barricade. Client seems distracted, keeps looking around, has trouble answering questions directly.

Case Scenarios

o Uncle calls 911 regarding 66 year-old niece, who has a diagnosis of Schizophrenia, reporting she is unable to care for self. Upon arrival, apartment is observed dirty with soiled furniture, food stains on walls. Client refuses to cooperate but is observed barely-clothed, verbally aggressive, and with a skin condition. It is unknown if she has been taking her medications; she has hypertension and diabetes.

Case Scenarios

o 911 call from male who reports feeling suicidal. Upon arrival, male is observed highly intoxicated, with slurred speech and difficulty walking. He reports he has not eaten in a few days, has been drinking all day, and has not taken medications for high blood pressure.

Case Scenarios

o 911 call from a female reporting that her house is "bugged". Upon arrival, client reports that she is receiving messages through the radio from someone who is threatening to hurt her. She has written notes of every message she has received. She reports that her house must be "bugged" because she is even hearing this person talking about private conversations and things that she is thinking. There are no signs of self-neglect and she denies hallucinations and S/H ideations. She does report that some of the messages she receives are telling her to kill herself but that she ignores them as she is a religious person. She just wants someone to investigate and search her house for "bugs".

Case Scenario

o Mother calls 911 reporting that her son is Bipolar, has been behaving in an aggressive manner, and that he is not taking his medications. Upon arrival, 19 year-old male reports that he is fine, that he became upset due to an argument, and that he does not need medications. He is observed calm and cooperative.

Crisis Intervention Team Training Miami-Dade County



SECTION FIVE



Eleventh Judicial Circuit Criminal Mental Health Project



BEHAVIORAL HEALTH RESOURCES

AHCA (Agency for Health Care Administration)
Receiving Facility & ALF Complaint Hotline
1.888.419.3456

Marchman Act Involuntary Petition
ADULT: Circuit Court-Probate Division
Dade County Courthouse – Room 234
73 West Flagler Street 305.349.7475

JUVENILE: Circuit Court –Juvenile Division

Juvenile Justice Center
3300 NW 27 Avenue 305.633.4745(59)

Department of Children and Families
Alcohol Drug Abuse & Mental Health Division
Contact:
Laura Menendez
Laura_Menendez@dcf.state.fl.us
786.257.5183

South Florida Behavioral Health Network
SFBHN.org
Betty Hernandez, VP of Behavioral Health Services
bhernandez@sfbhn.org
(305) 858-6301

Substance Abuse and Mental Health Svcs. Adm.
SAMSHA.gov

Mobile Crisis Team (24/7)
Evaluation and Assessment (no fee)
305.774.3616(7)
Police and community

NAMI
National Alliance on Mental Illness
Nami.org
NAMI of Miami
305.665.2540

Children's Trust Helpline (24/7)
211 (social services information line)

Switchboard of Miami (24/7)
(Crisis Helpline)
305.358.HELP (4357)

ALZHEIMER HELPLINE
1.800.272.3900

On line Mental Health Training
Bakeracttraining.org

BAKER ACT FORMS
Myflfamilies.com

BAKER ACT PETITION
Exparte Order (9:00 – 4:00 p)
Miami-Dade Courthouse
West Flagler Street, Suite 234
305.349.7474

Homeless Helpline
1.877.994.HELP (4357)

Habsi W. Kaba MS MFT CMS
Hkaba@jud11.flcourts.org
cell. 786.399.8591
Office 305.548.5639

CONSUMER AND FAMILY RESOURCE MANUAL

MIAMI-DADE
AND
MONROE
COUNTIES



FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM



South Florida
Behavioral
Health Network, Inc.

AUGUST 2012

THIS PAGE IS LEFT BLANK INTENTIONALLY

Table of Contents

INTRODUCTION	4
ABUSE HOTLINE.....	5
AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA) HOTLINE.....	5
AIDS FOR PERSONS WITH DISABILITIES AND PERSONS WITH LIMITED ENGLISH PROFICIENCY	5
BIRTH CERTIFICATES.....	6
BUS PASSES	7
CLUBHOUSES.....	8
COMMUNITY MENTAL HEALTH CENTERS (CMHC).....	9
COMPLAINTS/GRIEVANCES.....	10
CONSUMER NETWORK.....	10
CONSUMER RIGHTS.....	10
COST OF SERVICES.....	12
COURT/LEGAL SYSTEM.....	12
CRISIS SUPPORT.....	13
DROP-IN CENTERS	15
EMERGENCY SERVICES (PRIVATE BAKER ACT FACILITIES).....	16
EMERGENCY SERVICES (PUBLIC BAKER ACT FACILITIES).....	17
FEDERALLY QUALIFIED HEALTH CENTERS (FQHC).....	18
FLORIDA IDENTIFICATION CARDS AND DRIVER LICENSES.....	19
FOOD BANKS	20
FOOD STAMPS.....	21
FORENSIC SERVICES.....	21
HOMELESS HELPLINE.....	22
NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)	22
OMBUDSMAN	23
OSS (OPTIONAL STATE SUPPLEMENTATION)	23
PEER SPECIALISTS	23
PROVIDER SELECTION AND CHOICE.....	24
SENIOR MEDICARE PATROL (SMP).....	24

SOCIAL SECURITY DISABILITY BENEFITS	25
SPECIAL TRANSPORTATION SERVICE (STS).....	25
SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT	26
SUPPORT GROUPS.....	27
TELEPHONE WIRELESS SERVICES.....	28
VOCATIONAL REHABILITATION	29
WELLNESS AND RECOVERY	29
WELLNESS RECOVERY ACTION PLAN (WRAP)	30
PROVIDER DIRECTORY OF SFBHN FUNDED SERVICES.....	31

INTRODUCTION

Welcome to the Consumer and Family Resource Manual for individuals in Miami-Dade and Monroe Counties who receive mental health and/or substance abuse services from community agencies. This Consumer and Family Resource Manual is dedicated to the consumers, their families and their support systems. A consumer is the person receiving services from an agency.

This manual is also dedicated to the many individuals, agencies and stakeholders that share their time and energy working with consumers, their families, and support systems to improve their health and quality of life. We especially want to thank the consumers and Peer Specialists of the Consumer Network of Miami-Dade for giving us their support, suggestions and ideas for this manual.

The Substance Abuse and Mental Health (SAMH) Program Office of the Department of Children and Families contracts with South Florida Behavioral Health Network, Inc. (SFBHN) to manage the SAMH system of care. SFBHN ensures quality and best practices are provided to consumers and families seeking services in Miami-Dade and Monroe Counties.

This manual will give you information and direction on who to contact for more specific information. If you need assistance and/or have any questions related to mental health, substance abuse and/or other community services, **please call the Consumer Hotline at 1-888-248-3111**. You will also learn ways to be more involved in your services and community. Please read through the following pages and keep this manual for future use. We hope your experience with South Florida Behavioral Health Network, Inc. (SFBHN) is positive and beneficial to you.

ABUSE HOTLINE

Abuse can come in many forms, such as verbal, physical or sexual mistreatment. The Abuse Hotline is the phone number you can call to report abuse, neglect and/or mistreatment for all children and vulnerable adults in Florida.

Telephone Number: 1-800-96-ABUSE (22873)
TDD (Hearing Impaired) Number: 1-800-453-5145

An emergency situation occurs when someone appears to face immediate risk of abuse/neglect that is likely to result in death or serious harm. If your concerns are an emergency, FIRST CALL 911; SECOND contact the Abuse Hotline.

AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA) HOTLINE

If you have a complaint and/or need licensing information about an Assisted Living Facility (ALF), nursing home and/or hospital, please call AHCA at:

1-888-419-3456

You may also call this toll-free telephone number to get information about Medicaid, Medicare, Medipass and your HMO (Health Maintenance Organization).

AIDS FOR PERSONS WITH DISABILITIES AND PERSONS WITH LIMITED ENGLISH PROFICIENCY

If you have a disability and/or have limited English proficiency, the mental health and substance abuse agencies will provide appropriate help (auxiliary) aids, including qualified or certified language interpreters, to you and/or your companion at no cost. These agencies are listed in the **Provider Directory of Services** at the end of this Consumer and Family Resource Manual. **You need to request the appropriate help (auxiliary) aids when you first contact the agency so their staff has time to prepare and provide you with the best services.**

If you are deaf or hard of hearing, your communication options may include but not be limited to the CART (Communication Access Real Time) Translation, Florida Relay Service, TDDs (Telecommunication Devices for the Deaf), FAX (Telephone Facsimile Transmittal), phone amplifiers, qualified or certified sign language interpreters, flash cards, lip-reading, written notes, supplementary hearing devices, charts or a combination of these, as appropriate.

If you have low vision or are blind, it is important that you and agency staff discuss the best method of communication for you. Staff will document in your file the type of help (auxiliary) aids and service provided during their contact with you.

(continued on next page)

If you have sensory, speech or mobility limitations, information will be included in the meeting notices, conference and seminar announcements to let you know that you will be provided with the necessary (auxiliary) aids at no cost to you. The information will include the name of a contact person and a date by which you must request such assistance. This process will include discussing the type of personal assistance or accommodation that you need. **If you need assistance in getting help (auxiliary) aids from the agency that you receive mental health and/or substance abuse services, please call the Consumer Hotline at 1-888-248-3111.**

Florida Relay is the communications link for people who are Deaf, Hard-of-Hearing, Deaf/Blind, or Speech Impaired. Through the Florida Relay, people who use specialized telephone equipment can communicate with people who use standard telephone equipment.

To call Florida Relay, dial 7-1-1, or use the following toll free numbers:

- 1-800-955-8771 Text Telephone (TTY)
- 1-800-955-8770 (Voice)
- 1-877-955-8260 Voice Carry Over (VCO-Direct)
- 1-800-955-5334 Speech to Speech (STS)
- 1-877-955-8773 (Spanish)
- 1-877-955-8707 (Creole)

BIRTH CERTIFICATES

You may apply for a birth certificate in person at any County Health Department location if you were born in the State of Florida. If you choose to mail in your application, please address it to the Central Dade office or the Monroe County office (see next page for addresses). You may also apply on the internet at www.miamivitalrecords.com. You must meet one of the following criteria:

- Be the child named on the certificate AND over 18 years old, OR
- Be the parent, guardian or legal representative of the person named on the certificate.

ALL APPLICATIONS MUST INCLUDE THE FOLLOWING:

- The applicant's PICTURE ID (such as a valid driver's license, state identification card, passport or military identification card). A photocopy of your PICTURE ID is required for mail-in applications.
- The applicant's full name at birth, date and place of birth, mother's maiden name and father's name.
- The applicant's full name, address and telephone number.

The fee for each certified copy of a Florida birth record is \$20.00. When purchased at the same time, additional copies of the identical birth record are \$16.00 each. These fees are subject to change. For Walk-In applications, fees are payable either in cash, by money order or cashier's check. For Mailed-In applications, fees are payable by money order or cashier's check only. **DO NOT SEND CASH BY MAIL.** Money orders/cashier's checks should be made payable to Vital Records Unit.

Locations for the Miami-Dade and Monroe County Health Departments:

North Dade

18680 NW 67 Avenue
Hialeah, Florida 33015
(305) 628-7227
(WALK-IN APPLICANTS ONLY)

Central Dade

1350 NW 14 Street, Room 3
Miami, Florida 33125
(305) 575-5030
(WALK-IN AND MAIL APPLICANTS)

South Dade

18255 Homestead Avenue #113
West Perrine, Florida 33157
(305) 278-1046
(WALK-IN APPLICANTS ONLY)

Monroe County (Florida Keys)

1100 Simonton Street
Key West, Florida 33040
(305) 293-7500
(WALK-IN AND MAIL APPLICANTS)

BUS PASSES

If you receive benefits from Social Security and are a permanent Miami-Dade County resident, you are eligible to ride free on the buses and on the Metrorail with a **Golden Passport EASY Card**. The **Golden Passport EASY Card** is **FREE**. To obtain this card, you must apply in person at the **Transit Service Center** located on the second level of the **Government Center Metrorail station** at **111 N.W. 1st Street, Miami, FL, 33128**.

You must present:

- **Documentation from Social Security** stating how much money you receive
- **A current valid Florida ID**

The best time to go to the Transit Service Center is on Wednesday and Thursday as it is less crowded on these days.

(continued on next page)

All **honorably discharged veterans** who are permanent residents of Miami-Dade County and whose annual income is \$22,000 or less are eligible to ride on the buses and on the Metrorail for free with the **Patriot Passport EASY Card**. To obtain this card, you must apply in person at the **Transit Service Center**.

You must present:

- **A current valid Florida ID**
- **Proof of income**
- **The DD214 or VA 1010 form as proof of an honorable discharge**

If you have any questions, you can call 786-469-5028 Monday through Friday, 8 a.m. to 4:30 p.m. To renew by mail or fax, copies of the required documents must be forwarded to Miami-Dade Transit. The fax number is 305-375-1192. You can mail documents to Miami-Dade Transit, Special Pass Programs, P.O. Box 01-9005, Miami, FL, 33101.

If you live in the Florida Keys (Monroe County), you can apply for a reduced fare bus pass at the City of Key West, 627 Palm Avenue, Key West, FL, 33040. Please call 305-809-3910 first so that you have the necessary documents and are aware of the reduced fare.

CLUBHOUSES

Clubhouses provide non-clinical services which include a work-ordered day and peer-to-peer recovery support, services and assistance. Clubhouses promote recovery from mental illness and provide structured, community-based services designed to strengthen and/or regain the consumer's interpersonal skills, meaningful work, employment, education and help them do well in the community.

**Fellowship House
Club Fellowship**
5716 Commerce Lane
Miami, FL 33143
(305) 740-2420

Key Clubhouse of South Florida
260 NE 17th Terrace, Suite 202
Miami, FL 33132
(305) 374-5115

Monroe County

**Personal Growth Center
Guidance Care Center Clubhouse**
3000 41st Street Ocean
Marathon, FL 33050
(305) 434-7660

COMPLAINTS/GRIEVANCES

Each agency that serves consumers and families in Miami-Dade and Monroe Counties has its own procedure for consumers to file a complaint or grievance explaining their dissatisfaction with the agency's staff and/or services. This procedure includes investigating, tracking, managing and responding to the complaint. Please give your complaint in writing to staff within your agency. If your complaint is not resolved with the agency, you may present the complaint in writing to South Florida Behavioral Health Network, Inc. (SFBHN). You can do this by calling SFBHN at 305-858-3335 and asking for the Risk and Compliance Coordinator. If you have a complaint about SFBHN, the Risk and Compliance Coordinator can help you with this process too.

CONSUMER NETWORK

The Consumer Network of Miami-Dade is led by consumers who share a commitment to making a difference in mental health and/or substance abuse recovery. The Consumer Network of Miami-Dade meetings are held on the second and fourth Tuesday of every month from 10am-12pm at 401 N.W. 2nd Avenue, Suite N-423, Miami, Florida. At each meeting, approximately fifty consumers, Peer Specialists and stakeholders within the mental health and substance abuse community meet to discuss advocacy issues, education, training, and peer support.

The Consumer Network of Miami-Dade was formed to promote recovery, leadership and advocacy training for consumers. The Consumer Network of Miami-Dade provides education and empowerment to adults with mental health and/or substance abuse issues. For related events and resources, please visit: www.consumernetworkmiami.blogspot.com. You may also reach the Consumer Network Coordinator at Fresh Start of Miami-Dade, Inc. at 305-623-9937.

The Department of Children and Families and South Florida Behavioral Health Network, Inc. (SFBHN) are actively involved with the Consumer Network of Miami-Dade and promote consumer-driven leadership, activities and ideas within all of our agencies.

CONSUMER RIGHTS

Your rights as a consumer while receiving treatment at a facility are protected under Florida law. When you request or receive services, your agency should give you written information regarding your rights. You have the right to:

1. Be treated with kindness and respect.
2. Be given services based on your individual needs and regardless of your ability to pay. You will be involved in developing your recovery plan where medical, vocational, social, educational and rehabilitative services are individualized to meet your needs.

(continued on next page)

3. Sign documents showing that you understand the services that were explained to you and you can decide to stop services at any time unless you are court-ordered to a facility or involuntarily hospitalized.
4. Live in a safe and decent living environment.
5. Complain regarding the use of restraint, seclusion, isolation, emergency treatment orders, physical management techniques and increased levels of supervision.
6. Communicate freely and privately with individuals if you are in a facility, whether voluntarily or involuntarily. You have the right to communicate by phone, mail or visitation. You have the right to call the Abuse Registry at 1-800-96-ABUSE (22873) or your attorney. If your communication is restricted, written notice must be provided to you.
7. Keep your own clothing and personal belongings unless they are removed for safety or medical reasons. If your personal belongings are taken from you, a witnessed inventory is required.
8. Register and to vote in any election for which you are a qualified voter.
9. Ask the court to review the cause and legality of your detention or unjust denial of a legal right or privilege or an authorized procedure if you are involuntarily admitted.
10. Participate in your treatment and/or recovery and discharge planning. You are also guaranteed the opportunity to seek services from the professional or agency of your choice upon discharge.
11. Choose a representative who will be notified if you are involuntarily admitted. Your representative or advocate will be advised of all proceedings and restrictions of your rights. They will receive a copy of the inventory of your personal belongings, have immediate access to you, and is authorized to file legal documents on your behalf. However, this representative cannot make any treatment decisions, cannot access or release your clinical record without your consent, and cannot request your transfer to another facility.
12. Confidentiality which ensures that all information about you in a mental health and/or substance abuse facility remains confidential and is only released with your consent. However, certain information may be released to your attorney, in response to a court order, after a threat of harm to others or other very limited circumstances. You also have the right to access your clinical records.
13. Adequate and appropriate health care consistent with established standards within the community.
14. An opportunity for regular exercise several times a week and to be outside for frequent intervals except when prevented by inclement weather.

COST OF SERVICES

If you do not have money or health insurance, mental health and/or substance abuse services will still be provided to you. Community mental health centers that receive funds from the State provide treatment and services based on what you can afford to pay. This is called a sliding-scale or sliding fee basis of payment. Every person is responsible to pay for some of the cost of their care but if you have very little money or no money, services are still provided.

In addition, there are Federally Qualified Health Centers (FQHC) that provide medical care regardless of a person's ability to pay. **Please call the Consumer Hotline at 1-888-248-3111 if you have questions and/or issues.**

COURT/LEGAL SYSTEM

Jail Diversion Program

1351 N.W. 12th Street
Miami, FL 33125

Misdemeanor Cases

Contact: Lourdes Mata
305-548-5324

Felony Cases

Contact: Alejandro Aristizabal
305-548-5735

This program is designed to divert individuals with Serious Mental Illness (SMI), or co-occurring SMI and substance use issues from the criminal justice system into community-based treatment and support services. The program assists participants to navigate the requirements of the criminal justice process as well as to develop individualized transition plans to the community. Linkages to necessary psychiatric treatment, medication, supportive services and housing will be arranged prior to community re-entry.

Miami-Dade County Public Defender's Office

1320 N.W. 14 Street
Miami, FL 33125
305-545-1600 (felony)
305-545-3348 (misdemeanor)

The public defender's office provides legal representation, principally in criminal and mental health cases, to persons in jeopardy of losing their liberty. Representation is contingent upon the court finding the individual indigent and appointing a Public Defender.

(continued on next page)

Legal Services of Greater Miami (FREE LEGAL SERVICES)

Serving Miami-Dade County North of Kendall Drive
3000 Biscayne Boulevard, Suite 500
Miami, FL 33137

Serving Miami-Dade County South of Kendall Drive
11285 SW 211th Street, Suite 302
Miami, FL 33189
305-576-0080 for both locations

Monroe County Public Defender's Office

801 Eisenhower Drive
Key West, FL 33040
305-294-2501

Legal Services of the Florida Keys (Monroe County) (FREE LEGAL SERVICES)

Call with your legal question and they will provide you with free legal information over the phone
Monday-Friday
1-877-715-7464

CRISIS SUPPORT

ARE YOU OR SOMEONE YOU KNOW EXPERIENCING ANY OF THE FOLLOWING?

- Suicidal thoughts
- Thoughts about hurting yourself or someone else
- Feelings and thoughts of sadness, hopelessness, depression
- Feelings and thoughts of anxiety, nervousness, paranoia
- Problems with alcohol, prescription drugs, and/or illegal drugs
- Problems with your feelings and behavior that are interfering with work, school and/or relations with others
- Hearing voices and/or seeing things that do not exist

PLEASE CALL:

- **911 in case of a medical and/or psychiatric emergency**

Tell the operator if the emergency involves a person with mental illness so the **Crisis Intervention Team (CIT) Police** can respond to the situation. They can provide an evaluation of the situation, and if needed, de-escalate and transport individuals experiencing a crisis to the appropriate facilities. Evaluation, treatment, and referrals are provided as necessary by the receiving facilities.

(continued on next page)

- **Switchboard of Miami
Children's Trust 211 Helpline**

Dial 211 for adult and children's social services information and referrals, and crisis counseling
305-358-HELP (4357)
305-644-9449 (TTY)

- **Mobile Crisis Team--Miami-Dade County
Miami Behavioral Health Center**

This is an outreach service that provides mobile crisis intervention and assessment for adults
24 hours a day
305-774-3616
305-774-3617

- **Helpline, Inc.-Monroe County**

This is a crisis and information hotline for individuals in the Florida Keys
305-296-4357

- **National Suicide Prevention Lifeline**

For help during a suicidal crisis
1-800-273-TALK

- **South Florida Behavioral Health Network**

Call the Consumer Hotline at 1-888-248-3111 for information, access to services, and peer support

DROP-IN CENTERS

Drop-In Centers are intended to provide a range of opportunities for individuals with severe and persistent mental illness to independently develop, operate, and participate in social, recreational and networking activities.

Citrus Health Network

Kiva Drop-In Center

1339 SE 9th Avenue
Hialeah, FL 33010
(305) 884-1382

Fresh Start of Miami-Dade Drop-In Center

18075 NW 27th Avenue
Miami Gardens, FL 33056
(305) 623-9937

Miami Behavioral "Villa Esperanza" Drop-In Center

1566 SW 1st Street
Miami, FL 33135
(786) 378-5565

New Hope Drop-In Center

1251 NW 36th Street
Miami, FL 33142
(305) 635-2297

Volunteers of America Drop-In Center

1492 West Flagler Avenue
Miami, FL 33135
(305) 644-0335

Monroe County

Guidance Care Center Drop-In Center

3000 41st Street Ocean
Marathon, FL 33050
(305) 434-7660

EMERGENCY SERVICES (PRIVATE BAKER ACT FACILITIES)

A Baker Act is a means of providing individuals with emergency services and temporary detention for mental health evaluation and treatment when required, either on a voluntary or an involuntary basis. Private Baker Act facilities are funded by private insurance.

Aventura Hospital

20900 Biscayne Boulevard
Aventura, FL 33180
(305) 682-7000

North Shore Hospital

1100 NW 95th Street
Miami, FL 33150
(305) 835-6060

University of Miami Hospital

1400 NW 12th Avenue
Miami, FL 33136
(305) 689-5511

Jackson South Community Hospital

9333 SW 152nd Street
Miami, FL 33169
(305) 251-2500

Larkin Hospital

7031 SW 62nd Avenue
Miami, FL 33143
(305) 284-7500

Palmetto General Hospital

2001 West 68th Street
Hialeah, FL 33016
(305) 823-5000

Miami VA Medical Center

1201 NW 16th Street
Miami, FL 33125
(305) 575-3214

Jackson North Medical Center

160 NW 170th Street
North Miami Beach, FL 33169
(305) 654-5050

Miami Children's Hospital

3100 SW 62nd Avenue
Miami, FL 33155
(305) 666-6511

Southern Winds Hospital

4225 West 20th Avenue
Hialeah, FL 33012
(305) 558-9700

Mount Sinai Hospital

4300 Alton Road
Miami Beach, FL 33139
(305) 674-2000

Westchester Hospital

2500 SW 75th Avenue
Miami, FL 33155
(305) 264-5252

Kendall Regional Medical Center

11750 Bird Road
Miami, FL 33175
(786) 315-5901

Mercy Hospital

3663 South Miami Avenue
Miami, FL 33133
(305) 285-2618

EMERGENCY SERVICES (PUBLIC BAKER ACT FACILITIES)

A Baker Act is a means of providing individuals with emergency services and temporary detention for mental health evaluation and treatment when required, either on a voluntary or an involuntary basis. Public Baker Act facilities are funded by the State.

Miami-Dade County

Citrus Health Network

4175 West 20th Street
Hialeah, FL 33012
(305) 825-0300 ext. 2353

Community Health of South Florida, Inc. (CHI)

10300 SW 216th Street
Miami, FL 33190
(305) 252-4865

Jackson Mental Health Hospital

1695 NW 9th Avenue
Miami, FL 33136
(305) 355-7777

Jackson North Community Mental Health Center

15055 NW 27th Avenue
Opa-Locka, FL 33054
(786) 466-2834

Miami Behavioral Health Center

3800 W. Flagler Street
Miami, FL 33134
(305) 774-3600

New Horizons Community Mental Health Center

1455 NW 36th Street
Miami, FL 33142
(305) 635-7444

Monroe County

DePoo Hospital

1200 Kennedy Drive
Key West, FL 33040
(305) 294-5531

Guidance Care Center

3000 41st Street Ocean
Marathon, FL 33050
(305) 434-7660

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

Federally Qualified Health Centers (FQHC) are community-based organizations that provide comprehensive primary medical care and preventative medical care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.

Locations include:

Borinquen Health Care Center

Main Site

100 NE 38th Street
Miami, FL
305-576-1599

Borinquen Health Care Center

West Dade/Sweetwater Site

10528 SW 8th Street
Miami, FL
305-552-1201

Camillus House

336 NW 5th Street
Miami, FL
305-374-1065

Core Resource

5010 Biscayne Boulevard
Miami, FL
305-576-1234

Citrus Health Network

4125 West 20th Avenue
Hialeah, FL
305-424-3120

Community Health of South Florida, Inc. (CHI)

Doris Ison Health Center

10300 SW 216th Street
Miami, FL
305-253-5100

Community Health of South Florida, Inc. (CHI)

Martin Luther King Site

810 West Mowry Drive
Homestead, FL
305-248-4334

Helen B. Bentley Health Center

3090 SW 37th Avenue
Miami, FL
305-447-4950

(continued on next page)

Jessie Trice Community Health Center (JTCHC)
5361 NW 22nd Avenue
Miami, FL
305-637-6400

Miami Beach Community Health Center (MBCHC)
710 Alton Road
Miami Beach, FL
305-538-8835

Miami Behavioral Health Center
3850 West Flagler Street
Miami, FL
305-774-3300

For medical assistance in the Florida Keys (Monroe County), check with the Southernmost Homeless Assistance League, Inc. (SHAL) at 305-600-7624 and the Monroe County Health Department at 305-293-7500.

FLORIDA IDENTIFICATION CARDS AND DRIVER LICENSES

The documentation required for new identification cards and driver licenses as well as those being renewed is outlined below.

For Department of Motor Vehicle (DMV) visits, you must bring:

- **Your driver's license or Florida ID**
- **Your social security card**
- **Documentation that proves your residential address**

To visit a Florida DMV office, it is suggested that you make an appointment. The website to do this is www.gathergoget.com. Click on FAQs (Frequently Asked Questions) and then click on OASIS (Online Appointment Service and Information System) to schedule an appointment. The current cost for a Florida Driver's License is \$48.00 and the cost for a Florida Identification Card is \$25.00, but these are subject to change. These costs are different for renewals. The following payment methods are accepted: cash, check, money order, ATM/debit cards, Visa, Mastercard, Discover, and American Express.

FOOD BANKS

****CALL FIRST FOR DISTRIBUTION HOURS****

- South Florida Foods
5850 NW 32nd Avenue
Miami, FL 33142
305-633-9861
 - Rayfield Family Literacy
427 State Road 7
Hollywood, FL 33023
1-800-913-5481
 - Food of Life Outreach Ministries, Inc.
957 N.W. 3rd Avenue, Suite #3
Florida City, FL 33034
 - Sembrando Flores, Inc.
29355 S. Federal Highway
Homestead, FL 33030
305-247-2438
 - Stop Hunger, Inc.
12050 N.E. 14th Avenue, Suite #2
Miami, FL 33161
305-891-8811
 - Curley's House of Style Inc./Hope Food Bank
6025 N.W. 6th Court
Miami, FL 33127
305-759-9805
 - Pass It On Ministries
14617 N.W. 7th Avenue
Miami, FL
305-681-1594
 - Jewish Community Services
2056 N.E. 155th Street
North Miami Beach, FL
305-947-8093
-
- Florida Keys
Southernmost Homeless Assistance League, Inc. (SHAL)
Mobile Outreach Project
305-600-7624
www.shal.cc

FOOD STAMPS

Florida offers a Food Stamps program through the Florida Department of Children and Families. This program is designed to assist low-income households with the purchase of nutritious food for the family. **To obtain information about Food Stamps, call:**

ACCESS FLORIDA INFORMATION LINE

1-866-762-2237

You may apply for Food Stamps online using the ACCESS Florida system at the website www.dcf.state.fl.us/programs/access/. This system will take all of the information needed for your application and is the fastest way to receive Food Stamps. The Florida Department of Children and Families will approve or reject your application within 7-30 days. If you need assistance with applying, you can go to the Community ACCESS Network Participants. These participants are located in the community and include aging resource centers, child advocacy centers, community centers, county public health units, domestic abuse centers, faith-based organizations, food banks, homeless organizations, libraries, and Workforce One centers. Go to www.dcf.state.fl.us/programs/access/ for a complete listing of locations.

FORENSIC SERVICES

Forensic services is a service delivery system of mental health and substance abuse for adults age 18 and over who are diagnosed with a severe and persistent mental illness and because of their mental illness have a legal status indicating that they are 916 Not Guilty by Reason of Insanity (NGI) or 916 Incompetent to Proceed (ITP) in their criminal process.

Forensic services are most often incorporated within the other mental health/substance abuse services in our community. The biggest difference is that New Horizon's Forensic Team provides additional oversight of these individuals and reports any changes in their treatment/behavior to the court. In addition, there are several forensic specific programs that are only available for individuals that are Not Guilty by Reason of Insanity (NGI) or Incompetent to Proceed (ITP).

These programs include competency restoration and forensic residential treatment services which are comprised of: Short Term Residential Treatment (SRT) which includes Miami-Dade Forensic Alternative Center (MD FAC) and Citrus STAR. Other programs include Residential Treatment Level II and Level IV, and Crisis Support/Emergency.

HOMELESS HELPLINE

If you are homeless or need rental assistance in Miami-Dade County call:

1-877-994-HELP

OR

1-877-994-4357

If you need rental assistance, press option #1.

If you need assistance with homelessness, press option #2.

Follow the other prompts as instructed.

Housing and other services can be provided to help you get out of the streets, prevent homelessness and improve your quality of life.

No walk-ins will be accepted at the Homeless Assistance Center, Salvation Army, Miami Rescue Mission or Camillus House. Placement requires a referral obtained through the Homeless Helpline.

The Southernmost Homeless Assistance League, Inc. (SHAL) offers services throughout the Florida Keys. Their Mobile Outreach Project can be reached at 305-600-7624. The website is www.shal.cc. Their services include: food and hygiene, housing assistance, medical assistance, substance abuse, job services and training, transportation, identification and social security card, and veteran services.

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

NAMI of Miami is part of the National Alliance on Mental Illness. NAMI is friends, families and individuals with mental illnesses who offer information, support, advocacy and resources for each other.

The mission of NAMI is:

- To educate, comfort and support families
- To work for funding and establishment of comfortable, supportive residential facilities conducive to recovery
- To initiate and support public education for elimination of the stigma surrounding mental illnesses
- To collaborate with other organizations in achieving these goals

For information in English and Spanish, call:

305-665-2540

www.namiofmiami.org

For information on NAMI of the Florida Keys, call:

305-849-1278

OMBUDSMAN

An ombudsman is a specially trained and certified volunteer who has been given authority under federal and state law to identify, investigate and resolve complaints made by, or on behalf of, long-term care facility residents. Ombudsmen respond to resident complaints and concerns ranging from issues with medication and care administration to matters of dignity and respect. It is the ombudsman's role to protect the legal rights of residents and assure that they receive appropriate treatment and quality care. All investigations are confidential and provided at no charge.

Telephone Number: 1-888-831-0404 (toll-free)

OSS (OPTIONAL STATE SUPPLEMENTATION)

Optional State Supplementation (OSS) is a cash assistance program. Its purpose is to supplement a person's income to help pay for costs in an assisted living facility, mental health residential treatment facility, and adult family care home. It is NOT a Medicaid program.

To be eligible for OSS, a person must:

- Be 65 years or older, or 18 years of age or older and blind or disabled
- Be a U.S. citizen or qualified noncitizen
- Be a Florida resident
- Have a Social Security number or file for one
- File for any other benefits to which they may be entitled
- Disclose other third party liability (i.e., health insurance)
- Be certified by Adult Services or Mental Health case manager as needing placement in a licensed facility: Adult Family Care Home (AFCH), Assisted Living Facility (ALF), or Mental Health Residential Treatment Facility (MHRTF).

Only an Assisted Living Facility (ALF), Adult Family Care Home (AFCH), Mental Health Residential Treatment Facility (MHRTF), or case manager can apply for OSS. For more information, call Christina Dominguez at 305-377-5093.

PEER SPECIALISTS

South Florida Behavioral Health Network, Inc. (SFBHN) encourages agencies to employ Peer Specialists as part of their treatment and recovery programs. Peer Specialists are individuals that have progressed in their own mental health and/or substance abuse recovery and are willing to self-identify as a peer and work to assist other individuals with mental health and/or substance abuse issues. Because of their life experiences, these individuals have expertise that professional training cannot replicate.

(continued on next page)

There are many tasks that Peer Specialists can perform including assisting you in establishing goals for recovery, learning and practicing new skills, modeling effective coping skills based on the Peer Specialist's own recovery experience and supporting you in advocating for yourself to obtain effective services.

Certified Recovery Peer Specialists are Peer Specialists that are certified through the Florida Certification Board. Please see the website: www.floridacertificationboard.org for more information. Peer Specialists employed by agencies that provide mental health and/or substance abuse services should be working towards their certification. **Please feel free to contact the Consumer Hotline at 1-888-248-3111 for support, training and information.**

PROVIDER SELECTION AND CHOICE

If you are uninsured and need a provider, go to the list of Community Mental Health Centers and find your residence zip code. The Community Mental Health Center listed above your zip code is the provider that can give you services. It is best to call the Center and make an appointment before going there in person. Each Community Mental Health Center has multiple doctors so if you are not comfortable with one of the doctors, you can ask the staff for a different doctor. **If you need assistance with this process or wish to change providers, call the Consumer Hotline at 1-888-248-3111.**

If you have Medicaid and/or HMO (Health Maintenance Organization) insurance, call the Agency for Health Care Administration (AHCA) at 1-888-419-3456 to find out information about your provider.

SENIOR MEDICARE PATROL (SMP)

The Senior Medicare Patrol (SMP) was developed to empower seniors to prevent healthcare fraud. Seniors are defined as those aged 65 and older. Fraud consists of intentional deception or misrepresentation that someone makes, knowing it is false, that could result in the payment of unauthorized benefits. Fraud can also be misusing the system through unacceptable or non-standard medical or business practices such as prescribing unnecessary medical tests.

The SMP is a group of highly trained volunteers who help Medicare beneficiaries avoid, detect, and prevent health care fraud. SMP volunteers teach Medicare beneficiaries how to protect their personal information, identify and report errors on their health care statements, recognize scams and report fraud and abuse to the proper authorities.

If you suspect fraud, please call:

1-866-357-6677

SOCIAL SECURITY DISABILITY BENEFITS

The first step in the Social Security application process is determining whether you are eligible to apply for Social Security Disability Benefits based on the qualification criteria and strict definition of disability provided by the Social Security Administration. Please see the website www.ssa.gov for more information.

In order to qualify for SSDI (Social Security Disability Income):

- You must suffer from a permanent condition that prevents you from working
- Your disability must have lasted, or be expected to last a minimum of twelve months
- You must be unable to earn an income greater than \$1000 per month

The SSDI application process can be overwhelming so it is helpful to have your Case Manager assist you with the process. Many case managers in Miami-Dade and Monroe Counties have been trained in the SOAR (SSI/SSDI Outreach, Access, and Recovery) Initiative. It is important that you mention this to your case manager because it will help to make the application process quicker.

You are a SOAR candidate if you have:

- No history of approval for benefits
- Disability benefits suspended over one year
- A claim denied due to lack of medical evidence

It is helpful for your Case Manager to obtain and forward medical records to the Social Security Administration. You will need to sign a number of releases for the Case Manager to do this. The more information that you can remember and give to your Case Manager for documentation, the more successful your SSDI application process will be.

SPECIAL TRANSPORTATION SERVICE (STS)

In Miami-Dade and Monroe Counties, STS (Special Transportation Service) is available for individuals with a physical, mental, or intellectual disability who cannot ride the buses, Metrorail, or Metromover. Any resident whose disability prevents them from riding regular transit vehicles qualifies for STS. Residents with temporary disabilities may also be eligible for this service. To be certified for the STS Program, you must complete the STS application form (download from www.miamidade.gov/transit/rider or call Miami Dade Transit at 786-469-5000 (305-263-5459 for TTY users or the hearing impaired) and request that an application be mailed to you.

STS offers:

- Shared-rides
- Door-to-door travel
- Accessible vehicles
- 7 days a week, 24 hours a day, call for holiday schedule

(continued on next page)

- \$3 per one-way trip
- Call 305-264-9000 to make reservations

STS is available throughout most of Miami-Dade County, in some parts of South Broward County, and in the Monroe County Upper to Middle Keys. Use STS for trips to medical appointments, school, work, shopping, business, or recreation. Air-conditioned minivans, small buses, lift-equipped vans, and sedans transport passengers with disabilities safely in a clean, smoke-free environment. Pickups are usually within 30 minutes of the scheduled time but you need to call to confirm.

SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT

Many individuals have both substance abuse and mental health issues. In order to fully recover, you need treatment for both problems. Alcohol and other drugs may be used as a form of self-medication to alleviate the symptoms of the mental health issues. In some cases, substance abuse occurs before the development of mental health problems. For example, anxiety and depression may be brought on as a response to stressors from broken relationships, lost employment and other situations directly related to a drug-using lifestyle.

The Marchman Act is a means of providing individuals with emergency services and temporary detention for substance abuse evaluation and treatment when required, either on a voluntary or an involuntary basis.

**FOR INFORMATION REGARDING ADULT SUBSTANCE ABUSE TREATMENT, PLEASE CALL
SOUTH FLORIDA BEHAVIORAL HEALTH NETWORK AT:**

1-866-833-7477

**TO OBTAIN A WALK-IN ASSESSMENT FOR
ADULT SUBSTANCE ABUSE TREATMENT,
PLEASE CALL CENTRAL INTAKE AT:**

305-693-3251

SUPPORT GROUPS

- **Alcoholics Anonymous** 305-461-2425 www.aamiami.net
Call 305-296-7888 for groups in Monroe County
Alcoholics Anonymous is a group of men and women who share their experiences, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.
- **Narcotics Anonymous** 305-265-9555 www.namiami.org
Call 305-664-2270 for groups in Monroe County
Narcotics Anonymous is a group of men and women who share their experiences, strength and hope with each other that they may solve their common problem and help others to recover from addiction.
- **AI-Anon** (friends and families of individuals with alcohol issues)
305-663-1432 www.alanonsofla.org
- **Naranon** (friends and families of individuals with narcotic issues)
www.nar-anon.org
- **Double Trouble in Recovery** (12 step fellowship of men and women who share their experiences, strengths and hopes with each other so that they solve and receive support for their particular substance abuse issue and mental health issue).

A Double Trouble Meeting is hosted by Better Way from 7pm-8pm every Friday night in the west wing building at 810 NW 28th Street in Miami, Florida, 33127. The phone number is 305-634-3409. It is open to the community.

TELEPHONE WIRELESS SERVICES

Assurance Wireless Service

Assurance Wireless is a Lifeline Assistance program brought to you by Virgin Mobile and supported by the Federal Universal Service Fund. Please call 1-888-898-4888 or go to www.assurancewireless.com to see if you qualify.

Safelink Wireless Service

SafeLink Wireless makes wireless telephone service more affordable by offering Lifeline service for qualified individuals. Qualified individuals will receive a free SafeLink Wireless handset and free monthly minutes with no commitments, contracts, or bills. If you need additional minutes, you can buy TracFone Airtime Cards at any TracFone retailer (Walmart, CVS, Kmart, Target, Radio Shack, Walgreens, Family Dollar, Dollar General and Rite Aid stores).

You qualify for Lifeline service in your area if you already participate in one of the following assistance programs:

- Federal Public Housing Assistance/Section 8
- Food Stamps
- Low Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF)
- Medicaid

If someone in your household is receiving Lifeline Assistance, you must cancel the service before applying for Lifeline service through Safelink Wireless. In order for you to receive your FREE phone you must live at a residence that can receive mail from the U.S. Post Office. P.O. Boxes cannot be accepted. If you want to apply for Safelink Wireless, call 1-800-977-3768.

VOCATIONAL REHABILITATION

Vocational Rehabilitation (VR) is a federal-state program that works with people who have physical or mental disabilities to prepare for, gain or retain employment. VR is committed to helping people with disabilities find meaningful careers. In addition to the general customer employment program, VR has additional specific programs designed to help eligible people with disabilities become employed.

Examples of VR Services:

- Medical and Psychological Assessment
- Vocational Evaluation and Planning
- Career Counseling and Guidance
- Training and Education After High School
- Job-Site Assessment and Accommodations
- Job Placement
- Job Coaching
- On-the-Job Training
- Supported Employment
- Assistive Technology and Devices
- Time-Limited Medical and/or Psychological Treatment

Vocational Rehabilitation has offices throughout the State. Call 305-643-7600 for information or visit www.rehabworks.org to find the location closest to you.

WELLNESS AND RECOVERY

South Florida Behavioral Health Network, Inc. (SFBHN) supports a culture of wellness and recovery within each agency that serves consumers and families in Miami-Dade and Monroe Counties. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.

It is important to have hope as this makes recovery possible. Our agencies work to instill hope so that you can start to believe in yourself and your recovery. A key component of recovery is a "recovery plan" or "treatment plan." Staff at your agency can work with you to develop and start your personal recovery plan. Your plan should include your overall health and well-being, not just your mental health and/or substance abuse issues. Components of your plan may include support groups and individual therapy, basic health care maintenance, stable housing, improvements in your family life and personal relationships as well as community connections. Your plan may also include educational goals, occupational development, volunteer work and job seeking goals.

WELLNESS RECOVERY ACTION PLAN (WRAP)

WRAP is a self-management and recovery system developed by Dr. Mary Ellen Copeland and a group of individuals who had mental health challenges and who were struggling to incorporate wellness tools and strategies into their lives. WRAP is designed to:

- Decrease and prevent troubling feelings and behaviors
- Increase your emotional strength
- Improve your quality of life
- Assist you in achieving your life goals and dreams

The five key concepts of WRAP are:

- Hope
- Personal Responsibility
- Education
- Self-Advocacy
- Support

Anyone can develop a personal Wellness and Recovery Plan (WRAP). You may choose to have supporters and health care professionals help you create your WRAP. South Florida Behavioral Health Network, Inc. (SFBHN) encourages staff at the agencies to be trained in facilitating WRAP groups for you. This can help you with your recovery process in the community. **Please call the Consumer Hotline at 1-888-248-3111 if you are interested in WRAP groups or training in this area.**

PROVIDER DIRECTORY OF SFBHN FUNDED SERVICES

OUTPATIENT SERVICES

Outpatient services are designed to improve the functioning of individuals with mental health and/or substance abuse problems. These services are usually provided through regularly scheduled appointments, with arrangements made for non-scheduled visits during times of increased stress or crisis. The following providers offer outpatient services. **If you need additional assistance, please call the Consumer Hotline at SFBHN at 1-888-248-3111.**

AGAPE Family Ministries (South Florida Jail Ministries)

Adult Mental Health, Adult Substance Abuse

305-235-2616

Better Way of Miami, Inc.

Adult Mental Health, Adult Substance Abuse

HIV/AIDS Early Intervention Services

305-634-3409

Camillus House, Inc.

Adult Mental Health, Adult Substance Abuse

HIV/AIDS Early Intervention Services

305-374-1065

Care Resource

Adult Substance Abuse, HIV/AIDS Early Intervention Services

305-576-1234

Citrus Health Network

Adult Mental Health, Children's Mental Health

Children's Substance Abuse

305-825-0300

Community Health of South Florida, Inc. (CHI)

Adult Mental Health, Adult Substance Abuse

HIV/AIDS Early Intervention Services

305-253-5100

Comprehensive Treatment Center of South Florida, Inc. (CTC)

Adult Substance Abuse

305-825-7770

Concept House, Inc. (Concept Health Systems, Inc.)

Adult Substance Abuse, Adult Mental Health

Children's Substance Abuse, Prevention

HIV/AIDS Early Intervention Services

305-751-6501

Douglas Gardens Community Mental Health Center of Miami Beach, Inc. Adult Mental Health		305-531-5341
Family Counseling Services of Greater Miami, Inc. Children's Mental Health		305-740-8998
Family Resource Center of South Florida, Inc. Adult Substance Abuse		305-374-6006
Guidance Care Center, Inc. (Monroe County) Adult Mental Health, Adult Substance Abuse, Children's Mental Health, Children's Substance Abuse Prevention, HIV/AIDS Early Intervention Services		305-434-7660
Here's Help, Inc. Adult Substance Abuse, Children's Substance Abuse, Children's Mental Health		305-685-8201
Institute for Child and Family Health, Inc. (ICFH) Children's Mental Health, Children's Substance Abuse		305-685-0381
Institute for Family Centered Services, Inc. (IFCS) Children's Mental Health	North Miami-Dade County South Miami-Dade County	305-823-8665 305-670-0729
Jackson North Community Mental Health Center Adult Mental Health, Adult Substance Abuse Children's Mental Health	Children's Mental Health Adult Mental Health and Adult Substance Abuse	786-466-2700 786-466-2800
Jessie Trice Community Health Center, Inc. Adult Substance Abuse, HIV/AIDS Early Intervention Services		305-637-6400
King David Foundation, Inc. /CLAPA Adult Substance Abuse, Children's Substance Abuse, Prevention HIV/AIDS Early Intervention Services		305-935-6726

Kristi House, Inc. Children's Mental Health	305-547-6800
Miami Behavioral Health Center, Inc. Adult Mental Health, Adult Substance Abuse, Children's Mental Health, Children's Substance Abuse	305-398-6100
Miami-Dade County Community Action Human Services Department Adult Substance Abuse	305-694-2734
Miami-Dade County Juvenile Services Department Children's Substance Abuse	305-755-6200
New Hope C.O.R.P.S., Inc. Adult Substance Abuse	786-243-1003
New Horizons Community Mental Health Center, Inc. Adult Mental Health, Adult Substance Abuse, Children's Mental Health, Children's Substance Abuse	305-635-7444
Our Children Our Future, Inc. Children's Mental Health	305-893-9365
Psychosocial Rehabilitation Center, Inc. d/b/a Fellowship House Adult Mental Health, Adult Substance Abuse	305-667-1036
Public Health Trust (PHT)/Jackson Health System Adult Mental Health, Adult Substance Abuse Children's Mental Health, Children's Substance Abuse	305-355-7148
Recapturing the Vision International, Inc. Adult Substance Abuse	305-232-6003
Regis House, Inc. Adult Substance Abuse, Children's Mental Health Children's Substance Abuse	305-642-7600

Sembrando Flores, Inc.
Adult Substance Abuse, Children's Substance Abuse,
HIV/AIDS Early Intervention Services **305-247-2438**

Spectrum
Adult Mental Health, Adult Substance Abuse,
Children's Substance Abuse **305-398-6100**

St. Luke's Center at Catholic Charities
Adult Mental Health, Adult Substance Abuse
HIV/AIDS Early Intervention Services **305-795-0077**

The Center for Family and Child Enrichment, Inc. (CFCE)
Children's Mental Health, Children's Substance Abuse, Prevention **305-624-7450**

The Village South, Inc.
Adult Mental Health, Adult Substance Abuse,
Children's Mental Health, Children's Substance Abuse, Prevention
HIV/AIDS Early Intervention Services **305-573-3784**

FLORIDA ASSERTIVE COMMUNITY TREATMENT (FACT)

These non-residential care services are available twenty-four hours per day, seven days per week, and include community-based treatment, rehabilitation and support services provided by a psychiatrist, case managers, nurses and peer specialists. These services are provided to individuals with severe and persistent mental illness or to individuals with substance abuse issues and a severe and persistent mental illness. Enrollment on the FACT Team is through referrals only.

Citrus Health Network
Adult Mental Health, Adult Substance Abuse **305-825-0300**

**Psychosocial Rehabilitation Center, Inc. d/b/a
Fellowship House**
Adult Mental Health, Adult Substance Abuse **305-667-1036**

RESIDENTIAL SERVICES

AGAPE Family Ministries (South Florida Jail Ministries)
Adult Mental Health, Adult Substance Abuse **305-235-2616**

Inter Way of Miami, Inc.
Adult Mental Health, Adult Substance Abuse **305-634-3409**

Camillus House, Inc. Adult Mental Health, Adult Substance Abuse	305-374-1065
Citrus Health Network Adult Mental Health, Children's Mental Health	305-825-0300
Concept House, Inc. Adult Substance Abuse, Adult Mental Health	305-751-6501
Douglas Gardens Community Mental Health Center of Miami Beach, Inc. Adult Mental Health	305-531-5341
Guidance Care Center, Inc. (Monroe County) Adult Mental Health, Adult Substance Abuse	305-434-7660
Here's Help, Inc. Adult Substance Abuse, Children's Mental Health, Children's Substance Abuse	305-685-8201
Jessie Trice Community Health Center, Inc. Adult Substance Abuse	305-637-6498
Miami Behavioral Health Center, Inc. Adult Substance Abuse	305-398-6100
Miami-Dade County Community Action Human Services Department Adult Substance Abuse	305-694-2734
New Hope C.O.R.P.S., Inc. Adult Substance Abuse	786-243-1003
Passageway Residence of Dade County, Inc. Adult Mental Health	305-635-9106

**Psychosocial Rehabilitation Center, Inc. d/b/a
Fellowship House**
Adult Mental Health

305-667-1036

Spectrum
Adult Substance Abuse

305-398-6100

St. Luke's Center at Catholic Charities
Adult Mental Health, Adult Substance Abuse

305-795-0077

The Village South, Inc.
Adult Mental Health, Adult Substance Abuse,
Children's Mental Health, Children's Substance Abuse

305-573-3784

SUBSTANCE ABUSE DETOXIFICATION

Community Health of South Florida, Inc. (CHI)
Adult Substance Abuse

305-253-5100

Guidance Care Center, Inc. (Monroe County)
Adult Substance Abuse

305-434-7660

Jackson North Community Health Center
Adult Substance Abuse

786-466-2800

Miami Behavioral Health Center, Inc.
Adult Substance Abuse, Children's Substance Abuse

305-398-6100

Public Health Trust (PHT)/Jackson Health System
Adult Substance Abuse

305-355-7148

SUPPORTIVE HOUSING/LIVING

Supported Housing/Living services assist persons with substance abuse and mental health issues in the selection of housing of their choice. These services also provide the necessary services and supports to assure their continued transitioning and successful living in the community.

Carrfour Supportive Housing, Inc.
Adult Mental Health

305-371-8300

Volunteers of America
Adult Mental Health

305-644-0335

PREVENTION

Prevention programs involve strategies aimed at the individual and/or community level which try to prevent the development of substance abuse problems and promote healthy development of individuals, families and communities.

Aspira of Florida, Inc.

305-576-7705

D-FY-IT, Inc.

305-971-0607

**Family and Children Faith Coalition, Inc. d/b/a
Hope for Miami**

786-388-3000

Gang Alternative, Inc.

305-398-5985

Guidance Care Center, Inc. (Monroe County)

305-434-7660

Hosanna Community Foundation, Inc.

305-637-4404

King David Foundation, Inc. /CLAPA

305-935-6726

Monroe County Coalition

305-849-5929

Switchboard of Miami

305-358-1640

The Abriendo Puertas Governing Board of East Little Havana, Inc.

305-649-6449

The Center for Child and Family Enrichment, Inc.

305-624-7450

The Miami Coalition for a Safe and Drug-Free Community, Inc.

786-242-8222

Community Resources for Autism

The Autism Society of Miami-Dade

305-969-3900 office

Email- becerral9@aol.com

www.autismsocietymiami.org

A parent based organization that has been in existence since 1965. They offer direct support to parents, caregivers and their families in the form of educational meetings, Free Family Fun Day events, community resources and much more. We understand what you're going through because we live it ourselves! Funded by private donations.

The University of Miami Center for Autism and Related Disabilities

UM-NSU CARD

5665 Ponce De Leon Blvd.

Coral Gables, Florida 33124

1-800-9-Autism ext. 1

www.umcard.org

They provide a wide variety of excellent services to families and extended families at no cost. Individual & Family Support, Program Consultations, Technical Assistance and Community Outreach. They serve families in Miami, Broward and Monroe. Funded by the D.O.E.

Parent to Parent of Miami, Inc.

7990 S.W. 117 Ave. Suite 201

Miami Florida 33183

305- 271-9797

www.ptopmiami.org

This is also a parent based organization that can help families with a wide variety of issues, especially school related issues. Parent to Parent of Miami is well respected in the autism community as a community support provider. Funded by the D.O.E.

Florida Diagnostic Learning Center

FDLRS

5555 S.W. 93 Ave

Miami, Florida 33165

305-274-3501

www.fdlrs-south.dade.k12.fl.us

They provide Professional Development Trainings. They also maintain an Instructional Material Center where educational personnel and parents can borrow materials for a short period of time. Workshops are held for families who have children of all disabilities. Funded by the D.O.E.

CRITICAL INCIDENT STRESS INFORMATION SHEETS

You have experienced a traumatic event or a critical incident (any event that causes unusually strong emotional reactions that have the potential to interfere with the ability to function normally). Even though the event may be over, you may now be experiencing or may experience later, some strong emotional or physical reactions. It is very common, in fact quite *normal*, for people to experience emotional aftershocks when they have passed through a horrible event.

Sometimes the emotional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. And, in some cases, weeks or months may pass before the stress reactions appear.

The signs and symptoms of a stress reaction may last a few days, a few weeks, a few months, or longer, depending on the severity of the traumatic event. The understanding and the support of loved ones usually cause the stress reactions to pass more quickly. Occasionally, the traumatic event is so painful that professional assistance may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by himself.

Here are some common signs and signals of a stress reaction:

<i>Physical*</i>	<i>Cognitive</i>	<i>Emotional</i>	<i>Behavioral</i>
chills	confusion	fear	withdrawal
thirst	nightmares	guilt	antisocial acts
fatigue	uncertainty	grief	inability to rest
nausea	hypervigilance	panic	intensified pacing
fainting	suspiciousness	denial	erratic movements
twitches	intrusive images	anxiety	change in social activity
vomiting	blaming someone	agitation	change in speech patterns
dizziness	poor problem solving	irritability	loss or increase of appetite
weakness	poor abstract thinking	depression	hyperalert to environment
chest pain	poor attention/ decisions	intense anger	increased alcohol consumption
headaches	poor concentration/memory	apprehension	change in usual communications
elevated BP	disorientation of time, place or person	emotional shock	etc...
rapid heart rate	difficulty identifying objects or people	emotional outbursts	
muscle tremors	heightened or lowered alertness	feeling overwhelmed	
shock symptoms	increased or decreased awareness of surroundings	loss of emotional control	
grinding of teeth		inappropriate emotional response	
visual difficulties		etc...	
profuse sweating			
difficulty breathing			
etc...			

** Any of these symptoms may indicate the need for medical evaluation.
When in doubt, contact a physician.*

THINGS TO TRY:

- WITHIN THE FIRST 24 - 48 HOURS periods of appropriate physical exercise, alternated with relaxation will alleviate some of the physical reactions.
- Structure your time; keep busy.
- You're normal and having normal reactions; don't label yourself crazy.
- Talk to people; talk is the most healing medicine.
- Be aware of *numbing* the pain with overuse of drugs or alcohol, you don't need to complicate this with a substance abuse problem.
- Reach out; people do care.
- Maintain as normal a schedule as possible.
- Spend time with others.
- Help your co-workers as much as possible by sharing feelings and checking out how they are doing.
- Give yourself permission to feel rotten and share your feelings with others.
- Keep a journal; write your way through those sleepless hours.
- Do things that feel good to you.
- Realize those around you are under stress.
- Don't make any big life changes.
- Do make as many daily decisions as possible that will give you a feeling of control over your life, i.e., if someone asks you what you want to eat, answer him even if you're not sure.
- Get plenty of rest.
- Don't try to fight reoccurring thoughts, dreams or flashbacks - they are normal and will decrease over time and become less painful.
- Eat well-balanced and regular meals (even if you don't feel like it).

FOR FAMILY MEMBERS & FRIENDS

- Listen carefully.
 - Spend time with the traumatized person.
 - Offer your assistance and a listening ear if (s)he has not asked for help.
 - Reassure him that he is safe.
 - Help him with everyday tasks like cleaning, cooking, caring for the family, minding children.
 - Give him some private time.
 - Don't take his anger or other feelings personally.
-
- Don't tell him that he is "lucky it wasn't worse;" a traumatized person is not consoled by those statements. Instead, tell him that you are sorry such an event has occurred and you want to understand and assist him.



Director
Office for Civil Rights
Washington, D.C. 20201

January 15, 2013

Message to Our Nation's Health Care Providers:

In light of recent tragic and horrific events in our nation, including the mass shootings in Newtown, CT, and Aurora, CO, I wanted to take this opportunity to ensure that you are aware that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not prevent your ability to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when you believe the patient presents a serious danger to himself or other people.

The HIPAA Privacy Rule protects the privacy of patients' health information but is balanced to ensure that appropriate uses and disclosures of the information still may be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes, such as when a provider seeks to warn or report that persons may be at risk of harm because of a patient. When a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. Further, the provider is presumed to have had a good faith belief when his or her belief is based upon the provider's actual knowledge (i.e., based on the provider's own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (i.e., based on a credible report from a family member of the patient or other person). These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j).

Under these provisions, a health care provider may disclose patient information, including information from mental health records, if necessary, to law enforcement, family members of the patient, or any other persons who may reasonably be able to prevent or lessen the risk of harm. For example, if a mental health professional has a patient who has made a credible threat to inflict serious and imminent bodily harm on one or more persons, HIPAA permits the mental health professional to alert the police, a parent or other family member, school administrators or campus police, and others who may be able to intervene to avert harm from the threat.

In addition to professional ethical standards, most states have laws and/or court decisions which address, and in many instances require, disclosure of patient information to prevent or lessen the risk of harm. Providers should consult the laws applicable to their profession in the states where they practice, as well as 42 CFR Part 2 under federal law (governing the disclosure of substance abuse treatment records) to understand their duties and authority in situations where they have information indicating a threat to public safety.

We at the Office for Civil Rights understand that health care providers may at times have information about a patient that indicates a serious and imminent threat to health or safety. At those times, providers play an important role in protecting the safety of their patients and the broader community. I hope this letter is helpful in making clear that the HIPAA Privacy Rule does not prevent providers from sharing this information to fulfill their legal and ethical duties to warn or as otherwise necessary to prevent or lessen the risk of harm, consistent with applicable law and ethical standards.

A handwritten signature in black ink, appearing to read "Leon Rodriguez". The signature is written in a cursive style with a large initial "L" and "R".

Leon Rodriguez

City of Miami Homeless Assistance Program

Homeless Protocol for Police Departments or other Governmental Agencies

The Miami Homeless Assistance Program delivers mobile street outreach to homeless individuals and families in Miami-Dade County. Community Outreach Specialist seek out the homeless on the streets, under bridges or where ever they may sleep or congregate. Once found, through consistent contact, the outreach team seeks to build a basic level of trust and assess the needs of those served. Outreach workers offer referrals and, if accepted, will transport individuals to emergency shelters, mental health, substance abuse treatment programs or to the hospital emergency room or crisis stabilization unit if urgent care is needed.

The Miami Homeless Assistance Program operates 7-days a week, 24 hours a day, excluding holidays.

Please note that shelter space is very limited and we have a waiting list, therefore not all homeless individuals can be served right away.

We have a policy that no children will be left on the streets; so if a family with minor children is encountered, an outreach team will be dispatched immediately.

To refer a homeless individual or request the service of an outreach team:

(305) 960-4980

Or a Toll Free number could be provided to a homeless person seeking assistance.

1-877-994-4357 (English or Spanish)

To request assistance in closing an encampment or a specialized detail, contact the Outreach Supervisor:

Darren Morrison: (305) 960-4990 / dmorrison@miamigov.com

Please note that when closing an encampment for the first time we have to post notices with the closure date one week prior to closing the encampment. This will allow us time to work with the residents and secure shelter space for them.

Crisis Intervention Team Training Miami-Dade County



SECTION SIX



Eleventh Judicial Circuit Criminal Mental Health Project

11th Judicial Circuit Criminal Mental Health Project

VERBAL DE-ESCALATION
TECHNIQUES & INTERVENTIONS
Miami-Dade County CIT Program



UNDERSTANDING



ANXIETY

PERSON IN CRISIS BELIEVES:



- He/she must act now.
- There is no hope in negotiation or any other attempt to solve problem.
- He/she believes they have LOST CONTROL

PERSON IN CRISIS BELIEVES:



THERE IS NO TIME LEFT

Handwriting lines for notes.

THE ESSENCE OF
CRISIS INTERVENTION:



I HAVE ALL THE TIME I NEED

Handwriting lines for notes.

Be Prepared



WE FEED OFF OF ONE ANOTHER'S EMOTIONS
Be Aware of your Emotional State

- What is your state of mind?
- What is your perception due to your experience?
- What have been YOUR OWN crisis situations?
- What are your biases?
- Where is your stress level?
- How's your health?

Handwriting lines for notes.

Be Aware of your Emotional State



WE FEED OFF OF ONE ANOTHER'S EMOTIONS

- What is your state of mind?
- What is your perception due to your experience?
- What have been YOUR OWN crisis situations?
- What are your biases?
- Where is your stress level?
- How's your health?

FACTS

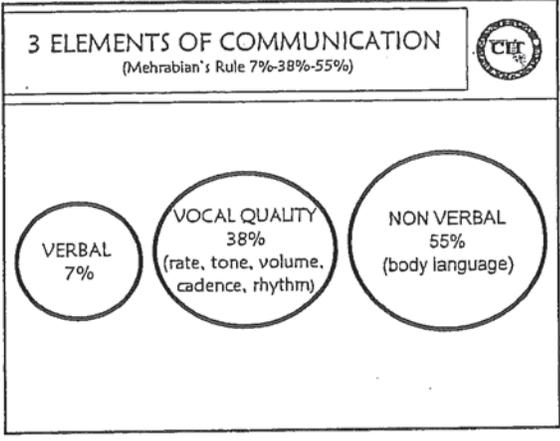


- Stress triggers symptoms
- Cognitive vs. Emotional

PARAVERBAL COMMUNICATION



BE AWARE OF NOT ONLY WHAT YOU SAY BUT HOW YOU SAY IT



PARAVERBAL COMMUNICATION

- The vocal part of speech, excluding the actual words one uses

Three Components of Paraverbal Communication

Component	Suggested Approach
Tone	a. Avoid inflections of impatience, condescension, inattention
Volume	b. Keep the volume appropriate for the distance and the situation
Cadence	c. Deliver your message using an even rate and rhythm

EFFECTIVE VERBAL INTERVENTION



- | | |
|----------|---------|
| SPECIFIC | CONCISE |
| CALM | RELAXED |
| STEADY | DIRECT |

NICE AND SLOW...

WHAT TO DO



- Be patient, accepting, encouraging but remain firm
- Indicate you are *trying* to understand
- Reassure that you don't intend to harm
- Speak slowly and quietly and pause between statements
- Make them aware of their behaviors (speech, pattern, content)
- Meet their basic needs

BE AWARE



- Person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds (voices), or the environment
- People suffering from mental illness often have a hard time processing what others are saying at a "normal" speed
- Allow for some extra mental processing time to avoid unnecessarily combative situation

NON-VERBAL BEHAVIOR



HOW DOES THIS AFFECT YOU?

- Proxemics- Personal Space
- Kinesics- Body posture and movement

GENERAL GUIDELINES FOR VERBAL INTERVENTION



- Maintain a safe distance
- Maintain intermittent eye contact
- No eye contact (culture, perception)
- Use clear tone voice
- Use voice volume lower than that of individual
- Use relaxed, well balanced posture

STRATEGIC DE-ESCALATION

The Five A's



ACTIVE LISTENING (EMPATHY)

ACKNOWLEDGEMENT (VALIDATION)

APPRECIATE (UNDERSTAND)

AGREE (ALIGNING)

APOLOGIZE (VINDICATED)

STRATEGIC DE-ESCALATION	
<ul style="list-style-type: none"> • Give person permission to vent, otherwise violence may seem to be only option • Ensure quiet to avoid escalation due to external influences • Do not use reason or logic, they are irrational • Offer alternatives gives person choices and control 	

SELF-AWARENESS (avoid triggering an adverse response)	
<ul style="list-style-type: none"> • What you wear, how you wear it • Hands/hand movements • Facial expressions/Fear • Your non verbal, their non verbal 	

KEEP IN MIND THAT...	
<ul style="list-style-type: none"> • A person acting out in his own space, but not directly threatening any other person or himself, should be given time to calm down. • Attempting to use logic/rationality with a psychotic person is counterproductive, will most likely escalate person. • Some medications that treat mental illness have side effects that may require attention. 	

VERBAL INTERVENTION



QUESTIONING – Information seeking questions vs. Challenging questions

INTERVENTION:

Answer information seeking questions as honestly as possible
Ignore the challenging questions (not the person) and redirect topic

VERBAL INTERVENTION



- Do not answer threatening questions directly instead respond by referring to the action and your concern

– (i.e. Have you ever seen someone blow their head off? Your question scares me, I don't know how to respond.. But I can help you if you'll let me.)

VERBAL INTERVENTION



REFUSAL – Loss of rationality

INTERVENTION:

Set limits, boundaries, structure

ONE STEP AT A TIME



Getting Personal – does it benefit the consumer?

Don't miss the obvious – notes, letter writing

SETTING LIMITS



- Recognize that you cannot force individuals to respond appropriately, results in a power struggle
- When you set limits you are offering a person choices
- Limits better received when the positive choice and/or consequences are stated first

Limits most effective when they are:



- Simple/Clear
- Reasonable
- Enforceable

CIT

Unless it is absolutely necessary, never use force when taking control of another state. Not using force will enable you to RELAX the FEARS of the people. When they realize the meaning of your intentions, they will follow your LEAD and obey if you have PROPERLY PREPARED. If they are approached with respect, and the INEVITABILITY of your action is understood, they will SEEK to ASSIST you as a means of PROTECTING their own interests.

The definitive interpretation of Sun Tzu's classic book of strategy
 Stephen R. Kaufman, Hanshi 10th Dan

CIT

REMEMBER

- You are in control
- Lead the way
- Guidance
- Structure

CIT

CONTACT INFORMATION

Habsi W. Kaba MS MFT
 Miami-Dade County CIT Coordinator/Consultant
 11th Judicial Circuit Criminal Mental Health Project
 Richard Gerstein Justice Building
 1351 N.W. 12 street Room # 226
 w. 305.548.5639
 c. 786.399.8591
 HKaba@jud11.flcourts.org

**CRISIS INTERVENTION TEAM TRAINING
ELEVENTH JUDICIAL CRIMINAL MENTAL HEALTH PROJECT**

**Verbal De Escalation Techniques
Role-Play Preparation**

In a confrontation, as long as the subject is “talking” and not “doing”, then there is no true danger, there is only true emotion. – Edward Lewis

In order to defuse a hostile situation with a mentally ill person you must establish TRUST and RAPPORT. This will put you in control of the situation and allow you to tactfully decrease the person’s agitation and increase your chances of gaining cooperation.

1. ASSESSING THE SUBJECT

- **Verbal** - speech, style, volume, pitch, accent, tone, imitation
- **Behavioral** - body movements, facial expressions, gestures, eye movements, attire (layers of clothing or lack of etc.)
- **Environment** - Items used to surround themselves with and create their own environment. (i.e. trash bags; shopping cart, plastic or aluminum foil on their person)

2. BE AWARE OF YOUR BODY LANGUAGE

A mentally ill person, who is symptomatic, will feed off of your anxiety/energy.

- Slow your body movements down
- Your demeanor should be natural, smooth and controlled
- Be aware of your facial expressions, gestures and posture
- Maintain hands to your side, hand gestures could play into their hallucinations and/or increase paranoia
- Be reassuring
- Do not stare, glare, shift eyes etc.

3. BE AWARE OF SUBJECTS BODY LANGUAGE

Being able to recognize, interpret and evaluate non verbal communication could give you an advantage in de-escalating and defusing a situation.

4. ENVIRONMENT

- Remove anything or anyone who may be further agitating subject.
- When back up is present, they should remain silent and at a distance.

5. VERBAL COMMUNICATION

- Be SPECIFIC: Concerned with the moment of crisis (why police were called) Be
- Be CONCISE: Get to the point, unnecessary chatter will confuse situation
- Be DIRECT: Seek resolution
- LISTEN
- Use a calm voice (maintain volume less than that of subject)
- Speak slowly
- Repeat yourself
- Use "I" statements
- Make requests
- Validate what subject is telling you
- Give firm and clear directions
- Be helpful
- Be understanding and empathetic
- Do not argue
- Do not joke
- Do not lie
- Do not threaten, warn or command

Remember, It's Not About YOU...Remain Emotionally Detached

See Section ____ in your binder titled: Effective Communication Tips

- Interacting with people with Mental Illnesses in Crisis Situations
- Techniques for handling frequently Encountered Situations
- What to Do
- CAF
- Effective Police Response to People with Mental Illnesses

The true art of restraining or self-defense is to control the situation without physically touching the subject.

6. UTILIZING TECHNIQUES

- Provide Structure
- Introduce self, state purpose
- Ask person's name
- Establish contact with person
- Slow the scene down – pacing
- Inquire about medication
- Inquire about doctor (psychiatrist)
- Determine immediate needs of the person
- Address relevant questions
- Be supportive and show concern
- Identify what precipitated the crisis
- Determine if substance abuse is involved
- Determine if overdose taken/medical clearance needed
- Consider your options: Mobile Crisis Team, Baker Act, Medical, De-tox etc.
- Have patience, wait them out

AVOID:

- Passivity, Counter-transference
 - Defensiveness
 - Power Struggle
-
- Deny delusions/hallucinations
 - Intervening Prematurely
 - Ignoring Danger Signals
 - Re-escalation

CIT Law Enforcement Mini-Mental Status Checklist

Affect

- Within Normal Limits
- Blunted
- Constricted
- Flat
- Labile
- Inappropriate

Mood

- Depressed
- Irritable
- Anxious
- Angry
- Euphoric
- Empty
- Confused
- Frightened
- Guilty
- Elevated
- Labile

Perception

- Hallucinations
 - Audio
 - Visual
 - Olfactory
 - Tactile
- Delusions
 - Grandeur
- Control
 - Influence
 - Persecution
 - Reference
 - Somatic
- Suggestibility
- Distracted- Dazed

Thought

- Coherent
- Relevant
- Reality Testing
- Thought Disorder
- Magical Thinking
- Neologisms
- Loose Associations
- Flight of Ideas
- Disassociation
- Racing Thought
- Circumstantiality
- Delusions
- Delirium/Dementia
- Somatic
- Psychosomatic
- Obsessions
- Phobia
- Paranoia
- Ideas of Reference

Speech

- Disorganized- Word Salad
- Tangential
- Poverty of Speech or Thought
- Pressured Speech
- Echolalia
- Talkative
- Slow
- Loud
- Dramatic
- Slurred
- Stuttering
- Mute

Behavior

- Catatonia
- Automatism
- Posturing
- Repetitive Movements.
- Agitation
- Decreased Activity
- Impulse Control
- Compulsions
- Purposeless Activity
- Pacing
- Unusual Gait
- Wringing Hands
- Inc/Dec in Appetite
- Sleep Disturbance
- Headache
- Other Pain
- Labile

Consciousness

- Oriented
 - Place
 - Person
 - Time
 - Situation
- Intoxicated
- Unresponsive
- Grossly Confused

Attitude

- Cooperative
- Uncooperative
- Seductive
- Inattentive
- Perplexed
- Hostile
- Guarded
- Suspicious

Appearance

- Healthy
- Casual
- Neatly Groomed
- Disheveled
- Bizarre
- Old Looking
- Young Looking
- Inappropriate
- Dirty

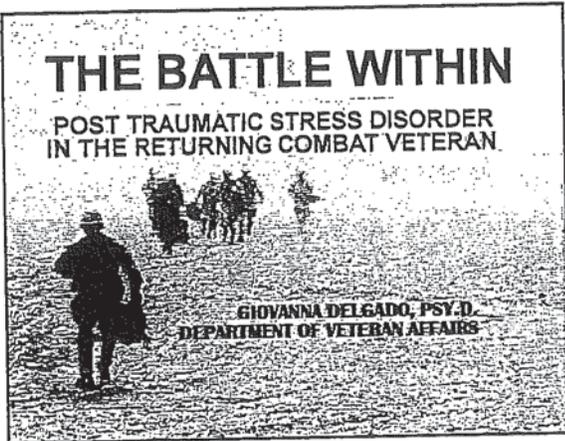
Crisis Intervention Team Training Miami-Dade County

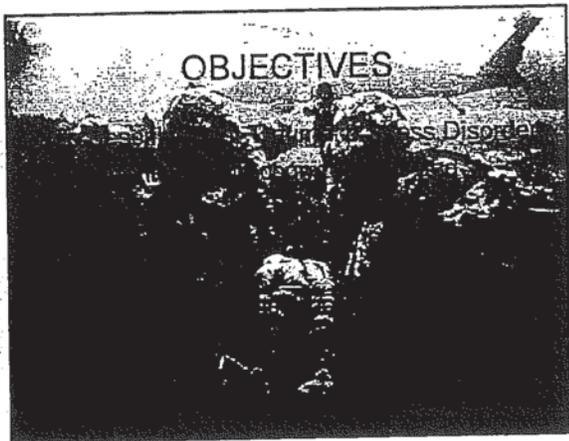


SECTION SEVEN



Eleventh Judicial Circuit Criminal Mental Health Project



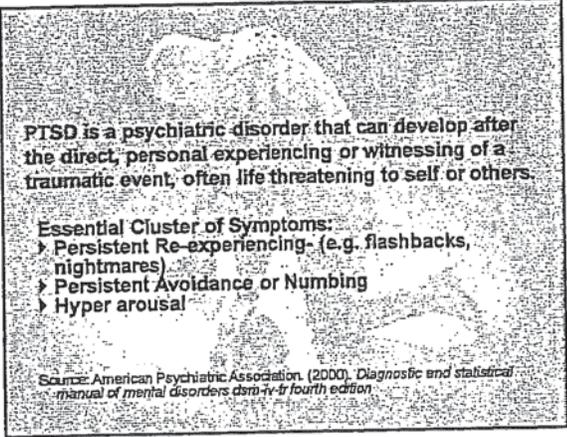


GLOBAL WAR ON TERRORISM

 **Operation Enduring Freedom (OEF)**
▶ October 7, 2001
▶ Afghanistan

 **Operation Iraqi Freedom (OIF)**
▶ March 20, 2003
▶ Iraq

 **Operation New Dawn (OND)**
▶ September 1, 2010

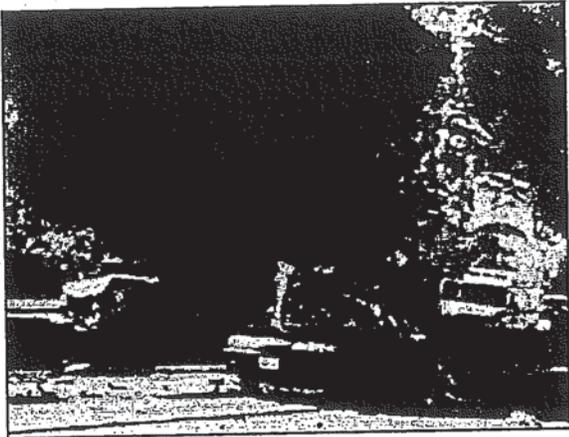


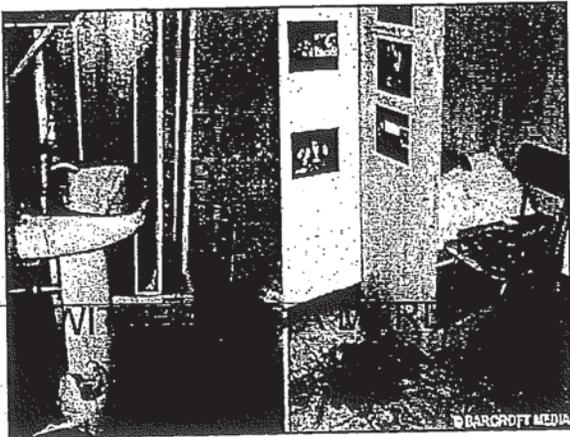
PTSD is a psychiatric disorder that can develop after the direct, personal experiencing or witnessing of a traumatic event, often life threatening to self or others.

Essential Cluster of Symptoms:

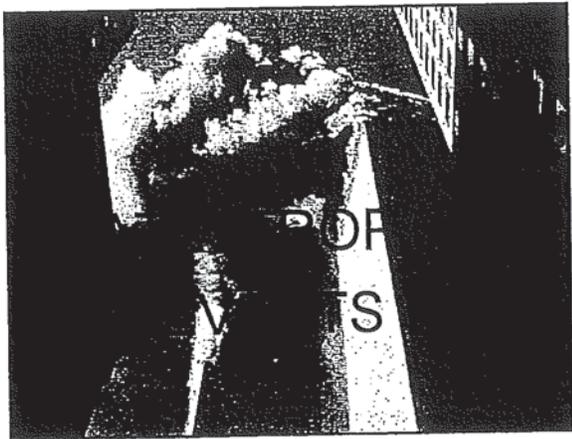
- ▶ Persistent Re-experiencing- (e.g. flashbacks, nightmares)
- ▶ Persistent Avoidance or Numbing
- ▶ Hyper arousal

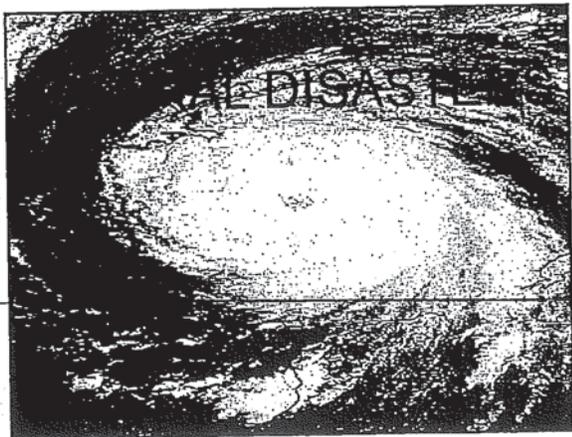
Source: American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders dsm-iv-tr* fourth edition



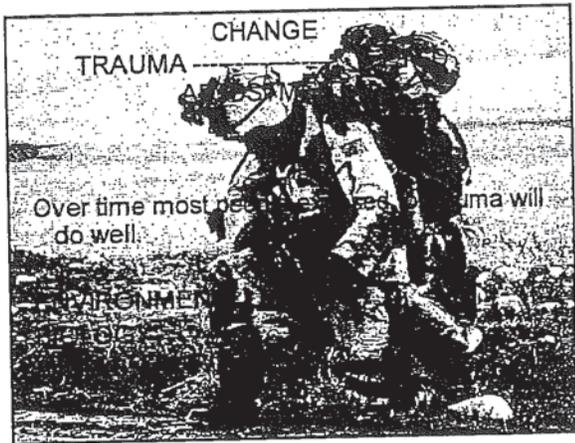


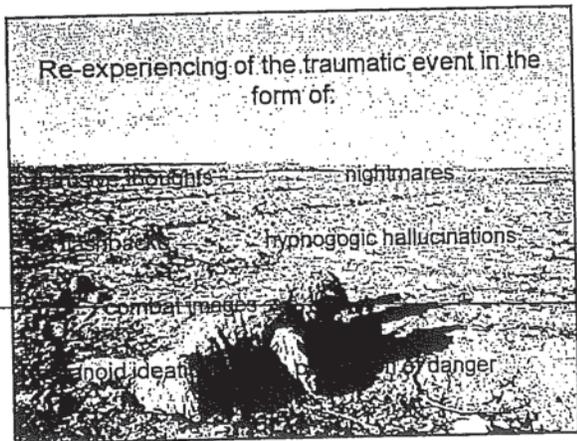






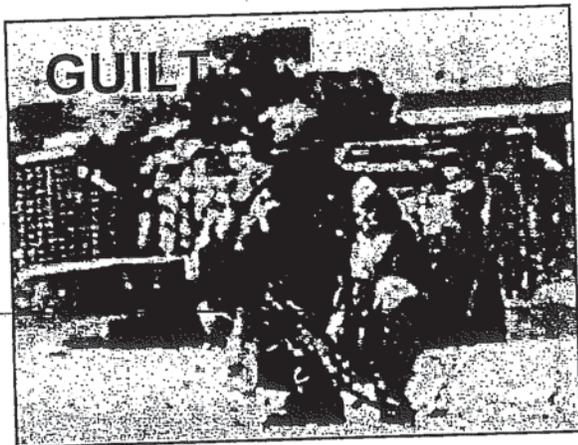






















MOST COMMON PSYCHIATRIC PROBLEMS



- ▶ Acute Stress Disorder
- ▶ Generalized Anxiety Disorder
- ▶ Panic Disorder
- ▶ Major Depressive Disorder
- ▶ Post Traumatic Stress Disorder
- ▶ Substance Abuse/Dependence
- ▶ Adjustment Disorder

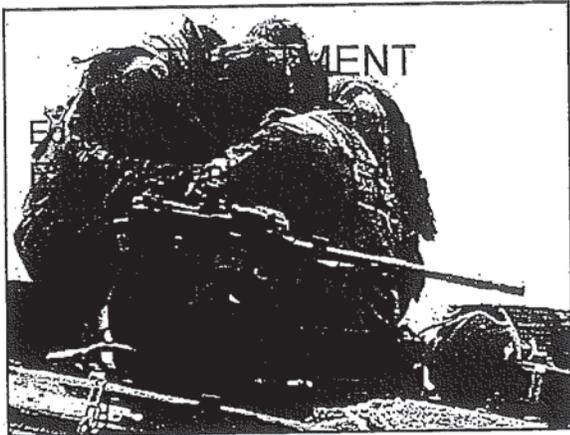
Source: Invisible Wounds of War, RAND 2008

Mild Traumatic Brain Injury

- The American Congress of Rehabilitation (1995) has identified Mild TBI as a traumatically induced physiological disruption of a brain function with at least one of four manifestations:

Any loss of consciousness

- Any loss of memory for events immediately before or after the injury
- Any alteration in mental status at the time of the accident
- Focal neurological deficits that may or may not be transient





MIAMI VA MENTAL HEALTH OUTPATIENT SERVICES

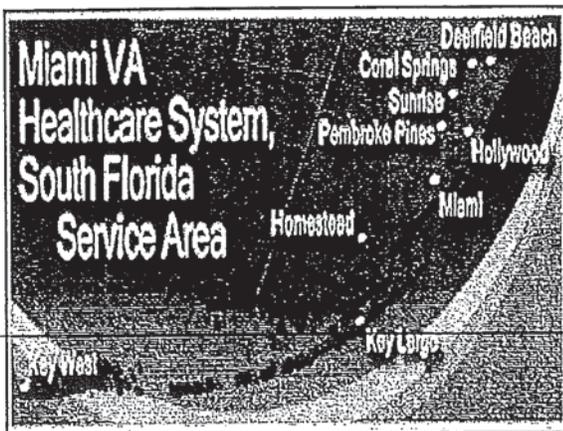
- General Adult
- Geriatric
- Post Traumatic Stress Disorder
- Military Sexual Trauma
- Substance Abuse
- Psychology
- Case Management
 - Severe Mental Illness
 - Geriatric



MIAMI VA MENTAL HEALTH INPATIENT SERVICES

- Acute Inpatient Unit
- Residential Programs
 - Post Traumatic Stress Disorder
 - Psychosocial Rehabilitation
 - Substance Abuse





THANK YOU



For helping their journey back home.



Crisis Intervention Team Training Miami-Dade County



SECTION EIGHT



Eleventh Judicial Circuit Criminal Mental Health Project

**Miami-Dade County
Department of Human Services
Office of Rehabilitative Services**

**FLORIDA STATUTE 397
To Place Someone Involuntarily into a Substance Abuse Treatment
Program**

What you can do when someone you know has a serious substance abuse problem.

1. Who can begin the process?

The potential patient's spouse, legal guardian, any kin, the head of any state treatment and research center, the Sheriff of the County in which the potential patient resides or is ground, or any (3) Florida citizens.

2. Criteria to File the Petition:

The potential patient has refused to submit to a medical examination.

The potential patient has lost the power of self-control with respect of the use of a substance defined by F.S. 397; an, has threatened, attempted or is likely to inflict harm on himself/herself or others, or is in need of substance abuse service, and by reason of substance abuse, his/her judgment has been so impaired that he/she is incapable of appreciating his/her need for care, and of making a rational decision in regard thereto.

3. Procedure to follow:

We must notarize the petition which requires that you bring a valid identification certificate (driver's license, passport, or other recognized photo identification).

There is a \$30.00 - \$45.00 fee for the Process Service Company to serve the potential patient the summons. This service is a requirement by law. In addition a urinalysis/blood test is ordered within the context of the involuntary assessment, there is a \$25.00 fee for this test.

4. Action by the Circuit Court:

A court hearing will be set for the initial hearing within 10 days of the filing of the petition with the Probate Court. The potential patient must be Served Notice and the petitioner should receive Notice of Hearing by U.S. Mail as to the date and place the hearing will be held. The petitioner must be present at all hearings that are required.

5. What happens at the Hearing:

When the potential patient has refused to be examined by a licensed physical, he/she has the right to a court appointment and physician. If the potential patient again refuses an examination and there is sufficient evidence that the allegations in the petition are true; the Court may issue a preliminary order committing the patient to an appropriate treatment resource for not more than five (5) days for the assessment. IF the Court then

determines that the proof is clear and convincing, it will order the patient into an appropriate treatment resource facility which, in general, has been prearranged for by the petitioner.

In general, the first time the court orders a person to treatment, the least restrictive treatment modality (such as an outpatient program) may be ordered. If this modality appears to be inappropriate or the patient fails to respond to this modality- a more restrictive modality will be ordered such as a day-care or an inpatient facility depending upon space availability.

6. What the Involuntary Treatment Order Entails:

This initial order is for 60 days, unless the patient is discharged earlier. After that, the patient is automatically discharged unless the treatment resource has filed a re-petition and the patient has received another court order for an extra period up to 90 days. ALL re- petitions initiated by a facility may ONLY be obtained when the patient's condition warrants it.

NARCOTIVES ANONYMOUS (NA)..... (305) 265-9555

IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
IN AND FOR MIAMI-DADE COUNTY, FLORIDA

CASE NO. _____

DIVISION
 PROBATE
 JUVENILE

CHAPTER 397 EX-PARTE
PETITION FOR
ASSESSMENT AND STABILIZATION

IN RE:

Respondent's Name: _____
Address: _____ DOB: _____ SEX/RACE: _____

I, _____, belong duly sworn, hereby state that I have personally observed the behavior and conduct of RESPONDENT, and have a good faith belief that said person is substance abuse impaired in that

1. He/She has lost the power of self-control with respect to substance use; and either
2. He/She has threatened, attempted, or actually inflicted harm on (himself) (herself) or another, or unless admitted is likely to inflict physical harm on (himself) (herself) or another, or is in need of substance abuse service, and by reason of substance abuse his/her judgment has been so impaired that he/she is incapable of appreciating a need for care, and of making a rational decision in regard thereto.
3. Respondent has an attorney: No Yes if Yes, Attorney Name _____
4. Is the Respondent indigent? No Yes Unknown .
5. The Respondent (has) (has not) refused to submit to an assessment.
6. The Petitioner's beliefs are based on the following:
7. The reason an Ex-Parte Order for assessment & stabilization is necessary is: _____

I hereby petition the Court to evaluate said person.

Petitioner's Address	Petitioner's Name
Petitioner's telephone number	Petitioner's Signature and Relationship
	Petitioner's #2 Name (needed if not a family member)
Petitioner's #2 Address (needed if Petitioner is not a family member)	Signature of Petitioner #2
	Petitioner's #3 Name (needed if not a family member)
Petitioner's #3 Address (needed if Petitioner is not a family member)	Signature of Petitioner #3

State of Florida
County of Miami-Dade
Sworn to or affirmed and signed before me on _____ by _____

Personally Known
 Produced Identification
Type of Identification Produced _____

Notary Public or Deputy Clerk of Courts
[Print, type, or stamp commissioned name of notary or Deputy Clerk.]

IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
IN AND FOR MIAMI-DADE COUNTY, FLORIDA

DIVISION
 PROBATE
 JUVENILE

CASE NO. _____

**CHAPTER 397
 PETITION FOR
 INVOLUNTARY TREATMENT**

IN RE:

Respondent's Name: _____
 Address: _____ DOB: _____ SEX/RACE: _____

I, _____, being duly sworn, hereby state that I have personally observed the behavior and conduct of RESPONDENT, _____, and have a good faith belief that said person is substance abuse impaired in that,

1. He/She has lost the power of self-control with respect to substance use; and either
2. He/She has threatened, attempted, or actually inflicted harm on him/her self or another, or unless admitted is likely to inflict physical harm on him/her self or another, or is in need of substance abuse service, and by reason of substance abuse his/her judgment has been so impaired that he/she is incapable of appreciating a need for care and of making a rational decision in regard therefore. The reasons for these beliefs are as follows:

CHECK ALL BOXES THAT APPLY

- a) Respondent has been placed under protective custody pursuant to Fla. Stat. 397.677 within the previous 10 days; or
- b) Respondent has been subject to an emergency admission pursuant to Fla. Stat. 397.679 within the previous 10 days; or
- c) Respondent has been assessed by a qualified professional within the previous 5 days; or
- d) Respondent has been subject to involuntary assessment and stabilization pursuant to Fla. Stat. 397.6818 a within the previous 12 days; or
- e) Respondent has been subject to alternative involuntary admission pursuant to Fla. Stat. 397.6822 within the previous 12 days; or
- f) Respondent is nearing the scheduled date of release from involuntary treatment pursuant to a Court order; however, Respondent continues to meet the criteria for involuntary treatment contained in Fla. Stat. 397.693.
3. Respondent has an attorney: No Yes if Yes, Attorney Name _____
4. Is the Respondent Indigent? No Yes Unknown .
5. A qualified professional has assessed the Respondent and the findings and recommendations of said professional are:

I hereby petition the Court to evaluate said person.

Petitioner's Address	Petitioner's Name
Petitioner's telephone number	Petitioner's Signature and Relationship
Petitioner's #2 Address (needed if Petitioner is not a family member)	Petitioner's #2 Name (needed if not a family member)
Petitioner's #3 Address (needed if Petitioner is not a family member)	Signature of Petitioner #2
	Petitioner's #3 Name (needed if not a family member)
	Signature of Petitioner #3

State of Florida
 County of Miami-Dade
 Sworn to or affirmed and signed before me on _____ by _____

Personally Known
 Produced Identification
 Type of Identification Produced _____

 Notary Public or Deputy Clerk of Courts

[Print, type, or stamp commissioned name of notary or Deputy Clerk.]

**IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT IN AND
FOR MIAMI - DADE COUNTY, FLORIDA**

JUVENILE DIVISION	EXPARTE ORDER FOR INVOLUNTARY ASSESSMENT AND STABILIZATION	CASE NUMBER: SECTION
IN THE INTEREST OF RESPONDENT	DOB	CLOCK IN

This matter was referred to and heard by the Judge/General Magistrate on the issue of whether the above RESPONDENT should be involuntarily ordered to a treatment program for assessment and stabilization because of substance abuse impairment. The General Magistrate filed recommended findings of fact and conclusions of law which are hereby ratified, confirmed, and incorporated by reference (subject to timely exception) as the finding of fact and conclusions of law of this Court. It is therefore

ORDERED that the RESPONDENT shall appear at:

THE MIAMI BEHAVIORAL HEALTH SPECTRUM PROGRAMS, INC. - JUVENILE ADDICTIONS RECEIVING FACILITY (JARF) located at 3800 W. Flagler St., Miami, Florida 33134 - phone 305-442-1453 (MUST CALL BEFORE YOUTH IS TRANSPORTED) where s/he will be held for substance abuse evaluation/treatment. If Miami Behavioral Health Spectrum Programs, Inc. is unable to accept the youth due to capacity of Unit then the respondent shall appear

1. To the **CITRUS HEALTH NETWORK**, 4175 WEST 20TH AVENUE, HIALEAH, FL 33012-5874, - PHONE (305) 825-0300 If the **THE MIAMI BEHAVIORAL HEALTH SPECTRUM PROGRAMS, INC. JARF OR CITRUS JARF** (MUST CALL BEFORE YOUTH IS TRANSPORTED) is unable to accept the youth due to capacity of Unit or
2. Other Facility: _____

A licensed service provider deemed appropriate as authorized by Chapter 397, Florida Statutes, on the ____ day of _____, 20 ____ at _____ a.m./p.m.

To be evaluated as to his/her present medical condition, for a period not to exceed five days. The RESPONDENT (shall) (shall not) be delivered to the licensed service provider by a law enforcement officer. Any law enforcement officer is authorized to take the RESPONDENT into custody and deliver the RESPONDENT to said Facility.

It is FURTHER ORDERED that violation of this ORDER of Court and/or rules and regulations of the licensed service provider shall be cause for civil or criminal contempt, for which the Court may impose sanctions, which may include incarceration/detention.

DONE AND ORDERED in Miami- Dade County, Florida this ____ day of _____, 20 ____.

CIRCUIT JUDGE

Notice

Respondent's Counsel	
State Attorney	

Appendix D: Law Enforcement and the Marchman Act Protective Custody

Law enforcement officers often serve as the front line for many social and health problems of our communities. Although substance abuse is a health problem, it is often a personal and a public safety issue as well. The Legislature in Florida and elsewhere has granted law enforcement certain authority and responsibilities under the Marchman Act.

Protective Custody

A law enforcement officer as defined in s. 943.10(1), F.S. may implement protective custody measures when a minor or an adult who appears to meet the involuntary admission criteria in s. 397.675 is either:

1. Brought to the attention of law enforcement; or
2. Is in a public place.

The purpose of protective custody is to remove the person from their immediate environment and transport the person to an environment which is conducive to their protection and the protection of others

Any adult or minor may request voluntary treatment for substance abuse. The disability of minority for persons under 18 years of age is removed solely for the purpose of obtaining voluntary substance abuse impairment services.

Criteria for Protective Custody

A person meets the criteria for protective custody if:

- There is good faith reason to believe the person is substance abuse impaired, a condition involving the use of alcoholic beverages or any psychoactive or

mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior.

- Because of this impairment, the person has lost the power of self-control with respect to substance use; and either:
- Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; or
- Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services.

A law enforcement officer may assist the person with or without the person's consent, as follows:

With Consent

A person in circumstances which justify protective custody may consent to be assisted by a law enforcement officer to his or her home, to a hospital, or to a licensed detoxification or addictions receiving facility, whichever the officer determines is most appropriate.

Without Consent

However, if a person in circumstances which justify protective custody fails or refuses to consent to assistance and a law

enforcement officer has determined that a hospital or a licensed detoxification or addictions receiving facility is the most appropriate place for the person, the officer may, after giving due consideration to the expressed wishes of the person:

1. Take the person to a hospital or to a licensed detoxification or addictions receiving facility against the person's will but without using unreasonable force; or
2. In the case of an adult, detain the person for his or her own protection in any municipal or county jail or other appropriate detention facility. This detention is not to be considered an arrest for any purpose, and no entry or other record may be made to indicate that the person has been detained or charged with any crime. The officer in charge of the detention facility must notify the nearest appropriate licensed service provider within the first 8 hours after detention that the person has been detained. It is the duty of the detention facility to arrange, as necessary, for transportation of the person to an appropriate licensed service provider with an available bed. Persons taken into protective custody must be assessed by the attending physician within the 72-hour period and without unnecessary delay, to determine the need for further services.

Minors

The nearest relative of a minor in protective custody must be notified by the law enforcement officer, as must the nearest relative of an adult, unless the adult requests that there be no notification.

Release of a minor client can only be made to the minor's parent, legal guardian, or legal custodian or to the authorized designee of the Department of children and Families or the Department of Juvenile Justice.

Provider Responsibilities

Unlike the Baker Act where designated receiving facilities must accept a person from law enforcement officer for involuntary examination, the Marchman Act prohibits substance abuse providers from exceeding their licensed capacity or accepting persons beyond the safe management capabilities of the service provider.

It is the responsibility of the service provider to:

- Ensure that a person who is admitted to a licensed service component meets the involuntary admission criteria;
- Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;
- Provide for the admission of the person to the service component that represents the least restrictive available setting that is responsive to the person's treatment needs;
- Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;
- Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and
- Take all necessary measures to ensure that each client in treatment is provided with a safe environment, and to ensure that each client whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

Non-Admission

When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her

medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

When the service provider is unable to reach the referral source, the service provider must refuse admission and attempt to assist the person in gaining access to other appropriate services, if indicated.

Upon completing these efforts, the service provider must, within one workday, report in writing to the referral sources, in compliance with federal confidentiality regulations:

- The basis for the refusal to admit the person, and
- Documentation of the service provider's efforts to contact the referral source and assist the person, when indicated, in gaining access to more appropriate services.

When, in the judgment of the service provider, the medical conditions or behavioral problems of an involuntary client become such that they cannot be safely managed by the service component, the service provider must discharge the client and attempt to assist him or her in securing more appropriate services in a setting more responsive to his or her needs. Upon completing these efforts, the service provider must, within 72 hours, report in writing to the referral source, in compliance with federal confidentiality regulations:

- The basis for the client's discharge, and

- Documentation of the service provider's efforts to assist the person in gaining access to appropriate services.

Clients shall be referred to more appropriate services if the provider determines that the person should not be placed or should be discharged. The decision to refuse to admit or to discharge shall be made by a qualified professional. Any attempts to contact the referral source must be made in accordance with federal and state confidentiality regulations.

Disposition After Protective Custody

A client who is in protective custody must be released by a qualified professional when:

1. The client no longer meets the involuntary admission criteria in s. 397.675(1);
2. The 72-hour period has elapsed; or
3. The client has consented to remain voluntarily at the licensed service provider.

A client may only be retained in protective custody beyond the 72-hour period when a petition for involuntary assessment or treatment has been initiated. The timely filing of the petition authorizes the service provider to retain physical custody of the client pending further order of the court.

List Of Licensed Facilities

The Department of Children and Families is required to provide each municipal and county public safety office with a list of licensed hospitals, detoxification facilities, and addictions receiving facilities, including the name, address, and phone number of, and the services offered by, the licensed service provider. A current list can also be found for each county on tmyflorida.com website.

Immunity From Liability

A law enforcement officer acting in good faith pursuant to this part may not be held criminally or civilly liable for false imprisonment

Behaviors to Look For

Individuals with substance abuse addiction who may need further evaluation typically exhibit a combination of the following behaviors, characteristics, or indicators of their illness:

Substance Abuse: abuse of prescribed medications, use of alcohol or illegal substances.

Psychological/Physical: Eyes glassy, red, dilated, etc. Labile mood (sad/happy, calm/angry), violent, hostile, irritable, lethargic/manic, self-isolative, non-communicative, paranoid, suicidal ideation.

Behaviors: Slurred speech, incoherent can't concentrate, mood changes quickly and frequently. Lengthy and unexplained absences, returning tired and dirty. Changes jobs frequently and unable to maintain employment.

Family: Domestic violence, isolated from family life and activities. Doesn't pay essential bills.

Criminal Activity: Pawning/selling personal or home possessions. Petty theft, trespassing, prowling, solicitation, DUI, and possession.

Self-Care Issues: insomnia or increased sleep, has not eaten for days, not taking prescribed medications, home is in disarray, neglects household, property, or personal hygiene-to the point of putting self/others at risk.

Suicidal Risks: has weapons or access to weapons, speaks about previous attempts, makes direct comments about dying or

hurting self, evidence of previous attempts such as scars on the wrists.

Elderly Issues: wandering at night, leaving things on stove unattended, not eating or sleeping or caring for personal needs, unrealistic fears, uncontrollable anxiety, confusion, quantity and age of unused foods in the home.

There are two important key points to remember:

Your role is not to diagnose. However, if you have reason to believe that someone appears to be substance abuse impaired, you can decide whether or not that person may be putting himself/herself or others in danger, and they meet the criteria for protective custody.

You do not need to witness all of the behaviors personally. The Marchman Act doesn't require that you see the behaviors personally, but you must have good faith reason to believe the criteria are met. You can consider credible eyewitness accounts from others as you determine the need for protective custody.

Frequently Asked Questions

1. How does the Marchman Act define a "law enforcement officer?"

A law enforcement officer means a law enforcement officer as defined in s. 943.10(1), F.S. Therefore, as Chapter 943 is revised in future legislative sessions, the Marchman Act will not have to be revised further. [s. 397.311(18), F.S.]

2. Do I have to be acting in my official capacity or "on duty" to initiate Protective Custody or to transport a person for an examination?

The statute doesn't distinguish between official and off-duty actions Department legal counsel should be consulted where

the officer is considered to be "on duty" 24 hours per day, 7 days per week.

3. I'm a law enforcement officer, not a substance abuse or mental health professional. How am I supposed to diagnose such problems?

Law enforcement officers, in the course of their duties, probably have more day-to-day interaction with persons who have serious substance abuse and mental illness than many behavioral health professionals. However, officers are not expected to diagnose substance abuse impairment. Substance abuse impairment is defined in the Marchman Act to mean:

a condition involving the use of alcoholic beverages or any psychoactive or mood-altering substance in such a manner as to induce mental, emotional, or physical problems and cause socially dysfunctional behavior. [s. 397.305(16), F.S.]

Criteria for Initiating Protective Custody
s. 397.677, F.S.

4. What are the criteria for initiating Protective Custody under the Marchman Act?

A person meets the criteria for involuntary admission if there is good faith reason to believe the person is substance abuse impaired and, because of such impairment:

(1) Has lost the power of self-control with respect to substance use; **and either**

(2)(a) Has inflicted, or threatened or attempted to inflict, or unless admitted is likely to inflict, physical harm on himself or herself or another; **or**

(b) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that the person is incapable of appreciating his or her need for such services and of making a rational decision in regard thereto; however, mere refusal to receive such services does not constitute

evidence of lack of judgment with respect to his or her need for such services.

5. Do I have to see the behavior myself to justify taking a person into custody under the Marchman Act?

No. Taking a person into custody under the Marchman Act is a civil procedure, not requiring the same probable cause required under criminal law. You may initiate Protective Custody by having "good faith reason to believe" "a person appears to meet the criteria." A law enforcement officer may consider the statements of other credible persons who have seen the behavior.

Transportation to a Facility

6. Are law enforcement officers required to transport people held under the Marchman Act?

No. The Marchman Act permits law enforcement officers to transport persons for substance abuse assessment, but doesn't require it if there is a more appropriate method of transportation, considering the person's condition. In some cases EMS transport may be required, while in others, there may be family members willing and able to provide such transport. In addition, law enforcement is specifically trained in the transportation of persons who are either violent, resisting transportation, or are otherwise unwilling to comply with directions. Others without that training may either injure or be injured by the person.

7. Can I take a person who meets the criteria for involuntary examination to jail instead of a Marchman Act facility if they have committed a misdemeanor?

Yes.

8. Can I use handcuffs and other restraints when transporting persons with mental illness to a Marchman Act receiving facility?

The Marchman Act states that persons held under the Marchman Act must have their right to individual dignity protected at all times and upon all occasions, included when the client is transported. It is not specific as to the use of restraining devices used with criminal suspects, however where the dangerous circumstances are clearly documented, such restraints may be used in accord with the law enforcement agency's written policies.

9. How can I find out which Marchman Act facilities are in my jurisdiction and their addresses?

The District Office of the Department of Children and Family Services can provide you with a list of the names and addresses of all Marchman Act receiving facilities in your locale.

10. Do I have to take the person to the nearest Marchman Act receiving facility or can I take them to another facility where the person, caregiver, or mental health professional has asked me to take them?

The Marchman Act requires you to take all persons to the nearest receiving facility, unless the person is suffering from an emergency medical condition, in which case they should be taken to the nearest emergency room. The person can be later transferred to another facility if requested by the patient or their guardian.

11. Do I have to return to a hospital to transfer the person to another facility?

No. Once the person is taken to the hospital, the state's Marchman Act and the federal COBRA law require the hospital to arrange for appropriate transfer, when necessary.

12. Can the Marchman Act facility refuse to accept the person I bring to them?

At the Facility

Yes. Unlike the Baker Act that requires facilities to accept persons brought by law enforcement officers, the Marchman Act requires facilities to refuse acceptance of persons if it would cause the facility to go over licensed census, to accept responsibility for a person beyond the safe management of the program, or if the person is unable to pay the cost of a private program. However, if the facility is a licensed hospital and the officer believes the person has an emergency medical condition as a result of the substance abuse issues, a hospital must accept the person under the federal EMTALA law and perform a medical screening and stabilization prior to releasing the person or transferring him or her to another appropriate facility.

13. Do I have to wait at a hospital for the person to be medically screened, treated, or have their insurance verified?

No. The officer's only duties are to present the person. However, if the person is acting in a dangerous manner, beyond the ability of the hospital staff to manage, the officer should stay to assist for a very temporary period until hospital clinical or security staff can arrive.

14. Why do the hospitals or crisis stabilization units release people with serious substance abuse problems so soon?

A substance abuse facility is only permitted to hold a person against their will for assessment and stabilization for a maximum period of 72 hours. However, as soon as a determination is made that the conditions for a petition for court ordered assessment or treatment are not met, the person must be released, unless the person is transferred to voluntary status.

See Flow Chart for Protective Custody

PROTECTIVE CUSTODY NON-COURT PROCEDURE

ELIGIBILITY PROFILE

- Substance abuser who is impaired in a public place or is brought to the attention of a law enforcement officer. Must meet criteria for involuntary admission found in section 397.675, F.S.

PURPOSE

- Remove the person from their immediate environment and transport the person to an environment that is conducive to their protection and the protection of others.

MEANS

- Person is transported by a law-enforcement officer (law enforcement officers report constitutes the authority to hold the person.

WHERE

- With the person's consent: to their home or, if they have no home, to a hospital, or to a licensed detox or addictions receiving facility.
- Without the person's consent: to a hospital, or to a licensed detox or addictions receiving facility.
- Without the person's consent: to a municipal or county jail, or other appropriate detention facility, only if the person is an adult.

SERVICES PROVIDED

- Assessment by physician (unless the person is taken to their home.

LENGTH OF STAY

- No more than 72 hours from the time of admission.

EXTENSIONS

- None

DISPOSITION ALTERNATIVES

- Release by a qualified professional when the client no longer meets the criteria for involuntary admission; or
- Release by a qualified professional once the 72-hour period has elapsed; or
- With the client's consent, allow the client to remain voluntarily at the licensed service provider; or
- Retain the client when a petition for involuntary assessment or treatment has been initiated with the court and until the petition is heard.

SPECIAL CONDITIONS

- For persons involuntarily admitted to a licensed service provider for the purpose of protective custody, release may be made without further court order only by a qualified professional.
- In the case of minors, release of a minor from protective custody must always be to the client's parent, legal guardian, or legal custodian or the authorized designee thereof.
- For persons admitted to a municipal or county jail or other detention facility for protective custody, the officer in charge must notify a licensed service provider within 8 hours of the person's detention and, if appropriate and a bed is available, arrange for transportation to the provider.

Crisis Intervention Team Training Miami-Dade County



SECTION NINE



Eleventh Judicial Circuit Criminal Mental Health Project

Law Enforcement and the Baker Act

Initiation: s. 394.463, F.S. and s. 65E-5.280, F.A.C.

Transportation: s. 394.462, F.S. and 65E-5.260, F.A.C.

Introduction

Law enforcement officers often serve as the front line for many social and health problems of our communities. Although mental illness is a health problem, it is often a personal and a public safety issue as well. The Legislature in Florida has granted law enforcement certain authority and responsibilities under the Baker Act.

- The authority to initiate an involuntary examination of persons when they meet certain criteria and are unable or unwilling to consent to the examination themselves.
- The responsibility, with few exceptions, to transport persons to the nearest receiving facility for involuntary examination.

The Baker Act is Florida's Mental Health Act and cannot be used interchangeably with other statutes. Other related but different statutes include:

- Marchman Act, Chapter 397, F.S., which governs all issues related to intoxication or substance abuse impairment.
- Chapter 393, F.S., which governs all issues related to intellectual disability, autism, and other developmental disabilities.
- Chapter 401, F.S., which is the emergency medical services law containing provisions for the Emergency Examination & Treatment of Incapacitated Persons who cannot provide consent to Emergency Medical Services (EMS) personnel.
- Florida's hospital licensing statute, Chapter 395.1041, F.S., which governs Access to Emergency Services and Care in hospital emergency departments.
- The federal Emergency Medical Treatment and Active Labor Law, or EMTALA, that requires all licensed hospitals to accept persons for medical screening and stabilization, and makes those hospitals responsible for arranging safe and appropriate secondary transfers to other facilities.
- Chapter 415, F.S., the Adult Protective Services law that protects vulnerable adults (persons age of 60 or older and disabled adults) from abuse, neglect and exploitation.

Voluntary Admission

Adults can only be admitted to a facility on a voluntary basis if they have a mental illness as defined in the Baker Act, are willing to be admitted without any coercion, are competent to provide express and informed consent, and are suitable for treatment. A minor must meet the same criteria, including willingness to be admitted, but the application for admission must be made by his or her parent or legal guardian following a judicial hearing.

Law enforcement officers have no legal duty to transport any person for voluntary admission to a psychiatric facility.

Involuntary Examination

A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she has a mental illness and because of his or her mental illness:

1. The person has *either* refused a voluntary examination *or* is unable to determine for himself or herself whether an examination is necessary; *and*
2. Either:
 - » The person is likely to suffer from *neglect* which poses a real and present threat of substantial harm to his or her well-being that can't be avoided through the help of willing family members or friends or the provision of other services; *or*
 - » There is substantial likelihood that without care or treatment the person will cause *serious bodily harm* to himself or herself or others in the near future, as evidenced by recent behavior.

Behaviors to Look For

Individuals with mental illness who may need further evaluation typically exhibit some combination of the following behaviors, or characteristics:

Behaviors: rapid speech, flight of thought, no eye contact, quick movements, disconnected speech patterns, constant movement, can't concentrate, swift and frequent mood changes, disorganized thoughts, disoriented to time and place, acts of violence, cutting self, combative/aggressive behavior, inappropriate dress or nudity.

Hallucinations: sees people who aren't there, hears voices telling them to hurt themselves or others, reports that the television is suggesting harm to others, turning the head as if listening to an unseen person.

Self-Care Issues: insomnia or increased sleep, has not eaten for days, not taking prescribed medications, home is in disarray, neglects household, property, or personal hygiene to the point of putting self/others at risk.

Feelings: low self-esteem with feelings of hopelessness or helplessness, flat affect, or not reacting with much feeling or interest.

Suicidal Risks: has weapons or access to weapons, speaks about previous attempts, makes direct comments about dying or hurting self, evidence of previous attempts such as scars on the wrists.

Elderly Issues: wandering at night, leaving things on stove unattended, not eating or sleeping or caring for personal needs, unrealistic fears, uncontrollable anxiety, confusion, quantity and age of unused foods in the home.

Substance Abuse: abuse of prescribed medications, use of alcohol or illegal substances while taking medications. (If substance abuse appears to be the only issue, the Marchman Act may be more appropriate.)

Initiation of Involuntary Examination

An involuntary examination under the Baker Act can be initiated by a circuit court judge, an authorized mental health professional or by a Florida certified law enforcement officer. The criteria is the same, regardless of which of the three methods is used to initiate.

A "law enforcement officer" is specifically defined in the Baker Act as a law enforcement officer as defined in s. 943.10, F.S. Therefore, as Chapter 943 is revised in future legislative sessions, the Baker Act will not have to be revised further. [s.394.455, F.S.] This definition includes a wide array of state certified law enforcement officers, but doesn't include probation officers who are licensed under chapter 943, but not as law enforcement officers.

943.10(1) "Law enforcement officer" means any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. This definition includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and

management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency.

The Florida Attorney General has determined that "Federal law enforcement officers do not constitute law enforcement officers for purposes of Florida's Baker Act, and thus possess no authority under the act to initiate the involuntary examination of a person or to transport such person as law enforcement officers."

There are three important key points to remember for officers:

1. **Your role is not to diagnose.** However, if you have reason to believe that someone has a mental illness, you *can* decide whether or not that person may be putting himself/herself or others in active danger or self neglect, and therefore meet the criteria for a complete evaluation.
2. **You do not need to witness all of the behaviors personally.** You can consider credible eyewitness accounts from others as you determine the need for further assessment.
3. **Law enforcement officers must complete two state forms when initiating a Baker Act.** The two forms are Report of Law Enforcement Officer Initiating Involuntary Examination (CF-MH 3052a), and Transportation to a Receiving Facility-Part 1 (CF-MH 3100). Generally, officers also must complete their own department's Offense/Incident report.

While a circuit court judge or mental health professional may initiate an involuntary examination if they believe the criteria are met, the Baker Act requires a law enforcement officer to take a person who appears to meet the criteria for involuntary examination into custody.

The statute is silent as to whether the officer must personally see the person's behavior; but there is no expectation that the officer should be able to clinically diagnose mental illness or predict dangerousness. Evidence of likelihood of harm to self or others is defined solely by the person's "recent behavior." The law requires that the law enforcement officer's report detail the "circumstances" under which the person was taken into custody, not personal observations. As the Baker Act is a civil law, not a criminal one, "probable cause" is not required.

Since the officer is rarely on site when the event prompting the Baker Act call occurs, his or her judgment may often be based upon the statements by the person or the credibility of the witnesses to the event. For example, one can usually presume a relative contacting law enforcement about a

family member has their loved one's best interest in mind, unless the officer believes that the call to law enforcement may be a retaliatory act. It is not the officer's job to conduct an examination, only to initiate the examination when the criteria appears to be met by taking the person to a designated receiving facility where an expert must perform the involuntary examination.

The Baker Act states that "any person who acts in good faith in compliance with the provisions of this part is immune from civil or criminal liability for his or her actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section does not relieve any person from liability if such person commits negligence." Law enforcement officers should consult with their department's legal counsel in determining whether there is greater liability in:

- Acting to protect a person even though a skilled clinician may ultimately determine that the person does not meet the more stringent statutory criteria for involuntary placement, or
- Failing to act when credible witnesses allege passive or active danger and the person ultimately suffers harm or commits an act of violence.

Most attorneys would gauge the seriousness of the consequences of the above decisions and suggest that the examination be initiated by law enforcement, leaving it to mental health experts to confirm whether the criteria have been met. While common sense should always prevail, each law enforcement department needs to develop explicit policies and procedures to reflect the actions which should be taken in such circumstances.

Initiation of Involuntary Examination by Others

If the involuntary examination has been initiated by the circuit court, a court order will be given to the law enforcement officer to deliver with the person to the nearest receiving facility where it will be made a part of the person's clinical record.

A law enforcement officer acting in accordance with an ex parte order may serve and execute such order on any day of the week, at any time of the day or night, and may use such reasonable physical force as is necessary to gain entry to the premises and any dwellings, buildings, or other structures located on the premises and to take custody of the person who is the subject of the ex parte order.

The court order for involuntary examination, along with the petition(s) seeking the order, will be delivered by the

law enforcement officer to the facility to be placed in the person's clinical record along with the "Transportation to a Receiving Facility" form (CF-MH 3100) completed by the law enforcement officer. [ss. 394.463(2)(a), (c) and (d), F.S.]

If the involuntary examination has been initiated by a *physician, clinical psychologist, psychiatric nurse, clinical social worker, licensed mental health counselor or licensed marriage and family therapist*, a certificate must be completed by the professional stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the professional's observations upon which that conclusion is based.

The professional, if not already located at a receiving facility or hospital emergency room, will call the law enforcement agency designated by the Board of County Commissioners to execute such certificates to transport the person to the nearest receiving facility for examination. The mental health professional's certificate (CF-MH 3052b) and the "Transportation to a Receiving Facility" form (CF-MH 3100) completed by the law enforcement officer will be made a part of the person's clinical record.

Transportation of Persons for Involuntary Examination

The Baker Act requires law enforcement officers to transport any person for whom an involuntary examination has been initiated to the nearest receiving facility. Law enforcement officers have the responsibility to transport persons under involuntary examination status, instead of health or social service personnel, because the involuntary criteria requires that the person be refusing examination or be unable to determine that the examination is necessary. For anyone other than those authorized by statute to take a person against his or her will or without informed consent could be a criminal offense such as battery, false imprisonment, kidnapping, etc. In addition, law enforcement is specifically trained in the transportation of persons who are either violent, resisting transportation, or are otherwise unwilling to comply with directions. Others without that training are much more likely to either injure or be injured by the person.

Two appellate cases and a Florida Attorney General Opinion apply to law enforcement duty to transport:

- *Administrator, Retreat Hospital v. Honorable W. Clayton Johnson of the Seventeenth Judicial Circuit In and For Broward County, FL, Alan Schreiber, Broward County Public Defender, and Fredrick A. Goldstein, Special Assistant Public Defender, Respondents*, 660 So. 2d 333 (Fla. 4th DCA 1995). Individuals were

G

transported by private entities to a receiving facility for involuntary placement under the Baker Act. The Circuit Court Judge found that this did not comport with the requirements of section, 394.463(2), F.S. which requires that only law enforcement officer may transport persons on involuntary status to a receiving facility. The Fourth District Court of Appeals affirmed that only a law enforcement officer may transport a Baker Act patient to a receiving facility.

- G**
- 33 Donald Pruessman v. Dr. John T. MacDonald Foundation, 589 So. 2d 948 (Fla. 3d DCA 1991). The 3rd DCA held that where a patient was discharged from a hospital and the patient refused to leave, and the hospital administrator contacted an outside doctor to evaluate the patient regarding Baker Acting the patient, the hospital was not legally responsible for any action taken by the outside doctor involved in Baker Acting the patient. The 3rd DCA also held that the actions of the city police officers who were called to the hospital to take the patient into custody, remove the patient from the hospital, and transport the patient to a Baker Act receiving facility based on a doctor's certification were not discretionary under the Baker Act and the city was not liable for the actions of the city police officers in transporting the patient to a receiving facility.
 - AGO 2001-73 Regarding the responsibility for Transportation of Mentally Ill Person to Treatment Facility. If a person is the subject of an ex parte order or certificate requiring involuntary examination and treatment under Florida's Baker Act, the single law enforcement agency designated by the county for this purpose is responsible for transporting that person to the nearest receiving facility. If a person is taken into custody by a law enforcement officer for minor criminal behavior or non-criminal behavior that meets the statutory guidelines for involuntary examination under the Act, the law enforcement officer taking the person into custody is responsible for transporting the person to the nearest treatment facility. If a law enforcement officer arrests a person for commission of a felony and believes that the person meets the guidelines for involuntary examination or placement, the person shall be processed through the criminal justice system like any other criminal suspect and is entitled to examination and treatment in the facility where he or she is held.

While a law enforcement officer is responsible for transporting all persons for involuntary examination, there is no responsibility for an officer to transport persons for voluntary examinations since persons on voluntary status are by definition both willing and able to provide consent

to the examination. However, there is nothing to prohibit such transportation if an officer and their law enforcement department (including legal counsel) concur.

Memorandum of Understanding (MOU) Required (394.462 (1),(K) F.S.) Each law enforcement agency is required by law to develop a MOU with each receiving facility within its jurisdiction reflecting a single set of protocols for the safe and secure transport, crisis intervention, and transfer of custody of a responsible individual at the facility. DCF has made available a template for the MOU to incorporate the requirements, but modifications to the format are allowed.

There are circumstances under which a law enforcement officer can delegate the responsibility to someone else to perform the transport. The Baker Act states that the designated *law enforcement agency may decline to transport the person to a receiving facility only if:*

1. The jurisdiction designated by the county has contracted with an emergency medical transport service or private transport company for transportation of persons to Baker Act receiving facilities at the sole cost of the county; and the law enforcement agency and the transport service agree that the *continued presence of law enforcement* personnel is not necessary for the safety of the person or others.
2. When a law enforcement officer takes custody of a person under the Baker Act, the officer can request assistance from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody (person may be too frail, heavy, non-ambulatory, or medically involved to be placed in a cruiser). Further, if the officer believes that a person has an emergency medical condition, the person can be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility. Once taken to a hospital for examination or treatment of an emergency medical condition, transportation of the patient to a Baker Act receiving facility is the responsibility of the sending hospital.
3. When a mental health overlay program or a mobile crisis response service evaluates a person and determines that transportation to a receiving facility is needed, it *may* transport the person to the facility *or* may call on the law enforcement agency or make other transportation arrangements best suited to the needs of the patient.
4. When a transportation exception plan has been approved by the Board of County Commissioners and the Secretary of the Department of Children and Family Services [s. 394.462(3), F.S.] permitting use of a "more humane method of transport.

Transportation for Medical Emergencies

Law enforcement officers are statutorily required to take persons to the nearest receiving facility for involuntary examinations. It is not appropriate to have law enforcement take individuals to a non-receiving facility for “medical clearance” first unless the officer believes the individual was in an emergency medical condition. An emergency medical condition is defined in Chapter 395, F.S. as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Once a person is delivered by law enforcement to a hospital for emergency medical examination or treatment and the person is placed in the hospital’s care, the officer’s responsibility to the person is over, assuming there are no criminal charges pending.

Eventual safe and appropriate transfer of the person from the hospital offering emergency medical treatment to the designated receiving facility for an involuntary examination under the Baker Act is the responsibility of the referring hospital, unless other appropriate arrangements have been made.

Designation of Transportation Responsibility

The law enforcement agency responsible for transporting people for involuntary examinations under the Baker Act is determined by each county’s Board of County Commissioners. The 1984 Florida Legislature required that each county designate a single law enforcement agency within the county, or portions thereof, to take persons into custody upon entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the nearest receiving facility for examination. This might result in the Sheriff’s Office being responsible for certain transportation and municipal police responsible for others. A copy of the formal action taken by the Board of County Commissioners should be available through the County Attorney’s office.

Nearest Receiving Facility

Law enforcement officers have to take persons to the nearest Baker Act receiving facility, regardless of whether the facility is public or private and regardless of whether a person has the ability to pay for care. Further, it cannot be to a different facility where the person, their caregiver, or mental health professional has asked they be taken. The only alternative

to this is when a Transportation Exception Plan has been approved by the Board of County Commissioners and the DCF Secretary that provides persons be taken to a central receiving facility or to facility that has specialized care for certain persons such as minors or elders. If a person is at a hospital or other receiving facility that can’t meet his/her medical or psychiatric needs or if the person’s age or financial status requires transfer, the federal EMTALA law and state Baker Act transfer provisions place responsibility on the sending hospital, not on law enforcement personnel.

The Baker Act requires that the person be taken to the nearest receiving facility, making no reference to remaining in an officer’s jurisdiction. However, if a transportation exception plan is approved by a Board of County Commissioners and the Secretary of the Department of Children and Families for a given county, the plan may result in jurisdictional boundaries.

Criminal Charges

The Baker Act requires a law enforcement officer who has custody of a person based on either non-criminal or minor criminal behavior that meets the statutory guidelines for involuntary examination to transport the person to the nearest receiving facility for examination, instead of to jail. [s. 394.462(1)(f), F.S.]

However, the transportation provisions of the Baker Act state that if the person meets the criteria for involuntary examination and has been arrested for a felony, the person must first be processed in the same manner as any other criminal suspect. [s. 394.462(1)(g) F.S.] Law enforcement officials must then contact the nearest *public* receiving facility which is then responsible for promptly arranging for the examination and treatment of the person. If the receiving facility can document that it cannot provide adequate security of a person with felony charges, it is required to provide the mental health examination and treatment to the person where he or she is held. The costs of transportation, evaluation, hospitalization, and treatment incurred by persons who have been arrested for violations of any state, county, or municipal law/ordinance can be recovered by the receiving facility as provided in s.901.35, F.S.

Use of Restraining Devices

The Baker Act states that the individual dignity of the person must be respected at all times, including any occasion when the person is taken into custody, held or transported. Procedures, facilities, vehicles, and restraining devices utilized for criminals or those accused of crime

may not be used in connection with persons who have a mental illness, *except* for the protection of the person or others. When the officer documents in his or her report that circumstances require such protection, restraints may be used in accordance with the law enforcement agency's written policies [s. 394.459(1), F.S.].

Procedures

1. **Facilities Must Accept.** The Baker Act states that the nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination. If the receiving facility believes the person should be "medically cleared," the facility must arrange appropriate medical transport for this purpose. It would be inappropriate for a law enforcement officer to place a person at medical risk back into the cruiser. If the receiving facility is at capacity or otherwise cannot meet the person's needs due to age or financial need, it should accept the person and arrange an appropriate transfer to another receiving facility.
2. **Weapons.** The Baker Act prohibits firearms or deadly weapons from being brought onto the grounds of a hospital providing mental health services, including by law enforcement officers, unless specifically authorized by law or by the hospital administrator. Law enforcement officers may choose to lock their firearms in their vehicle prior to entering a facility or may place the weapons in a lock-box at the facility, if one exists. [s. 394.458(1), F.S.]
3. **Hospital Security.** A law enforcement officer does not have to wait at a hospital or other receiving facility for the person to be medically screened, treated, or to have their insurance verified. The officer's only duties are to present the person and the required completed paperwork and make a responsible handoff to the appropriate staff member. However, if the person is acting in a dangerous manner, beyond the ability of the facility staff to manage, the officer should stay to assist for a temporary period until hospital clinical or security staff can arrive. If the person has criminal charges, the officer's Department Policy should be followed.
4. **Transfers.** A law enforcement officer does not have to return to a hospital to transfer the person to another facility following medical clearance. Once the person is taken to the hospital, the state's Baker Act and the federal EMTALA law require the hospital to arrange for appropriate transfer, when necessary.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) preempts any state law with which it is in conflict. EMTALA requires that a hospital accept

any person who presents or is brought to the emergency room for the purpose of performing a medical screening. If the ED staff determine the person has an emergency medical condition (including psychiatric and substance abuse emergencies), the hospital is then responsible for the person until the emergency has been stabilized, including the person's discharge or transfer from the hospital to another facility that has the capability and capacity to manage the person's condition. This includes, among other responsibilities, the duty to arrange a safe and appropriate method of transportation to the destination facility.

5. **Paperwork.** A law enforcement officer has to present certain completed forms to the Baker Act receiving facility staff. The Baker Act form entitled "Transportation to a Receiving Facility" (CF-MH 3100) must be presented each time a law enforcement officer takes a person to a receiving facility for involuntary examination, regardless of whether the examination is initiated by a judge, a mental health professional, or by the officer. In addition, the Baker Act form entitled "Report of Law Enforcement Officer Initiating Involuntary Examination" (CF-MH 3052a) must be completed when the officer, as opposed to the judge or mental health professional, initiates the examination. These forms, as well as all other Baker Act forms can be obtained from the circuit office of the Department of Children and Families or can be downloaded from the DCF website. [Chapter 65E-5.280, F.A.C.]

The Mental Health Professional's Certificate form should go with the law enforcement officer to deliver with the person to the receiving facility. Many receiving facilities want the original, although they are required to accept the person from law enforcement regardless of whether the form is an original or a copy. The initiating professional should retain a copy of the initiation form in the person's record.

Law enforcement officers are required to complete the front side of the transportation form (CF-MH 3100). In addition, they should complete and sign the back of the form when delegating the transportation to medical transport. Then the transport form as well as the initiation form (BA 52a, BA 52b, or ex parte order) must be sent with the person to the receiving facility.

The Baker Act is very clear. The nearest receiving facility must accept any person brought by law enforcement officers for involuntary examination. [s.394.462(1)(j), F.S.]

Escape or Elopement of Persons from a Baker Act Receiving Facility

It is the responsibility of each Baker Act receiving facility and hospital emergency departments to retain persons safely and not allow them to elope or to depart against medical advice if they meet criteria for involuntary examination.

If a person being examined or treated at a receiving facility or ER elopes from the facility, the following procedures are recommended:

1. If an adult is on voluntary status and does not meet the criteria for involuntary placement, law enforcement should not be notified by the facility.
2. If the person is on voluntary status and does appear to meet the criteria for involuntary placement, a certificate of a professional should be initiated by an authorized person at the facility and the appropriate law enforcement agency should be requested to take the person named in the certificate into custody for delivery to the nearest receiving facility. A transfer of the person, if appropriate, will then be arranged between facilities.
3. If the person elopes while on involuntary examination status within 72 hours of arrival at the facility, but prior to the Petition for Involuntary Placement being filed with the court, the appropriate law enforcement agency will be provided a copy of the original CF-MH 3052a or 3052b and requested to take the person into custody for delivery to the nearest receiving facility. A transfer of the person, if appropriate, will then be arranged from facility to facility.
4. If the person is on involuntary examination status and a Petition for Involuntary Placement has already been filed with the court, the appropriate law enforcement agency will be provided a copy of the petition form (CF-MH 3032) and requested to return the person to the facility from which the petition was filed.
5. If a person under a court's Order for Involuntary Placement (CF-MH 3008) at a treatment facility leaves the facility without authorization, the administrator may authorize a search for the person and the return of the person to the facility. While the statute is silent with regard to receiving facilities, it is presumed that the court order itself would provide the required authority. The administrator of the facility may request the assistance of a law enforcement agency in the search for and return of the person and may provide a copy of the order to law enforcement.
6. If a person elopes from a hospital emergency department, he/she should be returned to the hospital for appropriate transfer as required by the federal EMTALA law.

Confidentiality of Clinical Records

Many state and federal laws govern the confidentiality of medical information and some even require mandatory reporting. For example:

- Law enforcement officers, in addition to many other identified persons, have a duty to report suspected abuse, neglect, or exploitation of children or vulnerable adults.
- The Vienna Convention and bilateral agreements the United States has with other countries require law enforcement to notify the consulate whenever a Foreign National (even those with dual citizenship) is detained in any manner, including under the Baker and Marchman Act. The officer is not required to inform the consulate of the reason for the detention, considering the privacy rights of the person.
- HIPAA doesn't apply to law enforcement officers, except the medical records of inmates in the jail.
- Laws governing confidentiality of information on people with communicable disease and substance abuse are different than those applying to other medical or mental health diagnoses.

Any person, agency, or entity receiving information pursuant to the Baker Act has to maintain such information as confidential and exempt from the provisions of Florida's public records law [s. 119.07(1), F.S.].

Therefore, any documents initiating an involuntary examination, reports resulting from transportation of the person to a receiving facility, responses to a person's elopement from a facility, or other information which could provide for the identification of the person, may not be released by law enforcement.

However, the Florida Attorney General has issued opinions that state the officers' incident reports are public records and can be released to the public, even if the reports have the same information as is contained in the official forms.

The Baker Act permits release of confidential information when a person has declared an intention to harm other persons. When such a declaration has been made, the facility administrator can authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the person. The law does not allow the release of confidential information to law enforcement about confessions the person may have made about past crimes he or she may have committed. In fact, the 9th US Circuit Court of Appeals has ruled that while therapists are sometimes required to report incidents to authorities that could lead to violence, the court ruled that prosecutors can't use testimony from therapists to help convict their patients.

G

Crisis Intervention Teams

The use of CIT – Crisis Intervention Teams based on the Memphis Police Department model – has been a great innovation in reducing officer use of force and injuries to officers and to persons with mental illnesses.

Many Florida communities have implemented CIT to address issues of officer safety, consumer safety, and jail diversion. Over 6% of adults in the general population have a serious mental illness. Many people with serious mental illnesses have limited access to treatment or do not remain in treatment. As a result, these people are at increased risk for crises. Law enforcement officers are often the first responders in crisis situations after calls from families or citizen call for help.

Many other jurisdictions around the country have modeled their programs after the “Memphis Model.” While little State or Federal funds have been provided to most communities, program costs are minimal and deployment of non-law

enforcement personnel is not required. Six benefits identified in CIT studies showed:

- Few injuries to law enforcement officers
- Reduction in arrest rates and use of force incidents
- Few repeat commitments to inpatient care
- Reduction in patient violence
- Less officer time involved per call
- Reduction in jail days for offenders with mental illnesses

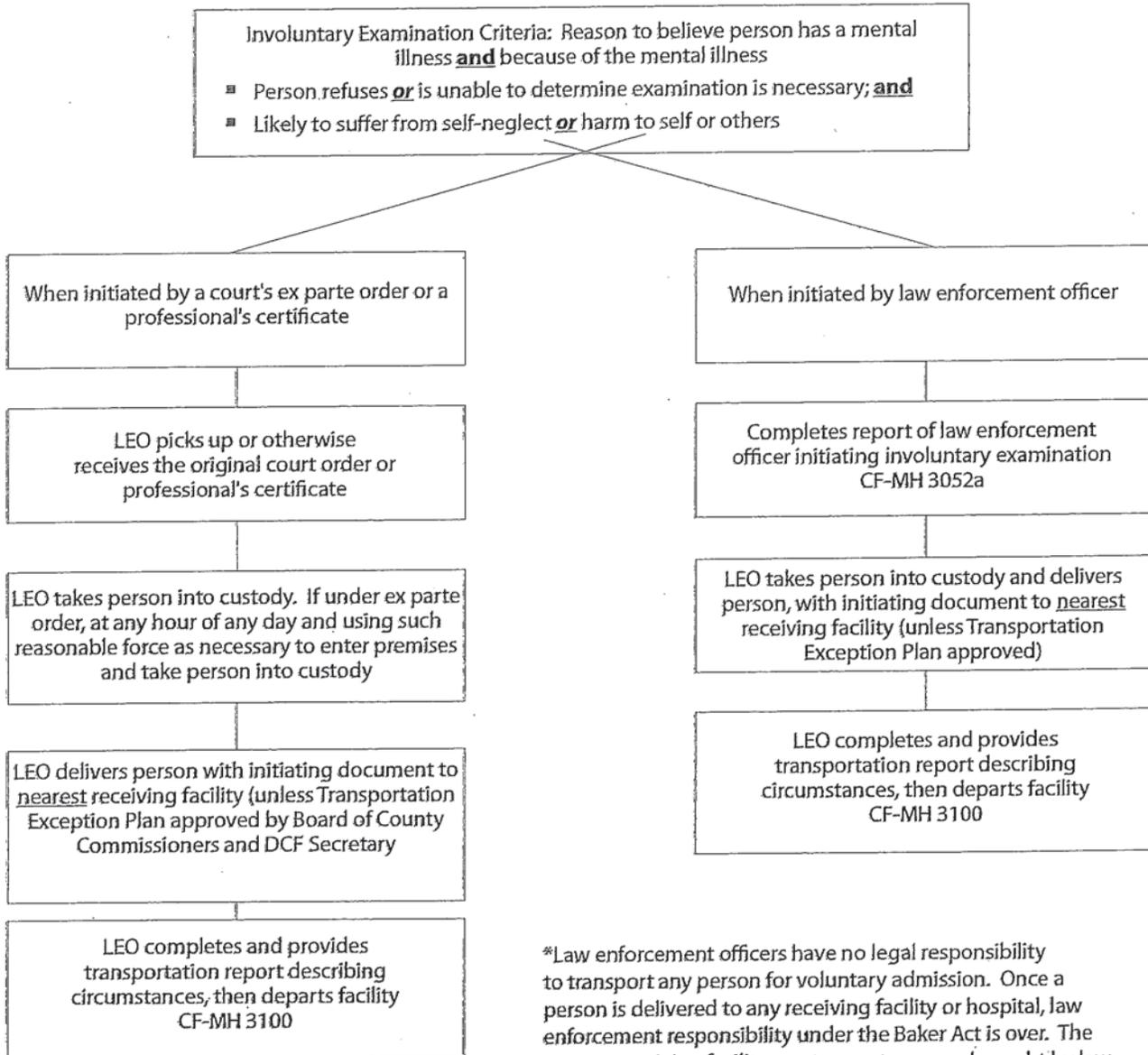
Conclusion

The role of law enforcement in dealing with persons having serious mental illnesses is a difficult one. The Department of Children and Families maintains extensive materials on its website regarding the Baker Act and the Marchman Act that can assist law enforcement personnel.

A specialized on-line Baker Act course for law enforcement officers can be found at
<http://www.bakeracttraining.org>.

For further assistance visit: <http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/index.shtml> to view DCF's most Frequently Asked Questions list.

Law Enforcement Officer (LEO)*



G

*Law enforcement officers have no legal responsibility to transport any person for voluntary admission. Once a person is delivered to any receiving facility or hospital, law enforcement responsibility under the Baker Act is over. The nearest receiving facility must accept persons brought by law enforcement for involuntary examination subject to the Baker Act. Hospitals, subject to federal EMTALA, must accept persons brought with emergency medical conditions (including psychiatric and substance abuse).

The Baker Act — A Quick Reference Guide for Law Enforcement Officers

SHOULD I OR SHOULDN'T I?

The **BAKER ACT** empowers law enforcement officers to initiate an involuntary evaluation of persons based on the following facts:

- They have a mental illness, and
- They are either a danger to themselves or to others, or
- Without treatment they are likely to suffer from neglect, which is potentially harmful.

Sometimes it's hard to know whether or not you should "Baker Act" someone. You want to be a responsible officer and do the right thing to protect individuals and those nearby, but you're not sure whether or not to take a person to jail or to initiate The Baker Act and take the person to a receiving facility.

There are three important key points for you to remember:

1. Your role is not to diagnose. However, if you have reason to believe that someone appears to have a mental illness, you can decide whether or not that person may be putting himself/herself or others in danger and meets the criteria for a complete evaluation.
2. You do not need to witness all of the behaviors personally. You can consider credible eyewitness accounts from others as you determine the need for further assessment.
3. Officers must complete two forms when initiating the Baker Act: Report of Law Enforcement Officer Initiating Involuntary Examination (CF-MH 3052a), and the Transportation to Receiving Facility (CF-MH 3100).

TRANSPORTATION

You must take persons to the *nearest* receiving facility unless they have a medical emergency or a Transportation Exception Plan has been approved by the Board of Commissioners and the DCF Secretary. It is very helpful if you call ahead to alert the facility that you are on the way. The following receiving facilities are available:

BEHAVIORS TO LOOK FOR

Individuals with mental illnesses who may need further evaluation typically exhibit a combination of the following behaviors, characteristics or indicators of their illness:

BEHAVIORS: rapid speech, flight of thought, no eye contact, quick movements, disconnected speech patterns, constantly moves or paces, can't concentrate, mood changes quickly and frequently from the highs to the lows, disorganized thoughts, disoriented to time or place, acts of violence, cutting self, combative / aggressive behavior, inappropriate dress or nudity.

HALLUCINATIONS: sees people who aren't there, hears voices telling them to hurt themselves or others, reports that the television is suggesting harm to others, turning the head as if listening to an unseen person.

SELF-CARE ISSUES: insomnia or increased sleep, has not eaten for days, not taking prescribed medications, home is in disarray, neglects household, property or personal hygiene—to the point of putting self/others at risk.

FEELINGS: low self esteem with feelings of hopelessness or helplessness, flat affect—not reacting with much feeling or interest.

SUICIDAL RISKS: has weapons or access to weapons, speaks about previous attempts, makes direct comments about dying or hurting self, evidence of previous attempts such as scars on the wrists.

ELDERLY ISSUES: wandering at night, leaving things on stove unattended, not eating or sleeping or caring for personal needs, unrealistic fears, uncontrollable anxiety, confusion, quantity and age of unused foods in home.

SUBSTANCE ABUSE: abuse of prescribed medications, use of alcohol or illegal substances while taking medications. (If substance abuse appears to be the only issue, the Marchman Act may be more appropriate.)

NOTE: If you have any doubts, don't forget to contact your CIT (Crisis Intervention Team) officers or one of the receiving facilities.

Family Interaction with Law Enforcement

Calling 911

Having to call 911 is an extremely stressful situation. It is by definition an emergency. Not only do you have concern for the person about whom you are making the call, but also you want to make sure that you give law enforcement enough information so that they will be able to respond effectively and safely.

Try to control the volume of your voice. When you shout over the phone it is difficult for the 911 Operator to understand what you are saying. Certainly this is a very emotionally charged time, but if the Operator can only hear shouting, the information is not efficiently received. As calmly and clearly as possible, answer the Operator's questions, follow directions you are given, and tell the Operator the following:

1. Your name and address
2. Name of person with mental illness
3. Your relationship to the person
4. That the person has a mental illness
5. Person's diagnosis
6. Any medication being used
7. Has medication stopped? How long?
8. Describe what the person is doing now.
9. Do you feel threatened?
10. Is there a history of violent acting out?
11. Does the person hear voices?
12. Does the person have fears?
13. Location of person in house?
14. Are there weapons available? (Try to remove them)
15. Request a Crisis Intervention Trained (CIT) officer, if available

When Law Enforcement Arrives

Have all the lights in the house turned on, so that all occupants can be clearly visible to the arriving officers. Have nothing in your hands if you come out of the house to meet the officers. Do not run up to the officers. They have no idea who you are and anything you may carry can possibly be interpreted as a weapon. It is essential that the officers responding to your emergency call establish a comfort zone - knowing who the person is and that you, who possibly may be also agitated, are not a threat. As calmly as possible, identify yourself. Tell the officers:

1. Who you are
2. Who you have called about
3. Your relationship to the person with a mental illness
4. That the person has a mental illness
5. What kind of mental illness it is
6. What medication is being taken
7. Has medication stopped? How long?
8. Is the person violent or delusional (paranoid)?
9. History of suicide attempts?
10. The attending psychiatrist's or case manager's names, if any, and their phone #s

Officers responding to a 911 emergency call are very focused when they arrive on the scene. First, they will make the scene safe for you, the patient, and themselves. The more informed and at ease the officers are, the less likelihood that someone will get injured or that the situation will worsen. Spend all the time that is necessary answering all of the officers' questions. Answer directly and concisely. Offer any advice you deem helpful. Do not ramble. Officers tend to tune out persons who try to tell their entire life's story. After this is done, they will usually be able to deal with you and to answer any questions. Although it is difficult in times of crisis, being patient is essential.

** This information was provided courtesy of NAMI California.*

G

Crisis Intervention Team Training Miami-Dade County



SECTION TEN



Eleventh Judicial Circuit Criminal Mental Health Project

Plan for Exception to Transportation Requirements for Baker Act Involuntary Examinations

Department of Children and Families
Circuit 11 (Miami-Dade County)

Background

The Florida Mental Health Act, usually referred to as "The Baker Act," requires that a person who appears to have a mental illness and who has either refused voluntary examination or is unable to determine for himself whether examination is necessary, and who is likely to suffer from neglect or refuse to care for himself which may then pose a real and present threat of substantial harm to his well-being, and that without care or treatment will cause serious bodily harm to himself or others in the near future be taken by law enforcement to the nearest receiving facility when involuntary psychiatric examinations are initiated by a circuit court judge, a law enforcement officer, or an authorized mental health professional.

The law requires that each county designate a single law enforcement agency within the county, or portions thereof, to take persons into custody upon the entry of a judge's ex parte order or the execution of a certificate for involuntary examination by an authorized professional. The State has vested only in law enforcement the legal authority to take persons into custody and to transport them to receiving facilities for involuntary examination under the Baker Act. The law requires law enforcement officers to take these persons to facilities specially designated by the Department of Children and Families (DCF) where they can be held for up to seventy-two (72) hours for examination and treatment. Section 394.462(1)(a) of the Florida Statutes requires transport to the nearest receiving facility. This requirement serves to reduce the amount of driving time used by law enforcement officers and also reduces abuse of the Baker Act by eliminating arrangements in which selected psychiatric facilities, located at a distance from the sending facilities, actively recruit patients for financial gain.

Crisis stabilization units (CSU) have been established in a number of community mental health centers to provide examinations and short-term treatment to persons with acute mental illness who lack insurance or ability to pay for their own care. These "public" receiving facilities are funded by DCF to care for indigent persons while "private" receiving facilities are not entitled to receive such State funding.

However, always taking persons to the nearest facility who may then require subsequent transfer to another facility is an unnecessary waste of resources and poor clinical practice for the patient and deprives some individuals of a specialized facility which could best meet their needs. For example, some persons with mental illness may have co-existing medical problems which require a general hospital rather than a free-standing psychiatric facility to ensure the availability of needed medical treatment. Others, such as juveniles, would be better served if transported directly to a facility licensed to treat minors since the law requires that minors be separate from adults in psychiatric facilities.

The 1996 Florida Legislature provided in section 394.462(3), F. S., that, if deemed necessary, a community could prepare a Plan and request an exception to the Statute's requirements. To address some of the issues identified in this section, an exception to the Baker Act's requirements for transporting persons to the nearest receiving facility for involuntary examination is hereby requested.

Recommendations

An exception is being requested under section 394.462(3)(b)1, F. S., which allows for an arrangement to improve service coordination or better meet the special needs of individuals within a circuit. Circuit 11's proposed Transportation Exception Plan calls for persons with specialty needs, for whom an involuntary examination has been initiated, to be taken to the nearest receiving facility that provides specialty services, regardless of payer source. The specific specialty needs are:

- (1) Persons, adults or minors, who are medically involved with acute or chronic medical conditions shall be taken to the nearest emergency room in an emergent situation or to the nearest general hospital with a psychiatric unit in non-emergent situations. The designated receiving facilities capable of providing substantial medical services for persons undergoing involuntary psychiatric examination as of the date of this Plan are found in Appendix A. The list of such receiving facilities is subject to change from time to time as new facilities are designated and others are closed or have their designations removed.
- (2) Persons age sixty (60) or older may be taken to the nearest designated receiving facilities offering specialized care to older adults. Facilities currently providing specialty geriatric care for older adults undergoing involuntary psychiatric examinations as of the date of this Plan are found in Appendix A. The list of such receiving facilities is subject to change from time to time as new facilities are designated and others are closed or have their designations removed.
- (3) Children (0-12 years old) and adolescents (13-17 years old) may be taken to the nearest receiving facility, whether designated as a public or private facility, that is licensed to serve children and adolescents. Facilities currently providing specialized care for children and adolescents undergoing involuntary psychiatric examinations as of the date of this Plan are found in Appendix A. The list of such receiving facilities is subject to change from time to time as new facilities are designated and others are closed or have their designations removed.
- (4) Persons in the custody of the Miami-Dade County Department of Corrections and Rehabilitation which have been assessed as having psychiatric issues that warrant an involuntary examination, and who are eligible for "diversion" into the community will be transferred to the receiving facility closest to his/her residence or where the person was arrested, contingent on bed availability. Absent bed availability, the person may be diverted to the most appropriate receiving facility, based on the person's individual needs.
- (5) Persons who are deaf and hard of hearing may be taken to Jackson Memorial Hospital's (JMH) receiving facility. This will expedite their placement in JMH's Deaf

and Hard of Hearing Program. Persons who are taken to other receiving facilities will have their transfers to JMH expedited. The JMH program offers easier and quicker access to an interpreter and/or peer specialist (if needed) while in the inpatient unit and linkage upon discharge to the program for outpatient services. The program provides outpatient services to children, adolescents, adults and their families.

NOTE: The medical needs of Baker Act patients as detailed in paragraph 1 above will take precedence in all transportation situations. Consequently, transportation to the nearest receiving facility that provides specialty services will only be accomplished when there are no medical issues requiring transportation to an emergency room or general hospital.

Improved Services / Simplicity

The proposed Plan will increase the likelihood that persons for whom a Baker Act involuntary examination has been initiated will be taken to the nearest appropriate receiving facility. This Plan will promote better clinical interventions while reducing the likelihood of unethical marketing strategies and referral arrangements.

Centralized Accountability

The DCF Circuit 11 Quality Improvement Supervisor will ensure plan compliance for the continued oversight and monitoring of the approved proposal as required by rule 65E-5.2601 (2)(c). Each critical entity will identify a contact person to assist DCF in resolving any inquiries, complaints, or request for assistance as it involves disputes arising regarding implementation of the Plan.

Impact on Law Enforcement and Transportation Authorities

A proposed Transportation Exception Plan is required to describe how it will be implemented by participating law enforcement agencies and transportation authorities. This Plan allows minors or older adults to be transported to receiving facilities that have specialized services and/or licensed beds for persons in these age groups, rather than to the nearest receiving facilities, unless the person has significant medical conditions. The Plan also permits persons who are deaf or hearing impaired or those in jail facilities who meet certain criteria to be taken to facilities more able to meet their needs. No delays or confusion as a result to the implementation of the Plan are expected given that the requested transportation exceptions are not mandatory for law enforcement, but are to occur when possible.

In accordance with State law, a receiving facility shall accept any person brought by law enforcement for involuntary examination. When the person is taken to a facility which is subsequently found to be inappropriate due to patient choice, lack of needed services, or payer status, the patient may be transferred in accordance with the provisions of the federal Emergency Medical Treatment and Active Labor Act (EMTALA) law and the Baker Act through non-law enforcement means. The cost of this transfer is to be paid by the sending facility unless agreement is reached between the two facilities for a

different payer source. In no case shall a law enforcement officer be required to further transport a person after bringing the person to a hospital or receiving facility.

Process/Agreement By Involved Parties

The Transportation Exception Plan was developed with the involvement and support of a wide array of community providers and stakeholders, law enforcement, public and private receiving facilities, crisis stabilization units, advocates, and DCF staff. A copy of all e-mails, meeting invitations, invitees, and attendance lists are available upon request. Appendix A of this Plan provides a list of the agencies that will be involved in implementation of the exception Plan.

As required pursuant to section 394.462(3), F.S., the proposed Plan will be submitted to the Miami-Dade Board of County Commissioners for approval. Upon BCC approval, the DCF Circuit Administrator will forward the Plan for approval to the Director of Mental Health, DCF Program Office.

DCF Circuit staff will provide written notification to all stakeholders community-wide once the Transportation Exception Plan is approved. Circuit staff will also coordinate and provide trainings regarding the Transportation Exception Plan as necessary.

Appendix A
Designated Receiving Facilities
(as of June 2015)

The following is a complete list of facilities in Miami-Dade County currently designated by the Florida Department of Children and Families to receive and hold persons with mental illness for involuntary examination and short-term treatment. The list is subject to change as new facilities are designated and others are closed or have their designations removed.

Public Receiving Facilities

Banyan Health Systems
3850 West Flagler Street
Miami, FL 33134

Jackson Behavioral Health Hospital
1695 NW 9 Avenue
Miami, FL 33136

Citrus Health Network
Adult & Children CSUs
4175 West 20 Avenue
Hialeah, FL 33012

Jackson Community Mental Health Center
15055 NW 27 Avenue
Opa Locka, FL 33054

Community Health of South Florida (CHI)
10300 SW 216 Street
Cutler Bay, FL 33190

Private Receiving Facilities

Aventura Hospital and Medical Center
20900 Biscayne Blvd.
Miami, FL 33180

Mount Sinai Medical Center
4300 Alton Road
Miami Beach, FL 33140

Jackson South Community Hospital
9333 SW 152 Street
Miami, FL 33157

Mount Sinai Aventura Emergency Room
2845 Aventura Boulevard
Aventura, FL 33180

Kendall Regional Medical Center
11750 SW 40 Street
Miami, FL 33175

Nicklaus Children's Hospital
3100 SW 62 Avenue
Miami, FL 33155

Larkin Community Hospital
7031 SW 62 Avenue
South Miami, FL 33143

North Shore Medical Center
1100 NW 95h Street
Miami, FL 33150

Mercy Hospital
3663 South Miami Avenue
Miami, FL 33133

Palmetto General Hospital
2001 West 68 Street
Hialeah, FL 33016

Southern Winds Hospital
4225 West 20 Avenue
Hialeah, FL 33012

Veteran's Administration-VA Medical Center
1201 NW 16 Street
Miami, FL 33125

University of Miami Hospital
1400 NW 12 Avenue
Miami, FL 33136

Westchester General Hospital
2500 SW 75 Avenue
Miami, FL 33155

The following is a complete list of currently designated receiving facilities in Miami-Dade County with the capability of providing significant **medical** examination and treatment of persons for whom an involuntary examination has been initiated.

- a. Aventura Hospital and Medical Center
- b. Jackson Behavioral Health Hospital
- c. Kendall Regional Medical Center
- d. Larkin Community Hospital
- e. Mercy Hospital
- f. Miami VA Medical Center
- g. Mount Sinai Medical Center
- h. Nicklaus Children's Hospital
- i. North Shore Medical Center
- j. Palmetto General Hospital
- k. University of Miami Hospital
- l. Westchester General Hospital

Designated receiving facilities that provide specialty geriatric care for **older adults** undergoing involuntary psychiatric examinations as of the date of this Plan are listed below.

- a. Kendall Regional Medical Center
- b. Larkin Community Hospital
- c. Mercy Hospital
- d. Mount Sinai Medical Center
- e. Palmetto General Hospital
- f. University of Miami Hospital

Designated receiving facilities that provide specialty psychiatric care for **children and adolescents** undergoing involuntary psychiatric examinations as of the date of this Plan are listed below.

- a. Citrus Health Network
- b. Jackson Behavioral Health Hospital
- c. Nicklaus Children's Hospital
- d. Southern Winds Hospital (Adolescents, 13-17 only)

The only designated receiving facility that provides specialty psychiatric care for persons of all ages who are deaf or hard of hearing is Jackson Behavioral Health Hospital.

**The list of receiving facilities is subject to change as new facilities are designated and others are closed or have their designations removed.*

Crisis Intervention Team Training Miami-Dade County



SECTION ELEVEN



Eleventh Judicial Circuit Criminal Mental Health Project

PRE-TRIAL DETENTION CENTER TOUR

Time: 7:45 am

Location: 1350 NW 13th Street (South side of bldg. between Jail and Courthouse directly under the catwalk)

Please be advised that the following items are prohibited in the jail, failure to comply will result in attending following scheduled jail tour at a later date.

- Weapons
- Cell phones
- Sunglasses
- Writing instruments
- Chewing gum
- Exposed cleavage
- Open toe shoes
- Handbags
- Hoodies
- Police clothing or anything that identifies you as police

JMH PSYCHIATRIC FACILITY TOUR

1695 NW 9th Avenue

All units, unmarked and civilian vehicles may park in the front of the mental health building in the circular driveway. PLEASE DO NOT BLOCK ENTRIES TO BUILDING.

**FIREARMS ARE PROHIBITED ON THE GROUNDS OF THE
MENTAL HEALTH FACILITY
(s.394.458(1), F.S.)**

HOW MUCH STRESS CAN YOU TAKE?



Habel W. Kaba MS MFT

WHAT IS STRESS?



Habel W. Kaba MS MFT

Stress is...
A Mental, Emotional, or
Physical Strain.



Habel W. Kaba MS MFT

HOW MUCH STRESS CAN YOU TAKE?



Habel W. Kaba MS MFT

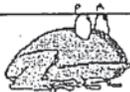
WHAT IS STRESS?



Habel W. Kaba MS MFT

Stress is...

A Mental, Emotional, or Physical Strain. 🐸



Habel W. Kaba MS MFT

Mental and Emotional Stress Symptoms

- Depression
- Anxiety
- Increase or unusual aggressiveness
- Feelings of panic
- Frequent crying
- Excessive worrying
- Decreased concentration
- Confused thinking
- Nightmares

Habel W. Kaba MS MFT

Mental and Emotional Stress Symptoms

- Moodiness
- Anger
- Impatience
- Feelings of helplessness
- Irritability
- Low frustration tolerance
- Trouble learning new information
- Inability to make decisions
- Self-defeating thoughts
- Loss of memory

Habel W. Kaba MS MFT

Mental and Emotional Stress Symptoms

- Sexual inadequacy
- Social withdrawal
- Fear of losing control
- Emotional numbness
- Decreased sense of humor
- Restlessness
- Feeling overwhelmed
- Thoughts of suicide
- Excessive worrying

Habel W. Kaba MS MFT

Physical Stress Symptoms

- Muscle tension
- Dry mouth or throat
- Chronic fatigue
- Sexual inadequacy
- Difficulty swallowing
- Neck pain
- Chest pains
- Weight gain or loss
- Frequent indigestion
- loss of appetite

Habib W. Kaba MS MFT

Physical Stress Symptoms

- Stomach aches
- Insomnia
- Excessive menstruation
- Nausea and/or vomiting
- Backaches
- Swollen joints
- Halting or stuttering speech
- Increased appetite
- Excessive sleeping



Habib W. Kaba MS MFT

Physical Stress Symptoms

- Headaches
- Nervous ticks
- Ulcers on tongue
- Constipation
- Dizziness
- Heartburn
- Racing or pounding heart
- Diarrhea
- Shakiness/tremors
- High blood pressure



Habib W. Kaba MS MFT

Behavioral Stress Symptoms

- Increased drug or alcohol use
- Inattention to dress or grooming
- Fast or mumbled speech
- Constant tiredness
- Increased number of mistakes
- Foot or finger tapping
- Increased smoking
- Chronic tardiness

Habel W, Koba MS MFT

Behavioral Stress Symptoms

- Overreaction to small things
- Nail biting
- Chronic procrastination
- Overall dissatisfaction
- Demanding
- Impatient
- Constant complaining

Habel W, Koba MS MFT

THE STRESS TEST

- Where is your STRESS level?

Habel W, Koba MS MFT

Take Notice of the Early Warning Signs and take Appropriate Action

- Like the dashboard warning lights in your car, your body and mind will also alert you when you're getting to close to the "red zone".

Hubel W. Kaba MS MFT

Early Symptoms

- Be aware of your earliest symptoms of stress (tightness in neck, shoulders, irritability, headache, anxious feeling in stomach,, etc.) and make it a point to:

SLOW DOWN
RELAX
DE STRESS

Hubel W. Kaba MS MFT

Ignoring Your Stress Symptoms

- If you repeatedly ignore your stress symptoms you may find yourself "blowing a gasket" or experiencing a total "breakdown" and/or maybe developing...



Hubel W. Kaba MS MFT

Generalized Anxiety Disorder

Can co exist with other disorders

■ SYMPTOMS:

- UNREALISTIC WORRY
- PHYSICAL TENSION
- AUTOMATIC AROUSAL AND HYPERACTIVITY
- APPREHENSIVE EXPECTATION, VIGILANCE AND SCANNING OF ENVIRONMENT

Habel W, Kaba MS MFT

PANIC DISORDER

■ A sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom.

■ Symptoms:

- Palpitation
- Tachycardia
- Fainting and dizziness
- Sweating, flushes, chills
- Chest pains

Habel W, Kaba MS MFT

PHOBIAS

■ Irrational Fears such as:

- Claustrophobia
- Social phobia
- Agoraphobia

Habel W, Kaba MS MFT

POSTTRAUMATIC STRESS DISORDER

❖ RESPONSES TO THE EXPERIENCE OF A TRAUMA OR
CATSTROPHIC EVENT

❖ SYMPTOMS:

- NIGHTMARES
- FLASHBACKS (RE-EXPERIENCING THE TRAUMA)
- EXTREME ANXIETY
- FEELINGS OF DETACHMENT
- OUTBURST OF ANGER
- HYPER-VIGILANCE

Habel W. Kabo MS MFT

COPING MECHANISMS

- Family Support
- Peer Support
- Social Support
- Exercise
- Hobbies/sports
- Be good to yourself/seek out the small pleasures
- Don't sweat the small stuff
- It's all small stuff

Habel W. Kabo MS MFT

COMMUNICATION

**TALK TO
SOMEONE!**

LET IT OUT!!

Habel W. Kabo MS MFT

RESOURCES

- Miami-Dade Police Psychological Services
- CISM Critical Incident Stress Management Foundation

CISM Contact Coordinator: Natalie Duran

305.975.5862

786.336.6675

- Children's Trust Helpline (24/7) 211
- Switchboard of Miami (24/7) 305.358.HELP

Habel W. Kaba MS MFT

**IF YOU DON'T
CONSUME
IT
IT WILL CONSUME
YOU!!**

Habel W. Kaba MS MFT

References

- Stress Busters, Katherine Butler N.C.C.; John Wiley & Sons, Inc.; 2004
- Mental Health Association; 2006
- Critical Incident Stress Management Miami, FL
- Eleventh Judicial Circuit Criminal Mental Health Project, CIT Training Program; 2009

Habel W. Kaba MS MFT

MORE THAN JUST TRAINING

"Eleventh Judicial Circuit Criminal Mental Health Project"



© 2008 by the Eleventh Judicial Circuit

Habsi W. Kaba MFT

■ **305.548.5639**

■ **Richard Gerstein Building
#226**

■ **Hkaba@jud11.flcourts.org**

Habsi W. Kaba MS MFT

ATTACHMENT #2



**CRISIS INTERVENTION TEAM
SCHOOL OF TRAINING**

SECTION ONE





**Criminal Mental Health Project
Jail Diversion Program
Miami-Dade County**

CRISIS INTERVENTION TEAM SCHOOL OF TRAINING

**16-Hour Training Manual for
Communications Personnel**



**Richard E. Gerstein Justice Building
1351 NW 12th Street Room #226
Miami, Florida 33125**

Miami-Dade County CIT Coordinator: Habsi W. Kaba MS MFT

MIAMI-DADE COUNTY MAYOR'S MENTAL HEALTH TASK FORCE

"Developing a model continuum of care for persons with mental illnesses"

Background: On January 11, 2005 the Miami-Dade County Grand Jury released a report detailing the crisis of people with untreated mental illnesses who become involved in the criminal justice system which concluded that these individuals are faced with a woefully inadequate system of community based care. Specific areas of need were outlined, as well as recommendations for improvements. The report cautioned that failure to adopt changes would likely result in continued financial and human costs with which Miami-Dade County is ill-prepared to contend.

Facts about Mental Illness in Miami-Dade County Revealed by the Grand Jury Report:

- An estimated **9.1%** of the general population (**210,000 individuals**) in Miami-Dade County experience mental illnesses. This represents largest percentage of people living with mental illnesses of any urban community in the United States.
- Because of a lack of access to care, **law enforcement, correctional facilities, and the courts** have increasingly become the **lone responders** to persons in crisis due to untreated mental illnesses.
- Law enforcement officers in Florida respond to more mental health calls than burglaries, assaults, or DUI cases.
- The City of Miami Police Department, alone, responds to **3,600 mental health calls annually**.
- On any given day, **the Miami-Dade County Jail houses between 800 and 1200 individuals with mental illnesses** (roughly **20%** of the total inmate population), and now exists as **the largest psychiatric facility in the State of Florida**.
- **One-third** of the inmate floors at the Pre-Trial Detention Center are now used to house people identified as requiring psychiatric treatment.
- People with mental illnesses remain in jail **8 times longer**, and at a cost **7 times greater** than persons without mental illnesses arrested for the exact same charge.
- Approximately **250** individuals from Miami-Dade County are committed to state forensic facilities every year, at an annual cost of **\$112,000 per person or \$28 million annually**.
- Without adequate access to treatment, many individuals cycle through this system for the majority of their adult lives.

Community Reaction:

In response to the Grand Jury's report, *Mayor Carlos Alvarez* has assembled the **Mayor's Mental Health Task Force**, co-chaired by *Judge Steve Leifman* of the 11th Judicial Circuit, *Ms. Silvia Quintana* from the Florida Department of Children and Families, and *Mr. Jack Lowell* of the Codina Group. This body, consisting of experts from the criminal justice, mental health, and social services communities, is charged with finding ways to implement the Grand Jury's recommendations.



ELEVENTH JUDICIAL CRIMINAL MENTAL HEALTH PROJECT Program Summary

The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was established in 2000 to divert individuals with serious mental illnesses (SMI; e.g., schizophrenia, bipolar disorder, major depression) or co-occurring serious mental illnesses and substance use disorders away from the criminal justice system and into comprehensive community-based treatment and support services. The CMHP provides an effective, cost-efficient solution to a community problem and works by eliminating gaps in services, and by forging productive and innovative relationships among all stakeholders who have an interest in the welfare and safety of one of our community's most vulnerable populations.

Short-term benefits include reduced numbers of defendants with SMI in the county jail, as well as more efficient and effective access to housing, treatment, and wraparound services for the individuals re-entering the community. This decreases the likelihood that individuals will re-offend and reappear in the criminal justice system, and increases the likelihood of successful mental health recovery. The long term benefits include: reduced demand for costly acute care services in jails, prisons, forensic mental health treatment facilities, emergency rooms, and other crisis settings; decreased crime and improved public safety; improved public health; decreased injuries to law enforcement officers and people with mental illnesses; and decreased rates of chronic homelessness. Most importantly, the CMHP is helping to close the revolving door which results in the devastation of families and the community, the breakdown of the criminal justice system, and wasteful government spending.

Impact to the Community

Everyday, in every community in the United States, law enforcement agencies, courts, and correctional institutions are witness to a parade of misery brought on by untreated or under-treated mental illnesses. Last year, roughly 2.2 million admissions to local jails in the United States involved people with SMI. Roughly, three-quarters of these individuals also experience co-occurring substance use disorders which increase their likelihood of becoming involved in the justice system. On any given day, there are 750,000 people with mental illnesses incarcerated in jails and prisons across the United States and 1.25 million people with mental illnesses are on probation in the community.

Although these national statistics are alarming, the problem is even more acute in Miami-Dade County which is home to the largest percentage of people with SMI of any urban community in the United States. Roughly 9.1% of the population in Miami-Dade County (175,000 adults) experiences SMI, yet only 1% of the population (24,000 adults) receives treatment in the public mental health system. As a result, police officers have increasingly become the first, and often only, responders to

people in crisis due to untreated mental illnesses. Too often, these encounters result in the arrest and incarceration of individuals for criminal offenses that are directly related to individuals' psychiatric symptoms or life-health contexts (e.g., homelessness, addiction, poverty).

The Miami-Dade County jail currently serves as the largest psychiatric institution in Florida and contains nearly half as many beds serving inmates with mental illnesses as all state civil and forensic mental health hospitals combined. Of the roughly 114,000 bookings into the jail last year, nearly 20,000 involved people with mental illnesses requiring intensive psychiatric treatment while incarcerated. On any given day, the jail houses approximately 1,400 individuals receiving psychotherapeutic medications, and costs taxpayers roughly \$65 million annually, more than \$178,000 per day. Additional costs to the county, the state, and taxpayers result from crime and associated threats to public safety; civil actions brought against the county and state resulting from injuries or deaths involving people with mental illnesses; injuries to law enforcement and correctional officers; ballooning court case loads involving defendants with mental illnesses; and uncompensated emergency room and medical care.

On average, people with mental illnesses remain incarcerated eight times longer than people without mental illnesses arrested for the exact same charge, at a cost seven times higher. With little treatment available, many individuals cycle through the system for the majority of their adult lives.

Need for Adequate Community-Based Treatment Services

In 2008, the National Leadership Forum on Behavioral Health/Criminal Justice Services (NLF) was established by the Substance Abuse and Mental Health Services Administration (SAMHSA) to address common barriers to successful diversion from the criminal justice system and community re-entry among individuals with SMI. Forum members consisted of national experts in the fields of public health, public safety, criminal justice, consumer advocacy, and behavioral healthcare service delivery. In September of 2009, the NLF issued a report, *Ending an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-Occurring Disorders*,¹ which details the crisis that currently exists, identifies barriers to more effective service delivery, and makes recommendations for immediate action necessary to reverse the tragic and costly trends associated with the inappropriate and unnecessary criminalization of people with mental illnesses.

Among the most pervasive findings from the NLF report is that communities lack accessible, high quality services targeting the unique needs of individuals with the most severe forms of mental illnesses who are involved in or at risk of becoming involved in the justice system. Services that do exist tend to be "inadequately funded, antiquated, and fragmented." (p.2) Inefficiencies in service delivery are compounded by poor coordination and redundancies across the criminal justice and mental health systems.

The NLF identifies and recommends an array of core services that comprise what is referred to as an *Essential System of Care*. These evidence-based practices, designed around the needs and experiences of individuals involved in the criminal justice system, include:

- Forensic intensive case management

¹ NLF report is available at: <http://gainscenter.samhsa.gov/pdfs/nlf/AmericanTragedy.pdf>

- Supportive housing
- Peer support
- Accessible and appropriate medication management
- Integrated dual diagnosis treatment for co-occurring substance use disorders
- Supported employment
- Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT)
- Cognitive Behavioral Treatment (CBT) targeted to risk factors

In addition to these core elements there are

- Proper diagnosis and treatment planning
- Treatment for histories of physical, sexual, and emotional trauma
- Dynamic and ongoing assessment of individual risks and needs
- Primary medical care examination and treatment
- Provision of meaningful day activities
- Provision of transportation assistance
- Assistance with access to entitlement benefits and other means of economic self-sufficiency

Eleventh Judicial Circuit Criminal Mental Health Project

The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was established nearly 15 years ago to divert nonviolent misdemeanor defendants with SMI, or co-occurring SMI and substance use disorders, from the criminal justice system into community-based treatment and support services. Since that time the program has expanded to serve defendants that have been arrested for less serious felonies and other charges as determined appropriate. The program operates two components: pre-booking diversion consisting of Crisis Intervention Team (CIT) training for law enforcement officers and post-booking diversion serving individuals booked into the jail and awaiting adjudication. All participants are provided with individualized transition planning including linkages to community-based treatment and support services.

The CMHP's success and effectiveness depends on the commitment of stakeholders throughout the community. Such cross-system collaboration is essential for the transition from the criminal justice system to the community mental health system. Program operations rely on collaboration among community stakeholders including: the State Attorney's Office, the Public Defender's Office, the Miami-Dade County Department of Corrections and Rehabilitation, the Florida Department of Children and Families, the Social Security Administration, public and private community mental health providers, Jackson Memorial Hospital-Public Health Trust, law enforcement agencies, family members, and mental health consumers.

Pre-Booking Jail Diversion Program

The CMHP has embraced and promoted the Crisis Intervention Team (CIT) training model developed in Memphis, Tennessee in the late 1980's. Known as the *Memphis Model*, the purpose of CIT training is to set a standard of excellence for law enforcement officers with respect to treatment of individuals with mental illnesses. CIT officers perform regular duty assignment as patrol officers, but are also trained to respond to calls involving mental health crisis. Officers receive 40 hours of specialized training in psychiatric diagnoses, suicide intervention, substance abuse issues, behavioral de-escalation techniques, the role of the family in the care of a person with mental illness, mental health and substance abuse laws, and local resources for those in crisis.

The training is designed to educate and prepare officers to recognize the signs and symptoms of mental illnesses, and to respond more effectively and appropriately to individuals in crisis. Because police officers are often first responders to mental health emergencies, it is essential that they know how mental illnesses can impact the behaviors and perceptions of individuals. CIT officers are skilled at de-escalating crises involving people with mental illnesses, while bringing an element of understanding and compassion to these difficult situations. When appropriate, individuals in crisis are assisted in accessing treatment facilities in lieu of being arrested and taken to jail.

The pre-booking diversion program has demonstrated excellent results. To date, the CMHP has provided CIT training, free of charge, to roughly 4,400 law enforcement officers from all 36 local municipalities in Miami-Dade County, as well as Miami-Dade Public Schools and the Department of Corrections and Rehabilitation. Countywide, CIT officers respond to 16,000 mental health crisis calls per year. Last year alone, CIT officers from the Miami-Dade Police Department and City of Miami Police Department responded to more than 10,000 calls, resulting in over 1,200 diversions to crisis units and just 9 arrests. Over the past four years, these two agencies have responded to nearly 38,000 mental health crisis calls resulting in almost 9,000 diversions to crisis units and just 85 arrests.

As a result of CIT, the average daily census in the county jail system has dropped from 7,800 to 4,800 inmates, and the county has closed one entire jail facility at a cost-savings to taxpayers of \$12 million per year. There has also been a dramatic reduction in fatal shootings and injuries of people with mental illnesses by police officers. From 1999 through 2005 there were nineteen persons with mental illness that died as the result of altercations with law enforcement officers in Miami-Dade County. Since 2005, this figure has dropped significantly.

Post-Booking Jail Diversion Program

The CMHP was originally established in 2000 to divert nonviolent misdemeanor defendants with SMI and possible co-occurring substance use disorders, from the criminal justice system into community-based treatment and support services. In 2008, the program was expanded to serve defendants that have been arrested for less serious felonies and other charges as determined appropriate. Post-booking jail diversion programs operated by the CMHP serve approximately 500 individuals with serious mental illnesses annually. Over the past decade, these programs have facilitated roughly 4,000 diversions of defendants with mental illnesses from the county jail into community-based treatment and support services.

Misdemeanor Jail Diversion Program: All defendants booked into the jail are screened for signs and symptoms of mental illnesses by correctional officers. Individuals charged with misdemeanors who meet program admission criteria are transferred from the jail to a community-based crisis stabilization unit within 24 to 48 hours of booking. Upon stabilization, legal charges may be dismissed or modified in accordance with treatment engagement. Individuals who agree to services are assisted with linkages to a comprehensive array of community-based treatment, support, and housing services that are essential for successful community re-entry and recovery outcomes. Program participants are monitored by CMHP for up to one year following community re-entry to ensure ongoing linkage to necessary supports and services. The vast majority of participants (75-80%) in the misdemeanor diversion program are homeless at the time of arrest and tend to be among the most severely psychiatrically impaired individuals served by the CMHP. The misdemeanor diversion program receives approximately 300 referrals annually. Recidivism rates among program participants has decreased from roughly 75 percent to 20 percent annually.

Felony Jail Diversion Program: Participants in the felony jail diversion program are referred to the CMHP through a number of sources including the Public Defender's Office, the State Attorney's Office, private attorneys, judges, corrections health services, and family members. All participants must meet diagnostic and legal criteria² as well as eligibility to apply for entitlement benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid. At the time a person is accepted into the felony jail diversion program, the state attorney's office informs the court of the plea the defendant will be offered contingent upon successful program completion. Similar to the misdemeanor program, legal charges may be dismissed or modified based on treatment engagement. All program participants are assisted in accessing community based services and supports, and their progress is monitored and reported back to the court by CMHP staff. Individuals participating in the felony jail diversion program demonstrate reductions in jail bookings and jail days of more than 75 percent, with those who successfully complete the program demonstrating a recidivism rate of just 6 percent. Since 2008, the felony jail program alone is estimated to have saved the county over 15,000 jail days, more than 35 years.

Forensic Hospital Diversion Program

Since August 2009, the CMHP has overseen the implementation of a state funded pilot project to demonstrate the feasibility of establishing a program to divert individuals with mental illnesses committed to the Florida Department of Children and Families from placement in state forensic hospitals to placement in community-based treatment and forensic services. Participants include individuals charged with 2nd and 3rd degree felonies who do not have significant histories of violent felony offenses and are not likely to face incarceration if convicted of their alleged offenses. Participants are adjudicated incompetent to proceed to trial or not guilty by reason of insanity. The community-based treatment provider operating services for the pilot project is responsible for providing a full array of residential treatment and community re-entry services including crisis stabilization, competency restoration, development of community living skills, assistance with

² Legal criteria specify a current most serious charge of a third degree felony, with not more than three prior felony convictions.

community re-entry, and community monitoring to ensure ongoing treatment following discharge. The treatment provider also assists individuals in accessing entitlement benefits and other means of economic self-sufficiency to ensure ongoing and timely access to services and supports after re-entering the community. Unlike individuals admitted to state hospitals, individuals served by MD-FAC are not returned to jail upon restoration of competency, thereby decreasing burdens on the jail and eliminating the possibility that a person may decompensate while in jail and require readmission to a state hospital. To date, the pilot project has demonstrated more cost effective delivery of forensic mental health services, reduced burdens on the county jail in terms of housing and transporting defendants with forensic mental health needs, and more effective community re-entry and monitoring of individuals who, historically, have been at high risk for recidivism to the justice system and other acute care settings. Individuals admitted to the MD-FAC program are identified as ready for discharge from forensic commitment an average of 52 days (35%) sooner than individuals who complete competency restoration services in forensic treatment facilities, and spend an average of 31 fewer days (18%) under forensic commitment. The average cost to provide services in the MD-FAC program is roughly 32% less expensive than services provided in state forensic treatment facilities.

Access to Entitlement Benefits

Stakeholders in the criminal justice and behavioral health communities consistently identify lack of access to public entitlement benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid as among the most significant and persistent barriers to successful community re-integration and recovery for individuals who experience serious mental illnesses and co-occurring substance use disorders. The majority of individuals served by the CMHP are not receiving any entitlement benefits at the time of program entry. As a result, many do not have the necessary resources to access adequate housing, treatment, or support services in the community.

In order to address this barrier and maximize limited resources, the CMHP developed an innovative plan to improve the ability to transition individuals from the criminal justice system to the community. Toward this goal, all participants in the program who are eligible to apply for Social Security benefits are provided with assistance utilizing a best practice model referred to as *SOAR (SSI/SSDI, Outreach, Access and Recovery)*. This is an approach that was developed as a federal technical assistance initiative to expedite access to social security entitlement benefits for individuals with mental illnesses who are homeless. Access to entitlement benefits is an essential element in successful recovery and community reintegration for many justice system involved individuals with serious mental illnesses. The immediate gains of obtaining SSI and/or SSDI for these people are clear: it provides a steady income and health care coverage which enables individuals to access basic needs including housing, food, medical care, and psychiatric treatment. This significantly reduces recidivism to the criminal justice system, prevents homelessness, and is an essential element in the process of recovery.

The CMHP has developed a strong collaborative relationship with the Social Security Administration in order to expedite and ensure approvals for entitlement benefits in the shortest time frame possible. All CMHP participants are screened for eligibility for federal entitlement benefits, with staff initiating applications as early as possible utilizing the SOAR model. Program data demonstrates that 90% of the individuals are approved on the initial application. By contrast,

the national average across all disability groups for approval on initial application is 37%. In addition, the average time to approval for CMHP participants is 30 days. This is a remarkable achievement compared to the ordinary approval process which typically takes between 9-12 months.

In November 2010, Miami-Dade County was awarded a 3-year, \$750,000 grant from the State of Florida to implement a collaborative project between the CMHP and the Miami-Dade Corrections and Rehabilitation Department to expand services to include individuals with SMI re-entering the community after completing jail sentences and to implement a specialized entitlement benefits unit utilizing the SOAR model to expedite access to Social Security and Medicaid benefits for individuals served by the CMHP's programs.

Recovery Peer Specialists

Recovery Peer Specialists are individuals diagnosed with mental illnesses who work as members of the jail diversion team. Due to their life experience they are uniquely qualified to perform the functions of the position. The primary function of the Recovery Peer Specialists is to assist jail diversion program participants with community re-entry and engagement in continuing treatment and services. This is accomplished by working with participants, caregivers, family members, and other sources of support to minimize barriers to treatment engagement, and to model and facilitate the development of adaptive coping skills and behaviors. Recovery Peer Specialists also serve as consultants and faculty to the CMHP's Crisis Intervention Team (CIT) training program.

Bristol-Myer Squibb Foundation Project

The South Florida Behavioral Health Network, which is contracted by the Florida Department of Children and Families to manage the substance abuse and mental health system of care in Miami-Dade and Monroe Counties, was awarded a 3-year, \$1.2 million grant from the Bristol-Myers Squibb Foundation to oversee development and implementation of a first-of-its-kind coordinated system of care demonstration project. The project, which serves as an overlay to both the Misdemeanor and Felony Jail Diversion Programs is designed around recommendations from the National Leadership Forum on Behavioral Health/Criminal Justice Services, targets individuals with severe and persistent mental illnesses who are at highest risk for involvement in the criminal justice system and other institutional settings. A primary goal of the project is to ensure timely and efficient access to a comprehensive array of services based on enhanced, individualized assessment of clinical and criminogenic needs and risk factors. Services, which incorporate criminal justice and trauma informed practices, are delivered by a coordinated network of community-based treatment providers and justice system stakeholders involved in cross-systems and cross-disciplinary treatment planning, service coordination, and information sharing. Project evaluation will include comparisons of behavioral health and criminal justice outcomes among individuals enrolled in the newly created system of care and enhanced services to outcomes among individuals participating in traditional community-based services.

Mental Health Diversion Facility

Since 2006 the courts have been working with stakeholders from Miami-Dade County on a capital improvement project to develop a first of its kind mental health diversion and treatment facility which will expand the capacity to divert individuals from the county jail into a seamless continuum

of comprehensive community-based treatment programs that leverage local, state, and federal resources. This project, which is funded under the *Building Better Communities General Obligation Bond Program*, was established to build on the successful work of the CMHP with the goal of creating an effective and cost efficient alternative treatment setting to which individuals awaiting trial may be diverted.

The diversion facility will be housed in a former state forensic hospital which has been leased to Miami-Dade County and is in the process of being renovated to include programs operated by community based treatment and social services providers. Services offered will include crisis stabilization, short-term residential treatment, day treatment and day activities programs, intensive case management, outpatient behavioral health and primary care treatment services, and vocational rehabilitation/supportive employment services. The proposed plan for the facility includes space for the courts and for social service agencies such housing providers, legal services, and immigration services that will address the comprehensive needs of individuals served.

The vision for the mental health diversion facility and expansion of the CMHP's diversion programs is to create a centralized, coordinated, and seamless continuum of care for individuals who are diverted from the criminal justice system either pre-booking or post-booking. By housing a comprehensive array of services and supports in one location, it is anticipated that many of the barriers and obstacles to navigating traditional community mental health and social services will be removed, and individuals who are currently recycling through the criminal justice system will be more likely to engage treatment and recovery services. Creation of this facility will also allow for the movement of individuals currently spending extended amounts of time in the county jail into residential treatment programs and supervised outpatient services supported by more sustainable funding sources. It is anticipated that the facility will begin operations in 2016.

Typical or Troubled?™ Program

Recently, the CMHP partnered with the American Psychiatric Foundation (APF) and Miami-Dade County Public Schools (MDCPS) to implement the *Typical or Troubled?™* School Mental Health Education Program for all public junior high and high schools in the Miami-Dade system. The program will train over 500 teachers, school psychologists, social workers and guidance counselors on early identification of potential mental health problems, will educate and engage parents and will ultimately link students with mental health services when needed.

Typical or Troubled?™ is an educational program that helps school personnel distinguish between typical teenage behavior and evidence of mental health warning signs that would warrant intervention. The program includes culturally sensitive technical assistance for school personnel on best practices and educational materials in English, Spanish and forthcoming in Haitian Creole. To date, the program has been used in over 500 schools and school districts, in urban, suburban and rural areas, and educated more than 40,000 teachers, coaches, administrators, and other school personnel across the country.

This initiative will take a proactive approach to tackle the issue of mental health in schools through partnerships and targeted training that hone in on the identification and effective treatment of

mental health problems before those problems manifest through increased truancy, substance abuse, violence or tragedy.

Conclusion

The CMHP has demonstrated substantial gains in the effort to reverse the criminalization of people with mental illnesses. The idea was not to create new services but to merge and blend existing services in a way that was more efficient and continuous across the system. The Project works by eliminating gaps in services and by forging productive and innovative relationships among all stakeholders who have an interest in the welfare and safety of one of our community's most vulnerable populations.

The CMHP offers the promise of hope and recovery for individuals with SMI that have often been misunderstood and discriminated against. Once engaged in treatment and community support services, individuals have the opportunity to achieve successful recovery, community integration, and reduce their recidivism to jail. The CMHP is a national model of excellence and has received numerous recognitions including the *2010 Prudential Davis Productivity Award for implementation of SOAR*, *2010 Eli Lilly Reintegration Award for Advocacy*, *2008 Center for Mental Health Services/National GAINS Center Impact Award*, the *2007 National Association of Counties Achievement Award*, the *2006 United States Department of Housing & Urban Development's HMIS National Visionary Award*, the *2006 Prudential Financial Davis Productivity Award*, and the *2003 National Association of Counties Distinguished Service Award*.

The CMHP provides an effective and cost-efficient solution to a community problem. Program results demonstrate that individualized transition planning to access necessary community based treatment and services upon release from jail will ensure successful community re-entry and recovery for individuals with mental illnesses, and possible co-occurring substance use disorders that are involved in the criminal justice system.



**CRISIS INTERVENTION TEAM
SCHOOL OF TRAINING**

SECTION TWO



REVIEW OF THE MAJOR PSYCHIATRIC ILLNESSES

MENTAL HEALTH DEFINED

PEOPLES' ABILITY TO INTEGRATE THEMSELVES WITH THE WORLD AROUND THEM

- ❖ SOCIALLY
- ❖ OCCUPATIONALLY
- ❖ ACADEMICALLY
- ❖ WITH FAMILY & FRIENDS
- ❖ SUCCESSFULLY ADAPT TO STRESS

MENTAL ILLNESS DEFINED

❖ GROUP OF DISORDERS RELATED TO ALTERED BRAIN CHEMISTRY

❖ "Mental illness" means an impairment of the mental or emotional processes (*serious thought or mood disorder*) that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology

Division of Social Control / Criminal Mental Health / 7/2004

INCIDENCE OF MENTAL HEALTH DISORDERS

ABOUT 1 IN 5 ADULTS SUFFER FROM SOME TYPE OF MENTAL HEALTH DISORDER (APPROXIMATELY 5 MILLION PEOPLE US)

- SCHIZOPHRENIA (2%)
- MOOD DISORDERS (DEPRESSION & BIPOLAR) (6%)
- ANXIETY DISORDER (8%)
- SUBSTANCE ABUSE (7%)
- ANTSOCIAL PERSONALITY DISORDER (2%)

Division of Social Control / Criminal Mental Health / 7/2004

CAUSES OF MENTAL ILLNESS

❖ SEVERAL CAUSES ARE SUGGESTED

- ❖ BIOLOGICAL (GENETICS)
- ❖ NEUROLOGICAL (BRAIN DAMAGE)
- ❖ BIOMEDICAL (MEDICAL CONDITIONS)
- ❖ ENVIRONMENTAL EXPOSURE

MENTAL ILLNESS
VS.
INTELLIGENCE

WHERE MENTAL ILLNESS BEGINS
DEVELOPMENT ENDS

CHEMICALS IMPLICATED IN PSYCHIATRIC ILLNESSES

- ❖ DOPAMINE
- ❖ SEROTONIN
- ❖ NOREPINEPHRINE
- ❖ ACETYLCHOLINE
- ❖ ENDORPHINS
- ❖ GLUTAMATE

WHO CAN BE AFFECTED WITH MENTAL ILLNESS?

- ❖ MILLIONS OF PEOPLE WORLD WIDE
- ❖ AFFECTS ALL RACES, GENDER, ECONOMIC STATUS, SOCIAL & CULTURAL GROUPS

MENTAL ILLNESS IS TREATABLE NOT CURABLE

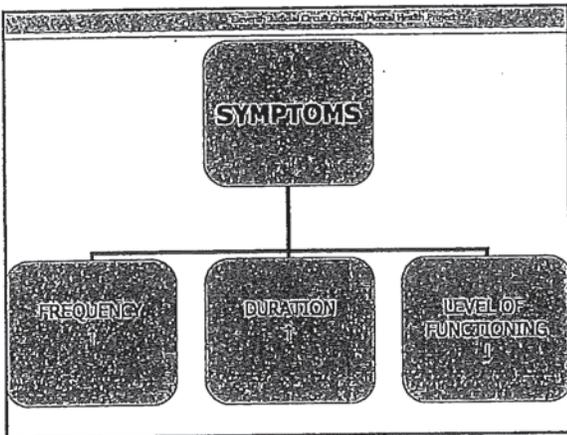
- ❖ MEDICATION
- ❖ THERAPY
- ❖ OTHER TREATMENTS

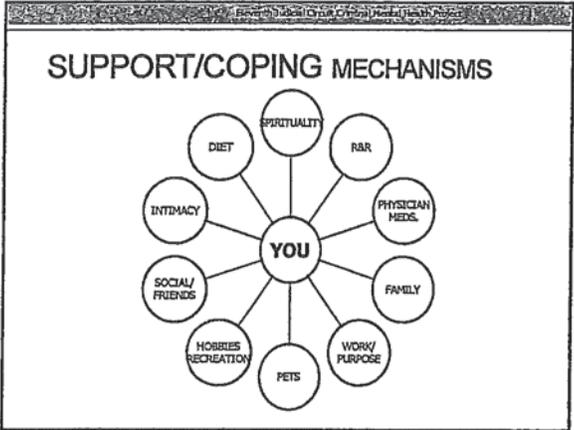
MEDICATION

- The Common Cold
- Not like Tylenol
- Cocktails

THE MOST SEVERE & PERSISTENT PSYCHIATRIC CONDITIONS

- ❖ SCHIZOPHRENIA & OTHER PSYCHOTIC DISORDERS
- ❖ BIPOLAR DISORDERS
- ❖ MAJOR DEPRESSION
- ❖ ANXIETY DISORDERS
- ❖ DEMENTIA
- ❖ DISORDERS SPECIFIC TO CHILDREN
- ❖ SUBSTANCE ABUSE DISORDERS (CAN CO-EXIST WITH ANOTHER MENTAL ILLNESS)





SCHIZOPHRENIA

- ❖ **THOUGHT TO BE AN IMBALANCE OF DOPAMINE & SEROTONIN IN THE BRAIN**
- ❖ **IT IS THE MOST SEVERE FORM OF THOUGHT DISORDER**
- ❖ **EARLY SIGNS OF SCHIZOPHRENIA**
 - **PROBLEM FUNCTIONING BEGINNING IN ADOLESCENCE**
 - **SUSPICIOUS, INTROVERTED, WITHDRAWN**
- ❖ **THE MAIN FEATURE OF SCHIZOPHRENIA IS PSYCHOSIS**

**DISORGANIZED THOUGHTS/
SPEECH/BIZARRE BEHAVIORS**

(THOUGHT PROCESSES)

- ❖ **THE PERSON CANNOT ORGANIZE HIS THINKING IN A WAY THAT MAKES SENSE (LOOSE ASSOCIATIONS, MAGICAL THINKING, DISASSOCIATION)**
- ❖ **THE PERSON IS UNABLE TO GIVE A STRAIGHT ANSWER TO A SIMPLE QUESTION (CIRCUMSTANTIAL, FLIGHT OF IDEAS, RACING THOUGHTS)**
- ❖ **THE PERSON MAKE STATEMENTS THAT DON'T MAKE SENSE TO YOU THE LISTENER (WORD SALAD, NEOLOGISMS)**
- ❖ **THE PERSON SEEMS CONFUSED AND DISORGANIZED (POOR REALITY TESTING)**
- ❖ **THE PERSON MAY BE ABLE TO GIVE THE CORRECT DAY/DATE, LOCATION, READ & WRITE**

WHAT IS PSYCHOSIS?

❖ THE PERSON HAS AN EXTREME BREAK FROM REALITY INVOLVING DELUSIONS, HALLUCINATIONS AND/OR BIZARRE BEHAVIORS

❖ THE RIGHT AND LEFT HEMISPHERES OF THE BRAIN FUNCTIONS OUT OF SEQUENCE. THE PERSON IS IN A DREAMLIKE STATE WHILE AWAKE

❖ THE PERSON HAS DISTURBANCES IN THINKING, FEELING AND BEHAVING/ RELATING

SYMPTOMS OF PSYCHOSIS

❖ HALLUCINATIONS

❖ DELUSIONS

❖ PARANOIA

❖ BIZARRE DISORGANIZED OR CATATONIC BEHAVIOR

❖ DISORGANIZED THOUGHT AND SPEECH

❖ FLAT AFFECT

❖ DETERIORATION OF SOCIAL, INTERPERSONAL AND SELF-CARE FUNCTIONING

❖ SUICIDE

HALLUCINATIONS

(FALSE EXTERNAL SENSORY PERCEPTION)

❖ THE PERSON EXPERIENCES THINGS THAT ARE NOT REALLY THERE BUT ARE REAL TO THEM

❖ SEEING (VISUAL) COMMON IN PATIENTS DIAGNOSED WITH SCHIZOPHRENIA

❖ HEARING (AUDITORY) COMMON IN PATIENTS WITH DRUG INTOXICATION

❖ SMELLING (OLFACTORY) MAY BE ASSOCIATED WITH SEIZURE

❖ TASTING (GUSTATORY) MAY BE RELATED TO NEUROLOGICAL PROBLEMS

❖ FEELING (TACTILE) USUALLY DUE TO ALCOHOL WITHDRAWAL AND OTHER DRUG ABUSE

TYPES OF AUDITORY HALLUCINATIONS

- COMFORTING
- CONDEMINING
- CONTROLLING
- COMMANDS
- NOISE

BEHAVIORS ASSOCIATED WITH HALLUCINATIONS

- ❖ THE PERSON IS TALKING, LAUGHING OR CRYING TO THEMSELF
- ❖ COVERING EARS WITH HANDS, CLOTHING OR HEADPHONE
- ❖ MAY DUCK OR FEND OFF SOMETHING
- ❖ SITTING, STANDING MOTIONLESS OR ROCKING MOTION
- ❖ LOOKING IN THE DIRECTION WHERE THE VOICES ARE COMING FROM

**DELUSIONS
(THOUGHT CONTENT)**

- ❖ THE PERSON HAS A FIXED, FALSE BELIEF OR IDEA THAT HAS LITTLE OR NO BASE IN REALITY, CANNOT BE ACCOUNTED BY CULTURAL BACKGROUND, AND CANNOT BE ALTERED BY RATIONAL ARGUEMENTS
- ❖ THE PERSON WITH PARANOID DELUSIONS IS POTENTIALLY MORE AGITATED AND VIOLENT

TYPES OF DELUSIONS

- ❖ **PARANOID TYPES:** IRRATIONAL BELIEF THAT ONE IS BEING PERSECUTED (BEING WATCHED BY THE CIA WHO TAPPED PHONE)
- ❖ **IDEAS OF REFERENCE:** BELIEF THAT SOME EVENT IS UNIQUELY RELATED TO THAT PERSON (JESUS IS SPEAKING TO THE PERSON THROUTH TV CHARACTERS)
- ❖ **THOUGHT BROADCASTING:** BELIEF THAT ONE'S THOUGHTS CAN BE HEARD BY OTHERS
- ❖ **DELUSIONS OF GRANDEUR:** BELIEF THAT ONE HAS SPECIAL POWERS BEYOND THOSE OF A NORMAL PERSON
- ❖ **DELUSIONS OF GUILT:** FALSE BELIEF THAT THAT ONE IS GUILTY OR RESPONSIBLE FOR SOMETHING (THE TSUNAMI IN ASIA AND AFRICA)

SYMPTOMS OF DELUSIONS

- ❖ THE PERSON BELIEVES HE IS AN IMPORTANT OR FAMOUS PERSON
- ❖ HE HAS SUPER POWERS AND CAN DO ANYTHING OR WAS SENT TO DO GREAT THINGS, OR DESTROY THINGS
- ❖ THE PERSON MAY TAKE ON A SPECIFIC IDENTITY WITH A SPECIFIC PURPOSE (HE IS JESUS CHRIST OR WAS SENT BY GOD TO ACCOMPLISH A TASK)
- ❖ THE PERSON BELIEVES THAT SOMEONE FAMOUS IS IN LOVE WITH THEM
- ❖ THE PERSON BELIEVES PEOPLE CAN READ AND OR CONTROL HIS MIND
- ❖ THE PERSON BELIEVES HE IS THE TARGET OF SECRET INVESTIGATION

SYMPTOMS OF DELUSIONS CONT'D

- ❖ THE PERSON IS CONVINCED THAT THE TV OR RADIO IS TALKING ABOUT HIM
- ❖ THE PERSON BELIEVES HE IS DEAD, NOT REAL, OR DOESN'T EXIST
- ❖ THE PERSON IS CONVINCED THAT THE FOOD IS POISONED
- ❖ THE PERSON MAY GIVE BIZARRE EXPLANATION OF CUTS & BRUISES, ABSENCE OF CLOTHES OR WHY THEY REFUSE TO DO CERTAIN ACTIVITIES

AFFECT AND MOOD

(FLAT, BLUNTED, LABILE, CONSTRICTED INAPPROPRIATE)

❖ THE PERSON'S EMOTION DOES NOT CORRESPOND WITH WHAT IS HAPPENING AROUND THEM AT THE MOMENT

❖ THE PERSON'S BEHAVIOR MAY OR MAY NOT SHOW WHAT OR HOW THEY ARE FEELING

BIPOLAR DISORDER

(MANIC DEPRESSIVE DISORDER)

❖ CHEMICAL IMBALANCE CAUSING ABNORMAL RANGE OF MOOD. FLUCTUATING BETWEEN EPISODES OF MANIA AND DEPRESSION (EXTREME HIGHS AND LOWS)

❖ DISTURBANCE IN MOOD, EMOTIONS, AND IMPULSE CONTROL (THE CHAMELEON DISEASE)

❖ MAY HAVE PSYCHOTIC FEATURES

❖ THE PERSON'S FUNCTIONING IS SEVERELY AFFECTED. MAY BE EXTREMELY VIOLENT

SYMPTOMS OF BIPOLAR DISORDER

❖ FEELINGS OF EUPHORIA

❖ RAPID SPEECH, NON STOP TALKING

❖ GRANDIOSE TYPE OF DELUSIONAL THINKING

❖ EXCESSIVE AMOUNT OF ENERGY

❖ DECREASED NEED FOR SLEEP

❖ INTRUSIVE, LACKS LIMITS AND BOUNDRIES

❖ REPETITIVE AND COMPULSIVE BEHAVIORS

❖ VERY ODD AND ECCENTRIC IN APPEARANCE

❖ EXCESSIVE AND DANGEROUS BEHAVIORS (DRINKING, DRUGGING, SEX, GAMBLING, SPENDING)

❖ UNABLE TO FOLLOW SIMPLE INSTRUCTIONS

❖ IRRITABLE, AGGRESSIVE, VIOLENT

❖ DEPRESSED, LABILE MOOD, SUICIDAL

ASSESSING BIPOLAR

- G GRANDIOSITY
- I INCREASED ACTIVITY
- D DECREASED JUDGEMENT, PROMISCUITY
- D DISTRACTIBLE
- I IRRITABILITY
- N NEED FOR SLEEP
- E ELEVATED MOOD
- S SPEEDY THOUGHTS
- S SPEEDY TALK

MAJOR DEPRESSION

- ❖ IMBALANCE IN BRAIN CHEMISTRY RESULTING IN DEPRESSED MOOD
- ❖ MAY BE CAUSED BY MAJOR MEDICAL ILLNESS, TRAUMATIC LIFE EVENTS/EXPERIENCE
- ❖ MANY PEOPLE MAY NOT BE AWARE THAT THEY ARE DEPRESSED. EXPRESSED VAGUE, SOMATIC COMPLAINTS

MAJOR DEPRESSION

- ❖ MAJOR DEPRESSION MAY HAVE PSYCHOTIC FEATURES
- ❖ ABOUT TWO THIRD OF ALL DEPRESSED PATIENTS CONTEMPLATE SUICIDE AND 10-15% COMMIT SUICIDE
- ❖ ONLY HALF OF PATIENTS WITH MAJOR DEPRESSION EVER RECEIVE TREATMENT

SYMPTOMS OF MAJOR DEPRESSION

- ❖ LOSS OF ENERGY, PLEASURE OR INTEREST IN USUAL ACTIVITIES
- ❖ ANXIETY AND/OR IRRITABILITY
- ❖ FEELINGS ASSOCIATED WITH BEING TRAPPED, HOLE, DARK CLOUD HANGING, CARRYING HEAVY LOAD
- ❖ FEELINGS OF GUILT, HOPELESSNESS, HELPLESSNESS, WORTHLESSNESS, USELESSNESS
- ❖ DIFFICULTY PAYING ATTENTION AND CONCENTRATING
- ❖ OFTEN THINKS ABOUT DEATH AND/ SUICIDE
- ❖ DOESN'T EAT OR OVEREATS
- ❖ CANT SLEEP OR SLEEPING TOO MUCH
- ❖ NO DESIRE FOR INTIMACY

ASSESSING DEPRESSION

- S** SLEEP (INCREASES/DECREASES)
- I** INTEREST/HOBBIES DECREASE
- G** GUILT/WORTHLESSNESS
- E** ENERGY DECREASES
- C** CONCENTRATION DECREASES
- A** APPETITE (INCREASES/DECREASES)
- P** PSYCHOMOTOR MOVEMENTS
- S** SUICIDE IDEATIONS/SEX (NO INTEREST)

STRESS & SYMPTOMS

- Triggers
- Structure
- Mental illness and a psychotic state

PREOCCUPATIONS

- Sexual
- Religious
- Political
- Lack of Insight and Denial

ERIC

- Education
- Recognition
- Identification
- Coping Skills

ANXIETY RELATED DISORDERS

GENERALIZED ANXIETY DISORDER

- ❖ CAN COEXIST WITH OTHER DISORDERS
- ❖ SYMPTOMS:
 - UNREALISTIC WORRY
 - PHYSICAL TENSION
 - AUTOMATIC AROUSAL AND HYPERACTIVITY
 - APPREHENSIVE EXPECTATION, VIGILANCE AND SCANNING OF ENVIRONMENT
- ❖ PHOBIAS
- ❖ IRRATIONAL FEARS
- ❖ SYMPTOMS:
 - SPECIFIC PHOBIAS (ANIMALS, SPIDERS, DOGS)
 - SOCIAL PHOBIA
 - AGORAPHOBIA

PANIC DISORDER

- ❖ RECURRENT SEVERE PANIC ATTACKS CAUSED BY A SUDDEN UNPREDICTABLE ONSET OF INTENSE APPREHENSION, FEAR, TERROR AND SENSE OF IMPENDING DOOM; OCCORING AT LEAST ONCE A WEEK
- ❖ SYMPTOMS:
 - PALPITATION
 - TACHYCARDIA
 - DYSPNIA, FAINTING AND DIZZINESS
 - SWEATING, FLUSHES, CHILLS
 - CHEST PAIN
 - HYPERVENTILATION
 - DEPERSONALIZATION, DEREALIZATION
 - THE PERSON BELIEVES HE/SHE IS DYING AND FREQUENTLY UTILIZES EMERGENCY SERVICES

POSTTRAUMATIC STRESS DISORDER

- ❖ RESPONSES TO THE EXPERIENCE OF A TRAUMA OR CATSTROPHIC EVENT
- ❖ SYMPTOMS:
 - NIGHTMARES
 - FLASHBACKS (RE-EXPERIENCING THE TRAUMA)
 - EXTREME ANXIETY
 - FEELINGS OF DETACHMENT
 - OUTBURST OF ANGER
 - HYPER-VIGILANCE

OBSESSIVE COMPULSIVE DISORDER

- ❖ COMPULSION THAT INTERFERES WITH SOCIAL, OCCUPATIONAL, AND INTERPERSONAL FUNCTIONING
- ❖ UNWANTED REPEATING AND UNCONTROLLED THOUGHTS, IMAGES OR IMPULSES

❖ SYMPTOMS:

- CLEANING
- WASHING
- CHECKING
- COUNTING
- REPEATING

SOMATIFORM DISORDERS (RELATING TO BODY)

DISSOCIATIVE DISORDER

- ❖ THE DISRUPTION OF THE USUALLY INTEGRATED FUNCTIONS OF CONSCIOUSNESS, MEMORY, IDENTITY, OR PERCEPTION OF THE ENVIRONMENT

❖ COMMON AREAS OF IMPAIRMENT INCLUDE:

- TEMPORARY MEMORY LOSS (AMNESIA)
- UNEXPECTED AND NON-DIRECTED TRAVELING(FUGUE)
- THE PRESENT OF TWO OR MORE SEPARATE, DISTINCT, PERSONALITIES (ALTERS)
- SENSATION OF NOT BEING REAL

ANTIDEPRESSANTS

- Celexa
- Effexor
- Paxil
- Prozac
- Serazone
- Wellbutrin
- Zoloft
- Lexapro



- Elavil
- Tofranil
- Anafranil

ANTIPSYCHOTICS

- Abilify
- Clozaril
- Geodon
- Zyprexa
- Risperdal
- Seroquel
- Haldol
- Prolixin
- Stelazine
- Thorazine
- Trilafon

STIMULANT



- Adderall
- Concerta
- Dexedrine
- Ritalin
- Strattera

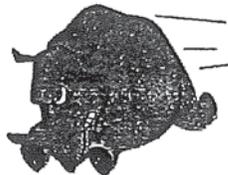
ANXIOLYTIC



- Ativan
- Librium
- Valium
- Xanax

MOOD STABILIZER

- Depakote
- Lithium
- Lamictal
- Tegretol
- Topomax



ANTIHISTAMINES AND ANTICHOLINERGICS

- Benadryl
- Vistaril/Atarax
- Cogentin



REFERENCES:

⌘ Diagnostic & statistical manual of mental disorders (1994). (4th ed.). American psychiatric association. Washington, DC.

⌘ Houseman, C. (1998). Psychiatric certification review guide for the generalist, & clinical specialist in adult, child & adolescent psychiatric & mental health nursing. (2nd ed.). Health Leadership Associates, Inc. Potomac MD.

⌘ Kaplan, H.I., Sadock, B.J. (1998). Synopsis of psychiatry: Behavioral sciences/clinical psychiatry (8th ed.). Philadelphia, PA: Lippincott.

SIGNS & SYMPTOMS OF SCHIZOPHRENIA

(Symptoms will vary from person to person)

Schizophrenia is thought disorder. The person cannot organize his/her thinking in a way that makes sense i.e. (words or sentences do not make sense). The person is unable to give a straight answer to a simple question and can appear confused and/or disorganized.

■ **HALLUCINATIONS** - *An external sensory perception (experiencing something that is really not there, but is real to the person). This perception can be experienced through one or more of the following:*

- VISUAL – seeing things
- AUDIO – hearing things
- TACTILE – feeling things
- GUSTATORY – tasting things
- OLFATORY – smelling things

■ **DELUSIONS** – *A false belief*

- PARANOID – Irrational belief that you are being followed, heard, watched etc.
- EROTOMANIA -famous people are in love with you
- GRANDEUR- belief that you are much greater, more powerful and influential than you really are.

OBSERVABLE BEHAVIOR

- **DISRUPTIVE THOUGHTS AND BEHAVIORS**
- **BIZARRE BEHAVIOR**
- **DISORGANIZED**
- **CATATONIC BEHAVIOR**
- **DISORGANIZED THOUGHT AND SPEECH**
- **DARTING GLANCES** (may be hallucinating, paranoid)
- **DISORGANIZED SPEECH** - person does not make sense or words are out of order
- **UNUSUAL SENSITIVITY** – any of the senses can be affected
- **FLAT AFFECT** – a lack of emotional facial expression
- **HOSTILITY**
- **AGITATION**
- **TALKING, LAUGHING OR CRYING TO THEMSELVES**
- **COVERING EARS WITH HANDS, CLOTHING OR HEADPHONE**
- **BOBBING AND WEAVING IN ATTEMPT TO FEND FOR HIM/HERSELF**
- **GLANCING IN THE DIRECTION OF A PERCEIVED THREAT OR NOTION**
- **SITTING, STANDING MOTIONLESS OR IN A ROCKING MOTION**
- **DETERIORATION OF PERSONAL HYGIENE/DISHEVELED**
- **DISPLAYS NO EMOTIONS**
- **WITHDRAWAL**
- **MANY LAYERS OF CLOTHING ON A HOT DAY**

SIGNS & SYMPTOMS OF BIPOLAR DISORDER

(Symptoms may vary from person to person)

Symptoms of bipolar disorder are disturbances or abnormalities in mood. Individuals who suffer from bipolar disorder are at risk of death either by dangerous behavior or in the manic state by suicide in a depressive state.

LOWS

FEELINGS OF:

SADNESS

ANXIOUSNESS

HOPLESSNESS

WORTHLESSNESS

PESSIMISM

GUILT

FATIGUED

LOSS OF INTEREST OR PLEASURE IN HOBBIES, ACTIVITIES ONCE ENJOYED

SUICIDAL THOUGHTS, IDEATION, ATTEMPTS

HIGHS

EUPHORIA – feeling high

AGITATION

INFLATED SELF ESTEEM, GRANDIOSITY, POOR JUDGEMENT

DELUSIONS

GRANDIOSE

HALLUCINATIONS

EDGINESS

SWIFT AND RAPID MOVEMENTS

IRRITABILITY

RESTLESSNESS

RACING THOUGHTS

TALKATIVE

RAPID ACCELERATED SPEECH

INCREASED ENERGY

SLEEPLESSNESS

RECKLESS SPENDING SPREES

AGGRESSIVE BEHAVIOR

DIFFICULTY CONCENTRATING

USE OF DRUG/ALCOHOL



CRISIS INTERVENTION TEAM
SCHOOL OF TRAINING

SECTION THREE



Understanding and Helping the Suicidal Person



Eleventh Judicial Circuit Criminal Mental Health Project

Mental health experts differentiate between five types of behaviors. Knowing their appropriate definitions will help you better understand the behaviors.

- Suicidal ideation
- Suicidal gesture
- Attempted suicide
- Self-injurious behavior
- Completed suicide

Eleventh Judicial Circuit Criminal Mental Health Project

Suicide Ideation

- Thoughts about suicide. This term generally refers to what people say about their ideas and intentions because it is not possible to know what a person is actually **thinking**
- **Documenting these thoughts is vital information for mental health professionals when initiating an involuntary examination.**

Eleventh Judicial Circuit Criminal Mental Health Project

Suicidal Gestures

- Often, a person will make what appears to be a suicide attempt, using means that are extremely unlikely to be lethal.
- Often, these gestures are dismissed as “manipulation.” However, it is not uncommon for a person who has previously made a suicidal gesture subsequently to kill himself or herself.
- All suicidal gestures need to be taken seriously and assessed by a competent mental health professional.

Eleventh Judicial Circuit Criminal Mental Health Project

Attempted Suicide

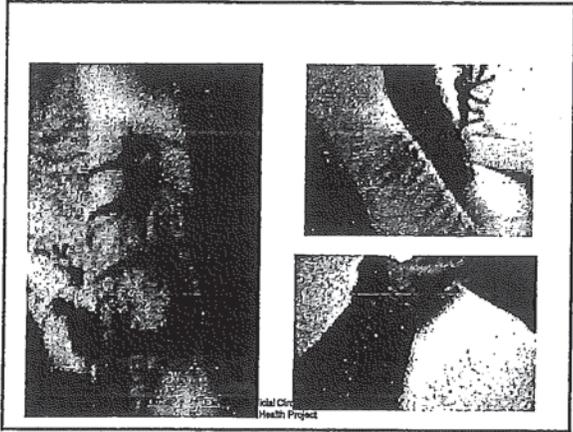
- A person tries to commit suicide or kill himself or herself but does not succeed because the method chosen was not lethal (e.g., small amount of drugs) or intervention prevented death; the person may or may not be injured.

Eleventh Judicial Circuit Criminal Mental Health Project

Self-Injurious Behavior

- Sometimes, people harm themselves, such as cutting their arms, with no apparent intention to die. There is a great deal of speculation about why people hurt themselves in this way.
- For law enforcement, such actions should be treated as very seriously.

Eleventh Judicial Circuit Criminal Mental Health Project



Self Injury vs. Suicide

- Some individuals who appear to be suicidal are actually displaying a behavior known as self-injury or self-mutilation.
- Description defines self-injury as: “deliberate, nonlife-threatening, socially unacceptable, self-inflicted harm to the body.”

Eleventh Judicial Circuit Criminal Mental Health Project

Self-Injury vs. Suicide

- This behavior may include cutting, scratching, burning, and even preventing wounds from healing and pulling out stitches.
- Self-injurers use the behavior as a way to release their intense emotions. It's a way of coping.

Eleventh Judicial Circuit Criminal Mental Health Project

Be Aware of the Signs

- Hopelessness, helplessness, worthlessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, out, seemingly without thinking
- Feeling trapped like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping too much
- Dramatic mood change
- No reason for living; no sense of purpose in life

Eleventh Judicial Circuit Criminal Mental
Health Project

Be Aware of the Facts

- Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems
- Most suicidal give definite warnings of their suicidal intentions, others are either unaware of the significance of these warnings or do not know how to respond to them.

Eleventh Judicial Circuit Criminal Mental
Health Project

Empty box for notes or additional information.

Eleventh Judicial Circuit Criminal Mental
Health Project

SUICIDE RISK "SAD PERSONS"

- S** SEX (MALE)
- A** AGE (YOUNG/ELDERLY)
- D** DEPRESSION
- P** PREVIOUS ATTEMPTS
- E** ETOH (ALCOHOL)
- R** REALITY TESTING
- S** SOCIAL SUPPORT
- O** ORGANIZED PLAN
- N** NO SPOUSE
- S** SICKNESS

Eleventh Judicial Circuit
Criminal Mental Health
Project

Be Aware of the Facts

- Talking about suicide does not cause someone to be suicidal.
- Suicide is the third leading death among young people ages 15 – 24 and it is the eighth leading cause of death among all persons.
- Youth (15 – 24) suicide rates increased more than 200% from the 1950's to the late 1970's, following the late 1970's, the rates for youth suicide have remained stable.

Eleventh Judicial Circuit Criminal Mental
Health Project

Be Aware of the Facts

- The suicide rate is higher among the elderly (over 65) than any other age group.
- Four times as many men kill themselves as compared to women, yet three times as many women attempt suicide as compared to men.
- Suicide cuts across all age, economic, social, and ethnic boundaries.

Eleventh Judicial Circuit Criminal Mental
Health Project

Be Aware of the Facts

- Firearms are currently the most utilized method of suicide by essentially all groups (male, female, young, old, white, non-white).
- Surviving family members not only suffer the trauma of losing a loved one to suicide, and may themselves be at higher risk for suicide and emotional problems.

Eleventh Judicial Circuit Criminal Mental Health Project

You should be aware of three specific mental illness that make a person more likely to commit suicide.

- Depression
- Bi-Polar Disorder
- Schizophrenia

Eleventh Judicial Circuit Criminal Mental Health Project

Depression

- Persons experiencing depression may commit suicide when their symptoms appear to be improving.
- This happens because depression often robs individuals of the energy and resolution to act forcefully.
- As they began to improve, the ability to act returns. They now have the will and the energy to carry out the suicide

Eleventh Judicial Circuit Criminal Mental Health Project

Suicide

- For adults, suicide is usually *planned (rather than impulsive) act*.
- For adolescents, suicide is often an impulsive act. However, especially in jail, where the person is often under extreme stress and possibly intoxicated, impulsive suicides are much more likely among all age groups.

Eleventh Judicial Circuit Criminal Mental Health Project

High Risk Suicide

- Client discusses specific suicide plan:
 - time
 - method
 - place
 - means
 - cause
 - perceived benefit

Eleventh Judicial Circuit Criminal Mental Health Project

L.E. MUST DOCUMENT

- T = Thoughts
- I = Intent
- P = Plan
- M = Means

Eleventh Judicial Circuit Criminal Mental Health Project

Let Your Instincts Guide You...

- Did you feel “uncomfortable” or worried about the safety of the client?
- All you need is “A reason to believe”

Eleventh Judicial Circuit Criminal Mental Health Project

Helping Someone Who is Threatening Suicide

- Show interest and support
- Ask if he/she is thinking about suicide
- Be direct. Talk openly and freely about suicide.
- Be willing to listen. Allow for expression of feelings. Accept feelings.
- Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life

Eleventh Judicial Circuit Criminal Mental Health Project

Helping Someone Who is Threatening Suicide

- Don't give advice by making decisions for someone else to tell them to behave differently.
- Don't ask “why”, this encourages defensiveness.
- Offer empathy not sympathy.
- Don't act shocked, this creates distance.

Eleventh Judicial Circuit Criminal Mental Health Project

Helping Someone Who is Threatening Suicide

- Don't be sworn to secrecy. Seek support
- Offer hope that alternatives are available, do not offer glib reassurance; it only proves that you don't understand.
- Take action! Remove means!

Eleventh Judicial Circuit Criminal Mental Health Project

Risk Assessment Questions

1. Have you been thinking of killing yourself?
2. What has happened that makes life not worth living?
3. How will you do it?

Eleventh Judicial Circuit Criminal Mental Health Project

Risk Assessment Questions

4. How much do you want to die?
5. How much do you want to live?
6. How often do you have these thoughts?
7. When you think of suicide, how long do the thoughts stay with you?

Eleventh Judicial Circuit Criminal Mental Health Project

Risk Assessment Questions

8. Have you ever attempted suicide?
9. Have you been drinking heavily lately or taking drugs?
10. Has anyone in your family committed or attempted suicide?
11. Is there anyone or anything to stop you?
12. On a scale of 1 to 10, what is the probability that you will kill yourself?

Elmerth Judicial Circuit Criminal Mental Health Project

Be Aware of Feelings, Thoughts, and Behaviors.

People in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently they can't:

- Get out of the depression
- Make the sadness go away
- See the possibility of change
- See themselves as worthwhile
- Get someone's attention
- Seem to get control

Elmerth Judicial Circuit Criminal Mental Health Project

Signs of Suicidal Behavior

- According to corrections/detention center mental health professionals, 60% of detainees/inmates who commit suicide have exhibited identifiable warning signs.
- Those who are suicidal usually talk about it.
- One of the most common signs are statements.
- These statements may be very direct.

Elmerth Judicial Circuit Criminal Mental Health Project

Adults vs. Adolescent

- For adults, suicide is usually planned rather than impulsive.
- For adolescents, suicide is often an impulsive act.
- However, especially in a jail setting stress is high and therefore, impulsive suicides are much more likely amongst all age groups.

Eleventh Judicial Circuit Criminal Mental Health Project

Stressful Environment/Incidents

- Stress triggers symptoms which may lead to suicidal behavior.
- Stressful events in corrections/detention facilities:
 - Jail visits
 - Court proceedings
 - Sentencing
 - Significant dates (anniversaries, birthdays etc.)
 - Rejection
 - Upon Release
 - Concerned about a loved one
 - Death

Eleventh Judicial Circuit Criminal Mental Health Project

Highest Risk of Suicide

- First time a person is detained/arrested within the first 3 – 24 hours of detainment.
- High vigilance for new admissions
- A completed suicide simply requires having the opportunity and the means coupled with limited activities and unsupervised time.
- Shift change

Eleventh Judicial Circuit Criminal Mental Health Project

Common Methods of Committing Suicide in Detention Facilities

- Hanging (death can occur in 3-5 minutes)
- Uncovered vents
- Light fixtures
- Clothes hooks
- Lockers

Eleventh Judicial Circuit Criminal Mental Health Project

Your Role

- As officers in detention centers, you are not expected or distinguish between behavior that is self-injury vs. suicidal.
- Your job is to report any unusual behavior, which includes cutting, burning, scratching etc.

Eleventh Judicial Circuit Criminal Mental Health Project

Guidelines for Good Listening in Crisis Situations

- Be prepared to listen
- Show interest
- Be aware of cultural preferences
- Respect the individual's situation
- Be aware of nonverbal communication
- Provide comfort
- Focus attention

Eleventh Judicial Circuit Criminal Mental Health Project

Guidelines for Good Listening in Crisis Situations

- Respect silences
- Listen carefully
- Avoid interrupting
- Allow expressions of emotion
- Tolerate repetition
- Ask simple and clear questions
- Be sure to understand

Eleventh Judicial Circuit Criminal Mental Health Project

Guidelines for Good Listening in Crisis Situations

- Give hope
- "Be" with the person even if you can't fix it.

Eleventh Judicial Circuit Criminal Mental Health Project

References

- American Red Cross (1982). Providing Red Cross disaster health services. ARC 3076
- Hafen, B.Q. & Frandsen, K.J.(1985). Psychological emergencies and crisis intervention. Englewood, CO: Morton Publishing company.
- Mitchell, J.T. & Bray, G. (1990). Emergency services stress: Guidelines for preserving the health and careers of emergency services personnel. Englewood Cliffs, NJ: Prentice Hall, Inc.
- Mitchell, J.T. & Resnick, H.L.P. (1981). Englewood Cliffs, NJ: Prentice Hall, Inc.
- Emergency response to crisis. Bowie, MD: Robert J. Brady, Co.
- Aunin, L.M. & Zunin, H.S. (1991). The art of condolence: What to write, what to say, what to do at a time of loss. New York: Harper Collins Publishers.

Eleventh Judicial Circuit Criminal Mental Health Project



**CRISIS INTERVENTION TEAM
SCHOOL OF TRAINING**

SECTION FOUR





**CRISIS INTERVENTION TEAM
SCHOOL OF TRAINING**

SECTION FIVE



PHONE INTERVENTIONS FOR PERSONS WITH AN EMOTIONAL DISTURBANCE (EDP)

These questions may be used to establish communication, to investigate, and to help resolve an emotional disturbance. All questions may not be needed or may be asked in different ways if the caller is an EDP, a family member, or a bystander. Take your clues from the caller's statements and responses. There is no absolute order to the questions. Attempt to obtain the most crucial information with as few questions as possible.

PRINCIPLES

- Establish a relationship
- Use active listening techniques
- Gather needed information
- Assess degree of risk
- Identify the problem
- Assess resources
- Mobilize resources

IDENTIFY THE CURRENT SITUATION

What is being observed or happening?

What is the individual doing?

What is the individual saying?

Obtain the necessary Who, What, and Where information.

What is your name? Or, do you know the person's name?

Can you describe this person? (What is he/she wearing?)

Where exactly are you (or the person) right now?

Are you alone? Or, who else is present?

IDENTIFYING MEDICAL EMERGENCIES

Do you need an ambulance/rescue now?

What are the physical symptoms?

The following physical symptoms may be clues to a medical emergency: fever, stiff neck, difficulty with talking, difficulty with vision, headaches, excessive sweating, noticeable rashes, seizures, facial flushing, weakness, numbness, tingling, chills, swelling, excessively dry skin, jerking eye movements.

Has the person behaved this way before?

When was the last time you (they) behaved this way?

What was done at that time?

Are you (they) currently under the care of a medical doctor or a mental health professional?

If yes, with whom and for what?

Are you (they) currently on medications?

If yes, what is this medication for?

Do they have any medical illnesses such as:

Diabetes, AIDS, Muscular Sclerosis, alcoholism, Alzheimer's, thyroid problems, head injuries, Lupus, etc.

DETERMINING IMMINENT RISK OF PHYSICAL HARM

General:

Is there a weapon present? If so, where is it?

Are you (they) upset or agitated?
Have you (they) behaved violently before?
Are you (they) hearing voices and/or seeing strange things?
Are you (they) thinking normally or seem confused and disoriented?
Are you (they) fearful and do they think someone may harm them?

Physical Risk to Others:

Do you (do they) want to hurt anyone other than your (them) self?
Have you (they) ever hurt anyone before?

Physical Risk to Self:

Obtain caller's name, address (and location), and telephone number.
Assume caller is seeking help.
Project a caring attitude and suggest collaboration.
Remember that delaying suicide = prevention.
Ask and evaluate suicide plan – (S) how specific is a plan, (L) lethality of proposed method, (A) availability of method, and (P) proximity of rescue.
Get backup- share the call.
Involve family when appropriate.
Use community resources.
If individual is suicidal risk, dispatch police and trace call (if necessary)

Helpful Do's and Don'ts

Be willing to listen.
Be supportive, but directive.
Focus on feelings – reflective and empathetic responses.
Do not minimize seriousness of threat or attempt.
Do not analyze, interpret, or “explain away” symptoms.
Do not reinforce feelings of guilt.
Do not argue, shock or challenge.
Do not confront or make promises you can't keep.
Do not agree to hold suicide plan in confidence.

EVALUATING THE PSYCHOLOGICAL STATUS

The context and characteristics of current crisis.

Are you (they) worried about something?
What caused you (them) to become upset?

The individual's mental health status.

Are you (they) currently, or have you (they) been in mental health treatment?
Are you (they) taking, or have medications for your (their) emotions?
If so, have you (they) taken your (their) medication today?

Is alcohol or other drugs involved.

Do you (they) use alcohol or any street drugs?
Have you (they) used alcohol or any street drugs today?

What resources are available?

Is there anyone you can talk to, or can you get anywhere for help?
Is there anyone we can contact to be with you?

All information that can be obtained and passed on to the responding officer may increase the safety of the officer, the EDP, and bystanders and may help bring about a more positive outcome.

1  **UNDERSTANDING**

ANXIETY

2  **PERSON IN CRISIS BELIEVES:**

- He/she must act now.
- There is no hope in negotiation or any other attempt to solve problem.
- He/she believes they have LOST CONTROL.

3  **PERSON IN CRISIS BELIEVES:**

4  **THE ESSENCE OF
CRISIS INTERVENTION:**

5  **Be Prepared**

WE FEED OFF OF ONE ANOTHER'S EMOTIONS
Be Aware of your Emotional State

- What is your state of mind?
- What is your perception due to your experience?
- What have been YOUR OWN crisis situations?
- What are your biases?
- Where is your stress level?
- How's your health?

6  **FACTS**

- Stress triggers symptoms
- Cognitive vs. Emotional

7  **PARAVERBAL COMMUNICATION**

BE AWARE OF NOT ONLY WHAT YOU SAY BUT HOW YOU SAY IT

8  **3 ELEMENTS OF COMMUNICATION
(Mehrabian's Rule 7%-38%-55%)**

9  **PARAVERBAL COMMUNICATION**

- The vocal part of speech, excluding the actual words one uses

10  **Three Components of Paraverbal Communication**

<u>Component</u>	<u>Suggested Approach</u>	
Tone inattention	a. Avoid inflections of impatience,	condescension,
Volume	b. Keep the volume appropriate for	the distance

and the situation

- Cadence c. Deliver your message using an even rate and rhythm
-

11  **EFFECTIVE VERBAL INTERVENTION**
NICE AND SLOW...

12  **WHAT TO DO**

- Be patient, accepting, encouraging but remain firm
- Indicate you are *trying* to understand
- Reassure that you don't intend to harm
- Speak slowly and quietly and pause between statements
- Make them aware of their behaviors (speech, pattern, content)
- Meet their basic needs

13  **BE AWARE**

- Person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds (voices), or the environment
- People suffering from mental illness often have a hard time processing what others are saying at a "normal" speed
- Allow for some extra mental processing time to avoid unnecessarily combative situation

14  **NON-VERBAL BEHAVIOR**

HOW DOES THIS AFFECT YOU?

- Proxemics- Personal Space
- Kinesics- Body posture and movement
-

15  **GENERAL GUIDELINES FOR VERBAL INTERVENTION**

- Maintain a safe distance
- Maintain intermittent eye contact
- No eye contact (culture, perception)
- Use clear tone voice
- Use voice volume lower than that of individual
- Use relaxed, well balanced posture
-

16  **STRATEGIC DE-ESCALATION**
The Five A's

17  **STRATEGIC DE-ESCALATION**

- Give person permission to vent, otherwise violence may seem to be only option
- Ensure quiet to avoid escalation due to external influences
- Do not use reason or logic, they are irrational
- Offer alternatives gives person choices and control
-

- 18  **SELF-AWARENESS**
(avoid triggering an adverse response)
- What you wear, how you wear it
 - Hands/hand movements
 - Facial expressions/Fear
 - Your non verbal, their non verbal
 -
- 19  **KEEP IN MIND THAT...**
- A person acting out in his own space, but not directly threatening any other person or himself, should be given time to calm down.
 - Attempting to use logic/rationality with a psychotic person is counterproductive, will most likely escalate person.
 - Some medications that treat mental illness have side effects that may require attention.
 -
- 20  **VERBAL INTERVENTION**
QUESTIONING – Information seeking questions vs. Challenging questions
Answer information seeking questions as honestly as possible
Ignore the challenging questions (not the person) and redirect topic
- 21  **VERBAL INTERVENTION**
- - Do not answer threatening questions directly instead respond by referring to the action and your concern.
 - (i.e. Have you ever seen someone blow their head off? Your question scares me, I don't know how to respond.. But I can help you if you'll let me.)
 -
- 22  **VERBAL INTERVENTION**
REFUSAL – Loss of rationality
Set limits, boundaries, structure
- 23  **ONE STEP AT A TIME**
Getting Personal – does it benefit the consumer?
Don't miss the obvious – notes, letter writing
- 24  **SETTING LIMITS**
- Recognize that you cannot force individuals to respond appropriately, results in a power struggle
 - When you set limits you are offering a person choices
 - Limits better received when the positive choice and/or consequences are stated first
 -
- 25  **Limits most effective when they are:**
- Simple/Clear
 - Reasonable



**CRISIS INTERVENTION TEAM
SCHOOL OF TRAINING**

SECTION SIX





FOR BEHAVIORAL HEALTH COMMUNITY RESOURCES

PLEASE SEE:

CONSUMER AND FAMILY RESOURCE MANUAL

SFBHN.ORG

BROUGHT TO YOU BY:

MIAMI-DADE AND MONROE COUNTIES

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

SOUTH FLORIDA BEHAVIORAL HEALTH NETWORK, INC.



BEHAVIORAL HEALTH RESOURCES

AHCA (Agency for Health Care Administration)

Receiving Facility & ALF Complaint Hotline
1.888.419.3456

Marchman Act Involuntary Petition

ADULT: Circuit Court-Probate Division
Jade County Courthouse – Room 234
73 West Flagler Street 305.349.7475

JUVENILE: Circuit Court – Juvenile Division

Juvenile Justice Center
1300 NW 27 Avenue 305.633.4745(59)

DEPARTMENT OF CHILDREN AND FAMILIES

Alcohol Drug Abuse & Mental Health Division)

Laura Menendez
laura_menendez@dcf.state.fl.us
786. 257.5183

South Florida Behavioral Health Network

SBHN.org
Betty Hernandez, VP of Behavioral Health Services
305. 858.6301

Mobile Crisis Team (24/7)

305.774.3616 (17)

Miami-Dade County CIT Coordinator

Tabasi W. Kaba MS MFT
t. 305.548.5639
f. 786.399.8591
tkaba@jud11.flcourts.org

NAMI

National Alliance on Mental Illness
NAMI.org
NAMI OF MIAMI
305.665.2540

Children's Trust Helpline (24/7)

211 (social services information line)

Switchboard of Miami (24/7)

(Crisis Helpline)
305.358.HELP (4357)

ALZHEIMER HELPLINE

1.800.272.3900

Baker Act Ex parte Order (9:00 – 4:00 pm)

Miami-Dade Courthouse
73 West Flagler Street, Suite #234

Homeless Helpline

1.877.994.HELP (4357)

Jackson Behavioral Health Hospital

Deidre Bethel
Compliance Officer
305.355.7012
DBethel@jhsMiami.org

Baker Act/Marchman Act Forms, Training and additional resources and information: Myflfamilies.com

City of Miami Homeless Assistance Program

Homeless Protocol for Police Departments or other Governmental Agencies

The Miami Homeless Assistance Program delivers mobile street outreach to homeless individuals and families in Miami-Dade County. Community Outreach Specialist seek out the homeless on the streets, under bridges or where ever they may sleep or congregate. Once found, through consistent contact, the outreach team seeks to build a basic level of trust and assess the needs of those served. Outreach workers offer referrals and, if accepted, will transport individuals to emergency shelters, mental health, substance abuse treatment programs or to the hospital emergency room or crisis stabilization unit if urgent care is needed.

The Miami Homeless Assistance Program operates 7-days a week, 24 hours a day, excluding holidays.

Please note that shelter space is very limited and we have a waiting list, therefore not all homeless individuals can be served right away.

We have a policy that no children will be left on the streets; so if a family with minor children is encountered, an outreach team will be dispatched immediately.

To refer a homeless individual or request the service of an outreach team:

(305) 960-4980

Or a Toll Free number could be provided to a homeless person seeking assistance.

1-877-994-4357 (English or Spanish)

To request assistance in closing an encampment or a specialized detail, contact the Outreach Supervisor:

Darren Morrison: (305) 960-4990 / dmorrison@miamigov.com

Please note that when closing an encampment for the first time we have to post notices with the closure date one week prior to closing the encampment. This will allow us time to work with the residents and secure shelter space for them.

Appendix A
Designated Receiving Facilities
(as of September 2014)

The following is a complete list of Miami-Dade County psychiatric facilities designated by the Florida Department of Children and Family Services to receive and hold persons with mental illness for involuntary examination and short-term treatment. Facilities currently designated as of the date of this Plan are found below, but the list is subject to change from time to time as new facilities are designated and others are closed or have their designations removed.

Public Receiving Facilities

Banyan Health Systems
3850 West Flagler Street
Miami, FL 33134

Jackson Behavioral Health Hospital
1695 NW 9 Avenue
Miami, FL 33136

Citrus Health Network
Adult & Children CSUs
4175 West 20 Avenue
Hialeah, FL 33012

Jackson North CMHC
15055 NW 27 Avenue
Opa Locka, FL 33054

Community Health Center of South Florida-
(CHI)
10300 SW 216 Street
Miami, FL 33190

Private Receiving Facilities

Aventura Hospital and Medical Center
20900 Biscayne Blvd.
Miami, FL 33180

Mercy Hospital, a Campus of
Plantation General Hospital
3663 South Miami Avenue
Miami, FL 33133

Jackson South Community Hospital
9333 SW 152 Street
Miami, FL 33157

Miami Children's Hospital
3100 SW 62 Avenue
Miami, FL 33155

Kendall Regional Medical Center
11750 SW 40 Street
Miami, FL 33175

Mount Sinai Medical Center
Emergency Department
2845 Aventura Boulevard
Aventura, FL 33180

Larkin Community Hospital
7031 SW 62 Avenue
South Miami, FL 33143

Mount Sinai Medical Center
4300 Alton Road
Miami Beach, FL 33140

North Shore Medical Center
1100 NW. 95th Street
Miami, FL 33150

University of Miami Hospital
1400 NW 12 Avenue
Miami, FL 33136

Palmetto General Hospital
2001 West 68 Street
Hialeah, FL 33016

Veteran's Administration (VA)
Medical Center
1201 NW 16 Street
Miami, FL 33125

Southern Winds Hospital
4225 West 20 Avenue
Hialeah, FL 33012

Westchester General Hospital
2500 SW 75 Avenue
Miami, FL 33155

The following is a complete list of Miami-Dade County designated receiving facilities with the capability of providing significant **medical** examination and treatment of persons for whom an involuntary examination has been initiated. Facilities currently designated that have the ability to provide extensive medical treatment as of the date of this Plan are found below, but the list is subject to change as new facilities are designated and others are closed or have their designations removed.

- a. Aventura Hospital and Medical Center
- b. Jackson Behavioral Health Hospital
- c. Kendall Regional Medical Center
- d. Larkin Community Hospital
- e. Mercy Hospital, a Campus of Plantation General Hospital
- f. Miami Children's Hospital (children and adolescents only)
- g. Miami VA Medical Center
- h. Mount Sinai Medical Center
- i. North Shore Medical Center
- j. Palmetto General Hospital
- k. University of Miami Hospital
- l. Westchester General Hospital

Designated Receiving Facilities that provide specialty geriatric care for **older adults** undergoing involuntary psychiatric examinations as of the date of this Plan are listed below. The list of such receiving facilities is subject to change as new facilities are designated and others are closed or have their designations removed.

- a. Kendall Regional Medical Center
- b. Larkin Community Hospital
- c. Mercy Hospital, a Campus of Plantation General Hospital
- d. Mount Sinai Medical Center
- e. Palmetto Hospital
- f. Southern Winds
- g. University of Miami Hospital
- h. Westchester General Hospital

Designated Receiving Facilities that provide specialty psychiatric care for **children and adolescents** undergoing involuntary psychiatric examinations as of the date of this Plan are listed below. The list of such receiving facilities is subject to change as new facilities are designated and others are closed or have their designations removed.

- a. Citrus Health Network (Adolescents, 13-17 only)
- b. Jackson Behavioral Health Hospital
- c. Miami Children's Hospital
- d. Southern Winds Hospital (Adolescents, 13-17 only)

The only designated receiving facility that provides specialty psychiatric care for persons of all ages who are **deaf or hard of hearing** is Jackson Behavioral Health Hospital.



**CRISIS INTERVENTION TEAM
SCHOOL OF TRAINING**

SECTION SEVEN



HOW MUCH STRESS CAN YOU TAKE?



Hazel W. Kabe MS MFT

WHAT IS STRESS?



Hazel W. Kabe MS MFT

Stress is...

A Mental, Emotional, or
Physical Strain. 



Hazel W. Kabe MS MFT

Mental and Emotional Stress Symptoms

- Depression
- Anxiety
- Increase or unusual aggressiveness
- Feelings of panic
- Frequent crying
- Excessive worrying
- Decreased concentration
- Confused thinking
- Nightmares

Hazel W. Kaba MS MFT

Mental and Emotional Stress Symptoms

- Moodiness
- Anger
- Impatience
- Feelings of helplessness
- Irritability
- Low frustration tolerance
- Trouble learning new information
- Inability to make decisions
- Self-defeating thoughts
- Loss of memory

Hazel W. Kaba MS MFT

Mental and Emotional Stress Symptoms

- Sexual inadequacy
- Social withdrawal
- Fear of losing control
- Emotional numbness
- Decreased sense of humor
- Restlessness
- Feeling overwhelmed
- Thoughts of suicide
- Excessive worrying

Hazel W. Kaba MS MFT

Physical Stress Symptoms

- Muscle tension
- Dry mouth or throat
- Chronic fatigue
- Sexual inadequacy
- Difficulty swallowing
- Neck pain
- Chest pains
- Weight gain or loss
- Frequent indigestion
- loss of appetite

Habel W. Kaba MS MFT

Physical Stress Symptoms

- Stomach aches
- Insomnia
- Excessive menstruation
- Nausea and/or vomiting
- Backaches
- Swollen joints
- Halting or stuttering speech
- Increased appetite
- Excessive sleeping



Habel W. Kaba MS MFT

Physical Stress Symptoms

- Headaches
- Nervous ticks
- Ulcers on tongue
- Constipation
- Dizziness
- Heartburn
- Racing or pounding heart
- Diarrhea
- Shakiness/tremors
- High blood pressure



Habel W. Kaba MS MFT

Behavioral Stress Symptoms

- Increased drug or alcohol use
- Inattention to dress or grooming
- Fast or mumbled speech
- Constant tiredness
- Increased number of mistakes
- Foot or finger tapping
- Increased smoking
- Chronic tardiness

Hazel W. Kaba MS MFT

Behavioral Stress Symptoms

- Overreaction to small things
- Nail biting
- Chronic procrastination
- Overall dissatisfaction
- Demanding
- Impatient
- Constant complaining

Hazel W. Kaba MS MFT

THE STRESS TEST

- Where is your STRESS level?

Hazel W. Kaba MS MFT

**Take Notice of the Early Warning Signs and
take Appropriate Action**

- Like the dashboard warning lights in your car, your body and mind will also alert you when you're getting to close to the "red zone".

Habal W. Kaba MS MFT

Early Symptoms

- Be aware of your earliest symptoms of stress (tightness in neck, shoulders, irritability, headache, anxious feeling in stomach,, etc.) and make it a point to:

**SLOW DOWN
RELAX
DE STRESS**

Habal W. Kaba MS MFT

Ignoring Your Stress Symptoms

- If you repeatedly ignore your stress symptoms you may find yourself "blowing a gasket" or experiencing a total "breakdown" and/or maybe developing...



Habal W. Kaba MS MFT

Generalized Anxiety Disorder

Can co exist with other disorders

• SYMPTOMS:

- UNREALISTIC WORRY
- PHYSICAL TENSION
- AUTOMATIC AROUSAL AND HYPERACTIVITY
- APPREHENSIVE EXPECTATION, VIGILANCE AND SCANNING OF ENVIRONMENT

Habib W. Kaba MS MFT

PANIC DISORDER

- A sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom.
- **Symptoms:**
- Palpitation
- Tachycardia
- Fainting and dizziness
- Sweating, flushes, chills
- Chest pains

Habib W. Kaba MS MFT

PHOBIAS

- Irrational Fears such as:
- Claustrophobia
- Social phobia
- Agoraphobia

Habib W. Kaba MS MFT

POSTTRAUMATIC STRESS DISORDER

❖ RESPONSES TO THE EXPERIENCE OF A TRAUMA OR
CATSTROPHIC EVENT

❖ SYMPTOMS:

- NIGHTMARES
- FLASHBACKS (RE-EXPERIENCING THE TRAUMA)
- EXTREME ANXIETY
- FEELINGS OF DETACHMENT
- OUTBURST OF ANGER
- HYPER-VIGILANCE

Hazel W. Koba MS MFT

COPING MECHANISMS

- Family Support
- Peer Support
- Social Support
- Exercise
- Hobbies/sports
- Be good to yourself/seek out the small pleasures
- Don't sweat the small stuff
- It's all small stuff

Hazel W. Koba MS MFT

COMMUNICATION

TALK TO
SOMEONE!

LET IT OUT!!

Hazel W. Koba MS MFT

RESOURCES

- CISM Critical Incident Stress Management Foundation
CISM Contact Coordinator: Natalie Duran
305.975.5862
786.336.6675
- Children's Trust Helpline (24/7) 211
- Switchboard of Miami (24/7) 305.358.HELP

Habel W. Kaba MS MFT

IF YOU DON'T CONSUME
IT
IT WILL CONSUME YOU!!

Habel W. Kaba MS MFT

References

- Stress Busters, Katherine Butler N.C.C.; John Wiley & Sons, Inc.; 2004
- Mental Health Association; 2006
- Critical Incident Stress Management Miami, FL
- Eleventh Judicial Circuit Criminal Mental Health Project, CIT Training Program; 2009

Habel W. Kaba MS MFT

MORE THAN JUST TRAINING

"Eleventh Judicial Circuit Criminal Mental Health Project"



Habsi W. Kaba MFT

- **305.548.5639**
- **Richard Gerstein Building #226**
- **Hkaba@jud11.flcourts.org**

Habsi W. Kaba MS MFT
