around the scene is reduced. The presence of bystanders may also cause an EDP to resist you because he or she does not want to *lose face* in public. In order to avoid this, ask bystanders to leave so that they do not affect the situation. If an EDP is stationary, establish a frozen area and keep all non-essential personnel out of the way. These situations are difficult enough without having to worry about whether a bystander's presence or actions will complicate matters. It will also be easier for you to hear, communicate with, and focus on the EDP.

When EDP Has Been Taken Into Custody

Once the EDP is taken into custody, either voluntarily or involuntarily, police officers are responsible for the proper care, custody and transportation of the EDP from the scene of the incident to an appropriate medical facility. You must take the following steps to ensure that proper and safe custody is maintained.

1. Remove property that is dangerous to life or will aid in escape.

2. Have the EDP removed to a hospital in an ambulance.

    - Restraining equipment may be used if the EDP is violent, resists, or if directed by a physician.

    - When a female EDP is being transported, another female officer or an adult member of the immediate family should accompany her.

3. The uniformed member of the service must ride in the body of the ambulance with the EDP.

    - At least two officers must be assigned to safeguard if more than one patient is being transported.

Firearm Safety Stations At Psychiatric Wards and Admitting Areas (P.G. 216-07)

Once you arrive at the hospital with an EDP, you must safeguard the EDP at the hospital until examined by a psychiatrist.

1. Inform the psychiatrist of the circumstances that brought the EDP into police custody.

2. If you are relieved by another officer at the completion of your tour, you must inform them of the circumstances in which the EDP was taken in custody. This

is critical information because the examining psychiatrist's main source of information about the EDP is likely to be the officer who is safeguarding them.

3. Make all pertinent entries in your Activity Log and prepare an Aided Report or a Medical Treatment of Prisoner form. Deliver this to the desk officer upon completion.

4. When entering a psychiatric ward:

   - Escort the EDP to designated area.
   - Sign in the Psychiatric Admitting Log maintained by hospital security police.
   - Unload your firearm at the firearm safety station. Place your ammunition in your pocket, and holster your weapon.
   - Confer with the psychiatric admitting staff and provide necessary information regarding the circumstances that brought the EDP into police custody.
   - Safeguard the EDP at the hospital until a psychiatrist examines them.

5. If the EDP needs to go to the emergency room, reload your firearm at the firearm safety station and sign out in the Psychiatric Admitting Log prior to departing the psychiatric ward.

THE USE OF FORCE WHEN HANDLING EDPS

As in all situations, police officers will use force only when necessary. **With EDPs, as in every case, you may use only the minimum amount of force reasonably necessary to control the situation**.

If the emotionally distressed person is dangerous to self or others, the law and Department policy allow the use of **necessary force** to prevent serious physical injury or death. One example illustrating this point might be that of a person attempting to jump off a roof. In this case, it may be proper for the officer to physically restrain the individual by grabbing and cuffing them.

Remember that deadly physical force may be used only as a last resort to protect your life or any other innocent person's life. The primary police mission when dealing with emotionally distressed persons is to isolate and contain them, while insuring that no person's safety is endangered.

In any case, when there is time to negotiate, take all the time necessary to insure the safety of all individuals concerned. Await the arrival of the supervisor and the ESU whenever no immediate action to prevent injury or death is required. Physical force will be used only to the extent necessary to restrain the subject until delivered to a hospital or detention facility.

A police officer's obligation is to do what is **reasonable and necessary** to insure the safety of all persons involved in any police-citizen contact. Police officers must remember that taking cover, establishing containment, and distraction are legitimate tools during potentially hazardous encounters.

Less-lethal devices carried in the ***patrol officer's RMP*** or on your person include:

- 3-foot polycarbonate shield (in RMP)
- Oleoresin Capsicum Pepper Spray (on person)
- Conducted Electrical Weapon (Taser): a device primarily designed to disrupt a subject's central nervous system by means of using electrical energy sufficient to cause uncontrolled muscle contractions and override an individual's motor responses (on person);

Less-lethal devices carried in ***patrol supervisor's RMP*** and by ***ESU*** (which are also equipped with additional equipment) include:

- 3-foot polycarbonate shield (in RMP).
- Velcro restraining straps (in RMP);
- Oleoresin Capsicum Pepper Spray (on person);
- Conducted Electrical Weapon (Taser);

Whenever possible, members should make every effort to avoid tactics such as sitting or standing on a subject's chest, which may result in chest compression, thereby reducing the subject's ability to breathe. After an individual has been controlled and placed under custodial restraint using handcuffs and other authorized methods, the person should be positioned to enable free breathing. The subject will not be kept, or transported in a facedown position. If a person appears to be having difficulty breathing, or is otherwise demonstrating life-threatening symptoms, medical assistance will be requested **immediately**. The use of restraints to "hog-tie" (restraining person by connecting or tying rear-cuffed hands to cuffed or shackled ankles or legs) a subject in a facedown position is **prohibited**.

Adhere to the following guidelines:

- ***Do not hogtie:*** under no circumstances may persons taken into custody be "hogtied." This technique may not be employed under any circumstances with an EDP or anyone else.

- ***Get people in custody off their stomachs as soon as possible:*** officers should be cognizant in assuring they do not restrain, confine, nor transport EDPs in a way that may seriously hurt, or kill, them. **THUS, NEVER CONFINE EDPs, OR ANYBODY ELSE, IN FACEDOWN, PRONE POSITIONS FOR LONGER THAN IT TAKES TO HANDCUFF THEM**.

- ***Do not use ropes on anybody:*** rope may not be used under any circumstances, to restrain an EDP, or anyone else.

- ***Do not use chokeholds:*** members of the service shall not use chokeholds against other persons.

- ***Provide immediate help to people who have difficulty breathing:*** whenever anyone taken into custody appears to have difficulty breathing or is otherwise demonstrating life-threatening symptoms, medical assistance must be ***immediately*** requested. The patrol supervisor will direct that alternate means to maintain custody be utilized, if appropriate. When no supervisor is on the scene of an EDP, the senior member present at the scene will direct and coordinate operations, pending the arrival of a supervisor.

INVOLUNTARY REMOVAL

Mental Health Removal Orders

A §9.43 involuntary removal order is a civil order issued by a judge when he or she is presented with evidence that an individual has, or may have, a mental illness, and presents a danger to self or others. A §9.43 order may be requested by a treating clinician or family member. A §9.43 order also can be issued by a judge in criminal cases when the individual appearing before the judge appears to have a mental illness and presents a danger to self or others, and the criminal case has been dispensed with (i.e. the person is no longer being held in regards to the criminal case.)

Mental Health Removal Orders (P.G. 216-06)

When a Mental Health Removal Order is received from the Commissioner of the New York State Office of Mental Health, police department personnel are required to

safeguard the mentally ill or emotionally distressed person. This individual need not appear to be an immediate danger to himself/herself or others; the presence of a valid removal order and the clinician grants us the authority to remove the individual to a hospital for evaluation.

The Desk Officer will review the Removal Order to verify that it is valid. Once the assigned city psychiatrist is present at the removal location the Communications Section will assign the Patrol Supervisor and police officer to assist with the removal.

1. Comply with provisions of P.G. 221-13, "Mentally Ill or Emotionally Disturbed Persons."

2. Upon assignment, a uniformed member of the service must accompany the subject in the ambulance to the psychiatric emergency room of the hospital named on the Removal Order.

3. Comply with P.G. 216-07, "Firearm Safety Stations at Psychiatric Wards and Admitting Areas" upon arrival at the psychiatric emergency room of the hospital.

4. Remain with the subject throughout medical triage and until examined by a hospital psychiatrist.

5. Notify the desk officer upon completion of the removal.

6. Enter details of transport in Activity Log, including the name of the of the admitting psychiatrist.
7. Prepare Aided Report –Indicate "Mental Health Removal Order," name of responding city psychiatrist and name of admitting psychiatrist under Details" on **AIDED REPORT.**

Mobile Crisis Teams

As of October 2015, there are twenty-three (23) mobile crisis teams citywide.

A mobile crisis team is an interdisciplinary team of mental health professionals ((e.g., nurses, social workers, psychiatrists, psychologists, mental health technicians, addiction specialists, peer counselors). Teams operate under the auspices of voluntary agencies and municipals hospitals. They respond to persons in the community, usually visiting them at home, although their mandate allows them to make contact at other locations.

Mobile crisis teams serve any person in New York City who is experiencing, or is at risk of, a psychological crisis, and who requires mental health intervention and follow

up support to overcome resistance to treatment. Mobile crisis teams usually are called by family members, neighbors, friends, landlords, clergy or other person(s) concerned about an individual.

Mobile Crisis Team staff provides a range of services including assessment, crisis intervention, supportive counseling, information and referrals, linkage with appropriate community based mental health services for ongoing treatment, and follow up.

If the team decides that a hospital psychiatric emergency room evaluation is needed, they will arrange transportation to emergency rooms if further psychiatric and/or medical assessment and care is indicated.

If the individual in crisis does not agree to go to the hospital willingly, and meets the specified legal standards, mobile crisis teams can request the police to involuntarily transport such persons via EMS, to the psychiatric emergency room for further evaluation and possible hospital admission.

The mobile crisis teams' authority to direct the involuntary removal of persons to the emergency room is provided by the NYS Mental Hygiene Law, Sections §9.37 and §9.58 designations, and some also have §9.37 designated psychiatrists. Mobile crisis teams are available throughout the 5 boroughs.

Referrals to the mobile crisis teams are made by calling **1-800-543-3638 (LIFENET)**

Mobile Crisis Outreach Teams and Assertive Community Treatment Teams (P.G. 216-22)

When directed to assist, on scene, designated physicians or qualified mental health professionals assigned to Mobile Crisis Outreach Teams or Assertive Community Treatment Teams, uniformed members of the service will:

1. Comply with P.G. 221-13, “Mentally Ill or Emotionally Disturbed Persons.” & P.G. 216-07 “Firearm Safety Stations at Psychiatric Wards and Admitting Areas”

2. Examine the Department of Health and Mental Hygiene photo ID card of the physician or qualified mental health professional on scene.

3. Record all the pertinent information in your Activity Log, including the identity of the physician or qualified mental health professional ordering the removal, and the length of time the aided was in police custody.

4. Ride in the body of the ambulance with the patient.

5. Remain with the patient until they are examined and are either released or admitted at the psychiatric emergency room.

6. Prepare **Aided Report** - attach Form OMH 475 (Application for Involuntary Admission on Certificate of a Director of Community Services or Designee) or Form OMH 482 (Mobile Crisis Outreach Team Authorization for Transport).

Remember, under the Mental Health Law, if a peace/police officer observes a person appearing to be mentally ill and behaving in a manner, which is likely to result in serious harm to the person, or others, officers may take custody and transport them to a psychiatric hospital.

Kendra's Law:

Kendra's Law established new mechanisms for identifying individuals who, in view of their treatment history and circumstances, are likely to have difficulty living safely in the community without close monitoring and mandatory participation in treatment. In addition, the Office of Mental Health promulgated regulations to support local mental health systems giving these individuals priority access to case management and other services necessary to ensure their safety and successful community living. The statute created a petition process, found in Mental Hygiene Law section §9.60, designed to identify at-risk individuals using specific eligibility criteria, assess whether court-ordered outpatient treatment is required, and if so, develop and implement mandatory treatment plans consisting of case management and other necessary services.

The law was named after Kendra Webdale, a young woman who died after being pushed in front of a New York City subway train by a person who was living in the community at the time, but was not receiving treatment for his mental illness. This law gives the courts the power to compel qualifying individuals to regularly receive psychiatric care as a condition of living in the community.

Under this law, if the patient has refused to comply with the treatment ordered by the court, the physician of record may request to have the person transported to the hospital for evaluation. If requested, the police will accompany the clinician and assist with the removal. The patient, in these cases, need not be an apparent immediate danger to themselves or others, only that they have failed to comply with Assisted Outpatient Treatment and the physician has made an authorized request, through channels, for assistance in the removal. Additionally, once the court orders a patient into this program, a subsequent petition to the court is not required in order to secure removal.

If such an order is obtained and presented to the precinct desk officer, the Patrol supervisors and an assigned uniformed member of service will accompany the clinician and once the person is in custody will follow these procedures:

Involuntary Removals Pursuant to
Mental Hygiene Law Section 9.60 (P.G. 216-17)

Assisted Outpatient Treatment (AOT) is also referred to as "Kendra's Law." This law establishes the procedure for a court to commit an individual against their will to outpatient treatment. Family members can make a petition for this law to the court for a person to be placed in AOT.

1. Comply with P.G. 221-13, "Mentally Ill or Emotionally Disturbed Persons." & P.G. 216-07 "Firearm Safety Stations at Psychiatric Wards and Admitting Areas"

2. Accompany the subject in the ambulance to the psychiatric emergency room of the hospital named on the Removal Order.

3. Remain with the subject throughout medical triage and until examined by a hospital psychiatrist.

4. Notify the desk officer upon completion of the removal.

5. Enter details of transport in Activity Log.

6. Prepare **Aided Report** – enter MHL section 9.60 (Kendra's Law) and name of assigned clinician under the "Details" section.

APPENDIX A
ELEVEN MYTHS ABOUT MENTAL ILLNESS

Myth 1: People with a severe mental illness, such as bi-polar illness or schizophrenia, are usually dangerous and violent. They are more likely to engage in violent behavior than those without mental illnesses.

Reality: People with mental illnesses are more likely to be victims of a crime, rather than perpetrators of crime. Studies show that there is no relationship between being treated for a mental illness and a potential for future violence.

Myth 2: Psychiatric disorders are not true medical illnesses. They are not like heart disease or diabetes. In fact, there really is not such a thing as mental illness. Some people just act crazy.

Reality: Mental illnesses, like heart disease and diabetes, are real illnesses that appear to be caused by a combination of biochemical imbalances that make someone more susceptible to getting ill. They appear to be brought on by some stress in the environment. Research is beginning to show that there are genetic and biological causes for some psychiatric disorders, and that they can be treated effectively.

Myth 3: Mental illnesses are not treatable and treatment cannot match the success rates of other illnesses.

Reality: Surgeon General David Satcher in his 1999 report estimated that the rates of successful treatment of schizophrenia, bi-polar or manic depression and clinical depression, equaled or exceeded other common illnesses.

Myth 4: Mental illness is the result of parenting.

Reality: Most experts agree that a genetic susceptibility, combined with other risk factors, leads to psychiatric disorder. Mental illnesses have a biological cause and are not caused by bad parenting.

Myth 5: Depression results from a personality weakness or character flaw, and people who are depressed could just snap out of it if they tried hard enough.

Reality: Depression has nothing to do with being lazy or weak; it results from changes in brain chemistry or brain function. Medication and/or psychotherapy often help people recover.

Myth 6: Schizophrenia means split personality, and there is no way to control it.

Reality: Schizophrenia is often confused with Dissociative Identity Disorder. Actually schizophrenia is a brain disorder that robs people of their ability to think clearly and logically. The estimated 2.5 million Americans with schizophrenia have symptoms ranging from social withdrawal to hallucinations and delusions. Medication has helped many of these individuals to lead fulfilling, productive lives.

Myth 7: Depression is a normal part of the aging process.

Reality: It is not normal for older adults to be depressed. Signs of depression in older people include loss of interest in activities, sleep disturbances, and lethargy. Depression in the elderly is often undiagnosed and it is important for seniors and their family members to recognize the problem and seek professional help.

Myth 8: Depression and other illnesses, such as anxiety disorders, do not affect children or adolescents. Any problems they have are just part of growing up.

Reality: Children and adolescents can develop severe mental illnesses. In the United States, one in ten children and adolescents has a mental disorder severe enough to cause impairment. However, only about 20 percent of these children receive needed treatment. Left untreated, these problems can get worse. Anyone talking about suicide should be taken very seriously.

Myth 9: If you have a mental illness, you can will it away. Being treated for a psychiatric disorder means an individual has in some way failed or is weak.

Reality: Serious mental illness cannot be willed away. Ignoring the problem does not make it go away, either. It takes courage to seek professional help.

Myth 10: Addiction is a lifestyle choice and reveals a lack of willpower. People with a substance abuse problem are morally weak or bad.

Reality: Addiction is a disease that generally results from changes in brain chemistry.

Myth 11: People with mental illness cannot work or be productive in the community.

Reality: Although people with mental illness may, at times, find it difficult to secure employment, with the right combination of medication, talk therapy, and community support, thousands of people with mental illness work, pay taxes, and make valuable contributions to their communities.

APPENDIX B
MENTAL DISORDERS

Familiarity with different kinds of mental illness and how they are defined by mental health professionals will enable you to better understand and recognize the complex behavior exhibited by people with mental illness. Knowing a person's mental condition may facilitate your ability to aid them safely, and with no more force than is necessary. In these situations, as in all others our goal should be to avoid using force if at all possible, and when force is required, to use no more than we absolutely must.

It can also be useful to know the types of medication that are used to treat certain mental illnesses. The discovery of bottles of medication on the property or person of a mentally ill individual may help you determine what sort of condition they have. People sometimes stop taking their medications because they don't like the side effects. A person who stops taking medication is more likely to show symptoms of mental illness than someone who is taking their medication as prescribed. Nevertheless, it can be difficult to assess whether or not the person is taking their medication by simply looking at the date and counting pills. This is because people may throw out pills or take a handful at once. Occasionally a person may develop psychiatric symptoms or disturbed behavior as a side effect of medications prescribed for physical illness. It can be useful to bring all bottles along with the EDP to the hospital.

Psychosis or Psychotic Episodes

The word psychosis is used to describe a group of conditions that affect the way a person thinks, feels and understands. Typically, a person may experience unusual or distressing perceptions such as hallucinations or delusions, which may be accompanied by a reduced ability to cope with usual day-to-day activities and routine. Someone who has these unusual experiences is described as having an episode of psychosis.

An individual who is psychotic has difficulty distinguishing fantasy from reality. He may have **hallucinations** (hear voices, see things and people that aren't there, smell, taste or feel things that are not there) or experience **delusions** (false beliefs that he is convinced are true). Psychosis may be linked to different mental disorders such as schizophrenia or manic-depressive psychosis. It can also be induced by drugs, such as cocaine.

Medications that are used to treat individuals who are psychotic and/or delusional include Haldol, Prolixin, Stelazine, Clozaril, Risperdal and Zyprexa, Geodon, and Abilify.

Paranoia

Paranoia is a condition in which individuals believe that the people around them are out to get them, and often interpret events as evidence of plots against them. In milder cases, they may believe that people are talking about or plotting against them. In more severe cases, they may be convinced that people want to hurt them. They may be dangerous if they are experiencing **command hallucinations** and are hearing a voice telling them to hurt someone. Individuals who are paranoid and psychotic may also be a danger to themselves if, for example, they drive at high speed trying to get away from the people they believe are trying to hurt them. Paranoia may be linked to different mental disorders such as manic-depressive psychosis, schizophrenia, and Alzheimer's disease.

Because paranoid individuals are likely to see the arrival of the police as part of such a plot, managing them can be very difficult. ***Do not try to disprove the person's false beliefs or pretend you agree with them.*** Avoid direct confrontation, and instead, assure the paranoid that you are there to help and protect, rather than to hurt. Challenges or dares will only heighten the person's suspicions, make them feel threatened, and motivate them to act out physically. It is best to start in a low key, non-confrontational manner. Use polite requests for cooperation rather than commands, and indicate that you are just trying to do your job. Move deliberately and slowly. Sudden changes in posture and bodily motion will make the individual feel threatened and needlessly stimulate the paranoid into action. Therefore, you should move in a way that shows that you do not intend to challenge or threaten the individual.

It is important to know that some paranoid individuals can fake normality and appear relatively undisturbed very quickly after mistreating others. It is therefore important that officers carefully interview the relevant people on the scene in order to properly assess the situation.

Medications that are used to treat individuals who are psychotic and/or delusional include Haldol, Prolixin, Stelazine, Clozaril and Risperdal, Zyprexa, Geodon and Abilify.

Bipolar Disorder

Bipolar disorder is a serious brain illness. It is also called manic-depressive illness. People with bipolar disorder go through unusual mood changes. Sometimes they feel very happy and "up," and are much more active than usual. This is called a manic episode. Sometimes people with bipolar disorder feel very sad and "down," and are much less active. This is called depression or depressive episode. Bipolar disorder can also cause changes in energy and behavior.

Bipolar disorder is not the same as the normal ups and downs everyone goes through. The mood swings are more extreme than that and are accompanied by

changes in sleep, energy level, and the ability to think clearly. Bipolar symptoms are so strong that they can damage relationships and make it hard to go to school or keep a job. They can also be dangerous. Some people with bipolar disorder try to hurt themselves or attempt suicide. People with bipolar disorder can get treatment. With help, they can get better and lead successful lives.[1]

Mania

Mania is one phase of a mood disorder called bipolar illness (or manic-depression) that is generally marked by periods of predominantly elevated but often irritable mood. The behaviors that characterize mania may be only minor changes from normal, or they may be extreme. Manic individuals are overexcited and irritable. They suffer from extreme mood swings, and typically come to police attention when they are overexcited and irritable. Manic individuals may not present communication problems if approached calmly and competently. Still, a manic individual can become combative, particularly if they are suffering from paranoid ideas (false beliefs that someone is trying to hurt him). Remember to ***isolate*** and ***contain*** the individual and call for the patrol supervisor, Emergency Services Unit (ESU) and Emergency Medical Services (EMS) personnel.

The range of behaviors and characteristics of a person experiencing a manic episode may include the following symptoms:

- Increase in activity level; socially, at work, or sexually;
- Physical restlessness;
- More talkative than usual or under pressure to keep talking;
- Conversation seems to race from one idea to another;
- Delusions of grandeur (i.e., opinion of self may be inflated, false beliefs that he/she if God);
- Distractibility (attention easily drawn to unimportant or irrelevant things);
- Actions may appear irresponsible (buying sprees, driving recklessly, sexual promiscuity);
- Diminished need for sleep;
- Delusions (false beliefs);
- Hallucinations (hear voices or see people who aren't there);
- Anger, irritability, explosiveness;
- Euphoria (extreme happiness);
- Paranoid delusions (false beliefs that someone is trying to hurt them);
- Delusions of grandeur (false beliefs that they are God);

[1] National Institute of Mental Health, Bipolar Disorder, November 2015

- Impulse control problems.

Medications used to treat the mania linked to manic-depressive psychosis include Lithium, an anticonvulsant medication called Lamictal, and Valproic acid (which is sold under the brand names Depakote and Depakene).

Depression

Depression is a mood disorder that is generally marked by periods of feeling very down or low. Everyone has experienced a measure of depression under certain circumstances. But when a person's emotional state does not seem appropriate to their circumstances, and their emotional behavior interferes with their life at home and at work, they may be regarded as emotionally distressed.

People who are depressed may experience or demonstrate:

- Feeling sad or "empty";
- Feeling hopeless, irritable, anxious, or guilty;
- Loss of interest in favorite activities;
- Feeling very tired;
- Not being able to concentrate or remember details;
- Not being able to sleep, or sleeping too much;
- Overeating, or not wanting to eat at all;
- Thoughts of suicide, suicide attempts;
- Aches or pains, headaches, cramps, or digestive problems.[2]

Medications used to treat moderate and severe forms of depression include Prozac, Zoloft, Paxil, Wellbutrin, Remeron, Effexor, and Celexa.

Schizophrenia

There are a wide variety of schizophrenic conditions, ranging from fairly good reality contact to major disorganization and deterioration of behavior. In its most common form, the individual exhibits a pattern of bizarre conduct, joined to periods of normality and good general orientation. During periods of flare-up in the illness, in the extreme form when likeliest to come to the attention of the police – the individual shows a frank loss of control, often with paranoia, an inability to communicate logically, and hallucinatory behavior – hearing and seeing things that aren't there. Types of schizophrenia include paranoid schizophrenia which is characterized by a well-

[2] National Institute of Mental Health, Depression, 2013

developed set of delusional beliefs that involve ideas of persecution. Characteristic beliefs and behaviors of schizophrenia may include:

- Thought and speech appear illogical, or loosely and incoherently connected;
- Unrelated attitude in conversation;
- Words may be combined in a meaningless string (word salad);
- Attention fades in and out;
- Severe indecisiveness and an inability to carry out normal activities;
- Disheveled appearance;
- Lack of drive or motivation;
- Withdrawn or absorbed in their own thoughts;
- Hallucinations;
- Paranoid thinking;
- Irrational belief that they are superior; has a special calling; is God;
- Hostility and belligerence;
- Repetitive movements;
- Incoherent and illogical patterns of thought and speech;
- Belief that someone is controlling their thoughts put thoughts into their head, or that people can read their thoughts;
- Belief that others are forcing them to act against their will;
- Dramatically increased or decreased body movements (characteristic of what is called catatonic schizophrenia);
- Impaired impulse control.

It is important to recognize that schizophrenia does not mean "split personality." Individuals suffering from **schizophrenia** have difficulty distinguishing fantasy from reality, and may suffer from delusions. Because their delusions are real to them, ***you will lose credibility with them if you try to talk them out of their delusions.*** Be empathic and try to establish a rapport. You may acknowledge that you know that the psychotic or schizophrenic believes what they are saying, ***but you can let them know that you don't share the same belief*** (e.g., "I know you're hearing voices but I cannot hear the voices myself"). You should be firm and reassuring. This may help the schizophrenic gain control of unwanted impulses and loose thoughts. It can be helpful to focus on some aspect of the individual's situation that is not strictly related to their mental illness (such as suggesting to a naked person in the subway that she might like to come with you and get a warm coat).

Medications that are used to treat individuals who are psychotic and/or delusional include Haldol, Prolixin, Stelazine, Clozaril, Risperdal, Zyprexa, Geodon and Abilify.

Anxiety Disorders

Anxiety is normally experienced by most people in response to external or internal events that trigger discomfort, uncertainty or danger. Such anxiety producers might include the impending loss of a loved one, preparing for and taking an examination, changing work environment, or confronting a new and potentially threatening situation. Some people, however, experience chronic and/or high levels of anxiety when exposed to situations that could be characterized as routine or normal. The different types of anxiety disorders include generalized anxiety, phobias, Post-Traumatic Stress Disorder (PTSD), and panic attacks.

Generalized Anxiety is a persistent, excessive and unrealistic worry about everyday situations. This kind of anxiety makes a person prone to impulsive acts. Very anxious people tend to get into disputes with other people. They are so edgy that they misperceive situations. People with generalized anxiety may be subject to "panic attacks."

Phobias: Characterized by a persistent, debilitating, and severe fear of specific objects (like spiders) or situations (riding in an enclosed space like an elevator). Typically, the person recognizes that their fear is excessive or unreasonable but feels helpless in controlling it.

Post-Traumatic Stress Disorder: A condition that develops in some survivors of catastrophic events such as military combat, rape, a shooting, or some other disaster. A person suffering from PTSD may suddenly feel as though the traumatic experience is happening again (a "flashback") and behave inappropriately and appear terrified.

Panic Attacks: Sudden, overwhelming feelings of anxiety, which can induce a state of frenzied agitation. The person is overwhelmed by terror. Symptoms may include sweating, vertigo (dizziness), palpitations, chest pains, fear of losing control, and a feeling of approaching death. Individuals with panic disorder may repetitively end up in medical emergency rooms until they are finally seen by a psychiatrist and released. Panic attacks usually last up to 10-15 minutes and then subside. Panic attacks can also be as short as 1-5 minutes, more than 20 minutes or until helpful intervention is made.

Medications used to treat anxiety disorders include Ativan, BuSpar, Klonopin, Paxil, Prozac, and Zoloft.

Physical Illnesses with Symptoms Similar to Mental Disorders

It is important to keep in mind that certain physical illnesses may manifest symptoms similar to mental disorders. There are also certain physical illnesses that are characterized by behavior that appears antagonistic, oppositional and belligerent. An individual with a brain tumor may appear to be psychotic. An elderly person with an infection may become agitated, actively fighting anyone who tries to take him to the hospital. A person who is epileptic and coming out of a seizure may seem disoriented, display a blank stare, and not be able to answer the officer's questions. Someone with Tourette Syndrome may spasmodically let out a stream of obscenities that he cannot control. Mostly illegal substances and prescription drugs, such as marijuana, cocaine or percocet, may cause some individuals to exhibit symptoms typical of certain mental illness, including psychosis, paranoia, belligerence, and euphoria.

This section intentionally left blank