A FIRST RESPONDER'S GUIDE FOR PERSONS WITH MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY

CALIFORNIA COMMISSION ON PEACE OFFICER STANDARDS AND TRAINING

Published February 2020

POST MISSION STATEMENT

The mission of the California Commission on Peace Officer Standards and Training is to continually enhance the professionalism of California Law Enforcement in serving its communities.

POST COMMISSIONERS

CHAIR

Joyce Dudley
District Attorney, Santa Barbara County

VICE CHAIR

Rick Braziel
Educator, Humboldt State University

Xavier Becerra
Attorney General, Department of Justice

Alan Barcelona
Special Agent, Department of Justice

Lai Lai Bui
Sergeant, Sacramento Police Department

Thomas Chaplin
Chief, Walnut Creek Police Department

Barry Donelan
Sergeant, Oakland Police Department

Robert T. Doyle
Sheriff, Marin County

Geoff Long
Public Member

John McMahon
Sheriff, San Bernardino County

Jethroe Moore
Public Member

James O'Rourke
Sergeant, California Highway Patrol

Batine Ramirez
Sergeant, Placer County Sheriff's Department

Laurie Smith
Sheriff, Santa Clara County

Walt Vasquez
Chief, La Mesa Police Department

FOREWORD

The purpose of this Behavioral Health Guidebook is to enhance law enforcement's understanding and awareness of mental health disorders, substance use disorders, physical disabilities, and intellectual/developmental disabilities while adhering to the four tenets of Procedural Justice:

- Voice
- Neutrality
- Respect
- Trustworthiness

Law Enforcement (LE) may frequently encounter individuals with these disorders/disabilities and not all contacts will be criminal in nature. The intent of this guidebook is to assist LE in the safe management of these encounters which can be complex and dynamic. LE is reminded that the material in this guidebook is not a substitute for the individual LE's training, judgement, experience, and safety.

Law enforcement encounters with persons who have behavioral health disorders may be challenging, potentially dangerous, and sensitive in nature. The fundamental duty of law enforcement is to protect the community and uphold the mission of the law enforcement profession.

This guidebook in itself is not intended to qualify law enforcement officers as behavioral health experts, nor establish standards for civil liability.

MANNY ALVAREZ JR.

Executive Director

ACKNOWLEDGEMENTS

Sgt. Mario Moreno
Stanislaus County Sheriff's Department

Marla Kingkade
Mental Health Training Consultant
San Diego County District Attorney's Office

Mark Stadler,
CIT Program Administrator
Ventura County Sheriff's Office

Jennifer Hunt, Psy.D.
Assistant Director, Psychological Services Bureau
Los Angeles County Sheriff's Department

Dr. Gary Taylor, Retired
Fresno Police Department

Brien Farrell, Retired
Santa Rosa City Attorney

Anne Robin, LMFT
Behavioral Health Administrator
Health Agency
County of San Luis Obispo

Vicki L. Smith, PhD.
California State Council on Developmental Disabilities

Detective III Charles Dempsey
Mental Evaluation Unit
Los Angeles Police Department

Captain Ray Sweeney
La Mesa Police Department

Mike Radford
POST, Bureau Chief

Stephen Crawford
POST, Senior Consultant

Jennifer Van
POST, Associate Governmental Program Analyst

TABLE OF CONTENTS

FOREWORD ..... **v**

CALLS FOR SERVICE **1-1**
- LE Assessment and Response to Scene 1-1
- Arrive on Scene 1-2
  - LE/Self Awareness Factors 1-2
  - Person Factors 1-2
  - Environmental Factors 1-2
  - Reporting Party Factors 1-3
- Strategic Communication 1-3
  - TACT: Tone / Atmosphere / Communication / Time 1-3
  - Assessment 1-4
  - Outcomes 1-4
  - Documentation 1-4

MENTAL ILLNESS **2-1**
- Behavioral Indicators 2-1
- Depression 2-2
- Bipolar Disorder 2-3
- Schizophrenia 2-4

OTHER MENTAL DISORDERS **3-1**
- Post-partum Depression 3-1
- Post-Traumatic Stress Disorder 3-1
- Personality Disorders 3-2
- Suicide 3-2
- Autism Spectrum Disorder (ASD) 3-3
- Cerebral Palsy (CP) 3-4
- Epilepsy 3-5
- Excited Delirium or Agitated Delirium (ExD/AD) 3-6
- Intellectual Disability 3-7

PHYSICAL DISABILITIES 4-1
Neurological Disorders 4-1
Dementia 4-1
Stroke 4-1
Blindness or Visual Impairment 4-2
Deaf or Hard of hearing 4-2
Suicide 4-2
Suicide by Cop (SBC) 4-5

DOCUMENTATION TIPS 5-1

APPENDIX A: GLOSSARY OF TERMS 6-1

APPENDIX B: LEGAL REFERENCES 7-1

SELECTED CODE SECTIONS 8-1

STATE RESOURCES 9-1

CALLS FOR SERVICE

When responding to a call that involves a person who is experiencing a behavioral health crisis, officers should obtain as much information as possible to assess and stabilize the scene. Information such as dispatch history and recent calls for service may be helpful. The more information an officer has prior to contact, the more likely the response will be appropriate. Reporting persons and bystanders are often the best source of information and officers should use them as a resource while on scene, if feasible.

LE ASSESSMENT AND RESPONSE TO SCENE

Intel/Information Gathering

- What is/was the subject doing and where is the subject now?
- Is the subject armed or have accessibility to any weapons, If so, what?
- Does the subject have any conditions or disabilities we should know about?
- Does the subject have any known drug or alcohol use?
- Does the subject have a criminal history or previous police contacts?
- Has the subject been violent today or in the past?

Pre-Planning

- Are there other people present?
- Staging, if feasible.
- Resources – (i.e. additional officers, specialty teams, K-9, paramedics, etc.)
- Tactical - (i.e. time, distance, slowing down/speeding up response if practical, contact, containment, communication, etc.)
- Environment - (i.e. proximity to schools, residential areas, open areas, community members, or populated areas, etc.)
- Reporting persons/bystanders may be able to assist with information on scene.
    - ➢ Gather information related to triggers and calming strategies.

Things to Consider to Reduce Situational Intensity

ARRIVE ON SCENE

Behaviors of the person and other stabilizing and destabilizing factors: Danger to the LE, subject, community, etc.

LE/SELF AWARENESS FACTORS

Stabilizing

- Calm demeanor
- Rested
- Perceptive
- Rational
- Confidence from;
  - ➢ Experience
  - ➢ Training

Destabilizing

- Emotionally upset/ stressed
- Fatigued
- Complacent
- Recent critical incident/personal problems
- Insecure/lacking confidence

PERSON FACTORS

Stabilizing

- No known weapon
- Talking/rational
- Compliant
- Responsive
- Calm behavior

Destabilizing

- Presence/suspicion of weapon(s)
- Not talking/irrational speech
- Non responsive, ignoring communication
- Non-compliant, resistive
- Poor/scanning eye contact
- Bizarre, belligerent, assaultive, shifty

ENVIRONMENTAL FACTORS

Stabilizing

- No weapons of opportunity
- Spacious and safe layout
- Accurate sensory functioning
- Back up is present/near

Destabilizing

- Potential weapons (tool, branch)
- Dangerous layout (elevated/tight space)
- Sensory interference (light/sound)
- Back up not present/delayed

REPORTING PARTY FACTORS

Stabilizing

- Calm(ing) informant
- Provides accurate info
- Few spectators/identifiable
- No report of unseen danger

Destabilizing

- Report of unseen danger
- Sterilizes info, defensive
- Crowd/involvement unknown
- Agitating informant

Assessment is continuous and on-going

STRATEGIC COMMUNICATION

TACT: Tone / Atmosphere / Communication / Time

Tone

- It's not only **what** you say — but **how** you say it.
- Present a calm and professional demeanor.
- Maintain respect and dignity.
- Remain professional.

Atmosphere

Reduce distractions/evaluate distance.

- Respect personal space.

Communication

- It's better to spend 15 minutes talking than 5 minutes fighting.
- Safely establish one point of contact.
- Develop rapport.
- LEAPS
  - ➢ Listen
  - ➢ Empathize
  - ➢ Ask
  - ➢ Paraphrase
  - ➢ Summarize

Time

- In general, time is on your side.
- Slow down, when practical.
- If the situation allows, take advantage of time.
  - ➢ Time + Distance = Options
- Reassess

ASSESSMENT

- Behaviors, observations
- Imminent threat/exigency (to self only, to officers, or to community) *(ex: weapons/behaviors)*
- Approachability (ex: verbal/physical)
- Slow it down, if possible; Speed up, as necessary
  - ➢ Laws, Force Options, Departmental Policies, Tactics

OUTCOMES

- Criminal
- Non-criminal
- Disengagement/Re-engagement
- Referrals and resources

DOCUMENTATION

- Department Reports
- Medical/5150/other documents and forms

MENTAL ILLNESS

Definition

Mental illnesses are medical conditions that affect a person's thinking, feeling, mood, ability to relate to others, and disrupts daily functioning.

Not all people with mental illnesses are dangerous. While some may represent danger only under certain circumstances or conditions, some may be capable of going very quickly from a state of calm to being extremely agitated.

Officers should never compromise or jeopardize their own safety or the safety of others when dealing with individuals who display symptoms of a mental illness.

Dual Diagnosis is a term for when someone experiences a mental illness and a substance use disorder simultaneously. Dual diagnosis may also refer to individuals with multiple co-occurring disorders such as mental health disorders, substance use disorders, physical disabilities, and intellectual/developmental disabilities.

BEHAVIORAL INDICATORS

Fearfulness

- Strong and unrelenting fear of people, places, or things
- May be extremely reclusive or aggressive without apparent provocation
- Extreme fright without known cause

Inappropriate Behavior

- Extreme expression of emotion out of context for the situation
- Nudity, extremely odd or inappropriate dress for weather or conditions, self-harm
- Reckless behavior (walking in an out of traffic/yelling)

Agitation

- Combative stance
- Rambling, incoherent
- Excessive movement

Impaired Self-care

- Reduced ability to provide or care for basic needs (e.g., stops bathing or eating, unusual sleep patterns, failure to find adequate shelter, etc.)

Hallucinations

- Hearing voices
- Feeling one's skin crawl
- Smelling strange odors
- Seeing visions

Do not reinforce false beliefs. Do not challenge a person's perception of reality. This may make the situation worse.

Delusions

- Persistent false belief or thoughts and actions that are not based on reality
- Delusions of grandeur
- Self-importance
- Being persecuted or conspired against

Communication

- Use a quiet non-threatening manner when approaching and conversing with the individual, when practical.
- Keep statements short.
  - "What's going on (today)?"
  - "Tell me more about that."
- Acknowledge the person's feelings.
- Ask the person if he or she is hearing voices and, if so, what they are saying.
- Avoid topics that may agitate the person.
- Utilize questions to assess the person's orientation (time, place, person).
- Guide the conversation toward subjects that will bring the individual back to reality (e.g., where are you?, day of the week?).
- Allow time for the person to consider questions and be prepared to repeat them.
- Do not agree or disagree with the delusions or hallucinations but validate the feelings (i.e. "It must be frustrating for you to feel this way.").
- Be truthful when establishing expectations and outcomes of the contact.
- Ask closed choice questions (e.g., do you want option A or option B?, do you want to talk in the driveway or the yard?).

DEPRESSION

Definition

Depression is a fairly common mood disorder. A condition that has mental and physical symptoms that can interfere with an individual's ability to function day to day.

Symptoms may include, but are not limited to:

- Isolation
- Sadness, inactivity, and self-negative talk
- Feelings of guilt, hopelessness, helplessness, or pessimism

- Loss/increased appetite
- Fatigue, decreased energy
- Loss of motivation/interest in activities
- Crying spells
- Chronic pain
- Decreased/increased sleep
- Restlessness or irritability
- Anger and/or rage
- Difficulty concentrating or making decisions
- Thoughts of death (including gestures, attempts or threats of suicide, such as "Things/people would be better off without me.")

BIPOLAR DISORDER

The risk of suicide attempts, suicide, and suicidal behavior is significantly higher for people who are affected by any form of depressive disorder.

Definition

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day to day tasks.

Symptoms may include, but are not limited to:

People having a manic episode may:

- Feel very "up," "high," or elated
- Increased energy/activity levels
- Feel "jumpy" or "wired"
- Trouble sleeping
- Talk really fast about a lot of different things/Highly distracted
- Agitated, irritable, or "touchy"
- Feel like their thoughts are going very fast
- Think they can do a lot of things at once
- Engaged in high-risk behaviors such as excessive shopping/gambling, or have multiple sexual partners or not practicing safe sex

People having a depressive episode may:

- Feel very sad, down, empty, or hopeless
- Very little energy
- Decreased activity levels
- Trouble sleeping- too little or too much
- Feel like they can't enjoy anything

- Feel worried and empty
- Trouble concentrating
- Forgetful
- Eat too much or too little
- Feel tired or "slowed down"
- Thoughts of death (including gestures, attempts or threats of suicide, such as "Things/people would be better off without me.")

SCHIZOPHRENIA

Substance use by an individual may lead to behaviors that mimic a number of different types of thought and mood disorders.

Definition

Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves. People with schizophrenia may seem as though they have lost touch with reality.

Symptoms may include, but are not limited to:

- Bizarre delusional thinking
- Hallucinations
- Incoherent, disconnected thoughts, and speech
- Pressured speech
- Expression of irrational fear
- Deteriorated self-care
- Poor reasoning
- Strange and erratic behaviors
- Trouble focusing or paying attention
- Limited verbal or facial expressions (flat affect)

OTHER MENTAL DISORDERS

POST-PARTUM DEPRESSION

Definition

Post-partum Depression is the onset/increase of mental disorder which can occur after the birth of a child. Mothers experience feelings of extreme sadness, anxiety, and exhaustion that may make it difficult for them to complete daily care and activities for themselves or for others. Symptoms may last a few weeks to several years.

Postpartum depression episodes may impact maternal attitudes towards infants and children and may include:

- Easily annoyed, agitated, or angry without knowing why
- Preoccupied with the care of the infant/child
- Child abuse and/or neglect
- Homicidal thoughts
- Uninterested in the infant/child

POST-TRAUMATIC STRESS DISORDER

(also known as Post-Traumatic Stress Injury)

Definition

Post-traumatic Stress Disorder (PTSD) is an anxiety disorder that can develop after exposure to a traumatic event or in which grave physical harm occurred or was threatened to the individual or someone close to them. These events may be cumulative over a person's lifetime or career.

These events may include, but not limited to:

- Combat or military exposure
- Adult/child sexual, physical/verbal abuse
- Terrorist attacks
- Serious accidents, such as a car wreck
- Natural disasters, such as a fire, tornado, hurricane, flood, or earthquake

Symptoms may include but not limited to:

- Recurring memories or nightmares of event (flashbacks)
- Sleeplessness
- Loss of interest/numbness
- Anger or irritability
- Hypervigilance or on guard
- Startled response
- Survivor's guilt
- Isolation
- Self-medication using drugs or alcohol

PERSONALITY DISORDERS

Definition

Occur when personality traits (enduring patterns of perceiving, relating, and thinking) become inflexible and maladaptive.

The most common personality disorders are:

- narcissistic (entitlement)
- antisocial (manipulative)
- borderline (abandonment)
- histrionic (theatrical)

Symptoms may include, but not limited to:

- Significant functional impairment or subjective distress
- Person may not see the problem

SUICIDE

Suicide is a major public health concern. Suicide is among the leading causes of death in the United States. There is no single cause for suicide. Stigma is the greatest barrier to seeking help. It most often occurs when stressors exceed the individual's current coping abilities.

Symptoms may include but not limited to:

- Direct or indirect statements about suicide, especially with comments that their problems will be over soon
- Giving away possessions
- Engaging in high risk behavior (excessive spending beyond means, erratic driving, etc.)
- Loss of a relationship (romantic partner, parent, child, friend)
- Loss of important/meaningful possessions (home, pets)
- Life threatening/major illness
- Chronic injury/pain
- Career threatening injury or other threats to job
- Alcohol/Substance Use/Misuse
- Depression, feeling helpless and hopeless
- Change in values, lack of caring about oneself
- Family history of suicide or suicide of a friend
- Legal/financial issues

Assess the suicidal means (firearm, drugs) and remove or limit their access.

Officers are reminded that a lawful detention no longer requires imminence and they shall take information from credible third party/witness and history of the event, when available.

AUTISM SPECTRUM DISORDER (ASD)

Definition

ASD is a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It affects the way a person acts and interacts with others, communicates and learns. Rate of ASD is more prevalent in males and ASD impacts every individual differently.

Indicators

- Difficulty relating to people
- Aversion to being touched, especially by strangers
- Sensory Sensitivity issues (sound, taste, touch, sight, noise)
- May act as if hurt when touched lightly, while totally ignoring painful injuries
- Drawn to water
- May cover their eyes or ears to cope with unpleasant stimulus
- Repetitive movements (e.g., rocking, spinning, hand twisting, etc.) Also referred to as stimming
- May be delayed or nonresponsive to questions and or commands
- May stare or avoid eye contact
- Tantrums, self-stimulation, or self-mutilation
- Difficulties with impulse control and social appropriateness
- Community may refer to this as Aspergers

Communication Tips:

- Consider equipment and environment factors which may impact sensory input.
- Explain each step before you do it.
- Have the individual remain stationary when talking.
- Allow extra time to speak and answer questions.
- Allow time for the person to respond.
- Speak directly to the person, even if assisted with technology or a caregiver is present.
- Do not exaggerate your speech features.

Many people with Autism live independently in the community and have productive lives.

"Stimming" while appearing that the person is in distress, can actually be a calming/grounding activity. Consider making the environment safe to accommodate the movement as opposed to stopping it.

CEREBRAL PALSY (CP)

Definition

Cerebral Palsy refers to a group of conditions that affect an individual's body movements and coordination.

There is no relationship between the extent of physical impairment and the person's intelligence. People with cerebral palsy may be highly intelligent and gifted or have normal levels of intelligence.

Indicators:

- Loss of motor control (awkward gait, poor balance)
- Use of mobility aids (wheelchairs)
- Limited range of motion
- Involuntary, spastic body movements
- Slow and/or slurred speech
- Increased or decreased sensitivity to touch or pain
- Tendency to have drooling (due to muscle coordination concerns)
- Motor function is impacted by stress—keep everyone calm

Communication Tips:

- Have the individual remain stationary when talking.
- Allow extra time to speak and answer questions.
- Allow time for the person to respond.
- Speak directly to the person, even if assisted with technology or a caregiver is present.
- Do not exaggerate your speech features.
  - ➢ Individuals with CP may fatigue easily due to involuntary muscle contractions.

If transporting a person with CP, consider double cuffing or cuffing to front to accommodate mobility issues AND request transport for mobility devices (chairs or communication devices). For LE safety, remember to search devices for contraband/weapons.

EPILEPSY

Definition

Epilepsy is a brain disorder that causes recurring seizures. A seizure is a medical emergency, that can cause changes in behavior, movement or feelings, and levels of consciousness. Individuals may wear an identifying medical bracelet/necklace.

Indicators:

- Staring spells
- Disorientation
- Lethargic/tired
- Slurred speech
- Staggering or impaired gait
- Tic-like movements
- Rhythmic movements of the head (e.g., jerking uncontrollably)
- Purposeless sounds and body movements
- Dropping of the head
- Lack of response
- Eyes rolling upward
- Lip smacking, chewing, or swallowing movements
- Partial or complete loss of consciousness
- Picking at clothing
- Bluish skin tone
- Loss of control (bladder or bowel)
- May appear similar to effects of drugs or alcohol

Communication Tips:

- If person indicates a seizure history, have them seated when practical during contact.
- Ask individual about what may happen to them before a seizure/any personal triggers.
- If a seizure occurs in your presence, call EMS and assist in preventing secondary injury—ensure a safe environment (place soft object between person and a hard surface is ok) but do not attempt to intervene (putting something in mouth, restraining the movements).

Seizures may be brought on by a variety of medical events or accidents, including poisoning or injuries to the head.

EXCITED DELIRIUM OR AGITATED DELIRIUM (EXD/AD)

Definition

Excited Delirium is a state of agitation, excitability, paranoia, aggression, and apparent immunity to pain often associated with stimulant use and/or certain psychiatric disorders.

This is a medical emergency—request EMS and additional LE personnel immediately.

Indicators:

- Naked or taking off clothes
- Extreme agitation/hostility/aggression
- Hyperactivity
- Overheating/hot to the touch
- Profuse sweating
- Excessive tearing of the eyes
- Superhuman strength
- Often make growling/animal sounds
- Acute paranoia
- Endurance without apparent fatigue
- Possibly under the influence of stimulants or alcohol
- Attraction to glass/mirrors/reflective surfaces
- Non-compliant
- May attempt to pour liquids on self to cool off
- Blank stare
- Nonsensible and/or pressured speech
- Destructive behavior
- Yelling/screaming

Communication Tips:

- Designate one person to speak/communicate.
- Simple directions, short statements.
- Be mindful of your tone, avoid yelling.
- When practical, reduce environmental stressors such as lights, sirens, radio, etc.
- Focus on the quickest possible restraint for transport and to receive medical intervention.
- Once restrained, monitor vitals until EMS arrives.

Recognition of Excited Delirium as a medical emergency
=
Qualified Immunity
(Hanson v Best, 2019)

INTELLECTUAL DISABILITY

Definition

A disorder with onset before age 18. It includes deficits and difficulties functioning in daily life areas such as communication, self-care, home living, self-direction, social/interpersonal skills, academics, work, leisure, health, and safety.

Behaviors (examples):

Comprehension

- Difficulties responding
- Slurred speech
- May not understand complex questions
- Lack of situational awareness
- Guarded posture
- Eager to agree/please authority figure
- Concrete reasoning
- Anxious

Communication Tips:

- Patience when talking
- Short, direct questions (open ended, don't ask leading questions)
- Speak to family/ caregiver/ guardians about best method of communication (verbal, assistive tech, writing)

**Term "Mental Retardation" shall not be used. Refer to as "persons with Intellectual Disability (ID) in words and writing.*

High chance persons with ID may be a victim of crime and not know it.

PHYSICAL DISABILITIES

Definition

Physical Disabilities for the purpose of this guidebook refer to the following: Neurological Disorders, Blindness or Visual Impairment, Deaf or Hard of Hearing.

NEUROLOGICAL DISORDERS

DEMENTIA (also referred to as Alzheimer's)

Indicators:

- Memory loss
- Agitation
- Verbal repetition
- Same questions repeated
- Unable to follow directions
- Loss of communication skills
- Disorientation of time and place
- Neglectful personal care and safety
- Wandering or lost
- Erratic driving
- Mistakenly reporting crimes (often against relatives)
- Indecent exposure
- May experience hallucinations/delusions (auditory, visual)

Communication Tips:

- Be patient and wait for responses
- Responses may not be sequential to questions
- Seek clarification without challenging statements
- Use present tense
- Reduce environmental distractions, when practical

STROKE (If you believe the stroke has just occurred, request immediate medical attention/assistance.)

Indicators:

- Muscular weakness
- Facial paralysis
- Incontinence
- Loss of balance
- Labored breathing
- Limited or slurred speech
- Loss of basic motor skills
- Partial paralysis

Consider alternate means of communication such as writing on paper, utilization of technology, phone, etc.

BLINDNESS OR VISUAL IMPAIRMENT

Indicators:

- May have a guide/support (white cane with red tip, service animal, person)
- Milky/film over eyes
- Eyes appear sunken into the socket
- Unusual head movement or position
- Close to printed material

Communication Tips:

- Identify yourself as LE and explain purpose for contact.
- Ensure that the location where you are speaking is safe and provide verbal directions in lieu of visual if you need to move, be aware of their guides/supports.
- When practical, verbally announce your intentions prior to physical contact.

DEAF OR HARD OF HEARING

Indicators:

- Upon verbal contact, person does not appear to respond.
- Visual cues: hearing aids or other devices.
- Individual may approach rapidly to get your attention and may want to touch to gain your attention or communicate.
- Individual may gesture to their ears, start to communicate through sign language, or try to approach with a sign.
- Something in hand such as a phone or a notepad.

Communication Tips:

- Determine preferred method of communication. If communication method is not available on site, call for an interpreter.
- Attempt to get their attention visually with body position or gesture.
- Determine if the individual is comfortable with California Relay (free operator video interpretation system) by calling 711.

SUICIDE

Definition: The act of intentionally taking one's own life.

Most suicides are completed in an impulsive act; many times an individual who is indicating suicidal intent can be prevented from completing the act by taking time to limit access to lethal means. Suicide does not have one single cause; things like untreated depression, substance use disorder, recent loss may contribute to one's suicide.

Warning Signs may include, but not limited to:

- Talking about wanting to die.
- Looking for ways to kill oneself.
- Talking about hopelessness, helplessness, uselessness.
- Chronic pain.
- Recent life changing events (medical diagnosis, divorce, losses- loved one, pets, job, sobriety, financial difficulties, etc.).
- Talking about being a burden to others.
- Increased use of alcohol or drugs.
- Anniversary of significant events.

Response:

- Time is on your side. *Time + Distance = Options*
- Consider surroundings; can the individual be contained in a safe location?
- Don't argue with the individual; listen first.
- Maintain communication, don't use commands unless absolutely necessary to maintain safety.
- Make simple requests.
- Do not force the situation, maintain calm, professional stance, and language.
- Do not make promises you can't keep.

Communication Do's:

- Slow down, be patient, and listen.
- Ask how you can help.
- Accept the person's feelings.
- Accept the emotional state of the person.
- Ask for the reason for not wanting to live.
- Listen for the reasons why he/she has chosen to live until now.
- Accept the person's life perspective.
- Show them that you care.
- Engage in conversation.
- Offer options.
- Locate helpful people (family, friends, etc) to assist with information.

Communication Don'ts:

- Don't say "don't talk like that".
- Don't say "You shouldn't feel that way".
- Don't minimize what is being said.
- Don't try to cheer him/her up.
- Don't make assumptions about what is important to them.

- Don't be judgmental or preachy.
- Don't lecture; listen more, talk less.
- Don't make promises you can't keep.

Behavioral Indicators

- Crying, agitation, shouting, pacing, fearful, sudden mood changes
- Statements of suicide or self-harm
- Presence or reference to weapons
- Access to other lethal means (jumping, running into traffic, ingestion)
- Showing rage or talking about seeking revenge
- Engaging in high-risk behaviors
- Giving away possessions, cleaning out workspace/tying up loose ends, or recent excessive purchases
- Nostalgic statements, saying goodbye/thank you
- Increased or heavy use of drugs or alcohol
- Feeling hopeless, helpless, useless, or a burden to others
- Poor grooming, weight loss
- Sleeping too much or too little
- Isolation
- Unexplained content or calmness

Documentation

- Write a 5150 application, ensure behavioral, observable terms are written clearly.
- Use observable terms: saying "I want to die", reports having a weapon, pills, etc.; "I'm feeling hopeless", "Nobody loves me" or "wants me".
- Write relevant historical timeline: recent loss, relapse, past attempts.
- Take credible third party reports of recent behavior, language, other actions. Ask bystanders, family, etc. about any other events such as anniversaries of loss/trauma.

Note: Getting better from depression can also lead to suicide due to the fear of return to illness, or having enough energy to complete an act.

SUICIDE BY COP (SBC)

Definition

An encounter where a person's behavior intentionally or spontaneously forces a law enforcement officer to use lethal force.

Indicators of a possible SBC incident:

- The individual says "kill me" or "shoot me" or otherwise expresses a wish to die.
- The individual appears to be depressed or in a mental health crisis.
- The individual is not behaving like a criminal offender, i.e. the individual does not attempt to leave the scene.
- The individual is behaving aggressively toward the police for no apparent reason.
- The individual is exhibiting strange behavior, such as committing random acts of vandalism or ramming a police car.
- The individual may make statements of resistance, refusal to be taken into custody.
- If possible, when gathering information from known available sources on scene:
  - Alert other officers that the situation may be an SBC incident.
  - Provide details about the subject of the call to responding officers.
  - Conveying the exact language that the 9-1-1 caller is using.
  - Listen carefully for key words or phrases such as: "I'm concerned he may harm himself"; "He has hurt himself before", "He's acting despondent".

Adapted from Police Executive Research Forum (PERF) Protocol and Training Guide August 2019 available at: https://www.policeforum.org/suicidebycop as well as "Suicide by Cop: A New Perspective on an Old Phenomenon." Alejandra Jordan, Nancy R. Panza, and Charles Dempsey. Police Quarterly. (2019). (forthcoming)

DOCUMENTATION TIPS

Report Writing

Documentation elements to consider—all information prior to, during, and after contact may be considered in future reviews of this contact. It is important to articulate and document the totality of circumstances.

Pre-call information

- include nature of the call
- reporting party information
- describe the behavior of the individuals involved
- prior call history related to the individual or location

On-scene information

- initial observations arriving to scene
- individual's actions
- witnesses
- reference to resources identified (Ambulance, Mental Health…etc)
- describe the environment where the individual is encountered
- articulate the assessment of threats and risks

Officer's actions

- steps taken to establish rapport
- techniques and strategies to de-escalate the intensity of the situation and the outcomes of each (what worked/didn't work)
- explain how the individual was taken into custody (as applicable)

Legal references (as applicable)

- WIC/PC laws
- Policy and Procedures

Conclusion/disposition

- detainment (criminal/civil)
- medical clearance/transport
- disengagement and re-engagement (as applicable)

Form(s)

Officers do not place individuals on a "5150 hold". Officers detain and complete a 5150 application.

The Application for Assessment, Evaluation and Crisis Intervention or Placement for Evaluation and Treatments a state form (WIC5150) was initially developed to protect civil rights. This form provides vital and important information to the medical professionals. This information may be a foundation for further assessment and arranging for critical and lifesaving treatment for the person in crisis. The form provides guidance to law enforcement to observe, advise, intervene and document interactions with individuals who are at risk for danger to self, to others, or who are gravely disabled due to a mental condition.

Although this is not a criminal arrest, it is a suspension of the 4th amendment, so proper articulation is essential.

The persons condition was called to your attention under the following circumstances

- Dispatched call from a reporting party
- Advised by citizen
- On view incident
- Actions of person (violent, self-harm, gravely disabled, suicidal)

The officer has probable cause believing the person is, as a result of a mental health disorder, a danger to others, or to himself/herself, or gravely disabled due to one or the following:

- Detail the eyes on observations
- State specific facts, (similar to a PC declaration) detailed explanation regarding behavior and/or statements – use quotes as available
- Prior calls for service to person or location
- Add or include additional report pages/documents for your narrative as needed (copies of social media posts, etc.)
- Do not diagnose but document any self-disclosure about their condition.

Remember

Terms like, "Bizarre behavior" does not explain a disorder or danger

- Notification to be provided to law enforcement agency.
- If checking box for criminal charges pending, you should indicate a designated person or number per department procedure to be notified upon release.
- This form is part of the individual's medical record and available to them.

APPENDIX A

Glossary of Terms

Absence Seizure
Also known as petit mal. Symptoms include a blank stare which lasts only a few seconds, accompanied by rapid blinking.

Action Imperative
A set of circumstances that demand immediate action; the action component to a cause and effect. An action which compels an officer to believe he/she must "do" something.

Agitation
Extreme restlessness.

Alzheimer's Disease
A disease that destroys the brain's ability to remember, reason and respond. It involves a gradual decline in memory, judgment, functionality, personality, language skills and resistance to infections and other diseases. See *dementia*.

Anxiety Disorder
A feeling of dread and apprehension about the future, with no specific cause for the fear.

Aphasia
An impairment in the understanding or transmission of ideas by language in any of its forms: reading, writing or speaking, due to an injury or disease of the brain.

Attention Deficit Disorder
A consistent pattern of inattention and/or hyperactivity/impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development.

Autism
A developmental disorder characterized by difficulties with social interaction and communication, and by restricted and repetitive behavior. (See *stimming*)

Bipolar Disorder
Also referred to as manic depression. A medical/mental disorder characterized by cyclic swings in emotion or mood. In the manic phase there is hyper-excitability, extreme elation, excessive motor activity, and a flight of ideas. In the depressive phase, the person displays depression, underactivity, unresponsiveness, anxiety, sadness, and sometimes suicidal

impulses. In its classic form, the disorder is an alternation between the two phases.

Catatonic Behavior
A reaction in which there is a marked decline of motor behavior, an inhibition of movement, and a display of stupor.

Cerebral Palsy
A neurological condition resulting in reduced control over motor functions. Because of the lack of muscle control, functions such as speech, hearing, or vision can also be affected.

Command Hallucination
An auditory hallucination that commands the person to commit specific acts, which may include acts of violence.

Consumer
Patient or client. A person who uses developmental or mental health services.

Co-occurring/Dual Diagnosis
is a term for when someone experiences a mental illness and a substance use disorder simultaneously. Either disorder, substance use or mental illness, can develop first.

Delirium
A state of medical condition accompanied by delusions, illusions and hallucinations. Delirium may be induced by mental health, fever, drugs, or shock.

Delusion
A fixed false belief that cannot be modified by reasoning or a demonstration of the facts.

Dementia
A term for conditions involving cognitive impairment, with symptoms that include memory, language, communication, and thinking.

Depression
A fairly common mood disorder. A condition that has mental and physical symptoms that can interfere with an individual's ability to function day to day.

Developmental Disability
A chronic disability that originates before the age of 18, and has a lifelong impact. Developmental disabilities include Intellectual Disability, Cerebral Palsy, Epilepsy, Autism and other neurological conditions.

Down's Syndrome
Often erroneously grouped into the category of intellectual disability. Down's Syndrome is a chromosomal abnormality, which results in a mental disability and a characteristic physical appearance.

People with Down's Syndrome have some level of intellectual disability, falling into the mild to moderate range.

Epilepsy
A brain disorder that causes recurring seizures. A seizure is a medical emergency, that can cause changes in behavior, movement or feelings, and levels of consciousness. Individuals may wear an identifying medical bracelet/necklace.

Flat Affect
Reduced emotional response or emotional flatness. The person appears to be indifferent and/or totally apathetic, and appears to be staring.

Hallucination
A false perception experienced through any one of the five senses (e.g. hearing voices, feeling one's skin crawl, smelling strange odors, seeing visions, etc.). Most hallucinations involve hearing voices or seeing visions that are not there.

Hypervigilence
An enhanced state of sensory sensitivity accompanied by an exaggerated intensity of behaviors whose purpose is to detect activity. May bring about a state of increased anxiety which can cause exhaustion.

Incoherent
Speech or thinking that is essentially incomprehensible to others because words or phrases are joined together without a logical or meaningful connection.

Intellectual disability
A disorder with onset before age 18; it includes deficits and difficulties functioning in daily life areas such as communication, self-care, home living, self-direction, social/interpersonal skills, academics, work, leisure, health, and safety.

Manic-depression
See *bipolar disorder.*

Mental Illness
Medical condition(s) that affect a person's thinking, feeling, mood, ability to relate to others, and disrupts daily functioning.

Mood Swings
Feelings that are easily changeable and move between extremes (sometimes rapidly).

Obsessive Compulsive Disorder
A debilitating anxiety order in which a person experiences recurrent, unwanted obsessions and/or performs repetitive, often ritualized actions that they feel powerless to stop or control.

Paranoia
Irrational fear of being persecuted or harmed that often involves a serious delusion. The fear may extend to family, loved ones, or others.

Personality Disorder
Deeply ingrained, inflexible, maladaptive patterns of relating, perceiving, and thinking.

Phobia
A persistent, irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid it.

Pressured Speech
A tendency to speak rapidly and frenziedly, as if motivated by urgency not apparent to the listener. The speech produced is difficult to interrupt. Such speech may be too fast, erratic, irrelevant, or too tangential for the listener to understand. It is an example of cluttered speech, and often associated with certain mental disorders particularly mania and schizophrenia. It can be unrelenting, loud and without pauses. Speech that is increased in amount, accelerated, and difficult or impossible to interpret, usually loud and emphatic. Frequently, the person talks without any social stimulation and may continue to talk even though no one is listening.

Psychosis
A major mental disorder in which a person's thought pattern is seriously disorganized and reality usually impaired. There are two types of psychoses: a) functional- typically of the schizophrenic, paranoid, or manic depressive type; and b) organic- caused by brain damage or disease.

Schizophrenia
is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves. People with schizophrenia may seem as though they have lost touch with reality.

Seizure
A medical emergency that results in a surge of energy through the brain, causing massive involuntary contractions of muscles and possible unconsciousness.

Stimming
Repetitive actions or movements that may be displayed by people with developmental disabilities, most typically autism.

Suicide By Cop (SBC)
An encounter where a person's behavior intentionally or spontaneously forces a law enforcement officer to use lethal force.

Tinnitus
A persistent ringing or buzzing in the ears.

Traumatic Brain Injury
A disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury.

APPENDIX B

LEGAL REFERENCES

Selected Case Summaries

Adams et al., v. City of Fremont

68 Cal.App.4th 243, 80 Cal.Rptr. 2d 196. (1998)

The Court of Appeal held that, under the facts presented, a police officer who responds to a crisis involving a person threatening suicide with a loaded firearm is not liable if the officer's conduct fails to prevent the threatened suicide from being carried out.

Alexander v. City of San Francisco

29 F.3d 1355 9th Cir. (1994)

In determining whether an officer's actions were objectively reasonable, the courts will consider all relevant circumstances, including the reasonableness of an entry into a residence. In contrast, *Graham v. Conner* and *Scott v. Henrich* focus on the reasonableness of an officer's actions at the instant that force was used, not on the tactics or earlier actions of the officer. The U.S. Supreme Court has not yet clarified this issue.

Deorle v. Rutherford

Ninth Circuit Court of Appeals (2001)

Whenever feasible, the officer should announce a warning before firing a distance impact weapon.

Graham v. Connor

490 U.S. 386 104 l Ed 443, 109 S Ct 1865 (1989)

Law enforcement is responsible for using objectively reasonable force. Peace officers need not use the least intrusive force option, but only use that force which is reasonable under the totality of the circumstances at the moment it is used.

Hainze v. Richards

207 F.3D 795 (5th Cir.) (2000)

Whether or not a 911 call refers to someone with a mental illness or disability, the court holds that the Americans with Disabilities Act (ADA) does not apply before the officer has secured the scene or assured himself or herself that there is no threat of death or serious injury.

Hanson v. Best

915 F.3d 543 (2019)

This is an excited delirium case where the court dismissed the lawsuit, which alleged that the officers exhibited deliberate indifference to the medical needs of a suspect who had taken amphetamine.

At 4:40 a.m. officers were dispatched to check on a man curled up in a fetal position in the foyer of a market. The officers assumed the man was intoxicated and asleep. An officer tapped the suspect with his left hand, after which he started to stir and flex his limbs. The suspect yelled incoherently, thrashed his arms, kicked his legs, spit at officers, made growling sounds, and attempted to twist away. Officers twice tased the suspect's thigh. Officers handcuffed Layton with two sets of cuffs. Officers applied a hobble restraint, connecting leg restraints to Layton's handcuffs. Officers and their on-scene commander believed that the suspect was "methed-out." The commander requested that the suspect be transported to the jail by ambulance because using the squad car would require removal of restraints. The commander also feared that Layton could asphyxiate.

The paramedics assessed the suspect's breathing, airway circulation, and heart rate and determined he could be safely transported to jail. A paramedic monitored the suspect's pulse and breathing en route to the jail. When officers and paramedics moved the suspect into the booking area of the jail, officers discovered that the suspect was in cardiac arrest. They removed his restraints, initiated CPR, and applied a defibrillator. While they restored a cardiac rhythm and brought the suspect to a hospital, he never regained consciousness.

The autopsy revealed that the suspect suffered from pneumonia due to probable excited delirium, heart disease, and liver disease. He tested positive for amphetamine and alcohol.

Obviously, in this case, extensive medical assistance was provided and measures were taken to reduce the risk of asphyxiation. In the end, the court ruled, without a trial, that the officers could not be liable for violating clearly existing law or deliberate indifference to the suspect's medial needs.

Hayes v. San Diego

736 F.3d 1223 (9th Cir. 2013)

Sheriff's deputies came to the home of Shane Hayes in response to a call from a neighbor. When the deputies arrived, Hayes' girlfriend informed them that Hayes was suicidal. The deputies then entered the house, where Hayes came toward them with a large knife raised in his right hand. The

deputies simultaneously drew their guns and fired at Hayes, who died from the gunshot wounds. Hayes's daughter filed a complaint in federal district court against the County of San Diego and the deputies, alleging three federal law claims and two state law claims.

The district court granted summary judgment for Defendants on all claims, finding that the deputies owed Plaintiff no duty of care with respect to their pre-shooting conduct. The Ninth Circuit Court of Appeals asked the California Supreme Court to answer a question of state law. The Court answered by holding that, under California negligence law, liability can arise from tactical conduct and decisions employed by law enforcement preceding the use of deadly force if the conduct and decisions leading to the use of deadly force show, as part of the totality of the circumstances, that the use of deadly force was unreasonable.

Reynolds v. County of San Diego

84 F.3d 1162 (9th Cir.) (1996)

In an effort to restrain an individual who was acting strangely and was waving a knife, the officer approached from behind, ordering the individual to drop the knife. When the subject responded by swinging the knife at the officer, it was then reasonable for the officer to use his own weapon to protect himself. Therefore, the officer was immune from federal civil rights liability.

Scott v. Henrich

39 F.3d 912 (9th Cir.) (1994)

The appropriate inquiry as to whether or not deadly force was properly used by police officers is whether the use of that force was objectively reasonable under the circumstances at the time it was used, not whether there were less intrusive alternatives available.

Sheehan v. San Francisco

135 S. Ct. 1765 (2015)

The Supreme Court held that police officers could not be sued over their use of force when arresting a knife-wielding woman with a history of mental illness in a group home, in which she was pepper sprayed and shot multiple times. The woman survived.

The court concluded the officers did not violate clearly established law during the 2008 incident at the group home for people with mental health issues where the plaintiff lived.

The Supreme Court did not decide whether the officers were required under the federal Americans with Disabilities Act to accommodate Ms. Sheehan's mental disability. Before the ADA issues were resolved, the

plaintiff settled for one million dollars with the insurance carrier of the group home operator. It is not known whether the insurance carrier and the City and County of San Francisco have resolved their dispute over the allocation of fault between themselves.

Sheila Doe v. City of Modesto

Cal. 5th Ct. App. Oct. 6, 2016

This case is unpublished and cannot be cited as precedent in other matters. However, it discusses how law enforcement can create a special relationship with a member of the public. Normally, under civil liability law, officers do not owe a duty of care to protect members of the general public (department policy may require that an officer respond, investigate and take appropriate steps to protect property or people). Giving assurances to people that you will "take care of them," or "make sure that they will be safe" can create a special relationship with an individual or family and potential liability.

Tennessee v. Garner

471 US 1, 85 L Ed 2d 1, 105 S Ct (1985)

Prohibits the use of deadly force to prevent the escape of a suspected felon, unless it is necessary to prevent the escape and the officer has probable cause to believe the suspect poses a significant threat of death or serious injury to the officer or others. Where practical, a warning should be given before deadly force is used. The apprehension of a person by the use of deadly force is a seizure and is subject to the reasonableness requirement of the Fourth Amendment. The reasonableness of the seizure depends on not only when it was made, but also how it was carried out. The question is whether the totality of the circumstances justified a particular sort of seizure.

People v. Triplett

144 Cal.App. 3d 283, 287-288 (1983)

Establishes the legal standard for probable cause to detain a person pursuant to section 5150: Specific and articulable facts known to an officer (or other authorized person) that would lead a person of ordinary care and prudence to believe, or entertain a strong suspicion that the person is mentally disordered, a danger to self or others, or gravely disabled. An officer must be able to point to specific facts which, when taken together with rational inferences from those facts (based on the totality of the circumstances), reasonably warrant his or her belief or suspicion that a person is mentally ill. An officer is justified in taking into account the past conduct, character and reputation of the person suspected.

Roell vs. Hamilton

870 F.3d 471 (2017)

Gary Roell had a serious, chronic mental illness. He quit taking his anti-psychotic medications and was in the throes of excited delirium. Naked, other than a t-shirt, Roell trashed his condominium and then went to the neighbor's condominium, where he threw a flower pot through the window. The neighbor called the police, reported the broken window and said Roell was "acting crazy."

Three deputies arrived at the scene and the neighbor told them Roell was in the back, breaking things. As the deputies went through the garden gate, they saw Roell in the state of excited delirium. When a deputy asked Roell what was going on, Roell turned and charged toward the deputies.

At this point, one deputy took his TASER® in-hand and arced it as a warning. The deputies told Roell to show his hands and drop the items, but Roell swung a hose and the basket at the deputies as he reached them. Two deputies then grabbed onto Roell. The deputies struggled briefly with Roell on the ground, but he broke away.

Roell stood and moved back through the garden gate. One deputy fired the TASER probes into Roell and then all three deputies tried, unsuccessfully, to handcuff him. A deputy then applied the TASER in drive-stun mode to Roell's leg, but Roell managed to break away from the deputies again and stood. A second set of TASER probes was fired and though Roell still fought, the deputies were able to handcuff him. Due to his powerful resistance, they needed to use two sets of handcuffs and had to handcuff Roell in front.

When Roell delivered a strong kick to the groin of one deputy, another deputy retrieved leg shackles from the patrol car. The deputies applied the shackles and restrained Roell, who went limp and began to snore. One of the deputies checked him and found no pulse.

Though deputies and medics administered CPR, Roell did not revive. The coroner ruled that Roell's death was due to "excited delirium due to schizoaffective disorder" and determined the death resulted from natural causes.

Roell's widow sued, claiming the deputies used excessive force and that they were inadequately trained. She also argued the deputies had a legal duty to de-escalate.

The court also considered testimony that the best practice in dealing with excited delirium subjects is to wait to contact the subject until there are multiple officers and medical personnel on-scene and to try to use verbal techniques.

Further, the court observed that even if there might have been a better approach, that doesn't mean the deputies violated constitutional rights. "The Fourth Amendment … does not require police officers to take the better approach, … only that they take a reasonable approach" *(Cook v. Bastin, 590 F. App'x 523, 528 (6th Cir. 2014))*. The court also held the agency "had a satisfactory training program in place regarding officer interactions with individuals suffering from mental illness and excited delirium." The court dismissed the suit.

SELECTED CODE SECTIONS

5151 WIC

Evaluation and services provided

A professional at the 72-hour treatment facility must assess the individual for appropriateness of the involuntary detention. If the professional concludes that the person can be served without being detained, the person shall be provided outpatient services on a voluntary basis.

5152.1 WIC

Notification of release

At the time of application, officers may make a written request for notification of the release of an involuntary detainee if the detainee's actions would support the filing of a criminal complaint. The notice is limited to the person's name, address, date of admission and date of release.

5156 WIC

Personal property

Officers are responsible for taking reasonable precautions to safeguard the property of the person taken into custody.

5157 WIC

Advisements

Requires officers to advise persons detained under 5150 that they are not under arrest. The officer must also tell the person their name, type of peace officer, agency, the name of the mental health facility he/she is being taken to, what they may bring, and that the person may call or leave a note for friends/family.

7325 WIC

Apprehension of a person who has escaped

Gives police officers the authority to apprehend, without a warrant, an involuntarily detained person who has escaped from a designated facility, upon written request of the facility or the patient's conservator, and deliver the person to the designated facility. The facility shall provide written or telephonic notification of the escape including name and physical description, potential for danger, and any additional information needed to apprehend and return the patient.

8102 WIC

Confiscation of weapons by law enforcement

Requires officers to confiscate any firearm or deadly weapon owned or under the control of a person who is detained or apprehended for examination of their mental condition.

1799.111 H&S (24-HOUR RULE)

Detention or release

A licensed general acute care hospital may keep a mentally disordered or gravely disabled person for up to twenty-four hours if the person cannot safely be released and the hospital is unable to find appropriate mental health treatment for the person.

STATE RESOURCES

These are statewide numbers as a supplement to your local jurisdictional resources.

LAW ENFORCEMENT RESOURCES

Dependent Adults

Project Safe Return (Alzheimer's)
800-572-1122
Medicalert.org

Developmentally Disabled

AutismSpeaks.org
888-288-4762

AutismSocietyCA.org
800-869-7069

Mental Health Services

CON-REP (Conditional Release Program)
800-877-0277

Physical Disabilities

California Relay Service (TTY) – Hearing Impaired
711

Speech To Speech Relay Service – Speech Impaired
711

Poison Control
800-222-1222
Poison.org

FAMILY REFERRAL RESOURCE LIST

Advocacy

Client Assistance Program (Dept of Rehabilitation)
800-776-5746
Disabilityrightsca.org

Long-Term Care Ombudsman
800-231-4024
Aging.ca.gov

Disability Rights CA
800-776-5746
Disabilityrightsca.gov

Alcohol and Drugs

Substance Abuse and Mental Health Services Administration (SAMHSA)
1-800-662-HELP (4357)

Children and Adolescents

California Youth Crisis Line (24 hr)
800-843-5200
(Text TEEN to 839863)
http://calyouth.org http://teenlineonline.org

Foster Care Ombudsperson Office
877-846-1602

LGBTQ Youth Trevor Project
1-866-488-7386
(Text START to 678678)
www.thetrevorproject.org

Teen DV Relationships
1-866-331-9474
(Text LOVEIS to 22522)
National Child Traumatic Stress Network
www.netsn.org

Runaway and Homeless Youth
1-800-RUNAWAY (786-2929)
(Text 66008)

Grief and Loss

National Center for Grieving Children & Families
1-866-775-5683
www.dougy.org

Developmental Disabilities

ARC
800-950-6264

Autism Society
800-328-8476

Early Start Program
800-515-BABY

Epilepsy Foundation
800-564-0445

UCP (United Cerebral Palsy)
800-872-5827

Disability Assistance Resources

Disability Rights
800-776-5746

California Relay Service (Hearing Impaired)
711

California Relay Speech to Speech (Speech Impaired)
711

California Foundation of Independent Living Centers
916-325-1960

Elderly/Aging Resources

Department of Aging
800-510-2020

Project Safe Return (Dementia/Alzheimer's)
800-572-1122

Department of Social Services
800-952-5253

Mental Health Resources

NAMI California
916-567-0163

Suicide Prevention Hotline
800-273-TALK (8255)
(Text HOME to 741741)

Spanish Language Suicide Prevention Hotline
888-628-9454

Veterans Affairs Crisis Line
800-273-8255
(Text HELP to 838255)

Blue Help (Suicide Prevention Hotline for Law Enforcement)
800-273 TALK (8255)
(Text BLUE to 741741)

COPLINE (International Law Enforcement Officers Lifeline)
800-267-5463