State of Michigan
MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS
Michigan Justice Training Competitive Grant Program

2021 GRANT APPLICATION

SECTION 1 - IDENTIFICATION

APPLICANT AGENCY	SIGMA ID/ADDRESS CODE
Grand Valley State University	

STREET ADDRESS/CITY/ZIP
401 W. Fulton Street, Grand Rapids, MI, 49504

TRAINING CONSORTIUM (if applicable)
West Michigan Criminal Justice Training Consortium

PROJECT TITLE (Limit 45 characters)
360° Behavioral Health for Law Enforcement

START DATE	END DATE	GRANT FUNDS REQUESTED
January 1, 2021	December 31, 2021	$25,055.12

AUTHORIZED OFFICIAL (PERSON AUTHORIZED TO ENTER INTO AGREEMENTS)

☑ ***As the Authorized Official, I have read and agree to all conditions set forth in the 2021 Grant Manual.***

NAME AND TITLE	
Michael Gouin-Hart, Director of the Office of Sponsored Programs	
STREET ADDRESS/CITY/ZIP	
049 JZH, One Campus Drive, Allendale, MI 49401	
TELEPHONE (Direct)	E-MAIL ADDRESS
616-331-6868	gouinmi@gvsu.edu
SIGNATURE	DATE
	June 4, 2020

PROJECT ADMINISTRATOR (PERSON RESPONSIBLE FOR IMPLEMENTING AND REPORTING THE TRAINING)

☑ ***As the Project Administrator, I have read and agree to all conditions set forth in the 2021 Grant Manual.***

NAME AND TITLE	
Williamson N. Wallace, Director of Criminal Justice Training	
STREET ADDRESS/CITY/ZIP	
157 Lake Michigan Hall, One Campus Drive, Allendale, MI 49401	
TELEPHONE (Direct)	E-MAIL ADDRESS
616-331-8515	wallacew@gvsu.edu
SIGNATURE Williamson N. Wallace, III	DATE
	June 4, 2020

FINANCIAL OFFICER (PERSON RESPONSIBLE FOR GRANT ACCOUNTING)

☑ ***As the Fiscal Officer, I have read and agree to all conditions set forth in the 2021 Grant Manual.***

NAME AND TITLE	
Ian Mills, Senior Accountant	
STREET ADDRESS/CITY/ZIP	
2015 Zumberge Hall, 4099 Calder Dr, Allendale MI. 49401	
TELEPHONE (Direct)	E-MAIL ADDRESS
616-331-2204	millsia@gvsu,edu
SIGNATURE	DATE
	6/4/2020

By authority of P.A. 302 of 1982, as amended
Submission of this application is required to participate in this program.

Applications must be submitted to MCOLES via email to thelend15@michigan.gov no later than May 22, 2020.

SECTION 2 - PROJECT NARRATIVE
A. PROBLEM IDENTIFICATION
Describe the problem or issue the training is expected to address. Connect the proposed training to the documented need. Explain why this proposal should be grant funded. **Refer to Page 18 of the Grant Manual**

PROBLEM IDENTIFICATION

Grand Valley State University, on behalf of the West Michigan Criminal Justice Training Consortium (WMCJTC), submits this grant request for training in two areas related to mental health education: (1) how to recognize, respond, and mitigate a behavioral health crisis incident – *Michigan Crisis Intervention System* and (2) how to lessen the harmful effects of accumulated job stress and trauma – *Career Survival and Emotional Wellness*.

According the National Institute of Mental Health, nearly one in five U.S. adults live with a mental illness (46.6 million in 2017) – this number represented 18.9% of all U.S. adults. Additionally, an estimated 49.5% of adolescents had a mental disorder. In a 2015 Reuters article posted on the Psychiatry & Behavioral Health Learning Network website, it was stated that "Americans with severe mental illness are 16 times more likely to be killed by police than other civilians."

Research has shown that stress from police work tends to lead to emotional reactions, some of which can be negative and increase the risk of drug abuse, alcoholism, anger, burn-out, depression, misconduct, and harm to self or others (Bishopp, N. Piquero, Worrall and A Piquero, 2019, Negative Affective Responses to Stress among Urban Police Officers). According to data released by Blue H.E.L.P., an organization that tracks police officer suicides, 228 American police officers died by suicide in 2019. For four consecutive years, more American police officers have been reported to die by suicide than all other line-of-duty deaths combined (Police, 2020).

Every day, law enforcement officers are faced with unknown, dangerous, violent, and traumatic situations. Because of these intense, adrenaline-filled, and stressful conditions, officers need specific education and training in mitigation techniques. By proactively training our officers and giving them information, tools, and practical skills to handle behavioral health crisis on the streets and identify the signs and symptoms of stress in themselves and their peers, we can increase the likelihood that officers will more effectively and professionally deliver services to the public and respond to personal stress and trauma in a positive manner.

WMCJTC agencies are excited about 360° Behavioral Health for Law Enforcement and are confident that through training and education, officers will show improved job performance and be able to better manage the high level of stress and trauma. Ultimately, better emotional health and improved relationships are a win-win for the profession and the community.

SECTION 2 - PROJECT NARRATIVE
B. TRAINING OBJECTIVES
Describe the subject matter for each course/topic. Provide global objectives in terms of outcomes, stating what the trainees are expected to know and do as a result of this training. **Refer to Page 18 of the Grant Manual**

~ PROGRAM ONE ~

MICHIGAN CRISIS INTERVENTION SYSTEM (MI-CIS)

The Michigan Crisis Intervention System is a robust and innovative behavioral health training initiative to equip emergency responders with the tools they need to effectively recognize, respond, and mitigate a behavioral health crisis incident. The MI-CIS program consists of *three linked training levels/segments.* The segments complement each other *(designed to be completed sequentially)* and enhance the educational experience through a flipped classroom training model and enhanced reality base training. ***MI-CIS program provider is Western Michigan University Homer Stryker M.D. School of Medicine, http://www.mi-cis.org. MI-CIS Program Manager is Robert T. Christensen, 269-377-1749, Robert.christensen@med.wmich.edu.***

This program is designed to enhance the knowledge, skills, and attitudes of emergency responders to effectively intervene for those experiencing behavioral crisis situations. Mental illness is common in our society, with approximately 1 in 4 people experiencing a mental health condition during their lifetime (NAMI.) Following efforts in the 1970s to de-institutionalize treatment more people with mental health conditions live in community settings, so interactions with emergency responders in the community are common. People who do not have a mental illness may also exhibit crisis behaviors as a response to stress. The material in this course is based on information in governmental references, the literature, and best practices, but responders must be aware of and comply with laws, policies, and procedures in their own jurisdictions and organizations.

Goals of MI CIS:

1. Increase safety of responders, consumers, and bystanders
2. Reduce injuries to responders by using proper de-escalation techniques
3. Appreciate the value of a community-based approach in a response for those with mental disorders
4. Identify appropriate resolutions available to first responders
5. Promote an environment of collaboration and partnership
6. Eliminate the use of force where possible
7. Divert persons with mental illness to treatment as opposed to incarceration where appropriate
8. Reduce the stigma associated with mental disorders

Key Principles – guiding all aspects of this initiative:

1. Safety is paramount
2. Recovery oriented
3. Dignity and respect
4. Patient centered
5. Trauma informed
6. Culturally competent
7. Sustainable

MI-CIS <u>AWARENESS LEVEL</u> – online delivery (4 hours):

LEARNING OBJECTIVES (C=Cognitive; A=Affective; P=Psychomotor) - Upon completion of this course, participants will be able to:

1. Define mental health, mental illness, and developmental disability (C)
2. Identify behaviors associated with mental illness and developmental disability (C)
3. Recognize commonly used medications for mental illness (C)
4. Discuss communication techniques appropriate for use in responses for individuals in crisis (C)
5. Discuss de-escalation techniques appropriate for use in responses for individuals in crisis (C)
6. Apply provisions of mental health laws to situations involving mental health crises in the community (C)
7. Describe the benefits of providing Trauma-Informed Care in response for mental health crisis (A)
8. Identify populations who may have specialized needs related to mental health crisis intervention (C)

(See attached MI CIS Awareness Curriculum)

MI-CIS <u>OPERATIONS PHASE I</u> – online delivery (4 hours):

LEARNING OBJECTIVES - Upon completion of this course, participants will be able to:

1. Demonstrate the ability to identify indicators of mental illness, developmental disabilities, and substance use disorders
2. Demonstrate knowledge of appropriate language usage when interacting with potentially emotionally distressed persons
3. Demonstrate the ability to utilize de-escalation to resolve a variety of situations involving individuals in crisis
4. Identify indications of potential violence in someone in crisis
5. Demonstrate knowledge of special populations who may be involved in crisis situations

(See attached MI-CIS Ops I Curriculum)

MI-CIS <u>OPERATIONS PHASE II</u> - Enhanced Reality-Based Training (8-hour day):

LEARNING OBJECTIVES - ***Scenarios 1-8 (4 hours)*** *– 1. Suicidal Subject - Depression/Drug Overdose; 2. Suicide by Cop - Police Use of Force Mitigation; 3. Veteran in Crisis; 4. Youth in Crisis; 5. Autism Spectrum Disorder or Co-Occurring Disorder; 6. Thought Disorder – Psychosis; 7. Cognitive Disorders - Dementia, Traumatic Brain Injury, Delirium; 8. Mood Disorders - Bipolar, Mania, Depression*:

1. Demonstrate a safe, tactically sound response
2. Demonstrate teamwork
3. Demonstrate active listening skills - ability to gain information about the subject and the

situation

4. Demonstrate the ability to show empathy and respect
5. Demonstrate strong verbal and non-verbal communication skills
6. Demonstrate the ability to achieve a safe and effective resolution
7. Demonstrate the ability to explain actions/decisions made throughout the event as part of the After-Action Review process.

LEARNING OBJECTIVES – ***Scenario 9 (30 minutes)*** – *De-escalation skills, patient restraints, excited delirium*:

1. Describe and demonstrate effective communication skills that focus on de-escalating a potentially violent patient
2. Describe and demonstrate treatment for patients experiencing excited delirium
3. Describe and demonstrate appropriate patient restraint techniques
4. Describe the dangers associated with positional asphyxiation

LEARNING OBJECTIVES – ***Scenarios 10-11 (30 minutes)*** – *MILO Range and MILO Response*:

1. Expose the student to behavioral health crisis situations involving rapidly changing scenarios that require split second decisions on force options and/or medical treatment options
2. Enhance and build upon stress-induced decision-making skills
3. Improve situational awareness to potential threats and dangerous scenes
4. Improve communication skills between partners and virtual reality role-players
5. Train Police Officer students on Use of Force options
6. Train EMS personnel to quickly assess medical emergencies and treatment options

LEARNING OBJECTIVES – ***Hearing Voices Simulation (30 minutes)***:

1. Participants will learn about the subjective experience of hearing distressing voices, increase their understanding of the day-to-day challenges facing people with psychiatric disabilities, become more empathetic toward voice hearers, and be inspired to consider changes in clinical/field practice which would better address the needs of people who hear distressing voices
2. Lecture on the phenomenon of hearing distressing voices
3. The simulation experience
4. After action review and discussion period

LEARNING OBJECTIVES – ***Petition for Mental Health Treatment (30 minutes)***:

1. Review of Michigan Compiled Laws: MCL 330.1401 (Person Requiring Treatment), MCL 330.1427a (Protective Custody), PA 368 Sec. 20969 (EMS Authority to Restrain)
2. Demonstrate proper documentation and completion of the Petition for Mental Health Treatment form

(See attached OPS II ERBT Scenarios & OPS II ERBT Curriculum)

~ PROGRAM TWO ~

CAREER SURVIVAL AND EMOTIONAL WELLNESS FOR LAW ENFORCEMENT OFFICERS

The Career Survival and Emotional Wellness training provides field-tested safety techniques and emotional wellness strategies to better prepare public safety workers for actual on-the-job experiences they face every day and the support mechanisms necessary for survival. The program is comprised of two main components: Career Survival and Emotional Wellness for Police Officers and Peer Support. ***Career Survival and Emotional Wellness program provider is 2 The Rescue. LLC, https://twotherescue.com/, 616-262-8455. Company owners are Terry Bykerk and Mike Wierenga.***

The program is designed as a one-day 8-hour training covering: (1) the stressors, trauma, and effects of being a law enforcement officer; (2) signs and symptoms of post-traumatic stress disorder, suicidal tendencies, and destructive behavior; and (3) peer to peer support (formal and informal). The intent of the training is to educate officers on the emotional health dangers of police work, provide officers with tools to assist in recognizing common warning signs of dangerous behavior related to job stress, present positive alternatives to deal with stress, and offer strategies for assisting coworkers who may be suffering from stress and trauma.

Training Objectives: At the conclusion of this training, participants will be able to (1) recognize warning signs in themselves and others; (2) make appropriate decisions on who, when, how they should respond to signs of stress and trauma; and (3) assist, intervene, and support others that need care, with the overall goal of improving the emotional health and wellbeing of all officers within their department.

Understanding the Heavy Toll of Working with Violence and Trauma (0800-1200 hours):

Offices will be taught and become familiar with the effects that working in law enforcement can have on their body, mind, emotions, behavior, and family life. Some of the effects include alcoholism, PTSD, suicide, and divorce. This first area of instruction will cover the lifestyle of a police officer and discuss disturbing facts related to police work. Officers will be shown emotional dangers of working in law enforcement. Understanding that this type of work will have an influence on an officer's emotional and physical wellbeing is a key factor to preventing or minimizing the negative effects stress and trauma. Discussion topics include:

- Understanding the lifestyle change
- Recognizing the heavy toll of police work
- Assessing the disturbing facts and acknowledging career realities
- Managing acute critical incident and post-traumatic stress
- Understanding the "Terrible 10" stressors
- Learning the good, bad, and ugly of adrenaline
- Controlling the adrenaline roller coaster
- Differentiating core values vs. situational values
- Staying ethically sound
- Identifying normal vs. abnormal behaviors

Recognizing Signs and Symptoms of Post-Traumatic Stress, Suicidal Tendencies, and Destructive Behavior (1300-1500 hours):

One step to living a healthy lifestyle is to identify the signs and symptoms of destructive behavior in an officer's life. This second area of instruction will help officers recognize warning signs of dangerous and unhealthy behavior in themselves and others, so that proactive steps can be made to eliminate or minimize the effects of stress and trauma related to the job. Instruction will include practical ways steps that officers can take to deal with stress in a health manner, as well as providing options to seek help. Discussion topics include:

- Maintaining the proper priorities to build a healthy resilience
- Recognizing the symptoms of post-traumatic stress
- Vicarious and secondary trauma for the officer's family
- Becoming aware of and recognizing suicidal tendencies
- Knowing crisis referral options
- Recognizing personal destructive behavior
- Addressing the stages of an officer's career
    - 0-5 years
    - 5-15 years
    - 15-20 years
    - 20 years into retirement

Peer Support - Formal and Informal (1500-1700 hours):

Many agencies within the West Michigan Criminal Justice Training Consortium have either formal or informal peer support teams. This third area of training will further enhance the knowledge of attendees and provide them with practical steps to assist, encourage, and support their peers. Training will prepare the officers to make appropriate decisions on when to intervene, what type of intervention is needed, and when to refer a peer for help. The goal is to teach attendees best practices that can be used to help other officers prevent harmful behaviors including substance abuse, depression, unethical behavior, and suicide. By intervening early and appropriately, attendees will be able to provide support to their coworkers before they suffer from many of the negative consequences from stress in their job. Discussion topics include:

- History of First Responder Peer Support
- Basic training needs and support
- Advanced training needs
- How to educate the new recruit
- Policy, procedure, and SOPs
- State Laws - privacy of peer to peer conversations
- What is a CISM Debriefing vs. Defusing, when is it time for one-on-ones?
- Mindset of an organization and its personnel
- Building awareness and trust, how to make your team visible
- Who is on this team and how to keep them active?
- Where does CISM fall when dealing with first responder family members?
- References, resources, and support

SECTION 2 - PROJECT NARRATIVE
C. TRAINING METHODS
Describe how the training will be delivered for each course/topic. Identify program developers and instructors and describe their qualifications. Outline the method(s) of presentation. Include the hours of training and where the training will occur. Describe the training materials that will be developed or provided. **Refer to Page 19 of the Grant Manual**

~ PROGRAM ONE ~

MICHIGAN CRISIS INTERVENTION SYSTEM (MI-CIS)

Teaching Methodologies:

The MI-CIS program contains a mix of instructional methods –

1. Self-paced online learning for the first two segments through the Moodle Learning Platform - *https://moodle.mi-ems.org/course/index.php?categoryid=15 (see attached Taking the MI-CIS Courses).*
2. Participants will apply the skills learned in the Awareness and Operations segments and put into practice intervention strategies in scenario exercises - *Enhanced Reality-Based Training* - that requires students to demonstrate decision-making skills and proper judgment.

The segments must be completed in order as they are prerequisites for the subsequent segments.

Contractor/Training Provider/Instructors:

MI-CIS program provider is Western Michigan University Homer Stryker M.D. School of Medicine, http://www.mi-cis.org. MI-CIS Program Manager and Lead Facilitator is Robert T. Christensen, 269-377-1749, Robert.christensen@med.wmich.edu. During the reality-based training segment, participants will be evaluated by mental health professionals and experienced CIS personnel.

Training Material:

All training materials will be provided by MI-CIS. A copy of the student materials will be on file with the GVSU Criminal Justice Education Center - available for inspection and use by other criminal justice practitioners.

Training Locations:

The West Michigan Criminal Justice Training Consortium currently consists of 96 entities. Members are located south from the Michigan-Indiana state line to as far north as Manistee. The area stretches from the Lake Michigan shoreline to as far east as Ionia County. Considering the size and geographical area of the consortium, it is common practice to host multiple offerings, using several locations, so as to allow the consortium to effectively and efficiently deliver training to any consortium agency wishing to send officers. We intend to offer four separate one-day training sessions covering southern, middle, and northern geographical areas.

The consortium will use venues owned by the local colleges and/or municipalities with areas suitable for scenario-based training. There will be no rental charges for these venues. All necessary A/V equipment will be provided. Currently intend to use Grand Valley State University (2 sessions),

Western Michigan University (1 session), and West Shore Community College (1 session).

~ PROGRAM TWO ~

CAREER SURVIVAL AND EMOTIONAL WELLNESS FOR LAW ENFORCEMENT OFFICERS

Teaching Methodologies:

Career Survival and Emotional Wellness will consist of a single training day (8 hours). Instruction will include lectures, group discussions, videos, and Q&A sessions. A unique aspect of this training allows for family members of the attendees to be present for the first portion of the class. Family life plays a vital role in the emotional health of officers. In addition to officers learning how to handle stress, family members will leave with tools they can use to help their loved ones minimize the negative effects of working in law enforcement.

Contractor/Training Provider/Instructors:

1. Mike Wierenga is a co-founder of Two The Rescue L.L.C. He has over 25 years of law enforcement experience, 18 years as a firefighter, and nearly 5,000 hours of classroom and practical skill instruction for public safety agencies, colleges, universities, hospitals and security agencies. Mike's training and experience includes over 320 hours of critical-incident stress management programs combined with an immeasurable number of front-line applications in line-of-duty deaths, officer-involved shootings, suicides, violent tragedies and deaths. Mike is an active team leader with his department's peer support Cop to Cop Critical Incident Stress Management Team and was instrumental in the creation and implementation of a pre-incident wellness educational program for new recruits and their families. Mike's passion for the emotional wellness and the safety of emergency responders is readily apparent in his professional presentation skills. Mike is currently assigned to the Training Bureau at the Grand Rapids Police Department.

2. Terry Bykerk has over 25 years of law enforcement experience in patrol, vice, S.W.A.T., field training, investigations and street undercover operations. He has extensive experience in standard operating guideline liability and implementation, training program development and adult learner advancement – including over 5000 hours of classroom and practical skill instruction in area colleges, universities, hospitals and security agencies as well as fire and police departments. Terry has a unique way of sharing his personal successes and pitfalls not just as "war stories," but in an educational way that will get you thinking.

Company Reviews:

"I wanted you to know how much I enjoyed the training. You and Mike are saving lives, saving relationships, and preventing substance abuse with every presentation. Every public safety employee should attend this valuable training. I admire the courage and forthright nature by which you tell your personal story to bring home the importance of emotional wellness for first responders."

- Daniel J. Mills, Senior Deputy Police & Fire Chief, Portage, MI

"I know that no one seeks recognition for the type of service that you were recognized for. Your peer support training and development and critical incident stress management programs provide a venue to those active, former and retired first responders who may feel overwhelmed by the effects of their work experiences. You are a peer's peer and friend's friend, and your programs provide a safe and confidential environment for the promotion of healing, education, and support to those dedicated to the emergency service professions. Great work and

congratulations on the award."

- Craig Coulson-Risk Manager City of Grand Rapids

Training Material:

All training materials will be provided by 2 The Rescue. A copy of the student materials will be on file with the GVSU Criminal Justice Education Center - available for inspection and use by other criminal justice practitioners.

Training Locations:

The consortium will use venues owned by the local colleges and/or municipalities that will provide for a large, comfortable learning environment. There will be no rental charges for these venues. All necessary A/V equipment will be provided. Currently intend to use Grand Valley State University (2 sessions), Western Michigan University (1 session), and West Shore Community College (1 session).

SECTION 2 - PROJECT NARRATIVE
D. EVALUATION
In addition to participant feedback, describe how the participants will be evaluated on their acquisition of knowledge for each course/topic. **Refer to Page 19 of the Grant Manual**

~ PROGRAM ONE ~

MICHIGAN CRISIS INTERVENTION SYSTEM (MI-CIS)

Knowledge Acquisition:

At the start and end of each online learning module a self-test is completed to evaluate each student's knowledge of the material presented and to offer a check on learning. Additionally, all EMS licensed personnel will receive 16 hours of continuing education credits for completing all three segments.

Performance Evaluation:

Students will be evaluated by mental health professionals and experienced CIS personnel on all of the practical skills during the reality-based training segment.

Participant Feedback:

A MI-CIS student evaluation will be completed prior to the issuance of each segment certificate of completion. Additionally, the MCOLES Participant Evaluation Form will be completed at the conclusion of the reality-based training segment *(see attached MCOLES Participant Evaluation Form)*. The purpose of the evaluation will be to gain the students' perspective of the course content concerning applicability to their job responsibilities. Additionally, the student evaluation will be used to evaluate the instructor's' presentation skills and training venue. Program adjustments will be made when and where the student has identified appropriate issues.

~ PROGRAM TWO ~

CAREER SURVIVAL AND EMOTIONAL WELLNESS FOR LAW ENFORCEMENT OFFICERS

Knowledge Acquisition & Performance Evaluation:

Knowledge and understanding of seminar topics will be evaluated by instructor led discussions and oral quizzing.

Participant Feedback:

The WMCJTC Course/Instructor Evaluation Form and MCOLES Participant Evaluation Form will be completed by attendees at the conclusion of the training day *(see attached WMCJTC Course Evaluation Form & MCOLES Participant Evaluation Form)*. The purpose of the evaluations will be to gain the students' perspective of the applicability of course content to their job responsibilities. Additionally, the student evaluation will be used to evaluate the instructor's presentation skills and the training venue. Program adjustments will be made when and where the student has identified appropriate issues.

SECTION 3 – COURSE DETAIL

Complete the Course Detail section for ***each topic/course*** included in your proposal. Copy and insert this page into your application as many times as needed.

Refer to Page 20 of the Grant Manual

Course Details			
Course Title Michigan Crisis Intervention System (MI-CIS): ***MI-CIS AWARENESS LEVEL Segment***			
Training Location Online			
Maximum Participants Unlimited (online)	Minimum Participants (2/3 of Max) Unlimited (online)	Hours of Training Per Session 4 hours	Number of Sessions 4

Cost Breakdown			
Per Session Costs	***Total Costs***	***Grant Share***	***Match Share***
Personnel	$0	$0	$0
Contractual Services	$0	$0	$0
Tuition	$0	$0	$0
Travel	$0	$0	$0
Supplies & Operating	$0	$0	$0
Equipment	$0	$0	$0
Total ***Per Session*** Costs	$0	$0	$0
Total ***Course*** Costs	$0	$0	$0

NOTES:

MI-CIS AWARENESS LEVEL ***(Segment is Delivered Online = No Fee)***

Course Details			
Course Title Michigan Crisis Intervention System (MI-CIS): ***MI-CIS <u>OPERATIONS PHASE I</u> Segment***			
Training Location Online			
Maximum Participants Unlimited (online)	Minimum Participants (2/3 of Max) Unlimited (online)	Hours of Training Per Session 4 hours	Number of Sessions 4

Cost Breakdown			
Per Session Costs	***Total Costs***	***Grant Share***	***Match Share***
Personnel	$0	$0	$0
Contractual Services	$0	$0	$0
Tuition	$0	$0	$0
Travel	$0	$0	$0
Supplies & Operating	$0	$0	$0
Equipment	$0	$0	$0
Total ***Per Session*** Costs	$0	$0	$0
Total ***Course*** Costs	$0	$0	$0

NOTES:

MI-CIS <u>OPERATIONS PHASE I</u> ***(Segment is Delivered Online = No Fee)***

Course Details			
Course Title Michigan Crisis Intervention System (MI-CIS): ***MI-CIS <u>OPERATIONS PHASE II</u> Enhanced Reality-Based Training Segment***			
Training Location TBD			
Maximum Participants 30	Minimum Participants (2/3 of Max) 20	Hours of Training Per Session 8	Number of Sessions 4

Cost Breakdown			
Per Session Costs	***Total Costs***	***Grant Share***	***Match Share***
Personnel	$192.49	$0	$192.49
Contractual Services	$6,620.00	$4,965.00	$1,655.00
Tuition	$0	$0	$0
Travel	$0	$0	$0
Supplies & Operating	$0	$0	$0
Equipment	$0	$0	$0
Total ***Per Session*** Costs	$6,812.49	$4,965.00	$1,847.49
Total ***Course*** Costs	$27,249.96	$19,860.00	$7,389.96

NOTES:

1. *MI-CIS <u>OPERATIONS PHASE II</u> Enhanced Reality-Based Training Segment is provided for a **flat rate of $6,620 per session**.*
2. The noted Grant Administrator hours (Personnel section) is based on 3 hours per session and includes handling individual training session logistics (venue, instructors, and attendees), ensuring correct student information for each course is documented and archived, preparing quarterly grant reports, and handling grant inspections and audits.

Course Details			
Course Title Career Survival and Emotional Wellness for Law Enforcement Officers			
Training Location TBD			
Maximum Participants 40	Minimum Participants (2/3 of Max) 27	Hours of Training Per Session 8	Number of Sessions 4

Cost Breakdown			
Per Session Costs	***Total Costs***	***Grant Share***	***Match Share***
Personnel	$192.49	$0	$192.49
Contractual Services	$1600.00	$1200.00	$400.00
Tuition	$	$	$
Travel	$131.71	$98.78	$32.93
Supplies & Operating	$	$	$
Equipment	$	$	$
Total ***Per Session*** Costs	$1,924.20	$1,298.78	$625.42
Total ***Course*** Costs	$7,696.80	$5,195.12	$2,501.68

NOTES:

1. The noted Grant Administrator hours (Personnel section) is based on 3 hours per session and includes handling individual training session logistics (venue, instructors, and attendees), ensuring correct student information for each course is documented and archived, preparing quarterly grant reports, and handling grant inspections and audits.
2. Contractor Travel total of $526.84 is only for two sessions hosted outside of the greater Grand Rapids area (location of contractor). Amount listed above is a per session amount (4 sessions) for calculation purposes only.

SECTION 4 - COST JUSTIFICATION

The cost justification section is the bridge between the project narrative and the budget detail. Describe the proposed expenditures for each course offering or topic separately. Explain the proposed expenditures (both grant and match) and why the costs are necessary. Provide sufficient detail to justify the expenditures and to support the calculations that are shown in the budget detail. If a student fee will be charged, specify the amount per student.

Refer to Page 20 of the Grant Manual

MATCH SHARE

*PERSONNEL - **Grant Administrator** (GVSU Administrative Professional)*:

The Grant Administrator will document and complete required quarterly grant reports, maintain grant documentation for audits and inspections, handling individual training session logistics (venue, instructors, and attendees), ensure student and course information is documented, and other administrative activities as required. Williamson N. Wallace has been designated as the Grant Administrator. It is estimated that his administrative duties will require approximately 24 hours.

- **Administrative in-kind labor contribution = $1,539.93** ($45.47 per hour x 24 hours x 41.112% fringe rate).

CONTRACTUAL:

The ***MI-CIS*** contractor is charging a flat rate of $6,620.00 for each OPERATIONS PHASE II Enhanced Reality-Based Training session, for a total of 26,480.00.

- **WMCJTC contractual match = $6,620.00** ($1,655.00 per session x 4 sessions)

The ***2 The Rescue*** contractor is charging a flat rate of $1,600.00 for each session, for a total of $6,400.00.

- **WMCJTC contractual match = $1,600.00** ($400.00 per session x 4 sessions)

*TRAVEL - **Contractor***:

The ***2 The Rescue*** contractor is charging mileage, lodging (dual occupancy), and meals ($526.84) for two of the four session that are outside of the greater Grand Rapids area (location of the company).

- **WMCJTC travel match = $131.72**

(See attached WMCJTC Matching Funds Letter)

Total Match Share = $9,891.65

GRANT SHARE

CONTRACTUAL:

The ***MI-CIS*** contractor is charging a flat rate of $6,620.00 for each OPERATIONS PHASE II Enhanced Reality-Based Training session, for a total of 26,480.00.

- **We are requesting grant funds to cover = $19,860.00** ($4,965.00 per session x 4 sessions)

The ***2 The Rescue*** contractor is charging a flat rate of $1,600.00 for each session, for a total of $6,400.00.

- **We are requesting grant funds to cover = $4,800.00** ($1,200.00 per session x 4 sessions)

*TRAVEL - **Contractor***:

The ***2 The Rescue*** contractor is charging mileage, lodging (dual occupancy), and meals ($526.84) for two of the four session that are outside of the greater Grand Rapids area (location of the company).

- **We are requesting grant funds to cover = $395.12**

Total Grant Share** = **$25,055.12

SECTION 5 - APPLICANT PRIORITIES

Prioritize the components of your application in descending order. Include the GRANT COSTS and MATCH COSTS. Single topic applications should list priorities by sessions or category expenditures. If the application contains more than one training topic, prioritize by topic. If more than one grant application is being submitted by an agency, prioritize the list of applications. The applicant's list of priorities will be followed to the highest degree possible; however, Commission priorities take precedence over a grantee's priorities.

BE SURE TO PROVIDE ACTUAL COSTS FOR EACH TOPIC.
Copy and insert this page into your application as many times as needed.
Refer to Page 21 of the Grant Manual

It is imperative that the consortium receive full grant funding for this project in order to deliver job essential training for police officers employed by the 96 consortium member agencies. If full funding is not available, the WMCJTC requests that this grant be funded in the priority order below.

HIGHEST TO LOWEST PRIORITY:

TOPIC PRIORITY LIST

Priority # 1 – Michigan Crisis Intervention System (MI-CIS)

Priority # 2 – Career Survival and Emotional Wellness for Law Enforcement Officers

EXPENDITURE PRIORITY LIST

Priority # 1 – Contractual

Instructional Fees: **$24,660.00 Grant** / $8,220.00 Match

Priority # 2 – Travel

Contractor Travel: **$395.12 Grant** / $131.72 Match

Priority # 3 – Personnel

Grant Administrator: $0.00 Grant / $1,539.93 Match

If fully funded:

Total Grant Share = $25,055.12

Total Match Share = $9,891.65

SECTION 5 - APPLICANT PRIORITIES

Prioritize the components of your application in descending order. Include the GRANT COSTS and MATCH COSTS. Single topic applications should list priorities by sessions or category expenditures. If the application contains more than one training topic, prioritize by topic. If more than one grant application is being submitted by an agency, prioritize the list of applications. The applicant's list of priorities will be followed to the highest degree possible; however, Commission priorities take precedence over a grantee's priorities.

BE SURE TO PROVIDE ACTUAL COSTS FOR EACH TOPIC.

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Refer to Page 21 of the Grant Manual

GRANT APPLICATIONS PRIORITY LIST

If full funding is not available, the West Michigan Criminal Justice Training Consortium requests that its grant applications be funded in the priority order below.

HIGHEST TO LOWEST PRIORITY:

Priority # 1 – Police Precision Driving, Grant funds requested = $56,946.20

Priority # 2 – 360° Behavioral Health for Law Enforcement, Grant funds requested = $25,055.12

CERTIFICATE OF CONSORTIUM MEMBERSHIP
The Certifying Official shall be the individual who administers consortium activities and has the authority to act on behalf of the consortium. Attach paperwork supporting the Consortium Membership to this document.

See Attached Certificate of Consortium Membership, WMCJTC Matching Funds Commitment Letter, Consortium Bylaws, and Consortium Member Agency List.

APPLICANT AGENCY:
Grand Valley State University

TRAINING CONSORTIUM (if applicable):

West Michigan Criminal Justice Training Consortium

PROJECT TITLE (Limit 45 characters):

360° Behavioral Health for Law Enforcement

Application Attachments

MI-CIS Awareness Level (all disciplines)

This program is designed to enhance the knowledge, skills, and attitudes of emergency responders to effectively intervene for those experiencing behavioral crisis situations. Mental illness is common in our society, with approximately 1 in 4 people experiencing a mental health condition during their lifetime (NAMI.) Following efforts in the 1970s to de-institutionalize treatment more people with mental health conditions live in community settings, so interactions with emergency responders in the community are common. People who do not have a mental illness may also exhibit crisis behaviors as a response to stress. The material in this course is based on information in governmental references, the literature, and best-practices, but responders must be aware of and comply with laws, policies, and procedures in their own jurisdictions and organizations.

Goals of MI CIS:

1 Increase safety of responders, consumers, and bystanders
2 Reduce injuries to responders by using proper de-escalation techniques
3 Appreciate the value of a community-based approach in a response for those with mental disorders
4 Identify appropriate resolutions available to first responders
5 Promote an environment of collaboration and partnership
6 Eliminate the use of force where possible
7 Divert persons with mental illness to treatment as opposed to incarceration where appropriate
8 Reduce the stigma associated with mental disorders

Key Principles: Guiding all aspects of this initiative:

1 Safety is paramount
2 Recovery-oriented
3 Dignity and respect
4 Patient-centered
5 Trauma-informed
6 Culturally-competent
7 Sustainable

Awareness Level – online delivery; all audiences

Content Area	Est Time
Intro; Overview and Purpose	10m
Mental Health Didactics	2h30
Response Strategies: Communication & De-escalation	1h
Groups with Special MH Needs	10m
Introduction to Trauma Informed Care	10m

Learning Objectives: (C=Cognitive; A=Affective; P=Psychomotor)

Upon completion of this course, participants will be able to:

1 Define mental health, mental illness, and developmental disability. (C)
2 Identify behaviors associated with mental illness and developmental disability. (C)
3 Recognize commonly used medications for mental illness. (C)
4 Discuss communication techniques appropriate for use in responses for individuals in crisis. (C)
5 Discuss de-escalation techniques appropriate for use in responses for individuals in crisis. (C)
6 Apply provisions of mental health laws to situations involving mental health crises in the community. (C)
7 Describe the benefits of providing Trauma-Informed Care in response for mental health crisis. (A)
8 Identify populations who may have specialized needs related to mental health crisis intervention. (C)

Intro, Overview & Purpose

Mental Illness: a group of psychotic disorders characterized by disturbances in thinking, feeling and relating. The onset of mental illness may occur at any time in an individual's life.

> **AMI:** Any Mental Illness – mild to severe
> **SMI:** Severe Mental Illness – severe functional impairment which substantially interferes or limits one or more major life activities. Sometimes referred to as Serious Mental Illness or Persistent Mental Illness.

General Symptoms: social withdrawal, severe depression, delusions, hallucinations, continuous hyperactivity, or inactivity. Examples of mental illness include schizophrenia, bipolar disorder, delusional disorders, and post-traumatic stress disorder (SAMHSA).

Anosognosia: The person with mental illness ay have an impaired awareness or ability to perceive his/her illness. This may interfere with medication adherence (taking as directed) or seeking treatment. "Lack of insight"

Stigma: A sign of disgrace or discredit which sets a person apart from others. In mental illness, stigma can be a barrier to accessing treatment or in social interactions.

Developmental disabilities: life-long disorders based on mental or physical impairments in physical, learning, language, or behavior areas (CDC.) These conditions usually begin during development, may impact day to day functioning, and usually persist throughout a person's lifetime. Examples include autism spectrum disorder, cerebral palsy, attention deficit

hyperactivity disorder (ADHD), hearing or vision impairment, and other similar cognitive and intellectual disorders. (APA, 2004).

Client/Consumer/Patient: The person being aided who encounters the emergency response system in a crisis situation.

Emotionally Disturbed Person (EDP): Person who appears to be mentally ill or temporarily deranged and is conducting him/herself in a manner that is likely to result in serious injury to him/herself or others. EDPs may appear depressed, agitated, frightened, confused, or aggressive. Note these symptoms can result from traditional medical conditions as well.

Mental Health Crisis: A state of mind where a person is unable to cope with stressful situations of everyday life and respond in a productive, safe manner. In some cases, those in crisis may be a danger to themselves or others, but not all people with mental illness are violent.

Responder: Any emergency or crisis response personnel. In this program, may be law enforcement, emergency medical, or dispatch among others.

Severe Mental Illness (SMI): Schizophrenia, bipolar disorder, or major depression.

Epidemiology:

MI state data for 2015 indicates 92,516 EMS responses out of 1.1M total identified a primary problem as mental health related, or 8.5% of EMS responses. (Fales)

MI state EMS responses for drug overdoses in 2015 totaled 26,668, or 2.5% of EMS responses. (Fales)

Nationally, 1 in 5 (20%) US adults will have experienced a mental health crisis in their lifetime. 4% of US adults (9.8 Million) have lived with a Severe Mental Illness (SMI) in the past year (SAMHSA.)

Mental Health Didactics – Information about common MH conditions

Mental health – a state of emotional, psychological, and social well-being

Factors which affect an individual's mental health:

- Biological (genes, brain chemistry)
- Life experiences (trauma, abuse) that negatively affect MH
- Family history of MH problems

DSM-5 Diagnostic and Statistical Manual of Mental Disorders 5th edition – classifies mental disorders to facilitate more reliable diagnoses of the disorders. Although emergency responders typically do not diagnose mental disorders, they should be familiar with general criteria for various mental disorders which may contribute to a crisis situation

Mental illness –A substantial disorder of thought, perception, or mood that:

- Significantly impairs judgement or the capacity to recognize reality
- Impairs the ability to cope
- Causes great distress to the individual affected
- Covers a range of conditions and levels of severity
- Includes symptoms and behaviors such as:
    - Social withdrawal, where the individual affected avoids contact with other people
    - Depression (a syndrome of sadness and hopelessness)
    - Delusions (false beliefs that are not based in reality)
    - Inappropriate expression of feelings
    - Hallucinations (hearing, seeing, or feeling imaginary things) – these may be associated with several different illnesses
    - Hyperactivity or inactivity

Is defined in Michigan law (MCL 330.1400) (MCOLES)

Severe, Persistent Mental Illness

Severe, persistent mental illness (SMI) refers to mental illnesses which are disabling, require routine management, and tend to affect individuals over a long period of time (often chronic.) (adapted from NREPP) Differentiated from "serious" to indicate long-term effects.

Examples of SMI Conditions: Schizophrenia; Bipolar Disorder; Mania; Depression
Categories:

Thought Disorders: Schizophrenia
Mood Disorders: Bipolar Disorder
Mania
Depression

Schizophrenia: A chronic, severe, debilitating disorder characterized by deficits in thought processes, perceptions, and emotional responsiveness.
Symptoms usually begin in adolescence or early adulthood (18-24) and can be associated with a stressful life situation such as beginning college or a new job.
Symptoms of schizophrenia are divided into positive, negative, and cognitive categories as relative to normal processes:

Positive symptoms: (positive does not = good)

- Hallucinations – sensations that appear real to the individual (sights, sounds, feelings, etc)
- Delusions – false beliefs (not based in reality)

- Disorganized thinking – speech or behaviors may indicate the person's thinking
    - "word salad" – disorganized speech that doesn't make sense
    - "thought blocking" – stops speaking abruptly in middle of sentence
    - "neologisms" – meaningless words
- Movement disorders
    - Catatonia - agitated body movements

Negative symptoms:

- Apathy – lack of interest or enthusiasm in surroundings
- "Flat affect" – reduced expression or emotional response
- Anhedonia – reduced enjoyment in everyday life
- Difficulty beginning/sustaining activity
- Reduced speaking
- Stupor – no reaction to surroundings
- Social isolation – secondary – results from other symptoms

Cognitive symptoms:

- Poor "executive functioning" – ability to understand information and use it to make decisions, planning, risk analysis
- Difficulty focusing – paying attention
- Difficulty with "working memory" – ability to use information just after learning it

Causes/Risk Factors: unknown, but probably interaction between factors involving:

- Genetics – tends to be found in families
- Environment
    - Maternal infection?
    - Viral exposure?
    - Prenatal complications?
    - Autoimmune disorder?
- Biology – brain chemistry relative to neurotransmitters (NTs), specifically dopamine, but possibly others

Treatment/Therapy:

Antipsychotic medications – reduce psychotic (hallucinations or delusions) thoughts and behaviors, however:

Anosognosia – may interfere with medication use

Side Effects – may interfere with medication use (may include drowsiness, weight changes, blurred vision, tremors, restlessness)

Psychosocial – learning and using coping strategies to address challenges of schizophrenia in everyday life

Suicide: many people with schizophrenia have suicidal thoughts or attempts

Mood Disorders: Bipolar Disorder, Mania, Depression

Bipolar Disorder: Characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to conduct everyday tasks. These fluctuations are much more dramatic than are typical for people without the disorder

May also be referred to as manic-depressive disorder

Bipolar disorder may affect adults or children and teens

1-3% of people in the US may have bipolar disorder

Categories:

- **Bipolar I Disorder** –manic episodes last at least 7 days, or manic symptoms that are so severe the person needs immediate hospital care. Usually has periods of depression typically lasting 2 weeks; this is the more serious category
- **Bipolar II Disorder** – pattern of depressive episodes and hypomanic (lower level, milder) episodes, but not full manic episodes
- **Cyclothymic Disorder** – numerous periods of hypomanic and depressive symptoms but symptoms don't meet full criteria for hypomanic and depressive episodes
- **Other** Specified and Unspecified Bipolar and Related Disorders – may result from substance or medication use, or other medical conditions

- Manic episodes – during a manic episode, a person may:
  - feel extremely "up", elated, energized, euphoric
  - have trouble sleeping
  - have increased activity levels
  - feel agitated, jumpy, or "wired"
  - feel that thoughts are going very fast
  - have increased self-esteem
  - do risky things or make poor decisions

  Hypomania: less severe manic episodes
- Depressive episodes – during a depressive episode, a person may:
  - feel sad, "down", or hopeless/depressed
  - have little energy
  - have decreased activity levels
  - have trouble sleeping (too much or too little)
  - feel worried and empty
  - have trouble concentrating
  - have changes in eating (too much or too little)
  - think about death or suicide

Causes/Risk Factors: unknown, but several factors probably contribute:

- Brain Structure/Function – communication within areas of brain
- Genetics – certain genes increase likelihood, but not clear
- Family History – tends to run in families

Treatment/Therapy:

Medications:

- Mood Stabilizers

- Atypical antipsychotics
- Antidepressants

Psychotherapy:

- Cognitive behavioral therapy (CBT)
- Family-focused therapy
- Interpersonal and social rhythm therapy
- Psychoeducation

Other possible therapies:

- Electroconvulsive Therapy (ECT)
- Sleep Medications

Mania: not a separate disorder, but manic episodes are present in Bipolar Disorders as described above. Manic episodes may also occur in conjunction with other mood disorders such as:

Substance/Medication-Induced bipolar and related disorder
Bipolar and related disorder due to another medical condition
Other/Unspecified conditions

Depression: Major depression is very common in the US and worldwide and accounts for the highest cause of disability burden among all mental and behavioral disorders (CDC.) Depression (also called Major Depressive Disorder, or MDD) is characterized by either a depressed mood or loss of interest in once pleasurable activities, and at least 4 other symptoms which reflect a change in functioning, such as problems with sleep, eating, energy levels, concentration, or self-image over a period of at least 2 weeks.
6.7% of US adults (16.1M people) who completed the National Survey of Drug Use and Health (NSDUH) had at least one depressive episode in 2015. This survey does not include populations who were homeless, in the military, or in institutions such as nursing homes, correctional facilities, or mental institutions.

Categories:

- Major Depressive Disorder, single and recurring episodes
- Persistent depressive disorder (PDD; Dysthymia) - symptoms >2 years
- Substance/Medication-Induced depressive disorder
- Depressive disorder due to another medical condition
- Other/Unspecified causes of depressive disorder (such as Seasonal Affective Disorder)

Causes/Risk Factors: probably results from interaction between factors:

- Biological
    - abnormal brain activity in specified brain areas (frontal lobe and limbic structures)
        - frontal lobe – executive functions of planning, decision-making
        - limbic structures – emotions and memories of pleasurable activities
    - increased stress hormone levels (cortisol)

- abnormalities in neurotransmitters (NTs) – serotonin, norepinephrine, dopamine
- neuroplasticity – the brain changes based on experiences

- Genetic - 10x higher risk if immediate family member has depression; more likely an inherited vulnerability
- Psychosocial - higher incidence of anxiety, Substance Use Disorder (SUD)
- Environmental

Treatment/Therapy:

Medications: Antidepressant medications to influence NTs in brain

- TCAs (tricyclic antidepressants)
- SSRIs or similar (selective serotonin/norepinephrine reuptake inhibitors)
- Anxiolytics (anti-anxiety medications)

Psychotherapy:

- Cognitive behavioral therapy (CBT)
- Interpersonal therapy

Children, Youth and Adolescence

Mental health developmental conditions can affect children as well as adults.

ADHD or Impulse Control Disorder:

ADHD is one of the most common childhood disorders and can continue into adulthood.

ADHD affects approximately 9% of 13-18 year olds, almost 2% of these have a severe disorder.

Symptoms:

- Inattention – wanders off task, has difficulty concentrating, is disorganized and unfocused
- Hyperactivity – moves about constantly, excessively fidgets, talks, even when inappropriate
- Impulsivity – person makes hasty decisions without thinking them through; seeks immediate rewards; has difficulty thinking of long-term consequences

Causes/Risk Factors: unknown, but the following may contribute:

- Genes
- Males have higher rates than females
- Environment
  - cigarette smoking
  - exposure to toxins during pregnancy
  - exposure to toxins at young age (lead)
  - low birth weight
  - brain injuries

Treatment/Therapy:

- Medication – stimulant medications which increase NT levels, such as Ritalin, Adderall, amphetamines; antidepressants sometimes used off-label
- Behavioral therapy – self-monitoring, CBT, family, mindfulness, keeping a schedule, using lists, calendars, etc

Disruptive Behavior Disorders:

A behavior disorder characterized by persistent defiant, disobedient, and hostile behavior towards authority figures; frequent loss of temper, arguing, anger or violence, or other negative behaviors. Includes Oppositional Defiant Disorder, Conduct Disorder, Antisocial Personality Disorder and others

Causes/Risk Factors:

- Child abuse/neglect
- Traumatic life experience (such as sexual abuse or violence)
- Family history

Treatment/Therapy:

- Psychosocial – parent, child, family therapy
- Medications – may include stimulants, ADHD, anticonvulsant, or antipsychotic medications

Autism, Childhood Schizophrenia: Autism Spectrum Disorder (ASD) is a developmental disability that can cause social, communication, and behavioral challenges, and includes disorders formerly categorized separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.

Symptoms: someone with ASD may:

- Not show interest in objects
- Have trouble relating to others or have no interest in other people
- Avoid eye contact
- Want to be alone
- Repeat or echo words or phrases
- Dislike physical contact
- Repeat actions over and over
- Have difficulty with changes in routine

Diagnosis: No definitive test; typically diagnosed around age 2

Causes/Risk Factors:

Genetic – tends to be higher risk if sibling has ASD; occurs more in people with some genetic abnormalities; 4.5x higher in males

Environmental – higher incidence when some drugs used in pregnancy (valproic acid, thalidomide); in children of older parents; thought to occur during critical period of development around birth (before/during/after)

Treatment/Therapy: early intervention therapies can improve development, but no cure exists

Developmental Disabilities (DDs): Group of conditions due to impairments in physical, learning, language, or behavior areas which begin anytime during development and last throughout life.

Conditions include:

- ADHD (see above)
- ASD (see above)
- Cerebral Palsy (CP) – affects an individual's ability to move and maintain balance and posture; symptoms vary
  - spastic – muscle stiffness
  - dyskinetic – uncontrollable movements
  - ataxic – poor balance and coordination

        - mixed – symptoms of more than one type of CP, ex spastic-dyskinetic CP
    - Intellectual disability (mental retardation) – sub-average intellectual function (IQ<70)
    - Hearing loss
    - Vision impairment
    - Learning Disability

Causes/Risk Factors:

- Genetic
- Environment – maternal smoking/drinking alcohol during pregnancy; fetal alcohol syndrome (FAS); exposure to toxins; maternal infections during pregnancy; low birthweight; birth trauma

Treatment/Therapy:

- Early intervention therapy to improve function of speech, motor skills, etc
- Adaptive equipment – braces, wheelchairs, communication assist devices etc.

Cognitive Disorders

Dementia: A group of conditions that affect cognition, memory, social interaction, and normal activities of daily living (ADLs.) Mostly neurodegenerative – protein fragments accumulate either in nerve cells or between neurons, affecting brain function

Types:

- Alzheimer's type
- Vascular – similar to stroke
- Lewy Body
- Fronto-temporal (Pick's Disease)
- Parkinson's'
- Other

Traumatic Brain Injury (TBI): An acquired injury where a sudden trauma causes damage to the brain. Damage can occur from a mild, moderate, or severe impact or a penetrating injury, and can range in severity from a mild condition such as a concussion to severe changes in cognitive, motor, sensation, and emotional function. TBIs can also cause epilepsy and increase risk of neurodegenerative diseases such as Alzheimer's or Parkinson's disease. Damage can also be cumulative from repeated impacts to the head.

Delirium: Condition characterized by a disturbance in consciousness and a change in cognition (sudden confusion) that began over a short period of time. It can be caused by a physical or mental illness, and can usually be reversed.

Causes:

- Alcohol, medications, drugs, poisons
- Electrolyte disturbances
- Infections
- Severe lack of sleep

Delirium with agitation: A subset of delirium, this condition is sometimes referred to as "excited delirium syndrome" or ExDS, and is characterized by:

- severe confusion
- irrational, agitated, potentially violent behavior
- extremely high strength and pain tolerance
- hyperthermia (high body temperature)

The mechanisms for developing this syndrome are not clearly understood, but often involve pre-existing mental illness and stimulant drug use, particularly cocaine. Encounters with emergency personnel often result in physical struggle and can have fatal outcomes for the patient.

Verbal de-escalation techniques may not be effective

Responders should be attentive to safety and attempt typical control or restraint techniques, quickly supplemented with sedative medications such as benzodiazepines or ketamine by appropriate personnel. Responders need to be attentive to sudden apnea or ceased struggle and provide resuscitation if necessary (ACEP, 2012.)

Special Focus Areas

Post-Traumatic Stress Disorder (PTSD): This condition develops in some individuals who have experienced or witnessed a stressful, shocking, or dangerous event such as violent crime or assault, military combat, natural disasters, or sexual assault/rape. All traumas may result in acute stress, but individuals with PTSD have a prolonged response (at least a month) to the stressful event which interferes with functioning.

Symptoms:

- Re-experiencing – flashbacks, nightmares, frightening thoughts
- Avoidance symptoms – staying away from places, things, or events which remind him/her of the trauma
- Arousal and reactivity symptoms – easily startled, on edge, difficulty sleeping, angry outbursts
- Cognition and mood symptoms – negative thoughts about self, distorted feelings (guilt or blame), difficulty remembering the event, loss of interest in enjoyable activities, numbness or detachment

Treatment/Therapy:

- Medications – antidepressants, antianxiety meds
- Psychotherapy – exposure therapy, cognitive restructuring therapy, hypnosis

Personality, Borderline, Dissociative Disorders:

Personality Disorder: An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the culture of the individual who exhibits it. The DSM-5 identifies 10 types of personality disorders: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive.

Borderline Personality Disorder (BPD): Is characterized by impulsive actions and unstable moods, behavior, self-image, function, relationships.

Dissociative Disorders: These are characterized by disruption in consciousness, memory, identity, perception, and behavior and disrupt everyday functioning. Conditions include Dissociative Identity Disorder and Dissociative Amnesia, among others. These disorders may be associated with trauma from childhood abuse or neglect. Individuals with dissociative disorder have a high incidence of suicide attempts or self-harm.
Treatment: involves psychotherapy and possibly medications to treat other associated conditions such as depression

Geriatric Issues:

Geriatric Issues: Approximately 20% of US adults over 55 experience some type of mental health concern (CDC.) The most common include:

- Anxiety
- Severe Cognitive Impairment (Alzheimer's, dementia)
- Mood Disorders (depression, bipolar)

A lack of social and emotional support services can contribute to decreased life satisfaction
Dementia can contribute to health issues such as malnutrition, dehydration, and wandering
Elderly individuals may also be subject to neglect or abuse (financial, physical)

Anxiety, Panic, Obsessive-Compulsive Disorders:

Anxiety Disorder/Generalized Anxiety Disorder (GAD): Characterized by excessive and unrealistic worry about life events that can interfere with normal functioning. May interfere with sleep and concentration. The worry is beyond the normal concern anyone might feel over a stressful situation, but is real for the individual. Treatment includes medications (antianxiety and/or beta-blockers) and psychotherapy (CBT, meditation, stress-management, and exposure therapy)

Panic Disorder: Characterized by "panic attacks," periods of intense fear, terror, and physical symptoms such as difficulty breathing, rapid breathing, rapid, pounding heart rate, dizziness, nausea, and numbness or tingling in extremities. (Similar to symptoms of a heart attack)
Treatment involves calming and reassuring the patient.

Obsessive-Compulsive Disorder: Characterized by chronic, long-lasting, uncontrollable thoughts (obsessions) and behaviors (compulsions) that the person feels compelled to repeat over and over. These may be physical behaviors such as tics, or can be rituals the individual must perform. Treatment includes medications (SSRIs) and cognitive therapy, or a combination.

Suicide

Suicide: Death caused by self-directed injury
Suicide Attempt: non-fatal, self-directed potentially injurious behavior with intent to die as a result of the behavior

Suicidal Ideation: Thinking about, considering, or planning suicide
"Suicide by Cop": Provoking a lethal encounter with law enforcement officers as a suicide mechanism

Because of stigma, suicide cases are under-reported, but according to the CDC, suicide is the 10th leading cause of death of adults in the US, with over 44,000 deaths each year. For every completed suicide there are 25 suicide attempts. Men die of suicide 3.5x more than women, but women attempt suicide 3x more than men.

People considering or attempting suicide are in so much psychological pain or distress that ending their lives seems like the only resolution. Because of frustrated psychological needs, people considering suicide can have tunnel vision and see it as the only way to resolve their pain. They may not want to die – but feel they must escape the pain. Suicide should not be considered a cowardly or selfish act. Responders should listen and be patient in talking with someone who is suicidal. (See de-escalation and communication sections.) Suicide threats should always be taken seriously.

Signs/Symptoms of someone considering suicide:

- Talking about wanting to die
- Feeling empty, hopeless
- Expressing feelings of great guilt or shame
- Social withdrawal
- Increased use of alcohol or drugs
- Agitation, anger, talking of revenge
- Putting affairs in order, giving away possessions

Steps to assist:

- Ask "Are you thinking about killing yourself?" (You won't put the idea in their head)
- Keep them safe – remove access to weapons or ask them to move to a safe place
- Listen – acknowledging and talking about probably helps reduce suicidal thoughts; explore ways to change the client's perceptions; develop options
- Focus on solutions – "What would be most helpful?"
- Connect –to suicide prevention resources such as National Suicide Prevention Lifeline 1-800-273-8255 (TALK) or local crisis response

Treatment/Therapy:

- Psychotherapy – CBT
- Medications: Clozapine (antipsychotic), antidepressants

Substance Use Disorders and Co-occurring Disorders

Substance Use Disorder (SUD): Recurrent use of alcohol or drugs (substances) causes significant impairment such as health issues, disability, or problems meeting responsibilities of work, school, or home life. SUD can occur with any substances (alcohol, tobacco, marijuana, stimulants, hallucinogens, etc., but opioids are currently particularly of concern due to epidemic

rates of addiction and overdose deaths. More than 50,000 people died of drug overdose in the US in 2015 (CDC.)

Substances cause changes in the brain itself which affect the pleasure and reward systems. Users develop *tolerance* to use and need increasing doses of a drug to achieve the same effect, and have a physical need for the drug, or can suffer unpleasant symptoms of *withdrawal.*

Opioids, both prescription and illicit, either alone or in combination with other drugs, account for most deaths. Opioids such as Oxycodone, heroin, fentanyl, and newer synthetic analogs (such as carfentanyl) can cause an overdose death in minutes. Opioids are often used in combination with benzodiazepines and result in many fatal overdoses due to respiratory depression. Many people with SUD developed their addictions through use of medically-prescribed opioid painkillers, then switched to illegal alternatives such as heroin because of availability or cost issues.

The antagonist medication, naloxone (Narcan ®) can block opioid receptors and reverse effects of an overdose if administered within a few minutes. Efforts are underway to increase availability of naloxone at intercept points where overdose deaths are likely. Responders should consider carrying naloxone for protection of the public and themselves.

Co-occurring (formerly dual-diagnosis): Mental disorders may be accompanied by substance use disorders. Approximately 7.9M adults in the US had co-occurring disorders in 2014. Those with mental health disorders are more likely to have an alcohol or drug use disorder than those who don't have MH disorders. Difficulty identifying these conditions may result in inadequate treatment for the underlying condition since one condition masks the other.

Intro to Psychopharmacology

Medications (known as psychotropic medications) are often used to treat mental illnesses – either alone or in combination with other treatments such as psychotherapy.

Individuals may stop taking their medication as directed (non-adherence) due to:

- Real or imagined serious side-effects
- An inability to obtain prescriptions or medications
- The belief that medications are harmful
- Anosognosia

Responders don't need to know the specifics of various medications, but being familiar with the major types and which conditions they treat can help them recognize people who have mental health conditions. Some more common medications used to treat psychiatric conditions include:

Antipsychotics (schizophrenia, bipolar, depression)

Trade	**Generic**
Abilify	aripipirazole
Clozaril	clozapine

	Geodon	zipraxidone	
	Haldol	haloperidol	
	Risperdal	risperidone	
	Seroquel	quetiapine	
	Thorazine	chlorpromazine	
	Zyprexia	olanzapine	

Antidepressants (depression and anxiety)

MAOIs (Monoamine oxidase inhibitors)

	Emsam	selegine	
	Marplan	isocarboxazid	
	Nardil	phenelzine	
	Parnate	trancycpromine	

TCAs (tri-cyclic antidepressants)

	Elavil	amitriptyline	
	Anafranil	clomipramine	
	Norpramin	desipramine	
	Sinequan	doxepin	

SSRIs (Selective serotonin/NT reuptake inhibitors)

	Celexa	citalopram	
	Effexor	venlefaxine	
	Lexapro	escitalopram	
	Paxil	paroxetine	
	Prozac	fluoxetine	
	Remeron	mirtazapine	
	Viibyrd	vilazodone	
	Zoloft	sertraline	
Other	Cymbalta	duloxetine	serotonin/norepi RI
	Wellbutrin	buproprion	norepi/dopamine RI

Anti-anxiety (anxiolytics) or sleep

	Ambien	zolpidem
	Ativan	lorazepam
	Buspar	buspirone
	Klonopin	clonazepam
	Librium	chlordiazepoxide
	Lunesta	eszopiclone
	Valium	diazepam
	Xanax	alprazolam

Beta Blockers

	Atenolol	tenormin
	Metoprolol	lopressor
	Propanolol	Inderal

ADHD Medications

Adderall	amphetamine
Concerta	methylphenidate
Ritalin	methylphenidate
Straterra	atomexetine

Mood Stabilizers (bipolar disorder)

Lithium	lithium
Calan	verapamil
Depakine	valproic acid
Depakote	divalproex
Lamictal	lamotrigine
Lithobid	lithium carbonate
Neurontin	gabapentin
Tegretol, Carbatrol	carbamazepine
Topomax	topiramate
Trileptal	oxcarbazapine

Child, Youth, Adolescent Psychopharmacology

Psychotropic medications used to treat children or adolescent patients are most commonly prescribed for conditions such as ADHD, depression, or anxiety. Most prescription medications are not FDA-approved for use in children because of limited clinical studies, and there is stigma associated with prescribing medications for childhood psychiatric conditions. Some medications increase the risk of suicidality in children and have an FDA "black box" warning.

ADHD medications

Adderall	amphetamine
Ritalin	methylphenidate

Depression medications

Prozac	fluoxetine (the only SSRI FDA-approved for children/adolescents)

Other medications may be used off-label (non-FDA-approved) for psychiatric conditions in children or adolescents

Recognizing Crisis Situations

Crisis – a temporary problem situation in which the consumer doesn't have the resources or coping ability to resolve the problem, resulting in intense emotional arousal
"Needs aren't being met"

Responder actions may mitigate (goal) or escalate (undesirable) the crisis

Crisis intervention is designed to help the emotionally disturbed person (EDP) to manage his/her emotions and maintain or regain control of his/her behavior

Indicators of possible mental health crisis:

- Inability to cope with stresses of everyday life
- Restless, pacing
- Irritable, verbally abusive
- Suicidal or homicidal thinking/threats
- Hopelessness
- Social withdrawal
- Excessive fear, worry, anxiety
- Changes in eating, sleeping
- Rapid speech, racing thoughts, uncoordinated thoughts
- Aggressive or provocative behavior
- Hallucinations or hearing voices others don't hear
- Believes others are monitoring/seeking/plotting to harm

Reflection:
Anxiety is high in a crisis situation – think about a time when you felt anxious – perhaps you were stuck in traffic while on the way to an important event like a job interview or the airport to catch a flight to go on vacation. How did you feel? Was it a pleasant emotion? How would you have reacted to someone talking loudly and firing questions at you? Your situation, while stressful, is probably not as severe as that of someone experiencing a mental health crisis.

Some crisis behaviors may be the result of either a mental illness or developmental disability, and some individuals may exhibit behavioral cues that reflect both. Not every crisis is a result of mental illness, but response and de-escalation principles are similar.

Only a very few individuals with a mental disorder are dangerous or violent - interpreting behavioral cues out of context may complicate the situation and lead to an inappropriate response or incomplete investigation.

- Only 3-5% of violent acts are committed by those with mental illness
- People with mental illness are 10 times more likely to be victims of violent crime than the general population (NAMI.)

Legal Aspects

Responders need to be familiar with and able to apply provisions of mental health laws to situations involving mental health crises in the community.

The Michigan Mental Health Code (Act 258 of 1974) has sections pertaining to the admission and discharge procedures for mental illness, emotionally disturbed, and developmentally disabled persons.

- A "person requiring treatment" (PRT) (MCL 330.1401) is defined as a person who is mentally ill and who:
    - Can be reasonably expected to intentionally or unintentionally physically injure himself or others and has engaged in acts or made threats to support the expectation
    - Is unable to attend to basic physical needs
    - Has judgement that is so impaired that he or she is unable to understand the need for treatment and whose behavior will cause significant physical harm, or
    - Has weakened mental processes because of age, epilepsy, alcohol or drug dependence

Law enforcement:

Recognize that protective custody is civil in nature and is not to be construed as an arrest (MCL 330.1427a)

EMS:

EMS Authority to Restrain (Public Act 368 Sec 20969)

"…if emergency medical services personnel, exercising professional judgement, determine that the individual's condition makes the individual incapable of competently objecting to treatment or transportation, emergency medical service s may provide treatment or transportation despite the individual's objections unless the objection is expressly based on religious beliefs."

Cultural Awareness & Diversity, Special Populations, Implicit Bias:

Culture pertains to the beliefs, attitudes, behaviors, etc. shared by a group of people. Characteristics may include race, ethnicity, language preference, literacy level, religion, sexual preference, or cultural beliefs and practices. We often naturally and subconsciously make judgements about others based on their observable characteristics. If we ascribe positive or negative opinions about someone based on his/her outward appearance we may be more likely to feel connected to them or distanced from them. This can interfere with efforts to form a collaborative relationship with the consumer. Being aware of this tendency can help to minimize its impact.

Culture influences communication styles, interactions with authority figures, and attitudes toward mental illness and suicide as well. Some cultures view mental illness as a retribution misdeeds in past lives or possession by evil spirits. In many cultures, mental illness carries stigma that may hinder access to care or treatment.

Special Populations:

Some populations may have high incidence or specialized needs related to mental health crisis intervention (NAMI):

Veterans (estimated 20 veterans die by suicide each day)

Children/Youth (half of chronic MI begins by age 14; 75% by age 24)
Homeless (estimated 46% have co-occurring disorders)
Women
Domestic/Intimate Partner Violence
People who are LGBTQ (3x incidence of depression/anxiety)
Justice-involved individuals

More information will be provided in later components of the course.

Communication techniques:

Effective communication and developing rapport with the consumer are important parts of de-escalation.

Factors that influence communication/processing of information:

- Culture
- Religion
- Gender
- Social class
- Perceptions/internal experiences
- Values
- Sensitivity

Message components:

- Verbal (content) 7% (lowest component!)
- Tone, volume 38%
- Body language 55% (highest component)

"It's not what you say, it's how you say it!" Make sure your body language, tone of voice, demeanor, and words all match your stance as a helpful partner

Listen! 2 ears, 1 mouth, use proportionately

Principles of Crisis Communication:

- Use "I" statements - "I am going to help you" or "I am concerned that you may harm yourself" or "I can see how upset you are"
- Active listening
  - Reflection – small repeats, don't "parrot"
  - Summary - paraphrase
- Courtesy

Contact and *Cover* roles:

One responder should initiate interaction with the consumer and perform all communication interactions

The other responder should stand back and provide cover for the contact responder

Only one responder should interact with the consumer

Communication DOs:

- Be honest, patient, and understanding
- Treat the consumer with respect and dignity
- Introduce yourself
- Ask consumer his or her name and use it in communication
- Asking questions more than once (but not arguing)
- Spend extra time to open the lines of communication and develop rapport
- Maintain a calm tone, low voice, and speak briefly
- Maintain distance between you and the consumer – probably more than usual
- Ask about medications and prior hospitalizations
- Ask direct questions and offer simple choices
- Ask direct questions of family members or friends, such as "has the person…"
    - Threatened suicide?
    - Taken medication or drugs?
    - Had any history of treatment or hospitalization?
- Recognize that those with mental disorders may ignore commands or requests, and that such behavior is not a challenge to authority, but rather might be a symptom of the underlying disability or instability
- Recognize that fear and apprehension may be the predominant emotions of those on scene and consumers may be confused, may not hear, or may misinterpret what the responder is saying

Communication DON'Ts:

- Make continuous, direct eye contact (the LE stare)
- Touch the consumer (unless required for safety or treatment)
- Challenge hallucinatory or delusional statements
- Move suddenly or give rapid orders

De-escalation:

Techniques (mostly verbal) to **reduce the level of emotion** and **slow down** reactions in a crisis so the consumer can regain control of his/her emotions and return to normal functioning. Responders must also remain calm and in control of their emotions – only one person should be in a crisis state. Training and practice of de-escalation helps responders to avoid a crisis response themselves.

Threatening/crisis situations generally result in emotional responses:

- Fear
- Anger

The body's stress response is activated (fight-flight-freeze) resulting in:

- Increased heart rate, breathing
- Changes in perception:
    - Reduced ability to hear
    - Tunnel vision
    - Time distortion

These changes in perception can interfere with the ability of the EDP to process the event and lead to further conflict. Responders should try to reduce the fight-flight-freeze response by slowing down the interaction and reducing the level of emotions involved.

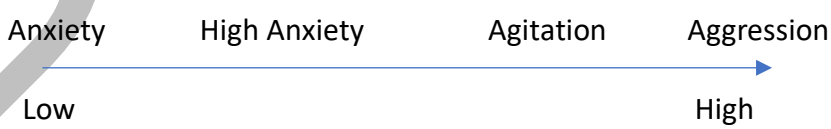
Principles of de-escalation:

Avoid overreacting, indicate a willingness to help and understand
Speak simply (but not simplistically) and move slowly
Be patient, accepting, and encouraging, but also remain professional
Announce actions before initiating them
Avoid touching (except for safety or necessary treatment)
Request additional resources, back-up units, or assistance, as needed
Consider using mental health practitioners or other community partners to assist (Richmond, 2012)

Goals of de-escalation:

Ensure safety of consumers, responders, others
Help EDP manage his/her emotions and maintain or regain control of his/her emotions
Reduce anxiety and distress
Avoid use of restraint when at all possible
Avoid coercive interventions that may escalate agitation

Agitation continuum:



De-escalation skills required of responder:

- Good attitude: positive regard and capacity for empathy
- Ability to control own negative reactions (patients often sense vulnerability) and remain calm and confident

EAR Model

Engage – build trust and rapport, talk with consumer
Assess – gather information necessary to achieve resolution
Resolve – gain control of situation and return to pre-crisis state

De-escalation **verbal loop** technique:

Listen (use active listening techniques)
Respond in a manner that agrees with or validates consumer's position (or agree to disagree) don't argue
State what you want consumer to do "I want you to go to the hospital"
Listen to consumer's response
Repeat (may require many repeats) "I want you to go to the hospital because I want to help you"

Typical time for 12 verbal loop repeats is 10 minutes – much faster than use of restraint or force

Critical components of de-escalation:

Persistence
Patience/Time (especially if consumer shows no escalation to violence)

Trauma-Informed Care

Trauma Informed Care means providing services that do not cause harm, inflict further trauma, or reactivate past traumatic experiences
Past trauma is prevalent among consumers of mental health services – Trauma Informed Care is the "universal precautions" of crisis intervention
Responders should avoid power and control techniques and instead provide dignified choices and seek consumer input when possible

A traumatic experience is one that caused intense physical and psychological stress reactions and can be from a:

- Single event
- Series of events
- Chronic condition

Trauma overwhelms an individual's resources to cope

- Reactions to traumatic events are individual – the same type of event may affect people differently
- Trauma is prevalent in society

  61% of men and 51% of women reported at least one trauma in their lifetime – witnessed or experienced (SAMHSA, 2014)

ACE – Adverse Childhood Experiences may contribute to lifelong behavioral health issues

Responders can use the 4 Rs:

Realize the prevalence of trauma
Recognize how trauma affects individuals
Respond by integrating knowledge of trauma into policies/procedures/practices
Resist re-traumatization (re: use of force, restraint, touching)

Promote safety, *resilience* and *recovery*

*Resilienc*e - ability to bounce back and rise above adversity
Recovery – process of change through which individuals improve their health and wellness and strive to reach their full potential

Summary

Responders are likely to face situations involving consumers who exhibit crisis behavior – whether from mental illness, developmental disabilities, medical conditions, substance use, combinations, or other causes. The awareness and communication techniques described in this program are intended to assist responders in de-escalating these situations to achieve a positive outcome. People with mental illness should be directed to treatment or supportive services to help them manage their conditions. Unfortunately, many times they are instead directed to jails because of their unusual behaviors, don't get treatment, and continue to cycle through such circumstances.

Partnerships between responders and community-based mental health treatment resources can help to divert individuals into treatment programs where appropriate instead of jails. Wrap-around services to assist with housing, employment, and social connections may help people with mental illness to live productive lives in their communities. Consider the various mental health treatment, social services, and support organizations available in your community and begin to make contact and form relationships before your next crisis response occurs.

MI-CIS Operations Phase I– Police

Objectives

- Demonstrate the ability to identify indicators of mental illness, developmental disabilities, and substance use disorders
- Demonstrate knowledge of appropriate language usage when interacting with potentially emotionally distressed persons
- Demonstrate the ability to utilize de-escalation to resolve a variety of situations involving individuals in crisis
- Identify indications of potential violence in someone in crisis
- Demonstrate knowledge of special populations who may be involved in crisis situations

Review - Awareness Level

Severe Mental Illness: includes thought disorders and mood disorders
Thought Disorders**:** Schizophrenia
Mood Disorders: Bipolar Disorder
Mania
Depression
Other mental health conditions:
Cognitive Disorders: Dementia
TBI (traumatic brain injury)
Delirium
Anxiety, Panic, Obsessive-Compulsive, Personality Disorders
PTSD (post-traumatic stress disorder)
Suicide

*Schizophrenia***:** A chronic, severe, debilitating disorder characterized by deficits in thought processes, perceptions, and emotional responsiveness.

*Bipolar Disorder***:** Characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to conduct everyday tasks.

Mania: not a separate disorder, but manic episodes are present in Bipolar Disorders as described above. Manic episodes may also occur in conjunction with other mood disorders.

Depression: Major depression is characterized by either a depressed mood or loss of interest in once pleasurable activities, and at least 4 other symptoms which reflect a change in functioning, such as problems with sleep, eating, energy levels, concentration, or self-image over a period of at least 2 weeks.

Cognitive Disorders: these include brain injury, dementias, and delirium.

Anxiety/Panic Disorder: Characterized by excessive feelings of worry, restlessness, or fear.

Borderline Personality Disorder (BPD): Is characterized by impulsive actions and unstable moods, behavior, self-image, function, relationships.

Post-Traumatic Stress Disorder (PTSD): A disorder that develops in some people who have experienced a shocking or dangerous event or trauma and symptoms persist long after the event.

Child, Youth, Adolescent Disorders:
*ADHD or Impulse Control Disorder***:** An ongoing pattern of inattention and/or hyperactivity/impulsivity that interferes with functioning or development

Disruptive Behavior Disorders: Irritable or angry mood most of the day, most every day and severe temper outbursts

Autism, Childhood Schizophrenia: A group of developmental disorders with a wide range (spectrum) of symptoms, skills and abilities which primarily affects social communication and interaction.

Developmental Disabilities (DDs): Disorders which negatively impact a person's physical, intellectual, or emotional development into adulthood and require ongoing support for activities of daily living (ADLs)

Signs/Symptoms of mental health conditions: (NIMH)

Anxiety/General Anxiety Disorder (GAD)

- Racing, pounding heart
- Palpitations
- Dizziness
- Numbness/tingling of fingers and lips
- Uncontrollable shaking
- Shortness of breath
- Difficulty concentrating
- Easily fatigued
- Muscle tension
- Difficulty controlling worry

Bipolar Disorder (manic-depressive disorder)

- Changes in mood, energy, and activity levels
- Manic and depressive episodes
- Bipolar I Disorder

    - Manic episodes that last at least 7 days
- Bipolar II Disorder
    - Pattern of depressive episodes and hypomanic episodes
- Cyclothymic Disorder
    - Hypomanic and depressive symptoms but not as severe as
- Other Specified and Unspecified Bipolar Disorders

Mania (component of bipolar disorder)

- Elevated mood
- Inflated self-esteem
- Racing thoughts
- Distractibility
- Agitation
- Decreased need for sleep
- Increase in goal-directed activity
- Excessive involvement in pleasurable activities (shopping sprees, binges)

Depression

- Persistent sad, anxious, empty feelings
- Hopelessness, guilt, poor self-worth
- Insomnia or oversleeping
- Weight changes (loss or gain)
- Restlessness, irritability
- Difficulty concentrating
- Thoughts of death or suicide
- Physical symptoms which can't be attributed to a physical cause (headaches, digestive disorders, pain)

Schizophrenia

- Onset usually between ages 16 and 30
- Positive symptoms:
    - Hallucinations
    - Delusions
    - Thought disorders
    - Movement disorders
- Negative Symptoms
    - Flat affect (reduced expression of emotions in facial expression/voice)
    - Reduced feelings of pleasure in everyday life
    - Difficulty beginning or sustaining activities
    - Reduced speaking
- Cognitive Symptoms
    - Poor executive function (decision making)
    - Trouble focusing
    - Poor working memory (ability to use information after learning it)

PTSD

- Re-experiencing symptoms:

    - Flashbacks – reliving the trauma
    - Bad dreams
    - Frightening thoughts
- Avoidance symptoms:
    - Staying away from people, places, events that are reminders of the traumatic event
- Arousal and reactivity symptoms:
    - Easily startled
    - Tense, on edge
    - Difficulty sleeping
    - Angry outbursts
- Cognition and mood symptoms:
    - Difficulty remembering key features of the trauma
    - Negative thoughts about self
    - Loss of interest in enjoyable activities
- In children – may also include developmental regressions or disruptive behaviors

Identify Mental Health Terms

Behavior – the way people act/perform; the things people do and the reasons for their actions. Behavior can be overt or covert.

Overt – open, understood by those around them

Covert – hidden meaning understood only by the person

Behavioral Crisis/Emergency – episode of mental or emotional distress that leads to instability or danger and is viewed as disruptive by the community or individuals close to the consumer. Extreme agitation, threats to harm self or others, or volatile behavior would be indications of danger.

Psychiatric Emergency – see behavioral emergency

Emotionally Distressed Person (EDP) – A person in crisis from mental illness (including from a perception disorder, thought disorder, mood disorder, or PTSD); substance use disorder; a medical condition; or situational stress; or a combination of factors

Stress – an increase in an individual's level of arousal caused by some stimulus

Crisis – a time-limited event that results from extended periods of stress unrelieved by adaptive coping methods

Mental Health Crisis - a state of mind where a person is unable to cope with stressful situations of everyday life and respond in a productive, safe manner. In some cases, those in crisis may be a danger to themselves or others, but not all people with mental illness are violent.

Crisis intervention – a professional strategy to address an immediate problem, resolve acute feelings of distress, and restore independent problem-solving skills of the consumer/patient

Mental Illness: a group of psychotic disorders characterized by disturbances in thinking, feeling and relating. The onset of mental illness may occur at any time in an individual's life.

Psychosis: Loss of contact with reality, characterized by hallucinations, delusions, incoherent speech, and behavior that is inappropriate for the situation.

Hallucinations: perceiving, seeing or hearing things that others don't see or hear

Delusions: false beliefs

Stigma: a mark of shame or disgrace associated with a certain person, characteristic, or circumstance. Stigma can lead to social isolation, fear, violence, mistrust, and prejudice.

Historical views of mental illness

Societal views of mental illness have shifted over time. At one point, mental illness was considered to be a result of demonic possession or witchcraft and was "treated" through charms, spells, and exorcisms. In later centuries, medical treatments such as bloodletting were used for both physical and mental illness. Psychoanalytic and psychopharmacologic approaches became common in the early twentieth century, while current focus is on biological and interpersonal models of mental illness. Deinstitutionalization of mental health patients in the 1960s has led to increased presence of people with mental illness in community settings, where treatment may be fragmented or poorly available. No one chooses to have a mental illness – they are conditions with biological causes just like heart disease, diabetes, or cancer.

Assessment & Commitment

Behavioral Emergencies: Most disordered behavior reflects a response to stress. The psychologist Selye developed the General Adaptation Syndrome listing 3 phases in the body's response to physiologic and/or psychologic stress:

Alarm – stress stimulates the sympathetic nervous system, causing "fight or flight" responses such as ADH, ACTH, and epinephrine/norepinephrine secretion which lead to increases in breathing, heart rate, blood pressure, pupil dilation, sweating, blood glucose

Resistance and recovery – the person responds to the stress and returns to a normal state, or progresses into the next phase, exhaustion.

Exhaustion – the person can no longer adapt to the continued stress

Stress beyond one's ability to cope can lead to a behavioral emergency. Observe the person's behavior – is he/she:

Responding to verbal questions/commands?
Coherent?
Able to make eye contact?
Agitated? (shouting, pacing, talking to people you don't see)
Talking to him/herself?
Wearing clothing appropriate for weather conditions?
In an appropriate state of hygiene?

If the person being aided is communicative you can ask about medical/mental health history, medications, etc. as well as how you can best help. Responders will not diagnose mental health conditions, but may identify signs and symptoms of common illnesses to guide intervention.

Sometimes behaviors can be perceived as resistance or non-compliance, but are actually indicators of an individual's reduced ability to understand and respond. Recognizing and understanding some of the unique indicators of mental illness, intellectual disabilities, and substance use disorders can help officers find ways to facilitate communication and de-escalation during contacts.

In situations where a person in crisis is not a threat to others, officers should create time, distance, and rapport with the person. This can increase officer safety by allowing for arrival of backup and enable officers to deploy communication skills and de-escalation techniques which can potentially avoid use of force. Less-lethal weapons may work differently or not as effectively on people in crisis so should not be used before attempts to verbally de-escalate.

In situations where a person in crisis is a threat to officers or others, officers should always keep safety as their highest priority.

Potential Precipitating Causes of Altered Client Behaviors/Crisis: A crisis occurs when a person faces a situation that is perceived as overwhelming and beyond the ability of the person to manage using normal problem-solving or coping strategies. There is a great deal of individuality in the level of a situation which reaches a crisis. One individual's threshold may be higher or lower than another's.

Often the perception of the situation as serious, uncontrollable, and beyond the person's ability to cope creates the crisis, not the situation itself. Life events which may precipitate a crisis include:

- Developmental – life transitions such as birth of a child, loss of a parent, retirement
- Existential – realization that one may not have a significant impact on the world or reach life goals
- Environmental – natural disasters, terrorist events
- Medical – newly diagnosed disease (MS, heart disease, etc)
- Psychiatric – mental health conditions

- Situational – loss of job, economic setback, trauma such as rape, assault

Potential Medical Causes of Altered Patient Behaviors:
Responders should carefully rule out potential medical causes of disruptive behavior – many medical conditions can lead to changes in behavior or consciousness and cause symptoms similar to those seen in mental health conditions. Failure to identify and treat medical conditions can lead to worsening of the condition or death.

Violence Potential:
Common Triggers Most crisis situations have a precipitating event (loss of a loved one, family conflict, economic or employment setback) and the client is unable to resolve the situation using normal coping methods. In many cases, the crisis results due to timing, when a person is already overloaded with other stresses. On another day, the issue may have been manageable, but at a time when someone already faces other stresses it may push him or her beyond his/her ability to cope. There is also great variability in the coping ability of individuals – one person may be mildly concerned by a stress while another is completely off balance facing the same circumstance. The same individual may deal with a stressor completely differently in different circumstances. People in crisis display heightened emotional levels and lowered rational thought. The stress response results in physiological changes in the body.

Cue*s* Physical or verbal cues may indicate a patient is potentially violent. Responders should be alert for *warning signs* such as:

- Direct eye contact
- Increased heart/respiratory rate and darkened facial color
- Tall stance
- Large movements
- Stop/start behavior

Danger signs indicate the person is beginning to lose control and may indicate an imminent attack. These danger signs include:

- Clenching/unclenching fists
- Fighting stance
- Pale facial color
- Lips tight over teeth
- Head lowered to protect throat
- Tense shoulders
- Target glances
- Hands above beltline
- Eyebrows low over eyes

De-escalation Tactics

Officers should attempt to de-escalate situations where possible to prevent violence, use of force, or injury to the consumer, officers, or bystanders. It is important to remember that de-

escalation is not always effective – if they see signs of violence responders should consider use of force appropriate for the situation to protect themselves and others. Safety is always the highest priority. De-escalation should not preclude safety if there are indications that the consumer may be violent.

Communication in de-escalation should be mainly focused on listening – allow the person to talk and express feelings. People want to be heard, understood, validated, and valued as human beings – not to be judged or criticized. Through active listening, responders can help consumers make sense of their feelings, validate and offer objective perspective, provide hope, identify resources to help, and give them power to make choices and take action to resolve the crisis.

EAR Model (review from Awareness)

Engage
Assess
Respond

Engage the patient by introducing yourself, "Hi, I'm officer Smith. What's your name?" Use "I statements" and open-ended questions such as, "I want to help you. What's going on today? Are you hurt?"

Avoid judgmental "you statements" such as, "You are acting crazy." These undermine efforts to build rapport between you and the patient. You statements can be helpful in active listening, as in, "you sound pretty stressed."

Assess the situation for indications of medical history, medication or substance use, or signs of potential violence. Assessment should be an ongoing process as you interact. Bystanders, family, friends, or clinicians may provide information on the patient's condition.

Resolve the situation in the most appropriate manner. This may be transport to a medical facility, mental health facility, or referral to another agency. Your agency's protocols will determine which destinations are allowed legally. In situations where the client shows potential danger to self or others, protective custody and transport for hospitalization would be an appropriate resolution and EMS and law enforcement should collaborate to facilitate safe resolution.

Verbal Loop Technique (review from Awareness) –

Listen
Respond with agreement/validation
Make request

Fogging – find something about person's behavior with which you can agree to build empathy

Broken record technique – repeat calming phrases such as, "I want to help" or "You're safe here"

Active listening techniques – paraphrasing, reflecting and emotional labeling, verbal or non-verbal encouragers, validating, reassurance/affirmations, and waiting are all effective in de-escalation

Paraphrasing – rephrasing in your own words
Reflecting – provide feedback on your sense of the situation (you seem angry)
Emotional labeling – identifying emotions to help control them
Encouragers – "uh huh", "go on", "I see…", nodding
Validating – conveys to consumer that it is ok to feel what he/she is feeling "I'd be upset about that too"
Affirmations – simple, direct statements to instill hope and confidence "I'm glad you are willing to talk to me about this"
Waiting – pause, allow silence to give time for thought and response

Steps to identify the nature of the crisis:

What happened to require a 911 call?
What led up to the precipitating event?
Who is involved?
What does the client feel about the situation?
What does the client fear?

Officers should then reduce stress in any way possible – remove stimuli, bystanders, move from a noisy or chaotic environment, and keep communication calm and slow to reduce levels of anxiety. If the client reports hallucinations, don't argue, accept that they truly believe what they perceive. Be honest – don't make false statements or promises.

To assist patients with the crisis situation, officers can use the **LOSS Model** of observable characteristics and intervention strategies:

Loss of Reality: Individuals may be experiencing delusions, paranoia, hallucinations, odd behavior, disorganized thinking, and may be frightened and confused

- Intervention: Re-orient the person repeatedly to time, place, name, event. If the person is experiencing a loss of reality such as hearing voices, acknowledge their report, "I don't hear the voices but I believe that you do."
- Goal: re-orient the person and reduce confusion, "We're here at your house on Main St."

Loss of Control: Individuals may display manipulation, hostility, impulsive or self-destructive behavior

- Intervention: Listen, de-escalate, defuse and allow the person to vent his or her frustration. Stay calm and maintain control of your emotions. Use active listening techniques.
- Goal: Allow venting; model desired behavior (calm, confident)

Loss of Perspective: Individuals may exhibit anxiety, panic, nervousness, restlessness or be overwhelmed by a situation that seems minor to others.

- Intervention: Calm, de-escalate, use active listening

- Goal: allow venting

Loss of Hope: Individuals may feel depression, sadness, anguish, despair or consider suicide

- Intervention: Form a personal connection, assess for suicidal thoughts or intent
- Goal: instill hope; obtain cooperation to get professional help

10 Domains of de-escalation (Richmond et al, 2012)

Officers should self-monitor their own emotional expression to project a calm and confident attitude toward the consumer and maintain congruence between verbal statements, tone, body language, and posture. Officers should also consider the 10 domains of de-escalation when trying to calm an agitated patient:

1. **Respect personal space**. Keep a safe distance between yourself and the client (at least 2 arms lengths.) Allow for a safe exit if needed, and be aware that many people experiencing behavioral emergencies may have past trauma which can be triggered by physical contact or violations of personal space.
2. **Don't be provocative**/avoid responder-caused escalation. Keep hands visible, maintain relaxed body language, don't make excessive eye contact, demonstrate care and respect. Maintain congruence between voice/words and body language. Don't cross arms or turn away, but stand slightly to the side at an angle.
3. **Establish verbal contact**. Only one person should interact with the client to avoid threatening or overwhelming him/her. (Contact/cover roles from Awareness.)
4. **Be concise**. Keep it simple. Allow time to process questions or requests. Permit silence, but repeat questions or requests if needed.
5. **Identify wants and feelings**. "I need to know what you need so I can help you." Even if you can't obtain what the patient wants you can assure them you will help them find resolution to their issue. Responding with empathy helps to de-escalate the level of emotion.
6. **Listen closely** to what the client is saying. Use active listening and clarifying questions to demonstrate that you are paying attention and care about the person's needs.

   Use Miller's Law: "To understand what another person is saying, you must assume that it is true and try to imagine what if it could be true of." This helps you to see the issue from the client's perspective. Ex – if a client says the CIA is stealing his/her thoughts, try to imagine how concerning this would be to him/her if it was true. This reduces your tendency to be judgmental and dismissive of the client's concerns.
7. **Agree, or agree to disagree**. 3 types of agreement:
   a. *directly agree* with the patient, "I understand that you're upset – I'd be angry too if that happened"
   b. agree in principle, "I think everyone should be treated respectfully"
   c. agree to disagree, if there is no way to honestly agree with what the patient is saying.
8. **Set clear limits.** Establish basic working conditions and clearly inform the client of acceptable behaviors. Communicate that injury to self or others is not acceptable

and will result in arrest and prosecution – but do so in a matter of fact tone, not as a threat or challenge. Explain your interest in helping to resolve the situation and tell the client that if you feel threatened or uncomfortable it will be harder to do so.

9. **Offer choices and optimism.** Choices (realistic options only) provide empowerment and reduce stress, and optimism that they will be safe and regain control of their emotions helps to calm agitated people.
10. **Debrief clients and family/bystanders.** Ask the client what has helped him/her in the past, or what can be done to prevent escalation of his/her behavior. Make a prevention plan for future interactions, "what can we do to help you stay in control of your emotions?**"**

Types of aggression

Instrumental aggression **–** used by those who have found they get what they want after violence or threats of violence. Use "I statements" to communicate acceptable behavior and use verbal de-escalation techniques.

Fear-driven aggression – used by those who feel threatened, afraid. Assure safety and use verbal de-escalation techniques.

Irritable aggression – 2 forms:

Boundaries have been violated- ex wronged by family member. Empathize and de-escalate

Chronically angry at the world – attempt de-escalation, but if unsuccessful may require physical intervention by trained responders (law enforcement)

Specific Situations:

Suicideis loss of life by self-directed means. Over 44,000 people committed suicide in the US in 2015 and it is the 10th ranked cause of death, 2nd for young people (CDC). More people die of suicide each year than of auto crashes or homicides, and rates of suicide have been increasing in recent years. For every completed suicide, there are estimated to be 25 attempted suicides.

Risk factors for suicide include:

prior attempts
mood disorders (particularly depression or bipolar disorder)
alcohol and drug use
access to lethal means
co-occurring mental health and alcohol or substance use disorders
hopelessness
impulsive or aggressive tendencies
barriers to accessing mental health treatment
relational, social, occupational, financial loss
physical illness
stigma which interferes with seeking help
influence of significant people who have died by suicide

cultural/religious beliefs
local “epidemics” of suicide
isolation, poor social connections

Protective factors (those which reduce the risk) of suicide include:

Effective clinical care for mental, physical, and substance abuse disorders
Access to care
Restricted access to lethal means
Family and community support
Learned skills in problem-solving, conflict resolution, dispute settlement
Cultural and religious beliefs

Those with higher risk of suicide than the general population include (SAMHSA):

American Indians and Alaska Natives
People bereaved by suicide
People in justice and child welfare settings
People who intentionally hurt themselves (non-suicidal self-injury)
People who have previously attempted suicide
People with medical conditions
People with mental and/or substance use disorders
People who are lesbian, gay, bisexual, or transgender
Members of the military and veterans
Men in midlife and older men

Depression and alcohol or other substance use are very strong risk factors in suicides. People with depression often self-medicate with alcohol or other drugs, and approximately 50% of those with severe mental illness have substance use disorders (SUDs) which can contribute to impulsivity and poor judgement.

There is usually a precipitating event when someone considers suicide – usually a conflict or loss for which the pain is so great that death is preferable to living through the sadness. In most cases there is an accumulation of circumstances such as stress, conflict, or loss. Examples include family conflict, job loss or setback, financial issues, legal issues, illness, or pregnancy. As in any crisis situations, the impact of these situations is very individual. To the person in crisis, suicide is a reasonable solution to the pain they feel. People contemplating suicide often fell hopeless, worthless, guilt, or shame, and that they are a burden to others. Caring connection and active listening can build rapport and help them see alternatives to suicide.

Maintain a non-judgmental, supportive stance and express authentic concern for the patient’s well-being. The goal of the responder is to prevent the suicide, while the goal of the patient is to end the psychological pain. Using crisis intervention skills to help the patient develop strategies to cope with the situation and regain control can help bring these disparate goals into alignment.

Warning signs of acute risk of suicide include threats of hurting or killing oneself, looking for ways to hurt or kill oneself, or talking or writing about death, dying, or suicide when these topics are out of the ordinary. Ask the patient if he/she is thinking about or planning to kill him/herself. Assess risk using the LAST model – but always take threats of suicide seriously and transport the patient to an appropriate mental health treatment facility.

Risk of suicide – Responders can use the LAST model to assess the potential likelihood of suicide in a person contemplating it by considering these aspects of their plan. The more specific and lethal the plan, the greater the immediate risk of completing suicide.

LAST Model:
Lethality of chosen method
Availability of chosen method
Specificity of the chosen method
Timing – rescuability, likelihood of being found

Therapeutic communication skills such as active listening and expressing empathy can help the person contemplating suicide to reframe the significance of the precipitating event. Responders have to be able to manage their own attitudes toward suicide and avoid negative messages. Interaction should be designed to help the client explore alternatives to deal with events and agree to seek additional help.

Suicide Attempt – responders should:

- Ensure safety of patient, bystanders, and other responders (remove access to lethal means, weapons)
- Assess for medical needs, treat injuries or life serious illness
- Establish rapport
- Ask if he/she is considering suicide
- Assess lethality using the LAST model (above)
- Seek agreement for obtaining help
- Detain and commit to involuntary treatment if necessary (attempts to gain voluntary agreement fail)
- Provide transport to a qualified mental health treatment facility or hospital

Recognize forms of suicide such as chemical suicide (reactions in a closed space, usually a vehicle, to asphyxiate) and “suicide-by-cop” (where a person will force a lethal confrontation by aggressive behavior or shooting at law enforcement) and ensure responder safety.

Response to a completed suicide may evoke strong feelings and cause frustration for responding officers. Having effective coping methods to deal with these emotions is important. Remember that suicide makes sense to someone in the context of his/her situation and desire to avoid pain or anguish.

Substance Use Disorders (Alcohol, drugs)

Mental health and substance use disorders (SUDs) are common among adolescents and adults in the US, and are expected to pass all physical diseases as a major cause of disability by 2020 (SAMHSA). Substances include alcohol, tobacco (nicotine) and other drugs (ATOD). May people with mental health conditions also have co-occurring SUDs, requiring a treatment approach that takes both illnesses into account. Many people with mental illness self-medicate with alcohol, tobacco, or other drugs.

Some drugs, particularly narcotics, can lead to addiction – a chronic, relapsing brain disease characterized by compulsive drug-seeking and continued use despite negative consequences. Drug use causes changes in the brain, which then requires ever-higher doses of the drug to provide the same level of response (tolerance). Self-control becomes impaired by the "hijacking" of the brain, so ability to voluntarily stop using is unlikely. Susceptibility to addiction varies among individuals, with both environmental and genetic influences playing roles. Teens and those with mental illnesses are at greater risk. The route of administration influences how quickly a drug affects the body, with IV injection and IN intranasal (snorting) fastest and inhalation, absorption and ingestion slower.

The major parts of the brain affected by drug use include the brain stem, responsible for controlling vital functions such as respiration and heart rate; the cerebral cortex, responsible for higher thinking and senses; and the limbic system, containing the brain's reward circuit. The limbic area of the brain mediates feelings of pleasure and reward, so we try to repeat activities which stimulate this area, such as certain types of drug use.

Major types of drugs include (NIDA):

- Nicotine – from tobacco smoking
- Alcohol – a depressant drug
- Club drugs – such as GHB, Rohypnol®, ketamine, methamphetamine, MDMA (Ecstasy; Molly), LSD (acid)
- Marijuana – impairs short-term memory, focus, and coordination and can cause psychosis in some users
- Prescription medications – particularly opioid pain relievers; anti-anxiety drugs; or ADHD meds that are used to self-medicate or to get high
- Heroin/Opioids – drugs produced from the opium plant or synthetic analogs; risk of sudden death due to CNS and respiratory suppression; includes OxyContin®, Vicodin®, fentanyl and others
- Inhalants – volatile chemicals in household products such as aerosol cans and paint can cause severe damage to the brain, heart, lungs, and kidneys
- Cocaine – a stimulant, usually snorted
- Amphetamines – stimulants
- Depressants - sedatives
- Synthetic cannabinoids – such as K2 or Spice are man-made mind-altering chemicals that are sprayed onto dried plant matter to be smoked or liquids to be vaporized
- Synthetic cathinones – (bath salts) stimulants with effects similar to the khat plant

Benzodiazepines – sedative, anxiolytics (anti-anxiety) which can be lethal when combined with other depressant drugs such as opioids

Drug use (either legal or illicit) can cause or contribute to a behavioral crisis. Responders need to consider the influence of drugs and resulting medical emergencies as part of their assessment of the situation and treat any life-threatening conditions which may result from drug use.

The level of severity of a SUD is diagnosed on a spectrum based on how many symptoms a person exhibits (NAMI.) The presence of 3 or more symptoms indicate a mild disorder and more symptoms indicates a more severe disorder:

- Inability to manage obligations at work or home
- Repeated use of substances in situations where it is dangerous to do so (ex. While driving)
- Ongoing interpersonal issues due to substance use
- Tolerance for the drug of choice (DOC)
- Withdrawal symptoms when without the DOC
- Taking more of the DOC than intended
- Inability to decrease or stop using
- Spending a large amount of time seeking, using, or recovering from use
- Avoiding family or social events or activities due to substance use
- Continued use despite awareness that substance use is causing physical, psychological, or social problems
- Cravings for the DOC

Addiction is defined as a physical and psychological dependence upon a drug (including alcohol) or multiple drugs. Physical dependence and continued use often leads to *tolerance,* where more of the substance is required to achieve the same effect, while psychological dependence leads to cravings and obsessive thoughts of obtaining the drug or getting and staying high (or avoiding withdrawal.)

Drug interactions can occur between prescription medications, and can also occur between prescription medications and illicit drugs. Side effects of interactions can include movement disorders, metabolic syndrome, thyroid dysfunction, renal (kidney) dysfunction, and hepatic (liver) dysfunction.

Gender, diet, smoking, physical health, genetic, and environmental factors may also affect drug action. Recent medication changes may be a contributor to physical or behavior changes in patients taking psychoactive medications. Law enforcement officers should request medical response whenever they suspect the client is experiencing a drug interaction.

Opioid abuse and overdose have soared, reaching epidemic proportions in the past 10 years. In the US in 2015, there were more than 50,000 deaths from drug overdose, with 33,000 of these

deaths due to opioids. Deaths from opioid overdoses quadrupled between 2000 and 2015 (CDC.)

Opioids include heroin, opium, and prescription painkillers such as oxycodone (OxyContin®), hydrocodone (Vicodin®), hydromorphone (Dilauded®), codeine, morphine, methadone, and synthetic chemicals such as fentanyl, acetyl-fentanyl, carfentanyl, and "designer drugs" such as U-47700 ("pink"). Many other types of both prescription and illicit opioids exist and are being developed, so this list is constantly changing.

Many heroin users report that they initially became addicted to prescription painkillers for an injury, but eventually switched to heroin due to difficulty in obtaining medications or because of cost. Heroin is generally cheaper than prescription pills.

Opioid overdose can cause sudden death due to respiratory arrest (stopped breathing), which can occur within minutes of use. The route of entry to the body plays a role in the speed of effect, with IV (intravenous) injection or IN (intranasal) administration acting faster than inhalation or ingestion. Naloxone, (Narcan®), is an opioid blocker which can prevent the drug from binding to opioid receptors in the brain and reverse the effects of an overdose. If naloxone is administered within a few minutes of overdose it can prevent this sudden death. Michigan has a standing order in place where anyone can obtain naloxone from participating pharmacies without an individual prescription.

Police agencies in Michigan may carry and administer naloxone in accordance with policies of their local Medical Control Authority. Because police are often first on the scene and because death can occur within minutes without support of breathing and/or administration of naloxone, police are strongly encouraged to carry and administer naloxone at the scene of an overdose. Naloxone is only indicated for an opioid overdose. Breathing support through use of a pocket mask or bag valve mask can also prevent death in a person whose respiratory rate is low or absent.

Signs of opioid overdose include:

- Unresponsive
- Slow, shallow, or erratic breathing (generally <8 breaths per minute is life threatening)
- Constricted pupils (pin-point)
- Blue, gray, pale, or ashen skin color
- Gurgling or noisy breathing
- Blue or purple fingertips and lips
- Slow pulse

Treatment of opioid overdose: If naloxone is available, administer it as directed and observe breathing and level of consciousness. Effect is usually quick and dramatic. Naloxone can be repeated if there is no change within a few minutes. If naloxone is not available, begin rescue breathing with a barrier device (pocket mask or BVM) according to CPR training.

Nearly half of opioid overdose deaths involved a prescription opioid painkiller, and many involved combinations of opioids with other drugs, particularly benzodiazepines. **Benzodiazepines** are primarily anti-anxiety or anti-seizure medications such as alprazolam (Xanax®), diazepam (Valium®), and clonazepam (Klonopin®) which act on GABA receptors and make neurons less receptive to excitation. This class of medications has a sedative effect, but this combined with the respiratory depressant effect of opioids can cause respiratory arrest and death.

Opioids bind to specific receptors (μ-receptors) in the brain and reduce or block nerve impulses which transmit pain. When these receptors are activated in the limbic/reward centers of the brain, they cause dopamine release and resulting feelings of pleasure and euphoria, or a "rush." Heroin users report a warm flushing of the skin, dry mouth, heavy feeling in the extremities, and sometimes nausea, vomiting, and itching of the skin. Mental function is clouded, and heart rate and breathing slow. The effects on respiration can lead to death, coma, or severe brain damage.

Use of opioids leads to *tolerance* and *physical dependence*. Tolerance occurs when the dose of the drug needed to produce the same effects (for instance, the "high") increases. Physical dependence occurs when the body adapts to the presence of the drug and sudden reduction in use leads to withdrawal symptoms. Symptoms of withdrawal include anxiety, muscle and bone pain, diarrhea, nausea, vomiting, and tremors. These physical symptoms are sometimes referred to as "dope sick" and are extremely unpleasant, making it difficult for someone who has developed tolerance and addiction to stop using. Addiction is beyond physical dependence and is characterized by uncontrollable drug-seeking without regard to the consequences. This compulsion can take over a person's life and make him/her indifferent to consequences of his/her behavior.

Negative consequences of addiction can result in loss of employment, family, friends, and social connections. These exacerbate susceptibility to behavioral emergencies and crisis. IV drug users are also susceptible to HIV (human immunodeficiency virus) and HCV (hepatitis C virus) and HBV (hepatitis B virus) from use of contaminated needles. Addiction can also co-occur with mental health conditions, and stigma can reduce ability to access treatment.

Strategies to reduce opioid overdose deaths include 3 main areas (CDC):

- **Naloxone availability** – if available within a few minutes of overdose naloxone can reverse life-threatening effects of opioids
- **Prescribing practices** – prescription guidelines for opioid medications and prescription drug monitoring programs can reduce the availability (supply side) of opioids. There is a risk that some opioid users will switch to heroin or illicit drugs
- **Medication Assisted Treatment (MAT)** – combines pharmacological treatment with behavioral therapies to treat addiction. Medications may include buprenorphine (Suboxone®, Subutex®), naltrexone (Revia® or Depade®), or methadone. These medications are agonists, which activate opioid receptors; partial-agonists, which

activate opioid receptors but produce a smaller response; or antagonists, which block opioid receptors. The medications reduce the compulsion and cravings for drug use while the behavioral therapies address underlying reasons for addiction.

SAMHSA Treatment Locator The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a behavioral health treatment locator on its website: https://findtreatment.samhsa.gov/
This can help responders to facilitate access to MAT and behavioral treatment for patients with substance abuse or mental health conditions.

Due to the high incidence of drug use, some law enforcement agencies have begun to assist in referring people with SUD to treatment facilities through use of "warm handoffs" where police facilitate a transfer of the person to an appropriate treatment facility. The **Police Assisted Addiction Recovery Initiative** (PAARI) is one model where police work with peer advocates in recovery to connect people to treatment programs for SUD. Diversion of people with drug or alcohol use disorders away from jails and into treatment has potential to address addiction more effectively than incarceration. (see paariusa.org for more information on this model)

Co-occurring Disorders (COD; also called dual-diagnoses)
People who have substance (drugs or alcohol) use disorders (SUD) and a mental illness (such as depression, anxiety, PTSD, OCD, eating disorders) are diagnosed with co-occurring disorders. The disorders exacerbate one another and make it difficult to distinguish the symptoms of one disorder from the other. In some individuals, a mental disorder precedes development of substance use (the person may be using substances to self-medicate), while in others a SUD precedes diagnosis with a mental disorder. In most cases a combination of factors is involved, including biology, genetics, trauma, environment, and life experiences. Effects of co-occurring disorders can lead to early death if not effectively treated, but treatment must address both conditions.

Integrated treatment that combines medication and counseling therapy to address psychological and behavioral issues can help a person deal with the effects of co-occurring disorders. Unfortunately, only a small proportion (7.5%) of those with co-occurring disorders enroll in a comprehensive treatment program (SAMHSA.)

IPV- Intimate Partner Violence (aka domestic violence)
IPV includes spousal relationships, cohabitation, parents of a shared child, and dating relationships. IPV may include sexual assault, assault, property crimes, violation of a court order, trespass, bodily injury, or placing a person in reasonable fear of imminent bodily injury. Abuse is planned behavior (not out of control behavior) to keep a victim under control. IPV can occur in any type of relationship and be perpetrated by either gender. Tactics may also include physical or emotional abuse, social isolation, financial abuse, blaming, denying, or minimizing the partner's concerns, using children, or threatening behavior.

Scene approach in these situations should include presence of backup and assessment of the scene before approaching. Hang-up calls to 911 from the address may indicate possible IPV. Responders should also assess for weapons available to either party and request they be secured before entry. Make contact with the caller – don't allow someone to tell you they are fine and don't need care without doing an assessment.

If the victim is present, responders should conduct an assessment for physical injuries or medical needs and speak to him/her alone, keeping the parties separated and out of sight/hearing of each other. Try to avoid bedrooms and kitchens due to likelihood of possible weapons. Ask both parties (separately) if they are hurt or in pain and evaluate and provide treatment for any injuries. Document condition, extent of injuries, and statements regarding events. If the victim is a child, a disabled, or dependent elder, responders must report suspected abuse to appropriate welfare agencies. Try to make as little impact as possible on the scene to preserve evidence.

Behavior and manner should convey a non-threatening, non-judgmental demeanor. Stay calm and keep a safe distance from either party. Be aware of exits and avoid being "cornered." Note if the victim seems afraid or gives conflicting answers, or has delayed seeking care. Provide encouragement and support with statements like, "you don't deserve to be treated this way" or "support is available." Ask directly, "do you feel safe here?" or, "has anyone tried to hurt you?" and offer resource information. If the victim acknowledges abuse, listen, validate, and document. Ask, "how can I help?"

Decisions to prosecute, seek treatment, leave, or to remain with the perpetrator are solely those of the victim. Provide support and reiterate that help is available if needed.

Rape/sexual assault – Sexual assault or sexual abuse (against children) refers to an act of sexual contact performed on one person by another without mutual consent, or with inability to give consent due to age, mental or physical incapacity. Rape is any sexual penetration using force or coercion or against the person's will. State laws vary in their specific definitions. Rape is an act of physical violence, not for sexual gratification.
One out of every 6 women and 1 of every 33 men in the US have experienced an attempted or completed rape. 90% of victims are women, but men and children are also victimized by rape. Law enforcement or EMS responders are often the initial public safety providers who encounter a survivor of sexual violence. They can begin the process of support for the survivor by not evaluating or judging the circumstances of the assault. *Any* emotional response of the survivor is appropriate – people will vary in their expression.
Note the time, date, location and any injuries. Ask the survivor, "are you hurt?" and treat any injuries, but don't ask probing questions about the assault. Document any evidence of trauma and assessment findings. Provide first aid if needed - obtain consent and explain procedures before performing them.

If the survivor hasn't bathed or showered since the assault he/she should refrain from doing so to preserve evidence. If clothing was changed, the clothing worn in the assault should be put in a paper bag and taken to the hospital or crisis center.
Responders should be sensitive to cultural or religious considerations related to sexual values and have a provider of the same sex perform assessment and treatment if possible. Responders also need to convey that the survivor is not at fault and is supported.

Veterans (military)
Military veterans may experience contact with the criminal justice system or crisis situations just like anyone else, but several aspects of military service and culture have impact on civilian life. Combat training for veterans emphasized non-defensive driving, being lethally armed at all times, and targeted aggression. These skills may cause difficulty in civilian life due to not following driving rules, being armed, and being overly aggressive in inappropriate situations.

Some veterans may be affected by depression, anxiety, PTSD, TBI, physical injury, military sexual trauma, substance use, or issues in adjusting to civilian life which lead to a crisis situation. Veterans may experience homelessness or be suicidal. The crisis intervention principles of communication, active listening, and de-escalation all apply, but officers who also served in the military may be able to build rapport around shared experiences. Asking about a person's unit, role and military experiences may provide opportunities for communication and establishing connection.

> DoD resources to assist the transition to civilian life are available at the website: afterdeployment.dcoe.mil

Homeless
Homelessness is an extremely complex social problem which often involves law enforcement due to the absence of effective solutions. Recent trends in US cities are to involve the criminal justice system to solve the problem through enactment and enforcement of laws which criminalize life-sustaining acts in public spaces such as parks, streets and libraries. This "criminalization of homelessness" can include:

- Laws making it illegal to sit, sleep, lay down, or store personal belongings in public spaces
- Selective enforcement of laws such as loitering or open container laws
- Sweeps of areas where homeless people are living
- Laws against begging or panhandling to move poor/homeless people out of an area

Economic conditions have led to an increase in the number of homeless people in recent years. In some cities, government and community groups have joined to provide services (particularly in non-traditional hours) and outreach to assist homeless individuals in meeting housing, medical, and daily living needs.

Some people who are homeless also have mental illness or SUD, but not all homeless people do. Although homeless people sometimes commit crime, people who are homeless are more likely to be victims than perpetrators of violent crime. (49% of homeless people report they have been victims of violence compared to 2% of the general public.)

The US Conference of Mayors conducts research and compiles an annual report on homelessness and hunger. In January 2016, the one day count of homeless people in the US identified 544,084 individuals, 31% of whom live in cities. Homeless people include single adults, families, and unaccompanied children or youth; gender breakdown is approximately 59% male, 40% female, and less than 1% transgender. Some people are homeless for shorter periods of time and can regain permanent housing. The chronically homeless are defined as those who have a disability (SMI or SUD) and are homeless repeatedly or for long periods of time. 7% of people who are homeless in the US are identified as military veterans.
Rates of homelessness have been decreasing in the past several years, but availability of emergency, transitional, and permanent housing and support services is still below need.

Human Trafficking
Exploitation of children and adults for commercial sex trade is a growing criminal enterprise in the US and worldwide. 100,00 to 300,000 children are victimized through prostitution each year in America, with the most frequent age of entry 11 years old. Police officers may encounter victims of human trafficking and should be aware of red flags:

- Not attending school or high absences
- Frequent moves
- Withdrawn, depressed, fearful demeanor
- An older "boyfriend" or controlling family figure
- Not being permitted to talk or answer questions
- Branding, tattoos, or body carvings (often $ signs in genital areas)
- Inconsistent stories of living in other cities
- Bruises in various stages of healing

The US HHS National Human Trafficking Training and Technical Assistance Center offers training using the SOAR model:

Stop – describe the scope of human trafficking in the US
Observe – recognize indicators of human trafficking
Ask – identify and interact with victims and survivors in a victim-centered and trauma-informed approach
Respond – to potential human trafficking in your community to identify needs and resources available to assist

SOAR training webinar: https://www.acf.hhs.gov/otip/resource/soarhealthcare

Legal Aspects

The Michigan Mental Health Code (Act 258 of 1974) has sections pertaining to the admission and discharge procedures for mental illness, emotionally disturbed, and developmentally disabled persons.

- A "person requiring treatment" (PRT) (MCL 330.1401) is defined as a person who is mentally ill and who:
  - Can be reasonably expected to intentionally or unintentionally physically injure himself or others and has engaged in acts or made threats to support the expectation
  - Is unable to attend to basic physical needs
  - Has judgement that is so impaired that he or she is unable to understand the need for treatment and whose behavior will cause significant physical harm, or
  - Has weakened mental processes because of age, epilepsy, alcohol or drug dependence

Law enforcement:

Recognize that protective custody is civil in nature and is not to be construed as an arrest (MCL 330.1427a)

EMS:

EMS Authority to Restrain (Public Act 368 Sec 20969)

"…if emergency medical services personnel, exercising professional judgement, determine that the individual's condition makes the individual incapable of competently objecting to treatment or transportation, emergency medical service s may provide treatment or transportation despite the individual's objections unless the objection is expressly based on religious beliefs."

Michigan Commission on Law Enforcement Standards (MCOLES) 2011 Policy Writing Guide on The Response to Persons with Mental Disorders discusses the following Interventions:

A. Law enforcement officers shall make informed decisions regarding intervention strategies at the scene. Officers shall evaluate the nature and seriousness of the situation by considering any physical injury, behavioral cues, current environment, and safety. The officers' decisions to resolve the situation must be based on the totality of circumstances and the legal authority to act.

B. The determination to take the individual into involuntary custody shall be based on a violation of the criminal statutes or a reasonable belief that the person requires treatment

(PRT)—see section VI. Officers shall also check for violations of court orders or outstanding warrants.

C. Officers shall consider alternatives to involuntary custody, in the absence of a serious offense, outstanding warrant, or PRT. Alternatives include:

a. voluntary hospitalization;
b. outpatient treatment;
c. counsel-and-release;
d. referral to a local community based mental health facility;
e. referral to local mental health practitioners, clinicians, or service providers; or
f. release to family members or peer support groups.

D. Some jurisdictions administer jail diversion programs, where those charged with less serious, non-violent crimes can be diverted to community based mental health treatment
services and other community services or programs.

Legal concerns surrounding the use of force in crisis situations consider the concept of *proportionality*, whether the use of force is proportional to the threat faced by officers. Officers need to consider whether they are only using the level of force necessary to mitigate a threat and whether a less injurious option is available that will safely and effectively reach the same objective (PERF). In situations where a person has a gun and is threatening officers or the public, deadly force is a proportional response. In other situations, such as a person with mental illness holding a knife at his side, a proportional response may be to tactically reposition, provide space, and attempt verbal de-escalation.

Case law dealing with use of force and objective reasonableness also set expectations for law enforcement response. The severity of the threat and totality of circumstances are relevant to the reasonableness of force. The following cases are briefly summarized:

Tennessee v. Garner established that deadly force is permissible when "the officer has probable cause to believe that the subject poses a serious threat of physical harm, either to the officer or to others."

Graham v. Connor established 3 factors for consideration in evaluating the reasonableness of use of force (any level of force):

- Severity of the crime at issue
- Is the subject an immediate threat to officers or the public?
- Is the subject actively resisting arrest or attempting to evade arrest by flight?

Griffith v. Coburn dealt with officers' response to an individual whom they knew was mentally ill or developmentally disabled and found that "the diminished capacity of an unarmed detainee must be taken into account when assessing the amount of force exerted."

These and other cases indicate that officers must learn how to recognize and interact with mentally ill or emotionally distressed subjects and how to handle situations without escalating

them unnecessarily. Officers are the professionals in these encounters and are held to a high standard.

Reporting/Documentation Procedures

Documentation of any crisis situation should be objective. Use quotes and begin with, "subject stated…" and document any threats, behavior, physical findings and any resistance. Document any verbal threats from the subject and any warnings or commands given by officers; also document any injuries the subject self-inflicted or inflicted on others.

Report actions – if de-escalation was attempted report it. If it failed, report, describe why, what changed, and describe next actions and communication. Documenting de-escalation attempts or why it was not attempted can demonstrate reasonableness to meet the standards required re: *Griffith v. Coburn.* For patients with suicidal behavior document risk assessment (using LAST model) and responses. Each officer should write his/her own individual report of the encounter and complete any department-specific incident reports or forms.

Implicit Bias, Police Legitimacy, and Procedural Justice

Police legitimacy reflects the belief that police should be permitted to exercise their authority to maintain social order, manage conflicts and solve problems in their communities. Legitimacy reflects how much confidence the public has in the police, their willingness to defer to law and police authority, and belief that police actions are just and appropriate. If the public does not believe the police are just, honest, and competent, they will react negatively to police power. Techniques to promote police legitimacy include:

- Explain actions and provide helpful information
- Be courteous and respectful
- Communicate with the public through a variety of mediums

Procedural justice techniques can help establish police legitimacy and build productive relationships with people in their communities. The 4 principles of procedural justice include:

- Give everybody a voice
- Use neutrality in decision-making (fair, transparent)
- Treat everyone with dignity and respect
- Be trustworthy

Bias is a form of preference for or against a social category. Bias may include stereotypes, prejudice, and/or discrimination.

Implicit (unconscious) bias, as opposed to explicit (conscious) bias, indicates that a person isn't aware of the bias. Humans are wired to make fast decisions about others using 2 systems in the brain to process information:

System 1 is the automatic, unconscious part of the brain

System 2 is the deliberative, logical, methodical part of the brain

Bias results from our human tendency to divide people into "in-groups" (people like us) and "out-groups" (people different than us) using our System 1 thinking. Implicit bias has been detected in studies of health care, education, and criminal justice personnel even where explicit biases are not detected and individuals are well-intentioned. We categorize people we don't know based on observable characteristics such as race, gender, age, sexual orientation, religion, and body shape, then attribute stereotypes we are aware of about those groups to the individuals. If people are made aware of these automatic, unconscious responses, they can replace them with responses which are non-prejudiced. Police deal with the small portion of the population who commit crimes much more than they deal with the general population, so can develop an "us vs. them" mentality. By using System 2 thinking to reprogram implicit associations officers can remove bias. Training and positive contact with stereotyped groups can help eliminate implicit biases.

Cultural Awareness & Diversity

Diversity – includes age, race, gender, ethnicity, religion, and sexual orientation.
Cultural competence – set of congruent behaviors, attitudes, and policies that come together in a system which enables that system to work effectively in multicultural situations with diverse groups.
Ethnicity – selected characteristics used to classify people into groups or categories considered to be significantly different than others.
Race – biological variations in traits of humans
Religiosity – behavioral and social factors which reflect religious observance within a particular faith
Spirituality – thoughts, beliefs, and values about the meaning of life, the divine, possibly associated with religious observance

Members of racial, ethnic, cultural, and social minority groups may have higher disease burdens for both physical and mental illnesses. These factors influence attitudes toward medical and mental health care and illness as well as authority figures. Responders may find that some cultural groups prefer communication with the head of the family rather than directly with the client. Willingness to seek help and the level of stigma surrounding mental illness may also differ in various cultural groups. Some cultural groups consider illness, particularly mental illness, to be punishment for negative actions of one's parents. This view may prevent people from taking steps to manage their disease because they feel powerless to change it. Some groups may incorporate more traditional healing practices or "folk" medicine with western medical care. Others may refrain from seeking help due to concerns about immigration status, being marginalized, or obtaining respectful treatment. Respecting and working within cultural differences will in most cases help to achieve safe resolution to the crisis situation. Cultural competence should be differentiated from stereotyping, or holding exaggerated beliefs about a person. Not every individual with certain traits will share beliefs and values, but the goal is to build rapport and trust to resolve crises.

Culture refers to patterns of learned behaviors, beliefs, norms and values held by a group of people and passed from older members to newer members to preserve the group. Culture is more than race or ethnicity - it may include religion, social class, and native language among other components. Parameters of culture may also include views on time, social distance/proximity, and gender. Examples of cultural differences include: punctuality may not be as important in some cultures, eye contact, touch, or close proximity may be offensive, and modesty may require a care provider of the same gender for treatment. Concerns about stigma or cost may prevent people from obtaining treatment. Accommodating these differences or concerns can reduce stress while improving communication and resolution to the situation.

Cultural and linguistic competence is defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations." (Rose, 2013). Public safety and emergency response professionals will encounter patients and clients of different cultures and who speak different languages through the course of their professional lives and are expected to provide effective interventions when needed.

Cultural competence in health care is based on the concept that cultural groups deserve to experience their care in an approach in which their culture is respected. The **LEARN model** can help officers improve interactions with clients:

Listen with empathy
Explain your perception of the problem
Acknowledge and discuss similarities and differences
Recommend treatment
Negotiate agreement

These steps are similar to those used in de-escalation – both allow patients to feel heard and respected while the crisis situation is resolved. Cultural competence reduces perceptions of bias, prejudice, and stereotyping on the part of the client which could interfere with effective communication.

Trauma Informed Care

Individual trauma results from an event, series of events, or set of circumstances that is perceived by an individual to be physically or emotionally harmful or life threatening and has lasting adverse effects on the person's functioning and mental, physical, social, emotional, or spiritual well-being. As many as 78% of justice-involved women report history of childhood or adult physical, sexual, or emotional abuse.

Due to the high prevalence of previous trauma, officers should use the "universal assumption of trauma" and assume that everyone is a potential survivor of trauma. Officers should provide respectful communication, explanation of what is happening and will happen next, provide notice before touching a subject, and actively resist re-traumatization. These actions should

facilitate and enhance an officer's effectiveness, not detract from it, by reducing the 2 common responses to trauma or re-traumatization:

- Fear
- Loss of control

4 Rs of Trauma-Informed Care (SAMHSA):

Realize the widespread impact of trauma and potential paths for recovery
Recognize signs and symptoms of trauma
Respond by integrating knowledge about trauma into policies and procedures
Resist re-traumatization

Many people have experienced trauma and it has shaped their beliefs, actions, and overall reactions to others. Behavior may be an expression to being out of control, not simply "bad" behavior. People who have experienced trauma may not react to situations the way you think they should. Memory of events by victims of trauma such as survivors of assault or sexual assault may be fragmented – remembering additional details later should not be perceived as lying. Traumatic memories are stored in the brain differently than normal events.

Use the three Es of trauma in communications with subjects:

- *Event* – focus on the event to place responsibility on the environment, not the individual
- *Experience* – individual determination if an event it physically or emotionally harmful or threatening
- *Effects* – goal is to support the individual by not complicating their situation unnecessarily

Resources

Law enforcement officers can begin to develop awareness and connections with organizations in their communities which provide resources to people with mental illness or SUD. Some departments maintain listings of all support and social service resource agencies in their area such as hospitals, clinics, treatment facilities, service organizations, support organizations, living facilities, hotlines, and government agencies. By maintaining connections with community resources in advance of a crisis situation officers can more effectively assist individuals in accessing treatment or support services. This is a more definitive solution than incarceration without treatment.

MCOLES includes the following in the 2011 Policy Writing Guide for The Response to Persons With Mental Health Disorders:

VI. The Coordinated Community Response

A. Officers shall use community programs and other services established to divert persons with serious mental disorders from potential incarceration.
B. Officers should engage in a coordinated community approach to situations that involve those with mental disorders by building on existing working partnerships in their

jurisdiction. Officers can become part of a long-term collaborative approach by interacting with other practitioners and using community resources and services. Further support may be achieved by identifying community stakeholders, consulting with healthy consumers as active partners, or exploring viable treatment options.

C. Officers must recognize that stakeholder institutions, organizations, and individuals in the community are crucial to supporting a coordinated response to those with mental disorders. For purposes of a long-term response, officers shall work with:

a. public and private inpatient and outpatient mental health facilities;
b. residential facilities serving individuals with mental disorders;
c. general hospitals;
d. counselors; or
e. therapists.

D. Further efforts may be pursued by identifying services for the homeless, advocacy organizations, as well as church-based organizations or emergency shelters.

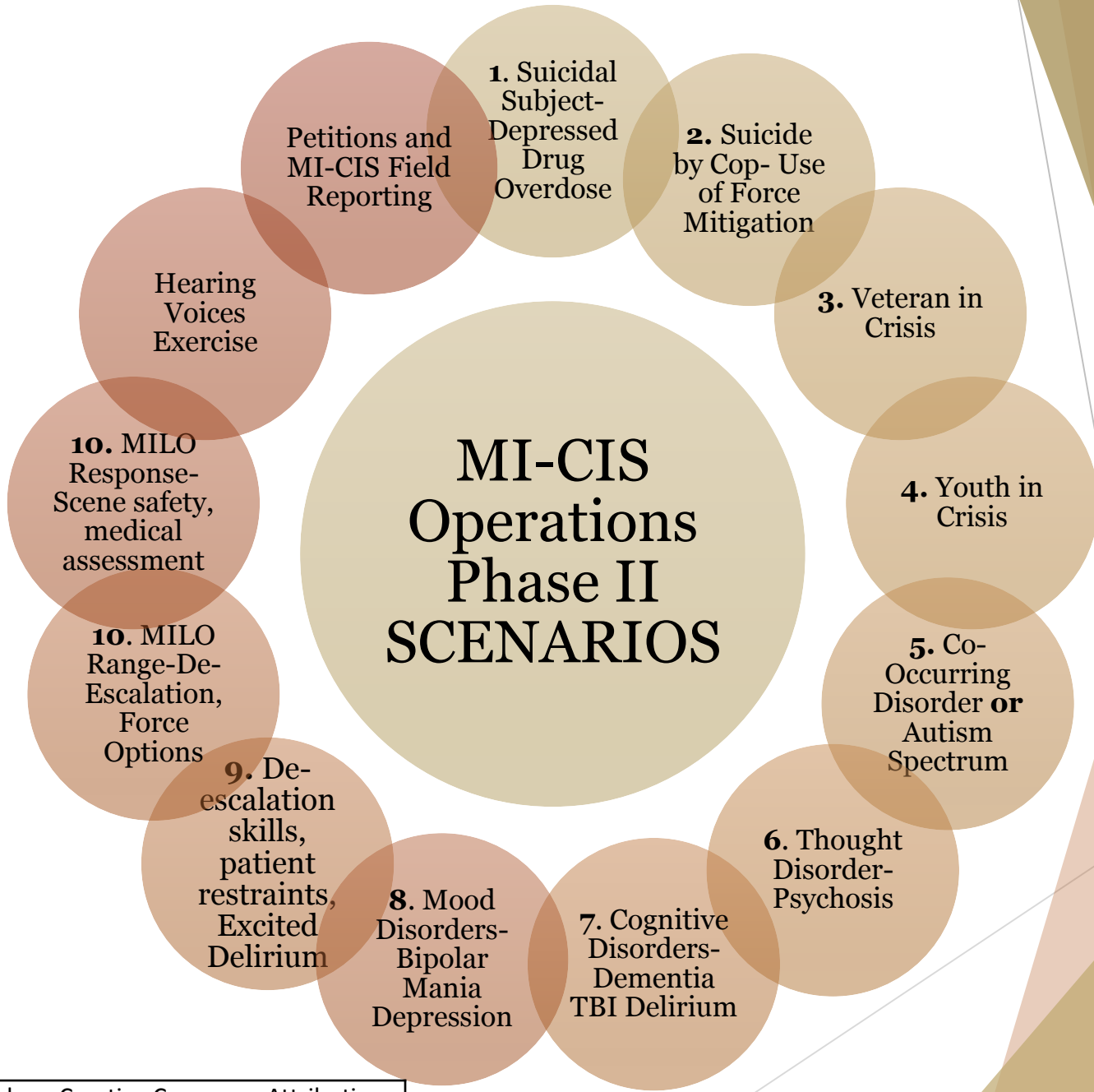
E. Additional resources may include services for those with substance abuse problems and other services for those with mental disorders in the community.

F. Determining the appropriate response is dependent on the nature and extent of the local partnerships in the community and the extent to which needed services can be identified and are available.

Self-Care

Self-care activities can help reduce stress on officers, particularly after involvement in a crisis situation. These include physical, mental, emotional, spiritual, personal, or professional activities to help oneself cope with demands of the profession and accumulated stress. Responders can be at risk of developing *compassion fatigue* or *vicarious trauma* from exposure to crisis situations or highly emotional response situations.

Activates such as exercise, talking with others about situations (without violating confidentiality), and engaging in enjoyable activities (not work-related) are examples of self-care. Eating right, getting sufficient sleep and engaging in regular exercise help keep responders physically and mentally healthy. Negative coping methods such as emotional withdrawal or drug or alcohol use are not effective forms of self-care and may exacerbate stress and create new issues. Stigma may interfere with an officer's willingness to seek treatment or therapy.



Michigan- Crisis Intervention System Operations II Enhanced Reality-Based Training (ERBT).

Participants will learn and apply skills previously taught within the Awareness and Operations level of training from distant learning modules and put into practice Intervention strategies through scenario-based training. Participants will be evaluated by mental health professionals and experienced CIS personnel. Training experiences will take place through interaction with the following:

1. **Suicidal Subject- Depression/Drug Overdose**
2. **Suicide by Cop- Police Use of Force Mitigation**
3. **Veteran in Crisis**
4. **Youth- In Crisis**
5. **Autism Spectrum Disorder or Co-Occurring Disorder.**
6. **Thought Disorder- Psychosis**
7. **Cognitive Disorders- Dementia, Traumatic Brain Injury, Delirium**
8. **Mood Disorders- Bipolar, Mania, Depression**
9. **De-escalation skills, patient restraints, excited delirium**
10. **MILO Range- De-escalation and Force Options**
11. **MILO Response- EMS scene safety, Patient Assessments**
12. **Hearing Voices Simulation**
13. **Petitions for Mental Health Treatment**

<u>Learning Objectives: (Scenarios 1-8) Duration time: 30 minutes each.</u>

- Demonstrate a safe, tactically sound response
- Demonstrate teamwork
- Demonstrate active listening skills- ability to gain information about the subject and the situation
- Demonstrate the ability to show empathy and respect
- Demonstrate strong verbal and non-verbal communication skills
- Demonstrate the ability to achieve a safe and effective resolution
- Demonstrate the ability to explain actions/decisions made throughout the event as part of the After-Action Review process.

Learning Objectives: MILO Range and MILO Response (Video-based simulation training.) Duration time: 30 minutes.

- Expose the student to behavioral health crisis situations involving rapidly changing scenarios that require split second decisions on force options and/or medical treatment options
- Enhance and build upon stress-induced decision making skills
- Improve situational awareness to potential threats and dangerous scenes
- Improve communication skills between partners and virtual reality role-players
- Train Police Officer students on Use of Force options
- Train EMS personnel to quickly assess medical emergencies and treatment options

Learning Objectives: 9. De-escalation skills, patient restraints, excited delirium. Duration time: 30 minutes.

- Describe and demonstrate effective communication skills that focus on de-escalating a potentially violent patient.
- Describe and demonstrate treatment for patients experiencing excited delirium.
- Describe and demonstrate appropriate patient restraint techniques.
- Describe the dangers associated with positional asphyxiation.

Learning Objectives: Hearing Voices Simulation. Duration time: 30 minutes.

- Participants will learn about the subjective experience of hearing distressing voices, increase their understanding of the day-to-day challenges facing people with psychiatric disabilities, become more empathetic toward voice hearers, and be inspired to consider changes in clinical/field practice which would better address the needs of people who hear distressing voices.
- Lecture on the phenomenon of hearing distressing voices.
- The Simulation experience
- After action review and discussion period.

Learning Objectives: Petition for Mental Health Treatment. Duration time: 30 minutes.

- Review of Michigan Compiled Laws: MCL 330.1401 (Person Requiring Treatment), MCL 330.1427a (Protective Custody), PA 368 Sec. 20969 (EMS Authority to Restrain)
- Demonstrate proper documentation and completion of the *Petition for Mental Health Treatment* form.

TAKING THE MI-CIS COURSES

Directions to help you get online and into the Michigan - Crisis Intervention System (MI-CIS) Courses.

http://moodle.mi-ems.org/course/index.php?categoryid=15

Overview

There are 3 over-arching steps you need to take to complete the Michigan - Crisis Intervention System's online content. These steps cannot be completed out of order.

1. Register/Log in with a Michigan EMS Moodle Account
2. Self-Enroll and complete the Awareness Level course
3. Self-Enroll and complete the Operations Phase I Course

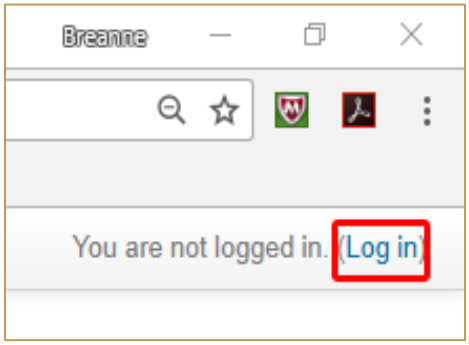
Breanne Hobrla

Breanne.Hobrla@med.wmich.edu

1. Register/Log in with a Michigan EMS Moodle Account

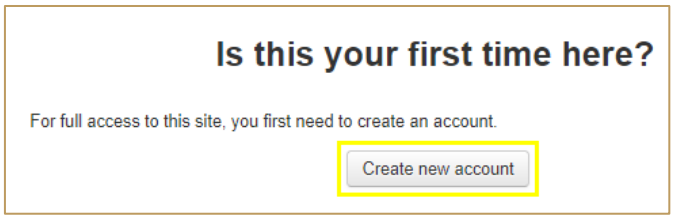
A. Go to our Michigan Crisis Intervention System Course list page on the Michigan EMS's Moodle site.

- Please go to the following page: http://moodle.mi-ems.org/course/index.php?categoryid=15
- In the upper right corner of the page, you will see the option to **log in**.
- Click on the text '**Log In**' (red to the right), and proceed to create a login (section B below) or log in if you already have an account (section C below).

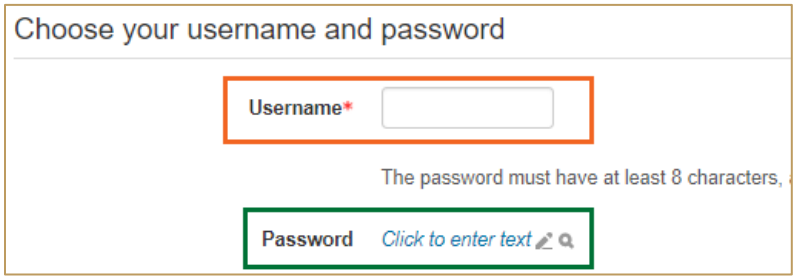


B. Creating a Login for the Michigan EMS Moodle site

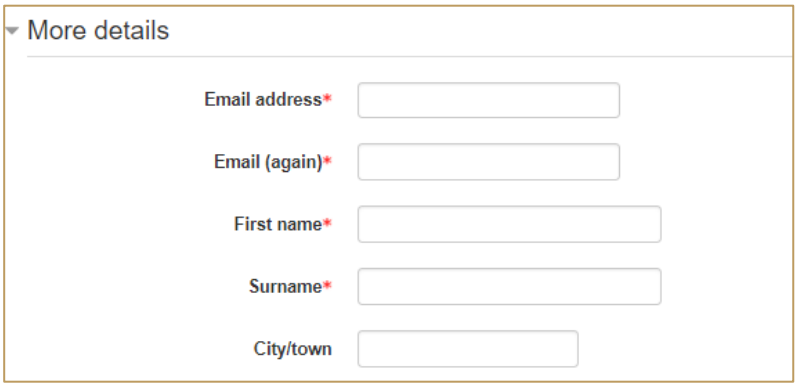
- On the right half of the page, click on the '**Create new account**' button (yellow).



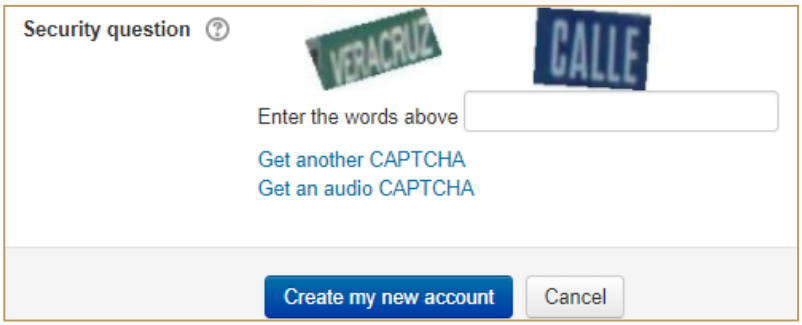
- Create a username (orange) and password (green).



- Enter in your email, name, and city (right).



- Answer the Security question, and select the '**Create my account**' button.



- An email will be sent to your email account. Click on the email verification link included. It will look like this:

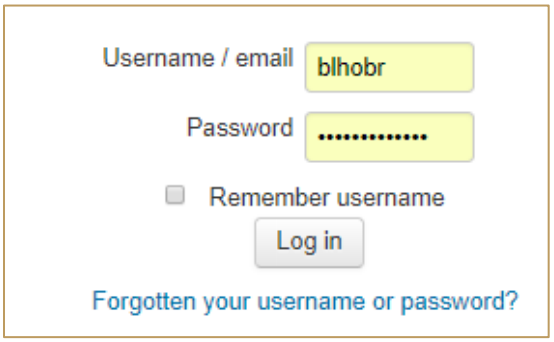
> To confirm your new account, please go to this web address:
>
> http://moodle.mi-ems.org/login/confirm.php?data=qbA8F2D1XGLhKlG/blhobr

- Clicking on this link the first time will automatically log you in for the first time. For all future accesses to the site, you will need to log in yourself using the username (or email) and password you created.

C. Logging into the Michigan EMS Moodle site

- **Log in** using your Michigan EMS Moodle site username (or email) and password.

- **NOTE:** If you cannot remember your username or password, then please use the blue '**Forgotten your username or password?**' link to retrieve your username or reset your password.



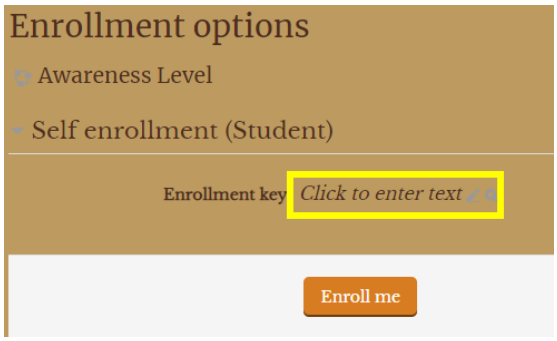
2. Self-enroll and complete the Awareness Level course

A. Self-enroll to the Awareness Level Course

- Once you login you should be returned to the MI-CIS course list page. If not, then use the link below to get back:
  http://moodle.mi-ems.org/course/index.php?categoryid=15

- In the MI-CIS course list, click on the '**Awareness Level**' course (boxed in red below).

- You will be taken to the self-enrollment page, please enter the following bolded key below into the 'enrolment key' text box (boxed in yellow to the right).
  Welcome2Awareness!

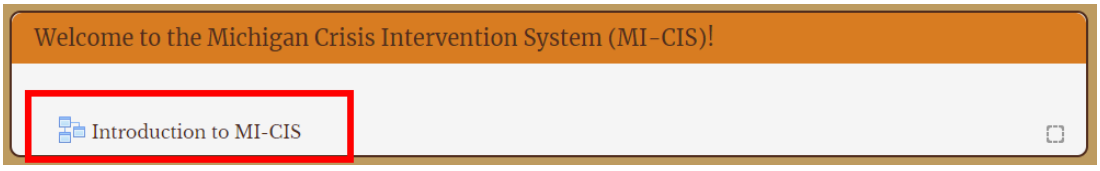


- It should look like this:

- Finally click on the orange 'Enroll me' button.

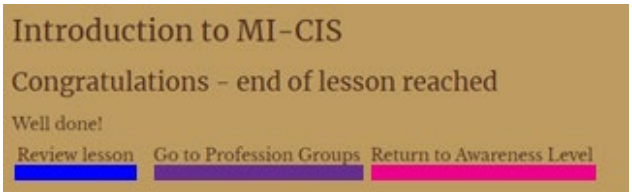
B. Complete your first MI-CIS Moodle Lesson.

- Click on the item titled "Introduction to MI-CIS" (boxed in red below).
  This your first MI-CIS Moodle Lesson:



- Watch and read the content on the lesson pages.
- When you're ready to move to the next page in the MI-CIS lesson, use the small orange arrow buttons towards the bottom of the page.
  - To see the next page, use this button: 
  - To go back to the previous page, use this button: 

- You will see the screen to the right when you have reached the end of the lesson. You may actually choose your next step from this page.
    - **Click** on the text "Review lesson" to start the lesson over again (blue).
    - **Click** on the text "Go to Profession Groups" to go to the next activity (purple).
    - **Click** on the text "Return to Awareness Level" to return to the main course page (pink).



Note: We can only provide next activity links ("Go to Profession Groups" in this example) from **some** lesson activities in Moodle. So, you may not always have the option to jump immediately to the next activity from a Moodle Lesson. But, the "Review lesson" and "Return to Awareness" links are always provided.

- We also provide the **"Return to Course" button** (pictured on the right) on every page to give you quick way to return to the main course page no matter where you are in an activity.

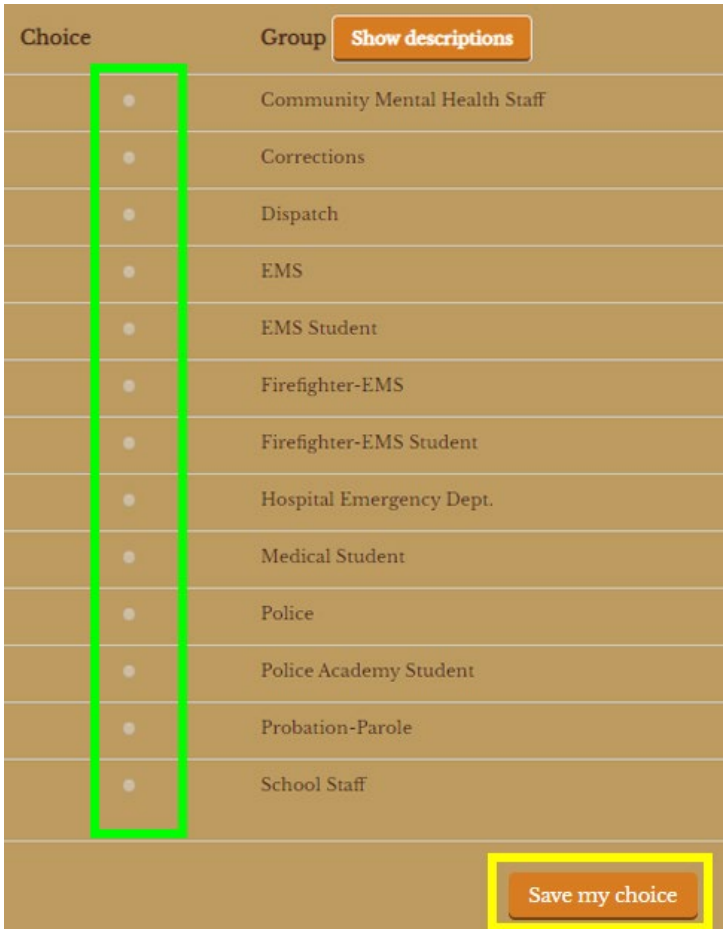
C. Self-enroll into your Profession's Group

- If you are still on the End of Lesson page from the "Introduction to MI-CIS" lesson, then click on the text "Go to Profession Groups".

- If you are on the main Awareness course page, then **click** on the "Profession Groups" activity.

- Once in the activity, **choose** the profession (options boxed in green to the right) that most accurately represents your profession.

- **Select** the "Save my choice" button (boxed in yellow to the right) once you have your profession selected.



D. Complete the Awareness course

- Once you have completed your profession selection activity (which places our users into course groups for the rest of Awareness and Operations Phase I courses), you may sequentially complete the remaining activities in the course.

- Click on the next course activity, **Demographics**.

- **NOTE:** Every time you fully complete a course activity, a blue check will appear in the box to the right of each activity. You cannot move on to the next activity until the activity prior is fully completed.

- Complete all items in the course activity list.

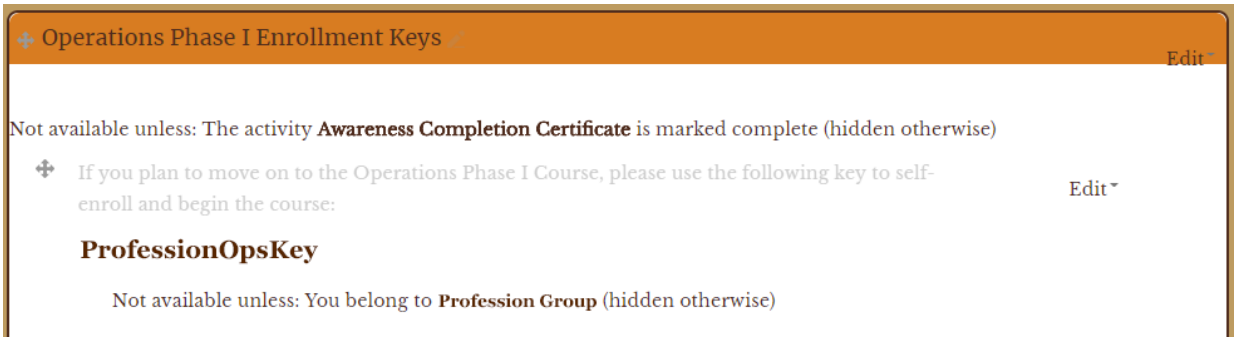
- Once you have completed the final activity for Awareness, which is titled "Awareness Completion Certificate", then a new section will appear providing you the enrollment key to the next MI-CIS course **Operations Phase I**. Directions for starting the next MI-CIS course is provided in the next section of this document.

- Remember, if you ever need to return to the course activity list, use the **Return to Course** button on the right of the page.

3. Self-enroll and complete the Operations Phase I course

A. Self-enroll to the Operations Phase I course

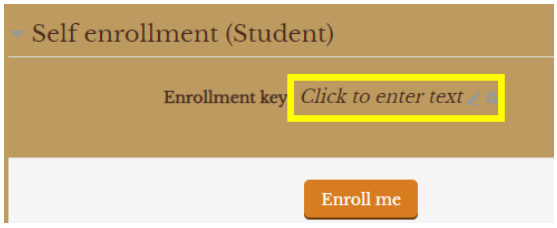
- If you have fully completed the Awareness course, and your profession's tailored course content is available, then at the very bottom of the Awareness Level course a section will become available with your profession's enrollment key. Below is an example of what you will see at the bottom of your fully completed Awareness level course.



- Copy the bolded enrollment key (for example, the text "ProfessionOpsKey" above).

- Go to the Operations Phase I course. You may click on the link below to get there quickly.
  https://moodle.mi-ems.org/course/view.php?id=49

- Take the key you copied from the Awareness course and paste or enter it into the self-enrollment key text box for Operations Phase I.
  (If you need to re-access your key, it will always be available at the bottom of the Awareness course for you)



- Click the orange "Enroll me" button.

B. Complete the Operations Phase I course

- Again, once in the course, you will see a list of course activities. Every time you fully complete a course activity, a blue check will appear in the box to the right of each activity. You cannot move on to the next activity until the activity prior is fully completed.

- Complete all items in the course activity list. If you ever need to return to the course list, use the **Return to Course** button to the right.

- When you have received your Operations Phase I certificate, you have successfully completed all the online content for the Michigan Crisis Intervention System.
  Congratulations and Thank you for taking part in this project!

Participant Evaluation Form

Program Title: _____Date: _____

1. Overall, I thought that the program was:

   Poor □ Fair □ Good □ Very Good □ Excellent □

2. To what degree will the information be helpful to you in your job?

   Not helpful □ Some Help □ Very Helpful □

3. Was the program what you expected it to be?

   Not at all □ Somewhat □ As Expected □

4. How would you rate the overall effectiveness of the instructors?

Name of Instructor	Poor	Fair	Good	Very Good	Excellent

5. Were there any parts of the program you would change? If so, please specify.

6. Other comments regarding this program:

7. What other kinds of in-service training would you like to have available?

West Michigan
CRIMINAL JUSTICE
Training Consortium

Course:_____

Location:_____ Date:_____

Course / Instructor Evaluation

Course:

	Poor				Excellent
The course objectives were covered.	○	○	○	○	○
The material was relevant and practical.	○	○	○	○	○
The time for this course was appropriate.	○	○	○	○	○
If not, why not?	☐ Too Much time		☐ Not Enough time		
The course description accurately described the training you received.	○	○	○	○	○
Would you recommend this course to others?	○	○	○	○	○

Instructor(s):

Was the instructor…

	Instructor Name					Instructor Name				
	Poor				Excellent	Poor				Excellent
…prepared and organized?	○	○	○	○	○	○	○	○	○	○
…able to generate interest?	○	○	○	○	○	○	○	○	○	○
…knowledgeable in the subject area?	○	○	○	○	○	○	○	○	○	○
…able to involve the students in the class?	○	○	○	○	○	○	○	○	○	○
Would you recommend this instructor to others?	○	○	○	○	○	○	○	○	○	○

Training Site:

	Poor				Excellent
The training site was appropriate for this class?	○	○	○	○	○
The environment was conducive to learning?	○	○	○	○	○

Major **Strengths** of the Program:

Major **Weaknesses** of the Program:

Comments: Please note any other comments.

CERTIFICATE OF CONSORTIUM MEMBERSHIP

The Certifying Official shall be the individual who administers consortium activities and has the authority to act on behalf of the consortium. Attach paperwork supporting the Consortium Membership to this document.

Identification:

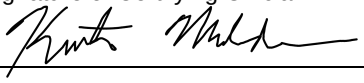
1. Applicant Agency: **Grand Valley State University**
2. Consortium: **West Michigan Criminal Justice Training Consortium**

Consortium:

3. Consortium Structure: **See attached by-laws.**
4. Geographic Region Served by the Consortium: **Counties served: Mason, Lake, Oceana, Newaygo, Muskegon, Ottawa, Montcalm, Kalamazoo, Kent, Ionia, Allegan, Berry, Van Buren, Berrien, Cass, St. Joseph**
5. Member Agencies: **See attached Member Agency roster.**
6. Financial Commitment from Member Agencies: **Each member agency is billed 35% of their Public Act 302 fund distribution semi-annually for membership fees.**

Certification:

I certify, on behalf of the consortium, the information contained in this document is complete, accurate and, in compliance with the requirements of the Michigan Commission on Law Enforcement Standards.

Printed Name of Certifying Official Keith Mulder	Title of Certifying Official WMCJTC Executive Committee Chair
Signature of Certifying Official 	Date 05/28/20

Other consortium certification may be submitted as addendum files.

WEST MICHIGAN CRIMINAL JUSTICE TRAINING CONSORTIUM

89 West 8th Street. Holland. MI 49423

June 4, 2020

To: Grand Valley State University
From: Keith Mulder, WMCJTC Executive Committee Chair
Ref: 360° Behavioral Health for Law Enforcement Grant Proposal

The West Michigan Criminal Justice Training Consortium has an interest in grant-funded training for member agency law enforcement officers. Grand Valley State University will submit a grant proposal to the Michigan Commission on Law Enforcement Standards (MCOLES) for a 360° Behavioral Health for Law Enforcement Program. The grant requirements include a portion of the total project cost to be provided by match funds.

To support this proposal, the West Michigan Criminal Justice Training Consortium and its member agencies commit to providing the following matching funds in each listed category:

CONTRACTUAL

Instructional Fees: $8,220.00

TRAVEL

Contractor Travel: $131.72

The total for the matching funds from the WMCJTC is $8,351.72. These matching funds meet the requirements set by MCOLES in the grant application process.

Thank you for your continued partnership with the West Michigan Criminal Justice Training Consortium.

Sincerely,

Keith Mulder, Executive Committee Chair
West Michigan Criminal Justice Training Consortium

EXHIBIT "B"

BY-LAWS

WEST MICHIGAN CRIMINAL JUSTICE TRAINING CONSORTIUM

ARTICLE 1

NAME

The name of the organization shall be the "West Michigan Criminal Justice Training Consortium," hereinafter sometimes referred to as "the Consortium."

ARTICLE II

PURPOSE

The Consortium is established as a voluntary, unincorporated association for the purpose of cooperatively providing joint training in police methods and investigative techniques. The members of the Consortium seek to maximize the utilization of available training funds, to improve their position for obtaining grants, to promote multi-disciplinary training, and to encourage the inter-agency use and sharing of training resources.

ARTICLE III

MEMBERSHIP

1. Composition. The membership of the Consortium shall consist of those Municipalities, state or private institutions of higher education and private entities who are certified by MCOLES under PA330 which execute the "West Michigan Criminal Justice Training Consortium Agreement."

2. One Member, One Vote. Membership in the Consortium entitles each member to one (1) vote in all matters related to Consortium business.

3. Membership Approval. To qualify for membership in the Consortium, an agency must be approved by a majority of the membership present at a regularly scheduled meeting of the General Membership Committee. Membership shall be limited to the 16 counties indicated, to include Mason, Lake, Oceana, Newaygo, Muskegon, Montcalm, Ottawa, Kent, Ionia, Allegan, Barry, Van Buren, Kalamazoo, Berrien, Cass, and St Joseph.

4. Membership Fees. Each member is billed 35% of the Act 302 funds (or equivalent amount per officer) semi-annually for their membership fees. If the respective agency's bill is delinquent after 30 days, the Consortium Finance Committee will follow up with a letter or phone call to make sure the bill was received and the member agency is taking steps to pay it in a timely manner. If the bill is still delinquent 60 days after originally being sent, the Finance Committee will notify the respective member agency one final time. If the bill is still delinquent 90 days after originally being sent, the Treasurer will notify the Executive Board of the name of any member agency. The Executive board will notify in writing a member agency they are suspended for non-payment of their membership dues. They will be instructed that any training attended will be billed at the same rate as non-members. Membership can be restored by paying the outstanding bill in full, along with any other membership fees that may be due at that time.

5. Corrections Membership Fees. Each county participating in the Corrections related training shall pay 5% of their retained PA 124 funds during each financial quarter as their membership fee. Each county shall submit with their payment to the treasurer, a copy of the same documentation required by the state when paying PA 124 funds. If the county's payment is delinquent after 30 days, the Consortium Finance Committee will follow up with a notice or phone call to make sure the member agency is taking steps to pay in a timely manner. If the payment is delinquent 60 days after originally sent, the Finance Committee will notify the respective member agency one final time. If the payment is still delinquent 90 days after originally sent, the Treasurer will notify the Executive Board of the name of the delinquent agency. The Executive board will notify in writing a member agency they are suspended for non-payment of their membership dues. They will be instructed that any training attended will be billed at the rate for non-members. Membership can be restored by paying the outstanding fee in full, along with any other fees that may be due.

ARTICLE IV

COMMITTEES

1. Appointment of General Membership. The membership of all standing and special committees, except as otherwise provided for herein, shall be appointed by the General Membership at a duly called annual meeting. The annual meeting shall be held at a date, time, and location specified by the Consortium Chairperson and shall occur in May of each year. The chairperson of the Curriculum Committee shall also be chosen at the annual meeting and the Chairperson of the Consortium shall also be Chairperson of the Executive Committee.

2. General Membership Committee. Each member shall be represented on the General Membership Committee by the chief administrative officer of the member's law enforcement agency, or by his/her designee. It shall be the duty of the General Membership Committee to provide overall guidance to the activities of the Consortium. The members of the General Membership Committee shall, at the annual meeting, select members to serve on the Executive Committee.

3. Executive Committee.

   a. Composition. The Executive Committee shall consist of six (6) members, who shall include the Consortium Chairperson, Vice-Chairperson, Secretary, Treasurer, and two at-large members appointed from the General Membership.

   b. Purpose. The purpose of the Executive Committee shall be to direct the functioning of the Consortium and to oversee, coordinate, and assign such responsibilities as may be necessary for the completion of the Consortium mission. The Executive Committee shall have the authority to act on behalf of the Consortium in all matters deemed necessary for the efficient and orderly conduct of business, including the addition of new members, or removal from membership for non-payment of funds.

4. Curriculum and Corrections Committees.

   a. Curriculum Committee Composition. Each member may be represented on the Curriculum Committee, by the chief administrative officer of the member's law enforcement agency, or by his/her designee. A majority of all members of the Curriculum Committee present shall constitute a quorum for the purpose of conducting business. The Treasurer of the Consortium shall be a member of the Curriculum Committee. Non-voting members, including faculty representatives of state or private institutions of higher education, may be appointed to the Curriculum Committee by the Consortium Chairperson.

   b. Corrections Committee Composition. Each corrections member may be represented on the Corrections Committee, by the chief administrative officer of the agency, or by his/her designee. The Executive Committee shall appoint the Chairperson of the Corrections Committee. A majority of all members of the Corrections Committee present shall constitute a quorum for the purpose of conducting business. Non-voting members, including faculty representatives of state or private institutions of higher education, may be appointed to the Corrections Committee by the Consortium Chairperson.

   c. Purpose. The purpose of the Curriculum and Corrections Committees shall be to direct the development of training priorities, to prepare and recommend an annual budget, to develop and recommend an annual training schedule, to keep training records and provide them to the State of Michigan and to members of law enforcement agencies as may be necessary, and to provide oversight and evaluation of training programs.

d. Utilization of Training. It shall be the responsibility of the Executive Committee to monitor the utilization of training by member agencies. As part of this responsibility, member agencies may be assessed a fee, as determined by the Executive Committee, for failure to utilize a reserved position which has not been cancelled prior to a pre-determined cancellation deadline.

The Treasurer will cause a notice be sent to the member agency of the fee and due date.

Member agencies may contest the fee at the next regularly scheduled meeting of the Finance Committee. The circumstances which led to the failure of the member agency to utilize the reserved position must be set forth in writing. Upon review, the Finance Committee may either waive the fee or determine that the fee is due. If the Finance Committee determines that the fee is due, and no appeal is taken, the fee must be paid within thirty (30) days of the determination.

The member agency contesting the fee may appeal the decision of the Finance Committee to the Executive Committee within fourteen (14) days of the determination for a review at the next regularly scheduled Executive Committee meeting. The appeal must be in writing for the Executive Committee reviewing the documents submitted and deciding the issue prior to concluding the meeting. The Executive Committee may waive the fee, reduce the fee, or determine the entire fee is due. If a fee is determined to be due it must be paid within thirty (30) days for the agency to remain eligible to participate in future Consortium offered training.

e. Retention and Disposition of Equipment

Equipment purchases approved by the Executive Committee or obtained through grant funding or donations will be retained by the Consortium as long as the equipment is used for the provision of in-service criminal justice training.

When equipment is no longer used for the provision of in-service criminal justice training by the Consortium, the Executive Committee may select one of the following actions:

- Transfer of the equipment to a member agency. The agency requesting transfer of the equipment must apply in writing to the Executive Committee for approval of the transfer. Costs and coordination of the transportation will be borne by the receiving agency.

- Approve the sale of the equipment with the following requirements: The member agency must first apply in writing to the Executive Committee for approval of the sale. The receipts from the sale shall be returned to the Executive Committee.

- Dispose of the property in any other manner consistent with the purposes of P.A. 302 of 1982, as amended. The member agency requesting disposal of the equipment must first apply in writing to the Executive Committee for the approval of disposal.

5. Finance Committee.

a. Composition. The Finance Committee shall consist of five (5) members, including the Treasurer (who shall be the Chairperson of the Committee), the Chairperson of the Consortium (who shall be the Vice-Chairperson of the Committee), and three additional voting members, one of whom will represent the north area of the Consortium, which

consists of agencies located north of the northern boundary of Allegan and Barry counties, one of which will represent the south area of the Consortium, which consists of agencies located south of the northern boundary of Allegan and Barry Counties, and one of whom will be a member-at-large.

b. Purpose. The purpose of the Finance Committee shall be to provide oversight concerning all financial matters of the Consortium, to assist the Treasurer as needed, to review and approve expenditures of the Consortium, and to conduct studies for and make recommendations to the Consortium Chairperson, as directed. Any action by the Finance Committee is not to replace any action or direction provided by the Executive Committee of the Consortium.

The Finance Committee will meet as needed when called by the Treasurer, and at a minimum shall meet at least once during each financial quarter of the year.

ARTICLE V

OFFICERS AND DIRECTORS

1. Chairperson; Vice-Chairperson; Secretary; Treasurer; Duties. The officers of the Consortium shall be the Chairperson, Vice-Chairperson, Secretary, and Treasurer. The Chairperson and Vice-Chairperson shall be responsible for calling and presiding at all meetings of the General Membership Committee. The Secretary shall prepare and maintain a permanent written record of all Consortium proceedings, shall transmit notices and agendas to the General Membership and shall transmit a copy of the minutes from each Consortium meeting to each member prior to the next regular meeting. The municipality or state or private institution of higher education which is represented by the Treasurer shall be the designed depository agency of the Consortium. The Treasurer shall be responsible for the maintenance of all financial records related to Consortium business, including records of the receipt, allocation, and disbursement of funds. All expenses relating to the maintenance of the financial and training records of the Consortium, including accounting and auditing expenses, if any, shall be born by the Consortium.

2. Election of Officers. At the annual meeting of the General Membership Committee, nominations shall be accepted for the offices of Chairperson, Vice-Chairperson, Secretary, Treasurer, and the at-large members of the Execute Committee and Chairperson of the Curriculum Committee. The officers shall be elected by majority vote of the General Membership. Terms of office shall be for a period of one (1) year.

3. Vacancies. If an officer is unable to perform the duties of his/her office, or if a vacancy in office exists, the Chairperson of the Consortium shall appoint a successor, and the appointee shall then serve until the next annual meeting of the General Membership Committee.

ARTICLE VI

MEETING OF THE CONSORTIUM

1. Annual Meeting; Regular Meetings. The annual meeting of the General Membership Committee shall be held in May of each year at a time and place to be selected by the Chairperson of the Consortium. Regular meetings may be scheduled for such other dates, time and locations as may be determined by the Chairperson of the Consortium.

2. Quorum; Action to be Taken by Majority Vote. A majority of all members of the General membership Committee present shall constitute a quorum for the purpose of conducting business. Actions of the General Membership Committee shall be taken by a majority vote of those attending, except as may be otherwise provided herein.

3. Note of Meetings. Notice of the date, time and location of all General Membership Meetings, along with an agenda therefore, shall be mailed to each member of the Consortium at least seven (7) days prior to the scheduled meet date.

ARTICLE VII

PARLIAMENTARY PROCEDURE

1. Robert's Rules of Order. Robert's Rules of Order, Revised, shall govern all matters of Consortium procedure not otherwise provided for in these By-Laws.

ARTICLE VIII

AMENDMENT

1. Amendments, These By-Laws may be amended by a two-thirds vote of the members of the General Membership Committee. Proposed changes in the By-Laws shall be transmitted to each member at least seven (7) days prior to the date of the meeting at which the vote will be taken.

* As amended by a vote of the general membership on May 25, 2016.

West Michigan
CRIMINAL JUSTICE
Training Consortium

Agency	Phone Number	Address	Training Officer
Allegan City Police Department	(269) 673-2115	170 Monroe St Allegan, MI 49010	Jay Gibson
Allegan County Sheriff's Office	(269) 673-0500	112 Walnut St Allegan, MI 49010	Mike Brown
Bangor Police Department	(616) 427-5801	414 N Division St Bangor, MI 49013	Tommy Simpson
Baroda-Lake Township Police Department	(269) 465-3258	3169 W Shawnee Rd Bridgman MI 49106	Shawn Martin
Barry County Sheriff's Office	(269) 948-4801	1212 W State St Hastings, MI 49058	Matt Houchlei
Belding Police Department	(616) 794-1900	120 South Pleasant St Belding, MI 48809	Dale Nelson
Benton Harbor Police Department	(269) 927-8414	200 E Wall St Benton Harbor, MI 49022	Mike Clark
Berrien County Sheriff's Office	(269) 983-7141	919 Port St Saint Joseph, MI 49085	Marty Kurtz

Agency	Phone Number	Address	Training Officer
Berrien Springs-Oronoko Twp Police Department	(269) 471-2813	4411 E Snow Rd Berrien Springs, MI 49103	Paul Toliver
Bridgman Police Department	(269) 465-5144	9765 Maple St P.O. Box 366 Bridgman, MI 49106	Dan Unruh
Buchanan Police Department	(269) 695-5120	107 West Front St Buchanan, MI 49107	Harry Burnett
Carson City Police Department	(989) 584-6448	123 E Main St Carson City, MI 48811	David Ellis
Cass County Sheriff's Office	(616) 445-1201	321 M-62 North Cassopolis, MI 49031	Rick Behnke
Chikaming Township Police Department	(269) 469-3245	13535 Red Arrow Highway Harbert, MI 49115	Todd Taylor
Coloma Township Police Department	(269) 468-8291 x12	4919 Paw Paw Lake Rd Coloma, MI 49038	Wes Smigielski
Covert Township Police Department	(269) 764-8986	33805 M-140, PO Box 6 Covert, MI 49043	Jay Allen
Decatur Police Department	(269) 423-2171	114 N Phelps Decatur, MI 49045	Tom VanDerWoude

Agency	Phone Number	Address	Training Officer
Dowagiac Police Department	(269) 782-9743	241 S Front St Dowagiac, MI 49047	Steve Grinnewald
East Grand Rapids Public Safety	(616) 949-7010	770 Lakeside Drive SE East Grand Rapids, MI 49506	Ric Buikema
Fennville Police Department	(269) 561-8123	177 N Maple St Fennville MI 49408	Greg Rekucki
Fremont Police Department	(231) 924-2100	101 E Main St Fremont, MI 49412	Randy Wright
Fruitport Township Police Department	(231) 865-8477	6543 Airline Rd Fruitport, MI	Andy Hunt
Gerald R. Ford International Airport Police	(616) 233-6015	5500 44th St SE Grand Rapids, MI 49512	Braden Myers
Grand Haven Department of Public Safety	(616) 842-3460	525 Washington Av Grand Haven, MI 49417	Lee Adams
Grand Rapids Community College Academy	(616) 234-3568	143 Bostwick Ave NE Grand Rapids, MI 49503	Jermaine Reese
Grand Rapids Community College DPS	(616)-234-4010	143 Bostwick Ave NE Grand Rapids, MI 49503	Bo Peters

Agency	Phone Number	Address	Training Officer
Grand Valley State University DPS	(616) 331-3255	1 Campus Dr Allendale, MI 49401	Nate Dornbos
Grand Valley State University School of CJ	(616) 331-8515	1 Campus Dr A1140 MAK Allendale, MI 49401	Billy Wallace
Grandville Police Department	(616) 538-6110	3181 Wilson Ave SW Grandville, MI 49468	Paul Anglim
Greenville Police Department	(616) 754-9161	415 S Lafayette St Greenville, MI 48838	Darren Jones
Gun Lake Tribal Police Department	(269) 397-1610	2869 Mno Bmadzewen Dr Shelbyville, MI 49344	Rick Rabenort
Hart Police Department	(231) 873-2488	407 State St Hart, MI 49420	Juan Salazar
Hastings Police Department	(269) 945-4358	201 East State St Hastings, MI 49058	Jeff Pratt
Holland Department of Public Safety	(616) 355-1100	89 West 8th St Holland, MI 49423	Scott Doza
Ionia County Sheriff's Office	(616) 527-5383	133 East Adams St Ionia, MI 48846	Jack Pieters
Ionia Department of Public Safety	616-527-4431	239 E Adams St Ionia, MI 48846	John Odette

Agency	Phone Number	Address	Training Officer
Kalamazoo County Sheriff's Office	(269) 383-8821	1500 Lamont Kalamazoo, MI 49048	Michelle Greenlee
Kalamazoo Township Police Department	(269) 343-0551	1720 Riverview Dr Kalamazoo, MI 49004	Darien Smith
Kalamazoo Valley Community College Academy	(269) 353-1260	7107 Elm Valley Dr Kalamazoo, MI 49009	Richard Ives
Kalamazoo Valley Community College Public Safety	(269) 488-4575	230 N Rose St Kalamazoo, MI	Don Benthin
Kent County Sheriff's Office	(616) 632-6101	701 Ball Avenue NE Grand Rapids, MI 49503	Joel Roon
Kentwood Police Department	(616) 656-6687	4742 Walma Ave Kentwood, MI 49512	Ryan Vanderveen
Lake County Sheriff's Office	(231) 745-2712	1153 Michigan Ave Baldwin, MI 49304	Lino Johnson
Lake Odessa Police Department	(616) 374-7110	839 4th Ave Lake Odessa, MI 48849	Kendra Backing
Lakeview Police Department	(989) 352-8444	10300 Edmore Rd Lakeview, MI 48850	Darin Dood

Agency	Phone Number	Address	Training Officer
Lawton Police Department	(269) 624-2382	125 South Main, PO Box 117 Lawton, MI 49065	Jeff Mack
Lincoln Charter Township Police Department	(269) 429-2444	5599 Cleveland Ave Stevensville, MI 49127	Daniel Sullivan
Lowell Police Department	(616) 897-7123	111 North Monroe Lowell, MI 49331	Chris Hurts
Ludington Police Department	(231) 843-3425	408 South Harrison Ludington, MI 49431	Steve Wietrzykowski
Mason County Sheriff's Office	(231) 843-3475	302 North Delia St Ludington, MI 49431	Oscar Davila
Mattawan Police Department	(269) 668-3661	24221 Front Ave Mattawan, MI 49071	Scott Herbert
Montague Police Department	(231) 893-0810	8778 Ferry St Montague, MI 49437	Robert Rought
Montcalm County Sheriff's Office	(989) 831-7589	659 North State St Stanton, MI 48888	Tom Goerge
Muskegon County Sheriff's Office	(231) 724-6351	25 W Walton Ave Muskegon, MI 49442	Shane Brown

Agency	Phone Number	Address	Training Officer
Muskegon Heights Police Department	(231) 733-8900	2715 Baker St Muskegon Heights, MI 49444	Mattie Porter-Dye
Muskegon Police Department	(231) 724-6750	980 Jefferson St Muskegon, MI 49940	Dennis Lord
Muskegon Township Police Department	(231) 777-1666	1990 E Apple Ave Muskegon, MI 49442	Tim Thielbar
Nashville Police Department	(517) 852-9866	208 N Main St Nashville, MI 49073	Chris Underhile
New Buffalo Police Department	(269) 469-1593	224 W Buffalo St New Buffalo, MI 49117	Rich Killips
New Era Police Department	(231) 861-5186	PO Box 1 New Era, MI 49446	David Vansumeren
Newaygo County Sheriff's Office	(231) 689-6623	1035 E James Street White Cloud, MI 49349	Jon Borgman
Newaygo Police Department	(231) 652-1655	28 State Rd Newaygo, MI 49337	Georgia Stroven
Niles Police Department	(616) 683-1313	1600 Silverbrook Ave Niles, MI 49120	Jim Millin

Agency	Phone Number	Address	Training Officer
North Muskegon Police Department	(231) 744-4313	1114 Ruddiman Dr North Muskegon, MI 49445	Edward Viverette
Norton Shores Police Department	(231) 733-2691	4814 S Henry St Norton Shores, MI 49441	Marc VanderStelt
Oceana County Sheriff's Office	(231) 873-2121	216 Lincoln St Hart, MI 49420	Shane Hasty
Ontwa Township - Edwardsburg Police Dept.	(269) 663-8444	26296 East Main St Edwardsburg, MI 49112	Doug Westrick
Otsego Police Department	(269) 692-6111	127 Court St Otsego MI 49078	Bn<="">
Ottawa County Sheriff's Office	(616) 738-4000	12220 Fillmore St West Olive, MI 49460	Derek Christensen
Paw Paw Police Department	(269) 657-5501	114 Harry L Bush Blvd PO Box 179 Paw Paw, MI 49079	Eric Marshall
Pentwater Police Department	(231) 869-4630	327 S Hancock St Pentwater, MI 49449	Laude Hartrum
Plainwell Department of Public Safety	(269) 685-9858	141 N Main St Plainwell, MI 49080	Bill Bomar

Agency	Phone Number	Address	Training Officer
Pokagon Tribal Police Department	(269) 782-2232	PO Box 180 Dowagiac, MI 49047	William Lux
Portage Police Department	(269) 329-4567	7810 Shaver Rd Portage, MI 49002	Brian Vandenbrink
Portland Police Department	(517) 647-2934	73 E Grand River Ave Portland, Mi 48875	Star Thomas
Richland Police Department	(269) 629-4807	7504 N 32nd St Richland, MI 49083	Evan Turanzas
Rockford Police Department	(616) 866-9557	7 South Monroe Rockford, MI 49341	Glenn Robinson
Roosevelt Park Police Department	(231) 755-3721	900 Oakridge Rd Roosevelt Park, MI 49441	David Boone
Sand Lake Police Department	(616) 636-8802	2 Maple St Sand Lake, MI 49343	Jim Reamsma
Douglas Police Department	(269) 857-4339	47 W Center St PO Box 815 Douglas, MI 49406	Lori Warsen
Scottville Police Department	(231) 757-4729	105 North Main St Scottville MI 49454	Donald Riley
Shelby Police Department	(231) 923-6493	36 Third St Shelby, MI 49455	Ryan Furman

Agency	Phone Number	Address	Training Officer
South Haven Police Department	(269) 637-5151	90 Blue Star Hwy South Haven, MI 49090	Mike Pauly
Sparta Police Department	(616) 887-8716	260 West Division Sparta, MI 49345	Andrew Milanowski
St. Joseph Police Department	(269) 985-0300	700 Broad St St. Joseph, MI 49085	Amy Sternaman
Sturgis Police Department	(269) 651-3231	122 N Nottawa Sturgis, MI 49091	Ryan Banaszak
Three Oaks Police Department	(269) 756-9585	14 Maple St Three Oaks, MI 49128	Dennis Buller
Van Buren County Sheriff's Office	(269) 657-2006	205 S Kalamazoo Paw Paw, MI 49079	Jim Charon
Walker Police Department	(616) 453-5441	4343 Remembrance Rd Walker, MI 49534	Jason Howe
Wayland Police Department	(269)792-9366	160 West Superior St Wayland, MI 49348	Mark Garnsey
Western Michigan University DPS	(269) 387-5555	511 Monroe St Western Michigan University Kalamazoo MI 49006	Jeff Lillard

Agency	Phone Number	Address	Training Officer
West Shore Community College	(231) 843-5831	3000 North Stiles Rd PO Box 277 Scottville, MI 49431	Dan Dellar
White Cloud Police Department	(231) 689-1696	12 N Charles St White Cloud, MI 49349	Dan Evans
Whitehall Police Department	(231) 894-4048	405 E Colby St Whitehall, MI 49461	Roger Squiers
Wyoming Police Department	(616) 530-7300	2300 DeHoop Wyoming, MI 49509	Robert Aungst
Zeeland Police Department	(616) 772-9125	29 W Main St Zeeland, MI, 49464	Tom Ball

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

PERSONNEL

Salary and Fringe Benefits

Course Employee Name	Assignment	Hourly Rate	Dev. Hours	Prep. Hours	Inst. Hours	Admin. Hours	Total Salary	Fringe Rate	Fringe	Total Cost	Grant Share	Match Share
Williamson Wallace	Grant Administrator	$ 45.47				24	$ 1,091.28	0.411	$ 448.65	$ 1,539.93		$ 1,539.93
							$ -		$ -	$ -		
							$ -		$ -	$ -		
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TOTAL PERSONNEL	**$1,539.93**	**$0.00**	**$1,539.93**

Rev. 03/2020

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

CONTRACTUAL

Contractor Fees

Contractor Name	Course	Hourly Rate	Dev. Hours	Prep. Hours	Inst. Hours	Admin. Hours	Total Cost	Grant Share	Match Share
MI-CIS - Western Michigan University Homer Stryker M.D. School of Medicine	MI-CIS OPERATIONS PHASE II Enhanced Reality-Based Training Session #1						$ 6,620.00	$ 4,965.00	$ 1,655.00
MI-CIS - Western Michigan University Homer Stryker M.D. School of Medicine	MI-CIS OPERATIONS PHASE II Enhanced Reality-Based Training Session #2						$ 6,620.00	$ 4,965.00	$ 1,655.00
MI-CIS - Western Michigan University Homer Stryker M.D. School of Medicine	MI-CIS OPERATIONS PHASE II Enhanced Reality-Based Training Session #3						$ 6,620.00	$ 4,965.00	$ 1,655.00
MI-CIS - Western Michigan University Homer Stryker M.D. School of Medicine	MI-CIS OPERATIONS PHASE II Enhanced Reality-Based Training Session #4						$ 6,620.00	$ 4,965.00	$ 1,655.00
2 The Rescue, LLC	Career Surival and Emotional Wellness for LEOs Session #1	$100.00			16		$ 1,600.00	$ 1,200.00	$ 400.00
2 The Rescue, LLC	Career Surival and Emotional Wellness for LEOs Session #2	$100.00			16		$ 1,600.00	$ 1,200.00	$ 400.00
2 The Rescue, LLC	Career Surival and Emotional Wellness for LEOs Session #3	$100.00			16		$ 1,600.00	$ 1,200.00	$ 400.00
2 The Rescue, LLC	Career Surival and Emotional Wellness for LEOs Session #4	$100.00			16		$ 1,600.00	$ 1,200.00	$ 400.00
							$ -		
							$ -		
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TOTAL CONTRACTUAL							**$32,880.00**	**$24,660.00**	**$8,220.00**

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

TUITION
Cost per Student

Training Provider	Course	Number of Students	Cost per Student	Total Cost	Grant Share	Match Share
None				$ -		
				$ -		
				$ -		
				$ -		
				$ -		
				$ -		
				$ -		
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				$ -		

TOTAL TUITION	$0.00	$0.00	$0.00

Rev. 03/2020

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

TRAVEL

Employee

	Mileage			Lodging			Breakfast			Lunch			Dinner						
Course Employee Name	Miles	Rate 0.34	**Total**	#	Rate $85.00	**Total**	#	Cost	**Total**	#	Cost	**Total**	#	Cost	**Total**	**Airfare/ Other**	**Total Cost**	**Grant Share**	**Match Share**
None			-			-			-			-			-		$ -		
			-			-			-			-			-		$ -		
			-			-			-			-			-		$ -		
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TOTAL EMPLOYEE TRAVEL			$0.00			$0.00			$0.00			$0.00			$0.00	$0.00	$0.00	$0.00	$0.00

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

TRAVEL

Contractor

	Mileage			Lodging			Breakfast			Lunch			Dinner						
Course Contractor Name	Miles	Rate 0.34	**Total**	#	Rate $85.00	**Total**	#	Cost	**Total**	#	Cost	**Total**	#	Cost	**Total**	**Airfare/ Other**	**Total Cost**	**Grant Share**	**Match Share**
2 The Rescue - Bykerk	313	0.34	106.42	2	85.00	170.00	2	8.50	17.00	2	8.50	17.00	2	19.00	38.00		$ 348.42	261.31	87.11
2 The Rescue - Wierenga	313	0.34	106.42			-	2	8.50	17.00	2	8.5	17.00	2	19.00	38.00		$ 178.42	133.81	44.61
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TOTAL CONTRACTOR TRAVEL			$212.84			$170.00			$34.00			$34.00			$76.00	$0.00	$526.84	$395.12	$131.72

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

TRAVEL
Trainee

	Lodging				Breakfast				Lunch				Dinner							
Course/Date Trainee Totals	# Lodging	# Nights	Rate 85.00	**Lodging Total**	# for B'fast	# of Days	Cost	**Breakfast Total**	# for Lunch	# of Days	Cost	**Lunch Total**	# for Dinner	# of Days	Cost	**Dinner Total**	**Airfare/ Other**	**Total Cost**	**Grant Share**	**Match Share**
None				$ -				$ -				$ -				$ -		$ -		
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TOTAL TRAINEE TRAVEL				$0.00				$0.00				$0.00				$0.00		$0.00	$0.00	$0.00

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

SUPPLIES AND OPERATING

Course	Description	Quantity	Unit Price	Total Cost	Grant Share	Match Share
None				$ -		
				$ -		
				$ -		
				$ -		
				$ -		
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TOTAL SUPPLIES AND OPERATING	$0.00	$0.00	$0.00

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

EQUIPMENT

Course	Description	Quantity	Unit Price	Total Cost	Grant Share	Match Share
None				-		
				-		
				-		
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TOTAL EQUIPMENT				$0.00	$0.00	$0.00

Rev. 03/2020

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

GVSU on behalf of WMCJTC - 360° Behavioral Health for Law Enforcement

2021 Proposed Budget Detail

Personnel	*Total Costs*	*Grant Share*	*Match Share*	*Comments:*
	$ 1,539.93	$ -	$ 1,539.93	

Contractual	*Total Costs*	*Grant Share*	*Match Share*	*Comments:*
	$ 32,880.00	$ 24,660.00	$ 8,220.00	

Tuition	*Total Costs*	*Grant Share*	*Match Share*	*Comments:*
	$ -	$ -	$ -	

Travel-Employee	*Total Costs*	*Grant Share*	*Match Share*	*Comments:*
	$ -	$ -	$ -	

Travel-Contractor	*Total Costs*	*Grant Share*	*Match Share*	*Comments:*
	$ 526.84	$ 395.12	$ 131.72	

Travel-Trainee	*Total Costs*	*Grant Share*	*Match Share*	*Comments:*
	$ -	$ -	$ -	

Supplies & Operating	*Total Costs*	*Grant Share*	*Match Share*	*Comments:*
	$ -	$ -	$ -	

Equipment	*Total Costs*	*Grant Share*	*Match Share*	*Comments:*
	$ -	$ -	$ -	

GRANT TOTALS	***Total Costs***	***Grant Share***	***Match Share***	*Comments:*
	$ 34,946.77	**$ 25,055.12**	**$ 9,891.65**	

Percentage of Total Costs	***Grant Share***	***Match Share***	*Comments:*
	71.7%	**28.3%**	