

Minister Destiny Testimony Schools

Law Enforcement: Mental Health Crises: Safe Response and Help Instead of Charges Where Possible

Law Enforcement — Class Book · Section 9

Minister Destiny Marie Morgan

Minister & Founder

A Prayer Before You Begin

In the name of God, the Most Gracious, the Most Merciful.

Lord, bless this reader on their journey. Guard their health in body, mind, and spirit as they study. Open their heart to knowledge and their mind to understanding, and let what they learn here become light in their hands. Guide them to the places where they are needed — to help others, and to save lives, safely. Bless their steps, their work, and every life their learning will one day protect.

Amen.

— Minister Destiny Marie Morgan

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Minister Destiny Testimony Schools — Law Enforcement: Mental Health Crises: Safe Response and Help Instead of Charges Where Possible.

Published by Minister Destiny Marie Morgan, Minister & Founder.

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This book is not an emergency service and does not replace 911. In an emergency, call 911 (or your local emergency number) if you can do so safely. In a mental-health crisis, call or text 988 (U.S.).

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This is community-designed training — Minister Destiny's program, built from lived experience in the neighborhoods being policed. It is not agency policy and does not replace your department's training, general orders, or the law. Where this program proposes new approaches, they are taught and labeled as proposals.

How This Book Works

This book is one class of Minister Destiny Testimony Schools — Law Enforcement: Section 9 — Mental Health Crises: Safe Response and Help Instead of Charges Where Possible. It is the study book for this class's test. Everything the test asks is taught in this book, in plain language: the full lesson, Words to know, the stories to think through, the Try-this activity, and Resources to keep.

Minister Destiny Testimony Schools is a free school. The classes, the tests, and the certificates are free online at destinymorganbooks.com — nothing about this class costs money. This book is the print edition, for people who want the class in their hands. You never need to buy a book to take a class or a test.

How to use this book: read the lesson, learn the Words to know, think through the stories, and do the activity. Try the word search for fun. Then take the Chapter Test at the back of the lesson — printed without answers marked. Score 80% or higher to complete the class and earn its certificate (the certificate page is in this book; write your name on it after you pass). The Answer Key is at the back of the book, for parents, teachers, and self-checking after you finish. Go at your own pace.

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Before You Start

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Before you start

- This school never collects your name. Progress and quiz answers stay on your device; pass the section quiz (80% or higher, retakes allowed) and your certificate downloads with a blank name line to fill in after saving. Answers are not shown.
- Some of the most difficult calls you will ever take involve a person whose mind, in that hour, is not giving them accurate information about the world — a person hearing threats no one else hears, believing neighbors are poisoning them, standing in traffic convinced they cannot be harmed, or telling you calmly that they intend to die tonight. This section teaches you to respond to that person first as someone in a health crisis, to slow time down where safety allows, to bring the right helpers in early, and to reach for help instead of charges where the law and safety make that possible. It does not ask you to be a clinician. It asks you to be the calmest person on the scene until clinical help takes over.

Section 9 — Mental Health Crises: Safe Response and Help Instead of Charges Where Possible

Minister Destiny Testimony Schools — Law Enforcement

The lesson

1. What a mental health crisis is — and what can look like one

A mental health crisis is a state in which a person's thoughts, emotions, or perceptions overwhelm their ability to stay safe or care for themselves. It can involve intense anxiety or panic, depression with talk of suicide, mania with racing speech and no sleep, psychosis with hallucinations or fixed false beliefs, severe agitation, or a shutdown in which the person barely speaks or moves. A crisis is an episode, not an identity. The same person may be a competent worker, parent, and neighbor on most days.

Several other conditions can look similar at first contact, and Section 2 trained you to keep them in mind:

- **Medical problems** — head injury, infection, seizure aftermath, low blood sugar, stroke, and other emergencies can cause confusion, slurred speech, aggression, or strange statements.
- **Substances** — intoxication and withdrawal (Section 7) can mimic or intensify mental health symptoms, and the two often occur together.
- **Trauma responses** — a person triggered into reliving danger may shout, flee, freeze, or fight without any intent to attack you.
- **Developmental disability and dementia** — communication differences and confusion can be misread as refusal or deceit (Section 11 goes deeper).

You are not required to sort the cause on a sidewalk. You are required to notice that a health explanation is plausible, rule out immediate medical danger as your training allows, and choose tactics — distance, calm speech, medical and crisis help early — that do not depend on knowing the exact diagnosis. **The working rule: strange is not the same as dangerous, and loud is not the same as violent.** Assess actual behavior: What is the person doing? Is anyone in immediate danger, including the person? What would make this scene safer in the next two minutes?

Warning signs that raise urgency: stated intent to die or to harm someone, with a plan or access to means; a weapon in hand or close by; movement toward traffic, heights, water, or another lethal hazard; severe agitation that is escalating despite space and calm; confusion combined with fever, injury, seizure, or inability to stay awake; and a person who cannot say where they are, cannot care for a dependent child present, or has stopped eating, drinking, or taking essential medication in a way family describes as a sharp change.

2. Talking with a person in crisis — communication that lowers danger

A person in crisis is often frightened — of you, of what they perceive, of being taken away, of the voices or thoughts themselves. Communication is your primary tool for buying safety:

- **Introduce yourself and your purpose, once, clearly.** “I am Officer —. I am here because people were worried about you. I want to understand what is happening and help you stay safe.” Then be quiet long enough for an answer that may come slowly.
- **One voice.** One officer speaks; others manage space, bystanders, and information. Competing commands terrify and confuse.
- **Short sentences, ordinary words, unhurried pace.** Ask one question at a time. Offer simple choices where a real choice exists: “Would you like to sit on the steps or stay standing while we talk?” Choice restores a small sense of control without surrendering safety.
- **Do not argue with a delusion or mock what a person perceives.** You do not have to agree that neighbors are broadcasting threats through the walls. You can say: “I don’t hear that, and I can see it feels real and frightening to you. I want to help you feel safer.” Arguing facts rarely persuades and often convinces the person you are part of the threat.
- **Name feelings you can see.** “You look exhausted and scared.” “You’ve been awake a long time.” Recognition is not therapy; it is proof you see a person, not a problem.
- **Explain every transition before it happens.** “An ambulance crew is coming to check your health. A clinician who works with our department is coming to talk with you. I will stay until they are with you.” Surprises — hands, vehicles, new uniforms — spike panic.
- **Respect personal space and watch your own hands, stance, and exits,** as trained. A cornered person in psychosis may strike out from terror. Distance protects both of you and gives the person time to use words.

What NOT to do: Do not shout a frightened person into calm. Do not threaten arrest to force “sense” into someone whose thinking is disordered — a threat they cannot process becomes only noise and menace. Do not promise they will not be taken for evaluation if that decision is not yours or has already been made. Do not turn the scene into a spectacle: move onlookers back, and never discuss a person’s diagnosis or history loudly in public. Do not physically rush a person who is agitated but contained and not endangering anyone, when time and help are on your side — haste is how contained crises become injuries.

3. Suicide risk — asking directly and acting seriously

Any crisis call can carry suicide risk, including calls that began as noise, welfare checks, or family arguments. This school teaches a plain approach:

1. **Ask directly and without flinching.** “Are you thinking about killing yourself?” “Have you thought about how you would do it?” “Have you done anything to hurt yourself today?” Direct questions do not create the idea. They open a door a person who is suffering may be waiting for someone to open.

2. **Listen to the answer as information, not argument.** Do not debate whether life is worth living, do not express shock or judgment, and do not reduce the answer to “attention-seeking.” Any stated intent deserves a serious, documented response under your policy.

3. **Reduce immediate means where you lawfully and safely can,** within your training and authority, and involve medical and crisis professionals. Ask family, separately, about access to firearms, large quantities of medication, or other means the person mentioned — and follow department procedure for safekeeping and referrals.

4. **Stay and connect.** A person at risk should not be left alone while help is arranged when you can prevent it. Call or text routes matter for the family too: **988** can be called or texted, and 988 also coaches people who are worried about someone else. Crisis Text Line, text HOME to 741741, offers a silent option.

5. **Communicate risk clearly in handoff and report.** Exact words the person used, plan and means described, actions taken, who was notified, and where the person was transported. Vague phrases like “seemed down” fail the next helper.

If the person denies intent, believe cautiously and still read the whole scene: notes or messages shared by family, recent giving away of belongings, a sudden calm after deep despair, prior attempts family reports, intoxication, and access to means all inform — without replacing — the person's own words and your department's process. When in doubt, consult: your department's crisis-intervention team, a co-response clinician if your department has one, a supervisor, and medical staff exist so this judgment is not carried alone on a doorstep.

4. Getting help instead of charges where possible — step by step

Not every crisis involves a crime, and not every crime in a crisis is best answered only with a charge. This section's position — within the law, victim safety, and your orders — is that **help is the preferred outcome when no serious harm demands enforcement**, because a charge alone rarely treats the condition that caused the call, and a record can cost the person housing, work, and treatment access (the collateral pattern of Adult Section 1 applies here too). Where a victim's safety or the law requires enforcement, enforce — and still treat the person's health needs with the same care.

A help-first sequence this school teaches:

1. **Stabilize safety.** Separate anyone in conflict, secure immediate hazards as trained, and confirm medical needs. Safety first is what makes every later option possible.

2. **Bring the right helpers early.** Request your department's crisis-intervention team or a co-response clinician if your department has one; request an ambulance for

medical assessment where signs warrant. Call early — clinicians en route can also advise by phone or radio through your channels.

3. Gather context from people who know the person. Family, friends, building staff, or a case worker can tell you what is usual, what changed, what has helped before, what medications or treatment are involved (as they report it), and who should be contacted. Verify through proper channels; treat scene reports as reports.

4. Separate the conduct from the condition in your decisions. Ask: What actual harm occurred? Is there a victim, and what does that victim need for safety? Is the behavior explained by a crisis that treatment can address? Does the law or policy require arrest here, or is transport for evaluation, referral, or a warning with a concrete plan available and appropriate? Discuss close calls with a supervisor rather than deciding alone under pressure.

5. Use the destination that matches the need. Hospital evaluation for medical or serious psychiatric risk; crisis services and follow-up referral for a person who is safe to remain home with support; a family member or trusted person brought to the scene where that genuinely helps and policy allows. State the plan plainly to the person and family.

6. Close with connection, not just departure. Leave 988 and Crisis Text Line information where crisis support may be needed again, confirm who in the home knows the plan, and document the referral and handoff with the same care you would document an arrest. A referral written clearly is how the next shift knows help — not only enforcement — was tried.

What this approach expects in real life: families may demand arrest (“teach him a lesson”) or demand you leave (“you’ll make it worse”). Both demands come from exhaustion. Hear them, explain what you can and cannot do, and do not let either demand replace your assessment. Some calls will still end in custody — for serious violence, for weapons offenses, where orders require it. Even then, how you spoke, whether medical care came, and whether family got information will shape whether that household ever calls early again.

5. After the call — families, repeat calls, and your own steadiness

Mental health calls repeat. The same address, the same person, the same frightened relative. It is easy, on the fourth visit, to arrive with the conclusion already written. Resist it. Each visit, re-run the basics: new medical problem? new means? new threat? a medication change, a death, a lost job, a new substance? Repeat calls are not proof help failed; many conditions are managed over years, and a person alive and connected to care on your shift is not a failure.

Support the family as secondary witnesses to suffering. Tell them, in general terms, what will happen next and how they will be informed through the hospital or agency process. Encourage them to write down changes they observe — sleep, medication concerns as they understand them, threats, means — for clinicians. Remind them 988 serves worried

family members too. If children witnessed the crisis, keep explanations to them brief, calm, and age-appropriate, and follow any reporting or referral duties that apply.

Finally, attend to yourself and your partner. Crisis calls accumulate: the person you could not persuade, the scene that turned fast. Use your department's peer support and employee assistance resources, talk honestly in debriefs, and name errors without cruelty — to yourself or each other. An officer who treats their own distress as weakness will eventually treat a resident's distress the same way. Steadiness is a skill this whole school builds; it is maintained, not assumed.

6. When it may be medical, not a mental-health crisis — believe first

Some of the most dangerous misreads in this work happen at the border between "mental-health crisis," "intoxication," and a plain medical emergency. A diabetic emergency, a stroke, a head injury, an allergic reaction, severe infection, withdrawal, and some medication reactions can all present as confusion, slurred speech, agitation, or noncompliance — the same surface signs officers are trained to read as resistance or intoxication. Section 2 of this school retired the assumption that everyone is on drugs; this section adds its partner rule: **when a person says they are sick, in pain, or cannot breathe — believe first, and get medical help moving while you sort out the rest.**

- **Ask and listen.** "What is happening with you right now?" "Do you have any medical conditions?" "Are you hurt anywhere?" Family and bystanders often know the answer — a condition, a medication, a recent injury — and their report is evidence, not interference.
- **Look for the medical signs.** Medical alert bracelets and phone medical IDs, insulin or an inhaler nearby, vomit, seizure activity, one-sided weakness, breathing trouble, a person who is deteriorating in front of you. Any of these moves EMS to the front of the call, not the end of it.
- **Never let an assumption delay care.** Handcuffs and a transport decision can wait for a blood-sugar check. If you are wrong about "faking" or "just drunk," the cost is measured in a person's brain or life — and in your report, which will be read by people asking one question: when did you know, and what did you do?
- **Hand off precisely.** Tell medical staff exactly what the person and family reported, in their words where you can — "she said the pain started at 9 and is getting worse" travels further than "patient is agitated." Write the same precision in your report.

The other side of this door matters too: Minister Destiny's Adult school carries an added unit on medical discrimination that teaches families to document, speak up, and file complaints when they are dismissed or not believed. Officers who believe first and document honestly are rarely the subject of those complaints — and communities that watch it happen learn that calling for help is safe. That is the trust this school is named for.

Words to know — Section 9

- **Mental health crisis** — a state in which thoughts, emotions, or perceptions overwhelm a person's ability to stay safe or care for themselves.
- **Psychosis** — a condition in which a person may hear or see things others do not, or hold fixed false beliefs, making the world feel threatening or unreal.
- **Hallucination** — a perception, such as a voice, that feels real to the person experiencing it but is not heard or seen by others.
- **Delusion** — a fixed false belief held despite clear evidence, such as being certain one is being poisoned without cause.
- **Co-response clinician** — a mental health professional who responds with or supports officers on crisis calls, where a department has such a program.
- **Crisis-intervention team (CIT)** — officers and partners with specialized crisis training, where a department has such a team.
- **Decompensation** — a worsening of a person's condition in which coping and daily functioning break down.
- **Means** — the method or items a person could use to harm themselves, such as firearms or stockpiled medication.
- **Handoff** — the factual transfer of risk information — exact words, plans, means, actions taken — to medical or clinical staff.
- **Involuntary evaluation** — a legal process, governed by law and policy, by which a person who may be a danger to themselves or others can be taken for professional assessment; this lesson does not teach its legal criteria.

Myths vs facts — Section 9

- **Myth:** Asking someone if they are thinking of suicide puts the idea in their head. **Fact:** Asking directly does not create suicidal thinking. It gives a suffering person a chance to tell the truth and be connected to help.
- **Myth:** A person in a mental health crisis who commits a minor offense always needs a charge to take it seriously. **Fact:** Where law and safety allow, prompt evaluation and treatment address the cause of the behavior; a record can block the housing, work, and care that prevent the next call.
- **Myth:** You should argue a person out of a delusion with facts until they agree. **Fact:** Arguing rarely persuades and often frightens. Acknowledge the person's fear without endorsing the false belief, and focus on safety and help.
- **Myth:** If someone is calm and polite, there is no suicide risk. **Fact:** Risk turns on the person's words, plans, means, history as reported, and circumstances — not on politeness. Ask directly when concern exists.

Think it through — Section 9

The situation: A store manager calls about a man in his forties standing outside the entrance for an hour, talking loudly to no one visible and warning customers that “signals” are coming through the windows. He has blocked the doorway twice but moved when asked. He holds no weapon. Customers are filming. When you approach, he tells you the signals say officers will hurt him, and he backs toward the parking lot, glancing at traffic.

Walk it through:

1. **Read behavior, not labels.** Actual facts: possible psychosis, fear of police, no weapon seen, doorway blocked intermittently, and — the urgent fact — movement toward traffic. Your first safety problem is the road, not the doorway.
2. **Set the scene.** One officer speaks. Position help to slow or block traffic exposure as trained, move onlookers and cameras back, and give the man space that does not corner him against moving cars.
3. **Speak to the fear without joining the belief.** “I can see you believe the signals are warning you about us. I am not here to hurt you. I am worried about the cars. Let's step onto the sidewalk together so you are safe while we talk.” Short sentences; one request at a time.
4. **Bring help early.** Request a co-response clinician if your department has one and your department's crisis-intervention team; consider medical assessment, because confusion and agitation have medical causes too. Tell the man who is coming before they arrive.
5. **Weigh help against charges honestly.** Trespass after warning or disorderly conduct may be legally available depending on facts and jurisdiction — but ask the Section 9 questions: what harm occurred, what does safety require, and will evaluation address what a charge cannot? If transport for evaluation is appropriate and authorized, choose help and document why. If enforcement is required, carry it out with the same calm communication.
6. **Hand off and write facts.** His exact statements, his fear, traffic risk, no weapon observed, who assessed him, and where he was taken. The clinician who receives him starts safer because your report was precise.

One more real-life story — Section 9

A mother calls 911 because her teenage son has locked himself in the bathroom and is shouting that he “can't do this anymore.” She whispers that he mentioned pills an hour earlier and she does not know what he took. The first officer at the door does not pound or threaten to force entry immediately. Through the door, in an even voice, she introduces herself, says an ambulance is coming because his mother is worried he took something, and asks two direct questions: “Are you thinking about killing yourself? Have you taken anything?”

He answers — a handful of pills, forty minutes ago, and yes, he wanted to die after a humiliation at school that spread online. That answer changes the call: medical emergency first. Fire and ambulance crews, already rolling, enter with the mother's key and the officer's coordination, and he is transported to the local hospital. The officer rides the family's fear down with information: what hospital, what she told medical staff, and 988 for the mother herself, who is shaking in the kitchen.

Takeaway: Two direct questions, asked calmly through a locked door, turned a “barricaded teen” call into a timely medical rescue. Asking about suicide and about substances early is not paperwork — it is the moment help becomes possible.

Try this — Section 9

Practice the crisis opener and the three safety questions until they are automatic:

Opener: “I am Officer —. People who care about you were worried, and I am here to help you stay safe. Can you tell me what has been happening?”

- One voice speaking; space given; onlookers moved back
- Emergency medical signs checked — confusion with injury, fever, seizure, or inability to stay awake treated as medical
- Asked directly where concern exists: “Are you thinking about killing yourself?” “Do you have a plan?” “Have you taken or done anything to hurt yourself?”
- Crisis help requested early — crisis-intervention team / co-response clinician if your department has one
- Every transition explained before it happens; no promises you cannot keep
- Help considered before charges where law, victim safety, and policy allow — and the decision documented factually

Resources to keep — Section 9

- **Emergency:** 911 — for immediate danger, a person in traffic or another lethal hazard, overdose or poisoning concern, or any medical emergency.
- **988 Suicide and Crisis Lifeline:** Call or text 988 — for the person in crisis and for family members worried about someone else.
- **Crisis Text Line:** Text HOME to 741741 — silent text support when speaking aloud is hard.
- **SAMHSA National Helpline:** 1-800-662-4357 — treatment referral and information when substance use is part of the crisis.
- **Poison Control:** 1-800-222-1222 — when pills or substances may have been taken.
- **On scene:** Your department's crisis-intervention team, a co-response clinician if your department has one, and the local hospital for assessment and handoff.

What you earned / what's next — Section 9

Section 9 complete (quiz score 80% or higher): You can recognize a mental health crisis and its medical look-alikes, communicate in ways that lower fear instead of raising it, ask directly about suicide and act on the answer, bring crisis and medical helpers in early, and choose help instead of charges where the law, victim safety, and your orders make that possible.

Word Search — Section 9

Find the words from this class's Words to know. Words run across, down, or diagonally.

S H B I Y L S E L F I T E
I H X N O Q O P H D X I Z
H A L L U C I N A T I O N
W N W N V C B P C B G X E
P D O W D D F S U A T M D
E O Y D E Z F Y D W F D E
P F M V T F Z C K A V I L
H F E B C K V H B E N G U
V U Y R A W M O X U H I S
H I I I X B E S W K W V I
H H Y P U C A I V Z B E O
S L U H M U N S D D E D N
Q W U I U S S S X S U T S

Words to find: Psychosis · Hallucination · Delusion · Means · Handoff

Chapter Test — Section 9

Answer every question. Score 80% or higher to complete this class and earn its certificate. The answers are in the Answer Key at the back of this book — for parents, teachers, and self-checking after you finish.

1. A person insists neighbors are sending threats through the walls. The school's communication approach is:

- A. Always argue the facts until the person agrees
- B. Acknowledge the fear without endorsing the belief: “I don't hear that, and I can see it feels real and frightening to you”
- C. Agree that the neighbors are broadcasting threats
- D. Ignore everything the person says

2. What does this school teach about asking someone directly if they are thinking of killing themselves?

- A. Ask directly — it opens a door and does not create the idea
- B. Never ask — asking plants the idea
- C. Only ask family members, never the person
- D. Ask only in writing after transport

3. In the worked scenario, a man outside a store warns customers about “signals,” fears officers will hurt him, and backs toward traffic. The primary read is:

- A. Trespass — arrest is always the answer
- B. A disorderly crowd problem
- C. Possible psychosis with fear of police and an urgent traffic risk — set the scene, give space, speak to the fear, and bring crisis help early
- D. A medical call only, with no safety role for officers

4. Which set of tactics lowers danger in a mental health crisis?

- A. Request backup to overwhelm the person quickly
- B. Promise the person will not be evaluated
- C. Discuss the person's diagnosis loudly so bystanders understand
- D. Use one voice, short sentences, simple choices, and explain every transition before it happens

5. A person tells you they intend to die and describes a plan. Your response should:

- A. Debate whether life is worth living
- B. Listen, reduce immediate means where lawful and safe, keep the person connected to help, and document exact words, plans, and means

- C. Express shock so the person sees the seriousness
- D. Note that the person “seemed down” and clear the call

6. Why does this school warn against assuming every crisis is a mental health condition?

- A. Head injury, infection, low blood sugar, seizure aftermath, substances, trauma responses, and dementia can all present similarly
- B. Strange behavior is always psychosis
- C. Medical causes never mimic mental illness
- D. Only intoxication can look like a crisis

7. Why does Section 9 prefer help instead of charges where possible?

- A. Charges are the only way families take a crisis seriously
- B. Treatment makes records unnecessary to consider
- C. Help is preferred when no serious harm demands enforcement, because a charge alone rarely treats the cause and a record can block housing, work, and care
- D. Officers should never enforce the law during a crisis

8. You are called to the same person in crisis for the fourth time. This school teaches:

- A. It proves help failed and the family is manipulating the system
- B. Each visit deserves a fresh check — new medical problems, new means, medication changes, losses — because many conditions are managed over years
- C. You should arrive with the conclusion already written
- D. Repeat callers should be charged to end the cycle

9. Which crisis resource also supports family members worried about someone else?

- A. SAMHSA only
- B. Poison Control only
- C. A department's social media page
- D. 988 — it can be called or texted, and it also coaches people worried about someone else

10. In the section's second story, how did the officer get the locked-in teenager the right help?

- A. Through the door she asked directly about suicide and about pills taken, turning a “barricaded teen” call into a timely medical rescue
- B. She threatened to force entry until he opened the door
- C. She waited silently for an hour
- D. She asked the mother to go in and check

Certificate — Section 9

Minister Destiny Testimony Schools

Certificate of Completion — Section 9: Mental Health Crises: Safe Response and Help Instead of Charges Where Possible

This certifies that

Name (write your name here)

has completed

Minister Destiny Testimony Schools — Law Enforcement

Section 9: Mental Health Crises: Safe Response and Help Instead of Charges
Where Possible

Date completed: _____

Presented by **Minister Destiny Marie Morgan**, Minister & Founder

Congratulations. You have learned to be the calmest person on the hardest calls — to ask the direct question that saves lives, to make room for clinicians to do their work, and to see a person in crisis before you see a charge. That steadiness is remembered by every family you meet. — Minister Destiny Marie Morgan

School completion and rank are school achievements only. It is not a law-enforcement rank, title, or credential, and it does not certify you for any duty.

Educational completion certificate only — not a state license, POST certification, or government credential.

Minister Destiny Testimony Schools — Law Enforcement

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My Agenda — Class Tracker

Everything in this agenda is yours to write in. It stays in your book — nothing is collected.

Step	Done	Date	Score	Grade
Week 1 — Study the lesson				
Week 2 — Study + Words to know				
Week 3 — Stories + Try-this activity				
Week 4 — Chapter test (pass at 80% or higher)				

Letter grades: A 90–100 · B 80–89 · C 70–79 · D 60–69 · F below 60.

My goals for this class

Write the goals you are working toward in this class — and for yourself.

My Weekly Planner

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Notes

Resources to Keep

This class's resources, in one place. Keep this page.

- Emergency: 911 — for immediate danger, a person in traffic or another lethal hazard, overdose or poisoning concern, or any medical emergency.
- 988 Suicide and Crisis Lifeline: Call or text 988 — for the person in crisis and for family members worried about someone else.
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- SAMHSA National Helpline: 1-800-662-4357 — treatment referral and information when substance use is part of the crisis.
- Poison Control: 1-800-222-1222 — when pills or substances may have been taken.
- On scene: Your department's crisis-intervention team, a co-response clinician if your department has one, and the local hospital for assessment and handoff.

Answer Key

For parents, teachers, and self-checking after you finish the chapter test.

Section 9 Test — Mental Health Crises: Safe Response and Help Instead of Charges Where Possible

1. Acknowledge the fear without endorsing the belief: “I don't hear that, and I can see it feels real and frightening to you”
2. Ask directly — it opens a door and does not create the idea
3. Possible psychosis with fear of police and an urgent traffic risk — set the scene, give space, speak to the fear, and bring crisis help early
4. Use one voice, short sentences, simple choices, and explain every transition before it happens
5. Listen, reduce immediate means where lawful and safe, keep the person connected to help, and document exact words, plans, and means
6. Head injury, infection, low blood sugar, seizure aftermath, substances, trauma responses, and dementia can all present similarly
7. Help is preferred when no serious harm demands enforcement, because a charge alone rarely treats the cause and a record can block housing, work, and care
8. Each visit deserves a fresh check — new medical problems, new means, medication changes, losses — because many conditions are managed over years
9. 988 — it can be called or texted, and it also coaches people worried about someone else
10. Through the door she asked directly about suicide and about pills taken, turning a “barricaded teen” call into a timely medical rescue

Sources & Credits

The lessons in this book were written for Minister Destiny Testimony Schools from public sources — official websites, public health and safety organizations, help lines, and the law itself. The sources each chapter was built from, and the help resources it points you to, are listed under that chapter's name, with credit, so you can check anything in this book and keep learning. Court opinions and laws are public documents that belong to everyone. Everything here is retold in the school's own plain words — nothing in this book is copied from anyone else's book.

Section 9 — Mental Health Crises: Safe Response and Help Instead of Charges Where Possible

- Emergency: 911 — for immediate danger, a person in traffic or another lethal hazard, overdose or poisoning concern, or any medical emergency.
- 988 Suicide and Crisis Lifeline: Call or text 988 — for the person in crisis and for family members worried about someone else.
- Crisis Text Line: Text HOME to 741741 — silent text support when speaking aloud is hard.
- SAMHSA National Helpline: 1-800-662-4357 — treatment referral and information when substance use is part of the crisis.
- Poison Control: 1-800-222-1222 — when pills or substances may have been taken.
- On scene: Your department's crisis-intervention team, a co-response clinician if your department has one, and the local hospital for assessment and handoff.
- Stay and connect. A person at risk should not be left alone while help is arranged when you can prevent it. Call or text routes matter for the family too: 988 can be called or texted, and 988 also coaches people who are worried about someone else. Crisis Text Line, text HOME to 741741, offers a silent option.
- Close with connection, not just departure. Leave 988 and Crisis Text Line information where crisis support may be needed again, confirm who in the home knows the plan, and document the referral and handoff with the same care you would document an arrest. A referral written clearly is how the next shift knows help — not only enforcement — was tried.

The school itself is free: every class in this book, with its test and certificate, is free online at destinymorganbooks.com.

About the Author

Minister Destiny Marie Morgan is an ordained Muslim minister. She was ordained on May 15, 2025, through the Universal Life Church, and she is registered clergy in Massachusetts.

Her ministry is advocacy — standing up to injustice and helping people, locally and internationally.

She is the founder of Minister Destiny Testimony Schools, a free school. She built it so people can learn for free what cost her years to learn — people who may not have jobs, good credit, or loans, and who deserve real knowledge anyway. Every class is free online, for every age, with no sign-up and nothing collected.

She is also the author of two testimony series — Chronicles of Destiny Morgan and The Chronicle Trials — her own story, in her own words. Those books are her testimony; these school books are her teaching.

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The school is free online at destinymorganbooks.com.

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From Minister Destiny

You finished this book — but the learning does not stop here. Keep your resources close, keep asking questions, and use what you now know to help the people around you. If this book helped you, pass it to someone who needs it. I built this school for you, and I am proud of you for showing up for yourself. — Minister Destiny Marie Morgan

Minister Destiny Testimony Schools — Law Enforcement
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