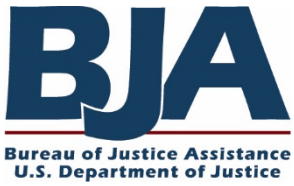

Effective Community Responses to Mental Health Crises:

A National Curriculum for Law Enforcement
Based on Best Practices from CIT Programs Nationwide

Instructor Guide

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Instructor Guide

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Course Purpose

This course was developed to expand the reach of effective crisis intervention strategies to law enforcement agencies and to encourage the development of mental health community-law enforcement partnership teams throughout the United States. There are approximately 18,000 law enforcement agencies in the country, yet estimates of active partnerships number below 3,000.

The different types of instruction presented throughout this curriculum are purposeful and take into account adult learning strategies. The ***course matrix*** on page 8 (listing topics by day and hours) provides an easy-to-follow color key: **Gray** boxes indicate Administrative Tasks; **Orange** boxes indicate Research and Systems, including an overview of concepts and course evaluation; **Light Blue** boxes indicate Mental Health Basics, which provide critical introductory instruction to signs and symptoms of mental illness; **Green** boxes indicate time set aside for community site visits, which may include hospital emergency rooms, community mental health clinics, central receiving facilities, local National Alliance on Mental Illness (NAMI) chapters and/or other relevant community resources; **Purple** boxes indicate instruction that focuses on community resources and viewpoints; and **Red** boxes indicate instruction that is geared for sworn law enforcement and includes tactical scenario-based skills training as well as discussions of key issues such as liability and policy. In order to accommodate local scheduling, we have developed two matrix options: **Matrix Option A** (on page 8) and **Matrix Option B** (on page 9).

In general, we recommend that law enforcement agency employees who are acting as course coordinators teach Gray, Orange, and Red modules; local mental health professionals teach Blue modules; local community leaders teach Purple modules; and a combination of law enforcement instructors and community leaders facilitate the Green site visits. Inviting local mental health professionals – whether they are psychiatrists, emergency room physicians, psychologists or counselors – to teach Mental Health Basics modules serves two primary purposes: it builds relationships between the participants (officers) in the class and the mental health community; and the professionals can answer specific questions with specific answers drawing on their local knowledge and experience. Oftentimes, local mental health professionals will volunteer to teach specific modules at no cost to the agency.

This course was designed to be customizable to any jurisdiction that wishes to use it.
Successful and effective community-based responses to mental health crises rely upon partnerships. We recognize that all communities are unique and all have different resources. Throughout this curriculum, you will find notes to instructors directing them to customize modules in order to harness available community resources and provide training that is appropriate to your community's unique needs. Each module is designed to provide some baseline information and best practices, but agencies and instructors are encouraged to make this curriculum their own. We encourage you to add relevant local examples, bring in topics that matter to your community, and harness the strength and resources in your area to make

this week-long course meaningful for your officers. We encourage instructors to bring their stories and lived experiences into the classroom as well; when placed into the context of the baseline curriculum material, personal stories add to the richness of the course and the learning experience. Throughout the curriculum materials, you will see notations in **red** that indicate where local agencies and communities should customize the materials to their jurisdiction. This curriculum lays out topics, issues and some content – but it is not designed to be "off the shelf." Using this curriculum requires some preparation by the agency wishing to utilize it effectively.

Matrix Option A:

Effective Community-Based Responses to Mental Health Crisis: A National Curriculum for Law Enforcement
Based on Best Practices from CIT Programs Nationwide
40-hour Curriculum Matrix | Based on University of Memphis CIT Matrix

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00	M1 | Administrative Tasks: Welcome	M9● Mental Health Basics: Neurodevelopmental & Neurocognitive Disorders	M10 | Mental Health Basics: Disorders in Children, Youth, & Adolescents	M16 | Mental Health Basics: Suicide	M20 | Community Support: Veterans & Homelessness
8:30	M2 | Research & Systems: CIT Overview				
9:00		M8 | Mental Health Basics: Psychopharmacology	M11 | Mental Health Basics: Disruptive, Impulse-Control, & Conduct Disorders		M21 | De-Escalation: Scenario-Based Skills Training
9:30					
10:00	M3 | Community Support: Culture & Mental Health	Site Visits	M12 | Mental Health Basics: Personality Disorders	M17 | Law Enforcement: Policies & Procedures	
10:30					
11:00	M4 | Mental Health Basics: Depressive Disorders		M13 | Mental Health Basics: Post-Traumatic Stress Disorder	M18 | Law Enforcement: Liability & Other Issues	
11:30					
12:00	Administrative Tasks: Lunch				
12:30					
1:00	M5 | Mental Health Basics: Bipolar Disorder, Psychotic Disorders, & Schizophrenia	Site Visits	M14 | Community Support: Local Resources	M19 | De-Escalation: Scenario-Based Skills Training	M22 | Law Enforcement: Incident Review
1:30					
2:00					M23 | Community Support: Special Topic
2:30	M6 | Mental Health Basics: Substance-Related and Addictive Disorders		M15 | De-Escalation: Scenario-Based Skills Training		
3:00					
3:30					M24 | Research & Systems: Evaluation
4:00	M7 | Mental Health Basics: Assessment, Commitment, and Legal Considerations				M25 | Administrative Tasks: Graduation & Presentation of Certificates
4:30					
5:00	Administrative Tasks: Dismiss				

Some agencies choose to conduct all scenarios on the same day, so that they can hire actors to participate in the scenarios or conduct scenarios at an offsite location. The course can be adjusted to meet each community's needs. See the example below for an alternate schedule.

Matrix Option B:

Effective Community-Based Responses to Mental Health Crisis: A National Curriculum for Law Enforcement
Based on Best Practices from CIT Programs Nationwide
40-hour Curriculum Matrix | Based on University of Memphis CIT Matrix

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00	**M1 | Administrative Tasks:** Welcome	**M8 | Mental Health Basics:** Neurodevelopmental & Neurocognitive Disorders	**M10 | Mental Health Basics:** Disorders in Children, Youth, & Adolescents	**M17 | Managing Encounters:** Scenario-Based Skills Training	**M19 | Mental Health Basics:** Suicide
8:30	**M2 | Research & Systems:** CIT Overview				
9:00		**M9 | Mental Health Basics:** Psychopharmacology	**M11 | Mental Health Basics:** Disruptive, Impulse-Control, & Conduct Disorders		
9:30					
10:00	**M3 | Community Support:** Culture & Mental Health	**Site Visits**	**M12 | Mental Health Basics:** Personality Disorders		**M20 | Law Enforcement:** Policies & Procedures
10:30					
11:00	**M4 | Mental Health Basics:** Depressive Disorders		**M13 | Mental Health Basics:** Post-Traumatic Stress Disorder		**M21 | Law Enforcement:** Liability & Other Issues
11:30					
12:00	**Administrative Tasks:** Lunch				
12:30					
1:00	**M5 | Mental Health Basics:** Bipolar Disorder, Psychotic Disorders, & Schizophrenia	**Site Visits**	**M14 | Community Support:** Local Resources	**M18 | Managing Encounters:** Scenario-Based Skills Training	**M22 | Law Enforcement:** Incident Review
1:30					
2:00					**M23 | Community Support:** Special Topic
2:30	**M6 | Mental Health Basics:** Substance-Related and Addictive Disorders				
3:00			**M15 | Community Support:** Veterans & Homelessness		
3:30					**M24 | Research & Systems:** Evaluation
4:00	**M7 | Mental Health Basics:** Assessment, Commitment, and Legal Considerations		**M16 | Managing Encounters:** Scenario-Based Skills Training		**M25 | Administrative Tasks:** Graduation & Presentation of Certificates
4:30					
5:00	**Administrative Tasks:** Dismiss				

This course was not designed to be a substitute for meaningful law enforcement-community partnerships, or for effective problem -solving strategies. Training for law enforcement officers is an important facet, but only one in a larger strategy of moving toward effective problem solving and connecting people with mental illness who come into contact with law enforcement to treatment. We strongly suggest that agencies who *do not have* meaningful partnerships in place with their communities focus on building them *before* undertaking training.

Course Development

This course was developed by drawing on many resources, chief among them the CIT Center at the University of Memphis (http://www.cit.memphis.edu/). The Center houses a collection of training modules for law enforcement from around the country, on a wide variety of mental health-related topics – some of which are repurposed here. This curriculum also leverages recent research findings and publications, discussions with officers across the nation, consultations with experts in the fields of psychiatry, psychology, social work, law enforcement, and most importantly, conversations with people with mental illness and their families.

This course was developed utilizing a slightly modified version of the model of curriculum development, which is organized into five phases: (1) Analysis, (2) Design, (3) Development, (4) Implementation and (5) Evaluation (piloting the new curriculum). Our curriculum design combines Implementation and Evaluation into phase 4 and adds a phase 5 for finalizing the curriculum based upon feedback from the pilot delivery.

Phase I: Analysis

The first phase consisted of conducting a thorough international review of existing crisis intervention approaches for law enforcement training models and programs, noting best practices and a content analysis of programs found on the CIT Center's website; the review aimed to identify any gaps in existing models.

Phase II: Design

The second phase focused on the design of classroom curricula. The CNA team developed the instructional, visual, and technical design strategy for the course; explored learning modalities in use by law enforcement across the country (e.g., coached social interaction during scenario-based training, multimedia, on-site learning through site visits); reviewed promising practices to guide flexibility and adaptability of standardized materials; and developed storyboards for course content. The team solicited feedback from the COPS Office and our advisors during this phase.

Phase III: Development

During this phase, our team opened a real-time feedback loop for project team members and advisors to review materials. This phase focused on the development of curriculum content and the revision of content based on feedback from advisors. During this phase we also carefully considered matching instructor expertise to content.

Phase IV: Implementation and Evaluation

The team piloted this course in two locations: Montgomery County, Maryland and Waukegan, Illinois. The team provided these communities with technical assistance as they engaged with community-based mental health partners, customized the curriculum for their local contexts, and implemented the course. During the pilot sessions, CNA conducted an evaluation of the course curriculum, instructor feedback, and participant experience.

Phase V: Finalize Curriculum

In the last phase, the team solicited additional feedback from subject matter experts, BJA, and pilot site instructors, participants, and partners to improve and enhance the course content. This feedback was incorporated into the final version of the curriculum.

Target Audience

This course is designed for law enforcement agencies and communities that have not yet trained their sworn officers on effective crisis intervention and/or for agencies who would like to update or refine their training strategies. The week-long training experience is designed for sworn law enforcement officers – but we also encourage the participation of dispatchers, 911 call takers, other non-sworn members of the department, and fire and emergency medical services. This course involves a blend of learning modalities which require a high degree of interactivity, including scenarios-based skills training. Therefore, we recommend audiences be limited to 25-30 participants.

Course Length and Prerequisites

There are no specific prerequisites for this course. This course is 40 hours in length and is designed for delivery over the period of five 8-hour days. The course may be adjusted to accommodate four 10-hour days of instruction. It may be delivered over multiple weeks (1 day per week for 5 weeks, for example), but we generally encourage a week-long continuous experience in order to maintain focus, generate relevant questions, and keep the learning experience flowing.

Course Structure

The course is structured around a variety of learning modalities, including: classroom instruction guided by a set of PowerPoint slides and instructor-led discussion; site visits to community mental health related facilities; and hands-on scenario-based learning. The course modules are sequenced so that learning occurs logically – for example, many of the mental health basics modules occur prior to the skills-based scenario training so that participants can recognize signs and symptoms of mental illness during those social interactions.

This ***Instructor Guide*** (IG) is meant to guide course coordinators through their preparation to teach this course, including suggestions for site visit locations and suggestions about instructor types for each module. The course is laid out module-by-module, according to the schedule on the course matrix (see page 9). Please note that the days are scheduled to being at 8:00 am and end at 5:00 pm, with a 1-hour lunch break from 12:00 pm to 1:00 pm. That schedule may be altered for your agency and your community. It is important to note that ***breaks*** are not built into this curriculum (i.e., the PowerPoint slide deck does not include slides that say "Break"). Individual instructors or course coordinators shall schedule 10-minute breaks when appropriate.

Participants in the course will receive a printed or electronic version of the companion piece to this Instructor Guide, the ***Participant Guide*** (PG). Everything appearing in the PG also appears in the IG, so as instructors are teaching, they have the PG material in front of them and can easily refer participants to it.

Videos, audio stories, and case studies may be substituted with local or current material

throughout this curriculum. Part of what will make this course a solid learning experience is the continuous updating of material – especially videos and audio drawn from news sources. Ask your local mental health professionals who are acting as instructors to provide alternate case studies, if you wish. The idea is to provide material that will speak to the officers in your community and to emphasize issues that make them think.

Course Activities

As mentioned above, this course will include learning outside of the classroom during site visits and will also include scenario-based learning activities that may occur outside of the classroom as well, such as in community venues or specialized training facilities. Specific information about each course activity -- for both participants and instructors -- is found throughout the Participant Guide and the Instructor Guide.

Some ideas for ***handouts*** are provided throughout this curriculum, but again – feel free to develop handouts that speak to your community and/or swap out the handouts provided here with updated or different ones.

List of handouts in this curriculum:

- **Module 2**: CIT Overview – Handout of "CIT Core Elements" can be found here: http://cit.memphis.edu/pdf/CoreElements.pdf
- **Module 9**: Psychopharmacology – Handout of Commonly Prescribed Psychotropic Medications can be found here: http://www.namihelps.org/assets/PDFs/fact-sheets/Medications/Commonly-Psyc-Medications.pdf
- **Module 20**: Veterans and Homelessness – Handout of *TIME Magazine* article can be found here: http://nation.time.com/2012/08/22/crisis-intervention-teams-for-vets-sure-beats-jail/

Course Preparation

It is recommended that communities designate a local coordinator to lead the planning and implementation of this training. Ideally, the coordinator would be an experienced CIT officer and have relationships within the police department and across community-based mental health service providers. The coordinator would serve as the central point of contact for all planning activities, including participant and instructor recruitment, site visit and guest speaker coordination, scenario development, and logistics planning. CIT International offers a certification course for CIT Coordinators; more information can be found here: http://www.citinternational.org/CIT-Coordinator-Certificate-Course.

CIT courses are most effective when they utilize every opportunity for community collaboration, necessitating a larger than typical number of individuals who may be involved in the implementation of the course. This course not only provides participants an opportunity to learn about mental health disorders and to practice effective skills when responding to mental health crisis situations, but also gives them an opportunity to learn about the services available

in their community and to talk directly with providers. Law enforcement officers may have a general sense of what types of services are available in their community, and through this course, they can build relationships with these partners, which paves the way for a sustainable CIT response.

Care should be taken to identify trainers who have experience working with people with mental health illnesses and have experience partnering with law enforcement. Experience has shown that instructors' credibility and delivery of the course content were the most important predictors of success. Instructors should not only be knowledgeable, but they should be skilled communicators who can bring their real-life experience into the classroom in a manner relatable to officers. Many of modules are best suited to be taught by mental health experts in your community. Local service providers or university professors may be well-suited to effectively present the materials. Likewise, modules specific to the legal framework for CIT may be best suited to be delivered by an active prosecutor, attorney, or police department leader who has expertise in understanding and navigating the laws and policies that govern CIT actions. It may be necessary, in some circumstances, to pair a law enforcement trainer with a community-based expert.

Communities should allow ample preparation time before hosting the course. The preparation phase may take up to twelve weeks to recruit instructors, tailor content to the local context, develop and practice scenarios that will resonate with the participants' experiences, and build training hours into the department's staffing schedules. Keep in mind that training schedules for many jurisdictions are finalized at the beginning of the year, so preparations to include CIT training into the training schedule should occur well in advance of an anticipated training date. See the checklist below for a list of the expected planning phase milestones.

Course Preparation Phase Checklist

Phase I (6-12 months in advance)

- ☐ Present CIT course to local leadership to gain support for the training
- ☐ Incorporate into annual training schedule
- ☐ Schedule dates for the course
- ☐ Designate a coordinator to lead preparation for the course

Phase II (2-4 months in advance)

- ☐ Recruit instructors for each module of the course
- ☐ Identify local service providers for site visits
- ☐ Identify guest speakers, including consumers, to participate in the course
- ☐ Update the curriculum matrix if needed
- ☐ Update and tailor content for the local community context
- ☐ Finalize all course materials and prepare materials for printing
- ☐ Recruit participants and make arrangements to accommodate their training hours
- ☐ Secure a location to host the course

Phase III (1 month in advance)

- ☐ Recruit actors (if used) and facilitators to participate in the scenarios
- ☐ Develop scenarios that are relevant to the local community
- ☐ Ensure classroom format is conducive to discussions, scenarios, and the number of people involved in each activity
- ☐ Secure and test technology needed for the course, including: projector and screen, audio speakers, computer, and internet access
- ☐ Secure food and drinks for participants for each day of the course

As previously noted, the content and materials for this course should be tailored to your community; these should be highlighted throughout the course. Instructors should incorporate local information, such as statistics, case studies, policies, and available resources throughout their presentations.

Instructor Preparation

Much of the success of this course comes from the engagement between instructor and participants. The most effective instructors are those that have deep knowledge of their topic, first-hand experience working with people with mental illness, a history of collaboration or engagement with law enforcement, and are engaging communicators.

This course may also be an opportunity to build new relationships with mental health experts in the community. In these situations, we recommend that new instructors spend time with the department trainers to learn about the needs and preferences of law enforcement students

and to go on ride-alongs in their community to observe how officers approach their work. New instructors may also want to consider partnering with a senior trainer from the department to ensure content and examples relate to officers' daily experiences.

As noted, instructors should take the time to customize their materials, incorporating local stories, background and information as they see fit. Videos have been particularly effective at demonstrating the signs and indicators of specific mental health symptoms and disorders, as well as in telling the stories of individuals with mental illnesses. Departments and instructors should identify video clips they feel are particularly enlightening or instructive and are relevant to their local community to include in the curriculum. Departments should ensure selected videos are appropriate and do not violate any copyright restrictions.

Instructors should keep in mind the goals of CIT training as they prepare their presentations; this course aims to teach officers how to recognize the signs of a potential mental health crisis and how to adapt their responses accordingly. Tips and real life examples that focus on communication skills and response strategies will be invaluable to participants.

The modules in this course are designed to build upon each other, each adding to the knowledge base and skills set for participants. Trainers should review the entire course curriculum in advance and identify opportunities to draw links between modules, in examples and explanations. It is likely that officers will encounter individuals with co-occurring disorders and should practice applying communications skills that apply across mental health crisis situations.

Subject Matter Experts, Content Contributors and Reviewers

We owe thanks to many people for their support and contributions throughout the course development process, including:

- Danica Binkley, Policy Advisor, BJA
- Major Sam Cochran, University of Memphis and CIT International
- Leigh Ann Davis, the ARC
- Dr. Randy Dupont, University of Memphis
- Maria Fryer, Policy Advisor, BJA
- Ron Honburg, NAMI
- Ruby Qazilbash, Associate Deputy Director, BJA
- Laura Usher, NAMI
- Dr. Amy Watson, Associate Professor of Social Work, University of Illinois at Chicago
- Alexa James, Executive Director, NAMI Chicago
- All who worked so hard to pilot this curriculum in Maryland, including from the Montgomery County Police Department: Scott Davis, Beth Tabachnick, Michael Chindblom, Mary Tiernan Brough, Noelle Gunzburg and Marc Sheelor; from NAMI Montgomery County: Stephanie Rosen; and from Frederick County Jason Null.
- All who worked so hard to pilot this curriculum in Illinois, including from Nicasa, Bruce Johnson; from the Lake County Sheriff's Office: Keith Keiser, Frances Foy, and James Yanecek; from the College of Lake County, Mary Guillen, Janet Mason, Thomas Crowe, Kevin Garren, Jennifer Hulvat, Mary Roberson; and from NAMI of Lake County, Mary Jouppi.

Module 1 | Administrative Tasks: Welcome and Overview Administration Page

Duration: 30 minutes | 8:00 am – 8:30 am

Scope Statement: This module serves to introduce the lead instructors and the classroom participants to each other; set expectations for the week of learning; ascertain the level of understanding about crisis intervention the students begin with; and sketch the basic concept of crisis intervention teams.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Define "crisis intervention team" and enumerate the members of an effective team;
- Describe the history of crisis intervention teams; and
- Identify the goals of crisis intervention.

Instructor/Participant Notes1: [blank for notes]

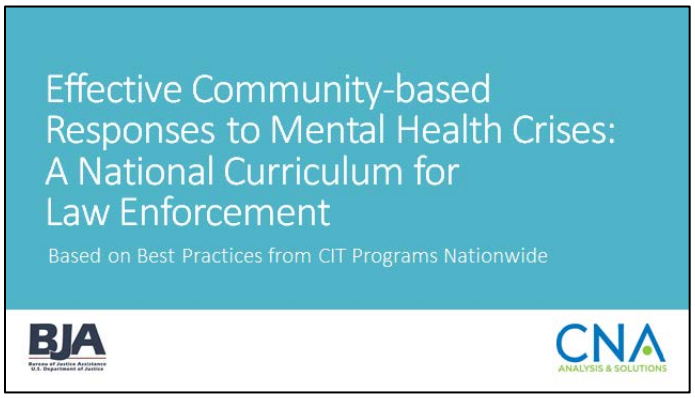
EFFECTIVE COMMUNITY-BASED RESPONSES TO MENTAL HEALTH CRISES
PRE-COURSE SURVEY

Please answer the following questions on a scale of one to five.	*1: Strongly disagree*				*5: Strongly agree*
	1	2	3	4	5
1. I feel comfortable working with people with mental illness.	☐	☐	☐	☐	☐
2. I believe I have an understanding of what people with mental illness face in their everyday lives.	☐	☐	☐	☐	☐
3. I believe that empathy and rapport building are necessary components to defuse crisis situations.	☐	☐	☐	☐	☐
4. Recovery from mental illness is possible.	☐	☐	☐	☐	☐
5. I see the symptoms of the mental illness separate from the person who has the illness.	☐	☐	☐	☐	☐
6. I am able to tell if a person is psychotic.	☐	☐	☐	☐	☐
7. I know how to interact with a person with serious mental illness.	☐	☐	☐	☐	☐
8. Jail is a safe place for people with mental illness.	☐	☐	☐	☐	☐
9. I am able to tell if a person has autism.	☐	☐	☐	☐	☐
10. Mental illness does not get better with treatment.	☐	☐	☐	☐	☐
11. People with severe mental illness do not respond to techniques meant to defuse crises situations.	☐	☐	☐	☐	☐
12. I believe that people with mental illness can be contributing members of society.	☐	☐	☐	☐	☐
13. People with severe mental illness often require the use of force to maintain officer safety.	☐	☐	☐	☐	☐
14. I can identify resources in my community for people with mental illness.	☐	☐	☐	☐	☐

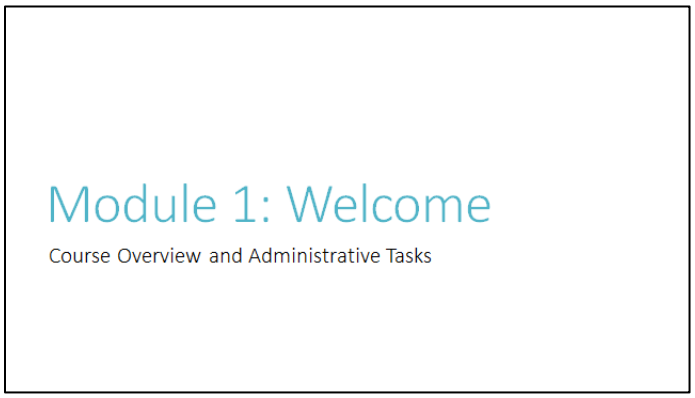
Please answer the following questions on a scale of one to five. *1: Strongly disagree* *5: Strongly agree*

	1	2	3	4	5
15. I can distinguish between the symptoms of a thought disorder and a mood disorder in an individual with mental illness.	☐	☐	☐	☐	☐
16. I am able to utilize communication techniques effectively with people with mental illnesses.	☐	☐	☐	☐	☐
17. I feel able to determine if a person with mental illness who has committed a crime should be taken to jail or to hospital/emergency room.	☐	☐	☐	☐	☐
18. I feel confident in my skills to interact with people with mental illness or people in crisis.	☐	☐	☐	☐	☐
19. I know who to call if I need assistance when interacting with a person with severe mental illness or in crisis.	☐	☐	☐	☐	☐
20. Mental illness is not anyone's fault.	☐	☐	☐	☐	☐

Slide 1

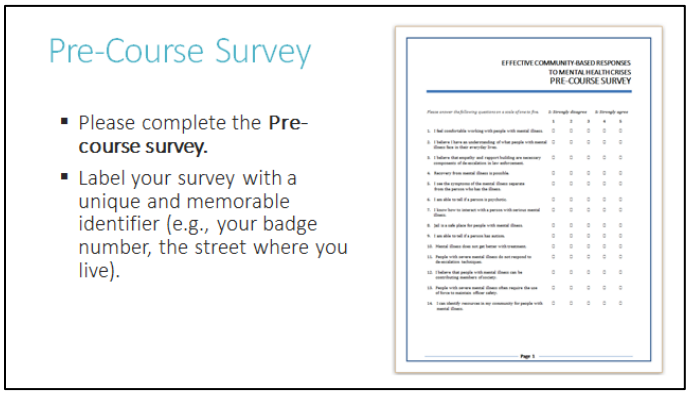


Slide 2



PG: Welcome to Day 1 of ***Effective Community-Based Responses to Mental Health Crisis***! We are glad you have committed time to learn about these important issues. Let's begin by taking the pre-course survey so your instructors know how well-versed you are about effective crisis intervention before we begin the course.

Slide 3



IG: Hand out pre-course survey, allow time for participants to complete it. Collect the surveys as participants finish them. The surveys may be anonymous, depending upon the preferences

of the agency. To make the surveys anonymous, instead of indicating name or badge number in the blank space at the top of the survey, please ask participants to come up with a unique identifier (that they will remember!) such as last four digits of their cell phone number, dog's name, etc. Advise participants that this survey is a measure of their baseline knowledge and that they will be asked to complete the same survey after the course is over.

Slide 4

PG: Please tell us about yourself: name, rank, how long you have been in law enforcement, the last encounter you had with a person with mental illness.

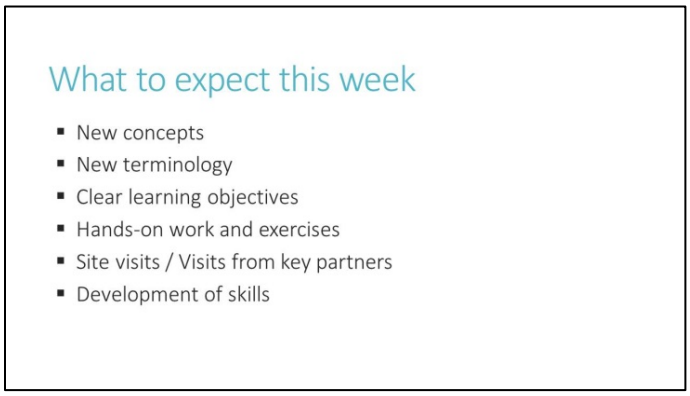
IG: Briefly introduce yourself and ask classroom participants to introduce themselves. Ask them to share their name, how many years they have been in law enforcement, perhaps one personal tidbit (such as favorite cop TV show), and to describe the last encounter they had with a person with mental illness. Introduce yourself and your co-instructor(s), stating credentials, experience and why you are teaching the class this week.

It is important to set the stage well so that participants are engaged from the beginning and are motivated to participate and share their thoughts and opinions throughout the training. You are encouraged to utilize an ice breaker to encourage participants to be active from the beginning. The instructor should choose an icebreaker that will be well received by their audience.

A simple ice breaker related to CIT could be used to compare associations between mental health disorders and other physical disorders. As a full class or in small groups, have participants share the first assumptions or associations that come to mind when they think of a person with mental illness. Alternatively, participants could write these words on paper to be read aloud by the instructor. Discuss these terms as a group.

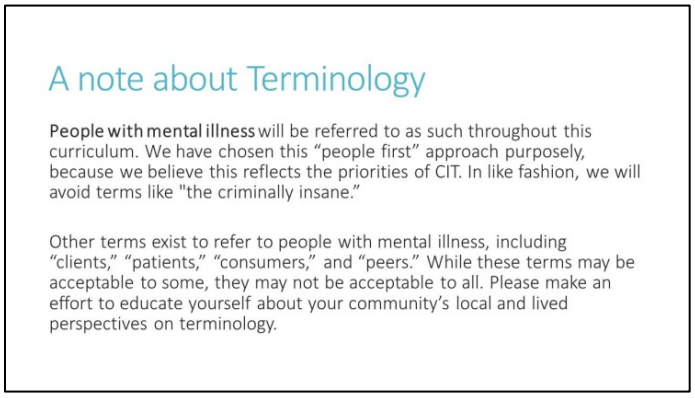
Next, ask participants what comes to mind when they think of a person who has cancer. Discuss as a group and debrief why the lists are so different.

Slide 5



IG: Briefly describe the experiences class participants should expect this week. Mention that they will spend time outside of the classroom (if possible) and will spend time with advocates, clinicians, and people with mental illness. This is a crucial week of training and it will likely shape their everyday policing for the durations of their careers. We hope they take away valuable knowledge and skills from this experience!

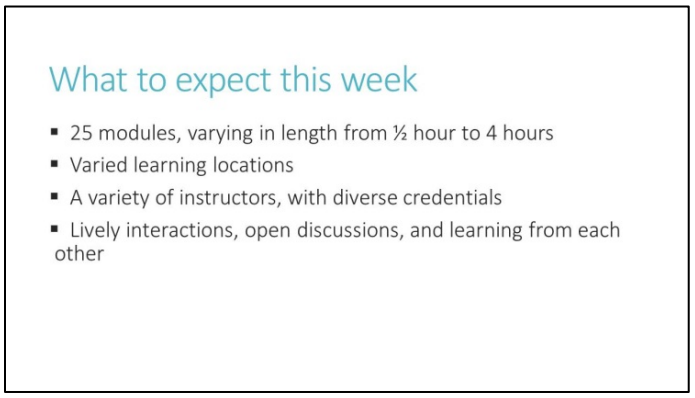
Slide 6



PG: Be sure to educate yourself about local terminology and the lived perspectives of people in your community and their preferred terminology.

IG: Give a brief explanation about why terminology is important for building trust and respect.

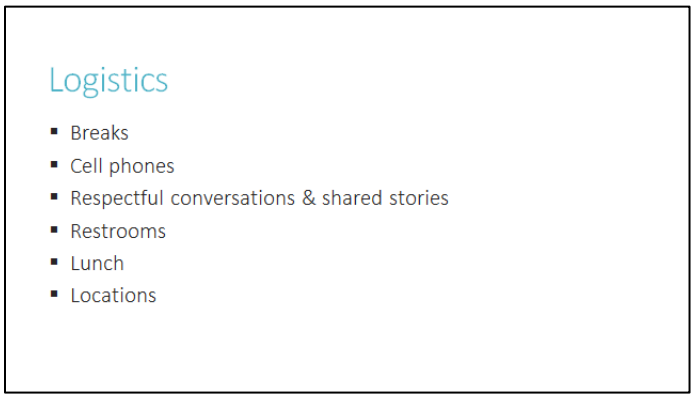
Slide 7



PG: The matrix above briefly describes the 25 modules and topics you will be learning about this week. Each module will be led by an instructor best qualified to teach the particular topics. For example, clinical topics will be taught by clinicians; hands-on scenario-based modules will be taught by law enforcement instructors, with the assistance of local actors (if available); and advocacy and community modules will be taught by advocates, people with mental illness, and other community members.

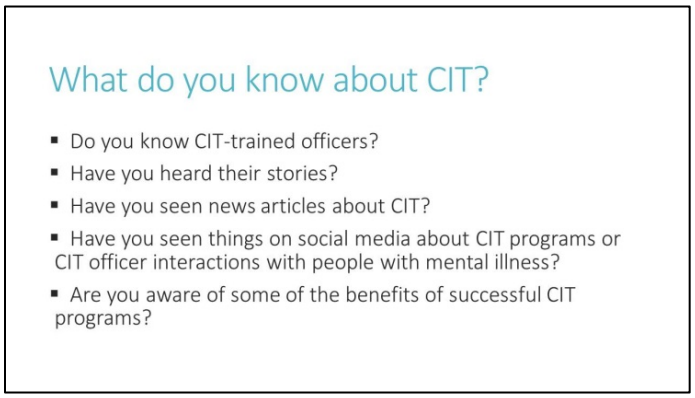
IG: Briefly explain the expectations for the week's training, laying out the schedule you have developed -- Option A, Option B, or another option tailored to your local needs (see pages 8-9 above for matrix options).

Slide 8



IG: Please explain to participants the locations of restrooms, nearby restaurants, and other logistics as necessary.

Slide 9



IG: Solicit responses to the questions on the slide from participants – listen to stories about interactions that they have heard of from colleagues, general impressions about CIT's helpfulness, concerns, etc.

Slide 10

PG: This audio clip from National Public Radio aired in September of 2014 and is an example of the kinds of media coverage CIT has gotten.
Link to AUDIO: http://www.npr.org/2014/09/23/349098691/as-run-ins-rise-police-take-crash-courses-on-handling-mentally-ill

TRANSCRIPT (from link above):

AUDIE CORNISH, HOST: A recent number of high profile police shootings - including that of Michael Brown in Ferguson, Missouri, last month - have led to increased scrutiny of police interactions with civilians. People with mental illness are disproportionally subject to the use of force by police. Across the country, local departments hold special sessions to train officers about mental illness and how to help the people they interact with. Durrie Bouscaren, of St. Louis Public Radio, reports.

DURRIE BOUSCAREN, BYLINE: Walking up and down the aisle of a police academy classroom in

downtown St. Louis, Lieutenant Perri Johnson tells the officers here that responding to calls when a person is a mental distress is never easy.

LIEUTENANT PERRI JOHNSON: You're going to get plenty of opportunity to utilize some things that you're learning. You're going to get thrown in a situation...

BOUSCAREN: This lecture on tactical communications is part of a weeklong crisis intervention training - or CIT. Officers are taught to recognize different types of mental illness and how to de-escalate situations where someone feels threatened or may react violently.

JOHNSON: You know, you'll see bipolar disorder, schizophrenia - various versions of that. What we see a lot of is people, who haven't been diagnosed, and they may be taking drugs, they may be drinking to mask those issues.

BOUSCAREN: These officers respond when people are experiencing some of their darkest moments. On rare occasions calls end with injuries to the person in distress, or the officer, or both. Lieutenant Johnson says he tells his students that most of all they need to use compassion.

JOHNSON: Lower your voice so that that person becomes comfortable, but at the same time you're keeping an eye of their movement - on their hands. Know where the doors are in case you need to get out quickly.

BOUSCAREN: In the late 1980s police in Memphis, Tennessee, shot and killed a man threatening suicide with a knife. It was outcry over the incident that led to developing the crisis intervention team model, which has now been expanded to almost 3,000 local departments and regional councils. Local providers for mental health services - including the National Alliance on Mental Illness - work closely with departments to develop the curriculum. Richard Stevenson is with that group. He says it's important that officers know where they can take a person to get help. Almost 90 percent of St. Louis CIT calls end with the person being taken to the emergency room or another treatment facility.

RICHARD STEVENSON: Because it is helpful, because it is successful, no one hears anything about it. There's not much great news value to an officer who does an effective job at calming a situation down and getting help for the person who is in distress.

BOUSCAREN: Linda Teplin teaches psychiatry at Northwestern University. She says increasingly police are taking on the role of street psychiatrists as a decline in funding for mental health programs leaves people with mental illness with fewer resources.

LINDA TEPLIN: So the issue is what is happening to these people? Who in past years would have been treated in the mental health system and now are not receiving treatment and are in the street.

BOUSCAREN: Teplin says this means people with mental illness now have more contact with

law enforcement, are more likely to be arrested and, in very rare cases, hurt during police encounters. An analysis of St. Louis area CIT reports shows that on average officers used force in about 4 percent of cases, most often with a Taser or constraint. Last month a St. Louis CIT-trained officer shot and killed a 25-year-old Kajieme Powell who was rushing towards officers while carrying a knife, imploring them to shoot him. St. Louis CIT coordinator Sergeant Jeremy Romo says his teams take these cases seriously. He says when officers are responding to someone who may pose a threat to themselves or others they're trained not to further escalate the situation.

SERGEANT JEREMY ROMO: But in some situations the situation is evolved and gone so far downhill that the officer's safety or citizen safety takes a priority.

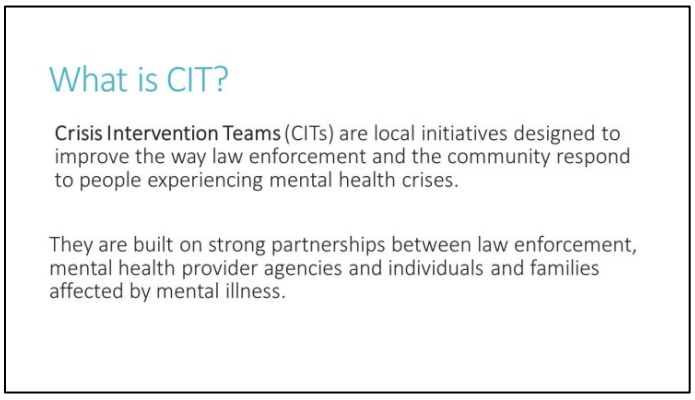
BOUSCAREN: Sergeant Romo says when force is used there's something else that comes to mind...

ROMO: I want to know how many times that individual was in the hands of the mental health system and the mental health system failed to provide them with adequate assistance.

BOUSCAREN: Romo says demand for CIT training classing has increased, but he notes the greatest need appears to be not in cities but in rural areas where emergency mental health services are often scarce or nonexistent. For NPR News, I'm Durrie Bouscaren in St. Louis.

IG**:** Listen to audio story and debrief, asking for participants' impressions.

Slide 11



PG: This definition comes from Dupont, et al., 2007. "Core Intervention Team Elements." University of Memphis. Available at http://cit.memphis.edu/pdf/CoreElements.pdf.

IG: Read the definition aloud and ask if the participants have questions about the concept.

Slide 12

What are the goals of CIT?

- Improve officer and consumer safety
  - Immediacy of response
  - In-depth training
  - Team approach
  - Change police procedures
- Redirect people with mental illness from the judicial system to the health care system
  - Single point of entry
  - No clinical barriers
  - Minimal officer turnaround time

IG: Emphasize these two main goals of CIT: improved safety and alternatives to incarceration.

Slide 13

CIT is about…

CIT is about *systems* and *infrastructure of services*
CIT is about *relationships*
CIT is about *community engagement*
CIT is about *partnerships*
CIT is about *advocacy*
CIT is about *leadership*
CIT is about *empathy*
CIT is about *you*

PG: CIT is about systems and infrastructure of services. How can we improve the way we do business? CIT is about figuring out how existing systems and resources can work together differently to provide effective responses to crisis situations, needed care for people with mental illness, advocacy and support for families.

1. CIT is about systems and infrastructure of services. How can we improve the way we do business? CIT is about figuring out how existing systems and resources can work together differently to provide effective responses to crisis situations, needed care for people with mental illness, advocacy and support for families.
2. CIT is about relationships. How can we build and maintain productive problem solving relationships with key partners? What problem solving strategies work best in your community?
3. CIT is about community empowerment. How can we empower the community to engage in problem solving with us? What are our community outreach strategies? Are they effective?

4. CIT is about partnerships. How can we build partnerships? How can we maintain those partnerships over time? We rely upon the following definition of partnership: A partnership is a cooperative relationship between two or more organizations to achieve some common goal.
5. CIT is about advocacy. How can we effectively work with advocates for people with mental illness in our community? It is important to acknowledge that our goals are the same: we want everyone to be safe and we want people to be able to access the care they need.
6. CIT is about leadership. How can we lead by example through our innovative CIT initiatives? YOU are a leader in your community. Your involvement in your community's crisis intervention team is an important demonstration of your leadership!
7. CIT is about empathy. How can we build trust with our community by displaying our human emotions? We rely on the following definition of empathy: Empathy is a human condition and part of being a great law enforcement officer is to draw upon your humanity. CIT is about understanding, caring, and patience.
8. CIT is about YOU – and your commitment to the concept. Trained CIT officers play a key role in a given community's CIT program success. Your problem-solving attitude and dedication to assisting people with mental illness is critical. We hope that you take what you learn this week and run with it in order to make your community a safer and better place for everyone to live.

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Module 2 | Research and Systems: CIT Overview Administration Page

Duration: 40 minutes | 8:30 am – 10:00 am

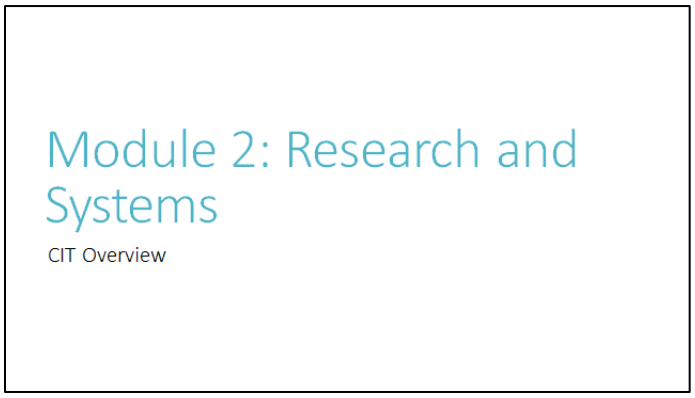
Scope Statement: CIT has a track record of safe intervention with persons experiencing a mental health crisis. Nationally, CIT officers are recognized to have the empathy and technical skills necessary to successfully resolve a mental health crisis. CIT has been recognized as a best practice model by multiple organizations including NAMI (National Alliance on Mental Illness), American Association of Suicidology, National Association of People of Color Against Suicide, Department of Justice, Substance Abuse and Mental Health Services Administration (SAMHSA), The White House Conference on Mental Health, and the John Jay College of Criminal Justice. CIT officers effectively divert persons in mental health crisis away from jail and into appropriate mental health settings. CIT has proven to be a potent agent for overcoming the negative stereotypes and stigma associated with mental illness.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Explain the background of the problem at hand.
- Describe the Memphis Model of Crisis Intervention Teams
- Describe the importance of community involvement and jail diversion.

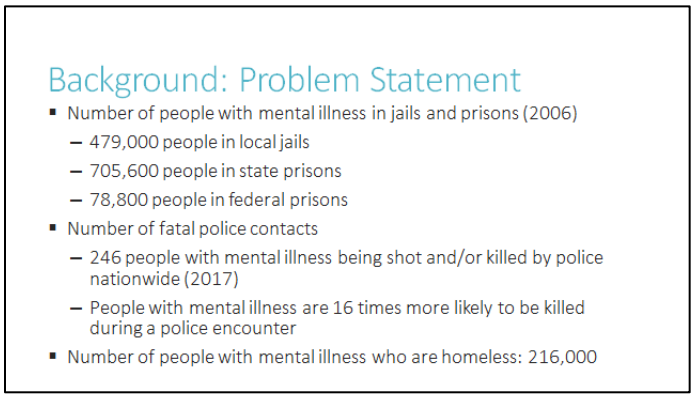
Instructor/Participant Notes: [blank for notes]

Slide 14



PG: CIT has a track record of safe intervention with persons experiencing a mental health crisis. Nationally, CIT officers are recognized to have the empathy and technical skills necessary to successfully resolve a mental health crisis. CIT has been recognized as a best practice model by multiple organizations including NAMI (National Alliance on Mental Illness), American Association of Suicidology, National Association of People of Color Against Suicide, Department of Justice, Substance Abuse and Mental Health Services Administration, The White House Conference on Mental Health (SAMHSA), and the John Jay College of Criminal Justice. CIT officers effectively divert persons in mental health crisis away from jail and into appropriate mental health settings. CIT has proven to be a potent agent for overcoming the negative stereotypes and stigma associated with mental illness.

Slide 15



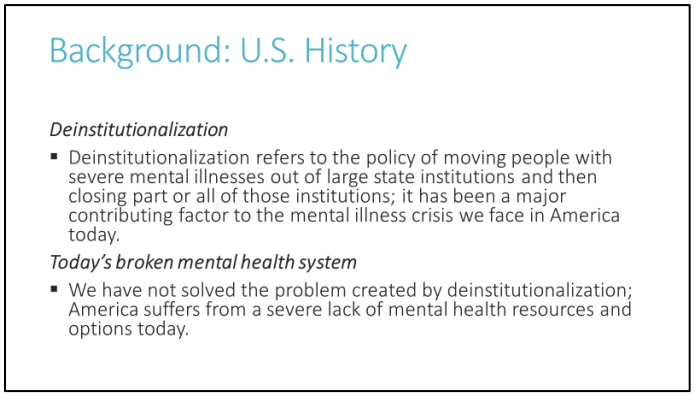
IG: Lead a brief discussion about these background facts – ask whether these are surprising to the officers in the room. [Please include updated numbers on this slide as reliable and more recent sources become available.]

PG: Understanding how we got where we are is challenging, but it informs how we move forward. Here are some facts to consider, by way of outlining these problems as they currently exist:

- In a 2006 special report, the Bureau of Justice Statistics (BJS) estimated that 705,600 mentally ill adults were incarcerated in state prisons, 78,800 in federal prisons and 479,900 in local jails. Source: http://www.bjs.gov/content/pub/pdf/mhppji.pdf.
- According to an ongoing *Washington Post* database, police shot and killed 246 people with signs of mental illness in 2017.
  Source: https://www.washingtonpost.com/graphics/national/police-shootings-2017/
- People with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement, according to a new study released today by the Treatment Advocacy Center. Source: http://www.tacreports.org/overlooked-undercounted
- People with untreated serious mental illness comprise approximately one-third of the total homeless population, and an even higher percentage among homeless women and among individuals who are chronically homeless. A 2010 HUD survey of the homeless reported that they numbered 649,917. Assuming that one-third have a serious mental illness, they would total approximately 216,000 individuals. Source: http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how%20many%20individuals%20with%20a%20serious%20mental%20illness%20are%20homeless%20final.pdf

IG: Lead a brief discussion about these background facts – ask whether these are surprising to the officers in the room. [Please include updated numbers on this slide as reliable and more recent sources become available.]

Slide 16

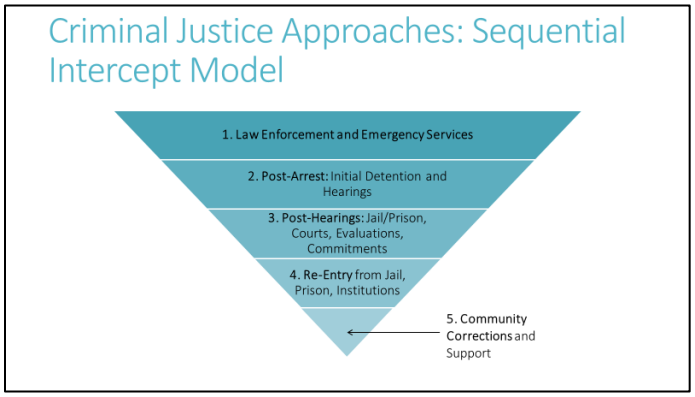


PG: The history of deinstitutionalization falls into several stages as policies and objectives have changed over time. The early focus was on moving individuals out of state public mental hospitals: from 1955 to 1980, the resident population in those facilities fell from 559,000 to 154,000. Only later was there a focus on improving and expanding the range of services and supports for those now in the community, in recognition that medical treatment was insufficient to sustain community residence. In the 1990s, institutions began to close in significant numbers and there was a greater emphasis on rights that secured community integration – such as access to housing and jobs.

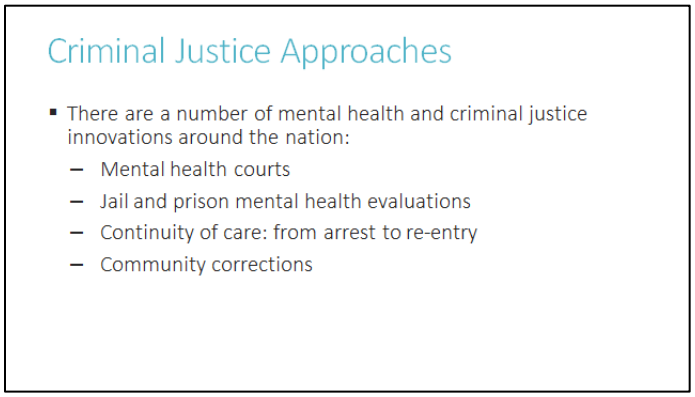
Source: Koyangi, Chris. 2007. "Learning From History: Deinstitutionalization of People with Mental Illness as Precursor to Long Term Care Reform." Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7684.pdf

IG: Lead a brief discussion about the history of deinstitutionalization and how it affects the roles of police officers in America today.

Slide 17



Slide 18



PG: Mental health court (definition): Mental health courts are a type of problem-solving court that combine judicial supervision with community mental health treatment and other support services in order to reduce criminal activity and improve the quality of life of participants. The first mental health court was established in Florida in 1997, with California implementing its first mental health courts in 1999. Mental health courts are established to make more effective use of limited criminal justice and mental health resources, to connect individuals to treatment and other social services in the community, to improve outcomes for offenders with mental illness in the criminal justice system, to respond to public safety concerns, and to address jail overcrowding and the disproportionate number of people with mental illness in the criminal justice system. Source: California Courts. Available at: http://www.courts.ca.gov/5982.htm

Jail and prison mental health evaluations (definition): Identifying entering inmates'

mental health needs when they first enter an institution is critical to providing necessary services and enhancing safety in corrections settings. Many serious mental illnesses are chronic and are subject to exacerbation and relapse. The stress of incarceration can worsen symptoms in persons with preexisting mental disorders, leading to acute psychiatric disturbances, including harm to self or others; inmates with histories of severe mental illness may present an even greater risk. Prisons and jails have a substantial legal obligation to provide health and mental health care for inmates. Still, screening procedures are highly variable; they may consist of anything from one or two questions about previous treatment to a detailed, structured mental status examination. Source: National Institute of Justice, U.S. Department of Justice. Available here: https://www.ncjrs.gov/pdffiles1/nij/216152.pdf

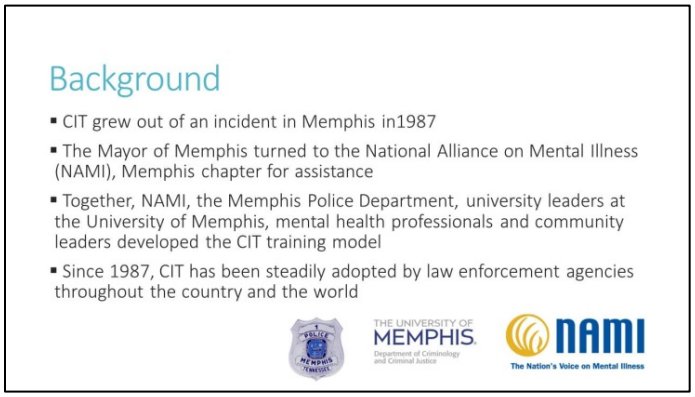
Continuity of care: from arrest to reentry (definition): Almost all jail inmates with mental illness will leave correctional settings and return to the community. Inadequate transition planning puts jail inmates who entered the jail in a state of crisis back on the streets in the middle of the same crisis. Outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, hospitalization, relapse to substance abuse, suicide, homelessness, and re-arrest. Planning for the continuity of care from arrest to reentry helps to minimize those increases. Source: Osher, Steadman & Barr. 2003. Available here: https://www.namiut.org/images/stories/Re-Entry.pdf

Community corrections (definition): The supervision of criminal offenders in the resident population, as opposed to confining offenders in secure correctional facilities. The two main types of community corrections supervision are probation and parole. Community corrections is also referred to as “community supervision.”

Source: Bureau of Justice Statistics, U.S. Department of Justice. “Terms & Definitions: Corrections.” Available here: http://www.bjs.gov/index.cfm?ty=tdtpandtid=1

IG: Talk through local examples of each. Please craft a local overview of these topics for inclusion in the Participant Guide.

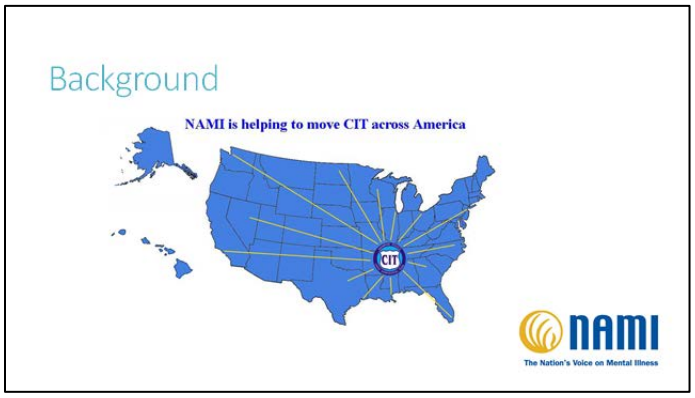
Slide 19



PG: In 1987 police officers were called to a public housing complex in Memphis, Tennessee where a young man was threatening people with a knife. When police officers ordered him to put down the knife, he refused. The officers eventually opened fire and the young man died of multiple gunshot wounds. The man had a history of mental illness. He was black and the officers were white. Many citizens raised their voices in angry protest against the officers with cries of racism and police brutality. Calmer voices prevailed, calling for the community to develop a better way to intervene with individuals in mental health crisis. The mayor of Memphis turned to local advocates from NAMI and enlisted police, community mental health professionals, university leaders, hospital administrators, and church officials to seek a new approach to working with persons with mental illness in crisis.

IG: Briefly explain the background and history of CIT's development.

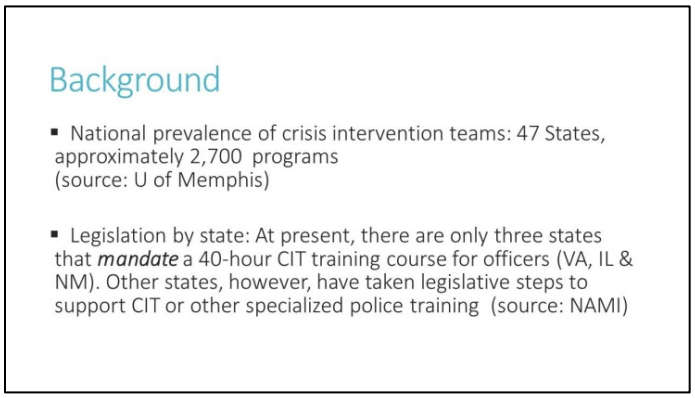
Slide 20



PG: NAMI has been highly active in supporting the expansion of CIT to new communities and jurisdictions. NAMI was one of the original partners in the creation of the CIT Model and has been instrumental in spreading the concept throughout the nation.

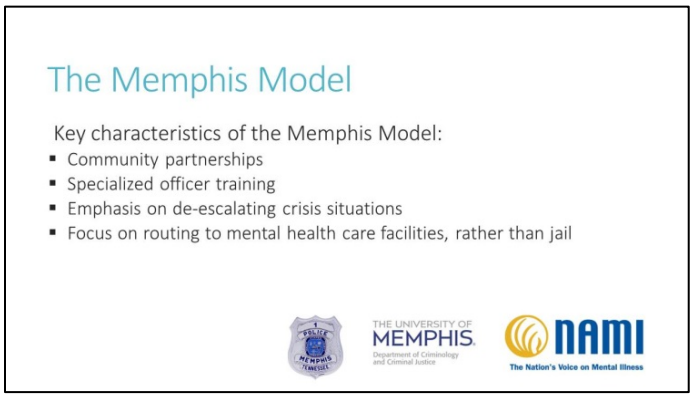
IG: If you have internet access, you may access www.nami.org to review the home screen.

Slide 21



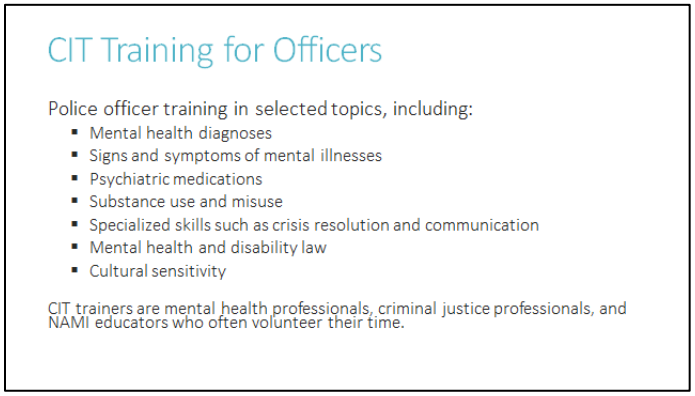
IG: Please double check for the most current facts and statistics for this slide and update this slide as necessary.

Slide 22



PG: The originators of CIT combined several insights that revolutionized how individuals with mental illness in crisis would be approached by police officers and effectively routed to appropriate mental health care facilities rather than jail. The CIT pioneers envisioned a team of uniformed patrol officers selected for specialized training in basic crisis intervention. The officers would be spread throughout the city on all shifts. These officers would perform the usual duties of uniformed patrol officers but would be available for immediate dispatch to mental health crisis scenes. Arriving without delay, CIT officers would be able to de-escalate the crisis, decreasing the likelihood of violence and injury to patients, family members, neighbors and police officers. With assistance from other police officers, the CIT officer would assess the individual in crisis and make the decision whether or not to transport a patient for further evaluation. The receiving facility would offer a single point of entry with referrals to resources such as community mental health services, social services and veteran's services.
IG: Explain the key characteristics of CIT and lead a brief discussion about them using the text in the PG as a guide.

Slide 23



PG: The topics listed on this slide are all things you will learn about this week during our CIT

course. Our goal is for you to come away with an understanding of each, and how you can apply your new knowledge to your every-day job.

IG: Tell class participants that the topics listed here are things that they will learn about this week.

Slide 24

PG: As the Crisis Intervention Team concept was implemented, it became clear that CIT decreased the likelihood of an individual with mental illness ending up in the criminal justice system. CIT also increased the chances of an appropriate health care referral. Thus, the CIT program has an important side effect of jail diversion. These two outcomes of crisis response and appropriate health care referral are part of the CIT intervention strategy.

Sources: Dupont and Cochran, 2000. "Police response to mental health emergencies--barriers to change." Available here: https://www.ncbi.nlm.nih.gov/pubmed/11055533
Compton, Bahora, Watson and Oliva, 2008. "A Comprehensive Review of Extant Research on Crisis Intervention Team (CIT) Programs. Available here: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.562.4881&rep=rep1&type=pdf

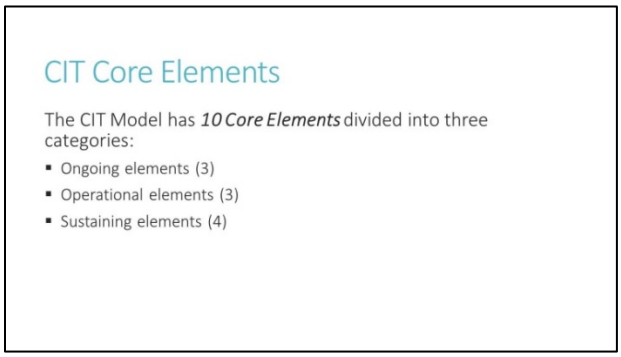
IG: It may be helpful to cite some local examples and/or success stories here.

Slide 25

PG: As the CIT model spread through other cities, a steering group composed of leaders from CIT programs developed a document to identify the core elements of a CIT model. This document recognizes the importance of community involvement in maintaining CIT programs. Steering groups, in newly developing CIT programs, are critical to success of the CIT model. The group provides a forum for the partnerships, networking and eventual community ownership. In Memphis, and in most of the CIT programs throughout the country, the steering groups take on the role of advocacy for the various components of the crisis intervention system, often obtaining significant funding for critical components of the psychiatric emergency system and other community-based mental health efforts. The steering group also allows for communication around clinical issues which can, in turn, develop into formal case conferences focusing on individuals at high risk of recidivism. The efforts of the Memphis founders of CIT led to a network of over 2,700 CIT sites throughout the nation. CIT International, a non-profit organization that was founded in 2009, promotes learning among CIT programs internationally and hosts an annual conference. The success of CIT throughout the world is a testimony to the grassroots support generated to help those struggling with mental illness and the leadership provided by those determined to make a difference in their community.

IG: It may be helpful to talk about the CIT steering groups and/or CIT coordinators already in place in this jurisdiction or bring up examples from neighboring jurisdictions.

Slide 26



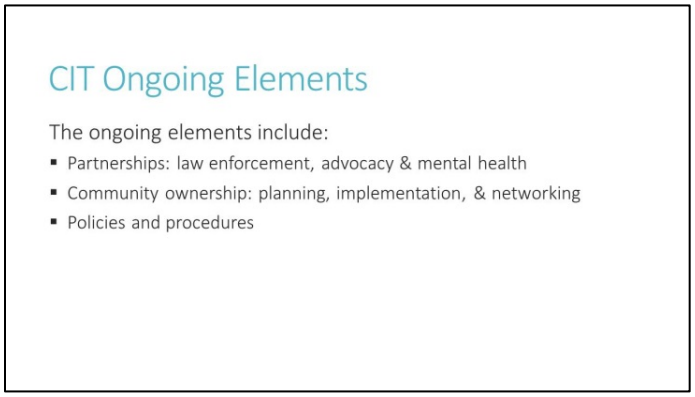
PG: The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. CIT provides law enforcement-based crisis intervention training for assisting those individuals with mental illness, and improves the safety of patrol officers, people with mental illness (commonly referred to as consumers by professionals in the mental health field), family members and residents within the community.

CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with mental illness. The CIT Model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice system and mental health care system and creates the context for sustainable change.

In order for a CIT program to be successful, several critical core elements should be present. CIT Model has ten "Core Elements," divided into three categories: *Ongoing Elements, Operational Elements*, and *Sustaining Elements,* which are explained in detail in this module.

IG: Be sure to distribute the "CIT Core Elements" handout to participants.

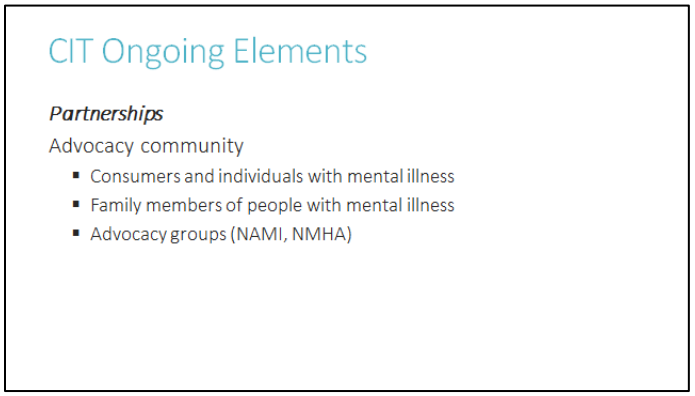
Slide 27



Slide 28

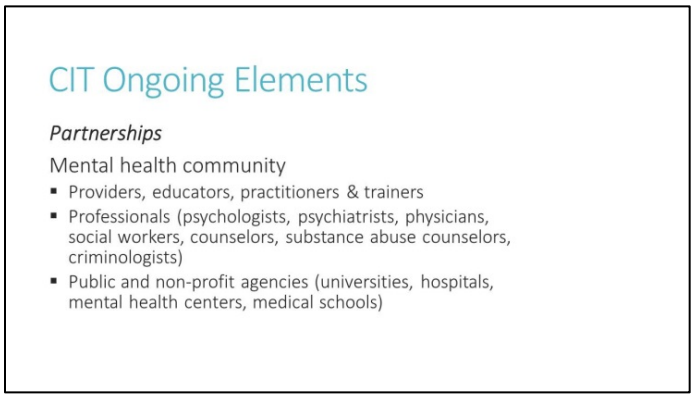
PG: Central to the formation and success of CIT is the role of the law enforcement community. Trained CIT officers handle crisis situations using strategic techniques that improve the safety of the officer, consumer, and family members. In addition, the law enforcement community is able to provide care and help to consumers by transporting individuals in need of special treatment to appropriate facilities. It is also critical that law enforcement representatives participate in the formation of CIT and engage in elements of the planning and implementation stages.

Slide 29



PG: Participation from the advocacy community is critical to the success of CIT. This partnership provides strong support from passionate and dedicated people whose shared goal is to improve the quality of life for individuals with mental illness and their loved ones. Leadership roles should develop to provide voice to the ideas and concerns of consumers and family members. This aspect of CIT brings the program to life by adding insight from those directly affected. This important partnership should be established early in the planning process and should continue as an ongoing operational element of CIT.

Slide 30

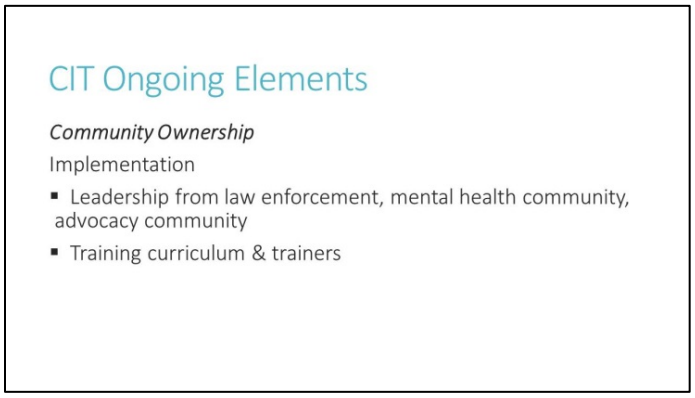


PG: The mental health community plays an important role in the successful development, implementation, and ongoing sustainability of CIT. The mental health community provides treatment, education and training; this partnership is essential to maintaining access to the health care system and to quality treatment.

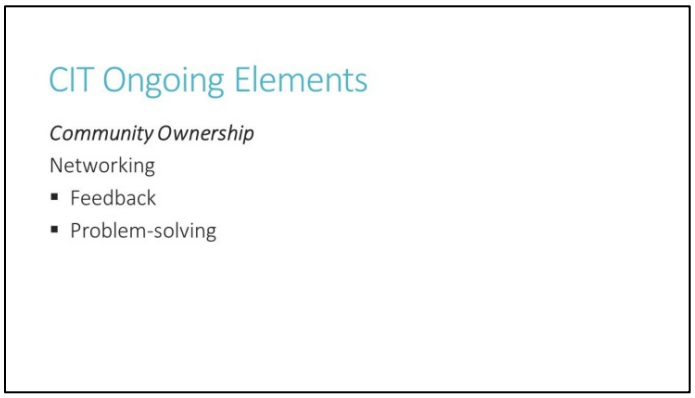
Slide 31

PG: Communities both large and small are seeking solutions to crisis issues and situations. Community collaborations and partnerships are essential to this effort. Additionally, it is important to establish community ownership, which refers to the dedicated investment that individuals within the community have in the CIT program. Individuals and organizations must have a stake in the initial planning stages, the implementation of the CIT program and its training curriculum, and ongoing feedback in order to maintain, improve, and ensure the success of CIT. Local professionals and agencies who donate their time to assist in training the patrol officers help to increase the sense of community ownership for CIT.

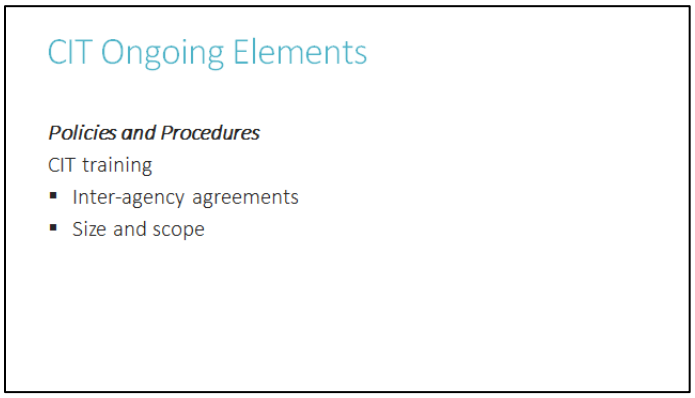
Slide 32



Slide 33



Slide 34

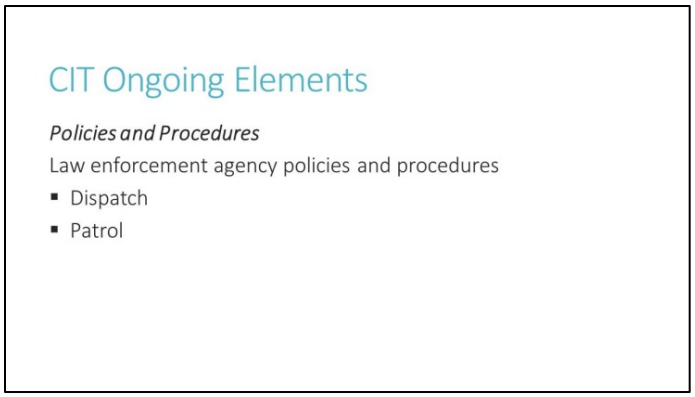


PG: Policies and procedures are necessary components of CIT. They provide a set of guidelines that direct the actions of both law enforcement and mental health officials. Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all involved. Within the law enforcement community, policies exist to provide guidance on how to properly transport consumers, how to develop inter-agency agreements, how emergency dispatchers handle calls, and how patrol officers respond to calls for service. Within the mental health community, policies exist to provide guidance on how to handle referrals from CIT officers.

The number of trained CIT officers available on any shift should be adequate to meet the demand load of the local consumer community. Experience shows that law enforcement agencies with successful CIT programs have about 20-25 percent of the agency's patrol division CIT-trained. Ultimately, the goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available at all times.

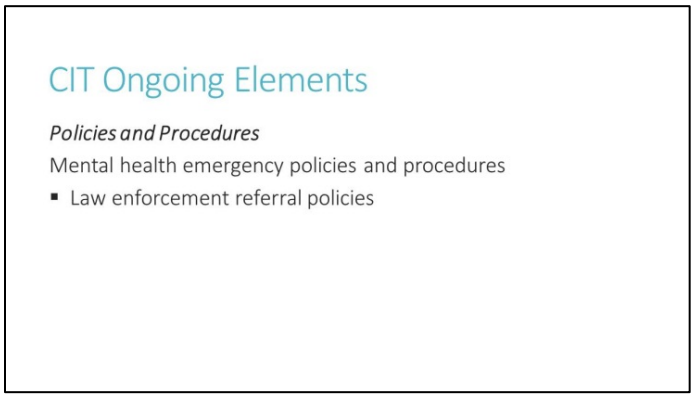
Likewise, call-takers and dispatchers should be trained to appropriately elicit sufficient information to identify a mental health-related crisis.

Slide 35



PG: The nearest CIT officer should be identified and dispatched to the crisis event. Policies that maximize an officer's discretion are critical. In addition, a policy should outline how to identify a lead CIT officer, should more than one officer be present at the scene. The lead CIT officer should guide the resolution of the crisis event.

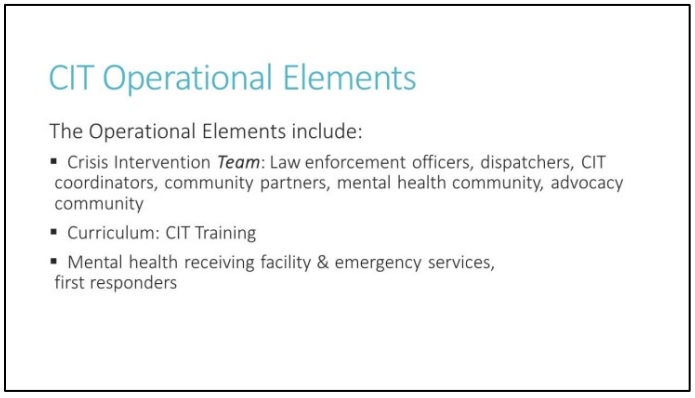
Slide 36



PG: Policies and procedures are a necessary component of CIT. They provide a set of guidelines that direct the actions of both law enforcement and mental health officials. Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all those affected. Within the law enforcement community, policies exist in order to provide guidelines regarding how to properly transport consumers and how to develop an infrastructure through a system of partnerships and inter-agency agreements. These law enforcement policies address the actions of both emergency dispatchers and CIT patrol officers. Emergency dispatchers identify the nearest available CIT officer to respond to the crisis. The CIT officer then responds to the crisis event and leads the intervention. CIT officers should be allowed to integrate the entire range of their law enforcement training when handling CIT calls. Within the mental health community, policies exist in order to provide guidelines regarding how to handle referrals from CIT officers. The mental health community also plays a key role in training and feedback for the CIT program. The role of the advocacy community in policies and procedures is often more informal but involves the critical elements of networking and feedback for the overall program.

The policies in place should allow for a wide range of inpatient and outpatient referral sources in order to accommodate law enforcement agencies with a CIT program. Barriers that prevent officers from accessing immediate mental healthcare for an individual with mental illness should be eliminated. In addition, policies should strive to ensure minimal turnaround time for CIT officers, so that it is less than or equivalent to the turnaround time for jail.

Slide 37



Slide 38

PG: Individuals within the law enforcement community primarily consist of CIT Officers, Dispatchers, and a CIT Coordinator. The following core element addresses the personnel required to effectively operate a CIT program.

CIT Officer: Officers within a patrol division should voluntarily apply for CIT positions. Each candidate then goes through a selection process, which is assessed according to the officer's application, recommendations, personal disciplinary police file, and an interview. Once selected, each of the CIT Officers maintains their role as a patrol officer and gains new duties and skills through the CIT training, serving as the designated responder and lead officer in mental health crisis events.

Dispatch: Emergency dispatchers are a critical link in the CIT program and may include call takers, dispatchers, and 911 operators. The success of CIT depends on their familiarity with the CIT program, knowledge of how to recognize a CIT call involving a behavioral crisis event, and the appropriate questions to ask in order to ascertain information from the caller that will help the responding CIT Officer. Finally, dispatchers should know how to appropriately dispatch a CIT Officer. Dispatchers should receive training courses (a minimum of 8-16 hours) in CIT and additional advanced in-service training.

CIT Law Enforcement Coordinator: The CIT coordinator is part of the law enforcement community and acts as a liaison by maintaining partnerships with program stakeholders in order to ensure the success of CIT. The coordinator's involvement with CIT should start from the beginning and continue through the planning, implementation, and evaluation stages. The CIT coordinator provides support to CIT officers through training and feedback. The qualifications should include leadership ability and experience as a law enforcement officer. The job responsibilities include program development, training coordination, and maintenance of relationships with community partnership. The CIT coordinator also is a point of contact with the law enforcement agency for the community and brings stability to the program.

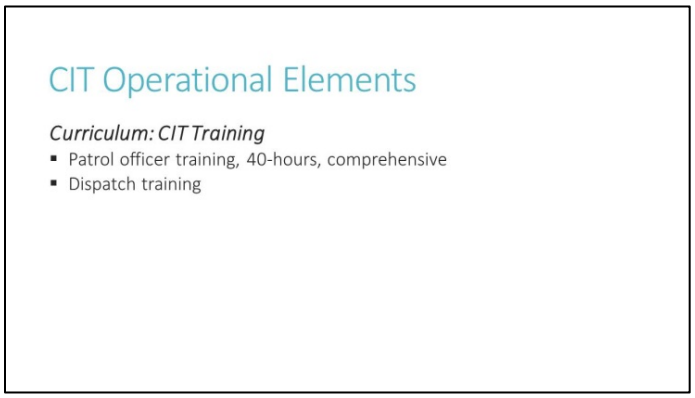
Mental Health Coordinator: The mental health coordinator is part of the mental health community who provides leadership and serves as a liaison with the advocacy and law enforcement communities. This position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is

important that each of them work with the overall community effort. This position has a significant operational component involving the training, curriculum and the function of the receiving facility or receiving facilities.

Advocacy Coordinator: The advocacy coordinator is part of the advocacy community, which includes advocates, family members, and individuals with mental illness. As with the mental health coordinator, the position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is important each of them work with the overall community effort. This position often involves the operational components such as training, curriculum and ongoing problem solving.

Program Coordinator: Multi-agency CIT programs may have a need for a Program Coordinator who is largely responsible for the day to day logistics of inter-departmental communication, data collection and management, records keeping and scheduling training. This person should be familiar with the roles of three primary components of the CIT program and comfortable and effective in communicating in all three environments. Much of the role of this person will be diplomatic in nature. They may have additional duties in identifying and securing sustaining programmatic resources.

Slide 39



PG: The number of trained CIT officers available to any shift should be adequate to meet the demand load of the local consumer community. Many successful CIT program have trained 20-25 percent of the agency's patrol division; other agencies train higher proportions of their patrol divisions. There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers. Ultimately, the goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available at all times. All dispatchers should be trained to appropriately elicit sufficient information to identify a mental health related crisis.

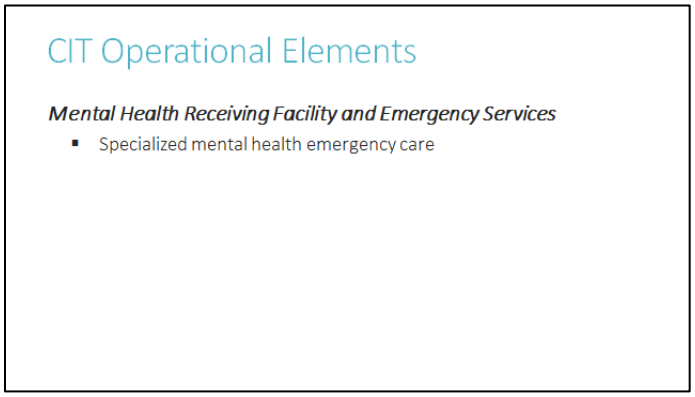
The CIT program is an innovative national model of police-based crisis intervention with community mental health care and advocacy partnerships. Police officers receive intensive training to effectively respond to citizens experiencing a behavioral crisis. Patrol officers already have training and a basic understanding of the pro per safety skills. Officers are encouraged to

maintain these skills throughout the course, while incorporating new communication and interaction techniques to more effectively approach and defuse a crisis situation. It is important that individuals from the mental health, law enforcement, and advocacy communities play a critical role in the training curriculum in order to bring experience, ideas, information, and assistance to the CIT officers in training. Additionally, all training faculty are encouraged to complete the 40-hour comprehensive course and participate in a ride-along in order to fully understand the complexities and differences that exist between mental health care and law enforcement.

Patrol Office Training: 40-hour comprehensive training: The 40-hour comprehensive training emphasizes mental health-related topics, crisis resolution skills, skills-based training, and access to community-based services. The format of a 40-hour course consists of basics/lectures, on-site visitation and exposure to several mental health facilities, intensive interaction with individuals with a mental illness, and scenario-based skill training. Experience has shown this is a minimum level of training hours. The material covered is complex, as desired learning outcomes go beyond simple cognitive retention of material. The outcome desired is the retention of behavioral changes learned as part of the training.

Dispatch Training: All dispatchers receive a specialized course detailing the structure of CIT. The training course also addresses how to properly receive and dispatch calls involving individuals with a mental illness and crisis situations. Additional and advanced in-service training courses should also be incorporated.

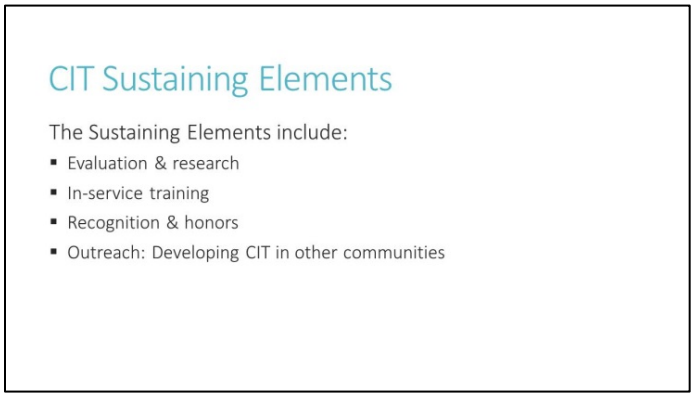
Slide 40



PG: A designated emergency mental health receiving facility is a critical aspect of the CIT model. It provides a source of emergency entry for consumers into the mental health system. To ensure CIT's success, the emergency mental health receiving facility must provide CIT officers with minimal turnaround time and be comparable to the criminal justice system. The facility should accept all referrals regardless of diagnosis or financial status. Additionally, the facility will need access to a wide range of emergency health care services and disposition options, such as alcohol and drug emergency services. Finally, the emergency mental health receiving facility is part of the operations of the CIT model that provides feedback and engages in problem-solving

with the other community partners, such as law enforcement and advocacy communities.

Slide 41



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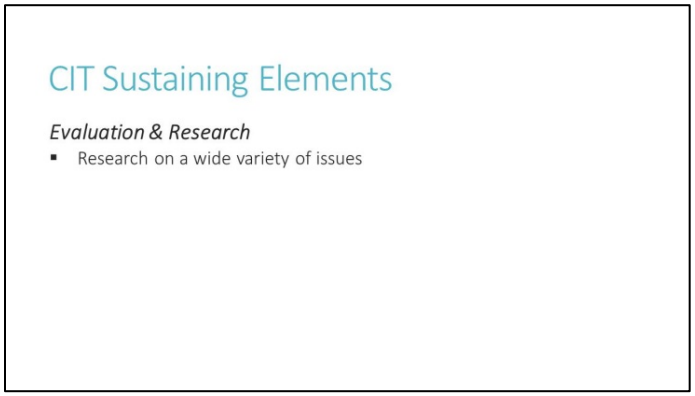


PG: Evaluation and research can help measure the impact, continuous outcomes, and efficiency of a community's CIT program. More specifically, it may help to identify whether the program is achieving its objectives and should be an ongoing part of CIT. Outcome research has shown CIT to be effective in developing positive perceptions and increased confidence among police officers; providing very efficient crisis response times; increasing jail diversion among those with a mental illness; improving the likelihood of treatment continuity with community-based providers; and impacting psychiatric symptomatology for those suffering from a serious mental illness, as well as substance abuse disorders. This is to be accomplished while significantly decreasing police officer injury rates. The following components are being studied within CIT, some currently and others in the planning stages of evaluation.

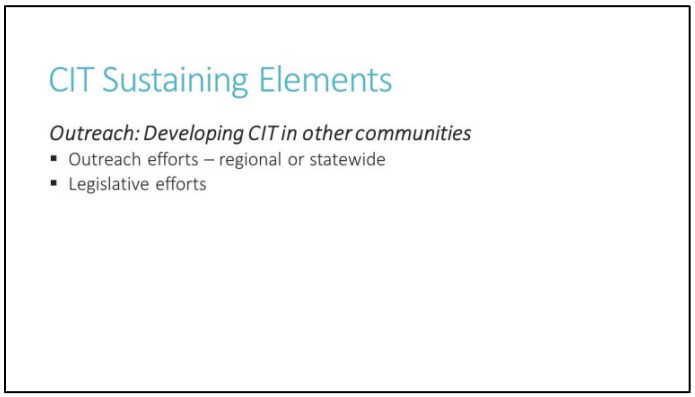
Slide 43

PG: In-service training provides CIT officers with additional knowledge and skills. In-service trainings should be offered regularly for current CIT officers who have completed the 40-hour comprehensive crisis response training course.

Slide 44

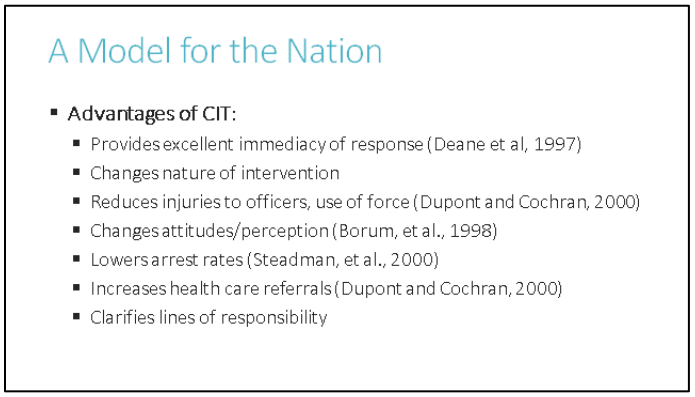
PG: Recognizing and honoring CIT officers provides a sense of accomplishment and ownership toward the program. It also gives officers an incentive to continue in their line of work. Recognition and honors can be awarded through local media, newsletters, program websites, or annual banquets. Such honors should be given to CIT Officers who have served the community in crisis situations with exceptional care and compassion, while ensuring the safety of themselves and others.

Slide 45



PG: Developing CIT programs in other communities, through partnerships and outreach efforts, will help to ensure that individuals who suffer from a mental illness receive the proper care needed, while increasing the safety of the community, patrol officers, family members, and consumers.

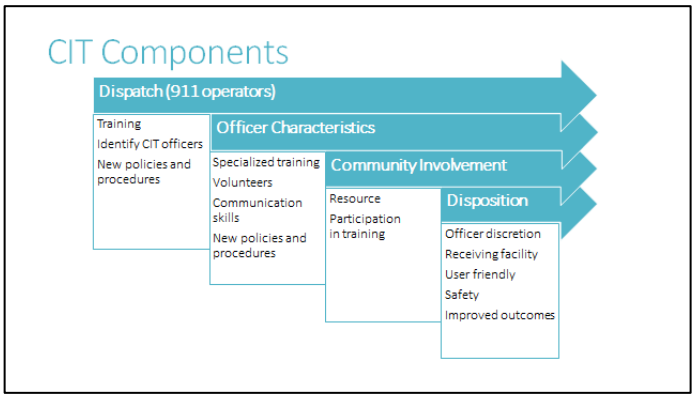
Slide 46



PG: CIT has produced many advantages for communities and many have been researched by academics and other trained researchers. Some of the findings include reductions in injuries and use of force and increases in health care referrals.

IG: See: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/ for updated research to include on this slide.

Slide 47



PG: CIT is an integrated approach for law enforcement agencies to operationalize within their organizations which includes: training for dispatchers to assist them in identifying crisis calls; training for officers to assist them with responding to crisis calls; community involvement; and finally, outcomes.

Slide 48

PG: CIT looks somewhat different depending on how agencies implement their programs. Some agencies have implemented co-responder models, such as the example in this video.

Video may be found at https://www.youtube.com/watch?v=R-MmPVSGcnM.

IG: Lead a discussion about ways in which communities and police can work together to solve problems. What types of CIT models have you seen in neighboring departments?

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Module 3 | Community Support: Mental Health and Cultural Awareness Administration Page

Duration: 1 hour | 10:00 am – 11:00 am

Scope Statement: This module will challenge participants to think about the communities they interact with every day in light of advocacy, cultural awareness and diversity topics.

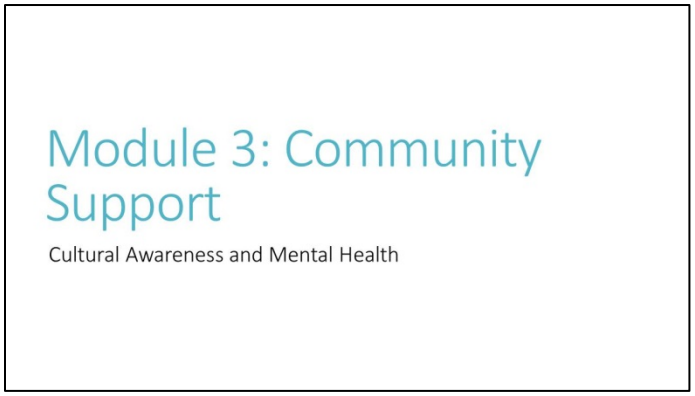
Student Learning Objectives:
Upon completing this module, students will be able to:

- Discuss culture in the context of mental health.
- Discuss the application of cultural competence skills in crisis situations.
- Explain the importance of cultural competence, cultural sensitivity and cultural awareness.
- Understand your own identify and how it helps shape your communication styles, values, beliefs, and behaviors.

[NOTE: We recommend bringing in a local community leader to discuss the intersections between culture and mental health. The slides in this module are optional, and may be replaced by a guest speaker or modified by a local expert, as appropriate.]

Instructor/Participant Notes: [blank for notes]

Slide 49



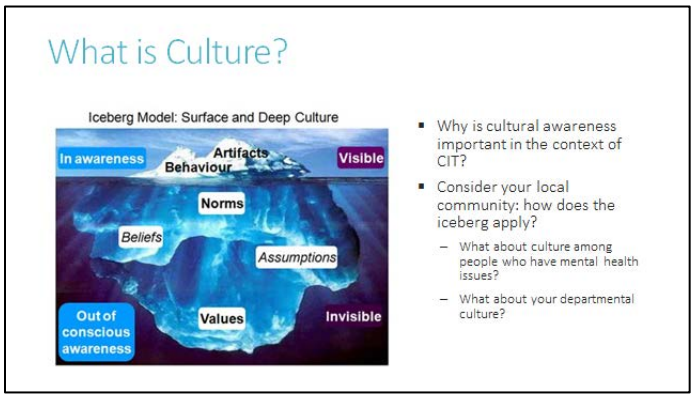
Slide 50

PG: What does culture mean to you?

Culture includes: integrated patterns of human behavior; thoughts; communications; actions; customs; beliefs; values; and institutions of racial, ethnic, religious or social groups. It also includes country of origin; language; gender; age; class; sexual orientation; gender identity; physical disabilities; mental health considerations.

IG: Lead a brief discussion about culture and ask whether this definition resonates with the participants. What is this definition missing, if anything?

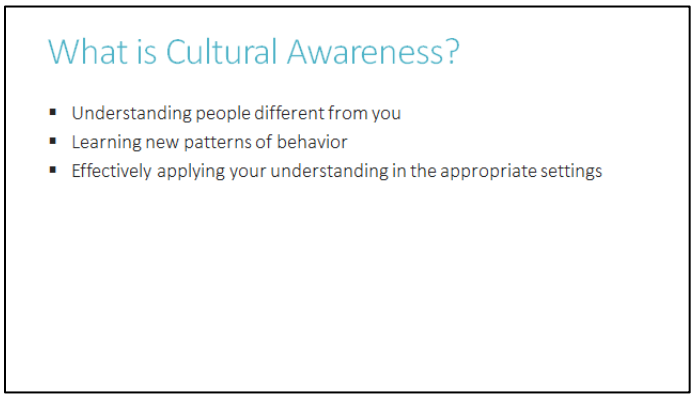
Slide 51



IG: Continue the conversation about culture and ask why this conversation is important to police interactions with people with mental illness. As you facilitate, remember that the goal is to dive into how culture affects a person (or that of a family, group, or an organization) perceptions of mental health and wellness. Consider the following questions:

- What cultural aspects might lead a person to be more (or less) responsive to mental health services or assistance from law enforcement?
- What are the norms, beliefs, assumptions, and values held by the community or the department related to mental health and wellness?
- What role does law enforcement play in shaping these norms, beliefs, assumptions, and values?
- In what ways might a person's behavior be at odds with their underlying beliefs or values?
- When discussing cultural awareness in the context of mental health, do perceptions or behaviors differ when thinking about one self and others?
- How would people describe law enforcement culture about mental health? This department's culture about mental health? Does departmental culture impact interactions with the community or help shape the community culture?

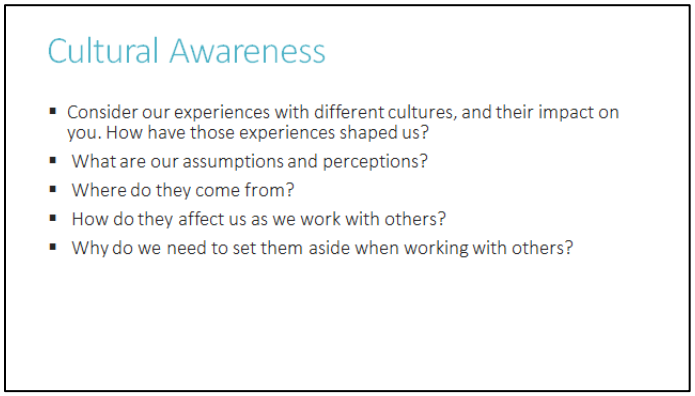
Slide 52



PG: Cultural awareness helps law enforcement interact with citizens and peers throughout their professional career. Interacting with people experiencing a mental health crisis may require a higher level of cultural awareness. Cultural awareness helps us to respond to a person in the most effective manner and is specific to the cultural needs of the individual in crisis. Demonstrating cultural awareness helps to build trust, which is vital during crisis situations.

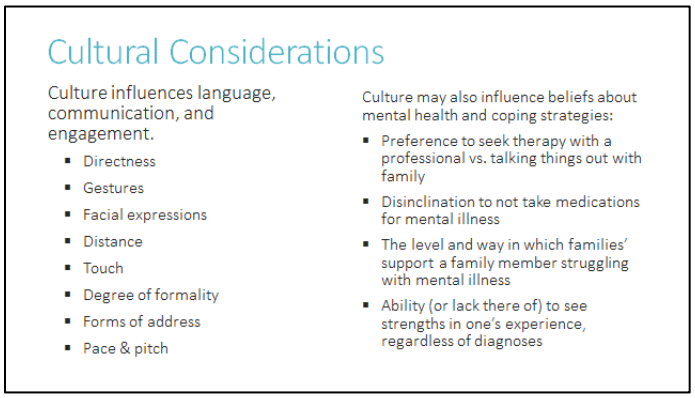
IG: Ask, "Why is being culturally aware important for you as law enforcement officers? What does this discussion have to do with mental health and CIT?"

Slide 53



IG: Lead a brief conversation about cultural awareness, bias, and how we are shaped by our experiences.

Slide 54



IG: Lead a brief discussion about participants' experiences with cultural considerations, perhaps during domestic violence calls. Discuss the types of cultural considerations with which participants are familiar.

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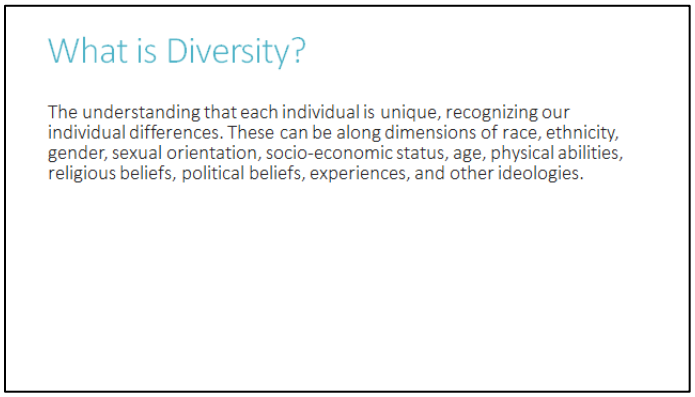
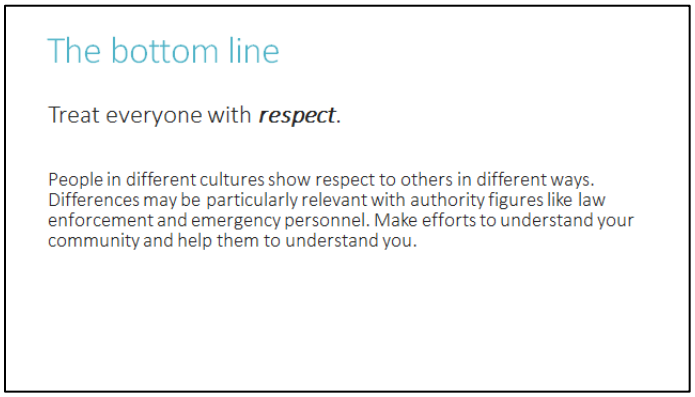


IG: Ask whether participants understand and agree with this definition. Is anything missing?

Slide 56



IG: Lead a brief discussion about respect. What does respect mean to the course participants?

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Module 4 | Mental Health Basics: Depressive Disorders Administration Page

Duration: 1 hour | 11:00 am – 12:00 pm

Scope Statement: This module will introduce participants to depressive disorders and their symptoms. This module includes an audio story for discussion and ends with a case study of Sarah, a 16-year-old, for discussion.

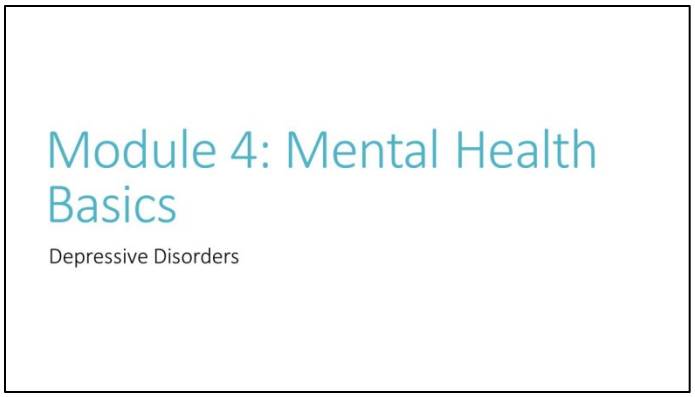
Student Learning Objectives:
Upon completing this module, students will be able to:

- Provide a general definition of depressive disorders;
- Describe some symptoms of depressive disorders; and
- Describe some behaviors that you may see in people with depressive disorders.

[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes: [blank for notes]

Slide 57



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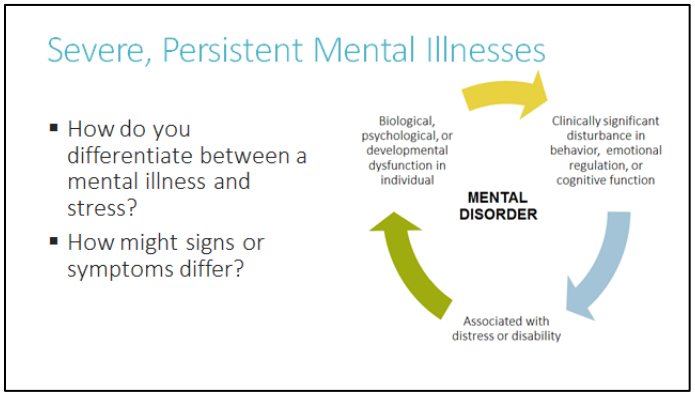
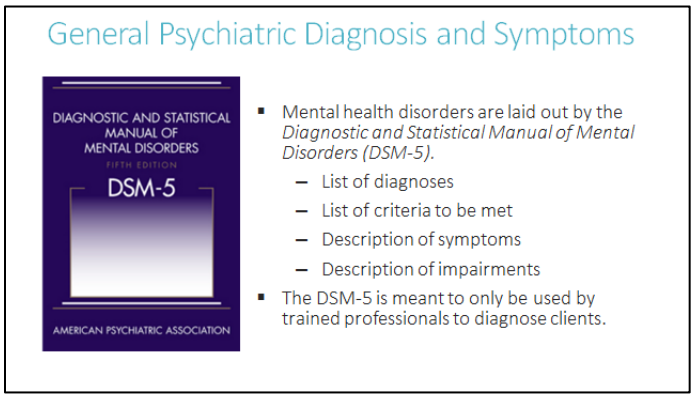


PG: Mental disorders are conceptualized as clinically-significant behavioral or patterns that occur in an individual and that is associated with present distress (e.g., a painful symptoms) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. They are not simply a predictable and culturally sanctioned response to a particular event (e.g., the death of a loved one).

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

Slide 59



PG: The text of *DSM*-5 provides information about each disorder under the following headings:

- Diagnostic Features
- Associated Features Supporting Diagnosis
- Subtypes and/or Specifiers
- Prevalence
- Development and Course
- Risk and Prognostic Factors
- Diagnostic Measures
- Functional Consequences
- Culture-Related Diagnostic Issues
- Gender-Related Diagnostic Issues
- Differential Diagnosis
- Recording Procedures

Symptoms (examples):

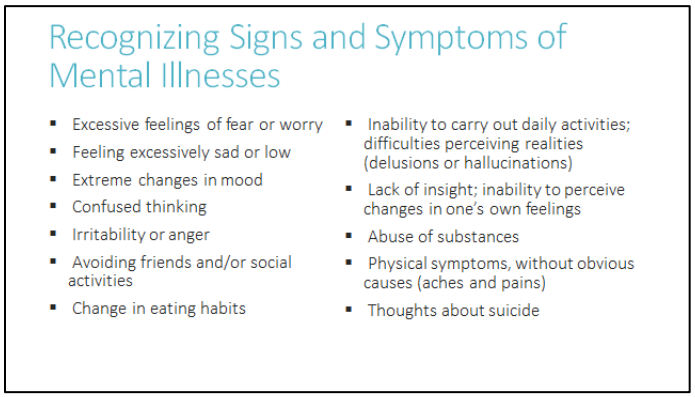
- *Emotional* – feelings such as sadness, anxiety, guilt, anger, mood swings, helplessness, hopelessness
- *Psychological* – self-blame, excessive fear and worry, mind racing, lack of concentration, impaired memory, confusion, suicidal thoughts, irritable, anger, restlessness, impatience, changes in emotions, thinking, and behavior
- *Behavioral* – avoidance of things/situations, obsessive or compulsive behaviors, phobias, distress in social situations, loss of motivation, substance abuse, loss of interest in various activities and appearance, worrying, neglect, withdrawal
- *Physical* – Fatigue, lack of energy, sleep (excessive or too little), weight loss or gain, unexplained aches and pains

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

IG: Each diagnosis found in the DSM-5 includes information about a disease; the information

provided in each category varies by diagnosis. Information and diagnostic features will be discussed further in the next few slides.

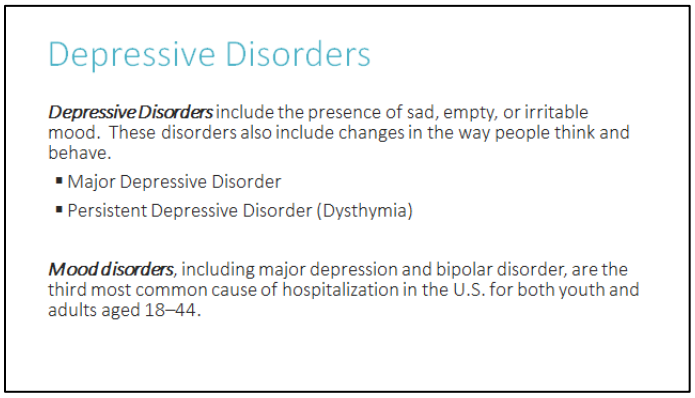
Slide 60



PG: Keep in mind that when mental illness presents in children, the symptoms may tend to be more behavioral because they may not be able to verbalize their thoughts and emotions.

IG: This is the first in a series of modules introducing various mental, intellectual, and developmental disorders. CIT officers should not feel pressure to be able to diagnose or distinguish between similar disorders. The important takeaways for the course participants is for them to recognize signs and symptoms of mental illness when they interact with people so they can adjust their behavior and possibly consider different options.

Slide 61



PG: Depressive disorders are not passing blue moods, but rather depressive disorders are persistent feelings of sadness and worthlessness and lack of desire to engage in formerly pleasurable activities. Depression is a complex mind/body illness and can be treated with drugs and/or therapy.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

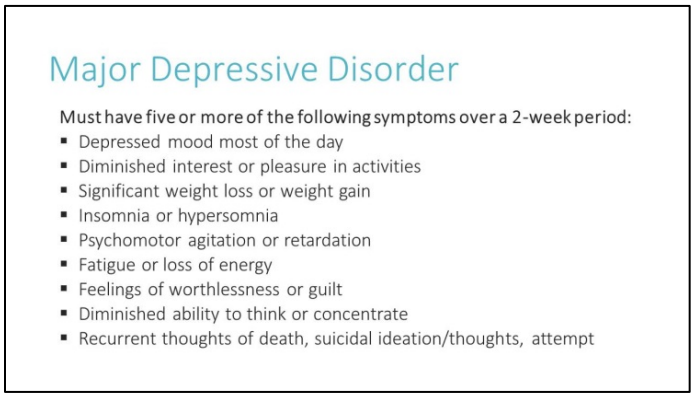
IG: Briefly introduce the two main depressive disorders covered in this module.

Slide 62

Video Title: “Living with Depression”

Video Link: https://www.youtube.com/watch?v=EJ_S5Rjt_iI

Slide 63



PG: This diagnosis requires the person to have five or more symptoms present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either of depressed mood or loss of interest or pleasure.

- The symptoms cause clinically significant distress or impairment in social or occupational functioning
- Symptoms must be present about every day to be considered present
- Insomnia or fatigue are often the presenting complaint
- The possibility of suicidal behavior exits throughout major depressive disorder/episodes.
- The biggest risk factor being a previous history of suicide attempts.

IG**:** Please provide an overview of this disorder and provide examples from your own clinical work.

Slide 64

Depression

Important notes:

- Not everyone who has depression becomes suicidal.
- Major depressive disorder (MDD) impacts social and occupational functioning.
  - MDD is frequently characterized by insomnia and agitation.
- Many people experience depression.
  - One in five Americans may experience a severe depressive episode at any point in time.
  - The ratio of women to men with depression is 2:1. It is believed that depression among men is underreported.
  - It is estimated that about 20 million people in America suffer from a depression severe enough to interfere with their life each year.
    - Depression may lead to substance misuse and eating disorders.
    - The economic impact of depression exceeds $210 billion a year.

Slide 65

Video Title: “Depression Isn’t Always Obvious”

Video Link: https://youtu.be/1Yq6W7YAHM4

Slide 66

Persistent Depressive Disorder (Dysthymia)

- Depression symptoms that are present for most days over a two-year time period
- Cognitive symptoms are more prevalent with dysthymic individuals
- Symptoms include:
  - ✓ *Poor appetite*
  - ✓ *Insomnia or hypersomnia*
  - ✓ *Low self-esteem*
  - ✓ *Hopelessness*
  - ✓ *Low energy*

Slide 67

PG: Link to Audio: http://www.npr.org/sections/health-shots/2016/06/23/481764541/depressed-teen-s-struggle-to-find-mental-health-care-in-rural-california

IG: Ask, "How might people's challenges to find mental health care affect your job?" and lead a short discussion with the class after listening to the audio segment.

Audio Transcript:

AUDIE CORNISH, HOST:

It can be really hard to get help for a mental health condition if you live in a rural part of the country. Insurance companies don't seem to make it any easier. April Dembosky of member station KQED brings us this story of an 18 year old with depression living in far northern California.

APRIL DEMBOSKY, BYLINE: There's a hot pink suitcase on the floor of Shariah Vroman-Nagy's bedroom. She's packing for a trip to Disneyland.

SHARIAH VROMAN-NAGY: Let's see.

DEMBOSKY: There are porcelain dolls and stuffed animals tucked into every corner of the room, and she's got posters and quotes from Marilyn Monroe all over the walls.

VROMAN-NAGY: And then that one - those are the lyrics to a song called "Smile."

DEMBOSKY: They hang in a frame over her bed.

VROMAN-NAGY: My mom made me that when I was struggling because that's a song that I would listen to.

DEMBOSKY: She sings it to herself when she feels her depression creeping in.

VROMAN-NAGY: (Smile) If you smile through your tears and sorrow, smile and maybe tomorrow...

DEMBOSKY: Three years ago, it was in this room where Shariah tried to kill herself. She was a freshman in high school.

VROMAN-NAGY: Everything piled up and piled up and piled up until I just couldn't handle it anymore. So I had my antidepressants, and I took a handful of those. But then I thought better of it, and I told my mom. And she took me to the emergency room.

DEMBOSKY: There's no adolescent psychiatric hospital in Redding. So Shariah was taken from the local ER to a hospital in Sacramento, an hour and a half to the south. She was there eight days, and the doctors diagnosed her with bipolar disorder. They said they wanted to keep her longer, but they told her the insurance company wouldn't cover it.

VROMAN-NAGY: I didn't really feel like I was ready because I had just been put on new medications right when I got there, and I was like in the past I've had reactions to medications.

DEMBOSKY: After Shariah went home. The hospital helped her find a therapist, but the insurance company said no to that, too. They said the therapist wasn't part of their network.

VROMAN-NAGY: We spent quite a long time with the insurance company battling them trying to get them to cover visits with her.

DEMBOSKY: Shariah says the insurer Anthem Blue Cross wanted her to see someone on its list of approved in-network providers. At the time, that list was six people. And when Shariah called them they either said they were full or retired, so she stayed with the out-of-network therapist.

TOM NAGY: It was at that point. I mean, you're talking, you know, possible life and death issues.

DEMBOSKY: That's Shariah's dad, Tom Nagy.

NAGY: That was my approach to pay for it, you know - run up the charge cards and things like that.

DEMBOSKY: He ended up paying thousands of dollars out of pocket. Nagy is a teacher. His wife is a nurse, and they couldn't afford to keep doing that. He had to fight with the insurance company for a year, until he was finally reimbursed.

NAGY: As a parent, it's hard enough to deal with these situations. You're trying to be supportive, but then you get the whole financial thing. It just adds a whole other layer, and it's real frustrating.

DEMBOSKY: Anthem Blue Cross declined an interview. In a statement, the insurer said it's committed to providing access to high quality mental health care and a range of resources to

help people find the best provider. Earlier this year, the company launched an online psychology service where patients can see a therapist using their computer or smartphone.

VROMAN-NAGY: Dad.

DEMBOSKY: It's Shariah's spring break.

VROMAN-NAGY: We're taking your car or mine?

DEMBOSKY: And she and her parents are getting ready for that family trip to Disneyland.

VROMAN-NAGY: They call it the happiest place on Earth, and I really do feel that. It really makes me happy when I go. So I'm glad we get to go this week because I have been having a little bit of depression kind of going on.

DEMBOSKY: Overall, Shariah says she has more good days than bad.

VROMAN-NAGY: Put on some music.

DEMBOSKY: She's in regular therapy. She works at In-N-Out Burger, and she's studying psychology and music at the local junior college. She'd like to be an adolescent therapist one day.

VROMAN-NAGY: (Singing) Can you show me...

DEMBOSKY: But first, she'd like to be a character singer at Disneyland. For NPR News, I'm April Dembosky in Redding, Calif.

VROMAN-NAGY: (Singing) Tell me more. Will you show me?

(SOUNDBITE OF SONG, "STRANGERS LIKE ME")

PHIL COLLINS: (Singing) Will you show me? Something's familiar about these strangers like me...

CORNISH: This story is part of a reporting partnership of NPR, KQED and Kaiser Health News.

(SOUNDBITE OF SONG, "STRANGERS LIKE ME")

IG: Lead a discussion about how people's struggle to find mental health care might affect the participants' roles as first responders.

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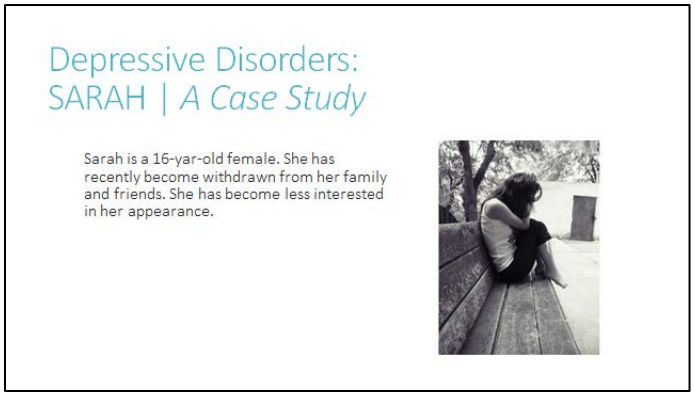

PG: Sarah is a 16-yar-old female. She has recently become withdrawn from her family and friends. She has become less interested in her appearance. She no longer plays sports or spends time at the mall with her friends; she has lost interest in the activities she used to enjoy, like going to concerts and movies. Sarah's grades have dropped and she is noticeably more moody and pessimistic about her future and life in general. She has recently reported to friends that she felt worthless and hopeless.

Sarah has recently been seen drinking and smoking with older students at her school. She has been found drinking on her own and has even been caught stealing small items from stores with friends. When family addressed Sarah's behaviors she broke down and began crying.

IG: Direct participants to read the case study in their PG. Then lead a discussion, asking:

- What are some of her notable symptoms?
- What might you expect Sarah is experiencing?
- Have you seen adolescents have difficulties expressing themselves and relying on substances to cope?
- Do you think Sarah might be receptive to intervention (whether it be general help or treatment?)
- How might you respond to Sarah if you were to come into contact with her?

Module 5 | Mental Health Basics: Schizophrenia, Psychotic, and Bipolar Disorders
Administration Page

Duration: 1.5 hours | 1:00 – 2:30 pm

Scope Statement: This module will introduce participants to severe, chronic mental illnesses including schizophrenia, psychotic disorders and bipolar disorders and their symptoms.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Describe schizophrenia
- Describe psychotic behavior
- Identify signs and symptoms of bipolar disorders

[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes: [blank for notes]

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Module 5: Mental Health Basics

Bipolar Disorders, Schizophrenia, & Psychotic Disorders

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Bipolar Disorder

- About one in one hundred people suffer from bipolar disorder which is similar to the rate of schizophrenia but far lower than the incidence of major depression.
- Men and women are equally likely to develop bipolar disorder.
- There is a **higher likelihood of attempted and completed suicides** among those with bipolar disorder than any other behavioral disorder.

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Bipolar and Related Disorders

- Bipolar disorder is a disorder that causes unusual shifts in mood, energy, and activity levels.
- Bipolar disorders may include both manic and depressive symptoms, which may last days to months.

Three Types of Bipolar Disorders	Bipolar I Disorder	Bipolar II Disorder	Cyclothymic Disorder

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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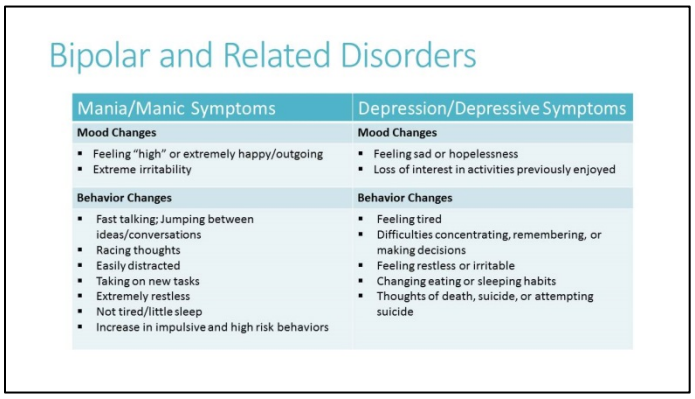

PG: Sometimes a person with severe episodes of mania or depression has psychotic symptoms too, such as hallucinations or delusions. The psychotic symptoms tend to reflect the person's extreme mood. For example, a person who is having psychotic symptoms during a manic episode may believe they are a famous person, have a lot of money, or have special powers. A person having psychotic symptoms during a depressive episode may believe they are ruined, penniless, or that they have committed a crime. As a result, people with bipolar disorder who have psychotic symptoms are sometimes misdiagnosed with schizophrenia.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml#part_145404

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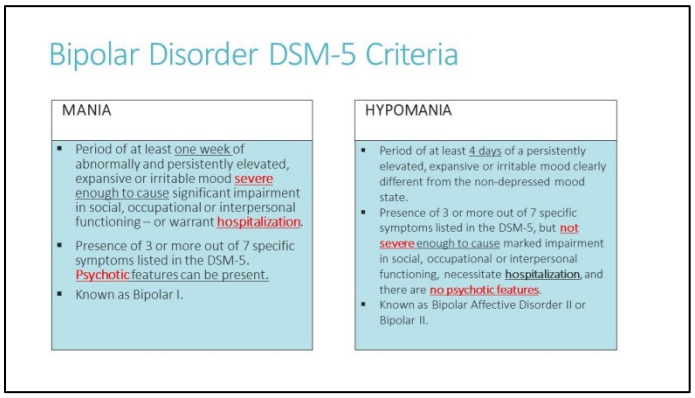

PG: A manic episode is an abnormally- or persistently-elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed energy. Criteria (three or more of the following symptoms are present to a significant degree and represent a noticeable change from usual behavior): Inflated self-esteem or grandiosity; decreased need for sleep; more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing; distractibility; increase in goal-directed activity lasting at least one week and present most of the day, nearly every day.

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Video Title: “Bipolar I Disorder: Hypomania and Rapid Speech”

Video Link: https://www.youtube.com/watch?v=kiEUibfC47oandfeature=youtu.be

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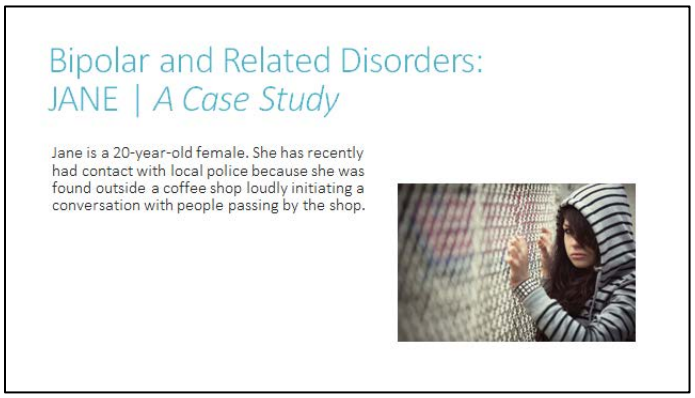

PG: In the last five days, Jane has gone without any sleep. She has recently been in a more heighted state of activity, talking to herself and having more grandiose ideas. She has recently had thoughts and even a conversation with a group of friends, about how she was a political mastermind. She was found writing her thoughts down and leaving post-it notes everywhere in her home. Her family has known her to be extremely clean and organized, so this was unusual for her. These more bizarre and wild behaviors have lasted for a period of time but would soon switch to a more depressed state. Following the above symptoms, Jane would then suffer from extreme depression. She wouldn’t be able to sleep again, have poor appetite, and have difficulties concentrating. She wouldn’t want to attend class and would even contemplate suicide, as she felt the nothing was going her way.

IG: Ask, “What are some of the symptoms you saw in this case study? During what stage do we think Jane had contact with the local police due to her actions outside the coffee shop?”

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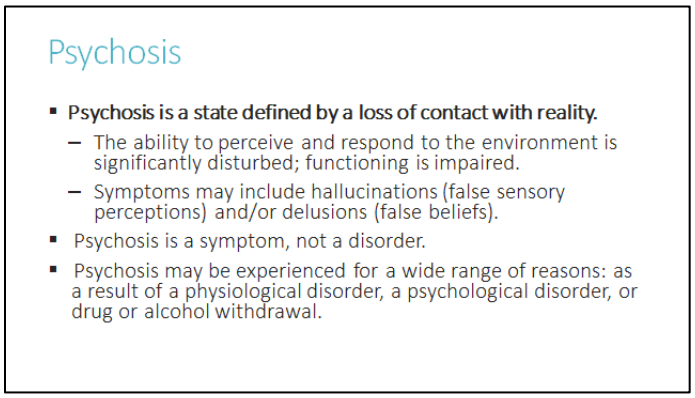

Psychosis may be brought on organically, through other physical issues, such as organ failure, hypoxia, hypoglycemia, vitamin deficiency, endocrinopathy (e.g., hyperthyroidism), fluid and electrolyte imbalance, drug or alcohol intoxication or withdrawal, infection, head injury, brain tumor, or cerebral degenerative disease

Psychosis can also be a functional response to a mental disorder, such as brief reactive psychosis, delusional disorder, Schizophrenia, Schizophreniform disorder, Schizoaffective disorder, drug-induced psychotic disorder, major depression with psychotic features, or Bipolar disorder.

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Video Title: “Teenager during a psychotic break”

Video link: http://youtu.be/yM064w5Ht54

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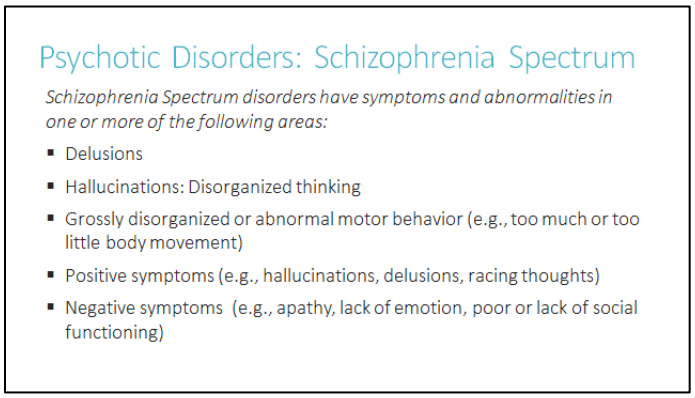

PG: The symptoms of Schizophrenia spectrum disorders must be present for six months and have at least one month of active symptoms.

Schizophrenia is characterized by delusions, hallucinations, disorganized speech and behavior, and other symptoms that cause social or occupational dysfunction. For a diagnosis, symptoms must have been present for six months and include at least one month of active symptoms.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

IG: for additional information, please consult: http://www.samhsa.gov/disorders/mental

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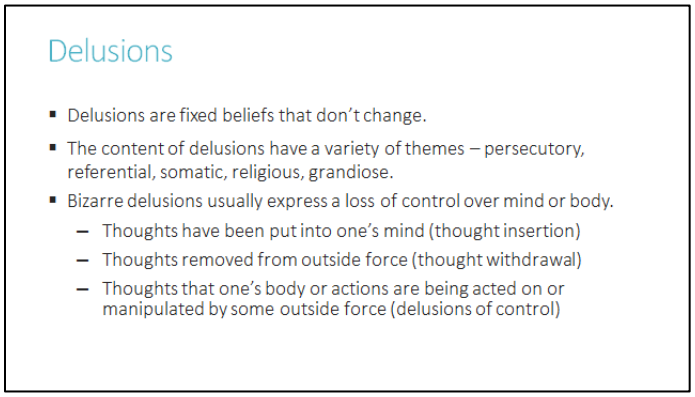

PG: Delusions: are fixed beliefs that do not change. The content of delusions has a variety of themes – persecutory, referential, somatic, religious, and grandiose.

- *Persecutory delusions- (*most common) belief one is going to be harmed, harassed by an individual, group, organization.
- *Referential delusions* – belief that certain gestures, comments, environmental cues are directed at oneself.
- *Grandiose delusions* – when an individual believes that he or she has exceptional abilities, wealth, or fame.

- *Erotomanic delusions* – when an individual believes falsely that another person is in love with him or her.
- *Nihilistic delusions* – the conviction that a major catastrophe will occur.
- *Somatic delusions* – focus on preoccupations regarding health and organ function.

Delusions can seem bizarre if they are not understood by peers (of the same culture) and don't come from ordinary life experiences. Bizarre delusions usually express a loss of control over mind or body.

- thoughts removed from outside force (i.e. thought withdrawal)
- thoughts have been put into one's mind (i.e. thought insertion)
- thoughts that one's body or actions are being acted on or manipulated by some outside force (i.e. delusions of control)

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

IG: for additional information, please consult: http://www.samhsa.gov/disorders/mental

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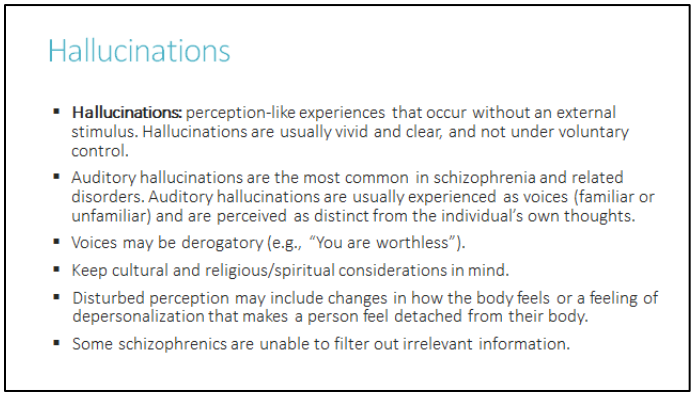

PG: Hallucinations are perception-like experiences that occur without an external stimulus. Hallucinations are usually vivid and clear and not under voluntary control. Auditory hallucinations are the most common in schizophrenia and related disorders. Auditory hallucinations are usually experienced as voices (familiar or unfamiliar) and are perceived as distinct from the individual's own thoughts. It is important to keep cultural and religious/spiritual considerations in mind, as cultural differences are likely to be represented in hallucinations.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

IG: For additional information, please consult: http://www.samhsa.gov/disorders/mental

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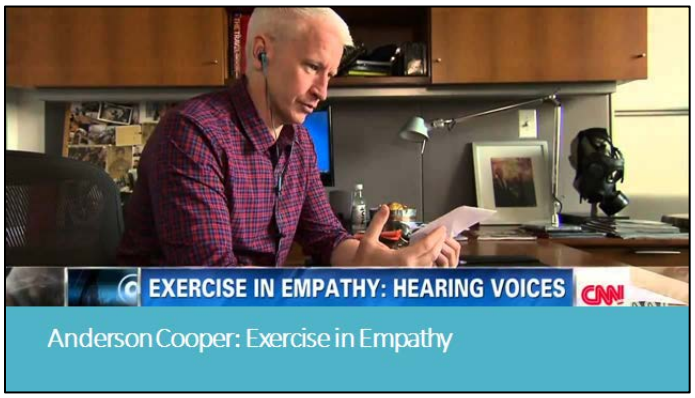

PG: This CNN video of Anderson Cooper shows him experiencing a schizophrenia simulator. He is attempting to focus on the task(s) at hand. Imagine if you were asking someone to comply with orders or directions when they were experiencing symptoms similar to what is shown.

IG: Debrief this video by asking the participants if they have had experiences when they made a request or gave an order that did not seem to be understood or followed.

Link to VIDEO: https://www.youtube.com/watch?v=yL9UJVtgPZY

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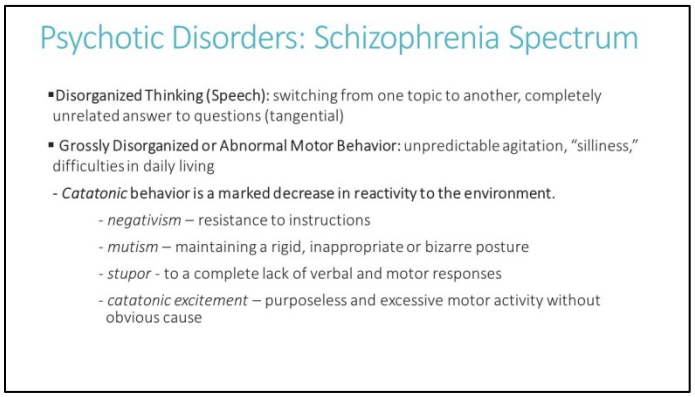

PG: Disorganized Thinking is a form formal thought disorder. It may involve switching from one topic to another (derailment or loose associations) or completely unrelated answers to questions (tangentially).

Example of disorganized thinking: *"I don't want to go to jail. Jail is for the birds. One time I saw birds flying around in the jail. Birds should be out in the air. The air is dirty in Atlanta. All of these big Marta buses. I ride the bus to get my groceries. Kroger is my favorite store."* (CIT MEMPHIS)

Grossly-Disorganized or Abnormal Motor Behavior involves unpredictable agitation, "silliness", difficulties in daily living. *Catatonic* behavior is a marked decrease in reactivity to the environment. *Negativism* is resistance to instructions. *Mutism* is maintaining a rigid,

inappropriate or bizarre posture. *Stupor* describes a complete lack of verbal and motor responses. *Catatonic excitement* – purposeless and excessive motor activity without obvious cause

Additional negative symptoms may include alogia (diminished speech output), anhedonia (decreased ability to experience pleasure from positive stimuli), and a-sociality (lack of interest in social interactions).

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

IG: for additional information, please consult: http://www.samhsa.gov/disorders/mental

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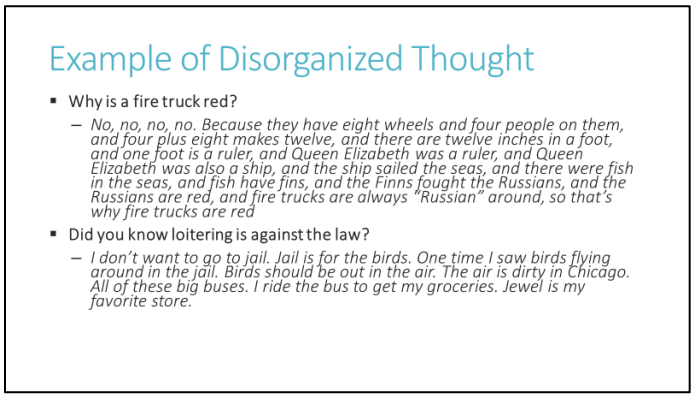
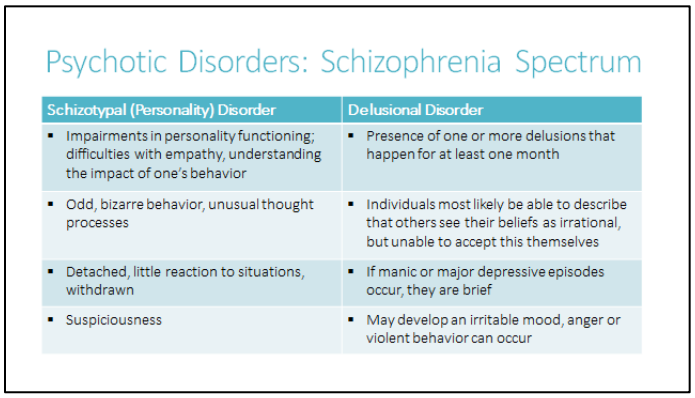


Source: Michael T. Compton, Raymond J. Kotwicki. 2007. *Responding to Individuals with Mental Illnesses.* Available here: http://www.jblearning.com/catalog/9780763741105/preview/

Slide 84



PG: Delusional Disorder specifiers include:

- *Erotomanic type* – central theme of the delusion is that another person is in love with the individual
- *Grandiose type* – central theme of the delusion is the conviction of having some great

(unrecognized) talent or insight or having made some important discovery

- *Jealous type* – central theme of the delusion is that his or her spouse or lover is unfaithful
- *Persecutory type* – central theme of the delusion is when the individual believes he or she is being conspired against, cheated, spied on, followed, harassed, etc.
- *Somatic type* – central theme of the delusion involves bodily functions or sensations.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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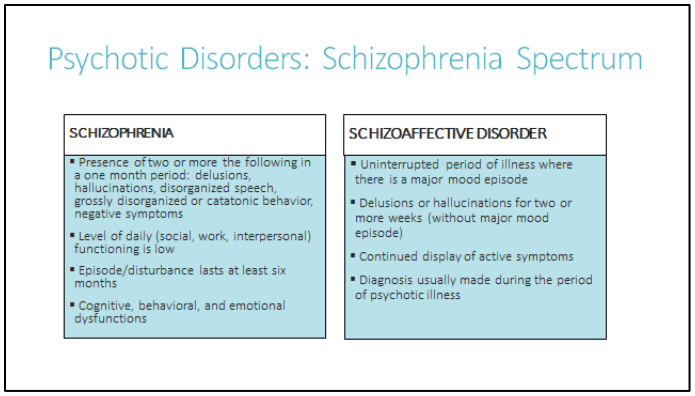

PG: Individuals with Schizophrenia may frequently display inappropriate affect; mood may appear in the form of depression, anxiety, or anger. Cognitive deficits with schizophrenia are common and are linked to impairments. Abnormalities in sensory processing, deficits in memory, language and executive functions. Some individuals lack insight or awareness of their disorder. Unawareness of the illness is a symptom of schizophrenia as well. Aggression and hostility associated with schizophrenia, **although spontaneous or random assault is uncommon**. A vast majority of individuals with schizophrenia are not aggressive, and more frequently victimized. The lifetime prevalence of Schizophrenia appears to be about 0.3 percent - 0.7 percent, with variations by race and ethnicity. *Catatonia* can occur with several disorders (bipolar, depressive, neurodevelopmental disorders). Catatonia is the presence of three or more of 12 psychomotor features – stupor, catalepsy, waxy flexibility, mutism, negativism, posturing, mannerism, stereotypy, agitation, grimacing, echolalia, or echopraxia.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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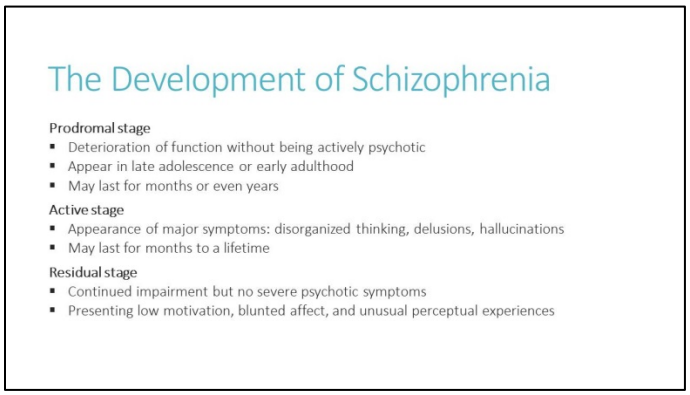

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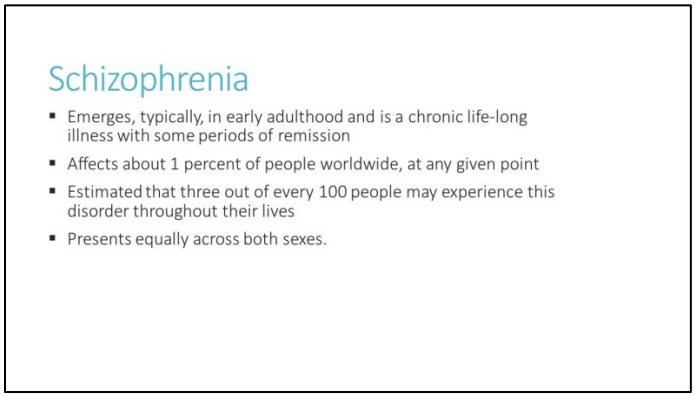

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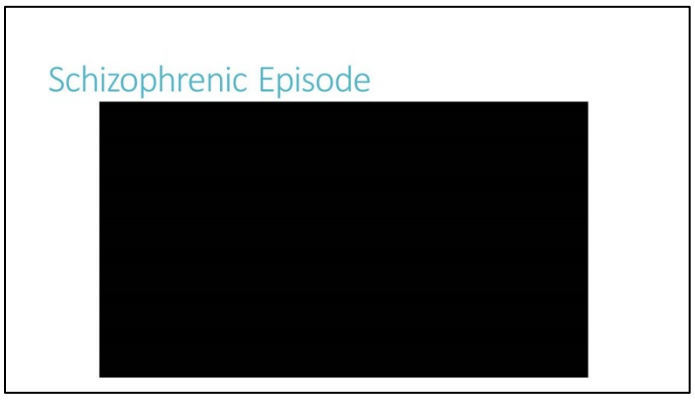

Video Title: “Schizophrenic Episode”

Video Link: https://www.youtube.com/watch?v=V521Umt1NjUandfeature=youtu.be

Slide 89

Tips and Tools for the Field

Your ability to defuse a mental health crisis is important.

- People experiencing psychotic symptoms may be genuinely terrified.
- People typically fight or flee ("flight) when scared.
- You cannot do either.
- Reasoning with an enraged person is not possible.
- We must reduce the level of arousal so discussion is possible.

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Tips and Tools for the Field

Inattention may be due to:

- Anxiety
- Depression
- Irritability
- Psychosis
- SUBSTANCE RELATED AND ADDICTIVE DISORDERS (May mimic any psychiatric disorder!)
- And others

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Tips and Tools for the Field

Non threatening stance – open not vulnerable
Eye Contact – Not constant, brief to show concern
Commands – Brief, slow, only as loud as needed, repeat as needed
Movement – Not sudden, announce actions when possible
Attitude – Calm, interested, firm, patient, reassuring
Acknowledge – Their delusions/hallucinations or feelings are real to them
Remove distractions, upsetting influences

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Tips and Tools for the Field

- Keep them talking/focused on the here and now
- Ignore rather than argue
- Allow verbal venting within reason
- Be sensitive to personal space/comfort zone
- Set limits as necessary
- Limit interaction to just the contact officer
- Avoid rushing – Slow things down
  - Patience
  - Dignity, respect
  - Person may be inattentive due to illness

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Tips and Tools for the Field

- Introduce yourself – "Hi, I'm John, I'm with the Waukegan Police Dept. Can we talk?"
- "What's your first name?"
- "Bob what's going on today?"
- "It seems you are upset. I would like to try to help you."
- "Help me understand what is happening to you."
- "I can't hear or see that, but I know you can." *(Redirect, do not feed into psychosis, but do not challenge their perceptions)*
- "I would like to get you some help, maybe talk with someone."

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Tips and Tools for the Field

Note the use of:

- Distance, space
- Calm, patient, reassuring
- Plan of action once additional units arrive
- Use of TASER
- Call for medics

Video Link: https://youtu.be/xDpdl6rgY1s

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Module 6 | Mental Health Basics: Substance-Related and Addictive Disorders
Administration Page

Duration: 1.5 hours | 2:30 pm – 4:00 pm

Scope Statement: This module will introduce participants to Substance-Related and Addictive Disorders and their symptoms. This module includes a brief video entitled "Addiction in America: By the Numbers."

Student Learning Objectives:
Upon completing this module, students will be able to:

- Define substance-related and addictive disorders; and
- Describe behaviors associated with these disorders.

[NOTE: This module should be taught by a substance use treatment from your community.]

Instructor/Participant Notes: [blank for notes]

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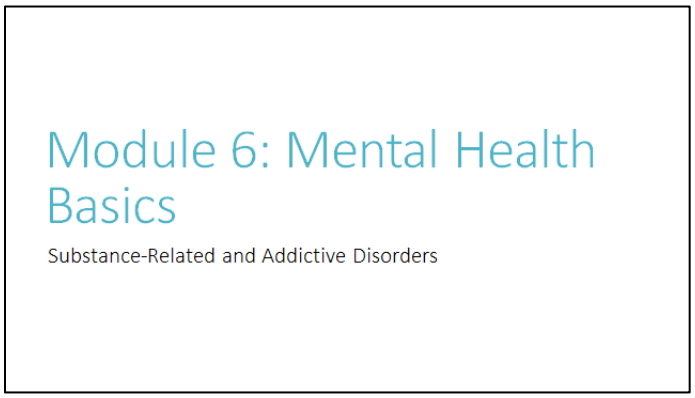

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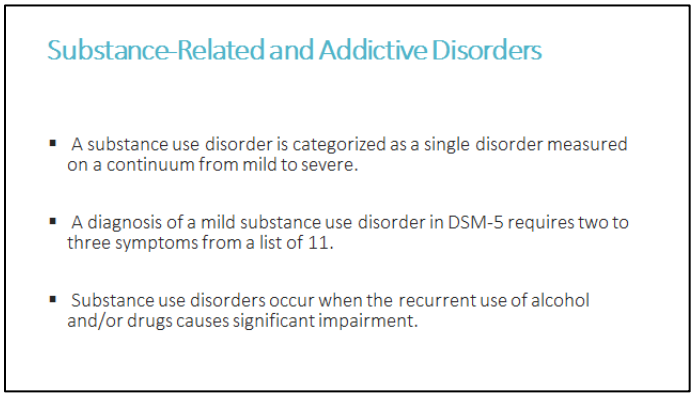

PG: The DSM-5 no longer uses the terms "substance abuse" and "substance dependence." Rather, it refers to "substance use disorders," which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Sources: Substance Abuse and Mental Health Services Administration. "Substance Use Disorders." Available here: http://www.samhsa.gov/disorders/substance-use

American Psychiatric Publishing. Textbook of Psychiatry. 2014. Available here: https://psychiatryonline.org/doi/abs/10.1176/appi.books.9781585625031.rh23

IG: Lead a general discussion about class participants' experiences with people who have substance-related and addictive disorders. They may share stories of interactions with people they have encountered on the job and some may volunteer more personal information about their family's struggles or their own – be patient and allow for some stories to be told if participants want to share and be heard. Be sure to keep the conversation respectful at all

times.

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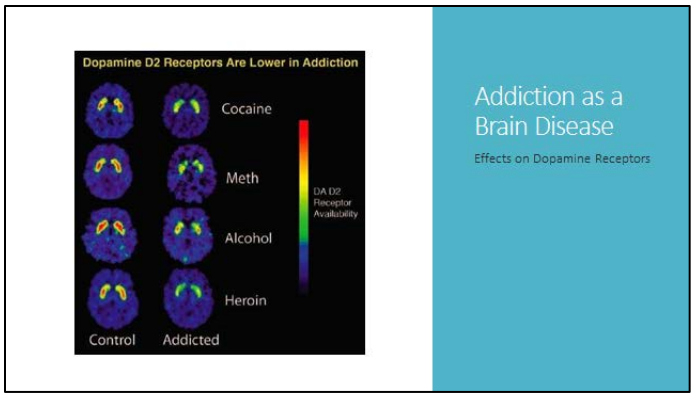


PG: What is addiction?

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain—they change its structure and how it works. These brain changes can be long-lasting and can lead to the harmful behaviors seen in people who abuse drugs.

Source: National Institute on Drug Abuse. "Drugs, Brains, and Behavior: The Science of Addiction." Available here: https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction

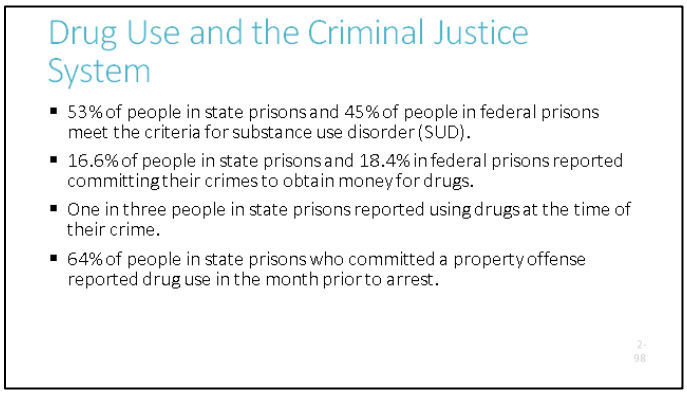
Addiction Science

"Many people do not understand why or how other people become addicted to drugs. It is often mistakenly assumed that drug abusers lack moral principles or willpower and that they could stop using drugs simply by choosing to change their behavior. In reality, drug addiction is a complex disease, and quitting takes more than good intentions or a strong will. In fact, because drugs change the brain in ways that foster compulsive drug abuse, quitting is difficult, even for those who are ready to do so. Through scientific advances, we know more about how drugs work in the brain than ever, and we also know that drug addiction can be successfully treated to help people stop abusing drugs and lead productive lives."

Source: National Institute on Drug Abuse. "Addiction Science." Available here: https://www.drugabuse.gov/related-topics/addiction-science

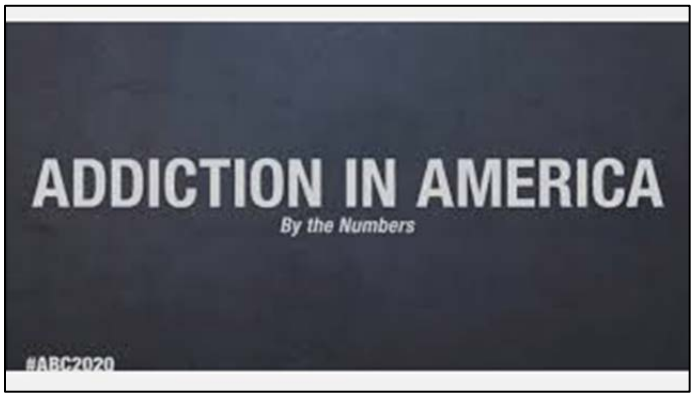
IG: Lead a discussion about the science of addiction as a brain disease, pointing out the differences in the brain scans on this slide.

Slide 98



Source: Bureau of Justice Statistics, U.S. Department of Justice. 2017. "Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009." Available here: https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf

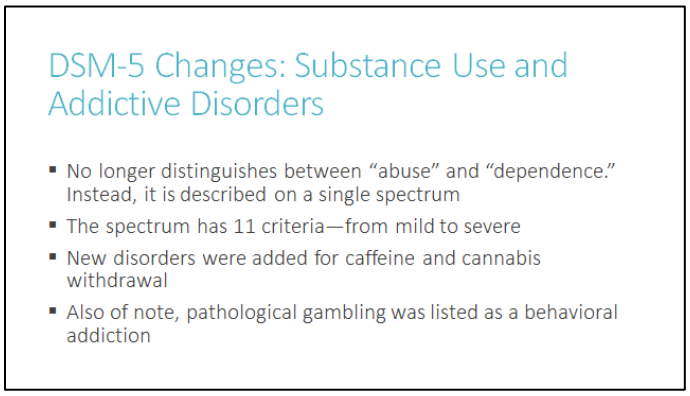
Slide 99



PG: Link to ABC News VIDEO: http://abcnews.go.com/2020/video/addiction-america-numbers-39934750. Video date: June 17, 2016.

IG: Video play time: 1:32
Following this brief video, lead a discussion about what struck the participants about the numbers in the video.

Slide 100



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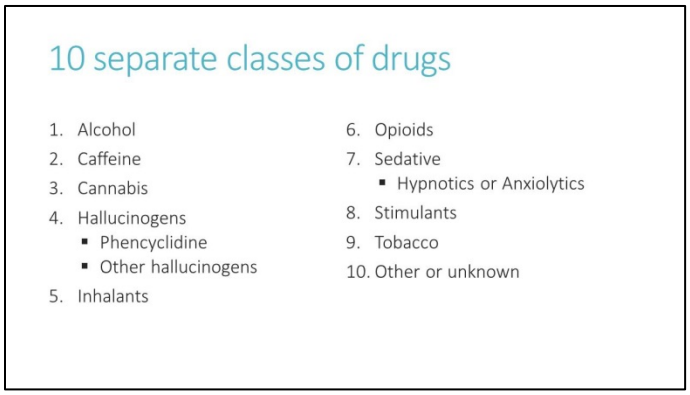

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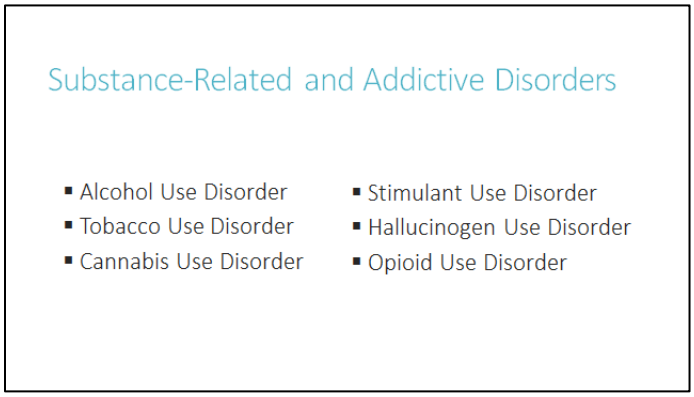


PG: *Alcohol Use Disorder (AUD)*

Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal symptoms. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year.

Data from the National Survey on Drug Use and Health (NSDUH) — 2014 (PDF | 3.4 MB) show

that in 2014, slightly more than half (52.7%) of Americans ages 12 and up reported being current drinkers of alcohol. Most people drink alcohol in moderation. However, of those 176.6 million alcohol users, an estimated 17 million have an AUD.

Many Americans begin drinking at an early age. In 2012, about 24% of eighth graders and 64% of twelfth graders used alcohol in the past year.

The definitions for the different levels of drinking include the following:

Moderate Drinking—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.

Binge Drinking—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 drinks for women and 5 drinks for men over a 2 hour period.

Heavy Drinking—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Excessive drinking can put you at risk of developing an alcohol use disorder in addition to other health and safety problems. Genetics have also been shown to be a risk factor for the development of an AUD.

To be diagnosed with an AUD, individuals must meet certain diagnostic criteria. Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

Learn more about alcohol from the Alcohol, Tobacco, and Other Drugs topic. Learn more about the treatments for AUD. Find more information at the NIAAA website.

Tobacco Use Disorder

According to the CDC, more than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking do damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses.

In 2014, an estimated 66.9 million Americans aged 12 or older were current users of a tobacco product (25.2%). Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (35%), followed by adults aged 26 or older (25.8%), and by youths aged 12 to 17 (7%).

In 2014, the prevalence of current use of a tobacco product was 37.8% for American Indians or Alaska Natives, 27.6% for whites, 26.6% for blacks, 30.6% for Native Hawaiians or other Pacific Islanders, 18.8% for Hispanics, and 10.2% for Asians.

For information and strategies to help you or a loved one stop smoking or using tobacco, visit SAMHSA's Treatments for Substance Use Disorders page. To find out more about smoking and tobacco, visit the CDC website.

Cannabis Use Disorder

Marijuana is the most-used drug after alcohol and tobacco in the United States. According to SAMHSA data: In 2014, about 22.2 million people ages 12 and up reported using marijuana during the past month.

Also in 2014, there were 2.6 million people in that age range who had used marijuana for the first time within the past 12 months. People between the ages of 12 and 49 report first using the drug at an average age of 18.5.

In the past year, 4.2 million people ages 12 and up met criteria for substance abuse based on marijuana use.

Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer-causing compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use.

Learn more about cannabis from the Alcohol, Tobacco, and Other Drugs topic. For information about the treatment of cannabis use disorder, visit SAMHSA's Treatments for Substance Use Disorders page.

Stimulant Use Disorder

Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. They include a wide range of drugs that have historically been used to treat conditions, such as obesity, attention deficit hyperactivity disorder and, occasionally, depression. Like other prescription medications, stimulants can be diverted for illegal use. The most commonly abused stimulants are amphetamines, methamphetamine, and cocaine. Stimulants can be synthetic (such as amphetamines) or can be plant-derived (such as cocaine). They are usually taken orally, snorted, or intravenously.

In 2014, an estimated 913,000 people ages 12 and older had a stimulant use disorder because of cocaine use, and an estimated 476,000 people had a stimulant use disorder as a result of using other stimulants besides methamphetamines. In 2014, almost 569,000 people in the United States ages 12 and up reported using methamphetamines in the past month.

Symptoms of stimulant use disorders include craving for stimulants, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use stimulants, and withdrawal symptoms that occur after stopping or reducing use, including fatigue, vivid and unpleasant dreams, sleep problems, increased appetite, or irregular problems in controlling movement.

To learn more about stimulants from the Alcohol, Tobacco, and Other Drugs topic. For information about the treatment of stimulant use disorder, visit SAMHSA's Treatments for Substance Use Disorders page.

Hallucinogen Use Disorder

Hallucinogens can be chemically synthesized (as with lysergic acid diethylamide or LSD) or may occur naturally (as with psilocybin mushrooms, peyote). These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception.

In 2014, approximately 246,000 Americans had a hallucinogen use disorder. Symptoms of hallucinogen use disorder include craving for hallucinogens, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, use in risky situations like driving, development of tolerance, and spending a great deal of time to obtain and use hallucinogens.

Opioid Use Disorder

Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, constipation, and, depending upon the amount of drug taken, can depress respiration. Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone can cause serious health effects in those who misuse them. Some people experience a euphoric response to opioid medications, and it is common that people misusing opioids try to intensify their experience by snorting or injecting them. These methods increase their risk for serious medical complications, including overdose. Other users have switched from prescription opiates to heroin as a result of availability and lower price. Because of variable purity and other chemicals and drugs mixed with heroin on the black market, this also increases risk of overdose. Overdoses with opioid pharmaceuticals led to almost 17,000 deaths in 2011. Since 1999, opiate overdose deaths have increased 265% among men and 400% among women.

In 2014, an estimated 1.9 million people had an opioid use disorder related to prescription pain relievers and an estimated 586,000 had an opioid use disorder related to heroin use.

Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain

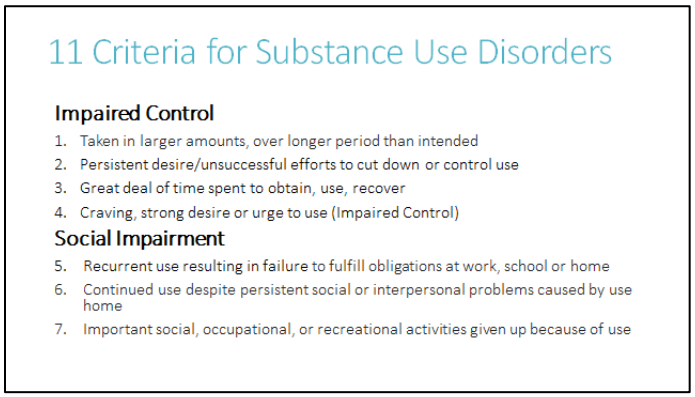
and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

Learn more about opioids from the Alcohol, Tobacco, and Other Drugs topic. For information about the treatment of opioid use disorder, visit SAMHSA's Treatments for Substance Use Disorders page.

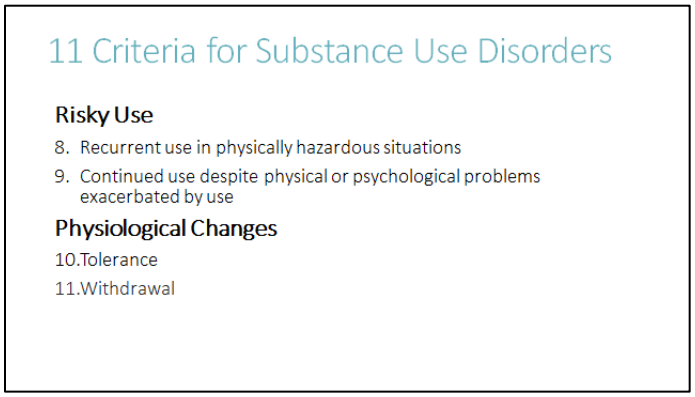
Source: Substance Abuse and Mental Health Services Administration. "Substance Use Disorders." Available here: http://www.samhsa.gov/disorders/substance-use

IG: Spend some time talking through the disorders listed on this slide, referring to the definitions in the PG and sharing some stories from your own clinical experience.

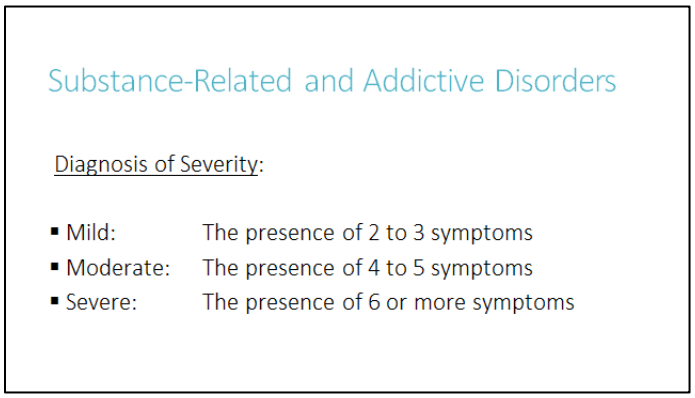
Slide 103



Slide 104



Slide 105

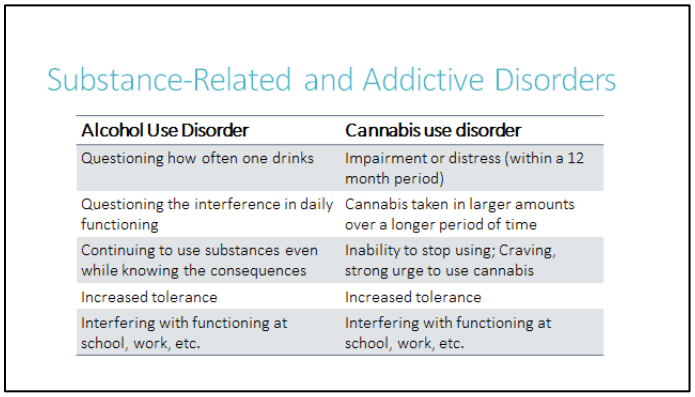


PG: The key diagnostic criteria include impaired control, social impairments, risky use, and tolerance and withdrawal.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

IG: Lead a discussion of disorders and the levels of severity; use examples from your clinical experience.

Slide 106



PG: *Alcohol Use Disorder* - The presence of at least 2 of these symptoms indicates an Alcohol Use Disorder (AUD). The severity of the AUD is defined as:

- Mild: The presence of 2 to 3 symptoms (yes answers to the questions below)
- Moderate: The presence of 4 to 5 symptoms
- Severe: The presence of 6 or more symptoms

In the past year, have you:

1) Had times when you ended up drinking more, or longer, than you intended?

2) More than once wanted to cut down or stop drinking, or tried to, but couldn't?

3) Spent a lot of time drinking? Or being sick or getting over other aftereffects?

4) Wanted a drink so badly you couldn't think of anything else?

5) Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?

6) Continued to drink even though it was causing trouble with your family or friends?

7) Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?

8) More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?

9) Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?

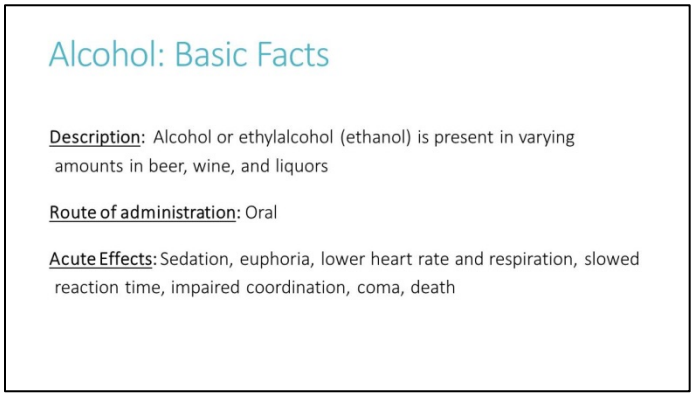
10) Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?

11) Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

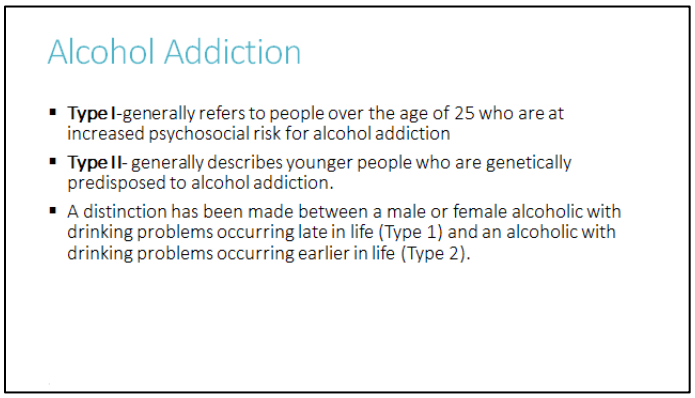
IG: Lead a discussion of these disorders and use examples from your clinical experience.

Slide 107



IG: Ask participants for examples of the acute effects of alcohol and for examples of situations they have responded to that involved alcohol.

Slide 108

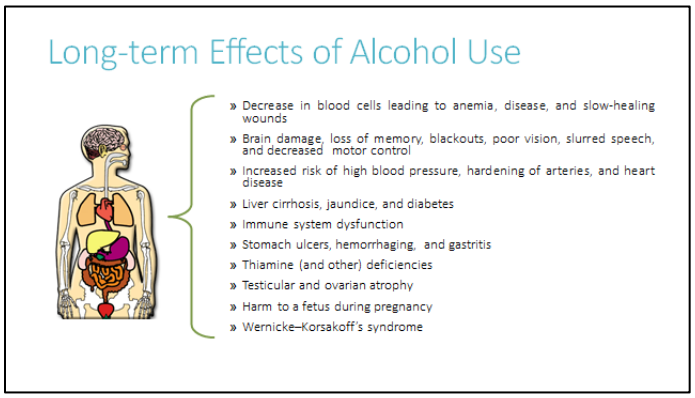


PG: Type I generally refers to people over the age of 25 who are at increased psychosocial risk for alcohol addiction. Type II generally describes younger people who are genetically predisposed to alcohol addiction.

Slide 109

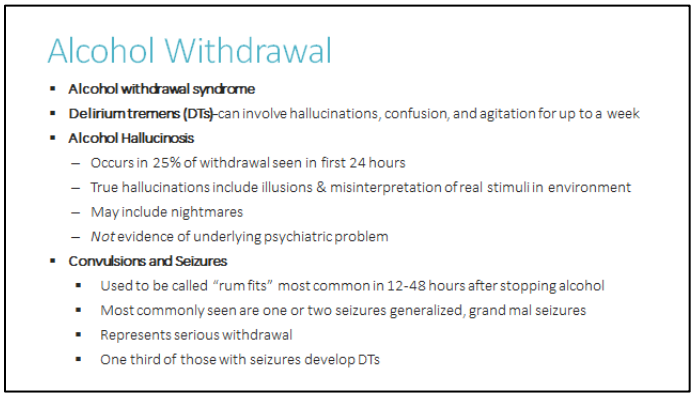
PG: Acute tolerance occurs during a given drug-taking session. Metabolic tolerance involves increases in enzymes that metabolize alcohol. Tolerance is associated with increased NMDA receptors. Behavioral tolerance involves reduced behavioral impairment. Sensitization occurs for the reinforcing effects of alcohol.

Slide 110



IG: Point to the areas of the body that are affected by the use of alcohol when explaining the content to participants.

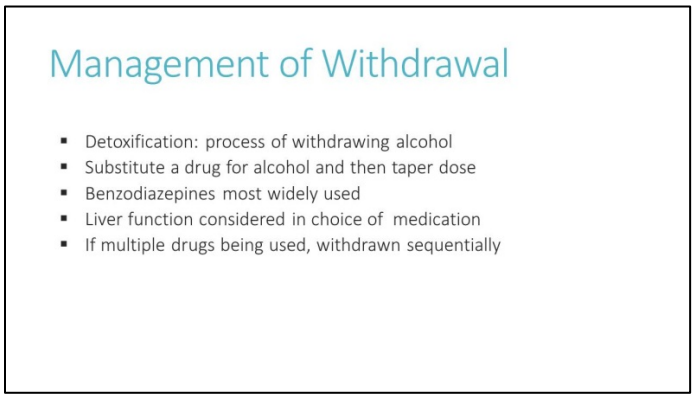
Slide 111



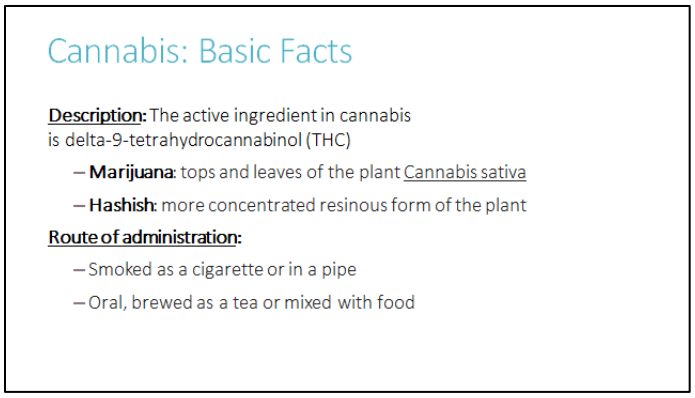
PG: Delirium tremens is a medical emergency associated with untreated alcohol withdrawal. It occurs 3-14 days after drinking is stopped. Delirium tremens include agitation, restlessness, gross tremor, disorientation, fluid and electrolyte imbalance, sweating and high fevers, visual hallucinations, and paranoia. The prevalence is < 5% of patients, and it may lead to death.

Source: Schuckit, Marc A., M.D. 2014. "Recognition and Management of Withdrawal Delirium (Delirium Tremens)." The New England Journal of Medicine. Available here: http://www.nejm.org/doi/full/10.1056/NEJMra1407298

Slide 112



Slide 113



PG: Marijuana is a dry, shredded green/brown mix of flowers, stems, seeds, and leaves of the hemp plant Cannabis sativa. It is usually smoked as a cigarette (joint, nail) or in a pipe (bong). It also is smoked in blunts, which are cigars that have been emptied of tobacco and refilled with marijuana, often in combination with another drug. It might also be mixed in food or brewed as a tea. As a more concentrated, resinous form it is called hashish, and as a sticky black liquid, it is called hash oil. Marijuana smoke has a pungent and distinctive, usually sweet-and-sour odour.

The main active chemical in marijuana is THC (delta-9-tetrahydrocannabinol). The membranes of certain nerve cells in the brain contain protein receptors that bind to THC. Once securely in place, THC sets off a series of cellular reactions.

IG: Ask participants for examples of the acute effects of marijuana.

Source: National Institute on Drug Abuse. “Drug Facts: What is marijuana?” Available here: https://www.drugabuse.gov/publications/drugfacts/marijuana

Slide 114

Cannabis: Basic Facts

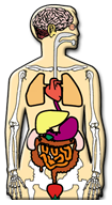
Acute Effects:

- Relaxation
- Increased appetite
- Dry mouth
- Altered time sense
- Mood changes
- Bloodshot eyes
- Impaired memory
- Reduced nausea
- Increased blood pressure
- Reduced cognitive capacity
- Paranoid ideation
- Impaired tracking ability
- Lung irritation
- High dose psychedelic effects
- Difficulty with multistep tasks

Source: National Institute on Drug Abuse. "Drug Facts: What is marijuana?" Available here: https://www.drugabuse.gov/publications/drugfacts/marijuana

Slide 115

Long-term Effects of Cannabis Use



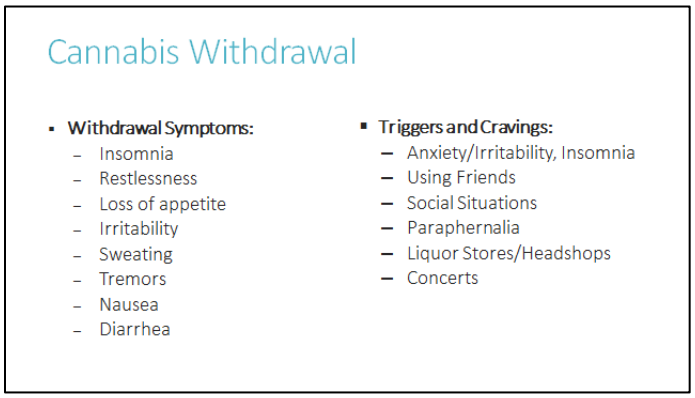
- Increase in activation of stress-response system
- Changes in neurotransmitter levels
- Psychosis in vulnerable individuals
- Increased risk for cancer, especially lung, head, and neck
- Respiratory illnesses (cough, phlegm) and lung infections
- Immune system dysfunction
- Harm to a fetus during pregnancy

Slide 116

Cannabis and Co-Occurring Disorders

- Heavy cannabis use may also accelerate or exacerbate schizophrenic symptoms.
- A study cited in the Diagnostic and Statistical Manual of Mental Disorders found evidence that daily marijuana users had rates of psychotic symptoms **1.6 to 1.8** times higher than those of non-marijuana users.

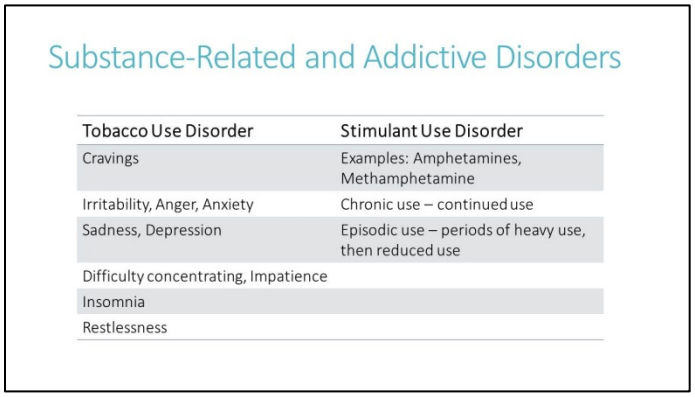
Slide 117



IG: Discuss how many people have believed that marijuana is not physically addictive. However, there appears to be a characteristic withdrawal profile indicating that physical dependence does actually occur.

Source: National Institute on Drug Abuse. "Drug Facts: What is marijuana?" Available here: https://www.drugabuse.gov/publications/drugfacts/marijuana

Slide 118



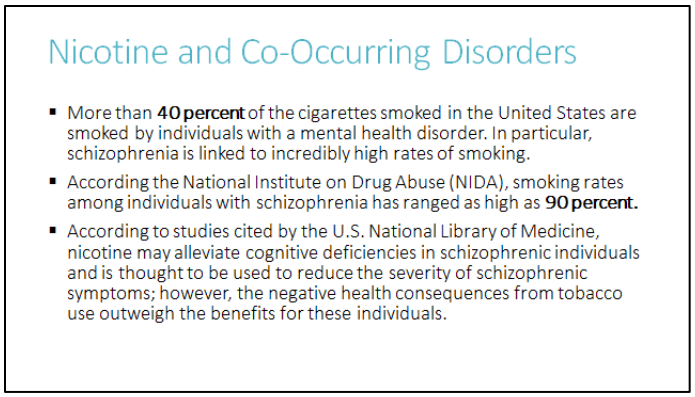
PG: *Tobacco Use Disorder* - According to SAHMSA – "In 2014, an estimated 66.9 million Americans aged 12 or older were current users of a tobacco product (25.2%). Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (35%), followed by adults aged 26 or older (25.8%), and by youths aged 12 to 17 (7%).

In 2014, the prevalence of current use of a tobacco product was 37.8% for American Indians or Alaska Natives, 27.6% for Whites, 26.6% for Blacks, 30.6% for Native Hawaiians or other Pacific Islanders, 18.8% for Hispanics, and 10.2% for Asians."

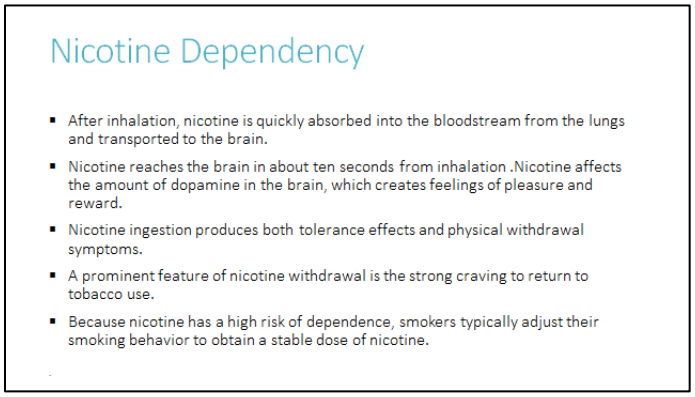
Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association. Available here: https://www.psychiatry.org/psychiatrists/practice/dsm

IG: Lead a discussion of these disorders and use examples from your clinical experience.

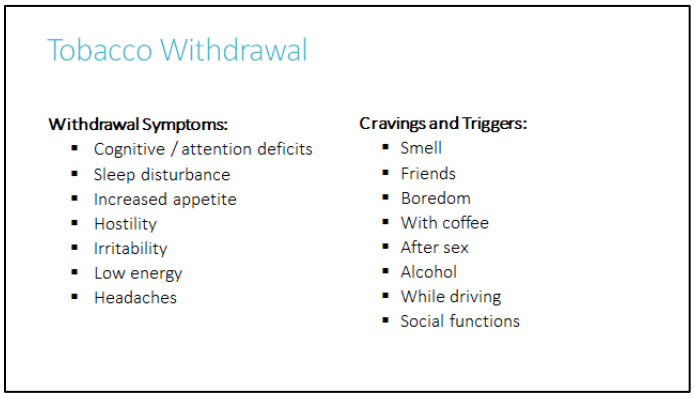
Slide 119



Slide 120



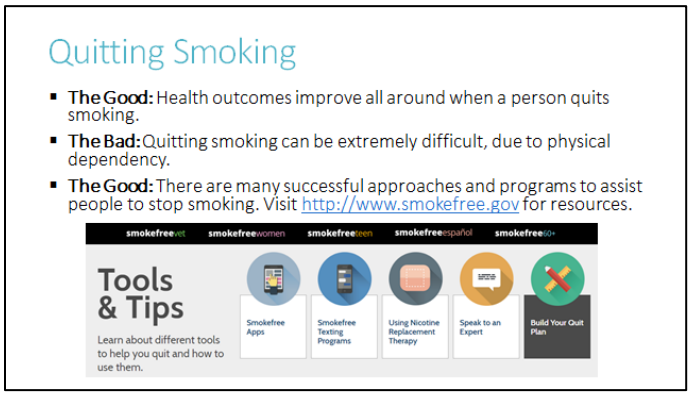
Slide 121



Research has found that when chronic smokers are deprived of cigarettes for 24 hours, they have increased anger, hostility, and aggression, and loss of social cooperation. Persons suffering from withdrawal also take longer to regain emotional equilibrium following stress. During periods of abstinence and/or craving, smokers have shown impairment across a wide range of psychomotor and cognitive functions, such as language comprehension.

Source: National Institute on Drug Abuse. "Drug Facts: What is tobacco?" Available here: https://www.drugabuse.gov/publications/drugfacts/cigarettes-other-tobacco-products

Slide 122

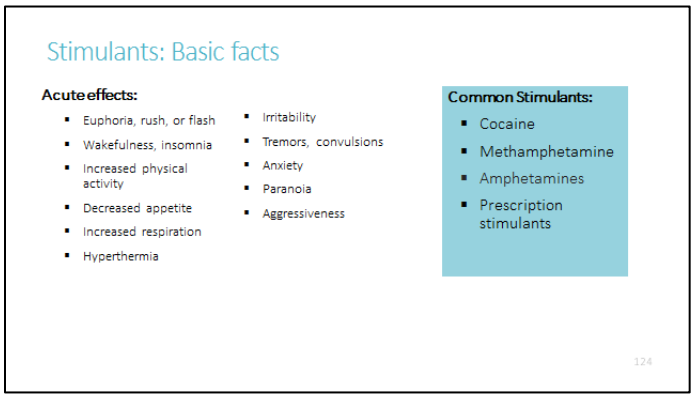


Slide 123

PG: Treatment options to aid in smoking cessation include nicotine patches or gum, Chantix, Zyban, and NicVac. Zyban is a form of Bupropian, which decreases cravings for cigarettes through adjusting the chemical functions related to nicotine intake in the brain. It is able to mitigate the symptoms of nicotine withdrawal.

Chantix decreases cravings for nicotine while mitigating withdrawal symptoms. Chantix can result in side effects such as mood disturbances and suicidal ideation.

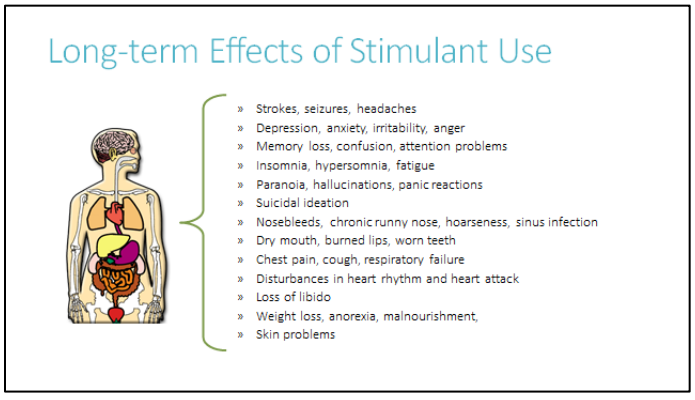
Slide 124



PG: The physical effects of cocaine use include constricted blood vessels, dilated pupils, and increased temperature, heart rate, and blood pressure. The duration of cocaine's immediate euphoric effects, which include hyper-stimulation, reduced fatigue, and mental alertness, depends on the route of administration. The faster the absorption, the more intense the high is. On the other hand, the faster the absorption, the shorter the duration of action. The high from snorting may last 15 to 30 minutes, while that from smoking may last 5 to 10 minutes. Increased use can reduce the period of time a user feels high and increases the risk of addiction.

Effects in the central nervous system (CNS) of methamphetamine include increased wakefulness, increased physical activity, decreased appetite, increased respiration, hyperthermia, and euphoria. Other CNS effects include irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, and aggressiveness. Hyperthermia and convulsions can result in death.

Slide 125



PG: The long-term effects of stimulant use to your audience, pointing to the areas of the body that are affected by the use of these drugs.

Regardless of how cocaine is used or how frequently, a user can experience acute cardiovascular or cerebrovascular emergencies, such as a heart attack or stroke, which could

result in sudden death. Cocaine-related deaths are often a result of cardiac arrest or seizure followed by respiratory arrest. Use of cocaine in a binge, during which the drug is taken repeatedly and at increasingly high doses, may lead to a state of increasing irritability, restlessness, and paranoia. This can result in a period of full-blown paranoid psychosis, in which the user loses touch with reality and experiences auditory hallucinations. Other complications associated with cocaine use include disturbances in heart rhythm and heart attacks, chest pain, respiratory failure, strokes, seizures, and headaches, as well as gastrointestinal complications such as abdominal pain and nausea. Because cocaine has a tendency to decrease appetite, many chronic users can become malnourished.

The long-term effects of methamphetamine: Methamphetamine releases high levels of the neurotransmitter dopamine, which stimulates brain cells, enhancing mood and body movement. It also appears to have a neurotoxic effect, damaging brain cells that contain dopamine as well as serotonin, another neurotransmitter. Over time, methamphetamine appears to cause reduced levels of dopamine, which can result in symptoms like those of Parkinson's disease, a severe movement disorder.

Source: National Institute on Drug Abuse. 2017. "Drug Facts: What is methamphetamine?" Available here: https://www.drugabuse.gov/publications/drugfacts/methamphetamine

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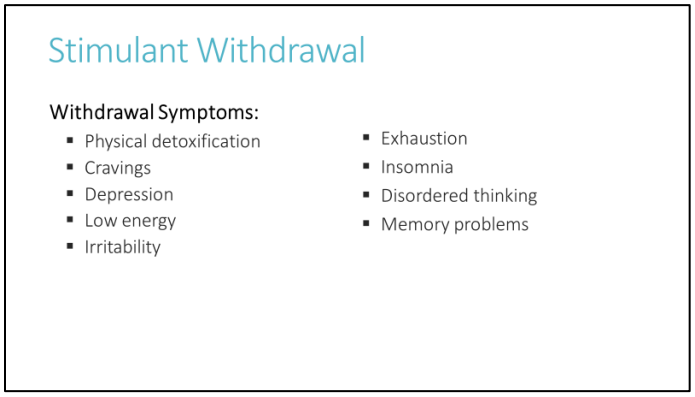

Withdrawal stage features include: Physical detoxification, cravings, depression, low energy, irritability, memory problems, disordered thinking, insomnia, and exhaustion.

People suffering from severe withdrawal should be viewed as having an acute psychiatric condition. Their brains are not functioning properly due to neurochemical imbalances. The condition may have dangerous consequences, such as suicide. Other problems include:

1. Medical problems such as seizure, infections, cardiovascular problems, weight loss, and vitamin deficiencies
2. Alcohol withdrawal: Alcohol is frequently used with other drugs of abuse. When the drug of choice is one other than alcohol, and the patient attempts total abstinence, he/she may go into alcohol withdrawal if he/she has unknowingly become physiologically dependent.

3. Depression: Occasionally, in cases of severe depression, an anti-depressant medication may be necessary.
4. Difficulty concentrating
5. Severe cravings
6. Contact with drug and alcohol stimuli: Exposure to objects, people, places, or situations, which have been associated with drug and alcohol use, can trigger cravings.
7. Excessive sleep and fatigue

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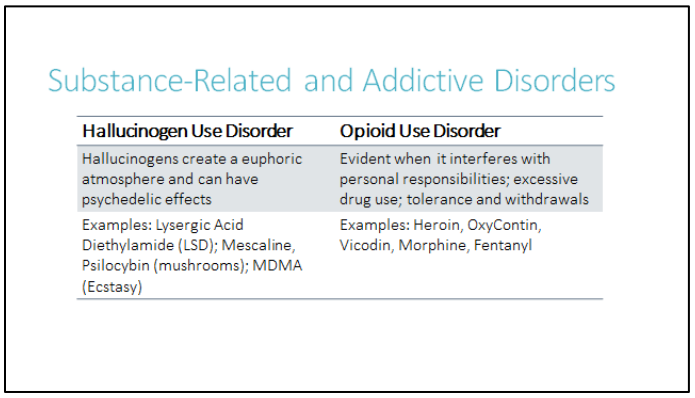

PG: Hallucinogen-related disorders have two sub-types: 1) phencyclidine and 2) other hallucinogens.

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association. https://www.psychiatry.org/psychiatrists/practice/dsm

IG: Lead a discussion of these disorders and use examples from your clinical experience.

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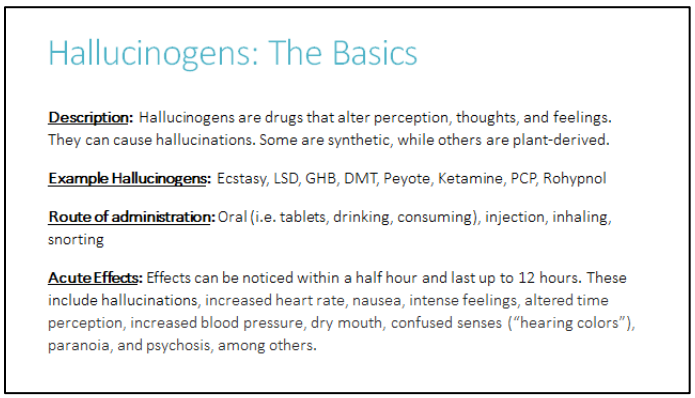

Hallucinogens are a diverse group of drugs that alter perception (awareness of surrounding objects and conditions), thoughts, and feelings. They cause hallucinations, or sensations and images that seem real though they are not. Hallucinogens can be found in some plants and mushrooms (or their extracts) or can be human-made. People have used hallucinogens for

centuries, mostly for religious rituals.

The effects of hallucinogens can begin within 20 to 90 minutes and can last as long as 6 to 12 hours. Salvia's effects are more short-lived, appearing in less than 1 minute and lasting less than 30 minutes. Hallucinogen users refer to the experiences brought on by these drugs as "trips," calling the unpleasant experiences "bad trips."

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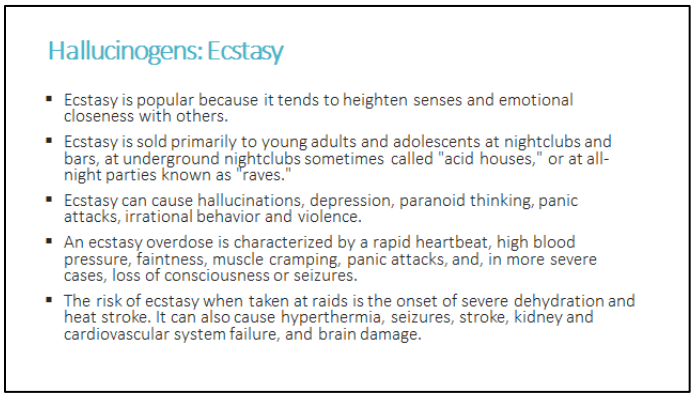

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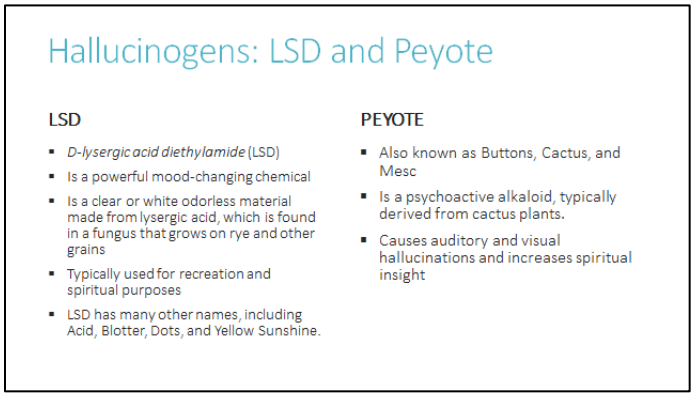

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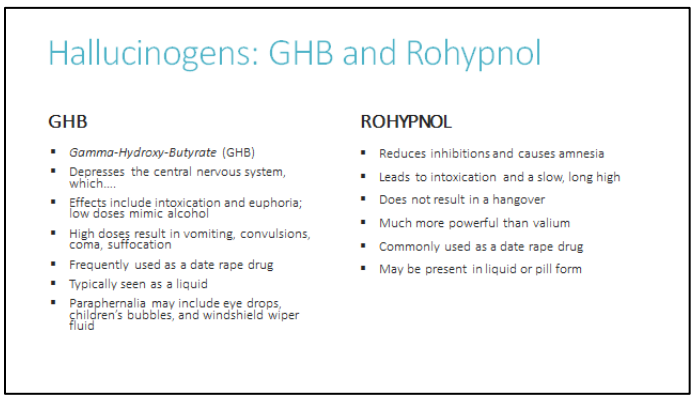

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Hallucinogens: Ketamine and PCP

KETAMINE

- Also known as "Special K"
- Effects include hallucinations and out-of-body experiences
- Typically dispensed in liquid or powder form. May be mixed with Heroin
- Frequently used as a veterinary animal tranquilizer

PCP

- *Phencyclidine* (PCP)
- Originally developed as surgical anesthesia, but has serious side effects
- May be dispensed in pill, liquid or white crystal powder.
- Goes by other names, such as Angel Dust, Hog, Love Boat, and Peace Pill.

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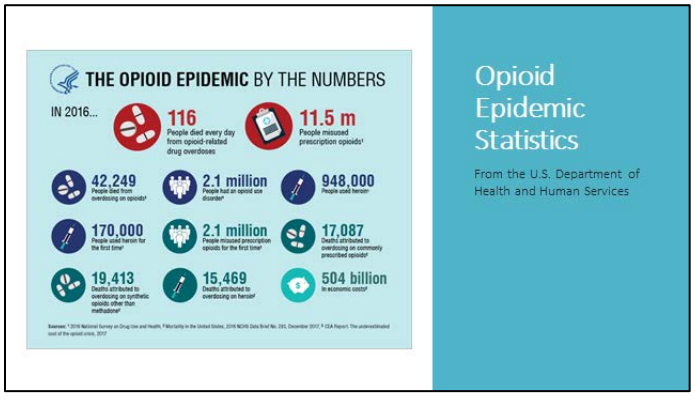
Opioids: Basic Facts

- Opioids may be extracted from opium (e.g., morphine, codeine, heroine), derived from opium (e.g., oxycodone, hydrocodone), or synthetically developed (e.g., fentanyl).
- Opioids are pain relievers that affect the nerve cells in the brain and throughout the body.
- Opioids are prescribed by a doctor for short-term use, but can be misused, leading to chemical and physical dependence.
  - Between 20-30% of patients prescribed opioids for chronic pain end up misusing them.
- Opioids are extremely powerful and run a high risk of overdose and death, particularly with opioids like fentanyl.
  - Approximately 80% of heroin users first misused prescription narcotics, like oxycodone or hydrocodone.

Source: National Institute of Drug Abuse. "Prescription Opioids and Heroin." Available here: https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-abuse-heroin-use/introduction

Slide 134



Source: https://www.hhs.gov/opioids/sites/default/files/2018-01/opioids-infographic.pdf

Slide 135

Possible Acute Effects of Opioid Use

- Surge of pleasurable sensation = "rush"
- Warm flushing of skin
- Dry mouth
- Heavy feeling in extremities
- Drowsiness
- Clouding of mental function
- Slowing of heart rate and breathing
- Nausea, vomiting, and severe itching

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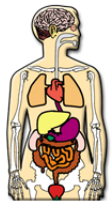
Long-term Effects of Opioid Use



- Fatal overdose
- Collapsed veins
- Infectious diseases
- Higher risk of HIV/AIDS and hepatitis
- Infection of the heart lining and valves
- Pulmonary complications & pneumonia
- Respiratory problems
- Abscesses
- Liver disease
- Low birth weight and developmental delay
- Spontaneous abortion
- Cellulitis

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Treatment for Heroin Abuse

Treatment for heroin abuse includes short-term detoxification and long-term interventions that address the continuing craving for the drug and physical dependence factors in the body.

Withdrawal:

- Mild: Non-opioid based (clonidine, supportive meds)
- Major: Opioid-based agonists (methadone, buprenorphine)
- Antagonist-based (naloxone, naltrexone: "rapid")

Relapse prevention:

- Agonist maintenance (methadone)
- Partial agonist maintenance (buprenorphine)
- Antagonist maintenance (naltrexone)

Slide 137

Opioid Withdrawal

Withdrawal symptoms:

- Intensity of withdrawal varies with level and chronicity of use
- Cessation of opioids causes a rebound in functions depressed by chronic use
- First signs occur shortly before next scheduled dose
- For short-acting opioids (e.g., heroin), peak of withdrawal occurs 36 to 72 hours after last dose
- Acute symptoms subside over 3 to 7 days
- Ongoing symptoms may linger for weeks or months

Triggers and Cravings:

- Stress
- Secondary drug/alcohol use
- Analgesic Use
- Andedonia, anxiety, depression
- Environmental cues
- Discontinuation of treatment, self-help groups, Naltrexone

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Treatment for Heroin Abuse

- Treatment for heroin abuse includes short-term detoxification and long-term interventions that address the continuing craving for the drug and physical dependence factors in the body.
- Medications to counter overdose or promote detoxification and relapse prevention:

Methadone	Buprenorphine	Antagonists
▪ Prevents withdrawal, reduces craving and use ▪ Facilitates rehabilitation ▪ Dispensed in a clinic setting ▪ Effects last 24 hours ▪ Once-daily dosing maintains constant blood level	▪ Subutex® or Suboxone (Buprenorphine and Naloxone) ▪ Aids in early recovery by decreasing withdrawal symptoms ▪ Prevents cravings for opioids ▪ Minimizes risk of relapse ▪ Dispensed in pill form by a clinic	▪ Naloxone – Narcan® ▪ Naltrexone – ReVia®, Trexan® ▪ Reverses effects of opioid overdose ▪ Dispensed through injection or nasal spray ▪ Works in as quickly as two minutes

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Treatment

Treatment for Substance Use Disorders	
▪ Individual and group counseling	▪ Medication
▪ Inpatient and residential treatment	▪ Recovery support services
▪ Intensive outpatient treatment	▪ 12-Step fellowship programs
▪ Partial hospital programs	▪ Peer supports
▪ Case or care management	

IG: Lead a discussion about treatment options and share stories from your own clinical experience. Again, some participants may wish to share experiences as well.

Source: National Institute on Drug Abuse. “Addiction Science.” Available here: https://www.drugabuse.gov/related-topics/addiction-science

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Module 7 | Mental Health Basics: Assessment, Commitment, and Legal Considerations
Administration Page

Duration: 1 hour | 4:00 pm – 5:00 pm

Scope Statement: Review of relevant federal laws, including the Americans with Disabilities Act, as well as locally applicable laws.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Describe the purpose of Assessment
- Define commitment

[NOTE: This module should be taught by a mental health expert or a lawyer from your community.]

Instructor/Participant Notes: [blank for notes]

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Module 7: Mental Health Basics

Assessment, Commitment & Legal Considerations

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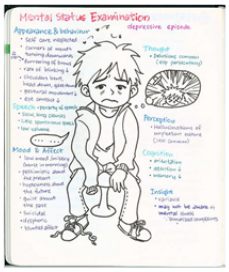
Assessment & Commitment

Assessment:

- Mental Status Exam (MSE)
- Intake Assessments

Commitment:

- Mental Health Law
- Client Rights
- Involuntary Commitment
- Immunity for certain actions



PG: Assessment seeks to understand a person's health so that appropriate help can be offered, while involuntary commitment (also known as civil commitment) is a legal process through which an individual is deemed to have symptoms of severe illness and is court-ordered into treatment.

Slide 142

Tips for Law Enforcement

- Law enforcement should recognize signs of mental health crisis.
- Some jurisdictions have CIT policies that outline pre-screening criteria for people experiencing mental health distress. Positive screens may indicate the need for a professional mental health assessment.
- While state laws vary, non-judicial custody for the purpose of a mental evaluation may be a necessary option for the safety of the person and those around them. This step occurs before issues of civil commitment are addressed; the first step is to acquire a mental health assessment to determine needs, competency, and willingness to enter treatment.
- Officers should document observed signs of mental health crisis on any requisite custody orders.

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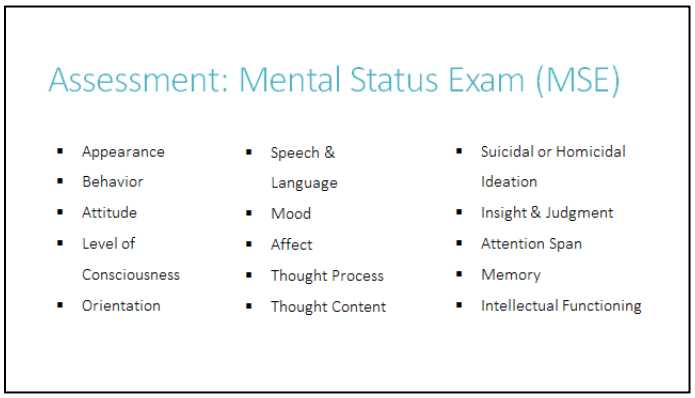

PG: A mental status exam should be completed through verbal inquiries, as well as, through observation.

- *Appearance* – Observe gait, posture, clothing (e.g., long sleeves in summer?), and grooming (e.g., hygiene)
- *Behavior* – Observe mannerisms, gestures, expression, eye contact, listening abilities, and ability to follow commands
- *Attitude* – Is the individual cooperative, defensive, hostile, suspicious, distracted, focused, and calm?
- *Level of Consciousness* – Observe if the individual is lethargic, drowsy, alert, confused, or fluctuating
- *Orientation* – Check if the individual has basic abilities and is oriented. Questions can include – What is your full name? What month, day, and year is it? Do you know where you are?
- *Speech and Language* – Is the individual talkative, expanding on the topic? Is the speech fast, slow, normal, or pressured? Is their volume too loud, soft, weak, or strong? Is there speech slurred or clear?
- *Mood* – Using questions to determine how they are feeling. Have they been depressed or sad lately? Have they been overly energized or out of control lately? Have they been angry or irritable lately?
- *Affect* – Does the affect match the mood? Observe if the individual seems to have a flat, sad, angry, even, overly excited, detached, anxious, irritable, or animated affect.
- *Thought Process* – Are their conversations and responses logical? Is it relevant to the topic, is there organization? Are they goal-directed individuals? Are they coherent?
- *Thought Content* – What has been on your mind lately? Are you worried or frightened about something? Are you thinking about something particular lately? What do you think about when mad or angry? Do things seem unreal to you? Do you ever see or hear things that are not really there? Do things not seem real?
- *Suicidal or Homicidal Ideation* – Determine if the individual demonstrates suicidal or homicidal ideation. "Do you ever feel like life is not worth living?" Have you ever thought about harming yourself? Have you done so in the past?" "Do you think about hurting others? Or getting even with people?" If possible, determine if there is a history of suicidal or homicidal ideation. Previous hospitalizations? If yes to any of the above

questions – inquire to determine if the individual has a plan of how to hurt or kill him/herself. When, where, how?

- *Insight and Judgment* – Inquire and/or observe how they describe the situation, what is causing their problems, understanding the current problem. Basic, common question used: "If you found a stamped and addressed envelope in the street, what would you do with it?"
- *Attention Span* – Determining the individual's attention and concentration abilities.

Examples to determine attention – give them a math problem ("Add these numbers," "multiply these numbers"). You may also want to recite a series of numbers to an individual and ask them to repeat them (forwards and backwards if necessary).

- *Memory* – Ask individual what his/her name is, if they took any medication that day, why are there here? To check memories – Where were you for 9/11? When did you graduate high school? Ask them to remember three words and repeat them in five or so minutes.
- *Intellectual Functioning* – Observe and inquire if an individual is aware of the largest cities in the country. Ask who is the current President, Vice President, Governor, and/or Mayor. Asking questions such as how are a chair and a table similar? How are an apple and an orange similar?

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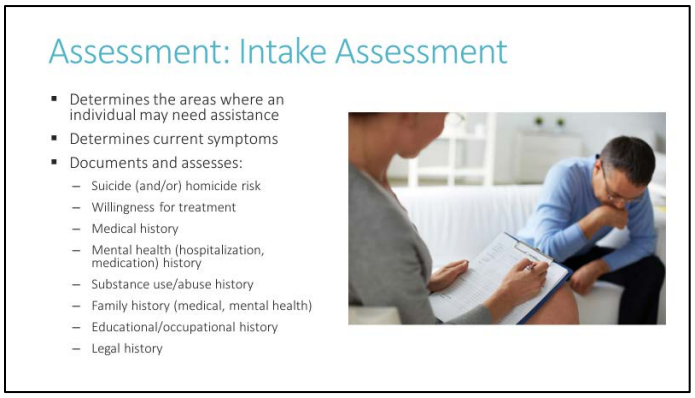

Source: National Institute on Drug Abuse. "Screening, Assessment, and Drug Testing Reources." Available here: https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/additional-screening-resources

Example of Intake Form available here: http://www.focusedsolution.net/MHI.pdf

Slide 145

PG: Sources on Mental Health Law:
National Conference of State Legislatures. 2015. "Mental Health Benefits: State Laws Mandating or Regulating." Available here: http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx
Substance Abuse and Mental Health Services Administration. "Laws and Regulations." Available here: http://www.samhsa.gov/about-us/who-we-are/laws-regulations
National Alliance on Mental Illness. "What is Mental Health Parity?" Available here: https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Understanding-Health-Insurance/What-is-Mental-Health-Parity

IG: Lead a discussion about your state's applicable mental health coverage laws, including benefits, discrimination, and insurance considerations.

Slide 146

PG: Source: Mental Health Partners. "Client Rights and Responsibilities." Available here: http://www.mhpcolorado.org/MHP/media/Documents/For%20Clients%20and%20Families/RIGHTS-AND-RESPONSIBILITIES-08-11.pdf

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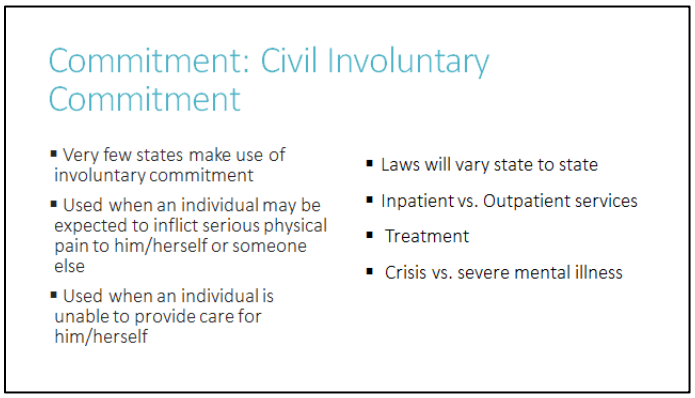

PG: Source: Testa, Megan and Sara G. West. 2010. "Civil Commitment in the United States. National Institutes of Health. Available here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/

Slide 148

IG: This slide will appear at the end of each day's slide presentation to acknowledge the departments whose work we drew upon for that day – coming from the Memphis online database of CIT modules.

Slide 149

Thanks for your participation during Day 1. We look forward to seeing you tomorrow.

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Module 8 | Mental Health Basics: Neurodevelopmental and Neurocognitive Disorders
Administration Page

Duration: 1.5 hours | 8:00 am – 9:30 am

Scope Statement: This module introduces participants to neurodevelopmental and neurocognitive disorders and their symptoms.

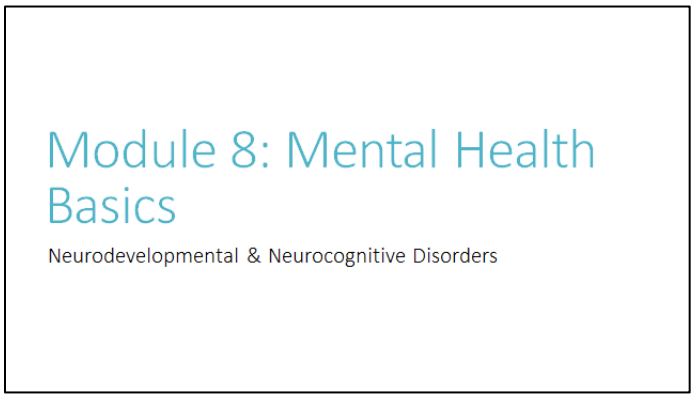
Student Learning Objectives:
Upon completing this module, students will be able to:

- Describe the difference between a neurodevelopmental disorder and a neurocognitive disorder
- Describe traumatic brain injury

[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes: [blank for notes]

Slide 150



Slide 151

PG: The DSM-5 classifies these cognitive disorders as “Neurocognitive Disorders” (NCDs).

IG: Introduce the topics of this module.

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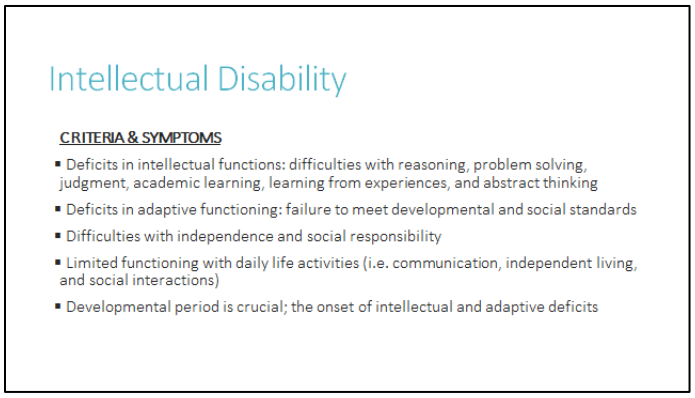
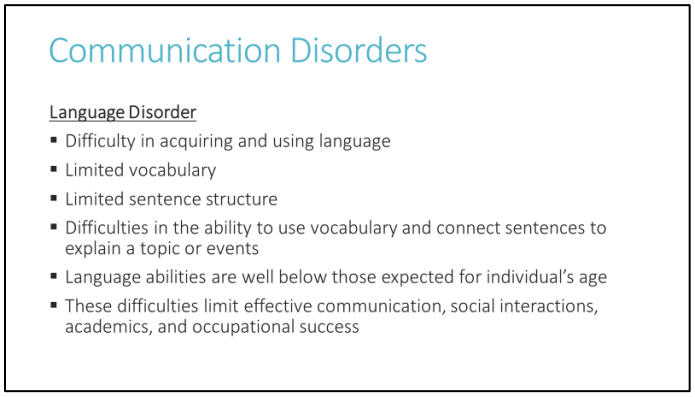


PG: Intellectual Disabilities are also known as Intellectual Developmental Disorders. The onset occurs during the developmental periods that include both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.

The levels of severity of Intellectual Disability include mild, moderate, severe, and profound. Each severity level is seen in conceptual, social, and practical domains. The age and features at onsets may depend on the severity of brain dysfunction. It may be possible to see delayed motor, language, and social milestones in the first two years of an individual's life.

Slide 153



PG: Communication disorders can include deficits in language, speech, and communication.

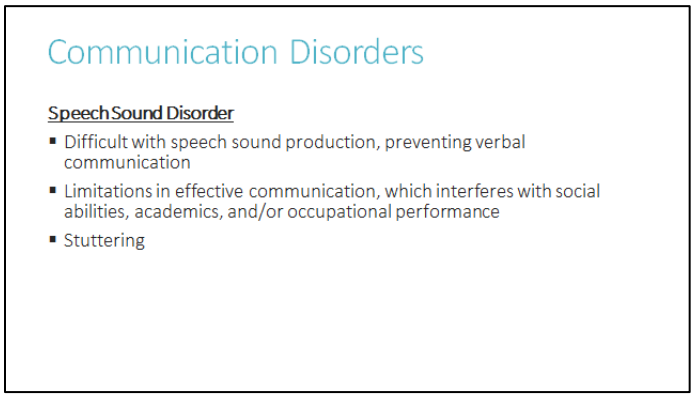
Speech: expressive production of sounds and includes articulation, fluency, voice, and resonance quality.

Language: the form, function, and use of symbols (spoken word, sign language, pictures, written words)

Communication: any verbal or nonverbal behavior that influences the ideas or attitudes of others

It is important to take an individual's cultural and language context when communicating with others. Onset of the Language Disorder symptoms is in the early developmental period.

Slide 154



PG: Childhood-Onset Fluency Disorder (Stuttering) is also included in the communication

disorders category. This involves disturbance in the fluency and pattern of speech that are inappropriate for the individual's age and language skills. The disturbance must continue over time, rather than being a standalone event, and must include at least one of these symptoms: sound and syllable repetitions; sound prolongations of consonants as well as vowels; pauses within a word; filled or unfilled pauses in speech; word substitutions to avoid problematic words; words produced with an excess of physical tension, or monosyllabic whole-word repetitions (example: "I-I-I-II see him").

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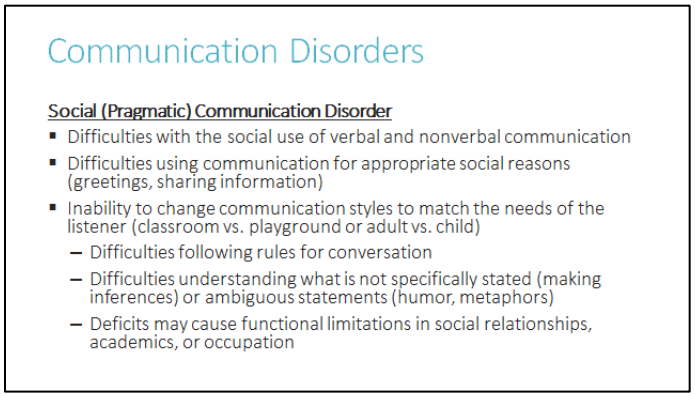
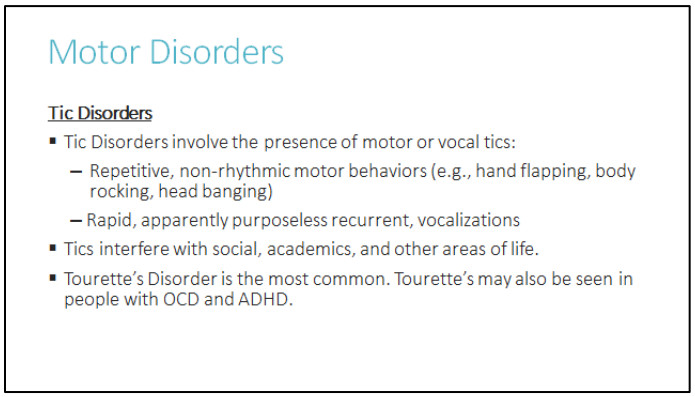


PG: The onset of symptoms is in the early developmental period for Social (Pragmatic) Communication Disorder.

Slide 156



PG: Tourette's disorder is a chronic motor or vocal tic that has been present for at least one year.

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Video Title: Living with Tourette Syndrome

Video Link: https://www.youtube.com/watch?v=e8HtTb0Vk_o

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Recognizing Neurodevelopmental Disorders

Neurodevelopmental disorders are sometimes referred to as "hidden disabilities"

- The symptoms may not be readily apparent to an outside observer
- The person may be high-functioning and excel in certain skills or environments
- The person may have learned to adapt to circumstances to overcome or hide their developmental or cognitive symptoms
- They are often present in combination with other mental or physical disorders which may be more readily recognized

Slide 159

Identifying a Potential Disability

Communication	Behavior	Interactions
• Limited vocabulary • Speech impairment • Difficulty answering questions • Short attention span	• Acts inappropriately • Easily Influenced • Difficulty with directions • Trouble with day to day tasks, such as making change or dialing a telephone • Repetitive motions or motor impairments	• Eagerness to please • Communication through others • Bluffing greater understanding than they hold • Over-engagement or under-engagement

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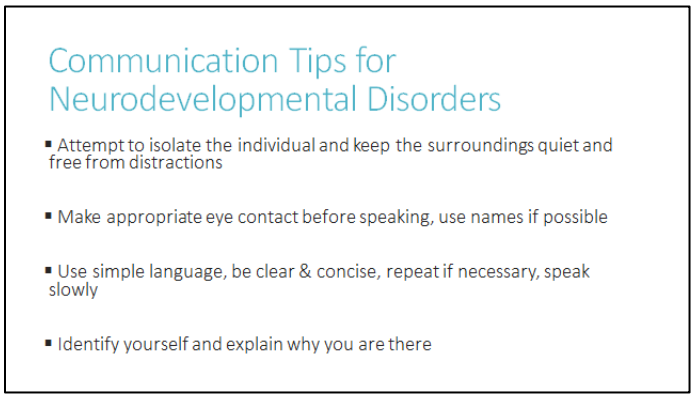
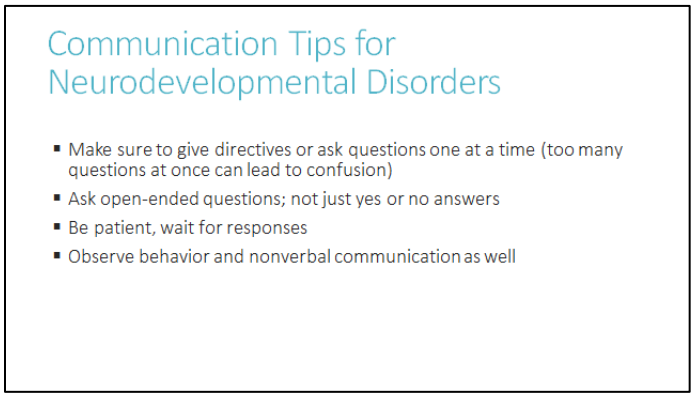


PG: Keep in mind that individuals may not communicate at their chronological age level. For example, someone may chronologically be 18, but they may be developmentally closer to the age of 10 or 12 years old. They may demonstrate a limited vocabulary and have an inability to process things as quickly or sufficiently. These individuals may have difficulties understanding and/or answering questions, and they may be unable to describe the events in their own words.

They may also not be able to understand consequences and may be easily persuaded by others.

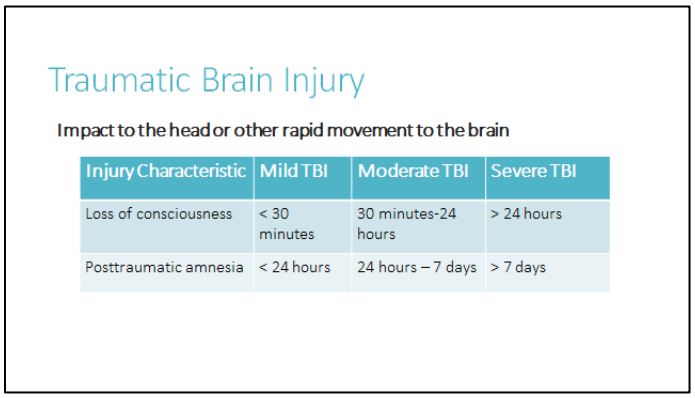
Source: CIT Memphis. "Hints for Communicating with People with cognitive disabilities." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/3/handouts/NC%20-%20Handout%20-%20Hints%20for%20Communicating%20with%20Cog%20Disabillities.pdf

Slide 161



PG: Individuals with neurodevelopmental disorders may also be unaware of appropriate social norms and have a low frustration tolerance and poor impulse control. Individuals may have difficulties reading, writing, telling time, and understanding money/currency or other basic life skills.

Slide 162

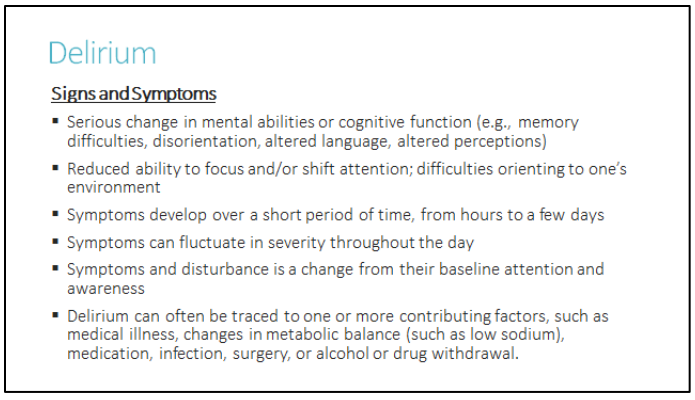


PG: Major or Mild Neurocognitive Disorders:
Traumatic Brain Injury (TBI)

A TBI requires the same criteria as major or mild neurocognitive disorder, with additional requirements. A TBI will involve physical evidence of a TBI, visible through brain scans. A TBI will also involve at least one of the following symptoms: loss of consciousness, post-traumatic amnesia, disorientation and confusion, neurological signs (e.g., new onset of seizures, marked worsening of a pre-existing seizure disorder), or a neurocognitive disorder that develops immediately after the occurrence of the TBI or immediately after recovery of consciousness and continues past the acute post-injury period.

Individuals with TBI frequently find loud noises challenging, have difficulty following conversations with many people at the same time, struggle to complete simple tasks (e.g., driving and grocery shopping), and may become easily overwhelmed when around too many stimulants. Simple tasks may require additional time and thought for an individual with a TBI.

Slide 163



PG: Delirium may lead to increased functional decline, and risk of hospitalizations or institutional placements. Older individuals with this diagnosis have 3 times the risk of being placed in a nursing home.

Slide 164

Neurocognitive Disorders

- Neurocognitive disorders are often referred to as "dementia".
- Dementia refers to a severe loss of cognitive abilities
  - **Aphasia** – Loss of ability to understand or express speech
  - **Apraxia** – Loss of ability to execute or carry out learned purposeful movements
    - *Unable to comb hair, shave self, button shirt*
  - **Agnosia** – Loss of ability to recognize or comprehend the meaning of objects
    - *May not know what an object is nor what it is used for*
- People with dementia may also experience changes in mood or personality
  - They may isolate themselves from others and appear very passive or become paranoid
- Dementia is categorized as either a major or mild neurocognitive disorder
- May be caused by physical health conditions, which can be treated to end dementia

Slide 165

Neurocognitive Disorders

MINOR

- Needs more time and energy to complete routine tasks
- Unable to multi-task, makes simple mistakes
- Becomes exhausted during social interactions
- Has difficulties recalling recent events
- Needs reminders to keep track of things, such as bills or appointments
- Has trouble finding the right words
- Makes grammatical errors
- May get lost or turned around easily
- Experiences subtle changes in attitude
- Has difficulties reading social cues and facial

MAJOR

- Has difficulty remembering new information and may not be able to repeat what was just said
- Struggles to remember past information, such as names, phone numbers, or address
- Needs simple directives, directions, and information
- Is easily distracted and struggles to stay focused
- May need help with daily living skills and making basic decisions.
- Has difficulties with speech and expressions
- Demonstrates unusual behavior in social settings
- Makes decisions without the regard for others or safety

Slide 166

Alzheimer's Disease

Signs and Symptoms

- Diagnosed if there is evidence of a genetic mutation from family history or genetic testing AND if there is no evidence of other neurodegenerative diseases/disorders (major/mild)
- Must see a clear decline in memory and learning, and one other cognitive domain (major/mild)
- Gradual decline in cognition (major/mild)
- Earliest symptoms are typically changes to mood or personality, such as passivity

Warning Signs of Alzheimer's

1. Memory loss
2. Difficulty performing familiar tasks
3. Problems with language
4. Disorientation to time and place
5. Poor or decreased judgment
6. Problems with abstract thinking
7. Misplacing things
8. Changes in mood or behavior
9. Changes in personality
10. Loss of initiative

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Older Adults with Neurocognitive Disorders: Agitation

- Many older adults with dementia demonstrate agitation
  - Seen in 50% of all persons with dementia
  - Seen in 75-90% of all nursing home patients
- It is an inappropriate verbal, vocal or motor activity, not an obvious expression of need
- Signs: physical or verbal aggression, hyperactivity, disinhibition, paranoia, refusal to accept assistance, disturbed sleep
- May be caused by medical conditions, medications, exhaustion, acclimating to new homes or reduced personal capacity, fear
- Agitation may increases risk of violent behavior

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Older Adults with Neurocognitive Disorders: Altered Perceptions

1. **Hallucinations**: can affect all five senses, in which persons perceive a sensation in the absence of actual stimuli. Hallucinations are seen in 15-50% of persons with dementia.
2. **Delusions:** create false fixed beliefs, often persecutory in nature. Delusions are seen in 20-75% of persons with dementia.
3. **Misidentifications**—result in the inability to recognize self or others. This is seen in 25-50% persons with dementia.

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Law Enforcement Encounters With the Elderly

- **Elder abuse and financial crimes:** Remember that older adults can be easily manipulated and abused by family, caretakers, or strangers.
- **Wandering**: Consider wandering an emergency situation where immediate protective action needed. Aging services should be alerted for further assessment. Be calm and supportive.
- **Indecent exposure:** Ensure the safety of person and void reprimands. Attempt to distract and assist in order to cover and protect.
- **Shoplifting**: Distract and treat gently to avoid inciting agitation. Contact family or doctor and intervene with store personnel.
- **Self-neglect**: Remain supportive and connect with aging services. It may be difficult to intervene in situations of personal care or hoarding.
- **Erratic behavior**: Offer immediate assistance for reports of erratic driving, dangerous wandering, placing self at risk. Contact doctors or seek medical evaluation and protective measures
- **Catastrophic reactions**: Stay calm and use simple language. The event may be alarming to all concerned and dangerous in the moment. Be patient throughout response.

Slide 170

Communication Techniques for Neurocognitive Disorders

- Assume older adults are cognitively intact unless given clear reasons to question this.
- Trust is essential to gain vital information from older adults.
- Identify yourself as law enforcement and explain why you have approached them.
- One person should speak at a time, one officer takes lead.
- Remember to assess for visual and hearing deficits.
- Speak slowly in a non-threatening, low-pitched voice. Don't assume hearing impairment.
- Maintain a calm environment and lessen stimuli.
- Avoid restraints, confinement may trigger agitation exacerbating confusion and disorientation.
- Be open to non-verbal communication if speaking does not work.

Slide 171

Communication Techniques for Neurocognitive Disorders

- Look for medical alert bracelets.
- Maintain good eye contact.
- Be patient.
- Ask "yes" and "no" questions.
- Avoid memory related questions.
- Ask one question at a time, allow time for response.
- Repeat with same wording if needed.
- Promote their sense of self-efficacy, even when offering assistance.
- Talk directly to the older adult as much as possible.
- Avoid demeaning tones or speaking to them as a child.
- Do not argue about their reality.
- Repeat, repeat, and repeat again if necessary.
- Acknowledge their frustration.

Module 9 | Mental Health Basics: Pyschopharmamcology Administration Page

Duration: 1 hour | 9:00 am – 10:00 am

Scope Statement: This module provides a general overview of medications and presents easy-to-understand categories. Handouts of common drugs used for various illnesses.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Name 4 types of psychotropic medications
- Name some common side effects of these medications

[NOTE: This module should be taught by a local psychiatrist or mental health professional with experience prescribing medications for mental health disorders.]

Instructor/Participant Notes: [blank for notes]

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Module 9: Mental Health Basics

Psychopharmacology

Slide 173

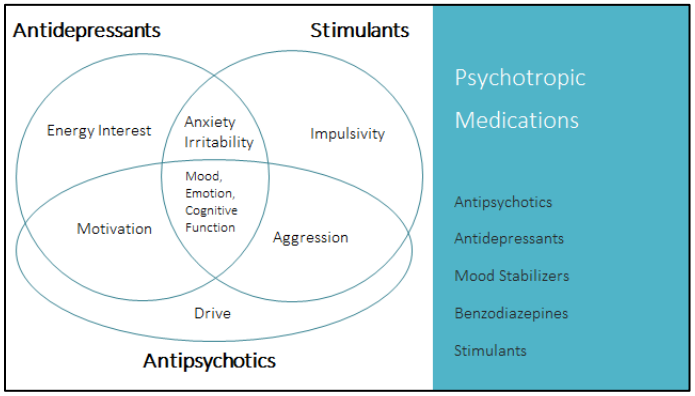
Why Understand Psychopharmacology?

- Medication helps a lot of people with mental illness; mental illness is treatable and many people do well on medication.
- There is increasing acceptance of mental illness as a chemical imbalance in brain.
- Psychotropic medication is becoming more accepted in society at large.
- Psychotropic medication alters chemical levels in the brain, impacting mood and behavior. Medications may impact the contacts law enforcement have within the community.
- It is important to know that medication is NOT a cure-all.
- CIT officers should understand why language such as "why don't you just take your meds?" is NOT helpful.

IG: Lead a discussion as to why it may be important for CIT officers to be aware of commonly-prescribed medication. How might knowledge about what these medications are prescribed for benefit responding officers?

PG: Link to Worksheet (handout): http://www.namihelps.org/assets/PDFs/fact-sheets/Medications/Commonly-Psyc-Medications.pdf.

Slide 174



PG: The three main classes of drugs used to treat mental illnesses are antipsychotics,

antidepressants, and mood stabilizers.

Antipsychotics: Haldol, Prolixin, and Thorazine are neuroleptics and effective for positive symptoms. Clozaril is a Neuroleptic that reduces positive and negative symptoms.

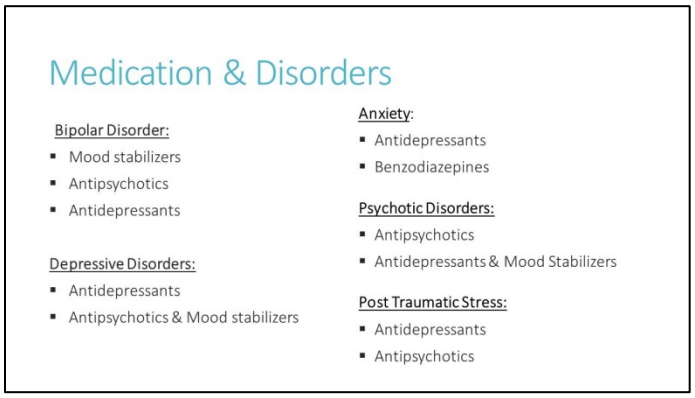
Antidepressants are used to decrease irritability, sadness, hopelessness, guilt, or suicidal thoughts. They may improve sleep patterns, appetite, and energy levels.

Mood Stabilizers are used to reduce the frequency and severity of mood changes, gain more control over emotions, cope better with daily living and potential problems, and reduce anger, irritability, or false senses of well-being. They may also help with depression (i.e. feelings of sadness and hopelessness).

Image derived from: Stahl, SM. Essential Psychopharmacology: Neuroscientific Basis and Practical Applications. Second edition. Cambridge, UK: Cambridge University Press; 2000: 152.

IG: Discuss the importance of monitoring medication and medication management. For example, the improved mood and activity produced by the antidepressants can provide the energy for a suicidal person to carry out his/her act. Therefore, even though an individual is medication compliant, there are still other factors to consider and monitor regularly.

Slide 175



PG: Source: CIT Memphis. "Psychiatric Medications." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/6/presentations/FL%20-%20Psychiatric%20Medications.pdf

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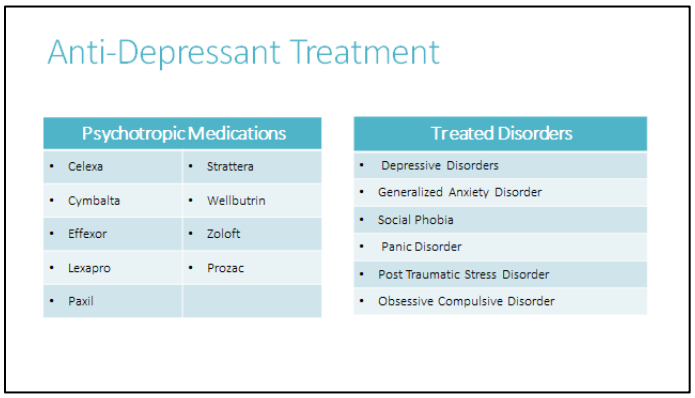

PG: Sources: CIT Memphis. "Psychiatric Medications 101: A brief guide for law enforcement." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/6/presentations/VA%20-%20Arlington%20-%20Psychiatric%20Medications.pdf

CIT Memphis. "Psychiatric Medication." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/6/presentations/FL%20-%20Psychiatric%20Medications.pdf

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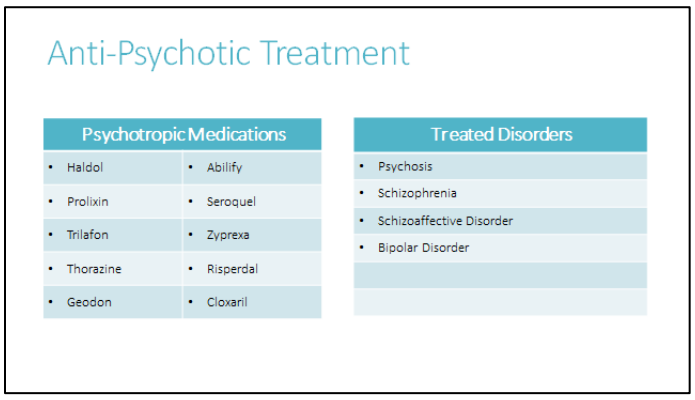

PG: Sources: CIT Memphis. "Psychiatric Medications 101: A brief guide for law enforcement." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/6/presentations/VA%20-%20Arlington%20-%20Psychiatric%20Medications.pdf

CIT Memphis. "Psychiatric Medication." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/6/presentations/FL%20-%20Psychiatric%20Medications.pdf

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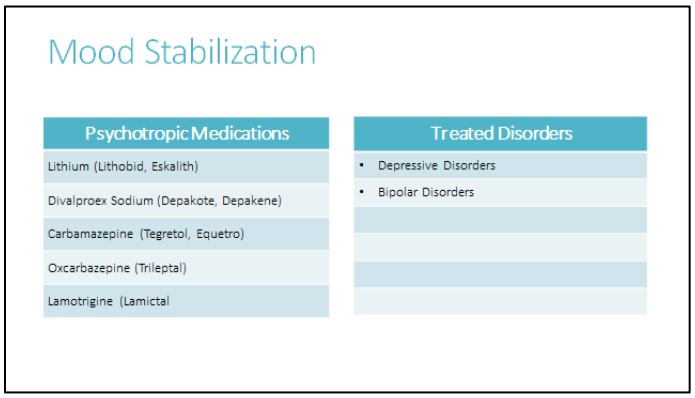

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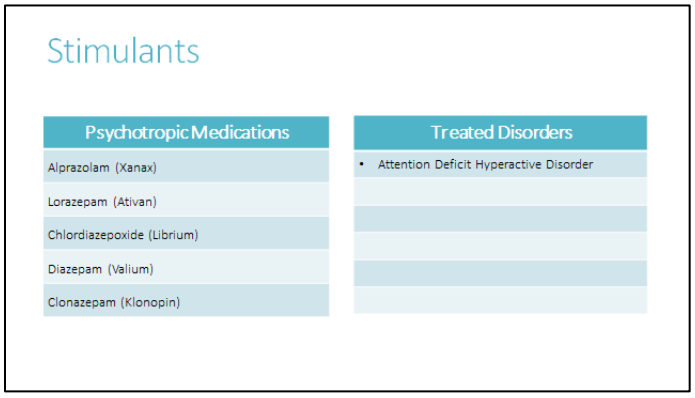

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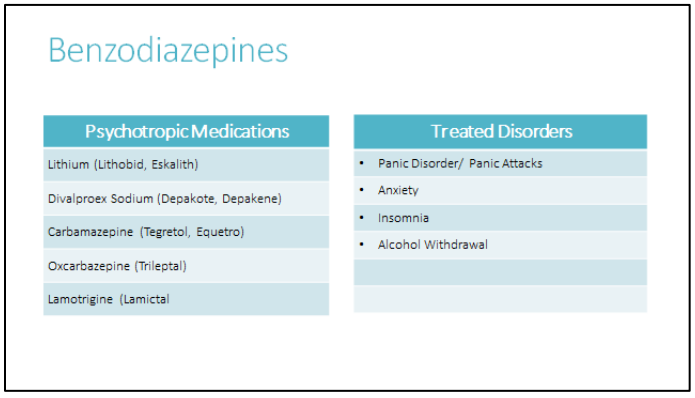

Sources: CIT Memphis. "Psychiatric Medications 101: A brief guide for law enforcement." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/6/presentations/VA%20-%20Arlington%20-%20Psychiatric%20Medications.pdf
CIT Memphis. "Psychiatric Medication." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/6/presentations/FL%20-%20Psychiatric%20Medications.pdf

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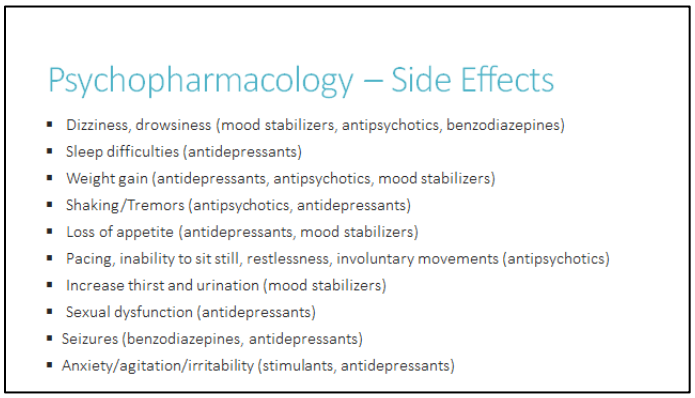

Sources: CIT Memphis. "Psychiatric Medications 101: A brief guide for law enforcement." Available here: http://www.cit.memphis.edu/modules/Mental%20Illness/6/presentations/VA%20-%20Arlington%20-%20Psychiatric%20Medications.pdf
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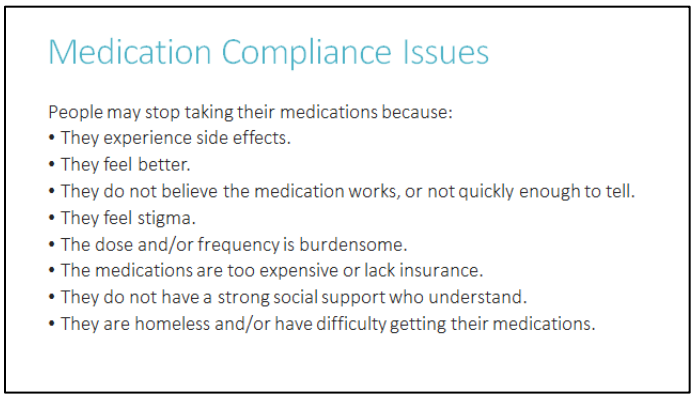

IG: Lead a discussion of why people do not take their medication.

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Implications for First Responders

- Check with family, friends, caregivers about all medications and their compliance. Knowing the type of medication will help you know the illness and its associated symptoms.
- Being able to identify pills and know which class of drugs they are part present can give you more information to assess the situation.
- The risk of unpredictable behavior increases if the person is if off their prescribed medications.
- Always consider possibility of medical emergency – assess level of consciousness and respiratory condition and EMS if unsure.

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Psychopharmacology – Officer Tips

Officers could say, "I understand that you're not taking your medication right now and I understand that it has side effects. Can we get you to the doctor to see if they can get you on something else that works better?"

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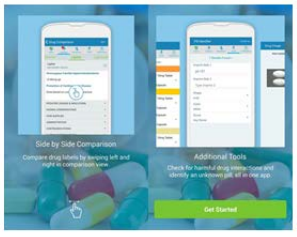
Pharmacology Resources

Mobile PDR App



BH Meds App

PG: The *Mobile PDR App* can be downloaded onto your phone to find informaiton about specific medications, including uses, interactinos, and pill descriptions. The *BH Meds App* can be downloaded onto your phone to find information about specific behavioral health medications, including uses, interactions, and pill descriptions.

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Site Visits Administration Page

Duration: 6 hours | 10:00 am – 5:00 pm (with 1 hour lunch break)

Scope Statement: Site visits are an important part of the participants' experience to solidify their understanding of the mental health system as well as the options available to them in certain situations. The site visit experience is meant to enhance and intensify the classroom learning of mental health Basics by providing opportunities for participating officers to meet and communicate with people with mental illness as well as mental health care professionals and familiarize them with the mental health care facilities and resources available to them in their communities.

It is important to plan site visits logically – according to the number of students in the course, the number of facilities willing to host your visit, and the hours available. Ideally, every student should visit at least *two* mental health care facilities in the community and spend a number of hours at each. Possible site visit locations include, but are not limited to: veterans' administration facilities, day treatment programs, emergency services, crisis stabilization facilities, programs for homeless individuals, psychiatric hospitals, outpatient facilities, or local NAMI chapters to have roundtable discussions with people with mental illness and their families.

If participants are divided to visit different sites, it may be useful to have all participants reconvene at the training site before the end of the day to debrief.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Describe TWO mental health care facilities in your community, including location, hours of operation, and conditions under which they will accept a patient intake; and
- Name one person they met today that they did not know previously and describe his/her role in the mental health care system.

Instructor/Participant Notes Site Visit: [blank for notes]

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Module 10 | Mental Health Basics: Disorders in Children, Youth and Adolescents – Autism and Developmental Disorders Administration Page

Duration: 1 hour | 8:00 am – 9:00 am

Scope Statement: This module introduces participants to disorders in children, youth and adolescents and their symptoms.

Student Learning Objectives:
Upon completing this module, students will be able to:

- List some of the warning signs of mental health conditions in youth
- Define Autism Spectrum Disorder
- Identify symptoms of Attention-Deficit Hyperactivity Disorder (ADHD)

[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes Module 10: [blank for notes]

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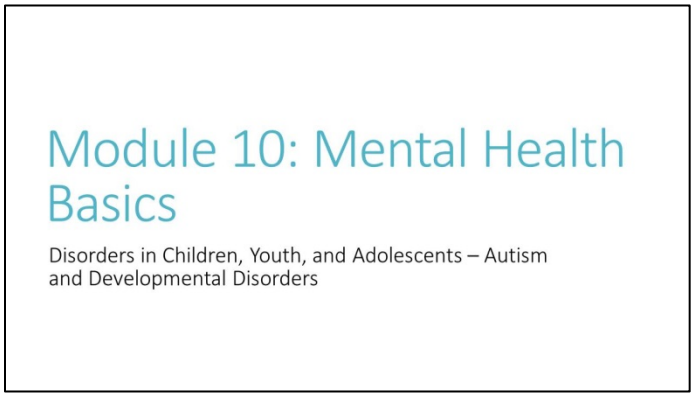

Slide 187

IG: Briefly introduce the topics that will be covered in this module.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

Slide 188

PG: Link to VIDEO: https://www.nami.org/Learn-More/Know-the-Warning-Signs

IG: [video will be embedded]

Show the video and briefly debrief it by asking whether the participants have seen these signs of mental health conditions in youth that they interact with.

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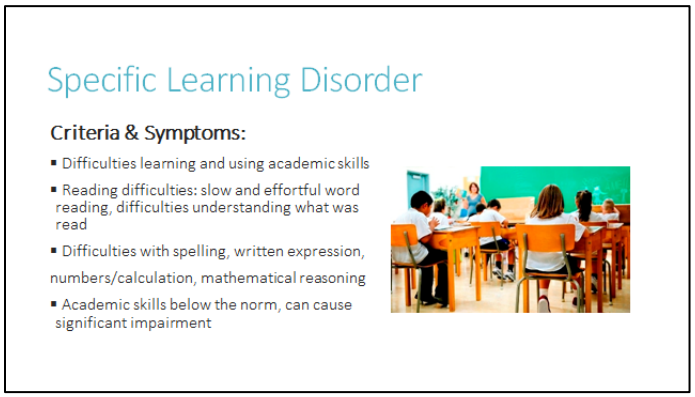

PG: Specific Learning Disorder symptoms usually occur for six months prior to diagnosis. Difficulties may begin during school-age years.

IG: Briefly discuss learning disorders and their symptoms.

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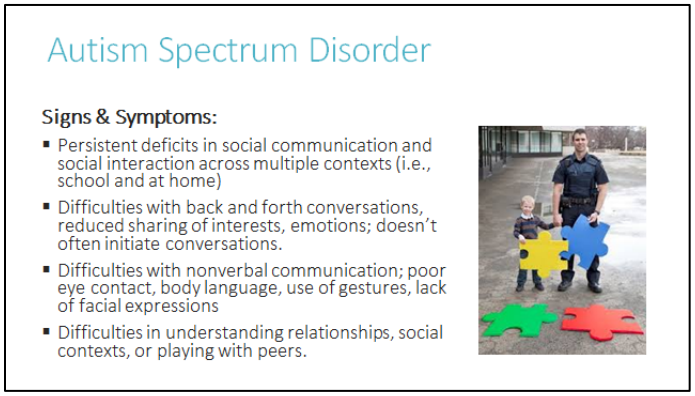

PG: Autism Spectrum Disorder

Severity is based on social communication impairments, repetitive patterns of behavior:

- Repetitive motor movements (lining up toys, flipping objects)
- Insisting things be the same, distress at small changes, difficulties with transitions, rigid thinking patterns
- Highly restricted, fixated interests that are abnormal in intensity (strong attachment to an unusual object)
- Hyper- or hypoactivity to sensory output (apparent indifference to pain/temperature, fascinated with lights or movement)
- Symptoms must be present in the early developmental period.
- Symptoms cause significant impairment in social, occupational, academic, or

other areas of current functioning.

For more information: https://www.autismspeaks.org/family-services/autism-safety-project/first-responders/law-enforcement

IG: Lead a brief discussion about the signs and symptoms of Autism Spectrum Disorder.

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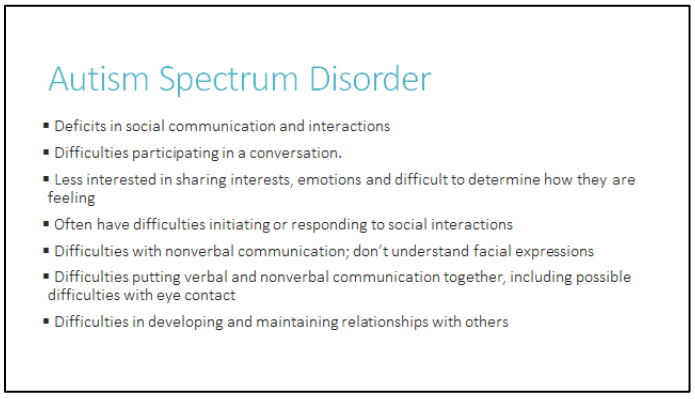

PG: Some difficulties with social interactions – which vary based on an individual's place on the Autism Spectrum. Individuals may rely on patterns, and often repeat these patterns. Symptoms must be seen during the developmental period, usually within the first two years. Additional symptoms for children, youths, and adolescents include having difficulty understanding the rules of conversation, lack of eye contact, difficulties taking turns and listening to others, or inappropriate responses to questions or conversations. The individual may focus on one particular subject of interest. Depending on where the individual lands on the spectrum, there may be difficulties with using specific words and organizing one's thoughts.

"The term 'spectrum' refers to the wide range of symptoms, skills, and levels of impairment or disability that children with ASD can have. Some children are mildly impaired by their symptoms, while others are severely disabled."

Sources: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association. Available here: https://www.psychiatry.org/psychiatrists/practice/dsm

National Institute of Mental Health. "Autism Spectrum Disorder." Available here: http://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd/index.shtml

IG: Lead a discussion about Autism in children, youth and adolescents drawing on your own clinical experience.

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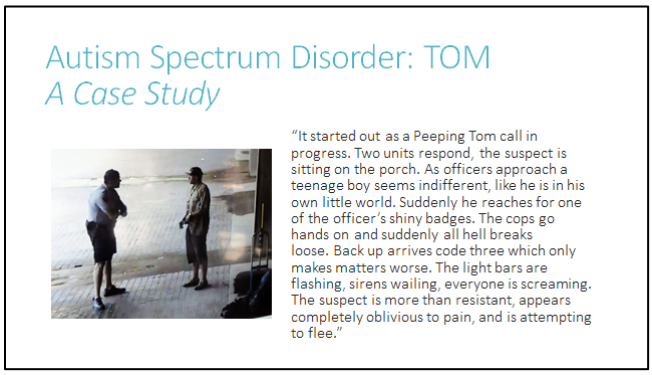

PG: *Case Study: Tom*

"It started out as a Peeping Tom call in progress. Two units respond. The suspect is sitting on the porch. As officers approach a teenage boy seems indifferent, like he is in his own little world. Suddenly he reaches for one of the officer's shiny badges. The cops go hands on and suddenly all hell breaks loose. Back up arrives code three which only makes matters worse. The light bars are flashing, sirens wailing, everyone is screaming. The suspect is more than resistant, appears completely oblivious to pain, and is attempting to flee. A responding medic notices a medical bracelet on the suspect's risk…he is autistic. Calls related to an autistic individual can be challenging at best. Recognizing autism, understanding the risks, and learning methods of interaction is critical for a successful crisis resolution."

Source: Kulbarsh, Pamela. 2015. "Law Enforcement and Autism." Available here: http://www.officer.com/article/10880086/law-enforcement-and-autism

IG: Discuss the case study. Ask, "What are some of the symptoms from the case study that might indicate the individual might be diagnosed with Autism Spectrum Disorder?

What were some of the potential difficulties about the interactions with police officers responding to this call? Knowing what you do now about Autism Spectrum Disorder, what might be alternative ways to de-escalate the situation?"

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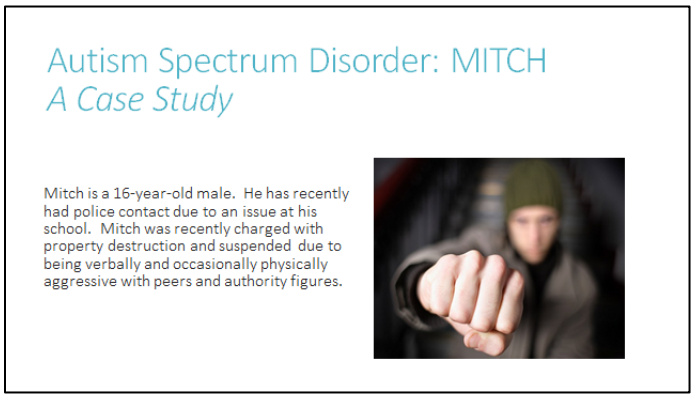

PG: *Case study: Mitch*
Mitch is a 16-year-old male. He has recently had police contact due to an issue at his school. Mitch was recently charged with property destruction and suspended due to being verbally and occasionally physically aggressive with peers and authority figures. Mitch often has trouble making eye contact with individuals. He speaks in long sentences, usually using the right words but not quite able to easily get his point across. He often needs to work harder at listening in the classroom and in general conversations, and it takes him longer to understand what is being said. When Mitch does contribute to the conversation, he is often focused on one particular topic (whatever his specific interest/favorite subject was at the time). Mitch does not play or interact much with his peers in school or in the neighborhood. While he is very curious, he is also impulsive and occasionally aggressive. These characteristics make it difficult for him to participate in activities with peers. It also makes it difficult for him to calm himself down once agitated about something or a situation.

IG: Ask: "What are some of the symptoms you may have noticed? What might be some of the ways you can work with an individual exhibiting these symptoms?"

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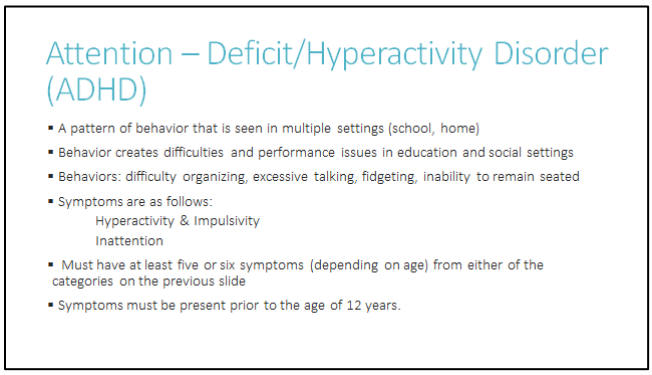
PG: Source: Autism Speaks. "Information for Law Enforcement." Available here: https://www.autismspeaks.org/family-services/autism-safety-project/first-responders/law-enforcement

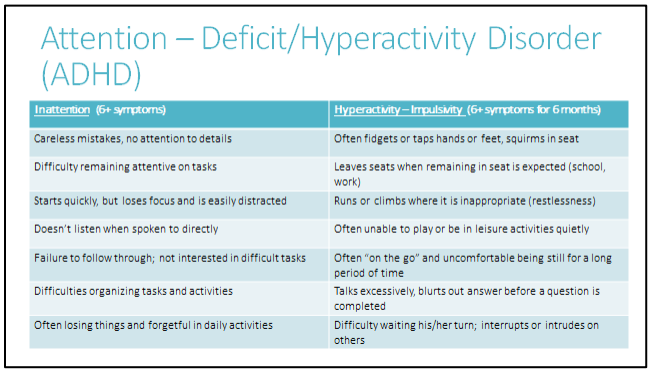
Slide 195



PG: Symptoms of ADHD include hyperactivity (i.e. more active than usual, moving from one thing to another quickly, unusually active) or inattention (the failure to pay attention, focus, or think about something).

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

Slide 196



PG: Criteria and Symptoms include:

- A pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning and/or development
- Several inattentive or hyperactive-impulsive symptoms were present prior to the age of 12 years.
- Several of the symptoms are present in two or more settings (home, school, work, with friends, with relatives, in other activities or settings)
- The symptoms clearly interfere with social, academic, or occupational functioning

According to the DSM-5, ADHD occurs in most cultures in about 5% of children and about 2.5% of adults.

Citation: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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Module 11 | Mental Health Basics: Disruptive, Impulse-Control, and Conduct Disorders
Administration Page

Duration: 1 hours | 9:00 am – 10:00 am

Scope Statement: This module introduces participants to disruptive, impulse-control, and conduct disorders and their symptoms.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Define conduct disorder
- Describe symptoms of impulse-control disorders
- Describe some signs and symptoms of pyromania

[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes Module 6: [blank for notes]

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Module 11: Mental Health Basics

Disruptive, Impulse-Control, & Conduct Disorders

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Disruptive, Impulse-Control, & Conduct Disorders

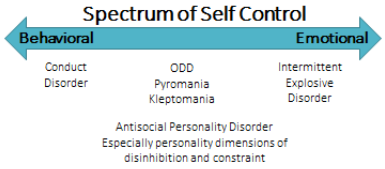
- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Pyromania
- Kleptomania

IG: Briefly introduce this module, noting the illness that will be covered, as listed on slide.

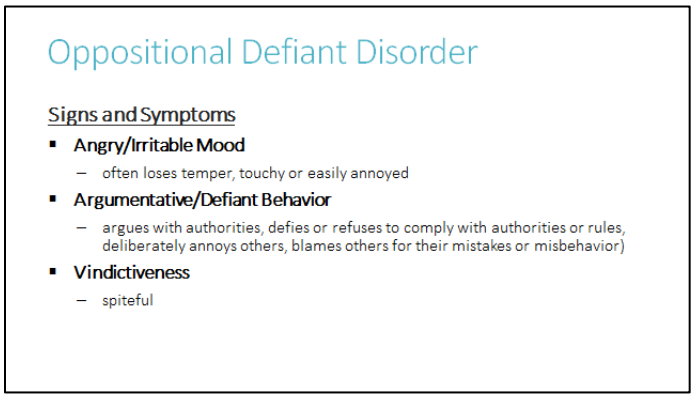
Slide 199

Disruptive, Impulse Control and Conduct Disorders

- All these disorders characterized by problems in emotional and behavioral self-control



Slide 200



PG: For an individual to be diagnosed with this disorder, you would see a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least six months, with at least four of the following symptoms:

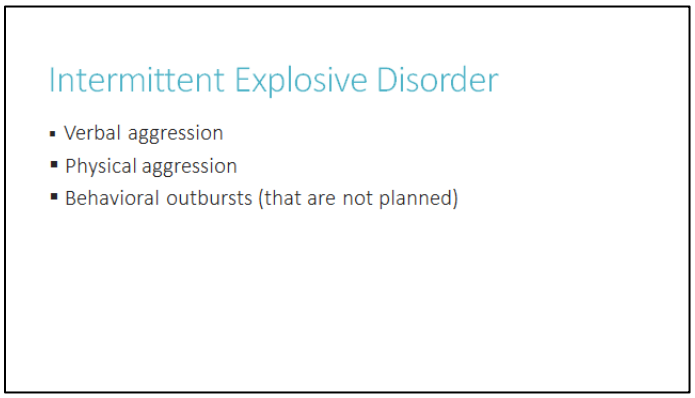
- Displays an angry/Irritable Mood
- Often loses temper
- Is often touchy or easily annoyed
- Is often angry and resentful
- Demonstrates argumentative or defiant Behavior
- Often argues with authority figures or, for children and adolescents, with adults
- Often actively defies or refuses to comply with requests from authority figures or with rules
- Often deliberately annoys others
- Often blames others for his or her mistakes or misbehavior
- Has been spiteful or vindictive at least twice within the past 6 months

"ODD is often diagnosed alongside ADHD. Children with ODD often have co-occurring mood disorders like depression, anxiety disorders, or learning or communication disorders. Professionals warn that ODD that goes untreated early in life is often linked to more severe disorders later, including conduct disorder and substance use disorder."

Source: Child Mind Institute. "ODD: Risk for Other Disorders." Available here: http://childmind.org/guide/oppositional-defiant-disorder/other-disorders/

IG: Lead a discussion of ODD and draw from your clinical experience.

Slide 201



PG: Behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following:

- Verbal aggression (temper tantrums, tirades, verbal arguments or fights)
  - Occurring twice weekly, on average, for about 3 months
- Physical aggression – towards individuals, property, or animals
  - Occurring twice weekly, on average, for about 3 months
  - Does not result in damage or destruction of property and does not result in physical injury to animals or other individuals
- Three behavioral outbursts involving damage or destruction of property
  - and/or physical assault involving physical injury against animals or other individuals
  - occurring within a 12-month period
- The aggressive response or outburst is much more intense (grossly out of proportion) to the situation or stressor
- The aggressive response was not planned or premeditated (they are impulse or anger based)
- Aggressive acts are not committed to achieve some tangible objective (money, power, intimidation)
- The aggressive outbursts cause distress in the individual or impair their occupational or interpersonal functioning, or are associated with financial or legal consequences
- Chronological age is 6-years-old (or similar in developmental level)
- The aggressive outbursts are not better explained by another mental disorder
- You might see Intermittent Explosive Disorder diagnosed in addition to the diagnosis of either Conduct Disorder, ADHD, ODD, or Autism Spectrum Disorder

IG: Lead a discussion of IED and draw some examples from your own clinical experience.

Slide 202

PG: Source: Paone, Tina & B. Douma, Kara. 2009. "Child-Centered Play Therapy With a Seven-Year-Old Boy Diagnosed With Intermittent Explosive Disorder." International Journal of Play Therapy. 18. 31-44. Available here.

ABOUT BOBBY

Bobby is a 7-year-old girl who lives with her mother, older biological sister, two older step-siblings, a foster sibling, and a stepfather. Her stepfather is the only father Bobby has known, and he has been with Bobby since birth. Although Bobby has never known her biological father, she is aware of him through family stories. Bobby's mother describes her biological father as an alcoholic, drug addict, and sociopath, as well as diagnosed with bipolar disorder. When Bobby's mother was pregnant with her, her biological father attacked, robbed, and attempted to murder Bobby's mother. Bobby's father was incarcerated for this act and is currently serving a prison sentence; however, Bobby remains unaware of this incident. Bobby's mother worries her daughter will inherently become his father if she does not get her help.

Bobby came to therapy because her parents were concerned about her overly-aggressive and explosive behavior. Bobby's parents believed that her strengths lie in her ability to be kind and gentle when she wanted to be, although they felt as though these times were slipping away with each passing week. They felt that it was Bobby's willful actions that determined her behavior. Bobby's parents indicated that she had always exhibited these types of behaviors, but they noticed it worsened as Bobby grew older. As a little girl, Bobby would upset easily, but she would also calm easily. She always threw temper tantrums and behaved in a manner they believed was developmentally-appropriate for a child her age; however, once Bobby started first grade, her behaviors began to increase in intensity and frequency at both home and school.

At the onset of therapy, Bobby was getting into trouble at school four to five times per week. Bobby's mother defined trouble as days when the principal, school counselor, or teacher would call her to discuss Bobby's disruptive behaviors in class. Often times, this would result in Bobby's mother leaving work to pick up Bobby from school for the remainder of the day. A teacher reported that Bobby had "flipped out," punched holes in the walls, knocked down bookshelves, and was unable to keep her hands to herself on a frequent basis.

Bobby was suspended on more than one occasion in first grade, during the early part of the

school year. The school counselor, coupled with Bobby's teachers, was pushing toward immediate special education testing and removal of Bobby from this public school site to a "special" school dealing specifically with behaviorally aggressive children. These school personnel deemed that special education testing was necessary to specifically address any existing behavior issues (i.e., emotional handicap). According to her parents, Bobby was very difficult to control. At home, she did not listen, was defiant, and was unafraid of anyone or anything. She did not respond to spankings, time outs, or removal of possessions. In addition, Bobby had kicked holes in walls, run from her parents in malls and other stores, dashed out into highway traffic, and kicked out a car window. When Bobby ran away from her parents in stores, it took both parents to restrain her during these temper tantrums. Bobby's parents also reported that she has impulsively flipped dressers, televisions, and destroyed an iPod. She broke many of her own toys and belongings. Bobby also exhibited baby talk at times when conversing with adults. Her parents reported that not all of the times were bad; they stated that "when she's good, she's really good, but when she's bad, she's really bad." They explained her good behavior as a child who listens, does what is asked of her, and does not act out. At the beginning of therapy, however, the bad times outnumbered the good. Bobby's parents brought her in for therapy because they did not know what else they could do.

After a thorough review of Bobby's history and a consultation between the agency psychiatrist, child psychologist, and licensed professional counselor (LPC) who was also a registered play therapist (RPT), she was diagnosed with IED. The team explored more common diagnoses for Bobby including oppositional defiant disorder (ODD), conduct disorder, and attention-deficit/hyperactivity disorder (ADHD), but determined that Bobby did not match the criteria for these diagnoses; however, she did for IED.

IG: Direct your participants to their PG to read the case study about Bobby. Debrief the case study by asking how they may come into contact with Bobby. Examples include: called to Bobby's home for a domestic incident, called to the school because Bobby was aggressive toward another student or teacher.

Slide 203

Conduct Disorder

Conduct disorder (CD) – Children with conduct disorder purposefully engage in patterns of antisocial behavior that violate social norms and the rights of others.

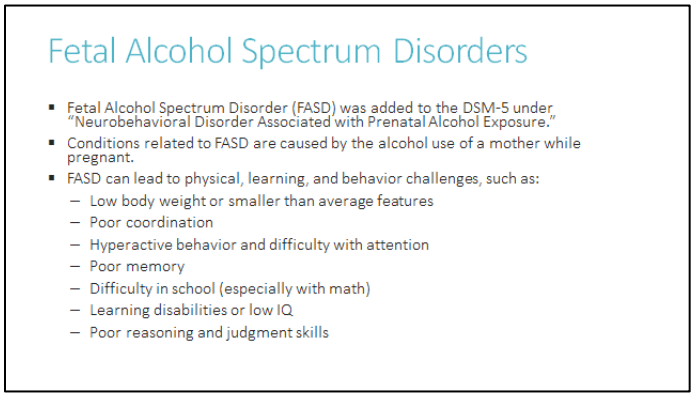
- Present in 12% of males, 7% females
- Average age of onset – 11.6 years old
- Linked to antisocial behavior in adults
- Signs and symptoms:
  - Intentionally aggressive and cruel behavior
  - Manipulative and deceitful behavior
  - Does not feel guilt, remorse, or empathy
  - Commits serious violations of rules
  - May engage in substance misuse and early sexual activity

Slide 204

PG: Link to VIDEO: https://www.youtube.com/watch?v=0-Mr3irlWIk

IG: Ask participants whether this case looks familiar to them. Have they come into contact with children who behave like this? If so, how did they handle it? What happened in the end?

Slide 205



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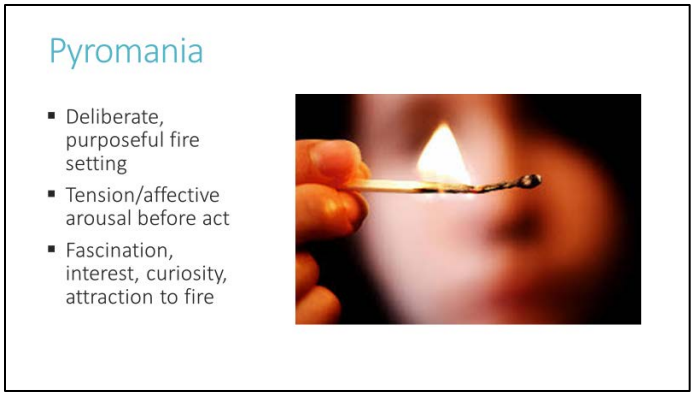
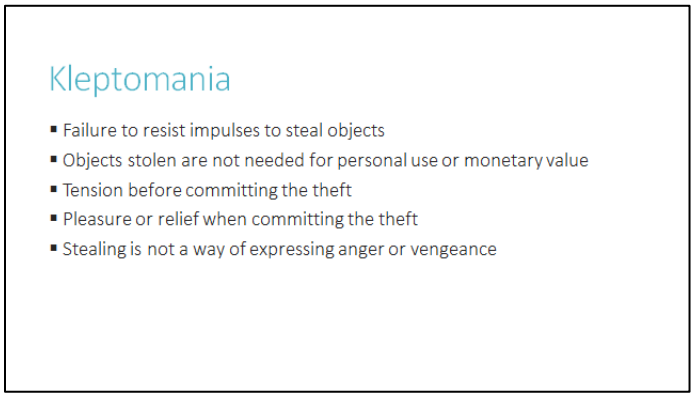


PG: *Pyromania* involves the deliberate and purposeful fire setting on more than one occasion. People with pyromania are fascinated, interested, curious, or attracted to fire and fire-setting

paraphernalia. Fires are not set solely for the fun of it; the individual experiences extreme tension or arousal before the act of fire setting, which they feel must be relieved by setting a fire. This is immediately followed by a sense of pleasure or relief when setting fires or witnessing their aftermath. It is also important to know that in pyromania, fire setting is not done to express anger or vengeance, nor is it done for any monetary gain, religious or political purposes, or to conceal criminal activity.

Slide 207



PG: Diagnostic requirements include that the stealing is not in response to a delusion or hallucination and that the stealing is not better explained by conduct disorder, a manic episode, or antisocial personality behavior.

Slide 208

PG: Link to case study: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4292012/

Jerry, a 45-year-old, divorced male was remanded three times in the same year for the same charges and evaluated specifically with regard to kleptomania. He was unemployed. He had previously been diagnosed with conduct disorder, alcohol dependence, depression, and antisocial personality disorder. He had started shoplifting from the age of 29. The diagnosis of kleptomania had been considered a few times but not established because of the lack of corroboration of his self-reported history of kleptomaniac pattern of stealing and the presence

of other diagnoses that are assumed to preclude kleptomania according to the criteria. What further complicated the diagnostic issue was that he was likely to have been intoxicated by alcohol at the material time. He gave a history of stealing for fun together with friends during his teenage years.

He started stealing again in his late twenties, committing the act more times than he was caught, but had spent more than seven years in prison for shoplifting items that he had no personal use for. The stolen items included candles, crayons, children's scissors, irons, bottles of ink, colored papers, printers, earrings, brooches, batteries, and shavers, and he kept these items in a cupboard at home. However, the house had been sold after his divorce, and his ex-wife could only corroborate seeing many electronic and stationery items that were never used and said that he claimed they had been given to him by people who owed him money. He also reported that he only stole on impulse and not from premeditation; he experienced tension prior to, and satisfaction after, shoplifting. In order to substantiate his history, details of his past criminal records of theft were requested from the Investigating Officer in charge of his case, and they were fairly consistent with what he reported. This case is interesting in that even though he had been diagnosed with conduct disorder and antisocial personality disorder, there was no evidence that these conditions accounted for all his acts of stealing, and that there were distinctly different patterns of stealing at different points in his life. He was finally diagnosed with antisocial personality disorder, alcohol dependence and kleptomania, and it was concluded that kleptomania contributed to only some of his offences.

IG: Direct participants to read the case study of Jerry in their PG, then lead a discussion about Jerry and bring in examples from your own clinical experience.

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Module 12 | Mental Health Basics: Personality Disorders Administration Page

Duration: 1 hour | 10:00 am – 11:00 am

Scope Statement: This module introduces participants to personality disorders and their symptoms.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Define personality disorders in general terms
- Give an example of a personality disorder and describe its symptoms

[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes: [blank for notes]

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Module 12: Mental Health Basics

Personality Disorders

Slide 210

Personality Disorders

- Paranoid Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder (HPD)
- Narcissistic Personality Disorder
- Obsessive – Compulsive Personality Disorder (OCPD)

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Paranoid Personality Disorder

SIGNS & SYMPTOMS

- Pervasive distrust and suspiciousness of others.
- Suspects others are harming, exploiting, or deceiving him/her
- Preoccupied with loyalty or trustworthiness of friends
- Reads hidden threating meaning into benign remarks or events
- Perceives attacks on his/her character that others don't notice, quick to react angrily
- Suspicions (without reason) of spouse or partner infidelity

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Paranoid Personality Disorder: Interactions and Treatment

- Help the individual exhibiting symptoms stay calm
- Do not argue with the paranoia. Be empathic and focus on the emotions, not the facts.
- Attempt to determine if they are aware of any current mental health difficulties, attempt to determine their mental health history
- Individuals may be suspicious of doctors, so it may take time
- Talk therapy
- Medication for some of the symptoms of the disorder.
  - Possible anti-anxiety medication
  - Possible anti-psychotic medication tor severe agitation, delusional thinking

IG: Lead a brief discussion about treatment for paranoid personality disorder, drawing on your own clinical experience.

Slide 213

Paranoid Personality Disorder: ROBERT | *A Case Study*

Robert has made multiple calls to the police department for various reasons; most calls were lengthy complaints of a suspicious person with stories that could not be validated.

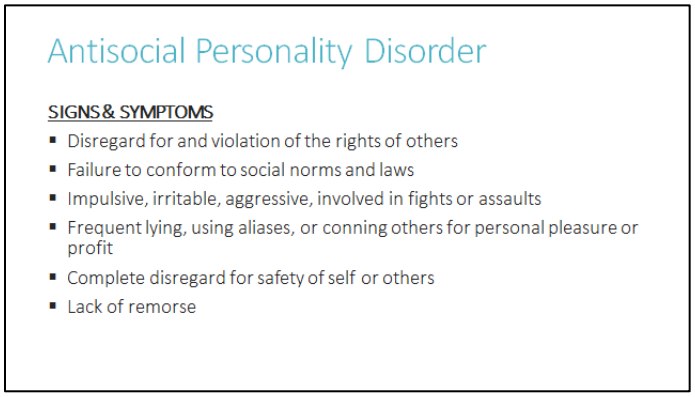
PG: Robert has made multiple calls to the police department for various reasons: most calls were complaints of a suspicious person, lengthy complaints with no validation to the stories.

Robert grew up in a lower middle-class neighborhood. In school he did exceptionally well, often getting the highest possible grades. While he did well in school, Robert was also rude to his classmates and teachers, often correcting them. Robert made fun of those who could not get an A in class and would mock and laugh at his peers. Robert was also considered very arrogant, always thinking he was better than everyone else. He had troubles with relationships, often thinking his friends and significant others were taking his ideas and couldn't trust them. He often avoided crowds of people. Robert has sought revenge on ex-girlfriends. When Robert was older and working, he showed hostility towards coworkers and was asked to resign after 3 years into a job. In his next job he accused the school he worked at of trying to kill him with radiation in the laboratory. Robert also began having panic attacks. When he went to the psychiatrist, the treatment provided was unsuccessful because Robert didn't believe he had any mental health difficulties.

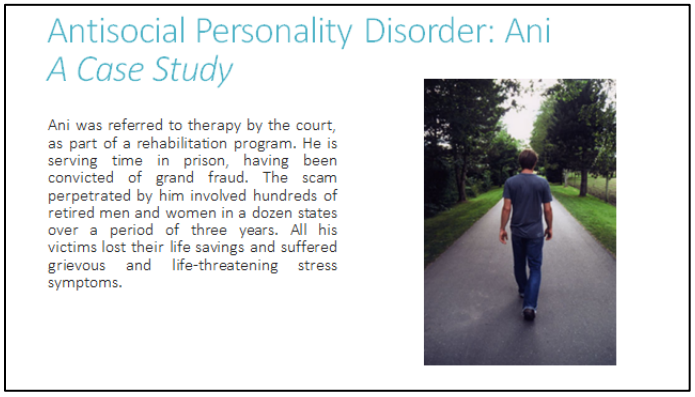
Source: Patel, K., and Daniel, J. "Paranoid Personality Disorder Case Vignette." Available here.

IG: lead a discussion about Robert and this case study. Touch upon signs and symptoms and the best approaches for officers to take when they come into contact with Robert.

Slide 214



Slide 215



PG: Source: Vaknin, Sam. "The Psychopathic Patient - A Case Study." Available here : http://www.healthyplace.com/personality-disorders/malignant-self-love/psychopathic-patient-a-case-study

Therapy session notes provide insight into living with Antisocial Personality Disorder (AsPD) - psychopaths and sociopaths. Notes of first therapy session with Ani, male, 46, diagnosed with Antisocial Personality Disorder (AsPD), or Psychopathy and Sociopathy:

Ani was referred to therapy by the court, as part of a rehabilitation program. He is serving time in prison, having been convicted of grand fraud. The scam perpetrated by him involved hundreds of retired men and women in a dozen states over a period of three years. All his victims lost their life savings and suffered grievous and life-threatening stress symptoms.

He seems rather peeved at having to attend the sessions but tries to hide his displeasure by claiming to be eager to "heal, reform himself and get reintegrated into normative society." When I ask him how does he feel about the fact that three of his victims died of heart attacks as

a direct result of his misdeeds, he barely suppresses an urge to laugh out loud and then denies any responsibility: his "clients" were adults who knew what they were doing and had the deal he was working on gone well, they would all have become "filthy rich." He then goes on the attack: aren't psychiatrists supposed to be impartial? He complains that I sound exactly like the "vicious and self-promoting low-brow" prosecutor at his trial.

He looks completely puzzled and disdainful when I ask him why he did what he did. "For the money, of course" - he blurts out impatiently and then recomposes himself: "Had this panned out, these guys would have had a great retirement, far better than their meager and laughable pensions could provide." Can he describe his typical "customer"? Of course he can - he is nothing if not thorough. He provides me with a litany of detailed demographics. No, I say - I am interested to know about their wishes, hopes, needs, fears, backgrounds, families, emotions. He is stumped for a moment: "Why would I want to know these data? It's not like I was their bloody grandson, or something!"

Ani is contemptuous towards the "meek and weak." Life is hostile, one long cruel battle, no holds barred. Only the fittest survive. Is he one of the fittest? He shows signs of unease and contrition but soon I find out that he merely regrets having been caught. It depresses him to face incontrovertible proof that he is not as intellectually superior to others as he had always believed himself to be.

How is he adapting to being incarcerated? He is not because there is no need to. He is going to win his appeal. The case against him was flimsy, tainted, and dubious. What if he fails? He doesn't believe in "premature planning." "One day at a time is my motto" - he says smugly - "The world is so unpredictable that it is by far better to improvise."

He seems disappointed with our first session. When I ask him what his expectations were, he shrugs: "Frankly, doctor, talking about scams, I don't believe in this psycho-babble of yours. But I was hoping to be able finally communicate my needs and wishes to someone who would appreciate them and lend me a hand here." His greatest need, I suggest, is to accept and admit that he erred and to feel remorse. This strikes him as very funny and the encounter ends as it had begun: with him deriding his victims.

IG: Debrief the case study.

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Video Title: “Ice Man Interviews.” HBO. 2003. Richard Leonard "The Iceman" Kuklinski (April 11, 1935 -- March 5, 2006) was an American mass murderer who was convicted for three murders. Kuklinski was given the nickname "Iceman" for his method of freezing a victim to confuse the time of death.

Video Link: https://www.youtube.com/watch?v=dhEEskkeJ7k

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Video Title: “Ice Man Interviews”

Video Link: https://www.youtube.com/watch?v=S-4nzmdYQTA

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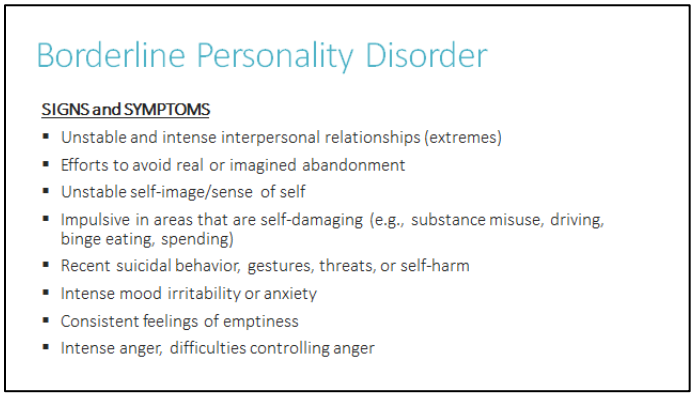

PG: For diagnosis, a patient needs five or more of the criteria noted above and in the DSM-5.

IG: Briefly talk through the symptoms of borderline personality disorder.

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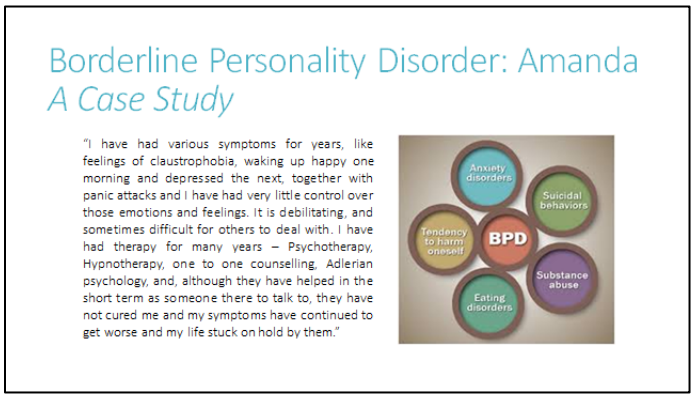


PG: Source: Green, Amanda. "Case study of Borderline personality disorder." Available here: http://amandagreenauthor.co.uk/case-study-of-borderline-personality-disorder/.

Amanda's story: "How I Feel"

"I have had various symptoms for years, like feelings of claustrophobia, waking up happy one morning and depressed the next, together with panic attacks and I have had very little control over those emotions and feelings. It is debilitating, and sometimes difficult for others to deal with. I have had therapy for many years – Psychotherapy, Hypnotherapy, one to one counselling, Adlerian psychology, and, although they have helped in the short term as someone there to talk to, they have not cured me and my symptoms have continued to get worse and my life stuck on hold by them.

Recently, I went to a Psychiatrist, as I was desperate to find out for sure that there was nothing seriously wrong. I had been told and had convinced myself that I had depression, but my symptoms did not last long enough for me to be depressed, as I could flit from being extremely down, extremely angry or fairly happy.

After two one hour sessions, the Psychiatrist came to his conclusion with a diagnosis of 'Borderline Personality Disorder' based on my current and past history of actions, feelings and behavior traits. I was relieved at first, as I had a name for it at last, and when I looked it up on various websites, I had all the symptoms just as they were described on the sites. Then I felt sad, as I didn't really want to have a mental disorder, and although I wanted to tell everyone my news, so that they would then understand why I am like I am, I knew that they might see me in a different light, and reject me. As my fear of rejection is so strong anyway, I decided to keep it to myself, telling only my boyfriend and one of my siblings.

How I feel

I never really feel 'happy and content' inside. I can feel excited, temporarily happy, angry, aggressive, loving, depressed and empty, extremely sad, charitable, obsessive, jealous, hopeless, worthless and confused. I can feel any of these emotions at any time, and often they are temporary (a few hours up to a day or so). The main emotion that stays with me most of the time is anxiety and I have trouble relaxing and dealing with the smallest of things sometimes.

I can switch from one good emotion to another in a flash, and no-one can understand why –

even though I have reasons of my own at the time. Everything is either black or white – I can switch from liking someone a lot, to disliking them completely, just through one individual incident. This hurts those people if I confront them with it, but most of all, it hurts me and my relationship. Because I moan about so many things, when I have something that really means something to me, it is not taken notice of. I feel 'needy' in relationships and I crave lots of attention. I don't really trust anyone.

I can be, as I would call it 'a performing monkey' when around others. Apart from my close family, who get to see some of the 'real me', I will put on a happy face and pretend everything is rosy most of the time. Most people, outside of my family, would probably say that I am happy go lucky and nice to be around. Whether it be through worry over what others would think, or just to make myself feel a little better, I have covered a lot up, and whilst on the outside, I have been a bubbly, happy go lucky person who seems to be doing ok, inside I have been often darkly miserable and wanted to cry, shout and sometimes just end it all. I have had hardly anyone they could talk to (apart from counsellors, doctors and therapists) as I feel people would not understand and it would possibly have meant that I would lose friends or mar relationships giving them that knowledge. This may not be the case, but I have preferred not to test them. I now have a very understanding boyfriend who, at first, could not understand, but now we are supporting each other and are much happier.

I felt that my past life and experiences were all good and I was a happy person, but when interviewed by the Psychiatrist, I realized that this was not correct. Once we uncovered the fact that I have suffered with self-harming, eating disorders, obsessive behaviors, no ability to stick with responsibility and jobs for long, have been in unstable and sometimes abusive relationships, drink and drug abuse, slept around when I was young and have spent a lot of time running away from people or events, I realized that perhaps I had not had the ideal life that I thought I had. I have, in fact, made lots of mistakes that have cost me dearly, due to my anxiety and impulsive decisions.

I am not a bad person – I just have a few issues. I behave within the social system, care for my family and friends, am polite in public and try to be as charitable as I can.

How could I be helped?

What I need is 'understanding' from others, so that they can provide help. Some of my friends abandoned me when I was younger, as they could not understand my moods, and it was very upsetting at the time, but I found out who my friends are! Therefore, I agree very much that the stigma around mental health problems needs to be lifted and I am very grateful to the 'Time to change' campaigns and other help.

I had a very bad experience a few years ago, when at my lowest level, I moved back home to my parents, and tried to get a doctor quickly to help, as I felt so awful. I trudged the doctor's offices in my area, desperately asking them for help – some said they were full, and others saw me first, and once I told them my problems tearfully and that I felt suicidal, I was told they could not take me on. Luckily, my old family doctor took me back on, and my symptoms subsided once I felt the comfort of someone caring, but the fact that I was dismissed by doctors in the national

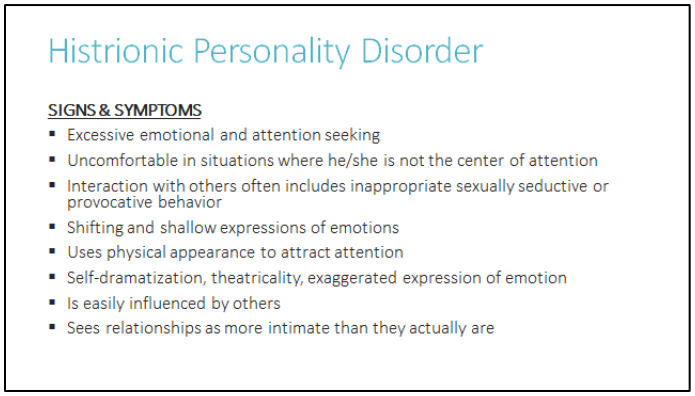
health system when telling them of my suicidal thoughts, is disgraceful and not acceptable.

The future

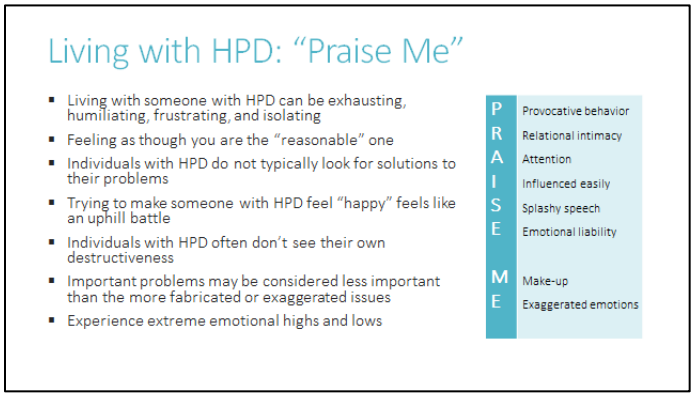
I decided not to take antidepressants as I do not like using drugs, but this could be seen by others that I do not need them. It is not the case. I have decided that rather than covering it up with drugs, so that I forget I have a problem, I would face it full on and not forget, so that I can help myself to understand my problem fully and recover. It has proven to be a long journey, but I am getting there, and life looks brighter right now and I have a wonderful boyfriend who is very understanding and has stuck by me.

I am going to get a second opinion with the National Health, as I cannot afford to have the suggested therapy and consultations with the private Psychiatrist and specialist that was recommended, and then move forward from there with the correct therapy for me. I am also writing as a self-therapy process. My main objective is to settle down and be more 'normal,' whatever that is.

Slide 220



Slide 221



PG: Source: Out of the Fog. "Personality Disorders: Histrionic Personality Disorder." Available here: http://outofthefog.website/personality-disorders-1/2015/12/6/histrionic-personality-disorder-hpd

A mnemonic that has sometimes been used to describe the criteria for histrionic personality disorder is “PRAISE ME”:

P - provocative (or seductive) behavior
R - relationships, considered more intimate than they are
A - attention, must be at center of
I - influenced easily
S - speech (style) - wants to impress, lacks detail
E - emotional liability, shallowness

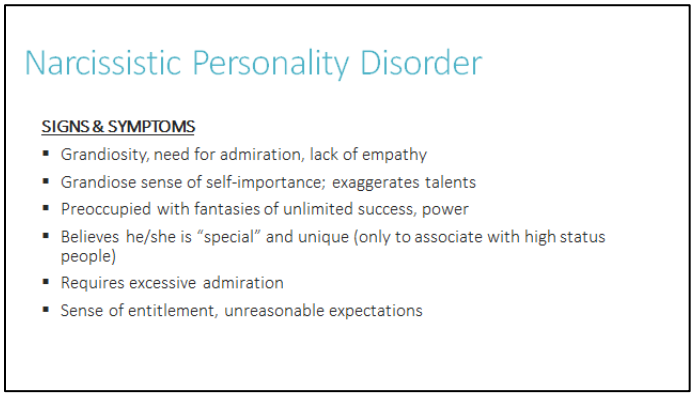
M - make-up - physical appearance used to draw attention to self
E - exaggerated emotions – theatrical

Movies Portraying Histrionic Personality Disorder Traits:

A Streetcar Named Desire is a is a 1947 play written by Tennessee Williams, later adapted for film, which tells the story of a woman who displays histrionic and borderline traits, who goes to live with her codependent sister and her narcissistic husband.

Gone with the Wind is a 1939 romantic epic starring Vivien Leigh and Clark Gable, set in the American Civil War portraying the story of Scarlett O'Hara, a southern woman who manifests symptoms of Histrionic Personality Disorder (HPD).

Slide 222



IG: Lead a brief discussion about antisocial personality disorder, drawing upon your own clinical experience.

Slide 223

Obsessive – Compulsive Personality Disorder

SIGNS & SYMPTOMS

- Fixating on lists, organization, schedules, rules, and minor details
- Rigid following of moral and ethical codes
- Excessively devoted to work, causing impairment in social activities
- Perfectionism
- Rigid and/or stubbornness
- Does not work well with others

Slide 224

Identifying & Treating OCPD

- Individuals diagnosed with OCPD typically do not believe they require treatment
- Psychotherapy:
  - Cognitive Behavioral Therapy (CBT): improving insight, providing techniques
  - Lessen expectations
  - Learn the value of relationships
  - Understanding interpersonal conflict and it's connection to job satisfaction (or lack thereof) may be a motivator for therapy
  - Less emphasis on work and productivity
- Medication: SSRIs (will be discussed more in Module 11) – assist individuals in focusing less on the minor details, assists with rigidity
- Relaxation: Breathing and Relaxation techniques to reduce stress

IG: Lead a discussion about treatment options for OCPD and draw upon your clinical experiences. Ask participants to share whether they have interacted with a person with OCPD.

Slide 225

PG: Video link: http://www.thedoctorstv.com/videos/jeff-lewis-on-living-with-ocpd
Video length: 4:44

Jeff Lewis is the star of the Bravo reality TV show "Flipping Out"; he is a well-known house

designer and flipper.

IG: Ask, “What do you think the host meant when he said ‘formerly diagnosed’?” When police officers come into contact with someone living with OCD or OCPD, how might that person react to officer requests or demands?

Module 13 | Mental Health Basics: Post-Traumatic Stress Disorder Administration Page

Duration: 1 hour | 11:00 am –12:00pam

Scope Statement: This module introduces signs and symptoms of PTSD.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Describe three symptoms of PTSD
- Name a type of treatment available for PTSD

[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes: [blank for notes]

Slide 226

Module 13: Mental Health Basics

Post-Traumatic Stress Disorder (PTSD)

Slide 227

Post-Traumatic Stress Disorder (PTSD)

PTSD can occur after an individual has been exposed to actual or threatened death, serious injury or sexual violation, including when he/she:

- Directly experiences traumatic event;
- Witnesses traumatic event;
- Learns that a traumatic event (violent or accidental) occurred to a close family member or close friend;
- Repeatedly hears about the extreme details of a traumatic event;
- Causes significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning.

Slide 228

Post-Traumatic Stress Disorder (PTSD)

Symptoms of PTSD

- Reliving the event, such as through bad memories, nightmares, or flashbacks
- Avoiding situations or people that remind them of the event; Avoiding talking or thinking about the event
- Negative changes in beliefs and feelings about self and others.
- Feeling jittery, always alert, or on the lookout for danger
- Irritable behavior, difficulties concentrating, self-destructive behavior
- Remaining always on alert – hypervigilance

Slide 229

Post-Traumatic Stress Disorder (PTSD)

Possible Traumatic Events
Combat exposure
Sexual or physical abuse
Terrorist attack
Sexual or physical assault
Serious illnesses or accidents, like a car accident
Natural disasters, like a fire, tornado, hurricane, flood, or earthquake
Community violence

Remember: People respond and react to trauma in very different ways. A majority of individuals might have some stress-related reactions after a traumatic event; however, not everyone will experience PTSD symptoms or receive a PTSD diagnosis.

Slide 230

Acute Stress Disorder

- Acute stress disorder shares many of the same signs and symptoms as PTSD.
- Acute stress disorder is what is experienced during the first month after a traumatic event. PTSD may be diagnosed after a month.
- A person experiencing acute stress disorder may describe out-of-body experiences more so than a person with PTSD.
- Traumatic events in acute stress disorder can be first-hand harm or exposure to actual or threatened traumatic event

Slide 231

PTSD in Children and Adolescents

- Children demonstrate similar symptoms as adults.
- Nightmares are linked specifically to a trauma theme or generalized to other fears.
- Children may experience flashbacks, particularly when tied to sensory information.
- Traumatic play – repetitive acting out of the trauma or trauma-related themes in play. Older children may reenact the traumatic event.
- Fantasized actions of intervention or revenge are common.
- Adolescents are at increased risk for retribution, impulsive acting out secondary to anger and revenge fantasies.
- Related behaviors include sexual acting out, substance use or misuse, delinquency, avoidance, or regressive behaviors (e.g., fear of sleeping, bedwetting).

Slide 232

PTSD Health-Related Risks

- Cardiovascular disease
- Alcohol and drug use or misuse
- Sexually transmitted infections
- Domestic violence
- Endocrinological issues
- Gastrointestinal issues
- Hypertension
- Hepatitis, Tuberculous
- Musculoskeletal systems, including pain, tolerance, and chronic pain
- Sleep Problems

Slide 233

PTSD Interventions/Treatment

- Chemicals in your brain affect the way you feel. For example, when you have depression you may not have enough of a chemical called ***serotonin***. Selective serotonin reuptake inhibitors (SSRIs) raise the level of serotonin in your brain.
- SSRIs are a type of antidepressant medicine. These can help people with PTSD feel less sad and worried. SSRIs include:
  - *Citalopram (Celexa)*
  - *Fluoxetine (Prozac)*
  - *Paroxetine (Paxil)*
  - *Sertraline (Zoloft)*

Slide 234

PTSD Interventions/Treatment

What types of therapy are available to people with PTSD?

Cognitive Behavioral Therapy	Other
Cognitive therapy	Group therapy
Exposure therapy	Family therapy
Eye movement desensitization and reprocessing (EMDR)	Brief psychodynamic psychotherapy

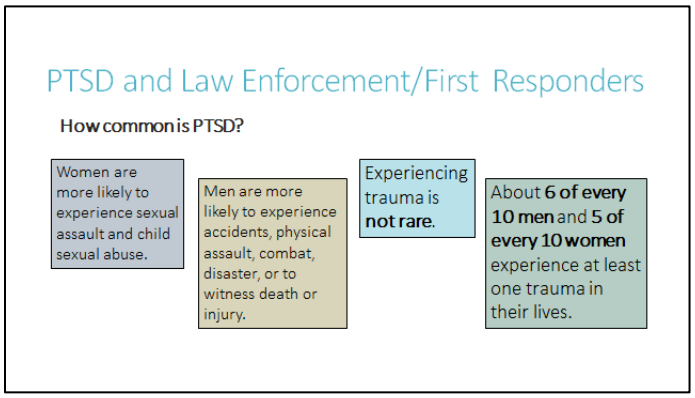
Slide 235

Video Link: https://www.youtube.com/watch?v=0y_a_V1QD3Uandt=27s

Slide 236

Video Link: https://youtu.be/GCXWuBYTwI0

Slide 237



Slide 238

PTSD and Law Enforcement/First Responders

While many people experience trauma, a much smaller percentage, however, develop PTSD.

- *About **7 or 8 out of every 100** people will have PTSD at some point in their lives.*
- *About **8 million** adults have PTSD during a given year.*
- *About **4 of every 100 men, and 10 of every 100 of women** develop PTSD sometime in their lives.*

Slide 239

PG: Video Link: http://www.military.com/video/specialties-and-personnel/veterans/ptsd-soldier-attempts-suicide-by-cop/853034360001

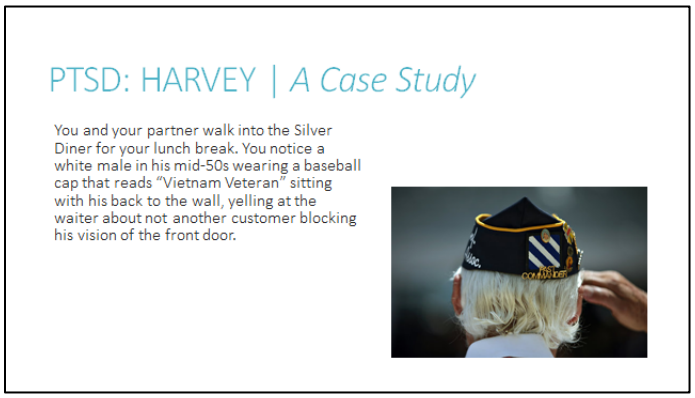
IG: Video time: 8:44. Lead a debrief discussion of the video.

Slide 240

Dealing With Trauma in the Field

- After a traumatic event:
  - Gently inquire about trauma as needed
  - You are thinking about trauma
  - You are open to listening
  - You provide adequate time for discussion
  - Maintain here and now, reality testing, safety
- A victim of trauma may shut off the images and feelings as a form of protection to cope with the strong memories
- Remember: Talking about the trauma is traumatic itself!

Slide 241



PG: You and your partner walk into the Silver Diner in Arlington for your lunch break. You notice a white male in his mid-50s wearing a baseball cap that reads "Vietnam Veteran" sitting with his back to the wall, yelling at the waiter about not another customer blocking his vision of the front door.

Harvey served our country in Vietnam. Before the war, he had been a happy person, but he rarely smiled once he came home. For many years, Harvey didn't talk about Vietnam, thinking he would spare people. He started drinking more and developed a short temper. Harvey went to the VA, where he was diagnosed with PTSD and given treatment and support. He's doing much better now.

IG: How might you as an officer approach Harvey? What about the situation helped you make your decisions on how to interact with Harvey?

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Module 14 | Community Support: Community Resources Administration Page

Duration: 1.5 hours | 1:00 pm – 2:30 pm

Scope Statement: This module should be tailored to the community/jurisdiction in which the training is occurring. Include information about local hospitals and mental health clinics; local advocacy groups; other relevant resources such as community centers. Bring in guest speakers from the local emergency room and other emergency mental health services to describe their facilities and organizations.

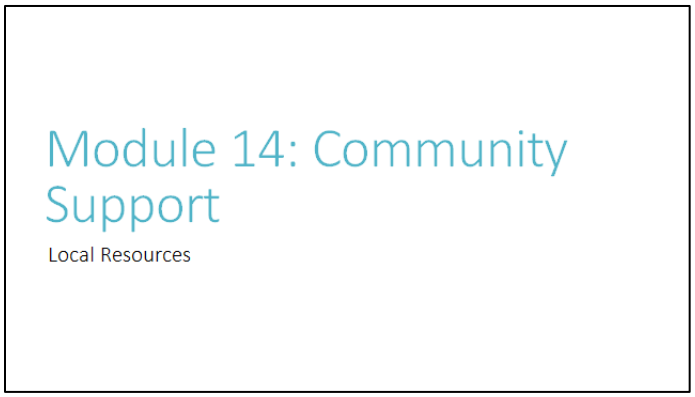
Student Learning Objectives:
Upon completing this module, students will be able to:

- Tailored to guest speaker presentations

[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes: [blank for notes]

Slide 242



Module 15 | Managing Encounters: Scenario-based Skills Training Administration Page

Duration: 1 hour | 4:00 pm – 5:00 pm

Scope Statement: This module introduces concepts relevant to managing encounters with people in mental health crisis using trained responses and begins scenario-based training.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Define the concept of defusing crisis situations
- Describe techniques used to "slow the situation down"
- Explain why communication skills are important for everyone's safety
- Describe how tone and body posturing can shape outcomes
- Apply newly acquired skills in interactive role-play situations to solidify techniques
- Integrate crisis management skills with police department officer safety procedures

Scenario Safety and Environment:

- As an instructor, your highest priority during scenario training is to make the training environment as safe as possible.
- Inform officers on the first day of this course that they will be participating in scenario training. Decide whether you prefer them to wear their uniforms and full duty belts on the scenario days or their regular duty clothes in lieu of the full uniform; communicate that clearly.
- Clearly state weapons are ***not allowed*** in the scenarios. Be sure officers lock up their weapons in their assigned secure storage spaces or have a lock box present on scenario days to secure all weapons. Designate a safety officer to ensure all weapons are secure before beginning scenarios.
- If available, you may offer red or blue handle training guns for use during scenarios; follow universal firearms safety rules at all times!
- Clearly state phones are ***not allowed*** in the scenarios. Distraction can be deadly! If participants need to make phone calls or send text messages during training scenarios, tell them to move to a safe space outside the training room to use their phones.
- Be sure you conduct scenarios in a well-lit and appropriate space; keep safety at top of mind when designing the scenarios in the space you are using.
- Be mindful of the number of people in the class and the number of people participating in the scenarios. Again, safety is paramount.
- Some departments have found it most effective to hire professional actors to participate in the scenarios. If resources allow, contact qualified local actors or consider local university acting students. Actors should be skilled in demonstrating realistic mental health crisis symptoms.

Scenarios Development:

- Scenarios should make sense in your local context and be aligned with common calls for service that the participants might respond to.
- Keep diversity in mind as you develop a collection of scenarios: demographics of people involved, types of calls for services, mental health disorders referenced, physical disabilities, and outcomes expected.
- If your course involves dispatchers, fire, or EMS personnel, be sure to incorporate these individuals into your scenarios. Utilize dispatchers to practice taking calls, logging information, and communicating with officers. Use fire and EMS to respond to calls.
- Not all scenarios need to result in an easy, non-enforcement outcome without use of force. The goal is for scenarios to be realistic. Realistically, there will be situations that necessitate arrest. Use these situations as an opportunity to discuss what outcomes might occur as a result of different approaches.

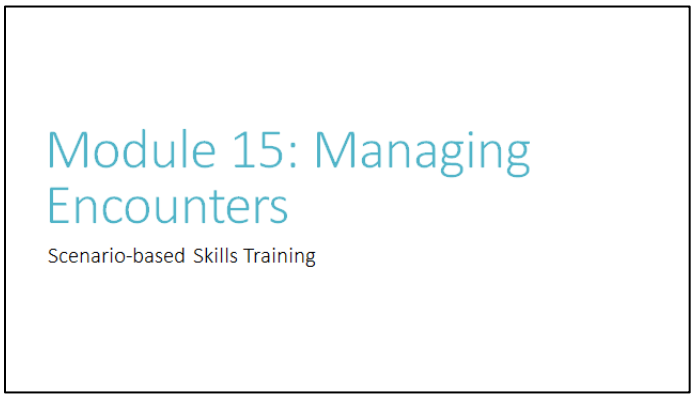
Scenario Facilitation:

- Designate a facilitator for each scenario. The facilitator will provide participants with basic background information, similar to what would be transmitted by a dispatcher. The facilitator should also evaluate participant's performance and lead a discussion afterwards, noting the areas of strengths and recommendations for improvement. You may want to utilize a formal evaluation form to document performance and/or record scenarios to play back strong example of CIT principles to the full group.
- If not all participants can be actively engaged at a scenario at the same time, identify opportunities to maximize their time during the training. Consider conducting site visits during this time or having local providers present to discuss their services and strategies to ease referrals and intakes with officers.

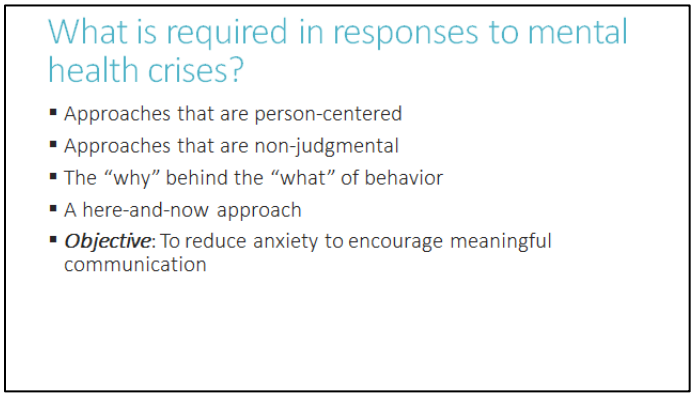
[NOTE: Ideally, this module should be co-taught by an experienced CIT officer and a mental health professional from your community.]

Instructor/Participant Notes: [blank for notes]

Slide 243



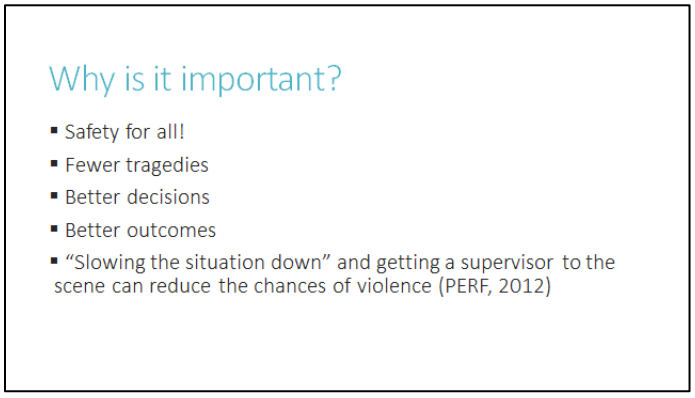
Slide 244



PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-Escalation Technique." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

IG: lead a discussion about the "why" behind the "what" of behavior. Ask participants: What does this phrase mean to you?

Slide 245



PG: Source: Police Executive Research Forum. 2012. "Critical Issues in Policing Series: An Integrated Approach to Defuse Crises and Minimizing Use of Force." Available here: http://www.policeforum.org/assets/docs/Critical_Issues_Series/an%20integrated%20approach%20to%20de-escalation%20and%20minimizing%20use%20of%20force%202012.pdf

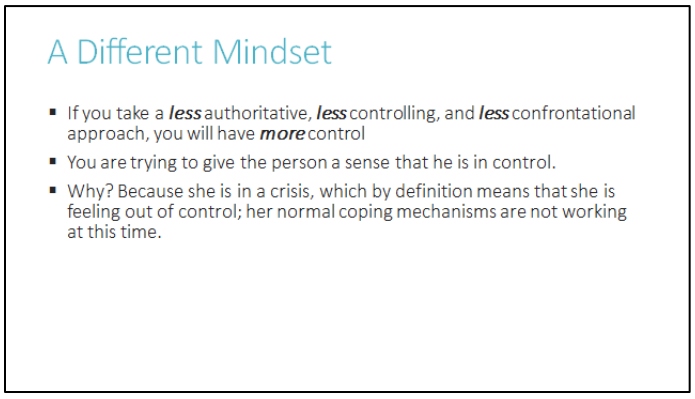
Slide 246

PG: Link to VIDEO: http://abc7news.com/news/sf-police-train-to-de-escalate-confrontations-before-using-deadly-force/1406096/

IG: Video run time: 2:13

There are many different ways to conduct training on managing mental health crises; some agencies use video scenarios, as in the San Francisco example. Other agencies use officers as role-play actors and some agencies use professional acting troupes who specialize in law enforcement or mental health training. Explore the resources available to you and plan a training strategy that works for you.

Slide 247



Slide 248

Models of Response

- This curriculum does not endorse a particular model of response to mental health crisis, but rather endorses the ***concept*** of slowing a situation down to defuse a crisis situation.
- We acknowledge that there are many models/instructors/concepts to choose that may be utilized with success.

Slide 249

CAF: A Model for First Response

CAF, which stands for ***Calm, Assess, Facilitate***, was developed by the University of Southern Florida.

Calm: to decrease the emotional, behavioral, and mental intensity of a situation

Assess: to determine the most appropriate response as presented by the facts

Facilitate: to promote the most appropriate resolution based on an assessment of the facts

PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 250

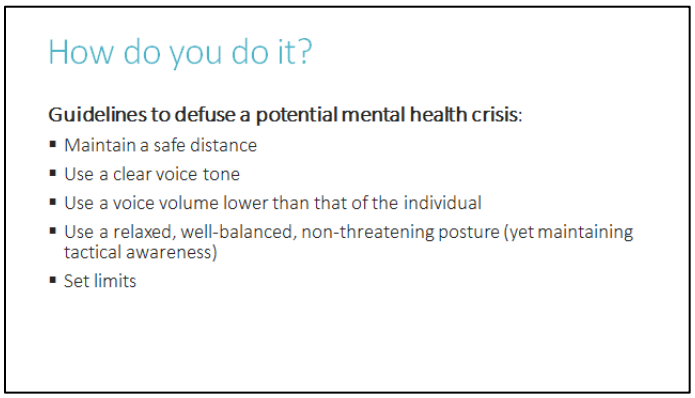
SEAR: A Staged CIT Model

- **SEAR** stands for **Safety, Engagement, Assessment, and Resolution** and was developed by the Ohio CIT, adapted from the E.A.R. framework created by the Findlay/Hancock County CIT Program.
  - **Safety:** The responding law enforcement officer needs to feel that the situation is safe or he/she will not be effective, because safety needs always come first.
  - **Engagement**: Gain rapport and build trust.
  - **Assessment**: Gather needed information, maintain focus.
  - **Resolution**: Return to pre-crisis state; Set clear limits; Communicate directly; Create options; Take action

PG: Source: CIT Memphis. "Interacting with Persons in a Mental Health Crisis." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/OH%20-

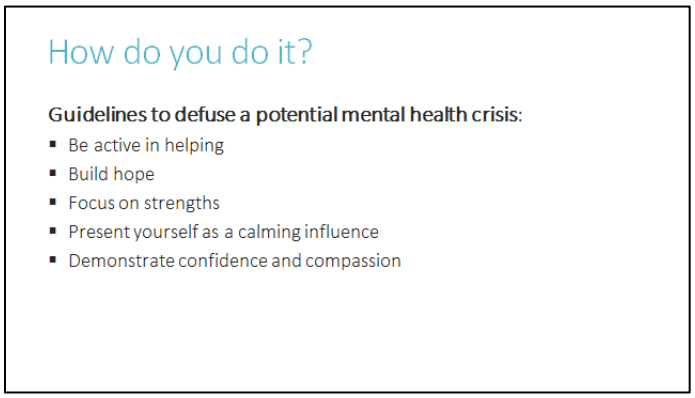
%20Non%20Verbal%20and%20Verbal%20De%20Escalation.pdf

Slide 251



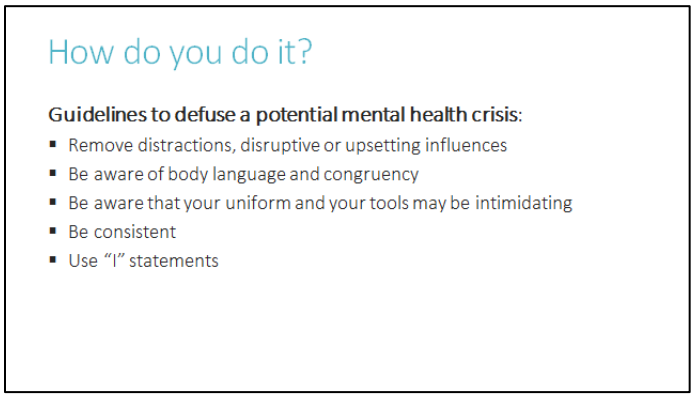
PG: Source: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 252



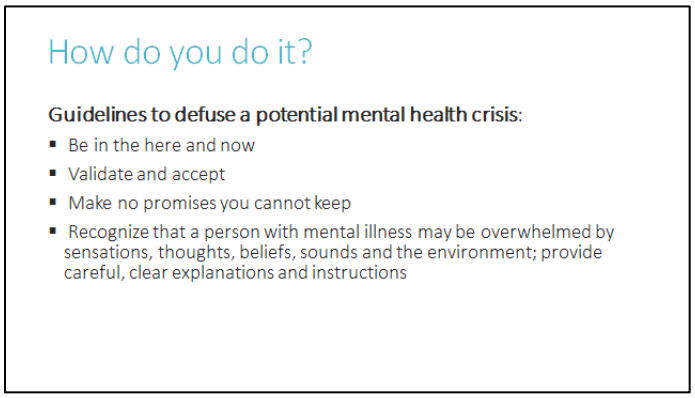
PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 253



PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 254



PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 255

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Determine the person's need for basic needs, including food and water
- Be patient
- Use active listening skills
- Be non-judgmental

PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 256

Behaviors and Attitudes

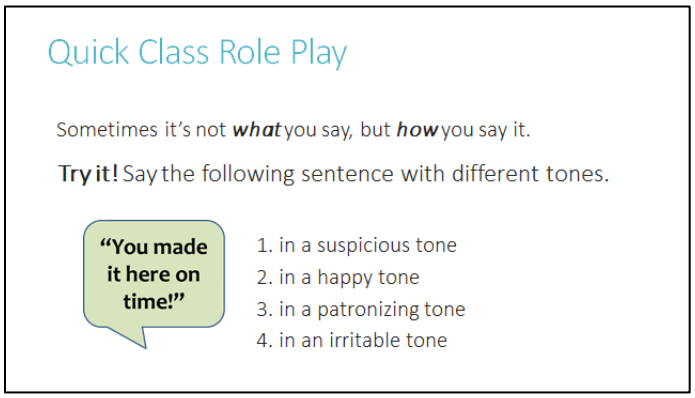
Officer behaviors and attitudes impact the behaviors and attitudes of the individual in question – and vice versa.

Slide 257

Behaviors and Attitudes

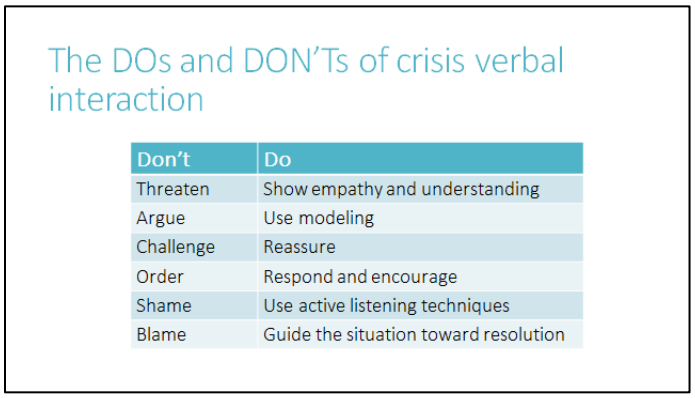
- Officers should ***model*** appropriate behaviors:
  - Tone of voice, volume, rate of speech, word choices
  - Body language / body positioning / non-verbal cues
  - Empathic listening
  - Active listening
  - Respect (please and thank you)

Slide 258



IG: Select 4 participants to say "you made it here on time" in the tones suggested on the slide. Emphasize that while the words do not change, the meaning does.

Slide 259



PG: It is important to attempt to build rapport when interacting with people in crisis. If you show you care and are trustworthy, you will likely have a better outcome. Practice active listening techniques:

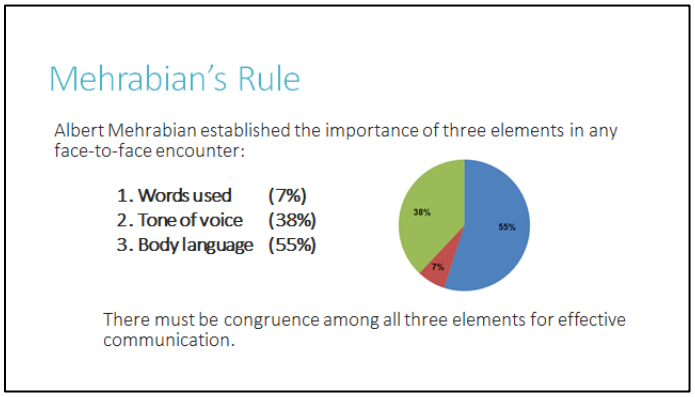
- Show empathy and understanding; attempt to calm an agitated person down by showing that you understand his/her feelings
- Use modeling; attempt to calm the person down by displaying your own level of calm. Speak slowly and evenly and do not raise your voice unless necessary
- Reassure the agitated person; calm them by assuring their safety
- LISTEN
- Respond and encourage; respond to the person's statements by encouraging him/her to keep talking – such as "I see…" "Tell me more about that…" "That would be one option. Are there others?" "Uh huh, ok, mmm hmm"
- Use active listening techniques, such as: *paraphrasing* or repeating back to the person what they said to demonstrate your understanding. It demonstrates that you are listening. You could say, "What I hear you saying is that…"
- *Reflecting feelings* is another technique. Showing that you understand what the person is feeling develops rapport and moves the conversation from the factual level to the

emotional level. It helps validate the person.

- *Summative reflections* are a technique in which your response summarizes the main facts and feelings the person has expressed over a relatively long period. It shows that you have been engaged and listening and serves to solidify trust. It reminds a person how far negotiations have come, for example, and clarifies remaining issues in a concise way that will focus attention on relevant issues.

IG: Lead a discussion about the dos and don'ts of crisis verbal interaction.

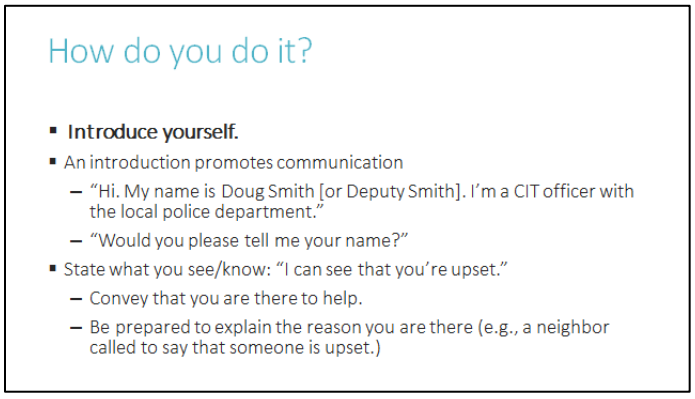
Slide 260



PG: Albert Mehrabian, currently Professor Emeritus of Psychology, UCLA, is known for his publications on the relative importance of verbal and nonverbal messages. His findings on inconsistent messages of feelings and attitudes have become known as the 7%-38%-55% Rule, for the relative impact of words, tone of voice, and body language when speaking.

Source: Saunders, Michele. CIT Memphis. "Communication and Verbal Skills: Practical Applications." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20Communication%20and%20Verbal%20Skills.pdf

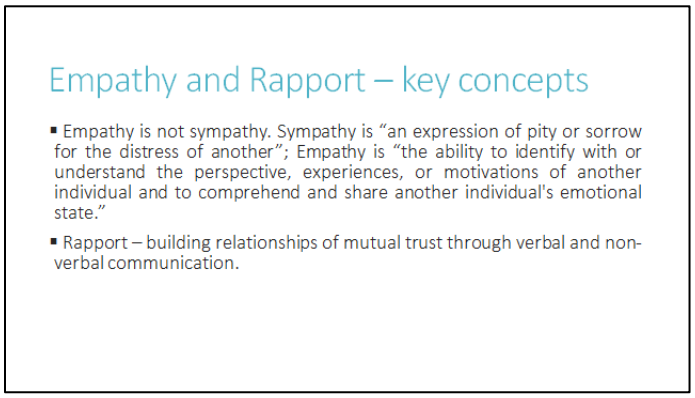
Slide 261



PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here:

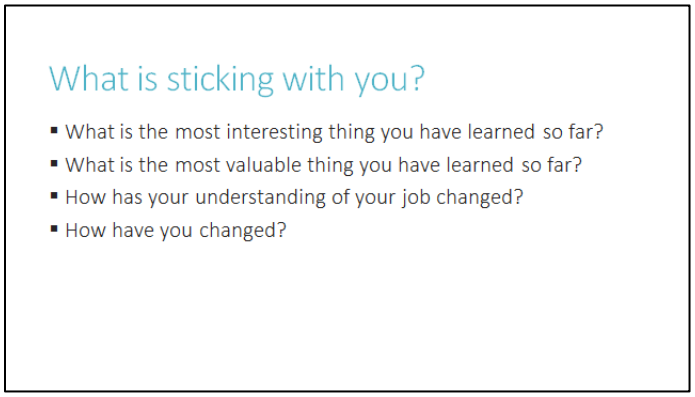
http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 262



PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 263



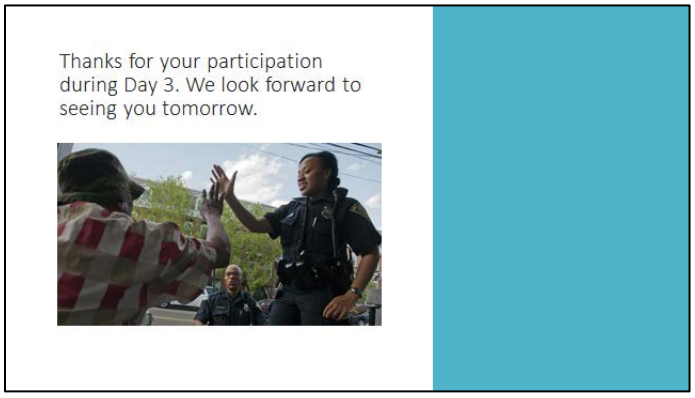
IG: Upon completion of the training scenarios for the day, bring the participants back together and debrief the scenarios. Ask, "What worked? What didn't? What did they feel good about? What will they work on during the next scenario?"

Then lead the group through a general debrief of the course so far, asking the questions on this slide.

Slide 264

IG: This slide will appear at the end of each day's slide presentation to acknowledge the departments whose work we drew upon for that day – coming from the Memphis online database of CIT modules.

Slide 265



Module 16 | Mental Health Basics: Suicide Administration Page

Duration: 2 hours | 8:00 am – 10:00 am

Scope Statement: This module introduces signs and symptoms of suicide.

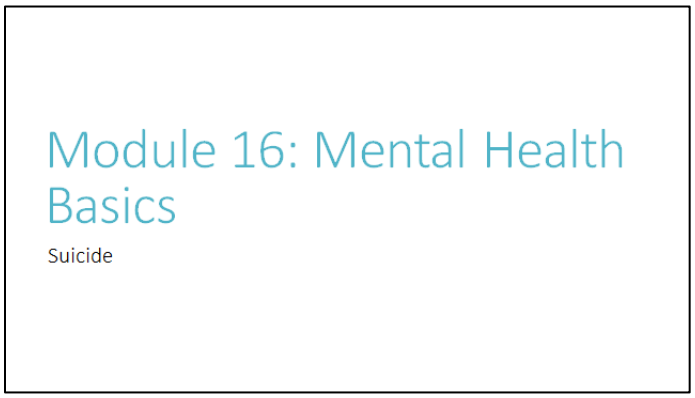
Student Learning Objectives:
Upon completing this module, students will be able to:

- Name three signs of suicidal behavior
- What should you say to someone who is suicidal?

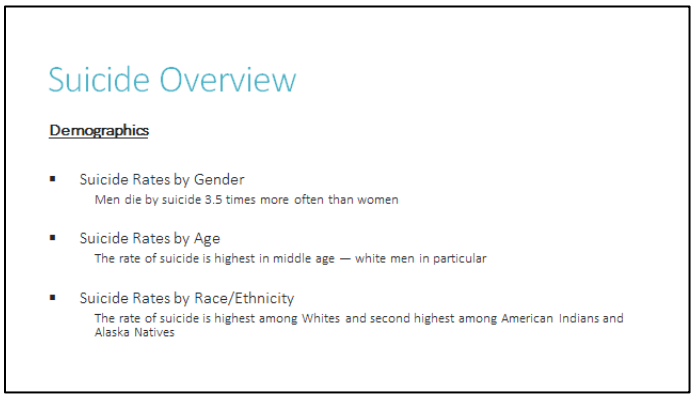
[NOTE: This module should be taught by a mental health expert from your community.]

Instructor/Participant Notes: [blank for notes]

Slide 266

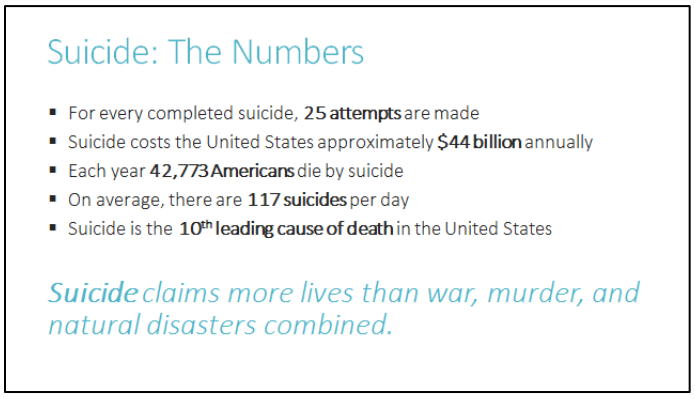


Slide 267



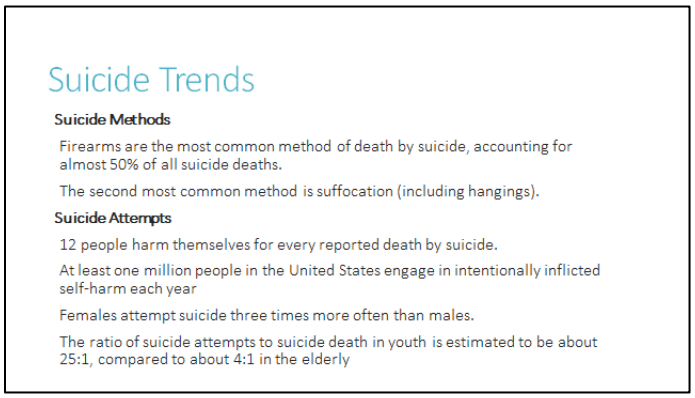
Source: National Institute of Mental Health. "Suicide." Available here: https://www.nimh.nih.gov/health/statistics/suicide.shtml

Slide 268



Source: American Foundation for Suicide Prevention. Available here: https://afsp.org/

Slide 269



Sources: National Institute for Mental Health. "Suicide." Available here: https://www.nimh.nih.gov/health/statistics/suicide.shtml; American Foundation for Suicide Prevention. https://afsp.org/

Slide 270

Substance Abuse and Mental Health Services Administration. 2012. "Stories of Hope and Recovery."

Video Link: https://youtu.be/mVXLj0bNe0o?list=PLBXgZMI_zqfR4dvBdX7XHD-fjgoehFM_9

Slide 271

Suicide: Introduction

Definitions:

- **Suicide thoughts:** the person is just thinking about it; they do not act on it (sometimes called ideation)
- **Suicide attempt:** the person does not die, maybe did not actually intend to die. Over their lifetime, 7-10% of these people die by suicide eventually.
- **Suicide, completed suicide, successful suicide:** the person actually dies. 1.4% of U.S. people will die by suicide.
- **Self-mutilation:** the person harms their self, but not with the intent to cause death.

Slide 272

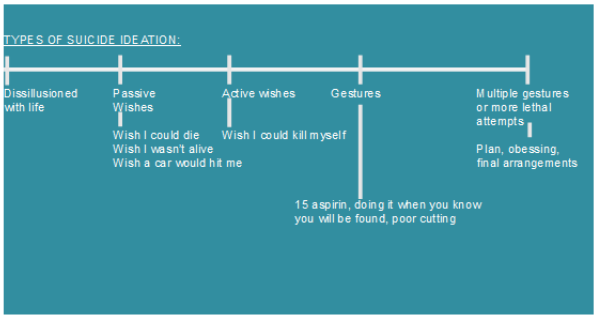
Suicide: Introduction

Definitions (continued):

- Assisted Suicide / Euthanasia: terminally ill or people in chronic pain with no hope of relief choosing suicide as a way to deal with it; may or may not involve the help of a physician.
  - These cases are often grouped with other suicide statistics, which is accurate or not depending on your view of it. This may skew the numbers on "suicides" of older people.

Slide 273

Continuum of Suicide Ideation



Slide 274

Suicide Assessment

Warning Signs	
Verbal	Person may talk about being a burden to others, feeling trapped, or having no reason to live.
Psychological	Person may have a mental health condition, substance abuse disorder, or serious or chronic health condition and/or pain.
Emotional	Person may display a depressed, irritable, or anxious mood.
Behavioral	Person may be looking for a way to kill themselves, acting recklessly or aggressively.
Situational	Person may be undergoing a divorce, job loss, or have access to lethal means, such as firearms and drugs.

Risk Factors
✓ Male
✓ Age: young or old
✓ Previous suicide attempts
✓ Constant suicidal thoughts
✓ Recent losses
✓ Family history of suicide
✓ Feeling hopeless
✓ Few existing resources
✓ Alcohol or drug use
✓ Disorientation
✓ Hostility
✓ Well-developed plan for suicide
✓ Well-developed plan for final arrangements

Slide 275

Suicide: Interventions

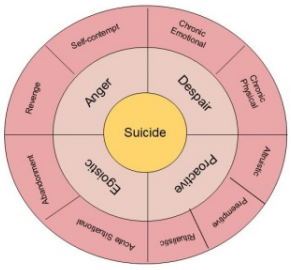
1. Stay CALM.
2. Take the person seriously.
3. Be empathic and non-judging.
4. DO NOT SAY things like:
   - *"I know how you feel."*
   - *"Things could be worse."*
   - *"You won't go to Heaven."*
   - *"Things can't be that bad."*
5. Assess the Risk
   - Don't be afraid to ask directly

Assess Severity of Suicide Plan	
S	Specificity
L	Lethality
A	Availability
P	Proximity

Slide 276

Types of Suicide

For those who respond to threatened suicides, a unified theory is less important than an understanding of the various types of suicide, and the risks they each pose for responders.



Slide 277

ANGER SUICIDE

- SELF-CONTEMPT

Suicide resulting from a hatred or dislike directed inwardly. Examples may include the alcoholic who cannot stop drinking, or the former soldier who committed war crimes and is now succumbing to extreme guilt. Another example might be the individual facing extreme financial hardship and feels they failed their family.

- REVENGE

Suicide resulting from a desire to exact revenge on another person. An example is the man who kills himself and his children following a divorce, or the teenager who kills himself as an act of revenge against his parents.

Slide 278

DESPAIR SUICIDE

- CHRONIC **PHYSICAL**

Suicide resulting from unending physical pain and suffering. Many assisted suicides fall into this category. The person simply wants relieved of their constant suffering.

- CHRONIC **EMOTIONAL**

Related to extreme depression. Like the chronic physical suicide, this person simply wants to end their suffering. Some assisted suicides have fallen into this category, however, because mentally ill people are not terminally ill, assisted suicide for this reason is illegal.

Slide 279

EGOTISTIC SUICIDE

- ACUTE SITUATIONAL

Suicide resulting from a sudden event that causes a deterioration of the person's self-identity. Examples include the man who loses his career, the wife who loses her husband in an unwanted divorce, or perhaps the pastor of a church caught trading child pornography on the internet.

- ABANDONMENT

One of the most complex emotions in the human repertoire. It results from an insecure attachment during childhood being transferred to a significant other in adulthood. Suicide results from an inability to emotionally separate from a significant other who has already made the decision to do so. Many murder-suicides fall in this category.

Slide 280

PROACTIVE SUICIDE

• RITUALISTIC

Suicide resulting from reasons external to the individual. They are seen as sacrificial acts carried out for religious, spiritual, or political reasons. Examples include the Kamikaze pilots of WWII Japan, and the various mass suicides that have taken place among cults.

• ALTRUISTIC

Suicides resulting from a desire to avoid becoming a burden on others. For example, the terminally ill patient who does not want his family to bear the physical and financial hardship of caring for him.

• PRE-EMPTIVE

Suicides resulting from a person's desire to end their life before their personal circumstances worsen, such as a terminally ill individual or someone sentenced to prison.

Slide 281

The Criminal Justice Response

Large amounts of resources are committed each day to saving the lives of those who would rather die. Police officers are routinely dispatched to threatened suicides, and suicide is a daily occurrence in America's prisons and jails.

For first responders, threatened suicides can be a very dangerous type of intervention. The person in crisis may try to provoke the police into shooting them, and if desperate enough, may threaten violence against anyone attempting to prevent their final act.

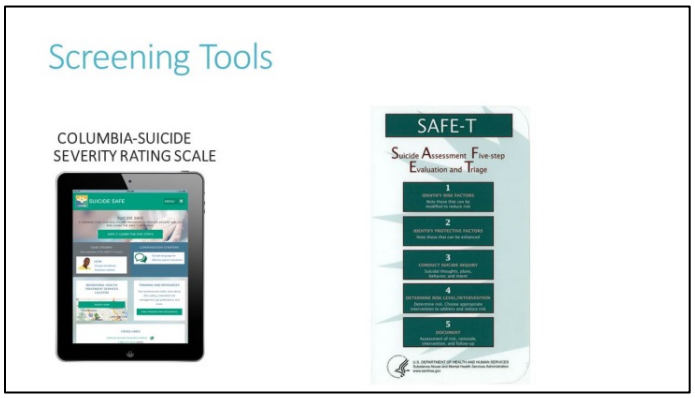
Slide 282

Suicide Intervention

Appropriate Questions/Conversation

- Are you thinking about hurting yourself or killing yourself?
- Do you ever feel so badly that you think about suicide?
- Do you have a plan to commit suicide or take your life?
- Have you thought about when you would do it (today, tomorrow, next week)?
- Have you thought about what method you would use?

Slide 283



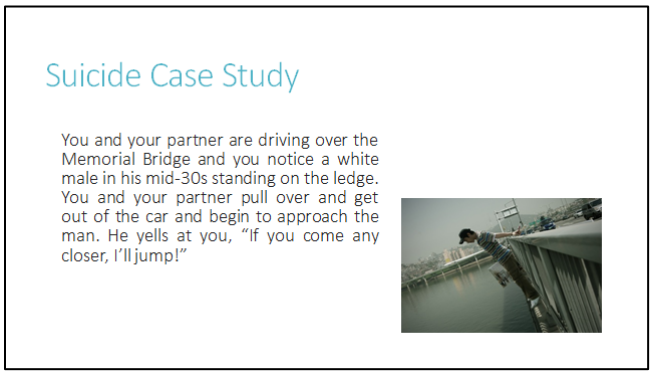
The *Columbia-Suicide Severity Rating Scale* and the *Suicide Assessment Five-Step Evaluation and Triage Tool* provide easily-accessible information about screening for the risk of suicide and provide information about resources to help a person considering suicide.

Sources: Columbia-Suicide Severity Rating Scale. Available here: http://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf
Suicide Assessment Five-Step Evaluation and Triage Tool. Available here: https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/SMA09-4432

Slide 284

PG: Source: Pow, Helen. 2013. "Officer is reunited with suicidal man he talked down from the Golden Gate Bridge eight years ago." Available here: http://www.dailymail.co.uk/news/article-2323468/Kevin-Berthia-Emotional-reunion-suicidal-man-hero-police-officer-Kevin-Briggs-talked-Golden-Gate-Bridge.html

Slide 285



PG: Case Study: You and your partner are driving over the Arlington Memorial Bridge and you notice a white male in his mid-30s standing on the ledge. You and your partner pull over and get out of the car and begin to approach the man. He yells at you, "If you come any closer, I'll jump!"

Frank is going through a divorce and found out today that he lost custody of his three children. During your conversation with Frank you learn that he has attempted suicide before. You talk to him, displaying active listening. He agrees to come down off of the ledge and be transported to a local crisis center, to determine if he needs to spend the night in the local hospital.

IG: Ask, "How would you speak to this individual?" "Specific questions, words?"

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Module 17 | Law Enforcement: Policies and Procedures Administration Page

Duration: 60 minutes | 10:00 am – 11:00 am

Scope Statement: Review of agency's policy/standard operating procedures (SOP) for responding to people with mental illness and/or people in crisis. Review of SOPs for barricaded/suicidal subjects.

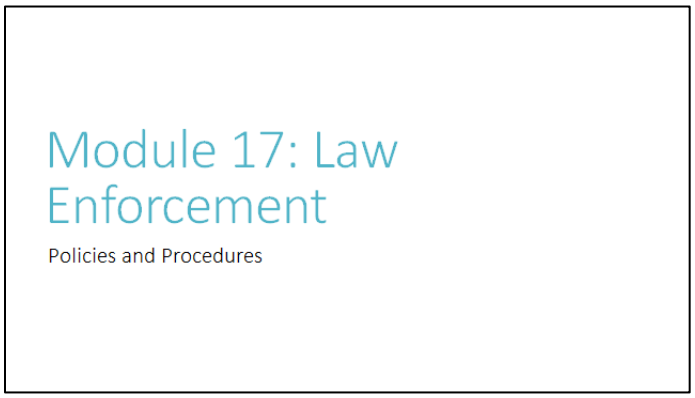
Student Learning Objectives:
Upon completing this module, students will be able to:

- Explain how your use of force policy applies to people in crisis.
- Describe how your agency's policies guide response to people in crisis.

[NOTE: This module should be taught by a sworn member of law enforcement.]

Instructor/Participant Notes: [blank for notes]

Slide 286



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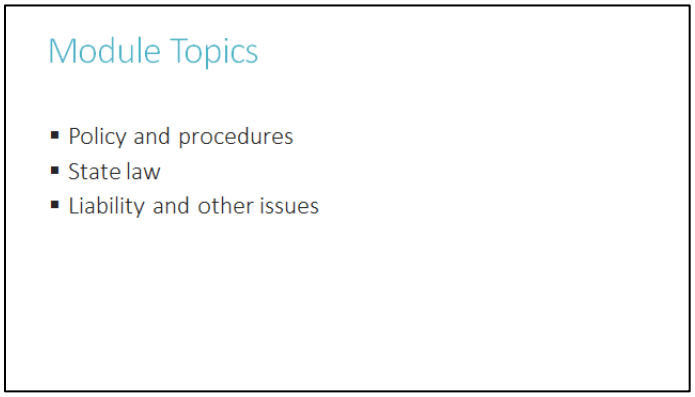

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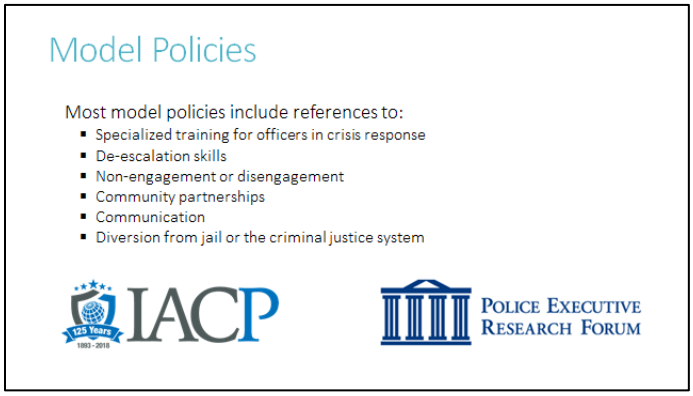

IG: Handout the model policies from the IACP and PERF, give class participants time to read them and then lead a discussion about the policies and their understanding of them. Use those policies to compare and contrast to the agency's policies.

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IG: This slide should be tailored to your audience. Seek out the agency's relevant policies and lead a discussion of them here. How do they compare to the model policies discussed earlier?

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Slide 291

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Module 18 | Law Enforcement: Liability and Other Issues Administration Page

Duration: 60 minutes | 11:00 am – 12:00 pm

Scope Statement: Review of liability issues for law enforcement agencies when officers interact with people with mental illness or people in crisis.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Describe the Fourteenth Amendment and its applicability to the topic at hand.
- Identify other liability considerations.

[NOTE: this module should be taught by an experienced law enforcement officer, a city representative, or a lawyer.]

Instructor/Participant Notes: [blank for notes]

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Module 18: Law Enforcement

Liability & Other Issues

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Fourteenth Amendment: Due Process

Did the officer inflict unnecessary and wanton pain and suffering?

"In determining whether this constitutional line has been crossed, a court must look to such factors as [i] the need for the application of force, [ii] the relationship between the need and the amount of force used, [iii] the extent of the injury inflicted, and [iv] whether the force was applied in a good faith effort to maintain and restore discipline or maliciously and sadistically for the very purpose of causing harm." *Orem v. Rephann*, 523 F.3d at 446 (4th Cir. 2008).

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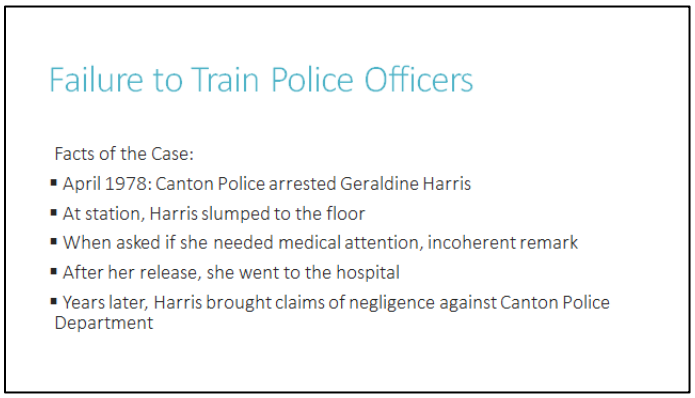
Failure to Train Police Officers

In 1989, the U.S. Supreme Court held that municipalities could be liable for failure to properly train police officers in ***City of Canton v. Harris*** 489 U.S. 378 (1989), which holds that the municipality is only liable for failure to train officers if the failure to train reflects deliberate indifference to the constitutional rights of the inhabitants of the municipality.

Slide 295



PG: In April 1978, Canton police arrested **Geraldine Harris**. At the police station, Harris slumped to the floor on two occasions and was eventually left there to prevent her from falling again. When asked if she needed medical attention, she responded with an incoherent remark. No officer summoned medical assistance for her. After her release about an hour later, Harris went to the hospital by an ambulance provided by her family and was diagnosed as "suffering from emotional aliments." She remained in the hospital for a week and then required outpatient treatment for a year after. Years later, Harris brought claims of negligence against the Canton Police Department. She argued that her Fourth Amendment right to due process was violated when the police failed to provide her medical attention while in custody. The case went to the U.S. Supreme Court in November 1988.

In February 1989 the Supreme Court ruled that local governments can be liable for monetary damages when deliberate indifference to the need for training and failure to train officers result in constitutional violations. The case was sent back to the lower court to reconsider Harris's claims in light of the Supreme Court's new standard.

Source: City of Canton, Ohio v. Harris 489 U.S. 378 (1989). Available here: https://supreme.justia.com/cases/federal/us/489/378/

IG: Lead a discussion of this case.

Slide 296

Failure to Train Police Officers

Liability for the municipality in ***City of Canton v. Harris*** can be shown if "(1)the officers exceeded constitutional limitations on the use of force; (2) the use of force arose under circumstances that constitute a usual and recurring situation with which police officers must deal; (3) the inadequate training demonstrates a deliberate indifference on the part of the city toward persons with whom the police officers come into contact; and (4) there is a direct causal link between the constitutional deprivation and the inadequate training."

Slide 297

Other Liability Considerations

- **Failure to Protect**

DeShaney v. Winnebago County, 489 U.S. 189 (1989). An officer's failure to protect an individual against private violence does not constitute a violation of the Due Process Clause. However, an allegation that police in some way assisted in creating or increasing danger to an individual could implicate those Due Process rights.

- **Disability Discrimination**

Arnold v. City of York, 340 F. Supp.2d 550 (M.D. Pa. 2004). Court found a possibly viable claim for disability discrimination under the Americans with Disabilities Act, based on alleged failure to provide adequate training for officers in handling encounters with mentally ill persons. Parents of a mentally ill man sued the police department after their son died, allegedly of positional asphyxia, after being taken into custody. Officers had transported the son to a hospital, handcuffed and hog-tied in a face-down position, and they had noticed his irregular breathing but failed to adjust his position.

PG: Source: Meek, Barry T. 2010. CIT Memphis. "Legal Authority, Liability, and Use of Force." Available here: http://www.cit.memphis.edu/modules/Law%20Enforcement/instructor/VA%20-%20Thomas%20Jefferson%20-%20Legal%20Authority,%20Liability,%20and%20Use%20of%20Force.pdf

Module 19 | Managing Encounters: Scenario-based Skills Training Administration Page

Duration: 4 hours | 1:00 pm – 5:00 pm

Scope Statement: This module introduces concepts relevant to managing encounters with people in mental health crisis using trained responses and continues scenario-based training.

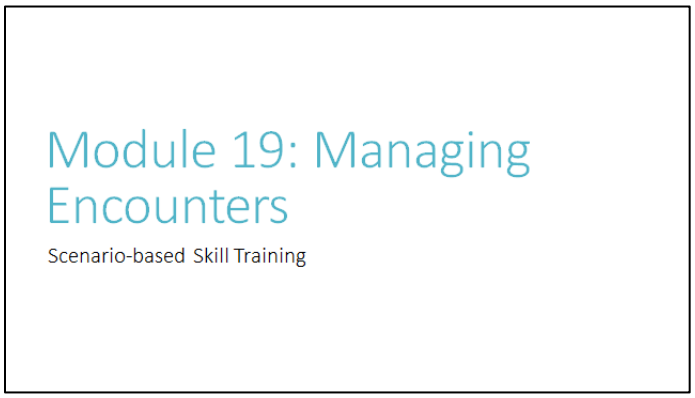
Student Learning Objectives:
Upon completing this module, students will be able to:

- Define the concept of defusing crisis situations
- Describe techniques used to "slow the situation down"
- Explain why communication skills are important for everyone's safety
- Describe how tone and body posturing can shape outcomes
- Apply newly acquired skills in interactive role-play situations to solidify techniques
- Integrate crisis management skills with police department officer safety procedures

[NOTE: Ideally, this module should be co-taught by an experienced CIT officer and a mental health professional from your community.]

Instructor/Participant Notes: [blank for notes]

Slide 298



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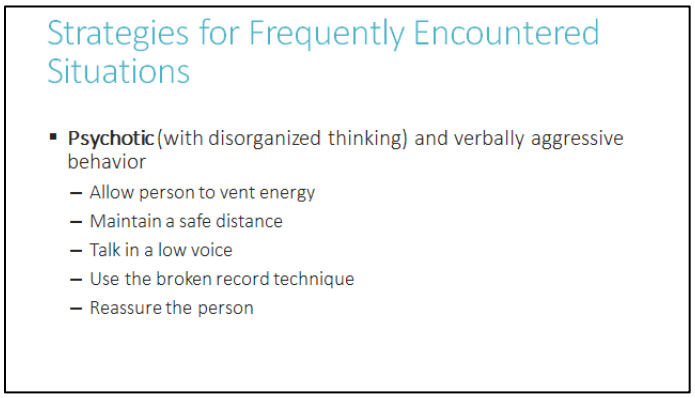
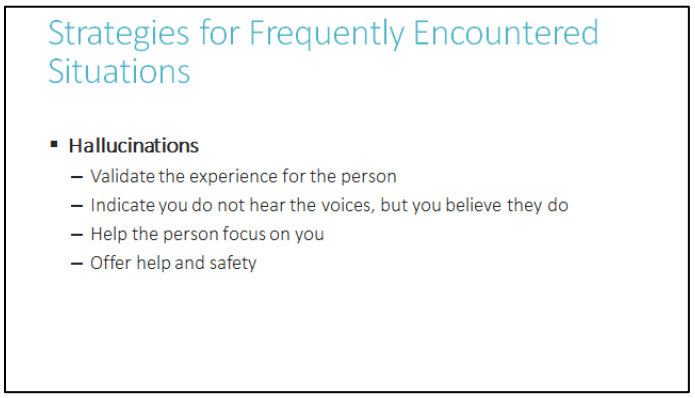


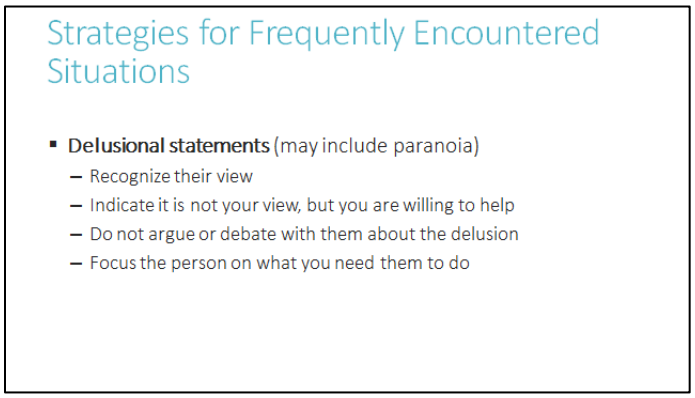
PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 300



PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

Slide 301



PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

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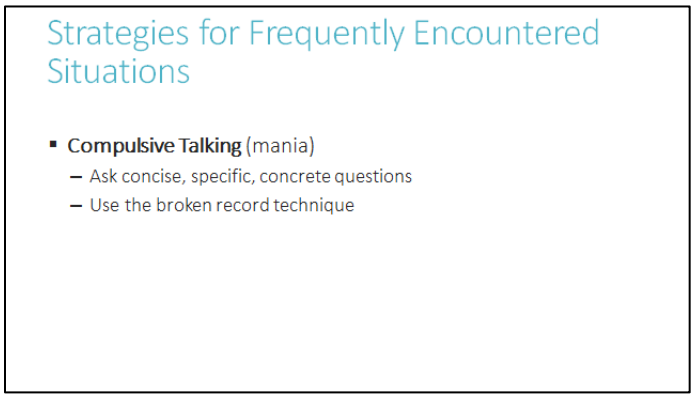

PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

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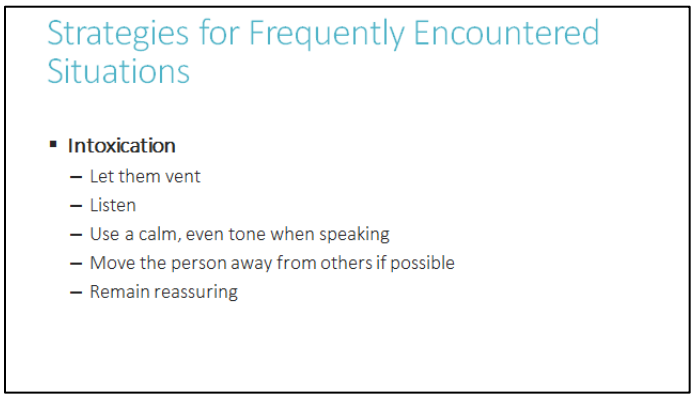

PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

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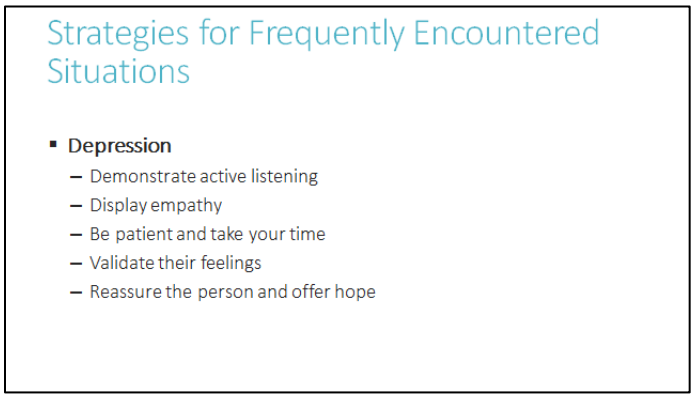

PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

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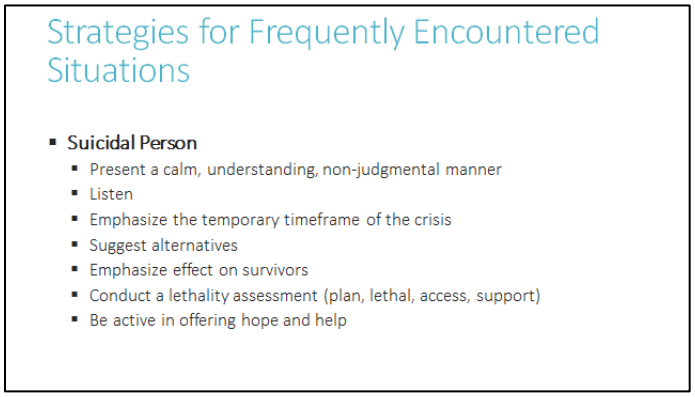

PG: Source: Saunders, Michele. CIT Memphis. "Crisis Intervention and De-escalation Techniques." Available here: http://www.cit.memphis.edu/modules/De-Escalation/presentations/FL%20-%20De%20Escalation%20Techniques.pdf

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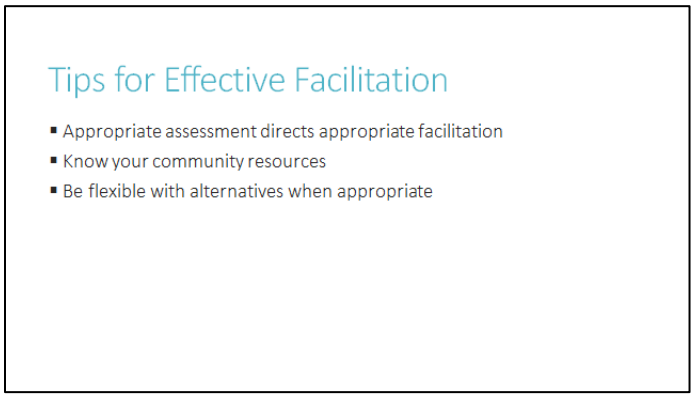
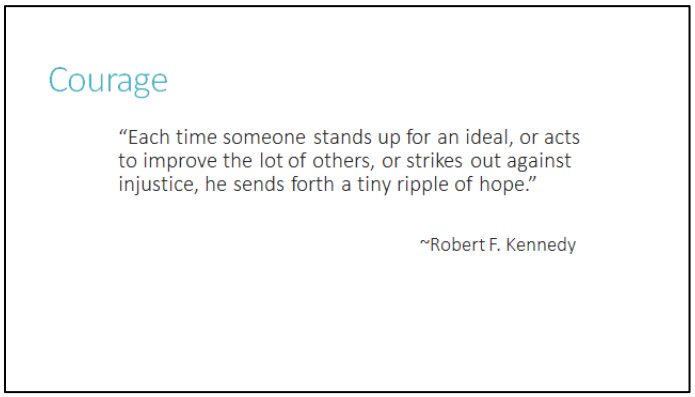


Slide 307



Slide 308

Slide 309


Florida CIT
Memphis CIT
Thomas Jefferson CIT
OF BRIDGEPORT
Special Thanks to the following CIT programs

Module 20 | Law Enforcement: Community Support: Perspectives: Veterans and Homelessness Administration Page

Duration: 1 hour | 8:00 am – 9:00 am

Scope Statement: The material in this module is a guide; we encourage local jurisdictions and communities to make this module their own by developing new content or refining the content provided. Further, if there is another community issue that is more relevant for your community, please feel free to re-develop this hour to address other local issues.

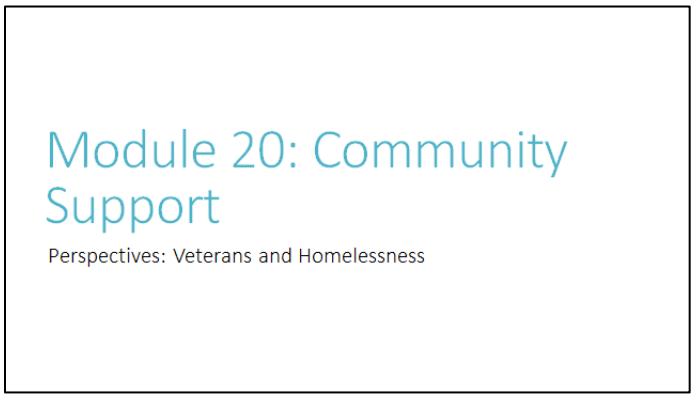
Student Learning Objectives:
Upon completing this module, students will be able to:

- Explain mental health challenges that are faced by some veterans and people who are homeless
- Other tailored learning objectives depending upon guest speakers.

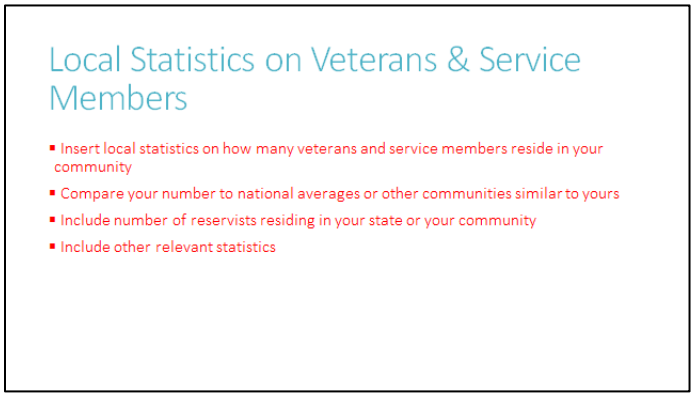
[NOTE: This module should be taught by a community member who is well-versed in local veterans and homeless issues and resources.]

Instructor/Participant Notes: [blank for notes]

Slide 310

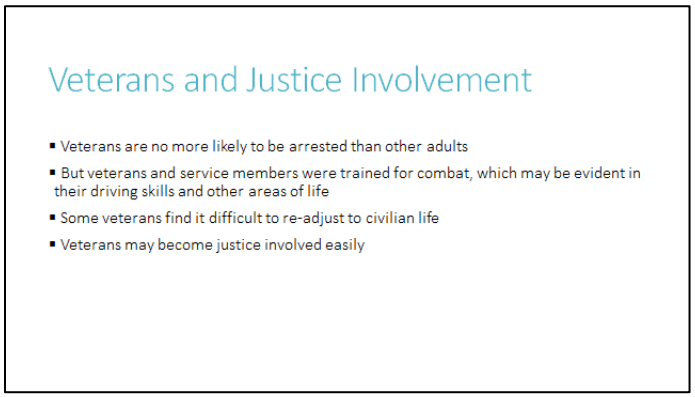


Slide 311



IG: Tailor this slide with local statistics. Lead a brief discussion about your community's veterans.

Slide 312



PG: Source: Halpern, Patrick. Virginia CIT Coalition. "Putting it All Together: Virginia CIT and Veterans." Available here: http://vacitcoalition.org/yahoo_site_admin/assets/docs/Veterans_Panel_-_Halpern.360111802.pdf

Slide 313

Guest Speaker

Content to be customized by agency/community.

IG: Optional – this slide is a place holder for a guest speaker who may be a veteran, from the local Veterans Administration hospital, or from a local advocacy group for veterans. If you identify a guest speaker, please invite them to tailor some slides for the part of the module.

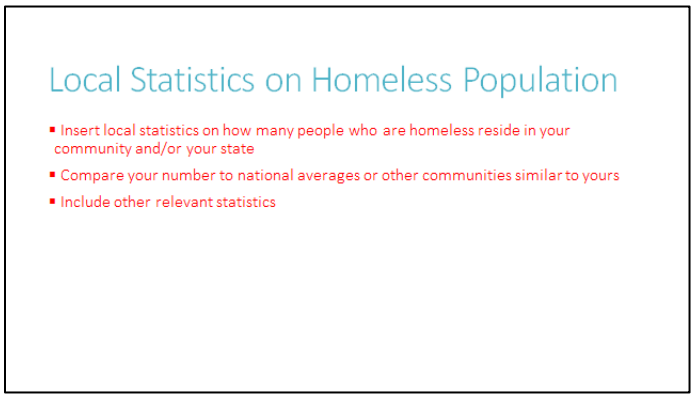
Slide 314

TIME Magazine "Crisis Intervention Teams for Vets: Sure Beats Jail"

PG: Link to article: http://nation.time.com/2012/08/22/crisis-intervention-teams-for-vets-sure-beats-jail/

IG: Handout printed out copies of this article, allow for some reading time and then lead a discussion about the numbers of vets that participant officers may come into contact with.

Slide 315



IG: Tailor this slide with local statistics. Lead a brief discussion about your community's homeless population.

Slide 316

PG: Link to the VIDEO: https://www.youtube.com/watch?v=I6BPKLbus1A

IG: Video run time: 11:55
Introduce video, which highlights the Houston Police Department's Homeless Outreach Team and other strategies HPD uses to address homelessness in their city. After the video, lead a discussion and ask: "How do the participant officers feel about arresting homeless people? Would these types of strategies work in your community?"

Slide 317

PG: Link to Houston's CIT and HOT: http://www.houstoncit.org/mental-health-division-2/

Goal: To obtain housing for the chronic homeless.

History: The Homeless Outreach Team (HOT) started as a pilot program in January 2011. It was made a permanent program in the department after a very successful six-month pilot. Sergeant Stephen Wick, the team's current supervisor, and Senior Police Officer Jaime Giraldo (at front in picture above) developed and implemented the program.

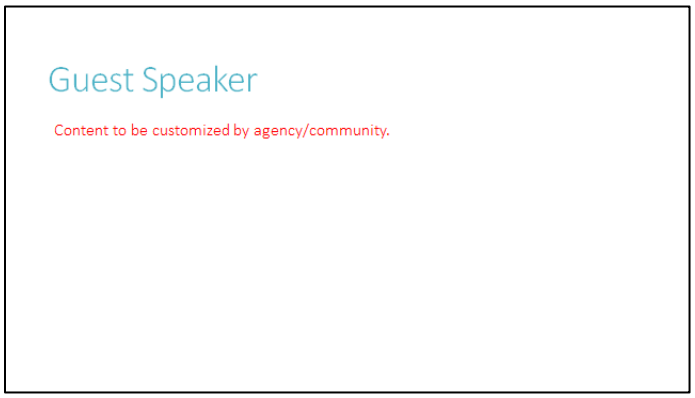
Program Description: HOT is comprised of one sergeant, four police officers, and three mental health professionals from The Harris Center for Mental Health and IDD. The team helps the homeless with the following:

- Housing
- Social Security cards
- Passports
- Birth certificates
- Shelter referrals
- Medical equipment
- Employment
- Bus fare
- Medical care
- Mental health treatment

Collaboration: The team works with several organizations. The following are a few:

- SEARCH Homeless Services
- Palmer Way Station
- Salvation Army
- Healthcare for the Homeless
- US Vets
- DeGeorge Veterans Housing
- Main Street Ministries
- Goodwill

Slide 318



IG: Optional – this slide is a place holder for a guest speaker who may be homeless or representing local advocacy group for homelessness issues. If you identify a guest speaker, please invite them to tailor some slides for the part of the module.

Module 21 | Managing Encounters: Scenario-based Skills Training Administration Page

Duration: 3 hours | 9:00 am – 12:00 pm

Scope Statement: This module introduces concepts relevant to managing encounters with people in mental health crisis using trained responses and continues scenario-based training.

Student Learning Objectives:
Upon completing this module, students will be able to:

- Define the concept of defusing crisis situations
- Describe techniques used to "slow the situation down"
- Explain why communication skills are important for everyone's safety
- Describe how tone and body posturing can shape outcomes
- Apply newly acquired skills in interactive role-play situations to solidify techniques
- Integrate crisis management skills with police department officer safety procedures

[NOTE: Ideally, this module should be co-taught by an experienced CIT officer and a mental health professional from your community.]

Instructor/Participant Notes: [blank for notes]

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Module 21: Managing Encounters

Scenario-based Skill Training

Slide 320

The ABCs of the CIT Scene

- be **A**ware of their view of the situation and your view
- **B**ecome the safe person they can trust and talk to
- **C**reate an open door for solutions

Slide 321

Silence is Golden

- You cannot talk and listen at the same time.
- You cannot be formulating your next reply and listening at the same time.

Module 22 | Law Enforcement: Incident Review Administration Page

Duration: 1 hour | 1:00 pm – 2:00 pm

Scope Statement: This module is to be customized by your agency/community. If your agency has an incident review process, first review that process.

You may either choose real incidents from your department, a neighboring department or a department in another state to review. Depending on their complexity, you may have time to review one or two incidents. In addition to considering safety, legal and policy ramifications of an incident, please also consider community perceptions. Did this incident affect police-community relationships – positively or negatively?

Student Learning Objectives:
Upon completing this module, students will be able to:

- Explain one concept you learned from incident review that will inform your every-day tasks.

[NOTE: This module should be taught by and experienced CIT officer in your department, a supervisor, or an experienced sworn CIT trainer.]

Instructor/Participant Notes [blank for notes]

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Module 22: Law Enforcement

Incident Review

Slide 323

Why conduct Incident Reviews?

- Law enforcement agencies are striving to become "learning organizations."
- Incident reviews help us assess both the positive and the negative aspects of a given incident.
- It may help us avoid future tragedies.
- It helps address department deficiencies in training, tactics, policies and procedures.

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Incident Review

Incident Reviews should include:

- Narrative of the police response to the incident, by stage or time (in minutes)
- Analysis of the incident, including: responses, investigations, communication, leadership, media

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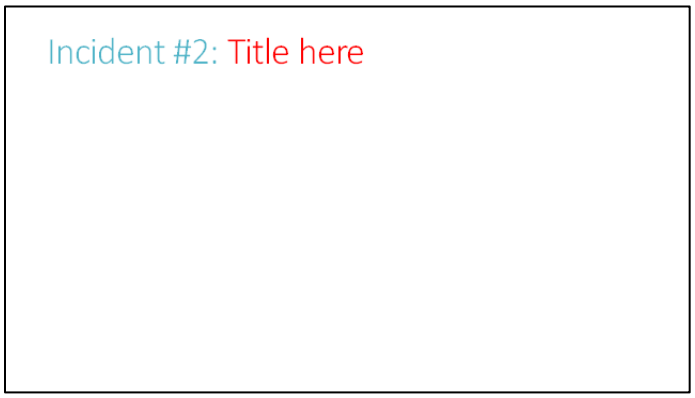
Slide 326



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Module 23 | Community Support: Advocacy: Special Topic Administration Page

Duration: 1.5 hours | 2:00 pm – 3:30 pm

Scope Statement: This module is to be used for a topic that is relevant to your community, such as problem-solving courts, officer wellness, childhood trauma, intellectual and developmental disorders, or other topics with local importance. Invite relevant guest speakers in to deliver brief talks about local issues or resources.

Resources for potential special topics:

Problem-Solving Courts

- Mental Health Courts from A to Z, The Council of State Governments, http://www.csg.org/pubs/capitolideas/2013_jan_feb/mentalhealthcourts.aspx
- Mental Health Courts, The Justice Center at the Council of State Governments, https://csgjusticecenter.org/mental-health-court-project/
- National Drug Court Resource Center, https://ndcrc.org/
- National Drug Court Institute, https://www.ndci.org/

Officer Wellness

- Officer Safety and Wellness Initiatives, DOJ Office of Justice Programs, Bureau of Justice Assistance, https://www.bja.gov/ProgramDetails.aspx?Program_ID=103
- Valor Officer Safety and Wellness Program, https://www.valorforblue.org/
- Vicarious Trauma Toolkit, DOJ Office of Justice Programs, Office for Victims of Crime, https://vtt.ovc.ojp.gov/

Childhood Trauma

- Resources for Juvenile Justice Professionals, Law Enforcement, and First Responders, The National Child Traumatic Stress Network, http://www.nctsn.org/category/products/juvenile-justice-professionalslaw-enforcementfirst-responders

Intellectual and Developmental Disorders

- Resources for Law Enforcement, First Responders, and Corrections, The Arc, https://www.thearc.org/NCCJD/resources/by-audience/law-enforcement

Student Learning Objectives:

Upon completing this module, students will be able to:

- To be customized to guest speaker(s).

[NOTE: This module should be taught by a guest speaker from the community.]

Instructor/Participant Notes: [blank for notes]

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Module 24 | Research and Systems: Training Evaluation Administration Page

Duration: 30 minutes | 3:30 pm – 4:00 pm

Scope Statement: Please ask participants to complete the post-course survey and the course evaluation.

Instructor/Participant Notes: [blank for notes]

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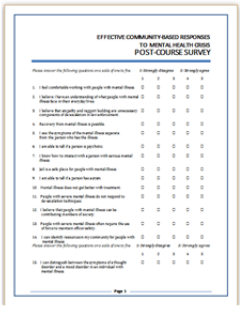
Module 24: Research & Systems

Training Evaluation

Slide 329

What do you know about CIT *now*?

1. Please complete the **Post-course Survey**
   - Label your survey with the same unique and memorable identifier (e.g., your badge number, the street you live on) that you used on day one.
2. Please complete the **Course Evaluation**


EFFECTIVE COMMUNITY-BASED RESPONSES TO MENTAL HEALTH CRISIS
POST-COURSE SURVEY

IG: Hand out both the post-course Survey and the Course Evaluation instrument to all participants and collect when finished.

EFFECTIVE COMMUNITY-BASED RESPONSES TO MENTAL HEALTH CRISES
POST-COURSE SURVEY

Please answer the following questions on a scale of one to five. *1: Strongly disagree* *5: Strongly agree*

	1	2	3	4	5
1. I feel comfortable working with people with mental illness.	☐	☐	☐	☐	☐
2. I believe I have an understanding of what people with mental illness face in their everyday lives.	☐	☐	☐	☐	☐
3. I believe that empathy and rapport building are necessary components to defuse crisis situations.	☐	☐	☐	☐	☐
4. Recovery from mental illness is possible.	☐	☐	☐	☐	☐
5. I see the symptoms of the mental illness separate from the person who has the illness.	☐	☐	☐	☐	☐
6. I am able to tell if a person is psychotic.	☐	☐	☐	☐	☐
7. I know how to interact with a person with serious mental illness.	☐	☐	☐	☐	☐
8. Jail is a safe place for people with mental illness.	☐	☐	☐	☐	☐
9. I am able to tell if a person has autism.	☐	☐	☐	☐	☐
10. Mental illness does not get better with treatment.	☐	☐	☐	☐	☐
11. People with severe mental illness do not respond to techniques meant to defuse crises situations.	☐	☐	☐	☐	☐
12. I believe that people with mental illness can be contributing members of society.	☐	☐	☐	☐	☐
13. People with severe mental illness often require the use of force to maintain officer safety.	☐	☐	☐	☐	☐
14. I can identify resources in my community for people with mental illness.	☐	☐	☐	☐	☐

Please answer the following questions on a scale of one to five. *1: Strongly disagree* *5: Strongly agree*

	1	2	3	4	5
15. I can distinguish between the symptoms of a thought disorder and a mood disorder in an individual with mental illness.	☐	☐	☐	☐	☐
16. I am able to utilize verbal de-escalation techniques effectively.	☐	☐	☐	☐	☐
17. I feel able to determine if a person with mental illness who has committed a crime should be taken to jail or to a hospital/emergency room.	☐	☐	☐	☐	☐
18. I feel confident in my skills to interact with people with mental illness or people in crisis.	☐	☐	☐	☐	☐
19. I know who to call if I need assistance when interacting with a person with severe mental illness or in crisis.	☐	☐	☐	☐	☐
20. Mental illness is not anyone's fault.	☐	☐	☐	☐	☐

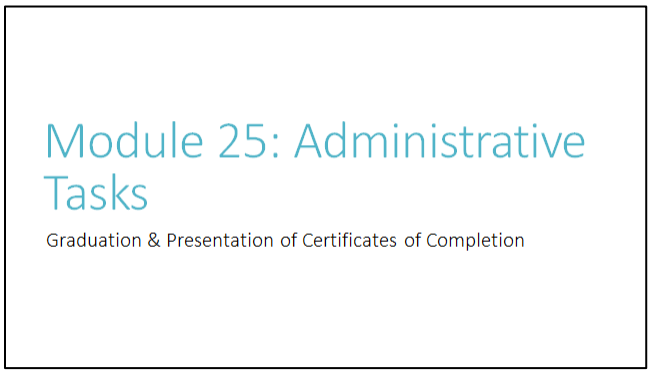
Module 25 | Administrative Tasks: Graduation and Presentation of Certificates of Completion
Administration Page

Duration: 1 hour | 4:00 pm – 5:00 pm

Scope Statement: This module is to be used for an overall review of the course, general feedback from the participants and to celebrate their commitment to learning about CIT. This is an opportunity for the participating officers to reflect upon the week, make observations and ask any last questions.

Instructor/Participant Notes: [blank for notes]

Slide 330



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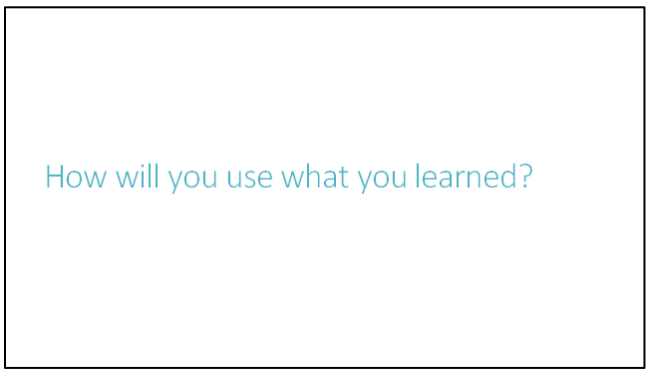
IG: Ask question on slide and lead brief discussion.

Slide 332



IG: Ask question on slide and lead brief discussion.

Slide 333

How will your new skills enhance your safety and the safety of others?

IG: Ask question on slide and lead brief discussion.

Slide 334

Congratulations!


Certificate of Completion

This certifies that

Officer J. Brown

of the City Police Department
completed the 40-hour course entitled
EFFECTIVE COMMUNITY-BASED RESPONSES TO MENTAL HEALTH CRISES: A NATIONAL CURRICULUM FOR LAW ENFORCEMENT
City, State | Date

Instructor Name(s) Date

BJA CNA

IG: Distribute Certificates of Course Completion by calling each student up to the front of the room and shaking hands.