Bureau of Justice Assistance
U.S. Department of Justice

Effective Community Responses to Mental Health Crises:

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

Participant Guide

CNA
ANALYSIS & SOLUTIONS

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Participant Guide

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U.S. Department of Justice

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Bureau of Justice Assistance
Office of Justice Programs
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Course Overview

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.

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.

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.

Course Materials

Participants in the course will receive a printed or electronic version of the Participant's Guide, which provides copies of the slides used during the trainings, case studies, evaluation forms, and links to relevant resources.

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 Matrix (Instructors: Please view the matrix options located in the Instructor's Guide on pages 8 and 9 and insert the appropriate matrix here)

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	**M16 | Mental Health Basics:** Suicide	**M20 | Community Support:** Veterans & Homelessness
8:30					
9:00	**M2 | Research & Systems: CIT Overview**	**M9 | Mental Health Basics:** Psychopharmacology	**M11 | Mental Health Basics:** Disruptive, Impulse-Control, & Conduct Disorders		**M21 | Managing Encounters:** 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 |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		**M15 | Managing Encounters:** 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				

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.

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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]

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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

Effective Community-based Responses to Mental Health Crises: A National Curriculum for Law Enforcement

Based on Best Practices from CIT Programs Nationwide

BJA Bureau of Justice Assistance U.S. Department of Justice

CNA ANALYSIS & SOLUTIONS

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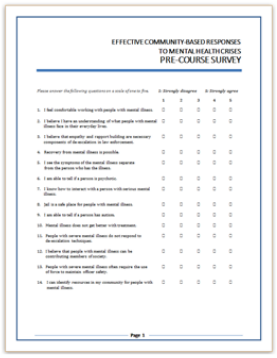
Module 1: Welcome

Course Overview and Administrative Tasks

Slide 3

Pre-Course Survey

- Please complete the **Pre-course survey.**
- Label your survey with a unique and memorable identifier (e.g., your badge number, the street where you live).


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

Slide 4

Introductions and Activity

- Instructors
- Participants

Slide 5

What to expect this week

- New concepts
- New terminology
- Clear learning objectives
- Hands-on work and exercises
- Site visits / Visits from key partners
- Development of skills

Slide 6

A note about Terminology

People with mental illness will be referred to as such throughout this curriculum. We have chosen this "people first" approach purposely, because we believe this reflects the priorities of CIT. In like fashion, we will avoid terms like "the criminally insane."

Other terms exist to refer to people with mental illness, including "clients," "patients," "consumers," and "peers." While these terms may be acceptable to some, they may not be acceptable to all. Please make an effort to educate yourself about your community's local and lived perspectives on terminology.

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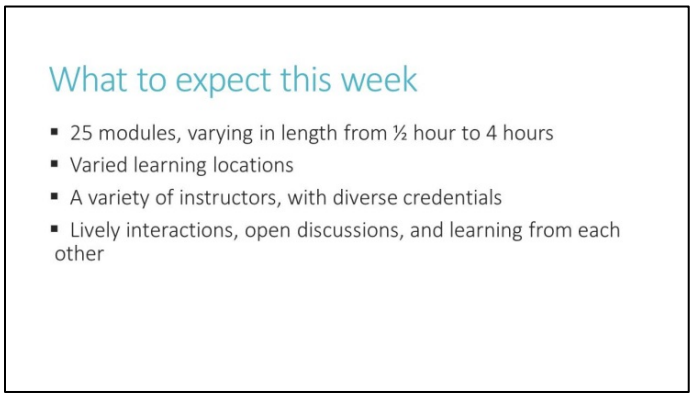

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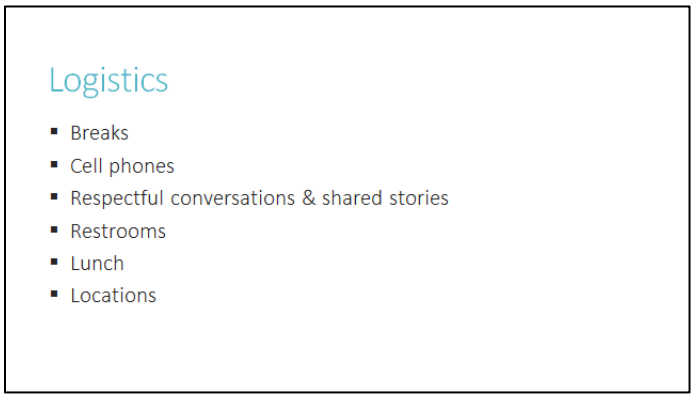

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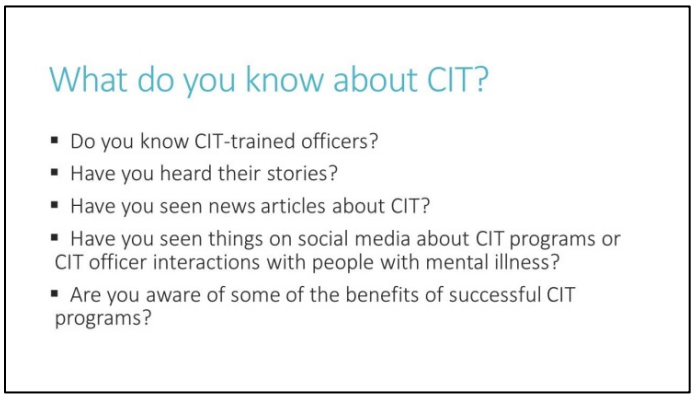

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This audio clip from National Public Radio aired in September of 2014 and is an example of the kinds of media coverage CIT has gotten.
Link to AUDIO: http://www.npr.org/2014/09/23/349098691/as-run-ins-rise-police-take-crash-courses-on-handling-mentally-ill

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.

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What is CIT?

Crisis Intervention Teams (CITs) are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises.

They are built on strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness.

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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

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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***

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]

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Module 2: Research and Systems

CIT Overview

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Background: Problem Statement

- Number of people with mental illness in jails and prisons (2006)
  - 479,000 people in local jails
  - 705,600 people in state prisons
  - 78,800 people in federal prisons
- Number of fatal police contacts
  - 246 people with mental illness being shot and/or killed by police nationwide (2017)
  - People with mental illness are 16 times more likely to be killed during a police encounter
- Number of people with mental illness who are homeless: 216,000

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Background: U.S. History

Deinstitutionalization

- Deinstitutionalization refers to the policy of moving people with severe mental illnesses out of large state institutions and then closing part or all of those institutions; it has been a major contributing factor to the mental illness crisis we face in America today.

Today's broken mental health system

- We have not solved the problem created by deinstitutionalization; America suffers from a severe lack of mental health resources and options today.

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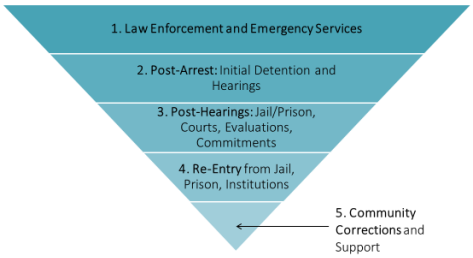
Criminal Justice Approaches: Sequential Intercept Model



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Criminal Justice Approaches

- There are a number of mental health and criminal justice innovations around the nation:
  - Mental health courts
  - Jail and prison mental health evaluations
  - Continuity of care: from arrest to re-entry
  - Community corrections

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Background

- CIT grew out of an incident in Memphis in1987
- The Mayor of Memphis turned to the National Alliance on Mental Illness (NAMI), Memphis chapter for assistance
- Together, NAMI, the Memphis Police Department, university leaders at the University of Memphis, mental health professionals and community leaders developed the CIT training model
- Since 1987, CIT has been steadily adopted by law enforcement agencies throughout the country and the world

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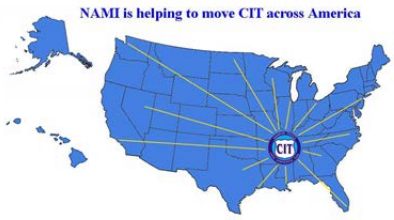
Background



NAMI
The Nation's Voice on Mental Illness

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Background

- National prevalence of crisis intervention teams: 47 States, approximately 2,700 programs (source: U of Memphis)
- Legislation by state: At present, there are only three states that ***mandate*** a 40-hour CIT training course for officers (VA, IL & NM). Other states, however, have taken legislative steps to support CIT or other specialized police training (source: NAMI)

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The Memphis Model

Key characteristics of the Memphis Model:

- Community partnerships
- Specialized officer training
- Emphasis on de-escalating crisis situations
- Focus on routing to mental health care facilities, rather than jail

THE UNIVERSITY OF MEMPHIS
Department of Criminology and Criminal Justice

NAMI
The Nation's Voice on Mental Illness

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CIT Training for Officers

Police officer training in selected topics, including:

- Mental health diagnoses
- Signs and symptoms of mental illnesses
- Psychiatric medications
- Substance use and misuse
- Specialized skills such as crisis resolution and communication
- Mental health and disability law
- Cultural sensitivity

CIT trainers are mental health professionals, criminal justice professionals, and NAMI educators who often volunteer their time.

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Jail Diversion & Alternatives to Arrest

Referral to appropriate health care:

- Community mental health centers
- Local hospitals
- Veteran's Administration (VA) facilities

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Community-based Model

- CIT steering groups and CIT coordinators:
  - Seek funding
  - Lead community coordination
  - Coordinates training and outreach

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CIT Core Elements

The CIT Model has ***10 Core Elements*** divided into three categories:

- Ongoing elements (3)
- Operational elements (3)
- Sustaining elements (4)

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CIT Ongoing Elements

The ongoing elements include:

- Partnerships: law enforcement, advocacy & mental health
- Community ownership: planning, implementation, & networking
- Policies and procedures

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CIT Ongoing Elements

Partnerships

Law enforcement community

- Police department
- Sheriff's department
- Corrections (Probation, Parole)
- Judiciary (Public Defender, State's Attorney, Judges)
- Law enforcement training staff
- Training & standards board or POST

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CIT Ongoing Elements

Partnerships

Advocacy community

- Consumers and individuals with mental illness
- Family members of people with mental illness
- Advocacy groups (NAMI, NMHA)

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CIT Ongoing Elements

Partnerships

Mental health community

- Providers, educators, practitioners & trainers
- Professionals (psychologists, psychiatrists, physicians, social workers, counselors, substance abuse counselors, criminologists)
- Public and non-profit agencies (universities, hospitals, mental health centers, medical schools)

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CIT Ongoing Elements

Community Ownership

Planning

- Advocates
- Community members
- Consumers & family members
- Government / Judiciary
- Law enforcement community
- Mental health community

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CIT Ongoing Elements

Community Ownership

Implementation

- Leadership from law enforcement, mental health community, advocacy community
- Training curriculum & trainers

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CIT Ongoing Elements

Community Ownership

Networking

- Feedback
- Problem-solving

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CIT Ongoing Elements

Policies and Procedures

CIT training

- Inter-agency agreements
- Size and scope

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CIT Ongoing Elements

Policies and Procedures

Law enforcement agency policies and procedures

- Dispatch
- Patrol

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CIT Ongoing Elements

Policies and Procedures

Mental health emergency policies and procedures

- Law enforcement referral policies

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CIT Operational Elements

The Operational Elements include:

- Crisis Intervention ***Team***: Law enforcement officers, dispatchers, CIT coordinators, community partners, mental health community, advocacy community
- Curriculum: CIT Training
- Mental health receiving facility & emergency services, first responders

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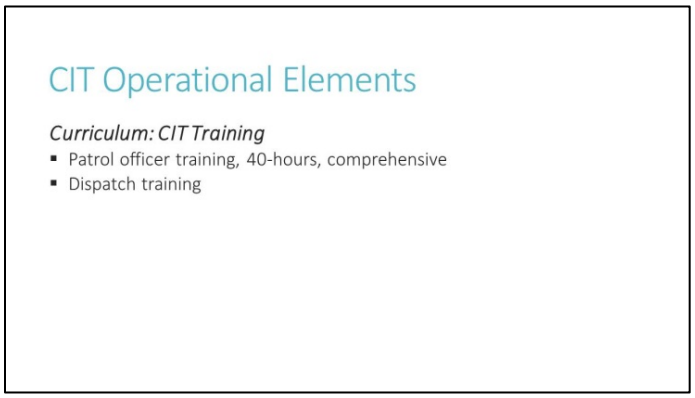

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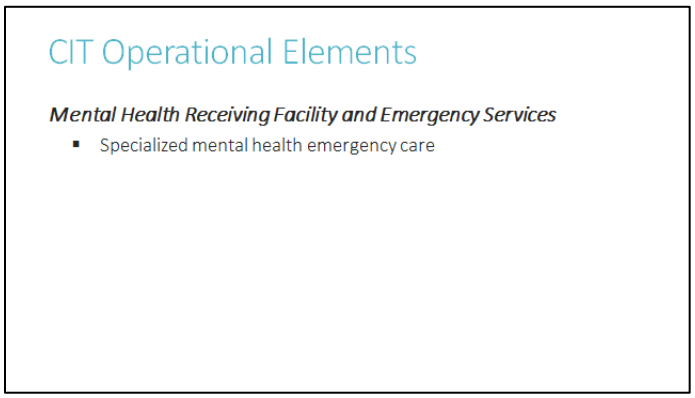

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CIT Sustaining Elements

The Sustaining Elements include:

- Evaluation & research
- In-service training
- Recognition & honors
- Outreach: Developing CIT in other communities

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CIT Sustaining Elements

Evaluation & Research

- Research on a wide variety of issues

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CIT Sustaining Elements

In-Service Training

- Extended and/or advanced training

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CIT Sustaining Elements

Recognition & Honors

- Awards, i.e. CIT Officer of the Year
- Certificates of recognition
- Annual banquets

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CIT Sustaining Elements

Outreach: Developing CIT in other communities

- Outreach efforts – regional or statewide
- Legislative efforts

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A Model for the Nation

- Advantages of CIT:
  - Provides excellent immediacy of response (Deane et al, 1997)
  - Changes nature of intervention
  - Reduces injuries to officers, use of force (Dupont and Cochran, 2000)
  - Changes attitudes/perception (Borum, et al., 1998)
  - Lowers arrest rates (Steadman, et al., 2000)
  - Increases health care referrals (Dupont and Cochran, 2000)
  - Clarifies lines of responsibility

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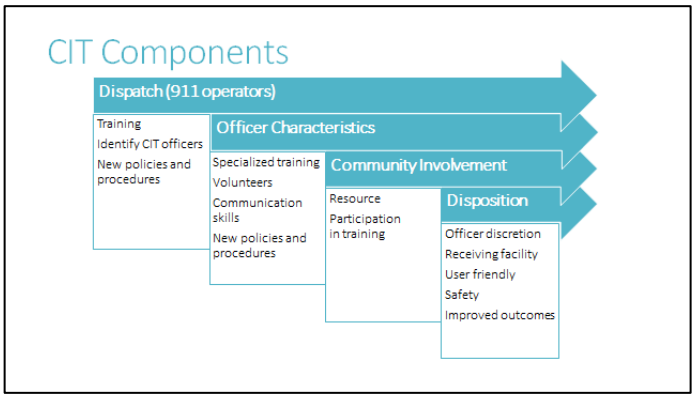

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Video may be found at https://www.youtube.com/watch?v=R-MmPVSGcnM.

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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

Module 3: Community Support

Cultural Awareness and Mental Health

Slide 50

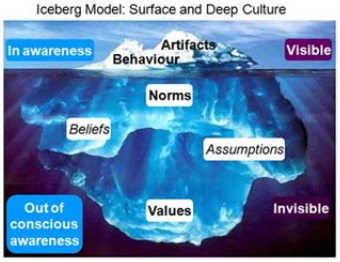
How would you describe culture?

Meaning, values, and behavioral norms that are learned and transmitted in society and within social groups.

Slide 51

What is Culture?

Iceberg Model: Surface and Deep Culture



- Why is cultural awareness important in the context of CIT?
- Consider your local community: how does the iceberg apply?
  - What about culture among people who have mental health issues?
  - What about your departmental culture?

Slide 52

What is Cultural Awareness?

- Understanding people different from you
- Learning new patterns of behavior
- Effectively applying your understanding in the appropriate settings

Slide 53

Cultural Awareness

- Consider our experiences with different cultures, and their impact on you. How have those experiences shaped us?
- What are our assumptions and perceptions?
- Where do they come from?
- How do they affect us as we work with others?
- Why do we need to set them aside when working with others?

Slide 54

Cultural Considerations

Culture influences language, communication, and engagement.

- Directness
- Gestures
- Facial expressions
- Distance
- Touch
- Degree of formality
- Forms of address
- Pace & pitch

Culture may also influence beliefs about mental health and coping strategies:

- Preference to seek therapy with a professional vs. talking things out with family
- Disinclination to not take medications for mental illness
- The level and way in which families' support a family member struggling with mental illness
- Ability (or lack there of) to see strengths in one's experience, regardless of diagnoses

Slide 55

What is Diversity?

The understanding that each individual is unique, recognizing our individual differences. These can be along dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, experiences, and other ideologies.

Slide 56

The bottom line

Treat everyone with ***respect***.

People in different cultures show respect to others in different ways. Differences may be particularly relevant with authority figures like law enforcement and emergency personnel. Make efforts to understand your community and help them to understand you.

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

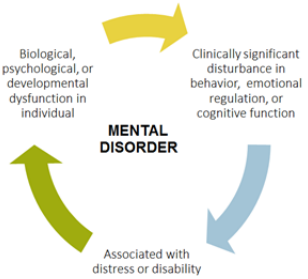
Module 4: Mental Health Basics

Depressive Disorders

Slide 58

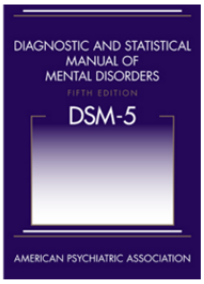
Severe, Persistent Mental Illnesses

- How do you differentiate between a mental illness and stress?
- How might signs or symptoms differ?



Slide 59

General Psychiatric Diagnosis and Symptoms



- Mental health disorders are laid out by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*.
  - List of diagnoses
  - List of criteria to be met
  - Description of symptoms
  - Description of impairments
- The DSM-5 is meant to only be used by trained professionals to diagnose clients.

Slide 60

Recognizing Signs and Symptoms of Mental Illnesses

- Excessive feelings of fear or worry
- Feeling excessively sad or low
- Extreme changes in mood
- Confused thinking
- Irritability or anger
- Avoiding friends and/or social activities
- Change in eating habits
- Inability to carry out daily activities; difficulties perceiving realities (delusions or hallucinations)
- Lack of insight; inability to perceive changes in one's own feelings
- Abuse of substances
- Physical symptoms, without obvious causes (aches and pains)
- Thoughts about suicide

Slide 61

Depressive Disorders

Depressive Disorders include the presence of sad, empty, or irritable mood. These disorders also include changes in the way people think and behave.

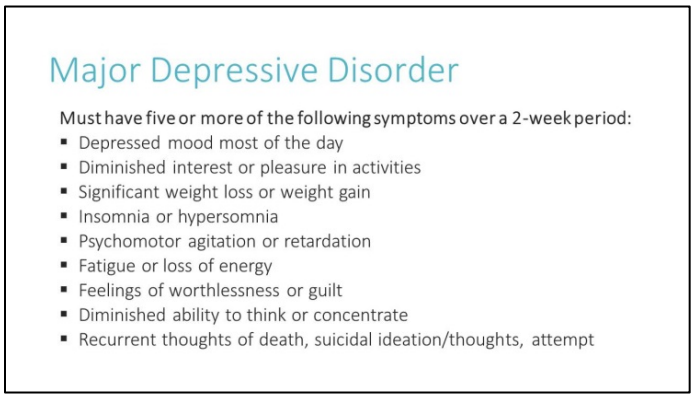
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)

Mood disorders, including major depression and bipolar disorder, are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18–44.

Slide 62

Video Title: "Living with Depression", https://www.youtube.com/watch?v=EJ_S5Rjt_iI

Slide 63



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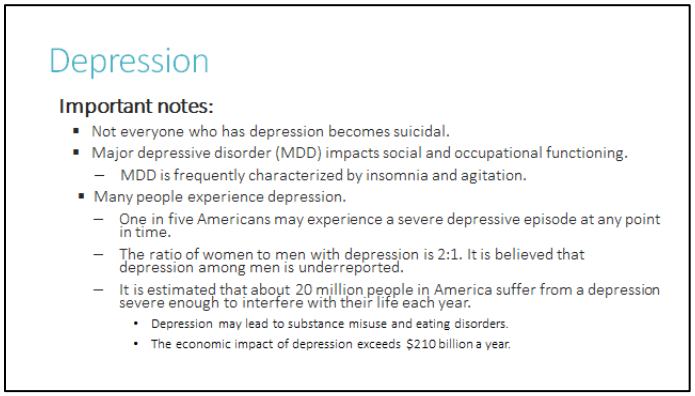
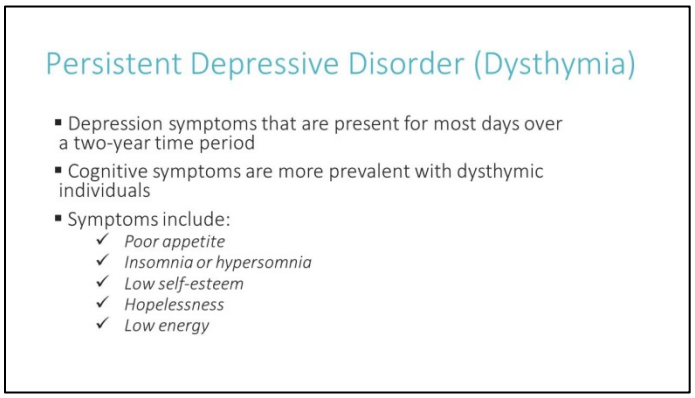


Slide 65

Video Title: “Depression Isn’t Always Obvious”, https://youtu.be/1Yq6W7YAHM4

Slide 66



Slide 67

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?

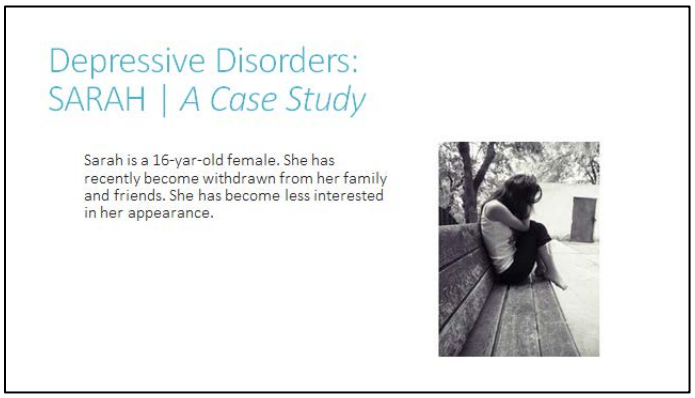
(SOUNDBITE OF SONG, "STRANGERS LIKE ME")

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")

Slide 68



Case Study:

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.

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]

Slide 69

Module 5: Mental Health Basics

Bipolar Disorders, Schizophrenia, & Psychotic Disorders

Slide 70

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.

Slide 71

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

Slide 72

Bipolar and Related Disorders

Mania/Manic Symptoms	Depression/Depressive Symptoms
Mood Changes	**Mood Changes**
▪ Feeling "high" or extremely happy/outgoing ▪ Extreme irritability	▪ Feeling sad or hopelessness ▪ Loss of interest in activities previously enjoyed
Behavior Changes	**Behavior Changes**
▪ Fast talking; Jumping between ideas/conversations ▪ Racing thoughts ▪ Easily distracted ▪ Taking on new tasks ▪ Extremely restless ▪ Not tired/little sleep ▪ Increase in impulsive and high risk behaviors	▪ Feeling tired ▪ Difficulties concentrating, remembering, or making decisions ▪ Feeling restless or irritable ▪ Changing eating or sleeping habits ▪ Thoughts of death, suicide, or attempting suicide

Slide 73

Bipolar Disorder DSM-5 Criteria

MANIA	HYPOMANIA
▪ Period of at least one week of abnormally and persistently elevated, expansive or irritable mood severe enough to cause significant impairment in social, occupational or interpersonal functioning – or warrant hospitalization. ▪ Presence of 3 or more out of 7 specific symptoms listed in the DSM-5. Psychotic features can be present. ▪ Known as Bipolar I.	▪ Period of at least 4 days of a persistently elevated, expansive or irritable mood clearly different from the non-depressed mood state. ▪ Presence of 3 or more out of 7 specific symptoms listed in the DSM-5, but not severe enough to cause marked impairment in social, occupational or interpersonal functioning, necessitate hospitalization, and there are no psychotic features. ▪ Known as Bipolar Affective Disorder II or Bipolar II.

Slide 74

Video Title: "Bipolar I Disorder: Hypomania and Rapid Speech", https://www.youtube.com/watch?v=kiEUibfC47oandfeature=youtu.be

Slide 75

Bipolar and Related Disorders: JANE | *A Case Study*

Jane is a 20-year-old female. She has recently had contact with local police because she was found outside a coffee shop loudly initiating a conversation with people passing by the shop.

Case Study:

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.

Slide 76

Psychosis

- **Psychosis is a state defined by a loss of contact with reality.**
  - The ability to perceive and respond to the environment is significantly disturbed; functioning is impaired.
  - Symptoms may include hallucinations (false sensory perceptions) and/or delusions (false beliefs).
- Psychosis is a symptom, not a disorder.
- Psychosis may be experienced for a wide range of reasons: as a result of a physiological disorder, a psychological disorder, or drug or alcohol withdrawal.

Slide 77

Video Title: “Teenager during a psychotic break”, Video link: http://youtu.be/yM064w5Ht54

Slide 78

Psychotic Disorders: Schizophrenia Spectrum

Schizophrenia Spectrum disorders have symptoms and abnormalities in one or more of the following areas:

- Delusions
- Hallucinations: Disorganized thinking
- Grossly disorganized or abnormal motor behavior (e.g., too much or too little body movement)
- Positive symptoms (e.g., hallucinations, delusions, racing thoughts)
- Negative symptoms (e.g., apathy, lack of emotion, poor or lack of social functioning)

Slide 79

Delusions

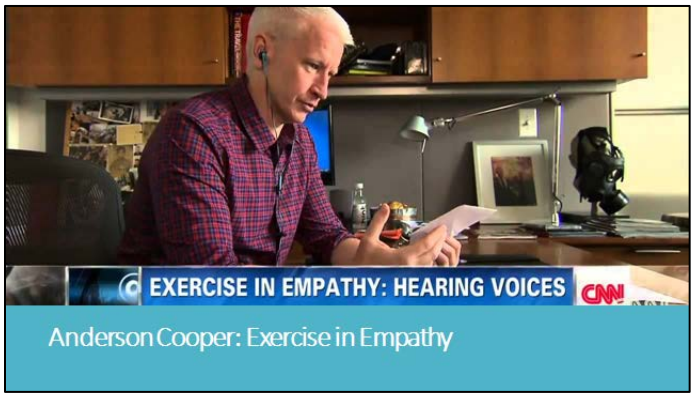
- Delusions are fixed beliefs that don’t change.
- The content of delusions have a variety of themes – persecutory, referential, somatic, religious, grandiose.
- Bizarre delusions usually express a loss of control over mind or body.
  - Thoughts have been put into one’s mind (thought insertion)
  - Thoughts removed from outside force (thought withdrawal)
  - Thoughts that one’s body or actions are being acted on or manipulated by some outside force (delusions of control)

Slide 80

Hallucinations

- **Hallucinations:** 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.
- Voices may be derogatory (e.g., "You are worthless").
- Keep cultural and religious/spiritual considerations in mind.
- Disturbed perception may include changes in how the body feels or a feeling of depersonalization that makes a person feel detached from their body.
- Some schizophrenics are unable to filter out irrelevant information.

Slide 81



Video Title: "Exercise in Empathy", https://www.youtube.com/watch?v=yL9UJVtgPZY

Slide 82

Psychotic Disorders: Schizophrenia Spectrum

- **Disorganized Thinking (Speech):** switching from one topic to another, completely unrelated answer to questions (tangential)
- **Grossly Disorganized or Abnormal Motor Behavior:** unpredictable agitation, "silliness," difficulties in daily living
- *Catatonic* behavior is a marked decrease in reactivity to the environment.
  - *negativism* – resistance to instructions
  - *mutism* – maintaining a rigid, inappropriate or bizarre posture
  - *stupor* - to a complete lack of verbal and motor responses
  - *catatonic excitement* – purposeless and excessive motor activity without obvious cause

Slide 83

Example of Disorganized Thought

- Why is a fire truck red?
  - *No, no, no, no. Because they have eight wheels and four people on them, and four plus eight makes twelve, and there are twelve inches in a foot, and one foot is a ruler, and Queen Elizabeth was a ruler, and Queen Elizabeth was also a ship, and the ship sailed the seas, and there were fish in the seas, and fish have fins, and the Finns fought the Russians, and the Russians are red, and fire trucks are always "Russian" around, so that's why fire trucks are red*
- Did you know loitering is against the law?
  - *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 Chicago. All of these big buses. I ride the bus to get my groceries. Jewel is my favorite store.*

Slide 84

Psychotic Disorders: Schizophrenia Spectrum

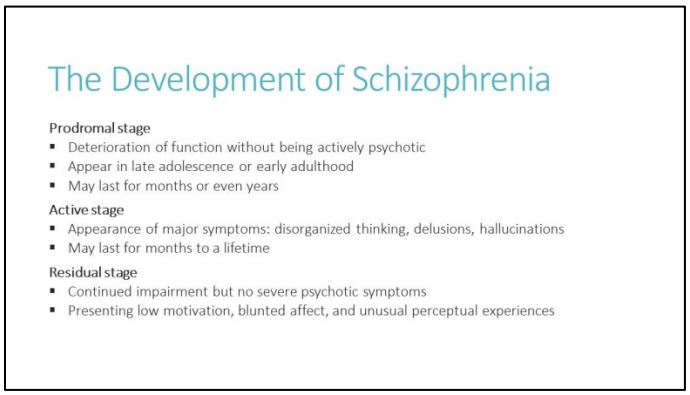
Schizotypal (Personality) Disorder	Delusional Disorder
▪ Impairments in personality functioning; difficulties with empathy, understanding the impact of one's behavior	▪ Presence of one or more delusions that happen for at least one month
▪ Odd, bizarre behavior, unusual thought processes	▪ Individuals most likely be able to describe that others see their beliefs as irrational, but unable to accept this themselves
▪ Detached, little reaction to situations, withdrawn	▪ If manic or major depressive episodes occur, they are brief
▪ Suspiciousness	▪ May develop an irritable mood, anger or violent behavior can occur

Slide 85

Psychotic Disorders: Schizophrenia Spectrum

SCHIZOPHRENIA	SCHIZOAFFECTIVE DISORDER
▪ Presence of two or more the following in a one month period: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms ▪ Level of daily (social, work, interpersonal) functioning is low ▪ Episode/disturbance lasts at least six months ▪ Cognitive, behavioral, and emotional dysfunctions	▪ Uninterrupted period of illness where there is a major mood episode ▪ Delusions or hallucinations for two or more weeks (without major mood episode) ▪ Continued display of active symptoms ▪ Diagnosis usually made during the period of psychotic illness

Slide 86



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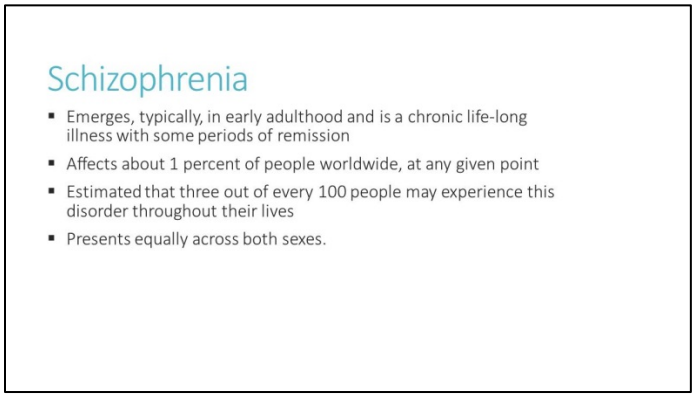

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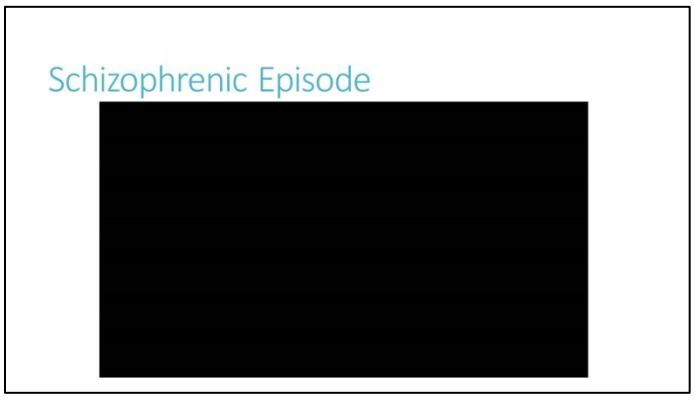


Video Title: “Schizophrenic Episode”,
https://www.youtube.com/watch?v=V521Umt1NjUandfeature=youtu.be

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.

Slide 90

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

Slide 91

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

Slide 92

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

Slide 93

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."

Slide 94

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

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]

Slide 95

Module 6: Mental Health Basics

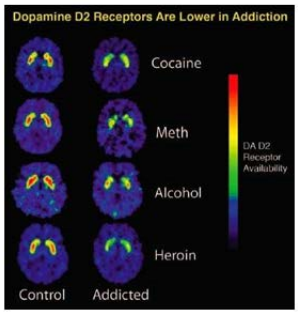
Substance-Related and Addictive Disorders

Slide 96

Substance-Related and Addictive Disorders

- A substance use disorder is categorized as a single disorder measured on a continuum from mild to severe.
- A diagnosis of a mild substance use disorder in DSM-5 requires two to three symptoms from a list of 11.
- Substance use disorders occur when the recurrent use of alcohol and/or drugs causes significant impairment.

Slide 97



Addiction as a Brain Disease

Effects on Dopamine Receptors

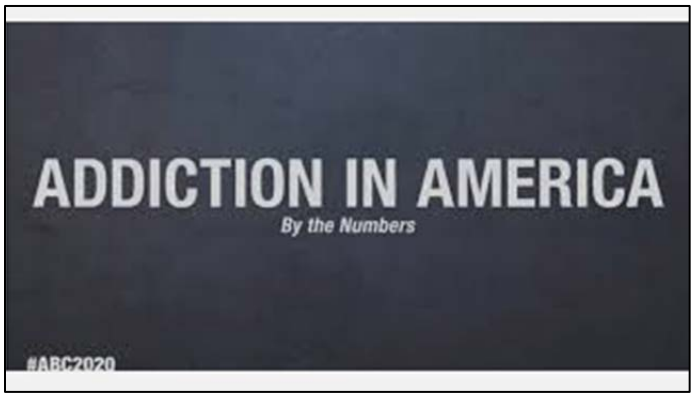
Slide 98

Drug Use and the Criminal Justice System

- 53% of people in state prisons and 45% of people in federal prisons meet the criteria for substance use disorder (SUD).
- 16.6% of people in state prisons and 18.4% in federal prisons reported committing their crimes to obtain money for drugs.
- One in three people in state prisons reported using drugs at the time of their crime.
- 64% of people in state prisons who committed a property offense reported drug use in the month prior to arrest.

2-98

Slide 99



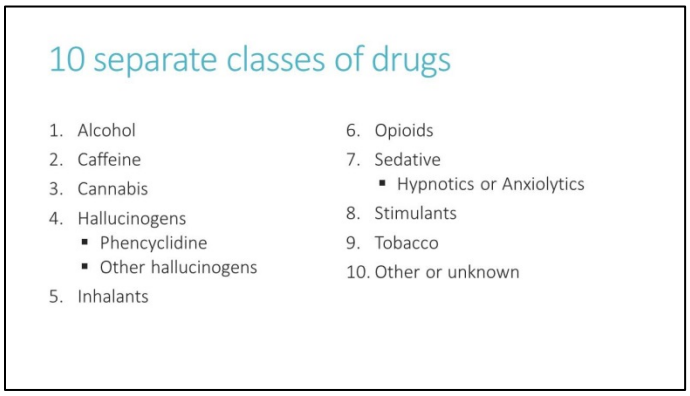
Video Title: "Addiction in America", http://abcnews.go.com/2020/video/addiction-america-numbers-39934750. Video date: June 17, 2016.

Slide 100

DSM-5 Changes: Substance Use and Addictive Disorders

- No longer distinguishes between "abuse" and "dependence." Instead, it is described on a single spectrum
- The spectrum has 11 criteria—from mild to severe
- New disorders were added for caffeine and cannabis withdrawal
- Also of note, pathological gambling was listed as a behavioral addiction

Slide 101



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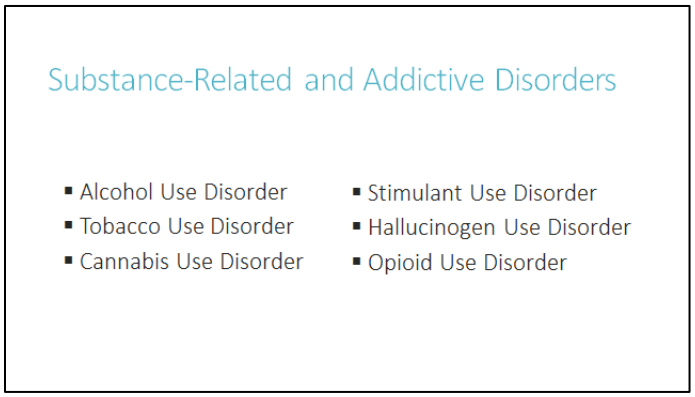

Alcohol Use Disorder (AUD)

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

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11 Criteria for Substance Use Disorders

Impaired Control

1. Taken in larger amounts, over longer period than intended
2. Persistent desire/unsuccessful efforts to cut down or control use
3. Great deal of time spent to obtain, use, recover
4. Craving, strong desire or urge to use (Impaired Control)

Social Impairment

5. Recurrent use resulting in failure to fulfill obligations at work, school or home
6. Continued use despite persistent social or interpersonal problems caused by use home
7. Important social, occupational, or recreational activities given up because of use

Slide 104

11 Criteria for Substance Use Disorders

Risky Use

8. Recurrent use in physically hazardous situations
9. Continued use despite physical or psychological problems exacerbated by use

Physiological Changes

10. Tolerance
11. Withdrawal

Slide 105

Substance-Related and Addictive Disorders

Diagnosis of Severity:

- Mild: The presence of 2 to 3 symptoms
- Moderate: The presence of 4 to 5 symptoms
- Severe: The presence of 6 or more symptoms

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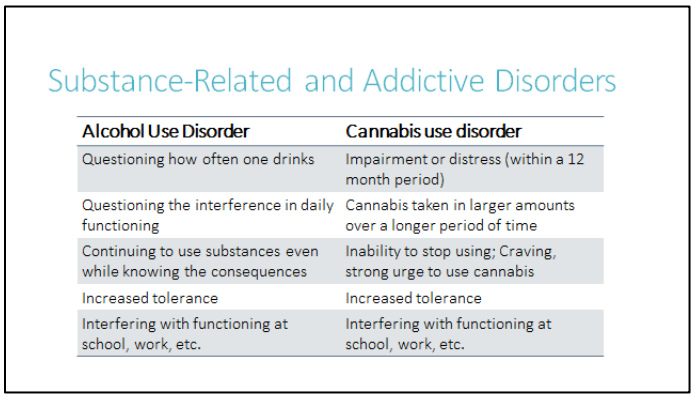

Alcohol Use Disorder Screening Questions:

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.

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Alcohol: Basic Facts

Description: Alcohol or ethylalcohol (ethanol) is present in varying amounts in beer, wine, and liquors

Route of administration: Oral

Acute Effects: Sedation, euphoria, lower heart rate and respiration, slowed reaction time, impaired coordination, coma, death

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Alcohol Addiction

- **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.
- A distinction has been made between a male or female alcoholic with drinking problems occurring late in life (Type 1) and an alcoholic with drinking problems occurring earlier in life (Type 2).

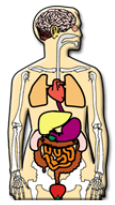
Slide 109

Tolerance and Sensitization

Acute tolerance
Metabolic tolerance
Pharmacodynamic tolerance
Behavioral tolerance
Sensitization

Slide 110

Long-term Effects of Alcohol Use



- Decrease in blood cells leading to anemia, disease, and slow-healing wounds
- Brain damage, loss of memory, blackouts, poor vision, slurred speech, and decreased motor control
- Increased risk of high blood pressure, hardening of arteries, and heart disease
- Liver cirrhosis, jaundice, and diabetes
- Immune system dysfunction
- Stomach ulcers, hemorrhaging, and gastritis
- Thiamine (and other) deficiencies
- Testicular and ovarian atrophy
- Harm to a fetus during pregnancy
- Wernicke–Korsakoff's syndrome

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Alcohol Withdrawal

- **Alcohol withdrawal syndrome**
- **Delirium tremens (DTs)**-can involve hallucinations, confusion, and agitation for up to a week
- **Alcohol Hallucinosis**
  - Occurs in 25% of withdrawal seen in first 24 hours
  - True hallucinations include illusions & misinterpretation of real stimuli in environment
  - May include nightmares
  - *Not* evidence of underlying psychiatric problem
- **Convulsions and Seizures**
  - Used to be called "rum fits" most common in 12-48 hours after stopping alcohol
  - Most commonly seen are one or two seizures generalized, grand mal seizures
  - Represents serious withdrawal
  - One third of those with seizures develop DTs

Slide 112

Management of Withdrawal

- Detoxification: process of withdrawing alcohol
- Substitute a drug for alcohol and then taper dose
- Benzodiazepines most widely used
- Liver function considered in choice of medication
- If multiple drugs being used, withdrawn sequentially

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Cannabis: Basic Facts

Description: The active ingredient in cannabis is delta-9-tetrahydrocannabinol (THC)

- **Marijuana**: tops and leaves of the plant Cannabis sativa
- **Hashish**: more concentrated resinous form of the plant

Route of administration:

- Smoked as a cigarette or in a pipe
- Oral, brewed as a tea or mixed with food

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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

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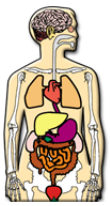
Long-term Effects of Cannabis Use



- 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

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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.

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Cannabis Withdrawal

- **Withdrawal Symptoms:**
  - Insomnia
  - Restlessness
  - Loss of appetite
  - Irritability
  - Sweating
  - Tremors
  - Nausea
  - Diarrhea
- **Triggers and Cravings:**
  - Anxiety/Irritability, Insomnia
  - Using Friends
  - Social Situations
  - Paraphernalia
  - Liquor Stores/Headshops
  - Concerts

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Substance-Related and Addictive Disorders

Tobacco Use Disorder	Stimulant Use Disorder
Cravings	Examples: Amphetamines, Methamphetamine
Irritability, Anger, Anxiety	Chronic use – continued use
Sadness, Depression	Episodic use – periods of heavy use, then reduced use
Difficulty concentrating, Impatience	
Insomnia	
Restlessness	

Slide 119

Nicotine and Co-Occurring Disorders

- More than **40 percent** of the cigarettes smoked in the United States are smoked by individuals with a mental health disorder. In particular, schizophrenia is linked to incredibly high rates of smoking.
- According the National Institute on Drug Abuse (NIDA), smoking rates among individuals with schizophrenia has ranged as high as **90 percent.**
- According to studies cited by the U.S. National Library of Medicine, nicotine may alleviate cognitive deficiencies in schizophrenic individuals and is thought to be used to reduce the severity of schizophrenic symptoms; however, the negative health consequences from tobacco use outweigh the benefits for these individuals.

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Nicotine Dependency

- After inhalation, nicotine is quickly absorbed into the bloodstream from the lungs and transported to the brain.
- Nicotine reaches the brain in about ten seconds from inhalation .Nicotine affects the amount of dopamine in the brain, which creates feelings of pleasure and reward.
- Nicotine ingestion produces both tolerance effects and physical withdrawal symptoms.
- A prominent feature of nicotine withdrawal is the strong craving to return to tobacco use.
- Because nicotine has a high risk of dependence, smokers typically adjust their smoking behavior to obtain a stable dose of nicotine.

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Tobacco Withdrawal

Withdrawal Symptoms:

- Cognitive / attention deficits
- Sleep disturbance
- Increased appetite
- Hostility
- Irritability
- Low energy
- Headaches

Cravings and Triggers:

- Smell
- Friends
- Boredom
- With coffee
- After sex
- Alcohol
- While driving
- Social functions

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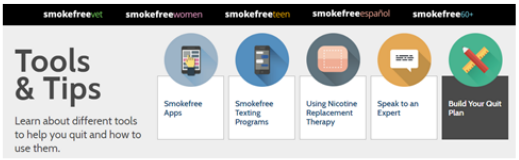
Quitting Smoking

- **The Good:** Health outcomes improve all around when a person quits smoking.
- **The Bad:** Quitting smoking can be extremely difficult, due to physical dependency.
- **The Good:** There are many successful approaches and programs to assist people to stop smoking. Visit http://www.smokefree.gov for resources.



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Treatment Options to Stop Smoking

Nicotine Patches & Gum

Chantix

Zyban

NicVax

Slide 124

Stimulants: Basic facts

Acute effects:

- Euphoria, rush, or flash
- Wakefulness, insomnia
- Increased physical activity
- Decreased appetite
- Increased respiration
- Hyperthermia
- Irritability
- Tremors, convulsions
- Anxiety
- Paranoia
- Aggressiveness

Common Stimulants:

- Cocaine
- Methamphetamine
- Amphetamines
- Prescription stimulants

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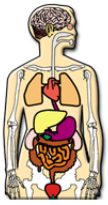
Long-term Effects of Stimulant Use



- Strokes, seizures, headaches
- Depression, anxiety, irritability, anger
- Memory loss, confusion, attention problems
- Insomnia, hypersomnia, fatigue
- Paranoia, hallucinations, panic reactions
- Suicidal ideation
- Nosebleeds, chronic runny nose, hoarseness, sinus infection
- Dry mouth, burned lips, worn teeth
- Chest pain, cough, respiratory failure
- Disturbances in heart rhythm and heart attack
- Loss of libido
- Weight loss, anorexia, malnourishment,
- Skin problems

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Stimulant Withdrawal

Withdrawal Symptoms:

- Physical detoxification
- Cravings
- Depression
- Low energy
- Irritability
- Exhaustion
- Insomnia
- Disordered thinking
- Memory problems

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Substance-Related and Addictive Disorders

Hallucinogen Use Disorder	Opioid Use Disorder
Hallucinogens create a euphoric atmosphere and can have psychedelic effects	Evident when it interferes with personal responsibilities; excessive drug use; tolerance and withdrawals
Examples: Lysergic Acid Diethylamide (LSD); Mescaline, Psilocybin (mushrooms); MDMA (Ecstasy)	Examples: Heroin, OxyContin, Vicodin, Morphine, Fentanyl

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Hallucinogens: The Basics

Description: Hallucinogens are drugs that alter perception, thoughts, and feelings. They can cause hallucinations. Some are synthetic, while others are plant-derived.

Example Hallucinogens: Ecstasy, LSD, GHB, DMT, Peyote, Ketamine, PCP, Rohypnol

Route of administration: Oral (i.e. tablets, drinking, consuming), injection, inhaling, snorting

Acute Effects: Effects can be noticed within a half hour and last up to 12 hours. These include hallucinations, increased heart rate, nausea, intense feelings, altered time perception, increased blood pressure, dry mouth, confused senses ("hearing colors"), paranoia, and psychosis, among others.

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Hallucinogens: Ecstasy

- Ecstasy is popular because it tends to heighten senses and emotional closeness with others.
- Ecstasy is sold primarily to young adults and adolescents at nightclubs and bars, at underground nightclubs sometimes called "acid houses," or at all-night parties known as "raves."
- Ecstasy can cause hallucinations, depression, paranoid thinking, panic attacks, irrational behavior and violence.
- An ecstasy overdose is characterized by a rapid heartbeat, high blood pressure, faintness, muscle cramping, panic attacks, and, in more severe cases, loss of consciousness or seizures.
- The risk of ecstasy when taken at raids is the onset of severe dehydration and heat stroke. It can also cause hyperthermia, seizures, stroke, kidney and cardiovascular system failure, and brain damage.

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Hallucinogens: LSD and Peyote

LSD

- *D-lysergic acid diethylamide* (LSD)
- Is a powerful mood-changing chemical
- Is a clear or white odorless material made from lysergic acid, which is found in a fungus that grows on rye and other grains
- Typically used for recreation and spiritual purposes
- LSD has many other names, including Acid, Blotter, Dots, and Yellow Sunshine.

PEYOTE

- Also known as Buttons, Cactus, and Mesc
- Is a psychoactive alkaloid, typically derived from cactus plants.
- Causes auditory and visual hallucinations and increases spiritual insight

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Hallucinogens: GHB and Rohypnol

GHB

- *Gamma-Hydroxy-Butyrate* (GHB)
- Depresses the central nervous system, which....
- Effects include intoxication and euphoria; low doses mimic alcohol
- High doses result in vomiting, convulsions, coma, suffocation
- Frequently used as a date rape drug
- Typically seen as a liquid
- Paraphernalia may include eye drops, children's bubbles, and windshield wiper fluid

ROHYPNOL

- Reduces inhibitions and causes amnesia
- Leads to intoxication and a slow, long high
- Does not result in a hangover
- Much more powerful than valium
- Commonly used as a date rape drug
- May be present in liquid or pill form

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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.

Slide 133

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.

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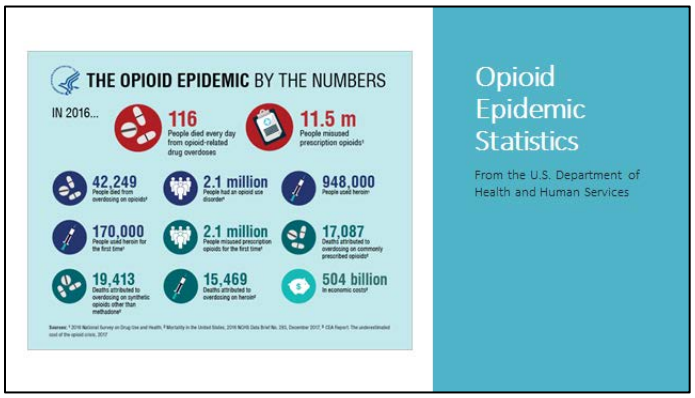

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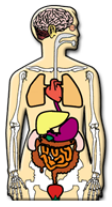
Possible Acute Effects of Opioid Use

- 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

Slide 136

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

Slide 137

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)

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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	

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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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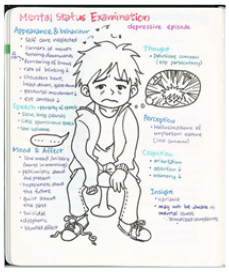
Assessment & Commitment

Assessment:

- Mental Status Exam (MSE)
- Intake Assessments

Commitment:

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



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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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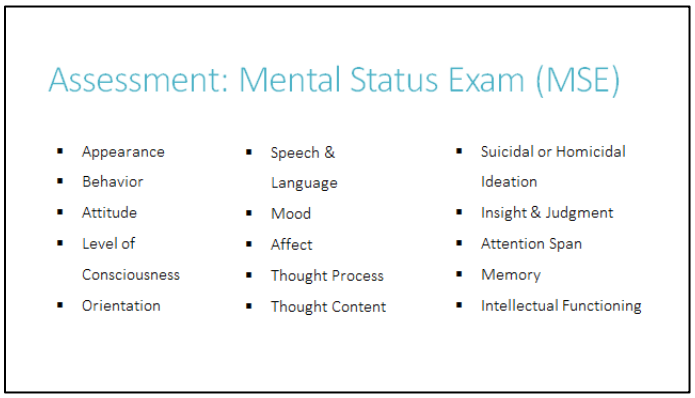

A mental status exam should be completed through verbal inquiries, as well as, through observation.

- *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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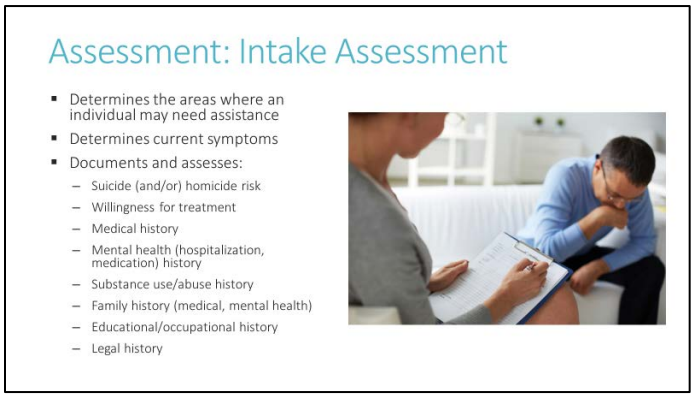

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Commitment: Client Rights

- Be treated with dignity and respect
- Receive appropriate services
- Cultural sensitivity
- Treatment plans – helped write and receive copy
- Explanation of benefits, risks, and any potential side effects of treatments
- Confidentiality
- HIPAA
- Understanding rights, grievance

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Commitment: Civil Involuntary Commitment

- Very few states make use of involuntary commitment
- Used when an individual may be expected to inflict serious physical pain to him/herself or someone else
- Used when an individual is unable to provide care for him/herself
- Laws will vary state to state
- Inpatient vs. Outpatient services
- Treatment
- Crisis vs. severe mental illness

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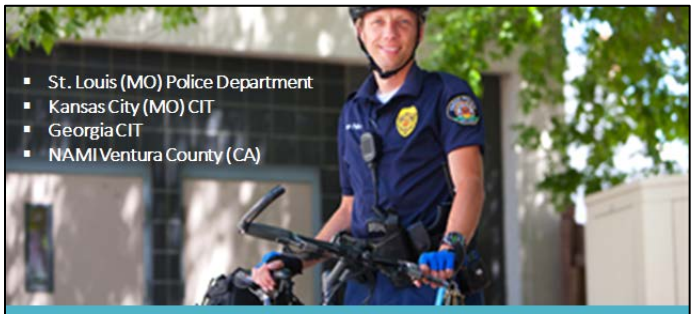

Special Thanks to the following CIT programs

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

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]

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Module 8: Mental Health Basics

Neurodevelopmental & Neurocognitive Disorders

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Neurodevelopmental Disorders

- Intellectual Disability
- Communication Disorders
- Motor Disorders
- Delirium
- Major and Mild Neurocognitive Disorders

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Intellectual Disability

CRITERIA & SYMPTOMS

- Deficits in intellectual functions: difficulties with reasoning, problem solving, judgment, academic learning, learning from experiences, and abstract thinking
- Deficits in adaptive functioning: failure to meet developmental and social standards
- Difficulties with independence and social responsibility
- Limited functioning with daily life activities (i.e. communication, independent living, and social interactions)
- Developmental period is crucial; the onset of intellectual and adaptive deficits

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Communication Disorders

Language Disorder

- Difficulty in acquiring and using language
- Limited vocabulary
- Limited sentence structure
- Difficulties in the ability to use vocabulary and connect sentences to explain a topic or events
- Language abilities are well below those expected for individual's age
- These difficulties limit effective communication, social interactions, academics, and occupational success

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Communication Disorders

Speech Sound Disorder

- Difficult with speech sound production, preventing verbal communication
- Limitations in effective communication, which interferes with social abilities, academics, and/or occupational performance
- Stuttering

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Communication Disorders

Social (Pragmatic) Communication Disorder

- Difficulties with the social use of verbal and nonverbal communication
- Difficulties using communication for appropriate social reasons (greetings, sharing information)
- Inability to change communication styles to match the needs of the listener (classroom vs. playground or adult vs. child)
  - Difficulties following rules for conversation
  - Difficulties understanding what is not specifically stated (making inferences) or ambiguous statements (humor, metaphors)
  - Deficits may cause functional limitations in social relationships, academics, or occupation

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Motor Disorders

Tic Disorders

- Tic Disorders involve the presence of motor or vocal tics:
  - Repetitive, non-rhythmic motor behaviors (e.g., hand flapping, body rocking, head banging)
  - Rapid, apparently purposeless recurrent, vocalizations
- Tics interfere with social, academics, and other areas of life.
- Tourette's Disorder is the most common. Tourette's may also be seen in people with OCD and ADHD.

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Video Title: "Living with Tourette Syndrome", 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

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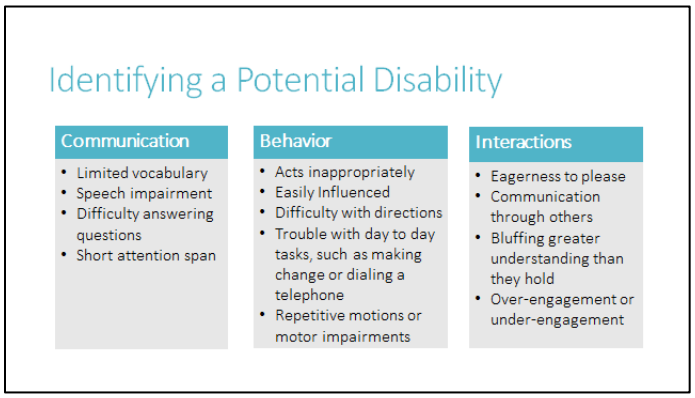

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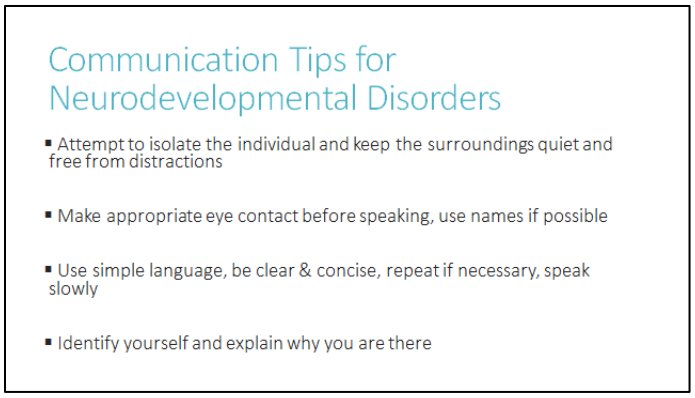

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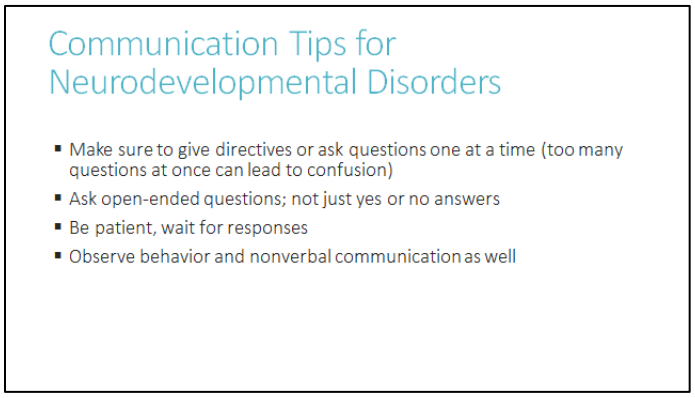

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Traumatic Brain Injury

Impact to the head or other rapid movement to the brain

Injury Characteristic	Mild TBI	Moderate TBI	Severe TBI
Loss of consciousness	< 30 minutes	30 minutes-24 hours	> 24 hours
Posttraumatic amnesia	< 24 hours	24 hours – 7 days	> 7 days

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Delirium

Signs and Symptoms

- Serious change in mental abilities or cognitive function (e.g., memory difficulties, disorientation, altered language, altered perceptions)
- Reduced ability to focus and/or shift attention; difficulties orienting to one's environment
- Symptoms develop over a short period of time, from hours to a few days
- Symptoms can fluctuate in severity throughout the day
- Symptoms and disturbance is a change from their baseline attention and awareness
- Delirium can often be traced to one or more contributing factors, such as medical illness, changes in metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

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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

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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

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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.

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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.

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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.

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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

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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.

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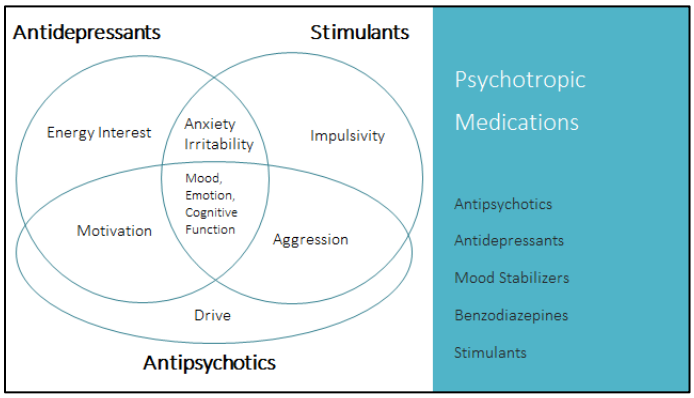

Psychotropic Medications

Antipsychotics

Antidepressants

Mood Stabilizers

Benzodiazepines

Stimulants

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Medication & Disorders

Bipolar Disorder:
- Mood stabilizers
- Antipsychotics
- Antidepressants

Depressive Disorders:
- Antidepressants
- Antipsychotics & Mood stabilizers

Anxiety:
- Antidepressants
- Benzodiazepines

Psychotic Disorders:
- Antipsychotics
- Antidepressants & Mood Stabilizers

Post Traumatic Stress:
- Antidepressants
- Antipsychotics

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Anti-Depressant Treatment

Psychotropic Medications	
Celexa	Strattera
Cymbalta	Wellbutrin
Effexor	Zoloft
Lexapro	Prozac
Paxil	

Treated Disorders
Depressive Disorders
Generalized Anxiety Disorder
Social Phobia
Panic Disorder
Post Traumatic Stress Disorder
Obsessive Compulsive Disorder

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Anti-Psychotic Treatment

Psychotropic Medications	
Haldol	Abilify
Prolixin	Seroquel
Trilafon	Zyprexa
Thorazine	Risperdal
Geodon	Cloxaril

Treated Disorders
Psychosis
Schizophrenia
Schizoaffective Disorder
Bipolar Disorder

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Mood Stabilization

Psychotropic Medications	Treated Disorders
Lithium (Lithobid, Eskalith)	• Depressive Disorders
Divalproex Sodium (Depakote, Depakene)	• Bipolar Disorders
Carbamazepine (Tegretol, Equetro)	
Oxcarbazepine (Trileptal)	
Lamotrigine (Lamictal	

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Stimulants

Psychotropic Medications	Treated Disorders
Alprazolam (Xanax)	• Attention Deficit Hyperactive Disorder
Lorazepam (Ativan)	
Chlordiazepoxide (Librium)	
Diazepam (Valium)	
Clonazepam (Klonopin)	

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Benzodiazepines

Psychotropic Medications	Treated Disorders
Lithium (Lithobid, Eskalith)	• Panic Disorder/ Panic Attacks
Divalproex Sodium (Depakote, Depakene)	• Anxiety
Carbamazepine (Tegretol, Equetro)	• Insomnia
Oxcarbazepine (Trileptal)	• Alcohol Withdrawal
Lamotrigine (Lamictal	

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Psychopharmacology – Side Effects

- Dizziness, drowsiness (mood stabilizers, antipsychotics, benzodiazepines)
- Sleep difficulties (antidepressants)
- Weight gain (antidepressants, antipsychotics, mood stabilizers)
- Shaking/Tremors (antipsychotics, antidepressants)
- Loss of appetite (antidepressants, mood stabilizers)
- Pacing, inability to sit still, restlessness, involuntary movements (antipsychotics)
- Increase thirst and urination (mood stabilizers)
- Sexual dysfunction (antidepressants)
- Seizures (benzodiazepines, antidepressants)
- Anxiety/agitation/irritability (stimulants, antidepressants)

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Medication Compliance Issues

People may stop taking their medications because:

- They experience side effects.
- They feel better.
- They do not believe the medication works, or not quickly enough to tell.
- They feel stigma.
- The dose and/or frequency is burdensome.
- The medications are too expensive or lack insurance.
- They do not have a strong social support who understand.
- They are homeless and/or have difficulty getting their medications.

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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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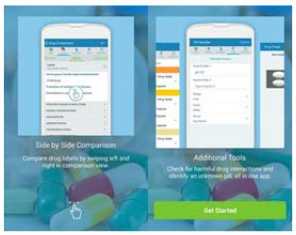
Pharmacology Resources

Mobile PDR App



BH Meds App

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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Module 10: Mental Health Basics

Disorders in Children, Youth, and Adolescents – Autism and Developmental Disorders

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Children, Youth, & Adolescents: Autism and Developmental Disorders

Specific Learning Disorder
Neurodevelopmental Disorders
Autism Spectrum Disorder
Attention-Deficit/Hyperactivity Disorder
Motor Disorders

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Specific Learning Disorder

Criteria & Symptoms:

- Difficulties learning and using academic skills
- Reading difficulties: slow and effortful word reading, difficulties understanding what was read
- Difficulties with spelling, written expression, numbers/calculation, mathematical reasoning
- Academic skills below the norm, can cause significant impairment

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Autism Spectrum Disorder

Signs & Symptoms:

- Persistent deficits in social communication and social interaction across multiple contexts (i.e., school and at home)
- Difficulties with back and forth conversations, reduced sharing of interests, emotions; doesn't often initiate conversations.
- Difficulties with nonverbal communication; poor eye contact, body language, use of gestures, lack of facial expressions
- Difficulties in understanding relationships, social contexts, or playing with peers.

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Autism Spectrum Disorder

- Deficits in social communication and interactions
- Difficulties participating in a conversation.
- Less interested in sharing interests, emotions and difficult to determine how they are feeling
- Often have difficulties initiating or responding to social interactions
- Difficulties with nonverbal communication; don't understand facial expressions
- Difficulties putting verbal and nonverbal communication together, including possible difficulties with eye contact
- Difficulties in developing and maintaining relationships with others

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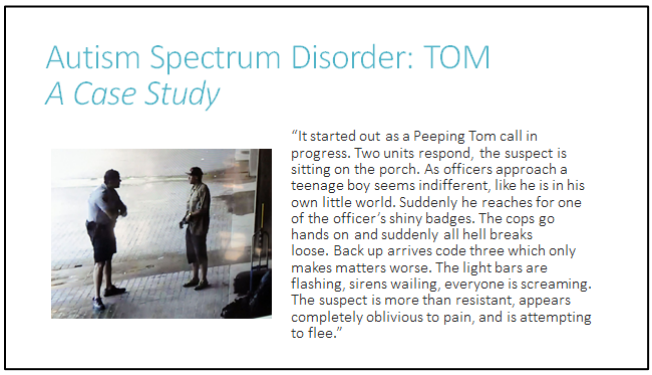

Case Study: Tom

"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

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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.

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Quick Facts for Law Enforcement: Autism

- Working with an individual diagnosed with the Autism Spectrum Disorder can challenge your experience and training.
- In most cases, the person will have difficulties following verbal commands, reading your body language, and have deficits in social understanding.
- It may be important to understand that sirens, lights, uniforms, and loud voices might make an already difficult situation even more difficult depending on the individual.
- There is a possibility that an individual diagnosed with the Autism Spectrum Disorder might become silent and uncooperative; possibly due to feeling uncomfortable.
- A police officer might be able to gain control of the situation by remaining calm, practicing patience. This will hopefully defuse the stress, tension, or danger of a situation.
- It may be necessary to repeat directives multiple times, in a clear and consistent tone.

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Attention – Deficit/Hyperactivity Disorder (ADHD)

- A pattern of behavior that is seen in multiple settings (school, home)
- Behavior creates difficulties and performance issues in education and social settings
- Behaviors: difficulty organizing, excessive talking, fidgeting, inability to remain seated
- Symptoms are as follows:
  - Hyperactivity & Impulsivity
  - Inattention
- Must have at least five or six symptoms (depending on age) from either of the categories on the previous slide
- Symptoms must be present prior to the age of 12 years.

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Attention – Deficit/Hyperactivity Disorder (ADHD)

Inattention (6+ symptoms)	Hyperactivity – Impulsivity (6+ symptoms for 6 months)
Careless mistakes, no attention to details	Often fidgets or taps hands or feet, squirms in seat
Difficulty remaining attentive on tasks	Leaves seats when remaining in seat is expected (school, work)
Starts quickly, but loses focus and is easily distracted	Runs or climbs where it is inappropriate (restlessness)
Doesn't listen when spoken to directly	Often unable to play or be in leisure activities quietly
Failure to follow through; not interested in difficult tasks	Often "on the go" and uncomfortable being still for a long period of time
Difficulties organizing tasks and activities	Talks excessively, blurts out answer before a question is completed
Often losing things and forgetful in daily activities	Difficulty waiting his/her turn; interrupts or intrudes on others

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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

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Disruptive, Impulse Control and Conduct Disorders

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

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Oppositional Defiant Disorder

Signs and Symptoms

- **Angry/Irritable Mood**
  - often loses temper, touchy or easily annoyed
- **Argumentative/Defiant Behavior**
  - argues with authorities, defies or refuses to comply with authorities or rules, deliberately annoys others, blames others for their mistakes or misbehavior)
- **Vindictiveness**
  - spiteful

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Intermittent Explosive Disorder

- Verbal aggression
- Physical aggression
- Behavioral outbursts (that are not planned)

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Case Study: 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.

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.

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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

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Fetal Alcohol Spectrum Disorders

- Fetal Alcohol Spectrum Disorder (FASD) was added to the DSM-5 under "Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure."
- Conditions related to FASD are caused by the alcohol use of a mother while pregnant.
- FASD can lead to physical, learning, and behavior challenges, such as:
  - Low body weight or smaller than average features
  - Poor coordination
  - Hyperactive behavior and difficulty with attention
  - Poor memory
  - Difficulty in school (especially with math)
  - Learning disabilities or low IQ
  - Poor reasoning and judgment skills

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Pyromania

- Deliberate, purposeful fire setting
- Tension/affective arousal before act
- Fascination, interest, curiosity, attraction to fire

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Kleptomania

- Failure to resist impulses to steal objects
- Objects stolen are not needed for personal use or monetary value
- Tension before committing the theft
- Pleasure or relief when committing the theft
- Stealing is not a way of expressing anger or vengeance

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Case Study:

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.

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

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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

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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

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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.

Case Study: 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.

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Antisocial Personality Disorder

SIGNS & SYMPTOMS

- Disregard for and violation of the rights of others
- Failure to conform to social norms and laws
- Impulsive, irritable, aggressive, involved in fights or assaults
- Frequent lying, using aliases, or conning others for personal pleasure or profit
- Complete disregard for safety of self or others
- Lack of remorse

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Antisocial Personality Disorder: Ani
A Case Study

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.

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.

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

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Video Title: "Ice Man Interviews" https://www.youtube.com/watch?v=dhEEskkeJ7k

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Video Title: "Ice Man Interviews" https://www.youtube.com/watch?v=S-4nzmdYQTA

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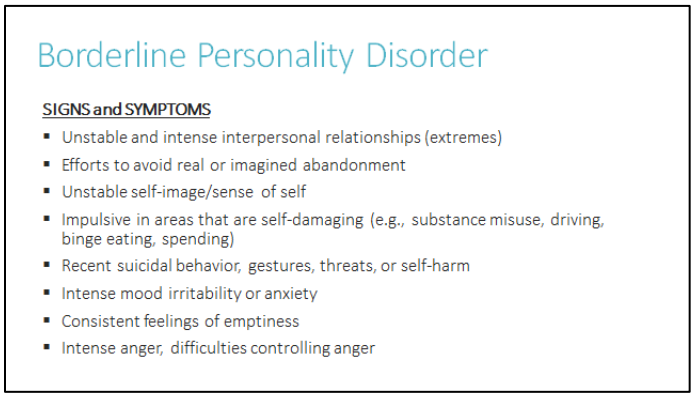

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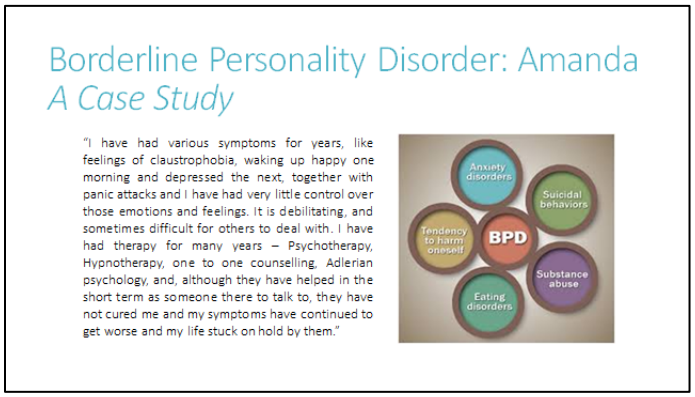

Amanda's story: "How I Feel"

"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.

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

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Histrionic Personality Disorder

SIGNS & SYMPTOMS

- Excessive emotional and attention seeking
- Uncomfortable in situations where he/she is not the center of attention
- Interaction with others often includes inappropriate sexually seductive or provocative behavior
- Shifting and shallow expressions of emotions
- Uses physical appearance to attract attention
- Self-dramatization, theatricality, exaggerated expression of emotion
- Is easily influenced by others
- Sees relationships as more intimate than they actually are

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Living with HPD: "Praise Me"

- Living with someone with HPD can be exhausting, humiliating, frustrating, and isolating
- Feeling as though you are the "reasonable" one
- Individuals with HPD do not typically look for solutions to their problems
- Trying to make someone with HPD feel "happy" feels like an uphill battle
- Individuals with HPD often don't see their own destructiveness
- Important problems may be considered less important than the more fabricated or exaggerated issues
- Experience extreme emotional highs and lows

P	Provocative behavior
R	Relational intimacy
A	Attention
I	Influenced easily
S	Splashy speech
E	Emotional liability
M	Make-up
E	Exaggerated emotions

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Narcissistic Personality Disorder

SIGNS & SYMPTOMS

- Grandiosity, need for admiration, lack of empathy
- Grandiose sense of self-importance; exaggerates talents
- Preoccupied with fantasies of unlimited success, power
- Believes he/she is "special" and unique (only to associate with high status people)
- Requires excessive admiration
- Sense of entitlement, unreasonable expectations

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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

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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

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Obsessive – Compulsive Personality Disorder
Video: Jeff Lewis on Living with OCPD

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]

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Module 13: Mental Health Basics

Post-Traumatic Stress Disorder (PTSD)

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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.

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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

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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.

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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).

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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

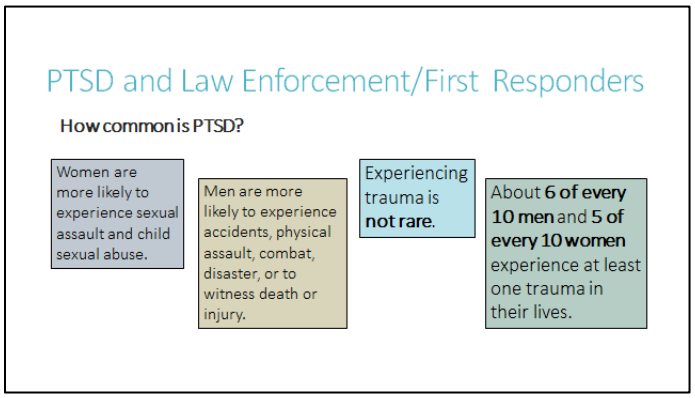
Slide 235

Video Title: "Watch Service Dog Calm War Vet's PTSD Reaction", https://www.youtube.com/watch?v=0y_a_V1QD3Uandt=27s

Slide 236

Video Title: "No Warning", 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

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

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

PTSD: HARVEY | *A Case Study*

You and your partner walk into the Silver Diner 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.

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.

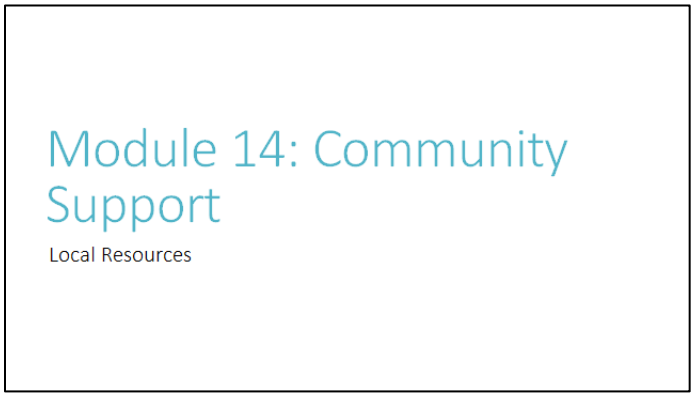
Student Learning Objectives:
Upon completing this module, students will be able to:

- 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]

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Module 15: Managing Encounters

Scenario-based Skills Training

Slide 244

What is required in responses to mental health crises?

- Approaches that are person-centered
- Approaches that are non-judgmental
- The "why" behind the "what" of behavior
- A here-and-now approach
- ***Objective***: To reduce anxiety to encourage meaningful communication

Slide 245

Why is it important?

- Safety for all!
- Fewer tragedies
- Better decisions
- Better outcomes
- "Slowing the situation down" and getting a supervisor to the scene can reduce the chances of violence (PERF, 2012)

Slide 246

Slide 247

A Different Mindset

- If you take a ***less*** authoritative, ***less*** controlling, and ***less*** confrontational approach, you will have ***more*** control
- You are trying to give the person a sense that he is in control.
- Why? Because she is in a crisis, which by definition means that she is feeling out of control; her normal coping mechanisms are not working at this time.

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

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

Slide 251

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Maintain a safe distance
- Use a clear voice tone
- Use a voice volume lower than that of the individual
- Use a relaxed, well-balanced, non-threatening posture (yet maintaining tactical awareness)
- Set limits

Slide 252

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Be active in helping
- Build hope
- Focus on strengths
- Present yourself as a calming influence
- Demonstrate confidence and compassion

Slide 253

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Remove distractions, disruptive or upsetting influences
- Be aware of body language and congruency
- Be aware that your uniform and your tools may be intimidating
- Be consistent
- Use "I" statements

Slide 254

How do you do it?

Guidelines to defuse a potential mental health crisis:

- Be in the here and now
- Validate and accept
- Make no promises you cannot keep
- Recognize that a person with mental illness may be overwhelmed by sensations, thoughts, beliefs, sounds and the environment; provide careful, clear explanations and instructions

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

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

Quick Class Role Play

Sometimes it's not ***what*** you say, but ***how*** you say it.

Try it! Say the following sentence with different tones.

"You made it here on time!"

1. in a suspicious tone
2. in a happy tone
3. in a patronizing tone
4. in an irritable tone

Slide 259

The DOs and DON'Ts of crisis verbal interaction

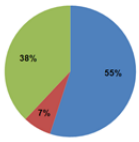
Don't	Do
Threaten	Show empathy and understanding
Argue	Use modeling
Challenge	Reassure
Order	Respond and encourage
Shame	Use active listening techniques
Blame	Guide the situation toward resolution

Slide 260

Mehrabian's Rule

Albert Mehrabian established the importance of three elements in any face-to-face encounter:

1. Words used (7%)
2. Tone of voice (38%)
3. Body language (55%)



There must be congruence among all three elements for effective communication.

Slide 261

How do you do it?

- **Introduce yourself.**
- An introduction promotes communication
  - "Hi. My name is Doug Smith [or Deputy Smith]. I'm a CIT officer with the local police department."
  - "Would you please tell me your name?"
- State what you see/know: "I can see that you're upset."
  - Convey that you are there to help.
  - Be prepared to explain the reason you are there (e.g., a neighbor called to say that someone is upset.)

Slide 262

Empathy and Rapport – key concepts

- Empathy is not sympathy. Sympathy is "an expression of pity or sorrow for the distress of another"; Empathy is "the ability to identify with or understand the perspective, experiences, or motivations of another individual and to comprehend and share another individual's emotional state."
- Rapport – building relationships of mutual trust through verbal and non-verbal communication.

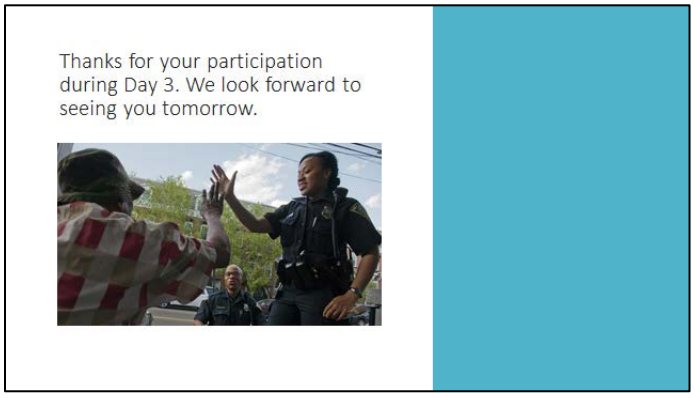
Slide 263

What is sticking with you?

- What is the most interesting thing you have learned so far?
- What is the most valuable thing you have learned so far?
- How has your understanding of your job changed?
- How have you changed?

Slide 264

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

Module 16: Mental Health Basics

Suicide

Slide 267

Suicide Overview

Demographics

- Suicide Rates by Gender
  Men die by suicide 3.5 times more often than women
- Suicide Rates by Age
  The rate of suicide is highest in middle age — white men in particular
- Suicide Rates by Race/Ethnicity
  The rate of suicide is highest among Whites and second highest among American Indians and Alaska Natives

Slide 268

Suicide: The Numbers

- For every completed suicide, **25 attempts** are made
- Suicide costs the United States approximately **$44 billion** annually
- Each year **42,773 Americans** die by suicide
- On average, there are **117 suicides** per day
- Suicide is the **10th leading cause of death** in the United States

***Suicide** claims more lives than war, murder, and natural disasters combined.*

Slide 269

Suicide Trends

Suicide Methods

Firearms are the most common method of death by suicide, accounting for almost 50% of all suicide deaths.

The second most common method is suffocation (including hangings).

Suicide Attempts

12 people harm themselves for every reported death by suicide.

At least one million people in the United States engage in intentionally inflicted self-harm each year

Females attempt suicide three times more often than males.

The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to about 4:1 in the elderly

Slide 270

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

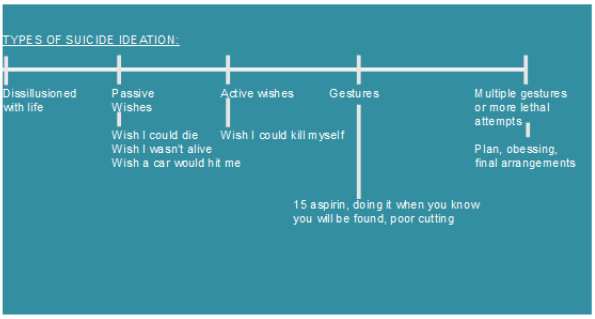
Suicide: Introduction

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



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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

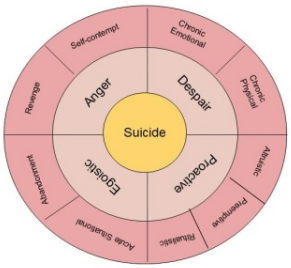
1. Stay CALM.
2. Take the person seriously.
3. Be empathic and non-judging.
4. DO NOT SAY things like:
   - *"I know how you feel."*
   - *"Things could be worse."*
   - *"You won't go to Heaven."*
   - *"Things can't be that bad."*
5. Assess the Risk
   - Don't be afraid to ask directly

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.

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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

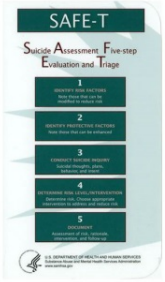
Appropriate Questions/Conversation

- 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

Screening Tools

COLUMBIA-SUICIDE SEVERITY RATING SCALE



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.

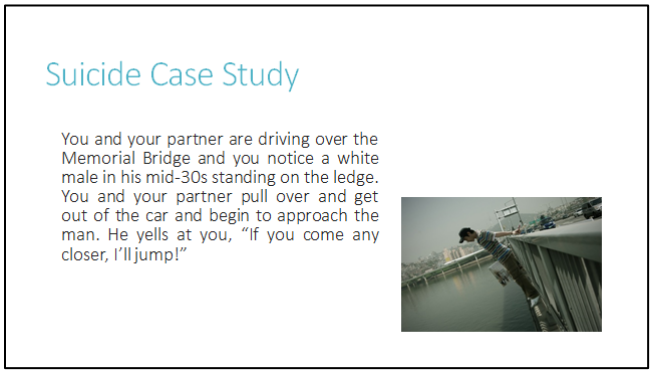
Sources: Columbia-Suicide Severity Rating Scale. Available here: http://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf
Suicide Assessment Five-Step Evaluation and Triage Tool. Available here: https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-

Triage-for-Clinicians/SMA09-4432

Slide 284

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



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.

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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]

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Module 17: Law Enforcement

Policies and Procedures

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Module Topics

- Policy and procedures
- State law
- Liability and other issues

Slide 288

Model Policies

Most model policies include references to:

- Specialized training for officers in crisis response
- De-escalation skills
- Non-engagement or disengagement
- Community partnerships
- Communication
- Diversion from jail or the criminal justice system

IACP

POLICE EXECUTIVE RESEARCH FORUM

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Slide 289

Your Crisis Intervention Policy

- If your agency has policies related to officer response to people with mental illness, people in crisis or barricaded subjects, please insert those policies here for discussion.

Slide 290

Your Use of Force Policy

- Place your agency's Use of Force Policy here for discussion.

Slide 291

Your Barricaded Subjects Policy

- Place your agency's Barricaded Subjects Policy here for discussion.

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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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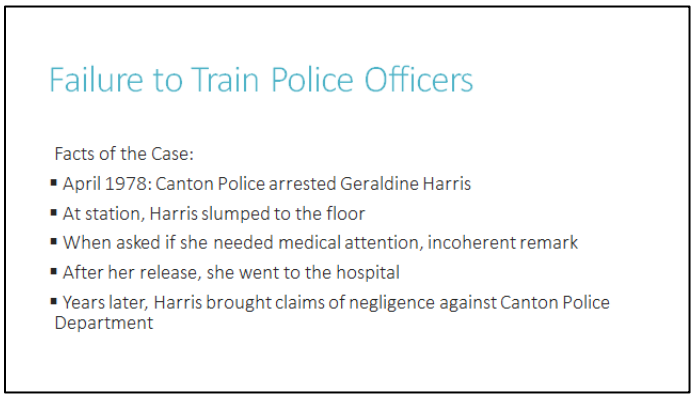
Failure to Train Police Officers

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/

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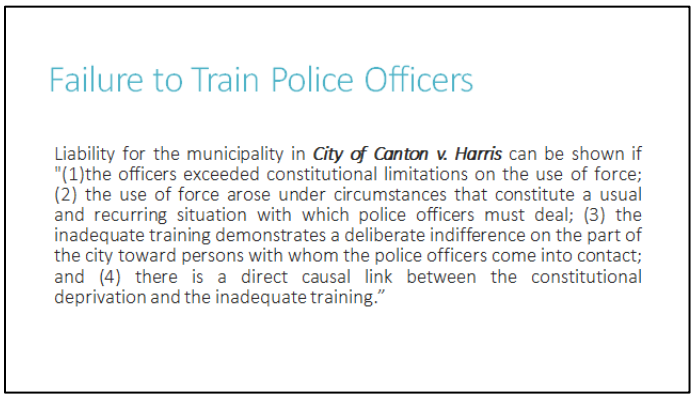

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Other Liability Considerations

- **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.

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]

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Module 19: Managing Encounters

Scenario-based Skill Training

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Strategies for Frequently Encountered Situations

- **Psychotic** (with disorganized thinking) and verbally aggressive behavior
  - Allow person to vent energy
  - Maintain a safe distance
  - Talk in a low voice
  - Use the broken record technique
  - Reassure the person

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Strategies for Frequently Encountered Situations

- **Hallucinations**
  - Validate the experience for the person
  - Indicate you do not hear the voices, but you believe they do
  - Help the person focus on you
  - Offer help and safety

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Strategies for Frequently Encountered Situations

- **Delusional statements** (may include paranoia)
  - Recognize their view
  - Indicate it is not your view, but you are willing to help
  - Do not argue or debate with them about the delusion
  - Focus the person on what you need them to do

Slide 302

Strategies for Frequently Encountered Situations

- **Compulsive Talking** (mania)
  - Ask concise, specific, concrete questions
  - Use the broken record technique

Slide 303

Strategies for Frequently Encountered Situations

- **Intoxication**
  - Let them vent
  - Listen
  - Use a calm, even tone when speaking
  - Move the person away from others if possible
  - Remain reassuring

Slide 304

Strategies for Frequently Encountered Situations

- **Depression**
  - Demonstrate active listening
  - Display empathy
  - Be patient and take your time
  - Validate their feelings
  - Reassure the person and offer hope

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Strategies for Frequently Encountered Situations

- **Suicidal Person**
  - Present a calm, understanding, non-judgmental manner
  - Listen
  - Emphasize the temporary timeframe of the crisis
  - Suggest alternatives
  - Emphasize effect on survivors
  - Conduct a lethality assessment (plan, lethal, access, support)
  - Be active in offering hope and help

Slide 306

Tips for Effective Facilitation

- Appropriate assessment directs appropriate facilitation
- Know your community resources
- Be flexible with alternatives when appropriate

Slide 307

Courage

"Each time someone stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope."

~Robert F. Kennedy

Slide 308

Safety is the Priority

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Special Thanks to the following CIT programs

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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]

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Module 20: Community Support

Perspectives: Veterans and Homelessness

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Local Statistics on Veterans & Service Members

- Insert local statistics on how many veterans and service members reside in your community
- Compare your number to national averages or other communities similar to yours
- Include number of reservists residing in your state or your community
- Include other relevant statistics

Slide 312

Veterans and Justice Involvement

- Veterans are no more likely to be arrested than other adults
- But veterans and service members were trained for combat, which may be evident in their driving skills and other areas of life
- Some veterans find it difficult to re-adjust to civilian life
- Veterans may become justice involved easily

Slide 313

Guest Speaker

Content to be customized by agency/community.

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TIME Magazine "Crisis Intervention Teams for Vets: Sure Beats Jail"

Slide 315

Local Statistics on Homeless Population

- Insert local statistics on how many people who are homeless reside in your community and/or your state
- Compare your number to national averages or other communities similar to yours
- Include other relevant statistics

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Video title: "#Shepherdsinblue", https://www.youtube.com/watch?v=l6BPKLbus1A

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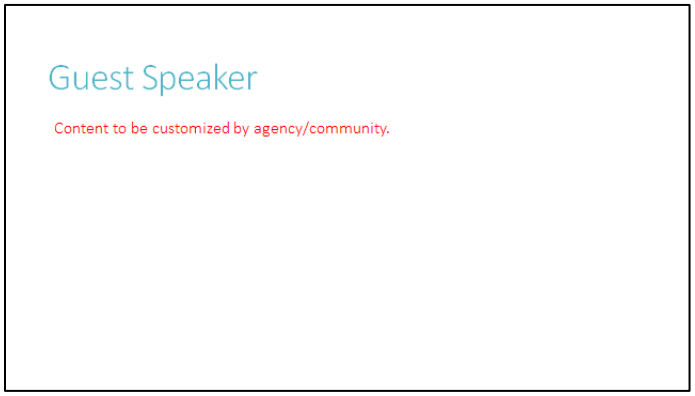
Link to Houston's CIT and Homeless Outreach Team: http://www.houstoncit.org/mental-health-division-2/

Slide 318



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

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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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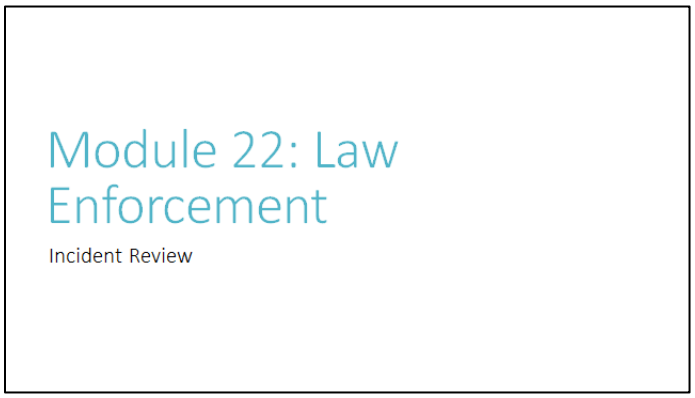

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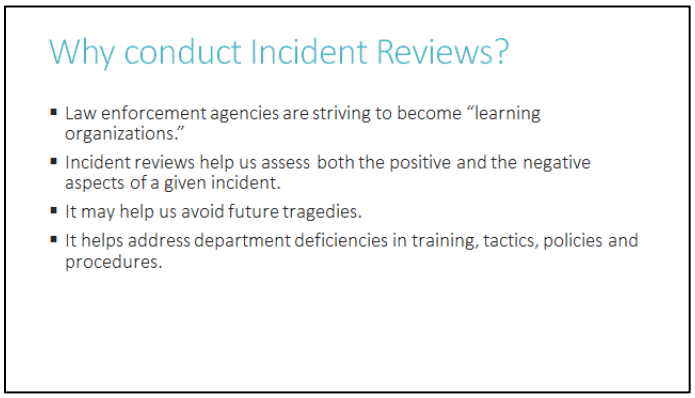

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Slide 325

Incident #1: Title here

Slide 326

Incident #2: Title here

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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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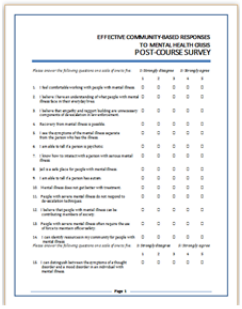
Module 24: Research & Systems

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

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]

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Module 25: Administrative Tasks

Graduation & Presentation of Certificates of Completion

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What's the most important thing you learned this week?

Slide 332

How will you use what you learned?

Slide 333

How will your new skills enhance your safety and the safety of others?

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