

Crisis Intervention Training (CIT) Suggested Course Materials

WSCJTC

053108



Crisis Intervention Training Table of Contents

Plan of Instruction

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Implementation Guide

Model Policies

Crisis Intervention Training (CIT)

Forward

It should be noted that this effort was made possible by the Mental Health Transformation Act that commissioned the formation of the development committee. A special thanks to those that gave time and effort to make this project possible.

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Intent

The intent of the resource guide is to provide suggested course materials, agenda, and delivery format as a starting point. It is acknowledged that each region may or may not have resources available to fulfill all of the sections outlined here.

The suggested course materials, guides, etc., are intended as resources to gain an understanding of what the committee thought was most helpful in training, developing, and sustaining a regional CIT team.

CRISIS INTERVENTION TRAINING Introduction to the Facilitator's Guide

FOR WHOM IS THIS GUIDE WRITTEN?

This FACILITATOR'S GUIDE outlines a 40-hour Crisis Intervention Training for law enforcement officers. The guide informs three functions which may or may not all be filled by the same person.

GUEST SPEAKERS with subject matter expertise in one or more areas *may use this guide as a suggestion for how to deliver information in a way audience members are most likely to absorb.* I.e.: ("Dr. Smart" may choose to intersperse her PowerPoint presentation on mental disorders with an "INTEGRATED QUIZ" in order to help heighten participants' retention of complex information.)

The COORDINATOR who juggles the logistics of multiple trainers, role-play actors and site visits *may use this guide to help understand the flow of the week's events and activities.*

The TRAINING FACILITATOR *may use this guide to create a cohesive learning environment: integrating a variety of materials, subjects and learning experiences.* In this context, the facilitator is a constant presence throughout the week, guiding the learning experience of program participants.

This guide assumes that these three functions interact in the following ways:

- A) The facilitator and the logistical coordinator work closely to manage the training resources, presenters and participants.
- B) The facilitator works with the guest speakers / subject matter experts to convey the best possible subject matter information in a manner most absorbable by participants.
- C) Together, the training facilitator and the guest speakers create a cohesive, multi-dimensional learning experience over a multi-day training period.

WHY A FACILITATOR?

- Every person learns differently. A training facilitator maximizes the information retained and the skills learned by consistently planning and adapting the way in which the materials are presented in order to best meet the needs of the learners.
- The big picture is essential. A training facilitator makes sure individual learning presentations collectively convey a cohesive message, consistent with larger organizational goals.
- People help each other learn, develop and employ new skills. A training facilitator can ensure a healthy training cohort in which individuals share their experiences and reinforce their new skills long after the training session has ended.

WHAT HAPPENED TO THE GOOD OLD LECTURE?

This guide not intended replace the tradition lecture (or PowerPoint presentations) that many presenters find comfortable. Instead, it offers suggestions for alternative presentation methods that *can be used either instead of or in addition to* the presenters' preferred style.

WHOSE MATERIALS ARE THESE?

The attached CIT reference manual provides sample PowerPoint materials, content outlines, articles and lecture notes all intended to provide guest speakers/content experts with a starting point. These materials are based on the work of content information experts throughout the State of Washington and are offered as reference materials that guest speakers may/may not choose to include in their presentations. The materials are not intended as prescriptive or exhaustive- simply informative.

COMMENTS WELCOME.

The usefulness of the CIT facilitators guide depends on input and feedback from the people who use it. Please contribute your comments- on the content, concepts, approaches and information to the program coordinator.

Plan of Instruction

PLAN OF INSTRUCTION – COURSE ELEMENTS

COURSE TITLE: Crisis Intervention Training (CIT) Law Enforcement

COURSE DESIGNERS: Ilana Guttman, Steve Lettic, Leanna Bidinger

1. RATIONALE FOR COURSE:

Communities around the state of Washington have identified the need to have teams of individuals that bring special skills in dealing with and helping people in crisis. The goal is to refer individuals to proper community resources rather than incarceration.

2. LEARNING OUTCOME (COURSE GOAL):

Officers will learn about Crisis Intervention Teams (CIT) and their practical application in their own police department. Officers will develop an understanding of how the CIT program works and how it fits into the department's patrol operation. Officers will also learn how to interact with persons in psychiatric crisis, learn how certain techniques may safely defuse potentially violent encounters. The state and community mental health system will be discussed to help officers help mental health consumers in crisis access community-based services.

3. TARGET AUDIENCE DESCRIPTION:

First responders that include, but not limited to: law enforcement, EMT, hospital staff, MHP staff, and community outreach members.

4. COURSE DEPLOYMENT:

This class is instructed in a classroom setting. Classes will be taught in Burien at the CJTC campus, or in other locations identified with proper logistical requirements. Budget will be dependent on need and assistance from various grants and organizations.

Additional classes may be held at the discretion of regional training managers who have identified additional need; in these cases, the additional funding may be provided from the regional training budget.

This class is 40 hours in length, running from 8:00 AM to 5:00 PM.

5. INSTRUCTOR QUALIFICATIONS:

Instructors and facilitators will be identified by content expertise, experience, and region specific knowledge. It is suggested that each has been through an Instructor Development course or equivalent.

6. SUBJECT MATTER EXPERT DESCRIPTION:

Ilana Guttmann served as the course designer. She has developed numerous courses for the public and private sector. She holds an advanced degree in Instructional Design specializing in the management, design and delivery of training.

7. COURSE STRATEGIES:

This course is highly participative. Course participants will be actively interacting with consumers and facilitators. They will draw upon their own experiences as first responders and contribute to the class discussions. The course includes a number of exercises and opportunities to receive feedback from peers and instructors as they participate in the course.

9. COURSE OUTLINE/TABLE OF CONTENTS/SCHEDULE AND DURATION:

***Note:** The following are proposed hours:

| <u>UNIT</u> | <u>TITLE/DESCRIPTION</u> | <u>TIME</u> |
|--------------------|--------------------------------------|--------------------|
| | Introduction/Overview | As needed |
| Unit 1 | Brain Disorders – PTSD | |
| Unit 2 | Signs and Symptoms of Mental Illness | |
| Unit 3 | Risks to Self and Others | |
| Unit 4 | Psychotropic Medications | |
| Unit 5 | Involuntary Treatment Act (ITA) | |
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10. COURSE SUPPLIES AND EQUIPMENT:

Laptop Computer
Multi-Media Projector
Instructor Guide
Student Manual
Easel Charts and Markers

Tape

11. PRE-COURSE ACTIVITIES:

None

12. COURSE REFERENCES:

Guide to implementing police based diversion programs for people with mental illness.

Olympia Police Department Crisis Intervention Training program

Spokane Police Department Crisis Intervention Training program

Skagit County Crisis Intervention Training program

13. PILOT TEST PLAN:

Three pilot test sites will be conducted. Participants will be provided with the suggested materials to critique and use as they see fit. This group should have various levels of experience with CIT training. Suggestions and corrections will be solicited.

The first pilot will also serve as a test bed for the regional perspective using the suggested materials and format as the coordinator sees fit.

Prior to the presentation, the instructors will be provided with the course materials and asked to review them for flow, grammar, content, etc. Suggestions and corrections made verbally during class by any and all participants will be documented in written form for reference.

14. EVALUATION PLAN:

A post course evaluation will be handed out prior to releasing the class. This form will have items to ascertain both the effectiveness and efficiency in the presentation. This will include questions about the amount of time spent on each unit, whether they had enough overall time to practice the skills, and absorb the material.

Additionally, a student survey with unit objectives will be mailed out three months after the end of the class. This survey will ask students to evaluate whether, in light of their current experience, the objective was important and if the material has been used.

Another survey will be sent out to the training coordinators of participating agencies, with follow-up interviews as needed to ascertain organizational benefit.

Community-Based CIT Model

*Respectfully submitted by Keith Cummings, John Hutchings, Jim Bloss, and Mary Heitzman
Proposed and agreed upon by the steering committee*

Program objectives: Proposed 40 hour- 5 day class

- Describe work-related experiences with people who have brain disorders.
- Become familiar with signs and symptoms of brain disorders.
- Examine risks to self and others.
- List general benefits of and problems associated with psychotropic medications.
- Describe basics of the involuntary treatment process.
- Become familiar with hospital resources for mental health issues.
- Develop skills for communicating with people with mental disorders.
- Identify effective communication techniques with elders who have mental disorders.
- Become familiar with views and needs of mental health consumers and families.
- Identify resources and special issues to aid corrections officers in charge of incarcerated offenders who have mental illness.
- Describe services offered through local community mental health provider.
- Identify effective communication techniques with children who have mental disorders.
- Identify resources and special issues with regard to chemical dependency and mental illness.
- Recognize and understand post-traumatic stress.

Advisory/Delivery Group for CIT Programs:

Advisory Group: *(in areas not having CIT programs)*

- Statewide CIT Facilitator
- Training Commander of Police/Sheriff Agency
- Chief of Police/Sheriff
- ANY COMBINATION OF Representatives from a:
 - Mental Health Provider
 - Hospital
 - NAMI Affiliate
 - Consumer Group/Representative

Delivery Group: *(or what is available within a community)*

- Coordinator – Recommended to be from Police/Sheriff Agency
- Rep. from Hospital
- Rep. NAMI Affiliate
- Rep. Consumer Group
- Rep. Psychiatrist or Psychologist

CIT model continued:

Make-up of Trainees:

Target Group:

- Police/Sheriff Deputies
- Hospital Guards
- State Patrolmen
- Dispatchers
- Corrections (Jail) Officers
- Officers from Rural Counties (rural counties do not necessarily have to adjoin active CIT groups)

Optional Group:

- EMT's
- Fire Personnel
- Other

Problem Statement and Solutions

TOPIC: Crisis Intervention Training

I. **Problem Statement:**

Citizens in our communities that may be a danger to self or others require specialized first responder assistance. Law enforcement agencies are most frequently first responders to crisis calls involving persons de-compensating from mental illness, co-occurring disorders, behavior problems and other associated crisis. Citizens suffering from mental illness should expect to receive the same level of care and service as any other member of the community.

Experience has shown that law enforcement officers and other emergency personnel need special training to develop strategies for interventions in low, medium and high risk crisis situations. Community-Based Crisis Intervention Training (CIT) is available but offered only sporadically throughout Washington State and is not uniform in its curriculum or its availability to Police/Sheriff Departments.

II. **Background:**

The problem outlined above is one that is recognized by law enforcement and mental health organizations working on the issue for many years. Washington State has developed research-based CIT programs that have been in operation for several years. Nationwide, evidence-based CIT programs have shown: reduction in use of force, reduction of injuries to officers and community members, increased referrals to mental health services, and increased community confidence towards first responders in crisis situations.

The mission of such training is to develop a community partnership to increase the ability of first responders to provide a safe, effective, and respectful resolution of incidents involving persons with mental illnesses, co-occurring disorders, behavioral problems and other/associated crises.

A CIT Program Accomplishes This Through:

- Education about mental illness for first responders,
- Communication and teamwork,
- Development of approach, assessment, and intervention techniques to de escalate a crisis,
- Collaborative training through multiple agencies, and
- Identifying alternatives to jail.

III. **Solution:**

- A. Accept that CIT is needed for all first responders and corrections.
- B. Create a uniform application of CIT programs across Washington State.
- C. Develop a community-based CIT model that can be used as a “base-line”.
- D. Direct and fund startup CIT efforts in local jurisdictions and provide ongoing funding for local jurisdictions that have existing CIT programs.

Crisis Intervention Training

Introduction and Historical Overview

The Crisis Intervention Project (CIT) was developed by a committee of stakeholders from across the state. The intent of project was to provide resources and guidance to large and small agencies in developing CIT teams. These individuals should be adept in supporting those that are in crisis, have training in the various issues surrounding those in crisis, be able develop teams that have various expertise or experience in crisis intervention and come from varied backgrounds. Examples of those backgrounds would include, but not be limited to Police Officers, Fire Personnel, Department of Social and Health Services Personnel, and community members.

The resource manual is designed to help those communities in both training and development of those teams in the following areas;

Unit 1-5 Highlight signs and symptoms that individuals who are in crisis, strategies and techniques to help and communicate with them, and the legal issues surrounding treatment.

Unit 6 -8 Lists and discusses several associations, community resources, and agencies that have expertise that can be drawn upon to help in crisis situations.

Unit 9 -10 View crisis intervention through the eyes of the consumers and give the attendees a perspective and guidance on how to best help them through their problems.

Implementation Guide and Model Policies section –

The committee believed that the Guide to Implementing Police Based Diversion Programs for People with Mental Illness was an excellent resource to work from. This guide is incorporates for reference as a suggested format for implementation. The section / guide provides step by step guidance that walks the reader through such things as *Core components of models of specialized response, training, and mental health partnerships*. There are also excellent references to the selection of team members, challenges and lessons learned from programs across the country.

The model policies have been gathered from well know and established CIT programs both in this state and others. This allows the adopting agency to tailor the information toothier needs and community.

Piloting the Implementation and Resource Guide

Three pilot courses were conducted to develop and test the format and content of the resource guide. In each pilot WSCJTC provided the resource manual and delivery format to the coordinator who assessed the need and resources available for their area

Lakewood – February 25th -29th

22 participants attended representing 5 police departments, two sheriff's offices, 3 corrections agencies and two EMS agencies. Feedback was excellent.

Kennewick – April 14th -18th

17 participants representing 3 police departments, 1 sheriff's department, and community outreach and MHP agencies. Feedback was excellent.

Poulsbo- May 5th - 9th

37 participants representing 2 police departments, 1 sheriff's department and 2 community resources. Feedback was again excellent.

The information gained from the pilot programs confirmed that each region has different resources available to it, needs in terms of information and access to services, and focus. The format and materials gave guidance and areas of focus. This shopping cart method better enables the regions and areas to use what was needed and realistic for their situations.

Sustainability

In order to sustain the Crisis Intervention Training Program (CIT) WSCJTC has identified and dedicated a program manager in the Professional Development Division (PDD). The program manager will act as a liaison for limited technical assistance, materials, and potential funding. The program manager will work with DSHS / Mental Health Transformation Act to establish links to electronic documents, resources, and assess needs in the regions for CIT on an annual basis.

Crisis Intervention Training

Unit 1

Brain Disorders – PTSD

CIT Training Lesson Plan Performance Objectives

Brain Disorders - PTSD

Unit Goal: Ability to recognize and understand specific developmental disabilities and traumatic brain injury.

Classroom Hours: 3.00

Presenter:

Performance Objectives:

Participants will be able to:

- Understand and recognize specific signs and symptoms of developmental disabilities, to include at a minimum autism, cerebral palsy, mental retardation, Alzheimer's, traumatic brain injury (TBI) and post traumatic stress disorder (PTSD). Emphasis should be placed on the kinds of behavior that officers will see in people who have a brain disorder.
- Understand and recognize brain disorders in various populations, i.e. children, adolescents, adults, and older adults.
- Understand and learn how to communicate with individuals who have a brain disorder.

Content Material:

See attached PowerPoint presentation for Post Traumatic Stress Disorder

I. Identifying Specific Developmental Disabilities

A. Autism

The rate of occurrence of autism has increased in the past ten years from 2 to 6 in *ten thousand persons*, to 2 to 6 in *one thousand persons*. Due to these statistics, law enforcement can expect to have an increasing number of interactions with them. Interacting with a child or adult who has an Autism Spectrum Disorder will challenge your experience and training.

1. Defining Autism

- a. Autism is a developmental disability that manifests itself within the first 3 years of a child's life.
- b. It is a broad spectrum neurological disorder, which presents itself in a variety of symptoms that affects individuals differently, but includes impairments in communication, socialization, and restricted or repetitive patterns of behavior.
- c. Autistic Disorder is classified as one of the Pervasive Developmental Disorders. Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS) are sometimes viewed as milder forms of autism or "high functioning autism."
- d. Autism typically appears during the first three years of life. It affects a person's ability to properly understand what they see, hear, and otherwise sense. Autism primarily affects communication. People with autism typically have difficulty understanding verbal and nonverbal communication and learning appropriate ways of relating to people, objects, and events. (Autism Society of North Carolina)
- e. Autism is four times more prevalent in boys than girls and knows no racial, ethnic, or social boundaries. Family income, lifestyle, and educational levels do not affect the chance of autism's occurrence. (Autism Society of America)
- f. People who have Autism may also have other disorders which affect the brain such as: Epilepsy, Cerebral Palsy, Down Syndrome, Tourette's Syndrome and Mental Retardation (now referred to as Cognitive or Intellectual Disabilities).

2. Characteristics of Autism

When responding to a call that involves a person with autism, officers may face a situation that will challenge the training, instincts, and professional conduct of even the most experienced police veteran.

Although people with autism do not have exactly the same symptoms and deficits, they tend to share certain social, communication, motor, and sensory problems that affect their behavior in predictable ways.

- a. Severe deviations in language development - Language is slow to develop and usually includes peculiar speech patterns or the use of words without attaching them to their normal meaning.
- b. Severe deviations in understanding social relationships - They may not use eye contact in social interactions and seem to “tune out” the world. This results in an inability to interact with others and an impaired ability to make friends.
- c. Inconsistent patterns of sensory responses - The person may appear to be deaf and fail to respond to words and sounds. At other times, they may be extremely distressed by everyday noises, such as a vacuum cleaner or a dog barking. They also may show insensitivity to pain and lack of responsiveness to cold or heat, or may overreact to any of these.
- d. Uneven patterns of intellectual functioning - The majority of people with autism have varying degrees of mental retardation. However, some may have peak skills - scattered things done quite well in relation to overall functioning - such as drawing, math, music, or memorization of facts.
- e. Marked restriction of activity and interests - A person with autism may perform repetitive body movements, such as hand flicking, twisting, rocking, or spinning. This person may also display repetition by following the same schedule everyday, same route, same order of dressing, etc. If changes occur in these routines, the person with autism may become upset.

3. Communicating with Persons with Autism

Autism is likely to be encountered by law enforcement through suspicious person calls, disturbance calls, child abuse calls, and missing persons calls.

a. Techniques

When law enforcement comes into contact with a person with autism, they should use the following techniques:

- Be patient
- Use clear, direct phrases and instructions, short and to the point
- Use visual aids/pictures when needed
- Use spinning toys for calming tools
- Allow extra time for responses, repeating or rewording if necessary
- Speak calmly and in a low voice
- Avoid quick movements
- Be alert for verbal/behavioral outbursts
- Repeat simple questions, allowing time (10-15 seconds) for a response
- Proceed slowly and give praise and encouragement
- Do not attempt to physically stop or interrupt self-stimulating or compulsive ritualistic behavior
- Turn off lights and sirens when possible

b. Things to Remember

- In a Criminal Justice Situation, a person with autism will not understand Miranda Warnings or other constitutional rights.
- They may have difficulty remembering facts or details of offenses.
- They become anxious in new situations.
- They may not understand consequences to their actions.

Remember: Each person with autism is unique and may act or react differently. Contact a responsible person who is familiar with the individual.

4. Dealing with an Agitated, Upset or Traumatized Person with Autism.

If an officer comes across a person with autism who is agitated, upset, or traumatized, they should take into consideration the following:

- a. Many people with autism, adults or children, do not speak. Some have receptive language, but little or no expressive language. Some can use sign language. They may appear not to hear you, while hearing every word.
- b. Many do not like to be touched. Some are so sensitive to touch that an effort to reassure by touching may cause a difficult situation to escalate quickly to an impossible situation.
- c. They often have heightened senses of touch, smell, hearing or visual receptivity. Noise, lights, sounds, smells, etc., that would not bother a normal individual, are often intolerable to them. Turn off lights and sirens.
- d. Attempts to restrain an individual with Autism can put them in a physical frenzy. When other options are available, an individual with autism should not be held down.
- e. Once quieted, they often respond to order, firmness, and structure. They must be told the circumstances of specific actions and will respond to quiet, firm, no-nonsense directions, not threats.
- f. Check for injuries, even if not obvious. Many times individuals with autism can't feel pain.
- g. If arrested, keep away from the general jail population as abuse could happen.

B. Cerebral Palsy

1. Defining Cerebral Palsy

- a. Cerebral Palsy refers to a group of disorders that affect a person's ability to move and to maintain balance and posture. It is due to a non-progressive brain abnormality, which means that it does not get worse over time, though the exact symptoms can change over a person's lifetime.

- b. It is caused by damage to the brain during pregnancy, delivery, or shortly after birth.
- c. It is a medical condition that affects control of the muscles.

2. Characteristics of Cerebral Palsy

- a. People with Cerebral Palsy tend to experience difficulty with speech and have difficulty in writing and problem solving.
- b. They are generally lacking in mobility skills, and perceptual skills may not be as developed as in non-disabled persons. Their behaviors may be mistaken as indicators of intoxication or drug use because of how they walk or talk.
- c. Frequently, they have nutritional deficiencies because of problems with swallowing.
- d. Some are verbal, whereas others use a communication board to interact with others.
- e. About 1 in 8 has hearing problems.

3. Communicating with a Person with Cerebral Palsy

- a. Many individuals with Cerebral Palsy have normal intelligence. Therefore, don't discredit what the person has to say or report.
- b. Make the person feel safe and comfortable in the environment.
- c. Be patient.
- d. Reword or rephrase questions to assist with understanding.
- e. Find different ways to communicate with this person. If communicating through writing, the person may not spell correctly.
- f. If the person is nonverbal, ask them to show how they say yes or no. Law enforcement can then ask closed-ended questions and still receive a response.

C. Mental Retardation *(Presently known as cognitive or intellectual disabilities)*

1. Defining Mental Retardation

- a. Mental retardation is characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, and getting along in social situations and school activities. Mental

retardation is sometimes referred to as a cognitive or intellectual disability. (National Center on Birth Defects and Developmental Disabilities)

- b. People with mental retardation may have other disabilities as well. Examples of these coexisting conditions include: cerebral palsy, seizure disorders, vision impairment, hearing loss, and attention-deficit/hyperactivity disorder (ADHD). Children with severe mental retardation are more likely to have additional disabilities than are children with mild mental retardation.

2. Characteristics of Mental Retardation

- a. No specific personality and behavioral features are uniquely associated with mental retardation.
- b. People with mental retardation may be:
 - Passive, placid, and dependent
 - Aggressive and impulsive
 - Lacking communication skills
 - Showing signs of self-injurious behavior
 - Vulnerable to exploitation through sexual or physical abuse
 - Physically different from the norm
 - Showing signs of mental disorders
- c. The symptoms of mental retardation appear before age 18.

3. Communicating with Persons with Mental Retardation

- a. To communicate effectively and sensitively with people with mental retardation, the officer should:
 - Be patient.
 - Be nonjudgmental.
 - Communicate on the person's level.
 - Some adults with mental retardation may function as children, for example.
 - Be compassionate.

II. Identifying Other Disabilities

A. Alzheimer's disease

1. Defining Alzheimer's disease

- a. Alzheimer's disease is a degenerative brain disease and the most common form of dementia.

- b. Dementia is a group of symptoms that includes memory loss and impaired thinking.
- c. Because Alzheimer's is degenerative, it worsens progressively.

As Alzheimer's progresses, it robs the patient of the ability to:

- Remember
 - Think
 - Make sound judgments
 - Care for him or herself
- d. Alzheimer's disease is not a normal aging process, nor is it a mental illness.
 - e. Alzheimer's is a terminal condition.

2. Prevalence of Alzheimer's disease

- a. Alzheimer's disease is the fourth leading cause of death among American adults.
 - Alzheimer's and its related disorders affect about 4 million people annually.
- b. Alzheimer's primarily strikes the elderly.
 - About 10 percent of those over 65 have Alzheimer's.
 - One study noted that 47 percent of those over 85 have Alzheimer's disease.
- c. A small population of people between 40 and 60 has Alzheimer's disease.
- d. Most people with Alzheimer's disease (75 %) live in the community, while the minority (25%) resides in nursing homes or adult-care facilities.
- e. Of those Alzheimer's patients living in the community, 20 percent live alone.

3. Identifying Alzheimer's disease

- a. A number of conditions can mimic Alzheimer's disease, including:
 - Depression
 - Alcoholism
 - Drug reactions

- Nutritional deficiencies
- Head injuries
- Infections like AIDS, meningitis, or syphilis

b. Alzheimer's disease progresses in five stages:

- In Stage 1, the Alzheimer's patient:
 - Gradually begins to lose mental faculties
 - Has minor memory loss
 - Experiences mood swings
 - Is slow to learn and react
 - Prefers familiar settings to new situations
 - Has less energy and spontaneity
- In Stage 2, the Alzheimer's patient:
 - Can complete normal activities (e.g., brushing the teeth) but has difficulty with complicated tasks (e.g., paying bills)
 - Loses more memory
 - Has slowed speech
 - Has impaired decision-making ability
 - Loses track of thoughts in mid-sentence
 - Loses feelings for others
- In Stage 3, the Alzheimer's patient:
 - Has poor short-term memory
 - Begins to get lost or forget where he or she is
 - Starts to forget dates, the time of day, and the season
 - May invent words
 - May fail to recognize family and close friends
- In Stage 4, the Alzheimer's patient:
 - Loses his or her essence (unique nature)
 - Requires full-time monitoring
 - Is completely disoriented
 - Experiences sleep disturbances and hallucinations
 - Loses bowel and bladder control
- In Stage 5, the Alzheimer's patient:
 - Loses the ability to chew and swallow
 - Becomes vulnerable to pneumonia, infections and other illnesses
 - Lapses into coma and eventually dies

c. Because there are no field tests for identifying Alzheimer's disease, the officer must rely on clues that include:

- Identification

A person with Alzheimer's disease may be wearing an identification bracelet with the words *memory impaired*.

If the person has no exterior identification, the officer should check for:

- A driver's license
- A wallet card
- Other paper identification
- Personalized clothing labels

- Behavior

The person's appearance, behavior, and interaction are clues to his or her condition.

The physical clues of Alzheimer's disease include:

- Blank facial expression
- Clothing inappropriate for the weather
- Unsteady gait

The psychological clues of Alzheimer's disease include:

- Repetition of questions
- Confusion of time and location
- Delusions
- Agitation

- Situation

- Wandering - A person with Alzheimer's disease may be missing or found wandering. All people with Alzheimer's are at risk of wandering. Between 60 and 70 percent of Alzheimer's patients wander from their homes during their illnesses.
- Accidents - They can become lost or cause accidents while driving because Alzheimer's disease affects reaction time and visual-spatial perception. Patients may leave an accident scene and forget the incident.
- Shoplifting - Since the person with Alzheimer's experiences short-term memory loss, they may leave a store without paying for an item that they have in their possession.

- Filing false reports - Because of delusional thinking, a person with Alzheimer's may call the police to report fictitious theft or intruders.
- Committing indecent exposure - Due to lowered social inhibitions, mental confusion, or delusions (false beliefs), the person may urinate in a public place or expose themselves.

4. Communicating with Persons with Alzheimer's disease

- a. While people with Alzheimer's disease may not be able to remember or to function normally, they still experience pain and fear.
- b. The officer should treat all Alzheimer's patients gently and compassionately.
- c. When approached by an officer, a person with Alzheimer's disease may:
 - Sob
 - Pace
 - Become extremely frightened
 - Become extremely agitated
 - Become extremely aggressive
- d. Most Alzheimer's patients the officer encounters are in Stage 3, which involves significant dementia:
 - The officer should make extra effort to avoid compounding the Alzheimer's patient's fear and confusion.
 - Whenever possible, the officer should dress in plain clothes and drive an unmarked vehicle when approaching the Alzheimer's patient.
- e. To ensure the safety of all people involved in an Alzheimer's disease encounter, the officer should:
 - Be very patient
 - Communicate simply, clearly, slowly, and calmly.
 - Approach the Alzheimer's patient from the front and introduce him- or herself.
 - Speak with the Alzheimer's patient individually whenever possible. A person with Alzheimer's disease may be easily overwhelmed by crowds and stimuli.

- The officer should not assume the Alzheimer's patient is deaf or hard of hearing. Loud noises like shouting do not enhance communication but instead often frighten or agitate the person with Alzheimer's.
 - Ask the Alzheimer's patient one question at a time and make the questions as simple as possible. If the Alzheimer's patient does not respond to a question, the officer should wait a moment and repeat it.
 - Be positive and avoid instructions that command the Alzheimer's patient to complete tasks. For example, the officer might say, "Please sit here. Everything will be okay."
 - Avoid restraining the Alzheimer's patient whenever possible. Restraints may cause the person with Alzheimer's to become extremely frightened or agitated. The officer should consider restraining the person with Alzheimer's only when he or she threatens his or her safety or the safety of others.
 - Use common sense. People with Alzheimer's disease tend to respond to the officer's body language and tone. For example, if the officer discovers a person with Alzheimer's disease sitting on the sidewalk, and the person refuses to stand, the officer should sit with the person initially so he or she will be more likely to stand when the officer does.
 - Be respectful. The officer may find that entering the reality of the Alzheimer's patient temporarily may help ease the officer-patient interaction.
 - (a) For example, if a person with Alzheimer's disease asks for her deceased son, the officer might tell her that he will arrive soon.
 - (b) Gently humoring the Alzheimer's patient is compassionate, not disrespectful.
- f. Return the person with Alzheimer's disease to the primary caregiver and notify the proper authorities.
- The officer should transport the person with Alzheimer's disease to the hospital whenever the person:
 - Clearly needs medical attention,
 - Appears to be suffering poor hygiene or neglect, or

- Has not been reported missing, has no identification, and cannot provide a clear name or address.
- The officer should transport the person with Alzheimer's disease to the primary caregiver whenever the person does not need medical attention.
- The officer should transport the person with Alzheimer's disease to a nursing home whenever the person does not need medical attention or the wandered from the nursing home. Advise the nursing home to contact the local Alzheimer's Association for assistance.
- If the person with Alzheimer's disease lives alone, the Officer should contact the Local Elder Protective Services agency; or follow up with the local Alzheimer's Association.
 - Like the local Alzheimer's Association, the National Alzheimer Wanderers Alert Registry is always on call (800) 733-9596.

B. Traumatic Brain Injury

1. Defining Traumatic Brain Injury (TBI)

Traumatic brain injury is sudden physical damage to the brain, which results in an impairment of cognitive abilities or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

(Adapted by the Brain Injury Association of America)

The leading cause of traumatic brain injuries are from motor vehicle accidents, followed by falls, sports injuries, violent crimes, and child abuse.

Every year 70,000–90,000 Americans will develop long-term disabilities from a traumatic brain injury experienced. The damage that the TBI causes can severely affect every aspect of an individual's life, causing extreme obstacles, as well as pain and suffering.

2. Characteristics of Traumatic Brain Injury

Traumatic brain injuries affect a person's cognitive, physical, and emotional aspects, depending on what area or areas of the brain

were affected.

(Traumatic Brain Injury Resource | Developed by eJustice, 2002)

- a. Cognitive traumatic brain injury symptoms may include:
 - Slowed ability to process information
 - Short term memory loss and/or long term memory loss
 - Spatial disorientation
 - Organizational problems and impaired judgment
 - Trouble concentrating or paying attention for periods of time
 - Difficulty keeping up with a conversation; other communication difficulties such as word finding problems
 - Inability to do more than one thing at a time
- b. Physical traumatic brain injury symptoms may include:
 - Pain
 - Seizures of all types
 - Muscle spasticity
 - Headaches or migraines
 - Double vision or low vision, even blindness
 - Balance problems
 - Loss of smell or taste
 - Speech impairments, such as slow or slurred speech
 - Fatigue, increased need for sleep
- c. Emotional traumatic brain injury symptoms may include:
 - A lack of initiating activities, or once started, difficulty in completing tasks without reminders
 - Increased anxiety
 - Impulsive behavior
 - Depression and mood swings
 - Denial of deficits
 - More easily agitated
 - Egocentric behaviors, such as difficulty seeing how behaviors can affect others

3. Communicating with Persons with a Traumatic Brain Injury

The characteristics of TBI are very similar to those characteristics of a drunk driver or a person under the influence of drugs. So, once you have completed your assessment of the situation and determine that the person you have encountered has suffered a traumatic brain injury; you will want to determine the best

communication strategies. When in doubt, ask the person what you can do to assist their communication with you.

Since no two traumatic brain injuries are alike, persons who acquire TBI may therefore experience different types of communication disorders. The severity of the impairment can be markedly different as well.

- a. Persons with motor speech disorders (dysarthria) only can understand what is being said but experience difficulty with the motor coordination for speech (breathe support/volume, voice or articulation). They are the persons with TBI who are most likely to sound like someone who is drunk due to the motor coordination problem.

Communicate by:

- Talking to the person face to face.
- Reducing background noise and giving them feedback, if you cannot understand what they are saying.
- Repeating what you think you heard and asking them to write for clarification if they can, or asking yes/no questions.

If the communication deficit is truly motor-based, the yes/no response should be reliable. Sometimes the motor coordination problem also impacts the motor coordination for writing or gesturing. Some persons with more severe motor speech deficits may use communication devices such as speech generating devices (SGD).

- b. Persons who have injury to the parts of the brain impacting language may have receptive and/or expressive language difficulties (aphasia or dysphasia). This can reduce the ability to understand language (reading or oral comprehension) and formulate responses (writing or oral language). Their yes/no response may not be consistent if they do not understand what you are saying or if they cannot control their expressive language. When language comprehension is impaired, it is important to:
 - Talk slowly with simple phrases
 - Use gestures to help with understanding
 - Give time for the individual to respond
- c. Persons with traumatic brain injuries may experience cognitive communication deficits, which impact functional abilities of their communication. They frequently experience poor short term memory. They may recall events of long ago

but not be able to recall/retain the memory of what occurred five minutes earlier. Communicate by:

- Asking if the person uses some type of memory aid
- Checking back for comprehension and retention after a discussion with the person

d. A TBI can also impact a person's hearing abilities, making it more difficult to actually hear or process what is heard. You can assist by:

- Making sure the person can see your face
- Standing in a well-lit area, keeping in mind officer safety issues
- Communicating in an area where there is not a lot of noise; therefore, you may need to ask the person to sit in your patrol car.

Source: Traumatic Brain Injury Association in Thurston County

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Published July 2005
Interacting with Persons with Developmental Disabilities and Mental Illness Training CD
Developer: Wanda Townsend, Instructional Designer

Posttraumatic Stress Disorder

Michelle H Link, Maj, USAF, BSC, BCD
Behavioral Health Flight Commander
Licensed Clinical Social Worker

Overview

- What Sort of Stress are we talking about?
- Differing Types of Potentially Traumatic Stressors
- What is PTSD
- How Often does PTSD Occur
- Who and How Many Develop PTSD
- Risk Factors
- Treatment Options
- Acute Stress Disorder
- Acute Traumatic Stress Management
- Co-Occurring Problems
- Non-Violent Crisis Intervention

What Sort of Stress are we Talking About?



What Sort of Stress are we Talking About?

- Normal Healthy Stress
- Combat Stress
- Acute Stress Disorder
- Posttraumatic Stress Disorder

Differing Types of Potentially Traumatic Stressors

- Abuse
 - Mental
 - Physical
 - Sexual
 - Verbal
- Catastrophe
 - Harmful/Fatal Accidents
 - Natural Disasters
 - Terrorism

Differing Types of Potentially Traumatic Stressors

- Violent Attacks
 - Animal
 - Assault
 - Battery and Domestic Violence
 - Rape
- War, Battle, and Combat
 - Death
 - Explosion
 - Gunfire

Not all Stressor Events are Equal

- Men more often experience: rape, combat exposure, childhood neglect, and physical abuse.
- Women more often experience: rape, sexual molestation, physical attack, threatened with a weapon, physical abuse.

What Is PTSD?

- An anxiety disorder that can occur after you have been through a traumatic event.
- Dominant Features:
 - Emotional Numbing
 - Hyper-arousal
 - Re-experiencing the trauma
 - Avoiding situations that remind you of the event

What Is PTSD?

- DSM-IV-TR
 - A1. Event &
 - A2. Intense fear, helplessness or horror.
 - B. Re-experienced by 1 of the following:
 - Recurrent distressing recollections
 - Recurrent distressing dreams
 - Acting or feeling like the even is happening again
 - Intense psychological distress at exposure to cues
 - Physiological reactivity on exposure to cues

What Is PTSD?

- DSM-IV-TR
 - C. Persistent avoidance by 3 + of the following:
 - Avoids thoughts, feelings or conversations
 - Efforts to avoid activities, places ore people
 - Inability to recall an important aspect
 - Diminished interest/participation in activities
 - Feeling detached/estranged from others
 - Restricted range of affect
 - Sense of foreshortened future

What Is PTSD?

- DSM-IV-TR
 - D. Increased arousal indicated by 2 + of the following:
 - Difficulty falling or staying asleep
 - Irritability or outbursts of anger
 - Difficulty Concentrating
 - Hypervigilance
 - Exaggerated Startle Response

How often does this kind of stress Occur?

- PTSD lifetime prevalence is at least 1% but may be as high as 15% in the US
- 1990 Study found that women will be 2 x as likely as men to develop PTSD
- In high risk groups such as combat veterans and victims of violent crimes prevalence ranges from 3% to 58%

How Many Traumatized People Develop PTSD?

- An estimated 7.8% of Americans will experience PTSD at some point in their lives.
- About 3.6% of US adults age 18-54 (5.2 million people) will have PTSD at any point during a given year.
- Approximately 60.7% of men and 51.2% of women reported at least 1 traumatic event

How Many Traumatized People Develop PTSD?

- PTSD is more prevalent among war veterans than any other group.
- Some recent studies show that 9 – 10% of returning soldiers from Iraq have been found to be suffering from PTSD.
- Army researchers found that 19.1% of returning US military personnel from Iraq as compared to 11.3 % from Afghanistan and 8.5% from other deployments suffered mental health difficulties of varying seriousness.
- Civilian population (1995 study) found that 5% of men and 10% of women will experience PTSD in their lifetime

Who Develops PTSD & Risk Factors

- Many people who go through a traumatic event don't get PTSD. It isn't clear why some people develop PTSD and others don't.
- Many factors influence who is at increased risk.

Who Develops PTSD & Risk Factors

- How intense the trauma was
- If you lost a loved one or were hurt
- How close you were to the event
- How strong your reaction was
- How much you felt in control of events
- How much support you got after the event

Treatment Options

- Medication Management
 - SSRI's
 - Anti-Anxiety Medications
- Cognitive Behavioral Therapy
 - Changing how you think about the trauma
 - Replacing thoughts with more accurate less distressing thoughts
- Exposure Therapy

Treatment Options

- Eye movement desensitization and reprocessing (EMDR)
- Group Therapy
- Marital/Family Therapy

Acute Stress Disorder

- **Acute Stress Disorder (DSM-IV-TR)**
- Event & Feelings of intense fear, helplessness or horror
- “Clinically significant” (causing significant distress or impairment in social, occupational, or other important areas of functioning) symptoms >2 days, but <1 month after exposure to a trauma as defined above (may progress to PTSD if symptoms last >1 month).

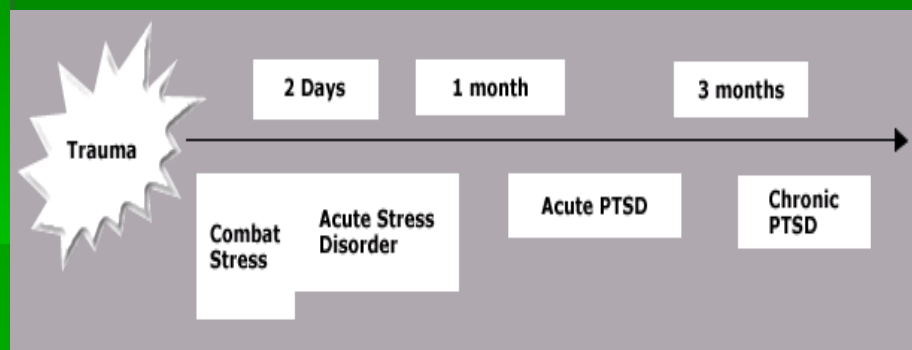
Acute Stress Disorder

- Either while experiencing or after experiencing the distressing event, the individual has at least three of the following *dissociative* symptoms:
 - A subjective sense of numbing, detachment, and/or absence of emotional responsiveness.
 - A reduction in awareness of his/her surroundings (e.g., "being in a daze").
 - Derealization (the feeling that familiar surroundings or people are unreal or have become strange).
 - Depersonalization (the feeling in an individual that (s)he is no longer him/herself. His/Her personality, body, external events, the whole world may be no longer appear real).
 - Dissociative amnesia (i.e., the inability to recall an important aspect of the trauma)

Acute Stress Disorder

- The traumatic event is persistently *re-experienced* in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.
- Marked *avoidance* of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people, sounds, smells, etc.)
- Marked symptoms of anxiety or *increased arousal* (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, and motor restlessness)

PTSD Continuum



Acute Traumatic Stress Management

- Acute intervention should ensure that the following needs are met:
 - Basic Needs
 - Safety/Security/Survival
 - Food, hydration, clothing and shelter
 - Sleep
 - Medication (i.e., replace medications destroyed/lost)
 - Orientation
 - Communication with family, friends and community

Acute Traumatic Stress Management

- Psychological first aid:
 - Really means assisting people with emotional distress whether it results from physical injury, disease or excessive traumatic stress. Emotional distress is not always as visible as a wound, a broken leg or a reaction to pain from physical damage. However, overexcitement, severe fear, excessive worry, deep depression, misdirected aggression, or irritability and anger are signs that stress has reached the point of interfering with effective coping.

Acute Traumatic Stress Management

- Protection from ongoing threats/toxins/harm.
- Protect survivors from further harm
- Reduce physiological arousal
- Mobilize support for those who are most distressed
- Keep families together and facilitate reunion with loved ones
- Provide information, foster communication and education
- Use effective risk communication techniques.

Co-Occurring Problems

- Substance Abuse/Dependency
- Major Depressive Disorders
- Panic Disorders
- Phobia's
- Obsessive Compulsive Disorder
- Employment Problems
- Relationship Problems
- Physical Symptoms

Non-Violent Crisis Intervention

- “A bad day alive beats the heck out of a good day dead.”

“Bless your Stress “ by Charles & Donaldson



Non-Violent Crisis Intervention

- 1. Assess for danger/safety for self and others
- 2. Evaluate the level of responsiveness
- 3. Address medical needs
- 4. Connect with the individual
- 5. Ground the individual
- 6. Provide Support
- 7. Normalize the response

Resources

- **Unit**
 - **Chaplain / Leadership / Wingman**
- **Wing**
 - **Medical Clinic (247-5661)**
 - **Mental Health Services (247-2731)**
 - **Airmen and Family Readiness Center (247-2246)**
 - **Sexual Assault Response Coordinator (247-7272)**

Resources

- **Off Base**
 - **Off-Base Mental Health professionals (First Call for Help 838-4428)**
 - **Military One Source (800-342-9647)**
 - **Other helping/supportive agencies**

Summary

- What Sort of Stress are we talking about?
- Differing Types of Potentially Traumatic Stressors
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- Risk Factors
- Treatment Options
- Acute Stress Disorder
- Acute Traumatic Stress Management
- Co-Occurring Problems
- Non-Violent Crisis Intervention

Questions?



Crisis Intervention Training

Unit 2

Signs and Symptoms of Mental Illness

CIT Training Lesson Plan Performance Objectives

Signs and Symptoms of Mental Illness

Unit Goal: Ability to recognize and understand the main diagnostic cluster for major mental illness.

Classroom Hours: 3.00

Presenter:

Performance Objectives:

Participants will be able to:

- Understand and recognize specific signs and symptoms of serious mental illnesses, to include at a minimum mood and anxiety disorders, schizophrenia, psychotic disorders, and personality disorders. Emphasis should be placed on the kinds of behavior that officers will see in people experiencing a mental health crisis.
- Understand and recognize mental illnesses in various populations, i.e. children, adolescents, adults, and older adults.
- Understand the common problem of co-occurring developmental disability, medical, and homelessness.
- Understand and differentiate mental retardation from mental illness.

Content Material:

See attached PowerPoint presentation for *Introduction to Mental Illness* and *Psychotropic Medications*

Introduction to Mental Illness and Psychotropic Medications

Matthew E. Layton, M.D., Ph.D.

**Medical Director, Spokane Mental Health
Director, UW Psychiatry Residency Program - Spokane Track
Clinical Associate Professor, UW Psychiatry & Behavioral Sciences
Adjunct Associate Professor, WSU College of Pharmacy**

Mental Health

Appendix A

A Report of the Surgeon General Executive Summary

DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. Public Health Service



The Center for Mental Health Services
Substance Abuse and Mental Health
Services Administration



National Institute
of Mental Health
National Institutes of Health

Suggested Citation

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

Table 1. Disease burden by selected illness categories in established market economies, 1990

| | Percent of Total DALYs* |
|---------------------------------------|-------------------------|
| All cardiovascular conditions | 18.6 |
| All mental illness** | 15.4 |
| All malignant disease (cancer) | 15.0 |
| All respiratory conditions | 4.8 |
| All alcohol use | 4.7 |
| All infectious disease | 2.8 |
| All drug use | 1.5 |

*Disability-adjusted life year (DALY) is a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration (Murray & Lopez, 1996).

**Disease burden associated with "mental illness" includes suicide.



PRESIDENT'S NEW FREEDOM

COMMISSION ON MENTAL HEALTH

www.MentalHealthCommission.gov

www.mentalhealthcommission.gov



Psychiatric Times

A CME, Inc. Publication • www.psychiatrictimes.com • April 2004 • Vol. XXI, No. 4

A Prescription for Disaster: Cutbacks on Mental Health Programs Curb Access to Care

by Richard A. Sherer

In Virginia, a state agency charged with the protection and oversight of the disabled has filed a lawsuit charging that state-run mental hospitals are neglecting patients. In Florida, the North Broward Hospital District has stopped paying for psychotropic drugs for indigent patients. In Missouri, the state mental health department plans to shut down a treatment center and a psychiatric rehabilitation hospital to save money. In California, proposed cuts in the state's budget will force counties to shut down mental health facilities despite legal mandates to provide care.

From Maine to Oregon, from West Virginia to Texas, mental health services are being curtailed as bureaucrats and lawmakers try to stretch fewer dollars across an increasingly large, underserved population.

State tax revenues per capita declined 7.4% in fiscal 2002. In a Kaiser Commission on Medicaid and the Uninsured report, the

wrote, "While the national recession was fairly mild, the falloff in state tax revenues was severe and led to daunting state budget shortfalls." They continued, "The big falloff in state tax revenue in 2002 means that it will take states some time to return to pre-2002 tax levels, and the recent modest growth in state tax revenues is far from sufficient to do that." Boyd is director of the Fiscal Studies Program at the Rockefeller Institute of Government, and Wachino is associate director of the Kaiser Commission on Medicaid and the Uninsured.

The immediate future does not look much better, according to Boyd and Wachino. "As the Rockefeller Institute recently observed, 'States will probably have to cut spending and/or raise taxes in order to balance the fiscal year 2005 budgets they will begin to consider in a few months.'" They added, "And unless the national economic picture, and especially employment, picks up significantly, states will have to face these condi-



Spokane County

| | <u>1998</u> | <u>1999</u> | <u>2000</u> | <u>2001</u> | <u>2002</u> | <u>2003</u> | <u>2004</u> | <u>2005</u> |
|--------------------|-------------|-------------|-------------|-------------|-------------|-------------|------------------|-------------|
| Suicides | 54 | 58 | 55 | 68 | 66 | 63 | <u>95</u> | 62 |
| (Age 10-19) | | | | 1 | 3 | 5 | 6 | 5 |

Rates (Total):

2000 = 13/100,000

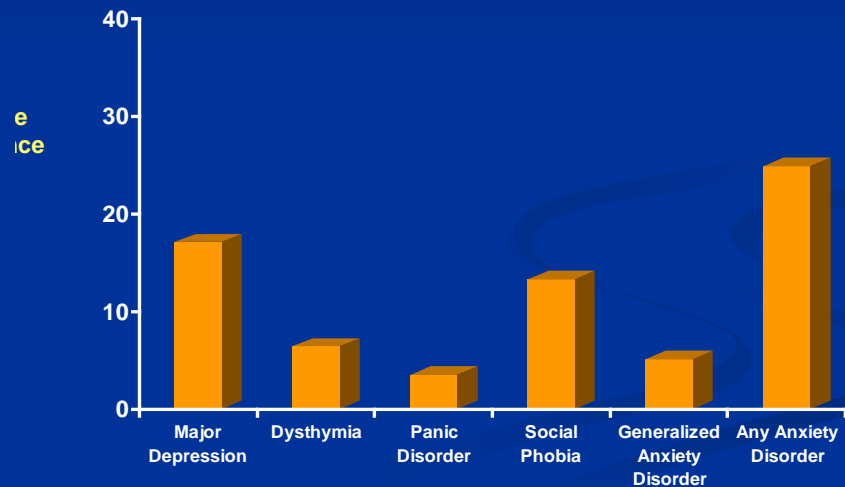
2004 = 22/100,000

- Spokane County Medical Examiner

2005 Annual Report

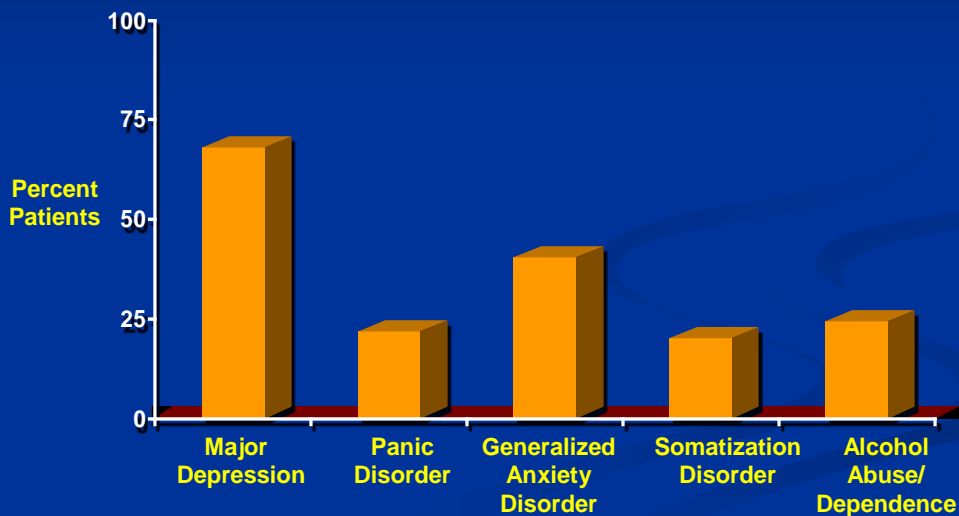
Prevalence Of Depressive And Anxiety Disorders

National Comorbidity Survey



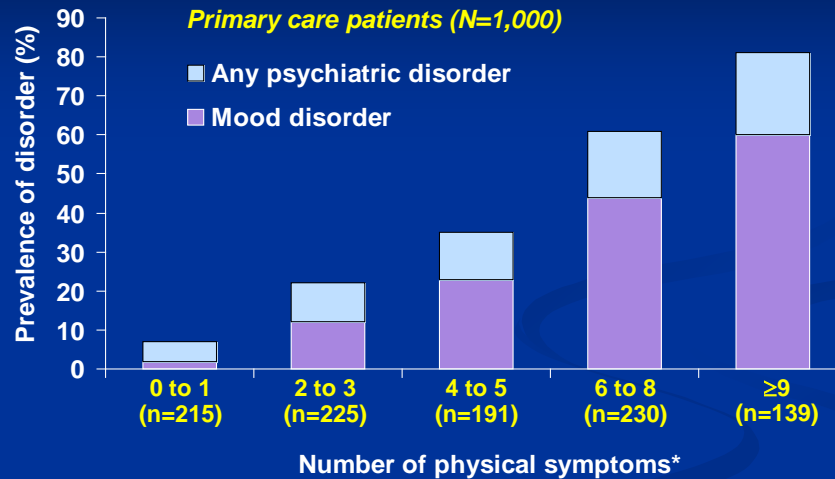
Kessler et al. *Arch Gen Psychiatry*. 1994;51:8.

Lifetime Mental Disorders Of Distressed High Utilizers Of General Medical Care (N=119)



Katon et al. *Gen Hosp Psychiatry*. 1990;12:355.

Multiple Physical Symptoms May Indicate Depression



*Physical symptoms included fatigue; disturbed sleep; menstrual problems; dizziness; GI complaints (nausea, vomiting, gas, constipation, diarrhea); headache; joint or limb pain; back pain; abdominal pain; chest pain; sexual dysfunction/apathy; and others.

Kroenke K, et al. *Arch Fam Med.* 1994;3:774-779.

Depression: A Systemic Illness— The Emotional and Physical Signs

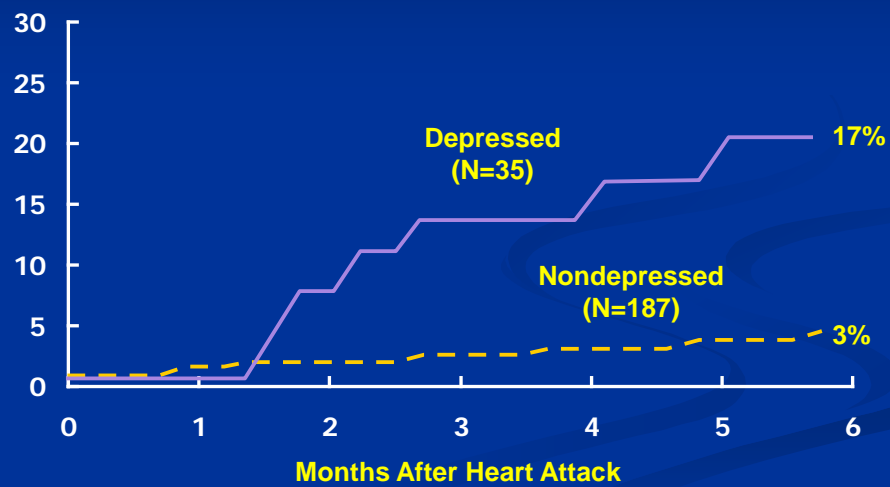
- *Depressed mood*
- *Anhedonia*
- Hopelessness
- Low self-esteem
- Impaired memory
- Difficulty concentrating
- Anxiety
- Preoccupation with negative thoughts



- Headache
- Fatigue
- Disturbed sleep
- Dizziness
- Chest pain
- Vague joint/limb pain
- Vague back/abdominal pain
- GI complaints (nausea, vomiting, constipation, diarrhea, gas)
- Sexual dysfunction/apathy
- Menstrual problems

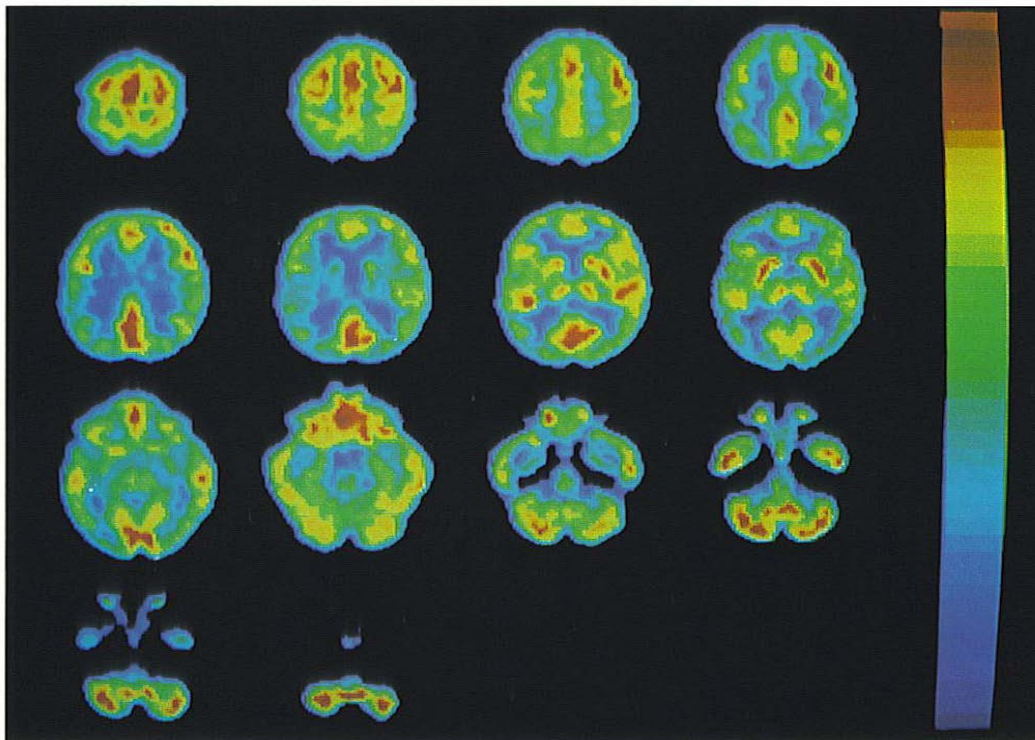
Adapted from:
DSM-IV-TR. Washington, DC: American Psychiatric Association; 2000.
Kroenke K, et al. *Arch Fam Med.* 1994;3:774-779.

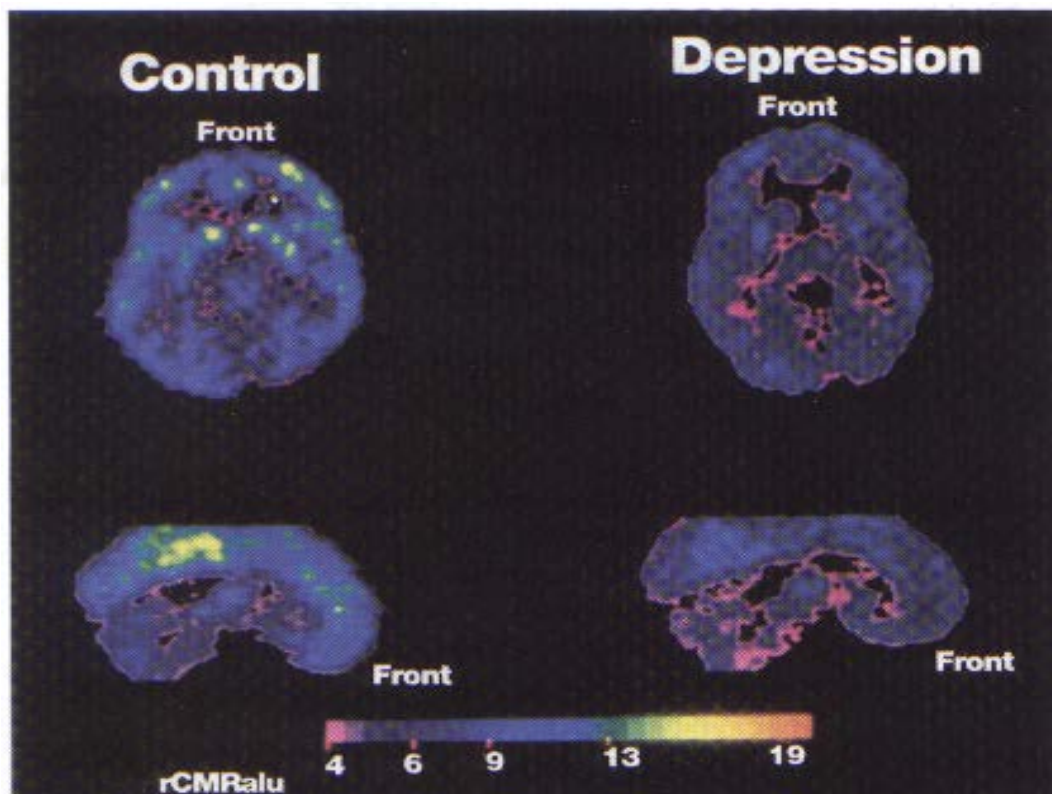
Cumulative Mortality For Depressed And Nondepressed Patients Following Heart Attack

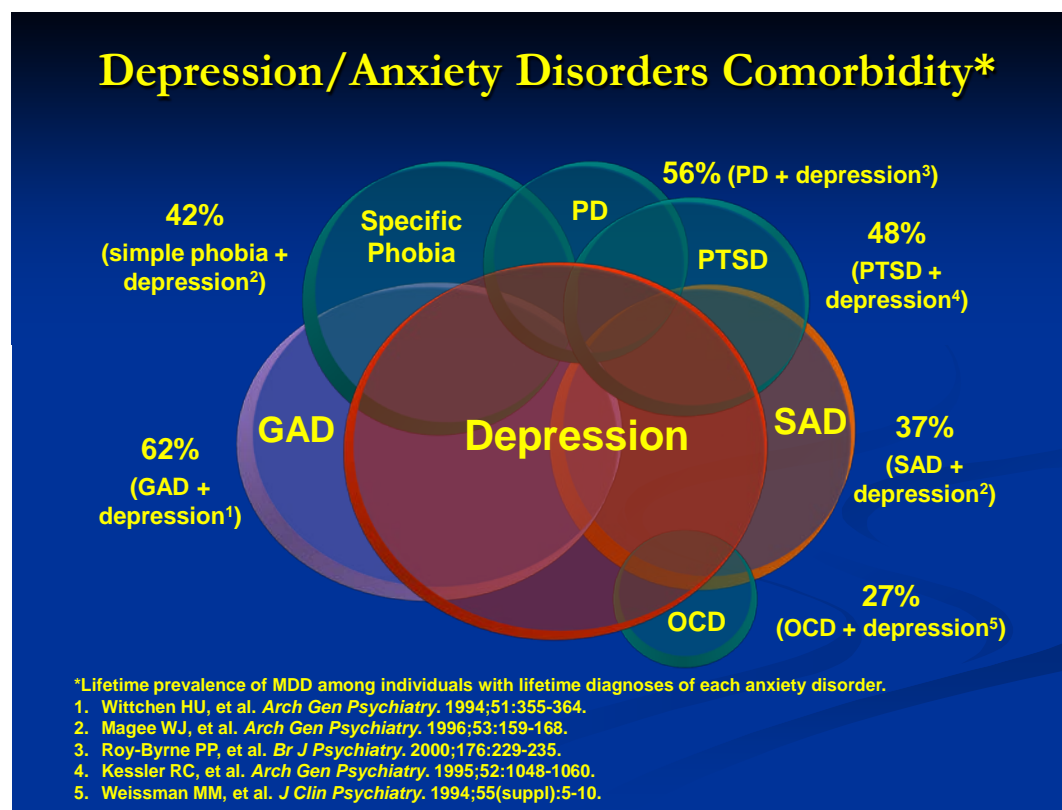
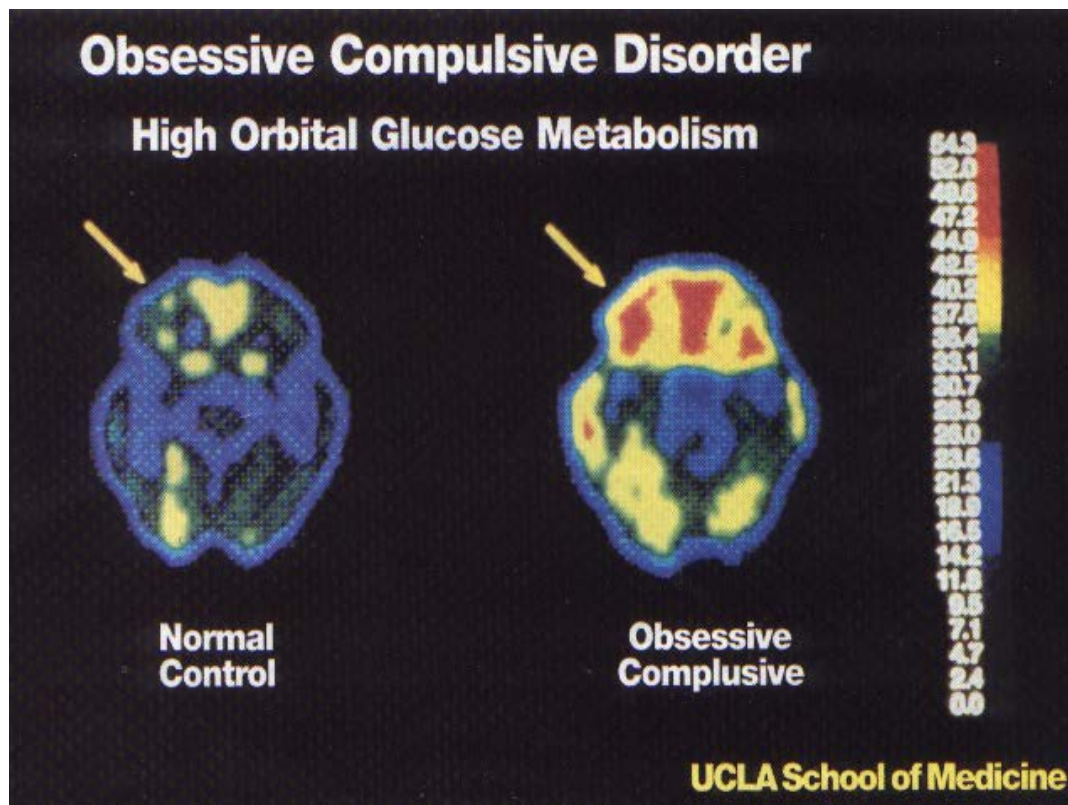


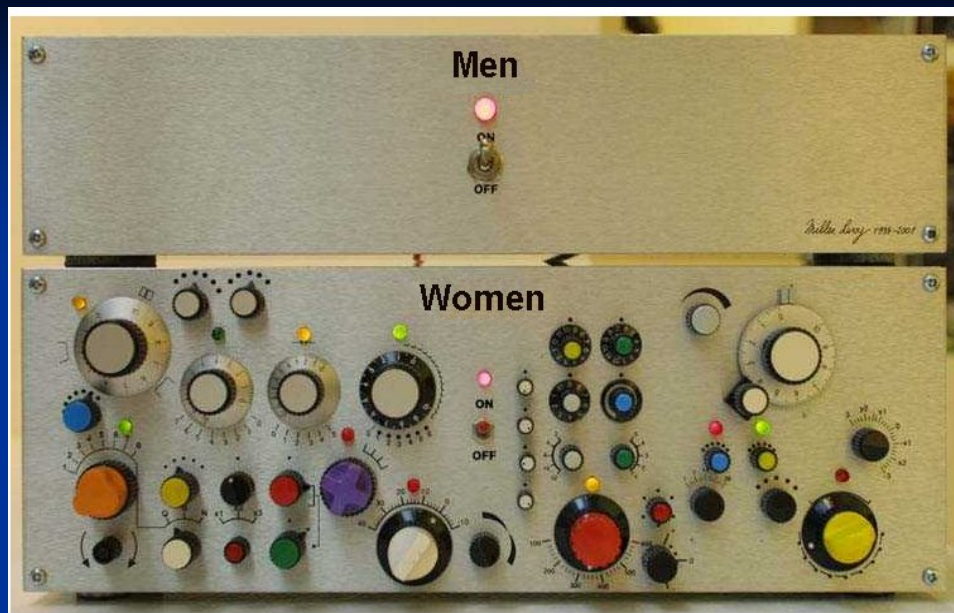
Frasure-Smith et al. *JAMA*. 1993;270:1819.

Normal resting pattern



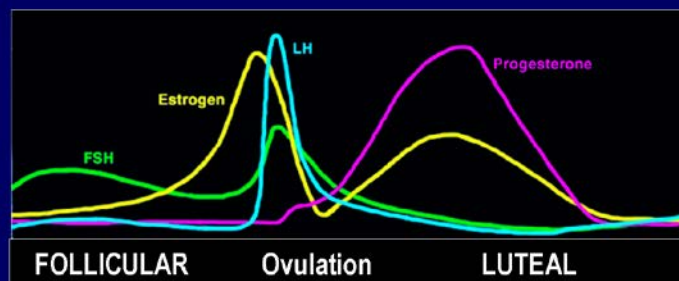






Proposed Etiology of PMDD^{1,2}

Hormones



- ✦ Symptoms are temporally associated with fluctuations in reproductive hormones
- ✦ Serum levels of reproductive hormones *do not predict* who will have PMDD

1. Britton K, et al. *Nature*. 1998;392:869-870.
 2. Mortola J. *Trends Endocrinol Metab*. 1996;7:184-189.

PMDD Is a Diagnosis of Exclusion^{1,2}

Metabolic/GYN Medical Disorders

- Anemia
- Autoimmune disorders
- Hypothyroidism
- Diabetes
- Seizure disorders
- Endometriosis
- Chronic fatigue
- Perimenopause

Neuro-Psychiatric Disorders

- Major depression
- Dysthymia
- Generalized anxiety
- Panic disorder
- Bipolar disorder
- Personality disorders

Premenstrual Exacerbation of

- Psychiatric disorders
- Seizure disorders
- Endocrine disorders
- Cancer
- Systemic lupus erythematosus
- Anemia
- Endometriosis

1. Plouffe L, et al. Premenstrual syndrome: Clinical update. In: *Primary Care in Obstetrics and Gynecology: A Handbook for Clinicians*. 1998. Chap 32, 461-70.
2. Plouffe L, et al. *Am J Obstet Gynecol*. 1993;169:295-307.

A Very Brief Historical Look at Mental Illness

Demonic possession

“The Alienist” by Caleb Carr *NY Times* bestseller
**Alienated not only from society, but
 from their own true natures**

U.S. Census

1840 “Idiocy/Insanity”

**1880 Mania, Melancholia, Monomania, Paresis,
 Dementia, Dipsomania, Epilepsy**

Psychosis Dementia praecox, Manic, Epileptic

A Very Brief Historical Look at Mental Illness (cont'd)

**1917 American Medico-Psychological Association and
National Commission on Mental Hygiene
Uniform census statistics in mental hospitals**

**Post-WW II U.S. Army/Veteran's Administration
Nomenclature**

**World Health Organization (WHO)
International Classification of Diseases (ICD) - 6th Ed.
included a Mental Disorders section for the first time**

A Very Brief Historical Look at Mental Illness (cont'd)

Diagnostic and Statistical Manual: Mental Disorders

DSM-I 1952

DSM-II 1960

DSM-III 1980

DSM-III-R 1987

DSM-IV 1994

DSM-IV

**No longer have to choose between
“Mental” and “Physical” Disorder**

Multi-axial Diagnosis System:

**Mental Illness/Substance Abuse/
Developmental Disabilities
Personality Disorders
Medical Problems
Psychosocial Stressors**

**“causes distress, impairs or interferes with
relationships and ability to function”**

“BioPsychoSocial”

Biological

Genetic

Toxic exposure

Medical

Psychological

Thought patterns

Behavior

Personality

Social

Abuse

Circumstances

Lack of resources

Overview of Mental Disorders in DSM-IV

Disorders of Infancy, Childhood, or Adolescence

**Mental Retardation, Pervasive Developmental Disorders,
Attention-Deficit and Disruptive Behavior Disorders**

Delirium, Dementia, and Cognitive Disorders

Medical emergencies, Alzheimer's, Amnesia

Mental Disorders due to a General Medical Condition

“Organic”; Hypothyroidism, Infection, Anemia, Cancer

Substance-Related Disorders

Abuse vs. Dependence, Intoxication, Withdrawal, Persisting

Schizophrenia and other Psychotic Disorders

Schizophrenia subtypes, Delusional Disorder, Psychosis NOS

Overview of Mental Disorders in DSM-IV (cont'd)

Mood Disorders

Major Depression, Bipolar Disorder

Anxiety Disorders

**Panic Disorder, Obsessive-Compulsive Disorder, PTSD,
Phobias, Generalized Anxiety Disorder**

Somatoform Disorders

Conversion Disorder, Hypochondriasis, Pain Disorder

Factitious Disorders

Munchausen's vs. Malingering

Overview of Mental Disorders in DSM-IV (cont'd)

Dissociative Disorders

“Multiple Personality Disorder”, Fugue, Amnesia

Sexual and Gender Identity Disorders

Dysfunction, Paraphilias, Transvestite vs. “Transsexual”

Eating Disorders

Anorexia, Bulimia

Sleep Disorders

Dyssomnia, Narcolepsy, Parasomnia (Terrors, Sleepwalking)

Impulse-Control Disorders

Kleptomania, Pyromania, IED, Pathological Gambling

Overview of Mental Disorders in DSM-IV (cont'd)

Adjustment Disorders

Personality Disorders

Cluster A: “Odd-Eccentric”

Paranoid, Schizoid, Schizotypal

Cluster B: “Dramatic-Emotional”

Antisocial, Borderline, Histrionic, Narcissistic

Cluster C: “Anxious-Fearful”

Avoidant, Dependent, Obsessive-Compulsive

Mental Status Examination

- I. Approaching a person with mental illness**
- II. Appearance and behavior**
- III. Speech and thought pattern**
- IV. Mood vs. Affect**
- V. Thought content**
- VI. Attention, concentration, knowledge-base**
- VII. Insight, judgment**

DSM-IV-TR Criteria for Major Depressive Episode (MDE)

≥ 5 Symptoms in the same 2-week period

Sleep: Insomnia or hypersomnia

Interest: Depressed mood,* loss of interest or pleasure*

Guilt: Feelings of worthlessness

Energy: Fatigue

Concentration: Diminished ability to think or make decisions

Appetite: Weight change

Psychomotor: Psychomotor retardation or agitation

Suicide: Preoccupation with death

* Must include 1 of these

DSM-IV-TR. Washington, DC: American Psychiatric Association. 2000.

Impact of Untreated Depression

■ Morbidity

- Comorbid medical illness
- Suicide attempts
- Accidents

■ Mortality

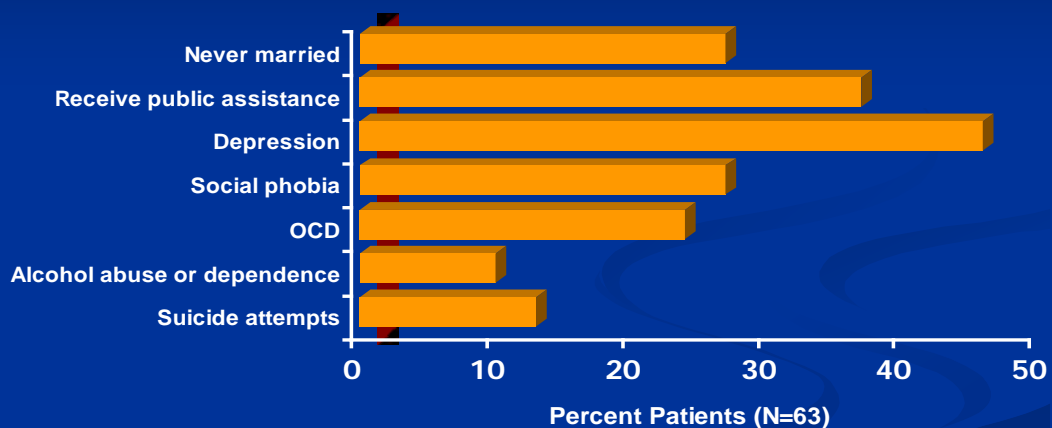
- 35,000 suicides per year
- Fatal accidents
- Death due to related illness (substance abuse)

■ Societal and Functional Burdens

- Dysfunctional families
- Divorce
- Substance abuse
- Absenteeism
- Decreased productivity
- Job-related injuries
- Lost jobs
- Failure to advance in career or school

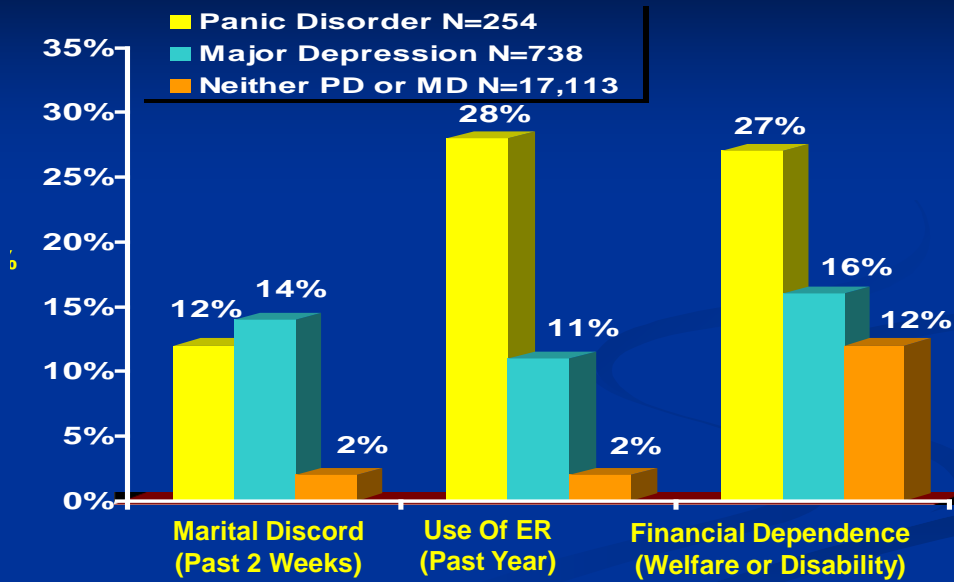
Preskorn, 1999

Quality Of Life And Psychiatric Morbidity In Generalized Anxiety Disorder



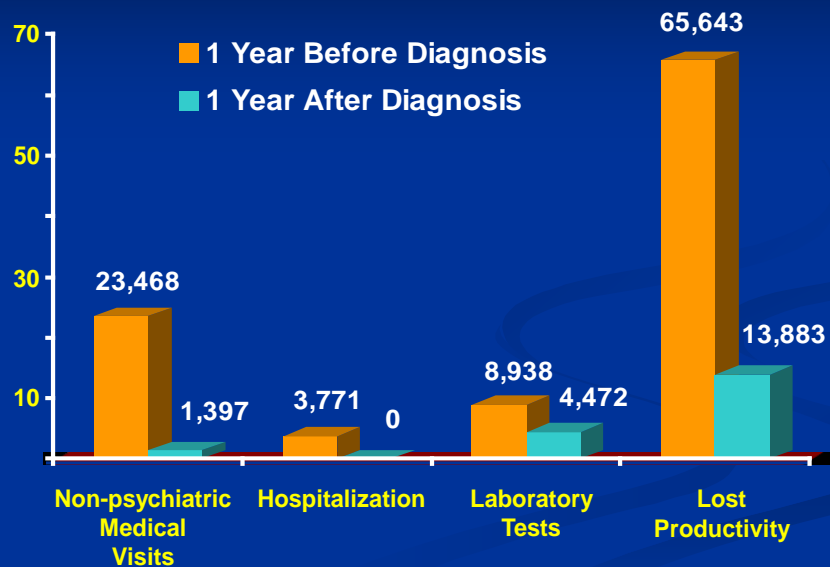
Massion et al. *Am J Psychiatry*. 1993;150:600.

Quality Of Life In Panic Disorder



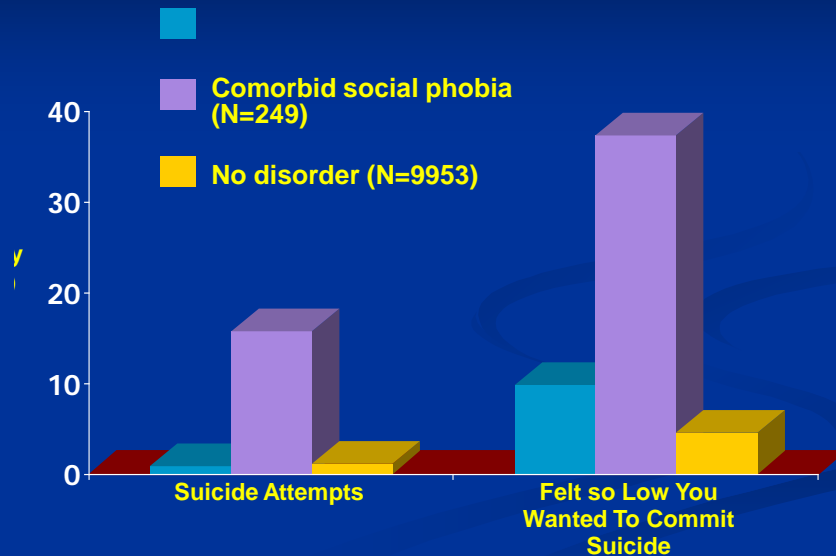
Markowitz et al. *Arch Gen Psychiatry*. 1989;46:984.

Diagnosis And Treatment Lower Costs Of Panic Disorder



alvador-Carulla et al. *Br J Psychiatry*. 1995;166(suppl 27):23

Suicidality In Social Phobia



neier et al. *Arch Gen Psychiatry*. 1992;49:282

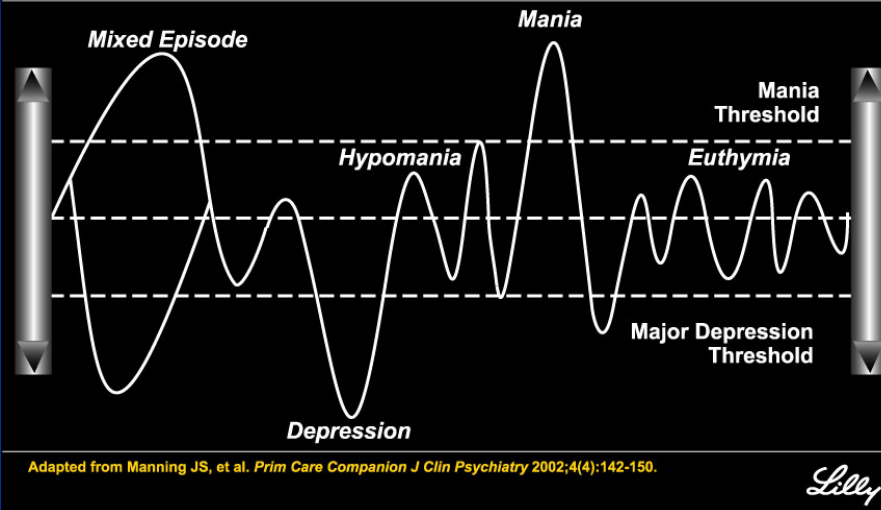
Target Symptoms of PTSD

Trauma

- Re-experiencing
- Avoidance/Numbing
- Hyperarousal

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. 1994.

Presentation Fluctuates



Epidemiology of Bipolar Disorder

- Epidemiological Catchment Study¹
lifetime prevalence: 1.2%
(3.3 million people in US)
- National Comorbidity Study²
lifetime prevalence: 1.6%
(4 million people in US)
- Equal sex distribution¹

¹Goodwin FK, Jamison KR, 1990

²Kessler RC et al, 1994

Symptom Domains in Mania and Mixed Mania

Manic Mood and Behavior

- Euphoria
- Grandiosity
- Pressured Speech
- Impulsivity
- Excessive Libido
- Recklessness
- Diminished Need for Sleep

Dysphoric or Negative Mood and Behavior

- Depression
- Anxiety
- Irritability
- Hostility
- Violence or Suicide

Cognitive Symptoms

- Racing Thoughts
- Distractability
- Poor Insight
- Disorganization
- Inattentiveness
- Confusion

Psychotic Symptoms

- Delusions
- Hallucinations
- Sensory Hyperactivity

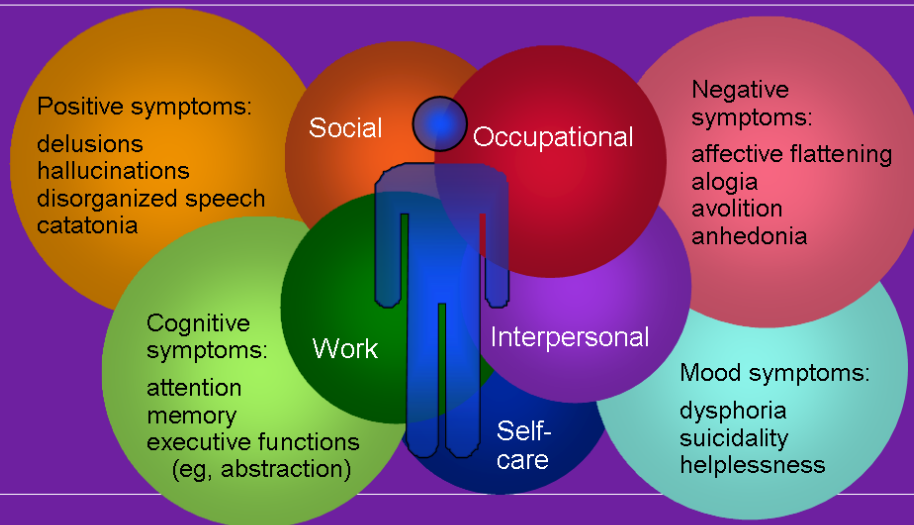
Mania



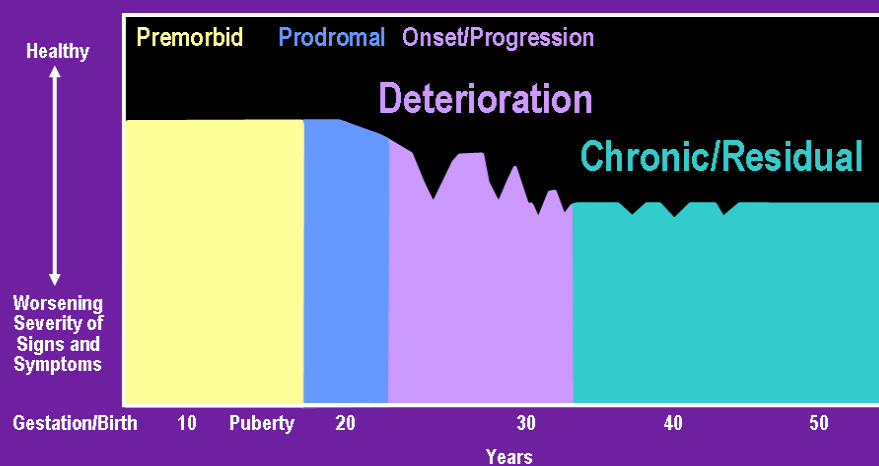
Schizophrenia: Socioeconomic Impact

- 1% of American population affected
- 25% of all hospital-bed days
- 40% of all long-term-care days
- 20% of all Social Security benefit days
- Total cost: \$33 billion/year

Impact of Symptoms of Schizophrenia on Overall Functioning



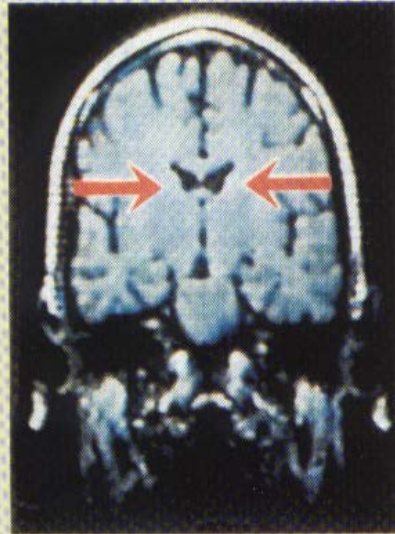
Schizophrenia: Stages of Illness



Adapted from: Lieberman JA, et al. *Biol Psychiatry*. 2001;50(11):884-897.

SCHIZOPHRENIA IN MONOZYGOTIC TWINS

Pair no. 2: 44 year old males

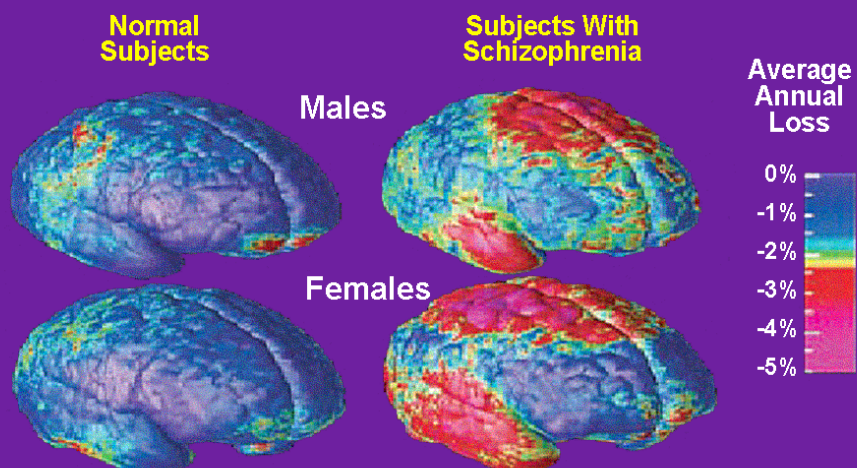


UNAFFECTED



AFFECTED

Gray Matter Loss in Schizophrenia and Control Subjects



Adapted from: Thompson PM, et al. *Proc Natl Acad Sci USA*. 2001;98(20):11650-11655.

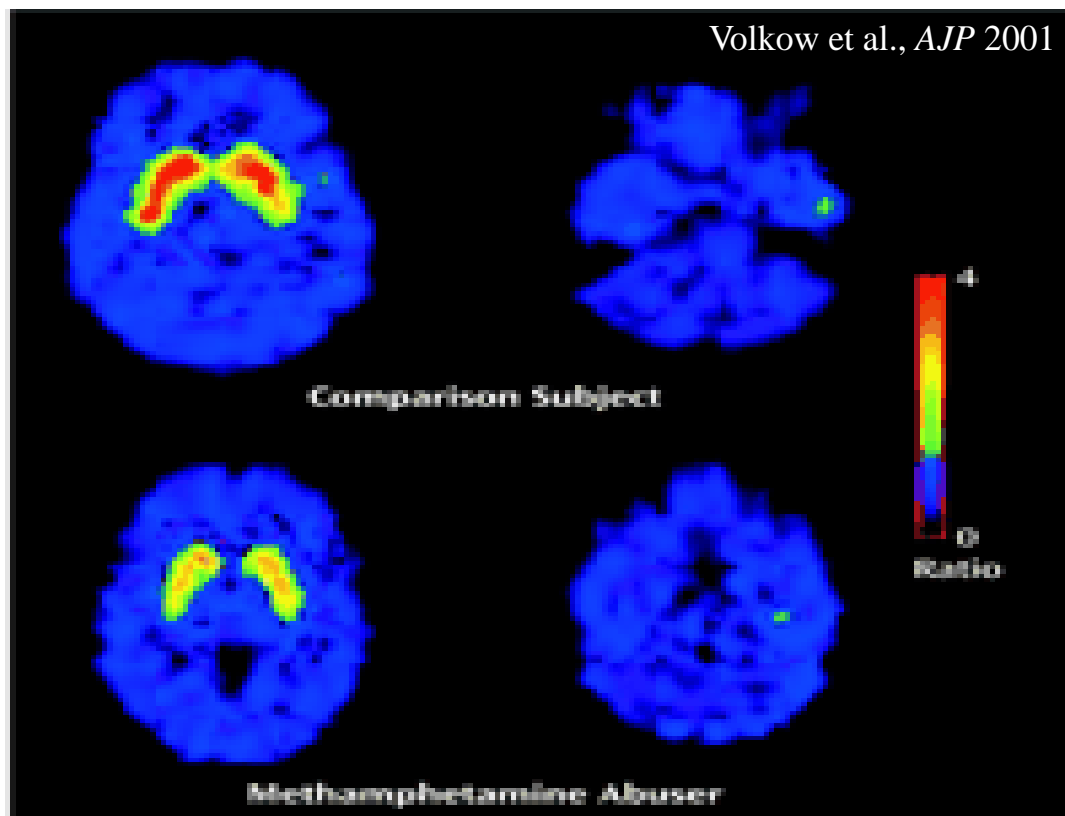
Schizophrenia and Hostile/Aggressive Behavior (IC-SOHO*)

N=3135, 6 month study

Presence of Substance Abuse doubles
the risk of Hostile/Aggressive behavior

Risperidone > Olanzapine > Quetiapine
> Clozapine > Haloperidol
in reducing incidence of hostile/aggressive behavior

*Intercontinental Schizophrenia Outpatient Health Outcomes
Bitter et al., *European Psychiatry* 2005



Violently Agitated Patients and Chemical Restraint

N = 202

146 (72%) Methamphetamine toxicity

28 (14%) Cocaine toxicity

20 (10%) Psychiatric illness

8 (4%) EtOH Withdrawal

98 (49%) EtOH intoxication

**Droperidol (i.v.) “more rapid and better sedation” than
Lorazepam (i.v.); more repeat dosing with lorazepam**

Richards JR et al., *J Emergency Medicine* 1998

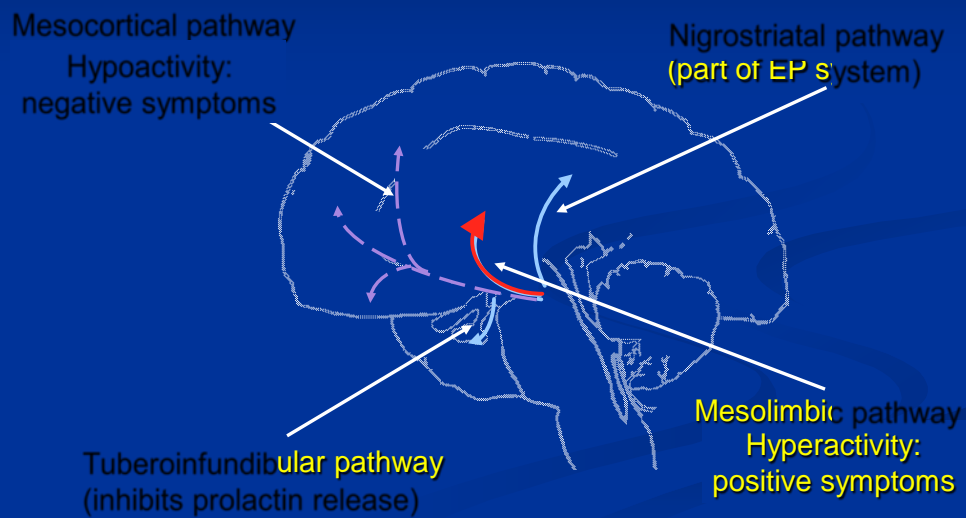
PSYCHOPHARMACOLOGY

DEFINITION

Psychopharmacology is the study of the mediation and modulation of behavior through the actions of endogenous signaling substances and drugs.

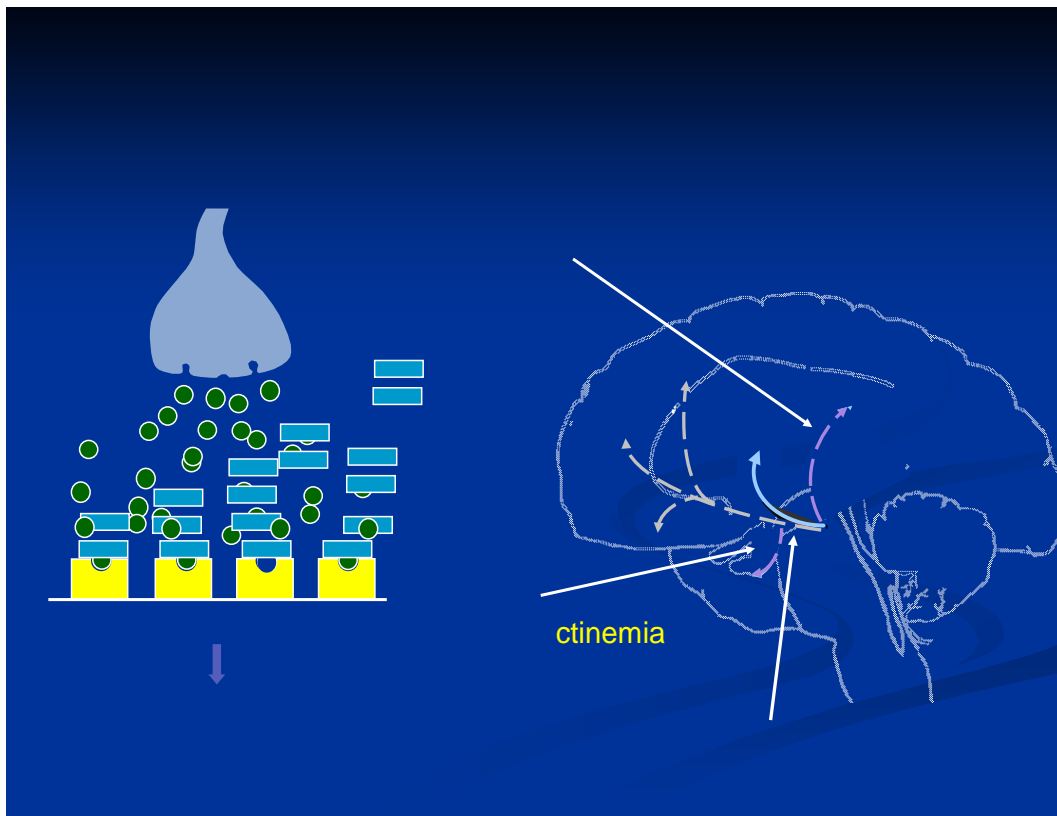
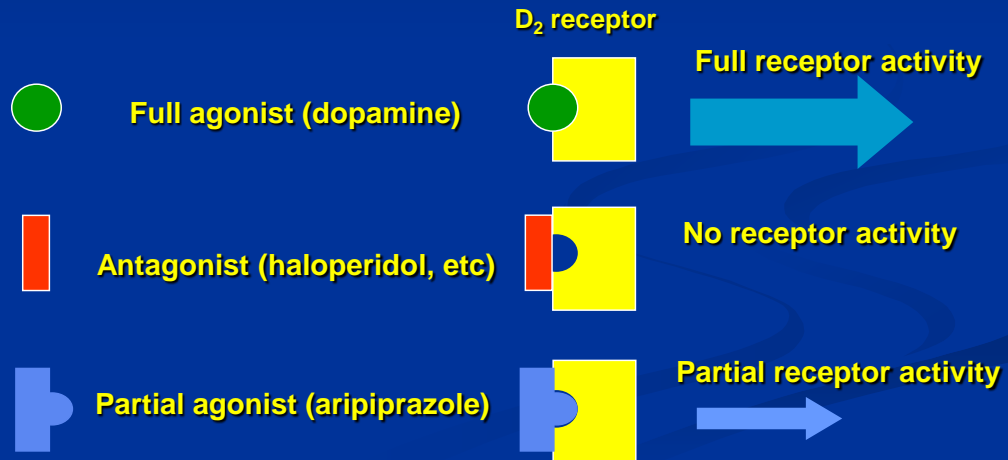
American Psychiatric Press Textbook of Psychopharmacology
Roland Ciranello, M.D. Schatzberg, Nemeroff Eds. 1995

Dopamine Hypothesis of Schizophrenia

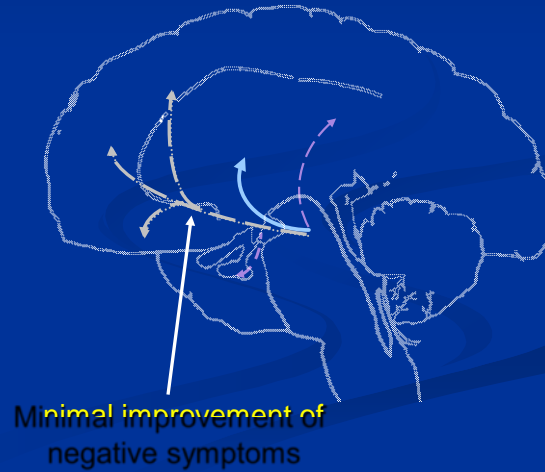
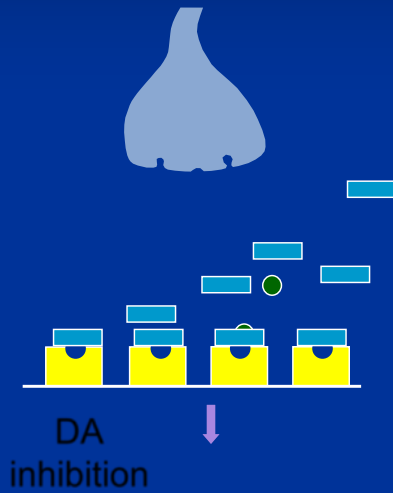


Intrinsic Activity at D₂ Receptors

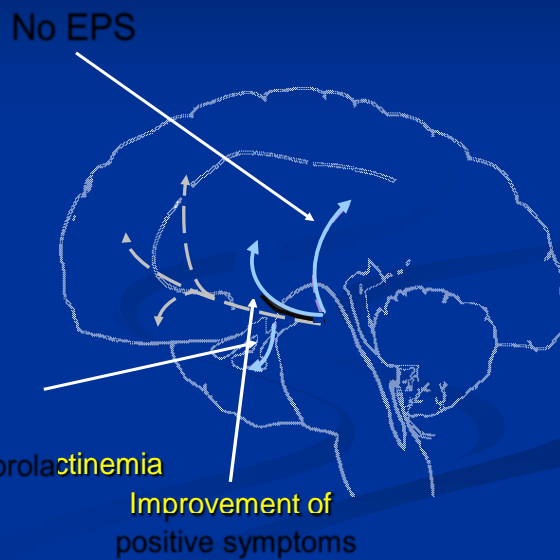
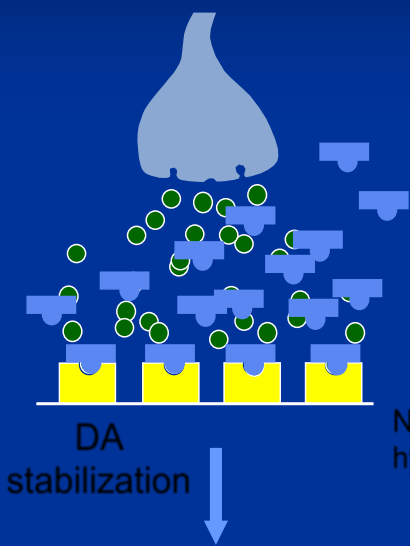
Intrinsic Activity Describes the Ability of a Compound to Stimulate Receptors



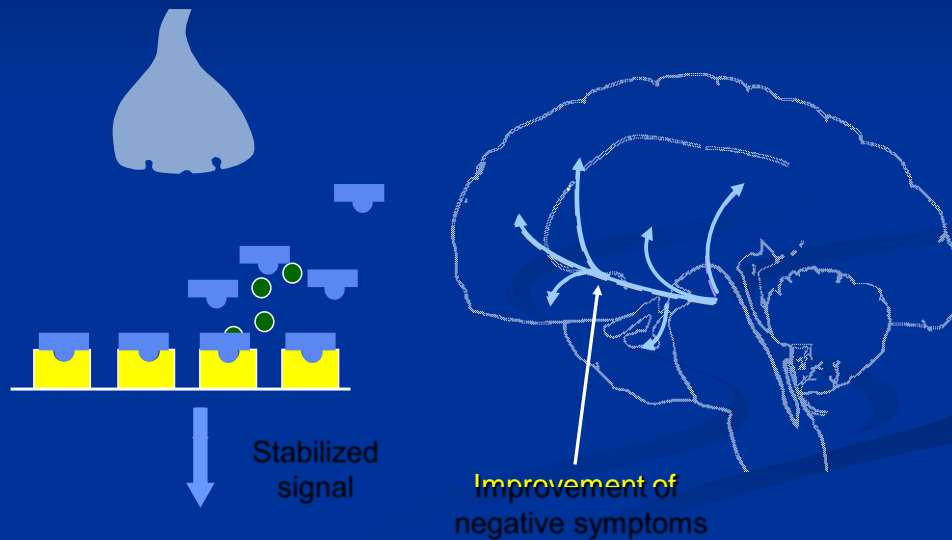
Dopamine Antagonism: Negative Symptoms



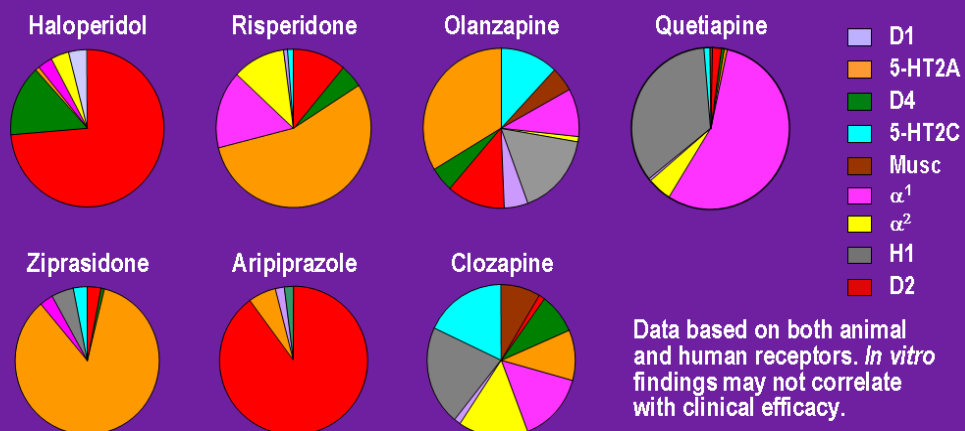
Dopamine Partial Agonism: Positive Symptoms and EPS



Dopamine Partial Agonism: Negative Symptoms



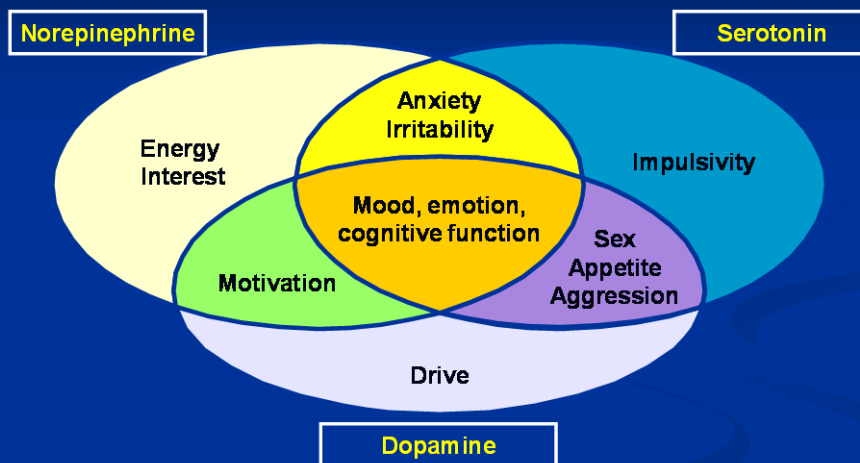
Relative Receptor Binding Profiles: ZYPREXA Among Other Antipsychotic Drugs



For additional safety profile, see Important Safety Information slides and the full Prescribing Information.
 For safety profiles of other products, see respective manufacturers' package inserts.
 Bymaster FP, et al. *Neuropsychopharmacology* 1996;14(2):87-96.
 Schotte A, et al. *Psychopharmacology (Berl)* 1996;124(1-2):57-73.

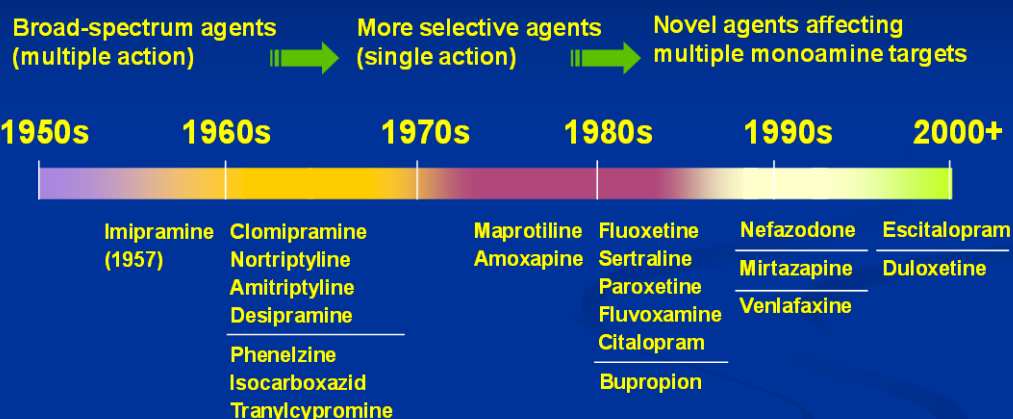
zyprexa
Olanzapine

Several Neurotransmitters Are Involved in Regulating Mood

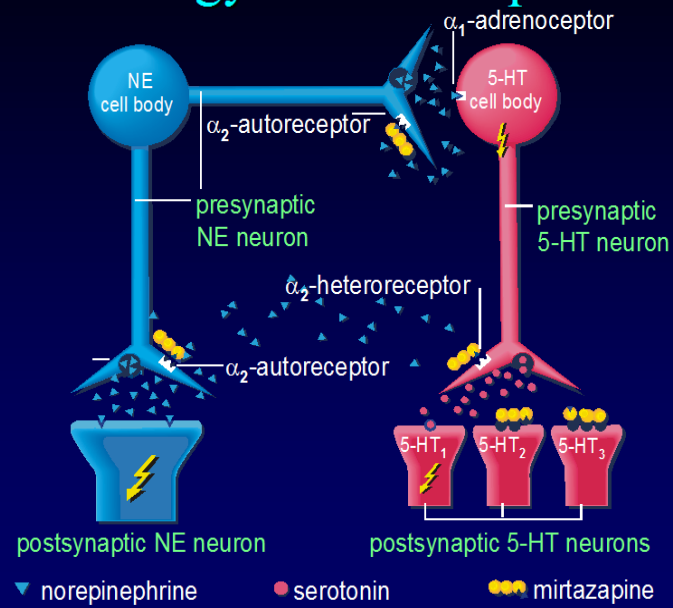


Stahl SM. *Essential Psychopharmacology: Neuroscientific Basis and Practical Applications*. 2nd ed. Cambridge, UK: Cambridge University Press; 2000:152.

The Evolution of Antidepressants: Trends in Development

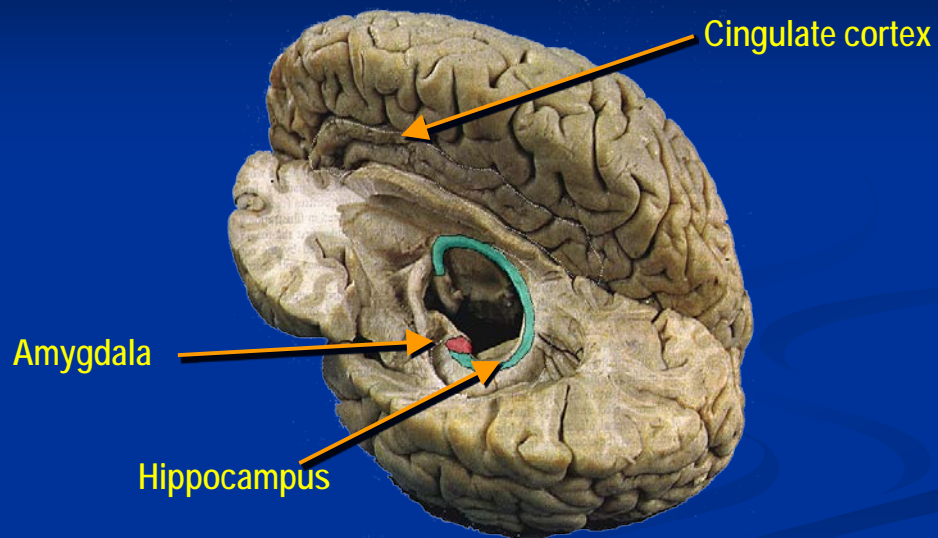


Pharmacology of Mirtazapine

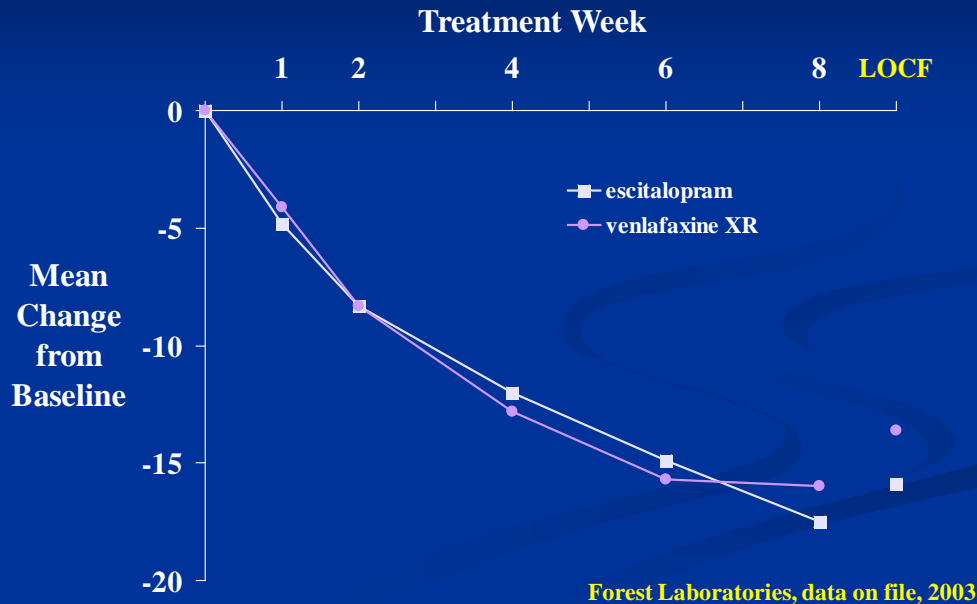


de Boer, *J Clin Psychiatry*, 1996

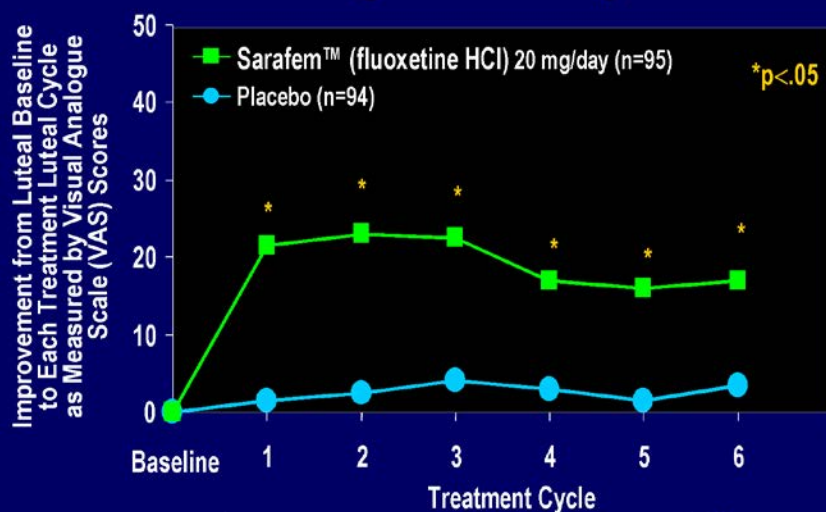
Potential Neuroanatomic Targets for Antidepressant Treatments



Fixed Dose Comparison of Escitalopram and Venlafaxine XR MADRS



Efficacy for Overall Mood Symptoms Sustained Throughout 6 Cycles in PMDD



Intent to treat analysis; last observation carried forward

1. Steiner M, et al. *N Engl J Med.* 1995;332(23):1529-1534.
2. Data on file, Lilly Research Laboratories.

The New England Journal of Medicine

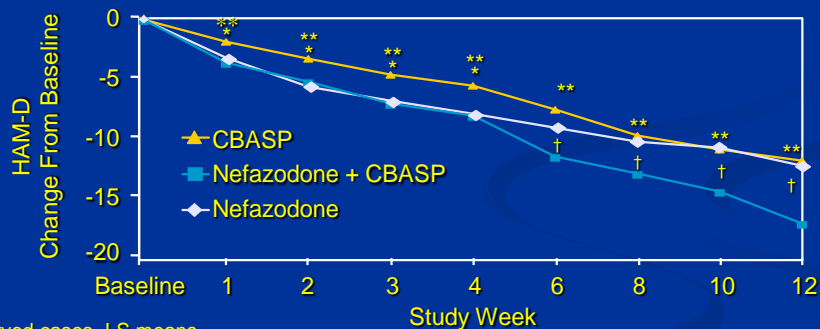
May 18, 2000

■ A Comparison of Nefazodone, Cognitive Behavioral Analysis System of Psychotherapy and Their Combination for the Treatment of Chronic Depression

This is the only antidepressant study published by the NEJM in over 10 years

Serzone® (nefazodone HCl) Chronic Depression Study

Acute-Phase Outcome Change From Baseline in HAM-D Scores



Observed cases, LS means

*P < 0.05 Nefazodone compared with CBASP

**P < 0.01 Nefazodone + CBASP compared with CBASP

† P < 0.01 Nefazodone + CBASP compared with Nefazodone

No statistical difference between Nefazodone compared with Nefazodone + CBASP through week 4.

Keller et al, NEJM 2000

Lexapro (escitalopram), Wellbutrin (bupropion), Effexor (venlafaxine), Serzone (nefazodone), and Remeron (mirtazapine). The FDA has not concluded that these drugs cause worsening depression or suicidality, but it wants health care providers to be aware that worsening of symptoms could be due either to the underlying disease or to drug therapy. The FDA's actions follow recommendations made by two advisory committees in February.

"The message is to watch for these behaviors when patients start on a drug," said Russell Katz, MD, Director of the FDA's Division of Neuropharmacological Drug Products, in an interview with *Neuropsychiatry Reviews*. "We

continued on page 16



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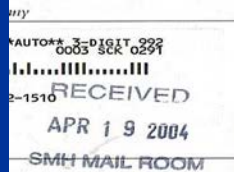
Brain Responds Differently to Drug, Cognitive Therapy for Depression

The hypothesis that antidepressants work by a "bottom-up" effect on the brain while cognitive therapies have a "top-down" effect has received support from imaging studies by researchers at the University of Toronto.

Senior author Helen Mayberg, MD, a Professor of Psychi-

atry and Neurology at Emory University in Atlanta, told *Neuropsychiatry Reviews* that response to cognitive behavior therapy is associated with a characteristic pattern of metabolic changes in the frontal cortex, cingulate, and hippocampus. These effects differ from changes in the prefrontal cortex, hippocampus, and subgenual cingulate seen with response to paroxetine, she observed.

continued on page 21



Photographic History
of Neuropsychiatry
Page 7

ORIGINAL ARTICLE

Outpatient Treatment of Child and Adolescent Depression in the United States

Mark Olfson, MD, MPH; Marc J. Gameroff, PhD; Steven C. Marcus, PhD; Bruce D. Waslick, MD

Background: Although psychotherapy has traditionally been the dominant form of treatment for children and adolescents with depression, there has been a recent increase in the prescription of antidepressants for this age group.

Objective: To describe patterns of outpatient treatment for children and adolescents with depression.

Design and Setting: Analysis of health service-use data from 4 consecutive years (1996-1999) of the Medical Expenditure Panel Survey, a nationally representative annual survey of the general population that is sponsored by the Agency for Healthcare Quality and Research, Rockville, Md.

Subjects: Patients aged 6 to 18 years who made 1 or more outpatient visits for the treatment of depression.

Main Outcome Measures: Rate of treatment, mental health problems, psychotropic medication use, psychotherapy use, number of outpatient treatment visits, and type of provider.

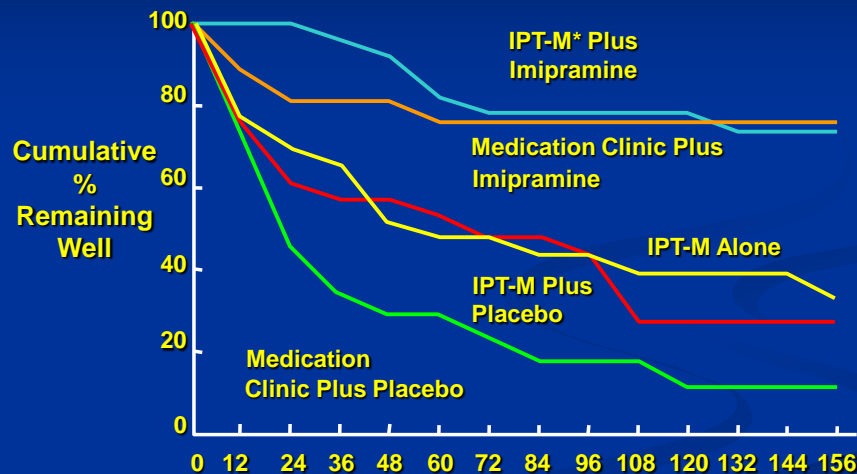
Results: Across the 4 survey years, the mean annual rate

of outpatient treatment for depression was 0.93 per 100 individuals. The rate of treatment was especially low for African American individuals (0.23 per 100) and uninsured individuals (0.43 per 100). Approximately three quarters (79%) of treated children and adolescents received psychotherapy and more than half (56.9%) were prescribed antidepressant medications. The mean number of treatment visits for depression was 7.8 per year. As compared with children and adolescents with depression who were treated without antidepressants, those who received antidepressants were significantly more likely to have evidence of anhedonia, to live in large urban communities, to have parents who graduated from high school, and to have health insurance.

Conclusions: The rate and pattern of treatment suggest that serious gaps exist in access to community outpatient treatment for children and adolescents with depression. At the same time, antidepressant medications are used far more commonly than would be expected on the basis of published treatment recommendations.

Arch Gen Psychiatry. 2003;60:1236-1242

3-Year Outcomes For Maintenance Therapies In Recurrent Depression



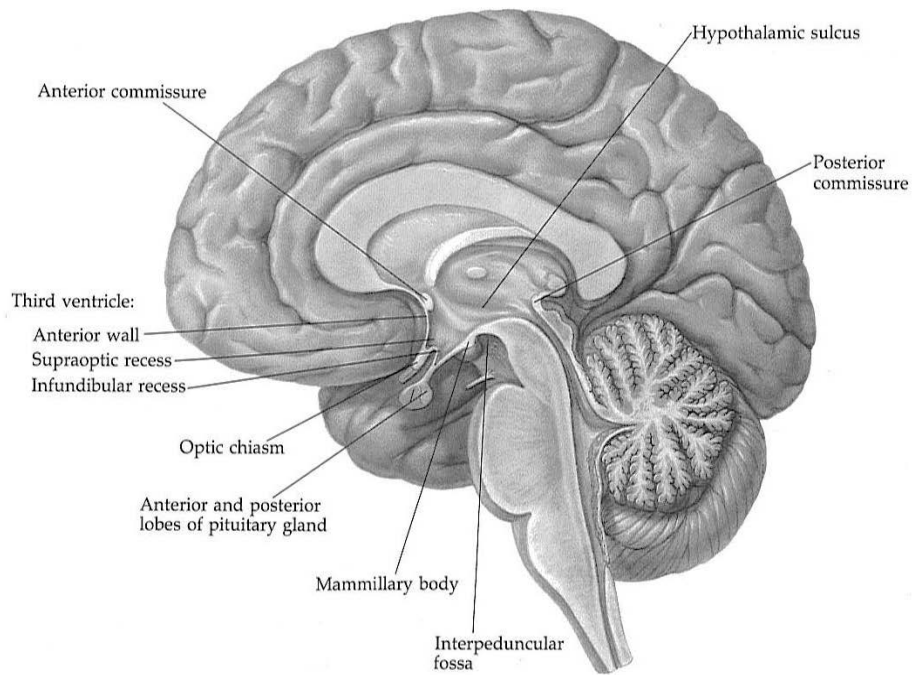
IPT-M = interpersonal psychotherapy - maintenance form.
Frank et al. *Arch Gen Psychiatry*. 1990;47:1093.

Drug-Induced Sexual Dysfunction

- SSRIs unbalance the 5-HT to DA ratio
- Serotonin effect causes various problems:
 - In men: low libido, delayed ejaculation, anorgasmia
 - In women: low libido, anorgasmia
- This is more of a problem in long-term treatment
- Patients in short-term treatment tolerate the effect. Should they have to?



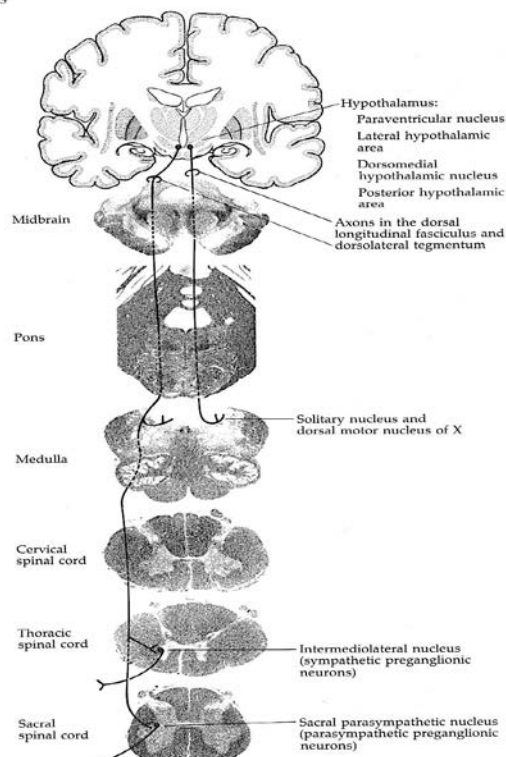
Hirschfeld, *J Clin Psychiatry*, 1999



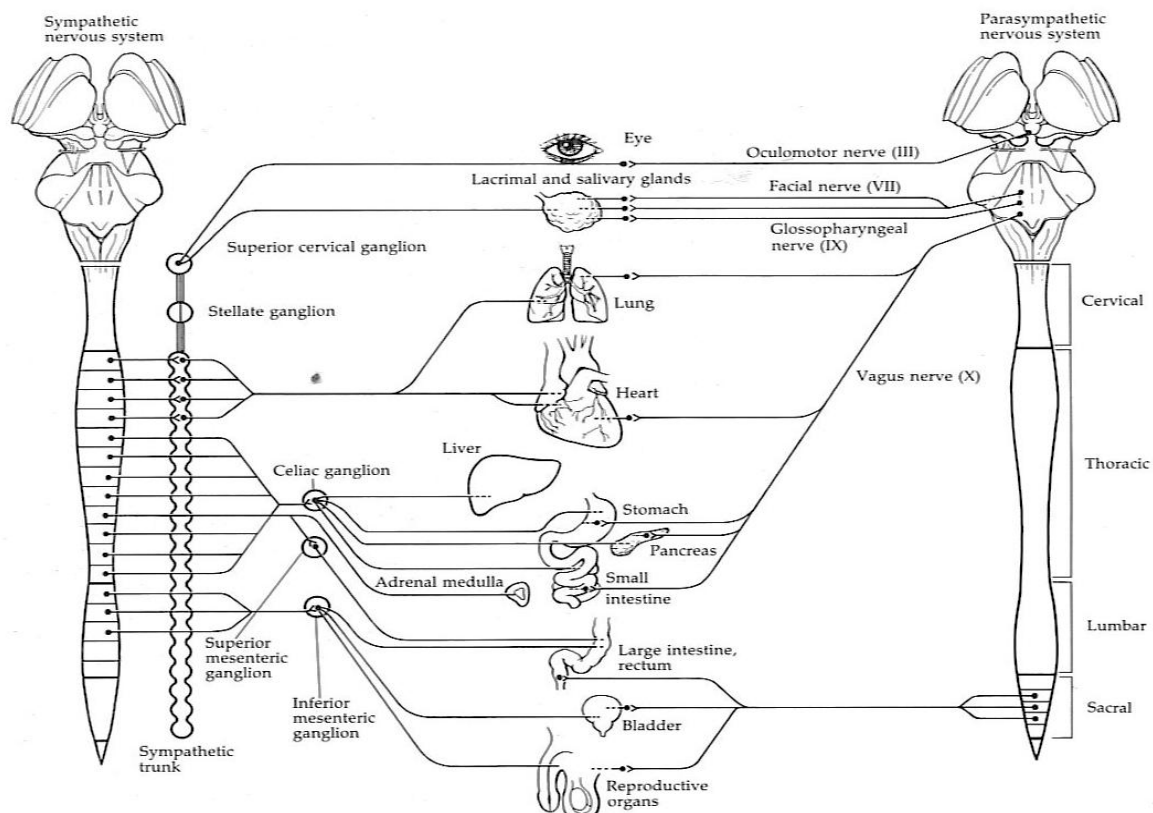
Martin J.H. Neuroanatomy Text & Atlas. Elsevier Publishers 1989

NEUROANATOMY: TEXT AND ATLAS

Figure 14.8 Regions of origin, course, and termination sites of descending hypothalamic pathways.



Martin J.H. Neuroanatomy Text & Atlas. Elsevier Publishers 1989



Martin J.H. Neuroanatomy Text & Atlas. Elsevier Publishers 1989

“Serotonin Syndrome”

Excessive serotonin receptor stimulation

Flushing, sweating, diarrhea

Autonomic instability (changes in blood pressure, pulse, temperature)

Mental status changes

Life-threatening

Discontinuation Symptoms May Be Associated With Discontinuation of SSRIs

Common discontinuation symptoms include:

- Dizziness
- Lethargy
- Vivid dreams
- Paresthesia
- Irritability
- Nausea
- Lowered mood

Sertraline has a low potential for discontinuation symptoms.

Pharmacologic features may explain the relative difference in the emergence of discontinuation symptoms.

Coupland 1996; Price 1996.

NeuroPsychiatry

R E V I E W S

Neuropsychiatric Trends and News for Psychiatrists

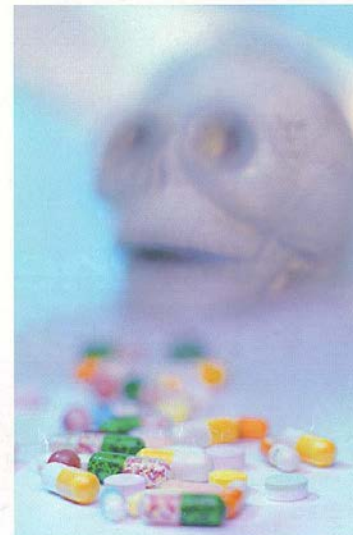
FDA Requests Warning Statement About Risks for Antidepressants

The FDA has urged clinicians, family members, and caregivers to carefully monitor patients who are taking certain antidepressant drugs for signs of worsening depression or the emergence of suicidality, particularly at the beginning of therapy or when the dose is changed. This recommendation coincides with the agency's request for manufacturers of 10 antidepressants to include a warning statement in their labeling that recommends close observation of both adult and pediatric patients for these behaviors.

The drugs included in the warning are Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), Luvox (fluvoxamine), Celexa (citalopram),

Lexapro (escitalopram), Wellbutrin (bupropion), Effexor (venlafaxine), Serzone (nefazodone), and Remeron (mirtazapine). The FDA has not concluded that these drugs cause worsening depression or suicidality, but it wants health care providers to be aware that worsening of symptoms could be due either to the underlying disease or to drug therapy. The FDA's actions follow recommendations made by two advisory committees in February.

"The message is to watch for these behaviors when patients start on a drug," said Russell Katz, MD, Director of the FDA's Division of Neuropharmacological Drug Products, in an interview with *Neuropsychiatry Reviews*. "We



U.S. Food and Drug Administration

Psychopharmacologic Drugs Advisory Committee

Pediatric Subcommittee of the Anti-Infective Drugs Advisory Committee

9 Antidepressants, 24 trials, 4,400 patients
(6 published trials, ~1,100 patients)

4% vs. 2% “treatment-emergent suicidality”
NO SUICIDES

15-to-8 vote for black-box warning

ORIGINAL ARTICLE

Relationship Between Antidepressant Medication Treatment and Suicide in Adolescents

Mark Olfson, MD, MPH; David Shaffer, MD; Steven C. Marcus, PhD; Ted Greenberg, MPH

Context: A decade of increasing antidepressant medication treatment for adolescents and corresponding declines in suicide rates raise the possibility that antidepressants have helped prevent youth suicide.

Objective: To evaluate the relationship between regional changes in antidepressant medication treatment and suicide in adolescents from 1990 to 2000.

Design: Analysis of prescription data from the nation's largest pharmacy benefit management organization, national suicide mortality files, regional sociodemographic data from the 1990 and 2000 US Census, and regional data on physicians per capita.

Participants: Youth aged 10 to 19 years who filled a prescription for antidepressant medication and same-aged completed suicides from 588 three-digit ZIP code regions in the United States.

Main Outcome Measures: The relationship between regional change in antidepressant medication treatment and suicide rate stratified by sex, age

group, regional median income, and regional racial composition.

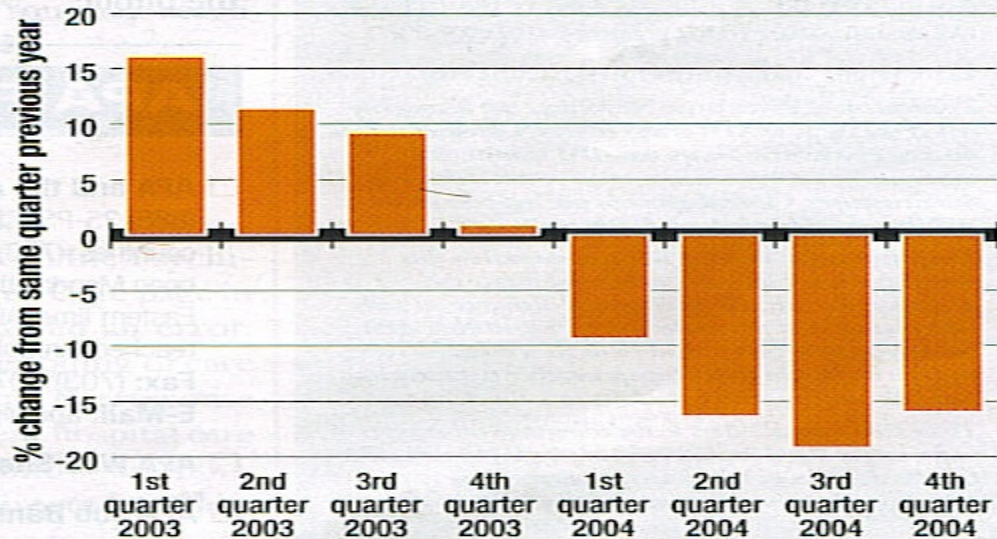
Results: There was a significant adjusted negative relationship between regional change in antidepressant medication treatment and suicide during the study period. A 1% increase in adolescent use of antidepressants was associated with a decrease of 0.23 suicide per 100,000 adolescents per year ($\beta = -.023$, $t = -5.14$, $P < .001$). In stratified adjusted analyses, significant inverse relationships were present among males ($\beta = -.032$, $t = -3.81$, $P < .001$), youth aged 15 to 19 years ($\beta = -.029$, $t = -3.43$, $P < .001$), and regions with lower family median incomes ($\beta = -.023$, $t = -3.73$, $P < .001$).

Conclusions: An inverse relationship between regional change in use of antidepressants and suicide raises the possibility of a role for using antidepressant treatment in youth suicide prevention efforts, especially for males, older adolescents, and adolescents who reside in lower-income regions.

Arch Gen Psychiatry. 2003;60:978-982

Youngsters Getting Fewer Antidepressants

The number of antidepressant prescriptions for children and adolescents covered by Medco has been declining since the start of the controversy over SSRIs and youth suicide—in May 2003, when the U.K. effectively banned the prescription of paroxetine to youngsters.



Source: Medco Health Solutions Inc., 2005

“Antidepressant Treatment and Risk of Suicide Attempt by Adolescents with Major Depressive Disorder: A Propensity-Adjusted Retrospective Cohort Study”

RJ Valuck et al., CNS Drugs 18(15):1119-1132, 2004

Age 12-18; 1997-2003

Paid Insurance Claims for healthcare and prescriptions

24,119 Adolescents (63% Female) diagnosed with MDD

Valuck et al. (continued)

17,313 (72%) had no antidepressant Rx in first 6 months after Dx

Suicide attempt rate 0-2.3% (mainly ER reports)

Tx with SSRIs, “Other”, or “Multiple” antidepressants

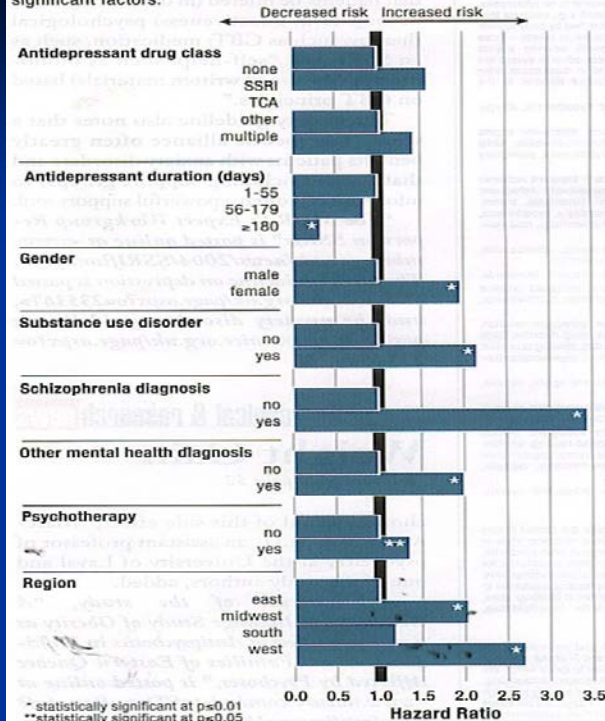
No statistically increased risk of suicide attempts (not “suicidality”)

Tx for 180 days reduced the likelihood of suicide attempt

Compared to Tx for < 55 days (8 weeks)

Multiple Factors in Play

Risk of suicide attempt was influenced by numerous statistically significant factors.



**“Effectiveness of a Quality Improvement Intervention
for Adolescent Depression in Primary Care Clinics”**

JR Asarnow, et al. (Kenneth Wells, UCLA)

JAMA 293(3):311-319, 2005

5 health care organizations (managed care, public, academic)

N=418 patients, Age 13-21

(n=207 “usual care”; n=211 in 6 month QI group)

MDD +: 28% Conduct problems
22% PTSD
25% Substance Abuse
27% Suicidal Ideation
14% Self-harm or Suicide Attempts

Asarnow et al. (continued)

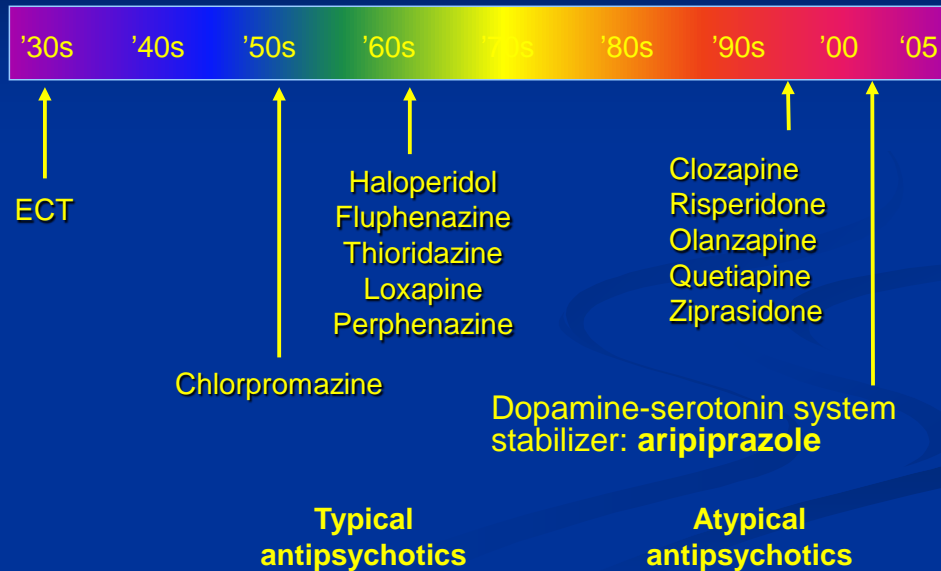
**“Care Manager” = Master’s or PhD in Mental Health or Nursing
Cognitive-Behavioral Psychotherapy, Antidepressant, or
Combination**

(SSRIs first-line)

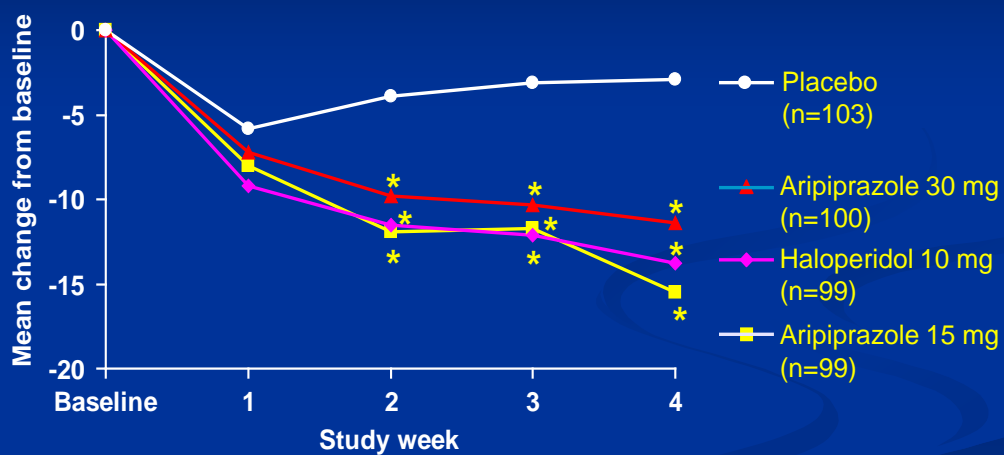
**Intervention: Improved Depression
Improved “Quality of Life”
Improved Satisfaction with Mental
Health Care
Decrease in Self-Harm Behavior and
Ideation**

Adolescents Preferred Psychotherapy over Antidepressants

Developments in Medical Treatments for Psychotic Disorders



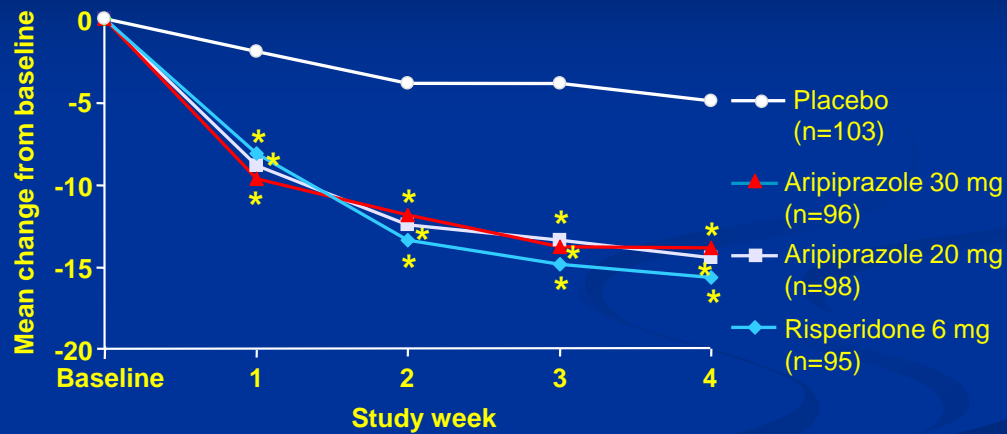
Aripiprazole and Haloperidol: Change in PANSS Total Score



*Significantly different from placebo, LOCF, $P < 0.05$.
Baseline mean scores ranged from 98.8-100.9.

Kane et al. *J Clin Psych*. 2002; 63(9):763-771.

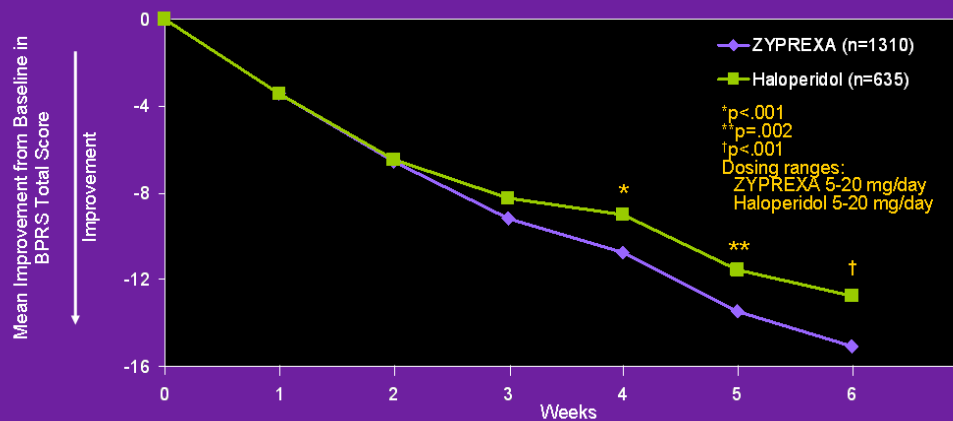
Aripiprazole and Risperidone: Change in PANSS Total Score



*Significantly different from placebo, LOCF, $P < 0.05$.
Baseline mean scores ranged from 91.6-94.1.

Saha et al. *W J Biol Psychiat.* 2001;2(suppl 1):305S.

ZYPREXA Rapidly Controlled Psychotic Symptoms in Schizophrenia

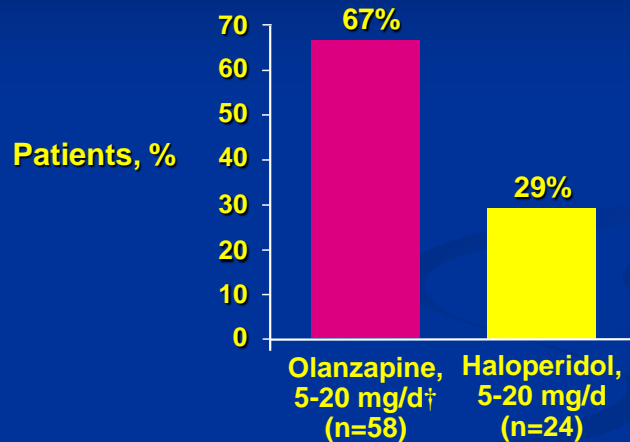


At week 1, both treatment groups showed significant improvement from baseline ($p < .001$). Treatment differences between groups were statistically significant at weeks 4, 5, and 6. These results were calculated on the basis of a visitwise OC analysis of mean improvement from baseline in BPRS Total Score. The data do not imply specific onset of action in individual patients.

For additional safety profile, see Important Safety Information slides and the full Prescribing Information.
Tollefson GD, et al. *Am J Psychiatry.* 1997;154(4):457-465.
Data on file, Lilly Research Laboratories.

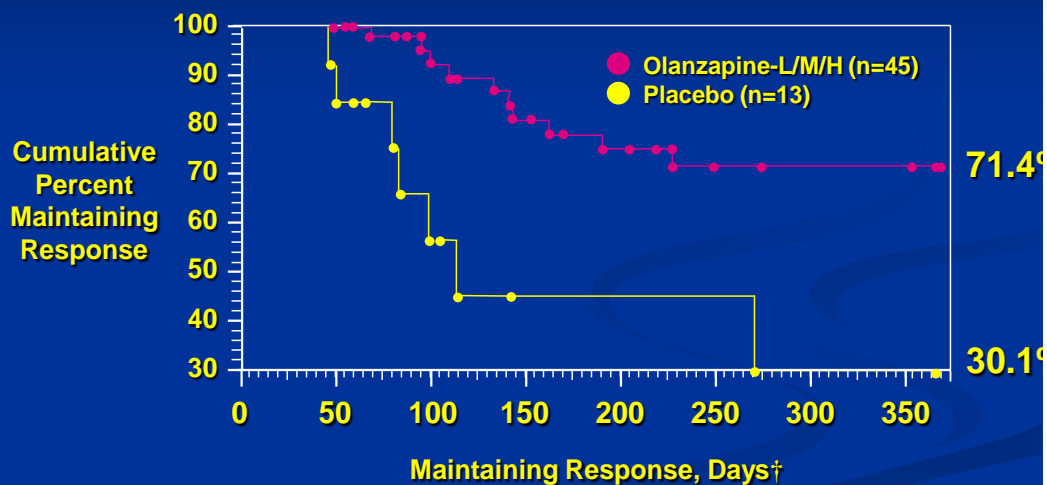
ZYPREXA
Olanzapine

First-Episode Patients (Study 4): Acute Phase Response Rate*



*Criteria for first-episode subsample: no previous psychotic episode; length of current psychotic episode ≤ 5 years; and age at onset of first psychotic episode ≤ 45 years. Response defined as $\geq 40\%$ improvement on BPRS total (items 0-6) from baseline.
† $P = .003$, olanzapine vs. haloperidol.

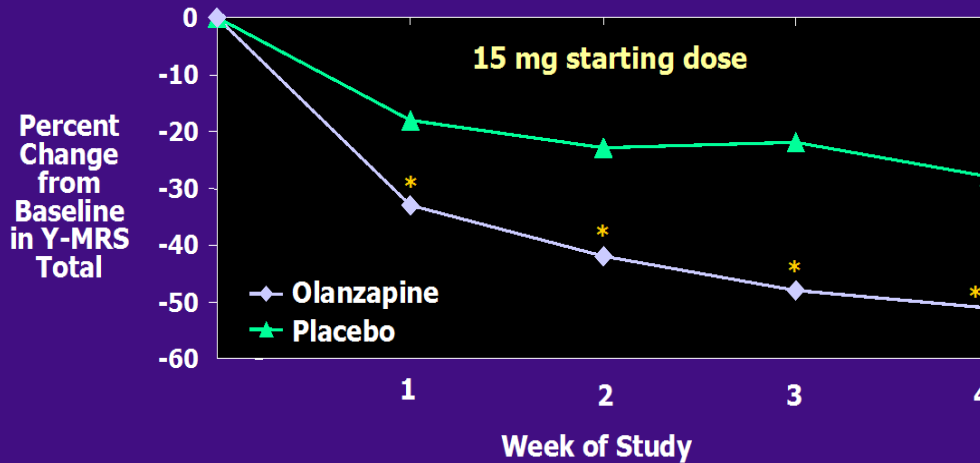
Time Maintaining Response (Study 2): Olanzapine vs. Placebo



* $P = .002$ vs. placebo.

†Time maintaining response = time maintaining a sufficiently reduced level of psychopathology such that hospitalization is not required.

Antimanic Efficacy of Olanzapine Is Significant Starting at the First Assessment (Week 1 Y-MRS)



* $p < .05$. Response curve illustrates four week study of olanzapine (n=54) vs placebo (n=56) for acute mania (four week study II)

Olanzapine vs. Lorazepam

Meehan K. et al. "A double-blind, randomized comparison of the efficacy and safety of intramuscular injections of Olanzapine, Lorazepam, or Placebo in treating acutely agitated patients diagnosed with Bipolar Mania" *Jour Clin Psychopharm* 21(4):389, 2001

Olanzapine: 10mg-10mg-5mg/24 hr

Lorazepam: 2mg-1mg-1mg/24 hr

Agitation at Baseline, Q 30 min for 2 hr, then 24 hr after first injection (3 scales)

Olanzapine superior at 2 hrs; 24 hours > placebo

BENZODIAZEPINES: Pros and Cons

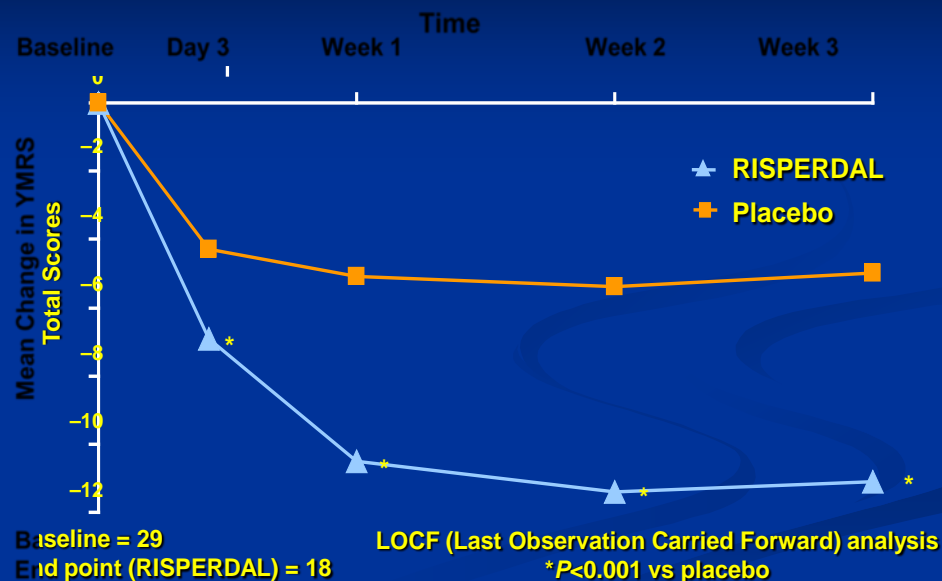
Pros

- Work Fast
- Broad Application (insomnia, agitation, anxiety)
- Relatively Safe

Cons

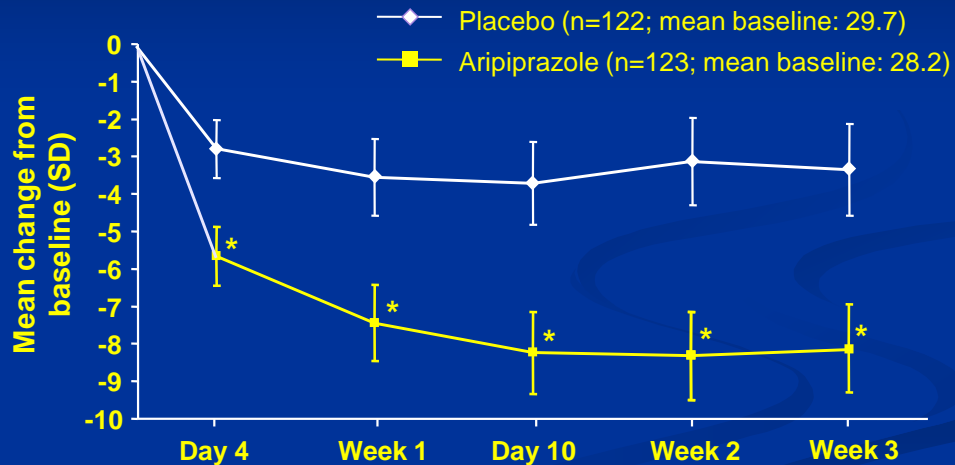
- Impair Memory
- Ataxia/Balance problems
- Dependence Issues

RISPERDAL® Monotherapy: Rapid Improvement in Manic Symptoms



ta on file: RIS-USA-239 study (a double-blind, placebo-controlled, monotherapy trial).

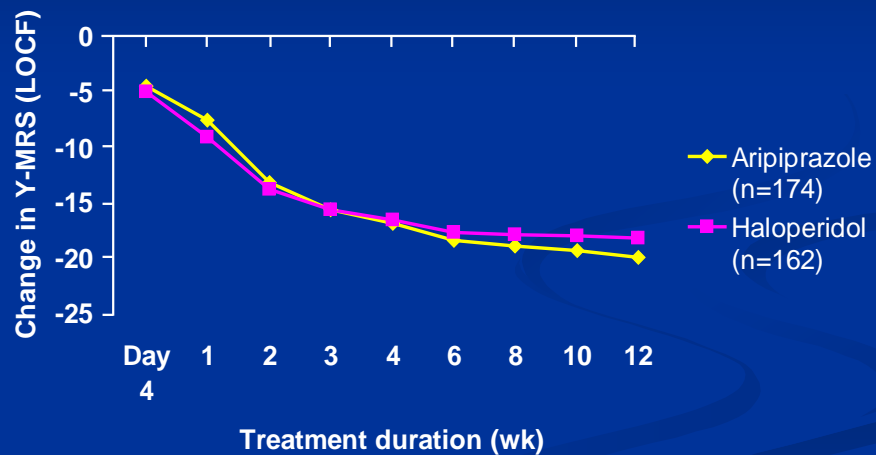
Aripiprazole in Acute Mania: Mean Change From Baseline in Y-MRS



* $P < 0.01$ vs placebo, LOCF analysis.

Jody et al. *Int J Neuropsychopharmacol.* 2002;5(suppl 1):S57.

Aripiprazole vs Haloperidol in Acute Mania: Efficacy (Y-MRS)

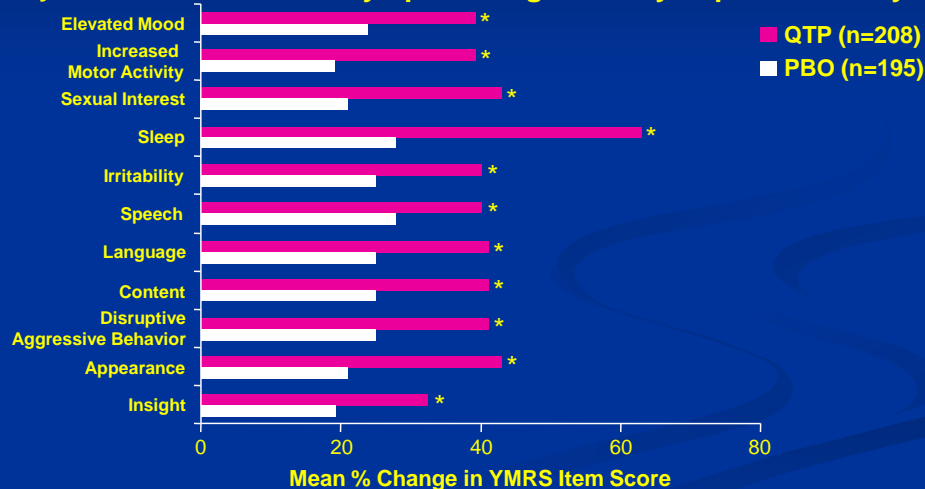


ine Y-MRS scores: aripiprazole = 31.07, haloperidol = 31.39.
on file.

Quetiapine: Change in YMRS Item Score From Baseline Monotherapy

Study 1 + 2

All manic symptoms significantly improved at Day 21

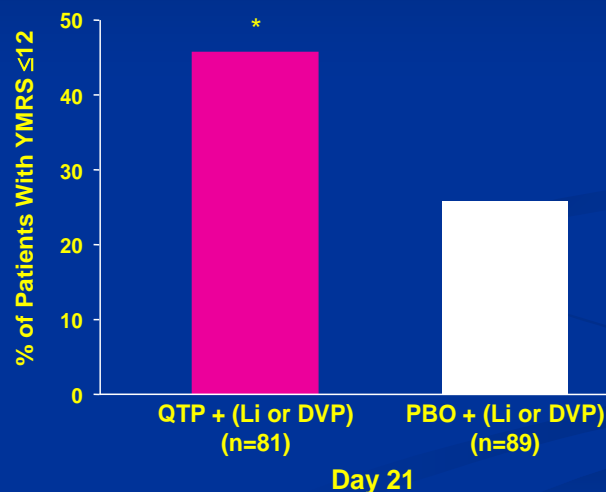


QTP=quetiapine; PBO=placebo.
Data on file, AstraZeneca Pharmaceuticals LP, Wilmington, DE

*P=0.007 vs PBO.

Significantly Greater Percentage of Quetiapine Patients Achieved Remission Adjunct Therapy

Study 3



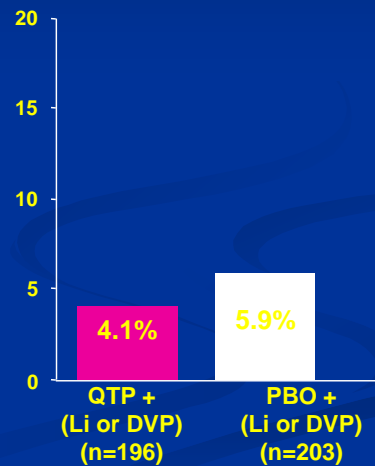
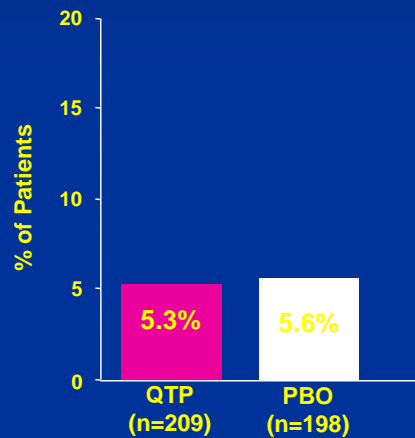
QTP=quetiapine; PBO=placebo; Li=lithium; DVP=divalproex.
Data on file, AstraZeneca Pharmaceuticals LP, Wilmington, DE

*P=0.007 vs PBO+(Li or DVP).

Withdrawal Rates Due to Adverse Events in Quetiapine Group Are Similar to Placebo Monotherapy/Adjunct Therapy

Study 1 + 2

Study 3 + 4



QTP=quetiapine; PBO=placebo; Li=lithium; DVP=divalproex.
Data on file, AstraZeneca Pharmaceuticals LP, Wilmington, DE

Cognition Scores Within Treatment in Schizophrenia

Overall

New Learning

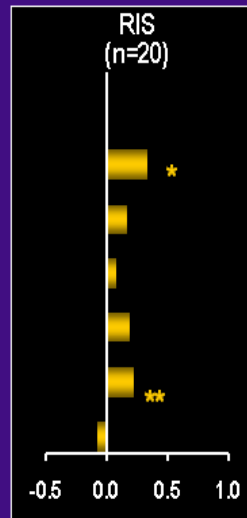
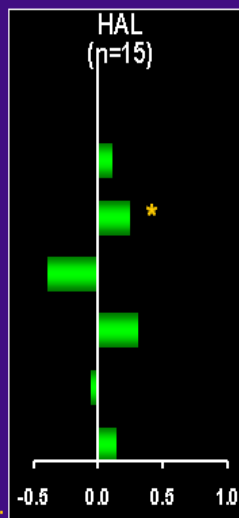
Attention

Motor

Executive

Verbal

Nonverbal



*p<.05 vs baseline.

**p<.01 vs baseline.

†p<.001 vs baseline.

Mean Change from Baseline, LOCF

Purdon SE, et al. *Arch Gen Psychiatry*. 2000;57(3):249-258.

Crisis Intervention Training

Unit 3

Risk to Self and Others

CIT Training Lesson Plan Performance Objectives

Intervention in High-Risk Situations

Unit Goal: Provide information about suicide and interaction techniques to assist in dealing with people who are suicidal.

Classroom Hours: 1.30

Presenter:

Performance Objectives:

Participants will be able to:

- Complete a risk assessment to determine if a person is a risk to themselves or others.
- Determine the difference between myths and facts about individuals with mental illness and violence.
- Understand and learn how to communicate with individuals who may be suicidal.
- Understand how to do a violence risk assessment to include at a minimum the difference between affective vs. predatory violence, patterns of violence, violence and youth.

Content Material:

See attached PowerPoint presentations for *Intervention in High Risk Situation*, *Assessing Suicidal Intent* and *Violence Risk Assessment*

Intervention in High Risk Situations

Lou Sowers, PhD
Spokane Mental Health
June 2007

Suicide: Myths & Facts

- Myth: Suicidal people keep their plans to themselves
- Fact: Most suicidal people communicate their intent to die during the week preceding an attempt

- Myth: People who talk about suicide don't do it
- Fact: People who talk about suicide may try, or even complete suicide

Suicide: Myths & Facts

- Myth: Once a person decides to complete suicide, there is nothing anyone can do to stop them
- Fact: Suicide is the most preventable form of death and almost any positive action may save a life
- Myth: Confronting a person about suicide will only make them angry and increase the risk of suicide
- Fact: Asking someone directly about suicidal intent lowers anxiety, opens-up communication, and lowers the risk of an impulsive act

Suicide: Myths & Facts

- Myth: Only experts can prevent suicide
- Fact: Suicide prevention is everybody's business and anyone can help prevent the tragedy of suicide
- Myth: If a suicidal youth tells a friend, the friend will access help
- Fact: Many young people do not tell an adult

Some Basic Concepts about Suicide

- Suicide is always multi-determined, but
- A profound sense of hopelessness is the common pathway and the primary intent is to end the pain
- Suicide is a solution to a perceived insoluble problem
- Most suicidal people do not want to die
- Most suicidal people want to find a way to live

Some Basic Concepts about Suicide

- Ambivalence exists until the moment of death
- Reduce risk factors and you reduce risk
- Enhance protective factors and you reduce risk
- Suicide prevention must involve multiple approaches
- The final decision rests with the individual
- Statistically, a non-suicide is a non-event. Therefore, it is hard to measure success and we often tend to focus on bad outcomes.

Suicide by Officer (Victim-Precipitated Homicide)

- Incidents where an individual determined on self-destruction engages in a calculated life threatening criminal incident in order to force a police officer to kill him or her
- Possibly 10% to 15% of officer involved shootings (Very little reliable data)
- Profile consistent with general suicide data

Suicide by Officer (Victim-Precipitated Homicide)

- Why do people choose this route for suicide?
 - The difficult decision to end one's life is made by someone else once initiated.
 - Police are the only community agency armed with lethal weapons and trained to respond with accurate and deadly force.
 - Police are only a phone call away.

- Stigma of social taboos of suicide can be absolved by being terminated by an external mechanism.
- Police are faceless and ending life is done in a dignified manner.
- Police may represent a "social conscience" and attract guilt ridden persons for punishment.

- A person who does not have the determination for a quick end by gun may use the police.
- Some people may fancy going out in a "blaze of glory" as part of a delusion or acting out in anger. Taking hostages, attracting attention for religious delusions or placing police in public contempt may be the motivation.

High Risk Profile Summary

- Age: Typically over 40, but not always
- Sex: Male
- Marital: Divorced, widowed, separated
- Employment: Unemployed
- Interpersonal style: Conflicted
- Family: Chaotic
- Health: Chronically ill, hypochondriac, substance abuser

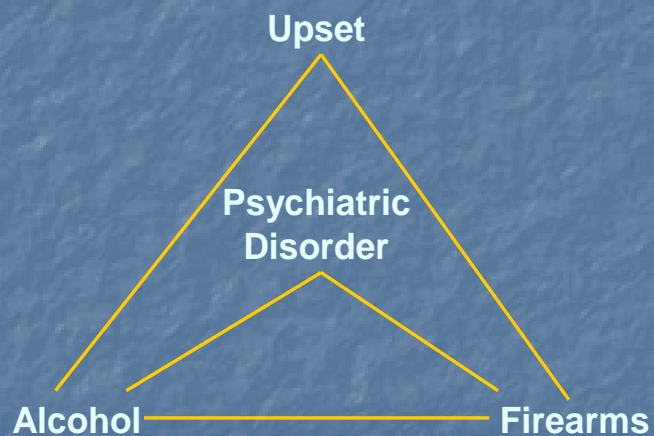
High Risk Profile continued

- Psychological: severe depression, psychotic, severe personality disorder, substance induced, anger or guilt.
- Suicidal Activity:
 - Ideation is frequent, prolonged, intense
 - Plan is clear
 - Means are available and lethal (e.g., gun)
 - Previous history for suicide thinking and behavior

High Risk Profile continued

- Personal:
 - Poor Achievement
 - Poor insight
 - Poor control of emotions.
- Social:
 - Isolated
 - Unresponsive family

Suicide Pyramid



Field Assessment

1. All of the elements of the high risk profile are important, but for crisis intervention, none is more important than suicidal ideation.
2. You must investigate:
 - a. The suicidal ideation itself: Content and Recurrent history (duration, frequency, intensity)
 - b. The Plan: Realistic, possible-History of plan
 - c. Resources: Access to means
 - d. Past acts: What, if any, past attempts occurred? What were the means in the past?

Additional Points to Consider

1. To investigate a suicide attempt, begin with the presenting current event, such as an overdose.
2. Move on to recent events.
3. Then ask questions about past events before returning to the current state.

Interviewing Techniques that Sharpen Assessment of Suicide Risk

1. Question factual behaviors. Ask the subject for facts, details or train of thoughts, as opposed to opinions or impressions. Instead of asking "How close were you to killing yourself?"

ask, "Did you pick up the gun?" "How long did you hold it?" "Where did you point it?" "Was the safety on or off?"

2. Decrease shame. Ask the question from the subject's perspective to minimize shame. Ask questions from a non-judgmental perspective.

Do not ask, "Do you have trouble keeping your job?"

Instead ask, "Does your boss make life hard at work?"

3. Gentle assumption. Assume that a given behavior has occurred. Let the subject correct or fill in the blanks.

Do not ask, "Have you thought of other ways that you might kill yourself?"

Instead ask, "What other ways have you thought of killing yourself?"

4. Behavioral exaggeration. Subjects will sometimes downplay their behaviors. Find the upper limits by exaggerating the threat.

"How many times have you thought of killing yourself in the past week?" "Thirty or 40?"

The subject may reply, "No only 20."

5. Denial of the specific. This technique may be useful when the subject has denied a generic question, such as "Have you thought of other ways that you might kill yourself?"

Instead be specific. "Have you ever thought of shooting yourself?" "Have you ever taken an overdose?" "Have you ever considered jumping off a bridge?"

6. Normalization. This approach suggests that most people in similar situations respond in a similar way.

Many people who have...feel they would be better off dead." "Do you feel this way too?"

CIT SAMPLE QUESTIONS

Questions for Consumers:

Begin by introducing yourself and telling the person a little about yourself: how long you've been a police officer, how long you've lived here (or elsewhere), etc. Ask getting-to-know-you questions such as where they're from, what kind of hobbies they have, etc.


- We're learning about how to deal more effectively with people who have a mental health disorder. What do you think are some of the important things we should know?
- What can you tell me about your mental illness?
- Have you ever had any encounters with police? Good interactions? Negative interactions? If good, what made them good? If bad, what would have made them better?
-If no encounters with police: What problems do you think people with a mental illness might have with the police?
- When you are going through a bad time with your mental health issues, what could a police officer do to make it better? What would be the wrong thing to do?
- What's the ONE THING you want me to take back to the other officers?

Questions for Family Members of Consumers:

Begin by introducing yourself and telling the person a little about yourself: how long you've been a police officer, how long you've lived here (or elsewhere), etc. Ask getting-to-know-you questions such as where they're from, what kind of hobbies they have, etc.


- We're learning about how to deal more effectively with people who have a mental health disorder. What do you think are some of the important things we should know?
- What can you tell me about your family member's mental illness?
- Have you or your family member ever had any encounters with police during a mental health crisis? Good interactions? Negative interactions? If good, what made them good? If bad, what would have made them better?
-If no encounters with police: What problems do you think people with a mental illness might have with the police?
- When your family member is going through a bad time with his or her mental health issues, what could a police officer do to make it better? What would be the wrong thing to do?
- What's the ONE THING you want me to take back to the other officers?

Sherwin Cotler, Ph.D.
Crisis Intervention Training
April 16 – 20, 2007



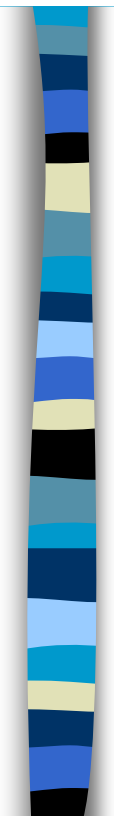
ASSESSING SUICIDAL INTENT

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- 
- When you are dispatched to a location involving a person with a mental illness or in an emotional crisis, you are most likely to encounter someone who is frightened, depressed, agitated, angry and/or confused
 - This is not a mental state they are in by choice



- In dealing with someone who may have a mental illness or may be in an emotional state of crisis, your primary job as a police officer is to deal with the behaviors at hand.
 - Our purpose in this training is not to make you “experts” in diagnosing a mental illness.
 - Our goal is to give you more tools to deal successfully with someone who may be out of touch with reality or may be experiencing severe emotional distress.
 - Hopefully, this will make your job safer for you and the outcome better for those with a mental illness or in severe emotional distress.
-

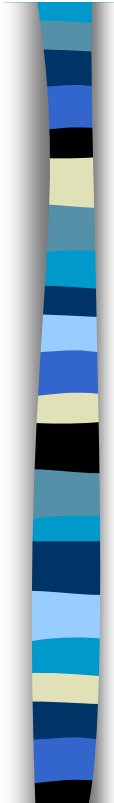


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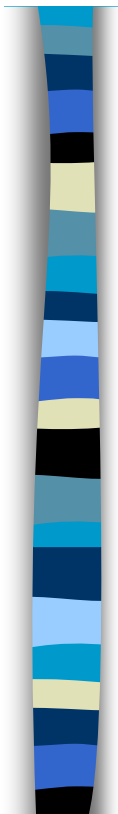
Our current mental health system is not working well

- Ideally, if the individual is clearly a danger to self or to others or is gravely disabled, that person can be hospitalized (even involuntarily).
- In reality, there are now 8 – 10 times as many individuals with a mental illness in jail as there are in mental health facilities.
- For various reasons, the majority of individuals who would not need to be in a hospital but who would greatly benefit from some mental health care, do not get the help they need.

- 
- At different times in our lives we may all experience periods of stress, irritability, anxiety, depression, fear or feel as though we are “losing control”.
 - Unless there is a certain intensity, frequency, duration and cluster to these conditions, they are not generally considered to be a mental disorder.
 - Each of us has a breaking point.



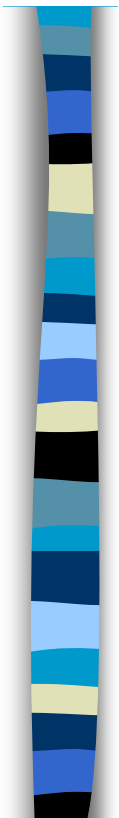
- In any given year in the USA, about 22% of the population (over 62 million individuals) will not be able to function adequately or safely for a period of time in their jobs or day-to-day activities as a result of how they are thinking, feeling and/or behaving.
- Some of these will have a “mental illness” such as schizophrenia or dementia, but most will be suffering from a different type of mental disorder.




- Some individuals may experience one episode of severe emotional distress in their life whereas others may have reoccurring symptoms and episodes throughout their lives
- Often one or more disorders exist together (e.g. anxiety and depression; substance abuse and psychosis)
- Mental issues can affect individuals at any age. They often appear first in late adolescence or early adulthood.



- It is estimated that 1 in 5 individuals (20%) will experience a mental illness at some point in their lives. Only 1% are schizophrenic.
- The term “mental illness” to me implies an organic/biological cause. I do not think this is always the case (e.g. depression, PTSD). Therefore, I think in terms of mental illness and mental disorders. However, they both involve the mind and the body.
- They both can generate unusual behaviors and distort reality for the individual.



- Mental disorders can often be treated successfully with medication AND/OR psychotherapy (not all conditions need both)
- Most all medications have side effects
- Behaviors you encounter may be the result of someone stopping their medications or starting a new medication.

- 
- Consider any person who is depressed, agitated, hysterical, frightened, confused or aggressive as being “emotionally disturbed”.
 - This is not the same as having a mental illness.
 - e.g. Person running from a burning building; dealing with someone who has just been sexually assaulted
-






- What we see is a function of:
Our belief system
Our biology
Past experiences and training
Physical and mental state at the time
(e.g. getting enough sleep)



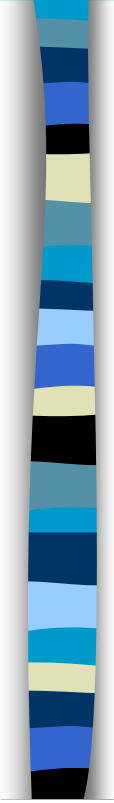
- When you approach an individual with a mental illness or emotional disturbance, try to incorporate respect, courtesy, calm voice, short & clear sentences, and staying calm yourself.
- Use 4 x 4 breathing




DANGER TO SELF AND SUICIDAL RISK




**EXERCISE: WHAT ARE THE
FIVE QUESTIONS YOU WANT
ANSWERED WHEN TALKING TO
SOMEONE YOU SUSPECT MAY
BE SUICIDAL?**

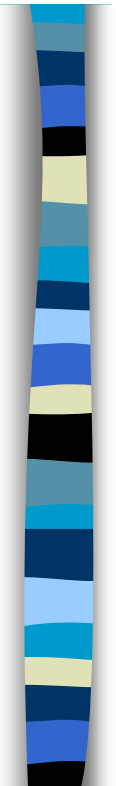
- 
- Intent. “Are you thinking of harming or killing yourself?”

- 
- Plan. “How do you plan to harm or kill yourself?” e.g. pills, gun, rope, running car into tree.


You may not get to ask this question if the plan is “suicide by cop”


With youth, guns account for 2/3 of suicides with boys and 1/2 with girls.

- 
- Access to Means. “Do you have access to the means (gun, pills) nearby?”

- 
- Time Frame: “When do you plan to carry out this act?”

Also look for conditions like giving things away, saying goodbye to others, recently making out a will.

- 
- Past History. “Have you made an attempt on your life before?”
-

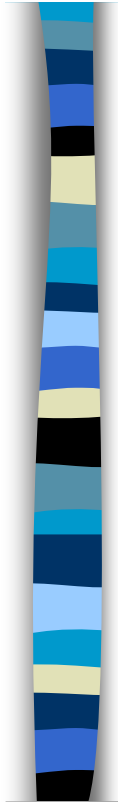
- 
- Feelings of **hopelessness**, **helplessness**, and **despair** often predominate in this condition.
 - Person has a difficult time seeing a solution or resolution to the situation.
 - Condition may follow a significant loss to the individual or something that haunts them from the past (e.g. death, loss of job, shame from something like a rape, war experiences).
 - Most individuals have had suicidal thoughts at some point in their lives.



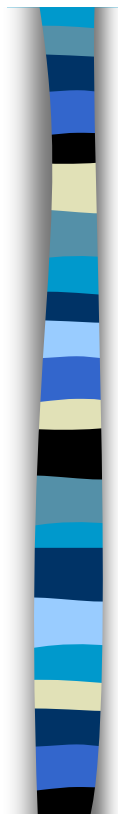
- Suicide is the 8th leading cause of death for adults in the US and 3rd for adolescents (behind accidents and homicides).



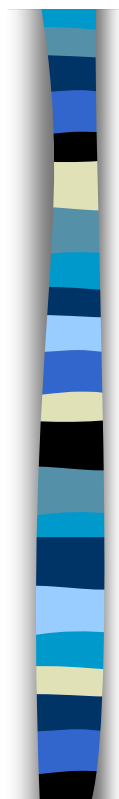
- Twice as many police officers die by suicide than are killed in the line of duty.
- This is at a rate twice that of the civilian population
- Factors for this include a higher risk for PTSD, keeping certain emotions to self, retirement from close-knit service group



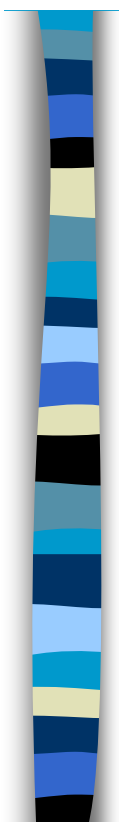
- Every year more than 30,000 Americans take their own lives (82 suicides per day). 500,000 make a serious suicide attempt each year (over 1,370 per day; 57 per hour).
- 3-5% do not seek help; 30% leave it to chance whether they die; 65% do not wish to end their life.



- The majority of suicides are committed by individuals who are depressed.
- Over 50% of them have been using alcohol and/or drugs.
- Depression often focuses on a past event and anxiety on a future event.




- 80% of those who kill themselves give some advanced warning.
- Over 50% of those who kill themselves have seen a physician within six months of their death.




Age. In general, suicide risk increases with age. Significantly increased with geriatric population. Rate peaks with men at >45 years and at >55 years with women. More physical illnesses and isolation come with age. Look for depression and alcohol as contributing factors

Gender. Men of all ages *commit* suicide 2.5 to 4 times more frequently than do women; whereas women *attempt* suicide 2 to 3 times more often than men.



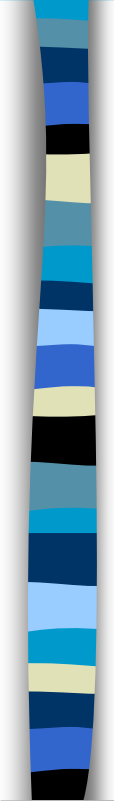
Marital status. Married persons have lowest risk of suicide. Rates for single persons are twice those of married persons, and rates for divorced, separated or widowed persons are 4 to 5 times higher than those married.

Employment. Higher risk if person is out of work. Retirement may increase risk (which is one of the reasons for higher rates for police)



Affect/mood. Sadness, hopelessness, and social withdrawal predispose a person to suicide more so than anger. A calm state is not necessarily a good sign.

Depression. 30 - 64% of persons who commit suicide have a primary depressive disorder. 15% of those with chronic depression ultimately die by suicide.



Psychosis. The presence of psychotic symptoms increases the risk factors (10% lifetime risk). Person may sometimes use an unusual means of harming self (e.g. cutting off body parts, using a broken piece of mirror).

Bipolar. 25 - 50% of individuals with a bipolar disorder will attempt suicide.

Anxiety. 7 - 15% lifetime risk of suicide




Borderline Personality Disorder. 7% lifetime risk.

Alcoholism. 3% lifetime risk; however, alcohol is associated with nearly 50% of all suicides.



“Suicide is a permanent solution to a temporary problem”

- There is no universal protocol for suicide threats because each situation has its own unique set of circumstances
 - Error on the side of caution and take each threat as a serious one
-

- 
- Those who contemplate suicide often feel hopeless and helpless
 - They often feel they have no more options left
 - Sometimes they are acting out of anger towards someone else or as a way of getting attention
 - If the person is hallucinating or is delusional, your words may be interpreted differently or not heard at all



Exercise

- Individual standing on bridge

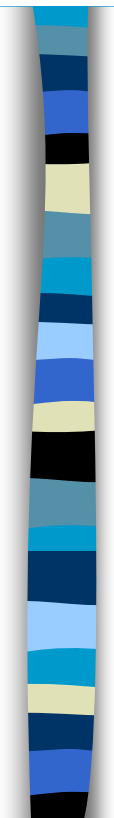


Verbal First Aid For Suicide

- Try to establish some rapport.
- Talk slowly and use a calm voice.
- Be respectful of the person.
- Listen for what brought them to this place in their lives.
- Do not rush the process.



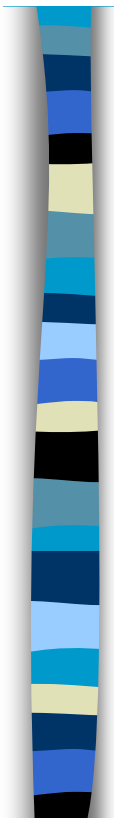
- **Keep questions simple.**
- **Repeat your words if necessary, and allow time for your words to register.**
- **Remember that the person may be feeling desperate or may be intoxicated.**
- **Take a breath between your sentences.**
- **If they are talking, they are not as likely to kill themselves.**



- **See if you can help the person find a reason not to take their life at this time (e.g. religion; family, friends or pets that may need them).**
- **Help them see their depression or pain as a temporary rather than permanent situation.**
- **Do not challenge them to take some negative action (e.g. come to you or jump).**



- **Do not make promises you cannot keep.**
- **If it appears they are getting angry or more agitated, change verbal tactics.**
- **Move slowly**
- **Handle with compassion**
- **Remember that ultimately the decision to live is theirs and not yours**




■ **Bathroom Scenario**

You receive a call from the dispatcher that a person has called in stating that their adult child is in the house threatening suicide. The parent has stated there are no guns in the house to their knowledge, but that their child may be armed with a knife from the kitchen. When you arrive at the house, the sobbing parent meets you at the door and tells you that their 33 year old son is in the bathroom alone and has been screaming at the parent to go away and not come into the bathroom so they can die. You can hear a loud voice coming from the bathroom, and the bathroom door is slightly ajar. As you approach the bathroom, you can see the person sitting in the bathtub full of water. The person is partially clothed, holding a knife, and has a string tied from his foot to an electric heater that is turned on and perched at the edge of the bathtub. The heater could easily be pulled into the water whereby it would electrocute the individual. The person seems to be arguing with someone, but no one else is in the room. What is your first impression of the situation, and what would you say or do next?



Recommended books:

- Darkness Visible by Styron (1992)
 - The Worst Is Over by Acosta and Simon-Prager (2002)
 - Not Fade Away by Laurence Shames & Peter Barton (2003)
-

- 
- Sherwin Cotler, Ph.D.
2617B 12th Ct. S.W., Suite 5
Olympia, WA. 98502
(360) 352-1750

Violence Risk Assessment

(A PowerPoint Presentation)

Sherwin Colter, Ph.D.
Crisis Intervention Training
April 16 – 20, 2007

- **EXERCISE:** You receive a disturbance call at 10:00pm. When you and another officer unit arrive on the scene, the house has some lights on, but you cannot see anyone inside. As you approach the garage, you get the sense that someone is close by. You hear the following sound (play sound). Can you identify what it is? Are you or your partner in any danger?

The first order of business is to ensure your safety, your partner's safety and the safety of others nearby. If there appears to be a risk of violence, controlling the potential violence takes precedence over trying to determine what caused the current state of affairs.

- Consider any person who is depressed, agitated, hysterical, frightened, confused, or aggressive as being “emotionally disturbed”.
- They may or may not have a longstanding mental illness.
- i.e. Person running from a burning building, individual who have just been served divorce papers.
- Many individuals who call the police are experiencing these mid to high levels of stress and may be in a flight/fight/freeze condition.
- The person's symptoms are very real to them.
- To come out of their terror and trust someone takes a great deal of courage.
- Those with a mental illness are often very sensitive to criticism.
- The mentally ill person is more than the symptoms of their illness.
- Stress often exacerbates the symptoms. The person may have difficulty understanding directions/orders.

- In any given year, 62 million Americans (22%) will suffer a clearly diagnosable mental disorder which will incapacitate or substantially interfere with their employment, school or daily life.
- One in five (20%) individuals in population will experience a mental illness at some point in their lives.
- What makes police different is that they march towards the sound of danger instead of fleeing from it.
- Safety to self and to others in the situation needs to be part of assessing the situation and establishing some form of control or containment.

In terms of assessment, attempt to determine if the individual is experiencing:

- Hallucinations
- Delusions
- Fear and/or disorganization
- Depression
- Catatonia
- Mania
- Paranoia
- Individuals with a mental illness may believe that the world wants to harm them or wants them dead.
- Medications often do not take away all the symptoms, and most medications have side effects that can be negative.
- Most often in dealing with someone experiencing a mental disturbance, your best initial response will be to identify yourself by name, say you are there to be some help, breathe evenly and do some reflective listening.
- This is much more difficult if you are in a state of physiological and/or mental arousal.

- Reflective listening involves restating what the person has just said to you. This allows the person to calm down and lets him/her know that you are listening.
- Police tend to be call driven and solution focused.
- If the perimeter is safe, the tendency is to quickly solve the problem and, perhaps, not listen to what the person is saying.
- If the person calms down and can tap into their brain that allows them to reason, then you can ask them,
 - “What do you want?”
 - “What are you doing to get what you want?”
 - “Is it working?”

Violence

- Violence peaks in the late teens and early 20s. Ten times more common in men than women, except with the severely mentally ill (SMI) where the rates are equal for men and women.
- We tend to underestimate the violence potential in women.
- Only 1% of the population is schizophrenic.
- Their sense of reality is often different than yours or mine (i.e. delusions, hallucinations).
- These individuals have a low incidence of violence (3%) unless alcohol is involved (then potentially 5x greater).
- 50-75% of schizophrenia patients go off their meds at times (which will increase their violence potential)
- Ask individuals about their medications.
- Ellis describes aggressive behaviors coming from a state of:
 - Fear (cornered wolf) - Belief of being harmed
 - Rage (bear) - Pent up energy/anger
 - Manipulation/tantrum – Rat

- Predatory – Cat – will do what they need to do in order to get what they want
- Deception – Snake – perhaps most dangerous
- Individuals with delusions have fixed beliefs (i.e. “I am dead”). Little humor. Make general statements rather than trying to talk out of their belief.
- Individuals with hallucinations hear, smell, see, and/or feel things that are not there. Can be from the mental illness, drugs, sleep loss, brain damage, mania and other things.
- Depression marked by feeling hopeless and helpless and feelings of despair.
- Paranoia marked by suspicion. Constantly looking for evidence to support their belief. Be careful with touch. Don’t show fear. Use simple, short sentences. Be respectful. Tell them what you are about to do.
- Catatonia can be from mental illness, injury, seizure, shock. Unusual postures. Much energy. Can be very dangerous. Speak slowly, calmly and respectfully. Be careful with touch.
- Mania marked by rapid speech, little sleep, delusions of grandeur, wild fantasies, sexual behavior. Can be irritable, aggressive, and paranoid. Sometimes caused by cocaine or amphetamines. Talk slowly. May need to repeat sentences several times.
- Fear. Person may be in a flight, fight or freeze mode. Talk slowly and reassure. Having person breathe slowly helps.
- Not very good in our ability to predict long term violence.
- Paranoid individuals more likely to become violent than any other type of mental illness; however, once hospitalized, they are less dangerous than those who with a disorganized mental illness or who are demented.
- In the community, a paranoid schizophrenic has access to weapons and their target.

- Hallucinations per say do not increase the likelihood of violence; however, certain hallucinations do (i.e. those that evoke a negative emotion like anger or sadness; command hallucinations.)
- The main command hallucination involves self-harm (more so than to others).
- Hallucination related delusions are more dangerous. More likely to harm someone else if person also believes they are evil.
- Prior firsthand experience with the police may affect this belief.
- If hallucination voice is familiar, the person is more likely to carry out violence. 60% of voices are familiar.
- A command from God not more likely to be carried out than a command from Satan.
- Delusions and violence. Thoughts being put into one's mind or being followed. Persecutory delusions more likely to be acted upon. The more specific the delusion, the more dangerous they are (followed by someone in a red car).
- Difficult to talk to person out of delusion. Do not agree or contradict (i.e. "Dead people do not bleed").
- Fear, agitation and anger often precede violence in both psychotic and non-psychotic individuals.
- There is a difference between violence predicated upon fear where the individual is trying to escape (which is part of the fight/flight/freeze response) and predator violence.

Affective vs. Predatory Violence

- With agitation based on fear, there is a rush of adrenaline and the aim would be to calm the person down.
- With a predatory individual, violence is planned, goal directed and cal, (i.e. anti-social personality, stalkers).

- With most individuals who are frightened, suspicious or agitated, you want to tell them what you are going to do next.
- With someone who is angry, try reflective listening to deescalate situation.
- It is harder to think when frightened, agitated or angry because part of our brain shuts down.
- Talk slowly and firmly.
- Try repeating back what the person is saying (reflective listening).
- Tone of voice is very important.
- Murder-suicide. Mothers may not want to leave their children behind when psychotic or depressed because she does not see the world as a better place. She is taking them to heaven.
- Ask suicidal women what their plans are with their children.

Patterns of Violence

- Some individuals commit violent acts only when they are acutely psychotic. Being schizophrenic does not make one more violent unless they are acutely psychotic at the time.
- Insult evoked violence: Person cannot tolerate being disrespected or criticized.
- Alcohol lowers the threshold to violence.
- Stimulants predispose a person to violence via three different mechanisms (lower threshold, causes grandiosity and creates paranoia).
- Weaponry and the person's affect toward these weapons. Are they excited when talking about their weapons?
- 25% of American households have a firearm and 43% keep it loaded.

- With a paranoid person, as if they have recently *moved* their weapon (i.e. “I put my gun under the pillow recently”). This person is more dangerous.
- If a man is laid off from a job, other things being equal, he is 6x more likely to be violent than continuing to work peers for the next 3 months.
- A person who is angry and lacks the capacity for empathy is more dangerous.
- Catatonia and catatonic rage.
- Mania. Can be drug induced. Person is more at risk to act out.
- Mothers are the most likely target for assault and homicide by adult psychotic son (even if both parents are present).
- In the 5 minutes before an inpatient psychiatric assault, the behaviors most likely to occur are verbal abuse, yelling, swearing and standing uncomfortably close.
- If a person is escalating out of control, consider offering some food (crackers).
- All threats (to self or others) should be taken seriously.

Violence and Youth

- We live in very dangerous times.
- Serious assaults have increased 5x in the USA from 1957-2000. 5x in Norway and Greece. 4x in Canada, Australia and New Zealand.
- Assaults are a better index of violence than murders because the medical procedures have improved so much.
- Unfortunately, this may be one of the populations you will need to deal with more in the future unless we can start reducing this constant exposure to media violence.
- Fifteen years after TV has been introduced into a new culture or country, there has been a dramatic increase in violence.

- The American Medical Association has stated that the number one medical emergency in the USA today is media violence and how it affects children.
- If you put media violence in a child's life, you will get an increase of violent behavior.
- Over 1,000 studies support the above statement.
- The average pre-school child in America watches more TV than any other single act.

According to David Grossman:

- There were no mass murders in US schools prior to 1990.
- For every 35 deaths in the US schools system, there are over 315,000 assaults, 257,000 serious injuries and 18 million incidents of bullying.
- All of the 17 school shooters in the US had a fascination for violence, watched violent movies and played violent video games. None on anti-depressants or involved in an organized school activity.
- The video game industry is a 20 billion dollar a year industry.
- Violent videos are especially dangerous because there is a first person interactive process, there are rewards for killing others, it is highly repetitive and it has become very realistic.
- "Grand Theft Auto" was one of the most frequently sold/played video games last year.
- In this game, the player is rewarded for shooting people in the head (including police officers) and beating women to death.
- Video games are currently used to teach soldiers and police officers how to fire their weapons more accurately and efficiently. Why would we expect the effects to be any different for young, developing minds?

Police Officer Skills: Part 1

- Assess situation for safety.
- Listen.
- Be respectful.
- Use a calm voice.
- Do not rush the situation.
- Reassure.
- Give extra space.
- Move slowly.
- Try to provide assistance.

Police Officer Skills: Part 2

- Talk directly to the person.
- Repeat your words if necessary.
- Breathe evenly while you talk (4x4 “combat breathing”).
- Tone of voice is important.
- Try to act in a calm, quiet manner.
- Keep questions simple and not too demanding. Be patient.
- May help to tell person what you are about to do.
- Continuously re-evaluate situation.

Exercise:

- Man on airplane
- Much of the content above comes from material presented by Dr. Phillip Resnick at the Western Reserve School of Medicine, Fr. Robert Marasky at DSHS in Washington, Lt Col. Dave Grossman and from the California Alliance for the Mentally Ill video tape entitled, “Metal Illness, Parts I, II & III”
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Crisis Intervention Training

Unit 4

Psychotropic Medications

CIT Training Lesson Plan Performance Objectives

Psychotropic Medications

Unit Goal: Ability to recognize and understand the different types of medications used to treat the most common mental illnesses.

Classroom Hours: 3.00

Presenter:

Performance Objectives:

Participants will be able to:

- Understand and recognize side effects associated with the medications used to treat mental illnesses.
- Understand and recognize how to assess an individual's medication usage.
- Understand and differentiate between a variety of medications such as antidepressants, mood stabilizers, anti-anxiety medications and antipsychotics.

Content Material:

See attached PowerPoint presentation for *Psychiatric Medications: A Brief Overview*

I. Introduction

In this unit we will discuss the different types of medications that are used to treat some of the most common mental illnesses, describe the side effects associated with these drugs, and learn how you can assess an individual's medication usage.

Medications can be an effective treatment for mental illness. Although they don't cure mental illness, medications can control symptoms and improve an individual's coping abilities, which can help reduce the severity of their condition.

Just as someone who has diabetes may take insulin to stabilize their blood sugar, someone with a mental illness may take medicine to stabilize the chemicals in their brain and bloodstream. For example, drugs like chlorpromazine can turn off the "voices" heard by some people with psychosis and help them to see reality more clearly. Antidepressants can lift the dark, heavy moods of depression.

It is important to remember that medications for mental illness, like all medications, may be helpful to one person, but harmful to another. Some people may need only one drug to address most of their symptoms, while other people may need to take a combination of drugs. Some have side effects, and others do not.

But most importantly, law enforcement must be aware that the type of medication is not an indication of how dangerous the person might be or how severe their disorder is. However, factors such as age, sex, body size, body chemistry, physical illnesses and their treatments, diet, and habits, such as smoking and alcohol consumption can influence a medication's effect.

II. Presentation

A. Types of Medications

A variety of psychiatric medications are available for the treatment of mental illness. Among them are:

- **Antidepressants.** These medications are used to treat various forms of depression. There are several types of antidepressants, grouped by how they affect brain chemistry. These include the newer selective serotonin reuptake inhibitors and the older monoamine oxidase inhibitors. Antidepressants may also help improve symptoms in other disorders.

- **Mood stabilizers.** These medications are generally taken to help treat bipolar disorder, which is characterized by swings in mood between depression and mania. The medications work by balancing out such mood swings.
- **Anti-Anxiety medications.** These medications specifically target anxiety and work more quickly to relieve symptoms, such as fear, pounding heart, and shortness of breath. They also give people a greater sense of control. However, these medications have two major drawbacks: they don't improve depression, and they can become habit-forming.
- **Antipsychotics.** These medications, also called neuroleptics, are typically used to treat psychotic disorders, such as schizophrenia. They may also be used to treat severe cases of depression accompanied by psychosis.

1. Antidepressants

- Tricyclics (TCAs)** – From the 1960s through the 1980s, tricyclic antidepressants were the first line of treatment for major depression. Though the Tricyclics are as effective in treating depression as the newer antidepressants, their side effects are usually more unpleasant. Tricyclics include:
 - Amitriptyline (Elavil)
 - Amoxapine (Asendin)
 - Clomipramine (Anafranil)
 - Desipramine (Norpramin)
 - Doxepin (Adapin, Sinequan)
 - Imipramine (Tofranil)
 - Nortriptyline (Aventyl, Pamelor)
 - Protriptyline (Vivactil)
 - Trimipramine (Surmontil)
- Monoamine Oxidase Inhibitors (MAOIs)** – also introduced during the 1960's through the 1980's. MAOIs are effective for some people with major depression who do not respond to other antidepressants. They are also effective for the treatment of panic disorder and bipolar depression. MAOIs approved for the treatment of depression are:
 - Phenelzine (Nardil)
 - Tranylcypromine (Parnate)
 - Isocarboxazid (Marplan)

- c. **Selective Serotonin Re-uptake Inhibitors (SSRIs)** – are newer medications that work as well as the older ones but have fewer side effects. These include:
- Citalopram (Celexa)
 - Fluoxetine (Prozac)
 - Fluvoxamine (Luvox)
 - Paroxetine (Paxil)
 - Sertraline (Zoloft)

2. Mood Stabilizers

- a. **Lithium (Eskalith, Lithobid)** – Lithium is used most often to treat bipolar disorder. Lithium evens out mood swings in both directions- from mania to depression, and depression to mania- so it is used not just for manic attacks or flare-ups of the illness, but also as an ongoing maintenance treatment for bipolar disorder.

Although Lithium will reduce severe manic symptoms in about 5 to 14 days, it may be several weeks to several months before the condition is fully controlled. Antipsychotic medications are sometimes used in the first several days of treatment to control manic symptoms until the Lithium begins to take effect. Antidepressants may also be added to Lithium during the depressive phase of bipolar disorder. If given in the absence of Lithium or another mood stabilizer, antidepressants may provoke a switch into mania in people with bipolar disorder.

- b. **Anticonvulsants** – Some people with symptoms of mania who do not benefit from or would prefer to avoid Lithium have been found to respond to anticonvulsant medications commonly prescribed to treat seizures:
- Valproic acid (Depakene), Divalproex sodium (Depakote) – The anticonvulsant valproic acid (Depakote, divalproex sodium) is the main alternative therapy for bipolar disorder.
 - Carbamazepine (Tegretol)
 - Lamotrigine (Lamictal)
 - Gabapentin (Neurontin)
 - Topiramate (Topamax)

3. Anti-Anxiety Medications

Anxiety is often manageable and mild, but sometimes it can present serious problems. A high level or prolonged state of anxiety can make the activities of daily life difficult or impossible. People may have generalized anxiety disorder (GAD) or more specific anxiety disorders, such as panic, phobias, obsessive-compulsive disorder (OCD), or post-traumatic stress disorder (PTSD).

Both antidepressants and anti-anxiety medications are used to treat anxiety disorders. The broad-spectrum activity of most antidepressants provides effectiveness in anxiety disorders as well as depression.

- a. **Tricyclics (TCAs)** – The first medication specifically approved for use in the treatment of OCD were the tricyclic antidepressant clomipramine (Anafranil). Tricyclics are effective in blocking panic attacks and may also reduce symptoms of post-traumatic stress disorder (PTSD).
- b. **Beta Blockers** – These drugs are used mainly to reduce certain anxiety symptoms like palpitations, sweating and tremors, and to control anxiety in public situations. They often are prescribed for individuals with social phobia. Beta blockers reduce blood pressure and slow the heartbeat.
- c. **MonoAmine Oxidase Inhibitors (MAOIs)** – These drugs are used in the treatment of panic disorder, social phobia, PTSD, and sometimes OCD, but they require dietary restrictions. Some doctors prefer to try other treatments first. Anyone taking a MAO inhibitor must avoid other medications, wine and beer, and food such as cheeses that contain tyramine.
- d. **Selective Serotonin Re-uptake Inhibitors (SSRIs)** – These are the newest medicines available for treating anxiety disorders. SSRIs may be considered a first-line of treatment for panic disorder. They are often effective against obsessive-compulsive disorder (OCD) and have traditionally been used to treat depression.
 - Citalopram (Celexa)
 - Fluoxetine (Prozac)
 - Fluvoxamine (Luvox)
 - Paroxetine (Paxil)
 - Sertraline (Zoloft)
 - Venlafaxine (Effexor)

- e. Benzodiazepines** – Most of the benzodiazepines are effective against generalized anxiety disorder (GAD). Some drugs in this group are also used to treat panic disorder and social phobia. Benzodiazepines are relatively fast-acting drugs.

Benzodiazepines vary in duration of action in different people; they may be taken two or three times a day, sometimes only once a day, or just on an "as-needed" basis. Dosage is generally started at a low level and gradually raised until symptoms are diminished or removed.

- Alprazolam (Xanax)
- Chlordiazepoxide (Librium)
- Clonazepam (Klonopin)
- Clorazepate (Tranxene)
- Diazepam (Valium)
- Lorazepam (Ativan)
- Oxazepam (Serax)
- Halazepam (Paxipam)

4. Antipsychotics

Antipsychotic drugs are medicines used to treat Psychosis and other mental and emotional conditions, such as Bipolar Disorder (manic-depressive illness). Antipsychotic drugs do not cure mental illness, but can reduce some of the symptoms or make them milder.

a. Typical (Traditional) Antipsychotics include:

- Chlorpromazine (Thorazine)
- Thioridazine (Mellaril)
- Mesoridazine (Serentil)
- Molindone (Moban)
- Perphenazine (Trilafon)
- Loxapine (Loxitane)
- Trifluoperazine (Stelazine)
- Thiothixene (Navane)
- Fluphenazine (Prolixin)
- Haloperidol (Haldol) – long lasting injections

b. Atypical (New) Antipsychotics – The 1990s saw the development of several new drugs for schizophrenia, called "atypical antipsychotics." Because they have fewer side effects than the older drugs, they are often used today as a first-line treatment. They include:

- Clozapine (Clozaril)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Risperidone (Risperdal)

If given at too high of a dose, the newer medications may lead to problems such as social withdrawal and symptoms resembling Parkinson's disease, a disorder that affects movement.

B. Side Effects

1. Side Effects of Antidepressant Medications

Antidepressants may cause mild, and often temporary, side effects (sometimes referred to as adverse effects) in some people. Typically, these are not serious.

a. Common Side Effects of Tricyclics

The most common side effects of tricyclic antidepressants are as follows:

- Dry mouth
- Constipation
- Bladder problems
- Sexual problems
- Blurred vision
- Dizziness
- Drowsiness as a daytime problem
- Increased heart rate

b. Side Effects of Newer Antidepressants

The newer antidepressants, including SSRIs, have different types of side effects, as follows:

- Sexual problems
- Headaches
- Nausea
- Nervousness and insomnia
- Agitation (feeling jittery)

Any of these side effects may be amplified when an SSRI is combined with other medications that affect serotonin. In the most extreme cases, such a combination of medications (e.g., an SSRI and an MAOI) may result in a potentially serious or even fatal "serotonin syndrome," characterized by fever, confusion, muscle rigidity, and cardiac, liver, or kidney problems.

Source: <http://www.nimh.nih.gov/publicat/medicate.cfm#ptdep7>

2. Side Effects of Mood Stabilizers

- a. **Lithium** – When people first take Lithium, they may experience side effects such as drowsiness, weakness, nausea, fatigue, hand tremors, and increased thirst and urination.

Lithium, when combined with certain other medications, can have unwanted effects. Some diuretics increase the level of Lithium and can cause toxicity. Other diuretics, like coffee and tea, can lower the level of Lithium. Signs of Lithium toxicity may include nausea, vomiting, drowsiness, mental dullness, slurred speech, blurred vision, confusion, dizziness, muscle twitching, irregular heartbeat, and, ultimately, seizures.

- b. **Valproic acid** – stomach upset/nausea/vomiting, headache, double vision, dizziness, anxiety, or confusion.
- c. **Carbamazepine** – drowsiness, dizziness, double vision, rash/itching, and headaches.
- d. **Gabapentin** – drowsiness, dizziness, double vision, and a stumbling walk.
- e. **Lamotrigine** – nausea/vomiting, drowsiness, dizziness, and rash.
- f. **Topiramate** – drowsiness, dizziness, confusion, lack of concentration, speech problems, and weight loss.

3. Side Effects of Anti-Anxiety Medications (Benzodiazepines)

- Drowsiness
- Dizziness
- Forgetfulness
- Paradoxical rage
- Unsteady walk (“drunk”)
- Muscle weakness
- Addiction (with long-term use)

Withdrawal Effects

- Flu-like symptoms
- Sweating
- Tremors
- Nausea
- Hallucinations
- Depression
- Seizures
- Rebound anxiety

4. Side Effects of Antipsychotic Medications

Most side effects of antipsychotic medications are mild. Many common ones lessen or disappear after the first few weeks of treatment.

Antipsychotic medications can produce unwanted effects when taken with other medications. Antipsychotics also add to the effect of alcohol and other central nervous system depressants, such as antihistamines, antidepressants, barbiturates, some sleeping and pain medications, and narcotics.

- Drowsiness
- Restlessness
- Muscle spasms
- Tremors
- Dry mouth
- Blurred vision
- Drooling
- Weight gain
- Sedation
- Constipation
- Urinary retention

Most of these can be corrected by lowering the dosage or can be controlled by other medications. Different patients have different

treatment responses and side effects to various antipsychotic drugs. A patient may do better with one drug than another.

Long-term treatment with one of the older, or “traditional” antipsychotic medications may cause a person to develop tardive dyskinesia (TD). TD is a disorder characterized by involuntary movements most often affecting the mouth, lips, and tongue, and sometimes the trunk or other parts of the body such as arms and legs. The risk has been reduced with the newer “atypical” medications. There is a higher incidence in women, and the risk rises with age.

C. Medication Assessment

When officers respond to a person in crisis, it is important to establish if the person is on medication and whether they may have stopped taking their medication. An officer can ask the individual or a family person the following questions:

1. Are you on medication? If so, what medication are you taking?
2. Did you take the medication today or when was the last time you took your medication?
3. Is this a new medication?

By asking these simple questions, you will be able to make a better assessment of the situation and possibly prevent the situation from escalating.

Psychiatric Medications

A Brief Overview

Katy Tomisser, Pharm D, BCPP
Western State Hospital
April 2007

Disorders in Which Psychosis May Be Present

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder – mania
- Substance-induced psychotic disorder or mania
- Psychotic depression
- Psychosis – due to general medical condition
- Dementia

Positive Symptoms of Schizophrenia

- Hallucinations (internal stimuli or false sensory information)
- Delusions (fixed, false beliefs not amendable to rationale explanation)
- Paranoia (fear not based on reality)
- Verbal incomprehensibility – disorganized speech
- Agitation
- Racing thoughts, thought broadcasting, thought insertion
- Hostility
- Disorientation
- Lack of judgment and insight
- Poor impulse

Negative Symptoms of Schizophrenia

- Social withdrawal
- Lack of motivation
- Blunted or flat affect (absence of emotion)
- Lack of pleasure
- Poor grooming/hygiene
- Limited spontaneous conversation
- Poor social skills

Typical (Traditional) Antipsychotics

- Chlorpromazine (*Thorazine*)
- Thioridazine (*Mellaril*)
- Mesoridazine (*Serentil*)
- Molindone (*Moban*)
- Perphenazine (*Trilafon*)
- Iloxapine (*Loxitane*)

- Trifluoperazine (*Stelazine*)
- Thiothixene (*Navane*)
- Fluphenazine (*Prolixin*)
- Haloperidol (*Haldol*)

Atypical (Newer) Antipsychotics

- Aripiprazole (*Abilify*)
- Clozapine (*Clozaril*)
- Olanzapine (*Zyprexa*)
- Risperidone (*Risperdal*)
- Paliperidone (*Invega*)
- Quetiapine (*Seroquel*)
- Ziprasidone (*Geodon*)

Typical Antipsychotics: Side Effects

- Sedation
- Dry mouth
- Constipation
- Blurred Vision
- Urinary retention
- Weight gain
- Tardive dyskinesia (abnormal movement)
- pseudo Parkinson's (tremors/shaking, slow movement, shuffling gait, muscle stiffness)
- Dystonia
- Drooling
- Akathisia (inner restlessness)

Atypical Antipsychotics: Side Effects

- Weight gain
- Diabetes
- High cholesterol
- Akathisia, activation
- Sedation
- Clozapine: decreased white blood cells

Bipolar Disorder Description

- Prominent mood swings between depression and mania or hypermania
- Psychosis may be present
- Caused impairment in functioning

Signs & Symptoms of Mania

- Decreased need for sleep
- High energy
- Inflated self-esteem
- Increased productivity

- Pressured speech
- Racing thoughts
- Uninhibited socializing hyper sexuality
- Psychomotor restlessness
- Inappropriate laughter
- Irritability
- Heightened distractibility

Mood Stabilizers

- Lithium (*Eskakith, Lithobid*)
- Carbamazepine (*Tergritol*)
- Valproic acid (*Depakene*)
- Divalproex sodium (*Depakote*)
- Lamotrigine (*Lamictal*)
- Oxcarbazepine (*Tripetal*)
- Atypical antipsychotics

Mood Stabilizers: Side Effects

- Lithium – *increased thirst, increased urination, fine hand tremor, nausea/vomiting, diarrhea, weight gain*
- Valproic acid – *upset stomach/nausea/vomiting, weight gain*
- Carbamazepine – *drowsiness, dizziness, double vision, rash/itching, headache*
- Lamotrigine – *nausea/vomiting, drowsiness, dizziness, rash*
- Oxcarbazepine – *dizziness, fatigue, nausea, double vision, low serum sodium*

Signs & Symptoms of Depression

- Sleep disturbances
- Low energy
- Feelings of inadequacy/guilt
- Decreased productivity
- Decreased concentration
- Loss of interest or pleasure
- Sexual disinterest
- Slow movement
- Pessimistic attitude
- Tearfulness
- Social withdrawal
- Thoughts of suicide
- Weight loss/gain

Uses for Antidepressants

- Depression
- Generalized Anxiety Disorder
- Posttraumatic Stress Disorder (PTSD)
- Social Phobia
- Obsessive Compulsive Disorder (OCD)

- Panic Disorder
- Premenstrual Dysphoric Disorder
- Bulimia
- Chronic Pain
- Attention-Deficit Hyperactivity Disorder (ADHD)
- Insomnia
- Aggression
- Smoking Cessation
- Borderline Personality Disorder

SSRIs

- Fluoxetine (*Prozac*)
- Paroxetine (*Paxil*)
- Sertraline (*Zoloft*)
- Fluvoxamine (*Luvox*)
- Citalopram (*Celexa*)
- Escitalopram (*Lexapro*)

SSRIs: Side Effects

- Nausea
- Headache
- Nervousness
- Sexual Dysfunction
- Irritability
- Insomnia
- Tremor

Other Antidepressants

- Venlafaxine (*Effexor*) (SNRI)
- Duloxetine (*Cymbalta*) (SNRI)
 - Side effects: *drowsiness/insomnia, nausea, constipation, dry mouth, sexual dysfunction, agitation*
- Bupropion (Wellbutrin)
 - Side effects: *tremor, sweating, dizziness, agitation, nausea, insomnia*
- Trazodone (Desyrel)
 - Side effects: *sedation, dizziness*
- Mirtazapine
 - Side effects: *drowsiness, increased appetite, dry mouth*

Withdrawal Effects of Newer Antidepressants

(Mostly with Venlafaxine and Paroxetine)

- Flu-like symptoms
- Dizziness
- Muscle aches
- Numbness
- Headache

Tricyclic Antidepressants (TCAs)

- Amitriptyline (*Evavil*)
- Amoxapine (*Asendin*)
- Clomipramine (*Anafranil*)
- Desipramine (*Norpramin*)
- Doxepin (*Adapin, Sinequan*)
- Imipramine (*Tofranil*)
- Nortriptyline (*Aventyl, Pamelor*)
- Protriptyline (*Vivactil*)
- Trimipramine (*Surmontil*)

TCAs: Side Effects

- Sedation
- Dry mouth
- Constipation
- Urinary retention
- Blurred vision
- Lethal in overdose

Monoamine Oxidase Inhibitors (MAOIs)

- Selegiline (*Emsam*)
- Phenelzine (*Nardil*)
- Tranylcypromine (*Parnate*)

MAOIs: Side Effects

- Dietary restrictions
- Decreases blood pressure
- Serious drug interactions

Signs & Symptoms of Anxiety

- Extreme agitation
- Sweating
- Trembling or shaking
- Sensations of shortness of breath/smothering
- Feeling of choking
- Chest pain/discomfort
- Restlessness
- Insomnia
- Nausea/abdominal distress
- Dizziness, lightheaded, faint or unsteady
- Feelings of unreality or detachment from oneself
- Fear of losing control or going crazy
- Fear of dying
- Chills or hot flashes

Anti-Anxiety Medications: Benzodiazepines

- Alprazolam (*Xanax*)
- Chlordiazepoxide (*Librium*)
- Clonazepam (*Klonopin*)
- Clorazepate (*Tranxene*)
- Dizepam (*Valium*)
- Lorazepam (*Ativan*)
- Oxazepam (*Serax*)

Benzodiazepines: Side Effects

- Drowsiness
- Dizziness
- Forgetfulness
- Confusion
- Falls
- Paradoxical rage
- Unsteady walk
- Muscle weakness
- In-coordination
- Addiction (with long-term use)

Benzodiazepines: Withdrawal Effects

- Flu-like symptoms
- Sweating
- Tremors
- Nausea
- Hallucinations
- Depression
- Seizures
- Rebound anxiety

Anti-anxiety Medications: Non-Benzodiazepines

- Buspirone (*Buspar*)
 - Side effects: *headache, nausea, dizziness*
- Hydroxyzine (*Vistaril, Atarax*), Diphenhydramine (*Benadryl*)
 - Side effects: *dry mouth dizziness, drowsiness*
- Propranolol (*Inderal*)
 - Side effects: *fatigue, dizziness, low blood pressure*
- Antidepressants

Agitation

- Excessive motor or verbal activity:
 - Psychomotor activation
 - Uncooperativeness
 - Irritability
 - Assaultiveness

- Verbal outbursts or abuse
- Threatening gestures or language
- Physical destructiveness
- Harm to self, others

Psychiatric Disorders Associated with Agitation

- Psychiatric conditions:
 - Schizophrenia
 - Mania
 - Mental Retardation
 - Dementia
 - Personality Disorder
 - Impulse Control Disorder
- Somatic conditions
 - Delirium
 - Intoxication
 - Akathisia
- Withdrawal states

Management of Acute Agitation

- Olanzapine (*Zyprexa*), IM
- Ziprasidone (*Geodon*), IM
- Aripiprazole (*Abilify*), IM
- Haloperidol (*Haldol*), IM
- Droperidol (*Inapsine*), IM
- Lorazepam (*Ativan*), IM or oral
- Diazepam (*Valium*), oral

Psychiatric Disorders Associated with Aggression

- Mental Retardation
- Bipolar Disorder
- Dementia
- Schizophrenia
- Substance Abuse
- Personality Disorders (antisocial, borderline)
- Conduct Disorder
- Delirium
- Intermittent Explosive Disorder
- Impulse Control Disorder

Drug Therapy of Chronic Aggression

- Lithium
- Anticonvulsants (*Tergretol*, *Depakene*)
- Propranolol, Clonidine
- Antipsychotics
- SSRIs

Insomnia

- Difficulty initiated or maintaining sleep
- Lasts at least one month
- Results in significant daytime impairment

Hypnotics

- Zolpidem (*Ambien*)
- Zaleplon (*Sonata*)
- Eszopiclone (*Lunesta*)
- Temazepam (*Restoril*)
- Estazolam (*ProSom*)
- Triazolam (*Halcion*)
- Ramelteon (*Rozerem*)

New FDA Warning 3/07

- “complex sleep-related behaviors which may include sleep-driving, making phone calls, preparing and eating food (while asleep)”

Anticholinergics

- Used to treat the following side effects of antipsychotic medications:
 - Tremors
 - Shaking
 - Muscle stiffness
 - Akathisia
 - Muscle spasms
 - Drooling
- Benztropine (*Cogentin*)
- Trihexphenidyl (*Artane*)
- Diphenhydramine (*Benadryl*)
- Biperiden (*Akineton*)
- Procyclidine (*Kemadrin*)

Anticholinergics: Side Effects

- Increased heart rate
- Constipation
- Dry mouth
- Urinary retention
- Heat intolerance, decreased ability to sweat
- Blurred vision
- Pupil dilation
- Psychosis
- Memory impairment
- Confusion delirium
- Dizziness
- Some abuse potential (for mild euphoric and hallucinogenic effects)

Anticholinergics: Withdrawal Effects

- Nausea/vomiting
- Drooling diarrhea
- Flu-like symptoms
- Insomnia
- Irritability
- Restlessness

Signs & Symptoms of Attention-Deficit Hyperactivity Disorder (ADHD)

- Inattention
 - Problems listening and following instructions, difficulty with organization, easily distracted, forgetful
- Hyperactivity
 - Fidgeting, inability to stay seated or engage in activities quietly, talks excessively
- Impulsivity
 - Often interrupts and has a hard time awaiting turn

Psycho Stimulants

- Methylphenidate (*Ritalin, Concerta, Metadate, Methylin, Daytrana*)
- Dextroamphetamine (*Dexedrine*)
- Amphetamine/Dextroamphetamine (*Adderall*)
- Pemoline (*Cylert*)
- Dexmethlyphenidate (*Focalin*)

Psycho Stimulants: Side Effects

- Decreased appetite
- Insomnia
- Headache
- Irritability
- Anxiety
- Abuse potential

Other Anti-ADHD Medications

- Atomoxetine (*Strattera*)
- Clonidine (*Catapres*)
- Guanfacine (*Tenex*)
- Bupropion (*Wellbutrin*)
- Venlafaxine (*Effexor*)
- Desipramine (*Norpramin*)

Crisis Intervention Training

Unit 5

Involuntary Treatment Act (ITA)

CIT Training Lesson Plan Performance Objectives

Involuntary Treatment Act (ITA)

Unit Goal: Ability to recognize and understand the legal issues and definitions associated with the Involuntary Treatment Act (ITA).

Classroom Hours: 3.00

Presenter:

Performance Objectives:

Participants will be able to:

- Understand the legal issues involved with the Involuntary Treatment Act.
- Understand the impact on law enforcement actions.
- Understand the RCW definition of the Involuntary Treatment Act.

Legal Issues

I. Vulnerable Adult Statute – State Statute RCW 74.34.020 (13)

A "Vulnerable adult" is defined as a person who is sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; found incapacitated; who has a developmental disability; admitted to any facility; receiving services from home health, hospice, or home care agencies licensed or required to be licensed; or receiving services from an individual provider.

A. Sections Applicable to Police – RCW 74.34.063 (2)(3)(4)

This section addresses when law enforcement must be notified of a possible vulnerable adult case. The statute states that:

“When the initial report or investigation by the department indicates that the alleged abandonment, abuse, financial exploitation, or neglect may be criminal, the department shall make an immediate report to the appropriate law enforcement agency. The department and law enforcement will coordinate in investigating reports made under this chapter. The department may provide protective services and other remedies as specified in this chapter.”

“The law enforcement agency or the department shall report the incident in writing to the proper county prosecutor or city attorney for appropriate action whenever the investigation reveals that a crime may have been committed.”

“The department and law enforcement may share information contained in reports and findings of abandonment, abuse, financial exploitation, and neglect of vulnerable adults, consistent with RCW 74.04.060, 42.17.310, and other applicable confidentiality laws.”

B. Impact on Police Actions – Operations

Will require law enforcement to complete a thorough investigation.

1. Who Can Be Liable?

- Police Departments
- Individual Officers

II. Involuntary Treatment Act – State Statute RCW 71.05.00

The Involuntary Treatment Act is the law, under which persons may be detained, evaluated and treated for a mental illness with and without their consent. The law's intent was to establish a bill of rights for people with a mental illness, empower mental health professionals to involuntarily commit patients for treatment, and define guidelines for police officers when interacting with the mentally ill.

A. RCW 71.05.010 – Legislative Intent.

The provisions of this chapter are intended by the legislature:

- (1) To prevent inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment;
- (2) To provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders;
- (3) To safeguard individual rights;
- (4) To provide continuity of care for persons with serious mental disorders;
- (5) To encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures;
- (6) To encourage, whenever appropriate, that services be provided within the community;
- (7) To protect the public safety.

B. RCW 71.05.020 – Definitions.

- (1) "Gravely Disabled" means a condition in which a person, as a result of a mental disorder: is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety.

(2) “Likelihood of Serious Harm” means:

(a) A substantial risk that:

- (i) Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;
- (ii) physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or
- (iii) Physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or

(b) The individual has threatened the physical safety of another and has a history of one or more violent acts.

(3) “Mental Disorder” means any organic, mental, or emotional impairment which has substantial adverse effects on an individual’s cognitive or volitional functions.

C. Sections Applicable to Police – RCW 71.05.150 (3) through (5)

This section addresses when law enforcement can commit mentally disordered persons for evaluation and treatment. This statute states that:

- (1) A peace officer may take such person or cause such person to be taken into custody and placed in an evaluation and treatment facility.
- (2) A peace officer may take or cause such (mentally disordered) person to be taken into custody and immediately delivered to an evaluation and treatment facility or the emergency department of a local hospital when he or she has reasonable cause to believe that such person is suffering from a mental disorder and presents an imminent likelihood of serious harm or is in imminent danger because of being gravely disabled.

- (3) Persons delivered to evaluation and treatment facilities by peace officers may be held by the facility for a period of up to twelve hours: PROVIDED that they are examined by a mental health professional within three hours of their arrival. Within twelve hours of their arrival, the county designated mental health professional must file a supplemental petition for detention and commence service on the designated attorney for the detained person.

D. RCW 71.05.040 – Detention or judicial commitment of persons who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering from dementia.

This statute states, “Persons who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering from dementia shall not be detained for evaluation and treatment or judicially committed solely by reason of that condition unless such condition causes a person to be gravely disabled or as a result of a mental disorder such condition exists that constitutes a likelihood of serious harm.”

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Interacting with Persons with Developmental Disabilities and
Mental Illness Training CD
Wanda Townsend, Instructional Designer

Crisis Intervention Training

Unit 6

Community Resources

CIT Training Lesson Plan Performance Objectives

Community Resources

Unit Goal: Ability to recognize and understand where to look in the community for resources for those who have a developmental disability and/or mental illness.

Classroom Hours: 3.00

Presenter:

Performance Objectives:

Participants will be able to:

- Understand and recognize where to go for community resources to include at a minimum Alzheimer's, autism, brain injuries, cerebral palsy, deaf and hard of hearing, diabetes and Tourette's syndrome.
- Understand how to build partnerships with community organizations.

Community Resources

When an officer is searching for a treatment or placement option for a person with developmental disabilities and/or mental illness, he or she can become frustrated by the lack of available community-based services. There is no question that community disability and mental health services are being stretched.

However, here is a list of different resources that law enforcement can contact for additional information or assistance. We encourage law enforcement to build partnerships with these and other community organizations within their jurisdiction. By working together, agencies will better understand differing perspectives and help create opportunities to address our community members' needs.

Alzheimer's disease

Alzheimer's Association

225 N. Michigan Ave., Fl. 17
Chicago, IL 60601-7633
Phone: (800) 272-3900
Email: info@alz.org
Web site: www.alz.org

Western and Central Washington State Chapter

12721 30th Ave. NE, Suite 101
Seattle, WA 98125
Phone: (800) 848-7097 or (206) 363-5500
Web site: www.alzwa.org

Inland Northwest Chapter

601 W. Maxwell, Suite 4
Spokane, WA 99201
Phone: (800) 256-6659 or (509) 483-8456
Web site: www.inwalza.org

Autism

Autism Society of America

7910 Woodmont Ave., Suite 300
Bethesda, Maryland 20814-3067
Phone: (301) 657-0881 or (800) 318-8416
Web site: www.autism-society.org

Autism Society of Washington

P.O. Box 111624
Tacoma, WA 98411-1624
Phone: (253) 223-8885
Email: info@autismsocietyofwa.org
Web site: www.autismsocietyofwa.org

National Information Center for Children and Youth with Disabilities (NICHCY)

P.O. Box 1492
Washington, DC 20013
Phone: (800) 695-0285
Web site: <http://www.nichcy.org>

Brain Injury**Brain Injury Association of Washington**

16315 NE 87th, Suite B-4
Redmond, WA 98052
Phone: (425) 895-0047 or (800) 523-5438
Web site: www.biawa.org

Brain Injury Association of America

8201 Greensboro Dr., Suite 611,
McLean, VA 22102
Phone: (703) 761-0750 or (800) 444-6443
Web site: www.biausa.org

Cerebral Palsy**United Cerebral Palsy (UCP)**

1660 L St. NW, Suite 700
Washington, DC 20036-5602
Phone: (800) USA-5-UCP or (202) 776-0406
E-mail: national@ucp.org
Web site: www.ucp.org/main.cfm/129

UCP of Oregon & SW Washington

7830 SE Foster Road
Portland, OR 97206
Phone: (503) 777-4166 or (800) 473-4581
E-mail: ucpa@ucpaorwa.org
Web site: <http://www.ucpaorwa.org>

UCP of South Puget Sound

6315 S. 19th St., #25
Tacoma, WA 98466-6217
Phone: (253) 565-1463
E-mail: info@ucp-sps.org
Web site: <http://www.ucp-sps.org>

Deafness and Hard of Hearing**National Association of the Deaf**

814 Thayer Ave.
Silver Spring, MD 20910-4500
Phone: (301) 587-1789
Email: NADinfo@nad.org
Web site: www.nad.org

**Washington State Department of Social and Health Services
Office of the Deaf and Hard of Hearing**

P.O. Box 45301
Olympia, WA 98504-5301
Phone: (360) 902-8000
Web site: <http://www1.dshs.wa.gov/HRSA/ODHH/index.shtml>

DeafWeb of Washington

Website: www.deafweb.org/signlang.htm#interps

Developmental Disabilities**Washington Protection & Advocacy System**

315 - Fifth Ave. S., Suite 850
Seattle, WA 98104
Phone: (206) 324-1521 or (800) 562-2702
*Interpreters Available in over 200 languages via AT&T Language Line
E-mail: wpas@wpas-rights.org
Web site: <http://www.wpas-rights.org>

**Washington State Department of Social and Health Services
Division of Developmental Disabilities**

P.O. Box 45310
Olympia, WA 98504-5310
Phone: (360) 902-8444
Email: ddcoreception@dshs.wa.gov
Web site: www.dshs.wa.gov

Diabetes

American Diabetes Association

1701 N. Beauregard St.
Alexandria, VA 22311
Phone: 1-800-DIABETES (1-800-342-2383)
Web site: www.diabetes.org

Mental Illness

National Alliance for the Mentally Ill (NAMI)

Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
Phone: (703) 524-7600 or (800) 950-NAMI (6264)
Web site: www.nami.org

National Institute of Mental Health (NIMH)

Office of Communications

6001 Executive Blvd., Room 8184, MSC 9663
Bethesda, MD 20892-9663
Phone: 301-443-4513 (local) or 1-866-615-6464 (toll-free)
Web site: www.nimh.nih.gov

Washington State Partners in Crisis

Peter Lukevich, Executive Director
P.O. Box 27575
Seattle, WA 98125
(206) 674-9559
Email: pic@wapic.org
Web site: www.wapic.org

Community Mental Health Centers located in the local community.

Mental Retardation

Association of Retarded Citizens – ARC

The Arc of the United States

1010 Wayne Ave., Suite 650
Silver Spring, MD 20910
Phone: (301) 565-3842
Email: info@thearc.org
Website: www.thearc.org

The Arc of Washington State

2600 Martin Way E., Suite D

Olympia, WA 98506

Phone: (360) 357-5596

Email: info@arcwa.org

Web site: <http://www.arcwa.org>

Community Mental Retardation Centers located in the local community.

Tourette's Syndrome**Tourette's Syndrome Association, Inc.**

42-40 Bell Blvd., Suite 205

Bayside, NY 11361-2820

Phone: 1-888-486-8738

Web site: <http://tsa-usa.org>

How to Start Up a CIT Class in Your Community

Provided by Mary Heitzman

It only takes one police chief or sheriff to begin the process. The Training Commander (of said police force) is key to developing the specs. It is out of that one police force that CIT can be promoted to/and offered to other jurisdictions. It is not necessary for more than one police jurisdiction to take the lead - within a particular county or region.

- 1a. Get together with all police/sheriff jurisdictions ahead of developing this class to make sure that they will be on board with your efforts.
- 1b. Need to form a training team to include members of NAMI, consumer groups, hospital, and local provider. A police agency representative on this team should be in charge of coordination of the class as well as the Moderator. (This makes it easier for getting returning FREE guest lecturers - as they come from these sources). You will have one guest lecturer expense or two, however.
- 2a. This training team needs to search out the trainers (guest lecturers), arrange for panel or home visitations for the trainee's for Consumers or Family Members - and will design a form letter/notification materials, evaluations, checklist - for police to take this class.
- 2b. Need power point presentations on all guest lecturers - to be put into a binder for each student. (Have a binder party right before the class with the CIT team).
3. You will want to get speakers that can come back every year so as not to have to change the power point presentations too often. However, Olympia finds that there is some evolution each year. Our CIT team goes over what information can be presented better to match the needs of the trainee.
4. Need to have a checklist of duties that you can check off each year. I will see if I can get an email copy for you as a sample.
5. Need to develop evaluation forms for officer input at the end of each day of the class.
6. Is this going to be a 3 day (24 hour) or 5 day (40 hour) class?
7. Whatever police rep is coordinating the class, make sure that his police or sheriff jurisdiction includes this class as part of the 24 hour re-cert requirements that police must have each year. This is an added incentive for officers to take a CIT class.
8. Some of the police officers from some jurisdictions do not volunteer to take the class (in our case). But they still benefit from the class and seem to enjoy it anyway.

9. Arrange for catering for continental breakfast and full lunch for CIT staff and trainees.
10. Try to find a large free space (like a fire hall or grange) that could give you space for 5 days, 9 hours per day, otherwise you will have to find a spot within your local town center or motel with conference space. Even with that, you may get a non-profit break.
11. Arrange for power point, sound systems, pull down screen, etc.
12. At the end of the class (during graduation), hand out CIT pins that you design (police wear them on their uniform and it identifies them as CIT trained to the public). Also hand out T-shirts with a CIT logo on it. Make sure that heads of police/sheriff dept. attend this graduation. Also present them with a Certificate of Completion.

Footnote: I am personally attached to "home visits" to consumers and/or family members (vs. consumer panels). We found that has the most impact on officers. Be careful not to find volunteers for home visits who are too bitter about the police. All volunteers need to educate.

Design a summary list of questions that officers can ask at home visits. (We keep home visits down to an hour). Allow for travel time. Have a cell phone contact for both home visit volunteers and officers.

Mary Heitzman

CIT Preparation Check List

*Updated as of March 12, 2007

Class Dates _____

| | <u>Task</u> | <u>Who</u> | <u>Comments</u> | <u>Due Date</u> |
|--|--|------------|-----------------|-----------------|
| | | | | |
| | <u>Set Class Dates</u> | | | |
| | Develop Budget | | | |
| | Secure Funding | | | |
| | Review Prior Class Evaluations | | | |
| | Set Agenda | | | |
| | | | | |
| | <u>Check Speaker Availability</u> | | | |
| | Keynote | | | |
| | Chief | | | |
| | Psychologist | | | |
| | Primary | | | |
| | Child | | | |
| | Elder | | | |
| | Medications | | | |
| | PSPH | | | |
| | BHR | | | |
| | Chemical Dependency | | | |
| | DMHP | | | |
| | PTSD | | | |
| | | | | |
| | <u>Confirm Room</u> | | | |
| | Confirm Date | | | |
| | Confirm Location | | | |
| | Plan Food Services | | | |
| | Speaker Hotel Reservations | | | |
| | Finalize Agenda | | | |
| | Prepare Evaluations | | | |
| | Daily | | | |
| | Program Weekly | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| | <u>Task</u> | <u>Who</u> | <u>Comments</u> | <u>Due Date</u> |
|--|---|-------------------|------------------------|------------------------|
| | | | | |
| | <u>Share Agenda with Speakers</u> | | | |
| | Advertise to Jurisdictions | | | |
| | Assemble Binders & Handouts | | | |
| | Collect Handouts | | | |
| | Order Binders | | | |
| | Order Pins | | | |
| | Order T-Shirts | | | |
| | | | | |
| | <u>Organize Visits</u> | | | |
| | ID Visitors | | | |
| | Plan Routes & Maps | | | |
| | Assemble Visit Packets | | | |
| | Confirm Visitors | | | |
| | | | | |
| | <u>Graduation</u> | | | |
| | Speakers | | | |
| | Graduation Certificate | | | |
| | Program | | | |
| | Media | | | |
| | Invite Chiefs and Sheriffs | | | |
| | <u>Payment-</u> Prepare Checks for: | | | |
| | *Speaker(s) | | | |
| | *Food | | | |
| | *Hotel | | | |
| | *Other | | | |
| | | | | |
| | <u>Thank You Letters</u> | | | |
| | Speakers | | | |
| | Visitors (with survey) | | | |
| | | | | |
| | <u>Review & Learn from the Class</u> | | | |
| | Debrief the Class | | | |
| | Review Evaluations | | | |
| | Establish Date for Next Class | | | |
| | | | | |
| | | | | |

Crisis Intervention Training

Unit 7

Communication Techniques

CIT Training Lesson Plan Outline and Presentation

Communication with Mentally Ill Individuals

Unit Goal: To provide participants with crisis intervention communication skills and techniques.

Classroom Hours: 4.00

Presenter:

Performance Objectives:

Participants will be able to:

- Understand how to manage behavioral emergencies.
- Understand and recognize how to communicate with those who have a mental illness.
- Understand and recognize mental illness in the elderly.
- Understand and recognize mental health in children.

Content Material:

See attached PowerPoint presentations for *Elderly and Mental Illness* and *Child Mental Health Crisis: the Biology behind Dangerous Behavior*

I. Introduction - Communication with Mentally Ill Individuals

A. Managing Behavioral Emergencies

1. As CIT members, you will be called to deal with:
 - a. "Out of control" people due to a mental health crisis.
 - b. Angry people involved in a domestic violence incident.
 - c. People who are suicidal in public and private places.
 - d. Barricaded individuals (at least until SERT/HNT arrive).
 - e. Intoxicated people who are displaying bizarre behaviors.
2. What is common among this group of people?
 - a. All will demonstrate some degree of serious impairment in their ability to communicate effectively.
 - b. The challenge is then to attempt to negotiate an alternative with a person to avoid violent behaviors.
3. Communication is the tool
 - a. Using different ideas and techniques that are practiced by mental health professionals.
 - b. You will be presented with strategies you can use to maximize your ability to deal with agitated people.
 - c. The objective is to present effective principles and techniques to deescalate an agitated person when possible.

II. Communication

A. Communication is a People Process

1. It is an interactive phenomenon that involves more than words.
2. Messages are often the result of a combination of words, behaviors and context.

B. Parts of the Message are:

1. Verbal Components

- a. Content
- b. Speech
 - i) Rate
 - ii) Productivity
 - iii) Tone
 - iv) Volume
 - v) Congruency with other messages

2. Nonverbal Components

- a. Stance
- b. Gestures - transient movements of the body or face
- c. Eye movements
- d. Facial expressions

- e. Motor movements
- f. Personal attire

C. Factors That Influence Communication

1. Culture
2. Religion
3. Sex roles
4. Social class
5. Perceptions or internal experiences
6. Values
7. Levels of relatedness. Do the individuals communicating have the same understanding of the subject matter?
8. Context
9. Sensitivity to content

D. Communication Statistics

1. The three parts of communication make up certain percentages of the total message. They are as follows:
 - a. Verbal or content: 7%
 - b. Tone and volume: 38%
 - c. Body language: 55%

III. Violence Curve

A. Calm State

1. Communication ability is at 100%.
2. Person will function at their normal baseline communications ability level. Ability may be different with each person.

B. Level 1: Anxiety (low agitation)

1. Communication ability is 50% to 75%.
2. Person will begin to show agitation but still be functioning as an adult.

C. Level 2: Anger (moderate agitation)

1. Communication ability is 25% to 50%.
2. Person will begin to show increasing agitation and could be characterized as acting like an adolescent.

D. Level 3: Hostility (high agitation)

1. Communication ability is 5% to 25%.
2. Person will begin to show increasing agitation and could be characterized as acting like a child.

E. Level 4: Violence (explosive agitation)

1. Communication ability is 0% to 5%.
2. Person will show the greatest level of agitation and could be characterized as acting like a toddler ("terrible 2 tantrums").

F. Related Issues

1. The violence curve does not take into consideration the variables of acute mental illness or intoxication or both.
2. Behaviors of individuals so affected will be erratic and tend not to follow progressive patterns.

IV. Introduction - Basic Life Support Crisis Cycle

A. Explanation of Each Stage

1. Normal State
2. Stimulation
3. Escalation
4. Crisis
5. Deescalation
6. Post-Crisis Drain
7. Stabilization

B. Summary and Issues

V. Review and Questions

I. Introduction - High-Risk Interventions

- A. Give current prevalence statistics.
- B. Give culture and sex role related suicide statistics.
- C. Provide age related statistics.
- D. Provide an explanation for the statistics if one exists.

II. Suicide by Officer (Victim-Precipitated Homicide)

A. Clarify This Type of Incident

1. Incidents where an individual determined on self-destruction engages in a calculated life threatening criminal incident in order to force a police officer to kill him or her.
2. Give incidence statistics if available.
3. Explain that profiles match general suicidal populations.

B. Reasons People Choose This Route for Suicide

1. The difficult decision to end one's life is made by someone else once initiated.
2. Police are the only community agency armed with lethal weapons and trained to respond with accurate and deadly force.
3. Police are only a phone call away.
4. Stigma of social taboos of suicide can be absolved by being terminated by an external mechanism.
5. Police are faceless and ending life is done in a dignified manner.
6. Police may represent a "social conscience" and attract guilt-ridden persons for punishment.
7. A person who does not have the determination for a quick end by gun may use the police.
8. Some fancy going out in a dramatic "blaze of glory" as part of a delusion or acting out of anger. Taking hostages, attracting attention for religious delusions, or placing police in public contempt may be the motivation.

III. High-Risk Profile Summary

- | | |
|--------------------------------|--|
| A. Age: | Over 45 |
| B. Sex: | Male |
| C. Marital: | Divorced or widowed |
| D. Employment: | Unemployed |
| E. Interpersonal style: | Conflicted |
| F. Family: | Chaotic |
| G. Health: | Chronically ill Hypochondriac Substance abuser |
| H. Psychological: | Severe depression Psychotic Severe personality disorder Substance induced Anger or guilt |
| I. Suicidal activity: | Ideation - frequent, prolonged, intense Plan - clear Means - possible and lethal Previous history |

J. Resources:

- 1. Personal:** Poor achievement
Poor insight
Poor control of emotions
- 2. Social:** Isolated
Unresponsive family

IV. Six Interviewing Techniques to Assess Suicide Risk

A. Interviewing Techniques

The following interviewing techniques sharpen assessment of suicide risk and are often more useful than traditional “open ended questions.”

- 1. Question factual behaviors.** Ask the patient for specific facts, details or train of thoughts, as opposed to opinions or impressions. Instead of “How close were you to killing yourself?” ask, “Did you pick up the gun?” “How long did you hold it” “Where did you point it?” “Was the safety on or off?”
- 2. Decrease shame.** Ask the question from the subject’s perspective to minimize shame. Do not ask, “Do you have trouble keeping a job?” Instead ask, “Does your boss make life hard at work?”
- 3. Gentle assumption.** Assume that a given behavior has occurred. Let the subject correct or fill in the blanks. Do not ask, “Have you thought of other ways that you might kill yourself?” Instead ask, “What other ways have you thought of killing yourself?”
- 4. Behavior exaggeration.** Subjects will sometimes downplay their behaviors. Find the upper limits by exaggerating the threat. “How many times have you thought of killing yourself in the past week?” “30 or 40?” The subject may reply, “No, only 20.”
- 5. Denial of the specific.** This technique may be useful when the subject has denied a generic question, such as “Have you thought of other ways that you might kill yourself?” Instead be specific. “Have you ever thought of shooting yourself?” “Have you ever thought of...?”
- 6. Normalization.** This approach suggests that most people in similar situations respond in a similar way. “Many people who have...feel they would be better off dead.”

B. Other Points

1. To investigate a suicide attempt, begin with the presenting/current event, such as an overdose.
2. Move on to recent events.
3. Then ask questions about past events before returning to the current state.

V. Field Assessment

- A. All of the elements of the risk profile are important, but for crisis intervention, none is more important than suicidal ideation (thoughts about suicide).
- B. You must investigate:
1. The suicide ideation itself
 - a. Content
 - b. Recurrent or history
 2. The plan
 - a. Realistic, possible
 - b. History of plan
 3. Resource
 - a. Access to means
 4. Past acts
 - a. What, if any, past attempts occurred? What were the means in the past?

VI. Clarify Any Related Points or Questions

VII. Review

CIT SAMPLE QUESTIONS

Questions for Consumers:

Begin by introducing yourself and telling the person a little about yourself: how long you've been a police officer, how long you've lived here (or elsewhere), etc. Ask getting-to-know-you questions such as where they're from, what kind of hobbies they have, etc.

- We're learning about how to deal more effectively with people who have a mental health disorder. What do you think are some of the important things we should know?
- What can you tell me about your mental illness?
- Have you ever had any encounters with police? Good interactions? Negative interactions? If good, what made them good? If bad, what would have made them better?
-If no encounters with police: What problems do you think people with a mental illness might have with the police?
- When you are going through a bad time with your mental health issues, what could a police officer do to make it better? What would be the wrong thing to do?
- What's the ONE THING you want me to take back to the other officers?

Questions for Family Members of Consumers:

Begin by introducing yourself and telling the person a little about yourself: how long you've been a police officer, how long you've lived here (or elsewhere), etc. Ask getting-to-know-you questions such as where they're from, what kind of hobbies they have, etc.

- We're learning about how to deal more effectively with people who have a mental health disorder. What do you think are some of the important things we should know?
- What can you tell me about your family member's mental illness?
- Have you or your family member ever had any encounters with police during a mental health crisis? Good interactions? Negative interactions? If good, what made them good? If bad, what would have made them better?
-If no encounters with police: What problems do you think people with a mental illness might have with the police?
- When your family member is going through a bad time with his or her mental health issues, what could a police officer do to make it better? What would be the wrong thing to do?
- What's the ONE THING you want me to take back to the other officers?

Elderly and Mental Illness

Nancy Holzinger, MN ARNP
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Objectives

- Identify effective communications techniques with elders who have mental disorders.
- Become familiar with views and needs of mental health consumers and families.

Dementia – Normal Aging

- Cognitive Decline
 - Not necessarily associated with normal aging
 - Minor memory problems – normal
 - Mild cognitive impairment
- Key –
 - Does NOT interfere with social or occupational functioning

Elderly & Mental Illness

- Dementia
 - Sub-types
- Pseudo-Dementia
 - False Dementia
- Delirium
- Depression
- Schizophrenia
 - Paranoid
- Bipolar Disorder
- Mood Disorder
 - Suicide
 - Older white males – 6x higher than the general population
- Anxiety Disorder
- Chronic Mental Illness
 - Due to bed reductions as State Hospital level more and more consumers in the community
- New Diagnosis
 - Dementia/Delirium
 - Depression
 - Bipolar Disorder

Dementia – Types

- Alzheimer's
 - Most prevalent
- Vascular
 - Multi-infarct
 - Stroke
 - High Blood Pressure
- Lewy Body Dementia
 - Visual Hallucinations
- Mixed Dementia
 - Vascular & Alzheimer's

Dementia – Less Common Types

- Parkinson's Dementia
 - Hallucinations
- AIDS
 - Advanced
- Pick's Disease
 - Judgment
- Substance – Induced
 - ETOH
 - Often younger
 - Wide – based Stance & Ataxia
- Creutzfeldt-Jakob

Dementia

- Cognition – Thinking
 - Intelligence – ability to learn
 - Memory - language
 - Problem Solving - Orientation
 - Attention - judgment
 - Concentration

Delirium

- *Sudden*, fluctuating & usually reversible cognitive disorder
- Key characteristic symptoms
 - Inability to pay attention
 - Hallmark Sx
 - Inability to think clearly/concentrate

Depression – Pseudo Dementia

- Mimics Dementia
- Lack concentration
- Cognitive impairment
- Difficult to distinguish from Dementia
- May have more insight than Dementia Pt
 - Someone with Dementia might deny they have Dementia/memory loss
- Hx: Depression

Other Causes of Cognitive changes in Older Adults

- Medications
 - Changes in medications
- Medical problems
 - Infections
 - Pain
- Delirium
 - Skilled nursing facilities
- Change/loss
 - Residence/spouse/peer
- Communication problems

Agitation/Aggression

- Sudden or gradual
 - Pacing – hand wringing
 - Confusion – pressured speech
 - Angry outbursts - confusion
- Causes
 - Over-stimulation - overwhelmed
 - Pain – approach to fast?

Communication

- How do you communicate with an older adult with:
 - Dementia
 - Paranoia
 - Mood Disorder
 - Depression
 - Anxiety

Communication: Cultural & Generational Considerations

- Cultural Considerations
 - Us
 - Them
 - Stereotyping
 - Stigma – Mental Illness
 - Personal failure vs. Weakness
- Generational Differences

- Respect
 - Prejudices
- English as a second language
- Personal Space

Communication Skills

- Active listening
- Validating
- Problem solving
- Verbal & non-verbal statements
- Statements
 - “It’s not always *what* you say – it is *how* you say it.”

Non-Verbal Communication

- Body language
- Posturing
- Authority figure
 - Uniform
 - Height
- Children
 - Son
 - Daughter

Communication – Dementia

- Early – middle stages of Dementia
 - Trouble with word finding
 - Expression of thoughts/ideas
 - Frustration, Embarrassing
- Late stages of Dementia
 - Aphasia
 - Inability to express or receive

Communication Skills

- Face to Face
- Speak
 - Slowly
 - Clearly
- Short sentences
- Do NOT use condescending tone/language
- Remember
 - Tone will be understood – even if words are not

Re-Directing

- Negative statements
 - “No! You can’t go outside. Why don’t you go to the TV room instead?”
- Positive statements

- *“Let’s sit down and look at these pictures?”*
- *“What’s this over here? Do you use this? Have you seen this before? Can you tell me about this?”*

Communication

- Do NOT talk about others in front of the client
- Difficult to determine how much a client with Dementia understands
 - Ability to understand may vary
 - Spark plugs firing
- Do NOT ask a lot of questions
 - Especially questions regarding memory
 - Leads to humiliation/anger/agitation
- Re-phrase
 - *“Who is this in the picture?”*
 - *“This must be you son/daughter (pointing to the picture)?”*
- Ask only one question at a time
- Use the same words in the sentence
- Short, simple sentences
- Allow time for response
 - *“Are you cold?” – pause – “Are you cold?”*
 -

More Interventions

- Reassure
- Reduce stimulation
 - Noise
 - Light
- Approach slowly
- Explain what you are doing
- Minimize talking

Reminders for Staff

- Has the client has a recent loss/change?
- Medications changed? Added?
- Fall?
- Urinary Tract Infection?
- Bowels?
- Blood Sugar tested?
- Is the staff member overwhelmed? New? Short staffed?

Family Response to Alzheimer’s

- Natural response to adjustment
- Five stages of response/adjustment
 - Denial
 - Over involvement
 - Anger
 - Guilt

- Acceptance
- Caring for the Caregiver
 - Geriatric Mental Health Foundation – American Association of Geriatric Psychiatry
 - http://www.gmhfonline.org/gmhf/consumer/factsheet/caring_alzheimer_diseasecg.html

Families & Mental Illness

- Home vs. Placement
 - Guilt
 - Frustration
- Family/son/daughter and older adult
- Caregiver
 - Depression
- Resources

Resources

- Families
 - Support groups
 - Skills training – Alzheimer's Association
- Geriatric Psychiatrist/ARNP
- Respite services
- Older adult
 - Day Programs – STARRS
- Alzheimer's Association
 - 1.800.272.3900
 - www.alz.org
- National Alliance for Care Giving
 - www.caregiving.org
- National Family Caregiver's Association
 - www.nfcacares.org
- National Institute of Aging
Alzheimer's disease Education and Referral Center
 - www.alzheimers.org

Child Mental Health Crises

The Biology Behind Dangerous Behavior

John Holttum, MD
Mary Bridge Children's Hospital
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Goals

- Learn to recognize common patterns of behavior related to childhood psychiatric disorders including:
 - Impulse control disorders
 - Explosive disorders
 - Manic symptoms
 - Post traumatic symptoms
- Learn predictors for homicidal and suicidal behavior
- Introduction to brain function as it relates to dangerous behavior

Sources of Dangerous Behavior

- Impulse Control Disorders
 - ADHD
 - Head injury
 - Developmental impairment
- Personality Disorders
 - Borderline
 - Antisocial
- Mood Disorders
 - Bipolar Disorder
 - Temporal Lobe Dysfunction
 - Depression
- Psychosis
- Drugs/Alcohol
- Homicidal Profile

What's With the Brain?

- No use memorizing diagnoses...that won't help you in a crisis.
- Understanding the brain helps predict how the subject is thinking and how they will react, regardless of diagnosis.
- Seeing the biology behind behavior helps take the mystery out of dangerous behavior.

Impulse Control Disorder (Prefrontal)

- Acting before thinking
 - Stabs a classmate with a pencil for taking his seat, and seems almost as surprised as everyone else.

- Grab's a girl's breast as she walks by and then seems embarrassed.
- Blurts out, "I'm going to blow up this school!" in response to a bad test score.
- No evidence of planning or strategy
- No obvious secondary gain except the thrill of the moment

Phineas Gage, After

- Left prefrontal cortex destroyed
- Not only survived, he didn't lose consciousness
- Personality and cognitive traits changed
- He became impulsive, inconsiderate, belligerent, inattentive and disorganized
- See http://en.wikipedia.org/wiki/Phineas_Gage for more information about Phineas Gage

Prefrontal Cortex Functions

- Focus
- Forethought
- Impulse control
- Organization
- Planning
- Judgment
- Empathy
- Insight

Prefrontal Cortex Problems

- Short attention span
- Impulsivity
- Distractibility
- Disorganization
- Poor judgment
- Lack of insight and "receptive" empathy

Approaches to Prefrontal Kids

- Nature of the problem is an inability to inhibit primitive impulses and think ahead
- Any intervention that takes longer than 30 seconds is useless
 - Explanations, lectures, logic, complicated reward schemes, moral lessons, etc.
- Stern authoritative approach can work well in a crisis. Why?
 - Can improve compliance and reduce danger with:
 - High structure
 - Immediate feedback for behavior (use your reflexes)
 - Medical evaluation if severity is moderate to high

Impulse Control Disorders (Temporal)

- Consistent pattern of overreacting, with relatively good function in between
 - Sudden fast-on/fast-off attacks of emotion in response to mild irritants
 - 15 minutes of hysteria in response teasing, quickly calms and then wonders why it's a big deal
 - Stabs a classmate with a pencil for taking his seat, and continues to rage for 15 minutes
- Difference from prefrontal is the presence of intense emotion, not just impulsive actions
- Potential danger is much higher

Temporal Lobe Functions

- Understand language
- Long term memory
- Auditory/visual processing
- Mood stability
- Temper control Reading social cues

Temporal Lobe Problems

- Reactive mood instability
 - Attacks of emotion or cognitive impairment
- Memory and learning problems
- Aggression
- Somatic Complaints
- Unusual perceptions
- Right TL = atypical depression and social skills deficits
- Case Example
 - 10 year old boy, fell off jungle gym
 - ADHD symptoms prior to injury
 - After injury, school failure and violence

Approaches to Temporal Kids

- Nature of the problem is short uncontrollable mood swings in response to minor stressors
- Level of danger is high
 - Most homicidal kids have histories consistent with temporal impairment
- Containment, low stimulation, high level of monitoring (reduce triggers)
- Remember that this is short-lived by nature and should dissipate if you remove the trigger
- Stern authoritative approach often backfires

Oppositional Kids

- Obsessive need to engage in power struggle and competition
- Adults' attempts to win conflicts and arguments appears to act like a reward (increasing the behavior)
- Rigid self-centered view of rules and behavior

- Blame behavior on external factors
- Unable to let go of grudges, minor insults, “injustice” as they see it
- Never seem to tire of arguing

Anterior Cingulate Dysfunction

- Anxious & rigid
- Can’t shift focus
- Gets stuck on things
- Procrastinates
- Oppositional
- Obsessive and /or addictive

Biology of Opposition

- Addicted to power struggles
- Anterior cingulate overactive
- Remember, these kids are physiologically driven to argue
- The more you do it, the more they like it

Approaches to Opposition

- Ironically, I tell parents to “think like a cop”
 - Give a few commands as possible, but when you do make them clear, unambiguous and unmovable
 - Minimize loopholes
 - Professional, emotional detached demeanor
 - NEVER pick up the gauntlet
 - It takes two to argue, don’t participate
 - Present choices as if you don’t care which one they pick
 - NOTHING is personal
 - This is a game, and showing that the kid is getting to you is a score for his team

The Bipolar Age

- The “Bipolar Child” increased awareness
- New criteria = wide net
- New medication myth
 - If mood stabilizers work, then it must be Bipolar
- Tendency to lump all rapid mood changes into Bipolar

Bipolar Disorder

- Once unheard of in children, now over diagnosed
- Sometimes used as excuse for criminal behavior
- Real Bipolar Disorder is made up of 3 phrases:
 - Baseline. Fairly normal state of mind, at least for them
 - Depression. Clear-cut episodes as rare as yearly, or as frequent as weekly (in kids)
 - Mania. Clear-cut episodes, same frequency range

- Manic episodes can last anywhere from several hours to two weeks

Manic Episodes

- Very much like amphetamine intoxication
 - Rapid uninterrupted speech
 - Uncharacteristic impulsivity
 - Hyper sexuality (masturbatory behavior, flirting, peeping. Bathroom humor)
 - Grandiose ideas (taking on bigger kids, knowing more than the teacher)
 - Decreased NEED for sleep (not insomnia)
 - Marked increase in energy

Bipolar Disorder

- Compared to normal Bipolar brains:
 - Generally overactive
 - Asymmetrical
 - Involve symptoms coming from a variety of brain regions
 - Gets worse with stimulating substances
- Bipolar Disorder does exist and is biological in nature

Approaches to Mania

- Not a reaction and not short-lived, so calming and decreasing stimulation are unlikely to help
- Stern authoritative approach may backfire
- Use the mood variability to your advantage
 - Play into grandiosity and self-importance
 - Manic moods are infectious, but that works both ways
 - May be able to steer them in that direction
- Most will need transport to ER for treatment and to rule out drugs

The Traumatized Child (PTSD)

- A child with this disorder may appear very agitated, or even violent, during flashbacks
- Aggressive approaches may escalate the situation
- Signs of a flashback:
 - Agitation or assault appears defensive in nature
 - Appears intensely fearful, animalistic, or much younger than their age with no obvious reason for that intensity in their immediate surroundings
 - Calls people by the wrong name or refers to people and events that are not there

Post Traumatic Stress

- 28 year old female multiple rape victim
- PTSD is a real physiological disease, acquired through trauma
- Flashbacks can be as physical as a seizure

Child Abuse

- Signs that law enforcement might observe. Not equal to abuse, but worth looking into:
 - Inadequately dressed for inclement weather (neglect)
 - Wears long-sleeved shirts or blouses during hot summer months to cover up bruises on arms
 - Unusually reluctant to share information or looks to the parent before answering questions
- More signs of abuse:
 - Malnourishment
 - Abrasions of the corners of the mouth (from the use of a gag) or rope/tape burns on wrists
 - Overly compliant, shy, withdrawn, passive and uncommunicative
 - Patterned injuries, such as bruises on both sides of the face, “grab” marks or hand-shaped bruises of adult size, circular burns (cigarettes), punctures from a fork, rope, belt buckle marks, etc.
 - Easily startled into a defensive stance (looks post traumatic)
 - Seems afraid of or uncomfortable with parent

Post Traumatic Stress Disorder

- Clue: Think flashback when agitation is disorganized and you can think of no way that it will profit the child
 - It isn't occurring conveniently when the marijuana was discovered in their locker
- Tip: use containment and de-escalation techniques rather than confrontation
 - Voice slow and low in volume
 - Exude calm, safety and reassurance, even if you must restrain them
 - Confrontation may feel like re-enactment of the past abuse or trauma

Suicidal Behavior

- Risk factors that might be noticed by parents and educators:
 - Giving away of personal possessions
 - Sudden changes in personality, grades, motivation or activity level
 - Preoccupation with death
 - Sudden withdrawal from friends and family
 - Sudden withdrawal from favorite sports and hobbies
 - Becoming suddenly “busy” or energized after a period of depression
- Suicidal statements may be overt threats; they may simply imply no future
- Actual quotes from kids who attempted suicide:
 - “I won't have to worry about prom.”
 - “Who cares if there's another earthquake?”
 - “Yeah, war scares me, but not much longer.”
- Non-harm contracts useful for cutters, but true suicide risks require intervention
- Risk of completed suicide increases sharply with these factors:
 - Male gender
 - Adolescent age group

- History of impulse control problems and violence
- Intoxication or a history of substance abuse
- Availability of a gun, even if it's "locked up"

Homicidal Behavior: Early Risk Factors

- Fire setting
- Cruelty to animals
- Bed wetting (not significant by itself)

Note: these are not very specific or helpful

Homicidal Behavior: Late Risk Factors

- Socially isolated, outcast, or withdrawn
- Feelings and behavior easily influenced by peers
- Victimized or humiliated by peers
- Alcohol or other drug use
- Dwelling on experiences of rejection, injustices or unrealistic fears
- Reacting to disappointments, criticisms or teasing with extreme and intense anger, blame or a desire for revenge
- Increasing unprovoked anger, aggression and destructive behavior
- Associates with children known to be involved with morbid, destructive or violent behavior/fantasy
- Preoccupation or interest in destructive or violent behavior
- Fascination, interest or an obsession with weapons or potential weapons
- Depicts violent or destructive behaviors in artistic or other creative expressions

Homicidal Behavior: Signs of Immediate Risk

- Recently assaulted or was assaulted by, another child
- Brought a weapon to an inappropriate place or situation
- Has control of a potentially lethal weapon
- Destructive, violent or threatening gestures or statements
- Has a plan for destructive, violent or suicidal behavior
- Saying or implying they are desperate or suicidal
- An identified target for destructive behavior or violence
- Case Examples:
 - There is no rule that says you can have one brain impairment
 - Recognizing which personality factors you're dealing with allows you to customize your approach
 - I am not implying that every dangerous youth has a brain disorder, but you already know how to deal with the ones that don't
- Road Rage:
 - 28 year old female with multiple vehicular aggressions
 - Anterior cingular temporal lobe problems
- Kip Kinkle:
 - School shooting in Oregon
 - Killed 4 people including his parents

- Wounded 26 students
- Took Ritalin and Prozac
- Jeff Weise:
 - Born August 8, 1988
 - Father committed suicide July 1997 after day-long standoff with police
 - Mother, a heavy drinker, suffered brain damage in a 199 car accident
 - Mother placed in nursing home and Jeff moved to reservation to live with grandfather
 - March 21, 2005 Jeff killed 9 people including his grandfather and then killed himself
 - Leading up to the incident he left an internet trail that showed him to be depressed, socially detached and plagued by dark homicidal and suicidal thoughts

Miscellaneous Tips

- Until you figure out what you are dealing with, just stand there
 - Use your automatic authority and the child's imagination to your advantage
 - It might help, and it will definitely give you more information before you commit yourself to an approach
- Remember that this incident may be a stepping stone to future incidents
 - Avoid downplaying or minimizing aggression even if it seems like "typical kid behavior" and an over-reacting parent
 - Communicate that and any legal limitations in private to parent
 - Discourage displays of helplessness, hysteria and aggression on the part of the parent
- Regardless of your psychological approach or age of the child always take the "fun" out of aggression
 - Symbolic arrest can be useful even if real arrest not an option
 - Patrol car can be a good isolation booth for temporal lobe kids to wait out the rage
- For oppositional kids help the parent see the game and adopt some professional detachment
 - Teach them to act like a cop

Substance Abuse

- Many of these brain problems increase the risk for substance abuse
- Substance abuse has clear and severe effects on brain function
- The only cure for impairment caused by substance abuse is sobriety and time
- Education is good prevention, but must have a visceral visual impact

This is Your Brain on Drugs

- Much ridiculed PDFA campaign in mid-late 1980s
- Panned by teens and declared a waste of money
- John Walters (DCP Director) officially declared it a failure
- Reproduction on posters sold in head shops

So Why Does Everyone Remember It?

- 2003 PATS study showed there was a significant drop in marijuana use between 1987 and 1990. Why?
 - The fried egg commercial really scared me when I was in high school. I remember picturing that egg in the frying pan and thinking it wasn't worth it...Drugs weren't hidden. The opportunities were there – I mean they still are, but I don't take them.

-Sepideh Modrek – age 26

Summary: Substance Abuse

- Brain function problems place students at risk for substance abuse
- Substance abuse creates additional brain function problems
- Seeing is believing, especially if it's your brain

Crisis Intervention Training

Unit 8

Needs of Mental Health Consumers

CIT Training Lesson Plan Performance Objectives

Needs of Consumers

Unit Goal: Consumers will provide first hand information about mental illness and how it has affected their lives.

Classroom Hours: 2.00

Presenter: Consumer Panel (Includes individuals and family members of individuals diagnosed with a mental illness)

Performance Objectives:

Participants will:

- Become familiar with the views and needs of mental health consumers.
- Become familiar with trauma-informed crisis response techniques- that is understood how an individual's trauma history may impact their presentation during a crisis.

Content Material:

- Use of 5-6 consumers and family members of consumers on a panel to provide participants with the following information:
 - Information about themselves and when they began showing signs and symptoms of a mental illness
 - How mental illness has affected their lives
 - Inpatient and outpatient treatment experiences
 - Interactions with law enforcement and what helps and does not help when they are in a crisis situation
 - What they are currently doing with their lives
 - How mental illness affects relationships with family, friends, etc.
- Facilitator can be used to prompt the panel with questions as needed.

ID: _____ / _____ / _____
Age / Yrs. in criminal / Initials of city
justice system where born

PRE-COURSE CIT PARTICIPANT QUESTIONNAIRE

1. Of the four symptoms of a mental disturbance call listed below, which one is **most likely** to result in some form of physical violence towards the police officer or somebody nearby:
 - A. Talking to self
 - B. Inappropriate lack of clothing in a public place (e.g. person wearing no shoes and no shirt during snowy weather)
 - C. Hearing “command voices” that order the person to do certain things
 - D. Carrying out the same behavior over and over again (e.g. repeatedly touching a sign pole or parking meter for several minutes at a time)
2. Which of the following groups is **most likely** to “successfully” complete a suicide attempt:
 - A. Teenage girls under the age of 18
 - B. Women between the ages of 28 – 40
 - C. College students of either sex
 - D. Men over the age of 45
3. Which of the following is **not true**:
 - A. More police officers die each year from self-inflicted wounds than are killed in the line of duty.
 - B. With individuals who are severely mentally ill, men are at least 5 times more likely to be violent than women.
 - C. Anger and fear often precede violence in psychotic and non-psychotic individuals.
 - D. Alcohol substantially increases the risk of violence towards oneself or others.

***See other side for questions 4 & 5**

4. Select the statement that is **most true**:
 - A. If a person with a chronic, serious mental illness takes their medication as prescribed, they are very unlikely to ever suffer symptoms again.
 - B. Mental illness in children is the result of poor parenting.
 - C. A person with a bi-polar disorder could perform well as the president of a company or of a country like the United States.
 - D. It is impossible to have a meaningful relationship with a person who is schizophrenic.
 - E. All individuals will eventually develop dementia (i.e. Alzheimer’s disease or senility) if they live long enough.

5. On a scale from 1 – 10 where “1” represents the lowest level of anxiety and “10” represents the highest level of anxiety, **please rate the anxiety you believe you would experience at this point in your career in each of the following situations** if you received a call from the dispatcher sending you to:

- ____A. A call involving a drunken person on foot in a downtown parking lot
- ____B. A suspicious person in a market
- ____C. A family dispute call with no known weapons involved
- ____D. A mentally ill person in a house yelling at other family members with no described weapons involved
- ____E. A suspected burglary call
- ____F. An armed robbery in progress
- ____G. A mentally ill person on the street carrying a sword
- ____H. A person speeding away from you after your lights and siren have been turned on

CIT SAMPLE QUESTIONS

Questions for Consumers:

Begin by introducing yourself and telling the person a little about yourself: how long you've been a police officer, how long you've lived here (or elsewhere), etc. Ask getting-to-know-you questions such as where they're from, what kind of hobbies they have, etc.

- We're learning about how to deal more effectively with people who have a mental health disorder. What do you think are some of the important things we should know?
- What can you tell me about your mental illness?
- Have you ever had any encounters with police? Good interactions? Negative interactions? If good, what made them good? If bad, what would have made them better?
-If no encounters with police: What problems do you think people with a mental illness might have with the police?
- When you are going through a bad time with your mental health issues, what could a police officer do to make it better? What would be the wrong thing to do?
- What's the ONE THING you want me to take back to the other officers?

Questions for Family Members of Consumers:

Begin by introducing yourself and telling the person a little about yourself: how long you've been a police officer, how long you've lived here (or elsewhere), etc. Ask getting-to-know-you questions such as where they're from, what kind of hobbies they have, etc.

- We're learning about how to deal more effectively with people who have a mental health disorder. What do you think are some of the important things we should know?
- What can you tell me about your family member's mental illness?
- Have you or your family member ever had any encounters with police during a mental health crisis? Good interactions? Negative interactions? If good, what made them good? If bad, what would have made them better?
-If no encounters with police: What problems do you think people with a mental illness might have with the police?
- When your family member is going through a bad time with his or her mental health issues, what could a police officer do to make it better? What would be the wrong thing to do?
- What's the ONE THING you want me to take back to the other officers?

I. Introduction

Many people suffer from both chemical dependency and mental illness. This combination is called a co-occurring disorder. Effective treatment of co-occurring disorders involves treating both disorders together. Recovery from co-occurring disorders means developing a recovery program for both disorders as well.

This recovery guide discusses ways to help you recover if you have a co-occurring disorder. It looks first at some basic facts about emotional or psychiatric illnesses and then at ways to help your recovery.

Discuss your answers to the questions in this guide with your treatment group, counselor, or case manager and ask for feedback.

II. Causes of Mental Illness

There is no simple way to explain most mental or emotional illnesses. Having one of these illnesses raises the odds of having a problem with alcohol or other drug abuse and dependence. In some cases, mental or emotional problems begin after alcohol or other drugs have been abused for a long time. In other cases, mental or emotional disorders cause people to abuse alcohol and other drugs in an effort to relieve their symptoms or self-medicate. Often it's hard to know which disorder came first. In fact, these two illnesses may even develop separately and may not be related at all.

Mental and emotional illness may be caused by many different factors, including the following:

- A. Biological.** Some mental disorders run in families. In such cases, a person may inherit a predisposition to developing a mental or emotional illness. Heredity stacks the deck in these cases. Brain damage due to certain illnesses, injuries, health problems, or the abuse of alcohol or other drugs can also play a role.
- B. Psychological.** A person's personality, how they handle stress and cope with problems, how they think about themselves and the world around them, and how they act may contribute to some psychiatric problems.
- C. Social and Cultural.** People are affected by their environment and the people around them- especially parents and other caretakers. People are also affected by life experiences and significant events, such as being sexually, physically, or emotionally abused.

III. Types of Mental Disorders

Chemically dependent people may have one or more psychiatric disorders. The most common ones are anxiety disorders, including phobic disorders and posttraumatic stress disorder (PTSD); mood disorders; personality disorders; and thought disorders.

A. Anxiety Disorders

Feelings of fear or dread create anxiety. We all have these feelings at times. They're normal, and sometimes they can protect us. But some people feel much more afraid than they need to. Feeling this way for a long time may keep them from living a normal lifestyle. It can interfere with relationships, work, school, or even the ability to have fun or relax. This can lead a person to avoid situations they feel anxious about. It can also lead to abuse of alcohol or drugs in order to feel better or to face anxiety-provoking situations.

Many people also get depressed along with feeling anxious.

1. Panic Disorder

There are many types of anxiety disorders. One type, called panic disorder, involves attacks in which many of the following symptoms are experienced for several minutes or longer:

- Dizziness or faintness
- Inability to catch your breath
- Shaking or trembling
- Sweating
- An upset stomach
- Hot or cold flashes
- A very fast heartbeat
- Chest pains or chest discomfort
- A fear of dying
- A fear that things aren't real
- A fear of going crazy or losing your mind

2. Generalized Anxiety Disorder

Some people worry much more than most people. They also worry about many things they don't need to worry about. When this continues for an extended period of time (six months or longer) and interferes with a person's life, it is called generalized anxiety disorder.

Signs of this disorder may include the following:

- Worrying too much about two or more aspects of life for six months or longer
- Expecting bad things to happen
- Feeling unable to stay in one place for very long
- Feeling keyed up or on edge
- Finding it hard to concentrate
- Having a dry mouth
- Frequent urination
- Sweating
- Shaking and trembling
- Having a very fast heartbeat
- Getting a "lump" in the throat
- Feeling muscle aches and tension
- Having trouble falling asleep or staying asleep

3. Phobic Disorders

Some people have a very strong fear of specific objects or situations. The fear is so strong that they avoid these things or situations even if they aren't dangerous. These fears cause distress and disrupt a person's life. This is called a phobic disorder.

A person can have a simple phobia, such as being very afraid of spiders, bugs, snakes, or sharp objects like knives. Or a person can have a social phobia, such as being greatly afraid of speaking, eating, or writing in public. These phobias cause intense anxiety and interfere with a person's daily routine, social activities, or relationships. They cause people to worry about embarrassing themselves and to worry that others will criticize or reject them.

a. Agoraphobia

Some people have an intense fear of being in a place they can't escape from, or get help should they need it. This is called agoraphobia. A person may avoid being in a crowd, standing in a line, being on a bridge, or traveling in a car, bus, airplane, or train. The phobia can be so severe that a person never leaves their home.

4. Posttraumatic Stress Disorder

People who have lived through a traumatic event, such as severe accidents, combat, natural disasters, assault, or rape may develop posttraumatic stress disorder (PTSD).

The symptoms of PTSD can include the following:

- Dreaming about, thinking about, and replaying the traumatic event over and over in your mind
- Losing interest in people and things in your life
- Being unable to show your feelings for others
- Feeling alone and apart from those around you
- Acting as if the event were suddenly happening again (having flashbacks)
- Having a hard time concentrating
- Having trouble sleeping
- Feeling guilty because you survived when others did not

B. Mood Disorders

1. Bipolar Disorder

Mood disorders involve depression, which means feeling very sad or down, or mania, which means feeling very high or euphoric. Some people experience both depression and mania. This is called bipolar disorder.

2. Depression

We all feel sad sometimes, but the illness of depression is much worse than a case of the blues. It can last for weeks or months and keep a person from doing normal daily activities. Sometimes depression results from upsetting events. It can also be caused by an imbalance of natural chemicals in the brain.

Some people with depression may just have one episode. Others suffer from multiple episodes of depression, a condition that is called recurrent depression.

Symptoms of depression can include the following:

- Feelings of emptiness or sadness for several weeks or longer
- Sleeping much more than usual or having trouble falling asleep or staying asleep
- Unintentionally gaining or losing a lot of weight
- Losing interest in things that you used to enjoy
- Lack of energy
- Having less of a sex drive
- Feeling restless or unable to get going
- Feeling worthless or guilty
- Often thinking of death, dying, or suicide
- Having trouble thinking or concentrating

3. Mania

After a bout of depression, some people switch to a manic phase.

Symptoms of the manic phase can include the following:

- Showing a sudden increase in work, social activity, or sexual activity
- Expressing feelings more freely than usual
- Thinking or talking about things that aren't related
- Sleeping much less than usual
- Being more cheerful or irritable than normal
- Doing foolish things, like spending too much money, driving recklessly, or being inappropriately sexual
- Talking much more than usual
- Feeling overly important
- Being easily distracted

Mania often causes serious problems in work, relationships, or ability to do everyday activities. Some people need to be hospitalized to prevent them from harming themselves and others.

C. Personality Disorders

1. Traits Associated with Personality Disorders

Personality refers to a person's usual patterns of relating to other people and thinking about the world. Personality traits show up in how people act toward themselves and others. These traits are ingrained and play a big role in how people get along in life.

Having a personality disorder means that some of a person's personality traits cause very serious problems for them and others. Examples of traits associated with different types of personality disorders include the following:

- Taking advantage of others, lying, cheating, or scheming
- Being very impulsive (acting without thinking about the consequences)
- Being overly dependent on or submissive to others
- Being very rigid or controlling and having trouble compromising
- Getting involved in unhealthy relationships
- Rapid and major shifts in moods
- Being very suspicious of others (paranoid)
- Acting cold and angry for no apparent reason
- Being antisocial or irresponsible

2. Problems Related to Personality Disorders

People with personality disorders may have problems doing the following:

- Forming or keeping close personal relationships
- Taking responsibility for their actions
- Keeping a job or finishing an important task
- Learning from past mistakes
- Handling feelings or emotions
- Thinking before acting

D. Thought Disorders

1. Schizophrenia

Thought disorders include schizophrenia, a brain disease that causes serious problems with a person's thoughts and ideas about reality.

Schizophrenia involves these symptoms:

- Delusions (bizarre thoughts about oneself, others, or the environment that are not based on reality).
- Extremely unusual or strange behavior.
- Disorganized speech (talking about things that aren't related, skipping from one topic to another without making any sense, etc.).
- Hallucinations (hearing, seeing, smelling, or feeling things that aren't there).
- Having great difficulty doing normal day-to-day things, such as getting up and getting dressed or working around the house.
- Inappropriate emotions or a complete lack of emotion.

IV. Duration of Illness

A. Acute Episodes

Some people experience an acute episode of mental illness only once or twice in their lifetime. They may need medication, counseling, or other services for a period of time, but eventually get better and have no new episodes.

B. Recurrent Illness

Others experience recurrent illness. This means they have three or more episodes of illness over time. Many of these people, however, are able to lead normal lives between episodes, when their symptoms are under

control. In these cases, treatment has a preventive function. By taking medication and seeing a counselor, case manager, or psychiatrist on a regular basis, they may reduce their chances of another episode or be able to get help before their symptoms get as bad as they used to be. This also increases the chances of spotting the early warning signs of relapse. People with recurrent illness need to stay in outpatient treatment and continue taking their medication, even when they are doing well.

C. Chronic Illness

Other people experience what is called persistent or chronic illness. They may have some symptoms almost all the time. Even though these people get better, they continue to be affected by their illness. Sometimes they have flare-ups of their symptoms and get sicker.

V. Important Recovery Tips

- A. **Get Help.** One of the most important things you can do to feel better is find out what mental illness you have. A psychiatrist or other mental health professional can evaluate you. Being evaluated may sometimes take time and patience is required, as is trust in the people who want to help you.

Sometimes medication can help you feel better or think more clearly. Taking this type of medication is very different from using alcohol or street drugs to get high. It is no different than someone with a disease such as diabetes having to take insulin or other medication to treat the symptoms of their illness.

Make sure you talk about your symptoms and problems with your doctor and ask questions. The more you know about your co-occurring disorders, the more hope you'll feel. The more you understand your illnesses, the more control you can take over your life.

- B. **Don't Blame Yourself.** The first step to recovery is to admit that you have a co-occurring disorder and to accept your chemical dependency and mental illness as no-fault illnesses. This means you have little or no control over whether you get them. But you do have control over whether you recover from these illnesses.

1. If you accept your mental illness, list at least three ways that accepting it helps you. If you have trouble accepting your illness, write down your thoughts about why this is so.

C. Use a Counselor and Other Professionals

Many people with co-occurring disorders benefit greatly from seeing a counselor, psychiatrist, case manager, or other professional. These people can help you understand and cope with your illnesses by helping you define your problems, set goals for change, and evaluate your progress. They can show you how to spot warning signs of relapse and help you figure out ways to deal with your day-to-day problems, without drinking or using non-prescribed drugs.

You can gain the most help from your treatment if you keep your appointments. During these appointments, talk about your thoughts, feelings, and problems. Let your counselor, psychiatrist, or case manager know if your symptoms change or get worse. Let him or her know if you use alcohol or other drugs, feel like using, or if you miss self-help meetings. When you share this information with whoever is treating you, he or she is better able to help you understand your problems and to adjust your treatment plan if needed. That's why it's important that you show up for your appointments and talk about what's bothering you.

1. List at least three benefits of meeting regularly with a counselor, case manager, or other professional in your ongoing recovery.

2. List at least three of your problems or concerns that you could discuss in your group or individual counseling sessions.

3. What can you do to avoid missing your counseling or treatment appointments when you don't feel like going? Or, if you stop treatment and need to get back in, what steps can you take to reconnect with treatment?

D. Use Support Groups and Self-Help Meetings

Support groups are available for people with co-occurring disorders. What groups you'll find depends on where you live. Many areas have self-help meetings, such as Alcoholics and Narcotics Anonymous (AA, NA). In addition there are support groups for specific mental disorders, such as bipolar disorder, schizophrenia, obsessive-compulsive disorder, and other disorders. Members of these various support groups can talk to each other about their disorders and recovery. Because they understand your problems, they can help you improve your life. Some members are available to be sponsors, people who can offer you friendship and advice in your recovery and teach you the ropes.

1. If you are going to support groups or self-help meetings, write down at least three ways they have helped you. If you do not attend any support groups or self-help meetings, list the reasons.

2. Do you have a sponsor? If so, list at least three ways that talking to him or her has helped you in your recovery. If you don't have a sponsor, how do you feel about getting one?

E. Take Psychiatric Medication as Prescribed

Some people with mental illness need to take medication prescribed by a psychiatrist or other healthcare professional. Some need it for only a short time; others need medicine for an extended period in order to prevent or reduce the likelihood of getting sick again.

If you have a co-occurring disorder and are taking medication, drinking alcohol or using other drugs not prescribed by a doctor can make your illness worse. Or it can temporarily cover up your symptoms, only to make things worse in the long run.

Two of the primary reasons people relapse to psychiatric illness are:

- They drink alcohol or take other drugs, and
- They stop taking prescribed psychiatric medications.

You should never stop taking your medicine on your own, even if your symptoms are a lot better. Always talk to your doctor and therapist about your desire to stop medication. If you have side effects or feel really good and don't think you need medicine, talk it over first. Some people with recurrent or persistent psychiatric disorders get sick when they stop taking their medicine, even though they did well for a long time.

1. If you are taking medication, list at least three ways your medication has helped you. If you have been prescribed medication but don't or have stopped taking it, list the reasons why.

2. List at least three ways that drinking alcohol or using other non-prescribed drugs can mess up your recovery.

F. Change Your Thoughts and Beliefs

How you feel and act depends partly on what you think and believe. You have probably heard that "stinking thinking" can hurt your recovery. It can even be a factor in relapse. Thoughts and beliefs sometimes contribute to depression and anxiety. For example, you might say things to yourself like the following:

- To be happy, I have to be successful in whatever I do.
- To be happy, I must be accepted by all people at all times.
- If I make a mistake, I am bad or incompetent.
- If people disagree with me, they don't like me.
- Things will never improve; I'll always be miserable.

These kinds of thoughts make it harder for you to feel good about yourself. Challenging your negative thinking and replacing negative thoughts with new ones that focus on the positive will help you in your recovery.

1. Do you often have negative thoughts, such as expecting the worst to happen or only seeing the negative side of things? If so, write down at least three of them. (Example: "When I make a mistake, I worry that I'll get criticized and other people will think I'm stupid.")

2. Now try to replace these negative thoughts with positive thoughts. (Example: "Making a mistake doesn't mean I'm stupid. Everyone makes mistakes. Plus, I can learn from them.")

G. Express Your Feelings and Emotions

Half the battle in handling emotions is acknowledging them. Start by admitting what you feel. Ask yourself, “Do I feel angry, bored, anxious, empty, depressed, lonely, guilty, or shameful?” This opens the door for you to take action. You can take action in many ways. You can talk about your feelings with another person. Or you can try changing how you see or react to a situation. It’s just as important to feel and express good feelings.

1. Which feelings are hardest for you to express? Write a few notes about at least two feelings that are difficult for you to express.

2. Who are some people you can share these difficult feelings with?

3. Who are some people you can share good or positive feelings with?

H. Change Your Behaviors and Character Defects

There's no quick fix for your problems. You must work hard to change. This includes changing how you deal with your thoughts or feelings and how you act. How you act is often tied to your personality or character. Working on character defects is often a big part of recovery. Working a Twelve Step program with a sponsor, especially Steps Four and Ten, helps you figure out what defects you have and how to start changing them.

1. List at least two character defects you need to change, and how each one has caused you problems. (Example: "I'm self-centered and don't care about what I say or do to other people. Because of this I have trouble keeping a relationship more than a few months.")

2. What can you do now to begin changing one of your character defects?

3. List at least two benefits of changing one of your character defects. (Example: "If I start listening more to other people and being less self-centered, I'll get more respect and get along better. This will help me keep my relationships.")

I. Learn to Spot Relapse Warning Signs

Addiction Relapse

Chemical dependency is a chronic, life-long disease. Relapse, which means going back to using alcohol and other drugs, is always a threat. Relapse is a process that builds over time. You can build up to a relapse over weeks or months. Learning about relapse warning signs, and what to do about them, should be part of recovery. Sometimes these warning signs are easy to notice, like when you miss or stop going to AA or NA meetings and don't have a good reason for doing so. Another relapse warning sign could be stepping into a bar or visiting old friends who still get drunk or high.

Other relapse signs aren't as easy to notice. These may include feeling restless or unhappy about yourself or your recovery. You also need to beware of cravings for your drug of choice and thoughts of getting high.

Most relapse warning signs show up as changes in thoughts, attitudes, moods, or actions. Learning about the warning signs of relapse can help your recovery.

Some of these signals include the following:

- Feeling angry, bored, depressed, lonely, ashamed, or empty
- Thinking too much about alcohol, other drugs, or partying
- Having frequent dreams about alcohol or other drugs
- Developing another addiction, like gambling or sex, to escape the pain
- Having serious relationship troubles
- Going through a major change in your life, like starting a new job or moving to a new city
- Getting pressure from family or friends to get high or drunk, or hanging out with people you used to get high with
- Skipping or cutting down on counseling sessions or self help meetings
- Experiencing a relapse of your psychiatric illness
- Not having any routine or structure in your day to day life
- Not having any goals for yourself

Once you learn what things can cause you to relapse, you can work on dealing with them.

1. Have you ever had an addiction relapse? If so, list at least three warning signs you had. If you haven't had a relapse, list at least three possible warning signs. (Example: "Before using drugs again, I told myself a few beers and a joint weren't a big thing.")

2. How could you handle these warning signs before using alcohol or other drugs? (Example: "I'll remind myself that my addiction is talking to me again. There's no way I can drink or smoke dope without messing up my recovery. I'll call my sponsor right away.")

Mental or Emotional Relapse

Many of the relapse signs listed in the previous section also apply to mental or emotional relapse. You can use some of what you've learned about relapsing with alcohol and other drugs to become aware of relapses with your mental illness. Some common relapse signs are using alcohol or other drugs, missing treatment sessions, or cutting down on or stopping your medication. This can cause you to get sick again. Knowing the warning signs and causes of a relapse of your mental illness can help prevent it or stop it early.

3. Have you ever had a relapse of your mental illness? If so, write down at least three warning signs you had. If not, list three possible warning signs.

4. If you noticed the warning signs, how could you cope with them?

J. Develop a Crisis Plan

Some types of mental illness can impair your judgment. If your illness can affect your judgment, prepare your family or friends so they can help you during these times. Ask them for help while you are well, while your judgment is good. They can help you take action when you may not see the need. This involves developing a crisis plan, which may include provisions for hospitalization or respite care.

1. Have you discussed with your family or friends the possibility of relapse? Explain your answer.

2. What do you want your family or friends to do if they notice that you're displaying relapse warning signs?

3. What should family members or friends do if you refuse to listen to them when they point out that you're showing relapse warning signs?

Crisis Intervention Training

Unit 9

Community Perspective

CIT Training Lesson Plan Performance Objectives

Community Perspective

Unit Goal: Ability to understand how to better deal with a crisis situation from the consumer/family perspective.

Classroom Hours: 3.00

Presenter:

Performance Objectives:

Participants will be able to:

- Recognize specific signs and symptoms of serious mental illnesses, to include at a minimum mood and anxiety disorders, schizophrenia and psychotic disorders, and personality disorders. Emphasis should be placed on the kinds of behavior that officers will see in people experiencing a mental health crisis.
- Recognize mental illnesses in various populations, i.e. children, adolescents, adults, and older adults.
- Understand the common problem of co-occurring developmental disability, medical, and homelessness.
- Understand and differentiate mental retardation from mental illness.

Content Material:

Consumer/Family Panels or Visits

Family and Consumer Perspective

By Mary Heitzman

You want the officer to “put a face to the public that they may come across and realize that if they get a call that they are often going to someone’s home and not just a location”. These visits help the officers empathize more with the trauma and community responses to the lifelong illness that consumers and their caretakers must deal with. This should help the officers in their jobs when they answer crisis calls for mental health issues.

- A. First you must decide if you are going to have a panel (which is less time consuming) or home visitations (which, I believe has the most impact but is more time consuming).
- B. Then you may design a list of questions that will help the trainees to seek out information that will best suit their needs.
 1. Contact clubhouses (usually Director or a “Programs Mgr.”) and NAMI affiliate to ask for volunteers. If you are already a NAMI member, you have easy access to all the affiliate’s members’ contact info. And NAMI usually has several members in each affiliate.
 2. If you have a mental health provider representative on your group, then that person can get names (via an ROI) or him/her self contact clients of the mental health system.
 3. When you access the clients, let them know that the nature of their volunteer time is to help EDUCATE the trainees on how to better deal with a crisis situation from the consumer/family perspective. And ask them not to show any bitterness in their dealing with the police officers, that you are asking them to educate. (At the point of asking this, you can weed out who you pick to volunteer by the tenor of their answers to you).
 4. Introduce to the class the purpose of these visits. You are going to want a panel of 5 to 7 members if you go with a panel to up to + or – 3 hours. If you go with “home visits” you want to send out officers in pairs to two visits. Each visit will therefore be a 2 on 1. Example, with a class size of 20, you will need 20 home visit time slots – or 10 to 20 volunteers depending whether or not your volunteers will give two time slots each.

5. Each visit should be preferably an hour (some do each visit in 50 min.) – with 15 to 20 min. for travel time between (including travel time to and from the class location) - which would translate to + or - 4 hours.
6. Then you ask the officers when they return to debrief the whole class about their experiences.
7. Most of the police officers are very vocal about their visits. Try not to restrict their time too much. This has historically been one of their favorite exercises in the training.

Crisis Intervention Training

Unit 10

Co – Occurring Disorders

CIT Training Lesson Plan Performance Objectives

Co-Occurring Disorders

Unit Goal: Ability to recognize and understand the main diagnostic cluster for major mental illness.

Classroom Hours: 3.00

Presenter:

Performance Objectives:

Participants will be able to:

- Understand and recognize specific signs and symptoms of serious mental illnesses, to include at a minimum mood and anxiety disorders, schizophrenia and psychotic disorders, and personality disorders. Emphasis should be placed on the kinds of behavior that officers will see in people experiencing a mental health crisis.
- Understand and recognize mental illnesses in various populations, i.e. children, adolescents, adults, and older adults.
- Understand the common problem of co-occurring developmental disability, medical, and homelessness.
- Understand and differentiate mental retardation from mental illness.

Content Material:

Chemical Dependency and MI

What an Officer Can Do:

Since it is hard to tell if a person's behavior is from overdose, drug interaction, or mental illness, an officer can consider the following:

1. Reasons why some people with mental illness abuse drugs and alcohol.
2. Inpatient and Chemical Dependency units and treatment.
3. Types and prevalence of illegal drugs and toxic effects of "bad mixes" of these drugs and alcohol.
4. Behaviors and symptoms of certain drugs and alcohol.
5. Law enforcement interaction with persons experiencing different illicit drug reactions.

Crisis Intervention Training

Unit 11

Resiliency for the Officers - PTSD

CIT Training Lesson Plan Outline and Presentation

Resilience

Unit Goal: Provide information on ways to build resilience.

Classroom Hours: 1.30

Presenter:

Performance Objectives:

Participants will be able to:

- Recognize and understand post traumatic stress disorder in law enforcement and first responders and become familiar with appropriate resources available to get assistance.
- Understand and recognize the definition of resilience.
- Identify strategies to build and enhance personal resilience.

I. Resilience

A. Introduction

How do people deal with difficult events that change their lives? The death of a loved one, loss of a job, serious illness, terrorist attacks and other traumatic events: these are all examples of very challenging life experiences. Many people react to such circumstances with a flood of strong emotions and a sense of uncertainty.

Yet people generally adapt well over time to life-changing situations and stressful conditions. What enables them to do so? It involves resilience, an ongoing process that requires time and effort and engages people in taking a number of steps.

This brochure is intended to help readers with taking their own road to resilience. The information within describes resilience and some factors that affect how people deal with hardship. Much of the brochure focuses on developing and using a personal strategy for enhancing resilience.

B. What Is Resilience?

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress - such as family and relationship problems, serious health problems, or workplace and financial stressors. It means "bouncing back" from difficult experiences.

Research has shown that resilience is ordinary, not extraordinary. People commonly demonstrate resilience. One example is the response of many Americans to the September 11, 2001, terrorist attacks and individuals' efforts to rebuild their lives.

Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress.

Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts, and actions that can be learned and developed in anyone.

II. Resilience Factors & Strategies

A. Factors in Resilience

A combination of factors contributes to resilience. Many studies show that the primary factor in resilience is having caring and supportive relationships within and outside the family. Relationships that create love, build trust, provide role models, and offer encouragement and reassurance help bolster a person's resilience.

Several additional factors are associated with resilience, including:

1. The capacity to make realistic plans and take steps to carry them out
2. A positive view of yourself and confidence in your strengths and abilities
3. Skills in communication and problem solving
4. The capacity to manage strong feelings and impulses

All of these are factors that people can develop in themselves.

B. Strategies for Building Resilience

Developing resilience is a personal journey. People do not all react the same to traumatic and stressful life events. An approach to building resilience that works for one person might not work for another. People use varying strategies.

Some variation may reflect cultural differences. A person's culture might have an impact on how he or she communicates feelings and deals with adversity- for example, whether or not a person connects and how a person connects with significant others, including extended family members and community resources. With growing cultural diversity, the public has greater access to a number of different approaches to building resilience.

Some or many of the ways to build resilience in the following pages may be appropriate to consider in developing your personal strategy.

III. Ten Ways to Build Resilience

- A. **Make connections.** Good relationships with close family members, friends, or others are important. Accepting help and support from those who care about you and will listen to you strengthens resilience. Some people find that being active in civic groups, faith-based organizations, or other local groups provides social support and can help with reclaiming hope. Assisting others in their time of need also can benefit the helper.
- B. **Avoid seeing crises as insurmountable problems.** You can't change the fact that highly stressful events happen, but you can change how you interpret and respond to these events. Try looking beyond the present to how future circumstances may be a little better. Note any subtle ways in which you might already feel somewhat better as you deal with difficult situations.
- C. **Accept that change is a part of living.** Certain goals may no longer be attainable as a result of adverse situations. Accepting circumstances that cannot be changed can help you focus on circumstances that you can alter.
- D. **Move toward your goals.** Develop some realistic goals. Do something regularly- even if it seems like a small accomplishment- that enables you to move toward your goals. Instead of focusing on tasks that seem unachievable, ask yourself, "What's one thing I know I can accomplish today that helps me move in the direction I want to go?"
- E. **Take decisive actions.** Act on adverse situations as much as you can. Take decisive actions, rather than detaching completely from problems and stresses and wishing they would just go away.
- F. **Look for opportunities for self-discovery.** People often learn something about themselves and may find that they have grown in some respect as a result of their struggle with loss. Many people who have experienced tragedies and hardship have reported better relationships, greater sense of strength even while feeling vulnerable, increased sense of self-worth, a more developed spirituality, and heightened appreciation for life.
- G. **Nurture a positive view of yourself.** Developing confidence in your ability to solve problems and trusting your instincts helps build resilience.
- H. **Keep things in perspective.** Even when facing very painful events, try to consider the stressful situation in a broader context and keep a long-term perspective. Avoid blowing the event out of proportion.

- I. **Maintain a hopeful outlook.** An optimistic outlook enables you to expect that good things will happen in your life. Try visualizing what you want, rather than worrying about what you fear.
- J. **Take care of yourself.** Pay attention to your own needs and feelings. Engage in activities that you enjoy and find relaxing. Exercise regularly. Taking care of yourself helps to keep your mind and body primed to deal with situations that require resilience.

Additional ways of strengthening resilience may be helpful. For example, some people write about their deepest thoughts and feelings related to trauma or other stressful events in their life. Meditation and spiritual practices help some people build connections and restore hope.

The key is to identify ways that are likely to work well for you as part of your own personal strategy for fostering resilience.

IV. Learning from Your Past

A. Some Questions to Ask Yourself

Focusing on past experiences and sources of personal strength can help you learn about what strategies for building resilience might work for you. By exploring answers to the following questions about yourself and your reactions to challenging life events, you may discover how you can respond effectively to difficult situations in your life.

Consider the following:

1. What kinds of events have been most stressful for me?
2. How have those events typically affected me?
3. Have I found it helpful to think of important people in my life when I am distressed?
4. To whom have I reached out for support in working through a traumatic or stressful experience?
5. What have I learned about myself and my interactions with others during difficult times?
6. Has it been helpful for me to assist someone else going through a similar experience?
7. Have I been able to overcome obstacles, and if so, how?

8. What has helped make me feel more hopeful about the future?

B. Staying Flexible

Resilience involves maintaining flexibility and balance in your life as you deal with stressful circumstances and traumatic events. This happens in several ways, including:

1. Letting yourself experience strong emotions, and also realizing when you may need to avoid experiencing them at times in order to continue functioning
2. Stepping forward and taking action to deal with your problems and meet the demands of daily living and also stepping back to rest and reenergize yourself
3. Spending time with loved ones to gain support and encouragement, and also nurturing yourself
4. Relying on others, and also relying on yourself

C. Places to Look for Help

Getting help when you need it is crucial in building your resilience. Beyond caring family members and friends, people often find it helpful to turn to:

1. **Self-help and support groups.** Such community groups can aid people struggling with hardships, such as the death of a loved one. By sharing information, ideas, and emotions, group participants can assist one another and find comfort in knowing that they are not alone in experiencing difficulty.
2. **Books and other publications.** For example, there are books written by people who have successfully managed adverse situations like surviving cancer. These stories can motivate readers to find a strategy that might work for them personally.
3. **Online resources.** Information on the web can be a helpful source of ideas, though the quality of information varies among sources.

For many people, using their own resources and the kinds of help listed above may be sufficient for building resilience. At times, however, an individual might get stuck or have difficulty making progress on the road to resilience.

4. **A licensed mental health professional.** Professionals, such as psychologists, can assist people in developing appropriate strategies for moving forward. It is important to get professional help if you feel like you are unable to function or perform basic activities of daily living as a result of a traumatic or other stressful life experience.

Different people tend to be comfortable with somewhat different styles of interaction. A person should feel at ease and have a good rapport in working with a mental health professional or participating in a support group.

D. Continuing On Your Journey

To help summarize several of the main points in this brochure, think of resilience as similar to taking a raft trip down a river.

On a river, you may encounter rapids, turns, slow water, and shallows. As in life, the changes you experience affect you differently along the way.

In traveling the river, it helps to have knowledge about it and past experience in dealing with it. Your journey should be guided by a plan, a strategy that you consider likely to work well for you.

Perseverance and trust in your ability to work your way around boulders and other obstacles are important. You can gain courage and insight by successfully navigating your way through white water. Trusted companions who accompany you on the journey can be especially helpful for dealing with rapids, upstream currents, and other difficult stretches of the river.

You can climb out to rest alongside the river. But to get to the end of your journey, you need to get back in the raft and continue.

Crisis Intervention Training

Unit 12

Cultural Sensitivity

CIT Training Lesson Plan Performance Objectives

Cultural Sensitivity

Unit Goal: Provide information about various cultures and their views on mental illness.

Classroom Hours: 1.30

Presenter:

Performance Objectives:

Participants will be able to:

- Identify unique perceptions about mental health by various cultures, to include Hispanic, Asian, African American, Eastern European, and Native American cultures.
- Learn how to utilize appropriate community skills and techniques for individuals from identified cultures.
- Identify local community resources available to identified cultures.

Content Material:

See attached PowerPoint presentation *Culture & Mental Health: Eliciting the Big Picture during a Crisis Intervention*

Culture and Mental Illness

Shankar Vedantam

Washington Post Staff Writer

Tuesday, June 28, 2005; 12:00 PM

What role does culture play in diagnosing and treating mental illness? In many poorer nations, social networks are a critical part of healing and recovery as patients continue to participate in society rather than becoming isolated, as is often the case in more developed nations. In the United States, some racial groups are more frequently diagnosed with schizophrenia than others, suggesting some sort of bias in the detection of such illnesses. This new information suggests a powerful link between societal factors and the diagnosis, treatment and outcome of mental illness.

Washington Post staff writer *Shankar Vedantam*, who covers health and science, was online Tuesday, June 28 at Noon ET to discuss his three part series on culture and mental illness.

Washington, D.C.: That anecdote of the woman hearing voices at Cambridge Hospital is certainly provocative. Help us understand the point a little better. Is it that in Latino communities, there is no such thing as psychosis based on hearing voices, but if the same patient wandered back into mainstream medicine, he/she would in effect become psychotic-meaning there is a hermeneutics of psychosis?

Shankar Vedantam: You raise an excellent question. For readers who don't remember the specific excerpt from Sunday's story, let me add it here and then address the question.

Roberto Lewis-Fernandez was a young doctor in training in Massachusetts when he encountered a patient who was 49 and suicidal at Cambridge Hospital. The Puerto Rican woman begged for help in resolving a conflict with her son, but the Harvard University-affiliated psychiatrists focused on one set of symptoms -- she was hearing voices, seeing darting shadows and sensing invisible presences.

They diagnosed her as depressed and psychotic, or out of touch with reality, and medicated her. She was discharged. Soon after, the woman had an argument with her son and nearly killed herself by overdosing on the medication.

For Lewis-Fernandez, who is Puerto Rican, the suicide attempt confirmed his fears that his superiors had misjudged the situation. For months, as top psychiatrists ordered him to keep increasing the potency of her drugs, he had told himself that hearing voices, seeing shadows and sensing presences is considered normal in some Latino communities. But he dared not challenge the wisdom of the medical model.

"I wasn't sure if she was psychotic, but I treated her as if she was," he said about the case, which he wrote up in a medical journal. "I gave her the medicines."

When the hospital's outpatient unit evaluated the woman anew, doctors there came up with a different diagnosis. They concluded that her symptoms were not abnormal in the context of her culture -- they were expressions of distress, not illness. Lewis-Fernandez helped her reconcile with her son. She still heard voices and saw shadows, but now, as before, they did not bother her.

I think it would be a huge mistake to suggest that there is no such thing as psychosis among Latinos from the Caribbean. Rather, the point of the story is that by focusing only on her symptoms, doctors were misled. The same symptoms, in other words, can mean different things, depending on the context. The goal of people like Dr. Lewis-Fernandez is to have doctors focus on the context as well as the symptoms, to ask, for instance, how the patient interprets the symptoms herself, and to ask how the culture from which the patient comes thinks about such symptoms. Many advocates of cultural competence talk about how the culture influences "idioms of distress" -- the ways in which patients express symptoms. Arthur Kleinman, the Harvard psychiatrist, told me that during his research in China after the Cultural Revolution, patients with what we would now call depression mainly complained about dizziness, exhaustion and sleeplessness -- symptoms associated with what was then known as *neuresthenia*. "Depression was a highly stigmatized mental illness, *neuresthenia* was thought of as a physical condition and didn't have any disgrace or humiliation," Kleinman told me. But as China has globalized, this has changed. Now depression is a very common diagnosis.

How Americans Cope with Stress

| | Total | Native Americans | African Americans | Hispanics/Latinos | Asians | Non-Hispanic Whites |
|-------------------------------|--------------|-------------------------|--------------------------|--------------------------|---------------|----------------------------|
| Watch TV, Read, Music | 82% | 84% | 84% | 86% | 88% | 81% |
| Talk to Family/Friends | 71% | 76% | 65% | 75% | 77% | 71% |
| Prayer and Meditation | 62% | 64% | 82% | 60% | 51% | 59% |
| Exercise | 55% | 67% | 56% | 59% | 70% | 52% |
| Eat | 37% | 41% | 33% | 37% | 38% | 38% |
| Smoke, Drink, Drug | 26% | 30% | 24% | 23% | 17% | 28% |
| Take Rx Medications | 12% | 13% | 8% | 10% | 7% | 13% |
| Hurt Self | 1% | 1% | 1% | * | 4% | * |

- When faced with stress, a vast majority of people, 82 percent, turn on the television, listen to music or read.
- Family and friends serve as a solid support for 71 percent of those polled.
- Prayer or meditation is a resource for 62 percent, and exercise sustains 55 percent.

African Americans, 82 percent, are far more likely than other groups to use prayer or meditation as a way to deal with stress and anxiety. Native Americans and Non-Hispanic Whites are more likely to engage in unhealthy coping skills to deal with stress- 30 percent of Native Americans and 28 percent of non-Hispanic Whites respondents drink, smoke or do drugs when feeling stressed out. Asian Americans are least likely to smoke, drink, or use drugs to cope. Asians also have the highest likelihood, 77 percent, of talking to a family member or friend or exercising to manage stress levels, 70 percent.

Women (42 percent) were significantly more likely than men (31 percent) to eat as a coping mechanism for stress.

People living with mental illnesses are more likely to drink, smoke, or do drugs to relieve stress (42 percent), or take prescribed medications (37 percent), talk with family (74 percent), eat (45 percent), and cut or injure themselves (3 percent- fewer than one percent of overall pointed to self-injury).

Source: Mental Health America, 2006

Culture & Mental Health: Eliciting the Big Picture during a Crisis Intervention

Jill San Jule
Mental Health Transformation Project

Why Cultural Awareness Training?

- Training assists officers in being able to better detect and react to or defuse a threat, gather more information in an investigation, and avoid becoming the target of a lawsuit or disciplinary action.

Why Cultural Awareness Training?

- Crisis intervention often requires an immediate development of trust between two people from different cultures for purposes of restoring the individual's coping mechanisms to a pre-crisis level of functioning
- The quick development of rapport and trust between people of different cultures often requires the crisis intervener to communicate, both non-verbally and verbally, a demeanor that one is knowledgeable about and accepting of cultural differences

Why Cultural Awareness Training?

- Cultural Awareness integrates knowledge and information about individuals and groups into specific approaches and techniques
- Culturally competent crisis response works to break down barriers that impede communication and limit the effectiveness of intervention.

Why Culturally Informed Interventions?

- Culture influences what type of threat or event is perceived as traumatic
- Influences how individuals interpret the meaning of crisis
- Influences how individuals and communities express traumatic reactions

Source: Young, M. (1997).

Why Culturally Informed Interventions?

- Culture forms a context through which individuals and communities view and appraise their own responses

“Traumatic events do not exist in a vacuum. Like other social phenomena, they should be understood within the social and cultural context in which they occur.”

(Young, 1997)

Why Culturally Informed Interventions?

- Culture influences communication – both verbal and non-verbal
- Culture influences how one perceives personal space – appropriateness of physical contact and proximity
- Culture influences one's beliefs about environmental control – that is external versus internal control

Asian Americans & Mental Health

- Many Asian Americans have considerable conceptual difficulties regarding the Western notions of mental illness and mental health services.
- Asian Americans frequently experience and express mental illness very differently from Westerners, often emphasizing **somatic** rather than psychological symptoms
- Individuals who embrace the theory of mind-body holism often experience great difficulty distinguishing between psychological and physical ailments.

Asian Americans & Mental Health

- Asian Americans are often uncomfortable with the concept of examining and discussing one's inner thoughts and feelings, especially given the commonly held Asian belief that the best way to deal with mental illness is to avoid morbid thoughts and repress emotions.

Asian Americans & Mental Health

A consistent pattern of underutilization of mental health services among Asian Americans has been well documented for several decades...

Those who do receive mental health treatment are often greatly delayed in help-seeking, and thus tend to be more severely ill upon treatment initiation, oftentimes taking place following a crisis situation

Asian Americans & Mental Health

Beliefs Specific to Chinese Culture

- Mental illness may be viewed as retribution for the misdeeds of ancestors or immediate family
- Interpretations of causes of depression include fate, imbalance of energy in the body or disharmony in natural forces
- Suicide, a potential result of depression, is discouraged in Chinese society. However, it is not considered a sin—if the death is viewed as relieving the family of a burden

Asian Americans & Mental Health

Beliefs Specific to Japanese Culture

- The values most respected in Japanese-American culture are self-reliance, self-control, independence and family honor. Mental-health issues have been a taboo subject fraught with stigma and associated with shame
- Older Japanese Americans have coped with trauma associated with internment based on their own resources. “*Shikata go nai*,” translated as “it can’t be helped,” is a dominant coping strategy, which continues to affect family communications and behavior associated with identity and control
- Suicide has historically been more accepted as an honorable alternative to shame. In the face of depression, suicide may be seen as more honorable than facing the shame of mental illness

Source: Takayanagi, P. (1997)

Asian Americans & Mental Health

Beliefs Specific to Hmong Culture

- Once a life event that may have resulted in *nyuaj siab* (depression) is passed and a healing ceremony has been conducted to relieve the depression, *nyuaj siab* will no longer exist
- If this normal depression—*nyuaj siab*—continues, the individual risks the label of “crazy,” resulting in reluctance to seek assistance either physically or mentally

Source: Xiong, X. (2003)

Asian Americans & Mental Health

A few facts to know:

- Asian American adolescent boys are twice as likely to have been physically abused
- Asian American women aged 15–24 and 65+ have the highest suicide rates in the U.S. out of all racial and ethnic groups
- 40% of Southeast Asian refugees suffer from depression, 35% from anxiety, and 14% from posttraumatic stress disorder (PTSD)
- The suicide rate among Chinese American elderly women has been found to be 10 times higher than for Caucasian elderly women

African Americans & Mental Health

- Historical and contemporary negative treatment has led to mistrust of authorities, many of whom are not seen as having the best interests of African Americans in mind
- Understanding why African Americans with mental illness may reject treatment is essential to breaking down barriers and helping them get the care they need

African Americans & Mental Health

The proportion of African Americans who fear mental health treatment is 2.5 times greater than the proportion of whites who do...

this stigmatized existence leaves many African Americans wide open to anti-psychiatry campaigns...

Some messages warn black communities of a genocidal plot to place African-American children on Ritalin...

Others convey that psychiatry is evil and destroys religion, which is very important to African Americans

Source: <http://pn.psychiatryonline.org/cgi/content/full/36/20/19>

African Americans & Mental Health

Blacks of all ages are more likely to be the victims of serious violent crime than are whites...

The link between violence and psychiatric symptoms and illness is clear...

One study reports that over one-fourth of African American youth who have been exposed to violence have symptoms severe enough to warrant a diagnosis of PTSD

Source: Fitzpatrick & Boldizar, 1993

African Americans & Mental Health

A few facts to know:

- Although schizophrenia has been shown to affect all ethnic groups at the same rate, blacks in the United States were more than **four times as likely to be diagnosed** with the disorder as whites
- Only 16 percent of African Americans with a diagnosable mood disorder see a mental health specialist, and fewer than one-third consult a health care provider of any kind
- African Americans are thought to make extensive use of alternative treatments for mental health problems. This preference is deemed to reflect African American cultural traditions developed partly when African Americans were systematically excluded from mainstream health care institutions

Source: Smith Fahie, 1998

Latinos & Mental Health

- Stigma and embarrassment remain major barriers to care among Latinos of all age groups

“People think that you are mentally retarded if they know you see a psychiatrist. In our community, they confuse mental illness with mental retardation.”

Latinos & Mental Health

- Many Latinos do not view mental illness as a medical problem and as a result, do not seek help when they experience mental health problems.
- Latinos may rely on home remedies “remedios caseros” and prayer when they are experiencing a mental health crisis instead of seeking medical care.
- Maintaining family members with disabilities in the family home is often an important goal for Latino families, who are less likely to place their family member in an outside facility

Latinos & Mental Health

- Mental Health is often viewed as the result of balance among one's faith, nutrition and how one has lived his or her life
- Folk concepts of disease relate to the effects of intense negative emotions such as anger, envy and fright. Treatments can include rituals based on purification, social reintegration and penance
- *Susto* or fright illness is one of the adult folk illnesses that have some overlapping symptoms with depression such as nervousness, listlessness, loss of appetite, or insomnia.

Latinos & Mental Health

A few facts to know:

- Although schizophrenia has been shown to affect all ethnic groups at the same rate, Latinos in the United States were more than three times as likely to be diagnosed with the disorder as whites
- Only 16 percent of African Americans with a diagnosable mood disorder see a mental health specialist, and fewer than one-third consult a health care provider of any kind
- African Americans are thought to make extensive use of alternative treatments for mental health problems. This preference is deemed to reflect African American cultural traditions developed partly when African Americans were systematically excluded from mainstream health care institutions

Smith Fahie, 1998

American Indians & Mental Health

- The diversity among American Indians must be noted. There are over 500 federally recognized nations, tribes, bands and Alaskan Native villages
- Some tribal groups attach little stigma to mental disorders because no division exists between physical and mental illness. Other groups identify mental-health problems as shameful
- Some traditions view depression as a form of spiritual possession, whereas others may see mental illness as imbalance with the natural world

American Indians & Mental Health

- Some Navajo elders view physical and mental illness as disharmony caused by an external force, such as a person or spirit
- Western treatment traditions of personal insight, awareness or self-actualization often run counter to Indian traditions that value the balance of the physical, mental and spiritual, interrelationships over independence, and a shared sense of trauma. Healing comes from identifying stress in the community, and is resolved through community ceremonies and traditional practices

Arab Americans & Mental Health

- Mental illness is considered to bring shame to the family. While honor, or *sharaf*, plays an important protective social role in many Arab-American families, actions perceived as shameful can be ignored or hidden
- Family tradition places the male in the role of breadwinner. Unemployment often affects men more than women, causing mental distress
- Isolation for refugees and immigrants due to economic hardship, language and assimilation barriers, separation from other family members, and loss of status may lead to mental health crisis

Crisis Intervention Training

Implementation Guide

**This is a separate document on the original
flash drive**

Crisis Intervention Training

Model Policies

**This is a separate document on the original
flash drive**