CIT Basic Curriculum Samples







2016

Core Elements: Training Curriculum is adapted from the "Memphis Model" and Crisis Intervention Team (CIT) Trainings throughout the country. Presentation samples were provided by CIT programs in Columbia, Deschutes, Douglas, and Umatilla Counties in Oregon as well as the nationally awarded Memphis, Tennessee and Charlottesville, Virginia CIT programs.

The training emphasizes a better understanding of mental illnesses, including substance use disorders and how it affects a person's life. The course increases communication skills, using both practical experience and role-playing. Class participants are introduced to local mental health professionals, consumers and family members both in the classroom and in the field during site visits.

This 40 hour intensive training program provides a common base of knowledge about mental illness and gives the participants a basic foundation from which to build. The course is intended to provide officers and first responders with the skills to:

Recognize signs and symptoms of mental illness and co-occurring disorders Recognize a mental health crisis situation

Verbally de-escalate mental illness crisis – when safe and appropriate Know local resources on where to take consumers in crisis

Learn about jail diversion options

Know what the appropriate steps to follow up are, such as contacting case managers and providing families with community resources.

Learn how to problem-solve with the treatment system

The curriculum outlined below allows flexibility for each community to develop aspects, needs and resources unique to their community.

Suggested CIT Core elements of the Memphis Model include:

Mental Health – 13 hours

- a) Severe, persistent Mental illness
- b) Child and youth, adolescence
- c) Special focus issues including suicide and PTSD
- d) Substance use disorder
- e) Assessment and commitment
- f) Crisis cycle
- g) Stress first aid
- h) Cognitive Disorders

Community Support – 6 hours

- a) Cultural Awareness & diversity
- b) Veteran's Perspective
- c) Community Resources
- d) Advocacy/Perspective De-

Escalation – 9 hours

- a) Verbal de-escalation
- b) Law Enforcement tactics
- c) Scenario Discussion
- d) Scenarios and role plays

Site Visits – depending on local resources, 2 – 6 hours

- a) Psychiatric hospital
- b) Veteran's centers
- c) Day treatment programs
- d) Homeless programs
- e) Outpatient treatment
- f) Foster home/treatment homes Law

Enforcement – 4 hours

- a) Policy and procedures
- b) Liability
- c) Officer Wellness
- d) Mental health courts/jail diversion programs

Research and Systems –

- a) CIT overview
- b) Evaluation of the training
- c) Administrative tasks

Core CIT Curriculum Classes (Total		T	E 1	
Recommended Courses (32 – 34 hrs.)	Minimum Hours	Maximum Hours	Example 1	Example 2
Age related issues	1		1	1
Cognitive Disorders	1		1	1
Community Resources	1		1	1
De-Escalation Role Plays	4		3	3
De-Escalation Strategies and Techniques	4		4	4
Graduation & CIT Evaluation	1		2	1
Lived Experience Panel (s)	2		2	3
Medication	1		2	1
Officer Wellness	1		2	1
Overview of CIT	1		1	1
Overview of Civil Involuntary Detention Laws and Liability	1		2	1
Overview of Mental Health Disorders	1		3	2
Site Visits	2		2	2
Substance use/Co-Occurring Disorders	1		2	1
Suicide Intervention	1		2	1
Veterans' issues and PTSD	1		2	2
Youth Intervention	1		2	1
The Minimum number of recommended class hours is 32. (6 additional hours from the above list are required to reach the 32 hour minimum)				27
The Maximum number of recommended class hours is 34 (no more than 8 additional hours from the above list are allowed to reach the 34 hour maximum)			34	

Elective Courses (6-8 Hours)	Minimum Hours	Maximum hours	Example 1	Example 2
	Tiours	Hours	т	
Autism Spectrum Disorder	1			
Bipolar Disorder	1			
CIT from the Officer (s) Point of View	1			
Eating Disorder	1			
Excited Delirium	1		1	1
Guardianship and Power of Attorney	1			
Homelessness	1			
Inpatient Hospital Assessment Process	1			1
Jail Diversion	1			
Law Enforcement Suicide	1			
Mental Health First Aid for Law Enforcement	6	8		7
Mood Disorder	1			
Networking Lunch (local sponsorship required)	1		2	2
Personality Disorders	1			
Psychosis Simulator	1		1	
Reducing Stigma	1			
Specialty Courts	1		1	1
Suicidal vs. non-Suicidal Self-Harm	1			
Suicide by Cop	1			1
Supervision of CIT Officers/report writing/ data				
Synthetic Drugs	1			
Trauma Informed Care	1		1	
Veteran's Perspective	1			
Select at least 4 classes from the list to equal up				
to 8 hours				
The Minimum number of elective class hours is 6	6		6	13
The Maximum number of elective class hours is 8		8		
Total hours			40	40

^{*}Achievement of the minimum/maximum hour requirement may be acquired throughout the training over several presentations. EX: De-escalation techniques may be included in the Autism Spectrum Disorder for specific ways to help de-escalate an individual with Autism.

Copy of sample class schedule – Example 1

(Chicago Police Department)

	Monday	Tuesday	Wednesday	Thursday	Friday
7:45 -08:00	Roll Call	Roll Call	Roll Call	Roll Call	Roll Call
	Introduction,	Suicide Risk	Child &	De-Escalation	Veterans Issues
0.00	History &	Assessment &	Adolescent	Techniques &	and PTSD
8:00	Overview	Crisis	Disorders	Crisis Cycle	8:00 – 9:50
	8:00 – 8:50	Intervention Skills	8:00 – 9:50	8:00 – 12:00	
9:00	Mental Illness:	8:00 – 9:50			
3.00	signs &	Medication			0.000
	Symptoms 9:00 – 12:00	10:00 – 11:00	Geriatric Issues		Officer Wellness
10:00	9:00 - 12:00	10:00 - 11:00	10:00 – 11:00		10:00 – 12:00
		Community	10:00 - 11:00		
11:00		Resources	Specialty Courts		
11.00		11:00 - 12:00	11:00 – 12:00		
			Lunch		
12:00	Lunch	Lunch	Psychotropic	Luncheon	Lunch
	Developmental	Family	Medications	provided	Crisis
13:00	Disabilities	Perspectives &	13:00 - 13:50		Intervention Role
13:00	13:00-13:50	Consumer Panel	Legal Issues		Play
		13:00 - 14:50	14:00 – 16:00		13:00-16:00
14:00	Substance Use			Excited	
	and Co-			Delirium	
1.5.00	Occurring			14:00 – 15:30	
15:00	Disorders.	Site Visits			
	14:00 -15:50	15:00 – 17:00			
16:00			Police Custody	Trauma	Course Evaluation
10.00			and Detention	Informed Care	
	Hearing Voices		Laws	15:30 – 17:00	Superintendent's
17:00	Simulation		16:00 – 17:00		Ceremony/
	Exercise				Graduation
	16:00 – 17:00				

Copy of sample class schedule – Example 2

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00	Introduction, History &	Family & Personal Perspectives	Hospital Procedures	Veterans Perspective &	Suicide Intervention 8:00 – 9:00
9:00	Overview 8:00 – 8:50 Mental Health	8:00 – 11:00	8:00 - 900 Dispatch 9:00 – 10:00	PTSD 8:00 – 10:00	Mental Health Court 9:00- 10:00
10:00	First Aid		Adult Protective	Overview of Mental	Officer Wellness 10:00 – 11:00
11:00	9:00 – 12:30	 Crisis Cycle	Services 10:00 – 11:00 Suicide by Cop	Health Disorders 10:00 – 12:00	Cognitive Disorders 11:00 – 12:00 NAMI Lunch
12:00	Lunch 12:30 - 13:00	11:00 – 12:00 <u>Lunch</u> De-Escalation	11:00- 12:00	Lunch Local	12:00 – 13:00
13:00	Mental Health First Aid cont. 13:00 – 17:00	Skills 13:00 - 17:00	Excited Delirium 13:00 – 14:00	Resources 13:00 – 14:00 Substance	De-escalation role plays 13:00 – 16:00
14:00			Crisis intervention –	Use & Co- Occurring Disorders	Course Evaluation Graduation
15:00			Juveniles 14:00 – 15:00	14:00 – 15:00	Gradation
16:00			Peace Officer Custody's 15:00 – 16:00	Site Visits 15:00 – 17:00	
17:00					
			Medication 16:00 – 17:00		

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Overview of CIT

Module: Research & Systems

Presenter: Law Enforcement or CIT Coordinator

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

• List at least two benefits of Crisis Intervention Training

Course Description:

This Unit will provide the participants with information on the history and benefits of Crisis Intervention Team Training.

Suggested videos:

Crisis Intervention Team Officer Training - 2015 - https://www.youtube.com/watch?v=4SbVP- JvxPk

Slide 1

What is CIT

The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in Memphis and has spread throughout the country. Known as the "Memphis Model," CIT provides law enforcement-based crisis intervention training for assisting those individuals with a mental illness, and improves the safety of patrol officers, consumers, family members, and citizens within the community.

What is CIT? (cont.)

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

Basic Goals:

- Improve Officer and Consumer Safety
- Redirect Individuals with Mental Illness from the Judicial System to the Health Care System

Slide 3

Statistics

- An estimated 26.2% of Americans ages 18 and older

 about one in four adults suffer from a diagnosable mental disorder in a given year (NIMH, 2009). Statistically, of Oregon's population of 2.8 million, between 150,000 and 190,000 people are diagnosed with a serious mental illness.
- Approximately 24% of people incarcerated in jails and prisons suffer from at least one mental illness.
- 80+% of those diagnosed with a mental illness have a cooccurring substance abuse disorder.
- In a 2006 study, the suicide rate was 10.9 suicide deaths per 100,000 people. An estimated 12 to 25 attempted suicides occur per every suicide death.

40 Hour Training Curriculum

- Recognizing Signs and Symptoms of Mental Illness.
- · Treatment Methodology
- · Suicidality and Self-Harm
- Child and Adolescent Intervention
- PTSD
- · Excited Delirium
- Consumer Advocacy/ Consumer Perspectives
- · Crisis Cycle
- Community Resources
- · Cultural Sensitivity
- · Legal Aspects and Issues
- Tactical Communication/Practical Exercises
- Site Visits to Treatment/Respite Care Facilities
- Introduction/Review/Examination/Graduation

Slide 5

People with mental illness are significantly overrepresented in the criminal justice system.

- The rate of mental illness in state prisons and jails in the United States (16%) is at least three times the rate in the general population (5%). The rates of mental illness in Oregon state prisons and county jails are at least this high.
- At least three-quarters of people with mental illness who are incarcerated have a co-occurring substance abuse disorder.
- Males who have been involved in the mental health system are 4 times more likely to be incarcerated. For women, the numbers are 6 to one.

- Nearly half the inmates with a mental illness in state or federal prison in the United States are incarcerated for committing a nonviolent crime.
- On average, the period of incarceration for a person with mental illness is 4 to 6 times longer than that of a person without mental illness.
- The cost of incarcerating an inmate with a serious mental illness is approximately 80% more than that of an inmate without SMI.

Slide 7

CIT Benefits

- Crisis response is immediate
- Arrests and use of force decrease
- Underserved consumers are identified by officers and provided with care
- Patient violence and use of restraints in the ER decrease
- Officers are better trained and educated in verbal de-escalation techniques
- Officer's injuries during crisis events decline
- Officer recognition and appreciation by the community and the consumer increase
- Less "victimless" crime arrests.
- Decrease in liability for health care issues in the jail
- Cost savings for the consumer as well as the taxpayer.



Special Thanks to:

Memphis Police Department ()



State of Georgia CIT



State of Florida CIT



City of Eugene Police Department 🍿



CITInternational &



NAMI

Overview of Civil Involuntary Detention Laws

Module – Law Enforcement

Presenter: Law Enforcement or City/County Legal Counsel

Hours: 2

Learning Outcomes:

At the completion of this unit, the participants will be able to:

 Identify legal issues an officer should consider with relation to use of force if time and circumstances allow.

Course Description:

The class will provide the participants with real life examples of police encounters with individuals experiencing symptoms of their mental illness. The presenter will show case law and litigation results for cases where officers have resulted in the use of force with mentally ill individuals and the results of some of those cases. Some of the case examples may include: Glenn vs.

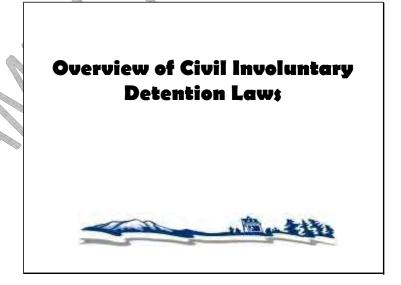
Washington Co.; Drummand vs. City of Anaheim; Deorle vs. Rutherford; James P. Chasse vs. Multnomah.

Active listening and de-escalation skills will be addressed as tools provided to the officers.

Suggested videos:

Alien Boy – the Story of James P. Chasse

Slide 1



Oregon Civil Commitment Laws

- Are governed by the Oregon Revised Statute Chapter 426 and the Administrative Rules from the DHS Office of Mental Health and Addiction Services.
- Apply to children and adults, with no age limitations, although the presence of a legal guardian can and does replace the process.

Slide 3

Correct Legal Terms

- **Peace Officer Custody** is short-termed and limited in order to get to a hospital for a mental evaluation.
- Transport Custody is limited up to 12 hours in order to get from one hospital to another that can assess and treat.
- **Voluntary** the patient signs themselves in, or signed in by a guardian.
- **Hospital Hold** involuntary admission status, up to five judicial days. Legal process and hearing.
- Civil Commitment by a Judge up to 180 days.



Initiation of Commitment Peace Officer Custody (ORS. 426.228)

- "A peace officer may take into a custody a person who the officer has probable cause to believe is a danger to self or to any other person and is in need of immediate care, custody or treatment for mental illness."
- "May" permissive verb that establishes that while actions are authorized, they are not required. Scovill v. City of Astoria, 324 Or 159 (1996)

Slide 5

Initiation of Commitment Peace Officer Hold (ORS. 426.228) cont.

- Deliberately vague.
- Requires the peace officer to believe the individual is <u>more likely than not</u> a danger to themselves or others <u>by reason of mental</u> illness.
- Must be based on a face-to-face assessment, but otherwise does not limit or define evidence necessary to establish belief in probable cause.
- Context is everything.

Unexplainable Changes

 Be very concerned when you hear this is a new behavior and there is an abrupt change in mental status or behavior. This could signal a serious medical problem.

Slide 7

If in doubt...

...consult with your local crisis line.

Limitations of Liability

 O.R.S. 426.335 (6) No peace officer, person authorized under O.R.S. 426.233, community mental health director or designee, hospital or other facility, physician or judge shall in any way be held criminally or civilly liable for action pursuant to O.R.S. 426.228 to 426.235 if the individual or facility acts in good faith, on probable cause and without malice.

Slide 9

Types of Transportation for Voluntary Commitments

Voluntary – Probable cause to believe the individual is <u>not mentally ill and dangerous:</u>

- · Family or friend
- Public transportation
- Caseworker in agency vehicle
- Ambulance (if medical concern)

Types of Transportation for Involuntary Commitments

Involuntary - You have probable cause to believe the person is mentally ill and dangerous:

- Secure transportation company if available in your community
- · Peace Officer
- Ambulance with police escort if there is a medical concern

Slide 11

Medical Clearance

• O.R.S. 426.228: If more than one hour will be required to transport the person to the hospital or nonhospital facility from the location where the person was taken into custody, the peace officer shall obtain, if possible, a certificate from a physician licensed by the Oregon Medical Board stating that the travel will not be detrimental to the persons physical health and that the person is dangerous to self or to any other person and is in need of immediate care or treatment for mental illness.



Directors Hold

ORS 426.228(2)

- "A peace officer shall take a person into custody when the community mental health program director, pursuant to ORS 426.233, notifies the peace officer that the director has probable cause to believe that the person is imminently dangerous to self or to any other person."
- "Shall" when used in a statute, "ordinarily is mandatory." Scovill v. City of Astoria, 324 Or 159 (1996)
- Same criteria as a POH, only advantage of a Director's Hold/Custody is the clinical training in determining the level of danger when the signs and symptoms are more visible.
- The director's designee may also take this action if the person is already committed, on some form of conditional release, and is not meeting the conditions of their release plan.
- In these cases the release status can be revoked.

Slide 13

Where are we going?

Wheretotakethecustody?

- Your local county crisis line can help you decide
 - Hospital facilities with Hospital Hold capacity and a Psychiatric Unit.

-vs.-

 Hospital facilities without Hospital Hold capacity and/or Psychiatric Unit



Applicable Oregon Revised Statutes

O.R.S. 430.399

When person must be taken to treatment facility

(1) Any person who is intoxicated or under the influence of controlled substances in a public place may be taken or sent home or to a treatment facility by the police. However, if the person is incapacitated, the health of the person appears to be in immediate danger, or the police have reasonable cause to believe the person is dangerous to self or to any other person; the person Shall be taken by the police to an appropriate treatment facility. A person shall be deemed incapacitated when in the opinion of the police officer or director of the treatment facility the person is unable to make a rational decision as to acceptance of assistance.

Slide 15

Applicable Oregon Revised Statutes continued...

- (2) The director of the treatment facility shall determine whether a person shall be admitted as a patient, or referred to another treatment facility or denied referral or admission. If the person is incapacitated or the health of the person appears to be in immediate danger, or if the director has reasonable cause to believe the person is dangerous to self or to any other person, the person must be admitted. The person shall be discharged within 48 hours unless the person has applied for voluntary admission to the treatment facility.
- (3) In the absence of any appropriate treatment facility, an intoxicated person or a person under the influence of controlled substances who would otherwise be taken by the police to a treatment facility may be taken to the city or county jail where the person may be held until no longer intoxicated, under the influence of controlled substances or incapacitated.

Oregon revised standards, continued

(4) An intoxicated person or person under the influence of controlled substances, when taken into custody by the police for a criminal offense, shall immediately be taken to the nearest appropriate treatment facility when the condition of the person requires emergency medical treatment.

(5) The records of a patient at a treatment facility may not be revealed to any person other than the director and staff of the treatment facility without the consent of the patient. A patient's request that no disclosure be made of admission to a treatment facility shall be honored unless the patient is incapacitated or disclosure of admission is required by ORS

430.397 (Voluntary admission of person to treatment facility). [Formerly 426.460; 2011 c.673 §30]

Overview of Mental Illness

Module: Mental Health

Presenter: Mental Health Professional

Hours: 2

Learning Outcomes:

At the completion of this unit, the participant will be able to:

 Demonstrate an increased awareness of the some of the more common mental health diagnosis

Course Description:

To provide education regarding mental illness and reduce the stigma associated with this disease.

Suggested videos:

Video by title:

"Therapeutic Communication with the Bipolar Manic" http://www.youtube.com/watch?v=O9ULMOETfd0

"Therapeutic communication with the Schizophrenic" http://www.youtube.com/watch?v=HBAeWH_WHRO

Slide 1

Overview of Mental Illness

Presenter – Mental Health Professional

Definitions

 Mental Illness is a condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and function each day. Each person will have different experiences, even with the same diagnosis.

See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions#sthas.TH9fzIVS.dpuf

Slide 3

There are several types of mental illness, including but not limited to:

Anxiety Disorders
Trauma Disorders
Eating Disorders
Addiction Disorders
Personality Disorders
Mood Disorders
Psychotic Disorders

Definitions (2)

• Personality Disorder;

Pervasive, unchanging pattern of behavior that causes general stress in life and in the lives of those around them

Slide 5

Definitions (3)

Intellectual Disability

Significantly substandard intellectual functioning along with serious life skill deficits, all occurring before age 18

Definitions (4)

Substance Abuse/Dependence:
 Habitual pattern of alcohol and legal or illegal drug use that results in significant problems in work, relationships, health, finances, legal issues, etc.

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Definitions (5)

• Dementia:

Gradual and continual decline in cognitive abilities that onsets in adulthood. May include problems with memory, physical skills, social skills, and ability to function with daily life skills.

Definitions (6)

Co-occurring (concurrent) Disorders:
 Any combination of two or more of the above disorders.

Slide 9

General Information

- Co-Occurring Disorders is the norm not the exception.
- Until recently the system has been set up to handle only one at a time.
- Co-Occurring Disorders make diagnosis much harder, makes treatment much harder and makes success much less likely.

Slide 10

What Is Psychosis?

- Psychosis is a symptom, not an illness
- Symptoms of psychosis include:
 - Difficulty concentrating
 - Depressed mood
 - Anxiety
 - Suspiciousness
 - Withdrawal from family and friends
 - Disorganized speech
 - Suicidal thoughts or actions

Slide 11

Psychosis includes a range of symptoms, but typically involves on of these two major experiences:

Hallucinations – seeing, hearing or feeling things that are not there, such as:

- Hearing voices
- Strange sensations or unexplainable feelings
- Seeing glimpses of objects or people that are not there.

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Delusions – strong beliefs that are not consistent with the person's culture, and are unlikely to be true, such as:

- Believing external forces are controlling thoughts, feelings
- Believing that trivial remarks, events or objects have personal meaning or significance.
- Thinking you have special powers, are on a special mission or even that you are God.

See more at http://www.nami.org/Learn-More/Mental-Health-Conditions/Early-Psychosis-and
Psychosis#sthash.c3m74M8K.dpuf-

Slide 13

Physical Symptoms that may be observed include:

- A blank, vacant facial expression
- Clumsy, inexact motor skills
- An awkward gait
- Unusual gestures or postures

Examples of feeling/emotions

- Inability to experience joy
- Sometimes feeling nothing at all
- Feeling indifferent to important events
- Feeling detached from your own body

^{*}Medical issues could include

How to interact with a person experiencing symptoms of psychosis

- Do not confront
- Frame things as your opinion
- Do not play along with the delusion
- Give space, if appropriate
- Use active listening skills
- Be curious
- Validate the experiences are real for the individual
- * Presenter may discuss the importance of not becoming involved in the person's delusion.

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Things to think about:

- Voices might be telling them not to trust you (or other things)
- Might not have had good experiences with police in the past
- Might be scared of going to the hospital /jail
- Might not know what they take their meds for
- · Might not know their diagnosis or believe it
- Might not pick up on non verbal's
- Just because it seems paranoid/delusional doesn't mean its not true

Bi-Polar Disorder

- What is Bi-polar Disorder?
- Bi-polar disorder, also known as manic depression, is a brain disorder that causes extreme shifts in mood, thought, energy and in a person's ability to function.

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 The symptoms of bi-polar can be extremely severe, with extreme "highs" that result increased energy, inability to sleep, racing thoughts, impulsivity or reckless behaviors. These symptoms feel good to the person, which can lead to a denial of any problem The other side of Bi-polar disorder is the depressed phase. While in the depressed phase a person may experience extreme sadness, hopelessness, irritability, agitation, despair, crying spells, and feelings of guilt, helplessness and worthlessness. While in the depressed phase they may complain of physical illness or pain with no physical cause. They often experience suicidal thoughts or attempts.

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Major Depression

- Major depression is a serious medical illness affecting 15 million American adults or approximately 5-8% of the adult population in a given year persistently sad or irritable mood; Symptoms include:
- pronounced changes in sleep, appetite and energy
- difficulty thinking, concentrating and remembering
- physical slowing or agitation
- lack of interest in or pleasure from activities that were once enjoyed
- feelings of guilt, worthlessness, hopelessness and emptiness
- · recurrent thoughts of death or suicide
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and chronic pain

When several of these symptoms of depressive illness occur at the same time, last longer than two weeks and interfere with ordinary functioning, professional treatment is needed

Depression Statistics, Unhappiness by the Numbers; Depression Facts & Statistics 2012 Infographic

Officer Strategies

- Listen to story over time if necessary
- Offer immediate solutions using local resources and referrals
- Suggest one easy, immediate change that can have an immediate effect.
- No excuses for their behavior arrest when needed, but do so with the steps above as you do it.

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Officer Strategies

- · Work with family or neighbors.
- USE Adult and Protective Services (APS) if they have a diagnosis or you suspect some shift in their ability to handle their affairs.
- · Use APS for exploitation concerns
- Tension between letting them have the consequences of their actions so they can learn, but at the same time, function as a light house to keep them off the worst rocks if possible



Thing to remember

- Be aware that your energy can reflect back to the person in crisis including adrenaline, fear and nervousness.
- While you are trained to get information as soon as possible, in many of these interactions if you slow it down and take time to be curious and establish rapport, you can get the information you need and reduce time in the long run.

In Our Own Voice

Module – Community Support

Presenter: National Alliance on Mental Illness (NAMI) and consumers of local mental health

agencies

Hours: 30 minutes – 1 ½ hours

Learning outcomes:

At the completion of this unit, the participant will be able to:

Identify challenges faced by individuals experiencing the symptoms of a mental illness

Course Description:

NAMI - In Our Own Voice presenters will provide the class with first-hand accounts of what it's like to live with a mental illness. Presenters humanize this topic by demonstrating that it's possible— and common—to live well with a mental illness. People with mental health conditions share their powerful personal stories.

Suggested videos:

http://www.nami.org/Find-Support/NAMI-Programs/NAMI-In-Our-Own-<u>Voice#sthash.d6c3LX8T.dpuf</u> (This is a link to the NAMI website where the video and how it can be used in trainings is explained. The actual video is 90 minutes in length and can be obtained through local NAMI partners or NAMI Oregon)

Family Perspectives

Module: Community Support

Presenter: NAMI and Family members of mental health consumers

Hours: 1 - 1.5

Learning Outcomes:

At the completion of this unit, the participant will be able to:

• Identify the challenges of family members, when they are faced with a loved one's mental illness

Course Description:

Family members will tell their stories of having loved ones affected by an illness of the mind. Their stories can be very personal and moving, allowing some insight into this disease and how it affects the people around them. The format is interactive with the participants.

Crisis Cycle

Module: Mental Health

Presenter: Mental Health Professional- may be co-presented with Criminal Justice Professional

Hours: 1-2

Learning Objectives:

At the completion of this unit, the participant will be able to:

- Describe the dynamics of the Crisis Cycle
- Identify Active Listening Techniques.
- Identify barriers to effective communication with a person experiencing a mental health crisis

Course Description:

The class is designed to provide the participants a better understanding of a crisis cycle.

Suggested videos:

It is not about the Nail - https://www.youtube.com/watch?v=5011 Ma20Rk

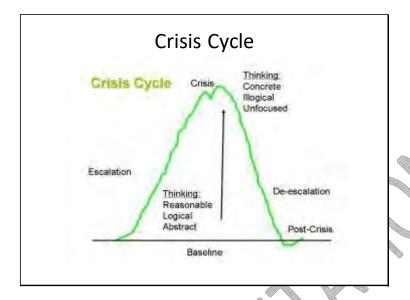
Empathy vs Sympathy - https://www.youtube.com/watch?v=1Evwgu369Jw

Managing a crisis – https://nursing.uiowa.edu/sites/default/files/documents/Hartford/ABC-SuppMat.pdf

Slide 1

Crisis Cycle and Intervention

Presenter – Mental Health Professional
May be co-presented with Law Enforcement Officer



Slide 3

Normal State

- ➤ 100% ability to communicate, perceive what you are saying and have the ability to reason
- ➤ Behavior is at baseline of function
- > There is no emotional content
- > Your actions during this stage.
 - ➤ You are calm/They are calm
 - > You are able to help solve the problem

Stimulation Stage

- ➤ 50-75% ability to communicate, perceive what you are saying and have some ability to reason
- ➤ Agitated Behavior, Anxious
- > Your actions during this stage:
 - ➤ Use simple sentences "I am here to help."
 - ➤ Empathize "I can see you are very frustrated right now"
 - ➤ Use calming body language hands at waist, palms up
 - ➤ Keep your voice low and calm

Slide 5

Escalation Stage

- ➤ 5-50% ability to communicate, perceive what you are saying and ability to reason
- > Loud and aggressive, fearful or frustrated
- ➤ Your actions during this stage:
 - Use simple sentences five words or less
 - Make an immediate request "sit down"
 - Continually repeat your request
 - Body language and voice firm yet calm

State of Crisis

- > 0-5% ability to communicate, perceive what you are saying and ability to reason
- ➤ Out of Control
- > Your actions during this stage:
 - ➤ Use firm, one-two word commands- "Stop"
 - ➤ Make Immediate Requests
 - ➤ Continually repeat your requests

Slide 7

De-escalation Actions

- > Take your time the person cannot remain in a crisis state forever
- >Constantly read feedback from the individual
- >Stop doing anything that escalates the individual
- ${\red} \textit{Reduce external stimulus} \textit{Family members, audience, animals, t.v./stereo}$
- ${\blacktriangleright}$ Have only one person talk to the individual if you are ineffective, trade off

Officer Safety

- Contact and Cover
- Cover + Distance = Time
- ➤ Slow it down
- > Time is on your side
- > Do not increase the subjects level of anxiety or excitement
- > Attempt to develop rapport

Slide 9

Active Listening

The Rules

- Seek to understand
- ➢ Be non-judgmental
- ➤ Give your undivided attention to the speaker
- Use silence effectively
- > Always treat the person with respect

Active Listening Tools

- Open ended questions
- Broad/not specific
- > Wait for the response
- Minimal encouragers Show your concern
- Uh-huh, yeah, nod your head

Slide 11

Intervention

- ➤ Rule #1: OFFICER SAFETY
 - > Introduce yourself
 - > Ask for, and use, the person's name
 - > Use a calm voice
 - Hooks and Triggers
 - > Tell them you are there to help
 - > Identify how they want to resolve the issue

Slide 12

QUESTIONS TO ASK

- > Are you thinking of suicide?
 - ➤ If so, how?
 - > Do you have the means available?
 - ➤ Past Attempts?
- ➤ Are you hearing voices?
 - ➤ Are they command hallucinations?
 - ➤ If so, what is the content?
 - ➤ Have you ever acted on what the voices have told them to do in the past?

Slide 13

WHAT TO AVOID

- Judging
- > Sarcasm
- ➤ Use of the word "surrender"
- ➤ Audience
- > Promises you can't keep
- ➤ Threatening
- ➤ Intimidating

Slide 14

Everyone you meet is fighting a battle you know nothing about.

Be kind. Always.

- Ian Maclaren

Age Related Issues

Module - Mental Health

Presenter: Mental Health Professional or Senior's Program

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

• Identify challenges faced by an individual experiencing age related cognitive disorders

Course Description:

This unit will provide the participants with introductory information on Alzheimer's disease and age related Dementia. This unit will discuss local, county and state resources.

Suggested activity: "Aging and Sensory Change" A Presentation Guide"

This presentation can be tailored to the presenter and audience and can range from 20 minutes (brief introduction and exercises) to approximately one hour. Overall, this set of activities is designed to help participants experience and understand some of the changes that may occur during the life course.

The activities include:

A brief introduction to gerontology, normal and disease-related aging processes, and sensory changes (approximately 5-30 minutes, depending on presenter and audience)

Sensory kit exercises (approximately 15-20 minutes)

Interactive discussion with participants about (approximately 10-20 minutes):

- How they felt about this experience,
- What kinds of tasks, activities or skills would be difficult with these limitations
- How to assist elders in their community with activities of daily living
- Reflections on lessons learned from activity that could be shared with colleagues, family and/or friends
- Other Questions and answers

Participants:

Professionals, community members, students, etc.

Supplies Needed:

- One clear plastic sandwich bag
- One pair of latex gloves
- One piece of yellow cellophane
- One piece of a newspaper
- One small button, a needle, and thread
- One piece of sandpaper
- One handful of peas or lentils in a small bag
- One piece each of white, yellow, blue & green paper
- Two cotton balls
- Two pieces of chocolate

Sensory Kit Exercises:

- Place each cotton balls in your ears. This represents someone who has difficulties with hearing.
- Look through the clear plastic sandwich bag (two layers of plastic). This represents 20/60 vision and is the minimum legal vision needed for permission to drive during the day in the United States. Try to read the newspaper.
- Fold the clear plastic bag in half (creating four layers of plastic) and look through it. This represents being legally blind.
- Look through the small piece of yellow cellophane. This represents the yellowing that occurs in the lens of the eye and its effect on vision.
- While looking through the yellow cellophane, look at the pieces of colored paper (white, yellow, blue, green). This represents the difficulty that older adults have distinguishing certain colors. This is why it is important to avoid giving instructions, for example, to take certain colors of pills on different days.
- Now look through the plastic bag and the yellow cellophane together. Try to read the newspaper. Notice the difficulty.
- Put the latex gloves on and touch the sandpaper. Notice the diminished sensation that you feel. This represents peripheral neuropathy.
- With the gloves on, try to grab the button and then try to thread the needle. While you are doing this, try to imagine having poor vision as well.
- Put the small bag of lentils or peas into each of your shoes and walk. This simulates the pain and loss of equilibrium associated with calluses and bunions on the feet.
- While holding your nose, eat a piece of chocolate. What do you notice? Another way to experience taste changes is to eat a food item labeled "No Added Salt" such as crackers or a can of vegetables. Now, go ahead enjoy the second piece of chocolate in your kit!

Adapted from materials developed by: Catherine R. Van Son PhD, RN vansonc@wsu.edu

Washington State University-College of Nursing, Spokane, WA

Responding to Older Adults with Social and Behavioral Health Concerns



Slide 2

Training Overview

- * Facts and Figures
- * Common behavioral health concerns
- * Sensory Awareness exercise
- * Dementia
 - * Warning signs and general approach
 - * Firearms
 - * Driving
 - * Shoplifting
- * Resources
 - * Adults and People with Disabilities; The Gatekeeper Program, Adult Protective Services

Slide 3

Depression is not....

- * A natural reaction to an upsetting event
- * A normal part of aging
- * A normal part of grieving
- * To be expected

Slide 4

Elder Self Neglect:

- * Can be a symptom of depression or dementia
- * Can cause or worsen serious health problems
- * Can be deadly

If you suspect self-neglect:

* Call 1-800-ORE-ARDC

Interventions for Older Adults at risk of suicide:

- * Assist to contact trusted family member or friend
- * FRIENDSHIP LINE: Suicide prevention hotline for older adults: 1-800.971.0016
- * Local Community Behavioral Health organization
- * Suicide Hotline: 1800-273-8255
- * Assist in scheduling appointment with medical provider

Slide 6

Alcholol and Older Adults

- Older Adults become more sensitive to alcohol as they get older.
- Heavy drinking can make some health problems worse.
- Medications and alcohol do not mix.

National Institute on Aging, 2011



Dementia is:

- * A brain disease characterized by a loss of neurons
- * Progressive
- * There is no cure



Slide 8

Disaster Response

- * Do not argue or correct; redirect instead
- * Avoid force or physical restraint
- * Be creative
- * Brainstorm ideas with someone who knows the individual (caregiver, family member)
- * Develop a strategy before approaching
- * 1:1 is preferred
- * Give simple task to focus on
- * Take to quiet place
- * Do not leave alone

Slide 9



Slide 10

* In 60% of homes where a person with dementia lives, there are firearms. Many are loaded, but even unloaded guns can be dangerous. * Judgment and personality changes can make having a weapon very dangerous for a person with dementia. Leaving a weapon unloaded may not be enough. The person could still show the gun and cause an unsafe situation.

Driving and Dementia

- Confusion or getting lost can be one of the first signs of dementia
- * The physical memory of driving may remain (opening door, starting engine, operating vehicle).
- * Judgement, spatial orientation, reaction time can be markedly impaired



Slide 12

Shoplifting Goals

- * No criminal charges
- * Caregiver notified
- * Merchandise returned



Calling in a false report



- Delusions and suspiciousness can be part of dementia
- * Do not argue or correct
- * Reassure and redirect
- * Check with caregiver
 - * Brainstorm ideas
 - Make sure the person with dementia is not aggressive toward caregiver

Slide 14

Recognizing Wandering



- * Inappropriate attire (i.e., wrong for the weather, mismatched or disheveled)
- * Unbalanced or shuffling gait
- * Person not aware of unsafe actions or situations
- * Age (Dementia is more likely with older age, however, it can affect those under age 65.)

Abuse, Neglect & Financial Exploitation

- Physical harm or injury
- Failure to provide basic
- Abandonment by the caregiver
- Verbal/emotional abuse Financial exploitation
- Unwanted sexual contact Involuntary seclusion
- Wrongful restraint
- Self-neglect

- * DHS Aging and People with Disabilities 503-397-5863
- * Oregon Department of Human Resources Abuse Reporting Line 1-855-503-SAFE (7233)

Cognitive Disorders

Module: Mental Health

Presenter: Intellectual Disabilities Service Provider or Mental Health Professional

Hours: 1

Learning Objectives:

At the completion of this unit, the participant will be able to:

• Identify barriers to effective communication with a person experiencing a developmental disability.

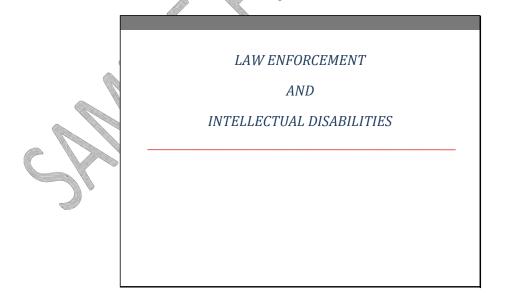
Course Description:

The class is designed to provide the participant a better understanding of 'ow a person' that developmental disability may act when they are experiencing a crisis.

Suggested videos:

- Executive Functioning https://www.youtube.com/wa_sh?v=SR1LJXc6d8
- Fetal Alcohol Syndrome one person's story https://www.youtube.com/watch?v=b02BK1? ... BY& ature=share

Slide 1



Slide 2

- Oregon Institutions Fairview {1908 2000}
 - Eastern Oregon Training Center {1909 2014}
 - In 1967, state institutions were homes to almost 200,000 people with disabilities.
 - In 1970, US schools educated only one in five children with disabilities, and many states had laws excluding certain students from school, including children who were deaf, blind, emotionally disturbed, or intellectually/developmentally disabled.
 - Organizations like the Opportunity School (now Foundation) were started by parents in 1965





Because of This History

- · Deinstitutionalization was considered a Civil Rights issue
- An individual with an Intellectual Disability (ID) also known as Developmental Disability, is considered capable to make his/her own decisions unless proven incapable in a court of law
- Developmental Disabilities services are voluntary
- Legal commitment is possible, but very rare and temporary

Slide 5

Who is eligible for services?

Medical diagnosis of a developmental Disability

- Ex. Autism, Down
Syndrome, Seizure
Disorder, Fragile X,
Cerebral Palsy, Fetal
Alcohol Spectrum
Disorder, etc.

Impairments in adaptive behavior (e.g.: skills that relate to daily living) that are directly related to DD

- Assessment score of 70 or below
- Cannot be primarily attributed to other

IQ score of 75 or below

Impairments in adaptive behavior (skills that relate to daily living) that are directly related to ID

- Assessment score of 70 or below
- Cannot be primarily attributed to other conditions including but not limited to mental or emotional disorder, sensory impairment, substance abuse, ADHD, etc.

Must originate prior to age 18 and expected to be permanent

Behavior Challenges

- · Inability to communicate needs/wants
- Memories can trigger responses
- · No real fear of danger
- · No response to verbal direction
- · Response to irritating stimulus
- Environmental overstimulation







Slide 7

Possible Contributing Factors

- Notfeeling well but unable to express
- · Being hungry or tired
- · Feel too hot or too cold
- · Personal space is invaded
- Medication changes
- Disrupted routine







LOOKFORSUPPORTS

Ask people who know them

Favorite toy or game

Pictures in person is non-verbal

Replace behaviors with appropriate ones.



Slide 9

Protective Services

- Similar to Adult Protective Services
- · Meets with the Multi-Disciplinary Team/DA's Office
- Called in response to protection of "extraordinary rights"
- Investigates all cases of adults with I/DD, including when the threshold of abuse does not rise above civil law
- Cross reports with Child Welfare for children with I/DD
- · Will involve law enforcement if crime is suspected

Who are you going to meet?

- People who live in the community and have some skills, but also require professional supports.
- High need for belonging and friends
- Hanging out with criminals.
- Doesn't learn from cause and effect
- Frequent recidivism

Slide 11

What do they have in common?

- Doing everything they can to hide their disability to be liked or accepted by others, especially authority figures.
- Or
- May be adapting to a tough guy image, when it's clear they can't carry it off.
- Or
- May be carrying it off very well. You'll pick it up by the way they're victimized by others.

Lack of abstract thought

- There are easy tests for this:
- Example: Give them a simple three step direction. "Walk to the back of the car, touch the bumper, come back and say hello". If they can't do it, you can suspect intellectual disability.

Slide 13

Now that I suspect something -

- Show the person what to do, rather than instruct.
 - · Example: turn your own pockets inside out
 - Example: Sit down on the curb
 - · Example: Showing them what your ID card looks like
 - Example: Walk away from the street to a safer place and ask them to follow you.
 - Example: Show them your cell phone and see if they show you theirs. Many people with limited speech now carry cell phones with emergency numbers programmed in.

Responses in the Field

- Reduce outside noise/lights/action
- Don't interfere with their belongings
- Don't try to stop stimming behaviors
- Don't force eye contact
- Give them extra response time
- Prepare them before each action you take
- Use "key words" such as "Quiet hands or feet" and "Good job for ..."

Slide 15

Resources and Information

- Law Enforcement Awareness Network (LEAN)
 - www.leanonus.org
- Autism ALERT (Alliance for Local Emergency Responder Training)
 www.autismalert.org
- Autism Spectrum Disorders: A Special Needs Subject Response Guide for Police Officers
 - http://nicic.gov/Library/023977

Stress First Aid @

Module: Mental Health

Presenter: (2) – one each from Mental Health and Law Enforcement

Hours: 2

Learning Outcomes:

At the completion of this unit, the participant will be able to foster natural resiliency through:

- Recognizing the physical and psychological effects of stress.
- Identify appropriate techniques for coping with stress

*(adapted from Caplan, 1964, Preventive Psychiatry)

Course Description:

Stress First Aid is a flexible multi-step process for the timely assessment and preclinical care of stress reactions or injuries in individuals or units, with the goal of preserving life, preventing further harm and promoting recovery.

The course can be taught in sections of a 30-minute overview; a 2 hour, a 4 hour or an 8 hour module.

Suggested videos:

Clip from the documentary "the Police Tapes" – 1976 Clip from the documentary "Boston's Finest: -

Slide 1

Stress First Aid

Adapted from the Navel Center Combat & operational Stress Control

Crisis Intervention Goals:

- To Foster natural resiliency through
 - 1. Stabilization
 - 2. Symptom reduction
 - 3. Return to adaptive functioning, or
 - 4. Facilitation of access to continued care
 - (adapted from Caplan, 1964, Preventive Psychiatry)

Slide 3



Suicidal Subjects

Module: Mental Health

Class: Suicidal Subjects

Presenter: Mental Health Professional

Hours: 1

Learning Outcomes:

At the completion of this unit, the officer will be able to:

 Provide the basic skills necessary to be effective with identifying and interacting with individuals at risk of self-harm.

Course Description:

Suicide is a nationwide epidemic that affects people of all ages, nationalities, and economic levels. The course is designed to recognize some of the more common risk factors and suicidal behaviors and to help equip officers with the tools that they need to effectively communicate and build trust.

Optional video to use:

http://www.bing.com/videos/search?q=kevin+hines+video&FORM=VIRE11#view=detail&mid=1088A4F024A1FA9B77321088A4F024A1FA9B7732 - Kevin Hines Story- 14 minutes

Slide 1

Suicde and Self Harm Behaviors

The Spectrum of Suicide and Self Harm Behavior

- It is not unusual for an individual, over the course of his / her lifetime during times of extreme distress, to consider suicide as a solution to a perceived problem.
- Self Harm behaviors can be anything from excessive risk taking to intentional self inflicted injury, to behaviors that will lead to eventual negative consequences. Motivations and intentions vary widely!
- In some individuals there may not be an intention to end one's life, but due to the compelling nature of an altered mental state end their lives.

Slide 3

Self Harm and Suicidal Behaviors

Non – Fatal Attempts (American Association of Suicidology ASA)

- 900,875 annual attempts in the US
- This translates to 1 attempt every 35 seconds
- Emergency Room visits increased 55 % between 2005 and 2009 for men ages 21-34, from 19,000 to 29,000 for medication related suicide attempts.
- All ages accounted for 78,000 suicide attempts / ED visits in 2009

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Slide 5

Self Harm and Suicidal Behaviors

Dr. Jan Fawcet

• "No one has been able to show that suicide is predictable in individuals,"



Self Harm and Suicidal Behaviors

- The Big Picture: It's Always about the Relationship
 The most useful information we can obtain in our interactions does not come from a checklist – it comes from taking the time to find out who the person is and letting them know that we're interested.
- Working with Ambivalence: Recognize strengths and
- When under a great deal of stress / loss / uncertainty, we lose perspective and sight of accomplishments, that we are not alone.
- Remember:
- · Most do not want to end their lives; they want an end to their suffering

Slide 7

Self Harm and Suicidal Behaviors

Time can be used strategically

- For most individuals, the cycle of a crisis episode is time limited.
- Talk openly and candidly with the individual about suicide w/out presenting judgment in either a positive or negative
- When appropriate move toward alternatives to suicide.
- · Whenever possible remove access to lethal means
- Avoid making promises that you cannot keep
- In many cases the individual has already engaged in a self harm behavior (s) cutting, overdose, reckless behavior. In those cases an evaluation in a medical setting is necessary. The intervention at that point is predetermined and harm reduction in this process becomes the goal.
- Consult as often as necessary



Mental Health and Adolescence (Adapted from Deschutes Co. CIT program)

Module - Mental Health

Presenter: Mental Health Professional

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Identify common childhood disorders
- Describe how trauma influences the behaviors of adolescences.
- Describe how to de-escalate a youth in crisis.

Course Description:

CIT for Youth is designed to assist officers by providing tools to help de-escalate crises in adolescence. For the participants to understand alternatives to the criminal justice system for adolescence and refer to appropriate mental health services. CIT for Youth helps to ensure that the officers are given the skills and the information that they may need to be seen as supportive, caring, safe and competent.

Suggested Videos:

- https://www.youtube.com/watch?v=H9bO0qbmjws
- https://www.youtube.com/watch?v=PJVpMod5JTA
- https://www.youtube.com/watch?v=eNYze6Z4M3A

Child & Adolescent Intervention

Presented by mental health provider

Slide 2

The Benefits of CIT for Youth

- CIT for Youth prevents mental health crises and deescalates crises when they occur.
- CIT for Youth prevents the criminalization of youth with mental health issues by ensuring that youth are identified and referred to appropriate mental health services rather than thrust into the courts and juvenile justice system.
- CIT for Youth ensures the safety and well-being of all youth by providing informed and effective interventions for youth and families.
- CIT for Youthensures that police are seen as supportive, caring, and competent which makes youth more open to accepting LE intervention in the future.

U.S. Youth with a Mental Disorder During Adolescence (Age 13-18)

	Prevalence		With Severe	e Impact (%)
Anxiety Disorders	31.9%		8	3.3%
Behavior Disorders	19.1%		9.6%	
Mood Disorders	14.3%		11.2%	
Substance Use Disorders	11.4%			N/A
Eating Disorder	3.0%			
ADD/ADHD	4%			
Overall prevalence (with sev	ere impact)		22.2%	
Centers for Disease Control and Prevention. Mental among children — United States 2005–2011. MMW 16, 2013):1-35.				

Slide 4

Types of Mental Health Crises In Youth

- 1. Depression: suicidal threats, self-harm, anger, hopelessness, school refusal.
- 2. Traumatic stress: anxiety, fear, running away, suicidal threats, depression, re-experiencing.
- 3. Mood disorder: fluctuations between depression and unusually high energy during which they will engage in risky behaviors, fail to sleep, and may exhibit odd thinking or perceptions.
- 4. Psychosis: thought disruption, loss of connection with reality, seeing/hearing things, paranoia, odd thinking.

Median Age of Onset

- One half of all lifetime cases of mental disorders begin by age 14, three-quarters by age 24
 - Anxiety Disorders Age 11
 - Eating Disorders Age 15
 - Substance Abuse Disorders Age 20
 - Schizophrenia Age 23
 - Bipolar Age 25
 - Depression Age 32
 - Centers for Disease Control and Prevention. Mental health surveillance among children United States 2005–2011. MMWR 2013;62(Suppl; May 16, 2013):1-35.

Slide 6

De-escalating Kids

- Explain that you are there to understand, maintain safety, and provide resources
- 2. Be aware of your influence on the situation:
 - a) Use simple language in a calm, easy voice and tone
 - b) Use non-threatening body language
 - c) Be empathetic remember they are hurting or have been hurt!

De-escalating Kids cont.

- 3. Get to their level (if safe)
- 4. Build rapport by showing interest in their feelings and experiences NOT by making small talk or using affectionate names.
- 5. Talk with the youth individually
- 6. Ask the youth what would help BUT be realistic about what you can/can't do
- 7. Avoid touch and limit surprises
- 8. Don't assume you know
- 9. Don't make promises you cannot guarantee

Slide 8

How to effectively communicate with youth:

- Be genuine
- Be careful about using slang
- Be comfortable with silence
- Be in the present with them without comparing to your own youth
- Be aware that the young person's feelings are very real
- · Be accepting even though you may not agree
- Be aware of your body language
- Be positive with your feedback
- Be helpful with language without telling them how they feel or "should" feel

Basic Safety Assessment

- 1. Don't make assumptions about what a threat means
- 2. Ask for clarification and get specifics
- 3. Suicidal or manipulation: It doesn't matter! Both are ways to get their needs met because they are hurting.
- 4. Follow suicide risk protocol
- 5. CONSULT, CONSULT, CONSULT

Slide 10

Encourage Appropriate Professional Help

- Up to 90% of individuals with mental disorders are treatable with a variety of therapies and support
- Types of professional help:
 - Doctors (PCP's, Pediatricians, Psychiatrists)
 - Nurse Practitioners
 - Mental Health Professionals
 - Drug & Alcohol Specialists
 - School Counselors
 - Nutritionists
 - Certified Peer Specialists
 - Clergy

Discussion about self-harm

- Ask about the purpose of their self-harming behaviors
- Connect to medical care if needed
- If medical care is not needed and purpose was not to end their life, develop a plan for keeping them safe and connecting them to more assistance
- If medical care is needed and/or purpose was to end their life, consult with MH and/or facilitate MH evaluation

Note: self-harming behaviors are usually a ways to cope with upsetting feelings/situations not an attempt to end one's life. If unsure, CONSULT!!!

Centers for Disease Control and Prevention. <u>Mental health surveillance among</u> children United States 2005–2011. MMWR 2013;62(Suppl; May 16, 2013):1-35.

De-escalation Techniques

Module - De-escalation

Presenter: Law Enforcement Professional

Hours: 2

Learning Outcomes:

At the completion of this unit, the officer will be able to:

- Describe the crisis cycle and challenges associated with a person at various levels within that cycle.
- Identify communication techniques that may be effective when communicating with a person experiencing a mental health crisis.

Course Description:

Presentation will include the elements of Active Listening, how prejudice (the participants and that of the person in crisis) can create barriers to communication; and how to connect to the person in crisis.

Suggested videos:

Therapeutic communication with the Angry Patient http://www.youtube.com/watch?v=tyUl3kqmeLo

De-escalation Techniques-6 minutes - http://www.youtube.com/watch?v=pBe4A32fpyl

Slide 1

Verbal De-escalation techniques

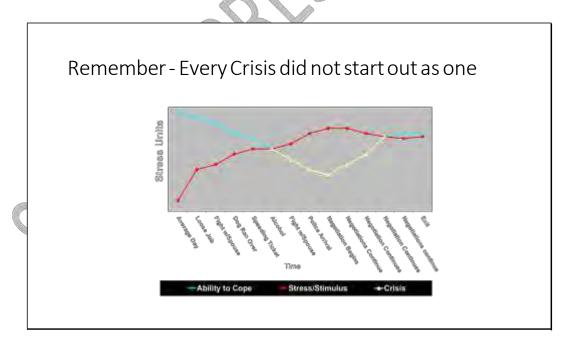


Slide 2

Objectives:

- Understand how Stimulus/Stress and Ability to Cope interact to create crisis situations
- Understand how to manipulate Stimulus/Stress and Ability to Cope to defuse a crisis situation
- Understand the keys to active listening, and how to use that skill to help defuse a crisis situation
- Understand how barriers to good communication can effect the crisis event
- How past Trauma can affect how a person reacts/responds to those around them.

Slide 3

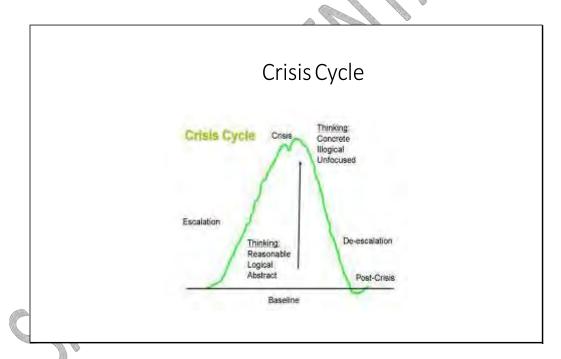


Splitting the Streams

Improving the subject's *ability to* cope while reducing stress

- Evaluation and intervention
- Active Listening
- Emotional Labeling
- Affirmation / Esteem building
- Reassurance

Slide 5



Slide 6

Evaluation and Intervention

- Normal (Baseline)
 - Comprehends 100% of information
- Stimulation
 - Comprehends 50 75% of information
- Escalation
 - Comprehends 5 24% of information
- Crisis
 - Comprehends 0 25% of information



Slide 7

Evaluation and Intervention

• When individuals become highly stressed, non-verbal communication becomes dominant.

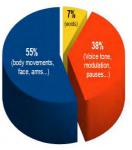


Exhibit the non-verbal's you wish to see

- Calm/Compassionate tone-Tone must fit the situation
- Slow cadence of speech
- · Physically relaxed
- Non-confrontational stance
- No excessive eye contact
- Kind Eyes

All of this is for nothing if it is not genuine.

Slide 9

De-Escalation

- Make the intervention a human process by introducing yourself. Leave out the titles or the authoritative position.
- As the person de-escalates, continue to reassure, speak calmly and clearly. Attempt to make a connection with the person. "I want to help you." I want to understand what you need."
- Person may suffer from post crisis depression become very tired, lethargic.
- May escalate up and down the cycle.

Active Listening

The Rules

- Be non-judgmental
- Give your undivided attention to the speaker
- Use Silence effectively
- Do not try to fix it!
- Seek to understand before you seek to be understood

Slide 11

What is Active Listening?

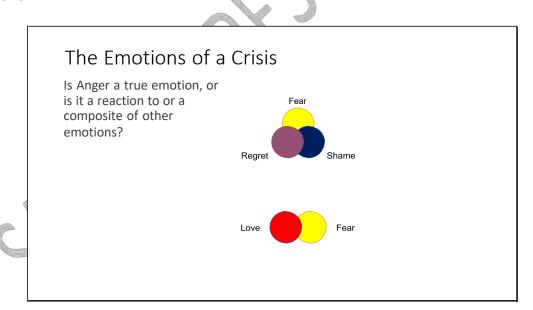
- Be Open and Unbiased
- Hear Literally
- Interpret Accurately
- Act Appropriately



Slide 12

Active Listening Tools L = Look interested - get interested l = Involve yourself by responding S = Stay on target T = Test your understanding E = Evaluate the message N = Neutralise your feelings

Slide 13



We can de-escalate a crisis more easily by dissecting the complex emotions and dealing with each primary emotion separately.



Slide 15

Things to consider when dealing with a person with mental health issues in a crisis

- People with mental illness are four times as likely to be the victim of a violent crime than the rest of the population.
- Suicide is the number one cause of premature death among people with mental illness.
- Crisis Cues may include:
 - Theymay be easily frustrated
 - They may have low tolerance for additional discomfort
 - May not be able to pick up on social cues
 - Fear is often the primary cause of the crisis, help them feel safe

Considerations for dealing with persons experiencing psychosis

- Recognize and acknowledge that their hallucinations/delusions are real to them
- Do not tell them that you are seeing/hearing/smelling something that you are not seeing/hearing/smelling
- Consider asking what the voices are telling the think safety!!
- Use brief, clear and simple language
- Do not argue with them about their hallucinations/delusions
- Always announce what you intend to do before doing it

Slide 17

Considerations when dealing with a person in a Bipolar Manic State

- Use a firm and direct approach
- Set clear limits on behavior
- Reduce environmental stimuli
- Re-direct behavior if they begin to escalate
- Help them to slow down, through controlled deep rhythmic breathing.

Time is your friend!

- Do not rush, time really is on your side when helping someone who is experiencing a crisis, especially those experiencing symptoms of a mental health disorder.
- Experiencing the crisis takes a lot of energy, as the person tires out and starts to come down, they will gain better ability to listen to what you are saying and may be in a better place to accept help

Psychotropic Medications - (Adapted from Columbia Co. CIT program)

Module - Mental Health

Presenter: Medical, Mental Health nurse or professional

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Identify the familiar classes of psychotropic medication and their uses
- Identify potential side effects
- Identify reasons why consumers may stop taking meds
- Gain an understanding of why someone may stop taking their medications

Course Description:

This unit will provide the participants with a basic understanding of psychotropic medications, their uses and some of the side effects of that medication.

Suggested videos:

My pill journey - https://youtu.be/0eV1o86 DB8

Francine's Tool Box

Suggested Activity: Optional Medication Exercise Guidelines

Purpose: This exercise is designed to illustrate the challenges people experience in taking medications as prescribed.

Preparation:

- Purchase candies "meds" as listed below or choose from a variety of others. Sort candy "meds" and place them in small baggies or pill bottles according to the Rx (included in this toolkit) and listed below. Have these ready to "dispense" to participants.
- Purchase 1-week pill boxes (or get these donated)
- Print off the prescriptions and medication instructions as provided in this toolkit.

Procedure:

Day 1. Introduce the exercise. Each participant is given a prescription, the associated candy "medications" that are to be taken as prescribed throughout the training week, and the medication description handout. (*TIP:* Using a variety of candy represents different pills by using different sizes, shapes, colors, and flavors.) The table below is a list of common psychiatric medications, intended use, # of pills to dispense, and examples of candy that could be used.

Participants can be given all the medications at once or you can have them receive their prescription and then go to another facilitator to have it filled. Finally, the participants put their medications in a one-week pill box according to the directions.

Days 2-4. Periodically (and playfully) check to ensure compliance with taking the medications as prescribed. This check-in can be accomplished between presentations, during breaks, lunch, end of scenarios, etc. Frequently, you will find that participants give the same reasons for not taking the candy medications that consumers give – e.g., "I forgot, don't like the taste/combination, don't have the diagnosis so why should I do this, makes me hyper...etc."

Debrief. On **Day 5** reflect on the exercise and additional challenges that some people experience (side effects, effect of mental illness on planning/meds compliance, etc.).

SAMPLE Medication "Pill" Chart

Medication	Use	Suggested Candy	# of pills
Abilify 7.5mg	Antipsychotic	Mini red M&Ms	5
Buspar 10mg	Antianxiety	Yellow Lemonheads	15
Pristiq 100mg	Antidepressant	Purple Skittles	5
Clonazepam 1mg	Antianxiety	Green Mike & Ikes	5
Trazodone 50mg	Insomnia	Red Skittles	5
Saphris 10mg	Antipsychotic	Orange Mike & Ikes	10
Haldol 1 mg	Antipsychotic	Mini Green M&Ms	25
Dextroamphetamine 10mg	Stimulant	Orange Skittles	10
Vistaril 50mg	Anxiety and Insomnia	Yellow Skittles	10 or 15*
Lithium Carbonate 300mg	Bipolar Disorder	Mini Blue M&Ms	25
Gabapentin 300mg	Pain and Anxiety	Green Skittles	15
Cogentin 1mg	Treatment of EPS	Mini Orange M&Ms	15
Prozac 20mg	Antidepressant	Red Hots	15 or 20*
Provigil 200mg	Antidepressant	Hot Tamales	5

Sample Rx slips

CIT Rx Exercise	CIT Rx Exercise		
Patient Name	Patient Name		
Training Date:	Training Date:		
DX: Bipolar Disorder	DX: Major Depression, PTSD		
Lithium Carbonate 600 mg q am, 900 mg q hs (mood stabilizer)	Gabapentin 300 mg tid (pain and anxiety)		
Pristiq 100 mg q pm; take with food	Vistaril 50 mg tid (anxiety and insomnia)		
(antidepressant)	Prozac 80 mg q day (antidepressant)		
Trazadone 50 mg q hs PRN (insomnia)	Dextroamphetamine 10 mg bid (stimulant		
Signatura			
Signature:	Signature		

Sample of medication and Rx information for Bipolar Disorder

Prescription: Lithium Carbonate 600 mg q am, 900 mg q hs

Uses: Treats Manic Episodes and is a mood stabilizer

Do not use if you are pregnant, nursing, or under the age of 12

Adverse Reactions: Hand tremor, mild thirst, diarrhea, vomiting, drowsiness, muscular weakness, lack of coordination.

Prescription: Pristiq 100 mg q pm (with food)

Uses: Antidepressant

Do not use if you are being treated with linezolid or methylene blue injection, or if you have taken an MAO inhibitor in the past 14 days.

Adverse Reactions: Mood or behavior changes, anxiety, panic attacks, trouble sleeping, impulsive, irritable, agitated, hostile, aggressive, restless, hyperactive, more depressed, thoughts of suicide or self-harm, easy bruising, seizure, blurred vision, cough, trouble breathing, dizziness, drowsiness, increased sweating, or sleep problems.

Prescription: Trazodone 50 mg q hs PRN

Uses: Antidepressant or insomnia

Do not use if you are being treated with methylene blue injection or if you have taken an MAO inhibitor in the past 14 days

Adverse Reactions: Erection that is painful or lasts six hours or longer, mood or behavior changes, anxiety, panic attacks, trouble sleeping, impulsive, irritable, agitated, hostile, aggressive, restless, hyperactive, more depressed, thoughts of suicide or self-harm, easy bruising, seizure, blurred vision, cough, trouble breathing, dizziness, drowsiness, increased sweating, or sleep problems.

Bipolar Disorder Fact Sheet

What is Bipolar Disorder?

Bipolar disorder, also known as manic depression, is a brain disorder that causes extreme shifts in mood, thought, energy and therefore in the ability to function. Unlike the ups and downs nearly everyone experiences, symptoms of bipolar disorder can be extremely severe. A person's mood swings from excessively "high" and irritable to sad and hopeless and then back again, with periods of normality in between. The symptoms of bipolar disorder can result in damaged relationships, difficulty in working or going to school, and even suicide. The good news is that bipolar disorder can be treated, and people with this illness can lead full and productive lives. At least two million Americans or about 1% of the population age 18 and older suffer from bipolar disorder.

What Causes Bipolar Disorder?

While the exact cause of bipolar disorder is not known, scientists are learning about the possible causes of bipolar disorder through several kinds of studies. Most scientists now agree that it is the result of many influencing factors rather than a single cause. Studies have shown that 80-90% of individuals with bipolar disorder have relatives with some form of either depression or bipolar disorder. It is possible that genetics may result in a greater susceptibility to developing the illness, which may then be triggered by environmental factors such as serious loss, chronic illness, illicit or prescription drug use, sleep deprivation, financial problems or some other distressing life event. Researchers remain active in their attempt to better understand a genetic predisposition to the illness. A biochemical imbalance in the brain, which alters a person's moods, is another factor. This imbalance is a problem with certain chemicals in the brain, called neurotransmitters, which act as messengers to our nerve cells. It can be related to irregular hormone production. Brain- imaging studies are assisting researchers in examining the structure and activity of the brain without surgery or other invasive procedures. This research is leading to a better understanding of the illness and more specific treatment options.

What are the Symptoms of Bipolar Disorder?

Bipolar disorder is often difficult to recognize and diagnose. It often begins as hypomania, which is an early sign of manic depression. Hypomania may cause a person to have a high level of energy, unrealistically expansive thoughts or ideas, and impulsive or reckless behavior. These symptoms may feel good to the person, which may lead to denial that there is a problem. Another reason for the lack of recognition may be that bipolar disorder may appear to be symptoms of other illnesses. This illness often occurs with other problems such as substance abuse, poor school performance, or trouble in the workplace. Anosognosia occurs in about 40% of people with b i p o l a r disorder. Anosognosia is associated with damage to the frontal lobes of the brain and causes people to be unable to tell they are ill.

Symptoms: Manic Phase

Often a person in the manic phase will display symptoms of psychosis, which can be hard to distinguish from the psychotic symptoms of schizophrenia.

- Excessive energy, activity and restlessness.
- Racing thoughts, racing speech Ideas that abruptly change from topic to topic expressed in loud, rapid speech that becomes increasingly incoherent.
- Excessively heightened or euphoric mood, exaggerated optimism and self-confidence A person may feel "on top of the world" and nothing, not even bad news or a horrifying event or tragedy, can

change his "happiness."

- Grandiose delusions Individuals imagine that they have special connections with God, celebrities, or political leaders and unrealistic beliefs in their abilities and powers.
- Provocative, intrusive or aggressive behavior, or extreme irritability A person may become enraged or paranoid if his or her grand ideas are stopped or excessive social plans are refused.
- Distractibility Individuals may have trouble concentrating.
- Decreased need for sleep An individual may only need two to three hours of sleep a night or may last for days with little or no sleep without feeling tired.
- Uncharacteristically poor judgment A person may make poor decisions which may lead to unrealistic involvement in activities, meetings and deadlines, reckless driving, spending sprees and foolish business ventures.
- Excessively risky behavior Reckless driving, outlandish spending sprees, foolish business investments, or out-of-character sexual behavior.
- Invincibility The person feels that nothing can prevent him or her from accomplishing any task.
- Abuse of drugs, particularly cocaine, alcohol, and sleeping medications.
- Hyperactivity Scheduling more events in a day than can be accomplished or the inability to relax or sit still.

Symptoms: Depressed Phase

If the person is first seen in the depressed phase and it is not known that the person has bipolar disorder, it may appear that the person is suffering from major depression. Treatment with antidepressants may trigger a manic episode in such persons.

- Persistent sadness, anxiety, irritability, agitation, despair, emptiness or crying spells Feelings of guilt, helplessness, hopelessness, and worthlessness.
- Loss of interest or the ability to take pleasure in activities once enjoyed, including sex.
- Loss of energy, fatigue, persistent lethargy.
- Pessimism, indifference.
- Sleep difficulties Either sleeping too much or not at all, middle-of-the-night or early morning waking.
- Significant changes in appetite Either a noticeable increase in appetite or a substantial weight loss unrelated to dieting.
- Difficulty concentrating, remembering, indecisiveness.
- Irritability or restlessness.
- Chronic pain or persistent physical bodily symptoms Unexplained aches and pains that are not caused by physical illness or injury and do not respond to treatment.
- Constant thoughts of death or suicide or suicide attempts.

Treatment of Bipolar Disorder

While there is no cure for bipolar disorder, it is a highly treatable and manageable illness. Because bipolar disorder is a recurrent illness, long-term preventive treatment is strongly recommended. Medication is an essential part of successful treatment for people with bipolar disorder.

Maintenance treatment with a mood stabilizer substantially reduces the number and severity of episodes for most people, although episodes of mania or depression may occur and require specific additional treatment. In addition, psychosocial therapies including cognitive-behavioral therapy, interpersonal therapy, family therapy, chemical dependency treatment and psychoeducation are important to help people understand the illness and to develop skills to cope with the stresses that can trigger episodes. Changes in medications or doses may be necessary, as well as changes in

treatment plans during different stages of the illness. Medications commonly used to treat manic episodes of bipolar disorder are called "mood stabilizers." During depressive episodes, people with bipolar disorder may need additional treatment with an antidepressant medication. Antidepressant medications relieve depression, elevate mood, and activate behavior, but it often takes three to four weeks to respond. Sometimes a variety of different antidepressants and doses will be tried before finding the medication that works best for a particular individual. Patients and their families must be cautious during the early stages of treatment when energy levels and the ability to take action return before mood improves. At this time — when decisions are easier to make, but depression is still severe — the risk of suicide may temporarily increase. Since bipolar disorder can cause serious disruptions and create an intensely stressful family situation, family members may also benefit from professional resources, particularly mental health advocacy groups. From these sources, families not only learn strategies to help them cope with their family member, but also learn to be an active part of the treatment.

This resource sheet was developed for educational purposes and is not meant to serve as an endorsement. Information may be subject to change.

Educating Patients on Mental Illnesses and Community Services A Joint Educational Collaboration Between

www.ohiopsych.org www.mhafc.org www.namifc.org

MEDICATION TIME



Why Don't You Just Take Your Medications

Slide 2

WHY DON'T YOU JUST TAKE YOUR MEDICATION?

• The right medication, for the right person is like a PUZZLE



 1^{st} – You sort out the pieces (symptoms – DX) 2^{nd} - The medication is matched to the DX

 $3^{\rm rd}$ – Wait for results

 4^{th} It's a process...

ISSUES REGARDING MEDICATION COMPLIANCE

Major Reasons why some individuals with serious mental illness refuse to take medications:

- 1. Person is unaware of their illness.
 - 1. Want to solve problem on their own
- 2. Medication Side effects (EPS)
 - 1. Claimed to be the most important reason for people with schizophrenia and bipolar
- 3. Alcohol and/or Drug abuse
 - 1. They are told they can't drink or drug so they stop taking their medications



Slide 4

PSYCHOTROPIC MEDICATIONS ARE PRESCRIBED FOR TARGET SYMPTOMS NOT THE DISEASE

- Antidepressants
- Depressed mood, Lack of energy, insomnia
- Anti Manic medications
- Agitation, Grandiosity, Impulsiveness
- Antipsychotic medications
 - Hallucinations, delusions
 - Different types of depression coupled with psychosis
- Mood Stabilizers
 - Usually to treat bipolar mood swings with increased mania and depression



WHY DON'T YOU JUST TAKE YOUR MEDICATION?

• Medications take time to work and time to reach the right combination for the client.

www.utube.com https://youtu.be/0eV1o86 DB8

Scenario Training

Module: De-Escalation

Presenter: (2) one actor and one evaluator per station. Ideally, one representative each from Mental Health and Law Enforcement for each team as evaluators to provide feedback on deescalation techniques and officer safety.

Hours: 4 - 6

Learning Outcomes:

At the completion of this unit, the participant will be able to:

 Demonstrate the de-escalation skills used when responding to an incident involving a person experiencing a mental health crisis

Course Description:

The practical examinations are hands-on scenarios that allow officers to demonstrate skills.

Sample of Scenario training for Role Players and Evaluators prior to scenario day

Slide 1



- □ People in crisis would prefer not to be.
- □ As such, individuals are more open to suggestion and advice than ordinarily.
- How would you want someone to treat your mother in a similar situation?

Slide 3

Putting it all together

□ Intervening in a crisis successfully depends on...

Remember this is on the spot triage. "Crisis Intervention is to psychotherapy as first aid is to surgery."

Be concrete, deal with the right now. You are not there to "fix" people. Just get them pointed and started in the right direction.

□ Intervening in a crisis successfully depends on...

Don't rush, letting the individual speak helps you to understand and allows them to vent.

Pulling out the individual's strongest points of support from what they told you is your "hook."

Slide 5

Putting it all together

- Be empathetic not sympathetic. Empathy is trying to understanding how someone feels where Sympathy is feeling sorry for someone.
- Be sincere and genuine. If you try and "act", people will know and you will come across as phony.

- Be accepting. Be wary and avoid coming across as judgmental.
- □ <u>Use "I" statements</u>. Take ownership of what you say. It shows you are personally committed to helping them.

Slide 7

Putting it all together

□ Safety and Security

Be aware of the scene.

Maintain proper distance.

Assume an open and non-threatening posture.

Maintain calm and steady tone, volume and cadence in your voice.

Clear non-essential personnel. If you have an audience you are more likely to have a show.

"The Four Plays" give us a simple and easy to follow framework. No part of them is locked in stone. These are guidelines to help you with your own style.

Slide 9

Putting it all together

Play Number 1

□ Introduce yourself

"Hello, I'm_____. I'm a CIT officer with the _____Police Department."

A simple introduction is the best ice breaker to let someone know you are there and want to help.

Play Number 2

□ Try and get their name.

"Can you tell me your name?"

Asking their name is an easy non-confrontational way to get someone to start talking.

Slide 11

Putting it all together

Play Number 3

□ Express what you see.

"You look upset."

"You sound angry."

By focusing on what is obvious you are nudging them to fill you in on what the immediate issue is.

Play Number 4

Restatement.

"So I hear you saying that you are upset because you are not able to find a place to live that you like."

Summarizing tells the individual you heard and understand what they are saying.

Slide 13

Putting it all together

The Four Plays

- □ Introduce yourself
- □ Get the individual's name
- □ Express what you see, hear or were told.
- Summarize

YOUR VERBAL CRISIS "PLAY BOOK" using the four Plays

1. Introduce yourself

"Hello, my name is......"

"I'm Mike and I'm a CIT Officer......"

2. Obtain the person's name

"What's your name?"

"My name is, what's yours?"

"Nice to meet you....may I ask what your name is?"

3. Expressive feelings... what you know... what you've learned... what you see...

"I hear you yelling....I see you're mad"

"I heard you say you are angry at your boss, you were fired from your job, you don't want to go home, and you're not taking your medications right now."

4. Restating and/or summary... a good "active listener"

"So, let me see if I got this right. You told me that"

"I want to make sure I heard you correctly......the following things are happening to you right now......"

INSTRUCTIONS PRIOR TO ROLE PLAYS:

Stationed at the entrance to the building where role plays will be conducted, an officer safety pat down will need to be performed by a law enforcement officer. There will be at least one armed LEA officer at the building entrance to help ensure the safety of the individuals inside of the building. All participants involved in the role play will be free of all weapons, i.e. guns, ammo, pepper spray, bailiwick, baseball bats, etc.

INSTRUCTIONS TO ROLE PLAYERS:

- 1. Follow the scenario. You may add supporting details, but stick to the main ideas.
- 2. Present and maintain a challenge to successful resolution, but remember to ALLOW for a successful resolution if the officer's response indicates that it might work.
- 3. Do not do anything that might warrant Use of Force by the officers.
 - a. Do not reach to put your hands in your pockets
 - b. Do not charge the officer
 - c. Do not lunge at the officer
 - d. Do not grab at the officer
 - e. Do not throw items at the officer
 - f. **No weapons** of any kind will be allowed into the training scenario.
 - h. If at any point you need to stop the role play, say the word ORANGE. This is the safe word. This word can be used by any party involved (the evaluators and those involved in the role play).

INSTRUCTIONS FOR EVALUATORS:

- 1. Do not let the scenario get out of hand to where the Officer is in a position that would warrant a Use of Force. Say the word ORANGE and all parties involved will stop the role play.
- 2. Ask the role player what they experienced or felt when the Officer talked with them.
- 3. Ask the Officer what he thought? Was it difficult/easy? Do they have questions?
- 4. Ask any other evaluators what thoughts they had while watching.
- 5. Give feedback about non-verbal skills you saw (good or bad).
- Give feedback about the skills you saw the officer use (i.e. empathetic, allowed client to vent).
- 7. Give feedback on what the Officers could have done better or might have tried?

SAMPLE SCENARIO: Setting - a local Primary Care Doctor's waiting area

SCENARIO: Officer is called to a local Primary Care Doctor's office because there is a patient in the waiting area who says she has an appointment but is not on the schedule. She is speaking loudly and in a manner that does not seem to make any sense to anyone around her. She is talking about someone murdering her children and scaring other patients in the lobby.

ROLE PLAYER ACTIONS: Appear frightened and confused. Jump back and forth between talking about

your murdered children and other unrelated topics. Continue to look around as if worried and paranoid. Do not respond well if the officer attempts to tell you that your belief about your children murdered is not true. Respond if he attempts to ask you about your emotions regarding the issue, validates emotions, and attempts to help you feel safe.

LEARNING OBJECTIVE: Demonstrate how to communicate effectively with someone with fixed delusions or who is actively psychotic. Officer should not confirm delusional beliefs but should defiantly not try to confront delusions. Focus should be on reducing emotions and/or refocusing on reality based information. Help the woman to a safe location to keep others safe.

(* Adapted from Umatilla's CIT program)

Scenario Evaluator Guidelines

GOAL: Facilitate scenarios to maximize learning Process:

- 1. Fill in Participant's name, scenario number, date, evaluator on evaluation form
- 2. Allow participant to engage with actor until he/she seems stuck or asks for time-out
- 3. If they get stuck, you may want to ask what they were trying to accomplish, offer a suggestion, and invite suggestions from others in the group.
- 4. Re-start scenario watch for attempt to utilize feedback
- 5. End of scenario together with actor provide skill-based feedback, invite feedback from group
- 6. Scenarios need to be timed, in order to move through the scenarios in an organized fashion. Suggested timing 5 minutes for scenario, 2-3 minutes to debrief, 2-3 minutes to get to next station and prepare for that scenario by identifying the student participants. Fill out top of evaluation form with name of participant. (10 minutes in total)
- 7. Evaluators may be stationed at a specific role play station and stay with that role player, or they may be assigned to a specific group of student participants and escort them from station to station and stay with them through all of the scenarios. Both options have advantages for the learning objectives.

Feedback: (2 examples)

- Observe scenario and provide feedback on demonstration of skills one sheet per student participant, per scenario. This form can be completed as the scenario plays out by the Mental Health evaluator, jotting down comments as the participant demonstrates CIT verbal de-escalation skills.
- 2. What are the scenario specific objectives Diversion? Safety plan? Transport? Was the participant able to reach this objective?
- 3. Share comments with the participant. Ask the participant how they think the scenario played out. The role player may also have some comments regarding what the participant did well.

	Sample provid	ed by the Thomas	Jefferson Area	Crisis Intervention Team (CIT) -	- Role play ev	aluation form
Student name:		Agency: Date:				
The	Introduce self	YN	Other	Ask about mental health treatn	nent	Y N
four		V 11				
plays	Name of citizen	Y N		Ask about medications		YN
	5 6 46 11					
	Reflect feeling	Y N		Ask about substance abuse		YN
	O	V N	4	A -la -la -u.dui-iu-la -u		V N
	Summarize	Y N		Ask about a crisis plan		Y N
0	to Manhal Gualesta accets			 ecting, explanation, "I" statement		0
		non-verbai (tone d	or voice, eye co	ontact, stance, approach) respo	nder safety	(for LEA only to
evaluate)					
Evaluato	r					
LvalualO	1					

Post Deployment readjustment of returning Soldiers

Module: Mental Health

Presenter: Mental Health Veteran Service Provider

Hours: 1.5 or 2

Learning Outcomes:

At the completion of this unit, the participant will be able to:

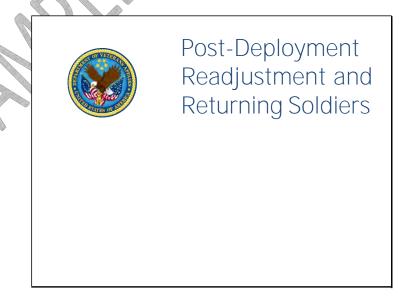
- Have a basic understanding of Veteran population, Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI)
- Describe potential effects of PTSD and TBI in a Veteran population
- Identify challenges veterans may face in adapting from a military environment to a civilian environment

Course Description:

Participants learn about the Veteran culture in their State. They will develop a basic understanding of PTSD and TBI and how these diagnoses can impact a Veteran's behavior. They will understand reintegration challenges Veterans have reentering a civilian environment and how those transitional challenges may bring the Veteran into the criminal justice system. Strategies specific to interacting with the Veteran population are provided. Resources for Veterans are provided.

Suggested videos:

Now, After (PTSD from a soldier's POV) https://www.youtube.com/watch?v=NkWwZ9ZtPEI



Objectives

- Overview of PTSD and TBI
- Familiarize with challenges veterans may face in adapting from military environment to environment back home.
- Highlight strategies to consider when interacting with veterans.

Slide 3

Oregon National Guard Returns from Deployment

April 2010	2700	41st IBCT
Aug/Sept 2011	600	3-116 Inf. Reg.
December 2011	200	1240 EN
August 2012	170	1186 MP
July 2013	26	142 Security
August 2013	150	3670 th Maint.
June 2015	1050	41 st IBCT

Stressors "New" to OEF/OIF

Multiple Deployments

Need for constant 360-degree readiness

Emphasis on use of IED's



Acuity and regency of any problems/challenges

Slide 5

Combat Zone Stress & Trauma

Soldiers returning from Iraq:

- 95% observed dead bodies or human remains
 - ◆Clackamas Mall Shooting / Newtown School / Ft Hood Texas (x 2) / Boston Marathon / Empire State Building
- 93% were shot at, or received small arms fire
 - California Officer killings / 28 officers killed by gunfire this year (2014) / No data base for all officers involved in shootings unless fatal



Combat Zone Stress & Trauma

Soldiers returning from Iraq:

- 89% were attacked or ambushed
 - ❖ Portland Officers parking roof
- 65% observed injured or dead Americans
 - ❖ Everyday violence / fatal vehicle crash
- 48% were responsible for the death of an enemy combatant
 - ❖ Officers who have taken a life
 - 387 Officers nationwide had to make this decision in 2010

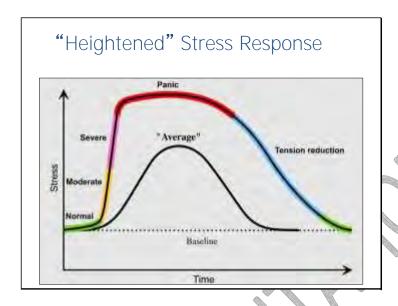


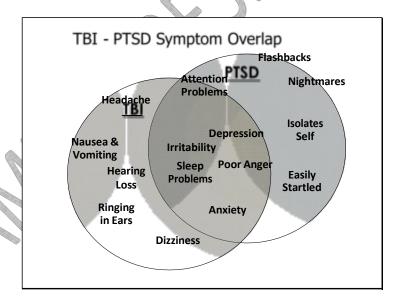
Family Responsibilities

- Changed roles
 - Hard to return to pre-deployment roles
 - Life goes on
- Value of Military skills vs. Civilian
 - "Important" job in military
 - "Insignificant" civilian job
- Military vs. Civilian Pay
 - Military pay, Overseas pay, Housing Allowance, Medical, etc. changes lifestyle
 - (example)
- Unemployment
 - Inability to find or keep a job

Dept. of Veterans Affairs - can not use without permission







Please Remember:

The majority of returning soldiers integrate into their communities

WITHOUT

problems and become active, positive members of their community

Slide 11

Post-Deployment Readjustment and/or PTSD and/or TBI is an Explanation, NOT an Excuse

AWARENESS

Increased awareness of identifying clues

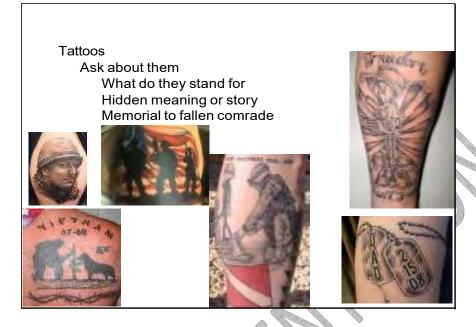
- Physical
- **■** Environmental
- Behavior

Slide 13

Identifiers

- Vehicles:
 - License Plates
 - Veteran, Medals / Campaign Ribbons
 - Branch, Unit, Memorial
 - RIP/In Memory Of/Dates
 - Disabled Vet
 - Additional awareness May have extra mental issues





Prescriptions

■ SSRI Anti-depressants

(Causes Horizontal Gaze Nystagmus (HGN))

Citalopram (Celexa)

Escitalopram (Lexapro)

Fluoxetine (Prozac, Sarafem)

Sertraline (Zoloft)

Paroxetine (Paxil)

■ SSNRI

Venlafaxine (Effexor)

Zolpidem (Ambien) (Can Cause HGN)

Benzodiazepine (HGN)

- Will exaggerate intoxication

- (1 shot of alcohol can look like 3 - 4)

Prazosin (Minipress, Vasoflex, Pressin, Hypovase) (HGN)

Strategies

- Take Extra Safety Precautions
- Space/Reduce sensory inputs
- Grounding (Bring them to now)
- Time
- Inform of steps
- Body Language



Slide 17

503-808-1932

VA Police 24 hour number

- "Life or Limb" Allows for immediate release of information from the VA
- VA Crisis Line
 - 1-800-273-8255 (TALK)
- Portland VA Medical Center
 - 503 220-8262 / 800 949-1004
- Oregon National Guard Family Programs
 - 503 584-2391



Thank You for your work with Veterans and for YOUR service to our community

Veteran's Perspective

Module: Community Support

Presenter: Veteran

Hours: 1.5 or 2

Learning Outcomes:

At the completion of this unit, the participant will be able to:

 Identify challenges veterans may face in adapting from a military environment to a civilian environment.

Course Description:

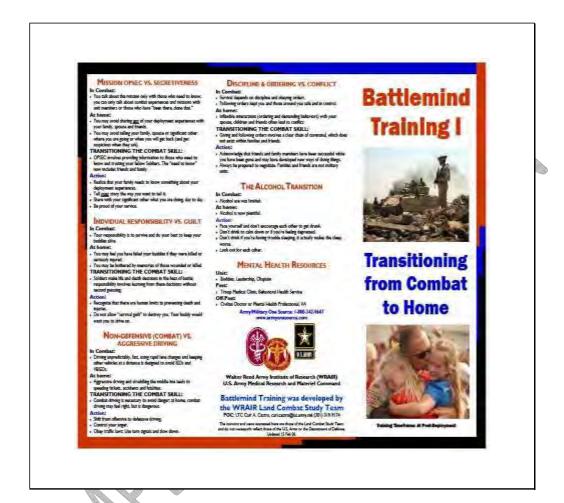
Participants will hear from a returning veteran their personal struggles and successes of reintegration post deployment and how those transitional challenges may bring the Veteran into the criminal justice system. Strategies specific to interacting with the Veteran population are provided.

Suggested videos:

http://media.fhpr.osd.mil/pdhra/buddies_driving.wmv http://media.fhpr.osd.mil/pdhra/soldier_spouse.wmv

Slide 1

Veterans: Battlemind, PTSD and Training



*Veteran's Battelmind Webpage: http://fhp.osd.mil/pdhrainfo/





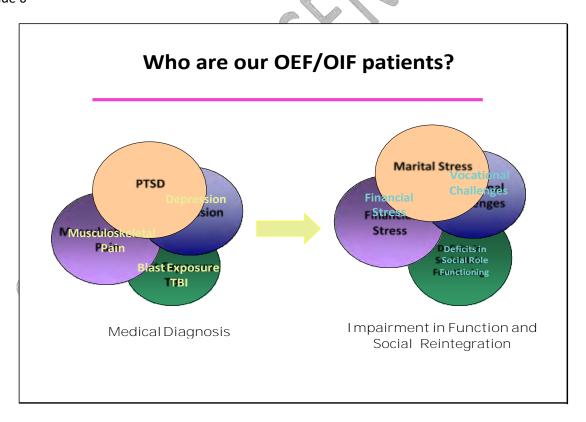
Reactions to Traumatic Events

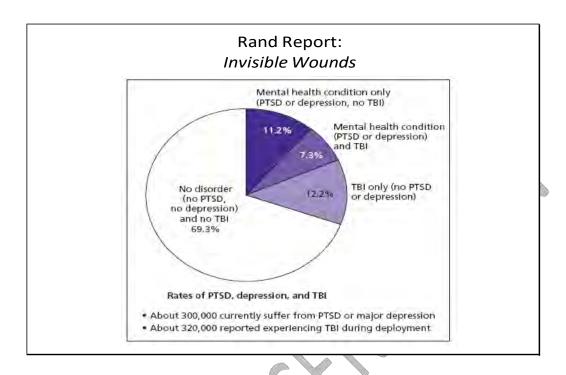
Psychological Physical

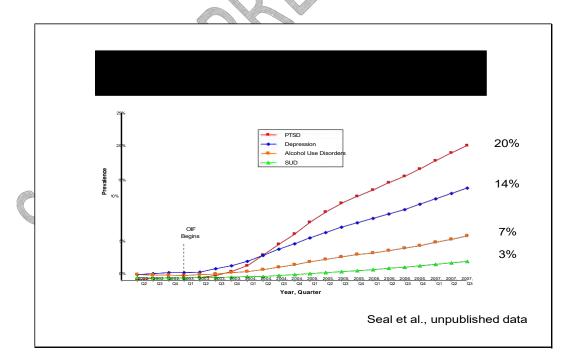
Emotional Interpersonal

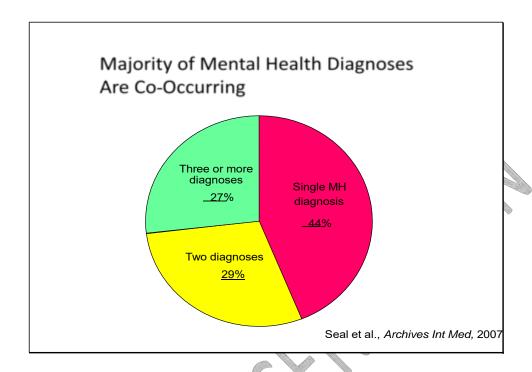
Cognitive Behavioral

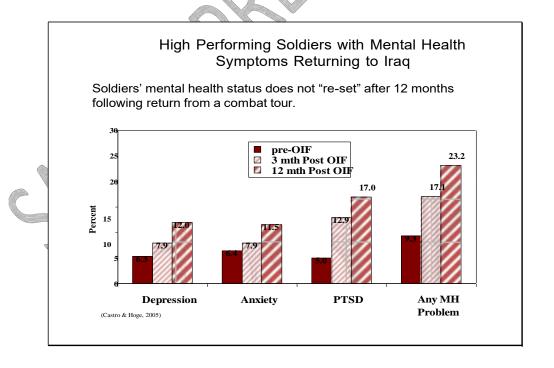
Spiritual











Types of Treatment

- 1. Counseling (individual, group, family)
- 2. Medications (improve sleep, nightmares, depression, irritability)
- 3. Substance use treatment
- 4. Social work and benefits counseling (financial, housing, educational)
- 5. Primary medical care

Wrap up and Graduation Celebration

Module: Research and Systems

Hours: 1-2

Presenter: CIT Coordinator

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Describe benefits of CIT
- Will have gained additional de-escalation skills, and a better understanding of community resources

Course Description:

This course will provide the participants with an opportunity to fill out evaluation forms of the training and offer feedback to program Coordinator about how the training went. Graduation Certificates will be presented to the participants. Local Media may be invited to attend.

Overview of Local Community Resources

Module: Community Support

Hours: ½ - 1

Presenter: Mental Health

Learning Outcomes:

At the completion of this unit, the participant will be able to:

 Describe local resources available to the officers when interacting with a person experiencing some type of mental health crisis.

Course Description:

This course will outline the community mental health resources. This may include contact information for hospital partners, inpatient and outpatient treatment providers and addictions treatment providers.

Examples of Elective Courses:

Psychosis Simulation

Module: Mental Health

Presenter: Mental Health, can be co presented with Law Enforcement (LE)

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Gain a greater understanding of what it is like to experience auditory hallucinations
- Identify challenges faced by an individual experiencing hallucinations

Course Description:

Participants will experience what it can be like to have auditory hallucinations.

Suggested videos:

Janssen "Mindstorm" – YouTube

Suggested activity – Use MP3 players with pre-recorded "voices" that class participants listen to through headphones while attempting to complete various tasks, which could include memory tests, reading a scenario and answering question, conducting an interview, etc.

Mental Health First Aid for Law Enforcement (@ copyright) (This is a pre-created certifiable program with its own slides)

Module: Mental Health

Presenter: Certified Mental Health First Aid Presenter

Hours: 6-8 hours

Learning Outcomes:

At the completion of this unit, the participant will be able to:

Identify barriers to effectively communicate with a person experiencing a mental health crisis

 Respond to a person experiencing a mental health crisis using the Mental Health First Aid Action Plan - ALGEE

Course Description:

To provide education regarding mental illness and reduce the stigma associated with this disease. Mental Health First Aid for Public Safety provides officers with more response options to help them de- escalate incidents and better understand mental illnesses so they can respond to mental health related calls appropriately without compromising the safety of the individual in crisis or the officers responding. The officers will be introduced to ALGEE – the Mental Health First Aid Action Plan – Assess for risk of suicide or harm; Listen nonjudgmentally; Give reassurance and information; Encourage appropriate professional help; Encourage self-help and other support strategies.

Slide 1



Legal Panel

Module: Research & Systems

Presenter: Representatives from the local DA office, mental health, courts, PSRB program, Public

Defender

Hours: 1 -1.5 hours

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Identify when subject may be appropriate for diversion program and how to make referrals.
- To gain a better understanding of each panel members processes and limitations.

Course Description:

This Unit will provide the participants with information on Civil Commitment, Police officer Custody, Mental Health Court and PSRB programs through a panel of presenters and discussion. Time will be provided for questions from the participants.

Personality disorders - (Adapted from Deschutes Co. CIT program 2015)

Module: Mental health

Presenter: Mental Health Professional

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

• List at least two types of Personality Disorder

Course Description:

The class will provide introductory information on Personality Disorders and strategies for engagement.

Suggested Videos:

What is Personality Disorder? (Mental Health Guru) – youtube 4:08

Slide 1

Personality Disorder

STRATEGIES FOR "QUIETING THE AFFECTIVE STORM"

Personality Disorder

- I. Strategies for Responding.
- II. Defining Personality Disorder
- III. Characteristics of Personality Disorder
- IV. Addressing para-suicidal and suicidal acts.
- V. Wrap Up.

Slide 3

Strategies for Responding

- Accepting people with PD just where they're at
- Over focusing on the story behind their distress is not the most effective way of responding to PD.
- Staying neutral, accepting, and firm.
- Be consistent every time.



Tools for Responding



De-escalation strategies

 Re-establish the window of tolerance by increasing a sense of safety, control and present orientation.

Slide 5

Tools for Responding

Safety

- Slowing Movements down.
- Limiting Sensory information in the environment.
- Proximity: checking out too close, too far.
- Getting 'low'.
- Making eye to eye contact.
- Staying calm in your body.
- Tone
- Continue to talk: don't leave gaps that can allow them to slip back into the past.

Tools for Responding

Control

- Re-establish the person's sense of control:
 - "Can we move to a quieter (safer) place to talk?"
 - "Would it be ok for me to ask you a few questions?"
- "Is it ok to talk for a moment?"
- "Is it ok for me to be this close as we talk?"
- "We can talk here for a moment or move to the other room etc.?"
- "Is my voice too loud?"
- Explain each step of the way; what is going to happen next.

Slide 7

Tools for Responding

Present Orientating

- "Can you hear me?"
- "Can you see me?"
- "Do you know where you are?"
- "Do you know what year it is? Do you know the day? Month?"
- "Are you warm enough?"
- "How old are you?"
- Grounding:(getting person oriented present through reconnecting with body in the present)
 - Walking
 - Asking whether they can feel their body (i.e. their feet on the ground, can they feel their body -or themselves- in the chair).



Tools for Responding

WHAT TO AVOID

- Entering the person's personal space without asking permission.
- Moving too quickly.
- Getting 'Big', 'Loud' or 'Commanding'.
- Touching the person without first informing them.
- Talking from an analytical place.
- Asking to many questions too quickly.
- Not giving information on what is going to happen next.
- Giving too much information at once that they cannot process.
- Getting dysregulated yourself



Strategies for Responding

- Validate but don't focus on their painful emotions, betrayals, abandonments. This is more likely to exacerbate their distressed states. Keeping the person away from thinking and talking about wounding can assist in deescalating.
- They might try to engage you in talking about their distress.
 Participating only provides more ways for the person to escalate and create more troubles for themselves and everyone involved.
- Each time the conversation seems to be going in the direction of distressing emotions redirect and focus on present options, protocols, or plans.



DEFINITION

- "a deeply engrained and maladaptive pattern of behavior of a specified kind, typically manifest by the time one reaches adolescence and causing <u>long-term</u> difficulties in personal relationships or in functioning in society."
 - People with personality disorders have an <u>enduring</u> and <u>pervasive</u> pattern of impulsivity and unpredictability, unstable interpersonal relationships, inappropriate or uncontrolled affect, especially anger, identity disturbances, rapid shifts of mood, suicidal acts, self-mutilations, job and marital instability, chronic feelings of emptiness or boredom, and intolerance of being alone.

Symbian (S60 3rd edition)Collins Essential English

Slide 11

Personality Disorders

- Cluster A (odd)
 - Paranoid Schizoid -
- Cluster B (dramatic)
 - Antisocial Borderline Histrionic Narcissistic
- Cluster C (anxious)
 - Avoidant Dependent Obsessive-compulsive
- Non-Specified
 - Depressive Passive-aggressive Sadistic Selfdefeating - Psychopathic.



"OREO COOKIE" MODEL OF COMMUNICATING

Sandwich your corrections or critical feedback between two honest, positive statements. An example of how to use the Oreo Cookie approach:

Cookie layer one: "Thank you for doing such a great job, putting this all together. I know you have worked hard on it and I love the way it is coming together.



Slide 13

Oreo Cookie, cont..

Filling: "While you are finishing it up, here are a couple of things that I happened to see when I was reading it. There were three typos on pages 23,42 & 56."

Cookie layer two: "I am so excited to see the finished Project. Thank you for all of your hard work."





Synthetic Drugs

Module: Law Enforcement

Presenter: Law Enforcement Professional/ Drug Recognition Expert

Hours: 1 - 2 hours

Learning Outcomes:

At the completion of this unit, the participant will be able to:

• Identify synthetic drugs and the behaviors associated with their use.

Course Description:

This unit will provide the officers with introductory information regarding synthetic drugs and how to identify the more commonly used synthetic drugs.

Suggested Activity: Have the class go online and see how easy it is to purchase these items off of websites.

Slide 1

DESIGNER/SYNTHETIC DRUGS

suggested presenter - Drug Recognition Expert (DRE)

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Slide 3

What are "Designer/Synthetic Drugs?"

- Designer drugs do not have FDA approval and are produced by chemists to stay ahead of legislation and have no interest in monitoring the quality control of the product.
- Designer drugs are not synthesized and purified for a specific purpose and are intended only for intoxication.
- Designer drugs contain numerous toxic impurities not separated from the desired active ingredient after the synthesis was completed.

Where Did They Come From?

The John W. Huffman research group at Clemson University synthesized over 450 cannabinoids $\,$

- Developed in U.S. in 1984
- 4 times as potent as THC
- Binds to CB1 Receptor 3:1 (THC=CB1, CB2 1:1)

HU 210:

- Raphael Mechoulam at Hebrew University 1988
- 100-800x more potent than THC

CP47,497:

- Pfizer
- 3-28 x more potent than THC



Slide 5

PiHKAL (1991): A Chemical Love Story & THiKAL (1997)

- Written by Dr. Alexander Shulgin the "Godfather" of synthetic psychedelics.
- "Phenethylamines i Have Known And Loved"
- "Tryptamines i Have Known And Loved"
- Spent years secretly dosing his wife, Ann, and detailing her reactions to the compounds.....She thought it was funny.
- Outlines detailed synthesis instructions for 179 different psychedelic compounds (most of which Shulgin discovered himself), including bioassays, dosages, and other instructions.

Common Characteristics of Synthetic Drugs

- Marketed as an innocuous item:
 - Incense, Bath Salts, Glass Cleaner, Plant Food, Room Spray
- Attractive packaging to appeal to young users.
- Very small dosage. (250mg-3gm)
- "Not for human consumption"
- "Research Chemical"

Slide 7

5 Categories of Synthetics

- Phenethylamines Similar to Peyote or Mescaline
- <u>Trytamines</u> Similar to Psilocybin
- <u>Cannabinoid</u>s Similar to Marijuana
- <u>Piperazines</u> Marketed as derived from pepper plant, but in reality no natural cousin exists.
- Cathinones Similar to chemicals in the leaves of a Middle Eastern plant known Khat.
 - Natural leaf was chewed, but compounds were unstable and would break down before distribution was possible.
 - Synthetic forms stabilized the molecule and gave birth to Bath Salts

Most Common Types Found



Slide 9

What are Bath Salts & Gravel?

- Synthetic Cathinones: Attempt similar effects to stimulants such as cocaine and/or methamphetamine.
- · Variety of labels that are constantly evolving
- Often "Not for human consumption"
- White, odorless, "pills", fine-grained powder or crystals (oxidizes to yellow or tan)
 - Delusional
 - Seizures
 - Restless / Irritated
 - Inflammation of heart
 - Teeth Grinding



Effects

DESIRED

- Euphoria
- Empathy/decreased hostility
- Hallucinations

WHAT REALLY HAPPENS

- Restless / irritated
- Delusional / paranoia
- · Nose bleeds, headache
- Increased insight/self-discovery Dilated pupils, blurred vision
- Increased energy
- Enhanced music appreciation
- Blue/cold extremities
- Nausea/vomiting
- Seizures, teeth grinding
- Chest pain (inflamed heart)
- Excessive sweating
- Go to Jail 🕲



What is it?

Dangerous synthetic research chemicals that have been dissolved in acetone and sprayed onto dried plant material.







Slide 13

Cannabinoids

- Plant material use as a base
- Marketed as incense
- Laced with various synthetic compounds that behave like THC
- Smoked or mixed in drink or food
- Was sold LEGALLY and LOCALLY
- 1g -3g packages about 2x price of marijuana

Slide 14

Spice/K2









Ingredients: Baybean, Blue Lotus, Lion's Tail, Lousewort, Indian Warrior, Dwarf Scullcap, Maconha Brava, Pink Lotus, Marshmallow, Red Clover, Rose, Siberian Motherwort, Canavalia Maritime, Leonotis Leonurus, Leonurus Sibiricus, Pedicularis Densiflora, Scuttellaria Nana, Vanilla Planifolia, Zorinia Latifolia, Magnolia Officinalis, Rosa Gallica, Trifolium

Slide 15



Symptoms:

- •Elevated BP (140-210 / 100-140)
- •Rapid heart rate (110-150bpm)
- Tremors / Seizures
- Unconsciousness
- •Hallucinations / Delusions / Paranoia
- •Numbness / Tingling / Muscle Loss

Slide 17

Treatment of a Synthetic Overdose





- No antagonist available.(i.e. Naloxone for Opioids)
- Regardless of the type of synthetic overdose symptoms are most often like Stimulants mixed with a Dissociative Anesthetic.
- Often will required chemical restraint to control for transport.
- · Airway and Circulation required constant monitoring.
- Not detectable on standard intake tox screen.

Can Mix Symptomology from All Categories.....

al Indicators	Disorientation	Anxiety	Body Tremors	Blank Stare	Constricted Pupils	Bloodshot/watery eyes	Body Tremors
	Droopy Eyelids	Body Tremors	Dazed Appearance	Chemical Odor	Depressed reflexes	Confustion	Disorientation
	Drowsiness	Dry Mouth	Difficulty with Speech	Confused (PCP)	Droopy Eyelids	Disorientation	Eyelid Tremors
	Drunk-like Behavior	Euphoric	Disorientation	Cyclical behavior(PCP)	Drowsiness	Flushedface	Impaired perception
	Flaccid Muscle Tone	Exaggerated Reflexes	Flashbacks	Difficultyw/Speech	Dry Mouth	Intense Headaches	of time & distance
	Gait ataxia	Excited	Hallucinations	Disorientation	Euphoria	Lack of muscle	Increased Appetite
	Slow, Sluggish	Eyelid Tremors	Memory Loss	Early HGN Onset	Facial Itching	control	MJ Debris in Mouth
	Thick, Slurred Speech	Grinding Teeth(Bruxism)	Nausea	Hallucinations	Flaccid Muscle Tone	Non-communicative	Marked reddening of
	Uncoordination	Increased Alertness	Paranoia	Incomplete verbal	Fresh Puncture	Normal or	the conjunctiva
	Note: With	Insomnia	Perspiring	responses	Nausea	Flaccid Muscle	Odor of Marijuana
	Methaqualone, pulse will be elevated & body tremors will be evident. Alcohol & Quaaludes elevate pulse. Soma &	Irritability	Poor time and	Increased pain	"On The Nod"	Odor of Substance	Possible Paranoia
		Redness to Nasal Area	distance perception	threshold	Puncture Marks	Possible Nausea	Relaxed Inhibitions
		Restlessness	Rigid Muscle Tone	"Moon Walking" (PCP)	Slow Low Raspy Speech	Residue of Substance	
		Rigid Muscle Tone	Synesthesia	Perspiring (PCP)	Slowed Breathing	Slow,thick,Slurred Speech	
	Quaaludes dilate pupils	Runny Nose	Uncoordinated	Possible violent &	Note: Tolerant users		
		Talkative	Note: With LSD	combative (PCP)	exhibit relatively	Note: Anesthetic	
			piloerection may be	Rigid Muscle Tone	little psychomotor	gases lower the blood	
			observed	Sensory Distortions	impairment	pressure. Volatile	
<u></u>				Slow, Slurred Speech	1	solvents and aerosols	
$\underline{\Psi}$						elevate blood	
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2014 National Roadside Survey

- About the survey
- Conducted for the first time in 1973; repeated in 1986, 1996, 2007, and 2013-14
- Collects data from 300 roadside sites across the country
- Road signs alert drivers to a voluntary paid survey ahead
- · Strictly voluntary and anonymous
- Drivers who are too impaired to safely drive from the research sites are offered other means to get home; of more than 30,000 participants over 40 years, none have driven away from the sites after being identified as impaired and none have been arrested
- Testing for presence of illegal drugs, prescription medicines, and over-the-counter drugs conducted for the first time in 2007



Slide 20

About the findings:

- · Drinking and driving is falling
- The proportion of drivers with measurable alcohol levels declined by about 30% from 2007 to 2014. This decline was seen across all alcohol levels. Since the first such survey in 1973, the prevalence of alcohol among drivers has declined by nearly 80%.
- In 2014, about 1.5% of weekend nighttime drivers had .08 or higher breath alcohol concentrations (BrACs).
- About 8.3% of drivers had some measurable alcohol in their systems.

Drugged driving is rising:

- About 20% of drivers tested positive for at least one drug in 2014, up from 16.3% in 2007.
- Some 12.6% drivers had evidence of marijuana use in their systems, up from 8.6% in 2007.
- More than 15% of drivers tested positive for at least one illegal drug, up from 12% in 2007.

Slide 22

The Catch......

Roadside screening and hospital intake screening will not currently detect these types of synthetic drugs.

Jail Diversion Panel - (Adapted from North Carolina CIT Program)

Module: Systems

Hours: 1

Presenter: Corrections staff, Parole & Probation, Jail Diversion, Jail Staff

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Identify when subject may be appropriate for diversion program and how to make referrals
- To have a better understanding of each panel members process and limitations

Course Description:

The class will provide the participants with information about jail diversion programs and service providers, including Jail staff and Parole and Probation, and information on barriers to resources.

Substance Use/Co-Occurring Disorders

Module: Mental Health

Presenter: Mental Health or Addictions Professional

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to"

- List at least two characteristics of substance us disorders
- Identify effective strategies for engagement

Course Description:

This course will provide introductory information on Co-occurring disorders and will present strategies for engagement.

Suggested videos:

A Guide for Living with Co-occurring Disorders



Addiction Counseling Videos

Slide 1

Co-Occurring Disorders

Adapted from The ASAM Criteria Treatment Criteria for Addictive, Substance-related and co-occurring conditions 3rd editions, 2013

Definition of addiction

Substance Abuse/Dependence:
 Habitual pattern of alcohol and legal or illegal drug use that results in significant problems in work, relationships, health, finances, legal issues, etc.

Slide 3

General Information

- Co-Occurring Disorders is the norm not the exception.
- Until recently the system had been set up to handle only one disorder at a time and Co-Occurring Disorders can make diagnosis much more difficult, but treatment facilities are identifying and working with clients in a much more holistic manner.

Biomedical conditions and complications

- Physical illness (other than withdrawal)
- Chronic conditions, may need stabilization or disease management
- Is this a communicable disease?
- Could a female client be pregnant?

Slide 5

Emotional, behavioral or cognitive conditions and complications

- Are there current psychiatric illnesses that create risk or complications to treatment?
- Are chronic conditions requiring stabilization or on going treatment?
- Are the emotional, behavioral or cognitive symptoms an expected part of the addictive disorder, or do they appear to be autonomous?
- Is the client able to manage activities of daily living?
- Can the client cope with any emotional, behavioral or cognitive conditions?

- Among the 20.2 million adults in the U.S. who experienced a substance use disorder, 50.5% or 10.2 million adults—had a co-occurring mental illness.
- Treatment must consider ways to address both needs simultaneously for best results.

Slide 7

How will you see this in the field?

 Can be anyone. Mental Illness and Substance Use Disorders do not discriminate with regards to age, sex, social economic status or race.

Officer Strategies

- Work with family or neighbors
- · Listen to their story using active listening skills
- Work with Adult Protective Services (APS) if you suspect some shift in their ability to handle their affairs.
- Use APS for exploitation concerns
- Offer solutions using local resources and referrals
- No excuses for their behavior—arrest when needed, but attempt to include the steps above when appropriate

Police Officer Suicides

Module: Mental Health

Presenter: Law Enforcement Professional

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Describe the principal behind a Police Officer Suicide event
- Identify measures an officer can take to prepare for or address the stress following a deadly force incident

Course Description:

This course will provide a discussion about Police Officer and First Responder Suicides and how it impacts officers involved.

Suggested videos:

Slide 1

Police Officer Suicides

(Presenter – Law Enforcement)

Police Suicides

- Nationally, the suicide rate is approximately 12 per 100,000 people.
- Among police officers, the average is a staggering 18.1 per 100,000.
 - 52% higher than the general population

* Police Suicide Statistics – The Badge of Life 201

Slide 3

- Ages 35 39 are at highest risk of suicide.
- Service time at highest risk was 10 14 years.
- 64% of suicides were "a surprise."

* Police Suicide Statistics – The Badge of Life 20



Slide 5

Prevention and Intervention

- Prevention begins with the observation and understanding there is a problem.
 - As co-workers and peers, it is important we are cognizant of signs/symptoms that are presented by those in need.
 - Police officers and first responders compartmentalize the things that traumatize them as a protection response. Often times the traumatizing event is not revisited until months or years later (PROBLEM)

Considerations

- Tactical Awareness
 - Police officers/First Responders are aware of procedures and tactics because of their training.
- Stigma
 - Police officers/First Responders are TRAINED not to show weakness... ESPECIALLY to their peers.
- The aftermath
 - What happens when they can't return to work because of their illness?

Slide 7

The Reality

- The police officer/first responder in crisis is a human being in need of assistance.
 - Treat them with the same respect and dignity that would be given to any individual in crisis.
 - Understand there will be long term repercussions from the suicidal incident.
 - Know there may be greater need for tactical sensitivity because of their position/standing as a police officer/first responder.
 - Do NOT sacrifice officer safety...

Suicide by Cop

Module: Mental Health

Presenter: Law Enforcement Professional

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Describe the principal behind a Suicide by Cop event
- Identify measures an officer can take to prepare for or address the stress following a deadly force incident

Course Description:

This course will provide a discussion about Suicide by Cop and how it impacts officers involved.

Suggested videos:

Slide 1

Subject Precipitated Homicide

(Suicide by Cop)

Suicide by Cop

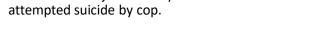
- Suicide-by-cop: A colloquial term used to describe a suicidal incident whereby the suicidal subject engages in a consciously, lifethreatening behavior to the degree that it compels a police officer to respond with deadly force.
- Police-assisted suicide: A term used by some researchers to describe a suicide whereby the suicidal subject completes the act with the assistance of a police officer.
- Victim-precipitated homicide: A term which implies a shared responsibility between two (or more parties) whereby a suicidal subject provokes his or her own death by means of another.

Slide 3

Diagnostic Criteria

The criteria below may be used to qualify the suicide

- The suicidal subject must demonstrate the intent to die
- The suicidal subject must have a clear understanding of the finality of the act.
- The suicidal subject must confront a law enforcement official to the degree that it compels that officer to act with deadly force.
- The suicidal subject actually dies otherwise it is an attempted suicide by con



The Numbers

- Researchers studied data from 1987 through 1997 and found that 11% of officer-involved shootings were suicide by cop incidents.
- 98% were male
- 39% had a history of domestic violence
- Many individuals abused alcohol and/or drugs
- Many individuals had a prior history of suicide attempts
- · About 50% of the weapons used were loaded
- 17% used a toy or replica gun

Slide 5

Potential Indicators of Suicide

- Verbalized intentions of self-destruction
- Longings or interest in death
- Prior attempted suicides
- Prior medical or psychiatric care
- Death of a spouse, significant other, or friend
- • Substantial loss of funds or outstanding and pressing debts
- Divorce
- Pending or actual loss of a job, including retirement
- Imminent arrest of the individual or a close friend/associate
- Health problems

Excited Delirium

Module: Law Enforcement

Presenter: Physician, EMS and/or Law Enforcement

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

Recognize the signs of Excited Delirium

Course Description:

The class will provide the officers with examples of police encounters with individuals experiencing signs of Excited Delirium. The class may be introduced to local area appropriate co-response by Law Enforcement Agencies (LEA) and Emergency Medical Services (EMS) and new co-responding protocol.

Suggested videos:

Appleton Police Department Jefferson Street incident, June 15, 2009 - YouTube video

Donald Lewis killed by Excited Delirium - www.Leawo.com

Slide 1



Excited Delirium - History

- Excited Delirium is not new:
 - referred to as "Bell's Mania"; first described by Dr. Luther Bell in 1849.
 - Dr. Bell described the symptoms as severe insomnia, loss of appetite, disorientation, paranoia, and extremely bizarre hallucinations (Goodwin & Jamison, 2007).
 - 1881 Term ED in medical literature

Slide 3

Excited Delirium - History

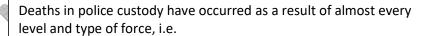
- Excited Delirium has been known by many names:
 - Bell's mania
 - Delirium grave
 - Acute delirium
 - Excited catatonia
 - Excited Delirium
 - Lethal catatonia
 - Acute Exhaustive Mania
 - Meth/Cocaine Psychosis

What is Excited Delirium

- Excited Delirium is first and foremost a medical condition that is usually fatal unless there is immediate advanced life support available.
- Excited Delirium is often related to Sudden Custody Death Syndrome, following an extreme agitation event where a suspect is restrained.

ACEP Excited Delirium Task Force (September 10, 2009). "White Paper Report on Excited Delirium Syndrome". American College of Emergency Physicians.

Slide 5



- Physically controlling a person
- Aerosols
- Batons
- Conducted energy weapons
- Handcuffing

Definitions

- Delirium Defined:
 - Acute change in mental status characterized by impairment of attention.
- Excited Delirium Defined:
 - Delirium with continuous agitation

http://www.exciteddelirium.org/indexForLawEnforcement.html — Excited Delirium for Law Enforcement — University of Miami. Retrieved 2011-07-01

Slide 7

Diagnostic Criteria

- Diagnostic Criteria for Delirium
 - Disturbance of consciousness with reduced ability to focus, sustain, or shift attention.
 - A change in cognition such as memory deficit, disorientation, language disturbance
 - The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate.

- Excited Delirium often involved psychostimulant drugs
 - Amphetamines
 - amphetamine derivatives
 - Cocaine
- Sometimes even the lack of having taken certain prescription drugs could cause a similar response behavior
 - i.e. lithium in the case of manic depressants

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Signs and symptoms typically associated with Excited Delirium include:

- Bizarre and violent behavior, most commonly toward glass.
- Removal of clothing, public nudity (even in cold weather)
- Aggression
- Hyperactivity
- Paranoia
- Hallucination
- Incoherent speech or shouting
- Grunting or animal like sounds
- Incredible strength or endurance (typically noticed during attempts to restrain victim)
- Imperviousness to pain (observed during violent acts or restraint)
- Hyperthermia (Body Temp 106 113 degrees)/Profuse sweating
- Other medical conditions that may resemble Excited Delirium:
 - Panic Attack
 - Hyperthermia
 - Diabetes
 - Head injury
 - Delirium Tremens (DT)

Law Enforcement Response

- Use LOTS of backup
- As soon as situation is identified as a possible Excited Delirium case, have medics dispatched and staged.
- Once subject is restrained, administer immediate first aid and request medics for advanced life support.
- DO NOT transport subject in your patrol car. Have subject transported by ambulance to the hospital.

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Avoid Positional Asphyxia

- Defined as death that occurs because the position of a person's body interferes with respiration (breathing), and the person cannot get out of that position. Death occurs due to the person's inability to breathe anymore.
- Place subject in a position to reduce stress on diaphragm
- Monitor breathing/mental state



Dispatch EMS early in the intervention

- Early administration of Advanced Life Support (ALS)
 By EMS may save the victim's life.
- Even with the administration of ALS, the victim may still die.



Slide 13

Medical Response

- Early Management:
 - CPR and defibrillation if necessary
 - Sedation
 - Cooling
 - Restraints if necessary
- Increased mortality if patient is restrained (without adequate sedation).

Post Test – Jeopardy

Module: Research & Systems

Presenter: (2) one each from Mental Health and Law Enforcement

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

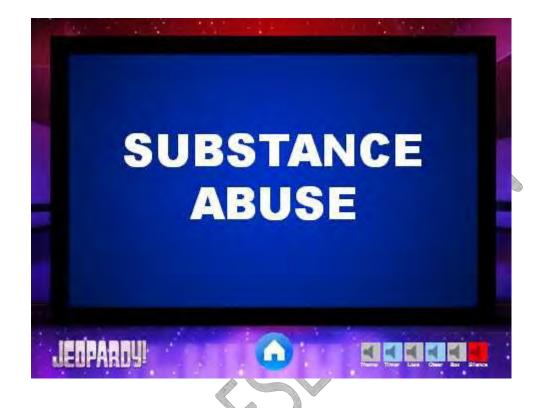
• Demonstrate a working knowledge of the concepts taught over the CIT Course

Course Description:

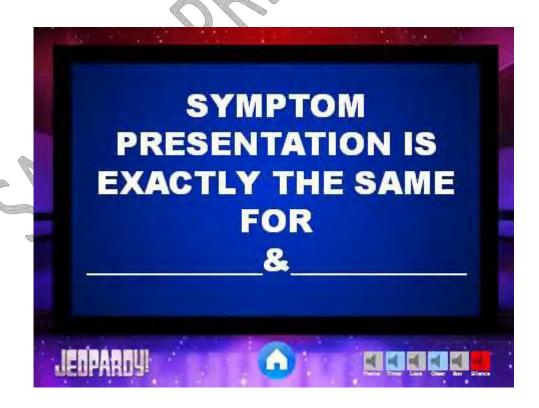
This unit will provide the officers the ability to articulate the concepts that have been presented over the course of the week, in a fun Jeopardy game.

Slide 1





Slide 3



Draft of additional CIT ELECTIVES

(Power Points would need to be created by presenter at the local level)

Mood Disorder

Module: Mental Health

Presenter: Mental Health Professional

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

 Have an understanding of the mental health conditions that are Mood Disorders (i.e. bipolar, depression)

Course Description:

Participants will have an understanding of how the signs and symptoms of Mood Disorders may appear in someone. They will have an understanding of strategies they can use when working with a person with Mood Disorders.

CIT from the Officer's Point of View

Module: Law Enforcement

Presenter: CIT Officer with CIT experience.

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Describe how CIT works for the CIT officer on the street
- Explain common experiences and issues encountered by a CIT officer
- Explain the value of a CIT Program

Course Description:

One or more CIT officer(s) explain his/her experiences as a CIT Officer.

Supervision of CIT Officers/Deputies and CIT Report Writing

Module: Law Enforcement

Presenter: CIT-trained law enforcement supervisor or officer

Hours: 1-2

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Explain how to effectively supervise CIT trained officers
- Describe how to complete a CIT report
- Explain the need for a CIT policy which is consistent with law enforcement standards
- Explain how a properly completed CIT report can be part of the continuum of care for an individual living with a mental health or substance use disorder

Course Description:

The CIT Supervisor or officers will provide participants guidance on how to effectively supervise CIT officers. The instructor will also explain how to properly complete a CIT report and how a CIT report can help connect the individuals with the appropriate mental health resources.

Suicidal vs. Non-Suicidal Self Harm

Module: Mental Health

Presenter: Mental health professional with training experience in suicide prevention and self-harm

behaviors.

Hours: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Identify the characteristics of at-risk individuals with respect to suicide
- Identify the characteristics of at-risk individuals engaging in self-harm
- Identify methods of, and reasons for self-harm
- Describe the difference between the manners in which a person presents oneself who is engaging in self-harm for the purposes of ending their life vs. a person who is engaging in self- harm for another reason

Course Description:

This class will provide participants with the ability to identify and distinguish between suicidal and non-suicidal self-harm.

Inpatient Hospital Assessment Process

Module: Mental Health

Presenter: Medical and/or mental health professional with expertise in inpatient assessment.

Hour: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Describe the mental health assessment process in a hospital setting
- Identify the criteria needed for inpatient hospitalization vs. outpatient referrals

Course Description:

This class addresses the process of a mental health assessment in the Emergency room. Topics to be covered: the mental health evaluation process, assessing need for treatment, treatment options, criteria (e.g. do they meet criteria for involuntary commitment or an outpatient referral).

Trauma Informed Care

Module: Mental Health

Presenter: Mental health professional(s) certified in Trauma Informed Care.

Hour: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Define the term "resilience" as it pertains to this lesson
- List different stressors someone may have at work

Course Description:

This class explains the Trauma Informed Care Initiative. The instructor will then explain how adviser experiences impact all of the body's psychological and biological systems throughout one's life. Finally, the instructor will explain stress management strategies.

Bipolar Disorder

Module: Mental Health

Presenter: Mental Health Professional

Hour: 1

Learning Outcomes:

At the completion of this unit, participant will be able to:

- Define Bipolar Disorder
- Define behavior characteristics in relation to Bipolar Disorder
- List crisis intervention strategies, techniques and community resources for individual(s) living with Bipolar Disorder

Course Description:

This class provides a foundation for understanding Bipolar Disorder.

Suggested Videos:

http://www.youtube.com/watch?v=O9ULMOETfd0

Autism Spectrum Disorder

Module: Mental Health

Presenter: An individual who has been diagnosed with an Autism Spectrum Disorder, or who is a parent or caregiver of an individual diagnosed with autism.

Hour: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Define Autism Spectrum Disorder
- List behaviors of an individual that indicate he/she may have an Autism Spectrum Disorder
- Describe tactics of effective law enforcement response to individuals with an Autism Spectrum Disorder experiencing a mental health crisis

Course Description:

This class will define autism, state its current prevalence, explain why people with autism may come into contact with law enforcement, describe the range of symptoms and behavioral manifestations of autism, and comment on unique elements of effective law enforcement response to individuals with autism experiencing a mental health crisis.

Hoarding Disorder

Module: Mental Health

Presenter: Mental health professional(s) with knowledge in Hoarding Disorder, behavior a n d interventions with the option of including a law enforcement officer/deputy with knowledge of Hoarding Disorder (e.g., Code enforcement)

Hour: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Define different characteristics of Hoarding Disorder
- Explain how Hoarding Disorder is a clinical disorder vs. a character flaw
- Identify appropriate referral resources

Course Description:

This class will focus on Hoarding Disorder, possible interventions and available resources.

Eating Disorders

Module: Mental Health

Presenter: Mental health professional(s) with knowledge in Eating Disorders, behavior and treatment.

Hour: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Define different types of Eating Disorders
- Define signs and symptoms of various Eating Disorders
- Identify options for treatment of Eating Disorders

Course Description:

This class will provide an overview of various Eating Disorders, suggest helpful resources, and discuss barriers to treatment.

Guardianship and Power of Attorney

Module: Mental Health

Presenter: Mental health professional(s) with knowledge in dealing with the guardianship process, and/or court staff (e.g. probate clerk, public administrator, attorney, etc.), and/or an advocate for people with lived experience.

Hour: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Describe how to refer families/individuals to obtain additional information on the guardianship process
- Explain the difference between Power of Attorney (POA), Guardianship and Limited Guardianship
- Identify barriers and benefits of guardianship

Course Description:

Guardianship is a topic that is a frequent question for families and significant others of chronically, severely mentally ill individuals. This class focuses on exploring and obtaining legal guardianship to familiarize trainees with this legal process.

Homelessness

Module: Community

Presenter: Professional with expertise in this area.

Hour: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Describe current information regarding homelessness in relation to mental illness
- Explain the availability of community services for individuals experiencing homelessness
- Explain how to access homeless services and outreach

Course Description:

This class will address definitions, types, and risk factors of homelessness in relation to mental illness. Crisis intervention, resource availability and accessibility relative to this chronic population also will be discussed

Reducing Stigma

Module: Mental Health

Presenter: Mental Health Professional or individual with knowledge of Community Mental Health Centers, National Alliance on Mental Illness (NAMI) and/or person(s) with lived experiences.

Hour: 1

Learning Outcomes:

At the completion of this unit, the participant will be able to:

- Describe the impact of stigma and discrimination on individuals with mental illness
- List actions and language which stigmatize individuals with mental illness.
- Explain strategies for reducing stigma and discrimination against individuals with mental illness

Course Description:

This class increases participant awareness of the stigma linked to mental illness, the role of language as associated with stigma, and strategies for reducing stigma, and discrimination against individuals with mental illness.