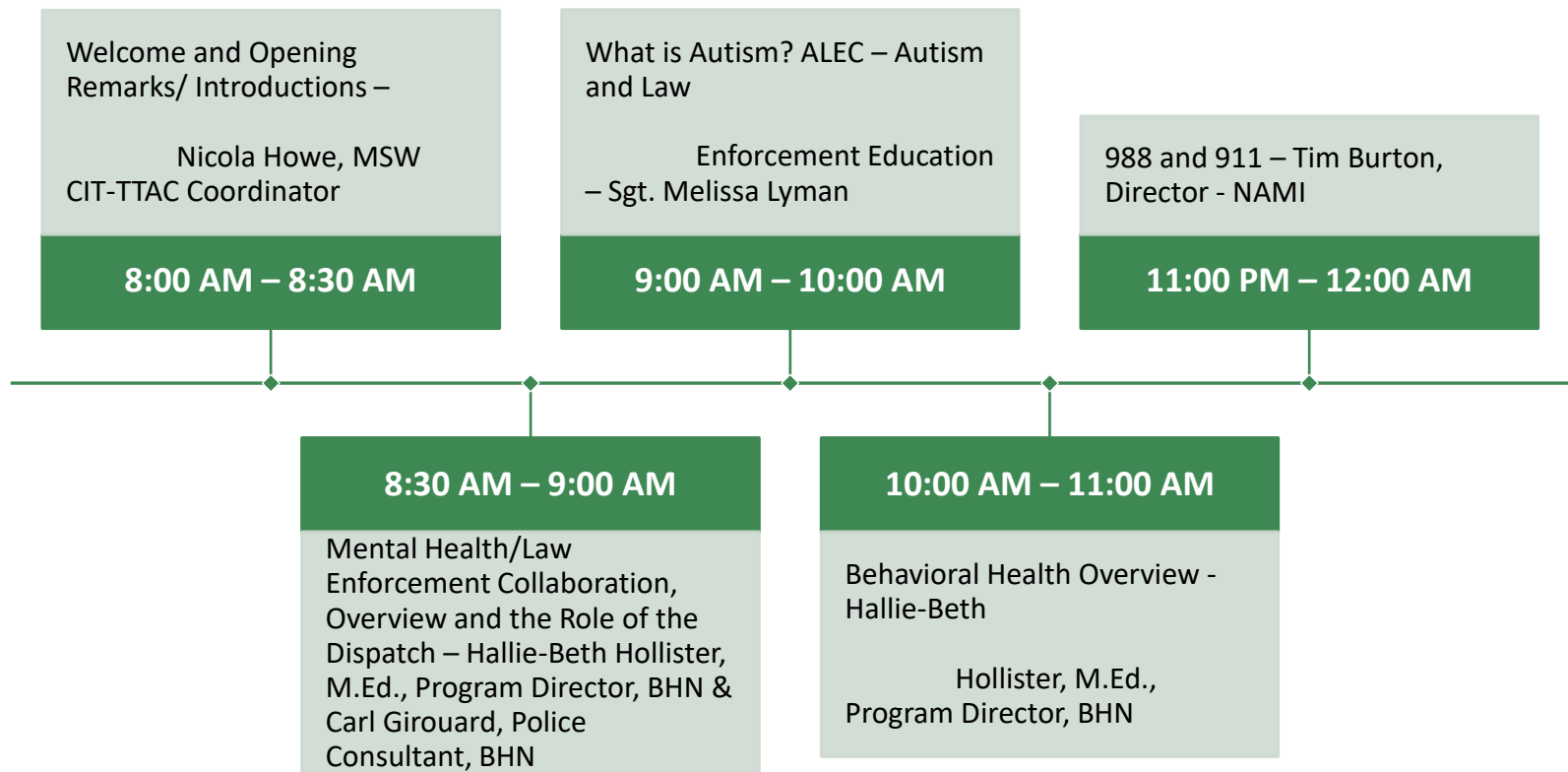




Crisis Intervention Training - Dispatch



AGENDA – CIT DISPATCH



Welcome & Opening Remarks

Nicola Howe

Welcome

Ground Rules

Materials

Introductions – Person – Role- System

Evaluations

Mental Health/Law Enforcement Collaboration

What and Why?

Hallie-Beth Hollister, M.Ed., Program Director, BHN
Carl Girouard, Police Consultant, BHN

Law Enforcement & Mental Health Services

Are being called on to collaborate more than ever

According to the Treatment Advocacy Center -

“Approximately one-third of individuals with severe mental illness have their first contact with mental health treatment through a law enforcement encounter.” –

But

Many communities continue to face pervasive gaps in mental health services, especially crisis services, placing a heavy burden on law enforcement agencies and, in particular, officers.

So

“Without access to appropriate alternatives, officers are often left with a set of poor choices: leave people in potentially harmful situations, bring them to hospital emergency departments, or arrest them.”

Traditional law Enforcement Training

- Has had little information on Mental Health
- Officers have been left to manage on their own instincts
- This may not go well for either the officer or the consumer

And Training for Mental Health professionals

- Has not included information needed for collaborating with law enforcement
- This can leave both groups at a disadvantage,
 - Acting on stereotyped ideas of how the other will be able to respond and engage in a crisis scenario

CIT Training

Helps to bridge the communication gap

Both “sides” can share their expertise to get better outcomes

What is CIT, Anyway?

Crisis Intervention Team is -

“An innovative, first-responder, model of police-based crisis intervention training”

The purpose is to set up systems that promote access to treatment

And decrease the likelihood of people entering the criminal justice system solely due to illness-related behaviors.

What are the “Core Elements” of CIT?

- Partnerships
- Advocacy Community
- Mental health Community
- Stakeholders Meetings
- Statewide conference
- Law Enforcement Community

What's the purpose of CIT Training?

Give Law Enforcement a better understanding of mental health issues and symptoms

Introduce community services that they can use when responding to calls

What is included in CIT Training at BHN?

- Six 40-hour sessions a year available to area Law Enforcement
- Three-four 8-hour sessions a year for Dispatchers
- Two 8-hour sessions a year focused on youth issues and targeted for SROs
- As of July 2021, we have trained 963 officers in “regular” CIT (48 departments), 80 in Youth CIT (14 departments), and 172 Dispatchers (22 departments).

But beyond training,

- The CIT approach has been shown to promote officer safety and the safety of the individual in crisis.
- CIT means collaboration and there are always new elements being added to the mix

So – why CIT for Dispatch?



Before the officer is on the scene

- Dispatch Professionals are the “First First Responders”
- Dispatchers handle all types of calls and caller presentations
- Dispatch is the line of communication to officers –

-
- The information they gather, and pass on, can set expectations before the encounter begins
 - they must be able to paint the most accurate picture possible regarding each call
 - This makes their involvement key to successful implementation of CIT in any department

The Origins of CIT

<https://www.youtube.com/watch?v=y99kODtyVhk&t=11s> 10:10

Collaboration between Mental Health and Law Enforcement

- Gives officers alternatives when they respond to crises
- Helps us optimize outcomes for the individuals we serve
- Leads to creative problem-solving in the communities involved

What is Autism? ALEC Autism and LE Education

Sgt. Melissa Lyman

Behavioral Health Overview

Hallie-Beth Hollister, M.Ed.,
Program Director, BHN

Overview

- Approximately 1 in 5 adults in the U.S. (43.8 million, or 18.5%) experiences mental illness in a given year.
- 90% of those who die by suicide have an underlying mental illness.
- Mental Illness results in more disability than:
 - Cancer
 - Diabetes
 - Heart Disease

Mental Health Facts IN AMERICA

Fact: 43.8 million adults experience mental illness in a given year.



1 in 5 adults in America experience a mental illness.



Nearly 1 in 25 (10 million) adults in America live with a serious mental illness.



One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.

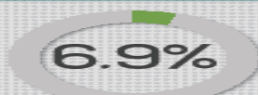
Prevalence of Mental Illness by Diagnosis



1 in 100 (2.4 million) American adults live with schizophrenia.¹



2.6% (6.1 million) of American adults live with bipolar disorder.¹



6.9% (16 million) of American adults live with major depression.¹



18.1% (42 million) of American adults live with anxiety disorders.¹

Consequences



10.2m

Approximately 10.2 million adults have co-occurring mental health and addiction disorders.¹



26%

Approximately 26% of homeless adults staying in shelters live with serious mental illness.¹



24%

Approximately 24% of state prisoners have "a recent history of a mental health condition".²

Impact



1st

Depression is the leading cause of disability worldwide, and is a major contributor to the global burden of disease.¹



-\$193b

Serious mental illness costs America \$193.2 billion in lost earning every year.³



90%

90% of those who die by suicide have an underlying mental illness. Suicide is the 10th leading cause of death in the U.S.⁴

Treatment in America



Nearly 60% of adults with a mental illness didn't receive mental health services in the previous year.⁴



Nearly 50% of youth aged 8-15 didn't receive mental health services in the previous year.¹



African American & Hispanic Americans used mental health services at about 1/2 the rate of whites in the past year and Asian Americans at about 1/3 the rate.⁵

Ways to Get Help



Talk with your doctor



Connect with other individuals and families



Learn more about mental illness



Visit NAMI.org

¹ This document cites statistics provided by the National Institute of Mental Health, www.nimh.nih.gov
² America's Prisoners by Department of Justice
³ American Journal of Psychiatry and U.S. Surgeon General's Report, 1999
⁴ Substance Abuse and Mental Health Services Administration

Follow Us!
[facebook.com/NAMI](https://www.facebook.com/NAMI)
[@NAMI](https://twitter.com/NAMI)

Consequences & Costs of Mental Illness

- **\$193.2** billion in lost earnings per year.
- Mood disorders are the **3rd** most common cause of hospitalization for ages 18 to 44.
- **26 %** of homeless adults in shelters have a MI
- **24%** of prisoners have a history of a MI

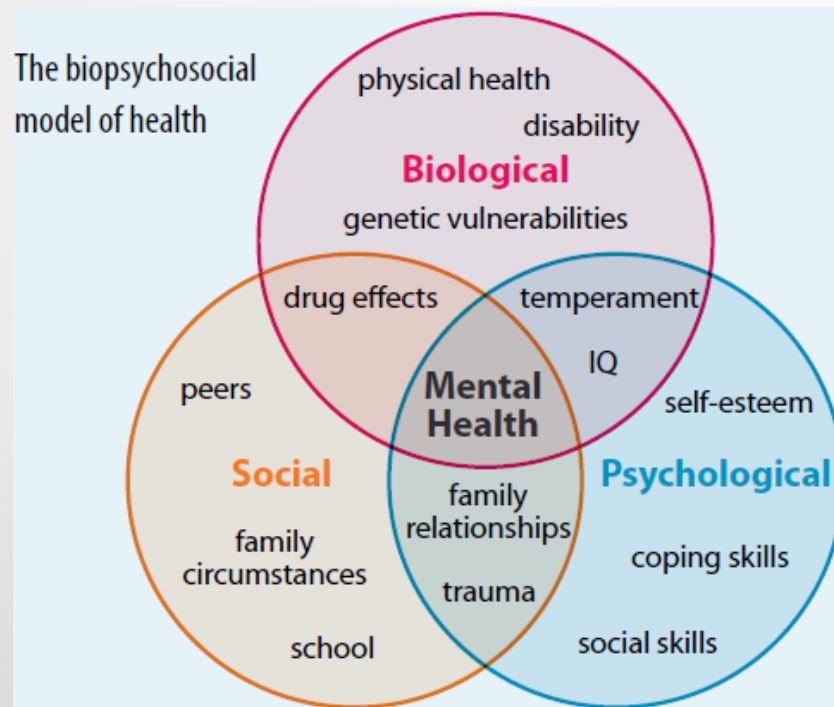
What is Mental Illness?

- Substantial disorder of
 - **Thought**
 - **Mood**
 - **Perception**
 - **Memory**
- Can significantly impair **judgment, behavior, capacity to recognize reality, or ability** to meet the ordinary demands of life

Types of Mental Illness

- ✓ Mood Disorders
 - ✓ *Anxiety Disorders, Depressive Disorders, Bipolar Disorder*
- ✓ Psychotic Disorders
- ✓ Personality Disorders
- ✓ Substance Use Disorders
- ✓ Stress & Trauma-Related DisordersDissociative Disorders
 - ✓ *Dissociative Disorders*

Causes



Biological Factors

- Biochemical Disturbances
- Genetics
- Infections- can cause brain damage
- Brain defects or injury
- Prenatal damage
- Poor nutrition, exposure to toxins

Social/Environmental Factors

- Significant life events: Death, divorce, changing jobs/school
- Significant local/world events
- Disasters
- A dysfunctional family life, including domestic violence
- Living in an unsafe environment
- Living in poverty
- Feelings of inadequacy, low self-esteem, or loneliness
- Social or cultural expectations
- Substance abuse

Psychological Factors

- Severe psychological childhood trauma, such as emotional, physical or sexual abuse
- An important early loss, such as the loss of a parent
- Neglect
- Poor ability to relate to others

What is **severe, persistent** mental illness (SPMI) ???

- **Complex** symptoms
- Often requires ongoing treatment and management.
- Most often requires varying types and dosages of medication, therapy, and support.
- Can vary in intensity and acuity.



The Good News?

**Mental illness is treatable
and people can recover.**

The not so good news??

- Nearly **60% of adults** with a MI do not receive treatment
- Nearly **50% of youth** (8yrs to 15 yrs.) do not receive treatment
- African American and Hispanic Americans used mental health services at about **one-half** the rate of whites.



The single most common barrier to seeking treatment?

Shame
and
Stigma



<https://www.youtube.com/watch?v=LuFbEKQME4A>

- Bipolar disorder

Anxiety Disorders

- ◆ Occasional anxiety and worry are a *normal* part of life.
- ◆ Anxiety *disorders* involve more than temporary worry or fear.
- ◆ The anxiety does not go away, can get worse over time, and can interfere with daily activities.
- ◆ Most anxiety disorders begin in childhood, adolescence and early adulthood.

Anxiety Disorders

- Panic Disorder
- Obsessive Compulsive Disorder *
- P**ost **T**raumatic **S**tress **D**isorder
- Social Anxiety Disorder
- Specific Phobias
- Generalized Anxiety Disorder

Symptoms of Anxiety Disorders

- ✓ Feelings of panic, fear and uneasiness
- ✓ Uncontrollable, obsessive thoughts
- ✓ Repeated thoughts or flashbacks of traumatic experiences
- ✓ Nightmares
- ✓ Ritualistic behaviors, such as repeated hand washing
- ✓ Problems sleeping
- ✓ Cold or sweaty hands
- ✓ Shortness of breath
- ✓ Palpitations
- ✓ An inability to be still and calm
- ✓ Dry mouth
- ✓ Numbness or tingling in the hands or feet
- ✓ Nausea
- ✓ Muscle tension

Anxiety Disorders: Why someone may call 911

- Experiencing panic attack symptoms
- Extreme worry
- Child won't go to school
- Feel like they are “going crazy”

Types of Depression

- Situational/Adjustment
- Bereavement
- Seasonal
- Dysthymia
- Post-Partum Depression
- Bipolar depression
- Clinical Depression**
- Psychotic Depression**

Clinical Depression: Signs & Symptoms

- Extreme sadness, guilt, shame
- Decreased memory and concentration, poor academic performance or work performance
- Decreased interest/enjoyment in daily activities
- Increased irritability, arguments
- Change in sleep, appetite, energy
- Physical unease
- Social withdrawal
- Hopelessness**, helplessness
- Suicidal** thoughts

Depressive Disorders: Why someone may call 911

- Suicidal thoughts
- Hopelessness
- Family, friends, providers may call for wellbeing check

Bipolar Disorder

- Also known as manic depression.
- A disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.
- Episodic *extremes* between states
 - depressed state and excitable,
 - euphoric/irritable, impulsive state

Symptoms of Bipolar Disorder

- Symptoms of mania (*"the highs"*):
 - ✓ Excessive happiness, hopefulness, and excitement
 - ✓ Sudden changes from being joyful to being irritable, angry, and hostile
 - ✓ Restlessness
 - ✓ Rapid speech and poor concentration
 - ✓ Increased energy and less need for sleep
 - ✓ High sex drive
 - ✓ Tendency to make grand and unattainable plans
 - ✓ Tendency to show poor judgment, such as deciding to quit a job
 - ✓ Drug and alcohol abuse
 - ✓ Increased impulsivity
 - ✓ Can become psychotic

Bipolar Disorder: Why someone may call 911

- Manic symptoms
- Grandiosity
- Placing self in unsafe situations
- Missing Person

Personality Disorders

- People with personality disorders have **extreme** and **inflexible personality** traits that are often distressing to the person and/or cause problems in work, school or social relationships.
- The patterns of thinking and behavior significantly differ from the expectations of society and are so **rigid** that they interfere with the person's normal functioning.
- Examples include: *antisocial personality disorder, obsessive-compulsive personality disorder, paranoid personality disorder, and borderline personality disorder.*

Personality Disorders: Why someone may call 911

- Suicidality
- Anger, aggression
- Connection
- Relationship issues

- 
- <https://www.youtube.com/watch?v=7Ku2Mv6guFI> –
Brandon Marshall

Schizophrenia Spectrum and Other Psychotic Disorders

- ◆ Schizophrenia
- ◆ Schizoaffective Disorder
- ◆ Delusional Disorder
- ◆ Schizotypal (Personality)
- ◆ Brief Psychotic Disorder
- ◆ Schizophreniform Disorder
- ◆ Substance/Medication-Induced Psychotic Disorder
- ◆ Psychotic Disorder Due to Another Medical Condition



Schizophrenia

- ❖ Schizophrenia is a chronic and severe mental disorder that affects how a person *thinks, feels, and behaves*.
- ❖ People with schizophrenia may seem like they have lost touch with reality, often experiencing delusions and hallucinations.
- ❖ Symptoms lasts longer than six months, often with a decline in work, school and social functioning.

Positive Symptoms

“*Positive*” symptoms are psychotic behaviors not generally seen in healthy people. may “lose touch” with some aspects of reality.

- Hallucinations
- Delusions
- Thought disorders (unusual or dysfunctional ways of thinking)
 - Disorganized or incoherent speech
- Movement disorders (agitated body movements)

Hallucinations and Delusions

- **Hallucinations** are unusual sensory experiences or perceptions of things that aren't actually present,
 - Can involve all *five senses*.
- **Delusions** are false beliefs that are persistent and organized, and that do not go away after receiving logical or accurate information.

Negative Symptoms

“*Negative*” symptoms are associated with disruptions to normal emotions and behaviors.

- “Flat affect” (reduced expression of emotions via facial expression or voice tone)
- Reduced feelings of pleasure in everyday life
 - Slowed or unusual movements
- Difficulty beginning and sustaining activities
- Reduced speaking

Cognitive Symptoms

- The cognitive symptoms of schizophrenia can be subtle or more severe.
- Symptoms include:
 - **Poor “executive functioning”** (the ability to understand information and use it to make decisions)
 - **Trouble focusing** or paying attention
 - Problems with **“working memory”** (the ability to use information immediately after learning it)

Psychotic Disorders: Why someone may call 911

- May call due to reality disturbance
- Paranoia
- Concern from family, friends, providers, etc.
- Danger to self or others
- Not caring for self

Psychosis

The 3 possible responses to a person who loses contact with reality, and are either hallucinating or delusional, are:

- A. Agree with them
- B. Dispute them, or
- C. Defer the issue

Which is the appropriate response: A, B or C?

Delusions

- Convey your acceptance—but let the individual know that you are not experiencing it and reinforce reality.
- “I can hear that you are scared that someone is out to get you, but I don’t know of anyone who is trying to hurt you . . . I’m here to help you and keep you safe.”
- Don’t argue about the delusion—no one will win this argument

Are childhood disorders different from adult disorders?

- Many diagnoses are the same across the lifespan, but the symptoms can appear different at different ages.
- Some diagnoses are pretty commonly made in childhood/adolescence rather than in adults. Primary examples: ADHD, Oppositional Defiant Disorder, Conduct Disorder, Disruptive Mood Dysregulation Disorder.

How are Childhood Disorders Diagnosed?

- Through observation
- Through reports from adults involved with the child
- Accurate diagnosis should involve input from multiple sources of observation/information.
- Childhood diagnoses are particularly subject to change and re-evaluation over time due to the child's development

- 
- <https://www.youtube.com/watch?v=yWkepfPIInk>

Mental Health Facts

CHILDREN & TEENS

Fact: 1 in 5 children ages 13-18 have, or will have a serious mental illness.²



20% of youth ages 13-18 live with a mental health condition¹



11% of youth have a mood disorder¹



10% of youth have a behavior or conduct disorder¹



8% of youth have an anxiety disorder²

Impact

50%



50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24.²

10 yrs



The average delay between onset of symptoms and intervention is 8-10 years.³

37%



37% of students with a mental health condition age 14 and older drop out of school—the highest dropout rate of any disability group.¹

70%



70% of youth in state and local juvenile justice systems have a mental illness.²

Suicide

3rd

Suicide is the 3rd leading cause of death in youth ages 10-24.¹



90%

90% of those who died by suicide had an underlying mental illness.²



Warning Signs



Feeling very sad or withdrawn for more than 2 weeks (e.g., crying regularly, feeling fatigued, feeling unmotivated).



Trying to harm or kill oneself or making plans to do so.



Out-of-control, risk-taking behaviors that can cause harm to self or others.



Sudden overwhelming fear for no reason, sometimes with a racing heart, physical discomfort or fast breathing.



Not eating, throwing up or using laxatives to lose weight; significant weight loss or gain.



Severe mood swings that cause problems in relationships.



Repeated use of drugs or alcohol.



Drastic changes in behavior, personality or sleeping habits (e.g., waking up early and acting agitated).



Extreme difficulty in concentrating or staying still that can lead to failure in school.



Intense worries or fears that get in the way of daily activities like hanging out with friends or going to classes.

4 Things Parents Can Do



Talk with your pediatrician



Get a referral to a mental health specialist



Work with the school



Connect with other families

¹ This document uses statistics provided by the National Institute of Mental Health. www.nimh.nih.gov

Follow Us!

facebook.com/officialNAMI
twitter.com/NAMIcommunicate





Parents might call 911 about these kids when:

- They run out of school, or away from home
- They act out in school or at home, and become physically aggressive or destructive of property
- They are involved in impulsive crimes, like shoplifting – *they may tend to be followers rather than leaders*

That's because –

- Problems with attention, focus and follow-through –
- Poor planning skills – not anticipating consequences
- Low frustration tolerance
- Social difficulties – speaking or acting without thinking can alienate their peers



Untreated, ADHD/ADD is correlated with

- Lower levels of educational achievement
- Lower job satisfaction
- Higher rates of substance use disorders,
- Disruptions in family life,
- Higher levels of incarceration

Keep in Mind -

- ADHD and ADD are highly heritable disorders,— 30% of men who have ADHD will have at least one child with ADHD.
- This makes behavior management challenging for these parents

Police might become involved when:

- Kids are picked up for minor infractions such as curfew violations,
- or more serious actions such as breaking and entering, selling and/or receiving stolen goods, drug use, physical aggression or property destruction,
- They violate a CRA or probation agreement
- 50-60% of youth in the juvenile justice system have some type of behavioral health diagnosis or mental illness

That's because -

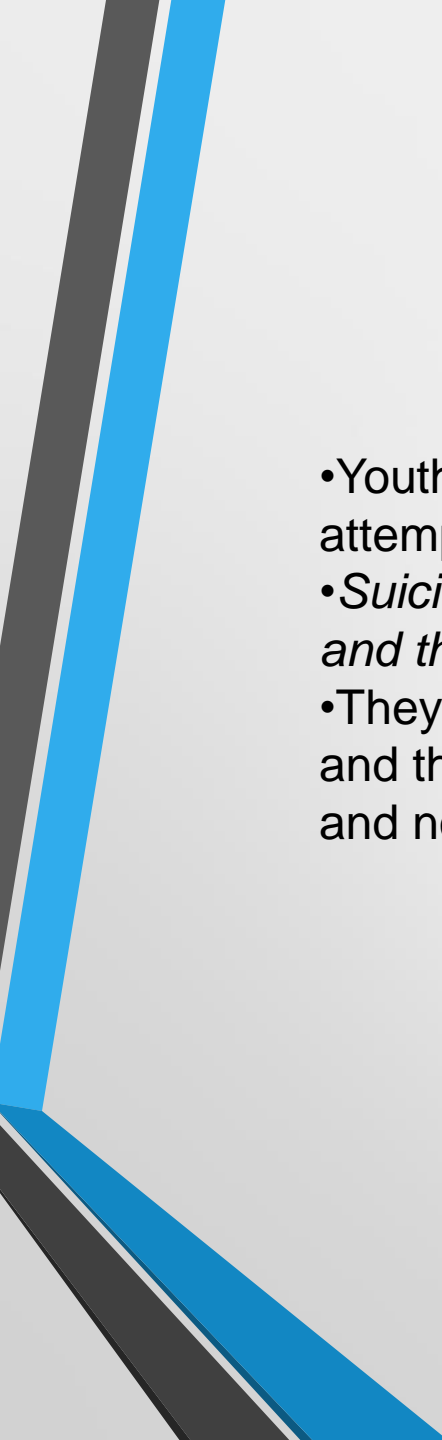
- Youth with these disorders are chronically defiant and resistant to direction
- They naturally come into conflict with all types of authority figures.
- They are also planners, rather than acting on impulse, so they may be engaged in more high-stakes behavior
- Their school/home discipline issues often spill over into aggression

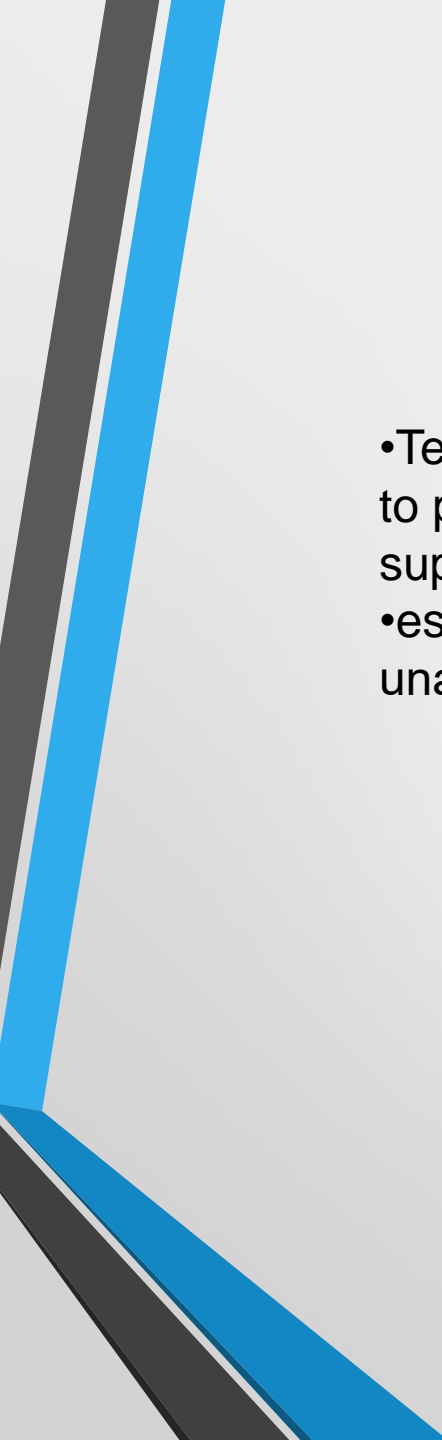
Commonly treated with:

- Medications to lessen any level of impulse disorder that may be complicating the picture
- Other medications to help with controlling aggressive outbursts or mood swings
- But – their behavior issues often lead to the legal system

You might get called about these kids (Depression, Anxiety disorders, Bipolar disorder) when:

- They exhibit self-destructive or aggressive behavior, in the home or at school
- Parents become concerned over statements they make threatening harm towards themselves or towards others
- They are involved in conflicts in the community with peers or authority figures

- 
- Youth with mood disorders are at high risk for suicide attempts and for self-injurious behavior.
 - *Suicide is the 3rd leading cause of death for youth 10-14 and the 2nd for youth 15-34*
 - They may engage in cutting, or develop eating disorders, and there are online communities that promote this behavior and normalize it for affected teens

- 
- Teens with these disorders are also highly vulnerable to predators, especially if they do not have a supportive social network in place –
 - especially online, where most parents will be unaware of their child's activities

That's because –

- They naturally want to “belong” with peers rather than with adults
- Adolescents are developmentally programmed to seek out peer approval
- This means that if they are not able to feel comfortable with a naturally occurring peer group they will find a peer group elsewhere, whether online or elsewhere

Commonly treated with:

- Medications to reduce the symptoms of mood swings, depressed mood
- Psychotherapy, cognitive behavioral therapy, group therapy, peer group support
- Youth compliance with medications becomes particularly problematic in the later teens when the stigma of having a mental health diagnosis is more pronounced and teens start to try out alternative “natural” ways of dealing with their mood instability
- Psychotherapy, cognitive behavioral therapy, group therapy, peer group support

Keep in Mind –

- Medication compliance is a problem in the later teen years because of stigma
- Youth may prefer to use “natural” remedies that seem more socially acceptable
- This can lead to increased symptoms and parents may not be aware that teens are not taking their medications or are self-medicating

You may get a call about youth with Psychotic disorders when:

- When youth experience a first psychotic episode, parents may reach out for assistance
- 🔊 • Parents may call 911 for help getting their loved one to a hospital or other site for evaluation or treatment.

Keep in Mind-

- Behaviors may appear purely oppositional but may really be a response to
- Chaotic or unstable home environments, trauma, or other undiagnosed disorders
- Kids may be communicating something with their behavior that they do not have the verbal skills or trust level to communicate in other ways

And also

- Experience and environment impact all aspects of development.
- This includes mental health/emotional development.
- Many of the children who need to receive mental health services have histories of trauma or come from extremely stressful environments.
- They will benefit from supportive consistent activities and adults teachers, coaches and mentors
- Any positive encounter may be that one encounter that makes a difference

988 & 911 – NAMI



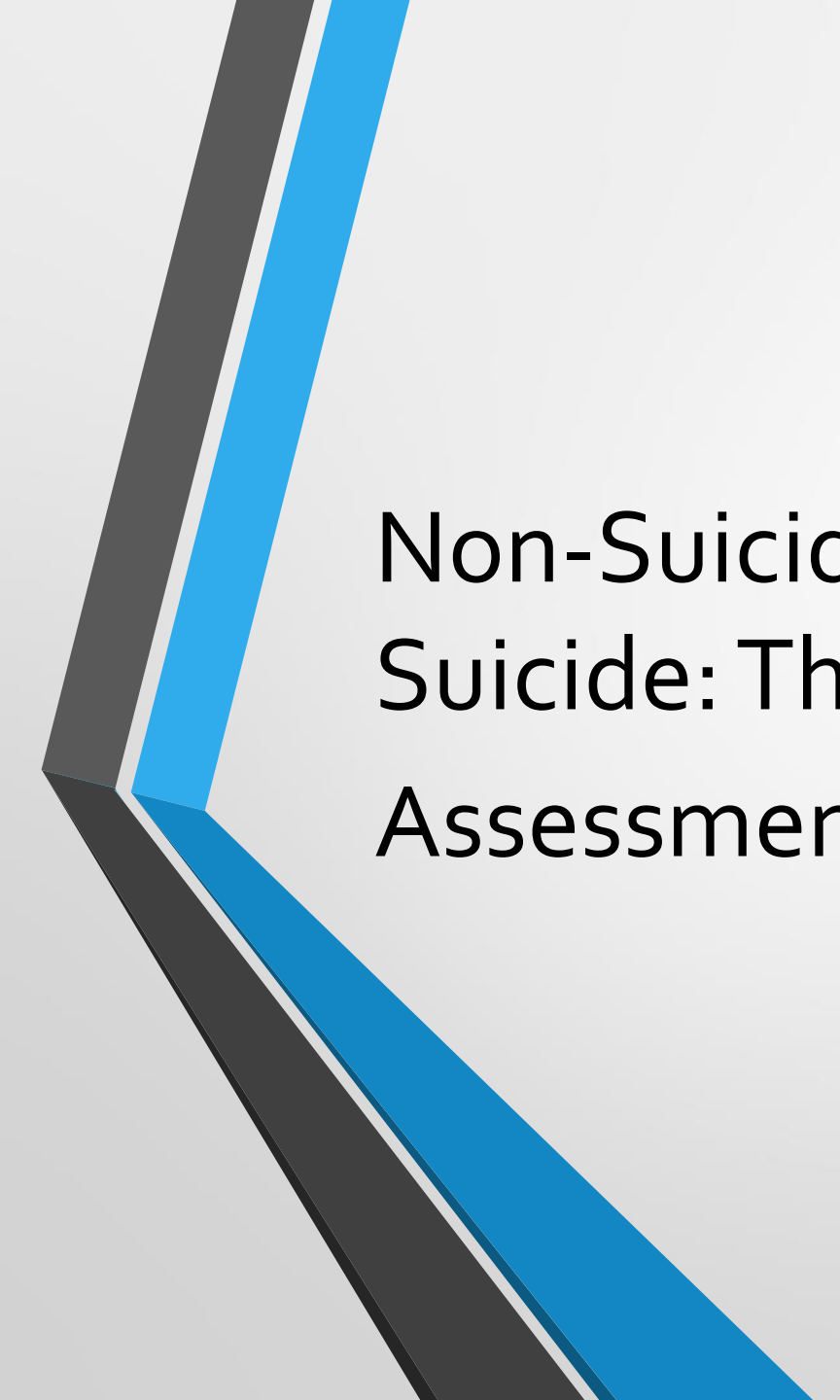
Tim Burton – Director, NAMI

Family Perspective

Amanda Pappas, Care
Coordinator – BHN/ICC

Non-Suicidal Self Injury & Suicide Risk

Nicola Howe, MSW, CIT-TTAC
Coordinator



Non-Suicidal Self-Injury and Suicide: Theory, Research, and Assessment

What is Non- Suicidal Self- Injury

The act of deliberately harming oneself.

What behaviors constitute non-suicidal self-injury?

- Cutting
- Burning
- Scratching
- Tattooing
- Biting
- **Piercing**
- **Head banging**
- Erasing
- **Digging at wounds**


Non-Suicidal Self-Injury

- What are some reasons people engage in non-suicidal self-injury?
- Discharge stress
- To penetrate numbness
- To punish themselves
- To achieve some other aim such as an adrenalin rush, control actions of others, express one's self, or as a distraction.
- Slight contagion effect.

For the most part, self-injurious acts are not an attempt at suicide

Non-suicidal self-injury: Signs and Symptoms

- Scars (burns cuts), fresh cuts, scratches, bruises or other wounds,
- Keeping sharp objects on hand,
- Wearing long sleeves, pants even in hot weather,
- Claiming to have frequent accidents resulting in cuts/bruises,
- Hidden razors or other sharp objects,
- Often in need of first aid materials frequently.
- Broken bones
- Spending a great deal of time alone
- Difficulties with interpersonal relationships
- Emotional instability
- Impulsiveness and unpredictability
- Depressed mood
- Irritability
- Frequent thoughts of helplessness, hopelessness, or worthlessness



Co- Occurring Disorders

Non-suicidal self-injury is a symptom

Borderline personality disorder

Major depressive disorder

Anxiety disorders

Eating disorders

Trauma

Post-traumatic stress disorder

Substance use disorders

Dissociation and dissociative disorders

Autism spectrum disorders

Possible Effects of Self-injury

- Permanent scars
- Disfigurement
- Worsening feelings of shame, guilt, low self-esteem
- Depression regarding the inability to stop self-injuring despite the consequences
- Stress of providing many reasons for injuries
- Social isolation
- Stress of having to hide the self-abuse from others
- Infected wounds
- Substance use and abuse to self-medicate
- Failure to address reasons behind the self-injury
- Long-standing problems cause decreased enjoyment in other areas of life
- Anxiety that someone will discover the self-mutilation
- Death

Statistics

- It's estimated 1%-4% of adults self-injure
- Prevalence of chronic self-harm occurs in approximately 1% of the adult population.
- Self-harm rates in adolescents are especially high, with about 15% of adolescents reporting self-injury behavior.
- College students have the highest number of reported self-injury, ranging about 17%-35%.
- Those between the ages of 20-29 have the largest hospitalization rate for self-harm.
- Self-harm rates are almost equal among genders

Non-Suicidal Self-injury: What might be helpful?

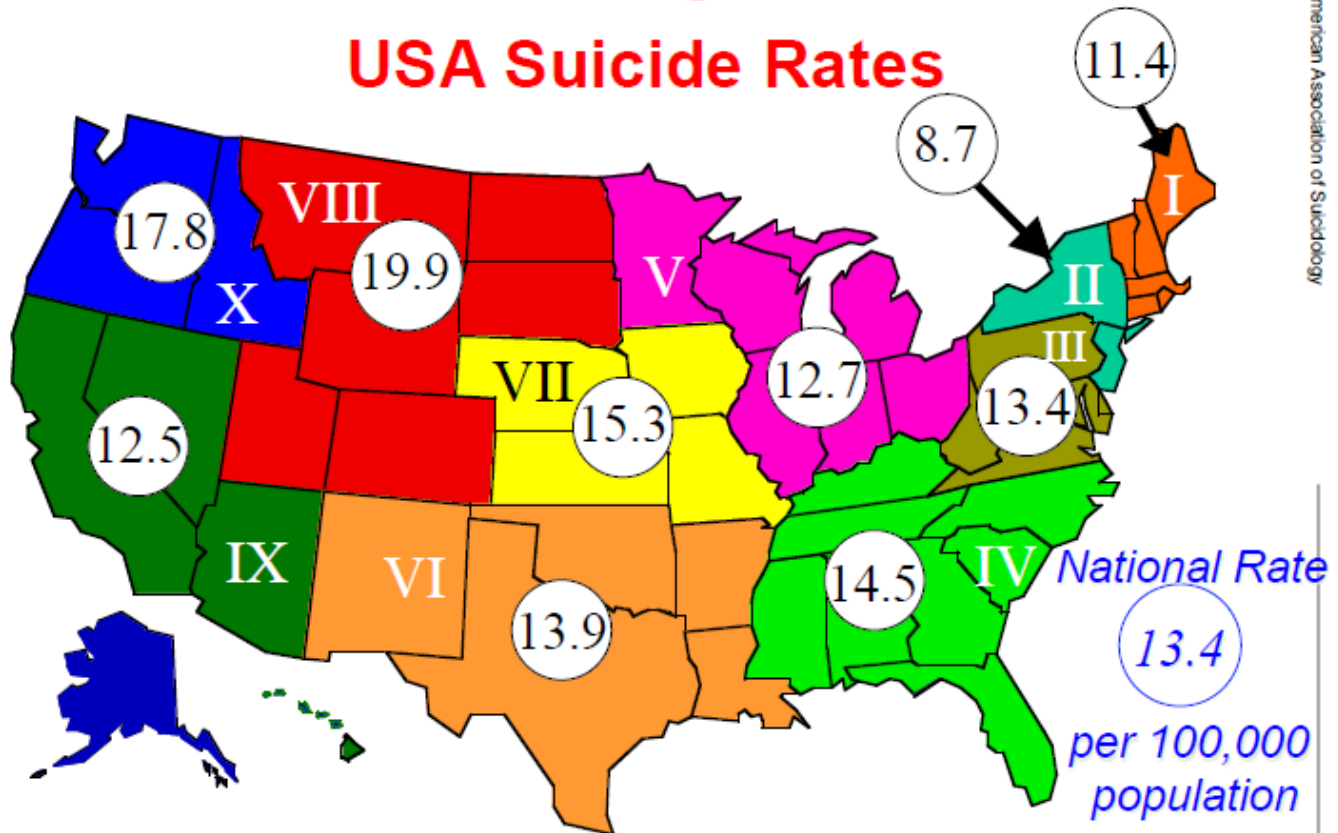
- Have a conversation about the relief it really provides.
 - How long does it last? What if there were other things that could provide similar stress relief?
- Harm Reduction
 - What techniques are available to reduce harm?
- You cannot stop the behavior – so do not try! It is a means of coping that is probably well established and needs a replacement before it can be stopped.
 - Any good you can identify in self-harming?

Suicide

- **Increase understanding of:**
 - Problem of suicide - statistics
 - Suicide risk and protective factors
 - Warning Signs
- **Throughout our discussion please keep these realities of suicide in mind:**
 - It is the outcome of an individual crisis and it causes crisis in others.
 - It produces trauma in all those who experience it in any way.
 - It happens in families and not in a vacuum.
 - It is one of the most abnormal forms of death.
 - It is always a premature death.
 - It is preventable.



Health Regions & USA Suicide Rates



2014 Data

Source: data calculated from figures posted at CDC's WISQARS website downloaded 18 December 2015 for 2014 data

National Suicide Statistics

- 2014

- **42,773 suicides in the U.S. (112.7 suicides per day; 1 suicide every 12.3 minutes). About 1 million attempts each year, which translates to one attempt every 31 seconds.**
- Suicide is the tenth leading cause of death. Homicide is 17th.
- **Suicide ranks 2nd as a cause of death among young (15-24) American.**
- Males complete suicide at a rate 3.5 times that of females. However, females attempt suicide 3 times more often than males.
- **Suicide rates are highest among those aged 45-54 (19.7 per 100,000).**

National Suicide Statistics Cont...

- Firearms remain the most commonly utilized
- method of completing suicide by essentially all groups. About one-half (51.5% of the individuals who took their own lives in 2013 used this method. Males used firearms more often than females.
- The most common method of suicide for all females was poisoning. In fact, poisoning has surpassed firearms as the most common method used in female suicides since 2001.
- **Caucasians have higher rates of completed suicides than any other group.**
- Suicide rates have traditionally decreased in times of war and increased in times of economic crises.
- **Suicide rates are the highest among the divorced, separated, and widowed and lowest among the married.**

* www.suicidology.org

SUICIDE: MASSACHUSETTS 2016 FACTS & FIGURES

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Massachusetts	596	8.25	49
Nationally	42,773	12.93	

Suicide is the **12th leading** cause of death overall in Massachusetts.



On average, one person dies by suicide **every 14.5 hours** in the state.



Based on most recent 2014 data from CDC

\$ Suicide cost Massachusetts a total of **\$728,322,000** of combined lifetime medical and work loss cost in 2010, or an average of **\$1,217,930** per suicide death.

IN MASSACHUSETTS, SUICIDE IS THE...

2nd leading cause of death for ages 15-34

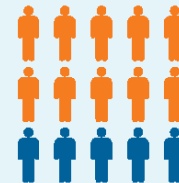
3rd leading cause of death for ages 10-14

4th leading cause of death for ages 35-54

8th leading cause of death for ages 55-64

19th leading cause of death for ages 65 & older

Five times as many die by suicide in Massachusetts annually than by homicide; the total deaths to suicide reflect a total of **11,665** years of potential life lost (YPLL) before age 65.




AMERICAN FOUNDATION FOR
Suicide Prevention

afsp.org

Massachusetts Statistics - 2013

- In 2013, there were 585 suicides that occurred in Massachusetts; a rate of 8.25/100,000.
- **The number of suicides was 3 times higher than homicides.**
- Most suicides occur in the middle age population: among individuals ages 45-54 years.
- **Suicides among males exceeded females by almost 4 to 1.**
- 585 completed suicides
- **7199 Emergency Department visits for self-inflicted injuries.**
- 4,388 Hospital Discharges for Self-Inflicted Injuries
- **MA Department of Public Health*



Risk and Protective Factors for Suicide

- Risk factors are variables strongly associated with suicide. Risk factors do not *cause suicide*.
- Protective factors are behaviors, characteristics, and other variables found to offset risk factors of suicide and precipitants of suicidal behavior. They contribute to feeling that life is worth living.



Risk Factors

- **Several conditions act as short-term risk factors:**
 - a sense of being a burden, helpless, not belonging, instability, agitation, panic, anxiety; relational conflict, aggression, and violence.
- **Impulsivity is linked to suicide risk because it makes it more likely that individuals will take on behaviors that increase the capability for lethal self-harm.**

Risk Factors for Suicide

- **A past suicide attempt and alcohol use are such strong risk factors that they almost qualify as “predictors” of suicide. They are present in many completed and attempted suicides. Other common risk factors are:**
 - Adult white male, Native American, veterans,
 - Poor coping, problem-solving, help-seeking
 - Intimate partner conflict, social isolation
 - Family history of suicide, mental disorder or *substance abuse
 - Family violence, including physical or sexual abuse
 - Firearms in the home or otherwise accessible
 - Legal charges, financial problems, incarceration
 - Physical illness and disability
 - Academic failure

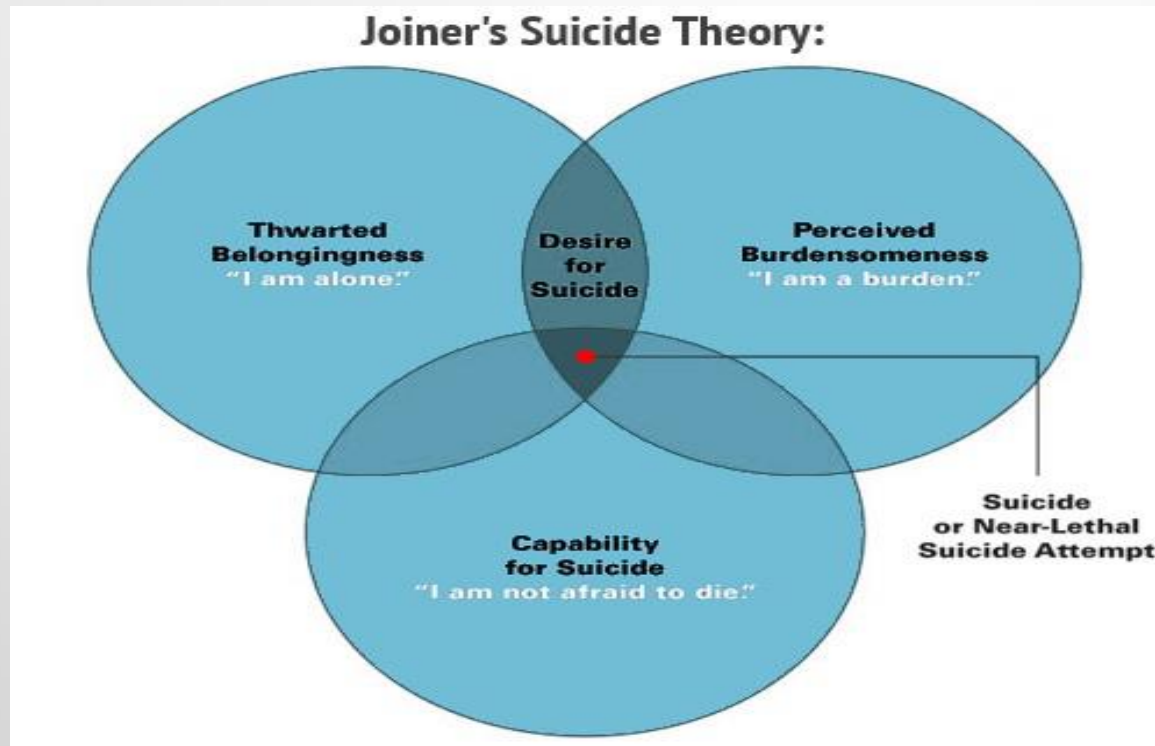
Protective Factors

The main protective factors for suicide:

- Strong family, social ties, support sources
- Optimism, resilience, life satisfaction, emotional stability
- Strong self-esteem, sense of self-worth
- Good problem-solving, coping skills, and willingness to seek help
- Religiosity, spirituality
- No firearms in household
- No alcohol or drug use
- Trusting relationship with provider
- Employment
- Childrearing responsibilities

Social support is a strong protective factor because it increases self-esteem and self-efficacy.

Suicide Model – Thomas Joiner



Danger/Warning
Signs

IS PATH WARM

- **I** Ideation
- **S** Substance Abuse
- **P** Purposelessness
- **A** Anxiety
- **T** Trapped
- **H** Hopelessness
- **W** Withdrawal
- **A** Anger
- **R** Recklessness
- **M** Mood Change

Danger/Warning Signs

- Threatening to hurt or kill self
- Looking for ways to kill self
- Talking or writing about death, dying, or suicide
- Talking about feeling hopeless, trapped, burden
- Increased use of alcohol
- Citing a doable plan specifying how and when
- Giving away valued possessions (e.g., pets, CDs, books, tools, money, etc.)
- Talking about seeking revenge
- Loss of interest
- Sleeping changes
- Making unexpected visits or calls to family members or friends
- Settling up affairs, making a will, dictating funeral arrangements

Asking the tough questions...

- Screening is the basic technique for finding suicide risk factors. It involves simple direct questioning. It requires training but not clinical skill or judgment. It does not evaluate or estimate an individual's level of suicide risk.
- Screening questions must be direct:
 - Have you ever thought about killing yourself?
 - Are you thinking about it right now?
 - Do you have a plan on how to kill yourself?
 - Do you have the means to carry out this plan?
 - Have you tried out or rehearsed your plan?
 - Have you ever attempted suicide?

More in depth risk assessment



All consuming versus fleeting thoughts



How specific is the plan?

Rescue factor
Insight into the severity situation/attempt



Recent attempt

Believed it would result in death
Feelings about being alive

Mitigating risk
(identifying risk/protective factors)



What impacts Communication?

- Development of emotions/responses
 - Anxiety, defensiveness, actions, calming
- Nonverbal and paraverbal communication
 - Personal space, body language, tone, volume, cadence
- Integrated experience – understanding our own anxiety, frustration, counter transference

Barriers to Treatment



DISCUSSION – WHY
DON'T PEOPLE GET
HELP???



CONNECTING WITH
CRISIS



FINAL THOUGHTS/
OPEN FORUM

Resources

- American Association of Suicidology
- Center for Disease Control and Prevention (CDC).
- Joiner, Thomas (2006). *Why people die by suicide*.
- Massachusetts Department of Public Health
 - www.mass.gov
- Substance Abuse and Mental Health Services Administration.



Thank You!

Verbal De-Escalation Techniques for Dispatchers

Western MA De-Escalation
Training Team

De-escalation Skills

- Presenter:



What is De-escalation?

De-escalation is less like a recipe or formula and more like a flexible set of options.

Not meant to replace all the training and experience that came before.

De-escalation will not always work.

What is Verbal De- escalation?

- Verbal de-escalation is used during potentially dangerous, or threatening, situation in an attempt to prevent persons from causing harm to us, themselves, or others

Goals of Verbal De-escalation

Open up clear lines of communication

Build trust and validate the individual's situation

Get the individual talking about his or her situation

Gathering the necessary information to create a positive resolution

The Logic of De- Escalation

If you take a LESS authoritative,
LESS controlling, LESS
confrontational approach, you
actually will have MORE control.



You are trying to give the
individual a sense that he or she
is in control.

What is a Behavioral Crisis?

- A crisis is a perception of an event or situation as an intolerable difficulty that exceeds the resources and coping mechanisms of the person



Vulnerable **Aggressive** Impulsive
Angry Sad **Hopeless**
Agitated
Anxiety **Suicidal** Alcohol Hatred
Psychosis Unable to Cope
Confused
Manic **Overload** Helpless
Stress Disorganized **FEAR**
DRUGS
Self Harm Powerless *Shame* Tension
Despair Doubt **RAGE** Fight
or Flight

What
does a
Crisis look
like?

Initial Presentation

- Be cognizant of all possible precipitants, life stressors, or other reasons for negative behaviors.
- What is the reason for the call?
- How is the individual behaving?

What's the Story?

- Frustration
- Unrealistic Expectations
- Family/Social Difficulties
- Mental Disorder
- Pain
- Medical Condition
- TBI
- Substance Use
- Past Trauma



Empathy

- Direct identification with, understanding of, and vicarious experience of another person's situation, feelings, and motives.
- “To my mind, empathy is in itself a healing agent . . . because it releases, it confirms, it brings even the most frightened person into the human race. If a person is understood, he or she belongs.” – Carl Rogers

Non-judgmental



Avoiding judgments based on one's personal and especially moral standards



Understanding



Acceptance and awareness

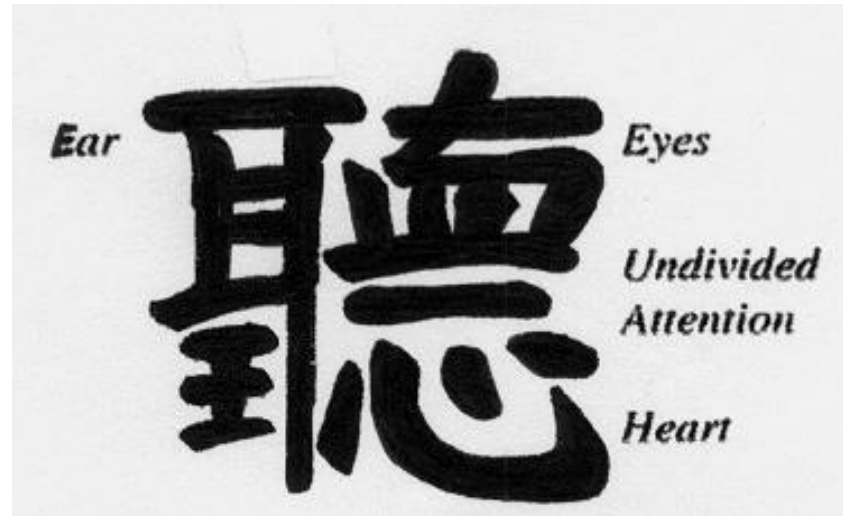
Active Listening



A conscious effort to hear not only the words that another person is saying but, more importantly, try to understand the complete message being sent.



Focus, Block out & Listen



The Chinese symbol for
listen: eyes, ear, heart

Barriers to Effective Communication

Barriers to communication are the things that keep the meaning of what is being said from being heard:

- Pre-judging
- Not listening
- Criticizing
- Name-calling
- Engaging in power struggles
- Ordering
- Threatening
- Minimizing
- Arguing





- # Verbal Techniques
- Voice
 - Tone – typically unconscious; attitude displayed or words inferred/unsaid but expressed
 - Volume – maintain even volume, do not raise volume to that of individual
 - Rate – speak slowly
 - Inflection – “May I help you?”, “Who are you waiting for?”, “I didn’t say you were stupid.”



Verbal Techniques

- Explain the process and procedures
- Simple, concrete responses/directions
- Set clear, reasonable limits when appropriate
- Utilize supportive statements

Verbal Techniques



Rephrasing, paraphrasing,
reflecting, summarization,
and clarifying questions



Open ended questions



Avoid "Why?" questions



Person centered speech: "I"
statements



Questions to Ask When Appropriate

- Does the individual need something (e.g., hungry, thirsty)?
- Is the individual receiving services; and if so where?
- Is the individual taking medication?
- When did the individual last take his or her medication?

Mistakes



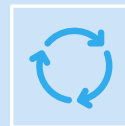
If you make a mistake (and you will) and the individual escalates:



Acknowledge: "I can see that mentioning your medication is a real sore point."



Apologize: "I'm sorry to have upset you. I didn't mean to."



Try Again: "I want to help, not upset you, so let's try something else."

QUESTIONS???





**SELF CARE FOR
DISPATCH
PROFESSIONALS**

A DAY IN THE LIFE

- <https://www.youtube.com/watch?v=497uMOa8oq0>

AS A DISPATCHER --

- You have to be constantly ready to respond
- Your brain and body are experiencing frequent repeated “rushes” of stress hormones (ACTH and Cortisol)
- These are intended to help you deal with the immediate situation BUT over the long haul they can leave you

READY TO SNAP



Download from
Dreamstime.com

This watermark-free image is for previewing purposes only.



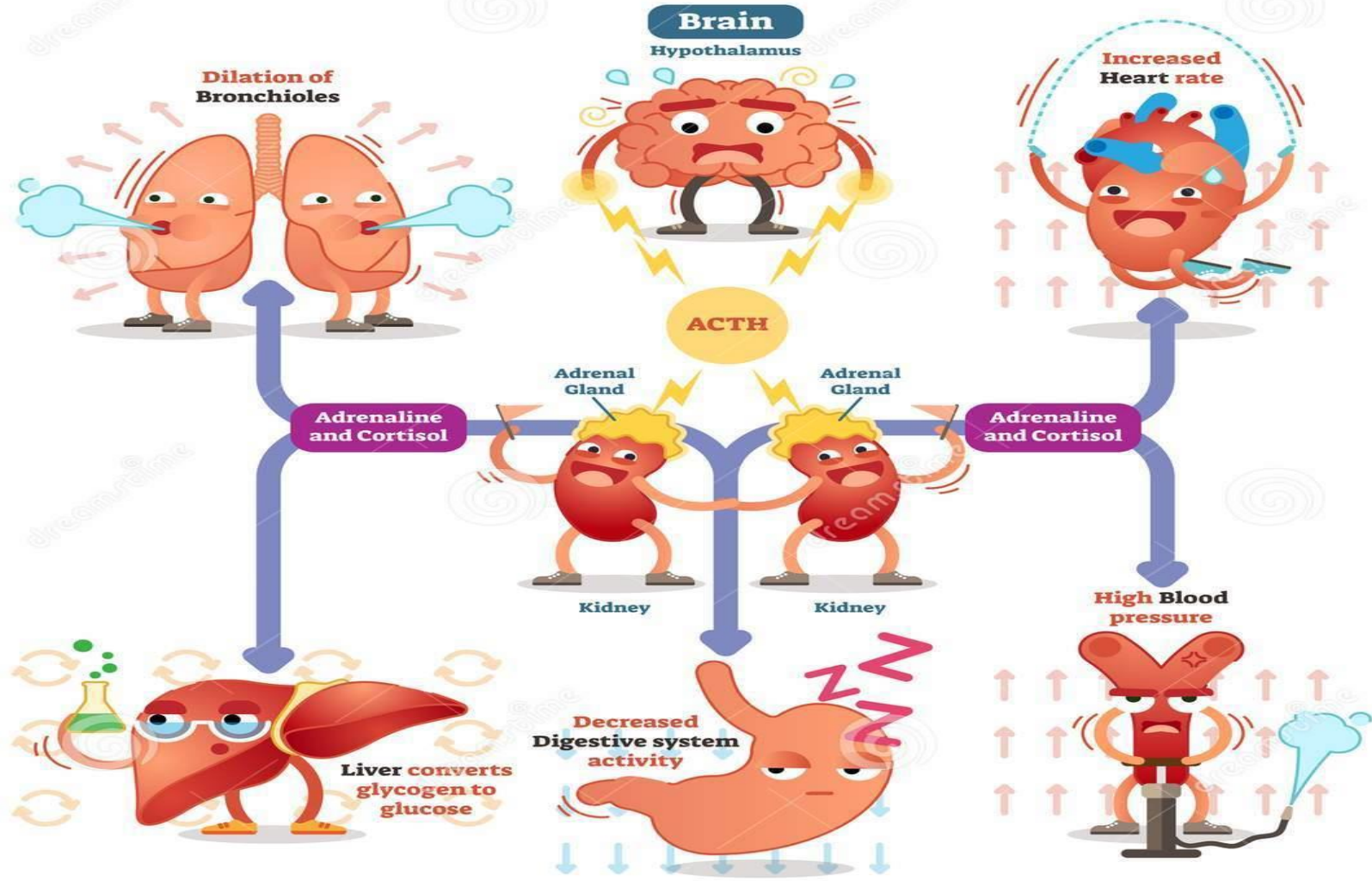
 89946835

 Spyros Arsenis | Dreamstime.com

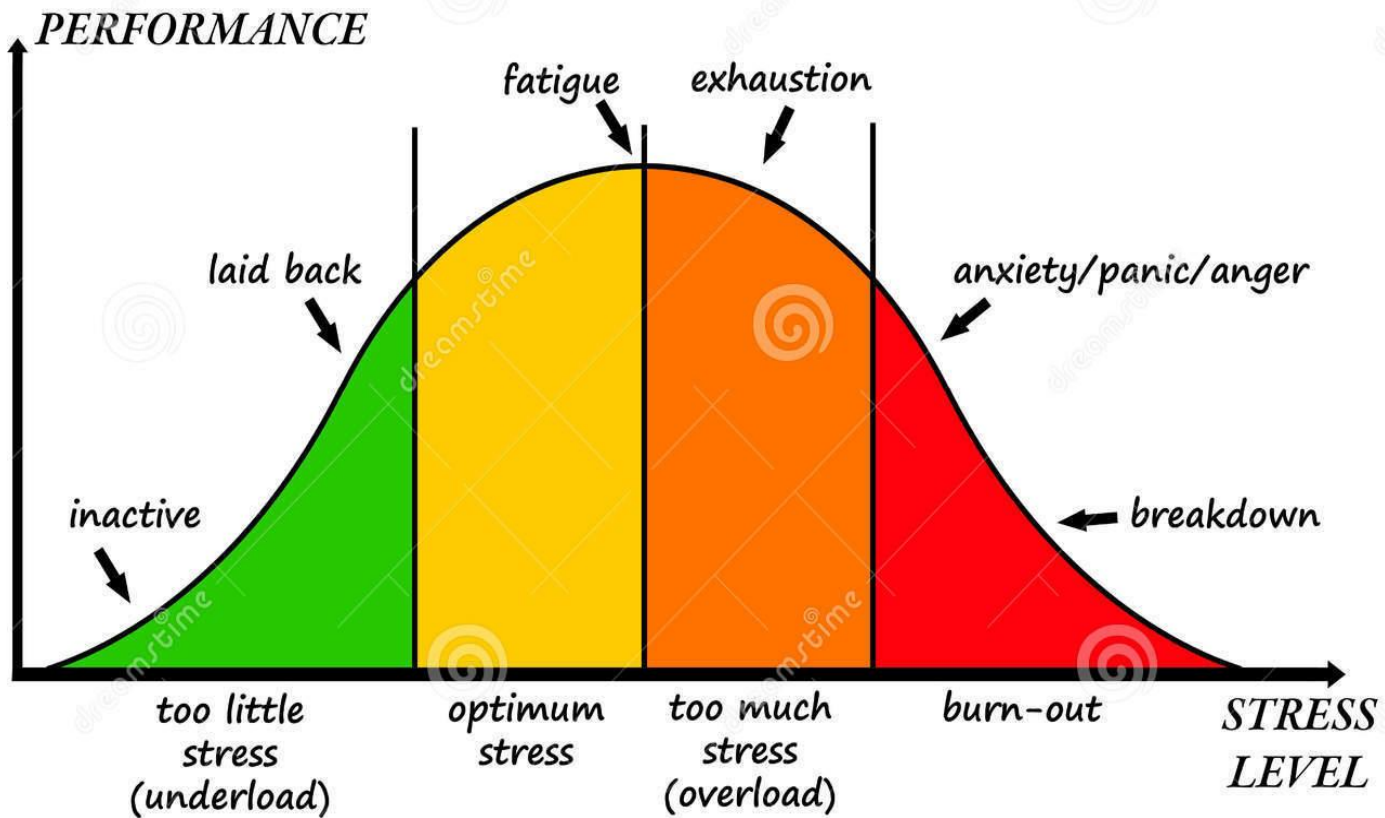
BUT WHY?

- Here's your brain on stress --

STRESS RESPONSE SYSTEM



STRESS CURVE



FIGHT, FLIGHT, FREEZE, OR ... RELAX?

- What is the Relaxation Response?
- The counterpart to the "fight/flight/freeze" response
- Naturally occurs when the body is no longer in perceived danger, and the autonomic nervous system functioning returns to normal.

WHAT IS ACUTE STRESS?

- Acute Stress Disorder (ASD) ASD refers to clinically significant symptoms occurring more than two days but less than one month after exposure to a trauma

WHAT IS CHRONIC STRESS?

- Chronic Stress Response - Ongoing activation of (or failure to resolve) the stress response. This chronic state can lead to impaired personal functioning and numerous physical diseases and psychological disorders.

WHAT ARE THE MOST COMMON STRESS SYMPTOMS FOR DISPATCHERS?

- **“Hypervigilance”** – can’t calm down or relax, can’t focus, problems falling or staying asleep
- **Weight gain** – long hours working (& sitting), stress eating
- **Physical symptoms** – muscle aches, backache, headache, digestive issues

LET'S TALK ABOUT SELF-CARE

- Self Care is not an acknowledgment of weakness.
- It's a way of drawing on, and building, your inner strength.

REMEMBER -

You can't pour from
an empty cup.

You need to take
care of yourself.



HOW TO TURN ON THE RELAXATION RESPONSE

- The relaxation response can be induced through techniques that relax your body or your mind.
- What are the most common techniques?

LEARNING TO BREATHE

- Simple deep breathing exercise can disrupt the body's stress response
- Many of us practice mainly shallow breathing – this leads to a decreased flow of oxygen to the brain
- Focused Breathing can be used anywhere and at pretty much any time to re-center yourself and at least prevent a stress-fueled response

WHY THIS WORKS

- Feeling overwhelmed can lead to frustration
- Frustration leads to – burnout – leads to decreased performance – leads to increased frustration - and make you just want to give up

BUT -

- Setting your own priorities gives back a sense of control
- checking off one task at a time can decrease that overwhelmed feeling

WHAT IS COMPASSION FATIGUE?

- 16% of dispatchers report symptoms consistent with Compassion fatigue

DEFINITION -

- **Compassion Fatigue:** (Figley, 1995) The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events.

EMOTIONAL SYMPTOMS INCLUDE

- Hypervigilance – “I can’t relax”
- Hopelessness – “I give up”
- Guilt – “I should have done better”

WHICH CAN LEAD TO -

- Impaired self-esteem – “I’m not good enough”
- Desensitization, cynicism – “your trauma is no big deal to me”
- Disconnection – “I really don’t care how this turns out”

THERE ARE PHYSICAL SYMPTOMS, TOO -

- Decreased Immunity

- Decreased Immunity
- Appetite disturbance, weight gain or loss
- Chronic indigestion, ulcers
- Physical problems – headache, back pain
- Sleep problems “I’m always exhausted”; “I wake up in the middle of the night thinking about work”

MANAGE YOUR EXPECTATIONS

- “The bigger the gap between your expectations and reality, the greater the stress” – Adam Timm

- <https://www.policeone.com/communications/videos/5955773-Give-closure-to-dispatchers-after-critical-incidents/>

WHAT'S THE BOTTOM LINE?

Put On Your Own Oxygen Mask
Before Helping Those Around You



REFERENCES

Journal of Emergency Dispatch
July/August 2016 – “Coming
Together on the 911 Stress
Front”

Adam Timm & Joe Serio,
Dispatcher Stress:50 Lessons
on Beathing the Burnout. LED
(Law Enforcement
Development) Training
Publications. 2015



Herbert Benson, MD:
The Relaxation
Response



Harvard Health
Publishing, Harvard
Medical School, “Breath
Control Helps Quell
Errant Stress Response”

- The End of Stress: Rewiring Your Brain for Success, Health, and Happiness – Don Joseph Goewey
- Better Health Channel
www.betterhealth.vic.gov.au
- www.CopsAlive.com November 2008

REFERENCES

- “De-Escalation Begins with Understanding your Brain, Stress & Emotional Intelligence”
– Phoenix PD, Fountain Hills AZ Dept of Pediatrics & Internal Medicine, Centerpoint for Hope: CIT Int’l Conference presentation 2017

REFERENCES

- WebMD
- MayoClinic
- Dirk Vernon, LMHC, Program Director, Therapeutic Mentoring Service, BHN
“Vicarious Trauma & Self Care for Behavioral Health Professionals”