DAY 4 – CIT TRAINING

8:00-9:00am	**Psychological Trauma** – Amber Robinson-Green, PsyD, DFP (Designated Forensic Psychologist), Adult Court Clinic
9:00-10:30am	**Suicide Prevention** – Sarah Gaer
10:30am- 12:00pm	**ALEC – Autism and law Enforcement Education Coalition** – Sgt. Melissa Lyman

Psychological Trauma

AMBER ROBINSON GREEN, PSY.D, DFP

LICENSED PSYCHOLOGIST
DESIGNATED FORENSIC PSYCHOLOGIST

The Basics - We know this!

- Trauma –damage to the mind - an emotional response – to a distressing event or events. Trauma is person specific and can occur when stress level exceeds person's ability to cope and integrate the emotions associated with traumatic event. Sense of helpless in the face of one's emotional and physical safety/wellbeing.

  i.e. - witnessing a terrible event, being the victim of interpersonal violence, natural disasters, car accidents and injury, loss of a loved one, public humiliation…..other ideas ???

Studies have shown that interpersonal trauma can be more damaging than natural disasters etc. WHY???

Prevalence of trauma

Who here has experienced an event that they consider to be traumatic?

The majority of Americans – 70% - of people experience an event or events that would be considered traumatic.

Risk factors – men, youth, history of prior trauma (sexual trauma), occupation (military, police), history of childhood conduct disorder, familial psychiatric history, personal characteristics such as extroversion, high crime neighborhoods

Police Work is Dangerous

Complex Trauma

Complex Trauma describes children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect.

- Needs are not fulfilled, attachments are not formed
- Life is seen as unpredictable
- World is not a safe place – survival, me vs. the world
- Early attachment pioneers / Bowlby and Ainsworth – It's basically the mother's fault!!!

* handout - New Yorker article

Adverse Childhood Experiences

Adverse Childhood Experiences (ACE) Study - decade-long and ongoing study designed to examine the childhood origins leading to health and social problems.

Key concept underlying the Study is that stressful or traumatic childhood experiences (abuse, neglect, witnessing domestic violence, or growing up with alcohol or other substance abuse, mental illness, parental discord, or crime in the home) lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality.

* Handout – ACES

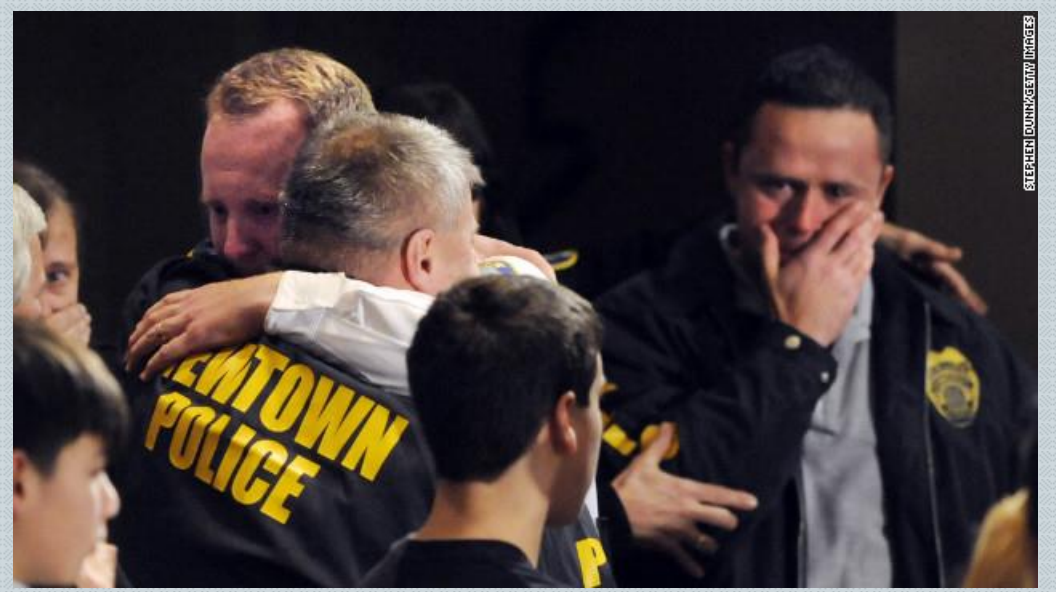
How Does Trauma Affect You?

The more categories of trauma experienced in childhood, the more likely one experiences the following…..

- **adolescent health**
- **teen pregnancy**
- **smoking**
- **alcohol abuse**
- **illicit drug abuse**
- **problem sexual behavior**
- **mental health problems**
- **risk of revictimization**
- **lack of stability of relationships**
- **poor performance in the workforce**

These behaviors lead to increased risk for heart disease, Chronic Lung disease, Liver disease, Suicide, Injuries-HIV and STDs Diabetes

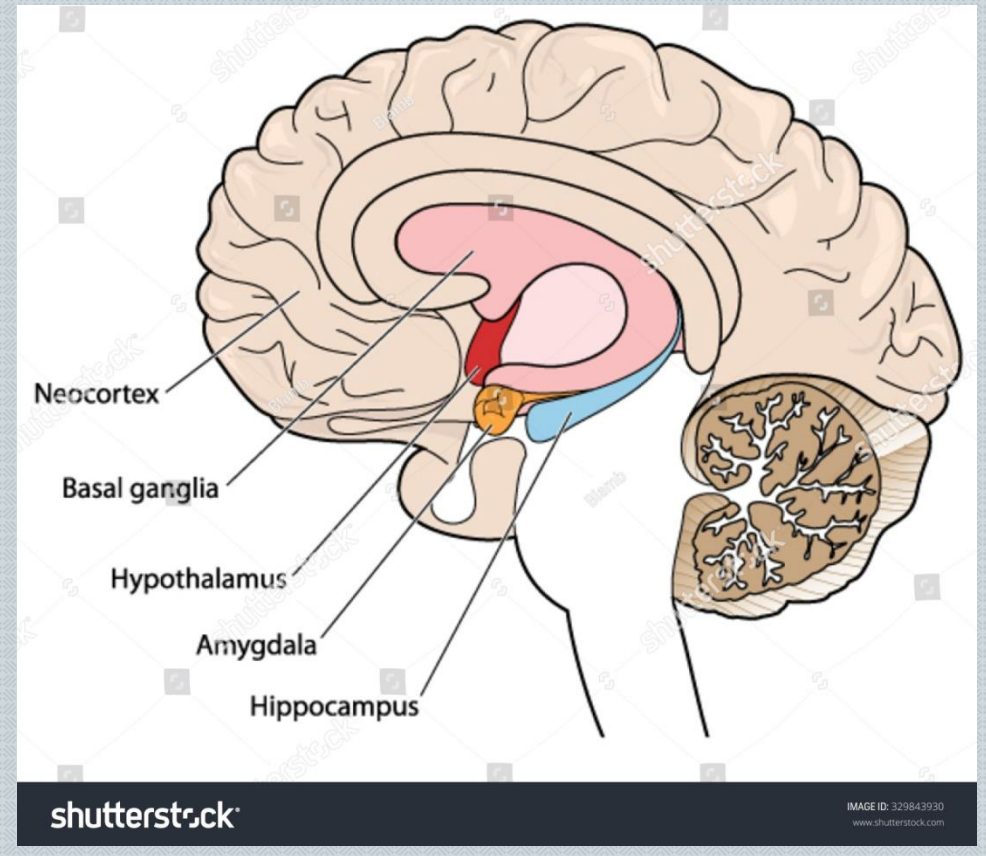
Are you allowed to feel the pain?



Neurological Response to Threat

Humans have an automatic response to threat that is common to all animals

Threat is processed in the lower, primitive part of the brain – amygdala which is a part of limbic system



Fight Flight Freeze

- When a threat occurs, the reptilian brain makes an immediate decision whether to fight, flee, or freeze.
- The reptilian brain learns from prior threats and over generalizes to keep you safe.
- ***Training and life experience can override these automatic impulses.***

Everybody is different

Severity and type of trauma, interpersonal trauma vs. accidental – sense of betrayal

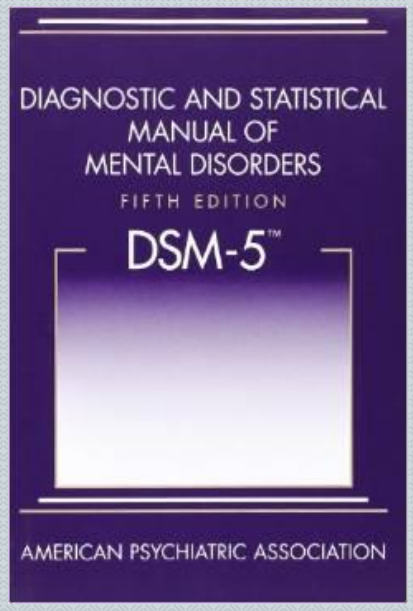
One time event or chronic underlying mental health condition

May not meet diagnostic classification for PTSD but….

Many other psychological problems can occur, depression, panic disorder, other anxiety disorders. Not just PTSD!

A diagnosis

It is natural to feel afraid. Fear triggers a "fight-or-flight" response – a typical reaction meant to protect a person from harm. Most people recover from initial trauma symptoms naturally. Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened even when they are not in danger.



PTSD **criteria**

Intrusive Symptoms

- Re-experiencing
  - Nightmares
  - Dissociative reactions including flashbacks – sensory triggers
  - Intrusive thoughts
- Intense or prolonged distress after exposure to traumatic reminders
- Marked physiologic reactivity after exposure to trauma-related stimuli

Avoidance - Persistent effortful avoidance of trauma-related stimulus

- Trauma-related thoughts or feelings
- Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

PTSD Criteria

Dissociation

Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).

Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

PTSD Criteria

Negative alterations in cognitions and mood

- Inability to recall key features of the traumatic event
- Persistent negative belief about self and world
- Persistent distorted blame on self or others for trauma
- Persistent negative trauma related emotions (fear, guilt, sadness, shame, or confusion)
- Lack of interest in activities
- Feelings of alienation
- Inability to feel positive emotions

Alterations in arousal and reactivity

- Central nervous system arousal
  - Trouble sleeping
  - Irritability
  - Reckless or self-destructive behavior
  - Exaggerated startle response
  - Poor concentration

Biological Perspectives

In PTSD multiple neurobiological systems are dysregualted and maladaptive

Brain Regions (prefrontal cortex, amygdala, hippocampus, dorsal raphe nucleus, locus coeruleus) In child brain - disruption to actual cognitive development

Neutrotransmitter/ Neurohormomonal System (Noradrenergic, Serotonergic, Hipothalamic-Pituitary-Adrenal axis (HPA axis)

What have you seen in your work?

Presentation # 2

9:00-10:30am

Suicide Prevention

Sarah Gaer

QPR: QUESTION, PERSUADE, REFER

Sarah Gaer, MA
Suicide Prevention & Trauma Response Consultant
QPR Master Trainer

WHAT TO EXPECT

Overview of Suicide and Risk

Learn how to ask someone about suicidal intensity

Learn how to persuade them to get the support that they need

Learn how to refer them to resources

Identify Resources available

Consider the importance of self care

TRAINING EXPECTATIONS: SUICIDE IS A SENSITIVE TOPIC

1. Please be sensitive to the experiences of others
2. Please be willing to reconsider your beliefs
3. Please take care of yourself: If you need a break, take it but please come back.
4. Please do not throw objects at your trainer.

FOR ATTEMPT & LOSS SURVIVORS:

THANK YOU FOR BEING HERE!

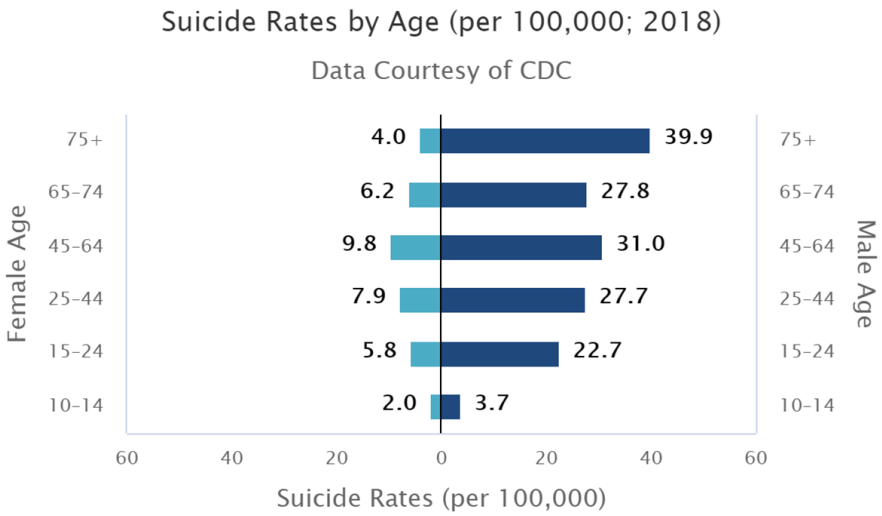
Activation of Memories

- Tyranny of Hindsight
- Challenging of current coping mechanisms: Anger, denial

PREFERRED LANGUAGE

- Suicidal thoughts vs Suicidal Intensity
- Committed, Completed vs died by suicide
- Successful vs Failed
- Serious vs level of lethality
- Attention seeking vs Attention needing

SUICIDE RATES BY AGE & GENDER



White men are at the highest risk – making up nearly 70% of all suicides

Men in the Middle Years are highest risk age/gender

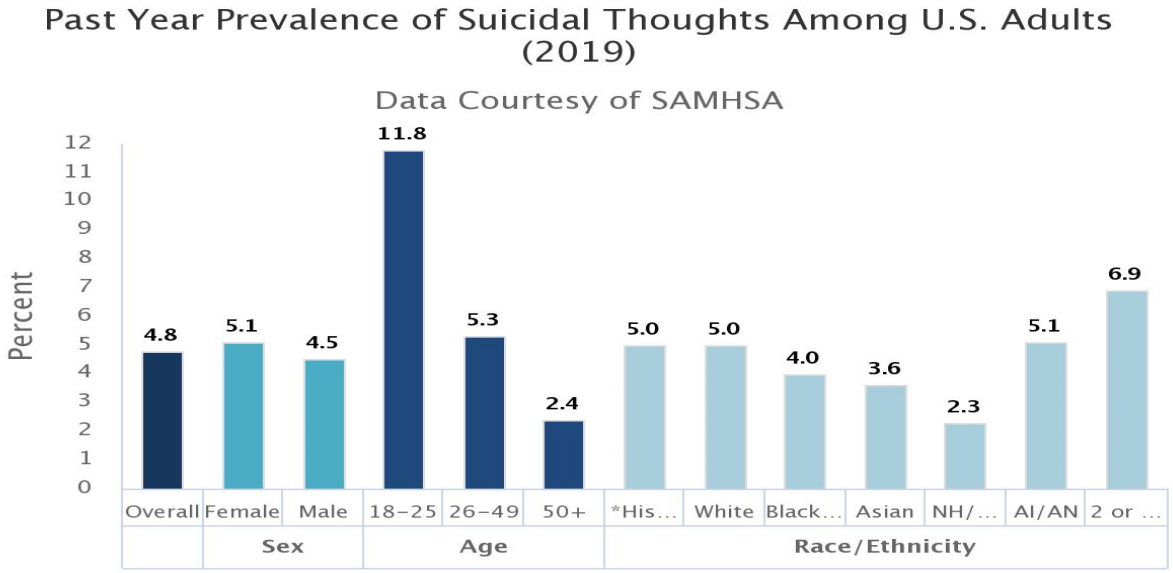
Black women are lowest risk demographic

For children: Black male children are the highest risk

Recent years there have been spikes in suicide deaths among LatinX men and attempts among LatinX female youth

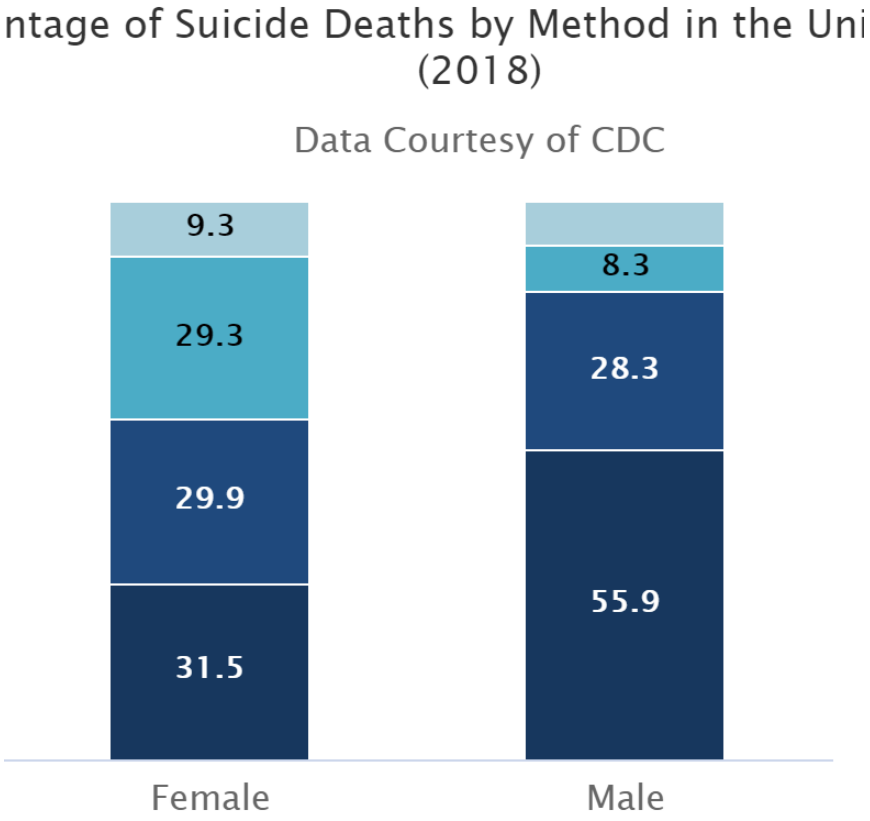
Nearly ½ of all transgender people will make a suicide attempt at some time during their lifespan

AND RESEARCH INDICATES THESE NUMBERS ARE ON THE RISE……..



WHAT EXPLAINS THE DISCREPANCY?

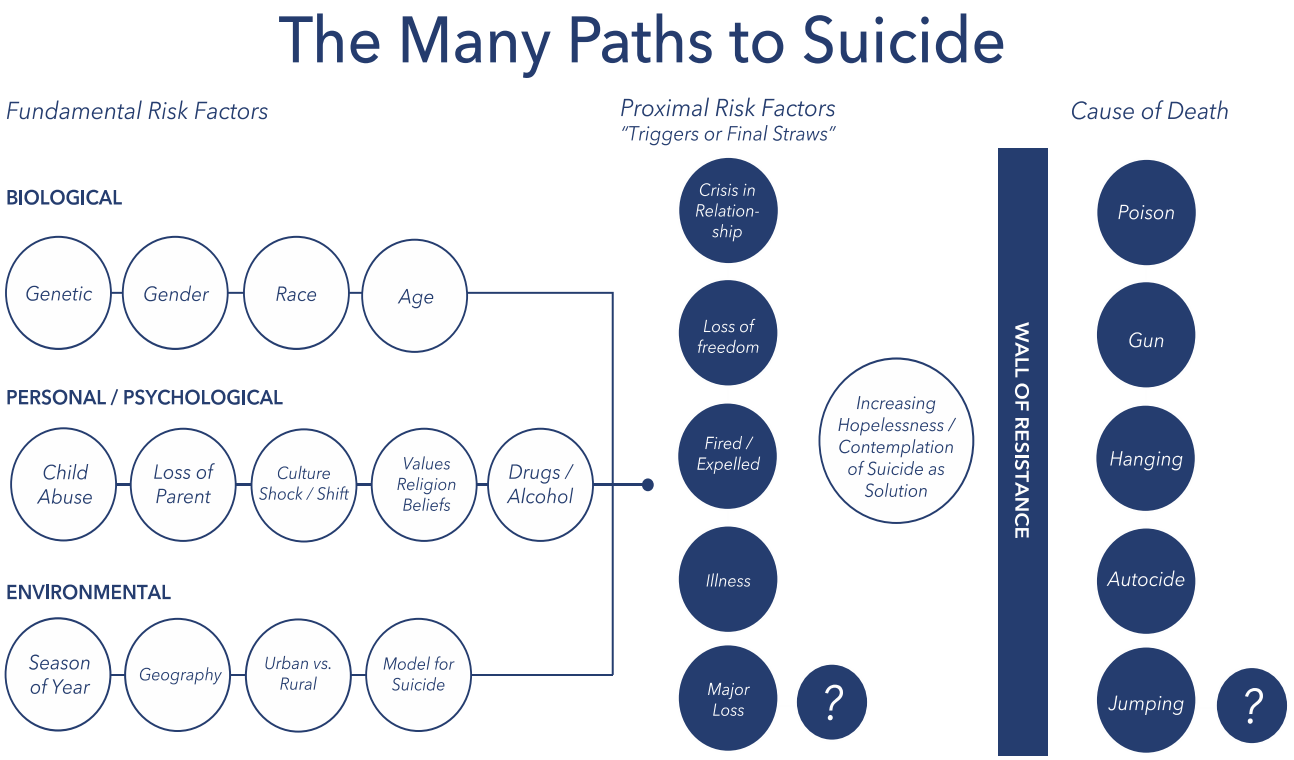
Access to lethal means!



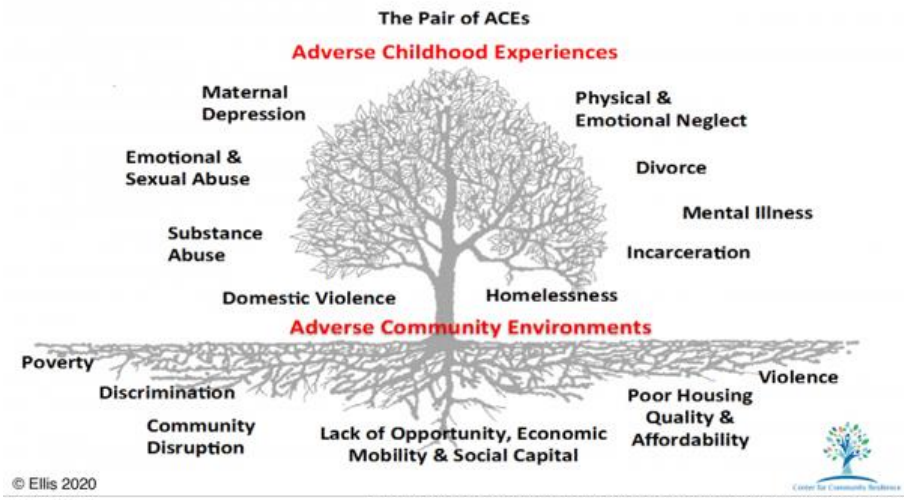
MOST IMPORTANT THING I AM GOING TO SAY……

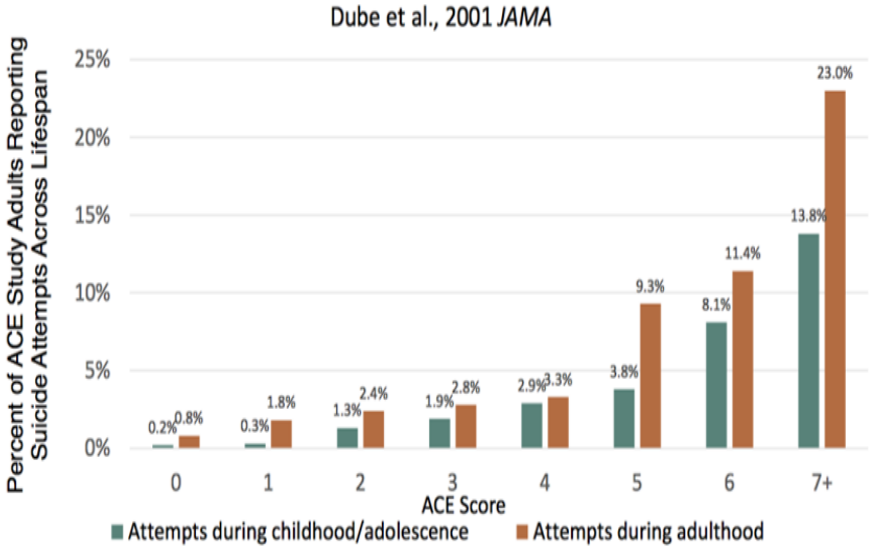
Suicide is a multi-factorial event. It is almost never caused by only one thing or event.

SUICIDE AS A MULTI-FACTORIAL EVENT



INVISIBLE RISK: ADVERSE CHILDHOOD EXPERIENCES





QPR: WHAT DOES IT STAND FOR?

Q = Question

P = Persuade

R = Refer

QPR

QPR is not intended to be a form of counseling or treatment.

QPR is intended to offer hope through positive action.

SUICIDE: MYTHS AND FACTS

- **Myth** No one can stop a suicide, it is inevitable.
- **Fact** If people in a crisis get the help they need, they will probably never be suicidal again.
- **Myth** Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact** Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.
- **Myth** Only experts can prevent suicide.
- **Fact** Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide

How can I help? Ask the question.

MYTHS AND FACTS (CONT)

- **Myth** Suicidal people keep their plans to themselves.
- **Fact** Most suicidal people communicate their intent sometime during the week preceding their attempt.
- **Myth** Those who talk about suicide don't do it.
- **Fact** People who talk about suicide may try, or even complete, an act of self-destruction..
- **Myth** Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact** Suicide is the most preventable kind of death, and almost any positive action may save a life.

How can I help? Ask the Question.

SUICIDE CLUES & WARNING SIGNS

The more clues and signs observed, the greater the risk.

Take all signs <u>seriously.</u>

DIRECT VERBAL CLUES

- “I’ve decided to kill myself.”
- “I wish I were dead.”
- “I’m going to commit suicide.”
- “I’m going to end it all.”
- “If (such and such) doesn’t happen, I’ll kill myself.”

INDIRECT VERBAL CLUES

- “I’m tired of life, I just can’t go on.”
- “My family would be better off without me.”
- “Who cares if I’m dead anyway.”
- “I just want out.”
- “I won’t be around much longer.”
- “Pretty soon you won’t have to worry about me.”

BEHAVIORAL CLUES

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability

SITUATIONAL CLUES

- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a spouse, child, or best friend, especially if by suicide
- Diagnosis of a serious or terminal illness
- Sudden unexpected loss of freedom/fear of punishment
- Anticipated loss of financial security
- Loss of a cherished therapist, counselor or teacher
- Fear of becoming a burden to others

TIPS FOR ASKING THE SUICIDE QUESTION

- If in doubt, don't wait, ask the question
- If the person is reluctant, be persistent
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; QPR Card, phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important that that you ask it!

Q: QUESTION

Less Direct Approach:

- “Have you been unhappy lately?
  Have you been very unhappy lately?
  Have you been so very unhappy lately that you’ve been
  thinking about ending your life?”

- “Do you ever wish you could go to sleep and never wake
  up?”

Q: QUESTION

Direct Approach:

- "You know, when people are as upset as you seem to be,
  they sometimes wish they were dead. I'm wondering if
  you're feeling that way, too?"

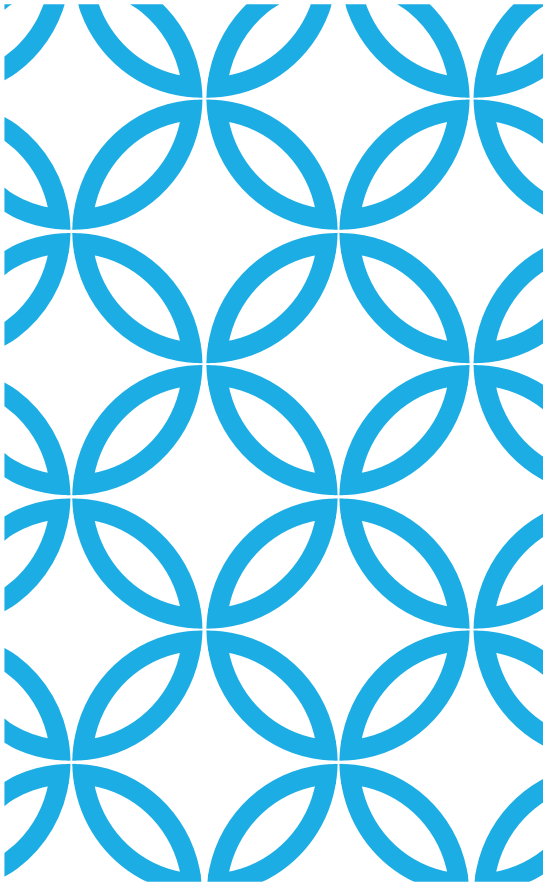
- "You seem really upset; I wonder if you're thinking
  about suicide?"
- "Are you thinking about killing yourself?"

* Note: If you cannot ask the question, find someone who can!

Q: QUESTION

How NOT to ask the suicide question:

- "You're not thinking of killing yourself, are you?"
- "You wouldn't do anything stupid would you?"
- "Suicide is a dumb idea. Surely, you're not thinking about suicide?"



KEY POINT!

If someone says they are suicidal, NEVER leave them alone!

P:PERSUADE

How to Persuade someone to stay alive

- Listen to the problem and give them your full attention
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

P: PERSUADE

Then Ask:

- "Will you go with me to get help?"
- "Will you let me help you get help?"
- "Will you promise me not to kill yourself until we've found some help?"

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE AND MAKE ALL THE DIFFERENCE.

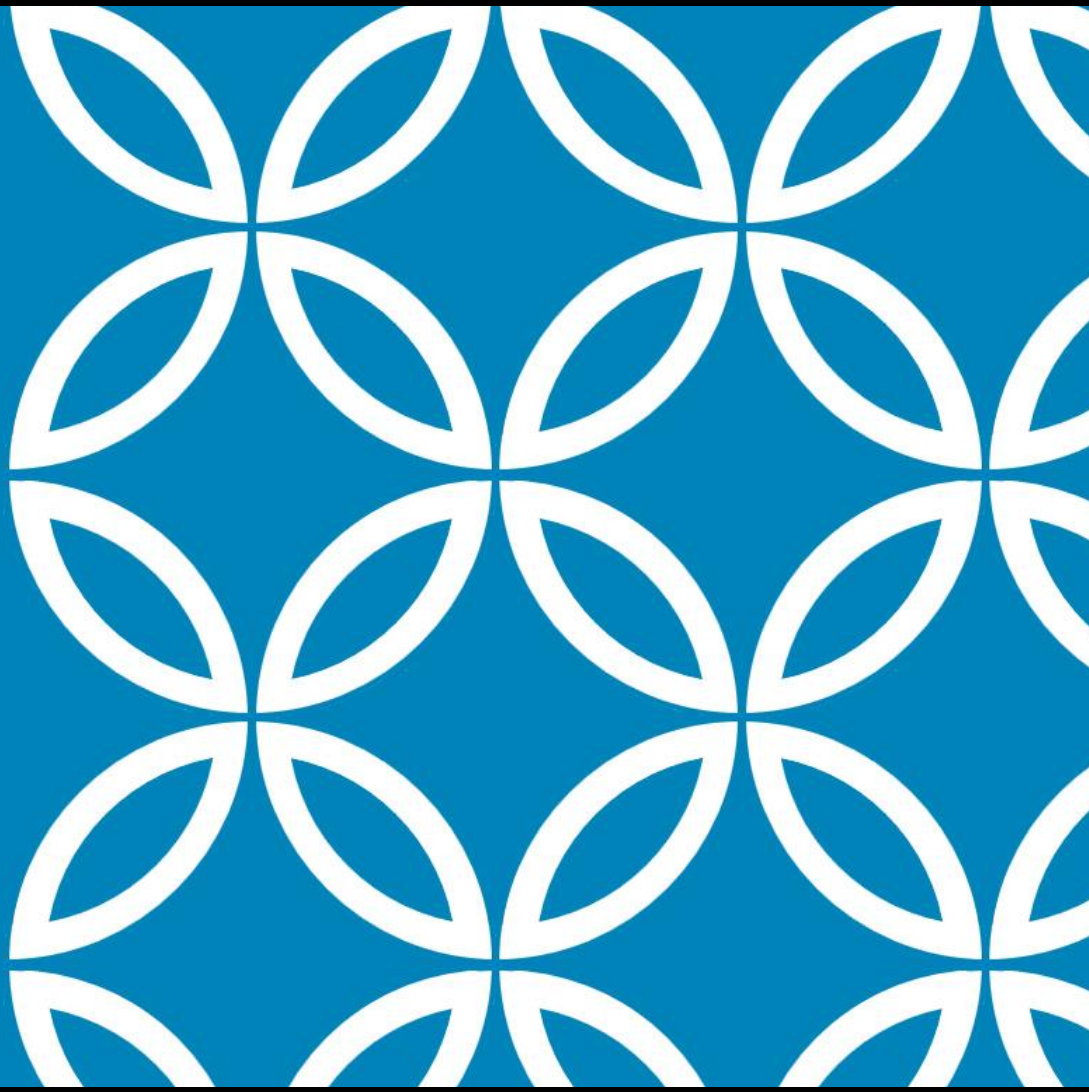
R: REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help.
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

REMEMBER

Since almost all efforts to persuade someone to live

instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.



FOR EFFECTIVE QPR

Say: “I want you to live,” or “I’m on your side…we’ll get through this.”

Get Others Involved. Ask the person who else might help. Family? Friends? Brothers? Sisters? Pastors? Priest? Rabbi? Bishop? Physician?

FOR EFFECTIVE QPR (CONT)

Join a Team. Offer to work with clergy, therapists, psychiatrists or whomever is going to provide the counseling or treatment.

Follow up with a visit, a phone call or a card, and in whatever way feels comfortable to you, let the person know you care about what happens to them. Caring may save a life.

REMEMBER

WHEN YOU APPLY QPR, YOU PLANT THE SEEDS OF HOPE. HOPE HELPS PREVENT SUICIDE.

RESOURCES:

National Suicide Prevention Lifeline: 1-800-273-TALK

Text Line: 741741

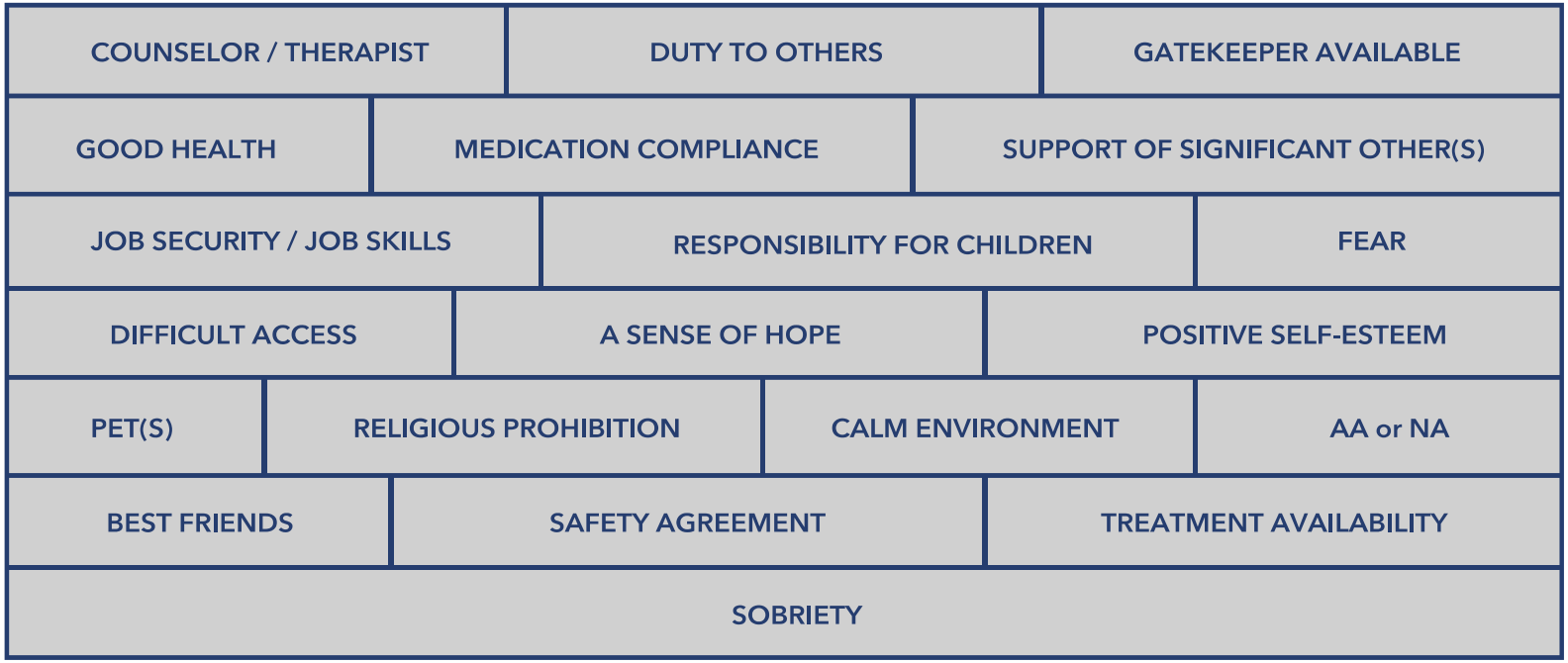
suicidepreventionlifeline.org

Trevor Project (LGBTQ) https://thetrevorproject.org

Hey Sam – Youth – 24years of age. Peer Support Text Line 9am-9pm 1-877-832-0890

Wall of Resistance to Suicide

Protective Factors

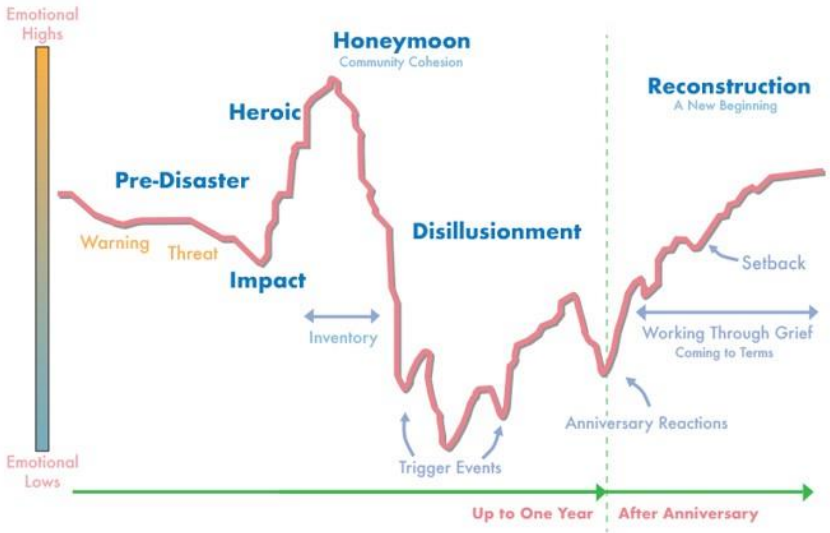


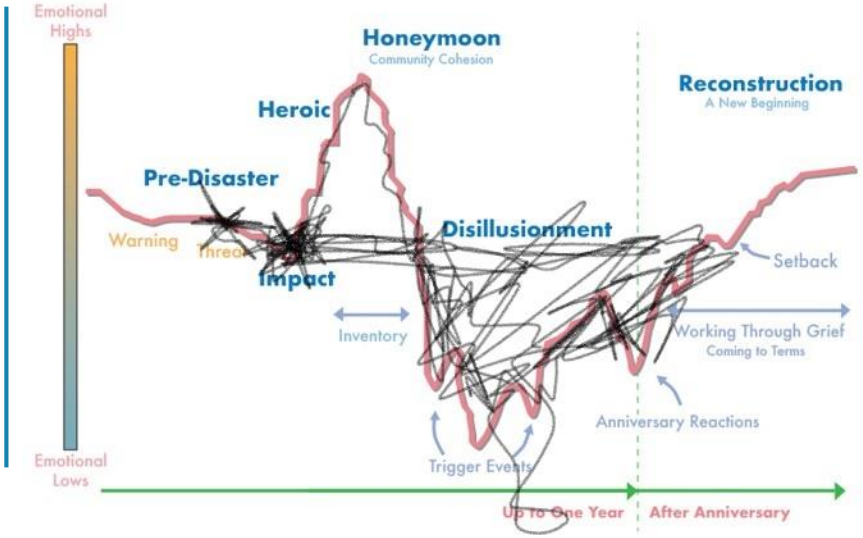
SELF CARE AS A NECESSITY

Interacting with someone who is potential experiencing suicidal intensity can be frightening, frustrating, exhausting and very sad.

It is extremely important that you create your own support system.

And pay special attention to your body and personal needs. Exercise, healthy eating & social connection



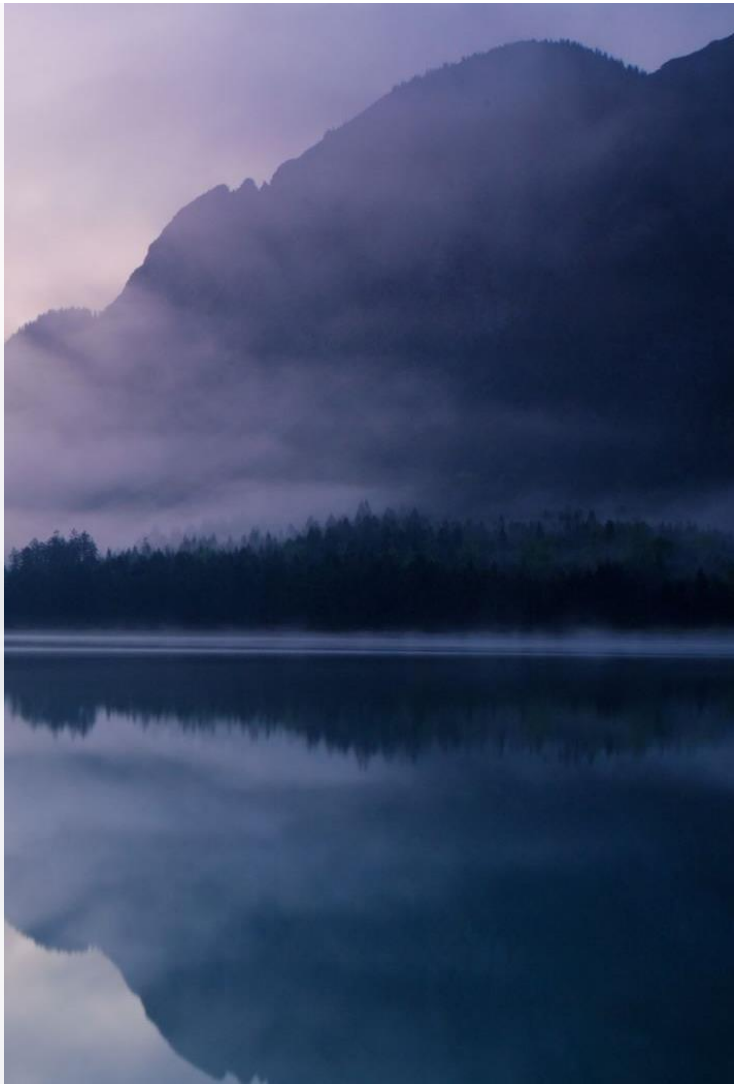


COVID 19

Community/Global Soul Exhaustion

SOUL CARE

Culture	Art	Nature
Meaning	Joy	Friendship
Creativity	Self-expression	Spirituality



Twitter: @SarahGaer

Facebook: Sarah Gaer

LinkedIn: Sarah Gaer

Email: Sarahgaer@gmail.com

Books – available on Amazon

Suicide Prevention & Postvention:

The Price

Guts. Grit & The Grind – Series 1-4

Adverse Childhood Experiences Children's Book:
Good Night Grace

SarahGaer.com

QUESTIONS

PRESENTATION # 3

10:30am- 12:00pm

ALEC – Autism and law Enforcement Education Coalition

Sgt. Melissa Lyman

Mental Health Issues in Older Adults

JENNIFER COX, LICSW
BAYSTATE HEALTH

Mental Illness vs. Cognitive Impairment

- After about age 70 (sometimes earlier) what looks like mental illness is often really a neurological problem with psychiatric symptoms
- Older adults are more likely than other populations to experience psychiatric symptoms related to
  - Delirium
  - Medication interactions
  - Confusion or agitation related to infection or medical condition
  - Dementia (many different types, some with hallucinations and delusions)
  - Increased anxiety and fear due to confusion or memory problems

Living with cognitive impairment

- Dementia is not just a “memory problem”. Domains that are affected
  - Sensory/motor input
  - Problem solving, sequencing and sorting
  - Wayfinding and navigation
  - Facial recognition
  - Incorrect (delusional) beliefs about themselves or their situation
  - Errors in judgement
  - Ability to predict consequences of actions or solve multi-step problems

It's all in your approach

- Never contradict or "reorient" a confused older adult
- Ask for permission to enter personal space
- Use a supportive stance with room
- Join with and validate the older adult's experience
- Engage in emotional mirroring even when it doesn't make sense
- Try and reach a collaborative solution
- "therapeutic fibbing" is fine
- Utilize the hand-over-hand technique when possible

Communication strategies

- Ensure you engage eye contact first, using the person's name
- Speak slowly and eliminate unnecessary words and phrases – pause longer between words and sentences than you think you need to
- Ask failure-free questions, and provide information when you can. Don't use open ended questions or ask someone to explain a situation
- Try and use a gentle tone of voice, even when a person is extremely agitated. Keep in mind that most aggressive behavior in older adults is rooted in fear.

PRESENATTION # 5

2:00-3:00pm

Mental Health Disorders

Karen Collins, M.A., M.Ed., M.S., Clinician,
Gandara Family Support & Stabilization (FSS)

Mental Health Significance to Law-Enforcement:
Police Officers /Correctional Officers

Karen Collins, M.Ed., Clinician

Gandara Family Support & Stabilization (FSS)

April 7, 2022

Agenda

- Mental History/Overview
- Mental Disorders: Signs/Symptoms
- Co-occurring Disorders
- Mental Health Knowledge Importance for Law- Enforcements/Correctional Officers
- Treatment/Crisis Intervention/Medication
- Summary

History: Overview

- The origin of the mental hygiene movement can be attributed to the work of Clifford Beers in the United States, born in New Haven, CT in 1876
- In 1908 he published a book “A Mind that Found itself (the book based on his personal of admissions to three mental health hospitals)
- Mental Health Hygiene was established in Connecticut in 1908
- From 1909 onwards the internationalization of activities led to the creation of National Associations concerned with mental hygiene, in France, South Africa and Italy in 1920 and Hungary in 1924.
- From these National Associations the International Committee on Mental Hygiene was created and later superseded by the World Federations of Mental Health
- By 1937 the U.S. National Committee for Mental Hygiene stated that it sought to achieve its purposes by
  - promoting early diagnosis and treatment
  - Developing adequate hospitalization
  - Stimulating research
  - Securing public understanding and support of psychiatric and mental hygiene activities
  - Instructing individuals and groups
  - Cooperating with governmental and private agencies whose work touches at any point the field of mental hygiene
- In 2001, the WHO dedicated its annual report (The World Health Report – Mental Health: new knowledge, new hope) to mental health (Ellis et al., 2021)

Mental Health: Societal Prevalence

Research shows that as many as 1 in 4 Americans will experience a mental health problem or will misuse alcohol or drugs in their lifetimes.

These disorders are among the most highly stigmatized health conditions in the United States, and they remain barriers to full participation in society in areas as basic as education, housing and employment.

Improving the lives of people with mental health and substance abuse disorder has been a priority in the United States for more than 50 years.

The Community Mental Health Act of 1963 is considered a major turning point in America's efforts to improve behavioral healthcare

It ushered in an era of optimism and hope and laid the groundwork for the consumer movement and new models of recovery.

The consumer movement gave voice to people with mental and substance use disorders and brought their perspectives and experience into national discussions about mental health

Common Mental Health Disorders that Affect Behavior

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) places mental disorders in discrete categories on the basis of clinical signs and symptoms

- Mood disorders
- Psychotic disorders
- Anxiety disorders
- Trauma Related Disorders
- Personality disorders
- Substance Use Disorder

Mood Disorder: The Signs/Symptoms

According to the Mayo Clinic:

- General emotional state or mood is distorted, inconsistent with your circumstances and interferes with your ability to function
- Extremely sad, feeling empty inside, irritable with everything
- Depressed or alternating mood with being excessively happy (mania)
- Mood disorder may increase risk of suicide

According the DSM-5 Diagnostic and Statistical Manual of Mental Disorder:

- Feelings of intense sadness, feeling hopeless, empty, depressed, excessive guilt

- What cause a Mood Disorder:
  - Many factors an imbalance of the brain chemicals, irritability, hostility, agreesion
  - Life events: stressful life changes
  - Runs in a family, sensitive to failure or rejection
  - Decrease energy
  - Relationship or loss of employment,

Psychotic Disorder: The signs/symptoms

- Social misconduct
  - Intimidating, threatening, coercing, hate speech, safety
- Schizophrenia
  - Delusions / hallucinations
  - People who show bizarre behaviors
  - Disorganized thinking and speech
  - Unusual or Unpredictable mental health behaviors
- Substance/Medication-Induced Psychotic Disorder
  - Withdrawal of substance use (bugs crawling in my skin or my spouse is trying to prison me)
  - A schizophrenic episode triggered by substance use
  - Many people abuse methamphetamines experience psychotic symptoms due to their drug use
- Unspecified Schizophrenia Spectrum

Anxiety Disorder: The Signs/Symptoms

Mayo Clinic stated:

- Anxiety disorders can also affect mood and often occur along with depression. It can impair a person's ability to function at work, school, and in social situation
  - Nervousness, restless or tense, withdrawal from social activity
  - Having an increased heart rate, breathing rapidly (hyperventilation)
  - Sweating, trembling
  - Feeling weak or tired
  - Trouble concentrating or thinking about anything other than the present worry
  - Recurring fears and worries about routine parts of everyday life

Trauma-related Disorder: The Signs/Symptoms

The DSM-5 (Diagnostic and Statistical Manual of Mental Disorder) explains trauma-related disorder as exposed to death, threatened death, actual, affect veterans/war soldiers

- PTSD – Posttraumatic Stress Disorder (symptoms create distress or functional impairment, e.g social, occupational)
  - Physical reactivity after exposure to traumatic reminders
  - Flashbacks, nightmare, unwanted upsetting memories
  - Overly negative thoughts and assumptions about oneself or the world
  - Exaggerated blame of self or others for causing the trauma
  - Decreased interest in activities
  - Feeling isolated
  - Risky or destructive behavior
  - Emotional distress after exposure to traumatic reminders

Personality Disorder: The Signs/Symptoms

DSM-5 explains as

- A pervasive patterns of instability of interpersonal relationships, self-image, and affects and marked impulsivity beginning by early adulthood and present in a variety of context
  - Lack of remorse, as indicated by being indifferent to or rationalizing
  - Reckless disregard for safety of self or others
  - Risk taking – engagement in dangerous, risky, and potentially self-damaging activities, unnecessarily and without regard for consequences, boredom, anxiousness, intense feelings of nervousness, feeling fearful, fears of falling apart or losing control

- Avoidant Personality Disorder
  - Impairments in self functioning
  - Low self-esteem associated with self-appraisal
  - Socially inept
  - Excessive feelings of shame or inadequacy

Substance Use Disorder: The Signs/Symptoms

- Drug addiction also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication. Substance such as alcohol, marijuana and nicotine also are considered drugs.
  - Maintaining a supply of the drug
  - Driving under the influence, risky activities
  - Neglected appearance – lack of interest in clothing, grooming or looks
  - Behavior changes
  - Erratic behavior
  - Aggression
  - Rapid speech
  - Dilated pupils
  - Confusion, delusions and hallucinations
  - Irritability, anxiety or paranoia

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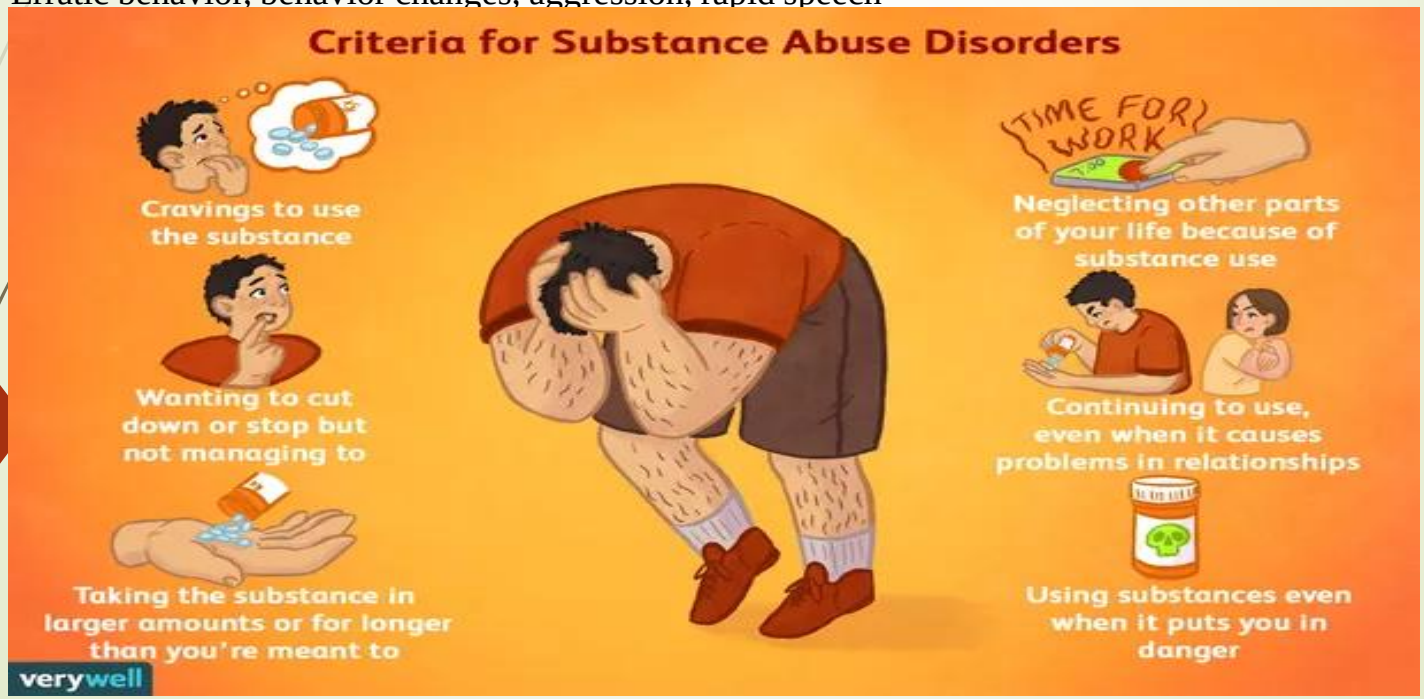
Substance Use Disorder: The Signs/Symptoms

Verywell / Brianna Gilmartin

Erratic behavior, behavior changes, aggression, rapid speech



Co-occurring Disorders

- DSM-5 explains that approximately two-thirds of individuals with illness anxiety disorder are likely to have at least one other comorbid major mental disorder. Individuals with illness anxiety disorder may have an elevated risk for somatic symptom disorder and personality disorders
- Most individuals who have mental illness that law enforcement ends up arresting have both mental health and substance use disorder
- Depression symptoms that develop during or soon after substance use or withdrawal or after exposure to a medication
- Worldwide, mental and substance use disorders are leading causes of morbidity and mortality. The social and disease burden of these disorders increased by 37 percent between 1990 and 2010, primarily due to demographic trends in population growth and aging (Whiteford et al., 2013).
- Of the nearly 23 million Americans who needed treatment (met standard criteria) for a drug or alcohol problem, less than one in ten received any treatment
- Untreated substance use disorders reflect an estimated $417 billion in annual costs related to crime, health care services, and lost work productivity. This estimate does not capture the many social costs of drug overdose and suicide.
- A survey from SAMHSA 2014 provides detailed information on the use of health care services by people with mental disorders.

Mental Health Knowledge Importance for Law-Enforcements/Correctional Officers

- Officers are often the first responders to incidents involving people with mental health
  - Erratic behavior
  - Someone threatening to harm themselves or other
- Reduces the risk of injury for the both the officer and the individual
- De-escalation techniques learn in CIT in any tense encounter (even if the situation does not involve mental health crisis
  - Safe distance
  - Let the person vent
  - Validate the person's feelings
- Effective programs and training can help officers de-escalate mental health situations and get people the help that they need
- Officers will quickly recognize the signs of mental health behavior
- Help the officers to develop approaches to protect themselves from an erratic dangerous mental health individual and avoid deaths
- Officers will understand untreated mental health & therapeutic language

The Roles that Stigma Plays in Receiving Treatment

- A survey of states in 2007 and 2009 showed that more than 80 percent of U.S. adults agreed that mental illness treatment is effective; people living in states with higher per capita expenditures on mental health services were more likely to agree that treatment is effective and were more likely to report receiving treatment (Centers for Disease Control and Prevention et al., 2012)
- According to Jorm and Reavley, 2014 Americans are more likely to believe in the dangerousness of people with mental illness than are citizens of other developed, industrialized nations
- Scholars and scientists have pointed to persistent stigma as a major barrier to the success of mental health reform.
- Stigma against people with mental or substance use disorders can stem from erroneous beliefs for example, their dangerousness or the unpredictability of their behavior.
- Lack of information about the nature of these disorders (e.g., their causes) can lead to public attitudes of shame and blame.

The Effect of Mental Health on Individual/family Behavior

- Individual behavior

It's normal to feel a whole range of emotions, such as guilt, fear, anger and sadness (Grieger, 2018).

- Leads to social isolation, dangerous behaviors
- Relationship differences/difficulties
- Long-term disorder can drive a person to commit suicide
- Problems with tobacco, alcohol and other drugs
- Work-related issues or school related issues
- Sleep problems, triggers other chronic illness
- Homelessness

- Family behavior

Mental health issues can be a extremely painful and traumatic time for all of the family

- Frequent family conflicts
- Emotional strain on families
- Financial impact
- Shamefulness

Treatment

- People with a serious mental illness have a higher rate of service use than the general population of people with any mental illness (69% versus 45%) but treatment and services vary in quality and timeliness of delivery
- Among adults who reported an unmet need for mental health care in the past year, the most common reasons were inability to afford the cost of care (48%)
- believing that the problem could be handled without treatment (26.5%)
- not knowing where to go for services (25%)
- not having the time to go for care (16%)
- they did not feel a need for treatment at the time (10%),
- they thought that treatment would not help (9%)
- they had fear of being committed to an institution or having to take medicine (9%),
- they had concerns about confidentiality and the potential negative effect on employment (8%)
- they did not want others to find out (6%)
- they had no insurance coverage or inadequate coverage of mental health treatment (6% to 9%).

Treatment/medication/self-care

- Mood Disorder:
  - Treatment: For most people can be successfully treated with medications and talk therapy (psychotherapy), self-care, antidepressants, and support
- Psychotic Disorder:
  - Long-term treatment with Antipsychotic medication may lead to a modest decrease in the intensity of delusion. Assessment of the risk of violence based on bizarre. Careful evaluation of the individual and the symptom particularly if the delusions involve an identifiable individual (e.g. a family member, neighbor, group of people/police officers which putting that identifiable person or group at risk.
- Anxiety Disorder:
  - Treatable evidenced by months of consistency with psychotherapy, medication/mood stabilizer

Organization Support

- Crisis Intervention
- Community Mental Health Teams (CMHTs)
- Social or community Care
- Residential Care
- Hospital Treatment/Behavioral/Psychiatric

Summary

- A chronic mood disorder is unlikely will go away on its own, and it may get worse over time
- Seek professional help before mood disorder becomes severe – may be easier to treat early
- Forensic clinicians routinely encounter psychotic and mood disorder with performing forensic evaluations and while caring for patients in correctional settings
- The psychotic disorders may also be seen in civil forensic evaluation for commitment and disability evaluation
- Aggression is more frequent for individuals with a history of violence, non-adherence with treatment, substance abuse and impulsivity
- Effective programs and training can help officers de-escalate mental health situations and get people the help that they need

References

- Jorm and Reavley, 2014
- Centers for Disease Control and Prevention et al., 2012)
- Whiteford et al., 2013
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- Mayo Clinic Family Health Book, 5th Edition
- DSM-5
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PRESENTATION # 6

3:00-4:00pm

Co-Response

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