Cleveland Division of Police
Mental Illness Overview
Instructor's Manual (version 2/1/17)

Slide 1 – Title

Slide 2 – Our purpose

- Start by asking the group to explain what they know about this training. What are they expecting? What have they heard?
- Why is a training on mental illness needed for police officers?

Key points to make

- You will routinely encounter people with various special needs including mental health problems, addictions, developmental disabilities, and those who are in various levels of distress
- Understanding those special needs will help you to respond in a manner that improves the chances for a safe and positive outcome for both you and those that you are responding to
- Understanding mental health and other special needs populations requires some study, practice and discussion – it cannot be done just on instincts
- To effectively respond to the complex needs of those in crisis requires elements of sound policing technique as well as knowledge of crisis response and special needs populations

Slide 3 – What is mental illness?

- Start by getting them comfortable speaking in the class/develop some interest
- What do you picture when you think of mental illness?
- How many know or know of someone what has experienced mental illness? What did it look like?
- How would you define it for a friend?

Key points:

- Mental illness takes many forms
- In one way or another all of our lives have been touched by it
- Our taxes help to pay for identification and treatment
- The United States Surgeon General talks about the "burden of disease" – the number of lost years of healthy life due to death or disability
- Burden of Disease for mental illness is second only to Cardiac Diseases.
    - MI accounts for 15% of all BD – more than all forms of cancers combined.

Slide 4 - Definitions

- Providing this definition to officers can help them start to understand that to be diagnosed with a mental illness, an individual must have a full syndrome, a complete combination of symptoms that impairs cognition, mood or behavior, and that causes impairment.
- It is effective to read this to officers, then break it down:
    - Mental illness is a cluster of symptoms that cause
    - Clinically significant disturbances, and

- Impaired functioning - leading to disability.

Slide 5 – Schizophrenia

- The instructors should explain that the term "schizophrenia" means "split mind" and it is used to describe how the mind splits off from reality in this illness.
- Make sure audience does not confuse this with split personalities, that is not schizophrenia and it will not be covered here.
- Drive home to that Schizophrenia is a LOSS OF TOUCH WITH REALITY.
- It is caused by an imbalance of dopamine – too much in the temporal lobes and not enough in the frontal lobes.
- Let people know that the disorder is very severe, but people can recover through a combination of medications and psychosocial rehabilitation.
- Next hallmark symptom is disorganization – when the persons speech is impossible to understand because the ideas do not connect, "word salad," or the behavior is completely non-sensical,
- Emphasize that people with Schizophrenia are FAR more likely to be victims of violence than perpetrators of violence.

Slide 6 – Schizophrenia

- The first hallmark symptom is that of delusional beliefs.
- Ask the participants to think of anything that they know of to be true – Explain that this is how a delusion feels to a person with Schizophrenia.
- It is not effective to try an convince the person that they are wrong when they have a delusion. It would be like trying to tell a participant that what they know is really not true.
- Types of Delusions
  - Paranoid delusions – Ex. The FBI is following me, my wife is poisoning me, etc.
  - Grandiose delusions – Ex. People believe they are God, Allah, a famous person, or very wealthy
- Explain that people will behave in accordance with their delusions. However, do not use a story about a patient acting violently – it increases stigma and fear.

Slide 7 – Delusions

- Brief video of a clinical interview with a delusional man
- Point out the degree to which he is convinced of his story, the fear which he seems to have related to the content of his belief
- Note the thought blocking that occurs – another symptom of schizophrenia
- Note the bizarre nature of his delusions – "they have a transmitter tuned into my brainwaves"

Slide 8 – Schizophrenia

- Hallucinations are unreal sensory experiences.

- Emphasize that any sense can produce a hallucination but in Schizophrenia there are two most common types of hallucinations:
  - Auditory hallucinations – hearing voices, the voices sound real just as your voice sounds to the audience
  - Visual hallucinations – more rare than hearing voices, typically will be shadows/figures
- Explain that people have hallucinations because of the excess of dopamine in the areas of the brain that process hearing and other senses. Their senses fire even without sensory input. It feels just as real as a sense anyone without Schizophrenia would experience!

Slide 9 – Video: A day in the life of schizophrenia (4 min)

- Explain that the video is a depiction of the experience of schizophrenia from the point of view of the individual
- The video is based on the descriptions of actual people with schizophrenia
- After the video point out the presence of multiple voices, very negative or alarming in tone and message and the relentless nature of the criticism and statements being made to the person
- Emphasize the ways in which the voices might make it hard to follow simple daily living steps as well as interefere with medication adherance

Slide 10 – Schizophrenia

- Explain that another hallmark of schizophrenia is disorganization
  - The person's speech may be impossible to understand because the ideas do not connect together well or logically ("word salad")
  - The person's behavior may seem nonsensical – it may not fit with the situation or purpose and cannot be expected to achieve any reasonable goal

Slide 11 – Schizophrenia

- This slide focuses on "negative symptoms"
- Explain that people with Schizophrenia don't interact with others the way you would expect a person to do so.
- They often don't engage, don't communicate a lot. They don't display the range of emotions that people without Schizophrenia show.
- They often don't have motivation and drive.
- This is due to having a chemical imbalance in the frontal lobes of the brain and medications do not improve negative symptoms.
- These symptoms most impair ability to work and have relationships.

Slide 12 – Schizophrenia - Treatment

- This slide focuses on treatment for schizophrenia

- Let participants know that medication is absolutely necessary in schizophrenia, but it doesn't fix everything and for some who are "treatment-resistant" it doesn't work.
- Medications block dopamine, so they help some symptoms, make others worse.
- Noncompliance is common – many times at no fault of the client. Sometimes meds are too expensive, insurance lapses, etc. Sometimes the person doesn't think they are ill and doesn't think they need meds. None of us would take meds for a condition we did not believe we had!
- Sometimes people cannot tolerate side effects.
- There is much more to treatment of schizophrenia than just meds, including case management, psychosocial rehabilitation, housing support, work support, etc!

Slide 13 – Mood Disorders

- Explain that we will now move on to discuss major disorders of mood
- As with Schizophrenia, the mood disorders described here are considered to severe disorders and can have a profound impact on all aspects of a person's life

Slide 14 – Major Depressive Disorder

- Emphasize that in MDD the mood is depressed all day, every day, or the person has a complete and total lack of interests, called anhedonia.
- It is not simply some sadness or occasional or fleeting sadness. It is persisting and relentless depressed mood.
- Additionally, people with MDD have to have a cluster of symptoms including those listed in the slide
- Explain that many people with MDD have the recurrent form, and that a person who has two separate episodes of major depression has a greater than 90% chance of having a 3rd, 4th, 5th, etc. episode without lifelong treatment.
- The brain is different in MDD – many neurochemicals are involved, including serotonin, norepinepherine and dopamine.
- Lead a discussion:
    - a) How is this distinct from non-clinical mood problems?
    - b) How those with the diagnosis might appear to an observer
    - c) How do those with the disorder describe the experience of a MDD (loss of energy, interest, feeling extreme sadness/hopelessness)

Slide 15 – Major Depressive Disorder

- This slide focuses on treatment
- Let audience know that antidepressants are absolutely necessary for people with recurrent MDD or depression will keep coming back over and over.
- Goal in treatment with a doctor is to find a medication that the person likes and that doesn't cause bad side-effects, and then continue it as long as possible.

- Noncompliance is common – first reason is that meds take 4-6 weeks at each dose to work, and dose adjustments are required. So – it takes three months or longer to get a good trial on an antidepressant. Some people give up.
- Other people stop the meds when the depression resolves, they figure they don't need it anymore, but depression returns.
- Side-effects are less severe than with antidepressants but still do occur. Weight gain and sexual side-effects are the biggest ones that lead to people stopping their antidepressants.
- When people are treatment resistant, ECT can help them. It is stigmatized and sometimes people won't do it even though it can be lifesaving.
- Lead a discussion regarding treatment - how do people seek out treatment and the barriers
- Presentation of common thinking errors in depression and relationship to therapy
- Brief discussion of statistics and relationship to suicide

Slide 16 – Bipolar Disorder

- We'll focus on Bipolar Type I disorder which used to be called "manic depression".
- There are other variants of bipolar disorder, but officers should focus on understanding true type I bipolar.
- The key features are alternating episodes of MDD and mania, not moment to moment mood swings or people flipping out or people having multiple personalities.
- Ask officers to remember that in Bipolar Type I, people have months to years of depression followed by weeks to months of mania. People with bipolar spend most of their lives depressed!
- Psychotic symptoms can occur in either mood state and are usually "mood congruent" meaning they match the mood.
- Manic people have grandiose delusions, depressed people hear voices telling them they are worthless, or suggesting they commit suicide.

Slide 17 – Bipolar, mania

- When describing mania, make sure people understand the mood must be high, very high, people are "on top of the world," for no reason whatsoever, and they stay like that for weeks.
- While in that mood state, people have the additional symptoms for at least 5 days.
- Emphasize how dramatic this is - people do not sleep for days on end with extremely high energy, high activity, running nonstop.
- I usually explain to audience that when a person is manic their head is filled with ideas, they all sound awesome, the person thinks that they can do all the ideas, and there is not a thought in the person's mind that it might not work out. This drives the poor judgment.

Slide 18 – Bipolar, treatment

- People will need life-long medications to stabilize the mood. The meds knock the highs down and bring the lows up to even things out for people with bipolar.
- Lithium, depakote and antipsychotics are most often used.

- The medications can be hard to use – doctors have to watch for kidney and thyroid damage when using lithium, and have to watch for liver damage when using depakote.
- Remember that antipsychotics can cause either tardive dyskinesia or diabetes or both.
- When the meds work and are tolerated, it is life-changing. But some people are treatment-resistant.
- Noncompliance is common.
    - Sometimes due to insurance, cost, etc.
    - Sometimes due to side-effects.
    - Also, in bipolar, some patients miss having mania, they lower or stop meds to get some of that feeling back.

Slide 19 – Borderline Personality Disorder

- Explain that personality disorders are believed to develop over time as the person moves from childhood to adulthood.
- Personality disorders come in different forms but all are believed to be resistant to change because they represent years of learning and development
- BPD is more common in females than males
- Associated with abusive childhood histories, particularly sexual abuse

Slide 20 – BPD Symptoms

- Briefly describe each of the following
    - Extreme emotional reactivity – often related to relationship problems
    - Unstable identity or self-image,
    - Impulsive actions in multiple areas and that can harm the person (sex, substances, dangerous driving)
    - extreme fear of and attempts to avoid abandonment,
    - feeling empty inside,
    - inappropriate and intense periods of anger,
    - transient paranoid thoughts when stressed and/or dissociative symptoms (such a feeling unreal, memory problems, feeling disconnected from one's own body)

Slide 21 – BPD

- Discuss the common occurrence of Self-mutilation and give examples such as cutting, scratching, burning self
- Note that while often thought of as suicidal, can also be an attempt to sooth self
- "Black and white thinking" is common - someone is viewed as all good or a "savior" at one point only to then later as extremely uncaring or bad if needs aren't met.
- Discuss potential for impulsive behavior (drugs, driving sex etc) placing the individual at risk for victimization
- Medications will usually not address the core symptoms of a personality disorder
- Note that psychotherapy can help with some symptoms (suicidal actions)
- Not all can find it or afford it treatment - may not be covered by insurance companies

Slide 22 - BPD

- Often challenging and frustrating for first responders, family and hospitals
    - Person may be well known to police, hospitals
    - Suicidal threats must be taken seriously, even when there is a pattern
    - Rates of completed suicide with this group range from 3-10%
    - Expressing doubt about true suicidal intent can lead to more intense actions
    - Depending on the circumstances seductive behavior could come into play

Slide 23 - BPD

- For calls to police – the mobile crisis unit is a good resource to aid in determining if a trip to an ER is indicated as well as help with needed linkage
- When possible, help the person establish a sense of safety and control
    - Communicate that you are there to help
    - Provide a sense of control if possible by offering choices
    - Display confidence, patience, and respect while listening actively
    - Avoid force while remaining vigilant
    - Don't make promises that you cannot keep
    - Do not be drawn into sharing personal information or taking an action outside of usual policy and procedures

Slide 24 – Posttraumatic Stress Disorder

- The inability to escape/loss of control is a key to experiencing a posttraumatic reaction
- Evolution prepared us to be able to fight intensely or flee in the face of serious danger
- A chain reaction from recognition of the threat to stress hormone release, to bodily changes to prepare us for flight or flight
- During fight or flight we respond more instinctually, our higher cognitive abilities are relatively silent during this period
- Impacts the brain's ability to make sense of the event and memory can be impacted –
- In some will get lasting changes in stress hormones even after the trauma has passed

Slide 25 – PTSD Diagnosis

- Describe how with PTSD a person has experienced or were exposed to a highly traumatic or stressful event related to serious injury, death, or sexual violence. This can include learning that such events happened to a family member or close friend. Can also be from repeatedly being exposed to details of horrific events involving death, child abuse, or similar occurrences. Particularly relevant to police officers as they accumulate these experiences over years.
- Note that different types of intrusive experiences can then be had by the individual. Examples include nightmares about the event, flashbacks where the person feels as though they are back re-experiencing the event, having powerful physiological reactions (rapid heart beat, sweating, panic) to cues that might resemble the event – for example the smell of the cologne from a rapist, the smell of gasoline following a horrible care accident.

- Briefly describe the avoidance of things related to the traumatic event, changes in reactivity and arousal as with numbing and hyper-reactive startle response.
- The person may experience cognitive changes with negative feelings, guilt, a sense of being detached from the world.
- Disturbance is more than a month

- Note that Lasting changes in stress hormones may lead to later problems in arousal
- Might takes less for the person to enter into flight or fight again
- Recent war vets with mild TBI = 48% with PTSD
- Substances, disordered eating, gambling, sib, compulsions might all be attempts to re-regulate emotions.

Slide 26 – PTSD treatment

- Emphasize the pervasive impact that PTSD can have on a person.
- Shame, disconnection from life, inability to fully experience joy
- Antidepressants often part of the treatment regimen
- Talk therapy – Work to "expose" the events gradually to direct awareness and discussion
- Allow fragmented experience to become part of the "life story"
- Mention of Veterans and suicide statistics
    - Approximately 22 suicides per day from Afghanistan and Iraq wars
- Does not have to be from war or extreme natural disasters
- Mention of reliance/protective factors with an emphasis on having had the benefit of a caring/protective adult during childhood – buffer to traumatic or toxic stress.

Slide 27 – Toxic Stress

- Research shows that kids from all walks of life can be exposed to adverse events which can impact their health and well being throughout their life
- Kids living in poverty are at particular risk for abuse/neglect/witness to violence
    - In extreme cases may learn that cannot trust adults for safety or comfort
    - Task becomes one of surviving in a chaotic and dangerous world
- These experiences impact the functional connectivity (learning) within the brain
- May interferes with normal learning and brain development
- Such brain changes can lead to cognitive and behavioral problems: impulse control, concentration, ability to trust others, reduced ability to take pleasure or comfort from others, difficulty distinguishing what is a true threat
- Results in higher risk for health problems, contribute to increased problems in school, vocation, and with the law
- Think of kids in this situation as having been injured, not just bad
- No simple solution - but one requirement is for kids be able to feel safe

Slide 28 – Later in Life

- Severe problems with childrearing and toxic stress early in life can impact the ability to feel safe and connected with others
- Increased risk of being victimized, of having health and mental health problems, and of social/vocational problems
- Better to think in terms of what has happened to a person, not what is wrong with them
- Key to resilience – having a trusted, caring person in one's life - a buffer between self and the world
- It might not be a parent, it might be a friend, a relative, a teacher – even a police officer

Slide 29 – Wrap-up

- Questions
- Post-test