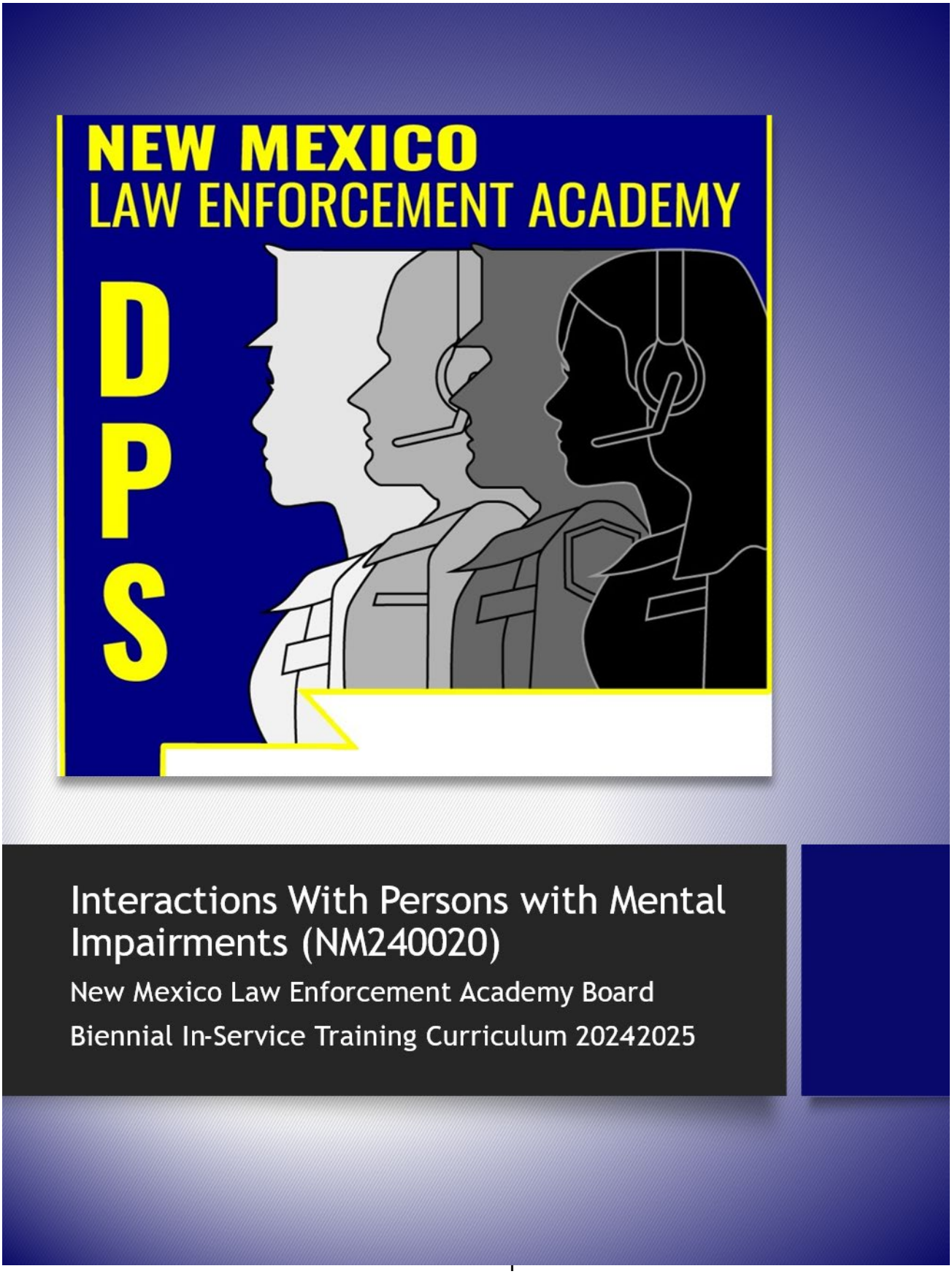
NEW MEXICO
LAW ENFORCEMENT ACADEMY
DPS
Interactions With Persons with Mental Impairments (NM240020)
New Mexico Law Enforcement Academy Board
Biennial In-Service Training Curriculum 20242025

COURSE TITLE:
Interaction with Mentally Impaired

INSTRUCTIONAL GOAL:
Provide the student with awareness of crisis management, including crisis intervention, confrontation, de-escalation practicum and proper interaction with persons with mental impairments.

INSTRUCTIONAL OBJECTIVES:
Upon completion of this block of instruction the participant will:

1) Identify and understand House Bill 93 and sections of the bill.
2) Identify and understand crisis management and intervention.
3) Identify proper interaction and de-escalation with persons with mental impairments.
4) Identify how to gather critical information between dispatch and officers to maximize safety.

INSTRUCTIONAL METHODS:
Classroom, PowerPoint, Class Exercise

HANDOUTS:
Recommended current statistics from Mental Health Quarterly Surveillance Report from NMDOH, "You Are Not Alone" from NAMI, Adult Mental Health and Service Use in NM, Young Adult Mental Health in NM, Navigating a mental health crisis- preparing for crisis, Navigating a mental health crisis – Warning signs and what to do

COURSE DURATION:
2 hours

CURRICULUM REFERENCES:
NMLEA Records
See Additional Resources at the End of Lesson Plan

EQUIPMENT, PERSONNEL, AND SUPPLIES NEEDED:
Computer, screen, projector, white board

TARGET AUDIENCE:

NM Certified Law Enforcement, Dispatch, and Corrections

INSTRUCTOR RATIO:

1:30

EVALUATION STRATEGY:

Class participation & Scenario

AUTHOR & ORIGINATION DATE:

Kelly Hampton/Ariana Torrez 12/7/2023

REVISION / REVIEW DATE(S):

REVISED / REVIEWED BY:

1) Introduction

Instructor(s) will need to conduct an introduction. Start with introducing all the instructor(s) and move on to student introductions. Instructor(s) can choose which icebreaker they prefer to use. It is recommended to use an ice breaker to start a rapport-building process with the students.

a) Responding to individuals during a mental health crisis has been problematic for law enforcement. Because a lack of training and understanding has led to new laws and requirements for agencies.
   i) *Instructors note: Pass out course material/handouts.*
b) This course is not designed to be a therapy or support group, this course is designed to help you recognize the signs and symptoms of someone in crisis. Due to the nature of the topic, participants may share personal information, all that information will remain confidential and within the confines of this class.
c) Instructor(s) need to keep in mind 1 of 5 people live with or know someone who lives with a mental health condition. This topic touches many feelings for a lot of people. Sometimes those feelings are sadness, hurt, and possibly anger due to the student's own lived impact.
d) Students may have trouble with the content and need to leave the room for a moment to compose themselves. This is okay but when they leave have them provide you with a thumbs up (if they are okay) or down (if not.) If a student is not okay the instructor or co-facilitator should leave the room with them and have a conversation to help them.

2) Topics Covered in this Class

a) Mental Illness is defined as: A wide range of conditions that affect mood, thinking, and behavior
b) Throughout this course we are going to increase mental health literacy and decrease the sigma attached to it.
c) We will work on learning the difference between a person experiencing a mental health crisis and the problem or circumstance itself.
d) Here are some things we will go over
   i) Crisis management
   ii) Crisis intervention
   iii) Confrontation and de-escalation
   iv) Interaction with persons with mental impairments
   v) Developmental disabilities
   vi) PTSD
   vii) Dual diagnosis
   viii) Autism
   ix) Youth in crisis

x) TBI

3) House Bill 93

- **It is important to advise the class that this class is no longer called HB93 as house bills have changed over time. This course is now to be referred to as Interactions with persons with Mental Impairment.**

a) Became effective 7/1/11
b) From Sandoval & Ulibarri and is officially called "Interaction with Persons with Mental Impairments – Training"
c) Requires 40 hours crisis management, including crisis intervention, confrontation de-escalation practicum in basic law enforcement training classes.
d) Requires minimum 2 hours in-service pursuant to Section 29-7-7.1 NMSA 1978
e) Requires in-service telecommunicator training of minimum 1 hour for each 2 year period.
f) Requires minumum 2 hours in-service for each chief law enforcement officer of a state, county, or municipal law enforcement agency.

4) Why are we here?

a) The number of negative police interaction with the mentally impaired is growing, and growing in media attention. With the addition of HB93 the number of hours required for law enforcement training on dealing with the mentally impaired is an attempt to slow and lesson the number of negative interactions.
   i) 1 in 5 people fatally shot by police have a mental illness
   ii) 15% of all calls anually involve someone struggling with mental illness
b) As we will discuss it seems that these numbers will seem to grow, especially due to quarantine orders.
c) In order to best serve our communities we must continue to learn how to interact and assist these people in crisis.

5) Police as a Safety Net

For years the mental health community has argued that police should not be the safety net for mental health crises. The response from decision-makers and elected officials has not been to increase mental health funding, or to build a comprehensive mental health crisis system to handle such situations; the response has been to pay for better police training.

Until money, effort and thought into building a better mental health system is developed, police officers will remain the safety net.

Mental health awareness and de-escalation training for police officers are vitally important and a critical part of any robust mental health system. Sadly, those experiencing mental health or substance use disorders come into contact with the police because their behavior sometimes appears criminal. In most cases, police officers compassionately and competently connect these folks to the treatment they need.

No one gets hurt, and the individuals and their families are grateful that officers have the knowledge and training to connect these individuals with the proper care.

Many departments are making it a priority to provide its officers with crisis intervention training. Nobody wants to see someone who may have mental illness get shot. It is one of the worst possible outcomes. That's why we need to do more than train police officers; we need to build a mental health safety net that goes far beyond law enforcement.

6) History of Mental Illness

a) In the middle ages people with a mental illness were believed to be possessed or in need of religion. Negative attitudes towards mental illness went on into the 18th century which lead to the sigma and confinement of mentally ill subjects.
b) In the 1840s Dorothea Dix persuaded the US government to fund 32 state psychiatric hospitals
   i) These were often underfunded and understaffed which drew harsh criticsm because of poor living conditions and human rights violations
c) In 1946 President Truman passed National Mental Health Act which created National Institute of Mental Health and allocated funds towards research into causes and treatments for mental illness.
d) In the mid 1950s deinstitutionalization and outpatient treatment began.
   i) Poor living conditions
   ii) Human rights violations
   iii) Facilitated by the development of antipsychotic drugs
e) In 1963 the “Community Mental Health Centers Act” was passed which made it so that only individuals “who posed an imminent danger to themselves or someone else” could be committed to a psychiatric hospital. In place of the instituion, community-based mental health care was developed which included more outpatient treatment facilities and psychiatric teams.
f) Mental health patients who lived in the institutions were dispersed back into the communities, where many of them became homeless or inmates. It was believed they would have better care in a community structure. This was a slow process and took almost 50 years. Half a million people who lived in the institutions were reduced to about one hundred thousand in 1980.

g) In 1979 the National Alliance for the Mentally Ill was founded to provide "support, education, advocacy, and research services for people with serious psychiatric illnesses."

7) History of Mental Illness Continued

a) Prior to the 1990s the way to solve mental health issues by law enforcement was usually with a bus ticket, a ride to another jurisdiction, to the local jail, or to the hospital.
b) Beginning the the 1990s Crisis Intervention trainings started to become available and law enforcement began inviting mental health workers to have input on their interactions with the mentally impaired.
c) By the 2000s there was more focus on crisis and crisis intervention in law enforcement training. The news and public became aware of this training and community input was noted during case reviews and lawsuits. In 2000 only 22 beds per one-hundred thousand people were available in any given area.
d) By 2015 there were over 1,500 crisis intervention programs worldwide and started being taught in law enforcement academies.

8) History of Mental Health Treatment

a) Prior to the 18th century doctors would perform intense surgeries on subjects who exhibited mental illness, which included drilling holes in their heads, or the use of leeches to suck out the "infected" blood of the patient.
b) The early 1900s brought "insane asylums" which were used punitively, and where many experimental treatments were attempted.
    i) This was the beginning of a Freudian therapy technique labled "talking cure". Other treatments included: electroshock therapy, crude antipsychotic drugs, the lobotomy and other psychotheraputic surgeries.
    ii) The medical knowledge of mental illness was misunderstood and many attempted to fix the perception of those with mental illness, rather than help them. Eventually lobotomy was viewed as morally wrong and stopped being used.
c) During the mid-1930s to 1945 there was a wave of soldiers and oppressed minorities that were diagnosed with hysteria or various neuroses.
d) The symptoms included:
    i) Shortness of breath
    ii) Chest pain
    iii) Chronic stomach aches

iv) Fainting
v) Anxiety
vi) Prolonged feeling of sadness, paranoia, and hopelessness
vii) Substance abuse

e) Until the 1960s, intentional insulin comas were commonplace. It was believed that if a patient was put into a low blood sugar coma for up to 4 hours, it could alter how the brain functioned. They would receive an insulin injection that would cause them to lose consciousness.
i) Today it is much more commonplace to use psychotherapy as well as proven biomedical treatment, and care is much easier to come by. Treatments are still evolving and improving but they have come a long way.

9) Facts of Mental Health by the Numbers

As of April 25, 2023 the CDC reported

1) More than 1 in 5 US adults live with a mental illness.
2) Over 1 in 5 youth (ages 13-18) either currently or at some point during their life, have had a seriously debilitating mental illness.[5]
3) About 1 in 25 U.S. adults lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression.[6]

i. In New Mexico according to the nmhealth.org, the last quarterly reported statistics from July 1, 2023 – September 30, 2023.
ii. New Mexico emergency departments reported the following number of visits:
a. 1,274 youth (ages 5-17) visits including a mental health issue.
b. 11,275 adult (ages 18+) visits including a mental health issue.
c. 81 youth (ages 5-17) visits related to a suicide attempt.
d. 408 adult (ages 18+) visits related to a suicide attempt.

a) **Go over the handout "you are not alone" from NAMI**
- *Instructor Note: All handouts and statictistics are the most current from time curriculium was submitted for accreditation. Some organizations only update their stats ever 2-4 years. Please remind students this the current stats of of 12/2023.*

i) 1 in 5 US adults experience mental illness
ii) 1 in 20 adults experiene serious mental illness
iii) 17% of youth (6-17) experience a mental health disorder
iv) Here is a breakdown of different mental illnesses In a 12 month span within US:
(1) 1% schizophrenia

(2) 1% boarderline personality disorder
(3) 1% obsessive compulsive disorder
(4) 3% bipolar disorder
(5) 4% dual diagnosis
(6) 4% post-traumatic stress
(7) 8% depression

v) 12 month US prevalence of mental illness in adults:
(1) 21% All adults
(2) 14% Asian adults
(3) 17% Black adults
(4) 17% Native Hawaiian or other Pacific Islander
(5) 18% Hispanic or Latinx adults
(6) 19% American Indian or Alaska Native adults
(7) 22% White adults
(8) 32% adults who report mixed/multirational
(9) 44% lesbian, gay, or bisexual

10) Mental Health by the Numbers Continued

a) Go over handout of Adult Mental Health and Service Use in NM.

11) Mental Health by the Numbers Continued

a) Go over handout of Young Adult Mental Health in NM

12) Fighting stigma

Exercise: Stigma exercise

Instructor(s) will conduct the below exercise with the class. For this exercise, the instructor will need 2 separate poster-size sheets of paper. On the first one write “mental health disorder” and on the second write “cancer.”

The instructor will post the metal health paper up in front of the class. A scribe will be requested from the class. The scribe will write the words of phrases the class comes up with on the paper.

The instructor will provide the below instructions:

Students will call out names or phrases they have heard or said about people who live with mental health concerns.

The is no filter, we want raw name-calling, no one will get in trouble for saying something.

Examples: one can short of 6 pack, crazy, insane, addicts, worthless, re-re…. etc.

Let this happen for about 5 minutes. Instructor(s) may need to provide an example to get things started. Once the 5 minutes is up post the paper labeled "cancer." Completed the same exercise with the cancer poster. The terminology is often different. October is known for Breast Cancer Awareness month. What terms do we see on our shirts that we wear? Terms like "warrior, survivor, fighter" as example.

Once the time has lapsed, we compare mental health and cancer posters. There should be a significant difference between the terminology used.

Ask the students: If both are medical conditions, why do we treat people so differently? Why are cancer survivors "brave" and someone with a mental health concern is "crazy"? The cause could be stigma around people who live with mental health conditions.

Students should understand both are a diagnosis. Both can be treated (maybe not be cured, but treated). Students are encouraged to remember that those dealing with a mental crisis, are still people; they are just fighting a different type of battle.

a) Movies, music, and TV shows often stigmatize mental illness. It is portrayed negatively with discriptors such as violent, aggressive, and demeaning. The behavior is often misunderstood, and the behavior can appear scary for those that are not familiar with recognizing the signs and symptoms. These are the reasons why people use this as their inspiration for horror type films.
   - **i)** We are so often inundated with information from what we see and hear that becomes what we believe to be true.
   - **ii)** Think of the horror films out there, such as Split or Psycho as an example. Split is a very popular movie that deals with dissociative identity disorder(DID) (previously called multiple personality disorder) DID forms when someone experiences a traumatic event and when they need to escape their reality their brain actually forms a new "person" that will deal with the trauma. Split portrays the main character with DID as a violent kidnapper. According to the Intertational Socety for the Study of Trauma and Dissociation of the 173 people with DID only 3% were charged with an offiense, less than 2% had been fined and less than 1% were jailed over a 6 month period, and they are more likely to hurt themselves than others.
   - **iii)** 13 Reasons Why is a Netflix series based on a novel. During the first seson,the main characher, Hannah makes 13 tapes for 13 people who she blames for her suicide. This show focuses on bullying instead of showing how there is not one single thing that leads a person to suicide. It also does not show the audience how they could help someone who is going through bullying

or depression. The show also does not mention mental illness or depression at all, and describes how she views suicide as her solution.

iv) The song "Mad Hatter" by Melanie Martinez draws a distinct line between "normal" and anyone with a mental health condition. This hurts advocacy efforts that want to enlighten people that those living with mental health conditions are just like everyone else. The song also uses many derogitory terms such as "mad" and "psycho".

13) Crisis Management

a) **Instructor note: Pass out, or share on screen the handout "Navigating a mental health crisis- preparing for crisis"**

b) In order to adequately manage a crisis you have to try and prepare for it as much as possible.

c) Whether this is for yourself, a friend or family member, or if you're dealing with a member of the public that you know has a mental illness but isn't currently experiencing a crisis here are some steps from NAMI (National Alliance on Mental Illness)

i) Remember that crises don't happen on a schedule, so it's best to have a plan before a crisis emerges.

ii) These plans need to be made by the person with the condition, their family, and friends,

iii) They need to be regularly updated.

iv) Include general information about the person, and have an emergency contact.

v) Keep a list of strategies that have and haven't work in the past.

vi) Include all medications and diagnoses and any safety plans.

14) Crisis Intervention

a) **Instructor note: Pass out, or share on screen, the handout "Navigating a mental health crisis – Warning signs and what to do"**

b) Remember it is crutial to distinguish between the person in crisis and the crisis itself, people are more than their circumstances.

c) It's important to look for warning signs that a crisis is coming, some of these signs include:

i) Trouble with daily tasks

ii) Sudden extreme changes in mood including increased agitation and isolation

iii) Abusive behavior

iv) Symptoms of psychosis such as difficulty recognizing people or halucinations

v) Paranoia

d) What to do when someone is in crisis?
   i) Keep your voice calm while expressing concern and asking how you can help
   ii) Give options instead of trying to take control
   iii) Avoid touching the person without asking and explaining first.
   iv) Be patient
   v) Offer resources, and dependant on the situation, offer to make that call for them if they are not in a place to do so.
   vi) Give them space – if they are not ready to take action, offer to make a call for them and if they refuse, leave them resources so that they know who they can reach out to when needed. We want them to be understand that help is there for them. Try to remember that, as an officer or dispatcher, when you tell them when they need help they can call and a dispatcher or officer assist. Be careful not to say "you i.e. Officer Smith or Dispatch operator 1234" will be there specifically, but an officer or dispatcher. You do not work 24/7 and do not want the person in crisis to think you are the only one that can help them. Convey that anyone in the department is ready to be of assistance.

15) Crisis De-Escalation

a) One way of helping someone in a crisis de-escalate is to validate what they are experiencing. What they are experiencing is real to them. For example; telling someone who is going through an anxiety/panic attack to "calm down, just breathe" is much less likely to help that person.
b) When encountering a high risk, high-uncertainty situations, it's important to think on your toes and outside the box. You need to be able to hold a conversation about different topics with different people, to follow the conversation where they take it and stay engaged.
   i) Try to help them redirect their thought process and become their ally. The longer you keep someone engaged, the more rapport you build. When a person you are interacting with starts to go silent, you most likely have lost them.
c) Adapt and adjust your game plan as you go. You may have to change the subject multiple times to avoid discussing a "bad situation". Examples would be if they are in a bad financial situation, try to change the topic to sports or hobbies. You can probably hear or look for clues when in contact with someone in crisis.
d) If at all possible, try to identify and avoid triggers. Your goal is to create a calm environment and get their mind off of whatever is pushing them over the edge. When you determine/find out what the triggers are, you have an advantage of directing them into a entirely different conversation.

e) Talking to people who have a relationship with the subject can be vitally important and help you get the full picture of what they are going through. They will have direct knowledge of diagnoses and any hospitalizations.
f) Actively listening is so important to give a person going through the crisis a safe space to express themselves and let them know they're being heard.

16) Crisis De-Escalation Continued

a) Never take anything personally. It's important to recognize that they have their own reasons for how they feel. They may curse, swear, or insult you. You're there to help, not to escalate their crisis.
b) Being honest accounts for credibility and for building a rapport. People in crisis can sense a script right away. It's important to let them know you actually care.
c) Providing choices helps add a sense of urgency and hope if you can offer more than "jumping from the bridge".
d) Never say, "I understand what you're going through." Instead, try a phrase such as "I see you're going through a rough time." everyone has their own way of coping with tough situations. Unless you've gone through the same exact struggle, trying to suggest that you got through it invalidates their struggle and their experience.
e) Connect a client to those with similar backgrounds. It helps if the person helping you is similar to you. For example, someone who may be experiencing PTSD would greatly benefit from talking with someone who has similarities.
f) Don't give in to their commands. Your position is to somehow coax them off a ledge. So you need to try and be in control of the situation. "we can talk and go around in circles all day, but the more we talk on the bridge, the more time they have to convince themselves to jump".
g) Practice self-care. People who have worked with those in crisis know that they have to make a conscious effort to engage in self-care and separate their work and personal life as much as they can. Finding activities or hobbies outside of this work can prove easier the more you do it.

17) Suicide Awareness

****Note: This can be a tough topic for people. Sometimes people will need to walk out because they have lived it or knew someone who died by suicide. If this occurs it's normal and okay.

Create a safe place. Announce at the beginning of the class if students need to step out it's okay. Just ask they give you a thumbs up if good or thumbs down if not. If a student gives you a thumbs down the instructor will break the class for a brief break or have the co-facilitator walk out with them to check on them.

Suicide Awareness:

All thoughts of suicide are taken seriously. People will talk about suicide differently. The terminology used will be based on their personalities, history, and the life they have lived.

In law enforcement, this is a common call for service for us. It is our responsibility to assess the situation and determine if the person is likely going to kill themselves or hurt other people.

Below are facts to speak with the class about. The statistics show how important it is to ask questions and identify signs/symptoms of depression.

- 2nd leading cause of death between ages of 10-34.
- The suicide rate increased 35% since 1995.
- 10th leading cause of death in the US.
- Men often die by suicide more than women.
- Women attempt suicide 3 times more than men.
- Increased attempts in youth .

Discussion with the class about suicide: Ask the class what terminology people use when they are thinking of suicide. What do people say?

18) Warning Signs

Discuss with the class the warning signs. Pick a few of the slides to read. Make sure they are impactful.

1. Threatening to hurt or kill oneself
2. Seeking access to means
3. Talking, writing, or posting on social media about death, dying, or suicide
4. Feeling hopeless
5. Feeling worthless or a lack of purpose
6. Acting recklessly or engaging in risky activities
7. Increasing alcohol or drug use
8. Withdrawing from family, friends, or society
9. Having a dramatic change in mood
10. Giving away their possessions

19) Asking the Question

Suicidal Behavior is always taken seriously and is preventable. A person who is thinking about killing themselves is in a significant crisis. They may not have the insight to understand the emotions they are feeling. This is very impactful because the emotions they feel are temporary.

How can we prevent a person from killing themselves?

Asking the question is an immediate way to understand what the person's intent is. The question needs to be direct. This will get their attention and make them think about what you just said.

If the Answer is "Yes" the next questions we need to know are below:

1. Do you have a plan?
2. What is the plan?

Example:

"Are you thinking about killing yourself? "

20) Do and Do Not

Discuss the Do' and Do nots with people feeling suicidal.

Do:

- Instill hope.
- Recovery is possible.
- Discuss what you observe.
- Assure not alone.

Do not:

- Express Negative Judgement.
- Blame them for their feelings.
- Tell them "Snap out of it."
- "I Know how you feel".

21) Commitment Order

Discuss state statute 43.1.10 Emergency Mental Health Evaluation.

Below are the four reasons you can take someone in for a mental health evaluation

1. Under Lawful Arrest

2. Reason to believe a suicide attempt was just made
3. Danger to self or others due to a mental health concern
4. Certificate of Evaluation

22) Developmental Disabilities

a) Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the developmental period, may impact day-to-day functioning, and usually lasting throughout a person's lifetime. They general begin anytime during the developmental period before birth but can happen after birth due to injury, infection, or other factors. They may involve dysfunction in attention, memory, perception, language, problem-solving, or social interaction. These disorders may be mild and easily manageable with behavioral and educational interventions, or they may be more severe, and affected children may require more support.

b) Developmental disabilities include but are not limited to:
   i) ADHD
   ii) ASD
   iii) Cerebral palsy
   iv) Hearing loss
   v) Intellectual disabilitiy
   vi) Learning disability
   vii) Vision impairment
c) Children and adults with disabilities need programs to stay well, active, and part of the community.
   Instructor Note: Ask the class: Where would we interact with these in law enforcement?

23) Post Traumaic Stress Disorder

a) The dictionary defines this as "a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world."
b) PTSD can affect a range of people, not just people who were physically at or involved in an event. Even though originally it was thought only to affect veterans and was known as "shell shock" or "combat fatigue" now we know more.
c) There has been a recent movement to change the name to PTS to attempt to destigmatize it by dropping the "disorder" portion of the diagnosis and have it be considered an injury instead. The

official diagnosis, however, is still PTSD and is what is required by insurance for benefit coverage or disability recognition.

24) Statistics of PTSD

i) According to the Department of Veterans Affairs the statistics for the US population for PTSD are:
- **(1)** 4 out of every 100 men will develop PTSD.
- **(2)** 8 out of every 100 women will develop PTSD.
- **(3)** And according to "The Community Dispatch" magazine 15 out of every 100 officers will develop PTSD.

25) Dual Diagnosis

a) Dual diagnosis refers most commonly to the co-occuring disorders of misusing alcohol and/or drugs and a mental illness. As of 2019 the National Survey on Drug Use and Health 9.5 million US adults experienced mental illness and substance use disorder.

b) Some people who suffer from mental illnesses may use drugs or alcohol as a way to self medicate. The drugs may temporarily help with some symptoms, over time it may make it worse. Also the brain changes that go along with mental disorders may enhance the rewarding effects of substances making them even more addicting.
   - **i)** If the substance abuse disorder came first, the substances themselves may trigger changes in the brain that make a preson more likely to develop a mental disorder.

c) Another reason that people tend to self-medicate rather than take their prescribed medication is the side-effects of many medications are so severe that they would rather use illegal drugs than deal with them. Also, it can be easier to get illegal drugs, and sometimes cheaper, than to get access to prescriptions.

26) Dual Diagnosis continued

a) Specific mental illnesses with a higher possibility of substance abuse
   - **i)** Schizophrenia and Tobacco use
     - **(1)** Schizophrenics are 5 times more likely to be a smoker than the general population
     - **(2)** Research is showing that nicotine is more rewarding and more difficult to quit because of abnormalities in a schizophrenic's brain. Nicotine also activates certain brain receptors involved in cognition and memory which counters some of the cognitive impairments associated with schizophrenia.
       - **(a)** This research is still ongoing to try and develop medication that will activate the same receptors without the negative effects of smoking/nicotine.

b) Approximately 40-60% of someone's vulnerability to a substace use disorder is attributable to genetics. There is also research on mental disorders developing after a substance abuse such as frequent marijuana use during adolescence is associated with increased risk of psychosis in adulthood, especially for people who are genetically pre-disposed.

27) Schizophrenia

Schizophrenia: Watch Video

"I am not a Monster" Cecilia McGough 14 Minutes

https://www.youtube.com/watch?v=xbagFzcyNiM

a) Instructor note: play video on person with Schizophrenia, discuss how she explains that people would not know she had a disorder unless she told you.
Class Discussion regarding the video:

- When did it start?
- Her interaction with the police?
- What was her experience?
- How does she determine reality vs. non-reality?
- What are her triggers?
- What does she see?
- What is her profession?
- Medication does not eliminate the signs or symptoms it provides the person clarity on what is real or not real.

b) **Schizophrenia** is defined as a "chronic brain disorder.. where symptoms can include delusions, hallucinations, disorganized speech, trouble with thinking, and lack of motivation". It is typically diagnosed in a person's late teens or early twenties. There are three general symptoms:
   i) Psychotic- altered perceptions, abnormal thinking, and odd behaviors.
   ii) Negative – loss of motivation, disinterest, lack of enjoyment in daily activities, withdrawal, difficulty showing emotions, and difficulty functioning normally.
   iii) Cognitive- problems with attention, concentration, and memory.

c) **How do we interact with someone with schizophrenia?**
   i) Remember that their beliefs and hallucinations are very real to them. Their eyes and ears are processing information the same way your eyes and ears are processing information right now. Don't try and tell them that you see or hear the same thing because when what they are seeing and hearingin changes and you do not see the change you will lose credbility and trust. Do not discredit what they're seeing. If you tell them that what they're seeing is wrong you will lose

their trust. Acknowledge that what they're seeing is real to them and it would be very scary to see and hear those things.

ii) Try and speak slowly, they might be hearing a lot of things (remember the example of 100 TVs?) and might have a hard time focusing on you. You can try to clap, or even ask them if they hear your voice and can focus on what your voice sounds like.

iii) They might move around a lot, be vigilant for your safety, but also try and let them expell that extra energy by pacing or moving their arms if they are not posing a present danger.

28) Bipolar Disorder

Bipolar: Watch Video
https://youtu.be/XQ2PbPr2AH4?si=t_2QFJ-2-e_pV6rr

a) *Instructor note: play video on introduction to bipolar disorder see if students learned anything from this video*

29) Bipolar Disorder

a) The Mayo Clinic defines Bipolar Disorder as "a mental health conditions that cuases extreme mood swings that include emotional highs (mania or hypomania) and lows (depression)"

b) Bipolar mood disorders fluctuate between mania, hypomania, and depression. These fluctuations are frequent and unpredictable. This can be very confusing for the individual and cause them to feel distressed.

i) Mania is an abnormally elated mental state characterized by feelings of euphoria, lack of inhibitions, racing thoughts, diminished need for sleep, talktativeness, risk taking, and irritability.

ii) Hypomania is similar to mania but milder.

c) Substance abuse can contribue towards episodes, drugs like cocaine, ecstasy, and ampetamines and trigger manic episodes and alcohol or tranquilizers can trigger depressive episodes.

d) How do we deal with people with Bipolar Disorder?

i) If they are in a manic state they may also be experiencing delusions, similar to Schizophrenia. They may also speak very rapidly which you may have to get them to repeat themselves or try and speak slower so they can mirror and speak slower.

ii) If they are in a depressive state remember to instill hope and be vigilant of suicide or harm to others.

A person who lives with Bipolar Disorder does not flip a switch from one second to another being happy or mad.

The character in the book Strange Case of Dr. Jekyll and Mr. Hyde probably lives with Dissociative Identify Disorder formally known as multiple personality disorder, not Bipolar Disorder as many assume.

Bipolar 1

- Characterized by Mania
- Associated with Psychotic Symptoms
- Had at least 1 manic episode

Bipolar 2

- Characterized by hypomania
- Will never indicate psychotic symptoms
- Had at least 1 hypomanic and depressive episode

Hypomania: May not require Hospitalization. Not a severe as mania.

Hypomania is **an abnormally revved-up state of mind** that affects your mood, thoughts, and behavior, and is a potential symptom of bipolar disorder, particularly type II

Manic: A **manic** episode involves a sustained period of abnormally elevated or irritable mood. Learn more about a **manic** episode, including symptoms and treatment.

Do

- Set limits and boundaries
- Keep control. Redirect
- Lock into a story
- Talk slow and clear

Don't

- Give in to demands
- Approach or touch

Questions?

30) Autism Spectrum Disorder

a) ASD is a developmental condition that affects a person's ability to socialize and communicate with others. People with ASD can also present with restricted or repetitive patterns of behavior, interests, or activities. There are varying degress in which the symptoms and behaviors severity within individuals.

31) ASD Continued

https://youtu.be/NHRFqGVAMu4?si=T6KkVX_vy6Go9XDd

a) Instructor note: optional video on officers interactions with autism.

32) Youth in Crisis

a) We must remember that adolescents have an immature frontal lobe, this means that they aren't able to see very far into the future of what the consequeces of their actions could be. They aren't easily able to restrain themselves, and often think themselves as invinceable. We also need to remember what a crisis could be for them, that might not be a crisis for us as adults.
   i) Instructor note: have class come up with a list of situations that could be a crisis for a teenager that might not be for an adult some examples could be:
      (1) Romantic relationship ended
      (2) Bad grades
      (3) Being grounded – inability to hang out with friends
      (4) Cyberbullying – or loss of "likes" or "shares" which could indicate loss of social status
b) NM ranks 42nd as of 2021 out of the United States for prevalence of mental illness/rates of access to care for youth.
c) Suicide is the second leading cuase of death in youth ages 10-24, and over 60% with major depression do not receive services.
d) A large number of US youth do not have access to health care coverage, or their coverage has gaps for behavioural health services.
e) Especially among adolessents, the stigma of mental illness remains high. Kids are bullied and isolated for being perceived as "weak".

33) Effects of COVID19 on Mental Health

a) Covid19 will be something we will all remember. It will become a "where were you when" type of converstaion how we speak of 9/11 or the JFK assasination now. It will leave a mark on every person who lived through the pandemic.
b) From the beginning of the pandemic to June 2021 there were 5,449 documents published in 132 countries. This alone shows how big of an effect COVID 19 had on mental health issues globaly.

c) When lockdown orders were issued throughout the world the number of people seeking mental health help grew. There was a great amount of chronic stress and anxiety put on the entire population. These ranged from loss of jobs/income to worry about contracting the virus and taking it home for essential workers who could not obey the quarantine. Children and adults who previously lived in abusive households now had no escape from their abusers, and children who relied on school lunches often had no access to food. This increased anxiety and stress because the social structures we depended on were gone without warning.
   i) People were no longer able to attend their religious services or exercise at their gym. This caused an inability to release their stress with the coping mechanisms they were used to.

d) An online survey was given to 1,047 participants and their answeres were recorded as a preliminary sample. The results showed 16.5% increase in people answered extremely to slightly dissatisfied in mental wellbeing and life satisfaction during quarantine period. The increase in people declaring a need for psychosocial support was 16.1%.
   i) These numbers were even higher in people who had, at any time, contracted COVID19.
   ii) Theories suggest that people who contracted the virus could be at a higher risk because of a fear of infecting the general population, or their family and an increased avoidance or fear of crowds even after their return to the population was deemed safe.

34) COVID 19 Continued

a) In January 2021 41% of adults reported symptoms of anxiety and/or depressive disorder. In June 2020 13% of adults reported new or increase substance abuse due to COVID 19 related stress, and 11% of adults reported thoughts of suicide within the past 30 days. From March-May 2020, the hight of lockdown, drug overdose deathls were the highest. With the lack of mental health services and the higher burden placed on mental health services during the pandemic people who felt they had no other option or place to get the help they needed turned to drugs and alochol as a way to self medicate.

b) Historacaly mental health impacts of disasters outlasts the disaster itself, sometimes up to 3 years or more because of the high financial componant related to this pandemic. There are analysis that project suidice and alcohol/drug misuse deaths will continue to be on the rise until 2029.

35) Traumatic Brain Injury

a) The definition of traumatic brain injury is “a sudden injury that causes damage to the brain. It may happen when there is a blow, bump, or jolt to the head. This is a closed head injury. A TBI can also happen when an object penetrates the skull. This is a penetrating injury.”

b) TBI can range from mild to severe with many different physical and psychological effects. Some effects may appear immediately, and some may take weeks to appear.

i) Mild TBI mental symptoms may include loss of consciousness, being in a dazed or confused state, memory or concentration problems, mood changes, feeling depressed or anxious, difficulty sleeping, or sleeping more than usual.
ii) Moderate to severe TBI mental symptoms may include profound confusion, agitation, combativeness, or unusual behavior, slurred speech, or even coma.
iii) There may also be behavioral changes including difficulty with self-control, lack of awareness of abilities, risky behavior, verbal or physical outbursts, or difficulty in social situations.
iv) Emotional changes may include depression, anxiety, mood swings, irritability, lack of empathy, anger, or insomnia.

c) We need to use care when dealing with a person who has suffered from TBI. Their altered mental state may have many different factors that play into their interaction with others and interaction with law enforcement. Vigilance is even more necessary because of their capability to be rash and risky.
d) Speaking with family members or close friends could prove to be invaluable because they have more time with this person and can help with tactics they have found to deal with this person's injury.

36) How to Get Help

a) Many employers offer an EAP (Employee Assistance Proram). Take advantage of that.
    (1) If you do not have access to an EAP you can download the NMConnect app for free. After downloading the app you can:
        (a) Call for support and resources,
        (b) Call if you are healthcare worker or first responder (this is still anonymous it just gives the calltaker information that you're a first responder because our problems can be different)
        (c) Text with a peer (1800-2300)
        (d) Call to connect with a pper (0700-2330)
    (2) This app will also guide you to mental health services in your area, give you videos, and provide reading material that will give you more tools to increase your mental health. It also includes resources for substance abuse.

37) Questions

a) Thank you for attending our class, please feel free to ask any questions.
b) Use the QR code to submit the course/instructor evaluation or ask for a paper copy if you are more comfortable with that.

ADDITIONAL RESOURCES

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COURSE AUDIT

PRIMARY INSTRUCTOR:

SECONDARY INSTRUCTOR:

SUPPORT STAFF:

DATE(S)/ TIME(S) OF INSTRUCTION:

LOCATION OF INSTRUCTION:

RECOMMENDED CURRICULUM CHANGES: Identify inaccurate information, outdated information, new information to be added to update material, etc. (Use additional pages if necessary)

ADDITIONAL INSTRUCTOR COMMENTS: (If any portion of the course content was not presented, indicate the specific content here)

☐ Alternative curriculum was taught.

Accreditation number of alternative curriculum:

	SIGNATURE	DATE
Primary Instructor		
Reviewed by Program Coordinator		
Reviewed by		
Reviewed by Director/Chief or Designee		