Albuquerque Police Department

Crisis Intervention Team Training

New Mexico Department of Public Safety Accreditation
NM170753

Revised 6/26/18

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New Mexico Behavioral Health Acronyms

A

AA – Alcoholics Anonymous
ABPP – American Board of Professional Psychology
ACT – Assertive Community Treatment
ADA – Americans with Disabilities Act
ADD – Attention Deficit Disorder
ADHD – Attention Deficit Hyperactivity Disorder
AFC – Adult Foster Care
AFD – Albuquerque Fire Department
AHCH – Albuquerque Healthcare for the Homeless
ACHR – Albuquerque Center for Hope and Recovery
AMHHC – Albuquerque Mental Health Housing Coalition
AOT – Assisted Outpatient Treatment
APD – Albuquerque Police Department
APS – Albuquerque Protective Services
APS – Albuquerque Public Schools
ASAM – American Society of Additional Medicine
ASI – Addiction Severity Index
ATR – Access to Recovery
ATTC – Addiction Technology Transfer Center

B

BAC – Business Associate Contract (HIPAA)
BCBSNM – Blue Cross Blue Shield of New Mexico
BHC – Behavioral Health Collaborative
BHIS – Behavioral Health Information System
BHO – Behavioral Health Organization
BHPC – Behavioral Health Planning Council
BHPC – Behavioral Health Purchasing Collaborative
BHSD – Behavioral Health Services Division
BIA – Bureau of Indian Affairs

C

CBHTR – Consortium for Behavioral Health Training and Research
CBT – Cognitive Behavioral Therapy
CC – Centennial Care
CCS – Creating Community Solutions
CCSS – Comprehensive Community Support Services
CET – Community Engagement Team (HB 222)
CEU – Continuing Education Unit
CFR – Code of Federal Regulations
CHADD – Children and Adults with Attention Deficit/Hyperactivity Disorder
CIT – Crisis Intervention Team (Albuquerque Police Department)
CIT – Crisis Intervention Team (Bernalillo County Sheriff Department)
CMHC – Community Mental Health Center
CMHS – Community Mental Health Services
CMS – Centers for Medicare and Medicaid Services
COBRA – Consolidated Omnibus Reconciliation Act
COD – Co-Occurring Disorder
COPE – Consumer Option Program for Empowerment
COSIG – Co-Occurring State Incentive Grant
CPSW – Certified Peer Support Worker
CPSWT – Certified Peer Support Worker Trainer
CRA – Community Reinforcement Approach and Family Training
CRAFT – Community Reinforcement Approach and Family Training
CSA – Core Service Agency
CSAP – Center for Substance Abuse Prevention
CSAT – Center for Substance Abuse Treatment
CSW – Community Support Worker

D

DASIS – Drug and Alcohol Services Information System
DBSA – Depression and Bipolar Support Alliance
DBT – Dialectical Behavioral Therapy
DD – Developmental Disability
DDPC – Developmental Disabilities Planning Council
DHI – Division of Health Improvement
DOJ – Department of Justice
DSM – Diagnostic and Statistical Manual of Mental Disorders
DVR – Division of Vocational Rehabilitation
DWS – Department of Workforce Solutions

E

EBP – Evidence-Based Practice
EIN – Employer Identification Number

EMDR – Eye-Movement Desensitization Reprocessing
EOB – Explanation of Benefits

F

FFS – Fee for Services
FIC – Forensic Intervention Consortium
FPL – Federal Poverty Level
FTE – Full Time Employee
FY – Fiscal Year

G

GAF – Global Assessment of Functioning
GED – General Education Developmental

H

HCH – Health Care for the Homeless
HIPAA – Health Insurance Portability and Accountability Act
HSD – Human Services Department

I

IDEA – Individuals with Disabilities Education Act
IDEA – Interface Data Exchange Application
IEP – Individualized Education Planning
IFN – Interagency Forensic Network
IHS – Indian Health Services
IOP – Intensive Outpatient Program
ISATS – Inventory of Substance Abuse Treatment Services

J

JJD – Juvenile Justice Division
JPO – Juvenile Probation Officer

L

LADAC – Licensed Alcohol and Drug Abuse Counselor
LBSW – Licensed Baccalaureate Social Worker
LFN – Local Forensic Network
LIHEAP – Low-Income Home Energy Assistance Program
LISW – Licensed Independent Social Worker
LMFT – Licensed Marriage and Family Therapist
LMHP – Licensed Mental Health Professional
LMSW – Licensed Master Social Worker

LPAT – Licensed Professional Art Therapist
LPC – Licensed Professional Mental Health Counselor
LPCC – Licensed Professional Clinical Mental Health Counselor
LPN – Licensed Practical Nurse
LSAI – Licensed Substance Abuse Intern

M

MAD – Medical Assistance Division
MADD – Mothers Against Drunk Driving
MCJCC – Metropolitan Criminal Justice Coordination Council
MCO – Managed Care Organization
MDC – Metropolitan Detention Center (Bernalillo County)
MFA – Mortgage Finance Authority
MHSIP – Mental Health Statistics Improvement Program
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MRN – Medical Record Number
MST – Multi-Systemic Therapy

N

NA – Narcotics Anonymous
NAMI – National Alliance on Mental Healthcare
NARMH – National Association of Rural Mental Healthcare
NASMHPD – National Association of State Mental Health Program Directors
NIDA – National Institute on Drug Abuse
NIMH – National Institute of Mental Health
NMBMI – New Mexico Behavioral Health Institute
NMCBBHP – New Mexico Credentialing Board for Behavioral Health Professionals
NMCBCDP – New Mexico Credentialing Board for Chemical Dependency Professionals
NSSATSS – National Survey of Substance Abuse Treatment Services

O

OBOT – Office-Based Opioid Treatment
OCA – Office of Consumer Affairs
OHCA – Organized Health Care Arrangement (HIPAA)
ORT – Opioid Replacement Therapy
OSAP – Office of Substance Abuse Prevenention

P

PACT – Program of Assertive Community Treatment
PAD – Psychiatric Advanced Directive

PAT – Peer Action Team
PATH – Projects for Assistance in Transition from Homelessness
PBE – Practice-Based Evidence
PCP – Primary Care Provider/Physician
PEBCAK – Problem Exists Between Chair and Keyboard
PHI – Protected Health Information
PMRI – Patient Medical Record Information
PMS – Presbyterian Medical Services
PPO – Preferred Provider Organization
PSR – Psychosocial Rehabilitation
PSU – Psychiatric Services Unit
PTSD – Post Traumatic Stress Disorders
PVA – Paralyzed Veterans of American

Q

QI – Quality Improvement
QM – Quality Management

R

RFI – Request for Information
RFP – Request for Proposal
ROI – Release of Information
RTC – Residential Treatment Center

S

SA – Substance Abuse
SAMSHA – Substance Abuse and Mental Health Services Administration
SAP – Substance Abuse Prevention
SAPT – Substance Abuse Prevention and Treatment
SBIRT – Screening, Brief Intervention, Referral and Treatment
SDMI – Serious/Severe Disabling Mental Illness
SED – Serious Emotional Disturbance
SED – Severe Emotional Disorder
SMI – Serious/Severe Mental Illness
SSA – Single State Agency
SSA – Single State Authority
SSA – Social Security Administration
SSAA – State Substance Abuse Authority
SSDI – Social Security Disability Insurance
SSI – Supplemental Security Income
SSN – Social Security Number

T

TA – Technical Assistance
TANF – Temporary Assistance for Needy Families Program
TBI – Traumatic Brain Injury
TCA – Total Community Approach
TFC – Treatment Foster Care
TIN – Taxpayer Identification Number
TLS – Transitional Living Services
TPO – Treatment, Payment and Health Care Operations
T-SIG – Transformation State Incentive Grant
TUPAC – Tobacco Use Prevention and Control

U

UM – Utilization Management
UPL – Upper Payment Limit
UR – Utilization Review

W

WRAP – Wellness Recovery Action Plan

V

VA – Veterans Administration
VAS – Value Added Services

Y

YDI – Youth Development Inc.

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Crisis Intervention Team Training

CIT Overview and History

Student Guide

CIT Overview

The term “CIT” is often spoken about when it comes to training and a law enforcement program. The below definitions are taken from some of the national leaders in the movement of CIT.

Definitions:

The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in Memphis and has spread throughout the country. It is known as the “Memphis Model.” CIT provides law enforcement-based crisis intervention training for assisting those individuals with a mental illness, and improves the safety of patrol officers, consumers, family members, and citizens within the community. CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness. The CIT Model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.

-Dupont, Randolph, Sam Cochran, and Sarah Pillsbury. "Crisis Intervention Team Core Elements." (2007). Print. University of Memphis.

National Alliance on Mental Illness

CIT (Crisis Intervention Team) programs are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. They are built on strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness.

History of CIT

Mental health contacts and intervention by law enforcement became part of the profession with the deinstitutionalization of nonviolent mentally ill patients in the 1960s. The goal was to allow people receiving treatment in an institution to continue to receive the treatment but from community service agencies. The money saved by hospital closing was to be transferred to outpatient community programs.

The money intended for outpatient services never found its way to the community. Funding for outpatient treatment services and programs are still lacking it most areas of the United States. This left a gap for people who were in need of services. Without the assistance many people stop their treatment programs; which resulted in many people becoming unstable while living in the community, with their families who were ill equipped to be caregivers.

When people living with the illness became psychotic or had poor quality of life in communities, the police became the go to resource for helping. Law enforcement has always been there to serve the most vulnerable in their community, which historically was viewed as victims of crime. With the lack of resources and treatment for people with mental illness they became the most vulnerable in many communities leading officers to become front line mental health workers.

METRO

MEMPHIS, WEDNESDAY, SEPTEMBER 30, 1987 THE COMMERCIAL APPEAL ***** SECTION B

Furor sparks call for crisis team

New options needed on handling of mentally ill, says alliance

By William C. Bayne
Staff Reporter

Approached aggressively, a person with severe mental problems may react aggressively — either fighting or fleeing from law enforcement officers or others trying to help.

"There's magic in the manner," said Ann Dino, president of the Alliance for the Mentally Ill of Memphis, the organization that suggested the task force approach for dealing with uncontrollable people with mental illness.

She said a better approach to Joseph Robinson, the 27-year-old man who was shot repeatedly and killed last Thursday by police, might have "prevented the tragedy."

On Monday, Mayor Dick Hackett announced he would speed up plans to create a crisis intervention team, which would include mental health professionals, to deal with people who have mental problems and are violent.

No evidence has emerged to show Robinson had a history of mental illness. A relative who had called police to subdue him said he was "trying to cut his throat, acting like he's on drugs," police reported.

Mrs. Dino and others with the alliance met with Police Director John Holt before Thanksgiving last year asking for a task force approach to handling the uncontrollable mentally ill.

She said Holt seemed receptive to the idea and assigned Patrolman John Dwyer to research the proposal.

"You have to have the research in order to see what best will work in connection with the assets you have," she said yesterday. "Los Angeles has the best one in the country, but it took them two years to work out the kinks in their operation."

Part of the research, she said, pointed out changes needed in ordinances and some state laws about the handling of emergency commitments.

She praised Dwyer's work as excellent and said the cooperation was tremendous between the Police Department and City Hall. She said the first-year start-up costs for the task force would [illegible] but she did not know the annual operating cost.

"John Dwyer's research showed the task force would pay for itself" in savings to the Police Department and other agencies, Mrs. Dino said.

Asked why it took so long for the city to announce the plan, she said, "Sometimes it just takes some hollering and screaming to get something done. It's sad that it took this tragedy for something to happen, but maybe something good is going to come

Ann Dino

Please see TASK, Page B2

Bayne, W. (1987, September 30). Furor sparks call for crisis team. *Memphis Metro*, pp. B1-B2.

In September 1987 Memphis, TN police responded to a 911 call involving a young man with a history of mental illness who was cutting himself with a knife and threatening suicide. When officers responded to the location they had ordered the man to drop the knife. The man became more upset and ran towards the officers with the knife still in his hand. Officers then discharged their firearms killing the man.

Officers were trained to use deadly force when they perceive their own or someone else's life to be in grave danger. This incident was criticized because the perception on the call was the only life in danger was the man who wanted to kill himself. This occurred during a time of racial tension in Memphis and the man was African-America while both officers were white. This incident was the catalyst for the creation of the Crisis Intervention Team (CIT) in Memphis.

The Memphis Police Department joined in partnership with the Memphis Chapter of the National Alliance for the Mentally Ill (NAMI), mental health providers, and two local universities (the University of Memphis and the University of Tennessee) in organizing, training, and implementing a specialized unit. This unique and creative alliance was established for the purpose of developing a more intelligent, understandable, and safe approach to mental crisis events. This community effort was the genesis of the Memphis Police Department's Crisis Intervention Team.

The Memphis CIT program has achieved remarkable success, in large part because it has remained a true community partnership. Today, the so-called "Memphis Model" has been adopted by more than 2000 communities in more than 40 states, and is being implemented statewide in several states, including Maine, Connecticut, Ohio, Georgia, Florida, Utah, and Kentucky.

University of Memphis CIT Center 2015

Sam Cochran was the coordinator of the Memphis Police Services Crisis Intervention Team (CIT). He retired from the Memphis police department as a Major after over 30 years of service and now provides consultation to CIT programs throughout the nation. He holds a Masters degree in Political Science from the University of Southern Mississippi. In addition to his nationally recognized work with the CIT program, Major Cochran was a coordinator for the Hostage Negotiation Team and the Critical Incident Services (CIS) for the Memphis Police Department. During his time as a law enforcement officer, Major Cochran (ret.) served in uniform patrol, the investigative division and was been an instructor at the training academy.

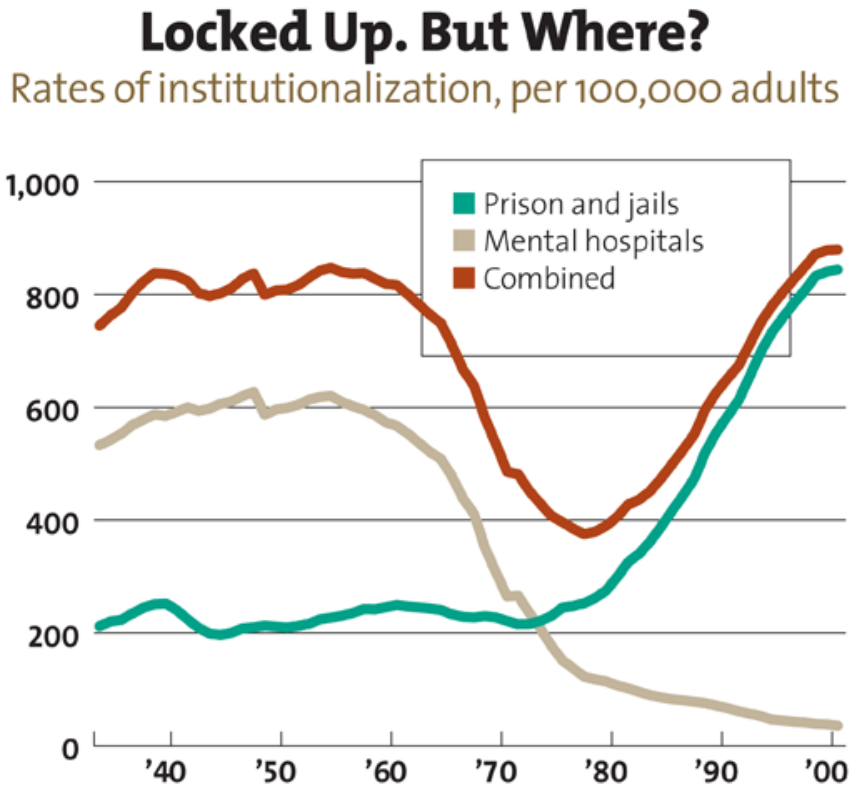
He is nationally known for his work in the field of crisis intervention. In addition to receiving the City University of New York (CUNY) John Jay College of Criminal Justice, Law Enforcement News Person of the Year Award (2000), the National Alliance of the Mentally Ill (NAMI) has named their annual law enforcement advocacy award after Sam Cochran. He has worked with police departments throughout the nation as well as departments in Canada, Australia, and England.

Randolph Dupont, PhD is a Professor and Clinical Psychologist at the University of Memphis School of Urban Affairs and Public Policy, Department of Criminology and Criminal Justice. Previously, he was a professor at the University of Tennessee Center for the Health Sciences where he directed the Regional Medical Center Psychiatric Emergency Services for 14 years. He was the principal investigator for the Tennessee Health and Human Services SAMSA Jail Diversion Research project and is currently a principal investigator in the National Science Foundations grant to study the use of advanced computer technology to train law enforcement officers in crisis de-escalation techniques.

Dr. Dupont is a nationally recognized expert in the fields of mental illness and crisis de-escalation systems and is the lead consultant and key instructor for the Memphis Police CIT program. He also directs the trauma recovery program for both the Memphis Police and Fire Departments. He has trained a wide variety of professionals, including those involved in criminal justice, fire, emergency medical services, healthcare, social service as well as business and industry.

University of Memphis CIT Center 2015

Jail Diversion



Before the creation of the CIT program responding to common calls involving someone living with a mental illness like disturbing the peace or minor misdemeanor offenses would often result in the person being taken directly to jail. This increased the population of the jail with people who would be better suited in a medical facility and created safety concerns for inmates. Memphis created the concept of jail diversion; taking known or suspected individuals showing signs of a mental illness to the hospital for treatment first before they entered the court system.

CIT Statistics

CIT helps keep people with mental illnesses out of jail, and gets them into treatment.

- Studies show that police-based diversions, and CIT especially, significantly reduce arrests of people with serious mental illnesses. Pre-booking diversion, including CIT, also reduced the number of re-arrests by 58%.
- In a one-year study of pre-booking jail diversion, including CIT, participants in jail diversion programs spent on average two more months in the community than non-diverted individuals. Individuals diverted through CIT and other programs receive more counseling, medication and other forms of treatment than individuals who are not diverted.
- CIT training reduces officer stigma and prejudice toward people with mental illness.
- CIT officers do a good job of identifying individuals who need psychiatric care[1] and are 25% more likely to transport an individual to a psychiatric treatment facility than other officers.

CIT reduces officer injuries, SWAT team emergencies, and the amount of time officers spend on the disposition of mental disturbance calls.

- After the introduction of CIT In Memphis, officer injuries sustained during responses to “mental disturbance” calls dropped 80%.
- After the introduction of CIT in Albuquerque, the number of crisis intervention calls requiring SWAT team involvement declined by 58%.
- In Albuquerque, police shootings in the community declined after the introduction of CIT.
- Officers trained in CIT rate their program as more effective at meeting the needs of people with mental illness, minimizing the amount of time they spend on “mental disturbance” calls, and maintaining community safety, than officers who rely on a mobile crisis unit or in-house social worker for assistance with “mental disturbance” calls.

History in APD

Police Crisis Team Honored

Officers Deal With Mentally Disturbed

BY GUILLERMO CONTRERAS

Journal Staff Writer

Mental health professionals on Saturday hosted a banquet to honor the Albuquerque Police Department and its fledgling Crisis Intervention Team.

The team is made up of officers who were selected for their ability to help defuse potentially volatile situations. The officers are trained to deal with people with mental-health problems that might put them or others at risk or who are threatening suicide.

The team was assembled in January, when 30 officers began taking classes instructed by mental health professionals. Part of the training includes how to talk people with mental health disorders out of committing crimes or from hurting themselves or other people.

Since then, 92 APD officers have been trained, including the department's SWAT team.

Outgoing Police Chief Joe Polisar, who spoke briefly at Saturday's banquet, said that in the late 1980s and early 1990s, the APD was criticized severely for the way it handled crisis-related incidents.

The department looked for ways to better deal with those situations. Members of the department heard about a program in place since 1988 in Memphis, Tenn., and two representatives were sent there to examine it in 1994.

The APD began networking with members of the mental health field and eventually established the team here.

L.J. Lovell, a case manager for the University of New Mexico's Mental Health Center, told the 150 people at the dinner that officers have recognized that some people need mental health evaluation and not incarceration.

Sgt. W. Gene Pettit, who coordinates APD's Crisis Intervention Team, says the program has been very successful. In the past three months, officers have taken an average of 85 to 89 people to mental health facilities — instead of to jail.

The department is gearing up for another class Nov. 17. To participate, officers have to volunteer and go through a rigid screening process. Officers are often chosen for their communication and tactical skills, including good judgment in high-pressure situations. They get 40 hours of training.

Pettit said he looks to the future when "the Crisis Intervention Team would no longer be looked upon as a change. It would be looked upon as tradition."

Contreras, G. (1997, November 9). Police Crisis Team Honored. *Albuquerque Journal*.

Dr. Donn Hubler APD Psychologist	Sgt. Gene Petit CIT Coordinator

In 1996 Sgt. Gene Pettit was assigned the task of starting a CIT program for the Albuquerque Police Department (APD). He began networking to build collaboration with the community. With a joint effort the University of New Mexico, NAMI, and the APD put on their first 40-hour CIT class that graduated January 31st, 1997. The class was taught in collaboration with community experts at the local resources that were available to officers.

The APD was an innovator in expanding the CIT program in law enforcement. By creating a unit of full time sworn officers for follow up with individuals living with mental illness the APD created a standard for police intervention in crisis situations. APD was the first department to have a psychiatrist employed to assist in guidance on police crisis intervention.

The APD and the Department of Justice created a settlement agreement in 2015 outlining changes in the CIT program to include increase in data collection, training, and increase in detectives.

Shoup, S. (1999, June 11). Crisis Training Cuts SWAT Deployments, Police Official Says. *Albuquerque Journal*.

Crisis Training Cuts SWAT Deployments, Police Official Says

By Steve Shoup
Journal Staff Writer

Training officers to deal with people who are mentally ill or suicidal has reduced the number of SWAT team deployments and the number of mentally ill people who wind up in jail, a police crisis specialist said.

"I think (crisis intervention training) has put the Albuquerque Police Department on the cutting edge of police work, especially in the Southwest," Sgt. Gene Pettit, who oversees APD's crisis intervention programs, said during a presentation Thursday to the city's Police Oversight Commission.

APD started training crisis intervention specialists in 1997. Now the department has 108 officers with crisis training, which is about a quarter of the officers on patrol, Pettit said. Officers with the training are available at all hours in all parts of the city.

Crisis officers handle routine patrols like other officers, but are called to incidents such as domestic violence, someone threatening suicide or behaving strangely or dangerously, Pettit said.

Officers handle about 300 crisis calls a month. Of those, about 48 percent of the people involved are using alcohol or illegal drugs, 12 percent have a weapon, 36 percent are threatening suicide, 61 percent are mentally ill, or are a combination of some of those categories, Pettit said.

The officers have been trained to talk to distressed people, find out how to defuse a crisis and how to get the person help. Consequently, only 12 percent of people handled by the crisis officers go to jail or its alcohol detoxification unit, while 48 percent are taken or referred to mental health services. The remainder of the crisis cases are handled at the scene of the call.

Only 1 percent of crisis calls result in use of force, such as chasing or restraining someone, which results in injury to a distressed or mentally ill person, Pettit said.

The SWAT team is used much less often to handle suicidal people now that crisis officers are available, Dr. Donn Hubler, APD's staff psychologist, told the commission.

The combination of crisis training and APD's less-lethal weapons, such as bean-baglike shotgun projectiles, have saved lives, Pettit said.

The Police Oversight Commission was created by the City Council last year after public outcry over the number of fatal shootings by APD officers in recent years.

In other business, the commission hopes to select three candidates to fill the new post of independent review officer, who is also part of the new police oversight system. Commission chairwoman Jill Marron said the commission will review the candidates in July and forward the names to the mayor and City Council.

The commission will also seek public comment at its July meeting on its proposed rules on handling appeals of citizens' complaints against police officers, Marron said.

Collaboration

On September 1st, 2015 a memorandum of understanding was signed between the APD, Bernalillo County Sheriff's Department, and the Rio Rancho Police Department. This marked a unique advancement in CIT for New Mexico creating the first metro team to assist the state's largest metropolitan area.

The APD CIT program collaborates with the following organizations:

- National Alliance on Mental Illness (NAMI)
- University of New Mexico (UNM)
- Mental Health Response Advisory Committee (MHRAC)
- St. Martin's Hospitality Center
- Noon Day Ministries
- Health Care for the Homeless
- CABQ Community and Family Services
- New Mexico Solutions
- Agora Crisis Center
- Albuquerque Heading Home Project
- Depression Bipolar Support Alliance (DBSA)
- Forensic Intervention Consortium
- Presbyterian Hospitals
- Veteran Affairs Hospitals
- And many more

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Crisis Intervention Team Training

De-escalation Tips and Techniques

Student Guide

De-Escalation

What is it?

- A variety of psychosocial techniques aimed at reducing violent and/or disruptive behavior.
- Skills used to reduce/eliminate the risk of violence during an escalation phase through verbal and non-verbal communications.
- Less authoritative, less controlling, less confrontational approach to gain more control.

Fight, Flight, or Freeze

Look at the following list of flight, fight freeze responses below, possible signs that someone is no longer feeling safe and might be at risk. This is not a complete list but may help to identify what you should be watching for:

Fight

- Crying
- Hands in fists, desire to punch, rip
- Flexed/tight jaw, grinding teeth, snarl
- Fight in eyes, glaring, fight in voice
- Desire to stomp, kick, smash with legs, feet
- Feelings of anger/rage
- Homicidal/suicidal feelings
- Knotted stomach/nausea, burning stomach
- Metaphors like bombs, volcanoes erupting

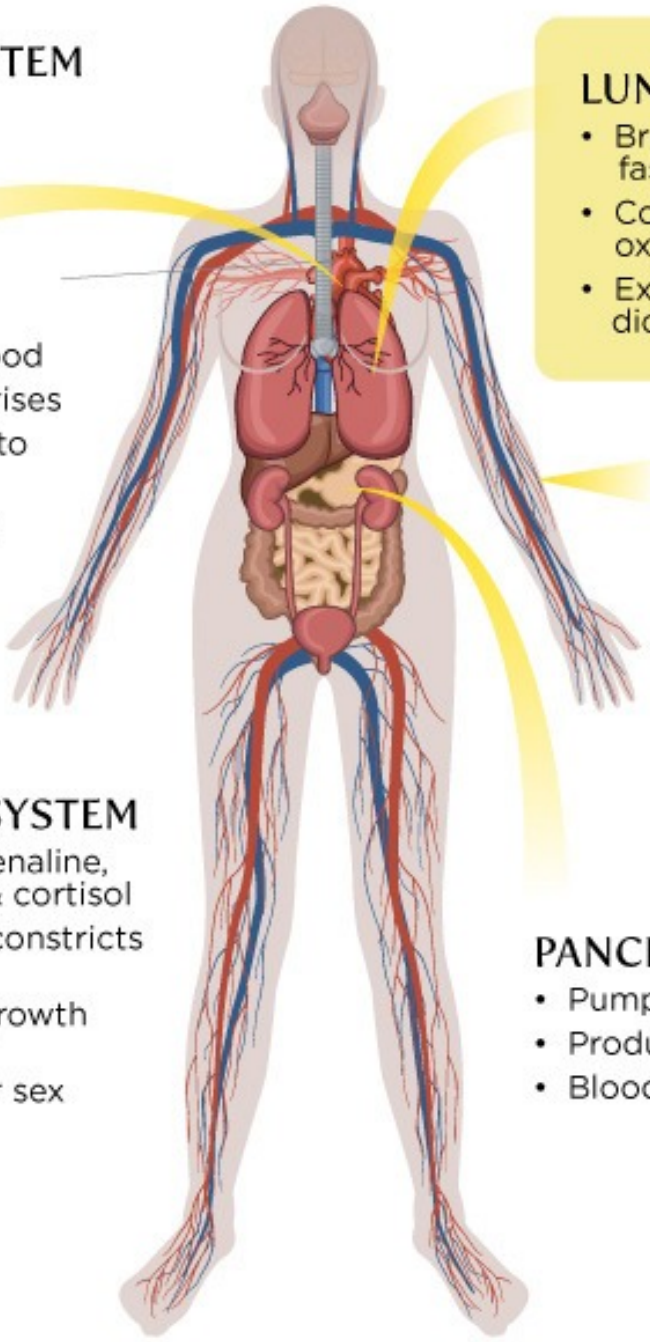
Flight

- Restless legs, feet /numbness in legs
- Anxiety/shallow breathing
- Big/darting eyes
- Leg/foot movement
- Reported or observed fidgety-ness, restlessness, feeling trapped, tense
- Sense of running in life- one activity-next
- Excessive exercise

Freeze

- Feeling stuck in some part of body
- Feeling cold/frozen, numb, pale skin
- Sense of stiffness, heaviness
- Holding breath/restricted breathing
- Sense of dread, heart pounding
- Decreased heart rate (can sometimes increase)
- Orientation to threat

Fight-or-Flight Response



IMMUNE SYSTEM
- Is repressed

HEART
- Beats faster
- Pumps more blood
- Blood pressure rises
- Blood increases to muscles
- Blood decreases to organs

LUNGS
- Breathing becomes faster & shallower
- Consume more oxygen
- Expel more carbon dioxide

SKIN
- Sweating begins

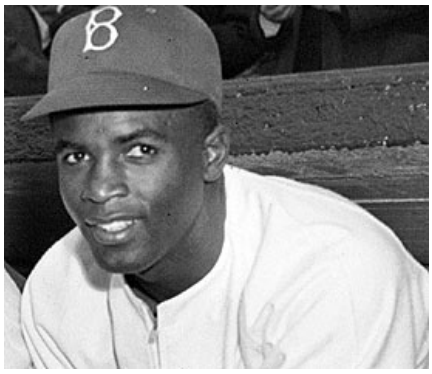
ENDOCRINE SYSTEM
- Pumps out adrenaline, noradrenaline & cortisol
- Noradrenaline constricts blood vessels
- Releases less growth hormone
- Produces fewer sex hormones

PANCREAS
- Pumps out glucagon
- Produces less insulin
- Blood sugar level rises

http://www.appliedbiofeedbacksolutions.com/fff.html

Respect & Dignity

“I'm not concerned with your liking or disliking me... All I ask is that you respect me as a human being.”
Jackie Robinson



“Dignity does not consist in possessing honors, but in deserving them.”
Aristotle

Respect

- a feeling of admiring someone or something that is good, valuable, important, etc.
- a feeling or understanding that someone or something is important, serious, etc., and should be treated in an appropriate way
- a particular way of thinking about or looking at something

Dignity

- a way of appearing or behaving that suggests seriousness and self-control
- the quality of being worthy of honor or respect

Merriam-Webster

Bias

Implicit Bias and Law Enforcement
By Tracey G. Gove, Captain, West Hartford, Connecticut, Police Department

The implicit bias phenomenon is being explored in many phases of the criminal justice system and is not limited to law enforcement. Specifically, implicit bias is being studied in judicial decision making (for example, jury selection, jury instruction, and sentencing decisions), as well as in hiring and promotion decisions within criminal justice agencies. Outside of the criminal justice field, the topic has been examined in the fields of education and medicine, as well as in CEO selection at Fortune 500 companies.

A discussion on implicit bias must start with a brief explanation of how the brain sorts, relates, and processes information. Much of the day-to-day processing is done at an unconscious level as the mind works through what Professor Kang calls schemas, which are "templates of knowledge that help us organize specific examples into broad categories. A stool, sofa, and office chair are all understood to be 'chairs.' Once our brain maps some item into that category, we know what to do with it—in this case . . . sit on it. Schemas exist not only for objects, but also for people. Automatically, we categorize individuals by age, gender, race, and role. Once an individual is mapped into that category, specific meanings associated with that category are immediately activated and influence our interaction with that individual."

When used to categorize people, these schemas are called stereotypes. Although the term stereotype carries a negative connotation, social scientists posit that stereotyping is simply the way the brain naturally sorts those we meet into recognizable groups. Attitudes, on the other hand, are the overall evaluative feelings, positive or negative, associated with these individuals or groups. That is to say, attitude is the tendency to like or dislike, or to act favorably or unfavorably, toward someone or something.

For example, "[I]f we think that a particular category of human beings is frail—such as the elderly—we will not raise our guard." Also, "[I]f we identify someone as having graduated from our beloved alma mater, we will feel more at ease."-Lastly, when introduced to someone new, about whom nothing is known but who is reminiscent of an old, admired friend, one may instantly feel comfortable and at ease with that person.

It is said that implicit bias, then, includes both implicit stereotypes and implicit attitudes and is shaped by both *history* and *cultural influences* (for example, upbringing; life experiences; relationships; and all manner of media—books, movies, television, newspapers, and so on). Research has shown that a person's previous experiences (both positive and negative) leave a "memory record." Implicit biases encompass the myriad fears, feelings, perceptions, and stereotypes that lie deep within the subconscious; they act on those memory records and exist without an individual's permission or acknowledgement. In fact, implicit bias can be completely contradictory to an individual's stated beliefs—a form of conscious-unconscious divergence.

Verbal Judo

"Treat people well, regardless of their differences." – **Dr. George Thompson**

The Five Universal Truths

For the last thirty years of his eclectic life, George "Rhino" Thompson crisscrossed America with a message the world desperately needs to hear – a message of tolerance for other human beings and our outer differences and his last chapter and to find common ground with Five Universal Truths.

1. All people want to be treated with dignity and respect.
2. All people want to be asked rather than being told to do something.
3. All people want to be told why they are being asked to do something.
4. All people want to be given options rather than threats.
5. All people want a second chance when they make a mistake.

This global perspective promoting universal respect, tolerance and forgiveness can connect all people, everywhere. We need a vehicle to develop understanding, and using our words for a defined purpose can create the forward momentum toward an ultimate goal.

L.E.A.P.S.

- Listen: gives you more information on where the person is today
- Empathize: gives you information on where the person has been
- Ask: fact finding, general, direct, open ended questions, opinion seeking
- Paraphrase: their meaning in your words
- Summarize: reconnects communication when interrupted

verbaljudo.com
Address: PO BOX 1351 Auburn, NY 13021
Phone: 800.448.1042
Fax: 800.805.9572

Verbal Judo Institute

Mental Health First Aid

Mental Health First Aid is an 8-hour course that teaches you how to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps someone identify, understand, and respond to signs of mental illnesses and substance use disorders.

The theme of the course is the de-escalation process broken down into 5 steps called **A.L.G.E.E.**

Mentalhealthfirstaid.org
info@mentalhealthfirstaid.org
202-684-7457

Assess for risk of suicide or harm

When helping a person going through a mental health crisis, it is important to look for signs of suicidal thoughts and behaviors, non-suicidal self-injury, or other harm. Some warning signs of suicide include:

- Threatening to hurt or kill oneself
- Seeking access to means to hurt or kill oneself
- Talking or writing about death, dying, or suicide
- Feeling hopeless
- Acting recklessly or engaging in risky activities
- Increased use of alcohol or drugs
- Withdrawing from family, friends, or society
- Appearing agitated or angry
- Having a dramatic change in mood

Mental Health First Aid

Listen nonjudgmentally

It may seem simple, but the ability to listen and have a meaningful conversation requires skill and patience. Listening is critical in helping an individual feel respected, accepted, and understood. Mental Health First Aid teaches you to use a set of verbal and nonverbal skills such as open body posture, comfortable eye contact, and other strategies to engage in appropriate conversation.

Give reassurance and Information

It is important to recognize that mental illnesses and addictions are real, treatable illnesses from which people can and do recover. When talking to someone you believe may be experiencing symptoms of a mental illness, approach the conversation with respect and dignity and don't blame the individual for his or her symptoms. Mental Health First Aid provides information and resources you can offer to someone to provide emotional support and practical help.

Encourage appropriate professional help

There are many professionals who can offer help when someone is in crisis or may be experiencing the signs and symptoms of a mental illness or addiction.

Types of Professionals

- Doctors (primary care physicians or psychiatrists)
- Social workers, counselors, and other mental health professionals
- Certified peer specialists

Types of Professional Help

- "Talk" therapies
- Medication

Other professional supports

Encourage self-help and other support strategies

Individuals with mental illness can contribute to their own recovery and wellness through:

- Exercise
- Relaxation and meditation
- Participating in peer support groups
- Self-help books based on cognitive behavioral therapy
- Engaging with family, friends, faith, and other social networks

De-Escalation

Four Encounter Types in Crisis Response

1. Loss of reality (LOR)
2. Loss of hope (LOH)
3. Loss of control (LOC)
4. Loss of perspective (LOP)

Loss of Reality

- Withdrawn
- False Beliefs
- Disorganized thinking
- Hearing/Seeing things
- Odd behaviors or mannerisms
- Suspicious/paranoia/fearful
- Highly distractible/disoriented

How can you inadvertently escalate a situation?

- Officer presence- Gun, Badge, Belt, Body Position, Use of Space Crowding
- Over-reliance on commands to get compliance – yelling, arguing, ordering
- Hands-on touching
- Lack of patience, empathy

Why confrontation does not <u>ALWAYS</u> work.

- Logic and ability to reason are compromised during a psychiatric crisis.
- Disorganized thinking causes difficulty in following simple requests
- Paranoid ideation causes mistrust of others, including officers
- Reasons for non-compliance are less about a power struggle (as they might be in a normal conflict) and more about the brain disorder that is mental illness.

CIT Paradox

By taking a less physical, less authoritative, less controlling, less confrontational, approach you will have more authority, more control over the person in a diminished capacity encounter.

Ground subject in the here and now.

Loss of Control

- Manipulation
- Impulsiveness
- Destructiveness
- Irritability/Hostility
- Anger/Argumentative
- Anti-social/oppositional

Listen, defuse, deflect

Loss of Hope

- Sad/Anguish
- Overwhelmed
- Emotional Pain
- Fatigue/helpless
- Suicidal talk/gestures
- Crying/deep despair

Instill Hope

Loss of Perspective

- Euphoric/Energetic
- Physical discomfort
- Restlessness/Pacing
- Verbal/rapid speech
- Apprehension/dread
- Grandiose/ambitious
- Anxiety/nervous/panic

Calm, Re-direct, Re-assure

In all four crisis situations the Goal is to CALM.

Three Phases of an Encounter

Engage:

- Establish rapport
- How you are presenting yourself
- Introduce yourself, ask the person's name
- State the reason you are there in a way that builds trust (make it about safety and empathy)
- Scene management – remove distractions, upsetting influences and disruptive people

Assess:

- Gather needed info
- Ruling in/out mental illness
- Medical or drug/alcohol issues
- Was a crime committed
- Assess lethality if suicide or depression is an issue
- Talk to others at the scene
- Trust the experts. Family members can be a great source of information

Resolve:

- Voluntary compliance
- Decide on course of action
- Forecast, tell the person what you are going to do. "I am going to put my hands in your jacket pocket to check for any weapons."
- Leading. Tell them what you expect and what you need form them.

Active Listening Skills

Safety, De-stigmatization, and Resources should be kept in mind when using Active Listening Skills. Keeping dignity and respect in mind will help with rapport building.

Definitions:

- A communication technique that a listener uses to show the speaker that they are paying attention and understand the message that is being relayed.

- Active listening is a communication technique used in counseling, training and conflict resolution, which require the listener to feed back what they hear to the speaker.

Why Active Listening:

Empathy vs Sympathy

- Empathy: Understanding what others are feeling and/or thinking because you have experienced it yourself or can put yourself in their shoes.

- Sympathy: Acknowledging another person's emotional hardships and providing comfort and assurance.

Using active listening skills and techniques can help the listener gain a better understanding of the situation that the speaker is going through. This helps relay to the speaker that the listener has empathy towards the situation. The listener gains more information by using skills and has the ability to retain the information more effectively. Rapport building in heightened emotional states is important because it can help you with gaining compliance through influence.

Clinical evidence and research suggest that active listening is an effective was to create behavioral change in others (Rogers, C., & Dymond, R., 1954). When listened to by another, individuals tend to evaluate their own feelings and thoughts, allowing them to have more clarity. This allows them to become better problem solvers and more accepting of someone else's point of view. Showing empathy allows the individual to have less fear of being criticized and open up to a realistic appraisal of their own position (Noesner, G., & Webster, M., 1997).

The use of active listening skills helps create an empathic relationship between the officer and the subject. Building this empathy can help create rapport, which in time can be used to influence the person's behavior. Using this approach in crisis intervention shows an effort in a short period of time to stabilize emotions and restores a subject's ability to think more clearly.

Active listening- Physical Skills:

Active listening starts with your physical characteristics and approach when engaging someone. These skills may not work on everyone you spend time with but if you use them consistently they will reflect professionalism on all your encounters.

Creating a scene with empathy and respect will help an individual feel safe enough to consider other perspectives and become more receptive to the positive suggestion from law enforcement.

- Face the speaker
- Nod occasionally
- Maintain eye contact
- Minimize distractions
- Keep an open mind
- Open and inviting posture when safe

- Open hands while talking or listening
- Thinking position
- Sitting when safe
- Respond appropriately
- Smile and other facial expressions
- Talk to the person directly

Internal and External distractions:
Internal distractions are your own personal biases and emotions.

Emotions:

- Anger
- Frustration
- Irritation

Biases:

- Giving more attention to people who look like you
- Wealthy
- Attractive

Barriers to Active Listening:

- Arguing
- Patronizing
- Interrupting
- Moralizing
- Rescue trap
- Demeaning
- Intimidating
- Police Jargon- 10 code, statue numbers, etc.
- "Why" questions
- Quick Reassurances
- Advising
- Preaching
- Lecturing

Seven Active Listening Skills:

- Reflecting/Mirroring
- Open-Ended Questions
- Minimal Encouragers
- Emotion Labeling
- Paraphrasing
- "I" Messages
- Effective Pauses

Use these techniques to show the speaker that you are listening. It can be used to help continue or start a conversation, and some techniques can be used to help you gather more information. Using these techniques can help you retain more information from your conversation with an individual. These are designed to let someone who is speaking know that you are listening, resulting in better rapport and de-escalation.

Reflecting/Mirroring:

- This should be simple and short. You repeat key words or the last few spoken words that the speaker just said. This shows the speaker that the listeners is trying to understand and is using the speaker's terms as reference. This also helps indicate to the speaker that the listener wants them to continue the conversation and maybe talk more about what the listener reflected back.
    - "Gist" of a sentence
    - Repeating the last few words
    - Results in more intelligence
    - Voice inflection is important- Asking it in the annotation of a question

Example: “Ever since we broke up I want to die”- Speaker
“You want to die…”- Listener (Mirroring)
“You want the pain to go away…” –Listener (Reflecting)

Open Ended Questions:

- These are designed to encourage a full, meaningful answer using the subject’s own knowledge and/or feelings. It is the opposite of close-ended questions, which encourages a short or single-word answer.
- Using the acronym WHaT can help you create open-ended questions.
    - What
    - How
    - (and)
    - “Tell me more about…”

Minimal Encouragers:

- These are small signals that let the speaker know you are listening and understanding what they are saying.
- Examples:
    - “uh-huh”
    - “mmm”
    - “ok”
    - Head nodding

- *Note:* Be cautious using “ok” in certain situations. It can relay that you are approving of an inappropriate action.
    - *Example:* I am going to kill myself.”, and the listener responds “ok”.

Emotion Labeling:

- This is an important step in building rapport. It helps the speaker know that the listener is seeing and understanding the emotions of the situation or content.
- You let the speaker know that you are seeing or hearing an emotion that they are experiencing or have experienced.
- Don’t be afraid of labeling the emotions incorrect.
- Examples:
    - “This experience sounds horrifying to you.”
    - “You look deflated and sad.”
- See the emotion wheel/list later in this section.

Psychological research has classified six facial expressions which correspond to distinct universal emotions: disgust, sadness, happiness, fear, anger, surprise [Black,Yacoob,95]. It is interesting to note that four out of the six are negative emotions.

Paul Ekman's initial research determined that there were six core emotions, which he termed *universal emotions*. These original universal emotions are:

1. Happiness - symbolized by raising of the mouth corners (an obvious smile) and tightening of the eyelids
2. Sadness - symbolized by lowering of the mouth corners, the eyebrows descending to the inner corners and the eyelids drooping
3. Surprise - symbolized by eyebrows arching, eyes opening wide and exposing more white, with the jaw dropping slightly
4. Fear - symbolized by the upper eyelids raising, eyes opening and the lips stretching horizontally
5. Disgust - symbolized by the upper lip raising, nose bridge wrinkling and cheeks raising
6. Anger - symbolized by eyebrows lowering, lips pressing firmly and eyes bulging

There is a seventh emotion that is sometimes considered universal.

7. Contempt - symbolized by half of the upper lip tightening up (using what is called the risorius muscle) and often the head is tilted slightly back.

Paraphrasing:

- You translate the conversation into your own words and let the speaker know.
- Let's the speaker know you are listening.
- Helps you gain more information and clarify the information you have been given.

"I" Statements:

- Used to convey your concerns in a manner that is non-threating and does not put the subject in an immediate defensive state.
- Helps to build rapport by establishing the listener as an individual and not a uniform.
- Example;
    - "I want to know what happened today but it is hard for me to focus on your words when you have a knife in your hand."

Effective Pauses:

- This is a break in conversation when you do not say anything.
- Used immediately before or after saying something meaningful.
- Silence is uncomfortable for most people.
- Gives you a chance to gather your thoughts.

S.A.F.E.R. Model

This model helps illustrate when active listening skills fail or when they should not be used. As professionals all situations are handled with dignity and respect, which should never be overlooked. The following are situations where active listening would not be utilized in law enforcement.

Security of Person and/or Property:
Always follow your officer safety training and SOP (standard operating policy) when handling situations involving the security of people and places. If you are on a scene where someone is being attacked you must react to the safety of the person (victim), this is not a time to attempted verbal de-escalation skills with the offender. If property is being destroyed or someone is trying to gain entry into a secure location active listening skills may not be affective when immediate action is required.

Attack
If you are being attacked protect yourself do not attempt to use active listening skills when your safety is at risk. Immediate safety for yourself and others should always trump active listening.

Flight
If during the course of an investigation the offender flees from custody, you must react to the situation and apprehend the offender. Active listening skills may not be useful in this situation but you may be required to give verbal commands.

Excessive Repetition
When voluntary compliance is not achieved after you have exhausted all verbal options, you must react. Some tips can be offering options and explaining what the recourse is for noncompliance.

Revised Priorities
If during a contact a more imminent calls comes out and you must take it, communication needs to end. If you are interviewing someone and over the air it comes out that they are wanted for a violent offense your technique needs to adjust towards taking the person into custody.

Article Review:

Livingston, J., Desmarais, S., Verdun-Jones, S., Parent, R., Michalak, E., & Brink, J. (2014). Perceptions and experiences of people with mental illness regarding their interactions with police. *International Journal of Law and Psychiatry*, 334-340.

This study examined perceptions and lived experiences of people with mental illness and their interaction with law enforcement. 60 people living with a mental illness who had contact with law enforcement in Vancouver, Canada were interviewed about their interaction and perceptions.

- 72% (almost three-quarters) were satisfied with how police officers handled their most recent interactions.
- 51% rated their previous contacts with the police as a positive experience.
- 32% rated their previous contacts with the police as a negative experience.

This study has quotes from people living with a mental illness about law enforcement interactions and here are a few:

On access to personal information

> "So they [the police] go into a situation and know how to handle the person, how to speak to the person, know a bit about his background, so the don't offend them or set them off, or how to get the situation under control."

On communicating effectively

> "Ask the person if they are under the care of a physician or psychiatrist. Are they on medication for a mood disorder? Be gentle, but ask questions… Ask if there is any help they need. Tell them we al need to be safe, treat them with dignity."

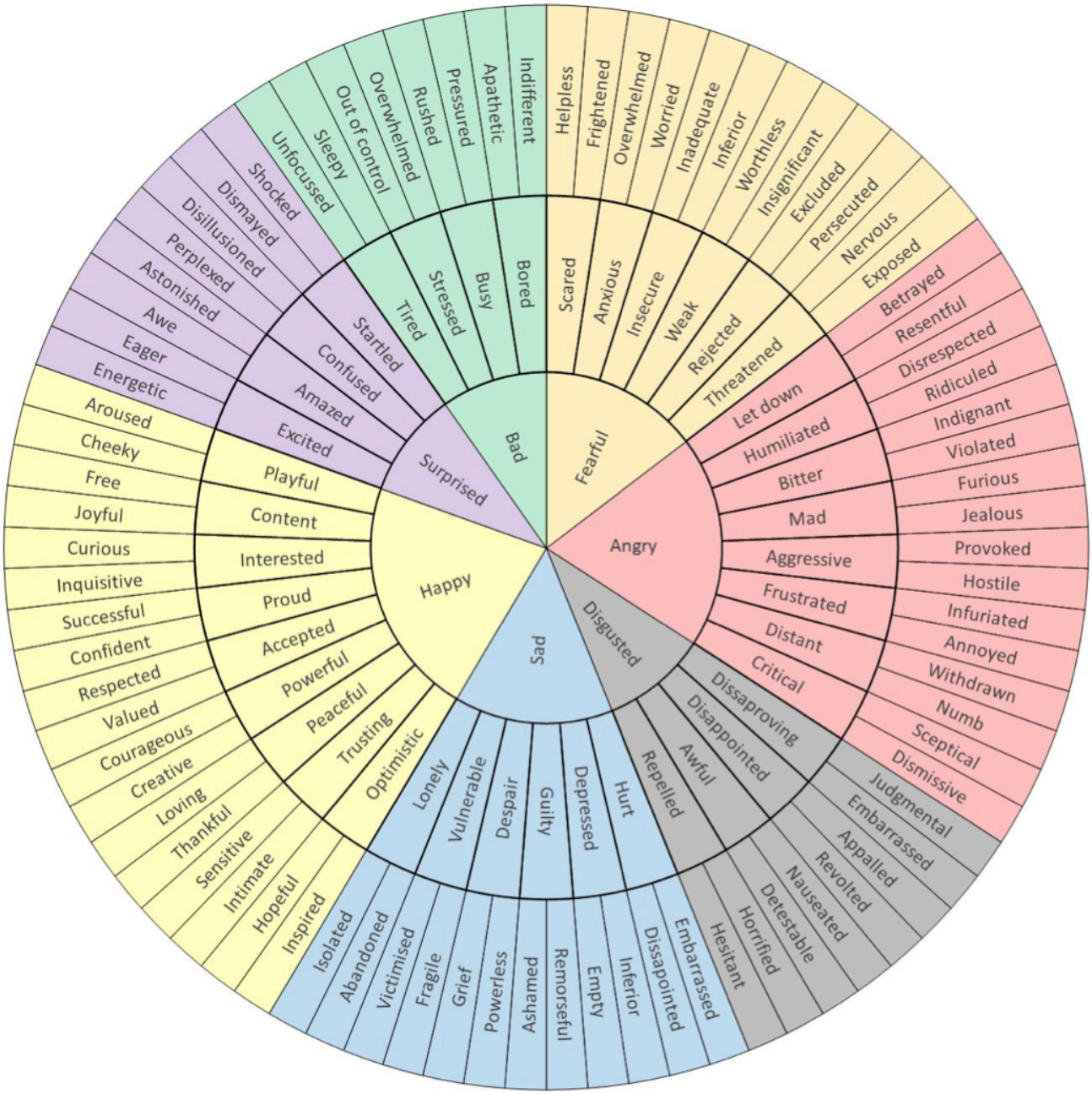
On treating people with compassion

> "Sometimes be more human, not so policy driven. And I don't just mean handcuffs, I mean sometimes I'm just transported and… I could have been a sack of flour. … It's all just by the book… and I'm just nothing, I'm not a human being"

On connecting with the community

> "Follow up with someone like me to see what I am like when I am well. Then they [the police] can learn more about mental illness and know how to handle people like me."

Emotion Labeling



Pleasant Feelings							
Open	Happy	Alive	Good	Love	Interested	Positive	Strong
Understanding	Great	Playful	Calm	Loving	Concerned	Eager	Impulsive
Confident	Gay	Courageous	Peaceful	Considerate	Affected	Keen	Free
Reliable	Joyous	Energetic	At Ease	Affectionate	Fascinated	Earned	Sure
Easy	Lucky	Liberated	Comfortable	Sensitive	Intrigued	Intent	Certain
Amazed	Fortunate	Optimistic	Pleased	Tender	Absorbed	Anxious	Rebellious
Free	Delighted	Provocative	Encouraged	Devoted	Inquisitive	Inspired	Unique
Sympathetic	Overjoyed	Impulsive	Clever	Attracted	Nosy	Determined	Dynamic
Interested	Gleeful	Free	Surprised	Passionate	Snoopy	Excited	Tenacious
Satisfied	Thankful	Frisky	Content	Admiration	Engrossed	Enthusiastic	Hardy
Receptive	Important	Animated	Quiet	Warm	Curious	Bold	Secure
Accepting	Festive	Spirited	Certain	Touched		Brave	
Kind	Ecstatic	Thrilled	Relaxed	Sympathy		Daring	
	Satisfied	Wonderful	Serene	Close		Challenged	
	Glad		Free and Easy	Loved		Optimistic	
	Cheerful		Bright	Comforted		Re-enforced	
	Sunny		Blessed	Drawn Toward		Confident	
	Merry		Reassured	Empathy		Hopeful	
	Elated					Earnest	
	Jubilant						
	Empowered						

Difficult/Unpleasant Feelings							
Angry	Depressed	Confused	Helpless	Indifferent	Afraid	Hurt	Sad
Irritated	Lousy	Upset	Incapable	Insensitive	Fearful	Crushed	Tearful
Enraged	Disappointed	Doubtful	Alone	Dull	Terrified	Tormented	Sorrowful
Hostile	Discouraged	Uncertain	Paralyzed	Nonchalant	Suspicious	Deprived	Pained
Insulting	Ashamed	Indecisive	Fatigued	Neutral	Anxious	Pained	Grief
Sore	Powerless	Perplexed	Useless	Reserved	Alarmed	Tortured	Anguish
Annoyed	Diminished	Embarrassed	Inferior	Weary	Panic	Dejected	Desolate
Upset	Guilty	Hesitant	Vulnerable	Bored	Nervous	Rejected	Desperate
Hateful	Dissatisfied	Shy	Empty	Preoccupied	Scared	Injured	Pessimistic
Unpleasant	Miserable	Stupefied	Forced	Cold	Worried	Offended	Unhappy
Offensive	Detestable	Disillusioned	Hesitant	Disinterested	Frightened	Afflicted	Lonely
Bitter	Repugnant	Unbelieving	Despair	Lifeless	Timid	Aching	Grieved
Aggressive	Despicable	Skeptical	Frustrated	Numb	Shaky	Victimized	Mournful
Resentful	Abominable	Distrustful	Distressed		Restless	Heartbroken	Dismayed
Inflamed	Terrible	Misgiving	Woeful		Doubtful	Agonized	
Provoked	In Despair	Lost	Pathetic		Threatened	Appalled	
Incensed	Sulky	Unsure	Tragic		Cowardly	Humiliated	
Infuriated	Bad	Uneasy	In a Stew		Quaking	Wronged	
Cross	A Sense of Loss	Pessimistic	Dominated		Menaced	Alienated	
Worked Up	Down	Tense	Worthless		Wary		
Boiling	Down n' out		Hopeless				
Fuming							
Aggitated							

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National Alliance on Mental Illness

Mental Health Response Advisory Committee

2018

Crisis Intervention Team (CIT) Training

Student Guide

COAST
Community Resources

COAST

Safety, De-stigmatization, and Resources should be kept in mind when using the Crisis outreach and Support Team (COAST). Keeping dignity and respect in mind will help with rapport building and assisting with resources.

COAST is comprised of civilian crisis specialist who assist individuals that come in contact with police with linkages to community services.

COAST PROTOCOL:

- Assists officers and detectives with non-violent individuals.
  - Ensure there are no weapons involved.
  - COAST cannot respond to combative subjects.
  - COAST cannot respond to highly intoxicated subjects or subjects
  - with emergency medical needs.
- COAST should NOT be dispatched to calls *without* officers.
- COAST will only enter a scene after it has been rendered safe.
- COAST receives referrals from the field for follow up
- COAST does NOT have any funds and does not provide treatment or direct services

COMMON TYPES OF COAST REFERRALS:

- Behavioral Health Issues
- Homelessness
- Substance Use
- Basic Needs
- Elderly Issues
- Family Issues
- Crisis Intervention & Response

ACCESSING COAST:

- COAST is assigned to each area command so officers/radio can reach them at substations by phone or in person
- Can also call Family Advocacy Center: **924-6000**
- For follow up or referrals, send reports to COAST Sergeant at **apdcit@cabq.gov**
- For an on-scene response contact radio and request a COAST unit. They can respond to your scene or call you back to answer questions

Note: there is limited availability after hours and on weekends
(COAST hours M-F 08:30 –17:00 hours)

ACCESSING SUBSTANCE USE DISORDER RESOURCES:

- Metropolitan Assessment and Treatment M.A.T.S, 468-1555
  - You can transport to 5901 Zuni SE or
  - MATS will pick up *intoxicated* persons for DETOX. Must be able to walk on own, make eye contact and give info.

- Medical Observation Treatment Unit M.O.T.U. 841-8978
  - Give priority for admission to people who have co-occurring medical or psychiatric illness.

*It should be noted that there are several other resources for Substance Use in the community please refer to your resource cards and student guide for more.

ACCESSING RESOURCES FOR PEOPLE WHO ARE EXPERIENCING HOMELESS

Shelter beds are available at the following:

- Albuquerque Opportunity Center- (505-344-4340) 715 Candelaria NE
  - Shelter for adult males for up to 30 days
  - Will take referrals from officers but no walk ins
  - Will take intoxicated but not combative or unable to do self-care
  - Watch your KDT for nightly openings
  - Adult males only

- Albuquerque Rescue Mission, (505-346-4673) 525 2nd St. SW
  - Food and services for adult homeless
  - Shelter for adult males in their program
  - They operate The Westside Winter Shelter
  - Winter Shelter opened November to March adults and some families, housed separately

- Barrett Foundation (Women and Children), (505-243-4887) 10300 Constitution NE

- Good Shepard Center (Men, 18 & Older) 218 Iron SW

- All Faiths Receiving Home (Children) (505-271-0329) 1709 Moon Street NE

- St. Martin's Hospitality Center 1201 3rd St. NW

    - Day Shelter 505-843-9405
    - Employment Services 505-843-9405
    - Mental Health Programs 505-764-8231
    - Housing 505-764-8231
    - ACT 505-884-4464
    - Dimas House Post Correctional Program 505-343-0746

- Homeless Veteran's Outreach Program 1217 1st St. NW 505-256-2784

- Veteran's Integration Center 4-Hills 13140 Central Avenue SE 505-296-0800

- Juveniles with psychiatric emergencies should be transported to UNM Psychatric Emergency Services 505-272-2920

- New Day (Teens) (505-260-9912) 2820 Ridgecrest Rd SE
    - 24 Hour Admission for teens 12 to 17
    - Runaways etc…

- Amistad, (505-877-0371), 2929 Barcelona SW
    - 24 Hour Admission for teens 13 to 17

City of Albuquerque Health and Social Service Centers

- There are four Health and Social Service Centers in the City of Albuquerque:
    - Alamosa 6900 Gonzales Rd. SW 505-836-8800
    - Los Griegos 1231 Candelaria Rd. 505-761-4050
    - John Marshall 1500 Walter St. SE 505-848-1345
    - East Central 7525 Zuni Rd SE 505-767-5700

      *All of these centers provide a multitude of services it is best to provide the person in need with the number and location. They will be able to better be served by the Community Support Specialist at each location.

RESPONDING TO PEOPLE IN CRISIS:

- It is essential to know your resources when out in the community so that you might better serve those in crisis if the COAST specialist is not available.

- People cycle in and out of crisis causing repeated calls to police for non-law enforcement issues,

    - *i.e. a person living with mental illness may call repeatedly to advise that there is somebody in their home that has stolen from them over and over again, and continues to stalk them or wait until they leave the home so they can enter and steal again. When officers arrive they find that there is no sign of theft, but the person continues to call again and again with the same outcome each time.*

- Linking these people to services and resources is the best way to minimize these calls for police service and truly help. Each responder should try their best to assist the individual or family in need with the resources provided. If for any reason the responder has questions or may not know how to access the resources needed please feel free to call COAST.

Notes:

REPORTING ABUSE/NEGLECT:

- **CYFD – Children, Youth and Families Department**
- **1-855-333-SAFE (7233) or (505) 827-8400 or #SAFE**
    - Police are required to contact CYFD to report any suspected child abuse or neglect or if they feel that children may be in danger as a result of their current environment/living situation
    - CYFD has in-house services and case management

- **APS – Adult Protective Services**
- **1-866-654-3219 or (505) 476-4912**
    - Investigates and provides services in cases where an adult is being neglected, abused, or exploited

CRISIS LINES:

- **Bernalillo County New Mexico Access and Crisis Line**
- **1(855)NMCRISIS or 1(855) 622-7474**
    - Answers calls from first and second party sources to assist adults in need of psychological help, exhibiting abnormal behavior or having suicidal thoughts
    - First responders and 911 personnel can give people the NMCAL number or dial the number for them
- **Agora Crisis Center**
- **(505) 277-3013 or chat online at www.agoracares.org**
    - Help line, online emotional support (chat)
    - All ages
    - Stress, suicide, grief, domestic issues, depression, etc.

Notes:

Albuquerque Housing Authority
Resource Guide

ALBUQUERQUE HOUSING AUTHORITY

"Empowering people in our community through affordable housing and self sufficiency opportunities."

ADULT BASIC EDUCATION

ABC (Albuquerque Bernalillo County) Library
(505) 768-5141
See site for other locations
http://abclibrary.org/computerclasses

Albuquerque GED
419 Pennsylvania SE & 6900 Gonzales SW
(505) 907-9957

Albuquerque Hispano Chamber of Commerce
(505) 842-9003
Computer, resume writing, & interviewing classes

Catholic Charities
2010 Bridge Blvd SE
(505) 724-4630
GED, ESL, Computer Literacy, Citizenship Classes (all free)

CNM
525 Buena Vista SE
(505) 224-3935
GED, ESL, Literacy

Encentro
714 4th St SW
(505) 247-1023
ESL (English as a Second Language)

Reading Works
1113 Rhode Island St NE
(505) 321-9620
Adult literacy

Southwestern Indian Polytechnic Institute
9169 Coors Blvd NW
(505) 346-7728
GED (serves American Indian & Alaskan Native Students)

UNM
1836 Lomas Blvd NE
(505) 925-8900
GED, ESL, Literacy

CHILDCARE / CHILDREN'S SERVICES

APS Title I Homeless Project
(505) 256-8239

Catholic Charities
Children's Learning Center, Daycare
2010 Bridge Blvd SW
(505) 721-4643
Mon-Thurs 7AM-5:30PM; Fri 7AM-4:30PM
Low income families - 1-5 yrs of age

Child Support Enforcement Division
(800) 288-7207

Cuidando Los Ninos Daycare
1500 Walter SE
(505) 843-6899
Mon-Fri 7AM-5:30PM; child care & therapy for homeless children

ECHO Inc.
300 Menaul Blvd NW
(505) 242-6777
Food for income NM residents, pregnant, child under 12 months, children under 6 if no WIC

NM Family Network
(505) 265-0430
Advocacy & support to families with behavioral health challenges

New Mexico Kids
1634 University Blvd NE
(505) 277-7900
Mon-Fri 9AM-4PM; child care referrals

PB&J Family Services
1101 Lopez Road SW
(505) 877-7060
Support children developmental disabilities/mental illness; health education; nursing; teach safety middle/high school

CHILDCARE / CHILDREN'S SERVICES (CONT.)

State Child Care Assistance (CYFD)
3401 Pan American NE
(800) 832-1321
Help low income families pay for day care (6 wk-13 yrs); parent education

St. Josephs Community Health
1516 5th St NW
(505) 924-8000
Prenatal & up to 3 yrs; education for 1st time parents

Tres Manos
832 Buena Vista SE
(505) 848-1310
Mon-Fri 9AM-5:30PM; child care
CNM students (3-5 yrs, must be potty-trained)

WIC (Women, Infants & Children)
2400 Wellesley Dr NE – (505) 841-4173
300 San Mateo NE – (505) 841-8929
1401 William St SE – (505) 764-0271
Low income families pay for food, formula, diapers, etc

Young Children's Health Center at UNM
306 A San Pablo SE
(505) 272-9242
1st Thurs month; 1PM-7PM must live in 87108 or 87123 zip; medical care for infants to 18yr

CLOTHING SITES

Bernalillo County Council of the PTA
1730 University SE
(505) 344-7481
9AM-1PM (during school yr) Tues-Fri

Good Shepherd Center
218 Iron St SW
(505) 243-2527
9AM-11:45AM & 12:45PM-1:45PM
Mon, Tues, Wed; only men's clothing

Immaculate Conception Church
619 Copper Ave NW
(505) 247-4271
12:45PM-1:45PM Sun only

John Marshall Health & Social Services Center
1500 Walter SE
(505) 848-1345
Call for appointment

Project Share
1515 Yale SE
(505) 242-5677

Salvation Army
4301 Bryn Mawr NE
(505) 881-4292

Steelbridge (formally Alb Rescue Mission)
2021 2nd St NW
(505) 554-2780

Storehouse – Rio Rancho
1030 Veranda Dr SE, Rio Rancho, NM
(505) 892-2077
Provides emergency food & clothing

St. Martin's Hospitality Center
1201 3rd St NW
(505) 843-9405
8:30AM Mon, Tues, Thurs, Fri

St. Vicente de Paul
4120 Menaul Blvd NE
(505) 346-1500
10AM-7PM Mon-Fri; 10AM-5PM Sat; low cost clothing

The ROCK at Noon Day
2400 2nd St NW
(505) 246-8001
9AM-11AM Tues-Fri

DISABILITIES

Adelante Development Center
(505) 341-2000
Adults w/ disabilities; assisted living & home-based care

ARCA
11300 Lomas NE
(505) 332-6700
Residential support systems for people with mental retardation & developmental disabilities

Casa Angelica
5629 Isleta Blvd SW
(505) 877-5763
Intermediate care facility for developmentally disabled children (Canossian Daughters of Charity)

Center for Disabilities Information Hotline
(800) 552-8195

Cornucopia Adult Services
2002 Bridge Blvd SW
(505) 877-1310

Division of Vocational Rehabilitation (DVR)
111 Lomas Blvd NW, #422
(505) 383-2500
Help w/ disabilities achieve a suitable employment outcome

Disability Rights New Mexico
1720 Louisiana Blvd NW, #204
(505) 256-3100
Protect, promote & expand the right of those w/ disabilities

HELP New Mexico
5101 Copper Ave NE
(505) 265-3717
Special Needs Housing Initiative

Home New Mexico
2300 Menaul NE
(505) 889-9486
Assist disabled home seekers with homeownership resources

Independent Living Resource
4665 Indian School, Ste 100
(505) 266-5022
Assists with housing for those with a disability

NM Aging & Disability Resource Center
(505) 476-4846 or (800)-432-2080

Transitional Living Services
4020 Central SE
(505) 268-5295
Emergency, group & rehabilitation programs for severely disabled mentally ill adults

Transitional Living Services
5601 Domingo Rd NE
(505) 323-3811
Short to long term housing services for those w/ mental disabilities

DOMESTIC VIOLENCE SHELTERS & SERVICES

Catholic Charities
2010 Bridge Blvd SW
(505) 724-4651
Legal help for immigrants of domestic abuse

Central NM Immigrant Law Center
714 4th St SW
(505) 247-1023
Legal help for immigrants of domestic abuse

Domestic Violence Helpline
(505) 243-4300 or (877) 974-3400

Domestic Violence Hotline
(800) 799-SAFE (7233)

DOMESTIC VIOLENCE SHELTERS & SERVICES (CONT.)

Domestic Violence Resource Center
625 Silver Ave SW
(505) 843-9123
Women/children support groups, counseling, legal/hospital advocacy, crime response

Enlace Comunitario
2425 Alamo Ave SE
(505) 246-8972
Advocates for victims of domestic violence

Haven House
(505) 896-4869 or (800) 526-7157
Emergency shelter, crisis intervention & support services for victims of domestic violence

Family Advocacy Center
(505) 243-2333
Victims of violence in interpersonal relationships, provides emergency medical staff, victim advocates, legal & financial assistance along with law enforcement

Morning Star House
1410 San Pedro NE
(505) 232-8299 or (505) 507-7720
Provide safety, advocacy, education & support for victims of domestic violence in Albuquerque

PB&J Family Services
(505) 877-7060

S.A.F.E. House (Domestic Violence)
(505) 247-4219 or (800) 773-3645 (24 hr toll free)
Emergency housing for domestic violence victims

UNM Police
(505) 227-2241

Women's Community Association
(505) 884-8856 or (505) 247-4219
Shelter, safe house & services for victims of domestic violence

EMERGENCY / HOTLINE NUMBERS

Agora Crisis Center (Crisis & Suicide Hotline)
(505) 277-3013 – 9AM-midnight
(866) 435-7166 – 24 hrs

NM Crisis Line
(855) 662-7474

United Way Resource Hotline
211 or (505) 245-1735

EMPLOYMENT ASSISTANCE & OPPORTUNITIES

Goodwill – Job Development
(505) 881-6401

Goodwill – Gateway to Work
(505) 881-6401

Goodwill – GoodSkills
(505) 881-6401

Goodwill – Senior Community Service Employment Program (SCSEP)
(505) 881-6401

HELP New Mexico
5101 Copper Ave NE
(505) 265-3717
Job placement & training

Job Corps – (800) 733-JOBS (5627)

Labor Ready – Lomas (505) 265-5148

Labor Ready – Central (505) 268-9040

Labor Ready – Montano (505) 344-8003

Labor Express – 2nd St (505) 344-4404

Labor Express – Jackson (505) 225-4383

Labor Express – Copper Ave (505) 766-5678

EMPLOYMENT ASSISTANCE & OPPORTUNITIES (CONT.)

Labor Express – Central Ave (505) 831-2345

NM Dept of Labor – (505) 222-4600

NM Works Career Link – (505) 827-7750

FAMILY SERVICES

Adoption Assistance Agency
(505) 263-5757

Adoption Plus
1111 Menaul Blvd NE, Ste 5
(505) 323-6002

All Faiths Receiving Home
(505) 271-0329
Daycare, therapy, child abuse prevention

American Red Cross
(505) 265-8514
Various locations. Minor home repair for low income, education on safety & health, youth programs

Birthright of Albuquerque
3228 Candelaria NE
(800) 550-4900
Support to pregnant women

Desert Hills for Youth
5310 Sequoia Rd NW
(505) 836-7330
Behavior mgt services, outpatient medication clinic, psychological services

Enlace Comunitario
2425 Alamo Ave SE
(505) 246-8972
Child support, divorce, custody, restraining orders & other legal services

Hogares
1218 Griegos Rd NW
(505) 345-8471
Youth & young adult (up to 24 yrs)

New Mexico Human Services
4330 Cutler Ave NE – (505) 222-9200
3280 Bridge Blvd SW – (505) 841-2300
1711 Randolph Rd SE – (505) 383-2600
1041 Lamberton Pl NE – (505) 841-7700
Income support

Project Rachel
(505) 831-8238 or (888) 456-HOPE
Leave voice mail, post abortion healing

Samaritan Counseling Center
1101 Medical Arts Ave NE
(505) 842-5300
Sliding scale payment services for family & relationship counseling

Saranam, LLC
1100 Eubank NE, Ste A
(505) 299-6154

St. Joseph Fertility Care Center
4000 St. Josephs Pl NW
(505) 831-8222
Natural Family Planning

Transitional Living Services
5601 Domingo Rd NE
(505) 323-3811
Short to long term housing services for those w/ mental disabilities

Youth Development (YDI)
(505) 352-3469
Various locations & programs for youth & families

FINANCIAL

Credit Rescue Now
2601 Wyoming Blvd NE, Ste. 117
(505) 792-7785

FOOD PANTRIES

Alamosa Food Pantry
6900 Gonzales Rd SW
(505) 836-8800
Mon-Thurs / last week of month 9AM-4PM

Albuquerque Drop in Center
1007 San Mateo SE
(505) 256-8289
Mon-Wed-Fri 10AM-12PM
Tue-Thur 1PM-3PM

Albuquerque Indian Center
105 Texas SW
(505) 268-4418
Food bank on Tuesdays & Thursdays 1PM

Angels Acts of Kindness
3213 Montreal NE
(505) 271-8622
Call for appointment

Casa de las Commundades
444 Chama SE
(505) 247-1387
Thurs, Sat & Sun / 2:30PM

East Central Multi-Purpose Center
306-B San Pablo SE
(505) 256-2070

ECHO Inc.
300 Menaul Blvd NW
(505) 242-6777
Food pantry for families with children under 6 & seniors 60+

Glory Christian Fellowship
2417 Wyoming NE
(505) 275-9623
Tues & Thurs / 9:30AM-12PM

Faith Tabernacle Baptist
(505) 255-6226

Grant Chapel
7920 Claremont NE
(505) 293-1300
Tues-Thurs / 9:30AM-1PM

HELP New Mexico
5101 Copper Ave NE
(505) 265-3717
Child & Adult Care Food Program

Holy Family Parish
562 Atrisco SW
(505) 842-5426

John Marshall Center
1500 Walter SE
(505) 848-1345

Los Griegos Multi-Purpose Center
1231 Candelaria NW
(505) 761-4050

Roadrunner Food Bank
(505) 247-2052

Rio Grande Food Pantry
600 Coors Blvd NW
(505) 831-3778
Food boxes for needy families; call for schedule

Storehouse – Albuquerque
106 Broadway SE
(505) 842-6491
Call for hours

Storehouse – Rio Rancho
1030 Veranda Dr SE
(505) 892-2077
Provides emergency food & clothing

SACM Food Pantry
3905 Las Vegas Dr SW
(505) 877-1472
1st Tues of month / 9AM-12PM

FOOD PANTRIES (CONT.)

Sacred Heart Parish
412 Stover SW
(505) 242-0561

Salvation Army
4301 Bryn Mawr NE
(505) 872-1171

Sandia Church of the Nazarene
2801 Louisiana NE
(505) 881-0267
Tues, Fri (2x/month) 9:30AM

Steelbridge (formally Alb Rescue Mission)
Food Box (reservations are required, no walk up service)
2021 2nd St NW
(505)-554.2780

St. John's Episcopal Cathedral
318 Silver SW
(505) 247-1581
Tues 9AM-10AM; sign up Monday

SE Highland Food Pantry
417 Palomas SE
(505) 256-1682
Tues & Thurs 2PM

The Church
3021 Todos Santos NW
(505) 836-4444
Sat mornings

New Mexico Veterans Integration Center
13032 Central Ave SE
(505) 265-0512
Veterans & Civilians (87123 zip code only) Mon, Veterans only Fri

Vision Unlimited
7701 Zuni SE
(505) 856-7606
4th Sat of month

HEALTH & DENTAL

Albuquerque Healthcare for the Homeless, Inc
1217 1st St NW
(505) 766-5197

Benefits Connection Center
(505) 273-5222

Care Net Pregnancy Center
(505) 880-8371

Children's Grief Center
(505) 323-0478

First Choice Community Healthcare
(505) 873-7400 or 873-7451
Free wellness programs & confidential teen clinic, primarily low income; no insurance

First Nations Community Healthsource
5608 Zuni Rd SE
(505) 262-2481
Mon, Tues, Thurs, Fri / 8AM-9PM
Wed / 8AM-12PM & 5PM-9PM, Sat 9AM-1PM
People with American Indian blood

Healthcare for the Homeless-Medical Clinic
1st & Mountain NW
(505) 242-4644
Mon, Tues, Fri, 8AM-12PM
Counseling, psychosocial analysis

Healthcare for the Homeless-Dental Clinic
1st & Mountain NW
(505) 242-8288

Indian Health Services
801 Vassar Dr NE
(505) 248-4000

New MexiKids
(888) 997-2583

HEALTH & DENTAL (CONT.)

Medicaid
4330 Cutler Ave NE
(505) 222-9200
Health insurance for children & pregnancy

People Helping People
Albuquerque & Rio Rancho
(505) 892-1951
Immediate & medical emergencies

Pharmacy – UNM Hospital
2211 Lomas Blvd NE
(505) 272-4110
Low cost prescriptions

Planned Parenthood – NE
(505) 294-1577

Planned Parenthood – SE
(505) 265-3722

Public Health Clinic (STD Info)
(505) 841-4100

Rio Grande Geriatrics & Family Practice
8400 Menaul Blvd NE
(505) 908-1171
Primary care, house calls; family nurse practitioner

Transitional Living Services
5601 Domingo Rd NE
(505) 323-3811
Short to long term housing services for those w/ mental disabilities

UNM Care
2211 Lomas Blvd NE
(505) 272-2521
Insurance at UNM for low income individuals; must qualify

WIC – North Valley
(505) 272-2283

WIC – SE
(505) 272-2283

University Center for Women's Health
(505) 272-8075

HOUSEHOLD ITEMS

From the Heart Foundation
(505) 256-7664

Grace Free Store
420 San Lorenzo NW
(505) 344-4152
Free household items to those in need.
Thurs & Sat 1-4PM

Goodwill Industries of NM
5000 San Mateo Blvd NE
(505) 881-6401
Low cost clothing, furniture & household goods

St. Vincent De Paul
(505) 242-3434

HOUSING

Barrett House Foundation Inc.
10300 Constitution Ave NE
(505) 243-4887
Housing & supportive services

Bridges Supportive Housing
(505) 255-3643
Supportive housing for homeless single women & homeless women with children, must be willing to work at least part time. Rent is 30% of income

Catholic Charities
2010 Bridge Blvd SW
(505) 724-4670
Transitional housing program to help move homeless families to permanent housing

HOUSING (CONT.)

City of Albuquerque Affordable Housing Hotline
(505) 768-3400
Information on City sponsored affordable housing developments

Consumer Credit Counseling Services
2727 San Pedro NE, Ste 117
(505) 308-2227
Provides education in the appropriate use of credit & home buying

Habitat for Humanity – Greater Albuquerque
4900 Menaul Blvd NE
(505) 265-0057
New home construction for low income families

Home New Mexico
3900 Osuna Rd NE
(505) 889-9486
Assists disabled people with home purchase repair & information

Supportive Housing Coalition
625 Silver Ave SE, St 325
(505) 255-3643
Assists with housing, landlord-tenant issues

Greater Albuquerque Housing Partnership
539 Pennsylvania St SE
(505) 244-1614
Developing affordable housing; provides counseling for first time low income homebuyers

Neighborhood Housing Services of Albuquerque
4605 4th St NW
(505) 243-5511
Home rehabilitation loans for low income families in the Downtown, Sawmill & Wells Park neighborhoods

New Mexico Apartment Search
Affordable rental housing service
http://www.housingnm.org/secured/affordablerentals/search/homepagepublic.htm

New Mexico Mortgage Finance Authority (MFA)
344 4th St SW
(505) 843-6880
Provides a variety of housing finance programs for low income New Mexicans

Sawmill Community Land Trust
904 19th St NW
(505) 764-0359
Develops & builds permanently affordable, quality housing for persons with low to moderate income

St. Vincent De Paul Society
714 4th St SW
(505) 346-1504
Rental assistance for person with eviction notices, along with other services

HOUSING SAFETY & RELATED

Housing Code Enforcement (City)
(505) 764-3954

Bernalillo County Environmental Health
(505) 314-0310

IMMIGRATION SERVICES

Catholic Charities
2010 Bridge Blvd SW
(505) 724-4651
Mon-Fri / 8AM-5PM
Sliding scale payment legal services

Central NM Immigrant Law Center
714 4th St SW
(505) 247-1023
Immigrant resource center (legal, ESL, DV)

Enlace Communitario
(505) 246-8972
Visa & immigration issues

LEGAL ASSISTANCE

City of Albuquerque Human Rights Office
(505) 924-3380
Promotes awareness & practice for fair housing laws, investigates housing discrimination & complaints

District Court-2nd Judicial
(505) 841-6737

Enlace Comunitario
2425 Alamo Ave SE
(505) 246-8972
Child support, divorce, custody, restraining orders & other legal services

Family Legal Assistance Group
(505) 256-0417
Low income families in Bernalillo County with free or low cost eviction prevention and assistance. Other housing issues can be addressed.

Law Access NM
(505) 998-4529 or (800) 340-9771
Statewide, pro-bono basis to get help with Landlord / Tenant disputes, eviction rights, unsafe housing

Lawyer Referrals
(505) 243-2615

Legal Help Line
(505) 998-4529 or (800) 340-9771
Mon-Fri 8:45AM-12PM & 12:30PM-3:45PM
Free telephone legal advice for low income NM

Metro Court
(505) 841-8100

New Mexico Legal Aid
301 Gold Ave SW
(505) 243-7871
Contact if you had problems renting or buying a home because of your race, color, national origin, religion, gender, family status or disability

NM State Bar General Program
Statewide, $35 for 30 mins
(800) 876-7227

Pegasus Legal Services for Children
3201 4th St NW
(505) 244-1101
Legal resource for children, caregivers, & community concerning the legal rights & needs of children & youth

Tenant Hotline
5121 Masthead NE
(505) 998-4529
Mon-Fri / 9AM-3PM
Low income individuals with rental issues

MEAL SITES

Bread & Blessings at
Immaculate Conception Church
619 Copper Ave NW
(505) 247-4271
Sun only / 12:45PM-1:45PM

Cross Roads Café
1020 Coal SE
(505) 242-0497
Wed only / 5PM-6:15PM

First Methodist Church
341 Lead SW
(505) 243-5646
Mon only / 12PM

Good Shepherd Center
218 Iron St SW
(505) 243-2527
Sat 11:30AM-12PM
Mon, Tues, Wed, Fri 3:15PM-4PM

International All Faith Center
3rd & Coal SW
(505) 243-1789
Sun only / 3PM

MEAL SITES (CONT.)

Joy Junction
4500 2nd St SW
(505) 877-6967
Everyday 5:30AM, 12PM, 5PM

The ROCK at Noon Day (Steelbridge)
2400 2nd NW
(505) 246-8001
Mon, Wed, Fri, & Sat 4PM-5:15

Project Share
1515 Yale SE
(505) 242-5677
Mon, Tues, Thurs, Fri, Sat, Sun 5PM-6PM

Restoration Ministries
825 San Mateo SE
(505) 255-7579
Saturdays / 11:30AM-1PM

MORTGAGE ASSISTANCE / HOME REPAIR

American Red Cross Emergency
Minor Home Repair
(505) 265-8514 Ext. 33
Minor home repair for low to moderate income homeowners

City of Albuquerque
Office of Neighborhood Revitalization
700 4th St SW, Ste A
(505) 767-5825
Provides assistance for home repairs for low income homeowners

Family Housing Development Corp
(505) 873-9638
Down payment & financing assistance for qualified first time homebuyers.
Mortgage Finance Authority (MFA)
344 4th St SW
(505) 843-6880

Southwest Neighborhood Housing Services
(505) 243-5511
Homebuyers training, landlord/tenant counseling, budgeting classes, foreclosure avoidance, home rehabilitation program & help for refinancing existing loans for the Albuquerque area

United South Broadway Corp.
1500 Walter St SE
(505) 764-8867
Foreclosure prevention and assistance services, HUD Certified Counseling Agency

RENTAL AND/OR UTILITY ASSISTANCE

Catholic Charities
2010 Bridge Blvd SW
(505) 724-4670

Century Link Telephone Assistance
Medicaid Only
(800) 244-1111

John Marshall Health & Social Services Center
1500 Walter SE
(505) 848-1345
First come, first serve

LIHEAP
(505) 841-2128
Help with PNM bill

The ROCK at Noon Day
2400 2nd NW
(505) 246-8001
Requires 4 days of volunteer time & documentation of eviction notice or utility late notice

Project Unite
(505) 761-9818

RENTAL AND/OR UTILITY ASSISTANCE (CONT.)

Salvation Army
Broadway & Coal
(505) 872-1171
Emergency rental assistance; requires eviction notice. PNM (all yr) & gas (winter)

Supportive Housing Coalition
625 Silver Ave SE, St 325
(505) 255-3643
Assists with housing, landlord-tenant issues

Storehouse – Homeowner's Low Income Credit Program
106 Broadway SE
(505) 842-6491

St. Vincent de Paul
4120 Menaul NE
(505) 346-1500

SECTION 8 / PUBLIC HOUSING

Albuquerque Housing Authority
1840 University Blvd SE
(505) 764-3920
Programs for affordable housing

Bernalillo County Housing
1900 Bridge SW
(505) 314-0200
Programs for affordable housing

Town of Bernalillo Housing Authority
(505) 867-2792
Programs for affordable housing

Office of Native American Program - HUD
201 3rd St NW
(505) 766-1372
Programs for affordable housing

SENIOR SERVICES

Aging & Long Term Care Services Dept
(800) 432-2080

Catholic Charities - Senior Transportation
2010 Bridge Blvd SW
(505) 721-4634

City of Albuquerque Dept of Senior Affairs
714 7th St SW
(505) 764-6400
Minor home repair & home chores for senior homeowners

Cornucopia Adult Services
2002 Bridge Blvd SW
(505) 877-1310

ECHO Food Commodities
300 Menaul NW
(505) 242-6777
Supplemental foods; seniors 60+

HELP New Mexico
5101 Copper Ave NE
(505) 265-3717

Legal Resources for the Elderly (LREP)
5121 Masthead NE
(505) 797-6005 or (800) 876-6657
Free, statewide help for NM residents 55 & older, no income restrictions

NewLife Homes
(505) 293-7553

NM Aging & Disability Resource Center
(505) 476-4846 or (800)-432-2080

Senior Citizens Law Office (60+)
4317 Lead Ave SE, Ste A
(505) 265-2300
Mon-Fri 8:30AM-12PM & 1PM-5PM

SENIOR SERVICES (CONT.)

Silver Horizons (60+)
1212 Candelaria NW
(505) 884-3881 x 14
Utility assistance, home repairs, free flu shots

St. Mary's Rest Home
205 7th St NW
(505) 243-5888
Only Catholic rest home in Albuquerque

St. Vincent de Paul
4120 Menaul NE
(505) 346-1500

United Way Resource Hotline
(505) 245-1735

SHELTERS

Albuquerque Opportunity Center
715 Candelaria NE
(505) 344-2323
Men only

Steelbridge (formally Alb Rescue Mission)
1st St SW (between Coal Ave & Iron Ave SW)
(505) 346-4673
1:30PM Mon-Sat. Day & night shelters

Amistad Crisis Shelter
2929 Barcelona SW
(505) 877-0371
Crisis shelter for youth aged 12-17

Barrett House Foundation Inc.
10300 Constitution Ave NE
(505) 246-9244
Emergency Shelter for women and children

Emergency Winter Shelter
(505) 346-4673

Family Promise of Albuquerque
(505) 268-0331

Good Shepherd Center
218 Iron St SW
(505) 243-2527
Opens 6PM daily

Joy Junction
4500 2nd St SW
(505) 217-9586
Families, Men & Women, No assault charge
For ride, call 800-924-0569
Marie Amadea Shelter
708 Tijeras Ave NW
(505) 242-1516
Shelter, counseling, transportation, education

Metropolitan Homelessness Project
715 Candelaria NE
(505) 344-2323

The ROCK at Noon Day
2400 2nd NW
(505) 246-8001
9AM-11AM / Tues-Fri
Laundry, showers, phones, clothes

Salvation Army
(505) 872-1171

Salvation Army (Rehab Center)
(505) 242-3112

Saranam, LLC
(505) 299-6154

St. Martin's Hospitality Center
1201 3rd St NW
(505) 843-9405
Day shelter, clothing exchange, supportive housing, motel lease assistance & other services

Trinity House, Catholic Worker House
1925 Five Points Rd SW
(505) 242-0497
Meals, hospitality, transition housing

West Side Shelter
Sign up 3PM-8PM; meet at Steelbridge (formally Alb Rescue Mission), Men, Women, Children 10 & under only open from Nov 15-Mar 15

Women's Housing Coalition
3005 San Pedro NE
(505) 884-8856
Single women with children; 2-year stay in program allowed. Thrift Store.

SHOWER SITES

St. Martin's Hospitality Center
1201 3rd St NW
(505) 843-9405
8AM / Mail, ID's & phones

The ROCK at Noon Day
2400 2nd NW
(505) 246-8001
Tues-Fri / 9AM-11AM

SUBSTANCE USE & MENTAL HEALTH

Agora Crisis Center
(505) 277-3013

Steelbridge (formally Alb Rescue Mission)
New Life Program for Men
Women's Center of Hope
214 Coal Ave SW
(505)-346.4673 (HOPE)

Al-Anon
(505) 262-2177
Various locations. Substance use recovery service

AA - Alcoholics Anonymous
1921 Alvarado NE
(505) 266-1900

Albuquerque Center for Hope & Recovery
1027 San Mateo SE
(505) 256-8289
Mental health and/or substance use

Albuquerque Rape Crisis Center
(505) 266-7711

Albuquerque Metro Central Intake (AMCI)
(505) 272-9033
Outpatient substance use counseling

Almas de Amistad
510 2nd St NW, Ste 101
(505) 246-9300
Substance use recovery service for women

Casa Verde
(505) 264-9244
Affordable housing for women with chronic mental illness call for phone interview

Children's Grief Center
(505) 323-0478

Cocaine Anonymous
(505) 344-9828
Various locations

Crossroads (for women)
805 Tijeras Ave NW
(505) 242-1010
Transition program for women w/ co-occurring addictive & mental health Issues

Desert Oasis Recovery
(505) 296-8184

ESH Recovery Home
126 General Chennault NE
(505) 332-8935
Men only; substance use, mental illness

SUBSTANCE USE & MENTAL HEALTH (CONT.)

Health Care for the Homeless
1217 1st NW
(505) 848-7611
STARS provide short-term assessments & long-term case mgt for homeless w/ mental health and/or substance use, etc

MATS Detox
5901 Zuni Rd SE
(505) 468-1555

Metropolitan Homelessness Project
715 Candelaria NE
(505) 344-2323

Metamorphosis (Methadone & Suboxone)
111 Monroe St NE
(505) 260-9917
Mental & substance use services

Methadone Treatment
(866) 675-4912

MHC Crisis Line (Suicide)
(505) 272-1121

NA (Narcotics Anonymous)
(505) 260-9889
Various locations

NAMI (National Alliance for the Mentally Ill)
(505) 256-0288

NewLife Homes
(505) 293-7553

NM Women's Recovery Academy
6000 Isleta Blvd SW
(505) 873-2761

Pathways
2551 Coors NW
(505) 338-3320
Mental health and/or substance use

Salvation Army men's residential rehab program
400 John St SE
(505) 242-3112
Men 21 & up

Samaritan Counseling Center
(505) 842-5300

Supportive Housing Coalition of NM
625 Silver Ave SE, St 325
(505) 255-3643
Behavior health issues

Susan's Legacy
11005 Spain NE
(505) 843-8450
Co-occurring mental & addictive disorders.
Diagnosis of mental health and substance use for program entry

St. Martins - Chemical Dependency
1201 3rd NW
(505) 764-8231
Individuals w/ co-occurring mental health & substance use issues

St. Martins - Mental Health
1201 3rd NW
(505) 764-8231
Case mgt, medication mgt, psychiatric & nursing care, housing support

St. Martins - Mental Health
Intake & assessment for the homeless.
Coffee Shop inside facility @ 700 2nd St. NW

Transitional Living Services
5601 Domingo Rd NE
(505) 323-3811
Short to long term housing services for those w/ mental disabilities

SUBSTANCE USE & MENTAL HEALTH (CONT.)

Therapeutic Living Services
(505) 268-5295
Application requires medical & psychological diagnosis, both community based living & independent housing services. Must qualify for Medicaid & meet MH criteria

Turquoise Lodge
(505) 468-1555
Substance use services

UNM Addiction & Substance Use Program
2600 Yale SE
(505) 944-7999
Youth & adults

UNM Mental Health Center
2600 Marble Ave NE
(505) 272-2800
24 hr crisis line: (505) 272-2920

UNM Children's Psychiatric Center
1001 Yale Blvd NE
(505) 272-2890

MEN

Albuquerque Opportunity Center
715 Candelaria NE
(505) 344-4340
Men only

Casa de Amigos
(505) 449-7677
Must find a job within 1 month, no sex offenders. Must be able to self-medicate

ESH Recovery Home
126 General Chennault NE
(505) 332-8935
Men only; substance use, mental illness

Good Shepherd
(505) 243-2527
Men only

Hoffman Hall
(505) 265-5122
Men only

NM Men's Recovery Academy (NMMRA)
1000 W. Main St, Los Lunas, NM
(505) 866-0590
Full array of residential re-entry

Salvation Army men's residential rehab program
400 John St SE
(505) 242-3112
Men 21 & up

WOMEN

A Peaceful Habitation
(505) 440-5937
Home & post prison aftercare ministry for women

Alas de Amistad
510 2nd St NW, Ste 101
(505) 246-9300
Substance use recovery service women only

Barrett House
10300 Constitution NE
(505) 246-9244 or (505) 243-4887
Women & Children

Bridges Supportive Housing
(505) 246-0944
Supportive housing for homeless single women & homeless women with children. Client must be willing to work at least part time. Rent is 30% of income

Casa Socorro
(505) 246-9244
Chronic homelessness

WOMEN (CONT.)

Casa Milagro
2818 Cuero NE
(505) 883-8870
Must be clean and sober for 3 months with proof of treatment prior to enter. Must be over 35 and have a history of chronic homelessness. 7-24 month program

Crossroads for Women
805 Tijeras Ave NW
(505) 242-1010
Transition program for women with co-occurring addictive & mental health issues

HELP New Mexico
5101 Copper Ave NE
(505) 265-3717
Offers transitional housing for women

NM Women's Recovery Academy (NMWRA)
6000 Isleta Blvd SW
(505) 873-2761
Full array of residential re-entry

Our Sister's Closet
YMCA of the Middle Rio Grande
210 Truman St NE, Ste A
(505) 254-9922
Business clothing, shoes & accessories at no cost for women going on job interviews/work

Proyecto La Cuz
Catholic Charities of Central NM
2010 Bridge Blvd SW
(505) 724-4670
Homeless women's & children's shelter

Susan's Legacy
11005 Spain NE
(505) 843-8450
Co-occurring mental & addictive disorders. Diagnosis of mental health & substance use for program entry

TenderLove Community Center
3600 4th St NW
(505) 349-1795
Day shelter, job training

Women's Community Association
(505) 884-8856 or (505) 247-4219
Safe house; Coalition Against Domestic Violence

Women's Housing Coalition
3005 San Pedro NE
(505) 884-8856
Single women with children; 2-year stay in program allowed; thrift store

Barrett House Foundation Inc.
10300 Constitution Ave NE
(505) 246-9244 or (505) 243-4887
Emergency Shelter for women and children

YOUTH

Alb Life Skills Academy
2820 Ridgecrest SE 87108
www.abqlifeskills.org
Collaborative, cross system learning network focused on building functional life skills in young people age 16-22 in the Albuquerque Area

All Faiths Receiving Home
1709 Moon NE
(505) 271-0329
Provide services to children & their families in a healthy environment which includes education, treatment, advocacy, food, clothing, affordable & safe housing

Amistad Runaway
1706 Centro Familiar SW
(505) 877-0371
Teens 12-17

Big Brothers, Big Sisters – (505) 837-9223

Boys & Girls Club – (505) 247-1553

YOUTH (CONT.)

Casa Hermosa YDI- Youth Development Inc.
630-632 Chama St SE
(505) 212-7470
Transitional living program for ages 16-21; 24 hr supervision for residents transitioning from homelessness into independent living; case management & counseling provided

Casa Q
(505) 872-2099
LGBTQ+ ages 14-17 at risk or homeless

CYFD
(505) 841-4800
Early Head Start
(505) 767-6500 or 764-3033

Haven of Love
4025 Isleta SW
(505) 877-9915 or 873-3771
Emergency shelter, meals & clothing for homeless young men aged 18-21

HELP New Mexico
5101 Copper Ave NE
(505) 265-3717
Youth Building Program

Life Options Academy
(505) 841-4875

MCH Partnership in Parenting
(505) 255-8740

Methodist Children's Home
(505) 255-8740
Counseling & information on assistance, including general life skills & self-sufficiency programs

New Day Youth & Family Services
2820 Ridgecrest SE
(505) 260-9912 or 938-1060
Temporary shelter for runaway/homeless youth; crisis shelter with counseling & referral service

Outcomes, Inc
(505) 243-2551

Parents Reaching Out
(505) 247-0192

PB&J Family Services Inc.
(505) 877-7060

Title I Child Homeless Project, APS
(505) 256-8239

UNM Addiction & Substance Use Program
2600 Yale SE
(505) 944-7999
Youth & adults

Youth Development Inc
6301 Central NW
(505) 831-6038
Transitional living programs for homeless families

Youth Development Inc. Headstart
(505) 244-0250

VETERANS

Goodwill – Homeless Veterans' Reintegration Program (HVRP)
(505) 881-6401

Goodwill – Supportive Services for Veteran Families (SSVF)
(505) 881-6401

New Mexico Veterans Integration Center
13032 Central Ave SE
(505) 265-0512

Rehabilitation Services & Veterans Program
406 San Mateo NE, Ste 122
(505) 255-8440
Transitional housing for homeless veterans with other services offered

OTHER SERVICE PROVIDERS

Accion
(505) 243-884
Micro-lending organization; Lending Record of over $1 million

American Red Cross
142 Monroe St NE
(505) 265-8514
Amtrak – (800) 872-7245

Goodwill Traumatic Brain Injury
5000 San Mateo NE
(505) 881-6401
Assistance after a traumatic brain injury

Greyhound Bus Station
320 1st St SW
(505) 243-4435

HELP New Mexico
5101 Copper Ave NE
(505) 265-3717
Adult mentoring, leadership development, foster grandparent, income tax assistance

Albuquerque Indian Center
(505) 268-4418

Animal Humane Association
(505) 255-5523

Child/Adult Protective Services
(505) 841-6100

Consumer Credit Counseling
(505) 884-6601

Dept. of Community Services
(505) 768-2860

Emergency Food Assistance Program (TEFAP)
(505) 841-2625

Human Services Dept
(800) 432-6217

Motor Vehicle Division
(888) MVD-INFO
New Mexico Dept of Health - Vital Statistics
Birth and Death Certificates
2400 Wellesley NE
(505) 827-0121 or (866) 534-0051

Oaks of Righteousness Transitional Living Program, East Central Ministries
134 Vermont St NE
(505) 266-3590
Provides a subsidized & supportive living environment to make sustainable life changes

Social Security Office
(505) 346-6694

United Way Resource Hotline
211 or (505) 245-1735

Love INC
(505) 255-5683 (option 1)
Share your story with a volunteer, list ALL your needs, receive a home visit to get information about places that can help

How To Get To AHA

By car: Take I-25 to Gibson Blvd SE, exit to eastbound Gibson, go east to University Blvd (traffic signal), then turn left and go north 1.5 blocks, to 1840 University Blvd SE. The AHA office is located on the east side of University Blvd, use the main entrance on the south side of the building.

By bus: The AHA office is served by two ABQ ride bus lines (route 16 and rush hour express route 217) and by Sun Van (para transit for the disabled).

For updates to this guide, please email mboen@abqha.org

Crisis Intervention Team (CIT) Training

Student Guide

Overview of Psychiatric Medications

Overview:

Psychiatric medications are some of the most common (and most profitable) medications in existence. For law enforcement, it can be helpful to have a basic understanding of these medications. Knowledge of medications, both their benefits and drawbacks, can help establish rapport with people living with mental illnesses. Rapport leads to safety, and by being conversant in psychiatric medications; you can show people that you have an understanding that mental illnesses are medical illnesses.

Medications are often divided into different classes based on what they are designed to treat.

Antipsychotics: used to treat psychosis and psychotic symptoms that go along with major mental illnesses such as Schizophrenia, psychotic depression, and bipolar with psychotic features.

Anxiolytics (aka Anti-anxiety or "anxiety meds"): Used to treat anxiety and anxiety disorders such as social anxiety disorder, panic disorder, and generalized anxiety disorders.

Antidepressants: used to treat major depression and other illnesses such as Post Traumatic Stress Disorder, and anxiety.

Mood stabilizers (aka medications for Bipolar): Used to treat mania, depression associated with bipolar disorder, and to help keep moods stable to avoid becoming manic or depressed.

Medication Side Effects

Side effects of Lexapro and other medications:

Lexapro, a very common medication used for depression is noted to have the following potential side effects. All medications, including aspirin have potentially serious side effects. In fact, by most measures, Lexapro is safer than aspirin.

Side Effects for Lexapro:

Rare

- Coma
- confusion
- convulsions
- decreased urine output
- dizziness
- fast or irregular heartbeat
- headache
- increased thirst
- muscle pain or cramps
- nausea or vomiting
- shortness of breath
- swelling of the face, ankles, or hands
- unusual tiredness or weakness
-

More common

- Constipation
- decreased interest in sexual intercourse
- diarrhea
- dry mouth
- ejaculation delay
- gas in the stomach
- heartburn
- inability to have or keep an erection
- loss in sexual ability, desire, drive, or performance
- sleepiness or unusual drowsiness
- trouble sleeping

Less common

- Bloated or full feeling
- burning, crawling, itching, numbness, prickling, "pins and needles", or tingling feelings
- chills
- cough
- decreased appetite
- excess air or gas in the stomach or intestines
- fever
- general feeling of discomfort or illness
- increased sweating
- joint pain
- muscle aches and pains
- not able to have an orgasm

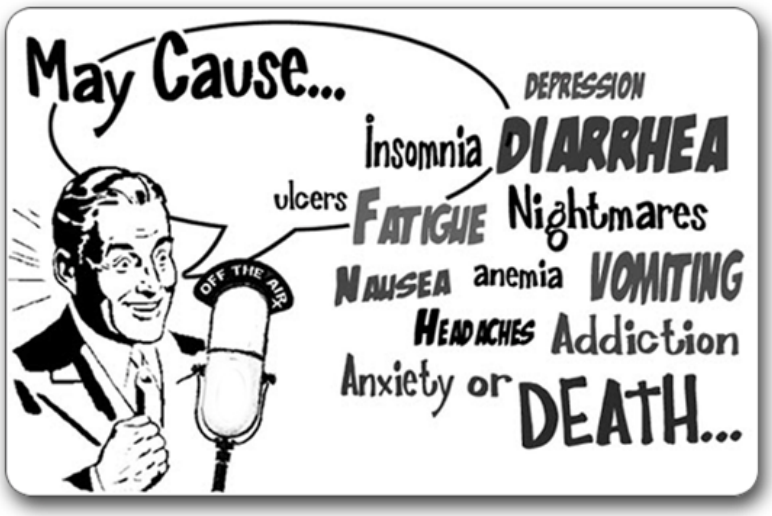
- pain in the neck or shoulders
- pain or tenderness around the eyes and cheekbones
- passing gas
- runny nose
- shivering
- sneezing
- sore throat
- stuffy nose
- tightness of the chest
- tooth problems
- trouble breathing
- unusual dreams
- unusual drowsiness, dullness, tiredness, weakness or feeling of sluggishness
- yawning

(From Drugs.com)

Nervous system side effects of Aspirin

Central nervous system side effects have included agitation, cerebral edema, coma, confusion, dizziness, headache, cranial hemorrhage, lethargy and seizures. Tinnitus and subjective hearing loss (or both) may occur. Some investigators have reported that modest doses may result in decreased frequency selectivity and may therefore impair hearing performance, particularly in the setting of background noise.

"Product Information. Bayer aspirin (aspirin)." Bayer, West Haven, CT.



Important medications to remember by class/symptom:

Psychosis: Haldol, Risperdal, Zyprexa

Other common medications: Geodon, Saphris, Abilify, Seroquel, Asinipine, Prolixin

Depression: Prozac, Lexapro, Paxil, Zoloft

Other common medications:_____

Bipolar: Lithium, Depakote, Tegretol

Other medications used for bipolar:_____

Anxiety: Ativan, Klonopin, Xanax

Other medications used for anxiety: _____

Notes:

Psychosis and medications for psychosis:

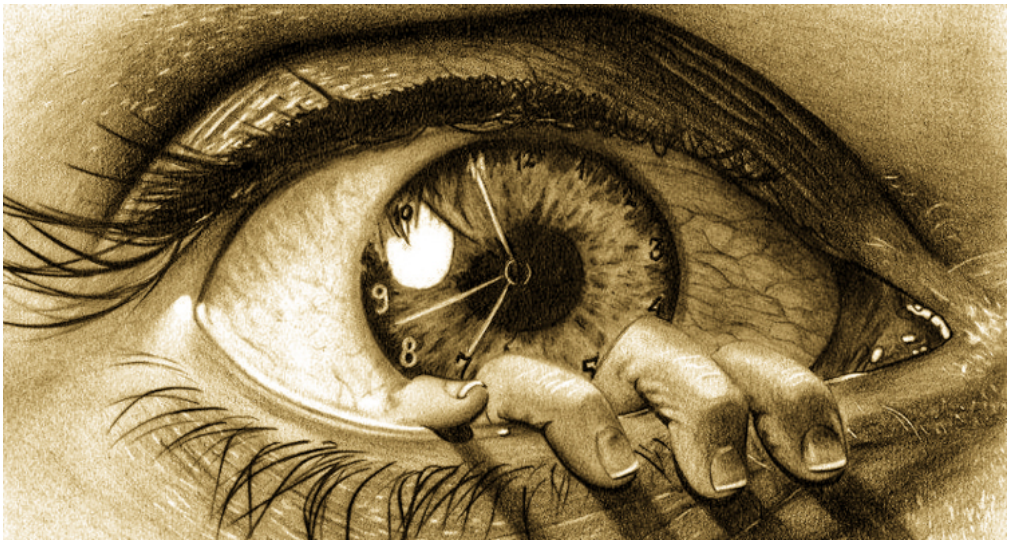
What Is Psychosis?

Psychosis (psyche = mind, osis = illness) is defined as the experience of loss of contact with reality, and is not part of the person's cultural group belief system or experience. Psychosis typically involves one of two major experiences:

A. ***Hallucinations*** can take the form of auditory experiences (such as hearing voices); less commonly, visual experiences; or, more rarely, smelling things that others cannot perceive. The experience of hearing voices has been matched to increased activity in the auditory cortex of the brain through neuroimaging studies. While the experience of hearing voices is very real to the person experiencing it, it may be very confusing for a loved one to witness. The voices can often be critical (*i.e.* "you are fat and stupid") or even threatening. Voices also may be neutral (*i.e.* "the radio is on") and may involve people that are known or unknown to the person hearing the voices. The cultural context is also important. For example, in some Native American cultures, hearing the voice of a deceased relative is part of a healthy grieving process.

B. ***Delusions*** are fixed false beliefs. Delusions could take the shape of paranoia ("I am being chased by the FBI") or of mistaken identity (a young woman may say to her mother, "You are an imposter—not my mother"). What makes these beliefs delusional is that these beliefs do not change or modify when the person is presented with new ideas or facts. Thus, the beliefs remain fixed even when presented with contradicting information (the young woman continues to believe her mother is an imposter, even when presented with her mother's birth certificate and pictures of her mother holding her as a baby). Delusions often are associated with other cognitive issues such as problems with concentration, confused thinking and a sense that one's thoughts are blocked. These experiences can be short lived (*e.g.* after surgery or after sleep deprivation) or periodic (as when associated with a psychiatric condition or persistent like bipolar disorder or major depression).

-http://www.nami-pw.org/Psychosis.html



Antipsychotics

These medications reduce or eliminate the symptoms of psychosis (delusions and hallucinations) by impacting the brain chemical called dopamine. Antipsychotics play an important role in treating schizophrenia and schizoaffective disorder.

Newer, or second-generation or atypical, antipsychotics can also treat acute mania, bipolar disorder and treatment-resistant depression. The antipsychotics developed in the middle of the 20th century are often referred to as first-generation or typical antipsychotics. Second-generation antipsychotics are known as atypical antipsychotics.

Second-generation drugs aren't necessarily better or worse than first-generation, but do have different side effects. First-generation antipsychotics are more likely to cause movement disorders. For example, tardive dyskinesia. This is an uncomfortable, potentially embarrassing condition in which the brain misfires and causes random, uncontrollable muscle movements or tics. These most typically affect the arms, fingers, legs, toes or facial muscles. Second-generation antipsychotics are more likely to result in weight gain. This increase in weight to other health complications such as metabolic syndrome.

-http://www.nami.org/Learn-More/Treatment/Medications

Akathesia is one of the most common side effects to antipsychotics. It is a rhythmic and uncontrollable movement caused by a feeling of internal restlessness.

Mania

With mania, people may feel extremely irritable or euphoric. People living with bipolar may experience several extremes in the shape of agitation, sleeplessness and talkativeness or sadness and hopelessness. They may also have extreme pleasure-seeking or risk-taking behaviors. - See more at: http://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder#sthash.Bs1zPJIn.dpuf

-http://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder

Mood Stabilizers

Mood stabilizers are the most common medications for treating the mood swings of bipolar disorder. The oldest of them, Lithium, has been in use for over 50 years and has proven very effective, particularly for bipolar I disorder. However, regular blood tests are a requirement if you're taking Lithium, which has potential serious side effects to the kidneys and thyroid.

There are also newer mood stabilizers originally created as anticonvulsants that may work better than Lithium for some people. Mood stabilizers can prevent highs (manic or hypomanic episodes) and lows (depressive episodes). All have important side effects to know about and monitor.

-http://www.nami.org/Learn-More/Treatment/Medications

Lithium

What are possible side effects of lithium?

Common Side effects: Sedation, nausea, loss of appetite, mild diarrhea, dizziness, fine hand tremors, increased production of urine and excessive thirst are common side effects.

Rare, but important: lithium may lead to a reversible condition known as diabetes insipidus. If this occurs you would notice a drastic increase in thirst and how much fluid you drink as well as how much you urinate.

Long term risks: Hypothyroidism and other thyroid conditions may occur with long term lithium use.

- See more at: https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Lithium#sthash.IOv0x5NQ.dpuf

Depakote

Common Side Effects Nausea, diarrhea, weight gain, feeling drowsy or dizzy

Rare Side Effects Hair loss, liver problems; Low platelets (platelets help the blood to clot. Bruising easier than normal is a symptom of low platelets; Pancreatitis (inflammation of the pancreas). Symptoms of pancreatitis include severe stomach pain, nausea, vomiting, and not feeling hungry; Increased ammonia levels. If this happens, you may get confused, disoriented, or have difficulty thinking.

Serious Side Effects Studies have found that individuals who take anticonvulsant medications including valproate have suicidal thoughts or behaviors up to 2 times more often than individuals who take placebo (inactive medication). These thoughts or behaviors occurred in approximately 1 in 550 patients taking the anticonvulsant class of medications.

- See more at: https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications/Valproate-(Depakote)#sthash.41hhJl6s.dpuf

Anxiety Disorders

Everyone experiences anxiety. Speaking in front of a group makes most of us anxious, but that motivates us to prepare and do well. Driving in heavy traffic is a common source of anxiety, but it keeps us alert and cautious to better avoid accidents. However, when feelings of intense fear and distress are overwhelming and prevent us from doing everyday things, an anxiety disorder may be the cause.

Anxiety disorders are the most common mental health concern in the United States. An estimated 40 million adults in the U.S., or 18%, have an anxiety disorder. Approximately 8% of children and teenagers experience the negative impact of an anxiety disorder at school and at home. Most people develop symptoms of anxiety disorders before age 21 and women are 60% more likely to be diagnosed with an anxiety disorder than men.

- See more at: https://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders#sthash.YYbY37h8.dpuf

Medications For Anxiety

Antidepressants are often the first choice of clinicians for the treatment of anxiety, as these medications have little potential for addiction or abuse, moreover, they are effective and relatively safe medications.

Certain medications work solely to reduce the emotional and physical symptoms of anxiety. Benzodiazepines such as alprazolam (Xanax) can treat social phobia, generalized anxiety disorder and panic disorder. Heart medications known as beta-blockers are also effective at treating the physical trembling and sweating that people with phobias experience in difficult situations.

Benzodiazepines work quickly and are very effective in the short-term. People prone to substance abuse may become dependent on them, however. It also may be necessary to increase the dosage over time. The body becomes accustomed to these medications over time and may require larger doses for the same therapeutic effect. People who stop taking benzodiazepines abruptly may experience unpleasant withdrawal symptoms

- See more at: https://www.nami.org/Learn-More/Treatment/Mental-Health-Medications#sthash.eqlk85zL.dpuf

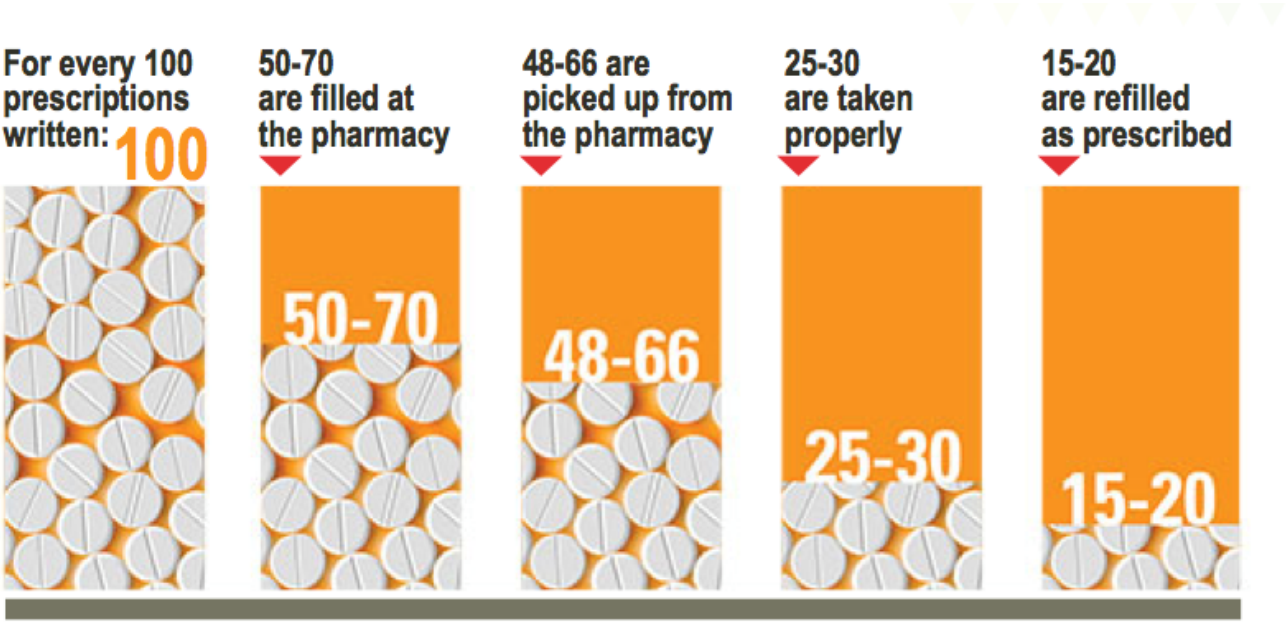
Medications have multiple names and multiple uses.

Antidepressants: are first line treatments for Panic Attacks and PTSD. They are often used as sleep aids or for pain control.
Antipsychotics: are used for anxiety, mania, bipolar, sleep, and even depression.
Anti-anxiety medications: can be used for sleep, seizures, and even muscle relaxation.
Blood pressure medications: are used for PTSD and anxiety.
Anti-seizure medications: are used for bipolar disorder.

Medication Compliance

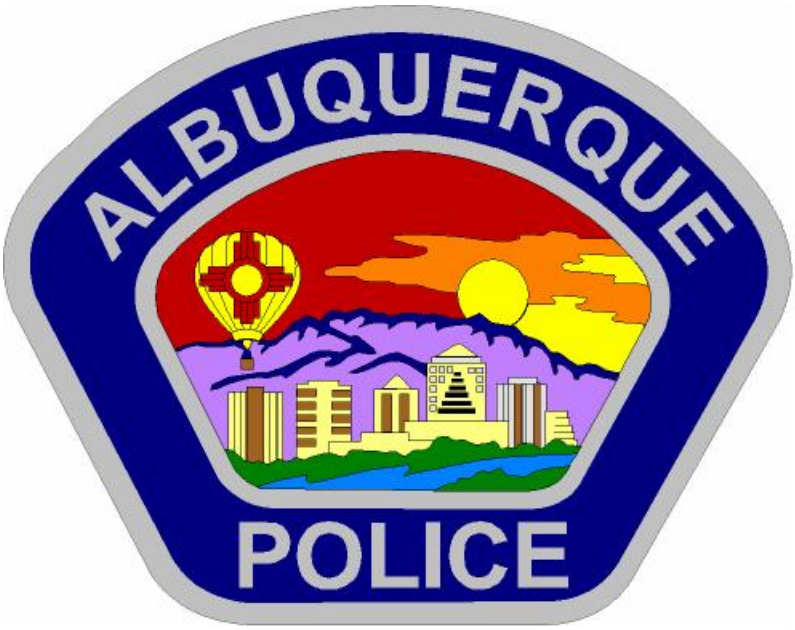
Almost no one takes medications as prescribed!

In its 2003 report on medication adherence, the World Health Organization (WHO) quoted the statement by Haynes that “increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.” Among patients with chronic illness, approximately 50% do not take medications as prescribed. This poor adherence to medication leads to increased morbidity and death and is estimated to incur costs of approximately $100 billion per year. Thus, Hippocrates' exhortation to the physician to “not only be prepared to do what is right himself, but also to make the patient…cooperate” has consistently failed for more than 2000 years. Today's ever more complicated medical regimens make it even less likely that physicians will be able to compel compliance and more important that they partner with patients in doing what is right together.



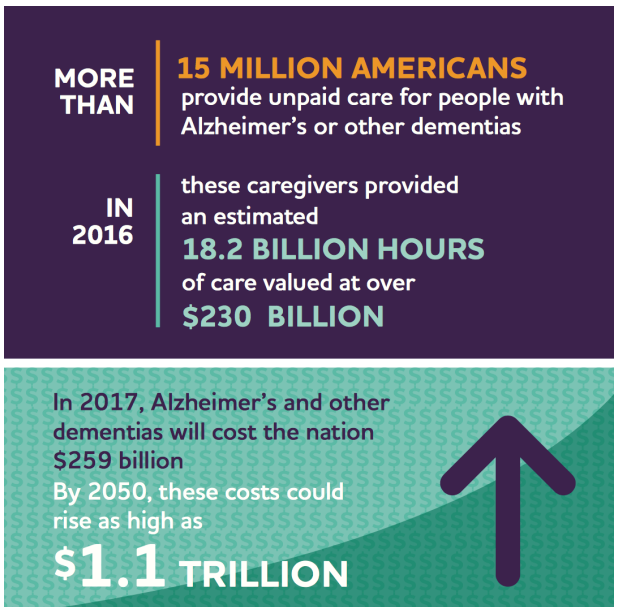
This guide was created by Nils Rosenbaum, MD with assistance from Matthew Tinney
If you find an error or would like to update the material please contact Matthew Tinney at mtinney@cabq.gov or 505-553-2229

Crisis Intervention Team (CIT) Training



Student Guide

Cognitive Disorders and Brain Injuries



Alzheimer's

Symptoms are divided into two main categories:

Intellectual/Cognitive

Memory loss, communication difficulty, motor skill deficits, inability to interpret sensations properly.

Psychiatric

Personality changes, depression, hallucination, delusions

- Dementia is not only about memory loss!
- People with early dementia can be very good at hiding memory problems.
- People with dementia will often make up stories (confabulation).
- Paranoia is not unusual, and can draw police attention, even if memory problems aren't obvious.
- Agitation can also draw police attention.
- People with early dementia may become good at voiding responses or situations that can show memory problems. "Hey, it's good to see you." Therefore, even if it's awkward, you can ask them the day of the week and the calendar date. Don't forget to ask the year!

Delirium

Delirium is a serious disturbance in mental abilities that results in confused thinking and reduced awareness of your environment. The start of delirium is usually rapid — within hours or a few days.

Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.

Because symptoms of delirium and dementia can be similar, input from a family member or caregiver may be important for a doctor to make an accurate diagnosis.

Signs and symptoms of delirium usually begin over a few hours or a few days. They often fluctuate throughout the day, and there may be periods of no symptoms. Symptoms tend to be worse during the night when it's dark and things look less familiar. Primary signs and symptoms include those below.

Reduced awareness of the environment

This may result in:

- An inability to stay focused on a topic or to switch topics
- Getting stuck on an idea rather than responding to questions or conversation
- Being easily distracted by unimportant things
- Being withdrawn, with little or no activity or little response to the environment

Poor thinking skills (cognitive impairment)

This may appear as:

- Poor memory, particularly of recent events
- Disorientation, for example, not knowing where you are or who you are
- Difficulty speaking or recalling words
- Rambling or nonsense speech
- Trouble understanding speech
- Difficulty reading or writing

Behavior Changes

This may include:

- Seeing things that don't exist (hallucinations)
- Restlessness, agitation or combative behavior
- Calling out, moaning or making other sounds
- Being quiet and withdrawn — especially in older adults
- Slowed movement or lethargy
- Disturbed sleep habits
- Reversal of night-day sleep-wake cycle

Emotional Disturbances

This may appear as:

- Anxiety, fear, or paranoia
- Depression
- Irritability or anger
- A sense of feeling elated (euphoria)
- Apathy
- Rapid and unpredictable mood shifts
- Personality changes
- Types of delirium

Experts have identified three types of delirium:

- **Hyperactive delirium.** Probably the most easily recognized type, this may include restlessness (for example, pacing), agitation, rapid mood changes or hallucinations.
- **Hypoactive delirium.** This may include inactivity or reduced motor activity, sluggishness, abnormal drowsiness or seeming to be in a daze.
- **Mixed delirium.** This includes both hyperactive and hypoactive symptoms. The person may quickly switch back and forth from hyperactive to hypoactive states.

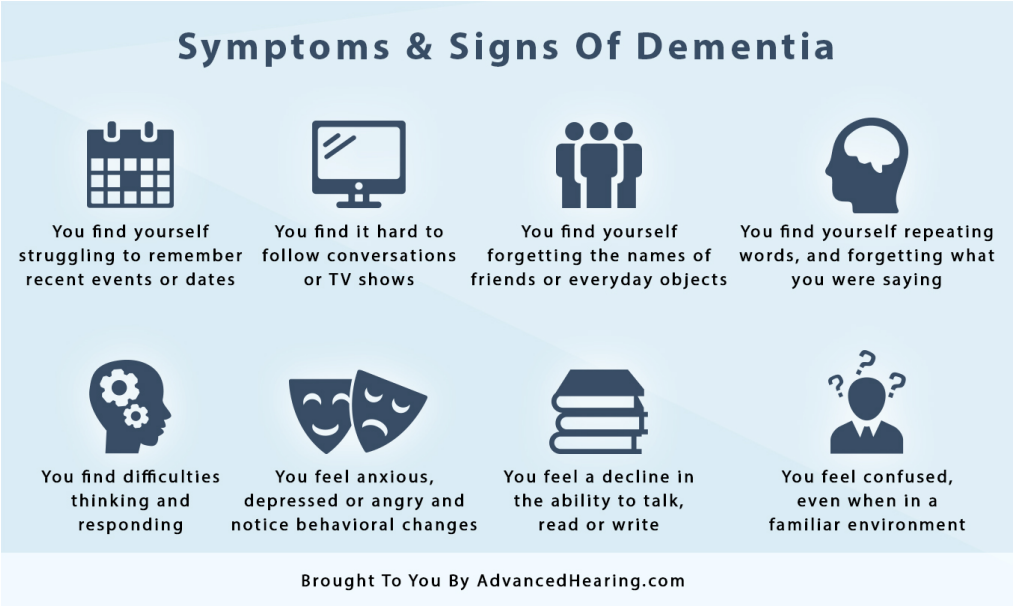
Delirium and dementia

Dementia and delirium may be particularly difficult to distinguish, and a person may have both. In fact, frequently delirium occurs in people with dementia.

Dementia is the progressive decline of memory and other thinking skills due to the gradual dysfunction and loss of brain cells. The most common cause of dementia is Alzheimer's disease.

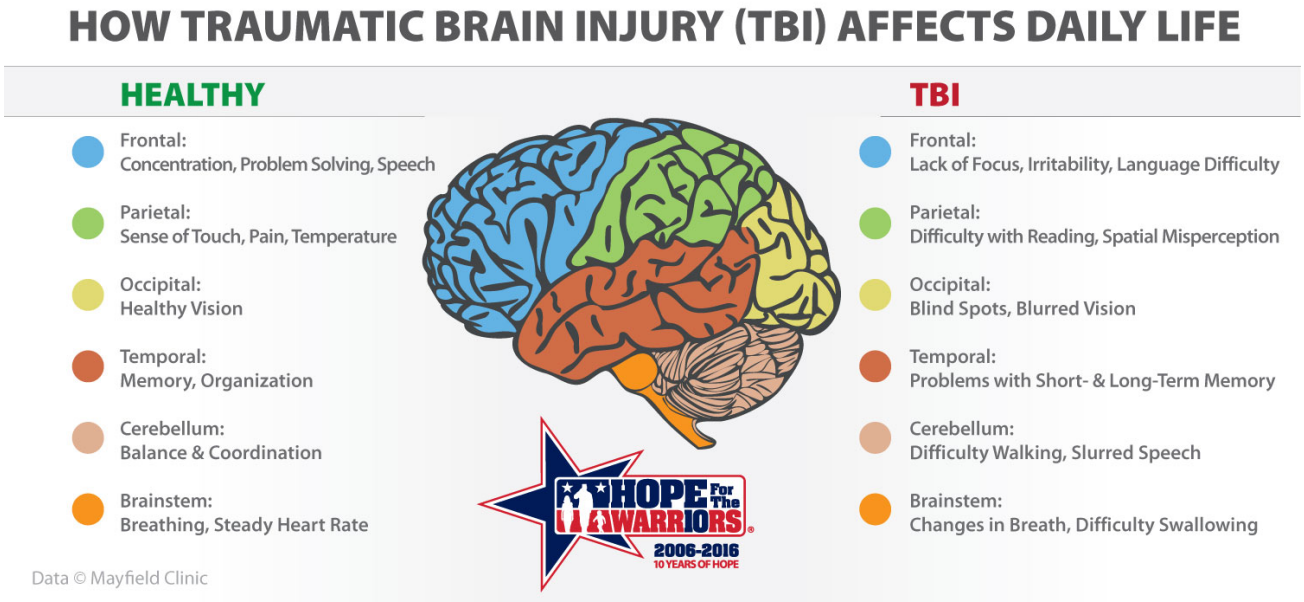
Some differences between the symptoms of delirium and dementia include:

- **Onset.** The onset of delirium occurs within a short time, while dementia usually begins with relatively minor symptoms that gradually worsen over time.
- **Attention.** The ability to stay focused or maintain attention is significantly impaired with delirium. A person in the early stages of dementia remains generally alert.
- **Fluctuation.** The appearance of delirium symptoms can fluctuate significantly and frequently throughout the day. While people with dementia have better and worse times of day, their memory and thinking skills stay at a fairly constant level during the course of a day.



Dementia is a general term for a decline in mental ability severe enough to interfere with daily life. Memory loss is an example. Alzheimer's is the most common type of dementia.

Though dementia and brain injuries can have overlap in their symptoms, brain injuries are unpredictable in their consequences.



Brain injuries affect who we are, the way we think, act, and feel. It can change everything about us in a matter of seconds. The most important things to remember:

- A person with a brain injury is a person first
- No two brain injuries are exactly the same
- The effects of a brain injury are complex and vary greatly from person to person
- The effects of a brain injury depend on such factors as cause, location, and severity

Traumatic Brain Injury

2.4 million people sustain a traumatic brain injury (TBI) each year. According to the Centers for Disease Control and Injury Prevention, the leading causes of TBI are:

- Falls (40.5%)
- Other/Unknown (19%)
- Struck by/against events (15.5%)
- Motor Vehicle-traffic crashes (14.3%)
- Assaults (10.7 %)

A Healthy Brain

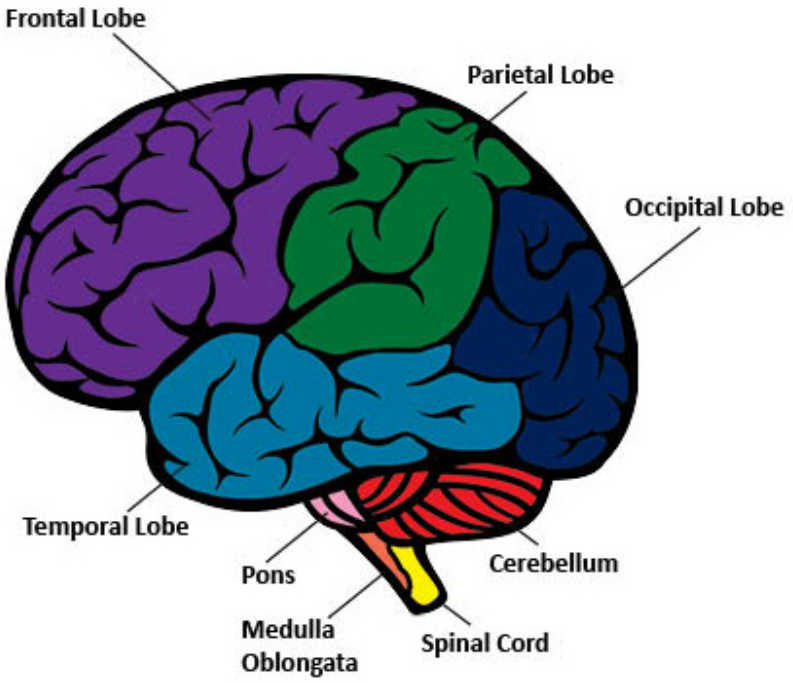
To understand what happens when the brain is injured, it is important to realize what a healthy brain is made of and what it does. The brain is enclosed inside the skull. The skull acts as a protective covering for the soft brain. The brain is made of neurons (nerve cells). The neurons form tracts that route throughout the brain. These nerve tracts carry messages to various parts of the brain. The brain uses these messages to perform functions. The functions include coordinating our body systems, such as breathing, heart rate, body temperature, and metabolism; thought processing; body movements; personality; behavior; and the senses, such as vision, hearing, taste, smell, and touch. Each part of the brain serves a specific function and links with other parts of the brain to form more complex functions. All parts of the brain need to be working well in order for the brain to work well. Even "minor" or "mild" injuries to the brain can significantly disrupt the brain's ability to function.

An Injured Brain

When a brain injury occurs, the functions of the neurons, nerve tracts, or sections of the brain can be affected. If the neurons and nerve tracts are affected, they can be unable or have difficulty carrying the messages that tell the brain what to do. This can change the way a person thinks, acts, feels, and moves the body. Brain injury can also change the complex internal functions of the body, such as regulating body temperature; blood pressure; bowel and bladder control. These changes can be temporary or permanent. They may cause impairment or a complete inability to perform a function.

Functions of the Brain

The brain is divided into main functional sections, called lobes. These sections or brain lobes are called the Frontal Lobe, Temporal Lobe, Parietal Lobe, Occipital Lobe, the Cerebellum, and the Brain Stem. Each has a specific function as described below.



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Parietal Lobe Functions

- Sense of touch
- Spatial perception
- Differentiation (identification) of size, shapes, and colors
- Visual perception

Occipital Lobe Functions

- Vision

Cerebellum Lobe Functions

- Balance
- Skilled motor activity
- Coordination
- Visual perception

Brain Stem Functions

- Breathing
- Arousal and consciousness
- Attention and concentration
- Heart rate
- Sleep and wake cycles

Frontal Lobe Functions

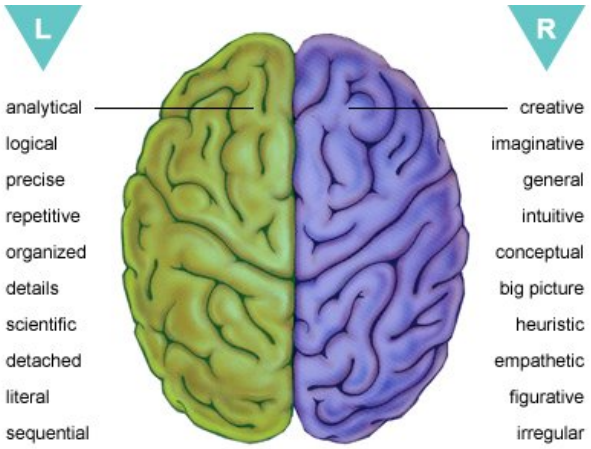
- Attention and concentration
- Self-monitoring
- Organization
- Speaking (expressive language)
- Motor planning and initiation
- Awareness of abilities and limitations
- Personality
- Mental flexibility
- Inhibition of behavior
- Emotions
- Problem solving
- Planning and anticipation
- Judgment

Temporal Lobe Functions

- Memory
- Understanding language (receptive language)
- Sequencing
- Hearing
- Organization

Right or Left Brain

The functional sections or lobes of the brain are also divided into right and left sides. The right side and the left side of the brain are responsible for different functions. General patterns of dysfunction can occur if an injury is on the right or left side of the brain.



Injuries of the left side of the brain can cause:

- Difficulties in understanding language (receptive language)
- Difficulties in speaking or verbal output (expressive language)
- Catastrophic reactions (depression, anxiety)
- Verbal memory deficits
- Impaired logic
- Sequencing difficulties
- Decreased control over right-sided body movements

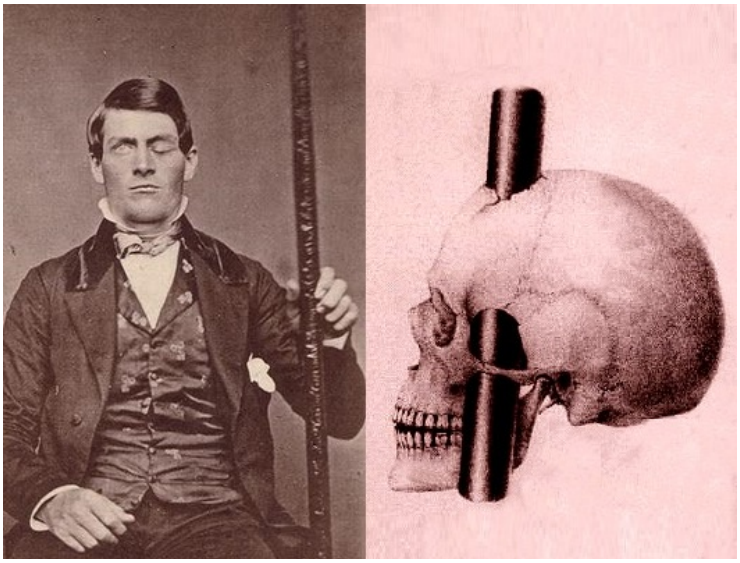
Injuries of the right side of the brain can cause:

- Visual-spatial impairment
- Visual memory deficits
- Left neglect (inattention to the left side of the body)
- Decreased awareness of deficits
- Altered creativity and music perception
- Loss of “the big picture” type of thinking
- Decreased control over left-sided body movements

Diffuse Brain Injury (The injuries are scattered throughout both sides of the brain) can cause:

- Reduced thinking speed
- Confusion
- Reduced attention and concentration
- Fatigue
- Impaired cognitive (thinking) skills in all areas

Phineas Gage



In 1848, Gage, 25, was the foreman of a crew cutting a railroad bed in Cavendish, Vermont. On September 13, as he was using a tamping iron to pack explosive powder into a hole, the powder detonated. The tamping iron—43 inches long, 1.25 inches in diameter and weighing 13.25 pounds—shot skyward, penetrated Gage's left cheek, ripped into his brain and exited through his skull, landing several dozen feet away. Though blinded in his left eye, he might not even have lost consciousness, and he remained savvy enough to tell a doctor that day, "Here is business enough for you."

Gage's initial survival would have ensured him a measure of celebrity, but his name was etched into history by observations made by John Martyn Harlow, the doctor who treated him for a few months afterward. Gage's friends found him"no longer Gage," Harlow wrote. The balance between his "intellectual faculties and animal propensities" seemed gone. He could not stick to plans, uttered "the grossest profanity" and showed "little deference for his fellows." The railroad-construction company that employed him, which had thought him a model foreman, refused to take him back. So Gage went to work at a stable in New Hampshire, drove coaches in Chile and eventually joined relatives in San Francisco, where he died in May 1860, at age 36, after a series of seizures.

In time, Gage became the most famous patient in the annals of neuroscience, because his case was the first to suggest a link between brain trauma and personality change. In his book *An Odd Kind of Fame: Stories of Phineas Gage*, the University of Melbourne's Malcolm Macmillan writes that two-thirds of introductory psychology textbooks mention Gage. Even today, his skull, the tamping iron and a mask of his face made while he was alive are the most sought-out items at the Warren Anatomical Museum on the Harvard Medical School campus.

When asking about possible brain injuries, be straightforward and ask in a professional manner.

- Ask if the person ever hit in the head with a loss of consciousness?
- Ask if they were they hospitalized for a brain injury?
- And if they were hosptialized, did they need rehabilitation after the injury?
  - Relearning to walk, talk, or use their memory?
- Do they have a scar or scars?
- Did their personality and life situation change as compared to before the injury?

Tips for Communicating with People with Brain Injuries

- Some people with TBI may have trouble concentrating or organizing their thoughts. If you are in a public area with many distractions, consider moving to a quiet or private location, and try focusing on short-term goals.
- Be prepared to repeat what you say, orally or in writing. Some people with TBI may have short-term memory deficits.
- If you are not sure whether the person understands you, offer assistance completing forms or understanding written instructions and provide extra time for decision-making. Wait for the individual to accept the offer of assistance; do not "over-assist" or be patronizing.
- Be patient, flexible and supportive. Take time to understand the individual, make sure the individual understands you and avoid interrupting the person.

Keys for law enforcement:

- Try not to take behaviors caused by brain injuries, dementia, and delirium personally
  - Don’t take them as a sign of disrespect
  - Don’t misread them as a lack of desire for help.
  - Respect the Person (Emphasize the person not the disorder.)
  - Be aware of symptoms and potential limitations the individual may have.
  - Understand as much as you can, and do not be afraid to ask questions so you become more informed.
  - Get help when you are not certain.

Crisis Intervention Team (CIT) Training

Student Guide

Personality Disorders

What are Personality Disorders?

Personality is the way of thinking, feeling and behaving that makes a person different from other people. An individual's personality is influenced by experiences, environment (surroundings, life situations) and inherited characteristics. A personality disorder is a way of thinking, feeling and behaving that deviates from the expectations of the culture, causes distress or problems functioning, and lasts over time.1

There are 10 specific types of personality disorders (such as borderline personality disorder). Common to all personality disorders is a long-term pattern of behavior and inner experience that differs significantly from what is expected. The pattern of experience and behavior begins by late adolescence or early adulthood, and causes distress or problems in functioning. Without treatment, the behavior and experience is inflexible and usually long-lasting. The pattern is seen in at least two of these areas:

- Way of thinking about oneself and others
- Way of responding emotionally
- Way of relating to other people
- Way of controlling one's behavior

"*My pain and sadness give me my strength.*
My strength ruins my mind, body and soul.
I've been trapped all my life.
Not by man or cages
But by my own emotions.
Where I've been by traveling inside myself
Can be summed up by one word —
Damn.
Pain manifests itself into peace and growth….
Only when you deal with the root of it the right way."

Brandon Marshall is a NFL wide receiver and advocate for mental health awareness. He has self disclosed living with borderline personality disorder.

The 10 specific personality disorders are grouped into three categories called "clusters".

Cluster A:

- **Schizoid Personality Disorder.** Schizoid personalities are introverted, withdrawn, solitary, emotionally cold, and distant. They are often absorbed with their own thoughts and feelings and are fearful of closeness and intimacy with others. For example, a person suffering from schizoid personality is more of a daydreamer than a practical action taker.

- **Paranoid Personality Disorder.** The essential feature for this type of personality disorder is interpreting the actions of others as deliberately threatening or demeaning. People with paranoid personality disorder are untrusting, unforgiving, and prone to angry or aggressive outbursts without justification because they perceive others as unfaithful, disloyal, condescending or deceitful. This type of person may also be jealous, guarded, secretive, and scheming, and may appear to be emotionally "cold" or excessively serious.

- **Schizotypal Personality Disorder**. A pattern of peculiarities best describes those with schizotypal personality disorder. People may have odd or eccentric manners of speaking or dressing. Strange, outlandish or paranoid beliefs and thoughts are common. People with schizotypal personality disorder have difficulties forming relationships and experience extreme anxiety in social situations. They may react inappropriately or not react at all during a conversation or they may talk to themselves. They also display signs of "magical thinking" by saying they can see into the future or read other people's minds.

Cluster B:

- **Antisocial Personality Disorder**. People with antisocial personality disorder characteristically act out their conflicts and ignore normal rules of social behavior. These individuals are impulsive, irresponsible, and callous. Typically, the antisocial personality has a history of legal difficulties, belligerent and irresponsible behavior, aggressive and even violent relationships. They show no respect for other people and feel no remorse about the effects of their behavior on others. These people ware at high risk for substance abuse, especially alcoholism, since it helps them to relieve tension, irritability and boredom.

- **Borderline Personality Disorder**. People with borderline personality disorder are unstable in several areas, including interpersonal relationships, behavior, mood, and self-image. Abrupt and extreme mood changes, stormy interpersonal relationships, an unstable and fluctuating self-image, unpredictable and self-destructive actions characterize the person with borderline personality disorder. These individuals

generally have great difficulty with their own sense of identity. They often experience the world in extremes, viewing others as either “all good” or “all bad.” A person with borderline personality may form an intense personal attachment with someone only to quickly dissolve it over a perceived slight. Fears of abandonment may lead to an excessive dependency on others. Self-mutilation or recurrent suicidal gestures may be used to get attention or manipulate others. Impulsive actions, chronic feelings of boredom or emptiness, and bouts of intense inappropriate anger are other traits of this disorder, which is more common among females.

- **Narcissistic Personality Disorder**. People with narcissistic personality have an exaggerated sense of self-importance, are absorbed by fantasies of unlimited success, and seek constant attention. The narcissistic personality is oversensitive to failure and often complains of multiple somatic symptoms. Prone to extreme mood swings between self-admiration and insecurity, these people tend to exploit interpersonal relationships.

Cluster C:

- **Avoidant Personality Disorder**. Avoidant personalities are often hypersensitive to rejection and are unwilling to become involved with others unless they are sure of being liked. Excessive social discomfort, timidity, fear of criticism, avoidance of social or work activities that involve interpersonal contact are characteristic of the avoidant personality. They are fearful of saying something considered foolish by others; worry they will blush or cry in front of others; and are very hurt by any disapproval by others. People with avoidant personality disorder may have no close relationships outside of their family circle, although they would like to, and are upset at their inability to relate well to others.

- **Dependent Personality Disorder**. People with dependent personality disorder may exhibit a pattern of dependent and submissive behavior, relying on others to make decisions for them. They require excessive reassurance and advice, and are easily hurt by criticism or disapproval. They feel uncomfortable and helpless if they are alone, and can be devastated when a close relationship ends. They have a strong fear of rejection. Typically lacking in self-confidence, the dependent personality rarely initiates projects or does things independently. This disorder usually begins by early adulthood and is diagnosed more frequently in females than males.

- **Obsessive-Compulsive Personality Disorder**. Compulsive personalities are conscientious and have high levels of aspiration, but they also strive for perfection. Never satisfied with their achievements, people with compulsive personality disorder take on more and more responsibilities. They are reliable, dependable, orderly, and methodical, but their inflexibility often makes them incapable of adapting to changed circumstances. People with compulsive personality are highly cautious, weigh all

aspects of a problem, and pay attention to every detail, making it difficult for them to make decisions and complete tasks. When their feelings are not under strict control, events are unpredictable, or they must rely on others, compulsive personalities often feel a sense of isolation and helplessness.

How are Personality Disorders Treated?

When these characteristics are carried to an extreme, when they endure over time and when they interfere with healthy functioning, a diagnostic evaluation with a licensed physician or mental health professional is recommended.

There are many types of help available for the different personality disorders. Treatment may include:

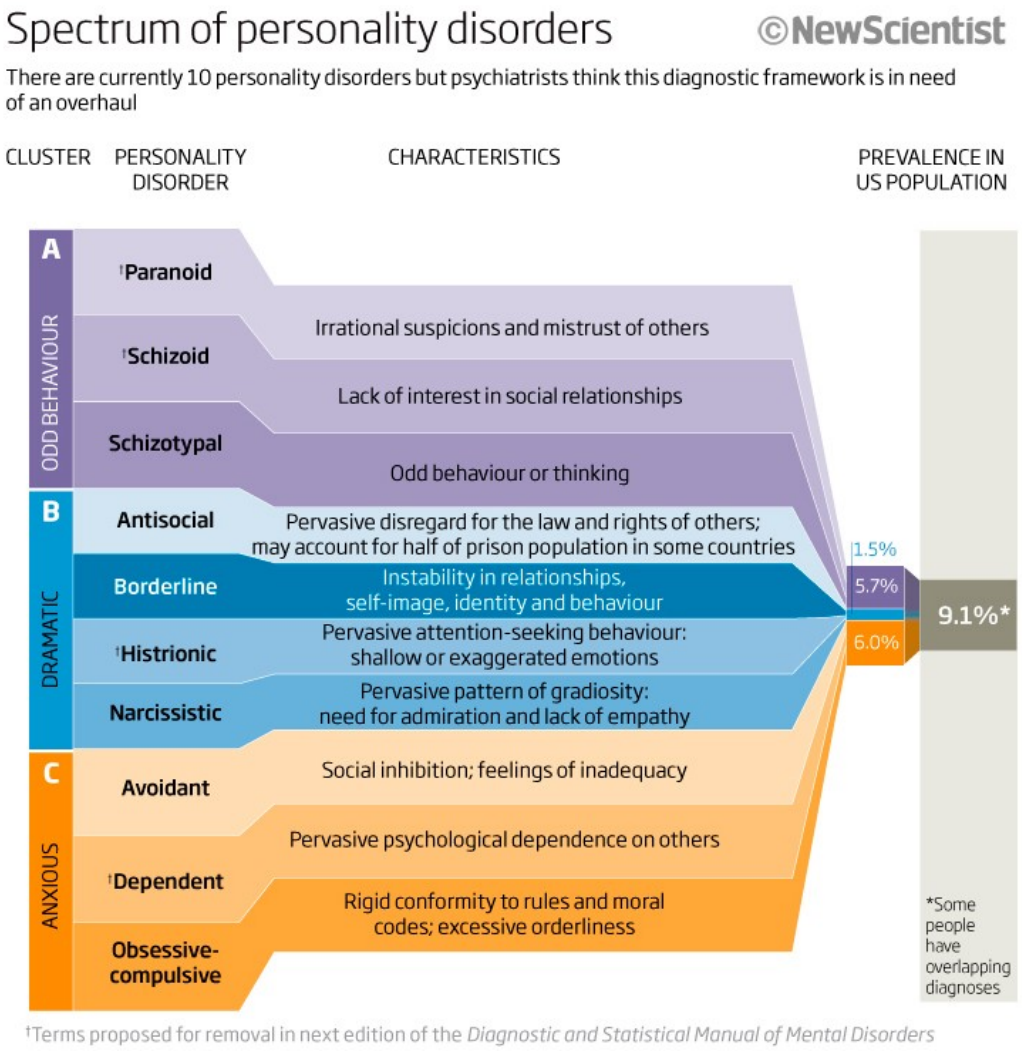
- Psychoanalytic/psychodynamic therapy
- Dialectical behavior therapy
- Cognitive behavioral therapy
- Group therapy
- Psychoeducation (teaching the individual and family members about the illness, treatment and ways of coping)

Psychotherapy for patients with personality disorders focuses on helping them see the subconscious conflicts that are contributing to or causing their symptoms. It also helps people become more flexible and is aimed at reducing the behavior patterns that interfere with everyday living.

In psychotherapy, people with personality disorders can better recognize the effects of their behavior on others. Behavior and cognitive therapies focus on resolving symptoms or traits that are characteristic of the disorder, such as the inability to make important life decisions or the inability to initiate relationships.

There is Hope

The more you learn about personality disorders the more you will understand that they are illnesses, with causes and treatments. People can improve with proper care. By seeking out information you can recognize the signs and symptoms of a personality disorder and help yourself or someone you know live a healthier more fulfilling life.



Resources

National Institute of Mental Health www.nimh.nih.gov
National Alliance on Mental Illness www.NAMI.org
Disability.gov
Substance Abuse and Mental Health Services Agency https://www.samhsa.gov
American Psychiatric Association

Crisis Intervention Team (CIT) Training

Student Guide

Schizophrenia Spectrum and Other Psychotic Disorders

Safety, De-stigmatization and Resources should be kept in mind when interacting with people living with Schizophrenia. Keeping **dignity** and **respect** in mind will help with rapport building.

Definitions:

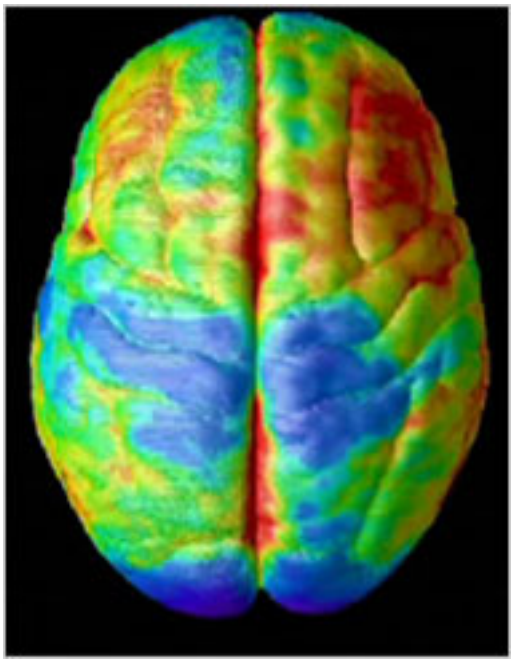
- Schizophrenia Spectrum represents a range of psychotic disorders that include Schizophrenia, Substance/Medication-Induced psychotic disorders, Psychotic Disorder due to another medical condition and other associated psychotic disorders.

- Psychosis is defined by key features that include delusions, hallucinations and disorganized thought and speech.

- Hallucinations can be in all of the sensory modalities, but are most commonly experienced as auditory or visual false sensory experiences.

- Delusions are strongly held false beliefs that do not change despite evidence that these beliefs are implausible.

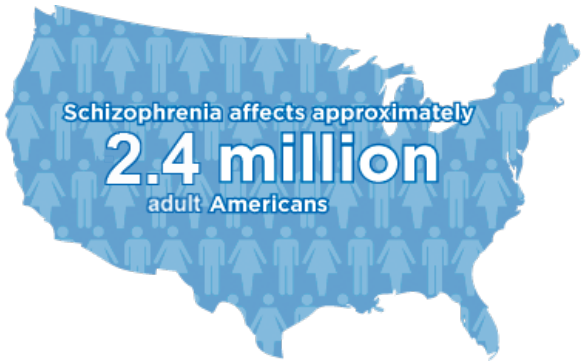
- Disorganized thinking and speech occur when an individual cannot stay on topic, cannot coherently answer questions or engage in conversation or most severely when “word salad” occurs and the individual is frankly incoherent



Diagnosis for Schizophrenia

For six months, person has at least two of the following symptoms that have caused impairment:

1. Delusions
2. Hallucinations.
3. Disorganized Speech.
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms.



Positive symptoms:

- Delusions
- Hallucinations
- Disorganized Thinking
- Abnormal actions and/or movements

Negative symptoms:

- Little or no facial expression
- Reduced feelings of pleasure in everyday life
- Difficulty beginning and sustaining activities
- Reduced speaking

Additional Associated Features:

- Inappropriate and bizarre behavior and facial expression
- Thought blocking or difficulty speaking
- Fear related to paranoia
- Hostility and aggression related to fear

"It should be noted that the vast majority of persons with schizophrenia are not aggressive and are more frequently victimized than are individuals in the general population."

(5th ed., text rev.; Diagnostic and statistical manual of mental disorders; American Psychiatric Association, 2013:101)

Psychotic Disorder Due to Another Medical Condition

- Prominent hallucinations or delusions
- Collateral information or other evidence suggests the disturbance is directly related to another medical condition

How to interact with people who are psychotic

- A person with Psychosis may hear voices or other intrusive noises in the background while you are talking, making it difficult for them to communicate.
- Reassurance rather than attempts at logic can be more effective with individuals who are delusional. Remember that their beliefs or hallucinations seem very real to them.
- Refer back to Active Listening, and try to listen for themes in the individuals words that might inform you regarding their distress.
- Obtain collateral information whenever possible regarding prior psychiatric illness, psychiatric care, medication compliance and the presence of illicit or overdosed medication and/or alcohol.
- Choose one problem at a time so as not to overwhelm the psychotic individual.
- Give specific behavioral instructions, e.g., "Bill, please stay where you are".
- Use phrases such as "I would like you to…" or "I would really appreciate it if you would…"
- Be respectful, supportive and kind without tolerating any dangerous or aggressive behavior.

What Can I Do?

- Learn about mental health-educate myself and others
- See the person not the illness- utilize active listening in order to understand
- Take action- model compassionate nonjudgmental attitudes when talking about and talking with mentally ill individuals

Schizophrenia:

- “Worldwide prevalence estimates range between 0.5% and 1%. Age of first episode is typically younger among men (about 21 years of age) than women (27 years). Of persons with schizophrenia, by age 30, 9 out of 10 men, but only 2 out of 10 women, will manifest the illness.
- Persons with schizophrenia pose a high risk for suicide. Approximately one-third will attempt suicide and, eventually, about 1 out of 10 will take their own lives.
- A Canadian study found that the direct health care and non-health care costs of schizophrenia were estimated to be 2.02 billion Canadian dollars in 2004. This, combined with a high unemployment rate due to schizophrenia and an added productivity and morbidity and mortality loss of 4.83 billion Canadian dollars, yielded a total cost estimate of 6.85 billion in U.S. and Canadian dollars.
- The economic burden of schizophrenia is particularly great during the first year following the index episode, relative to the third year onwards. This finding suggests the need for improved monitoring of persons with schizophrenia upon initial diagnosis.” (CDC, Burden of Mental Illness, 2016)

Causes

Research suggests that schizophrenia may have several possible causes:

• **Genetics**. Schizophrenia isn’t caused by just one genetic variation, but a complex interplay of genetics and environmental influences. While schizophrenia occurs in 1% of the general population, having a history of family psychosis greatly increases the risk. Schizophrenia occurs at roughly 10% of people who have a first-degree relative with the disorder, such as a parent or sibling.

• **Environment**. Exposure to viruses or malnutrition before birth, particularly in the first and second trimesters has been shown to increase the risk of schizophrenia. Inflammation or autoimmune diseases can also lead to increased immune system.

• **Brain chemistry**. Problems with certain brain chemicals, including neurotransmitters called dopamine and glutamate, may contribute to schizophrenia. Neurotransmitters allow brain cells to communicate with each other. Networks of neurons are likely involved as well.

• **Drug use**. Some studies have suggested that taking mind-altering drugs during teen years and young adulthood can increase the risk of schizophrenia. A growing body of evidence indicates that smoking marijuana increases the risk of psychotic incidents and the risk of ongoing psychotic experiences. The younger and more frequent the use, the greater the risk. Another study has found that smoking marijuana led to earlier onset of schizophrenia and often preceded the manifestation of the illness.

Diagnosis
Diagnosing schizophrenia is not easy. The difficulty of diagnosing this illness is compounded by the fact that many people who are diagnosed do not believe they have it. Lack of awareness is a common symptom of people diagnosed with schizophrenia and greatly complicates treatment. To be diagnosed with schizophrenia, a person must have two or more of the following symptoms occurring persistently in the context of reduced functioning:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms

Treatment
With medication, psychosocial rehabilitation and family support, the symptoms of schizophrenia can be reduced. People with schizophrenia should get treatment as soon as the illness starts showing, because early detection can reduce the severity of their symptoms. Treatment options include:

- **Antipsychotic medications.** Typically, a health care provider will prescribe antipsychotics to relieve symptoms of psychosis, such as delusions and hallucinations. Due to lack of awareness of having an illness and the serious side effects of medication used to treat schizophrenia, people who have been prescribed them are often hesitant to take them.

- **Psychotherapy** such as cognitive behavioral therapy (CBT) or cognitive enhancement therapy (CET).

- **Psychosocial Treatments**. People who engage in therapeutic interventions often see improvement, and experience greater mental stability. Psychosocial treatments enable people to compensate for or eliminate the barriers caused by their schizophrenia and learn to live successfully. If a person participates in psychosocial rehabilitation, they are more likely to continue taking their medication and less likely to relapse. Some of the more common psychosocial treatments include assertive community treatment (ACT).

If any editing or revisions need to be made to this document or if you would like to contribute new material please contact Matthew Tinney at mtinney@cabq.gov, 505-553-2229

Crisis Intervention Team Training

Substance Use and Co-Occurring Disorders

Student Guide

What is Substance Use Disorder?

The use of alcohol or other drugs does not mean that someone has a substance use disorder. People use substances for their effects, which can include pleasant feelings and decrease in negative feelings.

Substance use disorders include any of:

- *Abuse* of alcohol or other drugs which leads to work, school, home, health, or legal problems.
- *Dependence* on alcohol or other drugs.

Symptoms of substance dependence:

- Tolerance for the substance.
- Problems with withdrawal.
- Use of larger amounts over longer periods than intended.
- Problems in cutting down or controlling use.
- A lot of time spent getting the substance, using it, or recovering from its effects.
- The person gives up or reduces important social, occupational, or recreational activities because of substance.
- The person continues use of the substance despite knowing that the us has negative consequences.

What Causes Substance Use Disorders?

Most knowledge on the cause of substance use disorders is around the use of alcohol, but the causes are likely to be similar.

There is no single cause of substance use disorders. Many factors can attribute to a disorder, such as:

- *Availability and tolerance of the substance in society.*
  Where substances are readily available and acceptable, disorders are more likely to develop. This can apply to society as a whole and to unique social groups.

- *Social Factors.*
  Some groups are more susceptible to disorders, like alcohol use disorders, including males, people with low education and income, people who have divorces, and people in certain occupations with a drinking culture.

- *Genetic predisposition.*
  People who have a biological parent with a substance use disorder are more likely to develop the disorder.

- *Alcohol Sensitivity.*
  Some people are physiologically less sensitive to the effects of alcohol than others, and are more likely to drink heavily and develop alcohol use disorders.

- *Learning.*
  Someone can learn the habit of heavy substance use. The habit can be promoted because of the pleasant effects or reduction in stress.

- *Other health problems.*
  Some people may use substances to self-medicate their other health problem, which can lead to a disorder.

Use of drugs and/or alcohol is associated with criminal behavior.

- The probability of exhibiting criminal behavior appears to be three to four times higher among drug users than among non-users and several studies have described this relationship

- In general individuals with Substance Use Disorder (SUD) have a greater difficulty in areas such as family relationships, employment, legal matters housing and health.

These individuals are considered a difficult group in all settings due to their inclination toward extreme emotional reactions, high rates of comorbid psychiatric diagnoses, and the difficulty of getting them engaged in effective treatment until abstinence is achieved

Alcohol

- 20% of patients assessed to be alcohol intoxicated had no alcohol in blood. Assessed by both healthcare professionals and laypersons (there is a bit of an assumption here regarding police officers, but if doctor and nurses are getting it wrong I am extrapolating).

- Individuals' income, age and socioeconomic status significantly influenced these evaluations.

Conventional wisdom tells us that individuals who are under the influence of alcohol will act aggressively. This is a situation in which conventional wisdom is likely correct, crime studies consistently implicate alcohol intoxication as one of the most significant factors in violent behavior.

Alcohol poisoning:

- confusion
- vomiting
- seizures
- slow breathing (less than eight breaths a minute)
- irregular breathing (a gap of more than 10 seconds between breaths)
- blue-tinged skin or pale skin (cyanosis)
- low body temperature
- unconscious and unable to be woken up or focus

-It is not necessary to have all these signs and symptoms before determining that the individual requires medical assistance. A person who is unconscious or can't be awakened is at risk of dying.

Stimulants

- Overdose and/or chronic use of stimulants can result in paranoia, psychosis, irritability, anxiety, panic attacks, high blood pressure, excessive sweating, fast heart rate, hyperthermia, strong headache, chest pain, muscle spasms, and heart failure.
- Withdrawal is not life threatening. Mimics severe depression, dysphoria, and suicidality.

Methamphetamine

- Methamphetamine
  -Chronic use:
  -"Meth mouth" erodes enamel (salivary glands dry out)
  -Over time, destroys dopamine receptors
  -Psychotic behaviors
  -Severe memory, judgment & motor coordination
  -Impairment
  -Acne
  -Loss of skin luster
  -Gaunt, frail appearance
  -Binges on sugary food and drinks
  -Increased libido, later impotence
  -Convulsions

Opiates

- A drug-violence relationship exists for several reasons, some direct (drugs pharmacologically inducing violence) and some indirect (violence occurring in order to attain drugs) Moreover, the nature of that relationship is often complex, with intoxication, neurotoxic and withdrawal effects often being confused and/or confounded.
- There is inconsistency in the literature regarding the relationship between heroin and aggression. What seems more certain is that while intermittent use of opiates seems to produce euphoria and feelings of well-being, chronic administration produces more complex changes in mood and behavior, and an abrupt cessation of opioid administration after tolerance produces a variety of untoward consequences. Opiate withdrawal has consistently been shown to lead to a pattern of behaviors, including heightened aggression in animals, perhaps in part due to heightened pain sensitivity.
- Central Nervous System (CNS) depressant poisoning and overdoses most frequently involve alcohol, opiates or benzodiazepines.
- Patients will have levels of consciousness ranging from mildly altered to unresponsive, and may progress to coma and death
- Always consider other potential causes of altered level of consciousness

Polysubstance Intoxication

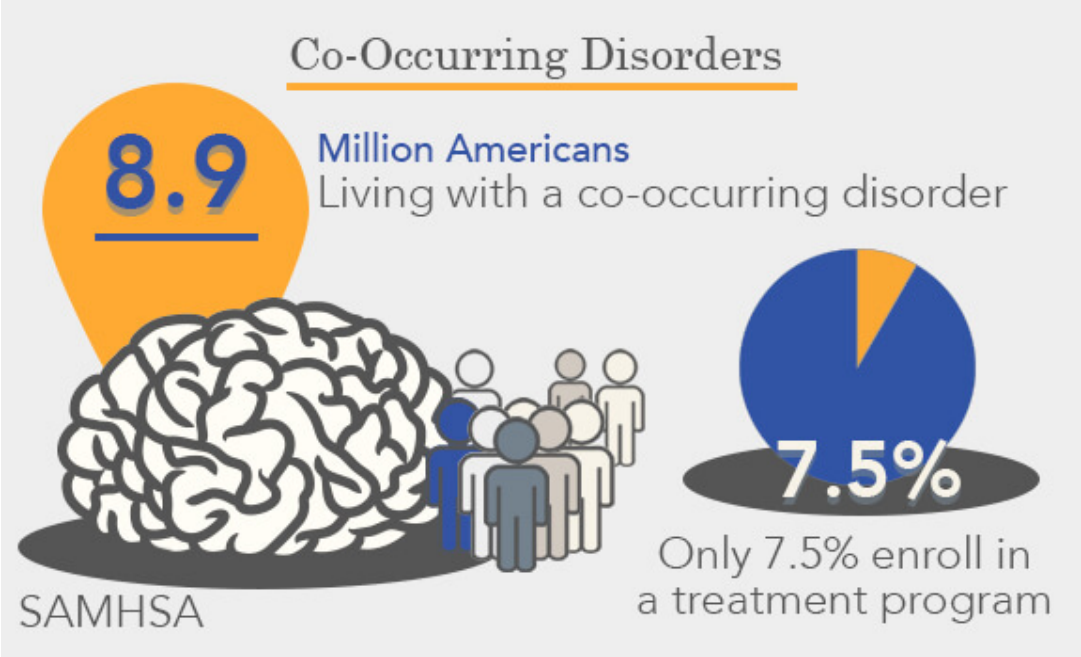
Unknown pharmacological impact on violence. There may be a relationship between personality types likely to engage in these behaviors, such as antisocial personality and psychopathy. The explanations are multi-factorial and perhaps predominantly indirect.

Co-Occurring Disorders

Over the past several decades there has been an increasing association between substance abuse and mental disorders.

This phenomenon impacts how we treat specific populations such as the homeless and those in our criminal justice system.

There are complex interactions between homelessness and co-occurring disorders.



According to SAMHSA's 2014 National Survey on Drug Use and Health (NSDUH) estimated 43.6 million (18.1%) Americans ages 18 and up experienced some form of mental illness. In the past year, 20.2 million adults (8.4%) had a substance use disorder. Of these, 7.9 million people had both a mental disorder and substance use disorder, also known as co-occurring mental and substance use disorders.

During the past year, for those adults surveyed who experienced substance use disorders and any mental illness, rates were highest among adults ages 26 to 49 (42.7%). For adults with past-year serious mental illness and co-occurring substance use disorders, rates were highest among those ages 18 to 25 (35.3%) in 2014.

What is Co-Occurring Disorders?

- The term co-occurring disorders replaces the previously used term dual diagnosis
- For the purposes of this manual co-occurring disorders refers to individuals suffering from both substance use (abuse or dependence) and mental disorders.
- Substance-Related and Addictive Disorders as defined by Diagnostic and Statistical Manual of Mental Disorders (DSM) “encompasses 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencycline…); inhalants: opoids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine and other stimulants); tobacco; and other (or unknown) substances”.
- The standard use of terms for mental disorders also derive from DSM-5 (2013).

What are common indicators of a co-occurring disorder?

- Use of alcohol or other drugs to reduce problems or pain associated with mental health issues
- A worsening mental health disorder because of alcohol or drug use
- A worsening substance use disorder because of mental health problems
- Difficulty getting treatment for both disorders, or difficulty benefiting from treatment
- Difficulty finding supportive professionals or peers who understand both disorders

What causes co-occurring disorders?

There may be a genetic risk factor with substance use and some mental health disorders, but genetics alone doesn’t explain all cause for co-occurring disorders. Other causes include environment, family, and life stress (traumatic event, poverty, loss, etc.). Some people may use alcohol and drugs to cope with the symptoms of their mental health disorders. People who are living with mental illness are at a higher risk of also having a substance use disorder.

Substance/Medication and mental disorders

- Personality Disorders, Schizophrenia Spectrum and Psychotic Disorders, Depression, Bipolar Disorder, etc. often co-exist with Substance-Related and Addictive Disorders.

Youth

A 2006 multisite, multisystem mental health prevalence study found that 70 percent of youth met criteria for at least one mental disorder; more than half of youth met criteria for two disorders, and over 60 percent of youth with a mental disorder also had a co-occurring substance use disorder. Co-occurring substance use disorders were most common for youth with disruptive disorders, although significant numbers of youth with anxiety disorders and mood disorders also had a co-occurring substance use disorder. Additionally, as youth become more involved in the juvenile justice system, the rates of co-occurring mental and substance use disorders increase.

When working with people experiencing Psychosis

- Before moving on to solutions, when possible, observe and assess for signs and symptoms of major mental illnesses and other disorders affecting cognitive of emotional states.
- Recognize indications for the presence of substance abuse
- Utilize behavioral management strategies including de-escalation techniques
- Access services appropriate to the circumstances.

Substance/Medication Induced Psychotic Disorder

- Anti-stigma education can assist officers to effect ethical decision-making
- Recognition of the interplay between substance intoxication and psychotic symptoms can assist the officer to determine whether or not the individual is capable of understanding and responding to any directions given by the police.
- Knowledge and skills related to risk assessment could include an understanding of the relationship between co-occurring disorders and dangerousness.

Working with people living with co-occurring disorders

- A non-judgmental attitude predicts for a more productive rapport.
- Some levels of intoxication and agitation preclude the use of verbal de-escalation. Safety must be the top priority.

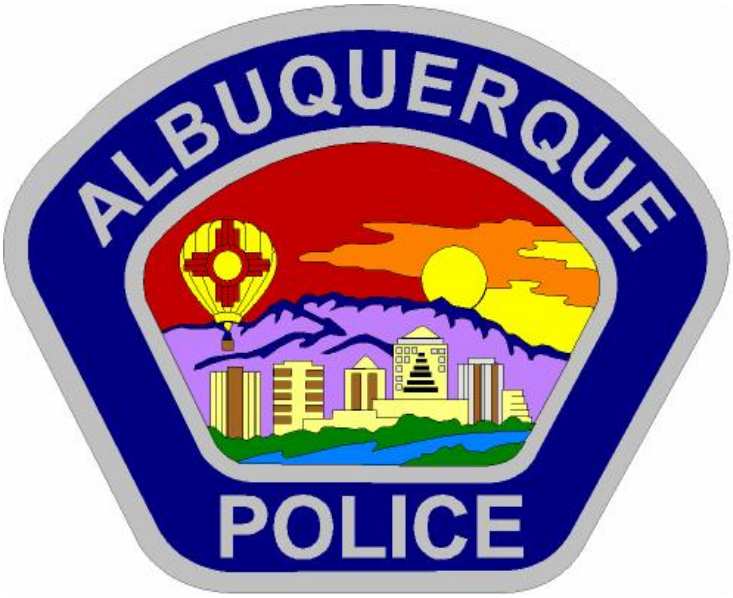
Interventions and Safety

- Keep in mind the great difficulty experienced by acutely psychotic individuals in following directions or understanding commands.
- Awareness of these multiple difficulties can inform the officer regarding their approach, their decision-making and the resources sought.

Treatment involves:

- Diagnosis of both disorders
- Education about substance use and psychiatric disorders
- The interaction between both the addiction and mental health concerns and the options for treatment
- Exploration of the individual's motivation and commitment to address his or her co-occurring disorder
- Therapies, including cognitive behavioral therapy, and Twelve Step facilitation that teach new skills and provide new insights
- Appropriate use of medications
- Involvement in treatment, including opportunities for education and skills development
- Ongoing and frequent monitoring for the return of psychiatric symptoms and substance use
- Participation in peer support groups such as Alcoholics Anonymous and Dual Recovery Groups

Crisis Intervention Team (CIT) Training



Student Guide

Developmental Disabilities

And

Autism Spectrum Disorder

Developmental Disabilities

What are developmental disabilties?

Development disabilities are a group of conditions due to an impairment in physical, learning, language or behavior area. The Centers for Disease Control that about one in six children have one or more developmental disabilities or other developmental delays. These conditons begin during the developmental period, may impact day-today functioning, and usually last throughout a person's lifetime.

What are some of the different types of developmental disabilties?

- Intellectual disabilty(mental retardation)
    - Limits ability to learn(IQ below 70) and to function in daily life
    - Onset prior to age 18
    - The cause is 80% of cases is unknown and there are 300 possible factors in the other 20%
- Autism Spectrum Disorders(ASD)
- Genetic and chromosol disorders
    - Fragile X(most common form of inherited ID)
    - Down Syndrome
- Fetal alcohol disorders/effects
- Cerebral palsy

Common Traits for Persons living with Developmental Disabilities

- They area often picked on, victimized and humiliated
- They have a desire for approval and acceptance and often do what others tell them to
- They have very poor impulse control and diffuculty with long term thinking
- They have difficulty handling stress
- They have difficulty predicting consequences or resisting strong emotional responses.

Contact with Criminal Justice System

- Here are some useful facts about persons living with Development disabilities and their contacts with the criminal justice system.
- They are involved as victims or suspects more often than people not living with developmental disabilities
- They have a 4 to 10 time higher risk of becoming a victim of crime than people not living with developmental disabilties
- As children they are three times more likely to become abused and or neglected
- Persons living with Intellectual disabilities have a very high rate of violent victimization
- They are more likely to confess to crimes that they did not commit
- They are more likely to say what they think the police officer wants to hear
- They are more likely to agree with advise given to them by a lawyer even if it means a guilty plea for a crime they did not commit
- They are often co-defendants because they are followers and not leaders

Things to remember

Officers are reminded to always think of safety when contacting a person living with a developmental diasability. Officers should take in all the risk factors of a situation and try to de-escalate the situation using any of the information given to help build rapport.

Officers are reminded that people living with developmental disabilities often have to live with the stigma that has been placed on people with disabilities. It is important that officers recognize that stigma and try to break down those barriers so that they can help the person.

Officers are reminded to use the many resources available to help that person living with the disability get connected to the help they need. It is hoped that by linking them to services it will improve that person's quality of life as well as reduce their interaction with police.

Autism Spectrum Disorder

Learning objectives for this section:

- Student will have a basic understanding of Autism Spectrum Disorder(ASD)
- Student will know the typical signs and behaviors to look for to help identify someone living with Autism Spectrum Disorder(ASD)
- Students will know what risk factors are associated with causing Autism Spectrum Disorder(ASD)
- Students will know the basic guildlines for interaction with individuals with Autism Spectrum Disorder(ASD)

What is Autism Spectrum Disorder?

Autism Spectrum Disorder(ASD) is a brain disorder that impairs someones socialization and communication. Someone with ASD may have trouble developing and maintaining relationships as well as communicating both verbal and nonverbally. They are socially awkward and often make no eye contact. Someone with autism may not recognize safety hazards or perceive the existance of real threats. Moreover, they may not recognize social cues and customs in everyday life settings.

Visual and verbal cues for Autism Spectrum Disorder:

- Stimming which is characterized by hand-flapping, rocking back and forth, or twirling.
- Repetition which can be seen in actions such as lining up objects or verbally when a word or phrase is repeated over and over again.
- Delayed response when asked questions or given commands
- Unusual tone of voice which can be manifested as monotone with no showing of emotion
- Flat affect in that their facial expressions are fixed showing no emotion
- Lack of eye contact (not a show of disrespect)
- Unusual or unbalanced gait appear to be clumsy or unsteady

What are the causes of Autism Spectrum Disorder?

The exact cause of autism spectrum disorder is not currently known. It's a complex condition and may occur as a result of genetics or environmental factors.

Genes – some researchers believe that certain genes our inherited from their parents that could make them more vulnerable to developing Autism.

Environmental factors – Some researchers believe that a child born with a genetic vulnerabilty to austim will only develop the condition when exposed to certain environmental trigger.

Interaction Guidelines

- When you know their name use it
- When giving orders or directions be specific and to the point
- Remember to use simple language and speak slow and clear
- When feasible give them time to understand what you are trying to communicate
- Make your questions simple and easy to understand and give them time to respond
- Offering praise can help build rapport
- Use non-threatening body language and a calm voice remember that your uniform and presence may be intimidating
- Use caution and be prepared for unexpected outbursts

The Autism-Vaccine Myth

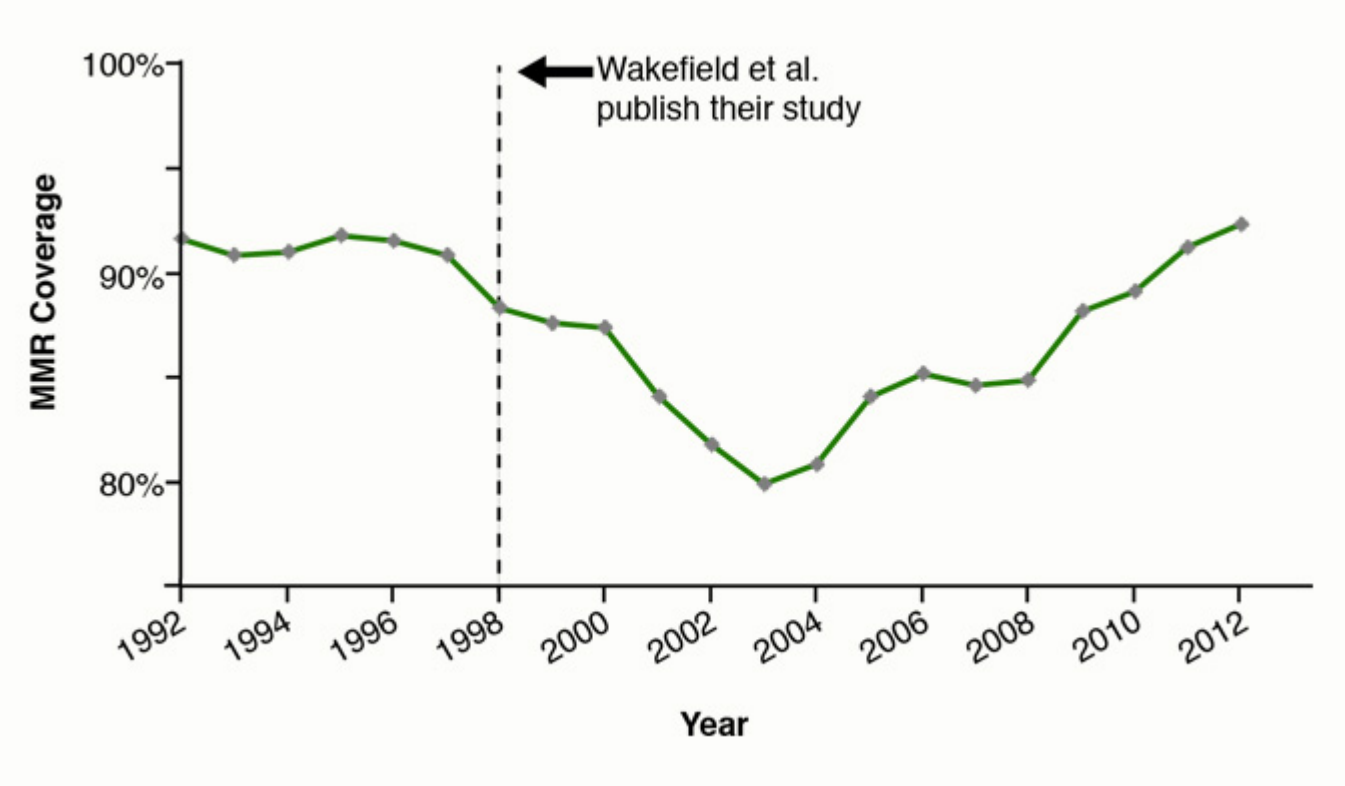
- By Emily Willingham and Laura Helft
- Posted 09.05.14
- NOVA

The assertion that vaccines could be linked to autism burst onto the international stage with the 1998 publication of a paper in the British journal The Lancet. Sensationalist media coverage of the claim followed. The paper, which suggested a link between the measles-mumps-rubella (MMR) vaccine and autism, was eventually retracted in 2010. Even before the complete retraction, however, in 2004, ten of the paper's 13 authors cosigned a partial retraction of its main interpretation.

What was the impact of the alleged vaccine-autism connection?

What the public didn't know in 1998 was that the now-retracted study, which involved just 12 children, would turn out to have some serious flaws—and even to contain apparently falsified data. The 12 years between its publication and its retraction, however, left a lot of time for the unfounded and never-confirmed vaccine-autism link to take hold in the minds of worried parents—and thus for vaccination rates to suffer.

In 1997, the year before the paper was published, measles vaccination rates in the United Kingdom were over 91%. They started to fall in 1998 and in 2003-2004 reached a nadir of just 80%, although rates were even lower than that in specific areas. Only in recent years have MMR vaccination rates started climbing again in the U.K., reaching about 90% in 2013.



As a result of a paper published in 1998, MMR vaccination rates dropped Europe. The dotted line indicates the year in which Wakefield and colleagues published a paper alleging a connection between the MMR vaccine and autism. Enlarge Photo credit: © Tangled Bank Studios; data from the National Health Service of the United Kingdom

The vaccine-autism question: A timeline

Here are some highlights along the scientific journey the vaccine-autism hypothesis made from its 1998 publication in The Lancet to today. The American Academy of Pediatrics has compiled an expanded list of relevant studies.

1998-The Lancet publishes a paper by Wakefield et al. titled "Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children." A press conference and interview in which Wakefield says it is his "feeling that the…risk of this particular syndrome developing is related to the combined vaccine, the MMR, rather than the single vaccines" set off a media storm.

1999—A U.S. Food and Drug Administration review of the vaccine preservative thimerosal, which contains mercury, finds no evidence of its causing neurological harm, but the agency recommends the precautionary removal of the agent from vaccines administered to infants.

2001—Thimerosal is removed from childhood vaccines on the U.S. market.

—The Journal of the American Medical Association publishes "Time trends in autism and in MMR immunization coverage in California" by Dales et al. These authors looked for and found no association between MMR vaccination rates in young children and increased autism occurrence.

—Pediatrics publishes "No evidence for a new variant of measles-mumps-rubella-induced autism." by Fombonne et al. In this study of 96 children with pervasive developmental disorders, the authors found no evidence of a specific syndrome being related to whether or not they had received the MMR vaccine.

2002—The British Medical Journal publishes "Measles, mumps, and rubella vaccination and bowel problems or developmental regression in children with autism: population study" by Taylor et al. This study of 473 children with autism who were born between 1979 and 1998 offered "further evidence against a link between MMR and autism." The authors found no differences in regression or bowel symptoms in those born before and after the introduction of the MMR vaccine.

—Pediatrics publishes "Neurologic disorders after measles-mumps-rubella vaccination" by Makela et al. This study of 535,544 children in Finland found no link between MMR vaccination and autism.

—The New England Journal of Medicine publishes "A population-based study of measles, mumps, and rubella vaccination and autism" by Madsen et al. These authors describe "strong arguments" against the hypothesis that the MMR vaccine causes autism, based on an analysis of data from 537,303 children in Denmark, 82% of whom had received the MMR vaccine.

2003—The Journal of the American Medical Association publishes "Association between thimerosal-containing vaccine and autism" by Hviid et al. These authors, using data from 467,450 children born in Denmark, found no link between autism risk and vaccines containing thimerosal.

2004—Of the 13 authors on the 1998 Wakefield paper, ten formally retract its interpretation, stating a wish to make clear that the paper established "no causal link" between the MMR vaccine and autism.

—The Institute of Medicine of the United States' National Academies issues a report from its Immunization Safety Review Committee, which concludes that vaccines don't cause autism.

2007—The New England Journal of Medicine publishes "Early thimerosal exposure and neuropsychological outcomes at 7 to 10 years" by Thompson et al. These authors looked for

links between early thimerosal exposure and neuropsychological outcomes in a group of 1,047 children aged seven to ten years and found no association.

2010—The Lancet, after an extensive investigation, including investigative work by journalist Brian Deer, issues a formal retraction of the 1998 Wakefield paper.

—The U.K,'s General Medical Council strikes Andrew Wakefield from the medical register (the U.K. equivalent of stripping a medical license), concluding, according to reports, that he had been "dishonest, irresponsible, and showed callous disregard for the distress and pain of children" in conducting the MMR-autism study.

—Pediatrics publishes "On-time vaccine receipt in the first year does not adversely affect neuropsychological outcomes" by Smith et al. This study of more than 1,000 children born between 1993 and 1997 found that on-time vaccination was associated with better performance on a number of neuropsychological tests.

—Pediatrics publishes "Prenatal and infant exposure to thimerosal from vaccines and immunoglobulins and risk of autism" by Price et al. This study of over 1,000 children found no increase in autism outcomes among children who had received thimerosal-containing vaccines, compared to those who had not.

2013—A major measles outbreak in Wales is linked to regional response to the 1998 Wakefield paper, which led to reduced measles vaccination rates in the region affected by the outbreak.

—The Journal of Pediatrics publishes "Increasing exposure to antibody-stimulating proteins and polysaccharides in vaccines is not associated with risk of autism" by DiStefano et al. This study of more than 1,000 children found no link between the number of antigens in vaccines and autism, and thus no support for the "too many, too soon" school of thought.

2014—Vaccine publishes "Vaccines are not associated with autism: An evidence-based meta-analysis of case-control and cohort studies" by Taylor et al. This meta-analysis of ten studies covering more than 1.2 million children finds no links between autism and MMR vaccination, mercury, thimerosal, or vaccination generally.

Why has the myth persisted?

Two fears powered the unfolding of these events. One was a fear of the unfamiliar ingredients in vaccines, including the mercury-containing preservative thimerosal, which as of mid-2014 was still used in some multidose flu shots but was otherwise phased out of routine childhood vaccines in the United States starting in 2001. The other was a fear of autism, an anxiety

fostered by media stories pitting emotional appeals by high-profile anti-vaccine advocates against statistically based reports by medical researchers.

No link with autism—not to mercury, not to thimerosal, not to any vaccines, including the MMR—has been found.

These fears persisted even as evidence mounted that they were completely unfounded. Scientific verification relies on a process of testing and confirmation, not on a single observation. Researchers sincerely grappled with the question of a vaccine-autism link in numerous studies following publication of the 1998 Lancet paper. Some of these studies analyzed data from millions of people, in the quest to see if vaccines and autism might be linked. The overwhelming scientific consensus is that they are not. The Lancet paper specifically addressed a possible association between the MMR vaccine and autism, but later studies also looked at other vaccine-related factors, such as the mercury-containing preservative thimerosal, which is not used in the MMR vaccine. Thimerosal initially raised concerns because mercury is neurotoxic. However, no link with autism—not to mercury, not to thimerosal, not to any vaccines, including the MMR—has been found.

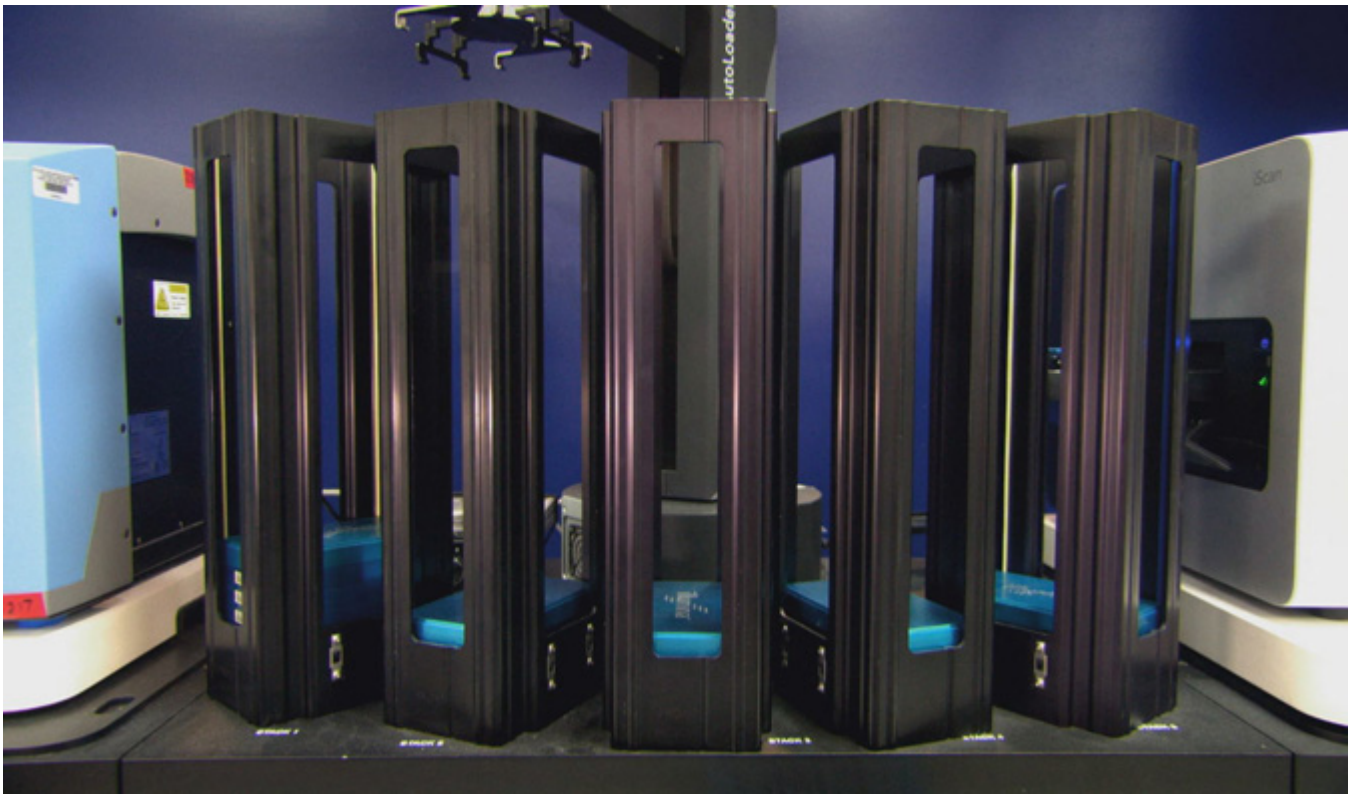
In some fraction of the American population, however, the belief in a link remains. One reason is a coincidence of timing: children are routinely vaccinated just as parents begin to observe signs of autism. Most vaccines are administered during the first years of life, which is also a period of rapid developmental changes. Many developmental conditions, including autism, don't become apparent until a child misses a milestone or loses an early skill, a change that in some cases can't help but be coincident with a recent vaccination.

Adding to such concern is the fact that, sometimes, vaccinations can lead a child to develop a high fever and accompanying febrile seizures. Such seizures are temperature-related and don't cause lasting damage. A tendency to experience febrile seizures runs in families, and about one in 20 young children will have one at some point. According to the U.S. Centers for Disease Control and Prevention, most febrile seizures happen when a child is sick rather than after a vaccination, though the MMR vaccine is associated with a slightly increased risk for febrile seizures. Children with and without autism have these febrile responses, but since their timing may coincide with emerging signs of autism, that can link the two incidents in a parent's mind, even though there is no causal relationship.

What do we know about what contributes to autism?

Largely ignored during this prolonged vaccine-autism controversy was clear evidence of a strong genetic influence on autism. For example, if one identical twin has been diagnosed with

an autism spectrum disorder (ASD), the other twin is from 60% to 90% more likely to also be diagnosed with an ASD. Also known is that males are more likely than females to be diagnosed with autism and that the older a father is, the higher the likelihood of a diagnosis of autism in his offspring.



Modern DNA sequencing is uncovering the myriad of genetic mutations that can lead to autism. Enlarge Photo credit: © Tangled Bank Studios

Nonetheless, autism has proven to be very difficult to pin down genetically in the way that single-gene disorders, such as cystic fibrosis and Huntington's disease, have been traced. The reasons for this difficulty have recently become clearer thanks to advances in DNA sequencing technology that have made it possible to compare the genomes of individuals with autism to those of individuals without autism, as well as to those of their parents. It is now evident that there are many genetic paths to autism, and that some mutations leading to autism are not inherited but arise spontaneously in reproductive cells or during development. These mutations help to explain how autism can appear in families that previously had no history of the condition.

Jodie Singer, who has autism, and her mother Alison Enlarge Photo credit: © WGBH Educational Foundation

Some mutations associated with autism are single changes in the DNA code that make up genes. Other kinds of mutations include extra copies or deletions of larger stretches of chromosomes that include multiple genes.

When investigators have homed in on specific genes, they have identified numerous candidates, many of them associated with the formation or function of the brain. These include genes that play roles in neural development and structuring, nerve signaling, and speech and language processing. Still, because of the rapid proliferation of genetic data regarding autism, scientists are still discovering the ways in which many other mutations lead to autism—a task that will likely take years.

The emerging scientific picture of autism is a condition that begins during fetal development, as a result of both genetic and environmental influences.

It is now very clear that vaccines are not among the environmental factors that cause autism. But scientists are eager to understand how genetic and environmental influences may interact and to explain how these factors play a role in the broad spectrum of symptoms manifest in different people with autism.

Emily Willingham is a Northern California-based writer who covers many topics, including vaccines and autism. She has written for the *New York Times*, *Discover*, and *Forbes* and is co-authoring an upcoming book on evidence-based parenting.

Laura Helft is the senior researcher for Tangled Bank Studios, a production company of the Howard Hughes Medical Institute. She produces supporting web content for the science programming produced by Tangled Bank.

In conclusion

Officers are reminded to always think of safety when having to deal with a person who is living with Autism Spectrum disorder. Officers should take in all the risk factors of a situation and try to de-escalate the situation using any of the above information to build rapport.

Officers are reminded that people living with Autism Spectrum Disorder often live with the stigma that has been placed on people living with disabilities. It is important that officers use the information they have gained in this class to help break the cycle of stigmatization.

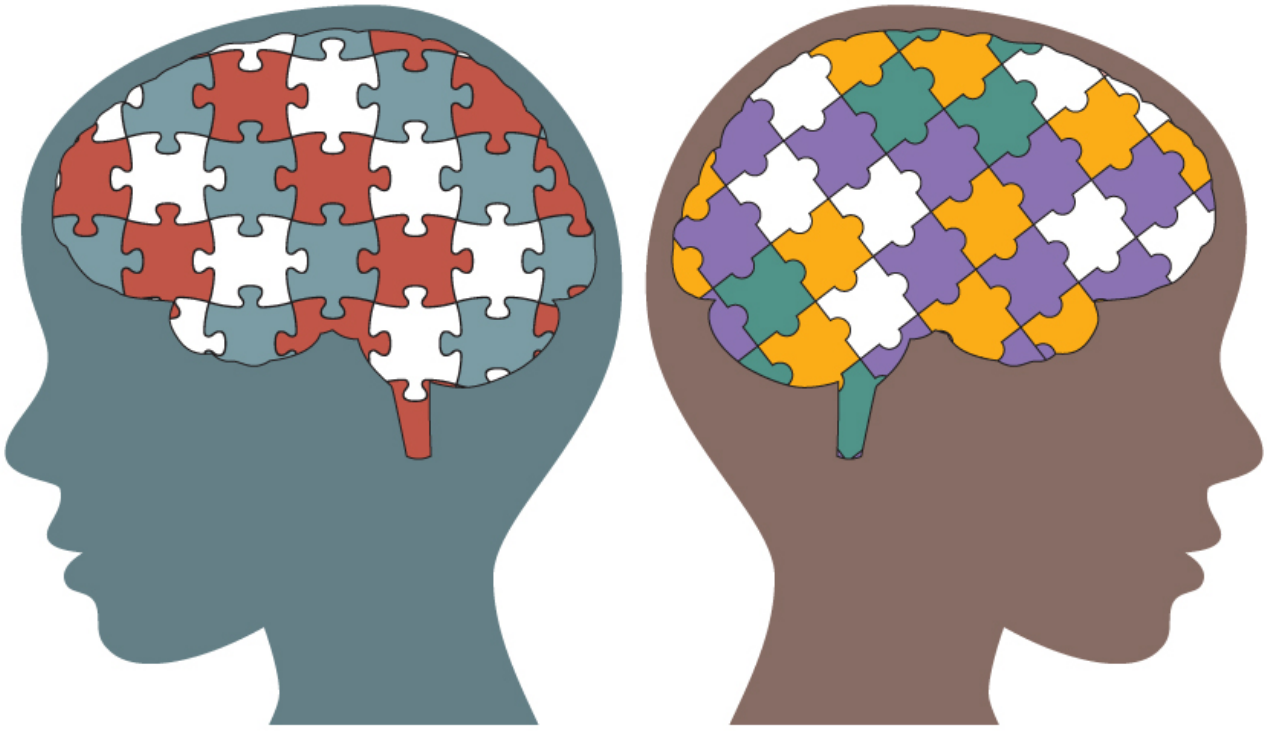
Officers are reminded to use the many resources at their disposal to assist people living with Autism Spectrum Disorder and their families. It can be a very difficult thing to live with this disorder and any help that can be given to the families will help with their quality of life.

Resources for people with developmental disabilities

- Center for Development and Disability
    - 2300 Menaul Blvd NE (505) 272-3000
- ARCA
    - Disabilty.gov (505)332-6700

Resources for Autism Spectrum Disorder

- Center for Development and Disability
    - 2300 Menaul Blvd NE (505)272-3000
- New mexico Autism Society
    - http://nmautismsociety.org/ (505)332-0306
- Autism Speaks
    - Autismspeaks.org



Crisis Intervention Team (CIT) Training

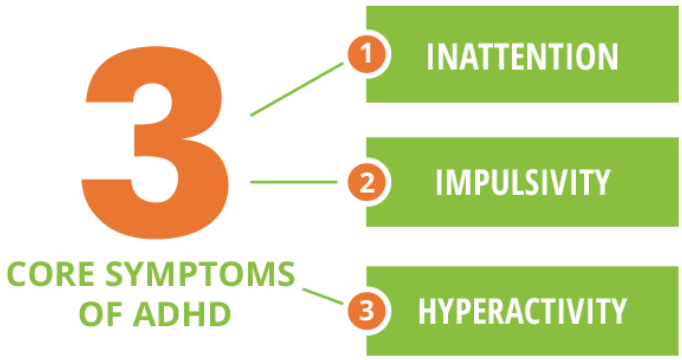
Student Guide

Children and Youth ADHD

Attention Deficit Hyperactivity Disorder

Definitions:

- ADHD is one of the most common childhood disorders that can continue into adulthood.
- According to the Center for Disease Control, ADHD affects approximately 9% of children ages 3-17 years of age and 4% of adults
- Symptoms include inattention, impulsivity and hyperactivity



Symptoms of Inattention:

- Easily distracted, unable to complete tasks
- Difficulty focusing
- Easily bored
- Disorganized, losing things
- Not listening when spoken to, difficulty following instructions
- Processing information slower than others
- Daydreaming

Symptoms of Impulsivity:

- Impatience
- Blurting out inappropriate comments
- Lack of emotional restraint
- Acting without regard for consequences
- Difficulty waiting for their turn

Symptoms of Hyperactivity:

- Fidgeting/squirming, touching things
- Excessive talking
- Constantly moving
- Difficulty doing quiet tasks

Causes Linked to ADHD:

Genetic:

- Research suggests that ADHD runs in families
- Researchers are evaluating a link to genes that may predispose people to ADHD
- Additional research shows a possible connection to brain tissue abnormalities that can improve as children grow up, reducing symptoms

Environmental Factors:

- Studies show a connection between cigarette smoking and drinking alcohol during pregnancy and ADHD in children.
- Small children exposed to lead have a higher risk of developing ADHD.

Other Factors:

- Children with a Traumatic Brain Injury (TBI) may exhibit behaviors similar to ADHD
- Only a small percentage of children with ADHD have a TBI.
- Some believe that sugar and food additives are related to ADHD, but there is lack of research to support these theories.

Diagnoses and treatment:

Diagnosing ADHD:

- Normal behaviors can be mistaken for ADHD
- ADHD-like symptoms may occur in ages 3-6 years
- No single test can determine diagnoses
- Mental health specialist must diagnose
- Pediatrician and mental health specialist may have to rule out other possibilities for behaviors/symptoms

Treatment:

- Include medication, psychotherapy, education/training or a combination of these
- There is no known "cure"
- Treatments focus on reducing symptoms and improving functioning

Conditions that May Coexist with ADHD:

- Learning disabilities
- Oppositional defiant disorder (ODD)
- Conduct disorder
- Anxiety and depression
- Bipolar Disorder
- Tourette Syndrome
- Mood disorders
- Substance use disorders

Most Prevalent of these Conditions is Oppositional defiant disorder (ODD) characterized by:

- Angry/Irritable Mood – loses temper often, touchy or easily annoyed, angry and resentful.
- Argumentative/Defiant Behavior – challenges authority figures, actively defies authority or rules
- Vindictiveness – has become vindictive or spiteful at least two times in the past six months.

  Note: For this to be considered a disorder it must interfere in the ability to maintain relationships and/or interfere with the relationships/job/school.

Treatment:

- Parent training – helping develop positive parent skills to assist child in a less frustrating manner
- Parent-child interaction therapy – coaching parents to help improve communication to decrease problem behaviors
- Individual and family therapy – to improve communication on both sides
- Cognitive problem-solving training – helping the child identify and change thought patterns
- Social skills training – helping the child to interact more positively with peers

ADHD in Teens:

ADHD symptoms may continue into adolescence or may not be diagnosed until adolescence.

Behaviors Associated with ADHD Teens:

- Hyperactive/restless – may try to do too many things at once
- Inability to delay reward – choosing activities that result in a quick payoff
- Struggling in school
- Difficulties in self-reliant activities
- May have difficulty maintaining their ADHD treatment
- Risk taking/rule breaking
- Impulsive
- Short-tempered

ADHD Teens and Driving:

- Involved in nearly four times as many car crashes as teens who do not have ADHD
- More likely to cause injury crashes
- Get three times as many speeding tickets as their peers

ADHD in Adults:

ADHD may continue into or be diagnosed in adulthood.

Possible ADHD Symptoms in Adults:

- Disorganized
- Difficulty at work or unable to keep a job
- Difficulty in relationships
- Being responsible and productive may be challenging
- May have multiple traffic accidents
- Seeking out quick fixes rather than taking steps to achieve greater rewards

ADHD in the Criminal Justice System:

Individuals with ADHD may be more likely to commit crimes, be incarcerated and/or be victims of crime. They may be easily manipulated into committing crimes. ADHD is also associated with some career criminal-related disorders such as Conduct Disorder and Antisocial Personality Disorder. Evidence suggests that treatments for ADHD may help reduce likelihood of criminal activity and criminal recidivism.

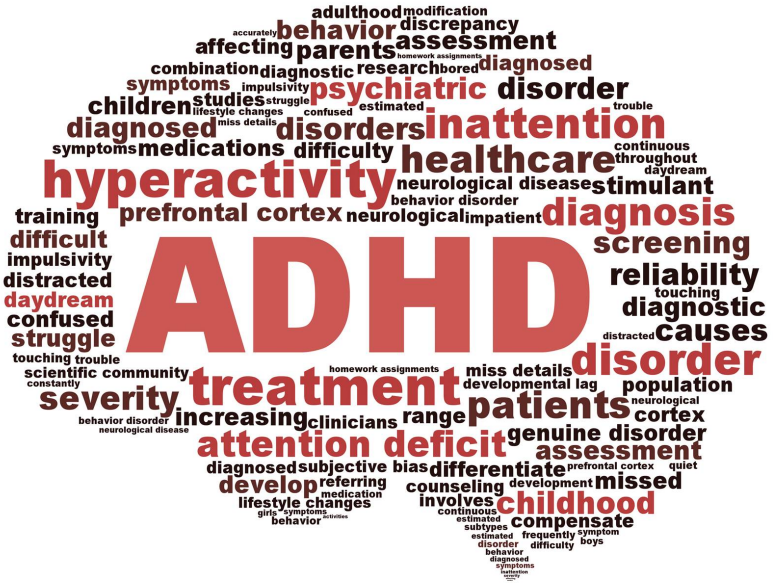
Criminals with ADHD may be more likely to commit impulsive, emotionally reactive crimes such as:

- Shoplifting
- Battery
- Assault
- Traffic Violations
- Vandalism

Considerations When Interacting with ADHD Citizens:

- Ask one question at a time
- Be clear, simple and direct
- Repeat questions/instructions
- Subject may have agitation/outbursts
- Subject may have poor memory

- Subject may have impaired sense of time/direction
- Subject may seem hasty, trying to rush through conversation
- Subjects may seem bored or distracted



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National Alliance on Mental Illness (NAMI)

Mental Health Response Advisory Committee (MHRAC)

If any editing or revisions need to be made to this document or if you would like to contribute new material please contact Matthew Tinney at mtinney@cabq.gov, 505-553-2229

Crisis Intervention Team Training

Post Traumatic Stress Disorder

Student Guide

Overview:

Most people who experience a traumatic event will have reactions that may include shock, anger, nervousness, fear, and even guilt. These reactions are common; and for most people, they go away over time. For a person with PTSD, however, these feelings continue and even increase, becoming so strong that they keep the person from living a normal life. People that are diagnosed with PTSD have symptoms for longer than one month and cannot function as well as before the event occurred.

PTSD is not a sign of weakness or moral failing. Anyone can be diagnosed with PTSD, not just those that serve in Military or First Responders. PTSD can affect anyone.

http://www.webmd.com/mental-health/post-traumatic-stress-disorder

Key Concepts:

All people experience anxiety. Without the experience of anxiety, life would be even more dangerous, though it might be more fun. People wouldn't prepare for tests or work deadlines. People would take risks that are stupid, and they would become obnoxious and insensitive.

Police are witnesses to the effects of violence at rates much higher than almost any profession. This puts them into contact with people living with PTSD, and puts them at risk for developing PTSD.

Extreme trauma and PTSD teaches people to fear the world and to feel helpless. If you've been attacked by a bear, you will naturally feel very frightened every time you see reminders of bears. What if the bear is your abusing father and you're eight years old?

PTSD has very high rates of co-occurring with other psychiatric illnesses, increasing the risk of having another illness by 80%. Men are more likely than women to have co-occurring conduct disorder and substance use disorders, both of which are associated with increased risk of violence.

Be effective rather than right! Trying to convince people you're right about something, for example, the trauma wasn't that bad, can usually have the opposite of the desired effect. Arguments and the desire to be right diminish compassion and empathy.

NORMAL STRESS RESPONSE vs. DISORDER

All people react to trauma. Most at minimum have some mild symptoms associated with PTSD such as hyper-vigilance, hyper-arousal, avoiding, numbing, and anger.

To be diagnosed PTSD, symptoms must last longer than a month. Like all disorders it must cause significant distress or impairment in the individual's social interactions, capacity to work, or other important areas of functioning.

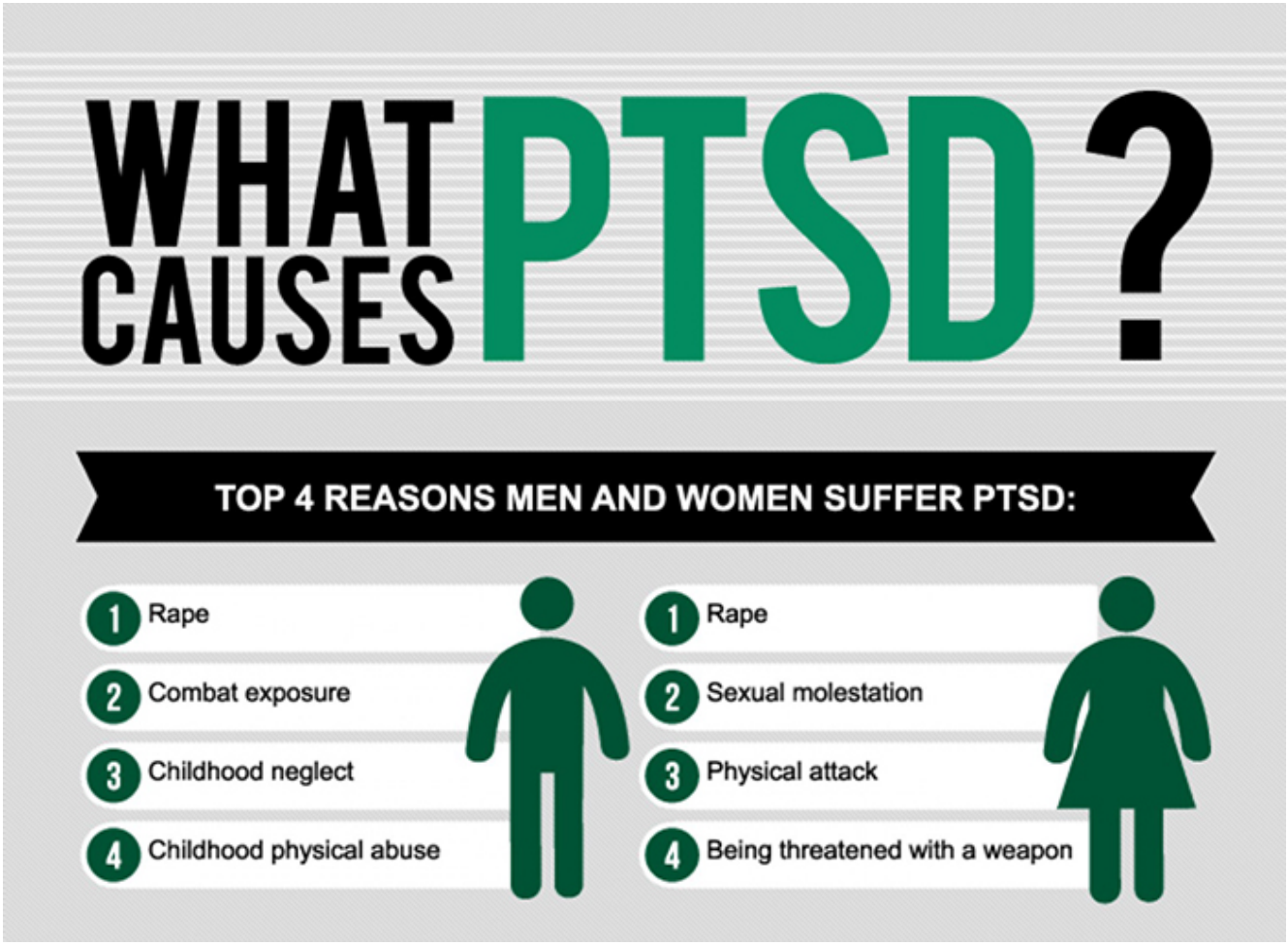
Rambo, a movie from 1982, though dated, depicts a soldier who suffers from Post-Traumatic Stress Disorder and has difficulty adjusting to normal life. He is shown to be prone to violence because of the torture he suffered at the hands of North Vietnamese soldiers in the Vietnam War. It's a good movie and can give a general sense of some PTSD symptoms such as a sense of being numb, as well as being prone to anger.

How do people respond to stress?

When your sense of safety and trust are shattered by a traumatic event, it's normal for the mind and body to be in shock. It's common to have bad dreams, feel fearful, and find it difficult to stop thinking about what happened. For most people, these symptoms gradually lift over time. But this normal response to trauma becomes PTSD when the symptoms don't ease up and your nervous system gets "stuck" and fails to recover its equilibrium.

PTSD develops differently from person to person. While the symptoms of PTSD most commonly develop in the hours or days following the traumatic event, it can sometimes take weeks, months, or even years before they appear. There are three main types of symptoms and they can arise suddenly, gradually, or come and go over time:

1. Re-experiencing the traumatic event
2. Avoiding reminders of the trauma
3. Increased anxiety and emotional arousal



PTSD Symptoms:

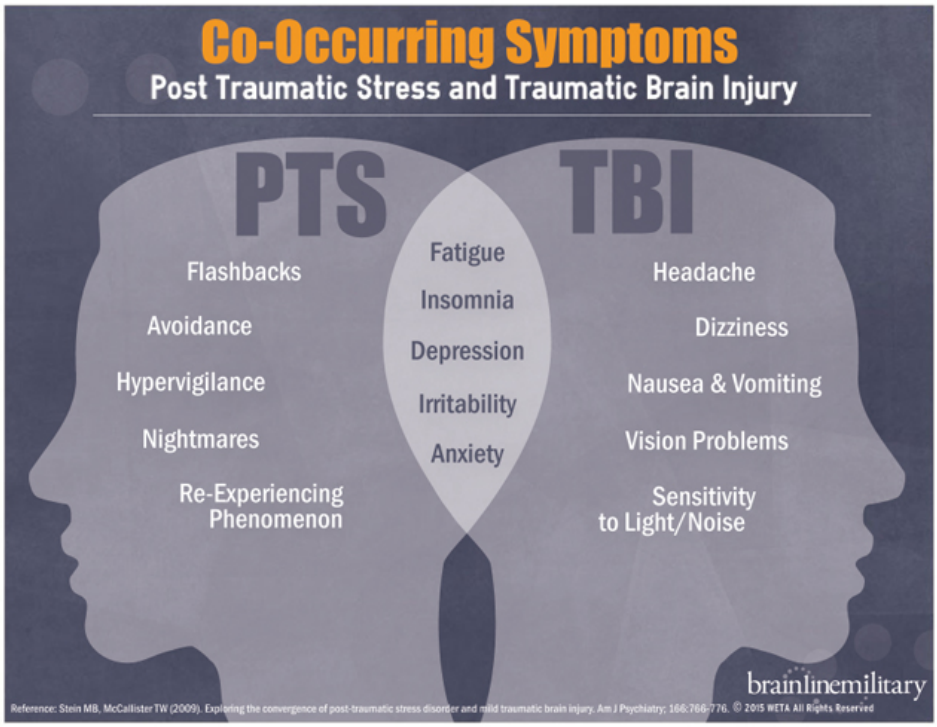
- History of significant trauma
- Persistent remembering, or "reliving" the stressor (intrusion symptoms)
    - "It just won't turn off…" (amped intensity)
    - Thoughts; memories; nightmares; re-enactment; flashbacks; physical, emotional distress at reminders (triggers)
- Avoidance
    - What you resist, persists
    - Efforts to avoid any and all reminders of the trauma, negative emotions, fails to show any emotion. Looks "numb" (exception: ANGER often only "safe" emotion).
    - Many, many methods of avoidance
- Disruption in arousal, reactivity
    - "Can't be still, can't be calm…"
    - Irritability; sleep disturbance; exaggeration startle; self destructive or reckless behavior
    - Maxed out nervous system, faulty danger assessment
- Disruption in thinking, mood
    - "I'll get you before you get me…"
    - Some amnesia around traumatic event; negative beliefs about self, world; blame; negative emotions; alienation from others; restricted emotions

PTSD Prevalence

- Prevalence
    - **~ 9% lifetime** (men < women); **3.5% current**
    - Highest rates: Rape, child abuse, military combat/captivity, torture, genocide

PTSD Co-occurs frequently.

- ~ 80% more likely to have a (second) psych disorder than general population is of having one.
    - Depression, anxiety, substance abuse, personality disorders
    - Among Vets from Afghanistan and Iraq, co-occurrence of PTSD and mild TBI is 48%
    - Suicidality: trauma increases risk, PTSD increases it more
        - Veterans: highest risk is wounded combat vets; watch out for GUILT, ANGER, & IMPULSIVITY



PTSD in Special Populations

- PTSD in Women compared to men
  - Diagnosed more frequently
  - Diagnosis persists longer than in men.
  - Women have less symptoms of irritability and impulsivity than men
  - "Most findings of gender differences in posttraumatic stress disorder (PTSD) prevalence found that females are reported to be diagnosed with PTSD after a trauma twice as often as males and developed stronger PTSD symptoms than males. The lifetime prevalence of PTSD in females is higher (10.4%) than in males (5.0%), and that kind of difference become evident in adulthood, peaked in early adulthood, then decreased with age. These findings also show that women experience a longer duration of posttraumatic stress symptoms (4 years duration for females compared to 1 year for males) and display more re-experiencing, avoidance and hyperarousal. In general, women are slightly less likely to experience life traumatic events than men. However, women are at higher risk for PTSD after exposure to a traumatic event because women and men often experience different types of trauma." **
  - PTSD in Children
    - Kids may develop new onset nightmares
    - Dreams often without content specific to the trauma
    - Young children express re-experienceing through play.
- PTSD in Veterans (women are veterans, too!)
  - Current conflicts → high number of veterans with combat and other trauma
  - Use of guardsman & reservists, repeated deployments, urban/guerilla warfare

PTSD Treatment

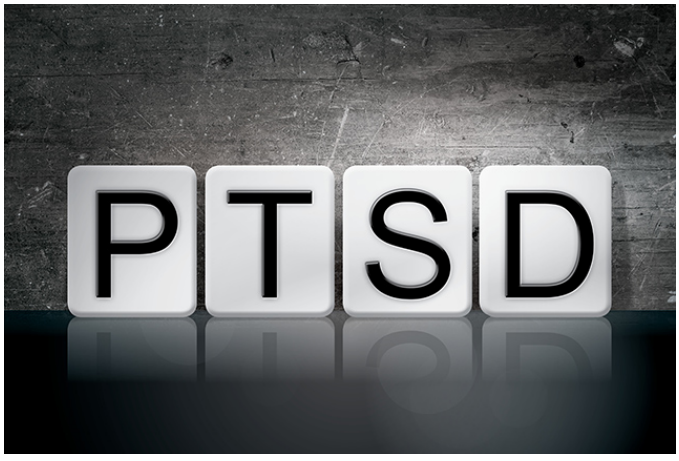
- PTSD is treatable!
- Psychosocial
    - Cognitive behavioral treatments have strongest research support
- Medication: antidepressants, prazosin, antipsychotics
- Support groups
- Stress management
- Prevention: education and support

Keys for Law Enforcement:

- It's *not* all about you…
    - May not be deliberately uncooperative
    - Anger may be the only "safe" emotion
- Then again, it may not *not* be about you
    - Appearance (uniform, gender, race) may be a trigger
    - Prior contact with you or other law enforcement
    - Authority & hierarchy may be a trigger
        - Immigrants & "Secret Police", veterans victimized by superiors

De-Escalation Strategies

- DO NOT minimize the trauma (Empathy and Sympathy)
    - DO NOT say “It wasn’t that bad…at least you survived…others had it worse…” etc.
- As best you can, empower the subject
    - People with PTSD may alternate between seeing you as rescuer or perpetrator
    - Only as safety/tactical allows: **Be predictable, Be simple and clear**
    - Communicate what’s going to happen: **Use clear, simple, language**
    - Allow the illusion of choice, face-saving measures
- Trust is very hard to come by; don’t promise anything if you can’t follow through.
    - Do not lie to them!
- PTSD may not always be the driver of the crisis, there are high rates of co-occurrence with PTSD.
    - Substance abuse, depression, anxiety, etc.
- You may need to repeat yourself frequently
    - Who you are, why you are there, current setting, safety, intent to help, etc
- Time is generally on your side, so patience is a virtue
- Instill hope as best you can



Things to consider about instilling hope:

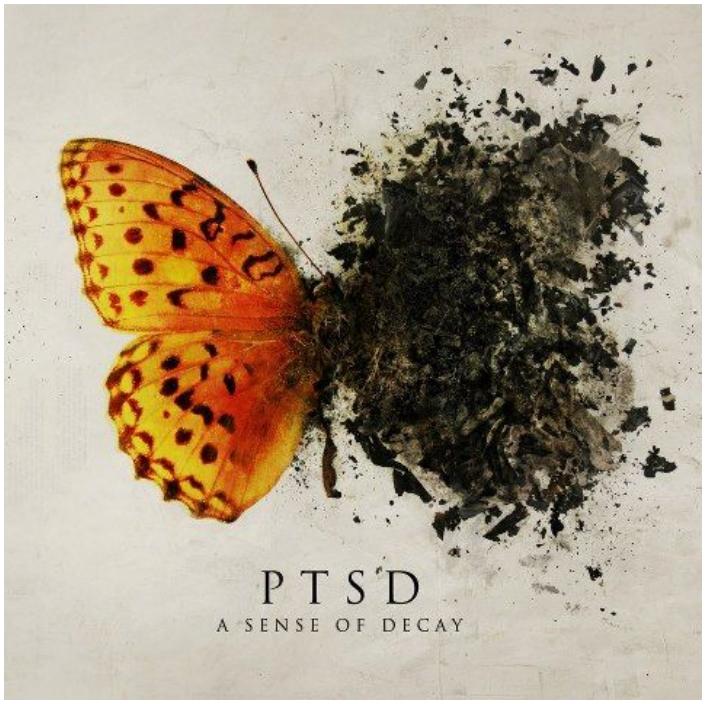
- It is a much more difficult task than you may expect.
- Try to give objective comforting information:
  - Examples:
    - "There are treatments for PTSD, and I've been taught that they really can work."
    - "The plan is that you'll go to your therapist tomorrow to talk about this."

A sense of safety is key

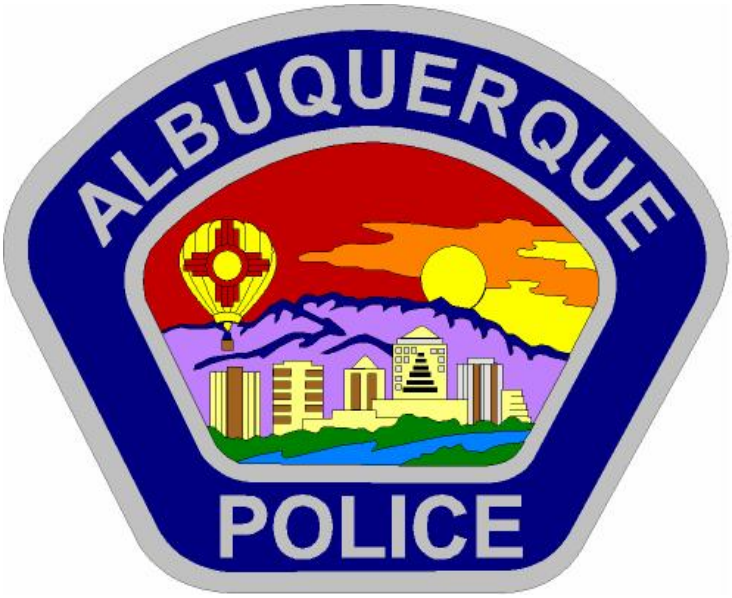
- Focus on, and use the word, "Safety." A loss of a sense of safety is a fundamental problem in PTSD.

But be careful not to moralize or minimize!

- Avoid statements like: "Why would you think about hurting yourself? Your wife loves you, you have so much to live for" Because he may believe his wife hates him, or maybe she actually does, either way, you'll get into an argument.
- Ask questions like: "What *keeps you alive?*" If they say their dog, children, etc. you can follow up with "What/who would take care of it/them if something happened?" It gives you clues to look for later as well. (They give dog away. Major sign that they now have a plan to commit suicide.)



Crisis Intervention Team (CIT) Training



Student Guide

Bipolar

Disorder

Bipolar Disorder

What is bipolar disorder?

Bipolar disorder is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. People with bipolar disorder can have extreme mood swings. They can have long periods of depression, periods where they experience mania, and then other times where they have normal moods. It should be noted that the time in between the depressive and manic stages of bipolar vary from person to person. These moods swings are much more severe than normal up and down days that everyone goes through as part of life.

Types of bipolar:

Bipolar I Disorder

- Defined by manic or mixed episodes that last seven days, or by symptoms that are so severe that the person needs immediate hospital care. Usually, depressive episodes occur as well, typically lasting at least two weeks.

Bipolar II Disorder

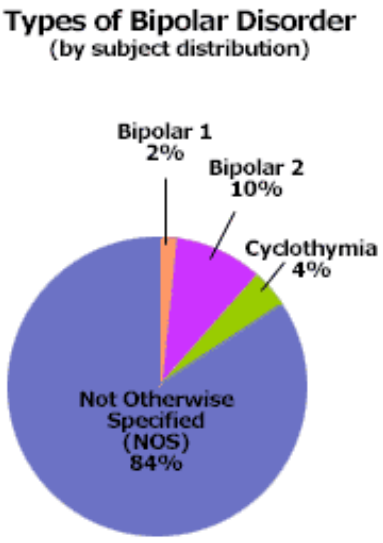
- Defined by a pattern of depressive episodes and hypomanic episodes, but no full blown manic or mixed episodes.

Unspecified Bipolar Disorder

- Diagnosed when symptoms of the illness exist but do not meet the diagnostic criteria for either bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.

Cyclothymic Disorder

- Can be thought of as a mild form of bipolar disorder. People living with cyclothymia spend at least half their lives in either a very good or very bad mood. Although these moods cause distress and impairment in functioning, they don't reach the severity of Bipolar I, Bipolar II, or major depression.



Symptoms of bipolar disorder:

(Manic state)

- Elevated, expansive, or extremely irritable mood. This mood is persistent throughout the course of several days. (Not simply a few hours).
- Increased energy and over activity
- Lack of inhibitions
- Excessive involvement in potentially destructive behaviors (such as spending sprees, sexual indiscretions).
- Grandiose thinking and possibly grandiose delusions
- Need for less sleep
- Rapid thinking
- Increased talking, and possibly pressured speech
- Can be easily irritated and get angry when frustrated
- Increased planning and goal setting, usually unrealistic goals and plans.
- Easily distracted

(Depressive state)

- Feel very sad, down, empty, or hopeless
- Have very little energy
- Have decreased activity levels
- Have trouble sleeping, they may sleep too little or too much
- Feel like they can't enjoy anything
- Feel worried and empty
- Have trouble concentrating
- Forget things a lot
- Eat too much or too little
- Feel tired or "slowed down"

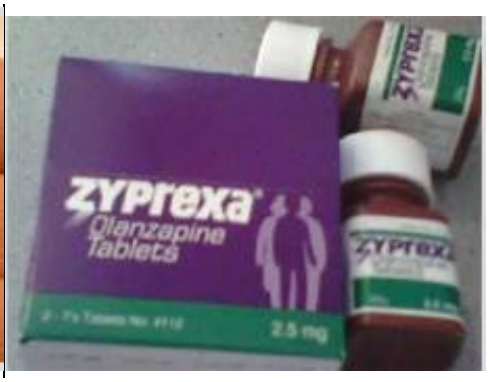
(Mixed affective state)

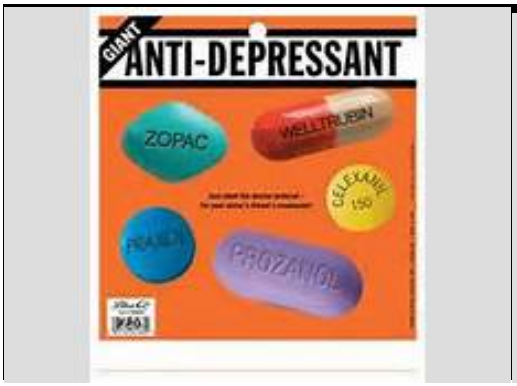
- Can exhibit both manic and depressive symptoms simultaneously
- Increased risk of self-harm or suicide

Risk Factors for Bipolar Disorder:

Most scientists believe that there is not one single cause for bipolar disorder but instead there are many factors likely acting together that result in the illness or increased risk. These risk factors may include the following:

- Genetic – a family history of bipolar disorder is one of the strongest and most consistent risk factors for bipolar disorder. People with first degree relatives people with BPAD I have about ten times the risk of developing Bipolar themselves.
- Environmental – Bipolar disorder is associated with divorced, separated or widowed individuals. Bipolar is more prevalent in countries with higher incomes as opposed to lower income countries.





Treatments for Bipolar Disorder:

Prescribed Medications

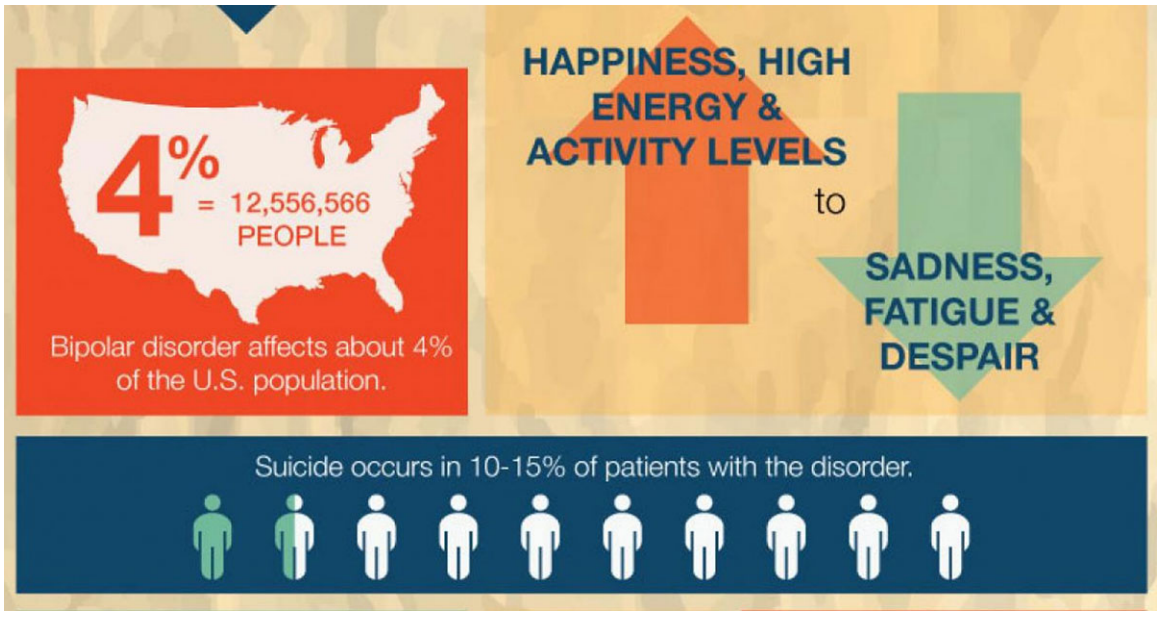
- Mood stabilizer such as: Lithium, Lamictal (for bipolar depression),Tegretol, Zyprexa, and Depakote.
- Antipsychotics such as: Risperidone, Olanzapine, Quetiapine, Ziprasidone and Asenapine.
- Antidepressants, generally used simultaneously with mood stabilizers, such as: Trazodone, Zoloft, Paxil, and Wellbutrin.

Therapy

- Cognitive Behavioral Therapy
    - Patient learns to change harmful or negative thoughts or behaviors.
- Psychoeducation

- Patient is educated on living with bipolar disorder and how it is treated. This education hopes to teach the patient how to recognize when they are headed toward an episode so that they can get help before things escalate.

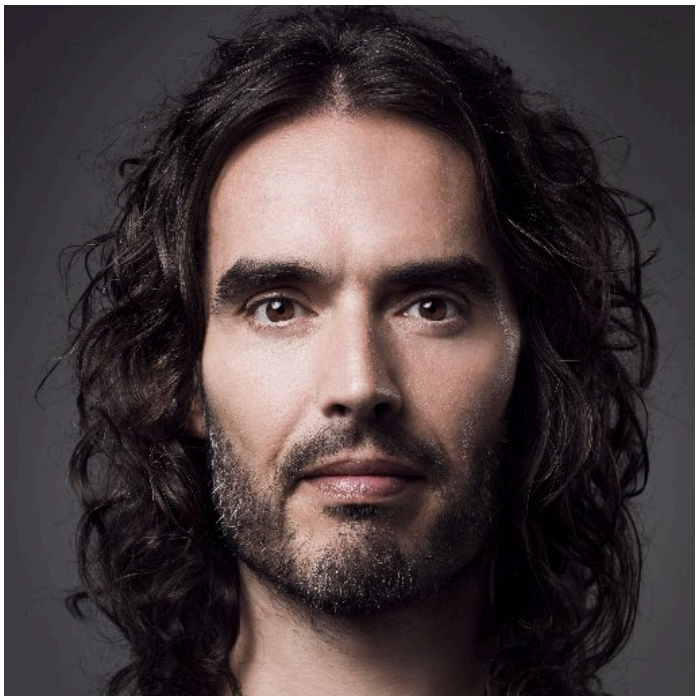
- Family focused therapy
  - Patient and family members learn how to cope with and recognize signs an impending episode so that they can help work through together.
- Interpersonal and social rhythm therapy
  - Patient learns to manage their relationships and day to day living in an attempt to "normalize" their daily routine. This accompanied by a strong sleep schedule can help protect against manic episodes.



Famous People Living With Bipolar Disorder

Catherine Zeta-Jones

Russell Brand



Demi Lovato

In conclusion:

Officers are reminded to always think of safety when to helping a person living with bipolar disorder. Officers should take in all of the risk factors of a situation and try to deescalate the situation using any of the above information to build rapport.

Officers are reminded that people living with bipolar disorder often have to live with the stigma that has been placed on people living with mental illness. It is important that officers not perpetuate that cycle of stigmatization by utilizing the information that they have gained in this section to help link them resources.

Officers are reminded to use the many resources at their disposal to assist any of the people they come in contact with living with bipolar disorder. It is hoped that by linking them to resources their quality of life will improve while lessening their interaction with law enforcement.

Resources for Bipolar Disorder:

- NAMI Albuquerque www.nami.org 2501 San Pedro NE Suite 212, Albuquerque NM 87110 (505)256-0288
- The International Society for Bipolar Disorders isbd.org
- Depression and Bipolar Support Alliance DBSA dbsalliance.org
- St. Martin's Hospitality Center www.smhc-nm.org 1201 3rd ST NW, Albuquerque, NM 87102 (505)242-4399
- Depression Bipolar Support Alliance (DBSA) dbsaAlbuquerque.org

Crisis Intervention Team (CIT) Training

Student Guide

Assessment and Commitment

Assessment and Commitment

State Statutes Governing Psychiatric Intervention and Treatment in New Mexico

43-1-11. Commitment of adults for thirty-day period

A. Every adult client involuntarily admitted to an evaluation facility pursuant to Section 43-1-10 NMSA 1978 has the right to a hearing within seven days of admission unless waived after consultation with counsel. If a physician or evaluation facility decides to seek commitment of the client for evaluation and treatment, a petition shall be filed with the court within five days of admission requesting the commitment. The petition shall include a description of the specific behavior or symptoms of the client that evidence a likelihood of serious harm to the client or others and shall include an initial screening report by the evaluating physician individually or with the assistance of a mental health professional or, if a physician is not available, by a mental health professional acceptable to the court. The petition shall list the prospective witnesses for commitment and a summary of the matters to which they will testify. Copies of the petition shall be served on the client, the client's guardian, and treatment guardian if one has been appointed, and the client's attorney.

B. At the hearing, the client shall be represented by counsel and shall have the right to present evidence on the client's behalf, including testimony by an independent mental health professional of the client's own choosing, to cross-examine witnesses and to be present at the hearing. The presence of the client may be waived upon a showing to the court that the client knowingly and voluntarily waives the right to be present. A complete record of all proceedings shall be made.

C. A court-appointed guardian for an adult involved in an involuntary commitment proceeding shall have automatic standing to appear at all stages of the proceeding and shall be allowed to testify by telephone or through affidavit if circumstances make live testimony too burdensome.

D. The court shall include in its findings the guardian's opinion regarding the need for involuntary treatment or a statement detailing the efforts made to ascertain the guardian's opinion.

E. Upon completion of the hearing, the court may order a commitment for evaluation and treatment not to exceed thirty days if the court finds by clear and convincing evidence that:

(1) as a result of a mental disorder, the client presents a likelihood of serious harm to the client's own self or others;

(2) the client needs and is likely to benefit from the proposed treatment; and

(3) the proposed commitment is consistent with the treatment needs of the client and with the least drastic means principle.

F. Once the court has made the findings set forth in Subsection E of this section, the court shall hear further evidence as to whether the client is capable of informed consent. If the court determines that the client is incapable of informed consent, the court shall appoint for the client a treatment guardian who shall have only those powers enumerated in Section 43-1-15 NMSA 1978.

G. An interested person who reasonably believes that an adult is suffering from a mental disorder and presents a likelihood of serious harm to the adult's own self or others, but does not require emergency care, may request the district attorney to investigate and determine whether reasonable grounds exist to commit the adult for a thirty-day period of evaluation and treatment. The applicant may present to the

district attorney any medical reports or other evidence immediately available to the applicant, but shall not be required to obtain a medical report or other particular evidence in order to make a petition. The district attorney shall act on the petition within seventy-two hours. If the district attorney determines that reasonable grounds exist to commit the adult, the district attorney may petition the court for a hearing. The court may issue a summons to the proposed client to appear at the time designated for a hearing, which shall be not less than five days from the date the petition is served. If the proposed client is summoned and fails to appear at the proposed time and upon a finding of the court that the proposed client has failed to appear, or appears without having been evaluated, the court may order the proposed client to be detained for evaluation as provided for in Subsection C of Section 43-1-10 NMSA 1978.

H. Any hearing provided for pursuant to Subsection G of this section shall be conducted in conformance with the requirements of Subsection B of this section.

History: 1953 Comp., § 34-2A-10, enacted by Laws 1977, ch. 279, § 10; 1978, ch. 161, § 5; 1979, ch. 396, § 3; 1989, ch. 128, § 7; 2009, ch. 159, § 14.

43-1-10. Emergency mental health evaluation and care

A. **A peace officer may detain and transport a person for emergency mental health evaluation and care in the absence of a legally valid order from the court only if:**

(1) the person is otherwise subject to lawful arrest;

(2) the peace officer has reasonable grounds to believe the person has just attempted suicide;

(3) the peace officer, based upon the peace officer's own observation and investigation, has reasonable grounds to believe that the person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Immediately upon arrival at the evaluation facility, the peace officer shall be interviewed by the admitting physician or the admitting physician's designee; or

(4) a physician, a psychologist or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency has certified that the person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Such certification shall constitute authority to transport the person.

B. An emergency evaluation under this section shall be accomplished upon the request of a peace officer or jail or detention facility administrator or that person's designee or upon the certification of a physician, a psychologist or a qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency. A court order is not required under this section. If an application is made to a court, the court's power to act in furtherance of an emergency admission shall be limited to ordering that:

(1) the client be seen by a certified psychologist or psychiatrist prior to transport to an evaluation facility; and

(2) a peace officer transport the person to an evaluation facility.

C. An evaluation facility may accept for an emergency-based admission any person when a physician or certified psychologist certifies that such person, as a result of a mental disorder, presents a likelihood of serious harm to himself or herself or to others and that immediate detention is necessary to prevent such harm. Such certification shall constitute authority to transport the person.

D. A person detained under this section shall, whenever possible, be taken immediately to an evaluation facility. Detention facilities shall be used as temporary shelter for such persons only in cases of extreme emergency for protective custody, and no person taken into custody under the provisions of the code shall remain in a detention facility longer than necessary and in no case longer than twenty-four hours. If use of a detention facility is necessary, the proposed client:

(1) shall not be held in a cell with prisoners;
(2) shall not be identified on records used to record custody of prisoners;
(3) shall be provided adequate protection from possible suicide attempts; and
(4) shall be treated with the respect and dignity due every citizen who is neither accused nor convicted of a crime.

E. The admitting physician or certified psychologist shall evaluate whether reasonable grounds exist to detain the proposed client for evaluation and treatment, and, if reasonable grounds are found, the proposed client shall be detained. If the admitting physician or certified psychologist determines that reasonable grounds do not exist to detain the proposed client for evaluation and treatment, the proposed client shall not be detained.

F. Upon arrival at an evaluation facility, the proposed client shall be informed orally and in writing by the evaluation facility of the purpose and possible consequences of the proceedings, the right to a hearing within seven days, the right to counsel and the right to communicate with an attorney and a mental health professional of the proposed client's own choosing and shall have the right to receive necessary and appropriate treatment.

G. A peace officer who transports a proposed client to an evaluation facility under the provisions of this section shall not require a court order to be reimbursed by the referring county.

History: 1953 Comp., § 34-2A-9, enacted by Laws 1977, ch. 279, § 9; 1978, ch. 161, § 4; 1979, ch. 396, § 2; 1989, ch. 128, § 6; 2013, ch. 39, § 2.

Criteria Considered for Inpatient Admission into Psychiatric Hospital:

- Psychiatric Illness
- Danger or self or others
- If the patient will benefit from treatment
- Medical staff must consider the least restrictive option

Goals of Hospitalization

- Safety
- Evaluation
- Stabilization
- Treatment (medication management and psychotherapy)

The goals for hospitalization parallel the reasons for commitment. There must be reasonable efforts to assure that hospitalization will improve the safety of the patient and those affected by the patient. The hospital will perform an evaluation to confirm a treatable illness, and stabilize that person by giving treatment for their illness.

Treatments and Interventions in the hospital

- Medical management
    - Treatment for chronic/acute illnesses that can be made worse by psychiatric problems
    - Treatment teams may include social workers, nurses, therapists, doctors, discharge planners and peer advocates
- Medications by mouth or injectable
- Psychotherapy: milieu, individual, group
    - Long term intensive talk therapy is not available in the hospital, which is often a misconception made by patients and families.
    - There will not be daily one-hour one-on-one sessions with therapists to have in-depth psychoanalytic breakthroughs.
    - Instead, group therapy and other therapies offered such as AA meetings, Occupational and Physical Therapy
- Safe placements
    - Boarding home
    - Group home
    - Nursing home
    - Family members

Crisis Intervention Team (CIT) Training

Student Guide

Veterans and Suicide Prevention

Veterans and Department of Veterans Affairs

Definitions:

- Veteran: Any individual having served in one of the 5 branches of the United States Military.

- VA Eligible Veteran: An individual having served on active duty for a minimum of 2 years, and having received a qualifying discharge.
    - Honorable, General Under Honorable Conditions

- National Guard and Reserve Veterans may be eligible for VA services if they meet the above criteria.

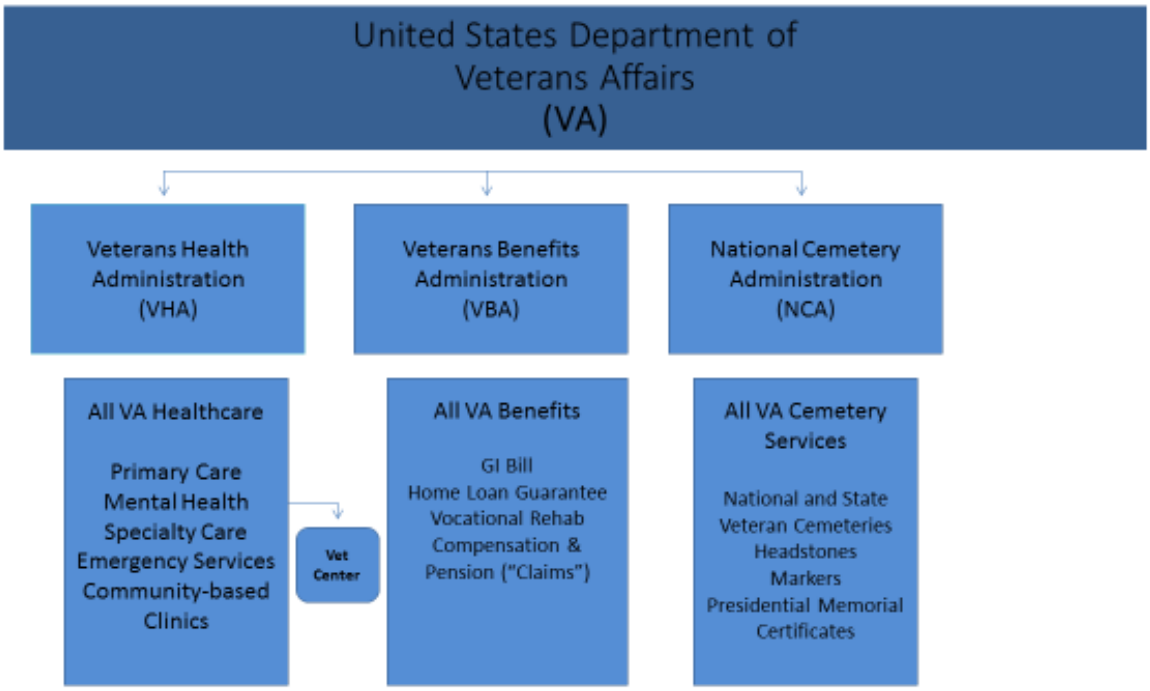
- DD214 or DD215: Separation documents provided by Department of Defense, indicating the specifics with regard to an individual's military service and character of discharge.

- Veterans Service Organizations: examples: Disabled American Veterans (DAV), Veterans of Foreign Wars (VFW), Vietnam Veterans of America (VVA), Military order of the Purple Heart

- State Department of Veterans Services

Department of Veterans Affairs:

The Department of Veterans Affairs is comprised of three branches: Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA). Each branch is responsible for administering a specific set of services.



The local addresses for VA services are listed below:

NM VA Health Care System
Raymond G. Murphy VA Medical Center
1501 San Pedro SE
Albuquerque, NM 87018
505-265-1711

VA Regional Office (financial benefits)
D. Chaves Federal Building
500 Gold Ave. SW
Albuquerque, NM 87102
www.ebenefits.va.gov

Veterans Benefits Administration (VBA):

The Veterans Benefits Administration manages all financial benefits available to Veterans of the United States Military. The specific criteria for each benefit is determined by Congressional order, and will not be addressed during this class.

Compensation & Service Connected Disability:

- Compensation may be awarded based on a disability resulting from all types of diseases and injuries encountered as a result of military service.
- The disability does not have to be combat or wartime related.
- There must be a link between a condition treated while in service and the condition that is now claimed.
- Service Connected Disabilities are rated from 0% - 100%.
- VA rating is independent of any military rating.
- Combined ratings for service connected disabilities may not add up to 100%.

VA Pension Benefit:

- Meant as assistance for eligible Veterans who demonstrate financial need.
- Paid to wartime Veterans who are ages 65 or older, or if under 65, who are permanently and totally disabled.
- One cannot receive both Compensation and Pension benefits. VA will pay whichever benefit is greater.

VBA also administers GI Bill, Vocational Rehabilitation, and Home Loan Guarantee programs.

Incarcerated Veterans and VA Benefits:

- Compensation is reduced on the 61st day of incarceration for a felony conviction.
- If a Veteran was receiving **Compensation** before incarceration VA will reduce the benefit to the 10% rate for the duration of incarceration.
- VA Pension is stopped on the 61st day of incarceration following conviction of a misdemeanor or felony.
- Failure to notify VA of incarceration by the 61st day may result in overpayment which will be collected upon release from incarceration.
- Benefits can be reinstated upon release from custody.
- VBA must receive notice of release via an official document that shows the date of release.

Veterans Health Administration (VHA):

The Veterans Health Administration is responsible for providing health care services to VHA eligible Veterans. VHA is an integrated health care system, providing a wide range of services.

Medical Services:

Primary care
Specialty care (oncology, surgery, orthopedics, etc.)
Spinal Cord Injury
Women's Health
Pharmacy
Laboratory, Imaging
Emergency Department
Palliative care

Behavioral Health Services:

Outpatient Mental Health
Inpatient & Outpatient Psychiatry
Substance Use Disorders
Residential Treatment
Military Trauma Treatment
Women's Trauma Services
Vet Centers

Vocational Rehabilitation Services:

Assessment
Supported Employment
Job skill development
Community Partnerships:
-Department of Workforce Solutions
-Goodwill Vocational Services

Vet Centers:

Services for combat Veterans and Military Sexual Trauma survivors
-Community Based Family Support Groups
-Individual and Group services

Substance Use Disorders:

Outpatient Treatment Clinic
Group & Individual Intervention
Medication Management
Medical Detox
Intensive Outpatient Program
Relapse Prevention

Homeless Support Services:

Shelter referrals
HUD/ VA Supported Housing
Transitional Housing
Partnerships:
-ABQ Heading Home
-NM Veterans Integration Center

Veterans and Post-Traumatic Stress (PTSD)

What is PTSD?

- A normal response to a life-threatening or horrific event
- Activation of the "fight, flight or freeze"
- The fight or flight or freeze response is still firing and giving off "false alarms"
- A change in the way a person thinks about him or herself, others, and the world

Signs and Symptom Review:

Hyper-arousal
Hyper Vigilance
Agitation
Anger issues
Violence
Anxiety
Isolation

Insomnia
Nightmares
Flashbacks
Avoidance
Numbing
Depression, increased risk of suicide
"Moral Injury"/Guilt

PTSD and Risk Factors:

- Risky behaviors to get the adrenaline rush, adrenaline seeking
- Speeding/erratic driving/road rage (drive down middle of road/avoidance of objects on side of road, swerving under bridges, driving over curbs.)
- In traffic jam, may panic, feel "ambushed" if stuck in traffic.
- Alcohol/substance misuse
- Family Violence
- Addictions:
  - Work, Alcohol, Drugs, Sex, Food, Adrenaline

Veterans and Traumatic Brain Injury (TBI)

- A traumatic brain injury is a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain.
- Concussive force injuries (IED blast exposure)
- The severity of such an injury may range from mild to severe.
- A TBI can result in short- or long-term problems with independent function.

Source: MIRECC Traumatic Brain Injury and Suicide: Information and resources for clinicians

Common Enduring TBI Symptoms:

Cognition

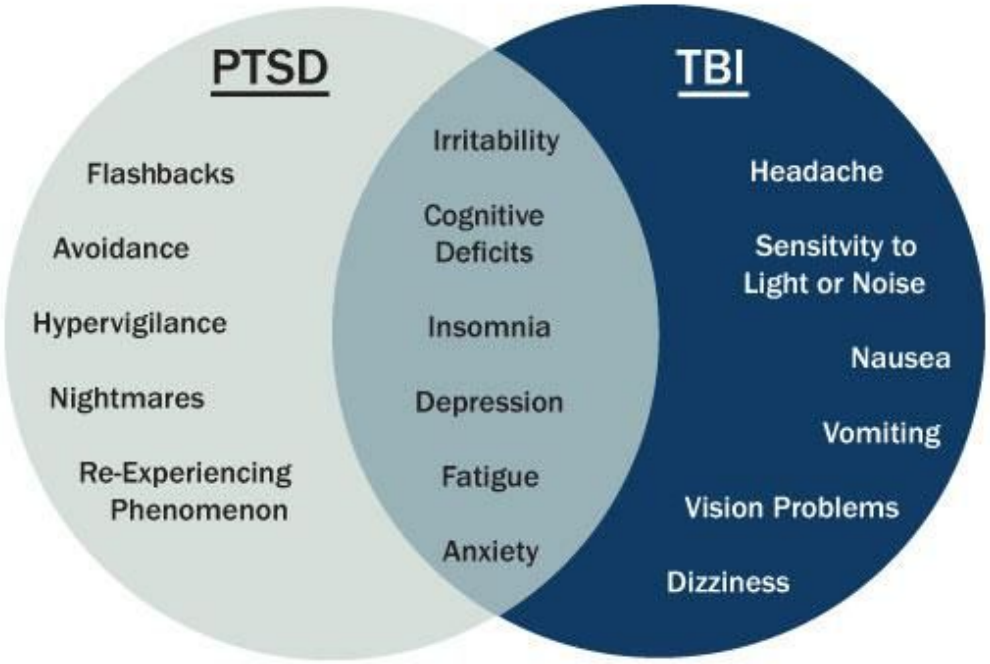
Motor/sensory disturbances
Impairments in:
Language, communication
Attention, concentration, memory
Learning new information
Speed of information processing
Judgment, decision-making, problem-solving, insight

Mood

Apathy/Depression
Anxiety
Irritability
Emotional lability
Insensitivity
Egocentricity

Behavior

Lack of initiation
Disinhibition
Impulsivity
Restlessness
Aggression
Agitation



TBI in Veterans:

- TBI represents ~ 22% of confirmed injuries in Iraq/Afghanistan War veterans.
- Many veterans have experienced multiple TBI's due to chronic exposure to blasts
- As many as 50% to 60% of veterans with chronic blast exposure have significant hearing loss or tinnitus ("ringing" in the ears) (Lew, et al. 2007)

What is most helpful when interacting with Veterans with TBI:

- Be patient and maintain a calm attitude.
- Recognize that thinking more slowly does not equal lower intelligence.
- Speak more slowly, with slightly longer pauses than usual.
- Allow more time for Veteran to respond.
- Veterans with TBI may have new hearing problems and can be more prone to suspiciousness. (Imagine if everyone around you was whispering.)
- Speak slowly and clearly.
- You may need to repeat information.
- Consider asking Veteran to state back what you've said in his/her own words.
- Decrease environmental stimuli when possible. Take Veteran to quiet area to talk.

Notes:

How Law Enforcement Can Help

The best negotiator is a good listener:

- Ask Veteran ("Have you served in the US military?")
- Be RESPECTFUL
- Establish rapport/TRUST
- Express appreciation for their service
- Active listening skills
- Softer/slower voice/be careful of tone/avoid sarcasm
- Stay calm
- Ask open-ended questions ("what, how, when – avoid why")
- Effective pauses
- Re-state/recap what they have said ("tell me if I'm understanding you correctly")
- Validate their feelings
- Watch physical demeanor/body language (sit if they are sitting, don't intimidate)
- Be sincere – they will recognize BS/insincerity
- Keep them informed of steps along the way

- Helpful language:
  - *"I can see/hear how angry/sad/frustrated you are."*
  - *"I'm listening/I hear you."*
  - *"How can I help?"*
  - *"How would you like this to work out?"*
- Strategy:
  - Make the Veteran a part of /in control of the solution:
  - "How can I help you solve this problem?"

Notes:

Acute and Chronic Suicide Risk

Consider that patients may have a baseline, chronic level of suicide risk, with periods of heightened, or acute, concern that come and go (Berman, 2006; Bryan & Rudd, 2006; Rudd, 2006)

Chronic Risk:
Static and more difficult to alter
Past suicide attempts with clear intent (2 or more)
Personality factors
Cognitive style

Risk Factors for Suicide:

Static Risk Factors:
Age
Intelligence
Gender
Education Level
Race
Family History
Marital Status
Personal History
Socioeconomic Status

Modifiable Risk Factors:
Depression
Impulsivity
Anxiety
Agitation
Panic attacks
Physical illness
Psychosis
Recent Loss (divorce, death, job loss, financial stress)
Substance use
Insomnia
Availability of lethal means

Protective Factors:

- Children in the home, except among those with postpartum psychosis
- Deterrent religious beliefs
- Life satisfaction
- Reality testing ability
- Positive coping skills
- Positive social support
- Positive therapeutic relationship

Suicide Warning Signs

- **The presence of any of the following signs requires attention**:
    - Thinking about hurting or killing themselves
    - Looking for ways to die
    - Talking about death, dying or suicide
    - Self-destructive or risk-taking behavior, especially when it involves alcohol, drugs or weapons

Responding to Suspected Suicidality:

- Asking the Question: Are you thinking about killing yourself?
- Do you ever wish you could go to sleep and not wake up? (Passive SI)
- Sometimes when people feel sad, they have thoughts of harming or killing themselves. Have you had such thoughts? (Active SI)
- Are you thinking about hurting or killing yourself? (Active SI)
- Take the Veteran to VA or other emergency room for evaluation.

Notes:

VA and Veterans Under Arrest:

Title 38 CFR 17.38 does not allow VA to provide:
hospital and outpatient care for a Veteran who is either a patient or inmate in an institution of another government agency as that agency has a duty to provide care and services.

What this really means:
If a Veteran is under arrest:

- If a Veteran is under arrest and will be transported to MDC or another detention facility – VHA cannot treat them and then release for arrest.

If a Veteran is NOT under arrest but needs evaluation & treatment:

- Take them to the VA emergency department.
- What you know could make all the difference in the success of their treatment.
- Tell the desk clerk you want to speak to a nurse or doctor.
- Tell the nurse or doctor what you know:
    - Why did you respond to Veteran's crisis?
    - What did the Veteran say to you?
    - What did the Veteran do?
    - Were there weapons involved?
    - Did they talk about suicide or attempt suicide?
- Clarify that the Veteran is NOT under arrest.

The VA Medical Center is on Federal grounds and there are Federal Law Enforcement Officers on station.

- Call 505-265-1711 x 4222, and let them know you are en route to VA.
- This will reduce the likelihood of any difficulty getting the Veteran care.
- VA staff are trained to report non-VA law enforcement and other individuals with firearms to VA police.

Crisis Services at NM VA Health Care System:

Emergency Department and BEACON Clinic

The BEACON Clinic is an emergent psychiatric clinic available to assist Veterans struggling with immediate mental health crisis.

You can access the BEACON clinic through the emergency department.

BEACON: 505-265-1711 x 2184

Veterans Crisis Line: Confidential Help for Veterans and Families 1-800-273-TALK (8255) Press 1

Acknowledgments:

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Crisis Intervention Team (CIT) Training

Student Guide

Homelessness

Definitions:

- *According to the Stewart B. McKinney Act, 42 U.S.C. § 11301, et seq. (1994), a person is considered homeless who "lacks a fixed, regular, and adequate night-time residence; and... has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations... (B) An institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." The term "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a state law." 42 U.S.C. § 11302(c)*[1]

- In other words, a homeless person is defined as:

    - A person who lacks a regular, fixed, adequate nighttime residence
    - Those forced to live in shelters, on the streets, motels/hotels, trailer parks, camping grounds or other temporary housing
    - Does not include imprisoned or detained individuals
    - Department of Housing and Urban Development (HUD) also includes those facing eviction within a week[1]

Factors that Contribute to Homelessness in America:

- Growing shortage of affordable rental housing
- Increase in poverty
- Stagnant or falling incomes
- Loss of jobs/Less secure benefits
- Foreclosure crisis and economic recession
- Lack of public assistance and affordable healthcare
- Change in family status
- Mental Illness or disability
- Addiction and substance use disorders
- Domestic violence

Gathering Statistics:

- Statistics for homelessness vary from study to study and are typically based on point-in-time counts. Whose purpose "is to try and determine how many people experience homelessness on a given night, and to learn more about their specific needs." (3)
    - Having an idea of how many people are homeless helps to secure funding for homeless service programs, including long term solutions.

    - The PIT Count has two components:
        - "A sheltered count- those staying in emergency shelters or transitional housing programs"

- "An unsheltered count- those sleeping in a place not meant for human habitation" (for example: in a park, an alley or their car)
- The Pit Count is a minimum estimate of people who are experiencing homelessness, and should not be considered as the whole picture of homelessness in Albuquerque.

- Every two years PIT counts are done in ABQ
- 2017 results for PIT on January 23, 2017:

Total Households and Persons

	Sheltered			Unsheltered	Total
	Emergency	Transitional	Safe Haven		
Total Number of Households	592	182	0	296	1,070
Total Number of Persons	706	228	0	384	1,318
Number of Children (under age 18)	124	50		10	184
Number of Persons (18 to 24)	36	22	0	26	84
Number of Persons (over age 24)	546	156	0	348	1,050

	Emergency	Transitional	Safe Haven		
Female	212	93	0	107	412
Male	492	133	0	265	890
Transgender	1	1	0	12	14

	Emergency	Transitional	Safe Haven		
Non-Hispanic/Non-Latino	427	130	0	228	785
Hispanic/Latino	279	98	0	156	533

	Emergency	Transitional	Safe Haven		
White	496	177	0	166	839
Black or African-American	52	28	0	26	106
Asian	4	0	0	1	5
American Indian or Alaska Native	105	19	0	170	294
Native Hawaiian or Other Pacific Islander	5	0	0	0	5
Multiple Races	44	4	0	21	69

The 2017 Annual Homeless Assessment Report (AHAR) to Congress (HUD)

EXHIBIT 1.3: **Demographic Characteristics of People Experiencing Homelessness**
2017

	All Homeless People		Sheltered People		Unsheltered People	
	#	%	#	%	#	%
Total	553,742	100	360,867	100	192,875	100
Age						
Under 18	114,829	20.7	103,289	28.6	11,540	6.0
18 to 24	53,438	9.7	31,742	8.8	21,696	11.2
Over 24	385,475	69.6	225,836	62.6	159,639	82.8
Gender						
Female	215,709	39.0	160,606	44.5	55,103	28.6
Male	335,038	60.5	198,935	55.1	136,103	70.6
Transgender	2,092	0.4	1,100	0.3	992	0.5
Does not identify as male, female or transgender	903	0.2	226	0.1	677	0.4
Ethnicity						
Non-Hispanic	434,323	78.4	285,867	79.2	148,456	77.0
Hispanic	119,419	21.6	75,000	20.8	44,419	23.0
Race						
White	260,979	47.1	154,489	42.8	106,490	55.2
African American	224,937	40.6	167,489	46.4	57,448	29.8
Asian	6,760	1.2	3,703	1.0	3,057	1.6
Native American	16,796	3.0	8,724	2.4	8,072	4.2
Pacific Islander	8,525	1.5	4,485	1.2	4,040	2.1
Multiple Races	35,745	6.5	21,977	6.1	13,768	7.1

Who is Homeless?

- **Age and Gender**
  - Teens

        - According to the National Runaway Switchboard there are roughly 1.3 million homeless youth living unsupervised on the streets, abandoned buildings, couch surfing with friends or with strangers.
        - Young people between the ages of 12-17 are at a higher risk of homelessness that n adults.
        - "Between 20 and 40 percent of homeless youth identify as Gay, Lesbian, Bisexual, Transgender or Questioning."

    - Families
        - Of the total population of homeless in the U.S. roughly 34% is made up of homeless families.
        - Of families who are homeless about 84% are headed by women.

    - Adults
        - According to the most recent HUD AHAR report 67% were individuals experiencing homelessness; of that 35% were sheltered and 32& were unsheltered.
        - Most of these individuals were over the age of 24.
        - 71% were men and the remaining 29% were women, transgender or those who did not identify as such.

- **Domestic Violence Victims**
    - In January of 2017 it was reported that 16% of the homeless population reported experiencing domestic violence at one point.

- **Veterans – Statistics from National Coalition for Homeless Veterans:**
    - Of all homeless adults 9% is made up of veterans, of that 91% were men.
    - 62% of homeless veterans stayed in emergency shelters and transitional housing programs while 38% were unsheltered.
    - About 54% have either a mental or physical disability or both.
    - 70% have substance abuse problems
    - 50% are 51 years of age or older

- **The Chronically Homeless**
    - About 24% of people experiencing homelessness display chronic patterns of homelessness.
    - 69% of those who are chronically homeless were staying in unsheltered locations.
    - "More than half of all chronically homes individuals were in three states: CA 42%, NY 6% and FL 6%."

- **People with Mental Illness**[5]
    - "20-25% of the homeless population suffers from severe mental illness."
    - An estimated 26% of sheltered homeless are mentally ill
    - Lack of treatment for people living with mental illness causes homelessness:
        - Person may have no support or resources
        - Person may be unwilling to participate in treatment due to delusions about the treatment, side effects, cost, stigma, etc.

        - Person may be so mentally ill that they have a lack of insight to see that they are mentally ill and need the treatment/help
    - Having delusions or exhibiting bizarre behavior isolates individuals
    - Deinstitutionalization of mentally ill in 1950's
    - Disproportionate # of mentally ill are incarcerated or homeless

- **People with Substance Use Disorders**
    - According to The Substance Abuse & Mental Health Services Administration (SAMHSA), 38% of homeless abuse alcohol, 26% abuse other drugs
    - Substance abuse often causes homelessness
        - Disrupts family relationships
        - Leads to job/housing loss
    - Substance abuse has been cited as the largest cause of homelessness for adults
    - Recovering from a substance use disorder is difficult while homeless:
        - Too busy finding food/shelter to try and seek out treatment
        - Substance use becomes a culture among the homeless in some areas
        - Lack of social support

Homelessness and Law Enforcement

Crimes Against the Homeless:

- Hate crime legislation has been proposed:

    - *H.R. 3528, Hate Crimes against the Homeless Statistics Act of 2011 was introduced in 2011 by U.S. Representative Eddie Bernice Johnson (D-TX) and co-sponsored by 5 other members of Congress. The bill had identical language to two bills introduced in the previous session of Congress: S. 1765, Hate Crimes against the Homeless Statistics Act of 2009 and H.R. 3419, Hate Crimes against the Homeless Statistics Act of 2009 which were introduced in 2009 by U.S. Benjamin Senator Cardin (D-MD) and U.S. Representative Eddie Bernice Johnson (D-TX), and co-sponsored by over 20 other members of Congress (11 Senators and 12 Representatives). On September 29, 2010, Senator Cardin convened a hearing of the Senate Judiciary Subcommittee on Crime and Drugs, entitled "Crimes against America's Homeless: Is the Violence Growing?"*[7]

- Many states have created laws to protect the homeless:

    - *Across the nation, communities are beginning to take action to protect the homeless members of their community. Alaska; California; Cleveland, OH; Florida; Los Angeles, CA; Maine; Maryland; Puerto Rico; Rhode Island; Seattle, WA; Washington; and Washington, D.C. have created laws that consider homelessness as a factor that may motivate a person to attack a homeless person. Some of these laws mandate stricter penalties for convicted perpetrators; while others require law enforcement to keep track of crimes where housing status may have been a motivating factor.*[7]

- New Mexico does not have laws to specifically protect the homeless
- Other important considerations:

- Homeless victims may be less likely to report crimes
- Police should be aware that homeless often carry weapons (traditional or makeshift) to protect themselves from attacks

Enforcement Issues:

- Police are called to remove and address homeless for various reasons/situations:
  - Business owners, bus stops, park benches, tent cities
  - Trash, human waste, drug paraphernalia, intoxicated people
  - Welfare checks on unconscious people in public ("down and outs")
  - Pedestrians walking, standing in roadway

- Political dynamics can lead to mixed messages for law enforcement
- Crimes committed by homeless can be difficult to investigate due to issues identifying and locating transient individuals

Resources:

- Emergency/Hotline Numbers
  - Adult Protective Services (APS)……1-866-654-3219
  - Agora Crisis Center……..505-277-3013
  - Child Abuse/ Neglect……...505-841-6100…1-800-797-3260
  - Crisis Text Line (Text HOME to)……741741
  - Domestic Violence Shelter……..505-247-4219
    (In State toll free)……..1-800-773-3645
  - New Mexico Crisis Hotline……...1-888-918-9441
  - Poison Control……...1-800-222-1222
  - Rape Crisis Center (24hr)……505-266-7711
  - Runaway Hotline (National)……1-800-786-2929
  - NMCAL (24hrs)……..1-855-227-5485
  - Warm Line……..1-855-466-7100
  - Suicide Intervention (Nationwide Hotline)……..1-800-suicide

- Healthcare for the Homeless:
  - Medical Clinic – 1217 1st St NW……505-242-4644
  - Dental Clinic – 1217 1st St NW……...505-242-8288
  - Artstreet - 1217 1st St NW……505-248-0817
  - Substance Abuse & Mental Health Services:
    - Resource Center & Case Management – 1220 1st St NW…....505-843-7611
    - Counseling & Assessment - 1217 1st St NW…….……505-242-4644
    - Harm Reduction/Syringe Exchange – 1217 1st ST NW……...505-266-4188

- Shelters for Women and Children
  - Barrett House- 10300 Constitution NE 8:30am-5pm……..505-243-4887
  - Safe House (Domestic Violence-24hrs)……505-247-4219
  - Esperanza Shelter (Santa Fe, Domestic Violence, 24hrs)…….1-800-473-5220
  - Valencia Shelter for Domestic Violence (Belen, 24hrs)……..505-864-3202
  - Valencia Shelter for Domestic Violence (Los Lunas, 24hrs)…….505-864-1383
  - Haven House (Rio Rancho, 24hrs)……505-896-4869

- Steelbridge…….505-554-2780

- Night Shelters
  - Heading Home (Men Only)-715 Candelaria NE (call 8:30am-no walk-ins)……..505-344-4340
  - Good Shepard Center (Men)-218 Iron SW……...505-243-2527
  - Joy Junction (families & women, 24 admission) – 4500 2nd SW…..505-877-6967
- Day Shelters
  - The Rock at Noon Day (Men, women all ages, Tu-F 8am-4pm) – 101 Broadway NE……..…….505-246-8001
  - St. Martins Hopeworks – 1201 third St NW……..505-843-9405

- Teen Shelters
  - Amistad (Ages 12-17, 24hr admission) - 1706 Centro Familiar SW……..…505-877-0371
  - New Day (Ages 11-17, 24hr admission) - 2820 Ridgecrest SE……505-938-1060

- Free Meal Sites
  - St. Martins Hopeworks – 1201 3rd St NW…….505-843-9405
  - The Rock at Noon Day – 2400 Second St. NW……..505-246-8001
  - First United Methodist – Fourth and lead…….505-243-5646
  - Good Shepard Center – 218 Iron SW……..505-243-2527
  - Restoration Ministries – 824 San Mateo SE…….505-255-7579
  - Bread and Blessings – 7th and Copper…….505-247-4271

- City of Albuquerque Resources (CABQ)
  - Alamosa Health & Social Service Center…….505-836-8800
  - Los Griegos Health & Social Service Center……505-761-4050
  - John Marshall Health & Social Service Center……505-848-1345
  - East Central Health & Social Service Center……...505-767-5700

- Employment Services……..505-764-8231
- Mental Health Programs……..505-764-8231
- Housing……..505-764-8231
- Hope Center – 1110 Second St NW……..505-242-4399

- Substance Abuse Recovery Services
  - Al-Anon……...505-262-2177
  - AA (Alcoholics Anonymous)- 1921 Alvarado NE……505-266-1900
  - Cocaine Anonymous……505-344-9828
  - Almas de Amistad (for women) – 609 Gold SW……..505-246-9300
  - ASAP (UNM Addiction & Substance Abuse Program)……...505-994-7999
  - Crossroads for Women……505-266-0110
  - New Mexico Solutions – 707 Broadway NE #500 (at Lomas)…..505-268-0701
  - Salvation Army men's residential rehab program……505-881-4292 ext. 100
  - Turquoise Lodge……...505-841-8978
  - Victory Outreach Programs…….Men 505-842-5394, Women 505-506-2003
  - UNM Mental Health Center (24hr crisis line)……505-272-2920

- Other Services
  - Albuquerque City Dept. of Senior Affairs……..505-764-6400
  - Albuquerque Housing Services……..505-764-3920
  - Albuquerque Indian Center…….505-268-1751
  - APD Evidence (Belongings)……505-823-4600
  - Bernalillo County Housing……...505-314-0200
  - CPI (Counseling and Psychotherapy Institute) – 803 Tijeras NW……..……..…505-243-2223
  - Disability Rights New Mexico (Legal Assistance)……505-256-3100
  - Domestic Violence Resource Center Helpline…..505-248-3165, 505-884-1241
  - DVR (Division of Vocational Rehabilitation)- 111 Lomas NW, 4th Floor……..……505-383-2500
  - ECHO Food commodities (seniors 60+)……505-2426777
  - Employment/Housing/Public Accommodation Rights…….505-768-4589
  - Enlace Comunitario (domestic violence)……..505-246-8972
  - Family Advocacy Center- 625 Silver Ave SW……..505-243-2333
  - Family Promise (shelter/housing for families w/ minor children)……....505-268-0331
  - First Choice……...505-873-7400
  - First Nations Community Healthsource…….505-262-2481
  - Goodwill (job information)……505-881-6401
  - Greyhound Bus Station……505-243-4435
  - Heading Home……..505-226-7600
  - HSD Offices (Food Stamps, GA, TANF, Medicad)
    - Cutler……..……...505-222-9200
    - Lamberton……..……505-841-7700
    - Randolph……505-383-2600
    - Bridge……505-841-2300
  - Indian Health Services…….505-248-4000
    - Behavioral Health…….505-248-4012
  - Law Access……505-243-2615
  - Lawyer Referrals (Bar Assoc.)……505-243-2615
  - Legal Aid…..……..505-243-7871
  - LGTBQ Resource Center- UNM (M-F 9am – 5 pm)……505-277-5428
  - Metro Court…...…….505-841-8151
  - Mexican Consulate – 1610 4th St NW……505-247-2147
  - NAMI (National Alliance on Mental Illness)
    - Albuquerque……505-256-0288
    - New Mexico…….505-260-0154
    - West Side…….505-990-2292
  - New Mexico AIDS Services – 625 Truman NE……..505-938-7100
  - Public Health Office on Wellesley…….505-841-4100
  - SAGE ABQ (LGBTQ Resource)……505-710-6987
  - Salvation Army (bus passes) – 411 Broadway……505-881-4292
  - Senior Citizens Law Office Legal Advice (60 or older)……..505-265-2300
  - Social Security Administration……1-800-772-1213
  - Storehouse – 106 Broadway SE..……505-842-6491
  - Supportive Housing Coalition of New Mexico……..505-255-3643
  - Susan's Legacy (for women with co-occurring disorders)…….505-967-7395

- TGRCNM (services for transgender individuals) – 149 Jackson St. NE…….....505-200-9086
- Therapeutic Living Services……505-268-5295
- Veterans Administration……..505-265-1711
- Jail/MDC…….505-839-8700
- Jail Psychiatric Service Unit (family members)…505-839-8832, 505-839-8836, 505-839-8841, 505-839-8884
- Women's Housing Coalition……505-884-8856

- Family Services
  - Aging & Long Term Services Dept…….505-476-4799
  - Catholic Charities (La Luz Program)…….505-724-4670
  - CLN Kids Daycare Center……..505-843-6899
  - HELP New Mexico……505-766-4958
  - Homeless Veterans/Veterans Crisis Line……1-800-273-8255
  - New Mexico Kids (child care referral-leave message)…….505-277-7900
  - Open Skies (formerly Hogares)……..505-345-8471
  - PB&J Family Services……..505-877-7060
  - Planned Parenthood……505-265-3722
  - State Child Care Assistance (CYFD)……..505-827-7499
  - Title 1 (APS program for homeless students)…….505-253-0330
  - WIC – South Broadway Center……..505-764-0271
  - Young Children's Health Center at UNm……..505-272-9242

- Youth Services
  - Casa Q……505-872-2099
  - Desert Hills for Youth……...855-436-3409
  - UNM ASAP (for adolescents)…….505-994-7999
  - Youth Development (YDI)……505-831-6038

- Homeless Veterans Outreach Program
  - Veterans Affairs Hospital – 1501 San Pedro Dr. SE..……505-265-1711
  - Veterans Integration Center – 13032 Central Ave SE……505-265-0512

Officers should familiarize themselves with current list of resources
Resource cards are available to hand out to individuals
Refer to resources outlined in CIT Community Resources Course

- Healthcare for the Homeless (medical, dental, mental health, etc.)
- MATS Detox
- AMCI (Albuquerque Metro Central Intake)
- ASAP (UNM Addiction & Substance Abuse Program)

- COAST (Crisis Outreach and Support Team) is now assigned to each area command as of February 2016. Field officers that need assistance from COAST can request aid from their respective area command COAST Units.

If any editing or revisions need to be made to this document or if you would like to contribute new material please contact Matthew Tinney at mtinney@cabq.gov, 505-553-2229

PEER SUPPORT TEAM

We're Here to Help

Call 24/7:
505.967.6587

Team Directory:
www.protopage.com/apdweb.cabq.gov

Email:
apdpeersupport@cabq.gov

Team Offices:
B1 (Basement) at the Main

A confidential, safe, and supportive environment for law enforcement personnel.

WHO WE ARE

Team members are volunteer law enforcement and civilian personnel who are familiar with, have experienced, or understand the pressures and stresses of law enforcement.

WHAT WE DO

Provide assistance and emotional support during and after crisis, serious illness, or injury. We also provide resources and referrals for professional assistance. Resources are available to all APD employees, no questions asked.

COMPLETELY CONFIDENTIAL

Confidentiality is essential to the integrity of the Peer Support Program. No records of any kind will be kept by the Peer Support Team.

JOIN THE TEAM

Contact: Melissa Schultz
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What is Self-care?

Basically, self-care is any activity that you do voluntarily which helps you maintain your physical, mental or emotional health. It can help you feel healthy, relaxed and ready to take on your work and responsibilities. Self-care is an approach to living that incorporates behaviors that refresh you, replenish your personal motivation, and help you grow as a person. Creating time for yourself each day is vital in maintaining energy, concentration, and overall wellness. There are five components of self-care: physical, mental/emotional, relationship, social, and spiritual.

Why is self-care important?

It keeps you healthy

Self-care does help you stay healthy! Physical activities like exercise can be a great form of self-care for different reasons. It keeps you strong, burns off nervous energy or just gives you some time to forget your responsibilities or things that stress you out. Self-care doesn't have to just be physical either, taking time out of your day to do something you enjoy like game or read a book is also a great way to distract your mind and body from things that could be stressing you out. Without self-care is important to your relationships with others. Self-care is also important for your family and friends because unhealthy relationships come about when you don't take time for your needs.

The long term effects of not exercising are dramatic and can lead to long term weakness in muscles and bones, reduced ability to consume oxygen, and a host of pathological conditions due to obesity. Here is a short list of the most common effects:

1. Muscular Atrophy
2. Skeletal Deterioration
3. Cardiac Loss
4. Obesity
5. Increased chance of developing hypertension
6. Colon and Breast cancer risk increases
7. Increased chance of Gallstone formation
8. Adult onset of diabetes
9. Higher chance of developing depression and anxiety

It helps you 'recharge'

Some people use self-care as a way to unwind and de-stress after a long day or week. Any activity that can help people catch up on rest and 'un-plug' themselves from the outside world for a little while is worth doing. Self-care is important, although some people think it's selfish or inconsiderate. We know self-care actually makes you more effective and energetic. When you avoid things that make you feel physically and mentally well, you deplete your confidence and self-esteem. Self-care is important to maintain a healthy relationship with yourself. It sounds strange but it is true. It produces positive feelings, which improves confidence and self-esteem, it energizes, and gives you a more positive outlook.

It can help you manage health issues

Self-care is sometimes a way of coping with physical or mental health issues. People in law enforcement can use self-care strategies to cope with stress and the effects of stress that can have a detrimental effect on health. These effects can be overwhelming physically, mentally, and emotionally. Self-care is a way to make sure that a person can live their life as fully as possible.

Overcoming obstacles to your SELF-CARE plan

Like everything else in life, your SELF-CARE plan has to be something that is purposeful and well planned if it is to be successful. This does not mean it has to be rigid. It will take thought, planning, and execution or it will otherwise fall into the trash heap of the well-intentioned. Let's talk about obstacles to your plan. Remember you are embarking on something new and different that will require adjustment to your existing way of life. That usually brings resistance in many forms. Change can be difficult and will need to be confronted on an ongoing basis.

One of the biggest obstacles is time. Time is a funny thing we never seem to have enough of it and always want more. However think about this, we all have the same 24 hours in a day and 7 days in a week. How is it that some are able to accomplish a lot of positive and life enhancing things and some of us…well not too much? The answer is priorities. You will need to look at what your priorities are and see how you are spending your time.

Let me give two examples of how this works out for many of us. Let say someone asks you, "What is your number one priority?" You may answer, "Well my family." Is that really true when you look at the amount of time you actually spend interacting with your family. Do you actually spend quality time with members of your family or have you mixed the ideal with the real?

Another example looks like this. I was talking to someone about exercising and asked if they were engaged in an exercise routine. The answer was, "No I don't have time." I asked, "Well what do you do when you get home from work?" The answer not only surprised me but also surprised the person I was questioning their answer given very sheepishly was, "Watch TV." You see we fall into routines that become so much a part of us that we don't question them to see if they are really meeting our life goals and our priorities.

Obstacles will come in many forms and varying degrees. The most effective way to overcome obstacles is what has been mentioned above; it must be purposeful, planned, and executed. When an obstacle comes your way having done these three things in mind will help you:

1. Remember what you goal is.
2. Help you look at the obstacle more objectively.
3. Help you measure the obstacle against your goal.
4. Help you to make adjustments when necessary.

Creating a self-care plan

When creating your Self-care plan begin thinking in terms of the various areas of your life, such as:

1. Physical
2. Emotional
3. Relationship
4. Social

5. Spiritual

Each of these area will need attention in terms of creating a purposeful plan. There are many ways that this can be accomplished. Here is an example of one possibility of a Self-care plan that would be considered a Biopsychosocial-Spiritual self-care plan. Afterwards I will give you a recommendation from the Law Enforcement Survival Institute of a stress Management plan that can in incorporated into any Care-plan.

Physical Health Plan:

- Workout at the gym 4 times per week. 2 days upper body 2 lower body.
- Treadmill or elliptical 4 times per week in winter. Bicycle and power walk in summer.
- Mountain hike on Saturday 1 hour.
- Use stairs at work instead of elevator.
- Eat more fruit and vegetables.
- Limit sugar or white flower.
- No fried foods.
- See my Primary care doctor once a year.
- See dentist twice a year.
- Lose 25 lbs: 2 Pounds per week.

Emotional Health Plan

- I will talk to my husband/wife/partner about my stress and stressors.
- I will go to counseling.
- I will begin keeping a journal.
- I will be more aware of my negative thinking and begin to insert more positive thoughts throughout the day.
- I will have a good support system in place.

Relationship Plan

- I am going to praise my husband/wife/partner more times than I criticize him/her.
- I will begin to be an active listener.
- I will be more attentive to my husband/wife/partner.
- I will give my husband/wife/partner a gift or a card or love note at least one time a month.
- I will no longer try to win arguments or disagreements but focus on mending the relationship.
- We will have a date night at least one time a month.

Social Plan

- Go out with family to diner.
- Meet friends for game night or social gathering at least 2 times per month.
- Meet coworkers for drinks/coffee at least 2 times per month.
- Join a book club/bicycle club/yoga

Spiritual Plan

- Go to church/mosque/temple weekly
- Join bible study or spiritual study of my choice.
- Keep a spiritual journal.
- Pray daily.
- Meditate on a daily basis.
- Have a spiritual mentor.

Final Note

What you have is an outline of a Self-care plan. It is suggested that you take each section and develop a more detailed plan so that you know exactly what you are trying to achieve in each category. The more detailed you can be the better chance you have of being successful. Don't forget the overall plan is for you to experience better overall health so the last thing you want to do is become rigid and create more stress in your life. Try to make your plan so it will flow naturally as you begin to implement the various changes. JO Prochaska and CC DiClemente are experts in the area of change recommend that the key ingredient to in bringing about change is support. It is important to recruit others close to you who want you to be successful and help support you though the process.

Resilience at work

Resilience is a person's capacity to respond to pressure and the demands of daily life. Dictionary definitions include concepts like flexibility suppleness, durability, strength, speed of recovery and buoyancy. In short, resiliency affects our ability to 'bounce back'. At work, resilient people are better able to deal with the demands placed upon them, especially where those demands might require them to be dealing with constantly changing priorities and a heavy workload.

Resilience is not a characteristic gifted to some individuals and not others. The key here is that resilience is not a passive quality, but an active process. How we approach life, and everything it can throw at us, has a massive impact on our experience. Resilient people do more of the things that help maintain that responsiveness, and it is relatively easy for those of us who are feeling less resilient to develop habits that will increase our ability to perform under pressure, and perhaps more importantly, to live better despite circumstances that try us to the limit.

"Why is it that some people thrive in the face of challenge and adversity at work, while others panic and withdraw into themselves? And why is it these same people who appear to get ahead while others tread water, or slowly drown in turbulent waters of life?

Most people think that a combination of intelligence, long working hours and lots of experience allows people to thrive in potentially hostile working environments. In fact, it is those with resilience who cope best with challenges like constant organizational change and upheaval, impending staff cutbacks, looming deadlines, argumentative meetings and incessant competition from business rivals.

The good news is that although some people seem to be born with more resilience than others, those whose resilience is lower can learn how to boost their ability to cope, thrive and flourish when the going gets tough." (Centre for Confidence and Well-Being, 2006)

How to develop resilience

The ability to cope well with pressure, adversity and uncertainty relies on developing behaviors, thoughts and actions. Anyone can learn these habits and create strategies to help increase resilience and hardiness.
Resiliency experts say that that people are helped by a particular pattern of attitudes and skills that helps them to survive and thrive under stress.

"Simply put, these attitudes are commitment, control, and challenge. As times get tough, if you hold these attitudes, you'll believe that it is best to stay involved with the people and events around you (commitment) rather than to pull out, to keep trying to influence the outcomes in which you are involved (control) rather than to give up, and to try to discover how you can grow through the stress (challenge) rather than to bemoan your fate." (Maddi and Kkhosshaba, 2006)

Building and maintaining personal resilience

Resilience is ordinary, not extraordinary. People commonly demonstrate resilience. For example, following the terrorist attacks of September 11, 2001 in the USA, most people got on and rebuilt their lives, and the anticipated rise levels of post-traumatic stress syndrome (PTSD) never occurred.

Developing resilience is a personal journey involving thoughts, behavior and actions. Anyone can do it.

9 Ways to build resilience

1. Cherish social support and interaction. Good relationships with family and friends and others are vital. Being active in the wider community also helps.
2. Treat life as a learning process. Develop the habit of using challenges as opportunities to acquire or master skills and build achievement.
3. Avoid making a drama out of a crisis. Stress and change are part of life. How we interpret and respond to events has a big impact of how stressful we find them.
4. Celebrate your successes. Take time at the end of each day to review what went well and congratulate yourself. This trains the mind to look for success rather than dwelling on negativity and 'failure'.
5. Develop realistic life goals for guidance and a sense of purpose. Do something each day to move towards them. Again, small is beautiful; one small step amid the chaos of a busy day will help.
6. Take positive action. Doing something in the face of adversity brings a sense of control, even if it doesn't remove the difficulty.
7. Nurture a positive view of yourself. Developing confidence in your ability to solve problems and trusting your instincts helps to build resiliency.
8. Keep a realistic perspective. Place challenging or painful events in the broader context of lifelong personal development.
9. Practice optimism. Nothing is either wholly good or bad. If we allow our thinking to dictate how we view something it will take over. Make your thinking work for your benefit, rather than letting it stymie you with doubt or by seeing only the bad side.

These are not the only ways to strengthening personal resilience. For example, for some people keeping a journal is useful, those with a religious conviction find prayer helpful, practicing mindfulness or meditation help some people connect with themselves and restore a sense of purpose. The key is to identify ways that are likely to work well for you as part of your own personal strategy for fostering resilience.

See also

Managing challenging times

7 Ways to change your thinking.

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- **Resilience**
  - Resilience at work

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Officer Safety Corner: Compassion in Law Enforcement

By Mike Force, Chief of Police, Lake Saint Louis Police Department, Lake Saint Louis, Missouri

The burden of dealing with tragedies associated with the day-to-day duties by police officers often remains unspoken and follows the officers into their off-duty and personal lives. Failure to recognize and provide an acceptable outlet for the disappointment and frustration felt by officers at the end of their shifts can lead to alcohol abuse, problems with personal relationships, self-rejection, disillusionment, and even suicide.

If asked what bothers them the most about their profession, many officers will offer concerns such as a lack of public respect, lack of manpower or equipment to do their job effectively, or a general frustration over the perceived ineffectiveness of the judicial system. Seldom will officers open their hearts to discuss the pain and frustration that stems from dealing with the injury, anguish, and distress suffered by the victims. Many officers are haunted by the effects of trying to resolve problems they encounter in their communities and with their victims only to find that the solution is beyond their control.

Officers do not discuss the sorrow they feel after having to notify loved ones about the loss of their spouse or child because of a vehicle collision. Nor do they discuss the tears that follow officers after having held an infant in their hands trying to breathe life back into the tiny body only to find that despite all of their training and practice their efforts are futile. Or the frustration of dealing with the children of a crack addict or an abusive parent who time after time evades the help of a system overburdened with cases that, left unresolved, ensure continued problems for generation after generation to come.

What Is Compassion?

Compassion is not a singular thing. Rather it is composed of five mental and emotional states.

- **Respect and Caring** – these are mental and emotional attitudes associated with commitment, responsibility, and reverence towards others.
- **Empathy** – is a deep understanding of the emotional state of another. It is what enables an officer to connect with others, which can lead to compassionate feelings.
- **Selfless and Unconditional** – this is placing others' before your own needs; this mental and emotional state does not expect reciprocity or equal exchange. It is giving unselflessly.
- **Committed Action** – for compassion to exist, it must be characterized by a helping action, a willingness to act on the mental and emotional state.
- **Benefitting Others** – this is action given without any thought of gain; an act to alleviate suffering and providing help without recognition.

The core of compassion is a heartfelt connection in situations where others are suffering and need help and the taking of action to provide help.

What Chiefs Can Do

Promoting Compassion
The most important step a chief can take is to lead with compassion. The compassionate leader is one who can inspire people with purpose, hope, and optimism. Compassionate leaders generate energy in others because they resonate, empathize, and connect with them.

People follow leaders for very specific reasons. Gallup has been researching what makes a great leader for over 30 years. Over 3 million people have taken the company's StrengthsFinder assessment. When asked, followers were able to describe exactly what they need from a leader with remarkable clarity: trust, compassion, stability, and hope.[i]

To lead with compassion, leaders should undertake the personal practices of kindness, thoughtfulness, and courteousness and compliment others. As a practice, these actions are infectious and will spread throughout the organization.

A 19-Year-Old Boy Commits Suicide

A police sergeant in a small department had responded several times to the calls from the parents and neighbors of a 19-year-old boy troubled by fits of psychotic behavior. The boy had seen frequent involvement with the sergeant as well as other members of the department. Many of these calls involved the threats of suicide. Officers dreaded the call that would eventually come to announce his successful completion of the act.

The call came, and the sergeant answered it. The boy had left a note to family members apologizing for his actions and reassuring them that this was the only way to escape the torment that engulfed his life. Knowing that the police and other emergency service personnel had tried hard to help him in the past and sensing that they would be upset by the decision he had made, he also left a note to the police. Carefully folded and placed under the rope around his neck that he would hang himself with, the note asked for forgiveness and thanked the police for all that they had done.

The suicidal boy had a twin brother and the sergeant often thought about the surviving brother and the sorrow that would ensue. Others did not know that the sergeant himself had lost a brother to suicide and knew firsthand the torment that would follow the death of this 19-year-old boy. The sergeant knew his role could not end here. He contacted the surviving twin and spent many days helping the young man to find answers to many questions that only another who had lost someone in this way could understand. They are friends today, and, although each still has demons that haunt their lives, together they help each other in a way that no one else can.[1]

Organizationally, the department should share information about appropriate acts of compassion as human interest stories with others, including the media. The organization should formally acknowledge the officers to demonstrate the department's support of compassionate action. By communicating to the community the compassion showed by officers, the policing image can change from one of enforcement to a helpful police image.

Watching for Compassion Fatigue

The chief should ensure that the supervisors and commanders have been trained to recognize compassion fatigue. When an officer reports "feeling burnt out," it means they are not taking good enough care of themselves. Because emotions are contagious, a dispirited attitude can quickly spread and permeate the organization. It is essential that the organization is prepared to meet this challenge.

Note:

[i]Tom Rath and Barry Conchie, *Strengths Based Leadership: Great Leaders, Teams, and Why People Follow* (New York: Gallup Press, December 2008).

The Murder of a Young Girl

Sometimes compassion takes a more subtle path, as in the officer who apprehended and helped prosecute a crack addict who had raped and murdered a young woman. A seasoned officer, he knew from past experience that most parents have no idea of the complexity of the U.S. judicial system, and he also knew the despair that victims encounter as they traverse the complex maze of prosecution and judicial review.

The perpetrator was very familiar with the life that he would spend in correctional institutions—having spent time in them, on and off, throughout his life. The case was solid, and his conviction was inevitable. After numerous cautions by the judge and strenuous objections from his attorneys, the man pleaded guilty to first-degree murder knowing that he would receive the death penalty. The parents of the murdered girl thought justice now would be sure and swift. But the officer knew that this was only the beginning of a long arduous road to justice. Appeal after appeal followed—and with each appeal came another disappointment accompanied by a new hope on the part of the parents.

Through the next 17 years of quagmire, the officer remained at the parents' side. He was with them as they waited through each appeal and shared their feelings of disappointment and frustration and felt their renewed hope as each one was rejected. Throughout the trials, testimony of the details of the murder and the lack of remorse on the part of the perpetrator forced the parents to re-live the horror of their daughter's murder. During the appeals, the officer was always there with the girl's family.

Knowing that her parents had become so fixated on the execution of the man who had murdered their daughter, the officer did all he could to help them remember the wonderful times that they had spent with her in hopes that would enable the parents to recapture their lives and move beyond the tragedy of her death. Throughout the many years following the murder, he laughed with them, cried with them, shared their hope and their despair, all the while, wishing he could do more but knowing that the fate of this case and the closure sought by the parents may never be seen.

Years went by, and the family eventually moved to another state—in part, to escape the daily reminder of their lost child. But even distance did not release the officer from his dedication to helping the family through their torment. He speaks to them often through email and on the phone. He sometimes visits the grave of their daughter calling

them to comfort them at what always seems to be just the right time. Now, 17 years later, the officer has become part of their extended family as they wait for justice to finally be served.[2]

A Pair of Boots

Compassion is not limited to small town policing. While in small towns there are more chances for the officers to know the victims and residents needing help, compassion is found throughout law enforcement.

The November 2012 action of New York City police officer Larry DePrimo went viral when a passing tourist captured a video of Officer DePrimo giving a homeless man a pair boots and helping him to put them on his feet. The tourist filmed the action with her cellphone camera and then shared the experience. News organizations worldwide picked up the story.[3] Throughout the coverage of this act of compassion there were additional stories published giving local accounts of officers buying meals, pitching in to help put gas in cars, paying for bus tickets, hotel rooms, groceries, all without asking for recognition or public acknowledgement of their kindness and compassion.

A Bicycle

In March 2013, a Phoenix police sergeant stopped to talk with a young man walking late at night. The sergeant learned the 18-year-old had missed the last bus home. He was walking and traveling over six miles to his job at a fast-food restaurant, because he did not have a bicycle.

The police sergeant and her spouse decided to help the young man out; they bought him a bicycle. Since he did not know how to ride the bicycle, squad members taught him to ride in the parking lot of the precinct and donated a bicycle helmet.[4]

Positive Effects of Compassion

When speaking about their acts of kindness, officers will often relate that there is recognition on their part that they have made a small difference in the lives of others through a chance meeting. That they, themselves, are better persons and better officers because of the impact they had on each other's lives. That is why they dedicated themselves to the policing profession where they have a purpose and

cause. They will say they care.

Negative Effects of Compassion

Some consider compassion fatigue as an occupational hazard in police work. Most likely everyone who cares about the community they serve will develop a varying degree of compassion fatigue. In highly stressful work environments, facing increasing workloads and dwindling resources and at risk of being physically assaulted, fatigue will develop in varying degrees. The signs of compassion fatigue follow:

- Exhaustion
- Difficulty separating work life from personal life
- Hypersensitivity or insensitivity
- Increased cynicism at work
- Loss of enjoyment in their career
- Anger and irritability
- Increased use of alcohol and/or drugs
- Absenteeism, missing work, taking excessive sick days
- Problems with intimacy and personal relationships
- Depression
- Suicidal thoughts

Learning to recognize compassion fatigue symptoms serves two purposes. First it enables the employees to do their own compassion fatigue check and secondly, it enables the administrators to recognize officers approaching the danger zone and take positive action.

Individual Checkup: When officers feel or express that they have developed feelings of being unhappy and dissatisfied but are unable to explain or describe why, this condition could be a warning that they are experiencing compassion fatigue. By borrowing a simple scale of 1 to 10 used by many physicians to evaluate pain, (with 10 being the worst they have ever felt and 1 being the best they have ever felt) officers can recognize their level of compassion fatigue and if it is creeping up to the danger zone. For example, if an officer registers a 7 in thinking about calling in sick when they are not, they are approaching the danger zone of compassion fatigue. Individuals can recognize what is happening and implement strategies to correct their fatigue before it gets worse.

Organization: Organizational strategies can be implemented to protect officers from compassion fatigue. Compassion fatigue exists on a continuum; at various times the organization's actions may help

the officers to mitigate its damaging effects and at other times make them feel very beaten down by it. Often the stress is found not in dealing with victims but in the amount of paperwork required or the need to learn a new computerized system, the lack of equipment, or the case load; all brought on by the administration not properly planning an implementation strategy.

An easy but effective organizational strategy to protect officers is to openly discuss and recognize that compassion fatigue exists in policing. The organization can develop a supportive environment that will encourage proper debriefing after traumatic incidents, as well as formalize a peer support program. Officers should be encouraged to use the employee assistance program for professional help when "small matters" affects them. Compassion fatigue is a gradual, cumulative developing process, and, if the original small matters are handled, it could well prevent the development of serious compassion fatigue.

The agency's leadership can demonstrate and encourage a balance of work and life effort to break the repeated exposure to traumatic incidents and engage in pleasant activities, such as volunteering in community activities or recreational leagues. Prevention and recovery are not achieved by just taking an occasional holiday; rather, they result from a well-thought-through plan by the department and the individual officer to have work and life balance so they can continue to help others. ♦

If you are interested in writing for the Officer Safety Corner, please visit http://www.theiacp.org/OSC or email officersafety@theiacp.org for more information.

Notes:

[1]Sergeant Kyle Dooley, personal interview, September 7, 2012.
[2]Unnamed officer, personal interview, June 28, 2013.
[3]Vera Chinese, Rocco Parascandola, and Joe Kemp, "NYPD Officer Larry DePrimo, Who Gave Homeless Man a Pair of Boots, Shares 'Once in Lifetime' Moment," *New York Daily News,* November 30, 2012, http://www.nydailynews.com/new-york/shoe-giving-shares-lifetime-moment-article-1.1211335 (accessed June 13, 2013).
[4]Deborah Stocks, "Phoenix Teen Gets New Wheels from Police," ABC 15, May 9, 2013, http://www.abc15.com/dpp/news/region_phoenix_metro/north_phoenix/phoenix-teen-gets-new-wheels-from-police (accessed June 13, 2013).

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Crisis Intervention Team Training

Psychosis and Mania

Student Guide

Psychosis

Disorganization

“Do you have a messy desk?”

- Disorganization is a core feature of schizophrenia. Disorganization is felt by all people, but for people living with severe mental illness, their entire world can become disorganized and chaotic.

Do you sometimes have a hard time explaining yourself?

- All people from time to time have a hard time getting their point across. Miscommunication is commonplace, but for people living with mental illness this state of confusion and difficulty communicating can become the norm.

Disorganization can be in both thinking and behavior.

- Examples of how it feels to have disorganized thinking:
  - Having trouble finding the right words to express your thoughts.
  - Trying your best to explain yourself, but people simply can’t follow your logic, no matter how obvious it is to you.

Delusions

Delusions are fixed false beliefs. These are beliefs that are held, even after contrary information says that the belief is not true.

Do you ever feel like people are taking advantage of you? Like a car salesmen?

- Most people feel paranoid when dealing with salesmen. Are they telling me the truth? They don't care about me; they just want something from me.
- People who are paranoid may feel as if the entire world is full of people concealing key information and trying to take advantage of them.

Grandiose Delusions are a common form of delusional thinking especially in people who are psychotic during mania.

- Do you ever overestimate your abilities? Maybe badly?
- Overestimating abilities doesn't become psychotic until it's very far from cultural norms.
- Whether it's delusional or not, the feeling of overvaluing abilities is the same for people living with schizophrenia and those without.
- People who are psychotic sometimes have grandiose delusions and believe they have special powers, such as reading minds or predicting the future.

Are you superstitious? Do you believe in ghosts?

- The only difference between psychosis and the belief in ghosts is that believing in ghosts is culturally acceptable and doesn't cause serious impairment.
- Do you feel like you know what's best and other people should learn from you?
  - When you have a discussion or an argument, and you're sure your right about something, don't you want other people to agree with you, and do as you suggest?
  - When you're feeling in the right, it's the same feeling people with psychotic beliefs feel – they simply know they are right.

Lack of insight

Delusions, by definition require a lack of insight. If you know that what you're believing isn't true, it's not a delusion.

Lack of insight is a human condition, it's not even a little bit exclusive to people living with mental illnesses.

- Think about people who overestimate their abilities: singers on talent shows, people who believe they can make the PGA (when facts contradict this belief).
- A gym consultant surveyed their gym members and asked them how often they actually went to the gym. The typical answer was, "Five times a week." But according to the scan cards that the gym used, the number was closer to 2 – 3 times a week.

Have you ever said, "I'm fine, I don't need to go to the doctor."

- It seems that most people have made a statement similar to this one. People can be very bad at estimating their health.
- This lack of insight is true for "normal" people, and it is true for people living with mental illnesses as well. But when people living with mental illness don't attend to their illness, they are labeled as non-compliant or looked upon with anger, "Why don't you just take your meds!"

- **Do you refuse or procrastinate going to the doctor?**

- **Do you tell yourself your health is fine, even if there's limited evidence that you're fine**: You have no lab results, you may not even know your blood pressure.
  - Holding an incorrect belief despite evidence is a fixed false belief, which is a definition of a delusion. Believing "you're fine" despite not having any objective evidence is the first step towards a delusion.

Hallucinations

Hallucinations happen when a person experiences a sensation without any actual stimulus from the environment, like hearing a voice when no one is talking.

- **Ever been alone and hear your name called an no one is around?** Maybe it's the wind?
    - More than half of people report having had at least one auditory hallucination in their life, hearing something when there's no source for the noise. Common examples are: hearing a loved one's voice after they've died, hearing voices and music as you fall asleep or while waking up (not while dreaming).
- **Have you ever heard from or believed you communicated with a loved one not around?**
    - This is a very common belief and is culturally normal.
- **Have you ever seen evidence of a ghost?**

Negative Symptoms

Negative symptoms are when normal functioning and behavior is "taken away," or "subtracted." So when a young man stops shaving and attending to his hygiene and isolates from his friends and family, he is experiencing negative symptoms.

- **Do you ever feel like doing nothing? Seeing no one? Being left alone in your own filth?**
- **Withdrawal is a common symptom of schizophrenia**. In fact, schizophrenia doesn't require hallucinations and delusions; one can be schizophrenic and be disorganized and withdrawn.
- These symptoms are seen in stereotypical portraits of homeless people who are living with schizophrenia – long beard, unkempt, not bathing, not talking with other people. These are the homeless people who the other homeless people don't want to hang out with.

Mania

Mania is an essential component for the diagnosis of Bipolar Affective Disorder. It is an elevated, expansive, with increased energy, and goal setting, that last at least of week, or less if treatment in a hospital is required.

Symptoms of mania can include

- Feeling overly happy for an extended period of time.
- An abnormally increased level of irritability.
- Overconfidence or an extremely inflated self-esteem.
- Increased talkativeness.
- Decreased amount of sleep.
- Engaging in risky behavior, such as spending sprees and impulsive sex.
- Racing thoughts, jumping quickly from one idea to another.
- Feeling agitated or "jumpy."
- Easily distractible.

(Above list provided from: NAMI's Bipolar Disorder FACT SHEET)

- **Have you ever felt fantastic, ecstatic, like you were "on top of the world?"**
  - Can you imagine sustaining that feeling for two weeks?
  -
- **Can you imagine what it would be like to win the lottery?**
  - How would you act?
  - What would you say

http://www.psychiatrictimes.com/psychotherapy/winter-rorschach-test

NIMH ANSWERS QUESTIONS ABOUT SUICIDE

HOW COMMON IS SUICIDE IN CHILDREN AND TEENS?

The Centers for Disease Control and Prevention **reported** that in 2014, suicide was the second leading cause of death for young people ages 10–24. Although these numbers may make suicide seem common, it is still a rare event. Suicidal thoughts or behaviors are more common than suicide deaths and **are signs of extreme distress. Suicidal thoughts and behaviors are not harmless bids for attention and should not be ignored.**

WHAT ARE SOME OF THE RISK FACTORS FOR SUICIDE?

Risk factors vary with age, gender, or ethnic group and may change over time. Some factors that increase an individual's risk for suicidal thoughts and behaviors are:

- Depression, anxiety, and other mental disorders
- Substance abuse disorder
- Chronic pain
- Prior suicide attempt
- Family history of suicide
- Family violence, including physical or sexual abuse
- Firearms in the home
- Having recently been released from jail or prison
- Exposure to suicidal behavior of others, such as family members or peers

It is important to note that many people who have these risk factors are not suicidal.

National Institute of Mental Health

WHAT ARE THE WARNING SIGNS?

The following are some of the signs you might notice in yourself or a friend that may be reason for concern:

- Talking about wanting to die or wanting to kill oneself
- Making a plan or looking for a way to kill oneself, such as searching online
- Buying a gun, or stockpiling pills
- Feeling empty, hopeless, or feeling like there is no reason to live
- Feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing from family or friends or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings
- Saying good-bye to loved ones, putting affairs in order

Seeking help is a sign of strength; if you are concerned, go with your instincts and seek professional help.

Reaching out to a friend you are concerned about is also a sign of strength.

WHAT CAN I DO FOR MYSELF OR SOMEONE ELSE?

Immediate action is very important. Here are a few resources:

- **National Suicide Prevention Lifeline: 1-800-273-TALK (8255)**, confidential help 24-hours-a-day. You can also visit the Lifeline's website at **www.suicidepreventionlifeline.org**
- **Veterans Crisis Line: 1-800-273-8255**, press 1
- **Crisis Text Line**: text CONNECT to 741-741
- **HealthReach**, information available in multiple languages: **www.healthreach.nlm.nih.gov/searchindex/Suicide**
- Help for Mental Illnesses: National Institute of Mental Health web page **www.nimh.nih.gov/findhelp**
- **Treatment Referral Routing Service: 1-800-662-HELP (4357)**, funded by the Substance Abuse and Mental Health Services Administration

WHAT IF SOMEONE SEEMS SUICIDAL ON SOCIAL MEDIA?

Many social media outlets, including Facebook, Twitter, YouTube, Tumblr, and Google+, have ways to report suicidal content and get help for the content creator. Each social media site has a different procedure, so search the site's help page for assistance.

WHAT IF I WANT TO WRITE A STORY ABOUT SUICIDE?

A: Great idea! Here are suggestions for reporting on suicide: **http://reportingonsuicide.org/**.

WHERE CAN I GO FOR MORE INFORMATION ON SUICIDE PREVENTION?

You can:

- Visit the NIMH website: www.nimh.nih.gov and search "suicide"
- Visit the National Library of Medicine's MedlinePlus,
  English: www.nlm.nih.gov/medlineplus
  En Español: www.nlm.nih.gov/medlineplus/spanish
- Find information on clinical trials at the National Library of Medicine Clinical Trials database: www.ClinicalTrials.gov/
- Information from NIMH is available in multiple formats. You can browse and order items online, download documents in PDF, and order paper brochures through the mail.
- If you do not have Internet access and wish to receive information that supplements this publication, please contact the NIMH Information Resource Center at the numbers listed below.

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OM 16-4308
September 2016

SUICIDE IN AMERICA:
Frequently Asked Questions

Suicide is a major public health problem and a leading cause of death in the United States. The effects of suicide go beyond the person who acts to take his or her life: it can have a lasting effect on family, friends, and communities. This fact sheet, developed by the **National Institute of Mental Health (NIMH)**, can help you, a friend, or a family member learn about the signs and symptoms, risk factors and warning signs, and ongoing research about suicide and suicide prevention.

If You Know Someone in Crisis: Call the toll-free **National Suicide Prevention Lifeline (NSPL)** at **1–800–273–TALK (8255)**, 24 hours a day, 7 days a week. The service is available to everyone. The deaf and hard of hearing can contact the Lifeline via TTY at **1–800–799–4889**. All calls are confidential. Contact social media outlets directly if you are concerned about a friend's social media updates or dial 911 in an emergency. Learn more on the NSPL's website. The Crisis Text Line is another resource available 24 hours a day, 7 days a week. **Text "HOME"** to **741741**.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
NIH National Institute of Mental Health

What Is Suicide?

Suicide is when people direct violence at themselves with the intent to end their lives, and they die because of their actions. It's best to avoid the use of terms like "committing suicide" or a "successful suicide" when referring to a death by suicide as these terms often carry negative connotations.

A **suicide attempt** is when people harm themselves with the intent to end their lives, but they do not die because of their actions.

Who Is at Risk for Suicide?

Suicide does not discriminate. People of all genders, ages, and ethnicities can be at risk.

The main risk factors for suicide are:

- A prior suicide attempt
- Depression and other mental health disorders
- Substance abuse disorder
- Family history of a mental health or substance abuse disorder
- Family history of suicide
- Family violence, including physical or sexual abuse
- Having guns or other firearms in the home
- Being in prison or jail
- Being exposed to others' suicidal behavior, such as a family member, peer, or media figure
- Medical illness
- Being between the ages of 15 and 24 years or over age 60

Even among people who have risk factors for suicide, most do not attempt suicide. It remains difficult to predict who will act on suicidal thoughts.

Are certain groups of people at higher risk than others?

According to the **Centers for Disease Control and Prevention (CDC)**, men are more likely to die by suicide than women, but women are more likely to *attempt* suicide. Men are more likely to use more lethal methods, such as firearms or suffocation. Women are more likely than men to attempt suicide by poisoning.

Also per the CDC, **certain demographic subgroups are at higher risk.** For example, American Indian and Alaska Native youth and middle-aged persons have the highest rate of suicide, followed by non-Hispanic White middle-aged and older adult males. African Americans have the lowest suicide rate, while Hispanics have the second lowest rate. The exception to this is younger children. African American children under the age of 12 have a higher rate of suicide than White children. While younger preteens and teens have a lower rate of suicide than older adolescents, there has been a significant rise in the suicide rate among youth ages 10 to 14. Suicide ranks as the second leading cause of death for this age group, accounting for 425 deaths per year and surpassing the death rate for traffic accidents, which is the most common cause of death for young people.

Looking for more data and statistics? For the most recent statistics on suicide and more information about risk, please visit the CDC website at **www.cdc.gov/ViolencePrevention/suicide/index.html.**

Why do some people become suicidal while others with similar risk factors do not?

Most people who have the risk factors for suicide will not kill themselves. However, the risk for suicidal behavior is complex. Research suggests that people who attempt suicide may react to events, think, and make decisions differently than those who do not attempt suicide. These differences happen more often if a person also has a disorder such as **depression**, **substance**

abuse, **anxiety**, **borderline personality disorder**, and **psychosis**. Risk factors are important to keep in mind; however, someone who has *warning signs* of suicide may be in more danger and require immediate attention.

What Are the Warning Signs of Suicide?

The behaviors listed below may be signs that someone is thinking about suicide.

- Talking about wanting to die or wanting to kill themselves
- Talking about feeling empty, hopeless, or having no reason to live
- Planning or looking for a way to kill themselves, such as searching online, stockpiling pills, or newly acquiring potentially lethal items (e.g., firearms, ropes)
- Talking about great guilt or shame
- Talking about feeling trapped or feeling that there are no solutions
- Feeling unbearable pain, both physical or emotional
- Talking about being a burden to others
- Using alcohol or drugs more often
- Acting anxious or agitated
- Withdrawing from family and friends
- Changing eating and/or sleeping habits
- Showing rage or talking about seeking revenge
- Taking risks that could lead to death, such as reckless driving
- Talking or thinking about death often
- Displaying extreme mood swings, suddenly changing from very sad to very calm or happy
- Giving away important possessions
- Saying goodbye to friends and family
- Putting affairs in order, making a will

Do People Threaten Suicide to Get Attention?

Suicidal thoughts or actions are a sign of extreme distress and an alert that someone needs help. Any warning sign or symptom of suicide should not be ignored. All talk of suicide should be taken seriously and requires attention. Threatening to die by suicide is not a normal response to stress and should not be taken lightly.

If You Ask Someone About Suicide, Does It Put the Idea Into Their Head?

Asking someone about suicide is not harmful. There is a common myth that asking someone about suicide can put the idea into their head. This is not true. Several studies examining this concern have demonstrated that asking people about suicidal thoughts and behavior does not induce or increase such thoughts and experiences. In fact, asking someone directly, "Are you thinking of killing yourself," can be the best way to identify someone at risk for suicide.

What Should I Do if I Am in Crisis or Someone I Know Is Considering Suicide?

If you or someone you know has warning signs or symptoms of suicide, particularly if there is a change in the behavior or a new behavior, **get help as soon as possible**.

Often, family and friends are the first to recognize the warning signs of suicide and can take the first step toward helping an at-risk individual find treatment with someone who specializes in diagnosing and treating mental health conditions. If someone is telling you that they are going to kill themselves, do not leave them alone. Do not promise anyone that you will keep their suicidal thoughts a secret. Make sure to tell a trusted friend or family member, or if you are a student, an adult with whom you feel comfortable. You can also contact the resources noted below.

How can doctors and other health care providers play a role in suicide prevention?
Health care providers can help prevent suicide when they understand the risk factors and use evidence-based treatments and therapies. In addition, **The Joint Commission** recommends screening all patients in all medical settings for suicide risk using validated, population and setting-specific tools.

Clinicians should be advised that it is no longer acceptable to "contract for safety" with patients. Safety planning for managing future suicidal thoughts and means restriction (removing or ensuring safe storage of potentially lethal items) have been proven to be effective ways of preventing suicide. Health care providers can find educational resources on the **Zero Suicide website** and news about the latest research on the NIMH website at **www.nimh.nih.gov**.

What if Someone Is Posting Suicidal Messages on Social Media?

Knowing how to get help for a friend posting suicidal messages on social media can save a life. Many social media sites have a process to report suicidal content and get help for the person posting the message. In addition, many of the social media sites use their analytic capabilities to identify and help report suicidal posts. Each offers different options on how to respond if you see concerning posts about suicide. For example:

- Facebook Suicide Prevention webpage can be found at **www.facebook.com/help/**[use the search term "suicide" or "suicide prevention"].
- Instagram uses automated tools in the app to provide resources, which can also be found online at **https://help.instagram.com** [use the search term, "suicide," self-injury," or "suicide prevention"]
- Snapchat's Support provides guidance at **https://support.snapchat.com** [use the search term, "suicide" or "suicide prevention"]
- Tumblr Counseling and Prevention Resources webpage can be found at **https://tumblr.zendesk.com** [use the search term "counseling" or "prevention," then click on "Counseling and prevention resources"].
- Twitter's Best Practices in Dealing With Self-Harm and Suicide at **https://support.twitter.com** [use the search term "suicide," "self-harm," or "suicide prevention"].
- YouTube's Safety Center webpage can be found at **https://support.google.com/youtube** [use the search term "suicide and self injury"].

If you see messages or live streaming suicidal behavior on social media, call 911 or contact the toll-free National Suicide Prevention Lifeline at **1–800–273–TALK (8255),** or text the Crisis Text Line (text HOME to 741741) available 24 hours a day, 7 days a week. Deaf and hard-of-hearing individuals can contact the Lifeline via TTY at **1–800–799–4889.** All calls are confidential. This service is available to everyone. People—even strangers—have saved lives by being vigilant.

What Treatment Options and Therapies Are Available?

Effective suicide intervention practices are based on research findings and tested to see how various programs benefit various specific groups of people. For example, research has shown that borderline personality disorder is a risk factor for suicidal behavior, and there are **programs** that are effective in reducing suicide attempts.

Among its research on suicide, the **National Institute of Mental Health (NIMH)** has supported research on strategies that have worked well for those who have mental health conditions related to suicide such as **depression** and **anxiety**. These mainly include types of psychotherapies (such as cognitive behavior therapy or dialectical behavioral therapy). NIMH also conducts research on suicide risk screening tools for health care clinicians to use as a guide for screening patients for suicide risk.

For basic information about **psychotherapies** and **medications**, visit the NIMH website **(www.nimh.nih.gov/health)**. For the most up-to-date information on medications, side effects, and warnings, visit the **Food and Drug Administration (FDA)** website.

Looking for a mental health provider in your area?
For general information on mental health and to locate treatment services in your area, call the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Referral Helpline at **1–800–662–HELP (4357).** SAMHSA also has a **Behavioral Health Treatment Locator** on its website that can be searched by location.

Talking to Your Doctor

Suicide is often not discussed in medical visits where physical symptoms are more of the focus. If you have thoughts of suicide, tell your health care provider. Asking questions and providing information to your doctor or health care provider can improve your care. Talking with your doctor builds trust and leads to better results, quality, safety, and satisfaction. Visit the Agency for Healthcare Research and Quality website for tips at **www.ahrq.gov/patients-consumers**.

Where can I learn about research on suicide?

NIMH is committed to supporting research to improve the ability to identify who is at risk for suicide and develop effective treatments for at-risk individuals. As the government lead in the **National Action Alliance for Suicide Prevention's Prioritized Research Agenda for Suicide Prevention**, NIMH has helped shape priorities in suicide prevention research. For example, NIMH-supported researchers continue to study:

- Long-term risk factors, such as childhood events like trauma
- Immediate risk factors, such as mental health and recent life events
- How genes can either increase risk of suicide or make someone more resilient to loss and hardships
- Treatments for patients with treatment-resistant depression and active suicidal ideation (e.g., ketamine infusions)
- Instruments to detect suicidal ideation and behavior

Visit the NIMH website to learn more about NIMH's **research priorities** and **recent research on suicide prevention**.

For additional information about suicide prevention efforts, visit Zero Suicide: **http://zerosuicide.sprc.org**.

What Are Clinical Trials?

Clinical trials are research studies that look at new ways to prevent, detect, or treat diseases and conditions. The goal of clinical trials is to determine if a new test or treatment works and is safe. Although individual participants may benefit from being part of a clinical trial, participants should be aware that the primary purpose of a clinical trial is to gain new scientific knowledge so that others may be better helped in the future.

Researchers at NIMH and around the country conduct many studies with patients and healthy volunteers. We have new and better treatment options today because of what clinical trials uncovered years ago. Be part of tomorrow's medical breakthroughs. Talk to your doctor about clinical trials, their benefits and risks, and whether one is right for you.

- For more information about clinical trials conducted at NIMH, contact us at 301–496–5645 or **nimhcore@mail.nih.gov**.
- For questions about participating in research studies that are being conducted at the National Institutes of Health (NIH) and where to find them, contact **prpl@mail.cc.nih.gov** (link sends e-mail).
- For a listing of clinical trials being conducted around the country by NIH and others, be sure to check the **www.clinicaltrials.gov** website.

Finding Help

Mental Health Treatment Locator

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides this online resource for locating mental health treatment facilities and programs. The Mental Health Treatment Locator section of the Behavioral Health Treatment Services Locator lists facilities providing mental health services to persons with mental illness. Find a facility in your state at **https://findtreatment.samhsa.gov/**. For additional resources, visit **https://www.nimh.nih.gov/findhelp**.

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For More Information

To learn more information about suicide, visit:
Medline Plus (National Library of Medicine)
http://medlineplus.gov (En español: **http://medlineplus.gov/spanish**)

For information on clinical trials, visit:
ClinicalTrials.gov: **http://www.clinicaltrials.gov**
(En español: **http://salud.nih.gov/investigacion-clinica/**)

For more information on conditions that affect mental health, resources, and research, visit the NIMH website (**http://www.nimh.nih.gov**).

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Instructor/Presenter Biography

Lisa Anderson, LCSW

Lisa is a clinical social worker for the Department of Veterans Affairs with the Veterans Justice Outreach Program. The Veterans Justice Outreach Program works collaboratively with law enforcement, jails, and the VA to connect eligible justice-involved Veterans to treatment and specialty courts.

Lisa has 10 years of experience working in the social services field, including work with victims of domestic violence and court-based advocacy. Lisa started her social work career with the Metropolitan Detention Center, providing crisis intervention, emergency psychiatric services, assessment, brief-solution focused therapy, and case management to the psychiatric inmate population. She has been with the VA for 5 ½ years and has experience working with Veterans with severe mental illness, including schizophrenia, bi-polar disorder, PTSD, and others. Lisa joined the Veterans Justice Outreach team in 2014 with a focus on misdemeanor specialty court programs.

Detective David Baca

David served in the United States Marine Corps Security Force (MCSF 8152) prior to beginning his career in law enforcement in 1992 with the NM State Police. He has since been employed with Albuquerque Police for the past 11 plus years. During his career in law enforcement he has served as an instructor, a Field Training Officer, Field Training Officer Coordinator, Accident Reconstruction Expert, Interview and Interrogation Expert IPTM, SWAT Operator, Honor Guard Team, Dignitary Protection Unit, Collateral duties in Horse Mounted Unit and Crisis Negotiation Team, and is currently a Detective with the Crisis Intervention Unit.

Detective Frank Baca

Frank Baca has been with the Albuquerque Police Department since 2006. Currently he is a Detective with the Crisis Intervention Unit. Prior to being a Detective he served the Albuquerque Police Department in the Field Services Bureau for eleven years, three of those years he was a Field Training Officer. Frank obtained a Bachelor's Degree in Business Administration from New Mexico Highlands University.

Detective Jeff Bludworth

Jeff has been with the Albuquerque Police Department since 2012. He is currently assigned as a detective to the Crisis Intervention Unit. Prior to being assigned to the Crisis Intervention Unit, Jeff served in the Field Services Bureau for five years. He was a Bicycle Patrol Officer and was awarded Officer of Month in August 2017. Jeff is currently attending school for a Degree in Criminology.

Paula K. Burton, CHT

Paula is a National Alliance on Mental Illness (NAMI) educator and Connection facilitator. She is a veteran of the USAF. She trained with the American Red Cross in Disaster Response Counseling. She has advanced certification in pain management and Neuro-Linguistic Programming. Her professional focus is on combining treatments from diverse health practices.

Detective Bonnie Briones

Bonnie has been with the Albuquerque Police Department since 2006. She is a detective with the Crisis Intervention Unit (CIU) and is a Hostage Negotiator for the Albuquerque Police Department Crisis Negotiation Team. She is a certified Mental Health First Aid trainer. She graduated from the University of New Mexico with a Bachelor of Arts in Criminology and a minor is Spanish.

Sam Chavez

Sam Chavez, 70, is a Native New Mexican born in Belen, NM and attended UNM graduating in 1971 with a Bachelors of University Studies. Married to Peggy for 49 years, he has 3 adult children, 6 grandchildren and 2 Yorkies. He has been self-employed as a Landscape and General Contractor and more recently as the owner of Professional Business Systems, an Audio Video Systems design and build firm. Sam sold his business 4 years ago and retired in June of 2017. Hobbies include mountain biking, writing, reading historical fiction, hiking and travel. He has been actively involved with NAMI NM (National Alliance on Mental Illness) for 15 years having served on the State Board of Directors and teaching Family to Family. Sam and his family currently reside in Albuquerque.

Sergeant Diane Dosal

Sgt. Dosal has been with the Albuquerque Police Department for 11 years she has a total of 19 years law enforcement experience. She attended the New Mexico Law Enforcement Academy in 1998. She has worked as a Field Training Officer, Gang Suppression Officer, Narcotics Agent, and Violent Crimes Detective. She obtained a Bachelor's of Science in occupational education and a Master's in Public Administration. She was promoted to Sergeant in 2015 and worked in the FH area command and SE area command. She currently is the sergeant for the CIU.

Nicole Duranceaux, Ph.D.

Nicole is a native New Mexican who earned her Ph.D. in Clinical Psychology from a joint program between San Diego State University and The University of California, San Diego. She completed her internship and residency in PTSD through the Southwest Consortium in Albuquerque. She holds multiple professional positions in Albuquerque, including psychologist with UNMH, and contract psychologist with both APD and the VA Medical Center.

Detective Terry Dye

Terry Dye has been with the Albuquerque Police Department for over 30 years. He started out as a Police Service Aid in 1986 and then graduated from the Police academy in 1988. During his time he has worked Field Service Bureau where he was a Field Training Officer and Crisis Intervention Team Officer. He retired in 2007 only to return to work, upon returning to work he walked a beat in the downtown area working with the homeless. He also worked Criminal Nuisance Abetment Unit, Field Services Bureau, and is a Detective in the Crisis Intervention Unit. He certified in Crisis Intervention Team, Enhanced Crisis Intervention Team, Basic Crisis Negotiation, and Basic Law Enforcement Instructor.

Jennifer Earheart, MA

Jennifer is the Project Coordinator for the CIT Knowledge Network, a collaborative project launched in 2016 by APD, UNM's Department of Psychiatry and Behavioral Sciences, and Project ECHO. Jennifer received her Master's in Applied Anthropology from the University of Memphis in 2013 and has worked on several research studies since then. If you are interested in joining the CIT Knowledge Network please email her at jearheart@cabq.gov.

Yvette Garcia

Yvette has been with the APD for 18 years. She is currently a crisis specialist with APD's COAST team. During her career in law enforcement she has served on several law enforcement boards. She has specialized training in crisis intervention and law enforcement suicide prevention. She studied at the University of New Mexico and Central New Mexico Community College with an emphasis on Sociology and Criminal Justice.

Detective Robert Garnand

Robert Garnand is currently a Detective with the Albuquerque Police Department's Crisis Intervention Unit. He has been with the Police Department since April 2015. Robert is currently enrolled at the University of New Mexico, working toward a Bachelor's degree in Psychology, minoring in Criminology. He is a Veteran of the United States Navy's Submarine Force where he served on board USS Topeka (SSN 754) and worked as a Radioman. As a collateral duty, Robert is currently a member of the Crisis Negotiations Team as a Scribe and Intern.

Taren Hill

Taren is a peer advocate for those living with mental illness. She received her Masters degree in social work and is a master hypnotist. She is the co-facilitator for the Wellness Recovery Action Plan from NAMI Albuquerque. She has been living with a mental illness from an early age and dreams of a worlds where mental illness can be treated the same as a physical illness.

Detective Aaron Hoisington

Aaron has been with the APD since 2001 and is currently a detective in the Crisis Intervention Unit. Aaron has served in the Field Services Bureau, SWAT, and the Emergency Response Team. He holds certifications in Crisis Intervention Team and Enhanced Crisis Intervention Team.

Denise Hovey-Thomas

Denise has worked for the City of Albuquerque for over 24 years. She spent the majority of the time working at Albuquerque Housing services doing social work and conducting housing inspections for Section 8. She went on to work for the Police Department and the Planning Department conducting Housing and Zoning inspections for the City. Always having an interest in working with people in crisis, she studied Psychology at CNM and finally began working as a Crisis Specialist in May of 2016.

Celina Lopez

Celina has worked with the City Of Albuquerque since 1997 where she was a trainer for computer and job development skills plus was a family development specialist. She became a crisis specialist for APD when the Crisis Outreach and Support Team started in 2006.

Troy Luna, LMHC

Troy is a retired Albuquerque Police Officer with over 25 years of law enforcement experience. He retired as a lieutenant and has had assignments in the DWI Unit, DWI Seizure Unit, Special Investigations Division Narcotic Unit, and the Regional Drug Task Force comprised of federal, state, and local agencies. After retirement, Troy was hired as the Intelligence Director for the New Mexico High Intensity Drug Trafficking Area (HIDTA). During his time as director, he obtained his Masters degree in counseling and has been practicing as a Licensed Medical Health Counselor. He is now an independent counselor for APD Behavioral Sciences Section.

Detective Ben Melendrez

Ben is a detective with the Albuquerque Police Department's Crisis Intervention Unit. He started his career with APD in 2002. Ben obtained a Master's degree (MS) in Cognition Brain and Behavior Psychology from the University of New Mexico and is a veteran of the armed forces. Prior to joining the Crisis Intervention Unit Ben worked as a uniformed patrol officer.

Rob Nelson

Rob from the Midwest, arriving in New Mexico, April of 2009. He has worked for St. Martin's and UNM in behavioral health and case management. Rob was the first in UNM's history to work both inpatient and outpatient case management. Working in the human services field for the last nine years, he experienced many of the struggles of the mentally ill in the community and in doing so, was educated on the resources available.

Mark Oberman, MA LPCC

Mark works for the Albuquerque Police Department Crisis Intervention Team as a Crisis Outreach Clinician. He is an independently licensed counselor in the state of New Mexico. Previously he worked with the University of New Mexico Psychiatric Hospital as a discharge planner on the adult psychiatric wards. Mark has a BA from Florida Atlantic University in Boca Raton, Florida in Organizational Change and Development and a Master's from Webster University in Counseling.

Detective David Padilla

David is a detective with the Albuquerque Police Department's Crisis Intervention Unit. He started his career with APD in 2003, spending 14 years in the field services bureau. He is certified in Crisis Intervention and Enhanced Crisis Intervention Team.

Nils Rosenbaum, MD

Nils has worked with the Albuquerque Police Department since 2007 and is the director for the Behavioral Health Division. He is a volunteer attending physician with UNM and is a staff psychiatrist for Kaseman Hospital. He has won NAMI New Mexico's outstanding psychiatrist award.

Detective Lawrence Saavedra

Lawrence has spent 24 years in law enforcement. He has served as an Albuquerque Aviation Police Officer, Sandoval County Sheriff's Deputy, and is currently a Detective with the Albuquerque Police Department. In APD he has served as a patrol officer, a field training officer, a crisis intervention detective, a school resource officer, and was a primary negotiator on the crisis negotiation team. Lawrence has trained law enforcement officers in crisis intervention and crisis de-escalation since 2006

Robert Salazar

Robert is a Peer Advocate, and a life-time resident of Albuquerque. He is a committee member for the Mental Health Response Advisory Committee and the Consumer and Family Advisory Board at UNM. He actively participated in all of the City's Creating Community Solutions Dialogs on Mental Health as well as the recent Senate Joint Memorial 4. He is the NAMI Vice President and a Connection Peer Support Group facilitator. He received the NAMI NM Domenici Family Award 2013 in the consumer category.

Theresa Singer, LPCC

Theresa has a Masters degree in Agency Counseling and is independently licensed in New Mexico and Colorado. She was on the faculty and taught at a Family Practice Residency in Colorado, before moving to Albuquerque and working for UNMH Psychiatric Center. Since March 2015, Theresa has been employed by Albuquerque Police Department as one on the Crisis Intervention Clinicians.

Anna Tabor

Anna graduated from St.Norbert College with a masters degree in theology in December of 2016. She is a lifelong writer whose first published book is her thesis. She has been a NAMI In Our Own Voice presenter for 15 years and also mentored Peer-to-Peer education classes. She holds a day job as a caregiver at ARCA for 13 years.

Detective Matthew Tinney

Matthew is a Detective with the Albuquerque Police Department's Crisis Intervention Unit and former primary negotiator for the Crisis Negotiations Team. He began his career with the City of Albuquerque in 2004, joining the police department in 2006. He has received the CIT Officer of the Year Award and Life Saving Medal. Matthew holds master instructor certifications in crisis intervention, dispute intervention behavior management, barricaded hostage situations, and handling of the mentally ill. He was the first detective to be published in the American Journal of Psychiatry.

Dave Webster, MA, LISW

Dave is a Clinical Social Worker and Psychologist with over 25 years' experience as the clinical lead for programs addressing the crossroads at which mental health/substance use issues and the criminal justice system intersect. Since moving to the Albuquerque area in 2013, Dave has been promoting and developing programming for this population.

Lt. Zachary L Wesley

Zachary began his career in Law Enforcement in 1999 with the North Little Rock Police Department. In 2001 he joined the Albuquerque Police Department. Zachary obtained a Bachelor of University Studies in 2002 from the University of New Mexico. He is the lieutenant for the Crisis Intervention Unit and the Crisis Outreach and Support Team, overseeing the Crisis Intervention Team program and training.

Danny Whatley

Danny has been the Executive Director of The Rock at Noon Day since 2008. The Rock at Noon Day is the largest homeless day shelter in the State of New Mexico and one of the largest in the Southwest. Danny retired from the U.S. Marshals Service after 23 years of service. He has a Bachelor degree from the University of Alabama in Birmingham, and was a police officer for the Birmingham Police Department. For five years with the Marshals Service, Danny worked in their Service Training Academy, where he was in charge of the agency's Court Security Division training.

Betty Whiton, MA, LPC

Betty is a retired School Psychologist and professional school counselor. She facilitated multiple trainings for school counselors. She was Principal Bassist for NM Symphony Orchestra for 25 years and also taught music in APS and UNM and has conducted student symphony concerts in 8 states. She is a tireless advocate for children and adults legislatively on mental health issues, tobacco education and public education. She is presently Vice President of NAMI Albuquerque, and member of MHRAC (Mental Health Resource and Advisory Committee formed by DOJ): Training Subcommittee, FIC (Forensic Intervention Consortium,) NMBN (New Mexico Brain Network,) and ABCGC (Albuquerque Bernalillo County Government Commission) Behavioral Health Committee for Crisis Services.