V-VICTA®

VirTra - Virtual Interactive Coursework Training Academy®

MENTAL ILLNESS: A PRACTICAL APPROACH - SUBSTANCE USE

Training Manual

VirTra

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AUTHOR

Nicole Florisi, M.S. - VirTra Subject Matter Expert; Investigative Focus

TRAINING COURSE CERTIFICATION

This "Mental Illness: A Practical Approach" training course has been certified by the IADLEST™ National Certification Program on 9/23/2022.
Certification number: 22505-2209

TOPIC

Mental Illness: A Practical Approach - Substance Use

ESTIMATED TIME

1 hour

PERFORMANCE OBJECTIVE

(Slide 3) At the end of 1 hour of instruction in a video simulation the student will successfully be able to:

A. Understand the role of contact professionals
B. Recognize signs, symptoms, and behaviors associated with substance use disorders
C. Demonstrate skills for dealing with individuals who have substance use disorders

CLASS SIZE

Designed for pairs of officers with maximum class size of 8 (4 pairs). If class size is smaller than 8 (4 pairs) scenarios can be cycled through.

The following training plan and lesson plan is designed to be used with the VirTra simulator. Where as many of the techniques have been used over many years in LE, this training plan maximizes training time and leverages the strengths of the VirTra Training System.

The instructor shall first ensure that students are familiar with the presented material. The outline is provided to supplement and provide context to the use of the simulation scenarios.

The simulation scenarios are used as a tool to facilitate the understanding of the concepts. The first scenarios will be provided in a slower tempo with the use of the PLAY/PAUSE feature to elaborate on the training points. Once the first simulation is provided in this format the remaining scenarios will be provided to each pair of officers. The Socratic methodology should be used for event debriefing.

"What did you know?"
"What did you see or hear?"
"What did you do and the reason behind it?"
"What would you do differently in the future?"

All officers will be allowed to watch the other pairs participate in the exercise. This is done to maximize the benefit of modeling for adult learners. Students shall be given the opportunity to ask questions at the end of each section.

SAMPLE STUDENT GROUP SET UP

Non-test scenarios should be used with the concept of social learning theory and observation. The non-participating students should be watching their peers and be ready to answer what other options may have been available after the initial Socratic debrief.

A. Officer Yackley and Officer Emerson
B. Officer Danninger and Officer Ashley
C. Officer Bacon and Officer Adams
D. Officer Stephens and Officer Marks

First Scenario - Executed in “PLAY/PAUSE” methodology for all students - key concepts are applied and discussed
Second Scenario - Group A participates while Groups B, C, and D watch
Third Scenario - Group B participates while Groups A, C, and D watch
Fourth Scenario - Group C participates while Groups A, B, and D watch
Fifth Scenario - Group D participates while Groups A, B, and C watch
Sixth Scenario - (Practical skills test) Class is sequestered with students brought one at a time (not pairs) to evaluate performance.

SCENARIO BANK TO BE USED

A. Party Pooper
B. Office Anxiety
C. Misery Mountain

I. INSTRUCTOR INTRODUCTION

II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS

A. WHAT IS MENTAL HEALTH?

B. MENTAL ILLNESS

C. WHO CAN DIAGNOSE?

D. THE ROLE OF CONTACT PROFESSIONALS

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I. INSTRUCTOR INTRODUCTION

Instructor will introduce themselves to the class. This introduction should be no more than 2-3 minutes long and establish why they are qualified to teach the course and how long they have been with the organization. This not a moment to brag but to build confidence and trust from the attending students.

II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS

A. WHAT IS MENTAL HEALTH?

(Slide 6) Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

B. MENTAL ILLNESS

(Slide 7) Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities. Many factors contribute to mental illness: biological factors, stress and trauma, life experiences, and long-lasting health conditions. Mental illness becomes problematic when daily activities, relationships, and work is affected. Mental illness can be very impactful in a person's life.

C. WHO CAN DIAGNOSE?

(Slide 8, 9) Psychiatrists, psychologists, counselors, clinicians, therapists, clinical social workers, psychiatric nurse practitioners, physicians, and nurse practitioners. This can vary by state, licensing requirements, and master's level program requirements. Only psychiatrists, physicians, physician's assistants, psychiatric nurse practitioners, and nurse practitioners (state dependent) can prescribe medication.

A mental health professional will conduct a full mental health assessment before diagnosing a person with a mental illness. The assessment may consist of:

1. Physical Exam
2. Lab Tests
3. Mental Health History
4. Personal History
5. Mental Evaluation
6. Cognitive Evaluation

D. THE ROLE OF CONTACT PROFESSIONALS

1. Contact professionals are not trained to diagnose nor should they. Familiarization and recognition of behaviors are critical in deciding an intervention response. The intervention response should be as safe and effective as possible for all parties involved.
2. Behavioral health response and/or crisis intervention should be a coordinated effort that is as safe and effective as possible for everyone involved.
3. The focus should fall in recognizing indicators and signs associated with behaviors.
4. Safety is paramount and should not be compromised situationally for a behavioral health response or crisis intervention. Crisis intervention, behavioral health intervention, and de-escalation tactics are integrated responses based on the totality of circumstances.
5. Refer to department policies and legal department mandates for behavioral health or crisis response.

III. SUBSTANCE USE DISORDERS (SUDS)

(Slide 11) People use alcohol and drugs for various reasons. Substance use disorders can affect anyone of any age from all walks of life. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[1]

Many people use substances in an attempt to self-medicate problems they are experiencing or to manage anxiety or depression. An estimated 14.5 million people aged 12 or older in 2017 had an alcohol use disorder while an estimated 7.5 million people aged 12 or older had at least one illicit drug use disorder. including health problems, disability, and failure to meet major responsibilities at work, school, or home.[2] The relapse rate for substance use disorders is estimated to be between 40% and 60%.[3]

The drugs discussed in substance use disorder cause a direct activation of the brain's reward center. This intense activation of the reward system causes normal activities to be neglected. There are both substance use disorders and substance induced disorders. Substance use disorders occur from direct use while substance induced disorders occur as a result of intoxication or withdrawal from the substance. Many people who have a substance use disorder also have another mental illness. About half of people who experience a mental illness will also experience a substance use disorder at some point in their lives and vice versa.[4]

A. COMMON FACTORS

(Slide 12) Problems from substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability and failure to meet major responsibilities at work, school or home. Substance use disorders include the following factors:[1] [5]

1. Abuse of the substance
2. Dependence
3. Tolerance
4. Use of the substance in greater amounts over time
5. Desire to stop and unsuccessful attempts to reduce or control use
6. A great deal of time is spent to obtain the substance and recover from the effects
7. Craving or strong desire to use the substance
8. Continued use despite problems
9. Recurrent use in physically hazardous situations
10. Withdrawal

B. RISK FACTORS [6]

(Slide 13) No single cause exists for the development of an alcohol or substance use disorder. Certain risk factors increase chances of a substance use disorder developing:

1. Genetic vulnerabilities
   It is estimated that 40-60 percent of an individual's vulnerability to substance use disorders is attributable to genetics.
2. Environmental factors[3]
   - i. Chronic stress
   - ii. Trauma
     Physically or emotionally traumatized people are at much higher risk for drug use and SUDs.
   - iii. Adverse childhood experiences
   - iv. Mental illness
     Certain mental disorders are established risk factors for developing a substance use disorder. Individuals with mental illness may use drugs as a form of self-medication.
   - v. Social acceptability
   - vi. Learned behaviors

C. DUAL DIAGNOSIS [2, 6]

(Slide 14) Dual diagnosis refers to a person experiencing a mental illness and a substance use disorder simultaneously. In 2017, 8.5 million adults suffered from both a mental health disorder and a substance use disorder, or co-occurring disorders.

Treatment for dual diagnosis is integrated intervention, where the substance use disorder and the mental illness are both treated simultaneously. In the past, it was thought that you could not treat both disorders at once and the substance use disorder needed treatment before any underlying issues could be addressed.

IV. ALCOHOL USE DISORDER

(Slide 16-19) In small quantities, alcohol can help a person relax as well as lower inhibitions. Alcohol impairs judgement, coordination and concentration. Over time, alcohol can cause short-term and long-term problems in mental health, physical health and ability to function. For some individuals, short-term memory is impaired after only a few drinks. Some individuals drink to the point of blackouts and engage in behaviors they would not normally do. Binge drinking is also a problem with alcohol use. It is never appropriate to encourage someone with an alcohol use disorder to STOP drinking. This is medically unsound and can cause serious medical complications, including death. Encouraging a reduction in drinking paralleled with medical care is more appropriate.

A. PROBLEMS ASSOCIATED WITH ALCOHOL USE [5, 8, 9]

1. Liver damage
2. Heart problems
3. Increased risk of developing certain cancers
4. Depression
5. Violent behavior
6. Fatal traffic accidents
7. Legal problems/jail

B. SHORT-TERM EFFECTS OF ALCOHOL USE [5,8,9]

1. Problems walking
2. Impaired coordination
3. Slurred speech
4. Blurry vision
5. Impaired reaction time
6. Reduced inhibitions
7. Increase in risk taking behavior
8. Aggression/violent behavior
9. Suicide and self-injury

C. LONG-TERM EFFECTS OF ALCOHOL USE [5,8,9]

1. Depression
2. Anxiety
3. Social problems
4. Weight gain
5. Problems with coordination
6. Nerve damage
7. Inflammation of the liver (alcoholic hepatitis)
8. Scarring of the liver (cirrhosis)
9. Cancer of the liver
10. Increased blood pressure
11. Damage to the heart muscle (alcoholic cardiomyopathy)
12. Disruption of the healthy growth of new brain cells
13. Korsakoff syndrome[10]
    - i. Korsakoff syndrome and its associated thiamine (vitamin b1) deficiency is not the only mechanism through which heavy drinking may contribute to chronic thinking changes and cognitive decline.
    - ii. Korsakoff syndrome is often - but not always - preceded by an episode of Wernicke encephalopathy, which is an acute brain reaction to severe lack of thiamine. Wernicke encephalopathy is a medical emergency that causes life-threatening brain disruption, confusion, staggering and stumbling, lack of coordination and abnormal involuntary eye movements.
14. Alcohol misuse may also lead to brain damage through:
    - i. The direct toxic effects of alcohol on brain cells
    - ii. The biological stress of repeated intoxication and withdrawal
    - iii. Alcohol-related cerebrovascular disease
    - iv. Head injuries sustained when inebriated

V. CANNABIS USE DISORDER [11,14]

(Slide 21-22) Marijuana is the most commonly used illicit drug in the United States. The primary psychoactive ingredient in marijuana is delta 9 tetrahydrocannabinol (THC). Over time, the percentage of THC in marijuana and cannabis infused oil, resin, or edibles had significantly increased. Research suggests that marijuana impairs critical thinking and memory functions during use and that these deficits persist for days after using. In addition, a long-term study showed that regular marijuana use in the early teen years lowers IQ into adulthood, even if users stopped smoking marijuana as adults. Additionally, studies have shown that cannabis use can induce psychosis.

A. SIGNS OF MARIJUANA USE

1. Bloodshot eyes
2. Increased appetite
3. Lack of motivation
4. Weight gain
5. Nervous or paranoid behavior
6. Impaired coordination
7. Slowed reaction time
8. Dry mouth
9. Dizziness
10. Memory impairment
11. Lack of motivation
12. Anxiety
13. Impaired judgement
14. Distorted perception
15. Relaxed state, sleepiness
16. Feeling “high” or euphoric

VI. OPIOID RELATED DISORDERS[15, 16]

(Slide 24-26) Opioids are a class of drugs that include pain relievers available legally by prescription, the illegal drug heroin, and synthetic opioids such as fentanyl. These drugs activate opioid receptors on nerve cells in the body and brain. Opioid pain relievers can be effective in treatment for relieving pain. However, regular use can lead to dependence, and misuse of opioid pain relievers can lead to dependence, addiction, overdose incidents and possibly, death. Common opiates and opioids are Morphine, Demerol, Oxycodone, Fentanyl, Methadone, Percodan, Percocet, hydrocodone, and heroin. Fentanyl is especially problematic.

Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine but is 50 to 100 times more potent. Illegal fentanyl is being mixed with other drugs. This is especially dangerous because people are often unaware that fentanyl has been added. The high potency of fentanyl greatly increases risk of overdose, especially if a person who uses drugs is unaware that a powder or pill contains it. They can underestimate the dose of opioids they are taking, resulting in overdose. Additionally, occupational fentanyl exposure for contact professionals is a serious concern. Contact professionals should follow established work practices as well as these recommendations when fentanyl or its analogues are known or suspected to be present. Some agencies allow contact professionals to carry and use Narcan (a drug used for the emergency treatment of opioid overdose) after appropriate training.

A. SIGNS OF OPIATE/OPIOID USE[17]

1. Relaxed state of mind and body
2. Feelings of calmness
3. Increased or false confidence
4. Slowed and shallow breathing
5. Impaired judgement
6. Itchy, flushed skin
7. Nausea
8. Vomiting
9. Constipation
10. Blurred vision
11. Weight loss
12. Hallucinations

13. Euphoric mood
14. Lightheadedness
15. Needle marks on arms and legs from intravenous (injected) use
16. Constricted, “pinpoint” pupils
17. Having trouble staying awake, or falling asleep at inappropriate times
18. Withdrawing from social activities that were once enjoyed
19. Sudden and dramatic mood swings that seem out of character
20. Impulsive actions and decision-making
21. Engaging in risky activities, such as driving under the influence
22. Visiting multiple doctors in order to obtain more prescriptions

B. SIGNS OF OPIATE/OPIOID OVERDOSE [18]

1. Runny nose
2. Enlarged pupils
3. Trouble sleeping
4. Sweating
5. Aching muscles
6. Dysphoria
7. Diarrhea
8. Nausea
9. Vomiting

C. WITHDRAWAL SYMPTOMS FROM OPIATES/OPIOIDS [17]

1. Runny nose
2. Enlarged pupils
3. Trouble sleeping
4. Sweating
5. Aching muscles
6. Dysphoria
7. Diarrhea
8. Nausea
9. Vomiting

VII. HALLUCINOGEN RELATED DISORDERS [19]

(Slide 28-31) Hallucinogens are a diverse group of drugs that alter perception (awareness of surrounding objects and conditions), thoughts, and feelings. They cause hallucinations, or sensations and images that seem real though they are not. Hallucinogens can be found in some plants and mushrooms (or their extracts) or can be human-made. Common hallucinogens are ayahuasca, DMT, D-lysergic acid diethylamide (LSD), peyote (mescaline) and 4-phosphoryloxy-N,N-dimethyltryptamine (psilocybin). Ecstasy (MDMA) is also considered a hallucinogen although it has stimulant drug properties as well. Ecstasy is commonly used at parties and raves. People who use ecstacy may feel emotionally and physically close to people around them. Long-term use diminishes sexual interest and can increase mental health symptoms. Ecstacy use is especially problematic as it damages the brain’s ability to use serotonin. Depression can follow use of a hallucinogen due to chemical changes in the brain.

A. SIGNS OF SHORT-TERM HALLUCINOGEN USE

1. Increase in blood pressure
2. Increase in heart rate
3. Increase in body temperature
4. Dizziness
5. Dry mouth
6. Sleeplessness
7. Profuse sweating
8. Numbness
9. Nausea
10. Energy increase
11. Dilated or floating pupils
12. Problems with coordination

B. LONG-TERM PROBLEMS ASSOCIATED WITH HALLUCINOGEN USE

1. Speech problems
2. Memory loss
3. Weight loss
4. Anxiety
5. Depression and suicidal thoughts

C. HIGH DOSE EFFECTS OF HALLUCINOGENS

1. Memory loss
2. Panic and anxiety
3. Seizures
4. Psychotic symptoms
5. Amnesia
6. Inability to move
7. Mood swings
8. Trouble breathing

VIII. SEDATIVE, HYPNOTICS AND ANXIOLYTIC RELATED DISORDERS [20]

(Slide 33, 34) Sedatives, hypnotics and anxiolytics are central nervous system (CNS) depressants used to treat sleep problems, anxiety, alcohol withdrawal, and seizure control. These drugs have similar effects on a person and they are central nervous system depressants. A group of drugs called benzodiazepines (or benzos) have short term complications of addiction as well as long term effects for dependency and cognitive decline. Common benzodiazepines include diazepam (Valium), alprazolam (Xanax), and clonazepam (Klonopin), among others.

A. SIGNS OF CNS DEPRESSANT USE

1. Anxiety
2. Insomnia
3. Anorexia
4. Headaches
5. Weakness
6. Drowsiness
7. Confusion
8. Dizziness
9. Blurred vision
10. Slurred speech
11. Lack of coordination
12. Difficulty breathing
13. Coma

B. WITHDRAWAL SYMPTOMS FROM CNS DEPRESSANTS

Individuals addicted to CNS depressants should not attempt to stop taking them on their own. Withdrawal symptoms from these drugs can be severe and - in the case of certain medications - potentially life threatening.

1. Seizures
2. Shakiness
3. Anxiety
4. Agitation
5. Insomnia
6. Overactive reflexes
7. Increased heart rate, blood pressure and temperature with sweating
8. Hallucinations
9. Severe cravings

IX. STIMULANT USE DISORDER [21, 22]

(Slide 36, 37) Stimulant-related disorders result from abuse of a class of medications known as stimulants, which include a wide range of drugs such as amphetamines, methamphetamine and cocaine. These drugs increase energy, attention and alertness and have a wide range of effects on the body, such as increased respiration and heart rate. The euphoria that follows the use of stimulants (especially cocaine and methamphetamine) can quickly lead to dependence and addiction. High doses can lead to anxiety, depression, paranoia and psychosis. Withdrawal symptoms can be especially problematic as well, ranging from agitation and restless behavior to aggression and violence.

A. SIGNS OF STIMULANT DRUG USE

1. Euphoria
2. Hyper-vigilance
3. Anger
4. Interpersonal sensitivity
5. Auditory hallucinations
6. Paranoid thoughts
7. Repetitive movement
8. Abnormally fast or slow heartbeat
9. Dilation of the pupils
10. Elevated or lowered blood pressure
11. Sweating or chills
12. Nausea or vomiting
13. Weight loss
14. Muscle weakness

B. WITHDRAWAL SYMPTOMS FROM STIMULANT DRUGS

1. Irritability and anger
2. Depression
3. Fatigue and lethargy
4. Suicidal thoughts
5. Agitation
6. Paranoia
7. Confusion and brain fog
8. Impaired memory
9. Anhedonia
10. Insomnia and/or hypersomnia
11. Unpleasantly intense dreams
12. Powerful drug cravings

X. HOW TO HELP SOMEONE WITH A SUBSTANCE USE DISORDER

(Slide 39)

1. Be direct. Talk openly and ask questions
2. Be willing to listen. Let the person talk. Do not interrupt or interject your own experiences
3. Allow expression of feelings. Emotions and feelings are energy and have to go somewhere
4. Accept the feelings
5. Be non-judgmental
6. Be cautious about saying you “understand” what someone is going through or experiencing. That can be inadvertently inflammatory. More appropriate would be “help me understand what you’re feeling or going through”
7. Encourage the person to get help
8. Call for medical assistance if a person appears to be experiencing a panic attack
9. If a person expresses thoughts of suicide or self-harm, there will be the need for behavioral health intervention

A. CRISIS BEHAVIORS

(Slide 40-42) Addressing crisis behaviors a person exhibits is imperative to stabilizing the situation and the person. Crisis behaviors associated with anxiety disorders are similar to that of depression.

1. Suicidal ideation and behavior

   Crisis intervention is critical for a suicidal person as well as asking the questions that determine the level of suicidality to provide the person the appropriate level of services. Be direct and ask the following questions:
   - i. Are you thinking about killing yourself?
   - ii. Are you having thoughts of suicide?
   - iii. Do you have a plan to kill youself?
   - iv. If so, what is your plan?

   Saying the word(s) suicide or killing yourself will not put that idea into the person's thoughts. A person talking about suicide can be reaching out for help and serious about completing the act. The only way to determine if the person wants to kill themselves is to ask directly.[23]

2. Non-suicidal self-injury (NSSI)
   - i. A non-suicidal self-injury (NSSI) is defined as intentionally causing destruction to one's skin or body without the intent to die.[24] NSSI can be both a mental health crisis and a physical health crisis dependent on severity of injury.
   - ii. NSSI is also known as self-mutilation, self-harm or self-injury
   - iii. Common behaviors associated with NSSI:[25]
     - a. Cutting
     - b. Burning
     - c. Interfering with wound healing (picking or reopening wounds)
     - d. Punching or hitting oneself or other objects
     - e. Inserting objects into the skin
     - f. Purposely bruising or breaking one's bones
     - g. Certain forms of hair pulling
3. Intoxication or withdrawal constituting a medical emergency
4. A person in crisis may exhibit many signs of distress and may require medical attention at some point during contact. Staging medical during a crisis situation is appropriate so there is not a delay in treatment for that person. Be aware of both the behavioral health and physical health crisis that may surface.
   - i. Shallow, rapid breathing
   - ii. Grunting
   - iii. Bluish tinge from a lack of oxygen
   - iv. Nasal flaring
   - v. Confusion/disorientation
   - vi. Seizures
   - vii. Vomiting
   - viii. Hyperventilating
   - ix. Unconsciousness
   - x. Headache

B. VERBAL DE-ESCALATION LOOPS [26, 27]

(Slide 43)

1. Speak in a low, calm voice
2. Listen with empathy
3. Respond to some aspects of communication with understanding
4. Be clear but non-confrontational
5. Use active listening skills

XI. CONCLUSION

As it is of utmost importance, below is a reiteration of the role of the contact professional.

A. Contact professionals are not trained to diagnose nor should they. Familiarization and recognition of behaviors are critical in deciding an intervention response. The intervention response should be as safe and effective as possible for all parties involved.
B. Behavioral health response and/or crisis intervention should be a coordinated effort that is as safe and effective as possible for everyone involved.
C. The focus should fall in recognizing indicators and signs associated with behaviors.
D. Safety is paramount and should not be compromised situationally for a behavioral health response or crisis intervention. Crisis intervention, behavioral health intervention, and de-escalation tactics are integrated responses based on the totality of circumstances.
E. Refer to department policies and legal department mandates for behavioral health or crisis response.

XII. QUESTIONS?

XIII. REFERENCES

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XIV. CONTACT VIRTRA

If you have any questions/issues with any part of this manual, please see contact below:

VirTra Training Department

VirTra

295 E. Corporate Pl
Chandler, AZ 85225 USA

Office: 480.968.1488
Email: training@virtra.com

VirTra

295 E. Corporate Pl
Chandler, AZ 85225 USA