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VirTra - Virtual Interactive Coursework Training Academy®

MENTAL ILLNESS: A PRACTICAL APPROACH - CRISIS DE-ESCALATION

Training Manual

VirTra

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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 - Crisis De-Escalation

ESTIMATED TIME

2 hours

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. Identify and explain crisis behaviors
C. Explain tips and skills for dealing with individuals who are in crisis or exhibit crisis-like behaviors

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.

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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. CRISIS AND CRISIS INTERVENTION

A. WHAT IS A CRISIS? [1]

(Slide 11, 12) A crisis is defined as any situation in which a person's perceived ability to cope is exceeded. It is a state where an individual's typical or normal level of functioning is disrupted by an event or series of events and previously used coping mechanisms do not resolve the event.

Mental illness is not synonymous with experiencing a crisis. Anyone can experience a loss of coping skills and emotional regulation during challenging times.

A precipitating event has usually occurred within the last 24-48 hours and normal coping mechanisms have failed to resolve the situation. Stressors can be social, physical, psychological or environmental in nature.

1. Death of a family member or pet
2. Divorce/break-up
3. Loss of employment or housing
4. Crisis of faith
5. Recent arrest
6. Onset of mental illness
7. Family conflict
8. Lack of sleep
9. Abuse/neglect

The seriousness of a crisis is related to two specific things: risk and degree of decline in daily functioning.

1. Risk issues: Is the person in crisis a risk to themselves or others?
2. Level of functioning: May decline slowly or rapidly plummet. Is the person using maladaptive coping skills (substance abuse, self-injurious behavior, etc.)?

B. THE CRISIS STATE

(Slide 13) The crisis state occurs when:

1. A person is in crisis or exhibits behaviors consistent with a crisis that warrant a response or intervention. Individuals behave on an intense emotional level rather than a rational/thinking level. Emotions, not reason, are controlling the individual's actions.

2. The situation is perceived to be a threat to the emotional, psychological and physical needs of the individual.

3. A crisis can lead to a severe decline in coping skills which can cause severe "affective, behavioral and cognitive malfunctioning" as well as infurious or lethal behavior to oneself or others.[2]

C. TYPES OF CRISIS

(Slide 14)

1. **Behavioral/psychiatric**: Extremes in behaviors due to mental illness or substance abuse

2. **Medical**: Extremes in behaviors due to an underlying medical condition: low blood sugar related to diabetes, hypoxia, TBI, reduced blood flow to the brain, respiratory acidosis or central nervous system infections such as meningitis. Severe pain can also cause a person to escalate into a crisis state.

IV. CRISIS BEHAVIORS

(Slide 16-20)

A. Suicidal thoughts and behaviors
B. Homicidal thoughts and behaviors
C. Anxiety
D. Yelling
E. Lashing out
F. Irrational thoughts
G. Hostile/angry
H. Aggressive
I. Frustrated
J. Emotionally distraught
K. Despondent
L. Listless
M. Violence

Risk factors for violence[3] - Many things can contribute to a person's risk factors for violence. There are both static and dynamic factors involved. Risk factors represent associations, but they do not imply causation.

1. Static factors - Cannot be changed with (clinical) intervention
    - i. Prior history of violence
    - ii. Male
    - iii. Younger age adult
    - iv. Lower intelligence
    - v. History of head trauma or neurological impact
    - vi. Dissociative states
    - vii. History of military service
    - viii. Weapons training
    - ix. Diagnoses of mental illnesses
        - a. Although the majority of people who have a mental illness are not violent, there is a very real possibility for violent behavior
        - b. A small sub-group of individuals with schizophrenia have an increase with violent behavior.[4]
        - c. Substance use, command hallucinations, persecutory delusions and mania increase the possibility for violence.

2. Dynamic factors - Can potentially be improved with (clinical) intervention
    i. Substance abuse or dependence
    ii. Persecutory delusions
    iii. Command hallucinations
    iv. Non-adherence to treatment
    v. Impulsivity
    vi. Homicidal thoughts and behaviors
    vii. Depression
    viii. Hopelessness
    ix. Suicidality
    x. Access to weapons
    xi. Untreated psychosis

Violence reduction strategies

1. Limit stimulation, people, traffic and access to the area.
2. Involve other team members with whom the person has a positive relationship.
3. Be mindful of personal space.
4. Allow the person to vent.
5. Energy needs to go somewhere.
6. Ignore personal attacks.

N. Signs of Distress

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 the person in crisis.

1. Shallow, rapid breathing
2. Grunting
3. Bluish tinge from a lack of oxygen
4. Nasal flaring
5. Confusion/disorientation
6 Seizures
7. Vomiting
8. Hyperventilating
9. Unconscious
10. Headache

V. CRISIS INTERVENTION [1, 5]

(Slide 22) Crisis intervention is a short-term, time-limited intervention designed to re-establish a person's equilibrium and to solve an immediate problem by helping them regain control over emotional responses.

A. THE GOAL OF CRISIS INTERVENTION [1, 5]

(Slide 23)

1. To protect yourself, the person in crisis, and others in as safe a manner as possible for everyone involved.
2. Stabilize the person to prevent the crisis from escalating to an emergency.
3. Engage the person with services designed to address the issues that precipitated the crisis.

B. THE ROLE OF LAW ENFORCEMENT

(Slide 24) De-escalation tactics and effective communication techniques have been used in successfully in law enforcement for many years. Officers are great at talking to people. Over time, crisis negotiation and crisis intervention teams developed.

The Memphis Model of Crisis Intervention developed in conjunction with the National Alliance on Mental Illness (NAMI), provided training to police officers who could respond to the needs of a person in crisis or other behavioral health challenge, with the goal of diffusing incidents while ensuring the safety of everyone involved.[7]

One important consideration for crisis intervention is to put aside the "normal" law enforcement response to rush in and fix the problem as quickly as possible. This can unintentionally escalate the situation.

For law enforcement, use of force, crisis/behavioral intervention, and de-escalation are branches from the same tree. Tactical considerations are part of the de-escalation and intervention process.

The goal of crisis intervention is safety for everyone involved: contact personnel, individuals in crisis, the public, etc. One of the greatest challenges in crisis intervention and de-escalation is knowing your own triggers as well as what makes you afraid and drives your own decision-making process. Fear, ego, and taking things personally can unintentionally escalate the situation and make it unsafe.

C. SUICIDE BY COP [8, 9, 10]

(Slide 25-27) Suicide by cop (SBC) is when an individual is actively suicidal and engages in life threatening or criminal behavior directed at police to elicit use of lethal force. Response to SBC calls can be harrowing and difficult. There are two victims of a SBC incident: the suicidal subject and the officer.

Factors that influence SBC

1. Critical family issues
2. Suicidal ideation
3. Past suicide attempts
4. Acute crisis
5. History of mental illness
6. Substance abuse
7. IPV/domestic violence incident

Statistics about SBC

1. 95% were male
2. Mean age of 35 years
3. 41% were Caucasian, 26% Hispanic and 16% African American
4. 37% were single
5. 29% had children; 18% of these were experiencing issues related to the child(ren)
6. 54% were unemployed
7. 29% did not have housing
8. 62% had confirmed or probable mental health history
9. 80% were armed; 60% of these possessed a firearm (86% loaded, 7% unloaded, 4% inoperable). 48% of those with a loaded firearm fired the weapon. 26% possessed knives
10. 19% feigned or simulated weapon possession; 46% did so by reaching or placing their hand in their waistband
11. 87% of individuals made suicidal communications prior and/or during the incident
12. 36% were under the influence of alcohol

13. Of the 5% of SBC incidents involving females:
    i. Mean age of 40 years
    ii. 50% Caucasian, 25% Hispanic
    iii. 42% single
    iv. 50% had children
    v. 100% armed with dangerous weapons
    vi. 50% had a firearm (33% loaded) and 50% had a knife
    vii. 100% had confirmed or probable mental health history; 67% suffered from depression or other mood disorders

Typology of SBC

1. Direct confrontation: Individual plans attacks ahead of time
    i. Kamikaze attack: Use of deadly force on police with no immediate provocation.
    ii. Controlled attack: Confrontation where individual escalates situation to use of lethal force.
    iii. Manipulated confrontation: Orchestrated situation for police investigatory response.
    iv. Dangerous confrontation: Deliberately orchestrates a serious crime with a higher level of danger.
2. Disturbed intervention
    i. Suicide intervention: Suicide attempt that appears ambivalent but was not a tactic to elicit police response. However, attempts at prevention are rejected or the police provide an alternative route.
    ii. Disturbed domestic: Domestic incident where an individual chooses death over arrest.
    iii. Disturbed person: A person under the influence of alcohol or drugs or mentally ill is acting in a dangerous manner.
3. Criminal intervention
    i. Major crime: Unwillingness to go to jail, person may be on parole or probation.
    ii. Minor crime: Individual resists police intervention in a minor crime or incident and the situation escalates.

Integrated response to SBC

1. Assess the situation and take the call seriously
2. Secure the scene and assess safety threats for everyone involved
3. Obtain background information on the individual if possible
4. Evaluate suicide risk
    i. Suicide intent
    ii. Suicidal plan
    iii. Suicidal means in terms of availability and lethality
5. Establish contact
    i. Establish rapport
    ii. Use crisis intervention and active listening skills
6. Determine the main problem
7. Talk the subject down
    i. Provide reassurance
    ii. Comply with reasonable requests
    iii. Offer alternative, realistic optimism
    iv. Avoid being baited and dropping your guard
    v. Consider non-lethal containment
    vi. Consider limited walk away containment
    vii. Employ appropriate follow-up after situation has been resolved

VI. DE-ESCALATION

A. WHAT IS DE-ESCALATION?

(Slide 29) De-escalation is a set of techniques and interventions that can help a person in crisis regain control over emotional reactions as well as reduce violent or disruptive behavior. De-escalation can reduce the emotional intensity of a situation.

B. WHY DE-ESCALATION?

(Slide 30)

1. De-escalation can potentially decrease the intensity, scope and magnitude of a conflict or violent situation.
2. De-escalation can potentially reduce violent behavior. Training in de-escalation gives you effective skills that can help manage crisis behaviors safely and reduce liability, if the person can be de-escalated.
3. De-escalation relies on specific communication skills and the ability to assess the potential impact of a situation.[11]

C. SEVEN STAGES OF BEHAVIORAL DE-ESCALATION [12]

(Slide 31)

1. Calm -- person is calm and cooperative
2. Trigger -- person experiences a conflict event and starts to escalate
3. Agitation -- person is unfocused and upset
4. Acceleration -- person focuses on the conflict
5. Peak -- person is out of control and exhibits severe behaviors
6. De-escalation -- severity of peak behaviors subside
7. Recovery-- Willingness to engage and participate in activities

D. SIGNS OF AN ESCALATING CONFLICT AND THREAT CUES

(Slide 32)

1. Clenching fist, tightening of jaw
2. Sudden change in body language or tone
3. Person starts pacing or fidgeting
4. Posturing-- chest protruding out more and arms away from body
5. Rapid breathing
6. Visible pulse in carotid artery

Be mindful that these signs may also indicate an adrenaline spike and a severe increase in energy without the conflict behavior that follows. After all, energy has to go somewhere. However, non-verbal communication makes up for 55% (as high as 93% in some studies) or greater of all communication, so be attentive.[13]

E. BEHAVIORAL CHANGE

Interventions must be implemented to affect behavioral change when engaging with a person to de-escalate them. Building rapport with a person is critical to de-escalation. The Behavioral Change Stairway encompasses the following: Empathy, Rapport, and Influence to develop a relationship to affect behavioral change. The model is underpinned by the critical communication skill of active listening. You can't have one without the other. The model works together to elicit and influence behavioral change.

F. CRISIS COMMUNICATION AND DE-ESCALATION TECHNIQUES [14]

(Slide 33, 34) Communication is more than just words. Communication is a blend of what we say, how we say it and the accompanying body language with what we say.[15]

1. Kinesics: Body movements (non-verbal communication)
    - i. Facial expression
    - ii. Head movement
    - iii. Eye contact
    - iv. Posture
2. Proxemics: Personal space
3. Haptics: Communication through touch
4. Paraverbal communication
    - i. Tone
    - ii. Volume
    - iii. Cadence
5. Active listening
    - i. A way of listening and responding to another person that improves mutual understanding.
    - ii. A way of paying attention to other people that can make them feel like you are hearing them.
        - a. We listen at 125-250 WPM and think at 1000-3000 WPM
        - b. 75% of the time we are distracted, preoccupied or forgetful
        - c. 20% of the time, we remember what we hear
    - iii. Active listening skills
        - a. Emotional labeling: Labeling the emotion or identifying the feeling.
            - "You sound..."
            - "You seem..."
            - "I hear..."
        - b. Mirroring: Repeating the last few of the person's words to capture the gist of his or her feelings.
        - c. Paraphrasing: Putting the meaning of others' statements into your own words.
        - d. Effective pauses: Silence
            - Immediately before or after saying something meaningful.
            - Helps focus thought and interaction.
            - Helps show the subject that conversation is a turn-taking process.
            - Can be an appropriate response to anger.
6. Minimal encouragers
    - i. "Uh-huh," "yes," "no," "hmmm"
    - ii. Best used when the person is talking through an extended thought or for extended period of time.
7. Verbal de-escalation loop interventions
    - i. Speak in a low, calm voice
    - ii. Listen with empathy
    - iii. Respond to some aspect of communication with understanding.
    - iv. Be clear, but non-confrontational

v. Use active listening skills

8. "I" messages
   i. Used to confront the subject about a behavior that is counterproductive, without being accusatory.
   ii. "When you....I feel....because...."
   iii. "When you yell at me, I feel frustrated because it stops me from listening to you."
9. Open-ended questions and statements
   i. Questions/statements that require more than a "yes" or "no" answer
   ii. How, what, when
      a. "What happened today?"
      b. "How would you like this to work out?"
      c. "Tell me more about....."
      d. "Give me an example of...."
   iii. Conveys a sincere interest in gaining understanding
   iv. Gives freedom of response while framing the scope

VII. BARRIERS

(Slide 36, 37)

A. BARRIERS TO ACTIVE LISTENING

1. Environmental
2. Hearing impairments
3. Language barriers
4. Cultural differences
5. Personal biases
6. Interruptions from others
7. Multi-tasking
8. Ego
9. Judgment
10. Automatic talking
11. Thinking about what you are going to say before the other person finishes speaking
12. Lack of interest

B. BARRIERS TO DE-ESCALATION

1. You cannot de-escalate anyone or diffuse every situation with de-escalation interventions.
2. If a person cannot hear you or chooses not to listen, you cannot de-escalate them.
3. De-escalation barriers:
   i. Psychosis
   ii. Delirium
   iii. Substance use
   iv. Hearing impairment
   v. Environmental
   vi. Unwilling to listen or engage
4. Remember that not every person or situation can be handled from the standpoint of de-escalation or crisis intervention. Some individuals have underlying motivation for their behavior and sometimes that motivation is violence towards law enforcement or other contact professionals

VII. OTHER USEFUL TOOLS AND INFORMATION

(Slide 39)

A. Be empathetic
B. Be non-judgmental
C. Be mindful of personal space. This can be challenging in law enforcement as we have to balance it with officer safety
D. Be non-threatening
E. Do not overreact. In fact, don't react, respond appropriately.
F. Allow the person to express their feelings (if safe to do so). Feelings and emotions are energy. If the person is screaming, yelling, pacing, etc., energy is being expended. If no one is in danger, let them express that energy.
G. Do not engage in a power struggle
H. Allow silence for reflection
I. Allow the person time to process information and make decisions. Reacting from an emotional standpoint can impair the decision-making process. Give the person time if safe to do so.

IX. 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.

X. QUESTIONS?

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