V-VICTA®

VirTra - Virtual Interactive Coursework Training Academy®

MENTAL ILLNESS: A PRACTICAL APPROACH - DEPRESSION

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 - Depression

ESTIMATED TIME

1 hour

PERFORMANCE OBJECTIVE

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 depression
C. Demonstrate skills for dealing with individuals who have depression

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. Misery Mountain
B. Office Anxiety
C. Party Pooper

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

III. DEPRESSION AND DEPRESSIVE DISORDERS

A. MAJOR DEPRESSIVE DISORDER

B. PERIPARTUM DEPRESSION

C. SEASONAL DEPRESSION

D. OTHER DEPRESSIVE DISORDERS

E. BIPOLAR DISORDER AND TRAUMA DISORDERS

IV. CAUSES OF DEPRESSION

V. SIGNS, SYMPTOMS, BEHAVIORS

VI. HELPING SOMEONE WITH DEPRESSION

VII. VERBAL DE-ESCALATION LOOP INTERVENTIONS

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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?

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

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?

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. VIDEO - DEPRESSION AND ANXIETY 1

Play the “Depression and Anxiety 1” 14 minute video from the simulator. Click on the V-VICTA icon > Content > Manuals > V-VICTA > Mental Illness > Videos

IV. DEPRESSION AND DEPRESSIVE DISORDERS

Depressive disorders can cause symptoms that range in severity that affect a person’s ability to function at home, work, and throughout everyday life. 6.9% of adults in the U.S.—16 million—had at least one major depressive episode in the past year.[1] Depression can be caused by many different things or by an imbalance in brain chemistry. People can feel depressed or sad which doesn’t mean they have a depressive disorder. Certain criteria must be met to have this diagnosis and the symptoms must cause significant distress in functioning. Once a person experiences depression, he may be prone to additional episodes.[1] Depression severity ranges from mild, moderate, to severe and someone with depression may also exhibit psychotic features. Depression can also co-occur with anxiety or substance use.[2]

A. MAJOR DEPRESSIVE DISORDER [2, 3]

At least two weeks of a depressed mood most of the day with five of the following:

1. Decreased appetite or loss of weight
2. Decreased concentration
3. Decreased interest in pleasurable activities
4. Dysphoric mood - sad, anxious, irritable
5. Fatigue or decreased energy
6. Guilt or excessive self-blame
7. Psychomotor retardation or agitation
8. Sleep disturbances
9. Suicidal ideation or suicide attempt

B. PERIPARTUM DEPRESSION [2, 3]

Peripartum depression (previously postpartum depression) occurs after childbirth. Associated factors are hormonal, physical, and emotional changes as well as increased responsibilities. The feelings must last for more than two weeks and can be a sign of this disorder. Symptoms may also be present during pregnancy.

C. SEASONAL DEPRESSION[2, 3]

Seasonal depression is a component of a depressive disorder that manifests during fall and winter months when there is less sunlight.

D. OTHER DEPRESSIVE DISORDERS[2]

There are other depressive disorders such as persistent depressive disorder (depression for over two years), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, and unspecified depressive disorder. The variations occur based on the diagnostic criteria.

E. BIPOLAR DISORDER AND TRAUMA DISORDERS[2, 3]

Depression and suicidality can be present in both bipolar disorder and trauma disorders. However, from a contact professional standpoint, again, the diagnosis is not the focus. Stabilizing the situation safely is the goal.

V. CAUSES OF DEPRESSION[3, 4]

Rarely is there a specific and single cause for depression. Myriad factors contribute to depression that encompass physical, emotional, and psychological components. Many times, depression can surface as a result of a loss of control or powerlessness over a situation. Many of the situations below can contribute to crisis behaviors as well. Some causes of depression are:

1. Death (or loss) of a family member, friend or partner (grief)
    i. The death of a loved one is a difficult experience. Sadness is a normal part of the grief cycle. Sadness and depression are not the same thing, but they are similar in nature and can share some of the same symptoms.
    ii. One major difference between sadness from grief and depression is what while grieving people do not lose self-esteem or self-worth. Depression can manifest later if stages of grief are not processed.
2. Stress
3. Loss of a job
4. Financial difficulties
5. Divorce/break up
6. Living in constant conflict or an unstable environment
7. Exposure to trauma or childhood difficulties (physical, emotional or sexual abuse)
8. Previous depressive episodes
9. Medical conditions that contribute to depression:
    i. Parkinson's Disease
    ii. Huntington's Disease
    iii. Lupus
    iv. Thyroid disease
    v. Stroke
    vi. Traumatic brain injury
10. Medication or drug side effects
    i. Taking certain medications can cause depression as a side effect. Stopping medications or dose changes may also contribute to depression.
    ii. The introduction of a new prescription to manage mental illness can have a depression component until the person adapts to the changes in the brain.

11. Chemical imbalances in the neurotransmitters of the brain
    i. Anti-depressant drugs are designed to counteract this issue.
    ii. Most drugs target the neurotransmitter serotonin, while some target norepinephrine.
12. Intoxication or withdrawal from medication or alcohol
13. Long-term disability
14. Lack of sunlight

VI. SYMPTOMS OF DEPRESSION[2, 4]

Depression can manifest in many ways. If we asked people to describe how they see depression we commonly hear "sad, crying, quiet, or isolated." One thing to keep in mind is that many people who have depression appear unmotivated or what would be described as lazy. Many people who are depressed do not have the energy to interact in their personal relationships or at work. That "laziness" many times is a depressive symptom and goes unrecognized. Be cognizant that people who are depressed may not show any symptoms and keep up an outward appearance of normalcy as well.

Compared to many mental illnesses, depression is observed and treated by primary care, more so than in a mental health setting and individuals are not sent for evaluation or treatment unless there are complicated risks (suicidal ideation or comorbidity for substance use). Many individuals are not treated by psychiatry for medication management or treated by a psychologist.[5] [6]

Other symptoms of depression are:

1. Persistent sad, anxious or "empty" mood
2. Feelings of hopelessness or pessimism
3. Irritability (especially in children)[7]
4. Feelings of guilt, worthlessness or helplessness
5. Loss of interest or pleasure in hobbies and activities
6. Decreased energy or fatigue
7. Moving or talking more slowly
8. Feeling restless or having trouble sitting still
9. Difficulty concentrating, remembering or making decisions
10. Difficulty sleeping, early-morning awakening or oversleeping
11. Appetite and/or weight changes
12. Thoughts of death or suicide, or suicide attempts
13. Irregular menstruation
14. Use of alcohol/drugs to self-medicate
15. Negative cognitions
16. Aches or pains, headaches, cramps or digestive problems without a clear physical cause and/or do not ease with treatment
17. Rarer is depressive disorder with psychotic features (delusions/hallucinations) or catatonia (a neuropsychiatric condition that affects both behavior and motor function and results in unresponsiveness in someone who otherwise appears to be awake
18. Men may experience depression with externalized symptoms of anger, aggression, risk taking behavior and substance abuse more so than women.

VII. HELPING SOMEONE WITH DEPRESSION

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. Even though a person may not be suicidal, there may still be a need for behavioral health intervention.

VIII. VERBAL DE-ESCALATION LOOP INTERVENTIONS[13, 14]

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

IX. CRISIS BEHAVIORS

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.

A. 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:

1. Are you thinking about killing yourself?
2. Are you having thoughts of suicide?
3. Do you have a plan to kill yourself?
4. If so, what is the plan?

Saying the word(s) suicide or killing yourself will not put that idea into a 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.[10]

B. NON-SUICIDAL SELF INJURY

A non-suicidal self injury (NSSI) is defined as intentionally causing destruction to one’s skin or body without the intent to die. NSSI can be both a mental health crisis and a physical health crisis dependent on severity of injury. NSSI is also known as self-mutilation, self-harm or self-injury.

Common behaviors associated with NSSI:[11] [12]

1. Cutting
2. Burning
3. Interfering with wound healing (picking or reopening wounds)

4. Punching or hitting oneself or other objects
5. Inserting objects into the skin
6. Purposely bruising or breaking one's bones
7. Certain forms of hair pulling

X. 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.
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E. Refer to department policies and legal department mandates for behavioral health or crisis response.

XI. QUESTIONS?

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