V-VICTA®

VirTra - Virtual Interactive Coursework Training Academy®

MENTAL ILLNESS: A PRACTICAL APPROACH - SCHIZOPHRENIA & MOOD DISORDERS

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 - Schizophrenia & Mood Disorders

ESTIMATED TIME

1 hour

PERFORMANCE OBJECTIVE

(Slide 3) At the end 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 schizophrenia, psychosis, and mood disorders
C. Demonstrate skills for dealing with individuals who have schizophrenia, psychosis, and mood 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. Government Spy Games
B. Party Pooper
C. On the Case
D. Misery Mountain

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II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS

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B. MENTAL ILLNESS

C. WHO CAN DIAGNOSE?

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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

III. SCHIZOPHRENIA VIDEOS

Play the "Schizoaffective"(17 minutes) and "PTSD and Hallucinations" (7 minutes) videos from the simulator. Click on the V-VICTA icon > Content > Manuals > V-VICTA > Mental Illness > Videos

IV. SCHIZOPHRENIA SPECTRUM

(Slide 11, 12) Schizophrenia is a serious mental illness that affects about 1% of the national population. Schizophrenia interferes with a person's ability to think clearly, make decisions, manage emotions and relate to others. The severity of unmanaged schizophrenia can be extremely debilitating and disabling.[1]

Age of onset varies for schizophrenia, but rarely it is diagnosed under the age of 12 or over the age of 40. In men, the average age of onset is late teens to early 20's, and in women late 20's to early 30's.[1]

Schizophrenia is often associated with violent behavior. This is especially purported by the media.[2] While there is a component of violent behavior associated with schizophrenia in a small sub-group, the proportion of violent crime falls consistently below 10%, although there is a marked increase in violent behavior with substance use or stopping prescription medication. Overall, however, persons with schizophrenia (and any mental illness) are more likely to become victims of a crime. Specific to schizophrenia, persons are 14 times more likely to be victimized compared to being arrested.[3] Schizophrenia is one of the top 15 leading causes of disabilities worldwide.

The schizophrenia spectrum includes delusional disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia schizoaffective disorder, substance/medication-induced psychotic disorder, psychotic disorder due to another medical condition, and catatonia. Schizotypal personality disorder also has components from the schizophrenia spectrum.[4]

Symptoms of schizophrenia (and other psychosis) fall into three categories: positive, negative and cognitive.[1]

A. POSITIVE SYMPTOMS

(Slide 13, 14) Positive symptoms manifest as psychotic behaviors.

1. Hallucinations[5]

   Hallucinations are false perceptions and experiences absent certain stimuli. About 70% of people with schizophrenia experience hallucinations. Having hallucinations does not mean a person has schizophrenia, as they are a symptom of other disorders. Hallucinations manifest as follows:

   i. Auditory: Hearing voices, whispering or murmuring. The voices may be angry or demanding.
   ii. Visual: Seeing people, objects, animals and/or lights that are not there. Can affect distance perception. One of the more distressing components can be seeing loved ones or other persons who have passed away.
   iii. Olfactory: Smelling or tasting things that are not there. This can be problematic if an individual stops eating thinking there is poison in their food or drink.
   iv. Tactile: Movements or sensations on the body that are not there.

2. Delusions[5]

   Delusions are false beliefs that conflict with reality. Delusions are common with schizophrenia. There are different types of delusions:

i. Persecutory: Believing a person, group of people or organization is out to get them or wanting to cause harm. These delusions persist even with evidence to the contrary.
ii. Erotomania: The individual believes a person (primarily a celebrity or powerful person) is in love with them despite a lack of evidence.
iii. Somatic: An individual believes an illness is affecting them despite contrary evidence.
iv. Grandiose: An individual believes they have superior abilities and qualities (fame, talent) without any evidence to support that.

3. Thought disorders
   i. Disorganized thinking: Affects the ability to process and connect thoughts and ideas, rendering them fragmented. Speech patterns may show repetition, rapid speech to the point of incoherence, and the invention and use of new words.
   ii. Lack of insight or awareness (anosognosia). It is easy to think about people who have schizophrenia or other mental illnesses as rejecting their diagnosis or refusing to get help. Anosognosia has Greek roots and means "to not know a disease." People with schizophrenia may not have the insight to understand they have a mental illness or they may not perceive their condition accurately. This self-awareness is fluid and can change over time.
4, Movement disorders
   i. Tics, tremors, rigidity, slow movement or inability to move. Some of the movements can be side effects of medication as well.

B. NEGATIVE SYMPTOMS

(Slide 15) Negative symptoms manifest as disruptions to normal emotions and behaviors.

1. Flat effect (reduced expression of voice tone and facial expressions)
2. Reduced feelings of pleasure in everyday life
3. Difficulty beginning and sustaining activities
4. Reduced speaking

C. COGNITIVE SYMPTOMS

(Slide 16) Cognitive symptoms manifest in changes in thinking and memory.

1. Difficulty focusing or paying attention
2. Problems with working memory
3. Problems with understanding information and making decisions

D. CAUSES OF SCHIZOPHRENIA[7]

(Slide 17) Causes of schizophrenia are complex in nature. The majority of research leans toward various genetic components and a family history increases the chances. Other factors are:

1. Environment
2. Social stressors
3. Infection or virus exposure during pregnancy
4. Birth complications
5. Brain chemistry
6. Substance use
   Substance use increases chances for psychotic episodes. A recent study showed that smoking marijuana can lead to early onset and manifestation of schizophrenia or psychosis, although the

direct connection is unclear. However, the earlier and more frequent the use, the greater the risk appears to be.[8] [9]

V. PSYCHOSIS

(Slide 19, 20) Psychosis describes a condition where an individual has lost touch with reality, usually aligned with severe disturbances in behavior, cognitive processing and emotional regulation. The disturbance in perception makes it challenging for an individual to determine what is real and what is not. Psychosis can occur as a symptom of a mental illness or a physical health condition. Around 100,000 young people experience it yearly and three out of 100 people will experience a psychotic episode in their life.[10]

1. Individuals with schizophrenia experience psychosis, but not everyone who has psychosis is schizophrenic.
2. There are usually early warning signs for psychosis in behavioral changes.
3. Treatment of psychosis is more successful if it begins closer to the onset. The length of treatment between the beginning of psychosis to when treatment begins is called “duration of untreated psychosis.” This is the critical factor in more effective treatment and greater quality of life.
4. Many people who receive early treatment never have another psychotic episode.

A. CAUSES OF PSYCHOSIS[4, 10]

(Slide 21, 22)

1. Mental illness: Psychosis is a symptom of a certain mental illness, primarily schizophrenia and bipolar disorder. It is also a symptom of schizoaffective disorder (which is a mental illness with components of schizophrenia) and mood disorders. Psychosis is also a feature of depression.

2. Substance induced psychosis. The drug categories classified to cause psychosis are:
    - i. Alcohol
    - ii. Cannabis
    - iii. Phencyclidine (PCP)
    - iv. Other hallucinogens
    - v. Inhalants
    - vi. Sedatives, hypnotics or anxiolytics
    - vii. Amphetamines (or other stimulants)
    - viii. Cocaine
    - ix. Other or unknown substances
3. Psychotic disorder due to another medical condition. Some of the medical conditions that cause psychosis are:
    - i. Brain tumors
    - ii. Traumatic brain injury
    - iii. Epilepsy
    - iv. Autoimmune disorders
    - v. Thyroid disease
    - vi. Huntington’s disease
    - vii. Central nervous system infections
    - viii. Cerebrovascular disease
    - ix. Auditory or visual nerve damage
    - x. Multiple sclerosis
    - xi. Stroke

xii. Migraine

B. WARNING SIGNS OF EARLY FIRST EPISODE PSYCHOSIS (FEP)[11]

(Slide 23, 24) FEP is usually a gradual increase in symptoms or decrease in healthy behaviors. Psychosis rarely has an onset without warning signs. Usually, the warning signs are a combination of factors and not one thing in particular.

1. Hearing, seeing, tasting or believing things that others don't
2. Persistent unusual thoughts or beliefs that can't be set aside regardless of what others believe
3. Strong and inappropriate emotions or no emotions at all
4. Withdrawing from family or friends
5. A sudden decline in self-care
6. Trouble thinking clearly or concentrating

Some signs manifest even earlier prior to the slide into psychosis and can precede the event for an undetermined amount of time. Distinguishing between normal teenage and young adult behavior and warning signs can be difficult as some of the signs mirror common behaviors:

1. A worrisome job performance
2. Trouble thinking clearly or concentrating
3. Suspiciousness or uneasiness with others
4. A decline in self-care or personal hygiene
5. Spending a lot more time alone than usual
6. Strong, inappropriate emotions or having no feelings at all

C. TOOLS FOR DEALING WITH PSYCHOSIS

(Slide 25, 26) Although individuals with psychosis do not normally exhibit violent behavior towards others, there is a small sub-group with psychotic symptoms of perceived threat and internal control override where there is an increase in violence. Another increase in violent behavior is tied to substance use disorder or personality disorders.[12]

Suicidality and self-harm are more common in psychosis than violent behavior, contrary to what the media portrays. Overall, 4% of violence in the United States is associated with individuals who have been diagnosed with a mental illness. Here are some strategies that can help in dealing with someone with psychosis.

1. Acknowledge what the individual has stated. For example, if the individual states they have bugs crawling inside of them, respond with "you say you have bugs crawling inside of you." This is not confrontational and validates the experience without reinforcing the thoughts.
2. Do not validate delusions or hallucinations, but do not argue about them or dismiss them either. Again, validate the experience: "I can see that this upsets you" or "I can see that you are scared," This is dependent on the emotion you see from the individual.
3. Use empathy. "I imagine I would feel scared if I thought I had bugs crawling inside of me."
4. Redirect toward previous coping strategies. "When you have felt scared in the past, what has helped?"
5. Be non-judgmental
6. Speak calmly and slowly
7. Don't interrupt or insert your own experiences
8. In acute psychosis, don't assume the individual cannot hear you or process the environment. They may be slow or limited.
9. The individual may need behavioral health intervention or medical intervention dependent on the severity of the episode and particular symptoms. Be prepared to assist the individual in those areas dependent on needs.

VI. BIPOLAR AND MOOD DISORDERS[4, 13]

(Slide 28) Bipolar disorder (manic-depressive disorder) is a chronic mental illness that causes dramatic shifts in an individual's mood, energy level and ability to think clearly. The mood dynamics of bipolar disorder range from extremely elevated, euphoric and elated (manic) to hopeless and sad (depressive). There is an additional stage of mania called hypomania that is not as severe as full-blown mania. There are different types of bipolar disorder: bipolar I, bipolar II, cyclothymia, and unspecified bipolar disorder. There are other sections related to substance or medication induced bipolar or due to another medical condition as well.

Facts about bipolar disorder:[13] [14] [15]

1. The average age of onset is 25 years old
2. Bipolar disorder can occur in teens and on rare occasions in childhood
3. Bipolar disorder affects men and women equally
4. 2.6% of the population is diagnosed with bipolar disorder

A. TYPES OF BIPOLAR DISORDER[4, 13]

(Slide 29)

1. Bipolar I
   Manic episodes that last at least 7 days, or by manic symptoms that are so severe that the person needs immediate medical care. Usually, depressive episodes occur as well, typically lasting at least 2 weeks. Episodes of depression with mixed features (having depression and manic symptoms at the same time) are also possible.[4, 13]

2. Bipolar II
   A pattern of depressive episodes and hypomanic episodes, but not the full-blown manic episodes described above.

3. Cyclothymia
   Numerous periods of hypomanic symptoms as well as numerous periods of depressive symptoms lasting for at least 2 years (1 year in children and adolescents). However, the symptoms do not meet the diagnostic requirements for a hypomanic episode and a depressive episode.

4. Unspecified bipolar disorder
   Bipolar disorder symptoms that do not match the three categories listed above.

B. SYMPTOMS OF BIPOLAR DISORDER[4, 13]

(Slide 30-33) Mania symptoms

1. Feeling very "up," "high" or elated
2. Highly energetic
3. Increased activity levels
4. Feeling "jumpy" or "wired"
5. Difficulty sleeping
6. Speaking extremely fast about a lot of different things
7. Being irritable or agitated
8. Racing thoughts
9. Thinking they can do many things at once
10. Risky and reckless behaviors (reckless sex or extreme spending of money)

Individuals may enjoy aspects of the mania phase, however the mania does not level off or regulate and continues to increase to a level that is not manageable. Mania behavior can become unpredictable and reckless with the potential for psychosis.

Hypomanic symptoms do not have the severity of full-blown mania and do not include the psychosis component. Individuals with hypomania may function better in social situations or at work. The mood swings that accompany hypomania are what can particularize the bipolar aspect versus someone who is feeling great and very productive.

Contact professionals may encounter people with bipolar disorder in a manic state as there can be more aggressive behavior associated with it along with reckless behaviors that may bring attention to the individual. Psychosis can surface in both the manic and depressive phase as well.

Depressive symptoms

1. Feeling slowed down or restless
2. Trouble concentrating or making decisions
3. Trouble falling asleep, waking up too early or sleeping too much
4. Talking very slowly, feeling lke there is nothing to say, or forgetting a lot
5. Lack of interest in almost all activities
6. Unable to do even simple things
7. Feeling hopeless or worthless, or thinking about death or suicide

Bipolar disorder has other features associated with it: anxious distress, mixed features, rapid cycling, melancholic features, atypical features, psychosis, catatonia, as well as peripartum or seasonal onset.

C. CAUSES OF BIPOLAR DISORDER[13]

(Slide 34) There is no specific cause for bipolar disorder, but genetics play a part. Stress can trigger episodes of bipolar disorder. Brain chemistry and brain structure are tied to bipolar disorder as well.

D. CHALLENGES WITH BIPOLAR DISORDER

(Slide 35) Bipolar disorder can be difficult to diagnose as it shares features with other mental illnesses. Individuals may be diagnosed with schizophrenia, depression, or borderline personality disorder. Misdiagnosis of bipolar disorder and treatment with incorrect medications can worsen symptoms and/or trigger manic episodes.

Contact professionals will most likely interact with an individual with bipolar disorder in the manic phase, severe depression/suicidality, or psychosis. The same skill sets apply as discussed previously with psychosis and elevated behavior. Suicidality will require a different crisis intervention response and depression without suicidality will have a different response as well.

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 your 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.[17]

VII. HOW TO TALK ABOUT SUICIDE

(Slide 37, 38)

1. Be direct. Talk openly and ask questions.
2. Be willing to listen.
3. Allow expression of feelings. Emotions and feelings are energy and have to go somewhere.
4. Accept the feelings.
5. Be non-judgmental
6. Don't debate on whether suicide is right or wrong, or whether feelings are good or bad
7. Don't lecture on the value of life
8. Don't call them a coward or weak
9. Be cautious about saying you "understand." That can be inadvertently inflammatory. More appropriate would be "help me understand what you're feeling or going through."
10. Be cautious about saying "you'll feel better tomorrow," "things will change" or "think about your family and friends." Individuals considering suicide are operating from an emotional standpoint and are not thinking rationally. Certain statements can trigger additional negative thoughts. More appropriate would be "in the past, what prevented you from killing yourself or going through with it?" This helps identify personal strengths.

A. THINGS TO ASK OR SAY TO SOMEONE WHO IS THINKING OF SUICIDE

(Slide 39)

1. I'm glad you told me you're thinking about this (suicide or killing yourself)
2. I'm sad to hear you're hurting
3. What is happening that makes you want to die?
4. When do you think you will act on your thoughts or plan?
5. What can I do to help?
6. You're not alone
7. We can get through this together
8. Have you felt this way before? What helped you get through it?
9. Help is available

B. HOW TO HELP SOMEONE WITH DEPRESSION

1. Be direct. Talk openly and ask questions.
2. Be willing to listen. Let the person talk. Do not interrupt or inject 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.[18]
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

(Slide 40)
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. 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[19, 20] for behavioral health or crisis response.

X. QUESTIONS?

XI. REFERENCES

1. National Alliance on Mental Illness. Schizophrenia. Retrieved from https://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia
2. Wehring, H. J., & Carpenter, W. T. (2011). Violence and schizophrenia. Schizophrenia bulletin, 37(5), 877–878. doi:10.1093/schbul/sbr094
3. Brekke JS, Prindle C, Bae SW, Long JD. Risks for individuals with schizophrenia who are living in the community. Psychiatry Serv. 2001;52:1358–1366.
4. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.
5. Smith, K. (n.d.). Schizophrenia: Hallucinations and Delusions: Learn how to recognize the varying types of hallucinations and delusions that are among the most common symptoms of schizophrenia. Retrieved from https://www.psycom.net/schizophrenia-hallucinations-delusions/
6. National Alliance on Mental Illness. (n.d). Anosognosia. Retrieved from https://www.nami.org/Find-Support/I-am/A-Family-Member-or-Caregiver/Anosognosia
7. National Institute of Mental Health. (n.d.). Schizophrenia. Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml
8. American Friends of Tel Aviv University. (2017). Cannabis use in adolescence linked to schizophrenia: Psychoactive compound in cannabis may trigger the brain disorder, researchers say. ScienceDaily. Retrieved from www.sciencedaily.

com/releases/2017/04/170426124305.html
9. R Douglas Fields. (2017). Link Between Adolescent Pot Smoking and Psychosis Strengthens: Research presented at a Berlin psychiatric conference show teenage cannabis use hastens onset of schizophrenia in vulnerable individuals. Scientific American. Retrieved from https://www.scientificamerican.com/article/link-between-adolescent-pot-smoking-and-psychosis-strengthens/
10. National Institute of Mental Health. (n.d.) RAISE: questions and answers about psychosis. Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/raise-questions-and-answers.shtml#1
11. National Alliance on Mental Illness. (n.d). Early Psychosis and Psychosis. Retrieved from https://www.nami.org/earlypsychosis
12. Swanson JW, Borum R, Swartz MS, et al. Psychotic symptoms and disorders and the risk of violent behaviour in the community. Crim Behav Ment Health. 1996;6(4):309-329.
13. National Institute on Mental Illness. (n.d). Bipolar Disorder. Retrieved from https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml
14. National Alliance on Mental Health. (n.d.) Bipolar Disorder. Retrieved from https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder
15. National Alliance on Mental Health. (n.d). Mental Health by the Numbers. Retrieved from https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
16. Bipolar Disorder Among Adults. (n.d.). Retrieved from http://www.nimh.nih.gov/health/statistics/prevalence/bipolar-disorder-among-adults.shtml
17. National Institute on Mental Health. (n.d.) 5 Common Myths about Suicide Debunked. Retrieved from https://nami.org/Blogs/NAMI-Blog/September-2018/5-Common-Myths-About-Suicide-Debunked
18. Freedenthal, S. (2017). !0 things to say to a suicidal person. Retrieved from https://www.speakingofsuicide.com/2017/10/03/10-things-to-say
19. Weaver, C. M., Joseph, D., Dongon, S. N., Fairweather, A., & Ruzek, J. I. (2013). Enhancing services response to crisis incidents involving Veterans: A role for law enforcement and mental health collaboration. Psychological Services, 10, 66-72. doi:10.1037/a0029651
20. National Institute for Mental Health. (n.d.) Suicide Prevention. Retrieved from https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml

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