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VirTra - Virtual Interactive Coursework Training Academy®

MENTAL ILLNESS: A PRACTICAL APPROACH - NEUROCOGNITIVE 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 9/22/2022.
Certification number: 22508-2209

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TOPIC

Mental Illness: A Practical Approach - Neurocognitive Disorders

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 dementia
C. Explain best practices for dealing with people who have dementia or neurocognitive 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.

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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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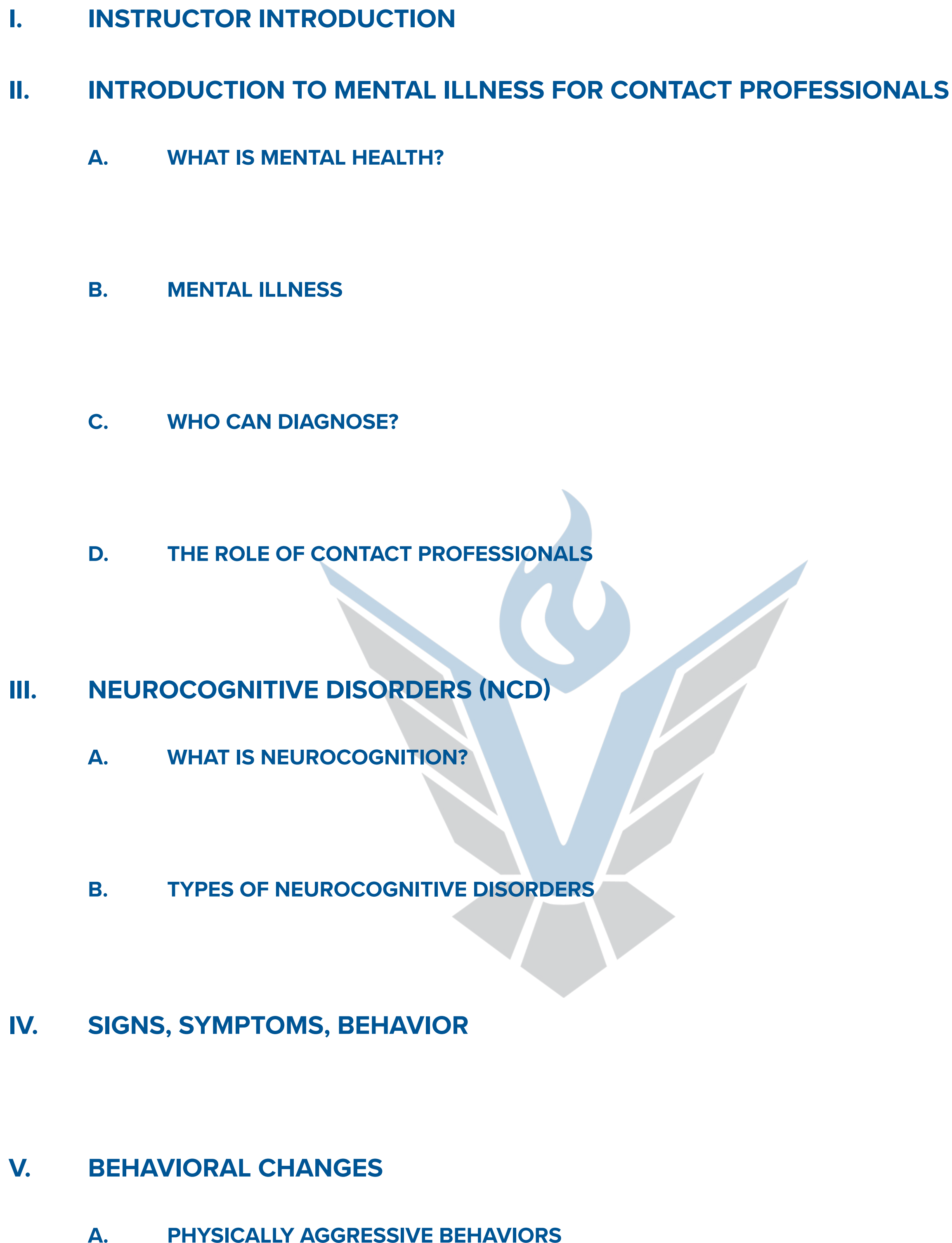

I. INSTRUCTOR INTRODUCTION

II. INTRODUCTION TO MENTAL ILLNESS FOR CONTACT PROFESSIONALS

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B. MENTAL ILLNESS

C. WHO CAN DIAGNOSE?

D. THE ROLE OF CONTACT PROFESSIONALS

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B. TYPES OF NEUROCOGNITIVE DISORDERS

IV. SIGNS, SYMPTOMS, BEHAVIOR

V. BEHAVIORAL CHANGES

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B. VERBALLY AGGRESSIVE BEHAVIORS

C. NON-AGGRESSIVE BEHAVIORS

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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.

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III. NEUROCOGNITIVE DISORDERS (NCD)

A. WHAT IS NEUROCOGNITION?

Neurocognition is defined as: of, relating to, or involving cognitive functioning and associated structures and processes of the central nervous system.[1] Neurocognitive function can be affected by medical issues and psychiatric issues. Neurocognitive disorders affect memory, thinking, reasoning, motor skills, understanding of language, ability to act within social norms, and performance of routine tasks.[2]

B. TYPES OF NEUROCOGNITIVE DISORDERS

In the past, all NCDs were classified as dementia due to similarities in decline and cognitive impairment, especially in the elderly population. NCDs are acquired and cause decline and deficit in previously attained levels of neurocognitive function. They are not developmental and are the result of an underlying brain pathology. NCD includes delirium, mild NCD and major NCD.[2]

1. Alzheimer's Disease accounts for the majority of all NCDs.
2. Major cognitive disorder is estimated to effect 1-2% of the population by age 65 and as high as 30% by age 85. Almost all dementias are major cognitive disorders.
3. Delirium is an NCD that encompasses severe confusion and rapidly changing brain function. Delirium is related to structural or metabolic brain dysfunction. Delirium is a medical emergency and requires immediate medical intervention. Signs of delirium are as follows:[3]
    - i. Disturbance of consciousness
    - ii. Cognitive and perceptual disturbances
    - iii. Sudden onset, usually over hours or days
    - iv. Symptoms may result from:
        - a. Substance use/withdrawal
        - b. Adverse medication reactions
        - c. Dehydration or malnutrition
        - d. Head trauma
        - e. Cerebral hemorrhage
        - f. Electrolyte abnormalities
        - g. Liver or kidney failure
        - h. Hypoperfusion (inadequate/reduced blood supply)
        - i. Post-operative state
    - v. NCD encompasses various etiological subtypes such as Alzheimer's Disease, Frontotemporal Lobe degeneration, Lewy Body disease, vascular disease, traumatic brain injury (TBI), substance/medication abuse, HIV infection, Prion disease, Parkinson's disease, Huntington's disease and other medical conditions.[1][4]
        - a. Not all TBI causes NCD. However, many TBI's result in major NCD.
        - b. Frontotemporal dementia (a group of disorders caused by progressive nerve cell loss in the brain's fronal lobes or temporal lobes) has consistent indicators of behavior and personality changes, including violations of social norms and criminal behavior. Some criminal behaviors associated with FTD are repetitive shoplift despite an ability to pay, attempted child molestation and hit and run.[5][6]

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IV. SIGNS, SYMPTOMS, BEHAVIOR [4, 5]

1. Memory impairment, such as difficulty remembering events
2. Difficulty concentrating, planning or problem-solving
3. Problems finishing daily tasks at home or work
4. Confusion with location or passage of time
5. Having visual or space difficulties, such as not understanding distance in driving, getting lost or misplacing items.
6. Language problems, such as word-finding problems or reduced vocabulary in speech and writing
7. Using poor judgement in decisions
8. Withdrawal from work events or social engagements
9. Changes in mood, such as depression or other behavior and personality changes
10. Wandering behaviors[8]
    - i. 94% of individuals with dementia are found within 1.5 miles of where they disappeared from
    - ii. 29% of individuals are found in brush and briar
    - iii. Gather information about previous wandering patterns if possible
11. Erratic driving behavior and breaking general road rules
12. Inappropriately dressed for the weather
13. One consideration is that a person with dementia may appear coherent at first but will soon show signs of confusion or disorientation.

V. BEHAVIORAL CHANGES

Dementia has the component of chronic and progressive decline in daily functioning that frequently includes behavioral disturbances. The spectrum of behavior covers aggressive through non-aggressive.

Some of the aggression can result from an inability to recognize and articulate needs. Reasons for aggression can be physical needs not being met (pain, feeling sick, medication side effects, hearing impairment, hallucinations or delusions, loss of inhibition and lack of awareness of behaviors), social needs not being met (loneliness, boredom, lack of stimulation, lack of trust of caregiver, hiding condition), or psychological needs not being met (frustration at inability to complete tasks, feeling ignored, depression and/or other mental health problems).

Symptoms may be managed with behavior therapies, social support, sensory stimulation, or psychomotor therapy. Other symptoms may be managed by medication if indicated.

The behavior changes can manifest as physically/verbally aggressive to physical/verbally nonaggressive.

A. PHYSICALLY AGGRESSIVE BEHAVIORS [8]

1. Physical abuse
2. Physical sexual advances
3. Self-harm
4. Physically hurting others
5. Throwing things
6. Scratching
7. Pushing
8. Biting
9. Kicking
10. Spitting

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B. VERBALLY AGGRESSIVE BEHAVIORS [8]

1, Verbal aggression/abuse
2. Cursing
3. Making strange noises
4. Yelling/screaming
5. Verbal sexual advances

C. NONAGGRESSIVE BEHAVIORS [8]

1. Physical
   - i. Repetitious mannerisms
   - ii. Inappropriate removal of clothing
   - iii. Eating inappropriate substances
   - iv. Handling things inappropriately
   - v. Hoarding
   - vi. Hiding things
   - vii. Intentional falling
   - viii. Trying to get to a different place
2. Verbal
   - i. Complaining
   - ii. Negativity
   - iii. Repetitive sentences or questions
   - iv. Seeking attention or help constantly

D. MANAGING BEHAVIOR [9]

1. Identify yourself (law enforcement, fire personnel, EMS, etc.)
2. Maintain good eye contact
3. Speak slowly in a non-threatening manner
4. Be mindful of how loud you are talking. Loudness can convey anger
5. Use short, simple words and ask yes or no questions
6. Ask one question at a time and allow the individual to respond
7. Repeat your question if necessary
8. Stay calm and reduce stimuli if possible
9. Avoid restraints and containment if possible as this can increase agitation
10. Avoid confrontation and "reality checks"

VI. MYTHS [10]

A. "Memory loss is a natural part of aging" - While some memory loss is natural, dementia and Alzheimer's are diseases that cause brain cells to malfunction and die.

B. "Alzheimer's is not fatal" - Alzheimer's is fatal and has no survivors.

C. "Only older people can get Alzheimer's" - People in their 30's, 40's and 50's can get Alzheimer's or dementia.

D. "There are treatments available to stop the progression of Alzheimer's" - There is no treatment, cure or delay for Alzheimer's, although a small population who take FDA-approved drugs have a temporary delay in worsening of symptoms for 6-12 months.

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VII. BEST PRACTICES[11]

Many best practices for law enforcement and other first responders are sectioned out in dealing with dementia. There is the education component of recognizing signs, symptoms, and how to manage behaviors. This is important for all contact professionals. For first responders, there is also the aspect of conducting appropriate missing person investigations and searches to conclusion.

A. IACP recommends the following basic evaluation questions when officers encounter an individual that may be an at-risk older adult:
   1. Where are you coming from? Where are you going?
   2. What route are you taking to get there? Who are you meeting?
   3. What is your full name and address? What is your phone number?
   4. What day of the week is it? What month is it?
   5. Can you tell me what city and state we are in?
   6. What time is it right now? (Answer should be correct within one hour.)

B. If the person cannot provide the correct answers, personnel should secure the person and follow department policy in dealing with the individual. This may entail attempting to locate family from the scene, taking the individual somewhere more comfortable while the investigation continues, or taking the individual to a hospital if warranted.

C. The Alzheimer's Association has a recommended Quick Tips for First Responders that breaks down appropriate responses to dementia calls.[12]
   1. Use TALK tactics
      i. Talk it slow
      ii. Ask simple questions
      iii. Limit reality checks
      iv. Keep eye contact
   2. Remind the individual that you are there to help
   3. Address firearms safety with caregivers in the home
   4. Recognize wandering signs
      i. Blank or confused facial expression
      ii. Inappropriate attire
      iii. Unbalanced or shuffling gait
      iv. Person not aware of unsafe actions or situations
      v. Age (dementia is more likely with advanced age, but can also affect those under 65
   5. Recognize erratic behavior and attempt to positively resolve the incident
   6. Be aware of the potential for shoplifting calls
   7. Be cognizant of individuals involved in dangerous situations and disaster response
      i. Avoid physical force or restraint
      ii. Be creative rather than rely on reality
      iii. Provide one-on-one attention
      iv. Provide step-by-step instructions using simple language
      v. Try to relocate the person to a quiet place
      vi. Use distraction by giving the person a simple task
      vii. Ensure the person is watched at all times to prevent wandering

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VIII. 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.

IX. QUESTIONS?

X. REFERENCES

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XI. CONTACT VIRTRA

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

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