Using Simulation to Engage Police in Learning about Mental Illness:

The Impact of Realism on the Learning Process

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Executive Summary

Police officers are often the first responders to situations in the community involving mentally ill persons. Police contacts with individuals who have a mental illness have risen dramatically over the past few years, and police services are becoming increasingly aware of the need to provide officers with training beyond what is currently offered to new recruits in terms of mental illness and strategies for effectively engaging individuals who are presumed to have a mental illness. The objective of this study was to evaluate the impact of using simulation to educate police officers about mental illness and how to respond effectively to common critical incidents involving mentally ill persons they encounter in the community using a mixed qualitative-quantitative design which included focus groups, surveys, and use of the Opinions about Mental Illness (OMI) scale.

Four simulations were developed and provided the basis for this research study. A product of a collaborative effort between Durham Regional Police Services, Whitby Mental Health Centre, Durham College, and the University of Ontario Institute of Technology, the simulations depicting critical incidents involving mentally ill persons (suicidal behaviour, delusional thinking, experiencing a hallucination, and self harming behaviour) were developed to promote a better understanding of some of the challenges experienced by individuals with a mental illness. Each of the four simulations includes interactive video clips with response options, learning activities, detailed feedback provided on both the response choice and the answers selected on the learning activities, and a library containing additional learning resources.

The findings of this study indicate that simulations are an effective tool for educating officers about mental illness. Police participants showed a high level of engagement and appreciation for the learning objects. They found the simulations to be realistic and easy to use and several of the participants suggested that this type of education should be mandatory for all frontline officers as well as members of the police leadership. However, rooted in a strong oral culture, the majority of the police officers did indicate a preference for face-to-face education sessions, citing the ability to dialogue, share ideas and stories, as well as seek clarification when necessary as key components of the learning process. They did see the simulations as providing a good foundation for their learning; they also believed a follow up discussion group or seminar would further add to benefits of the simulations as educational resources. This would suggest that a hybrid teaching methodology would be the most effective.

Justification and Background

Mental illness is not only a major public health concern in Canada but indeed globally. According to the World Health Organization, five of the ten disabilities worldwide are mental health disorders. First responders to emergencies are generally not mental health professionals; therefore it is imperative that first responders develop the skills necessary to be effective when interacting with mentally ill citizens. Police officers are often the first responders to situations in the community involving mentally ill persons. Police contacts with individuals who have a mental illness have risen dramatically over the past few years. The push to deinstitutionalize the mentally ill without having the required community supports, inadequate social assistance rates, increasing poverty, reduced number of hospital beds for psychiatric admissions, lack of affordable housing and increasing rates of homelessness are all contributing to this alarming community issue (Watson, Corrigan, & Ottati, 2004)**.** Police services are becoming increasingly aware of the need to provide officers with training beyond what is currently offered to new recruits in terms of mental illness and strategies for effectively engaging individuals who are presumed to have a mental illness (Adelman, 2003).

Current literature indicates that the best practice models for police response involve specialized and ongoing education for all frontline officers (Adelman, 2003). Durham Regional Police Services in partnership with the University of Ontario Institute of Technology and Whitby Mental Health Centre has provided week long education sessions for 44 officers over the past two years and has committed to educating another 25 officers in 2009. In addition, eight commonly experienced critical incidents involving citizens suspected of having a mental illness were identified. These on the job real life experiences of frontline officers provided the basis for the subsequent development of a set of four interactive simulations, supported with funds from a 2007 Inukshuk grant.

Simulations and Education

A very large and diverse literature converges on the idea that there are educational benefits to simulations and gaming technology. These benefits include: involving individuals in complex practice skills without risk, improved psychomotor skills, enhanced retention of knowledge as well as enhanced decision-making skills, interactive learning, opportunities for replay at a particular step in a sequela as well as repeated practice of a sequela, options for immediate feedback, and retention of knowledge related to procedures. Some of this literature was nicely presented in the report on the recent Summit on Educational Games sponsored by the Federation of American Scientists (2006). The following four key conclusions from the report have particular relevance to the proposed research project:

1. Attributes of simulations and games could be useful in applications in learning (contextual bridging, increased time on task, improved motivation and goal orientation, personalization of learning, feedback, cues, and partial solutions)
2. Rigorous research is required to help translate the art and technologies of simulations into teaching, learning, and assessment systems.
3. Educational institutions are slow to transform practices and organizational systems that take advantage of new technology, including gaming and simulations.
4. There is no serious evidence-based learning framework that currently exists for implementing large-scale evaluations of the outcomes of using educational simulations.

Bogost (2007) and Gee (2007) also provide good syntheses of this literature. Work in healthcare has been reviewed by Feingold, Calaluce, and Kallen (2004), while the United States National Research Council (2001, 2000) presented summaries of research covering topics in the areas of how people learn and the science and design of educational assessment. Work on cognitive taxonomies (Anderson & Krathwohl, 2001) also holds promise for informing how and why to build educational games.

A comprehensive review of literature from science education, general education, multimedia and psychology reveals many different types of studies focused on how to help students move from novices to experts or at least from novices to a more knowledgeable state (Bogost, 2007; Cacioppo, Petty & Feinstein, 1996; Cacioppo, Petty, & Kao, 1984). Referred to as "experimental and mundane realism" in the psychology literature (Aronson, Brewer & Carlsmith, 1985) and as "fidelity" in the simulation and educational literature (Welk, 2002; Fonteyn, 1998), this research considers the "look and feel" of simulations to be extremely important to students' learning and retaining knowledge and skills.

Simulation Realism and Learning

More recent work has explored relationships between simulation realism and engagement in learning (Tashiro & Dunlap, 2007) as well as the ethical issues resulting from not using frameworks for evidence-based learning to build and then implement simulations for education and training (Tashiro, 2009). This recent work extended earlier research syntheses of how and why instructional materials should be developed within a framework evidence-based learning. The United States National Research Council (2000, 2001; see also Institute of Medicine, 2003, 2005) reviewed a broad research literature and offered a streamlined list of critical issues in developing educational materials. These issues can be expressed as seven questions that set standards for any kind of instructional materials: (1) How do the instructional materials enhance predisposition to learn? (2) How do the materials provide multiple paths

for learning? (3) How does an instructional package help students overcome limitations of prior knowledge? (4) When and how do the educational materials provide practice and feedback? (5) Can the instructional materials help students develop an ability to transfer knowledge acquired by extending knowledge and skills beyond the contexts in which they were gained? (6) How will the instructional package incorporate the role of social context? (7) How and why will the instructional materials address cultural norms and student beliefs?

The vast majority of instructional materials (electronic or non-electronic) do not address all of these issues. With the proliferation of electronic educational materials we have an opportunity to examine emerging product development strategies within an ethical framework related to whether or not an electronic instructional product actually works to improve the learning outcomes for which it was designed. As a particular focus, we examined the findings of researchers who had previously hypothesized an interesting relationship between a user's learning and the level of realism in a simulation (Alessi & Trollip 2001), predicting different learning curves for simulation users who were novices, had intermediate knowledge of the simulation area, or were experts in the subject or skills area being simulated. These researchers concluded that as realism increased, the complexity of what was portrayed in the simulation or the actions required of the user would reach a point at which the simulation became too confusing or stressful for novice or even intermediate users. However, a variety of researchers have noted that the user's perception of the fidelity or realism may be different than the actual fidelity

Objective

The objective of this project was to evaluate the impact of using simulation to educate police officers about mental illness and how to respond effectively to common critical incidents involving mentally ill persons they encounter in the community. The following questions guided the research project:

1. To what extent can simulations be used as a tool to educate police officers about mental illness and how to respond effectively in interactions with mentally ill persons?
2. To what extent do simulations enhance police officers' confidence in their ability to interact effectively with mentally ill persons?
3. To what extent do police officers find simulations a) easy to use b) reflective of reality?

Methodology

This research study was a mixed methods design involving both qualitative and quantitative data collection. Pre-post-tests were conducted to determine officers' knowledge and understanding of mental illness and how to engage effectively with mentally ill persons and the Opinions about Mental Illness

(OMI) Scale was also administered in a pre-post format to determine any changes in the officers' attitudes towards mental illness. A rating scale was used to evaluate the usability of the simulation templates. In addition, focus groups provided data about police officers' perceptions of: 1) their knowledge about mental illness and how to effectively interact with mentally ill persons, 2) their level of confidence in engaging with the mentally ill, and 3) the impact, if any, the educational session (simulation, face-to-face) would have on their confidence level.

Recruitment and Participants.

Recruiting participants for the study proved to be very challenging. Several different communication strategies were implemented, including posting a message electronically on the DRPS "What's New" Information Board, emailing a formal invitation to participate to every police officer and following up with another email two weeks later; and additional emailing by individual Inspectors, Staff Sergeants and Sergeants to frontline officers reminding them of the opportunity to participate in this collaborative research project.

Officers who had attended any of the previous week long education sessions about mental illness or who had participated in the development of the simulations were not eligible to participate in the study. Recruitment continued during the actual implementation phase; some participants took the initiative to communicate with fellow officers encouraging them to also volunteer for the study.

Table 1 provides a demographic profile of the control, quasi-control/face-to-face, and simulation group. Of particular note, members of the control group were younger, had less policing experience, less additional education related to mental illness, and only 73% had on the job experience with mentally ill persons in compared to 100% in the other two groups.

Table 1

Demographic Profile of Control, Quasi-Control (Face-to-Face), and Simulation Group

Gender	Control	Face-to-Face	Simulation
M	94%	62%	71%
F	6%	38%	29%
Age			
30 & under	44%	44%	30%
31-40	51%	19%	46%
>40	5%	37%	24%
Years of Police Experience			
<5	44%	25%	29%
6-15	50%	37%	35%
>15	6%	38%	35%
On the Job Experience - Emotionally Disturbed Persons			

Yes	78%	100%	100%
No	22%		
Number of EDP Reports Filed a Year			
10 or less	83%	81%	71%
>10	17%	19%	29%
Previous Education related to Mental Illness			
Yes	22%	56%	53%
No	78%	44%	47%
Experience Outside of Work - Emotionally Disturbed Persons			
Yes	75%	75%	94%
No	25%	19%	6%
Not Sure		6%	

Materials/Measures Used

The simulations developed with funding from an Inukshuk grant provided the basis for this research study. A product of a collaborative effort between Durham Regional Police Services, Whitby Mental Health Centre, Durham College, and the University of Ontario Institute of Technology, the simulations depicting critical incidents involving mentally ill persons were developed to promote a better understanding of some of the challenges individuals with a mental illness experience and to facilitate the ability of frontline officers to respond effectively. Four simulations were selected for this research project: 1) young man exhibiting suicidal behaviour, 2) male adult demonstrating delusional thinking, 3) male adult experiencing hallucinations, and 4) young woman exhibiting self harming behaviour. Each of the simulations includes interactive video clips with response options, learning activities, detailed feedback provided on both the response choice and the answers selected on the learning activities, and a library containing additional learning resources. Individual DRPS constables and nurses from WMHC actively participated in all of the phases of the simulation development, from the initial script writing to the video shooting and designing of the learning activities.

Figure 1.

Example of main encounter screen in the simulation depicting suicidal behavior.

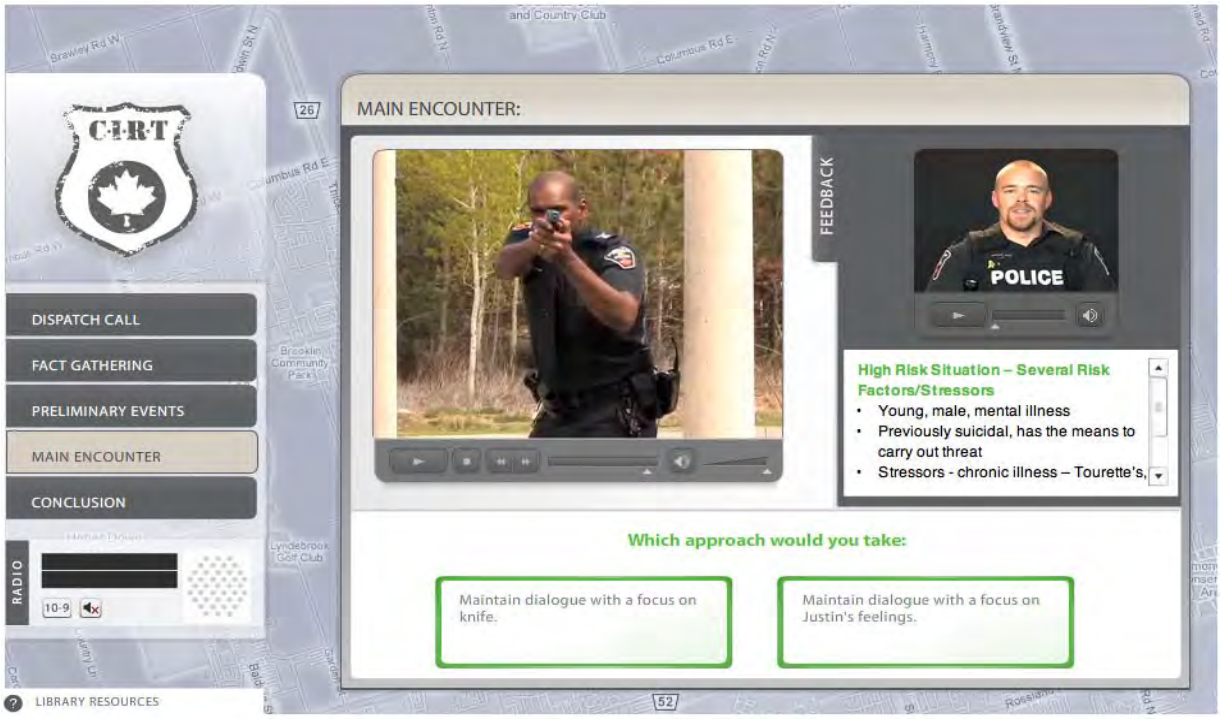

Figure 2.

Example of a fact gathering screen in the simulation exhibiting suicidal behavior.

Figure 3.

Example of a learning activity screen in the simulation exhibiting suicidal behavior.

The participants' knowledge of mental illness was assessed using a questionnaire developed by the researchers (Appendix C). There were 16 questions covering key issues related to mental illness including: identifying signs of mental illness, assessing suicide risk, and strategies for engaging with mentally ill persons. All but one of the questions was short answer format; the other question was a true/false.

The Opinions about Mental Illness Scale (Appendix D) was administered to gain an understanding of the officers' opinions and ideas about mental illness and mentally ill persons. Using a six-point Likert-type scale with response alternatives ranging from strongly disagree to strongly agree, items are organized into five factorially-derived subscales: Authoritarianism (Factor A), Unsophisticated Benevolence (Factor B), Mental Illness Ideology (Factor C), Social Restrictiveness (Factor D), Interpersonal Etiology (Factor E).

Focus groups were conducted using a question guide to gather police officers' (in all three groups) subjective perceptions (affective domain) of their knowledge about mental illness and how to effectively interact with mentally ill persons. Officers were also asked to discuss how confident they were in their ability to effectively interact with mentally ill persons and about factors that affect their confidence. Officers in both the simulation and face-to-face groups were asked following the educational session what

impact if any they believed the educational session they had just participated in would have on their confidence in future interactions with mentally ill persons. Participants in the simulation group were also asked for feedback on the simulations in terms of their ease of use and how closely the simulations reflect reality.

Procedure

Officers did not sign up to be part of a particular group (control, quasi-control/face-to-face, simulation). Dates were set according to officer availability and the group type was assigned later, with consideration given to maintaining a similar sample size for each of the three groups. The original goal was to recruit 120 officers (40 participants in each group). The final number of participants was 51 officers (18 control, 16 quasi-control/face-to-face and 17 simulation).

A total of 10 sessions were conducted and the same format was followed for each: a) completion of the consent, demographic form, knowledge about mental illness questionnaire, and Opinions about Mental Illness Scale (OMI) for all three groups, b) intervention for the quasi-control group (participating in a mental illness seminar) and the simulation group (working through the four computerized simulations), c) completion of the knowledge about mental illness questionnaire and the OMI a second time by the quasi-control and simulation groups as a post- test, d) rating the usability of the simulation templates (Appendix E) by the simulation group, and e) participation in a focus group for all three groups.

The mental illness seminar also followed a predetermined format. A leader's guide (Appendix G) was used to ensure consistency in the way the information was presented and discussed. Officers were given one scenario at a time to read. They completed related learning activities, which mimicked as closely as possible the material covered in the simulations and the answers to the learning activities were provided in a discussion format.

For the simulation group, each officer was provided with a laptop computer. They worked independently and at their own pace to complete all four of the simulations. The participants were provided with a brief explanation of the navigation tools prior to commencing.

Again in an effort to maintain consistency, a question guide (Appendix F) was developed for the focus groups and a minimum of two researchers were present at each session. Although every effort was made to keep the group sizes similar, the challenges experienced in the recruitment process and having to rely on officer availability resulted in the focus groups ranging in size from three to eight participants. However there was some consistency within the two intervention groups. The quasi-control group (mental illness seminar) consisted of two groups of eight, and the simulation group consisted of four groups – two with five participants, one with four, and one with three.

Data Analysis

Quantitative analysis. Participants' scores on the knowledge about mental illness questionnaire were calculated using an answer sheet developed by the researchers. Two researchers blind marked each of the pre-test and post-test questionnaires. The researchers then compared their scoring; any discrepancies were discussed and a final mark was assigned. The questionnaires were divided into participant groups (control, simulation and face-to-face) only after the scoring was completed. The mean test score for the control group and the mean pre-test and post-test scores for the simulation group and the face-to-face group were calculated.

A paired t-test was used to compare each individual officer's pre-test result with his or her own post-test result (simulation and face-to-face groups); if officers arrived with different pre-knowledge of mental illness, the test focused on how each individual's score changed—specifically from his or her own starting point. By this measure, the score change was highly significant.

A two-way analysis of variance (ANOVA) was carried out to check whether changes from pre to post-test results may have been distorted by interactions with unknown aspects of the four groups of officers who participated in the simulation education or by any differences in the facilitators or in the number of members in each of the four sub groups. The same procedure was carried out on the test results for the two groups of officers who participated in the face-to-face education session. No distorting interaction effects were found.

An ANOVA test was also carried out to determine if there was a significant difference between the mean test score of all officers (including the scores for those who were in the control group as well as the pre-test scores for officers in the simulation and face-to-face groups) and the post-test scores for those who participated in either of the education sessions (simulations or face-to-face). A significant difference was found between the scores of those had not (yet) participated in education sessions and those who had participated.

A similar process of statistical analysis was followed for the Opinions about Mental Illness Scale (OMI) completed by all of the police participants. A paired t-test was used to compare each individual officer's pre response score with his or her own post response score (simulation and face-to-face groups). A t-test was also used to determine if there was a significant difference between the mean response score of all officers (including the scores for those who were in the control group as well as the pre response scores for officers in the simulation and face-to-face groups) and the post response scores for those who participated in either of the education sessions (simulations or face-to-face). Statistically significant conclusions were reached for only one of the five OMI factors – Factor C – Mental Hygiene Etiology.

Qualitative analysis. All of the focus groups were audiotaped and later transcribed verbatim to ensure transcript accuracy. The transcripts were read a number of times by a researcher and research assistant and, with each reading, themes were identified and the data were coded supported by NVivo software version 8.0.

Findings

1. To what extent can simulations be used as a tool to educate police officers about mental illness and how to respond effectively in interactions with mentally ill persons?

On the surface this question seems to be simply about the use of simulations. Our research provided findings related to this question as well as information about the training of police officers, their preferences for learning, and suggestions as to how best utilize simulations as a training tool. Our research question also points to the notion of effective interactions with mentally persons in the terms of such interactions having an "effectiveness" that is objectively defined. We discovered that there are many factors governing the interactions with mentally ill people and hence what might be perceived as effective interactions. These factors include the officers' previous experiences, their view of their role with respect to individuals with a mental illness, and their perceptions of the role of the healthcare system.

Preferences for Learning

In discussions with the officers we determined that they are very people-oriented and appear to be rooted in a strong oral culture. They have a history of sharing their stories, whether it is in a formal de-briefing or in the squad car on the way to a call. One aspect of this predilection is that they like some measure of face-to-face contact in their learning.

When we hear:

> *"I like the scenario training. It's a new thing in police training and has become quite popular. I like classes...passing on...what police officers have heard."*

The notion of an oral culture as well as the desire to communicate directly with fellow officers is reinforced. Although sometimes it was mitigated with other aspects of their learning preferences, such as self-paced learning and input from experts:

> *"Definitely having some face-to-face I think is needed. ...I can work independently as well but...having someone who does know what they're talking about to answer questions..."*

However, the desire for face-to-face connection is loud and clear even if only to clarify what they might have heard in an online simulation:

> *"But I think I would like to have a further debrief with other officers, because...the computer would say something and...?"*
>
> *"...I've learned...but not as much as I think I would learn face-to-face with someone teaching the course. ...you're going to get more...you hear stories about it in the situations they've had, rather than just reading the textbook."*

Conversely, officers who experienced the face-to-face educational intervention were not totally satisfied either. There were concerns about whether the pace of the seminar was adequate or not for the learner, and whether such training matched individual learning styles. Being reluctant to speak up in certain circumstances either due to their personal style or the makeup of the group, and having to make the effort to read and comprehend a scenario in class were also issues. One participant was very articulate about the demands of speaking out in a group environment:

> *"My opinion differed greatly from some...but they were told immediately that they had it exactly right. ...why would I suggest my idea if the right answer has already been given?"*

In terms of learning styles or interactivity one participant had this to offer:

> *"…with all the different learning styles, there's going to be a lot of people...who won't speak…you might actually get more information if it was a smaller group setting or it was something interactive where they could key something in afterwards."*

Such a comment recognizes learning style issues as well as the positive benefit of working with an interactive tool.

Perspective on Police Training

The officers' perspective of training was that it should be very practical and was most effective when it was story-based. Again this is a strong indication of the oral culture that they work in. In terms of officer ability, the number of experiences and not simply years of experience was deemed important. They have a strong desire for practical ideas that come from real life and can be applied on the job.

> *"I think that the skills learned on the job far exceed any training you receive…..you can sit there and answer all of the questions you want, but when you're actually in the situation…"*
>
> *"…get a lot of it just hearing people's stories. If someone tells you about something, it's maybe something…you never thought of…where it might work out."*

These statements are a strong indication as to the nature of any educational interventions involving the officers. They have to be grounded in real life and speak of real experience. They need to be couched in terms of a story from an experienced officer or advice born of the "real world".

We also discovered some pre-conceived ideas about online learning based on some of the officers' previous experiences with police e-learning sessions. They described them as something to be gotten through, preferably by clicking as rapidly as possible.

> *"...I think you're going to find with most police officers...we're kind of 'go, go, go'. ...by the fourth scenario, I figured out that you could click without actually having to listen to all of it."*
>
> *"...we're more face-to-face. I see the e-learning that we have already and I see people whiz through it."*

Such comments reinforce the importance of understanding any existing biases to online learning prior to implementing a simulation-based educational program to educate all officers with the Durham Regional Police Services.

Participant Response to the Simulation Experience

The simulations did strike a positive chord with all of the participants, perhaps because they were scenario-based and hence fit with the notion of sharing stories in such an oral culture. Addressing different learning styles, being able to go at one's own pace, or even backtrack and redo a scenario were seen as a positive.

> *"It [interface] just seemed to be more engaging. ...watching it play out and listening to feedback rather than just picking through it...so that it says that it's done."*
>
> *"...addresses different learning styles...visual learner, an interactive learner."*
>
> *"...on the computer....you get to do it at your own pace. You're not in a classroom..."*
>
> *"...if you make a mistake you see what the consequences are of the mistake, or you go back and you choose the right one and then you know for next time, what to do."*

The participants were engaged by the learning objects and felt involved in the scenarios. They also appreciated the multiple interactive media and having the ability to choose options in their response to the scenarios presented by the objects.

> *"I found it more engaging than previous visual related training."*
>
> *"...that's the best training I've had in terms of response to EDP's in a long, long time."*
>
> *"I think it is better to have visual as well.... ...I found myself watching the person speaking and reading the text underneath."*

They also recognized that there was an immediate benefit to what they were learning through the simulations:

> *"...the officers in the scenario were asking a few questions that I had never thought about asking on a call before. ...hopefully, I will be able to put those in my repertoire."*

"...I thought it was good to have that refresher training."

Another testimony to the effectiveness of the simulations is to be found in their comments about who should actually take this type of training:

"Sergeants at least....are on the roads... So they at least need this training."

"I think it should be mandatory for something like this."

"...it should be done in this format...once a week, you could sit down and off you go."

Responding Effectively to a Mentally Ill Person

Another aspect of this research question is the elements of responding effectively to a mentally ill person. By examining some of the participants ideas about how to respond effectively to a mentally ill person we can gain insight that will inform further educational interventions. There was evidence of a high degree of sensitivity, either acquired through experience or intuitively held, in how they approached the situations. Their feelings matter in the decision making process. The following quotes provide some indication of what officers perceive to be effective strategies for engaging with mentally ill persons.

"...try to listen to what they're saying, because if they're ...delusional...try to grab their attention...and interest to focus in on you".

"...we build a rapport...get some basic information and conversation going..."

"...saying the wrong thing...can escalate a situation.... ...knowing what to say is important as well."

"...showing some empathy. Trying to understand... listen to...what they're thinking, what they're feeling and trying to help them along."

"...your tone of voice...the proximity to mentally ill people, I've seen a lot of people who invade their personal space and it really agitates them."

"....you can't argue with them about what they're seeing or experiencing. You just have to acknowledge it is what it is."

"One of the key things...with people with mental health issues is patience."

They take safety very seriously, their own and that of the people they apprehend. They are also keenly aware of the potential negative consequences of any decisions they make and as such, they may opt to transport the person to hospital just as a precaution.

"I mean, my top priority is that I go home, and anyone I'm with goes home."

"...I tend to err on the side of caution...I'm not a doctor, I'm not a healthcare professional, I'm a police officer."

Officers' desire not to escalate the situation led to some comments about the use of a taser, chiefly in terms of it being a positive choice before resorting to the use of lethal force.

"...I had a taser experience...I was blown away at...its effectiveness."

"He's not in a state of mind ... to follow commands. He gets tasered. It's a matter of two minutes ...and he's not hurt."

A major recurring theme was the relationship of the officers to the medical profession, particularly the physicians in hospital emergency departments. While there seemed to be a clear understanding and appreciation of the role of the doctor, this was also coupled with frustration at the system and the amount of time they spend "babysitting" mentally ill persons only to see them eventually released. Officers often do not believe their input is valued and they described many situations where they were not even asked for any input. This extreme frustration may stem from their powerless feeling in this type of setting, which is in direct contrast to the degree of power they hold in the field.

"But we got to the hospital, and, you know, were sitting there basically babysitting him and waiting for the doctor."

"It's our job to get them the help they need as quickly as possible...we have to move on to that next call...could be a robbery in progress. Now, I'm babysitting an EDP in the hospital, that[other] person's at risk of being killed because I'm here."

"...I think our input is not...appreciated or taken into account enough before they make their decision to release them...."

We also heard some suggestions for resources to assist them on the job:

"...a notepad of references...phone numbers and different resources and things."

I think they should deputize...security guards at hospitals.... I don't see...why we have to sit there for hours."

Knowledge about Mental Illness Scale

The quantitative, statistical analysis of the participants' scores on the knowledge about mental illness questionnaire strongly suggests the simulations can be used to educate police officers about mental illness and how to effectively interact with mentally ill persons. Table 2 shows that in the simulation group there was a 30.7% increase in officers' mean scores on the knowledge questionnaire, from before to after their simulation experience.

Table 2

Scores on Mental Illness Knowledge Test for Simulation Participants (by focus group)

	Group 1	Group 2	Group 3	Group 4	Mean Score (30)
Pre-test	14; 20; 18.5; 20; 21	17.5; 20; 17.5; 15; 16	16.5; 19; 23.5; 16.5	21.5; 17; 20.5	18.4706
Post-test	25; 27; 22.0; 22; 24	20.5; 25; 24.5; 21; 22	24.0; 27; 27.0; 24.5	27.0; 24; 24.0	24.1471

(Note: Scores line up individuals, i.e. 1st pre-test and first post-test are the same person)

The data also indicates that simulation is at least as effective as the face-to-face education session. In the face-to-face group there was a 35.9% increase in officers' mean scores on the questionnaire, from before to after their educational experience (Table 3).

Table 3

Scores on Mental Illness Knowledge Test for Face-to-Face Participants (by focus group)

	Group 1	Group 2	Mean Score (30)
Pre-test	15; 15.5; 19.5; 14; 24; 12.5; 6; 14	23; 12.5; 25.5; 16.5; 19; 16; 17; 16.5	16.7
Post-test	20; 24.0; 24.0; 22; 28; 21.5; 14; 19	25; 21.5; 27.5; 21.5; 24; 23; 23; 24.5	22.7

(Note: Scores line up individuals, i.e. 1st pre-test and first post-test are the same person)

A comparison of the knowledge about mental illness pre-test scores for all of the study participants (face-to-face, simulation and control groups) with the post-test scores for those officers who participated in either one of the educational sessions (face-to-face or simulation) provides further support for educating police officers about mental illness. Table 4 shows that the mean score for the officers who were educated was 43.2% higher than for those who were not (control group), which is a statistically significant difference. One reason for this larger increase in scores, compared to the increase in the mean post-test scores reported in Table 2 (simulation group) and Table 3 (face-to-face group), is an apparent difference between the three groups (face-to-face, simulation, control) in their performance on the knowledge about mental illness questionnaire (Table 5). The slightly lower scores of the participants assigned to the control group can be accounted for in part by the fact that they were younger with less years of experience in policing, and less additional education related to mental illness. Furthermore, only 73% of the group had on the job experience with mentally ill persons in comparison to 100% in the other

two groups. Nonetheless, the improvement effect of education is larger than the initial difference between the groups.

Table 4

Comparison of Knowledge about Mental Illness Pre-test Scores (Face-to-Face, Simulation, Control) and Post-test Scores (Face-to-Face, Simulation)

Group	Number of Participants	Sum of Scores	Mean Score (30)
Pre-test (Face-to-Face and Simulation) and Control	51	834	16.353
Post-test (Face-to-Face and Simulation)	33	773	23.424

Table 5

Knowledge about Mental Illness Test Scores for Face-to-Face, Simulation and Control Groups

Group	Number of Participants	Sum of Scores	Mean Score (30)
Face-to-Face Pre-test	16	266.5	16.65625
Simulation Pre-test	17	314.0	18.47058824
Control	18	253.5	14.08333333

Opinions about Mental Illness Scale (OMI)

Based on the statistical analysis of the participants' responses on the OMI, significant conclusions could only be reached about Factor C – Mental Hygiene Ideology. This factor reflects positive views of mental illness, focusing on the similarities rather than the differences between 'normal' and mentally ill individuals. The score changes for both the face-to-face (T value = -4.63; p-value = 0.000) and simulation group (T value = -2.57; p-value = 0.021) were significant; there was no evidence that the education type affected this result. There was also a significant difference in scores between the officers who participated in an educational session (face-to-face or simulation) and those officers who did not (T value = -3.911; p-value = 0.000). These findings suggest that educating police officers about mental illness can encourage them to adopt more favourable attitudes towards mental illness. However, it is understood that these findings are based on the self reported responses of the police participants and the opinions they expressed may not necessarily be translated into action on the job.

2. To what extent do simulations enhance police officers' confidence in their ability to interact effectively with mentally ill persons?

This research question led us to a wide range of evidence on topics as diverse as the simulations, the officers' level of confidence, factors that affect their decision making, and how they respond to mentally ill people. Our question presupposes that confidence is a primary factor in how police officers engage with mentally ill persons and that education/increased knowledge is a key to increasing their confidence. While the participants did not always feel confident about their level of knowledge and understanding of mental illness, they were absolutely confident in terms of the use of force policy and they were adamant that if at any time their efforts to diffuse or contain a situation involving a mentally ill person failed, the use of force policy provided clear directions as to the required course of action and that they would not hesitate to follow these directives.

> *"I feel confident, just because...officer safety is number one. And that can't change..."*
> *"Mental patients are no different...the police use what we call DWI, meaning if they have a delivery system present, they have a weapon and they have intent, then we have justification to kill."*
> *"...your safety and... the use of force is ingrained in you ...regardless of who you're dealing with..."*

Confidence

Our evidence shows that the majority of the police participants self identify as having a high level of confidence. Officers talked about the nature of policing and the need to be confident on the job. Using a rating scale of one (not confident at all) to five (very confident), the majority of the participants placed themselves in the upper range of the scale. However, with further probing it is clear that mentally ill persons are one type of call that can give them trepidation.They are taken out of their "comfort zone" with a resulting negative effect on their confidence:

> *"You have to take your crime-fighter hat off and then try to work through the hundred issues that are in the way. So it's a very, very confusing situation to have someone trying to kill themselves, what do you do? So I'd say two."*
>
> *"I'd be probably a two or a three. I think I could recognize it [mental illness], but knowing exactly how to deal with it, I just try to do the best that I can."*

Officers did indicate that experience and training such as the simulations can have a positive impact on their confidence:

> *"…experience and knowledge go a long way...having the confidence to make the right decision."*

"I'd say I'm fairly confident...comes with experience...just being more knowledgeable... And of course the training helps..."

"…it's just being more knowledgeable...whether you've got your university, or... only got high school, or what kind of life experience you have, how old you are, what you've seen, what you've done."

"I agree with receiving as much training as we can get, especially on something like this where we really don't have a lot of training."

However, the potential unpredictability of emotional disturbed person (EDP) calls is a significant factor and officers expressed never feeling totally confident in their ability to engage with mentally ill persons.

"So it's a real conundrum...there are so many different variables...it's a lose-lose situation as a police officer...affects confidence level."

"I'd rather deal with six organized crime guys with have an armed car robbery with a lot of bad weapons than an emotionally disturbed person with a knife."

"I don't think I could ever feel fully confident...because of the complexity of what...we're dealing with."

Our discussions revealed other factors or circumstances that seemed to lead to increased or diminished confidence or that played a role in their decision making. Their experiences with the medical profession were again raised as an issue.

"I'm going to take him to the hospital. I'm going to sit there and wait for...how long..."

"...you advised a healthcare worker....and...they discount what you say..."

We also discovered that certain circumstances or experiences can increase their confidence. It appears that taking the time to build a rapport with the individual and engaging them in conversation were key components in diffusing situations and in increasing officers' confidence:

"...speaking with that person is extremely important...try to get as much feedback as you can before making the decision."

"...every call you go to, you're going to gain something...helps you for the next time."

Their propensity for sharing stories also plays a role in developing their confidence.

"...it's just being exposed to it, seeing it more often, talking to the other officers about the call they went to, how they dealt with it...So it's sharing experiences."

Responding effectively to a mentally ill person

We again heard confirmation of a high degree of sensitivity and that officers' recognized the need to try and make meaningful connections with a mentally ill person. Further evidence to support their

empathetic stance can be seen in their tacit criticism of peers who tend to rush a situation or exacerbate a situation with a lack of sensitivity.

> *"...a lack of education. The officers...This is taking too long. You got two choices. You're coming or you're not coming!"*

Such a pre-emptive approach is contrasted to situations where there is a high degree of consultation between officers or with officers who show a caring approach:

> *"I don't think it's up to one officer. Like there's plenty of people and - to speak with and - and collaborate with."*
>
> *"…so we locate her and we keep our distance...the officer who initially got there...is traditionally one of those "throw gasoline on the fire" officers. But he had taken the Mental Health Course.... He responded like textbook how you're trained. Don't touch. Keep your distance. Can we talk? You know, so I was so impressed."*

Factors affecting decision making

In the focus groups it also became clear that there were a number of factors that affect officers' decision making in situations involving mentally ill persons. This decision making is only partly influenced by confidence and the decisions that are made will determine the effectiveness of the final outcome.

Other issues that came forward included the long waits in an emergency department and the likelihood that the individual would not be admitted to the hospital.

> *"...you go to those calls...you're always wondering...Will they end up kicking them out of the hospital...am I just wasting my time?"*

This reluctance to sit for long periods at a hospital is countered by concern for their safety and that of the public and the mentally ill person and by their strong sense of accountability:

> *"...there are too many situations...you try and reason...in the end, somebody gets hurt."*
>
> *"...our necks are on the line... So I'll let the doctor make a decision."*
>
> *"...I'm very confident with what my grounds are... I think that I would tend to apprehend more often than not. ...it comes down to accountability."*

This sense of accountability is also present in their adherence to the use of force policy:

> *"...our training is the same...an armed person...gets treated the same across the board."*

Although we heard some alternatives to the direct reliance on use of force:

> *"I'm smaller than most of the guys....I find that I have to use...mouth to de-escalate the situation, rather than use of physical force."*

"I have the same use of force options as the guys... the same training...but I opt for tactical communication."

Of course accountability is closely related to liability:

"I've taken people to the hospital...knowing that the hospital isn't going to keep them. ..to make sure that my career is okay if they do go out and do something."

"...err on the side of caution...take them, because you don't want to risk you leaving and them harming themselves."

"...that liability and legal issues. ...actually does affect the way you deal with things."

The other aspect of this awareness is the consequences of public scrutiny of their actions:

"And you can be grilled in the public forum for years afterwards for your actions..."

Rodney King taught us all.... ...the level of scrutiny and the level accountably..."

"...before you to make all decisions, legality always come to mind."

Nonetheless with all the factors to consider, safety seems to be on the forefront:

"I think for me, unfortunately, safety trumps their individual rights."

"...regardless of who you're dealing with. So you and your partner come first..."

"But the bottom line is...everybody's safety..."

Concern about how they were viewed by their peers or by their supervisor could also have an impact on their decision making. For the less experienced officers establishing a positive reputation with fellow officers and the police administration was a priority. Also, some officers described being influenced by the approach or response of a particular supervisor.

"You want to be seen as being a solid officer."

"... you can end up riding by yourself...other people won't want to ride with you."

"So, young officers – and all of the officers no matter what their experience...criticism from a higher rank is big."

"And when you're trying to prove who you are, and if they are going to let you into that type of circle that they maintain..."

"It also depends on your supervisor. Some supervisors are very open to a conversation, and some supervisors are, "It's my way or the highway!"

There was also some indication of the importance of their relationship with their peers. Decisions made on the job often involved trusting the judgement of fellow officers.

"...not too many professions that you actually have to rely on the guy next to you." "...you have to trust each other. If you don't have that...you don't have anything."

"I've never had the situation where...I wanted to deal with it one way, and he or she wanted to deal with it another way."

3. To what extent do police officers find simulations a) easy to use, and b) reflective of reality?

Easy to Use

Data from the Rating of Simulation Templates Usability scale indicated that the officers found the simulations easy to use. The majority of the participants (100% for the suicidal and experiencing hallucinations scenarios; 88% for the delusional thinking and self harming behavior scenarios) rated the usability of the simulation templates as a five or six (on a scale of 1-6; one being not friendly and 6 being very friendly). Officers also added positive comments about "having access to the library", the "variety of realistic response options" and the drag and drop learning activities being "good". The participants also made some suggestions for future simulation development including having the video clips show the consequences of the officer's actions; more response options; larger screen for the video clips; access to a help box prior to making a decision; and the ability to ask questions (question tabs) of the Dispatcher en route to a call.

Officers' comments in the focus groups also confirmed that they found the simulations easy to use.

"I found this model...was excellent because the material that was in the content was easy to understand and learn."

"...just having that feedback...it was very well presented, clear and concise and great information."

"It was a mix of reading and videos... it was very easy to work with. So, if it's going to be on-line, something like that is good – for me."

"...there were a few words...underlined that you could just click on it and the definition pops up. And it doesn't stop the video...I thought that was really professionally made." "You could just look at the definition and re-close that."

Reflective of Reality

There was recognition that the simulations were contrived scenarios and that limitations existed in the medium but at the same time they seemed to see them as realistic.

"...approach to the situation was realistic. The outcome was probably realistic but we just got there a lot quicker."

"...reactions were common, everyday situations that we may deal with. So I thought the

content was great, the length was great."

"...granted, the dialogue is very scripted. You're not necessarily going to be saying the same things or in that tone of voice or anything like it. But you can buy into it...you could accept it as a reasonable...strategy in dealing with somebody like that."

"It was definitely more realistic than what I've ever done before. And new information..."

Using real police officers in the videos also added to the credibility and realism of the simulations.

"...one of the guys...in the clip is on my platoon so I know him. And that probably added an element of realism to it because he was dealing with the scenarios on there the same way that he's dealt with calls that I have been to with him."

There was some criticism of the realism related to how rapidly a positive outcome was reached in the scenarios. Officers did, however, recognize the time constraints inherent in this type of educational resource.

I know the time constraints there, but to...look...and I say, "Okay, if I say this, it's going to diffuse that way." So it's unrealistic..."

Limitations and Future Research

The findings of this study are based on a one-time knowledge assessment and the self reported data of a small group of officers with the Durham Regional Police Services. Further research is required to determine if the increased knowledge and understanding about mental illness and subsequent anticipated increase in confidence expressed by the police participants in this study are actually enacted in their on the job interactions with mentally ill persons, and are sustainable over time. Including representatives from other policing organizations in any future research would also be beneficial.

Conclusions

The findings of this study support using simulations to educate police officers about mental illness and how to respond effectively in interactions with mentally ill persons. Police officers who participated in either of the education sessions (face-to-face or simulation) demonstrated a statistically significant increase in their scores on a knowledge about mental illness questionnaire that was administered pre and post their educational session, indicating that the simulations are at least as effective as face-to-face education sessions. There was also a statistically significant difference between the post-test scores of officers who participated in an education session and the scores of the officers who did not (control group). Further support for the use of simulation was provided by the qualitative data from the focus group; officers described the simulations as engaging and they appreciated the multiple interactive media,

having the ability to choose response options and receive immediate feedback, as well as being able to go at their own pace.

However, rooted in a strong oral culture, not surprisingly, officers expressed a strong appreciation for face-to-face interaction and the ability to exchange stories. This would suggest that a hybrid teaching methodology would be the most effective; simulations could be coupled with a group debrief in which key concepts and the learning activities are discussed and officers have the opportunity to ask questions and learn from each other.

What constitutes effective interactions with mentally ill people encompasses a wide range of opinions but generally officers equated success with no one getting hurt and the individual receiving the kind of help that is needed. As a result, there is frustration with the medical establishment; officers do not feel their input is valued and they perceive that some individuals are released from hospital too quickly for their own good.

The majority of participants self identified as being confident in their handling of mentally ill persons. However, it was clear that interactions with mentally ill persons were something they found challenging. Although officers indicated they gained confidence primarily through experience and the ability to learn from their mistakes and each other, they did acknowledge that training, such as the simulations, can also have a positive impact on their confidence, and they were very open to additional education about mental illness. Their stories also shed light on additional factors that affect their confidence and decision making in interactions with mentally ill persons. These included frustration with the medical system, concern for the safety for all parties involved in a situation, feeling pressured by peers or supervisors, issues of legal liability, and public perceptions of their actions.

In defining how they see an effective interaction with a mentally ill person they showed sensitivity to the condition of the individual and to the circumstances that can either escalate the situation or defuse it. Such awareness also helps explain the frustration they have in dealing with emergency departments where their opinions are not valued, their time is consumed, and they witness the mentally ill person being released in what they believe is a premature fashion.

The police officers were highly complimentary of the simulations. They provided positive feedback about their ease of use and level of realism, making specific mention of the use of real police officers in the video clips. There were no criticisms of the interface and comments were made that validated the usefulness of the learning activities and library resources. In probing whether the learning activities are best placed before the main encounter or interleaved with the video, the officers seemed to prefer viewing the video in an uninterrupted fashion and attempting the activities either before or after.

Implications

As first responders, police often encounter mentally ill persons in the community and their police training provides little if any education about mental illness and how to respond effectively when engaging with mentally ill persons. Police services are becoming increasingly cognizant of the inadequacy of the current constable training programs and with one in four Canadians going to experience a mental illness in their lifetime, identifying effective educational strategies and resources is becoming more of a priority within the policing sector.

This study's research findings will make a significant contribution to the professional development of police constables with the Durham Regional Police Services with respect to their knowledge and understanding of mental illness and their ability to interact effectively with mentally ill citizens in the Durham Region. The DRPS is the 10th largest municipal police service in Canada and the 5th largest municipal police service in Ontario, employing over 800 police officers. Police constables from across Canada also have access to the simulations and research findings through the DRPS' membership in national learning networks such as the Canadian Association of Police Educators and the Canadian Association of Chiefs of Police. The research team has already been approached several times by other police and mental health service organizations during our presentations at the various conferences we have been invited to. We have been asked to share the simulations as well as our research findings and there is every indication that our project may impact police professional development not only at a local level but also provincially, nationally, and internationally in terms of mental illness awareness and better understanding of the strategies that can be helpful when police are responding to EDP calls.

The study's findings also help inform the leadership at Ontario Shores, Centre for Mental Health Sciences (formerly Whitby Mental Health Centre) about the potential of simulation as an educational methodology and how best to integrate the use of simulations into the future professional development plans for staff. The interactive simulations are available as learning resources for staff in-services and ongoing professional development sessions.

The research findings are also of interest to the UOIT community. A laptop university, UOIT invests in educational technology and examining the impact of technology including simulation on learning is already a primary research focus. The research team was invited to speak at the Health Education Technology Research Unit (HETRU) rounds in April, 2009. As well, teachers in Durham College's Registered Practical Nursing, Police Foundations, and Paramedic programs already incorporate simulation resources into their course materials and so the results of this study help inform their decisions about teaching practices. Based on the research findings, the simulations may also be an excellent

learning resource for professors teaching relevant senior level courses to students in the Faculty of Health Sciences and the Faculty of Criminology, Justice and Policy Studies at UOIT.

The findings of our research add to simulation literature in terms of usability and reflection of reality, which could have a wide impact on education in general; given that more and more educational institutions and programs are taking advantage of existing and new and innovative technologies, simulation has the potential for adding value to a wide range of courses and disciplines.

Additional contributions of the project have been the partnering of a police force, mental health facility, university and college, which in and of itself provided insights into the collaborative process and the challenges and benefits to partnering with other community-based organizations. Each partner developed a better understanding of the roles and responsibilities of the other members of the team. These observations and insights may well lead to the creation and sharing of a best practice model for collaborating across multiple service sectors.

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Appendix A

September 2008

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Title of Study: Using Simulation to Engage Police in Learning about Mental Illness: The Impact of Realism on the Learning Process

Principal Investigator: Wendy Stanyon, Faculty of Health Sciences

University of Ontario Institute of Technology

Co-Investigators: Chris Hinton, Director, Centre for Excellence and Innovation, DC-UOIT
Jay Tashiro, Faculty of Health Sciences

You are being invited to participate in a collaborative research study involving the Durham Regional Police Services, the University of Ontario Institute of Technology and Whitby Mental Health Centre. In order to decide whether or not you want to be a. part of this research study, you should understand what is involved and the potential risks and benefits. This form provides detailed information about the research study, which will be discussed with you. Once you understand the study, you will be asked to sign this form if you wish to participate. Please take your time to make your decision.

The results of this study will be distributed in academic journal articles and conference presentations and a summary of the results will be made available to the organisations and participants in the study.

WHAT IS THE PURPOSE OF THIS STUDY?

The objective of this research project is to evaluate the impact of using simulation to educate police Officers about mental illness and how to respond effectively to common critical incidents involving mentally ill persons they encounter in the community.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?

If you volunteer to participate in this study, we will ask you to complete a questionnaire about your opinions about mental illness and a pre/post test related to your knowledge about mental illness. If you are part of the simulation group, you will also be asked to complete three surveys related to your experience with technology. You will be asked to complete the Opinions about Mental Illness questionnaire prior to the educational session and again at the end of the session. You will be asked to complete the surveys at the end of the educational session. You will also be invited to participate in a focus group with other police constables from the Durham Regional Police Services who are involved in the research study. The focus group will take approximately one and a half hours and will be recorded for research purposes. Please remember the content of discussions during the focus groups is to be kept confidential and is not to be shared outside of this forum.

WHAT ARE THE POSSIBLE RISKS?

There are no known risks to participating in this study.

HOW MANY PEOPLE WILL BE IN THIS STUDY?

There will be 120 police constables with the Durham Regional Police Services participating in this study.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?

Police constables participating in the education sessions will have the opportunity to increase their knowledge and understanding of mental illness and learn strategies to effectively interact with mentally ill individuals. All of the police participants through completion of the OMI questionnaire will have the opportunity to learn about their own personal thoughts and attitudes about mental illness. The study will also help to inform other police services, community organizations and educational institutions about the benefits of educating frontline officers about mental illness and effective strategies for interacting with mentally ill individuals. Once the research project is completed and the final results are available, a summary of the results will be made available to the partnering organizations and to all of the participants in the study. The results of this study will also be distributed in academic journal articles and conference presentations.

WHAT IF I DO NOT WANT TO TAKE PART IN THE STUDY?

It is important for you to know that you may choose not to take part in the study. Refusing to participate in this study will in no way affect your position or employment status and you may still choose to attend the educational sessions.

WHAT INFORMATION WILL BE KEPT PRIVATE?

Your data will not be shared with anyone except with your consent or as required by law. All personal information will be removed from the data and will be replaced with a code. A list linking the code with your name will be kept in a secure place, separate from your file. The data, with identifying information removed will be securely stored in a locked cabinet located in the office of the principal investigator.

Your name will not be used and no information that discloses your identity will be released or published without your specific consent to the disclosure.

Audio tapes will be accessed only by members of the research team and will be destroyed following completion of the research project.

CAN PARTICIPATION IN THE STUDY END EARLY?

If you volunteer to be in this study, you may withdraw at any time and this will in no way affect your employment or job status. You have the option of removing your data from the study. You may also refuse to answer any questions you do not want to answer and still remain in the study.

WILL THERE BE ANY COSTS?

Your participation in this research project will not involve any additional costs to you.

IF I HAVE ANY QUESTIONS OR PROBLEMS, WHOM CAN I CALL?

If you have any questions about the research now or later, please contact **Wendy Stanyon, Principal Investigator, 905 721-3111 ext. 2250, wendy.stanyon@uoit.ca.**

If you have any questions regarding your rights as a research participant, you may contact the UOIT Research Office, 905 721-3111 ext. 2357 or you may send an email to compliance@uoit.ca.

CONSENT STATEMENT

SIGNATURE OF RESEARCH PARTICIPANT

I have read the preceding information thoroughly. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. **By signing this form, I freely give my consent to participate in this study.** I understand that I will receive a signed copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant Date

Consent form administered and explained in person by:

_____

Name and Title

_____ _____

_____ _____

Signature Date

SIGNATURE OF INVESTIGATOR:

In my judgement, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

_____ _____

Signature of Investigator Date

This study has been reviewed and received ethics approval through the University of

Ontario Institute of Technology Research Ethics Board. **(File #)**

Please keep a copy of this form for your records.

Appendix B

Demographics

Age:

Gender: Male Female

Rank:

Years of Police Experience:

Have you had any additional education about mental illness (other than what was covered in your original police training)?

Yes (please describe)

No

Have you had on-the-job experience with an emotionally disturbed person (EDP)?

Yes No Not Sure

If yes, approximately how many EDP reports have you filed in the last year?

Outside of your work, have you had any experience with an individual(s) with a mental illness?

Yes No Not Sure

Appendix C

Mental Illness Questionnaire

1. What are some key thoughts, feelings, behaviours that might indicate an individual is experiencing a mental illness?

2. List 3 risk factors for suicide.

3. Asking individuals if they are thinking about killing themselves is not wise since this may put the idea into their head.

   True False

4. For an individual who is talking about feeling suicidal, what question(s) would you want to ask her/him to determine the level of risk?

5. When communicating with an individual, what does it mean to respond with empathy? Provide an example.

6. When is a depressed person at the highest risk for suicide?

7. What are some symptoms of schizophrenia?

8. What are some common symptoms of depression?

9. Explain the difference between a hallucination and a delusion.

10. What are command hallucinations?

11. What strategies would you use to effectively engage with an agitated person?

12. You are talking to a person who appears distracted by his/her mental illness (for example, may be hearing voices). What strategies would you use to engage with this person?

13. Under the Mental Health Act, what is/are the criteria for involuntary admission to hospital?

14. What does a Form 1 authorize?

15. Who can require an individual be taken to the hospital for a mental health assessment?

16. List community mental health supports/services you are familiar with.

Appendix D

Opinions about Mental Illness Scale

Directions:

The statements that follow are opinions or ideas about mental illness and mental patients. By mental illness, we mean the kinds of illness which bring patients to mental hospitals, and by mental patients we mean mental hospital patients. There are many differences in opinion about this subject. In other words, many people agree with each of the following statements while many people disagree with each of the statements. We would like to know what you think about these statements. Each of them is followed by six choices.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

Please check (✓) in the space provided that choice which comes closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right or wrong answers: we are interested only in your opinion. It is very important that you answer every item. Please do NOT sign your name.

1. Nervous breakdowns usually result when people work too hard.

strongly agree | agree | not sure but probably agree | not sure but probably disagree | disagree | strongly disagree

2. Mental illness is an illness like any other.

strongly agree | agree | not sure but probably agree | not sure but probably disagree | disagree | strongly disagree

3. Most patients in mental hospitals are not dangerous.

strongly agree | agree | not sure but probably agree | not sure but probably disagree | disagree | strongly disagree

4. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

5. If parents loved their children more, there would be less mental illness.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

6. It is easy to recognize someone who once had a serious mental illness.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

7. People who are mentally ill let their emotions control them: normal people think things out.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

8. People who were once patients in mental hospitals are no more dangerous than the average citizen.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

9. When a person has a problem or a worry, it is best to think about it, but keep busy with more pleasant things.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

10. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

11. There is something about mental patients that makes it easy to tell them from normal people.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

12. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh about them.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

13. Most mental patients are willing to work.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

14. The small children of patients in mental hospitals should not be allowed to visit them.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

15. People who are successful in their work seldom become mentally ill.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

16. People would not become mentally ill if they avoided bad thoughts.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

17. Patients in mental hospitals are in many ways like children.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

18. More tax money should be spent in the care and treatment of people with severe mental illness.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

19. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

20. Mental patients come from homes where the parents took little interest in their children.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

21. People with mental illness should never be treated in the same hospital with people with physical illness.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

22. Anyone who tries to better himself deserves the respect of others.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

23. If our hospitals had enough well-trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

24. A woman would be foolish to marry a man who had a severe mental illness, even though he seems fully recovered.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

25. If the children of mentally ill parents were raised by normal parents, they would not become mentally ill.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

26. People who have been patients in a mental hospital will never be their old selves again.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

27. Many mental patients are capable of skilled labour, even though in some ways they are very disturbed mentally.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

28. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

29. Anyone who is in a hospital for a mental illness should not be allowed to vote.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

30. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

31. The best way to handle patients in mental hospitals is to keep them behind locked doors.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

32. To become a patient in a mental hospital is to become a failure in life.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

33. The patients in mental hospitals should be allowed more privacy.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

34. If a patient in a mental hospital attacks someone, he should be punished so he doesn't do it again.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

35. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

36. Every mental hospital should be surrounded with a high fence and guards.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

37. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

38. People (both veterans and non-veterans) who are unable to work because of mental illness should receive money for living expenses.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

39. Mental illness is usually caused by some disease of the nervous system.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

40. Regardless of how you look at it, patients with severe mental illness are no longer really human.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

41. Most women who were once patients in a mental hospital could be trusted as babysitters.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

42. Most patients in mental hospitals don't care how they look.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

43. College professors are more likely to become mentally ill than are businessmen.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

44. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

45. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

46. Sometimes mental illness is punishment for bad deeds.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

47. Our mental hospitals should be organized in a way that makes the patient feel as much as possible like he is living at home.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

48. One of the main causes of mental illness is a lack of moral strength or will power.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

49. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well-fed.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

50. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

51. All patients in mental hospitals should be prevented from having children by a painless operation.

strongly agree	agree	not sure but probably agree	not sure but probably disagree	disagree	strongly disagree

PLEASE CHECK BACK AND MAKE SURE THAT YOU HAVE NOT LEFT OUT ANY STATEMENTS OR PAGES OF STATEMENTS.

Adapted from Cohen, J., &Struening, E. L. (1959). Factors underlying opinions about mental illness in the personnel of a large mental hospital. American Psychologist, 14, 339.

Appendix E

Rating of Simulation Templates Usability

Item	Rating
Please rate the navigation and general usability of Simulation Template 1. Suicidal Behaviour	Not at all User-Friendly 1 2 3 4 5 6 Very Friendly
Please rate the navigation and general usability of Simulation Template 2. Experiencing Hallucinations	Not at all User-Friendly 1 2 3 4 5 6 Very Friendly
Please rate the navigation and general usability of Simulation Template 3. Delusional Thinking	Not at all User-Friendly 1 2 3 4 5 6 Very Friendly
Please rate the navigation and general usability of Simulation Template 4. Self Harming Behaviour	Not at all User-Friendly 1 2 3 4 5 6 Very Friendly
List and describe the types of navigation and usability features that would be present in your ideal simulation:	

Appendix F

Focus Group Protocol

Focus Group for Control Group

Preferences for Educational Interventions

Do you believe you would benefit from education sessions about mental illness and strategies for effectively interacting with mentally ill persons? Please elaborate.

What are your preferences for professional development training focused on working with people who have mental illness?

Researcher could stimulate discussions by outlining examples such as those below for percentage of contact with a trainer:

- 100% = Trainer present in face-to-face instruction.
- 75% = Trainer present in face-to-face instruction.
- 50% = Trainer present in face-to-face instruction.
- 25 % = Trainer present in face-to-face instruction.
- 0% for educational program that is totally online, but with trainer providing support online.
- 0% for educational program that is totally online, without a trainer providing support online.

Confidence

Ask about their confidence level with regards to mentally ill individuals.

- How confident do you feel (scale of 1-5)?
    - Identifying the person as mentally ill
    - Engaging with the mentally ill person – effective communication responses (person who is delusional, hallucinating)
    - Responding to an individual who is suicidal
    - Determining whether or not to apprehend the individual under the MHA

- Factors that impact your confidence?
    - Concern for your own safety
    - Concern for public safety
    - Concerns about liabilities
    - Critique of fellow officers
    - Critique by your sergeant/ staff sergeant

Working with Mentally Ill Persons

1. Please describe recent on the job experiences with mentally ill persons.

2. Describe two interactions you have had with mentally ill persons, one in which you felt confident and one in which you did not feel confident.

3. Describe the factors you believe made the difference between these situations.

4. How confident do you feel now about your ability to effectively interact with individuals with a mental illness?

5. How would you rate your confidence level on a scale of 1 to 5 (1 = not confident at all; 5 = very confident)

6. What impact, if any, do you believe the education session will have on your confidence level? Please describe a couple of on the job examples to support your perceptions.

Other Themes

Describe your comfort with policies related to use of force and describe situations in which you are uncertain about how to act.

How have you developed "street smarts" and in what ways does your knowledge gained in the field help you make decisions?

When and why do you encounter differences of opinion among officer colleagues in working within what you perceive to be unpredictable situations (such as working with a mentally ill person)?

Focus Group Guide for Face-to-Face Intervention

Preferences for Educational Interventions

Do you believe you would benefit from education sessions about mental illness and strategies for effectively interacting with mentally ill persons? Please elaborate.

What are your preferences for professional development training focused on working with people who have mental illness?

Researcher could stimulate discussions by outlining examples such as those below for percentage of contact with a trainer:

- 100% = Trainer present in face-to-face instruction.
- 75% = Trainer present in face-to-face instruction.
- 50% = Trainer present in face-to-face instruction.
- 25 % = Trainer present in face-to-face instruction.
- 0% for educational program that is totally online, but with trainer providing support online.
- 0% for educational program that is totally online, without a trainer providing support online.

Usability and Realism

Describe how the educational intervention helped you understand how to work with people who are mentally ill.

Did the educational intervention provide you with realistic examples?

Confidence

Ask about their confidence level with regards to mentally ill individuals.

- How confident do you feel (scale of 1-5)?
  - Identifying the person as mentally ill
  - Engaging with the mentally ill person – effective communication responses (person who is delusional, hallucinating)
  - Responding to an individual who is suicidal
  - Determining whether or not to apprehend the individual under the MHA

- Factors that impact your confidence?
  - Concern for your own safety
  - Concern for public safety
  - Concerns about liabilities
  - Critique of fellow officers
  - Critique by your sergeant/ staff sergeant

Working with Mentally Ill Persons

1. Please describe recent on the job experiences with mentally ill persons.

2. Describe two interactions you have had with mentally ill persons, one in which you felt confident and one in which you did not feel confident.

3. Describe the factors you believe made the difference between these situations.

4. How confident do you feel now about your ability to effectively interact with individuals with a mental illness?

5. How would you rate your confidence level on a scale of 1 to 5 (1 = not confident at all; 5 = very confident)

6. What impact, if any, do you believe the education session (face-to-face) you participated in will have on your confidence level? Please describe a couple of on the job examples to support your perceptions.

Other Themes

Describe your comfort with policies related to use of force and describe situations in which you are uncertain about how to act.

How have you developed "street smarts" and in what ways does your knowledge gained in the field help you make decisions?

When and why do you encounter differences of opinion among officer colleagues in working within what you perceive to be unpredictable situations (such as working with a mentally ill person)?

Focus Group Guide for Simulation Intervention

Preferences for Educational Interventions

Do you believe you would benefit from education sessions about mental illness and strategies for effectively interacting with mentally ill persons? Please elaborate.

What are your preferences for professional development training focused on working with people who have mental illness?

Researcher could stimulate discussions by outlining examples such as those below for percentage of contact with a trainer:

- 100% = Trainer present in face-to-face instruction.
- 75% = Trainer present in face-to-face instruction.
- 50% = Trainer present in face-to-face instruction.
- 25 % = Trainer present in face-to-face instruction.
- 0% for educational program that is totally online, but with trainer providing support online.
- 0% for educational program that is totally online, without a trainer providing support online.

Usability and Realism

Describe how the educational intervention helped you understand how to work with people who are mentally ill.

Did the educational intervention provide you with realistic examples?

What did you notice about the navigation in the four simulations? Researcher can show four slides showing the way the four simulations were designed. Probe subjects' perceptions of values and disvalues for each navigation schema.

Confidence

Ask about their confidence level with regards to mentally ill individuals.

- How confident do you feel (scale of 1-5)?
  - Identifying the person as mentally ill
  - Engaging with the mentally ill person – effective communication responses (person who is delusional, hallucinating)
  - Responding to an individual who is suicidal
  - Determining whether or not to apprehend the individual under the MHA

- Factors that impact your confidence?

- Concern for your own safety
- Concern for public safety
- Concerns about liabilities
- Critique of fellow officers
- Critique by your sergeant/ staff sergeant

Working with Mentally Ill Persons

1. Please describe recent on the job experiences with mentally ill persons.

2. Describe two interactions you have had with mentally ill persons, one in which you felt confident and one in which you did not feel confident.

3. Describe the factors you believe made the difference between these situations.

4. How confident do you feel now about your ability to effectively interact with individuals with a mental illness?

5. How would you rate your confidence level on a scale of 1 to 5 (1 = not confident at all; 5 = very confident)

6. What impact, if any, do you believe the education session (simulation) you participated in will have on your confidence level? Please describe a couple of on the job examples to support your perceptions.

Other Themes

Describe your comfort with policies related to use of force and describe situations in which you are uncertain about how to act.

How have you developed "street smarts" and in what ways does your knowledge gained in the field help you make decisions?

When and why do you encounter differences of opinion among officer colleagues in working within what you perceive to be unpredictable situations (such as working with a mentally ill person)?

Appendix G

Leader's Guides for the Four Scenarios

Leader's Guide for Delusional Scenario

1. Officers read the scenario (Delusional Scenario – **Handout #1**)

2. Discussion of Delusional Scenario

You go up to the young man's room and ask him if you can speak to him and he agrees. You indicate that you are aware that he went to Whitby Mental Health Centre and then left. You ask him why and he says the nurses "pissed him off". You again ask him to tell you what happened. He becomes agitated, asking why you want to know and saying he didn't do anything wrong. You indicate you need to know and he becomes increasingly agitated. He responds by saying he doesn't have to tell you anything and he asks who you are. He then asks you if you know that his parents are the King and Queen of England and he asks you if you want to meet them.

What's happening with this young man? (he's experiencing a delusion, which may be indicative of a psychosis (being out of touch with reality); focusing on getting information you want further compromises his sense of control and increases his level of anxiety)

3. Learning Activities #1 and #2 (**Handout #2**) Review the answers (**Handout # 3)**

4. Resume discussion of Delusional Scenario

Considering his delusional thinking, how would you decide to proceed?

- Ignore his comment and try to assess his mental and emotional state
- Indicate concern, acknowledge that you heard what he said and focus on options to assist him

What's the difference between these 2 approaches?

- Delusions are very real to the person experiencing them. Ignoring his comment may indicate to him that you are not listening and this can increase his anxiety and prevent you from being able to establish rapport and engage with him
- Acknowledging you heard what he said indicates you are listening. You give him a sense of control by asking him what you can do to help.

If you choose to try and assess his mental state and he becomes increasingly agitated, what would you do next?

- Continue to try and dialogue with him
- Arrest him under the Mental Health Act

He has not demonstrated that he fits the criteria required for apprehension. Having a mental illness and being delusional is not sufficient grounds. Showing interest by continuing to try and talk with him may help him to calm.

He continues with his delusional thinking and he questions whether you are really listening to him. How would you proceed?

- Assist him to realize his parents are not the King and Queen
- Agree with what he is saying about his parents
- Acknowledge the importance of his parents

What are the differences between these approaches?

- You cannot reason a person's delusions away. The person is likely to become more anxious anxiety, feeling that you do not believe him and he then may refuse to talk with you further.
- Agreeing with Brian that his parents are the King and Queen is actually disrespectful. Mental illness is not synonymous with low intelligence. He may well recognize you are not being honest, which could result in him refusing to talk to you anymore
- Acknowledging that his parents are important to him demonstrates understanding of his feelings (empathy) and helps to build trust and rapport. He is likely to be willing to continue talking with you, which helps you to be able to assess his mental status more thoroughly

5. Learning Activities # 3 and #4 (**Handout #4**) Review the answers (**Handout #5)**

6. Resume Discussion of the Delusional Scenario

You continue to talk with him. You assess whether or not he is suicidal. You also ask him about harming anyone else. He denies both. You ask him if he's willing to go back to the hospital. He adamantly refuses saying if you try to force him that would be a crime against the royal family, which is punishable by death.

How would you respond?

- Take the mention of violence as a change in his behavior and arrest him under the Mental Health Act
- Continue the conversation, exploring his comments

Arresting him under the MHA is premature; you do not have evidence that he fits the criteria. You need to talk with him further in order to accurately assess the level of threat. You would ask him directly about his comments and if he intended to hurt either himself or anyone else. You would also want to assess if he was experiencing command hallucinations by directly asking him if he is hearing voices telling him what to do. His comments are part of his delusional thinking. Helping him to access community resources/supports would be a good option.

7. Review the Summary of Delusions (**Handout #6**)

8. Discuss community resources

Description of Delusional Scenario (Handout #1)

Dispatch Call

Respond to 123 Avenue group home for a disturbance. Male 16 year old was reported missing earlier that day. He was sent to Whitby Mental Health to see his doctor but left before seeing anyone. He has now returned. He was sent there because he assaulted another male resident. He has schizophrenia and has not taken his medication today.

Factors to Consider En Route to the Call

Has schizophrenia (mental disorder that impairs a person's ability to think clearly, manage his or her emotions, and relate to others)

Has not taken his medication today (may be starting to relapse)

Known to Whitby Mental Health Centre (has been in treatment, he was actually able to get himself there today, WMHC can be contacted for further follow up)

Earlier assaulted another resident of the group home (the majority of mentally ill persons are NOT violent)

Learning Activities for Delusional Scenario (Handout #2)

1. Characteristics of Delusion: Select applicable descriptors from the following list:

   False thinking

   Fixed beliefs

   Perceptual distortions

   Sensory distortions

   Cannot be reasoned away

2. Read the following descriptions of the different types of delusions. Then match the type with the correct example.
   A. **Delusion of jealousy**: Belief that spouse or lover is having an affair.
   B. **Erotomania**: Belief that another person, usually someone of higher status, is in love with him/her.
   C. **Grandiose delusion**: Exaggerated sense of self-importance; convinced that he/she has special powers, talents, or abilities.
   D. **Persecutory delusion**: Belief involving the theme of being followed, harassed, cheated, poisoned or drugged, conspired against, spied on, attacked, or obstructed in the pursuit of goals.
   E. **Religious delusion**: Any delusion with a religious or spiritual content.
   F. **Somatic delusion**: Belief that the body is somehow diseased, abnormal, or changed.

      Believing Madonna is secretly in love with you.

      Convinced that your spouse is being unfaithful.

      Thinking there are insects under your skin.

      Accusing your neighbour of spying on you.

      Fear that your food is poisoned.

      Announcing that you have supernatural powers.

Learning Activities for Delusional Scenario – Answers – Activity 1, 2 (Handout #3)

1. Characteristics of Delusion: Select applicable descriptors from the following list: Answer = 1, 2, 5 Delusion is a thought not a perception (5 senses)
   1. False thinking
   2. Fixed beliefs
   3. Perceptual distortions
   4. Sensory distortions
   5. Cannot be reasoned away

2. Read the following descriptions of the different types of delusions. Then match the type with the correct example.

A. **Delusion of jealousy**: Belief that spouse or lover is having an affair.

B. **Erotomania**: Belief that another person, usually someone of higher status, is in love with him/her.

C. **Grandiose delusion**: Exaggerated sense of self-importance; convinced that he/she has special powers, talents, or abilities.

D. **Persecutory delusion**: Belief involving the theme of being followed, harassed, cheated, poisoned or drugged, conspired against, spied on, attacked, or obstructed in the pursuit of goals.

E. **Religious delusion**: Any delusion with a religious or spiritual content.

F. **Somatic delusion**: Belief that the body is somehow diseased, abnormal, or changed.

Believing Madonna is secretly in love with you. (B)

Convinced that your spouse is being unfaithful. (A)

Thinking there are insects under your skin (F)

Accusing your neighbour of spying on you (D)

Fear that your food is poisoned (D)

Announcing that you have supernatural powers (C)

Learning Activities 3 and 4 for Delusional Scenario(Handout #4)

3. Responding with Empathy - From the following list, select all the examples of the empathetic responses.

    1. You're a great worker; I know you can handle it.
    2. You want to do a good job but you're frustrated by all the pressures.
    3. I think you let him push you around.
    4. You sound quite fed up with your husband’s lack of assistance at home.
    5. I really feel sorry for you.
    6. Everyone understands what it’s like to feel down.
    7. What I’m hearing is that you‘re anxious about returning to school in the fall.
    8. I sympathize with your insecurities about your weight.

4. Comparing Delusions/Hallucinations. Categorize the descriptors according to hallucinations or delusions

    Thoughts

    Perceptions

    False, fixed belief

    Sensory distortions

    Visual

    Cannot be reasoned away

    Without a stimulus

    Grandiose ideas

Learning Activities for Delusional Scenario – Answers for Activity 3, 4 (Handout #5)

3. Responding with Empathy - From the following list, select all the examples of the empathetic responses. Answer – 2, 4, 7 – connect with the feeling(s) being expressed.

    1. You're a great worker; I know you can handle it. (No, does not connect with the person's thoughts and feelings)
    2. You want to do a good job but you're frustrated by all the pressures. (Yes, connects with person's desire to succeed and feelings of frustration)
    3. I think you let him push you around. (No, does not connect with the person's thoughts and feelings)
    4. You sound quite fed up with your husband's lack of assistance at home. (Yes, connects with the person's feelings of annoyance that her husband doesn't help out at home)
    5. I really feel sorry for you. (No, is an example of sympathy)
    6. Everyone understands what it's like to feel down. (No, diminishes the person's feelings by equating them to how everyone else feels)
    7. What I'm hearing is that you're anxious about returning to school in the fall. (Yes, connects with the person's anxious feelings about academic life).
    8. I sympathize with your insecurities about your weight. (No, feeling sorry for the person who is concerned about their physical appearance.)

4. Comparing Delusions/Hallucinations. Categorize the descriptors according to hallucinations or delusions

Thoughts (D)

Perceptions (H)

False, fixed belief (D)

Sensory distortions (H)

Visual (H)

Cannot be reasoned away (D)

Without a stimulus (H)

Grandiose ideas (D)

Summary for Delusional Simulation (Handout #6)

Definition of Delusion

- false belief which is firmly sustained and based on incorrect inference about reality
- belief held despite evidence to the contrary; not accounted for by culture or religion
- can vary in strength over time
- Primary - no preceding reasons; strongly suggestive of schizophrenia
- Secondary - e.g. depressed person feeling worthless
- 3 main criteria required for a delusion
  - person absolutely believes the delusion
  - belief cannot be shaken
  - delusion is definitely untrue

Types of Delusions

- Jealousy - believe partner is being unfaithful
- Grandiose - belief of exaggerated self worth
- Persecutory - belief involving the theme of being threatened or conspired against
- Erotomania - belief a person, usually of higher status, is in love with him/her
- Religious – belief with a religious or spiritual content
- Somatic - belief that the body is somehow diseased, abnormal, or changed

Causes

- Neurological diseases e.g. dementia, brain tumours
- Psychiatric conditions e.g. schizophrenia, delusional disorder
- Psychotic disorders

Helpful Strategies for Managing Delusions

- Avoid arguing with the person; delusions are extremely fixed and difficult to change
- Connect with the emotion of the delusion e.g. 'It must be frightening to believe that you are Jesus Christ'
- Listen non judgmentally
- Calm things down - reduce the number of people and noise around the person
- Show compassion for the person's feelings and do what you can to help e.g. turn off the TV if they think it is talking to them.
- Call them by name or ask how they would like to be addressed
- Speak slowly, calmly and quietly; use simple language
- Allow them sufficient time to respond (may take longer to process information)
- Assess risk for suicide, harm
- Encourage person to seek help

DID YOU KNOW

- 30% - 70% of a GP's caseload consists of individuals whose problems are significantly related to psychological factors
- Canadian economy loses $30 billion annually due to mental health/addiction problems

Leader's Guide for Hallucination Scenario

1. Officers read the scenario (Hallucination Scenario – **Handout #1**)

2. Learning Activities #1, #2 and #3 **(Handout #2)** Review the answers **(Handout #3)**

3. Discussion of Hallucination Scenario

You arrive on scene to see that there is no blood, the lobby is deserted, and there is no sign of a struggle. You go up to the person's apartment. He's on the phone, yelling and pointing to the TV "they're in the lobby! Look at them. They're right there!

You try to engage him in conversation; he doesn't initially respond. What's happening? (persons who are actively hallucinating will appear preoccupied and may be slow to respond)

What approach would you take?

- Tell him you're here to help, encourage him to hand the phone over to your partner and engage him in a conversation about what he's seeing
- Help him to focus by directing him to put down the phone and turn off the TV so as to reduce the stimuli; emphasize that there's no one in the lobby

What's the difference between these 2 approaches?

While reducing stimuli may help him focus better on what you're saying; it's important to first establish some trust/rapport and to then encourage him to be a part of any decision making. It's important to acknowledge that you understand the hallucinations are very real to him before indicating you do not see the same thing; otherwise he "hears" you saying that he is lying and this will negatively affect any attempt to engage him.

Once you've established some rapport/trust with him, what would you do next?

- Take the time to reassure him that there's really nothing there.
- Acknowledge that you understand it's real to him, but that you don't see the same thing.

(Acknowledging that you understand his hallucinations are very real to him and responding with empathy to the feelings he's expressing is critical to developing trust and a positive relationship. Gathering information about the hallucinations can be helpful. It's also important to let him know that you do not see what he sees as this helps to reinforce reality)

Would you apprehend this young man under the MHA or refer him to community resources? What is your rationale?

(Does not fit criteria – danger self/others; lack of competence to care for self; having a mental illness is not sufficient reason to be assessed/hospitalized against your will)

4. Learning Activities #4, and #5 **(Handout #4)** Review the answers **(Handout #3)**

5. Review the Summary of Hallucinations **(Handout #6)**

6. Discuss community resources

Hallucinations Scenario (Handout #1)

Dispatch call:

Armed person call; male on line with ambulance talking about seeing twins with shotguns, can see them on TV through the lobby watch. Male states man is shooting 2 females. Male sounds very agitated. Male is talking to TV; advised that he has an 80 lbs compound bow for hunting deer, has agreed to put it in the bedroom. Male is calling from apartment 412. Paramedics will be standing by. Male is 37 years old.

Factors to Consider En route to the Call

Male	Males tends to be more violent than females. Young males have a higher rate of suicide
Level of agitation	Individual's ability to process information may be hindered. Be clear, talk slowly and avoid fast movements.
Weapons accessible	Majority of mentally ill persons are NOT violent
No address or person history	Obtaining as much information as possible would be helpful.

Learning Activities 1-3 for Hallucinations Scenario (Handout #2)

1. Recognizing/Understanding Hallucinations (Definition – perceptual distortions may involve any one of the five senses and there is no trigger)

From the following list, identify the behaviours that might be indicative of a person who is hallucinating.

1. Mumbling to oneself
2. Isolating, off by oneself
3. Spitting out food
4. Scratching, brushing things off oneself
5. Sniffing, holding ones nose
6. Looking around, appearing distracted
7. Appearing preoccupied, unaware of one's surroundings
8. Laughing out loud

2. What is the most common type of hallucination?

    Tactile

    Gustatory

    Auditory

    Olfactory

    Visual

3. From the following list, select examples of command hallucinations (Definition = hallucination that tells someone to do something)
    1. Feeling the FBI is spying on you.
    2. Believing the weather man on TV is talking to you.
    3. Preaching the word of God in response to a request from the Pope
    4. Being suspicious that someone is poisoning your food.
    5. Fasting because Madonna wants you to be thin.

Learning Activities for Hallucination Scenario – Answers for Activities 1-3 (Handout #3)

1. Recognizing/Understanding Hallucinations (Definition – perceptual distortions may involve any one of the five senses and there is no trigger)

   Correct answer = all of them.

1. Mumbling to oneself (individual is possibly responding to auditory hallucinations - voices)
2. Isolating, off by oneself (individuals who are hallucinating often try to "hide" the fact)
3. Spitting out food (possibly indicative of a gustatory hallucination – sense of taste is distorted)
4. Scratching, brushing things off oneself (possibly indicative of a tactile hallucination – sense of touch is distorted)
5. Sniffing, holding ones nose (possibly indicative of an olfactory hallucination – sense of smell is distorted)
6. Looking around, appearing distracted (individual is possibly responding to a visual or auditory hallucination)
7. Appearing preoccupied, unaware of one's surroundings (individual is possibly listening intently to auditory hallucinations – voices)
8. Laughing out loud (Individual may be responding to auditory hallucinations - voices)

2. What is the most common type of hallucination? Answer = auditory

   Tactile
   Gustatory
   Auditory
   Olfactory
   Visual

3. From the following list, select examples of command hallucinations (Definition = hallucination that tells someone to do something) Correct Answers = 3, 5

   1. Feeling the FBI is spying on you. (Incorrect – this is a suspicious thought = paranoid delusion)
   2. Believing the weather man on TV is talking to you. (Incorrect – also a thought = delusion/ideas of reference)
   3. Preaching the word of God in response to a request from the Pope (**Correct** – responding to what you hear the Pope telling you what to do)
   4. Being suspicious that someone is poisoning your food. (Incorrect – is a thought = paranoid delusion)

5. Fasting because Madonna wants you to be thin. (**Correct** – responding to a request from Madonna for you to be thin)

Learning Activities 4 & 5 for Hallucination Scenario (Handout #4)

4. Match the Form with the correct explanation

   Form 1

   Form 2

   Form 3

   Form 4

   A. Certificate of Renewal allows for a person to be kept in a psychiatric facility for an additional month.
   B. Order from a Justice of the Peace for a person to be taken to hospital for a psychiatric assessment.
   C. Lasts for 7 days after being signed. Allows a doctor to hold you for up to 72 hours in a hospital to complete a psychiatric assessment.
   D. Certificate of Involuntary Admission signed by a physician allows for a person to be held in hospital for up to 2 weeks.

5. From the following list, select the signs/symptoms of depression:
   1. Sad, despairing mood that lasts for more than 2 weeks
   2. Impairs performance at work, school or in social relationships
   3. Difficulty Sleeping
   4. Overeating
   5. Lack of appetite
   6. Weight loss
   7. Fatigue
   8. Irritability
   9. Trouble concentrating
   10. Difficulty making decisions
   11. Agitation
   12. Feeling slowed down
   13. Feeling helpless/hopeless
   14. Loss of interest in previously pleasurable activities
   15. Low self esteem
   16. Guilty feelings

17. Hallucinations
18. Delusions
19. Crying easily
20. Inability to cry
21. Withdrawing from family and friends

Learning Activities for Hallucination Scenario – Answers for Activities 4-5 (Handout #5)

4. Match the Form with the correct explanation

   Form 1 = C

   Form 2 = B

   Form 3 = D

   Form 4 = A

   A. Certificate of Renewal allows for a person to be kept in a psychiatric facility for an additional month.
   B. Order from a Justice of the Peace for a person to be taken to hospital for a psychiatric assessment.
   C. Lasts for 7 days after being signed. Allows a doctor to hold you for up to 72 hours in a hospital to complete a psychiatric assessment.
   D. Certificate of Involuntary Admission signed by a physician allows for a person to be held in hospital for up to 2 weeks.

5. From the following list, select the signs/symptoms of depression: **Correct Answer = ALL**
   1. Sad, despairing mood that lasts for more than 2 weeks
   2. Impairs performance at work, school or in social relationships
   3. Difficulty Sleeping
   4. Overeating
   5. Lack of appetite
   6. Weight loss
   7. Fatigue
   8. Irritability
   9. Trouble concentrating
   10. Difficulty making decisions
   11. Agitation
   12. Feeling slowed down
   13. Feeling helpless/hopeless
   14. Loss of interest in previously pleasurable activities
   15. Low self esteem

16. Guilty feelings
17. Hallucinations
18. Delusions
19. Crying easily
20. Inability to cry
21. Withdrawing from family and friends

Summary for Hallucinations Simulation (Handout #6)

What is Psychosis?

- Mental health challenge in which a person is not in touch with reality.
- Severe disturbances in thoughts, feelings and behaviours (hallucinations, delusions)

Mental illnesses associated with psychosis

- Schizophrenia
- Bipolar Disorder (manic depressive disorder)
- Major Depression
- Schizoaffective Disorder
- Drug Induced Psychosis

Causes of Psychosis

- Combination of genetic, chemical and stress related factors.

Definition of Hallucination

- Perceptual distortion involving one of the 5 senses (sight, hearing, taste, touch, smell)

Types of Hallucinations

- Visual; Auditory; Gustatory; Tactile; Olfactory

Command Hallucinations

- An auditory hallucination that tell the person to do something
- Can be an increased risk since the person may go ahead and act on what the voice(s) is telling him/her to do

Helpful Strategies for Engaging a Person Who is Experiencing Hallucinations

- Help alleviate fears; create a calm environment – respect personal space; do not touch them without permission; encourage person to sit down if possible; adopt a non threatening stance
- Call them by name or ask them how they would like to be addressed
- Speak slowly, calmly and quietly; use simple language
- Allow them sufficient time to respond (may take longer to process information
- Reduce stimuli (turn off radios, televisions, bright lights when possible)
- Help person focus on reality – ask person to focus on your voice; to look at you
- Listen non judgmentally; Do not argue with their hallucinations – they are REAL to them
- Acknowledge the person's emotional stress
- Provided reassurance and information; don not make promises you cannot keep
- Do not lie; Do not pretend that you are experiencing similar hallucinations
- Assess risk for suicide, harm
- Comply with reasonable requests – allows person to feel a sense of control
- Encourage person to seek help

Did You Know…

- 20% of Canadian workers experience a stress related illness per year (2001).
- Depression is expected to rank 2nd in global diseases, after heart disease, by 2020.

Leader's Guide for Personality Disorder Scenario

1. Officers review the scenario (Personality Disorder scenario – **Handout #1)**

2. Officers complete Learning Activity #1, #2 and #3 **(Handout #2)** Discuss answers with group after each activity **(Handout #3)**

3. Discussion of Personality Disorder Scenario

After talking with the mother, you go upstairs, knock on the daughter's bedroom door. You tell her your name and say you're from the DRPS. She yells at you to go away and to take her mother with you. She states that she hasn't broken any laws.

At this point what would you choose to do?

- Force the door open
- Talk to her through the door
- Focus on getting her to open the door

What are the differences between these 3 approaches?

- Focusing on the door can lead to a power struggle and could further escalate the situation. Although you cannot see her, she is communicating with you.
- Storming into the room could intensify the situation and increase the risk. She is communicating with you (so not in imminent danger). How you engage with her this time will have an impact on her response to any future contact with police.
- Talking to her initially through the door, gives her time to calm and she may then decide to open the door.

What strategies would you use as you try to engage with her? (respond with empathy; indicate interest in listening to her "story"; avoid being judgmental, allow her to vent her frustrations)

You succeed in establishing some rapport – you indicate you would like to sit down and talk with her further. She decides to open the door.

What would you want her to know first? (There is another officer with you)

Once in the room, how would you proceed? (Continue to build rapport)

- Encourage her to tell her "story"
- Continue to demonstrate empathy (discuss meaning of empathy)

She goes on to express her frustrations with her mother.

What other information would you want to gather/communicate? (Focus on the present circumstances)

- Ask about drinking/drugs
- Ask about any attempts to hurt herself
- Ask directly about any suicidal thoughts/intent
- Acknowledge her good decision – coming to her room to avoid further conflict with her mother
- Ask about the knife and ask her if you may take it
- Ask if she'd be willing to speak with a professional

Building rapport and trust helps facilitate a positive interaction.

How you approach this situation can affect how she will respond to any future contacts with police.

4. Officers complete Learning Activity #4 (Criteria for Involuntary Admission under MHA - **Handout #4)** Discuss answers with the group **(Handout #5)**

5. Continue the discussion about the scenario

She indicates she is willing to talk with someone

Would you choose to apprehend this young woman under the MHA or refer her to community resources? What is your rationale?

- She does not fit the criteria
- You asked directly - both she and her mother denied any suicidal thoughts/intent
- Individuals who "cut" themselves do not do so with the intent to kill themselves (it is a way of relieving their psychic pain by creating physical pain)
- Accessing community resources would provide supports for her and her family

6. Officers complete Learning Activity #5 **(Handout #6)** Empathic Responses **Handout #7)** Discuss answers with the group

7. Continue discussion of scenario (how you would complete this call)

You contact a crisis worker, he arrives and you introduce him to the young woman

You speak with mother again to outline the decisions/plans that have been made

8. Review the Summary of Personality Disorder **(Handout #8)**

9. Discuss community resources

Description of Personality Disorder Scenario (Handout #1)

Dispatch call

6102, 604, to attend 728 Allstate St. Mother calling in about 17 year old daughter who has been depressed and known to self-cut. Has locked herself in her bedroom and won't respond to mom. Has been violent towards mom in the past. Police have attended 6 times before.

You arrive on scene and speak with the mother before going up to talk to the daughter

Mother provides you with the following information:

- Lately 17 year old daughter has been getting into trouble lately– not following rules, problems at school
- Last night she was drinking, mother and daughter got into an argument today, daughter has barricaded herself in her room
- Has not been drinking today
- Is concerned she is cutting herself; she has cut herself superficially twice before
- Believes she has a knife somewhere in her room – mother has not been able to find it
- She is being seen by her family doctor – she's taking medication for her anger
- She is not suicidal; does not take street drugs

Learning Activities for Personality Disorder Scenario (Handout #2)

1. Violence and Mental Illness – Based on the above scenario, select the potential indicators of violence from the following list:

    1. Gender
    2. Childhood abuse
    3. Socioeconomic status
    4. Age
    5. Substance abuse
    6. Stressful/unpredictable environment
    7. Little or no social support
    8. Previous history of violence

2. What is the greatest predictor of violence?
    1. Having a chronic mental illness
    2. Past history of violence
    3. Being a young male with schizophrenia
    4. History of sexual abuse
    5. Manic behaviour
    6. Refusal to take medication

3. Medication- Classify the following medications under the correct categories:
   Antidepressant (AD) Antipsychotic (AP) Antianxiety (AA) Mood Stabilizer (MS)
   Doxepin (Sinequan)

    Lorazepam (Ativan)

    Quetiapine (Seroquel)

    Risperidone (Risperdal)

    Fluxetine (Prozac)

    Haloperidol (Haldol)

    Clozapine (Clozaril)

    Carbolith (Lithium)

    Valproic acid (Depakene)

    Diazepam (Valium)

    Paroxetine (Paxil)

Learning Activities for Personality Disorder Scenario – Answers 1-3 (Handout #3)

1. Violence and Mental Illness – Based on the above scenario, select from the following list the potential indicators of violence. Answer = 6, 7, 8

    1. Gender (no – males are more likely to be violent than females)
    2. Childhood abuse (no evidence of this)
    3. Socioeconomic status (no evidence this is an issue)
    4. Age (no, more common in the 20s)
    5. Substance abuse (no, she denies using drugs)
    6. **Stressful/unpredictable environment (yes, previous divorce, current stressors with mother)**
    7. **Little or no social support (possible – parents are separated, she does not see her mother as a support)**
    8. **Previous history of violence (yes, pushed mother; also has previously "cut" herself)**

2. What is the greatest predictor of violence? Answer = 2

    1. Having a chronic mental illness
    2. **Past history of violence**
    3. Being a young male with schizophrenia
    4. History of sexual abuse
    5. Manic behaviour
    6. Refusal to take medication

3. Medication- Classify the following medications under the correct categories:
    Antidepressant (AD) Antipsychotic (AP) Antianxiety (AA) Mood Stabilizer (MS)

    1. Doxepin (Sinequan) AD
    2. Lorazepam (Ativan) AA
    3. Quetiapine (Seroquel) AP
    4. Risperidone (Risperdal) AP
    5. Fluxetine (Prozac) AD
    6. Haloperidol (Haldol) AP
    7. Clozapine (Clozaril) AP
    8. Carbolith (Lithium) MS
    9. Valproic acid (Depakene) MS
    10. Diazepam (Valium) AA
    11. Paroxetine (Paxil) AA

Learning Activities for Personality Disorder Scenario (Handout #4)

4. What are the criteria for involuntary admission under the Mental Health Act?

    1. History of serious mental illness (no, criteria is based on a person's current status, not past history)
    2. Experiencing hallucinations (no, having hallucinations does not necessarily put the person or others at risk for harm)
    3. Experiencing delusions (no, being delusional does not necessarily put the person or others at risk for harm)
    4. Danger to self
    5. Danger to others
    6. Deteriorating to the point of requiring hospitalization

Learning Activities for Personality Disorder Scenario – Answers 4 (Handout #5)

4. What are the criteria for involuntary admission under the Mental Health Act?
   Answer = 4, 5, 6

1. History of serious mental illness (no, criteria is based on a person's current status, not past history)
2. Experiencing hallucinations (no, having hallucinations does not necessarily put the person or others at risk for harm)
3. Experiencing delusions (no, being delusional does not necessarily put the person or others at risk for harm)
4. **Danger to self**
5. **Danger to others**
6. **Deteriorating to the point of requiring hospitalization**

Learning Activities for Personality Disorder Scenario (Handout #6)

5. Responding with Empathy - Select the empathic response(s) from the following list:

    1. “I know exactly how you feel; I have had similar concerns.”
    2. “Try not to worry; I promise everything will work out.”
    3. “It must be difficult to feel so alone and frightened.”
    4. “Everyone gets depressed now and again; you’re in good company.”

Learning Activities for Personality Disorder Scenario Answer 5 (Handout #7)

5. Responding with Empathy - Select the empathic response(s) from the following list: Answer = 3

    1. "I know exactly how you feel; I have had similar concerns." (No) (Explanation – Focusing on how you feel minimizes the feelings of the other person)

    2. "Try not to worry; I promise everything will work out." (No) (Explanation – Providing false reassurances)

    3. "It must be difficult to feel so alone and frightened." (Yes) (Explanation – Acknowledges the feelings being expressed)

    4. "Everyone gets depressed now and again; you're in good company." (No) (Explanation – Equating the person's feelings with how everyone else feels minimizes the person's feelings.

Summary for Personality Disorders (Handout #8)

Personality disorders involve patterns of behaviour, mood, social interaction, and impulsiveness that cause distress to the persons experiencing them, as well as to other people in their lives.

Causes of Personality Disorders

- Combination of early life experiences, genetics and environmental factors.

There are several types of personality disorders. Some of the more common types:

Type	**Patterns**
Borderline Personality Disorder	Unstable interpersonal relationships, self image, mood Impulsive
Antisocial Personality Disorder	Disregard for, and violation of, the rights of others.
Narcissistic Personality Disorder	Grandiosity, need for admiration, and lack of empathy.
Paranoid Personality Disorder	Distrust and suspiciousness in which others' motives are interpreted as malicious.
Obsessive-Compulsive Personality Disorder	Preoccupation with orderliness, perfectionism and control.

Treatment of Personality Disorders

- Difficult to treat – tend to deny problems
- Unless they are suicidal, most are treated in the community rather than in hospital
- Many are never diagnosed or treated

Helpful Strategies

- Calm, matter of fact approach
- Listen without judging
- Focus on the present (not past events)
- Encourage participation in decision making, finding solutions
- Convey confidence in their ability to regain/maintain self control
- Carefully assess any suicidal threats

DID YOU KNOW - According to the World Health Organization, 5 of the top 10 disabilities worldwide are mental illnesses. Currently there are a billion and a half people in this world living with a mental illness.

Leader's Guide - Suicidal Behaviour

1. Officers read the scenario (Suicide Scenario – **Handout #1)** – Ask them what suicidal risk factors they identify
   - Young man
   - Mentally illness, currently agitated and losing control
   - Tourette's Syndrome (chronic illness)
   - Previous history of violence.
   - Loss of girlfriend.

2. Officers complete Learning Activities **(Handout #2)** – discuss the answers with the group following each of the activities **(Handout #3)** – Explain **psychosis** (fact/myth activity)

3. Discussion of the suicidal scenario

You head over to the park to see if you locate the person. He's in the park, holding a knife in his hand.

As you approach him, he indicates he will shove the blade in his head if you come any closer. What would be your approach? (Use of Force – your gun is drawn)

- Try to engage with him and focus on getting him to drop the knife OR
- Try to engage with him about how he is currently feeling

What's the difference between these 2 approaches?

- Focusing on gun – adds to his fear/agitation – could become a power struggle -he's not feeling in control, knife gives him a sense of control – more likely to use it on himself (Suicide by Cop is also a consideration)
- Focusing on his emotions – Helps to calm so he may be able to give up the knife

If you choose to keep your gun drawn, and the person becomes increasingly agitated what can you do to try and safely manage the situation? (minimize the gun, explain the rationale, engage him in conversation, emphasize you want to help and do not want to hurt him, attempt to get him to participate in the decision making (keep everyone safe)

Would you apprehend this young man under the MHA or refer him to community resources? What is your rationale?

What are the implications of police encounters on individuals' perceptions/responses to future police contacts?

4. Review the Summary of Suicidal Behaviour **(Handout #4)**

5. Discuss community resources

Learning Activities for Suicidal Scenario (Handout #2)

1. Are there other factors to consider other than the risks factors when trying to assess an individual's level of intent to follow through on their threats?

2. Which of the following statements are Facts about Suicide?

    1. Only depressed people kill themselves.

    2. Young people and seniors are least likely to consider suicide.

    3. Suicide is more common among individuals with a lower socioeconomic status.

    4. There is a high correlation between suicide and substance abuse.

    5. Only hospital staff or mental health professionals can prevent suicide.

    6. Suicidal persons rarely seek medical attention so it is difficult to identify them

    7. Improvement during hospitalization means the danger of suicide is over.

    8. The presence of a psychosis increases the risk of suicide

    9. .A suicidal person is most often unsure about his/her desire to die.

    10. People who talk about killing themselves rarely do.

    11. Suicide happens without warning.

    12. Once a person has made a suicide attempt, he/she will always have suicidal impulses.

    13. An individual who is grieving the death of a friend who committed suicide is at a greater risk for committing suicide

    14. Asking a person about his/her suicidal intention may put the idea into his/her head.

    15. Most suicides are completed with a drug overdose.

3. Which of the following individuals is/are at: Least risk for suicide? Moderate risk? High risk?

    1. A young college student actively involved in college sports, recently informed he has been placed on academic probation.

    2. A young woman with a history of schizophrenia and command hallucinations.

    3. An elderly widowed male, recently diagnosed with prostate cancer

    4. A high school teacher, 2 young children, recently diagnosed with depression and taking antidepressants for the past week.

    5. A police officer identified as subject officer in an SIU investigation, increased alcohol consumption, wife is pregnant.

    6. A middle aged female, strong religious ties in her community, recently fired from her job.

    7. A university graduate, recently approved as a Big Brother, family history of suicide, has had difficulty getting employment in his field of expertise.

    8. A married, employed male, 2 children.

    9. A married woman, recently hospitalized with severe depression and suicidal ideation, discharged home after 6 weeks of antidepressant medication, reported by family members to be showing improvement.

4. In the scenario you just read, what is this young man's level of risk for acting on his suicidal threats?

    A. Least risk

    B. Moderate risk

    C. Greatest risk

Learning Activities for Suicidal Scenario - Answers (Handout #3)

1. If you answered…

Yes: Right Answer. Certain factors can in fact act as protection against the likelihood of an individual acting on his/her suicidal ideation;

No: Incorrect. In assessing suicide risk it is also important to consider if there are any factors that can in fact act as protection against the likelihood of an individual acting on his/her suicidal ideation. Below is a list of possible protective factors:

External Factors

1. Family cohesion, e.g., involvement, shared interests and emotional support.
2. Good relationships with other youth and adults.
3. Academic achievement.
4. Stable environment.
5. Social integration and opportunities to participate in activities.
6. Responsibilities for other people or pets.
7. Adequate care for substance use, physical and mental disorders.
8. Lack of access to means for suicidal behaviour.
9. Connection to a religious community.

Internal factors

1. Sense of belonging.
2. Sociability, i.e., ability to be a friend.
3. Love of learning.
4. Perceived connectedness to school.
5. Sense of worth and self-confidence.
6. Self-motivation.
7. Help-seeking and advice-seeking behaviour.
8. Service, i.e., gives of self in service to others or a cause.
9. Life skills, e.g., good decision-making, assertiveness, impulse control, coping skills, flexibility and perseverance

2. If you answered… 4, 8, 9, 13: Fact

Fact

	Explanation
There is a high correlation between suicide and substance abuse	Alcohol and drugs are factors in 85% of all suicides, but they are not direct causes
The presence of a psychosis increases the risk for suicide	Individuals who are not in touch with reality may respond to their delusions and/or hallucinations, which may be causing them to believe they should kill themselves
Suicidal person is most often unsure about his/her desire to die	The suicidal person wants to end the pain and despair not necessarily to die
An individual who is grieving the death of a friend who committed suicide is at a greater risk for committing suicide	Unresolved grief can progress to a depression; also there is a genetic component to mental illness so if the 2 individuals were related, there is an increase risk

Myth

	Explanation
Young people and seniors are least likely to consider suicide	Individuals between the ages of 16-24 and over the age of 65 have the highest rates of suicide
People who talk about killing themselves rarely do	8 out of 10 people who die by suicide give clues to their intention up to several months prior to the attempt
Only depressed people kill themselves	Depression is a common factor in suicidal behaviour but depression alone may not lead to suicide
Suicide is more common among individuals with a lower socioeconomic status	Suicide transcends all cultural, economic, and social boundaries

Suicide happens without warning	Most suicidal people convey their intent to at least 1 other person prior to the attempt
Improvement during hospitalization means the danger of suicide is over	The first 3 months after an attempt is the highest risk time for another attempt
Once a person has made a suicide attempt, he/she will always have suicidal impulses	With counseling and support a person may never again consider suicide as a viable option
Only hospital staff or mental health professionals can prevent suicide	Any caring person who offers emotional support can help prevent suicide
Asking a person about his/her suicidal intention may put the idea into his/her head	A person does not develop and act on a suicide plan because they were asked about suicidal thoughts
Suicidal persons rarely seek medical attention so it is difficult to identify them	Many suicidal individuals have sought some kind of medical care; however, they may not voluntarily discuss their suicidal thoughts. It is always important to assess an individual's suicidal intent
Most suicides are completed with a drug overdose	Drug overdoses are very common method for committing suicide, particularly for women; however, if the person is found quickly and treated, there is a good chance for survival

3. Least: 1, 6, 8; Moderate: 4, 7; High: 2, 3, 5,

Least

	Explanation
Young college student actively involved in college sports, recently informed he has been placed on academic probation	Risk factor is age, protective factor is sense of belonging, engaged in activities
Middle aged female, strong religious ties in her community, recently fired from her	Only potential risk factor is a recent stressor, protective factor is strong ties to

job	the community
Married, employed male, 2 children	Only potential risk is gender; has some protective factors – married with children; income)

Moderate

	Explanation
High school teacher, 2 young children, recently diagnosed with depression and taking antidepressants for the past week	Diagnosis of depression, medication has not had a chance to take effect; protective factors – employed, dependents, not high risk age category
University graduate, recently approved as a Big Brother, family history of suicide, has had difficulty getting employment in his field of expertise	Family history of suicide; stressor related to employment; possible hopelessness related to employment status; protective factor – he's sought out volunteer opportunities

High

	Explanation
Young woman with a history of schizophrenia and command hallucinations	Schizophrenia with command hallucinations – may act on voices
Elderly widowed male, recently diagnosed with prostate cancer	Several risk factors – age, widowed, potentially life threatening illness, no known protective factors
Police officer identified as subject officer in an SIU investigation, increased alcohol consumption, wife is pregnant	High stress job, currently involved in an organizational conflict, access to firearms, substance use; protective factor – child on the way
Married woman, recently hospitalized with severe depression and suicidal ideation, discharged home after 6 weeks of antidepressant medication, reported by	Depression, suicidal ideation, medication has had time to be effective and may now provide the energy required to act on her suicidal thoughts; improvement may be

family members to be showing improvement	indicative that she has made a decision to follow through; protective factors – gender, age and under care of a physician

4. Greatest risk is Correct - he has several of the known risk factors for suicide - young, male, ongoing, suicidal ideation, has the means; recent loss, chronic medical condition

Summary for Suicidal Behaviour (Handout #4)

Major Risk Factors

- Serious physical/mental illness
- Drug/alcohol abuse
- Major loss (death, unemployment, divorce)
- Major changes in life (seniors, adolescents)
- Previous suicide threats
- Family member who committed suicide (modeling a maladaptive coping mechanism)
- A few weeks after anti-depressant treatment was initiated/post discharge from hospital (they now have the energy to do it)

Warning Signs

- Feelings of helplessness/hopelessness
- Change in behaviour – engaging in risk talking
- Sudden change to a cheerful mood
- Giving away possessions
- Depression – difficulty sleeping, withdrawn; lack of interest in activities
- Talking about death/dying
- Preparing for death – making a will

Helpful Strategies

- ASK what's been happening; encourage person to talk about his/her feelings
- LISTEN without judgment
- ASSESS the risk – Risk Factors? Protective Factors?
- ASK directly about suicidal thoughts? PLAN? MEANS to carry out the plan?
- INDICATE your concern
- ASK what you can do to help; TALK about resources; supports
- GET HELP

Did You Know…

- Suicide is a worldwide concern – globally, every 40 seconds someone commits suicide.
- Depression is the most common mental illness leading to suicide
- 121 million people worldwide suffer from depression
- Depression is expected to rank 2nd in global diseases, after heart disease, by 2020