COURSE GRADE COVER SHEET

Complete student information portion, make copies, and submit one form with each course.
(In the event you are not able to make copies, please hand-write this page with each course.)

I have read the frequently asked questions on the back of this page: XX ***Yes*** ___ ***No.***

Student Number (Same as Inmate Number) 180161

Student Name: Eric St. George

Student Address: c/o CCF--180161; PO Box 600

City: Cañon City State: CO Zip Code: 81215

Unit Number: Fox Name of Prison: Centennial

Degree you are working toward: Masters of Ministry & Christian Counseling

My records indicate this is my 5th course. (paper 1 of 3)

Course Number & Title: or Name of Book From the Bible: CO0623 Counseling for Crisis and Addiction

Book Title: Mental Health First Aid

Author: National Council for Behavioral Health

Begin/End Date of Enclosed Course: Jan 1 / Jun 30 2024

Please note that if you are turning in a course that involves textbooks you need to turn in a complete course that normally has three books.

To Be Completed By Student:

Do you need us to send you your next course? ___ *YES* XX *NO*

(This question applies only to those working on books of the Bible)

If no, what books will you use for your next course?

___

___

___

Please give us the name and ID number of a few people that are interested in receiving information on attending our college. Thanks and God Bless You!

1. ___
2. ___
3. ___

International Christian College and Seminary
P.O. Box 530212 • Debary, Florida 32753-0212
www.iccscampus.org

Q: Can you send me another grade coversheet?
A: You can handwrite your grade cover page.

Q: How long does it take to grade my work?
A: We normally send correspondence out once per month. However, you do not need to wait on us to grade your work to continue your courses.
If you are doing books from the Bible, we can e-mail them to your loved ones and they can print and send them to you. Just ask them to e-mail us.

Q: Can I do my courses in pencil?
A: Yes, but only if you have access to nothing else.

Q: Should I staple or paperclip my work?
A: If you do it is ok. However, we prefer that you do not use staples or paper-clips because we scan your work and it takes time to remove them from the papers.

Q: What course will books from the Bible substitute for?
A: We use the books from the Bible as foundation courses. You need 20 courses to graduate. We will determine which courses they will substitute for as you get closer to graduating.

Q: Is there a way I can contact you other than by mail?
A: If you are a federal inmate in good standing you can send me an invitation on Corrlinks and I will accept. If you are a state inmate you can have your loved ones forward an e-mail to me and I will respond. My e-mail is drmccorkle@iccscampus.org. You, your family or friends are welcome to call me. My cell number is (407) 760-5616. The office number is (877) 391-3741 ext. 700. As long as I do not have to pay, I will accept all calls. If for any reason you do not reach me on your first attempt, please keep trying. I will pick up.

Q: How do I know if books I have available are acceptable to use as substitutions?
A: As you know, we have a list of suggested books for your degree. However, we can customize some of your future courses to assist you in obtaining your goal. Everyone knows what they need help with. Please pray about it and once you have identified an area where you would like to improve, look in your chapel library or psychology department for a combination of books that are 900 pages. Once you find the books give me the name of the book, the author and the page numbers and I will enter these as a custom course for you.

Q: Is there a time limit for each course?
A: No, you can work at your own pace.

Q: Can I send in my work if my tuition is not current?
A: Please do not send in your work if your tuition is not current. If your tuition is not current your student file is flagged on hold in our system and we are unable to grade any work until the tuition is current. If the college does not receive a payment within 90 days the student file is permanently closed.

Q: I have been writing sponsor letters but have not obtained a sponsor.
A: Some students have to write 50-100 letters before they received a positive response. It depends on your letters. You need to pray and write each one individually from your heart. Also, ask family and friends to help find sponsors.

Q: Will I receive feedback from the graders/readers?
A: Courses are graded by graduate students. They jot down notes for me to read about each of your papers. They normally put down opinions that are highlighted to advise that this is interesting. Unless they point out a problem on the paper, I will accept it as-is. If they provide a problem, I return the paper with their notes asking you to re-do and re-submit. In the past I would write down some comments and students would brag to other students in their dorm making them feel inferior. For that reason, I normally just keep to the basic comments. I know some of you put a lot in your papers and deserve complete feedback. You can call me from your chaplain's or unit man- ager's office and I will be glad to discuss your papers in full detail.

Q: Can you send back my original work?
A: When we receive your work, your courses and correspondence are scanned into your student records. If you want your original work sent back to you, you must send us a self-addressed, stamped brown envelope with as many stamps as you used to send your original work to us, clearly stating that you want all of your work returned. Once your tuition is paid, if you want a copy of your work, we will email it to you upon your release or you can have your sponsor send a request and we will email it to them.

Q: How long can I use the Books from the Bible?
A: You can use books/questions from the Bible up to your Bachelor's Degree.

Q: Tell me again about your accreditation
A: We are accredited by the International Theological Accountability Association (ITAA) and are recognized by the Department of Education in Florida. ICCS has been privileged to work with several regionally accredited colleges and universities that do accept some ICCS course transfer credits into their programs. This offers our students the option of benefitting from their ICCS training when pursuing a formal degree at various academic institutions.

There are different kinds of accreditation. Governmental Accreditation and non-governmental accreditation. Governmental accreditation is requested in order to receive student aid money. We, along with Rhema Bible College and many more, choose non-governmental accreditation. With governmental accreditation, we would not be able to offer higher degrees unless the student took some courses on campus. That would make our prison program ineffective to you and many others.

Q: How many credits are each course?
A: Three (3) credits or one (1) course is equivalent to 45 contact hours,
60 credits or 20 courses is equivalent to 900 contact hours.

A contact hour is a measure that represents an hour of scheduled instruction given to students. A semester credit hour is normally granted for satisfactory completion of one 50-minute session (contact hour) of classroom instruction per week for a semester of not less than fifteen weeks.

Q: Do I have to start with my Associate's degree or can I go directly to my Doctorate degree?
A: If you have college credits, we need to see the official transcripts and we will enroll you in the appropriate degree program. If you have no college credits you need to start with the Associate's degree. The undergraduate degrees (Associate's and Bachelor's) each require 60 credits or 20 courses to graduate. For graduate degrees, the Master's requires 48 credits or 16 courses plus a Master's thesis and the Doctorate requires 36 credits or 12 courses plus a dissertation paper to graduate.

Q: Will you write a letter to the Parole board for me?
A: Yes. If you are a student in good standing with us, we will gladly help with Parole and Letters to the court. You must have a hearing date. If the date is near, I suggest you have your family or friends get in contact with us so we can have the rough draft approved and we can obtain the name and address of who you want it addressed to. Otherwise, you can write to us with the information.

Q: How can I help ICCS?
A: Help us spread the word about our college by sharing the school's flyer wherever you can i.e. your prison chapel, library or common area.
You can also support us through prayer and by recommending us to your friends who are interested in pursuing a theological degree. To go a step further, consider "paying it forward" by sponsoring a new student.

Q: Why is my coursework postmarked from Austin, Texas?
A: Our grading center is in Austin, Texas. All of your correspondence is to be sent to:

International Christian College and Seminary
P.O. Box 530212
Debary, FL 32753

Q: Can I continue my degree when I am released?
A: Yes. You are welcome to continue upon your release. We will keep your tuition at the same price for the first two years. You will have an option of taking your classes online or textbooks or a combination of the two. It will be your choice.

Q: What is the cost for my next degree?
A: We offer men and women in prison an 85% discount from our normal tuition. Our current tuition is $9,497.00 (It continues to go up each year). We offer it to inmates at $1,425. If you pre-pay you receive an additional discount and only pay $997. Please note that the rate you will be paying is $22.00 per credit hour. The standard community college charges between $150 - $300 per credit hour. There is no additional discount.

COUNSELING FOR CRISIS AND ADDICTION
C00623
(paper 1 of 3)

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Text Read: Mental Health First Aid USA, first edition (revised)
ISBN: 978-0-692-60748-0, 133 pages in 3 sections and 8 chapters
National Council for Behavioral Health and the Missouri Department of Health

Section One: Mental Health Problems. (ch 1) Mental Health Problems in the United States (ch 2) Mental Health First Aid Section Two: First Aid for Developing Mental Health Problems (ch 3) Depression (ch 4) Anxiety Disorders (ch 5) Psychosis (ch 6) Substance Abuse Disorders (ch 7) Eating Disorders Section Three: First Aid for Mental Health Crises (ch 8) First Aid for Mental Health Crises

INTRODUCTION: Reviewing the foreword of the text. The Mental Health First Aid Training and Research program was developed in Australia in 2001 by Betty Kitchener and Anthony Jorm. The purpose of Mental Health First Aid is to respond in a mental health emergency and offer support to someone who appears to be in emotional distress.

It is estimated that one in five Americans will experience a diagnosable mental disorder in any given year. [Substance Abuse and Mental Health Services Administration. Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49 HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.] This is a prevalence that is greater than heart disease, lung disease, and cancer combined. [12-month Prevalence Estimates in the National Comorbidity Survey Replication (NCS-R). Harvard School of Medicine, 17 July 2007] Mental Health First Aid may be used to respond to individuals in distress as a result of depression, anxiety, substance abuse, eating disorders, trauma, psychosis, and deliberate self-injury. The key concepts are "trust" and "relationship." These are key because people in mental health distress are leery of those who offer assistance as a result of stigma. Stigma can appear as prejudice, discrimination, fear, distrust, and stereotyping. Stigma is one of the biggest barriers to seeking help, and as such is a prime barrier to recovery. [Babic, D. "Stigma and Mental Illness." Materia Socio Medica, 22(1):43-46. (2010)]

Mental health disorders were once believed to be rare, but today it is known that they are fairly common. People with mental health illnesses lead full, and satisfying lives. Many misconceptions about mental healt disorders exist, to include: mental health disorders are signs of weakness or personality flaws, people with mental health disorders are violent, and "healthy" people aren't affected by traumatic events. These are myths. Mental disorders have nothing to do with laziness or lack of willpower. Research shows that people with mental disorders are actually no more violent than the population at large. Contrarily, they are 11 times more likely to be victims of violence than the general public. [Teplin, L.A., McClelland, G.M., Abram, K.M., and Weiner, D.A. Crime victimization in adults with sever mental illness: Comparison with the national crime victimization survey. Archives of General Psychiatry. 62:911-921 (2005)] Further, according to the research the vast majority of violent people do not suffer from mental disorders. [Teasdale, B. Mental disorder and violent victimization. Criminal Justice and Behavior. 36(5):513-535 (2009)] Trauma can affect anyone, even if they are not suffering with a mental disorder. Author Viktor Frankl wrote: "An abnormal reaction to an abnormal situation is normal behavior." [Man's Search for Meaning (1959)] Soldiers returning from tours in foreign wars actually have an extremely high level of suicidality according to the U.S. Department of Veteran Affairs Suicide Prevention [www.mentalhealth.va.gov (4 JAN 2016)]

RECOVERY FROM MENTAL DISORDERS

Research from the 1980's showed that for people who had once been institutionalized a high percentage of them were living successfully in their communities when researchers followed them 30 years later. [Gagne, C., White, W., and Anthony, W.A., Recovery: A common vision for the fields of mental health and addictions. Psychiatric Rehabilitation Journal. 31(1):32-37 (2007)] Recovery is defined by many as the reduction or complete remission of symptoms. [New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America. Final Report. (DHHS Pub. No. SMA-03-3832) (2003)]

The federal Substance Abuse and Mental Health Services Administration lists these components as core to recovery: "Hope," "Nonlinear," "Strengths-Based," "Peer Support," "Self-Direction," "Responsibility," "Holistic," "Individualized and Person Centered," "Empowerment," and "Respect." These core concepts are defined as follows: Hope is the catalyst of the recovery process and fostering hope is considered a possible most valuable contribution one may make in Mental Health First Aid. Nonlinear is a description of the path that a recovery may take. The upshot being that there may be setbacks and tangents in a recovery. Strengths-Based is the concept of focusing on a person's strengths -- not deficits -- when assisting with their mental health crises. Peer Support is steering a person in distress is the one who "knows best" and who ultimately makes decisions in the recovery process. Responsibilities is being obligated for our own self care and recovery journey. Holistic is realizing that recovery is comprised of an individual's entire life to include housing, employment, education, mental health and health care treatment, spirituality, creativity, social networks, community participation and family support. Individualized and person centered is basing each recovery plan on one's preferences, experiences and cultural background. Empowerment is a person in mental health distress having authority to participate in decisions that affect recovery and wellness. Respect "ensures inclusion and full participation in all aspects of life."

WHY THIS TEXT WAS CHOSEN FOR USE IN THIS COURSE

As I write (February 2024) I am being held in a Colorado prison illicitly incarcerated. This prison is specifically geared toward incarcerating prisoners with mental health disorders and I am housed along with many prisoners who suffer from any number of mental disorders to include; depression, schizophrenia, personality disorders, and addictions. There are others who have no diagnosed mental disorders and are held here for other reasons. The proximity to so many who suffer from mental disorders permits me to engage and to recognize what I've studied from textbooks in vivo, in real people. This text, Mental Health First Aid USA, 1st ed. (Rev.), is used by the "peer assistants" here in the facility. Through interactions with the peer assistants, I shared that I was studying to obtain my PhD in Counseling (by way of my Masters, instantly) and this text was offered to me.

The text covers explicitly the subject of those who are in crisis due to mental health disorders in depth. It also covers the subject of substance abuse disorders. Mental Health First Aid has all of the traits of general first aid. It is a set of instructions for both first responders and for a layperson to render immediate care to a person in distress and to stabilize them. It is not intended for professionals as a full program to heal all mental disorders; no more than medical first aid is a program for a medical doctor. Also, like medical first aid, this is a system for dealing with a person in acute mental health distress. The text does not describe chronic care for mental health disorders like forms of talk therapy, psychoanalysis, or pharmaceutical interventions. For these reasons, these skills are valuable to the professional, the first responder, or the layperson because anyone can encounter someone in acute mental health distress.

Another particular interst stems from my prison environment. Those who surround me all are here because at some point they've had some interaction with law enforcement. A great proportion -- I might even venture a majority -- of those interactions that ultimately led to incarceration involved being in mental health crisis. Would training in Mental Health First Aid for police officers lead to safer interactions between law enforcement and the civilian population? Would this form of training lead to better legal outcomes for the people that police encounter? If so, why does this training not occur? Or, is it occurring? These last questions are beyond the scope of the text, but I will attempt to answer them with citation to legal resources available to me in the law library.

MENTAL HEALTH PROBLEMS IN THE UNITED STATES

The text begins with an explanation of "Mental Health" as it is directed to a general audience and does not presume the reader to be educated in mental health matters. It tells us "In this Mental Health First Aid USA manual, mental health is seen as a continuum ranging from having good mental health to having a mental disorder." It then covers some additional vocabulary: "A variety of terms are used to describe mental health problems: mental disorder, serious emotional disorder, extreme emotional distress, psychiatric illness, mental illness, nervous exhaustion, mental breakdown, nervous breakdown, and burnout." The text gives the slang terms such as, "crazy, psycho, mad, loony, nuts, cracked up, and wacko." A textbook definition follows: "A mental disorder or mental illness is a diagnosable illness that affects a person's thinking, emotional state, and behavior and disrupts the person's ability to work or carry out other daily activities and engage in satisfying personal relationships." The text tells us that a "mental health problem" is a "broader term that includes both mental disorders and symptoms of mental disorders that may not be severe enough to warrant the diagnosis of a mental disorder."

One in five American adults 18 years old or older experience mental illness in any given year. [Substance Abuse and Mental Health Services Administration, supra] The text covers some common mental disorders, and it itemizes the prevalence of each in terms of adults per year. For anxiety disorders, 18.1% [National Institute of Mental Health (NIMH), www.nimh.nih.gov, accessed 4 JAN 2016] For Major Depressive Disorder (MDD), 6.8% [NCS-R, supra] For Bipolar Disorder, 2.8% [Id.] For eating disorders, 5-10% [Wade, T.D., Keski-Rahkonen, A., and Hudson, J., Epidemiology of eating disorders. In M. Tsuang and M. Tohen (Ed.) Textbook in Psychiatric Epidemiology (3rd Ed.), 343-360. New York:Wiley (2011)]

For Schizophrenia 0.3%-0.7% [American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-5) p. 102 (2013)] These prevalences are similar to those that I have found quoted in other texts.

That these percentages sum up to more than the 20% that 1 in 5 implies is due to the fact that there is a high level of comorbidity with mental illnesses. (Eg., it is not unusual for a person with an anxiety disorder to also develop MDD)

Mental disorders are incredibly disabling to those that suffer with them. "Medical experts rate mental disorders among the most disabling illnesses." [US Burden of Disease Collaborators. The State of US Health, 1990-2010: Burden of Diseases, Injuries, and Risk Factors. JAMA, 2013; 310(6):591-606] These next two facts I found truly breathtaking: (1) "The disability caused by <u>moderate depression</u> is similar to the impact from relapsing multiple sclerosis, severe asthma, or chronic hepatitis B." and (2) "The disability from <u>severe depression</u> is comparable to the disability from quadriplegia." [Idem]

The text identifies Mental Health First Aid as an intervention that is appropriate at the late prevention stage when a person is just becoming unwell to the early phase of treatment when the patient is unwell but not yet recovering. MHFA is an intervention for a patient in crisis and is not at the level of treatment.

Treatments include medical/pharmacological ones, which are medicines that are prescribed by a physician. Also, there is psychological treatement which is talk therapy with a mental health professional one-on-one or in a group setting. The text also discusses lifestyle changes, peer support groups and rehabilitation programs.

Early intervention is a key to recovery. MHFA is precisely the type of early intervention that can lead to quicker recovery. When access to a mental health professional is limited, a person trained in MHFA can make a great difference. Delay in helping a person in a mental health crisis may lead to more difficulty in accomplishing a recovery. [Jorm, A. F., Mental health literacy: Empowering the community to take action for better mental health. American Psychologist, 67(3):231-243 (2011)]

Today it is a foregone conclusion that recovery is possible for people who suffer from mental illness. This was not always the case. Historically the mentally ill were locked away into sanitariums where they would be expected to spend the remainders of their lives with no hope. It was believed that mental illness had no cure. This is no longer the case. Recovery for mental illness is the norm, not an exception. "In 2003, the final report of the President's

New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America, called for recovery to be the 'common, recognized outcome of mental health services,' stating emphatically 'the goal of mental health services is recovery.'" [New Freedom Commission on Mental Health, supra] This report presents six goals for improving the lives of mental illness sufferers. (Goal 1) Americans understand that mental health is essential to overall health. (Goal 2) Mental health care is consumer and family driven. (Goal 3) Disparities in mental health services are eliminated. (Goal 4) Early mental health screening, assessment, and referral to services are common practice. (Goal 5) Excellent mental health care is delivered and research is accellerated. (Goal 6) Technology is used to access mental health care and information. The Commission has also given this vision statement: "We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports essentials for living, working, learning, and participating fully in the community."

MENTAL HEALTH FIRST AID

"First Aid is the help given to a person who is injured before professional medical treatment can be obtained. The aims of first aid are to: 1) Preserve life 2) Prevent further harm 3) Promote recovery 4) Provide comfort to the person who is ill or injured." "Mental Health First Aid is the help offered to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate treatment and support are received or until the crisis resolves. The aims of Mental Health First Aid are to: 1) Preserve life when a person may be a danger to self or others 2) Provide help to prevent the problem from becoming more serious 3) Promote and enhance recovery 4) Provide comfort and support." "Mental Health First Aid teaches the public how to recognize symptoms of mental health problems, how to offer and provide initial help, and how to guide a person toward appropriate treatments and other supportive help. Mental Health First Aid does not teach people to be therapists." Because mental health problems are common, and because laypeople are not well informed about mental health disorders Mental Health First Aid serves to give instruction on how to handle mental health crises in an emergency. No different than knowing how to render first aid doesn't require a medical doctor, providing mental health first aid doesn't require a mental health professional as a therapist/psychologist/

psychiatrist.

The Mental Health First Aid Action Plan provides steps for how to help a person in a mental health crisis. In a first aid course, students will learn a basic mnemonic for CPR which is C-A-B. This stands for Chest compressions, Airway, and Breathing. [American Heart Association and American Red Cross, "CPR Training and Education Joint Statement." www.instructorscorner.org/media/resources/eccu/AHA%20Red%20Cross%20CPR%20Training%20and%20Education%20Statement.pdf accessed 4 JAN 2016] The mnemonic for Mental Health First Aid is ALGEE. Action "A" is "Assess for rist of suicide or harm." Action "L" is "Listen nonjudgmentally" Action "G" is "Give reassurance and information." Action "E" is "Encourage appropriate professional help." And Action "E" is "Encourage self-help and other support strategies." The initial action is to assess for any crises such as a possibility of self-harm (eg. attempt suicide, use drugs or alchohol to become intoxicated, self-injure); panic attacks are another possible crisis. Some may become aggressive or exhibit bizarre behavior due to a lost sense of reality. The first aider next must listen intently and without judgment. The person in crisis needs to feel free to talk and that he is being heard. Giving encouragement and emotional support is the next step for the first aider. He may also provide some information about mental health problems. Helping to find professional help follows encouragement. A person in crisis may not be able or willing to seek out a mental health care professional. Last in the mental health first aid is to further encourage one in crisis to engage in self-help strategies and to seek support from family, friends, and others.

MENTAL HEALTH FIRST AID FOR DEPRESSION

Recognizing Depression: Clinical depression is not the same thing as being in a short-term depressed mood, or being sad or "down" when bad things happen in life. Major Depressive Disorder (MDD) is marked by "an unusually sad mood" and/or "loss of enjoyment and interest in activities that used to be enjoyable" which persists nearly every day for at least two weeks. A person suffering with MDD may also experience; a lack of energy and tiredness, feeling worthless or feeling guilty though not really at fault, thinking often about death or wishing to be dead, difficulty concentrating or making decisions, moving more slowly or sometimes becoming agitated and unable to settle, having sleeping difficulties or sometimes sleeping too much, or loss of interest in food or sometimes eating too much with concomitant weight loss or gain. [DSM-5, supra @ pp. 160-161] A person with a history of depression is more prone to having depressive symptoms and bouts of depression again. [Monroe, S.M., Harkness, K.L., Recurrence in major depression: A conceptual analysis. Psychological Review. Advance online publication. (2011)]

Additional warning signs of which a first aider should take heed include: frequent self-criticism, self-blame, worry, pessimism, impaired memory and concentration, indecisiveness and confusion, a tendency to believe others see you in a negative light, thoughts or talk of death or suicide, crying spells, withdrawl from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation, slowed behavior, use of drugs and alcohol, chronic fatigue, lack of energy, sleeping too much or too little, overeating or loss of appetite, constipation, weight gain or loss, headaches, irregular menstrual cycle, loss of sexual desire, and unexplained aches and pains.

Causes of depression can include; a breakup of a relationship, poverty, job loss, disability caused by an accident, bullying or victimization, being a crime victim, developing a long-term illness, death of a friend or conditions such as Parkinson's disease, Huntington's disease, traumatic brain injury (TBI), stroke. hypothyroidism, systemic erythematosus, childbirth (postpartum depression), intoxication or withdrawl from drugs or alcohol, premenstrual changes in hormone levels. lack of sunlight in winter months (seasonal affective disorder or SAD), caring full time for a person with a long-term disability. Some other traits that may predispose a person to MDD are previous episodes of depression, family history of depression, people with a more sensitive emotional nature, those who suffered with childhood trauma including emotional or sexual abuse, and being of female gender.

-SUICIDALITY- The hazard of suicide is especially high for those who are depressed. In the 2013 National Survey on Drug Use and Health: Mental Health Findings [Supra] was found that in a 12 month period 3.7% of US Adults had serious thoughts of suicide, 1.1% made a plan and 0.6% attempted to commit suicide. In 2013 41,149 people took their own lives, the 10th leading cause of death in that year. Men are four times more likely to succeed in suicide attempts, women are three times more likeiy to make an attempt. In 2013, 45 to 64 year olds had the highest rate of suicide (19.1%) and 85+ year olds have the second highest rate (18.6%). [Centers for Disease Control and Prevention (CDC). Web-based injury Statistics Query and Reporting System. www.cdc.gov/injury/wisqars/index.html (4 JAN 2016)] Suicide was the 2nd leading case of death among 15-24 year olds and 25 to 34 year olds. [Idem at leading_causes_of_death_by_age_group_2013_a.pdf]

In the same time period, 17% of high schoolers in the US reported seriously considering attempting suicide and 8% made one or more attempts. [Kann, L. Kinchen, S., Shanklin, S.L., et al. Youth Risk Behavior Surveillance -- United States, 2013-MMWR 2014; 63(SS04):1-168 (4 JAN 2016)] In 2010, toxicology reports from suicide decedents gave positive results for alcohol in 33.4%, anti-depressants in 23.8%, opiates including heroin and prescription pharmaceuticals in 20%, marijuana in 10.3% and cocaine in 4.6%. 84% had symptoms of a mental health problem, and 44% had a mental health diagnosis. [Parks, S.E., Johnson, L.L., McDaniel, D.D., Gladden, M. Surveillance for Violent Deaths -- National Violent Death Reporting System, 16 States, 2010. MMWR 2014; 63(SS01):1-33]

Those suffering with depression may also exhibit self-injury behaviors that are non-suicidal. This includes cutting, scratching, or pinching the skin enough to mark and/or wound. Also, punching or banging to the point of bleeding or bruising, burning oneself with cigarrettes, matches, or hot liquid, pulling out large amounts of hair, and deliberately overdosing on medications in a manner not intended to be a suicide attempt; termed "parasuicide." [Whitlock, J., Eckenrode, J., and Silverman, D. Self-injuring behaviors in a college population. Pediatrics. 117:1939-1948 (2006)]

The Action Plan for intervening in a crisis of a person suffering with depression is the same "ALGEE" step as any Mental Health First Aid intervention. With depression, there is a special consideration regarding the possibility of suicidality. When a person is showing signs of depresion the first aider must be observant of warning sighns of suicidality. These include but are not limited to: threats to hurt or kill oneslelf, looking for the means to commit suicide (pills, guns), social media engagement with content related to death or suicide, hopelessness, rage, anger, seeking revenge, dangerous or reckless behavior, increased drug and/or alcohol use, no sense of purpose or reasons to live. [Whitlock, et al., supra]

When talking with someone who is suicidal, it is important to do these things: tell the person that you want to help and express care, be empathetic, advise that thoughts of suicide are common (he is not alone) and that the thoughts are a result of a treatable mental disorder -- instilling hope. Also tell him that he doesn't have to follow through with his plan. It is okay to step back from a plan to kill oneself. Ask if he has a plan, if he knows when he wants to do it, and if he's already got the things he needs to carry out his plan. The more planning and preparation that's been done, the more perilous is the risk.

A person that is suicidal should not be left alone. The first aider should stay with the suicidal person or make arrangments for someone else to be with him. Also make sure that the person has a safety contact at all times, a family member, friend, or suicide telephone hotline to call. The National Suicide Prevention Hotline is (800)273-TALK.

Other specifics to keep in mind about how to talk to a person who is suicidal is not to guilt or threaten the person to prevent suicide. It is not advised to say things like, "You'll go to hell," or "Your family will hate you." Also, the text advises not to agree to keep someone's suicide plan a secret. While respecting one's privacy and involving him in the decision on who else does need to know, never promis to keep it a secret. Throughout the first aider's interaction with a suicidal person he needs to keep calm and talk in a psitive manner, avoiding negativity or being judgmental. Verbal skills for first aiders talking with a suicidal person -- or nonsuicidal depressed person -- further include: asking questions to show that you genuinely care, being patient even if the person is not communicating well like being repetitive or slow and muttering. Patience means NOT interrupting, especially to share your opinions or to offer unhelpful advice like "cheer up!" "Get it together!" or "Toughen up!" These are not the correct message for a person in crisis. Avoid being confrontational, unless it is absolutely necessary to prevent dangerous acts. After the crisis is over, the first aider needs to be sure to help the person find professional help.

When encouraging someone who is suffering with depression or suicidality to self-help or find support, some examples are: exercise (which releases endorphins and naturally elevates mood), SAMe (S-Adenosyl methionine) and St. John's Wort (hypericum perforatum) which are available in supplement stores, relaxation therapy, self-help books, computerized therapy, and light therapy. The most effective treatments are antidepressant medications, cognitive-behavioral therapy (CBT), psychotherapy and exercise. [Parker, G., and Crawford, J., Judged effect-iveness of differing anti-depressant strategies by those with clinical depression. Australia and New Zealand Journal of Psychiatry, 41:32-37 (2007)] A first aider could propose to work-out with someone, or attend a first therapy session along-side them as encouragement.

-BIPOLAR DISORDER- A person suffering from Bipolar Disorder (BPD) can have periods of depression, periods of mania, and periods of normal mood in between. Mania is depression's apparent opposite. Mania may lead to talkative and ener-getic behavior, impulsivity, and overconfidence. Mental Health First Aid with

with a person who suffers from Bipolar Disorder and is experiencing a crisis will take the same ALGEE steps and considerations as working with someone with Major Depression.

ANXIETY DISORDERS

Anxiety is an adaptive trait, able to help the human animal to avoid danger in survival situations or motivate him in everyday situations. An anxiety disorder is, by contrast; more intense, long lasting, and interferes with the person's work, activities, or relationships. Anxiety may range in degree from mild uneasiness to the terror of a panic attack. 18% of adults in the US suffer with anxiety in a given year. [NIMH, Any Anxiety Disorder Among Adults, www.nimh.nih.gov (4 JAN 2016)]

The symptoms of anxiety are physical, psychological, and behavioral. The physical symptoms are; cardiovascular: pounding heart, chest pain, rapid heartbeat, and flushing. Respiratory: hyperventilation, and shortage of breath. Neurological: dizziness, headache, sweating, tingling, and numbness. Gastrointestinal: choking, dry mouth, stomach pains, nausea, vomiting, and diarrhea. Musculoskeletal: muscle aches and pains (especially neck, shoulders, and back), restlessness, tremors and shaking, and inability to relax. The Psychological symptoms are unrealistic and/or excessive fear and worry (about past and future events), mind racing or going blank, decreased concentration and memory, indecisiveness, irritability, impatience, anger, confusion, restlessness or feeling "on edge" or nervous, tiredness, sleep disturbance and vivid dreams. The Behavioral symptoms are avoidance of situations, obsessive or compulsive behavior, distress in social situations and phobic behavior.

There are several different types of disorders that are under the umbrella of anxiety disorders. These include specific phobias, social anxiety disorder, Post-Traumatic Stress Disorder (PTSD), Generalized Anxiety Disorder (GAD), Panic Disorder, Obsessive-Compulsive Disorder (OCD), and Agoraphobia (without panic). These were all covered extensively in the Psychopathology essay written for class PSY4031, and a verbose treatment here is redundant. Briefly, GAD is an overwhelmingly unfounded anxiety and worry persisting for six months where more than half of the days a person suffers with symptoms. A panic disorder is when a person suffers with recurring panic attacks for at least a month. A panic attack is a sudden onset of intense apprehension, fear or terror. A person may suffer a panic attack without developing a panic disorder. Social anxiety disorder is a fear of being embarrassed or humiliated in situations such as dating, public speaking, or dining out. Merely being hesitant doesn't qualify, the fear must be debilitating and avoidance total. (eg. many people dislike public speaking as an example, but are capable of performing this where necessary) Specific phobias are irrational and debilitating fears of a specific thing. The fear must rise to a level of disability, and must be irrational. Legitimate fears do not qualify as phobia. Common phobias include spiders, snakes, insects, heights, blood and injections. Agoraphobia, or fear of public spaces, is a separate category. The fear is centered around a fear of having a panic attack. For example, an agoraphobic person may have a fear of shopping malls, but only when there is a crowd and if they are alone. The same person will comfortably walk through an empty mall if accompanied. OCD is marked by obsessive thoughts and compulsive behaviors. Obsessive thoughts are intrusive and unwanted and cannot be purged from the person's conciousness; the compulsive behaviors feel as though they cannot be stopped without extreme anxiety.

-TRAUMATIC EVENTS- It is important for the first aider to understand trauma. A traumatic event is any incident perceived to be traumatic. Common examples include traffic or physical accidents, assaults (physical, sexual, verbal, mugging, robbery, domestic abuse, etc.), witnessing a terrible event, terrorist attack, mass shooting, or natural disasters. Interestingly, our text advises that an event that is traumatic to one person may not be at all traumatic to another.

Anxiety disorders are more common among people who are more emotionally sensitive and tend to view the world as threatening. Also among those who have a childhood history or family history of anxiety disorders. Those who are shy. Women. Drug and alchohol users. Those who have suffered trauma. Those who are in poverty. And those wha are separated or divorced.

-ANXIETY CRISIS- Mental Health First Aid for anxiety takes the same form as already described, using the ALGEE mnemonic; Assess, Listen, Give (reassurance and info), Encourage (professional help), and Encourage (self-help). The panic attack is a perfect example of the prototypical mental health crisis. A mental health first aider can do a great deal of good in following the ALGEE steps and rendering aid to a person having a panic attack -- or any anxiety crisis.

PSYCHOSIS

Psychosis is defined as a person experiencing a loss of contact with reality. Psychosis can be marked by hallucinations, delusions, and delirium. In psychosis a person's emotions can be severely disturbed. One may display: depression, anxiety, irritability, suspiciousness, a flat or blunted affect, or inappropriate emotions. Psychosis is most common in people diagnosed with schizophrenia. Schizophrenia is much less common than other mental disorders, affecting 0.3%-0.7% of Americans. 50% of people with schizophrenia will have their first episode by the age of 25. It is rare to develop schizophrenia after age 45. For these reasons, a mental health first aider should be cognizant that if they are encountering a person who is having a psychosis crisis, and it is a young person, it may be a first episode of an undiagnosed schizophrenic.

The risks of harm with psychosis is elevated. One in three schizophrenics attempt suicide, and one in ten complete suicide. [Hor, K., and Taylor, M., Suicide and schizophrenia: a systematic review of rates and risk factors. Journal of Psychopharmacology, 24(11):81-90 (2010)] Another risk factor is that schizophrenia is highly comorbid with substance abuse. While violence is not common, a small percentage of those suffering with psychosis do threaten violence. This rises with drug and alcohol use. The drug and alcohol use is more closely associated to aggression than psychosis. [Rueve, M.E., and Welton, R.S., Violence and Mental Illness. Psychiatry 5:34-48 (2008)] Another true hazard is a first responder perceiving a person in psychosis as aggressive due to their erratic behavior, or failing to recognize true aggression driven by the psychosis.

-MENTAL HEALTH FIRST AID FOR AGGRESSIVE BEHAVIOR- If a person does become aggressive, a first aider must ensure their own safety at all times. He must remain calm and try to de-escalate the situation: Speak to the person slowly and confidently with a gentle, carring tone of voice. Do not respond in a hostile, disciplinary, or challenging manner. Do not argue. Do not threaten, as this may increase fear or prompt aggressive behavior. Avoid raising your voice or talking too fast. Be aware the person may overreact to negative words; therfore use positive words, such as "stay calm" instead of negative words, such as "don't fight." Stay calm and avoid nervous behavior, such as shuffling your feet, fidgeting, or making abrupt movements. Do not restrict the person's movement, if he or she wants to pace, allow it. Remain aware that certain acts, such as involving law enforcement, might exacerbate the situation. Consider taking a break from the conversation to allow the person to stay calm. [Mental Health First Aid Training and Research Program. Psychosis: First Aid Guidelines. ORYGEN Research Centre, University of Melbourne, Australiea. http://mhfa.com.au (2008)]

-ALGEE FOR PSHYCHOSIS- While the majority of the ALGEE steps for psychosis are the same as those discussed for other mental disorders, psychosis does introduce the unique considerations surrounding delusions and hallucinations. Delusions are false beliefs and hallucinations are perceiving things that are not real. The important fact is that to the person experiencing delusions and/or hallucinations is that they ARE REAL to the person experiencing them.

As the first aider, you are advised not to dismiss, minimize, or argue with the person about their delusions or hallucinations. Instead say, "That must be horrible for you," or "I can see that you are upset." You should not act alarmed, horrified, or embarrassed by the person's delusions or hallucinations. Do not laugh at the persons's symptoms of psychosis. Do not encourage or inflame the person's paranoia, if the person exhibits paranoid behavior.

SUBSTANCE USE DISORDERS

Because this course on Crisis and Addiction will cover drugs and alcohol in another book in more depth, we will skip descriptions of symptoms and behaviors for now. The ALGEE steps for first aid of a person in crisis due to substance abuse are the same as for the other mental health disorders. The concerns for both suicidality and for aggression are heightened for substance abuse and these must be assessed in the ALGEE procedure.

EATING DISORDERS

A person with an eating disorder can be underweight, normal weight, or overweight. People with eating disorders are very distressed about appearing overweight and/or physically unattractive. The eating disorders anorexia, bulimia, and binge eating affect as many as 30MM people in the United States across age and gender. [Wade, T.D., Keski-Rahkonen, A., and Hudson, J., Epidemiology of eating disorders. In M. Tsuang and M. Tohen (Eds.) Textbook in Psychiatric Epidemiology (3rd ed.) (pp. 343-360) New York:Wiley (2011)] Eating disorders are two to three times more common in females than in males. [Hudson, J.I., Hiripi, E., Pope, H.G., and Kessler, R.C., The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biological Psychiatry. 61:348-358 (2007)]

The warning signs a would-be first aider needs to look for include: Dieting, binge eating, vomiting or laxative use, excessive/obsessive/ritualistic exercise, changes in food preferences, skipping meals, lying about eating, cutting out entire food groups (eg. meat or dairy), weight fluctuations, changes in menstruation, distorted body image, preoccupation with food and body shape/weight.

Specific non-supportive speech to avoid while engaging the ALGEE steps with an eating disorder sufferer include criticism, blame, disappointment or shock. Using shame or guilt, or calling the person "disgusting" or "stupid" or "selfdestructive." Using generalizations like "you're always moody" or "you never do anything but exercise." Never focus on body image such as to say "you're too thin," or "it's good you've gained weight, you look better now." These statements reinforce priority of physical appearance. Also avoid "all you have to do is eat." It is an oversimplification and is condescending to the sufferer.

The priority for the first aider is to be supportive and ultimately be able to steer the person to professional help. The eating disorders are treated with Cognitive-Behavioral Therapy (CBT) and aintidpressants and/or family therapy for Anorexia. These are offered by mental health professionals.

MENTAL HEALTH FIRST AID FOR FIRST RESPONDERS

The issue of better training for first responders as to mental health concerns is one that is very personal to me. I am a victim of an attempted murder inflicted upon me by police officers from Lakewood Police Department in Colorado. While my experience was not a mental health crisis, per se, it had the markers of one. I was intoxicated, having been drinking throughout the day -- my 39th birthday -- and should have been safe as I was back in my own home. The police arrived at my home owing to a "SWATTING" 911 call (defined as making a false report with the intended purpose of initiating a police response, generally to harm another or as a prank.) The LPD never knocked on my door, announced themselves, or shouted out their identification. They hid their police cars, hid themselves, and used a cellphone with blocked Caller ID to call my cell phone and ask me to come outside to talk. Once outside, they did not speak to me, they hid. After two more calls and walks outside, frightened, I armed myself with a shotgun that was kept for home protection. The police shot me with intent to kill from a hiding place behind a neighbor's parked vehicle. I returned fire in self-defense and later was tried and convicted for doing so. See St. George v. City of Lakewood, 2021 U.S.App.LEXIS 24934 (10th Cir. 20 AUG 2021)

I live in a metropolitan area where police attacks are commonplace (as I have learned since my incident), and have made national news. An example case that reached national news was the killing of Elijah McClain by Aurora Police; he suffered from autism. Estate of McClain v. City of Aurora, 2021 U.S.Dist.LEXIS 84943. Another Lakewood local incident was the attack of Ameer Allen. In typical form, he was charged with assaulting the police in order to try to limit police liability. He was acquitted. [Clark, Moe, "Lakewood man who alleged police brutality cleared of all charges stemming from 2021 arrest." Colorado Newsline 26 APR 2022]

Another Lakewood Police incident that resulted in the killing of a man with a mental health matter was that of Jason Waterhouse. His sister Heather Lopez contacted police because Jason was having a mental health breakdown and was barracaded in the basement. Once arrived, she advised the LPD that Jason used illegal drugs, and had mental health difficulties. She advised she was not frightened of him, and was seeking care for his welfare. Jason heard voices in his head and had delusions of being presecuted. After a one hour attempt to deescalate, with Jason hurling epithets, The sister told LPD they could go into the basement "if that's what it takes, 'cuz I can't deal with this." There were no guns in the house. LPD armed themslves with pepper spray, Tasers, and less-than-lethal ammunition loaded shotguns. They stormed into the basement to confront Jason. A fire was set in the basement by Jason. The fire department could not fight the fire until Jason was out of the basement. Overwhelmed by smoke, officers fled from the basement, and in the stairwell as Jason too fled the smoke, they shot him with two bean bags from the shotgun. He crumpled. Then Agent Marc DiRezza drew his service pistol and killed Jason. See Estate of Waterhouse v. City of Lakewood, 2022 U.S.Dist.LEXIS 125034 If LPD had been trained in techniques of Mental Health First Aid (full disclosure, in response to an Open Records Request made to LPD for an example officer -- Sergeant S---- -- as to his training history, had received 1766 hrs and 51 min of training between 1999 and 2020. His total "de-escalation" training was a 2 hr class in 2016; and total mental illness training was "First Responders and Alzheimer's" 2 hrs 2018, "Autism" 1 hr 2017 and "Mental Illness" 1 hr 2014) officers would not have charged into the basement to confront Jason. They would have listened to Jason as MHFA advises. They would have de-escalated the situation without confronting him with aggression. They would have slowed things down and not injected anxiety and exigency into the situation. Jason would be alive today. Shamefully, the courts granted summary judgment to the officer that killed Jason. See Estate of Waterhouse v. DiRezza, 2023 U.S.Dist.LEXIS 187401 Police are inundated with training on weapons and tactics, and are daily given talks about the threats that the public pose to them, all while given scant training on mental health. It is a recipe for dangerous interactions and more dead civilians.

I chose another example from the Tenth Circuit that did not involve Lakewood PD, but does include a mental health crisis and another department that failed to announce themselves properly and failed to yell a warning of intent to use force as is required by Tenth Circuit precedent Pauly v. White. The

Pauly case is particularly important to me because my case against LPD is heavily dependant on that precedent. In Lone Grove Oklahoma, Travis Graham calls his girlfriend Kelleigh Schoonover and they break off their relationship. She later calls the Lone Grove PD to ask for a welfare check on him, stating that she's afraid he may be suicidal. The LGPD arrive at 1:00AM and knock on the front door. The door opens, and Travis appears armed with a handgun. One second elapses, and without warning Officer Gilbert Hensley III fires three rounds at Travis. He survives. The LGPD policy provides that their officers must announce themselves as police. The also allege they provide specific training on mental health encounters and in de-escalation of mental health encounters as to use of force. Allegedly, Hensley, who goes by the nickname "Trey" was familiar with Travis from numerous prior encounters. He alleges in the suit that he spoke through the door "Hey Travis, its Trey, checking to see if you're okay;" but this is disputed. The court cited Pauly as controlling precedent but held that it was differetiable because this encounter was a "welfare check," and Pauly was not. The court granted summary judgment to the police defendants. Graham v. City of Lone Grove, 2022 U.S.Dist.LEXIS 102157 Travis Graham appealed, but later voluntarily dismissed his appeal due to reaching a settlement agreement. Graham v. City of Lone Grove, 2022 U.S.App.LEXIS 36054. Here the message for implementing more training on police procedures and on mental health encounters is critical and two-fold. The Plaintiff, Travis, would not have suffered the gunfire at him if the officer had received proper training on mental health encounters. If he had used MHFA principles, he could have prevented an armed encounter. In the court's opinion, the judge conceded that a reasonable jury could find that Travis believed the person at his door to be intruders and not to be police; it was reasonable for Travis to arm himself. (one can see how this case mirrors aspects of my own) The officer was obligated to assuage Travis' fears and concerns, afterall, the police were at his door at 1:00AM and not the other way around. Also, the police department will lose substantial resources by having to pay a settlement. Had the resources been invested in training police officers Mental Health First Aid (recognizing that they allege to provide mental health and de-escalation training) the costs would be lower and pay dividends going forward. The maxims "a stitch in time saves nine" and "an ounce of prevention is worth a pound of cure" seem to hold here. It only seems reasonable, police are far more likely to encounter people during a mental health crisis than they are to encounter people while everything is normal.

CONCLUSION

The text, Mental Health First Aid USA, was a fantastic entry-level introduction to numerous mental health disorders, something that was review to me at my level of study. Notwithstanding, the specific steps and instructions for interacting with a person in mental health crises was fully appropriate at any level of study. Having encountered the text in a prison setting -- used for training of prisoner peer assistants -- leads one to the conclusion that by extension this should be offered as required reading and training for all who work in a law enforcement setting. (corrections officers, police, sheriffs, parole and probation officers, etc.) One can only hope. I included discussion about law enforcement and supported it with citation to legal authority because it is a subject that is very important to me personally, and because I have ready availability to infinite reading on legal matters in my law library in the prison. (limited only by access to appointments to attend LL sessions)