LAW ENFORCEMENT OUTREACH to the community

Mental Health in Southwestern Pennsylvania

Media & Mental Health

Building Healthy Communities in SWPA

entertainment & media communication institute

A Division of the Entertainment Industries Council, Inc.

eic

staunton farm foundation

EST. 1937

ACKNOWLEDGEMENTS & THE EIC TEAM

ACKNOWLEDGEMENTS

Involvement in health issues can be as simple as finding a research paper on the Internet, or as complex as delving into public policy and the philosophical opinions of specific interest groups. Most important is the perspective of people who dedicate their time to a cause.

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SPECIAL MESSAGE

from JONI S. SCHWAGER

Executive Director
Staunton Farm Foundation

The Staunton Farm Foundation is pleased to help individuals of Southwestern Pennsylvania counties by providing resources to increase public awareness and understanding of behavioral health issues in their community. As a foundation dedicated to benefiting those with mental illness, we believe the first step toward improving public acceptance of mental illness is education. In order to promote change and decrease overall misconceptions, the Staunton Farm Foundation has collaborated with the Entertainment Industries Council, Inc., to launch a dynamic behavioral health awareness project which includes media training for mental health service leaders, published action strategies, and a special media recognition program.

The diagnosis of a mental illness should be something that begins a personal journey for both the patient and his or her loved ones that will ultimately lead to a healthier and more fulfilling life. Instead, shame, embarrassment, and secrecy are still the emotions frequently tied to an individual's mental health diagnosis.

Local law enforcement plays an important role influence in the community making sure that everyone is safe. Police officers are the first line of defense when protecting people suffering from mental illness. They are the ones called if there is a problem or misunderstanding. Now that resources in the community are becoming more limited, local law enforcement helps more people than they would otherwise have needed to in the past since mental health services have been cut back.

Please utilize this toolkit as a resource for responding to people living with mental illness. It may also be used to educate local law enforcement and clear up misconceptions about mental illness. We know that accuracy yields powerful social change. Through educating and informing the community, great things can be achieved in generating awareness and action about mental health. This toolkit continues our efforts towards enhancing the behavioral treatment, support, beliefs, and attitudes.

SPECIAL MESSAGE

from Brian L. Dyak

President, CEO, and Cofounder
Entertainment Industries Council, Inc.

The Entertainment Industries Council, Inc. recognizes that local law enforcement make a variety of positive contributions to the community. In particular, Southwestern Pennsylvanian police officers have the ability to work with the media industry and deal with mental health issues in the community by being sensitive to behavioral health issues in the area utilizing accurate information on mental illness.

According to the National Institute of Mental Health (NIMH), about one in four adults in the United States suffer from a mental illness. The effects of mental illness may lead the patient to withdraw from normal activities, exhibit abnormal behaviors or feel afraid. The symptoms are often related to what the public perceives as a "mentally ill individual". In truth, many people lead healthy lives that are virtually symptom-free mainly due to an appropriate diagnosis and treatment plan. When portraying and telling stories about behavioral health issues, police officers can use the media and other means to inform and empower the public to seek medical attention and support by reducing their fear surrounding what a diagnosis means.

This toolkit was designed to give local law enforcement the tools to become aware of mental health information, personal stories, and accurate mental health information for local precincts. In this toolkit, law enforcement will find tips, local health resources, and tools to help deal with behavioral health issues. Law enforcement is a major part of the community; with the inclusion of accurate information, positive social and behavioral change is inevitable.

SUPPORT FROM POLICY-MAKERS

from Tim Murphy

United States Congressman,
18th Congressional District of PA, Co-Chair Congressional Mental Health Caucus

"We have really three issues we're dealing with when involving the media. First is the portrayal of mental illness; second is making sure we understand how it affects attitudes and beliefs about mental illness; and third, what can be done to break down some of the stigmas? We all have roles to play, information comes over the TV—that flat screen in people's homes—and it has an impact.

We recognize that impact is huge. About 54 million Americans suffer from some type of mental illness. According to mental health studies, suicide is the eighth leading cause of death in the United States, as well as a leading cause of death among adolescents and the elderly. About 30,000 Americans commit suicide annually, and 500,000 Americans attempt suicide annually, and these are folks who are looking for a sense of hope and oftentimes feel hopeless.

The exchange of ideas and information among a wide range of professionals, the media, the mental health field, families and others concerned, is essential. The media is a great avenue for this. I believe that in television news and in television entertainment, accurate portrayals of mental illness and getting behind the story actually makes for a more fascinating story.

Think of it this way: in some ways, we have not advanced much beyond the days of the Salem witch trials if all we do is see people with mental illness as people we want to be away from. We hear stories from people who don't want treatment facilities in their town, let alone their neighborhood, because they fear it is a bunch of drug addicts and other people who authorities may come searching after creating problems in their community. This is not the case.

Mental health professionals working with folks in the media can help provide background information that, without a doubt, will make for interesting stories and compelling television, newsprint and radio. Each story told in its own way contributes to the greater public awareness which is needed."

BIOGRAPHY

In January 2011, Congressman Tim Murphy began serving his fifth term in Congress representing the 18th District of Pennsylvania, encompassing the South Hills of Pittsburgh and portions of Washington and Westmoreland counties.

Congressman Murphy relies on his three decades as a psychologist to advocate for meaningful reforms in the US healthcare system. As one of only a handful of members of Congress with a background in healthcare, Tim quickly established himself as a leader on the issue. He is Co-Chair of the 21st Century Healthcare Caucus, Mental Health Caucus, GOP Doctor's Caucus, and Men's Health Caucus, providing him with a platform to educate other members of Congress and the public on ways to make healthcare more affordable and accessible for all families.

Congressman Murphy also serves as a Lieutenant Commander in the U.S. Navy Reserve Medical Services Corps, working with wounded warriors with Traumatic Brain Injury and Post-Traumatic Stress Disorder.

SUPPORT FROM POLICY-MAKERS

from Jake Wheatley

State Legislator,
19th Legislative District of Allegheny County, PA

"If you are under some directions and guidance and have some support system, you can definitely live and manage a very productive and long life. And so, for me, I'm very committed to this question of: What do we do, not only to raise and heighten the awareness around the question of mental health, but how do we develop support systems, real support systems, real ways to help people deal with their circumstances?

They're all health issues. So I think this step today, the Picture This, trying to educate individuals, trying to popularize a different way of looking at this subject matter, I think, will go a long way in attacking the stigma of mental health.

I'm glad we're going to have this conversation, I'm glad, hopefully, that we'll start to see images and portrayals of people and regular everyday folks who live, for the most part, normal productive lives."

BIOGRAPHY

PA Rep. Jake Wheatley Jr., D—Allegheny, has been serving the people of the 19th Legislative District since 2002, which includes historic Pittsburgh neighborhoods such as: the Hill District, North Side, Downtown, and Oakland among many others.

He is a recognized United States Marine combat Veteran of Operation Desert Storm who received the Combat Action Ribbon, National Defense Service Medal and the Kuwaiti Liberation Medal. Rep. Wheatley holds a bachelor's degree in political science from North Carolina Agricultural and Technical State University where he graduated Magna Cum Laude. He received his Masters of Public Administration from the Graduate School of Public and International Affairs at the University of Pittsburgh.

RESPONDING TO VICTIMS WITH A MENTAL ILLNESS

TIPS

This toolkit, developed for law enforcement officers, offers police training models for responding to calls involving mental illness, along with research and video links, tips, personal stories, and other materials ranging from ADA requirements to dealing with the news media on mental health issues. It also includes information for officers, who, by virtue of their willingness to serve and protect and place their lives on the line, are at risk of developing a number of mental health issues during their career, and into retirement.

RESPONDING TO VICTIMS WITH MENTAL ILLNESS

Anyone who is the victim of a crime may be traumatized and experience the victimization as a crisis. But for people with a mental illness, this crisis may be experienced more profoundly. The following guidelines can assist law enforcement in better responding to crime victims who have a mental illness.[13]

- Approach victims in a calm, nonthreatening, and reassuring manner. Victims may be overwhelmed by delusions, paranoia, or hallucinations. They may be afraid of you or feel threatened by you. Introduce yourself personally by your name, then your rank and agency. Make victims feel that they are in control of the situation.

- Determine whether victims have a family member, guardian, or mental health service provider who helps them with daily living. If they do, contact that person immediately. Remember that these people could themselves be the offenders, or may try to protect the offenders.

- Contact the local mental health crisis center immediately if victims are extremely agitated, distracted, uncommunicative, or displaying inappropriate emotional responses. Victims may be experiencing a psychological crisis.

- Ask victims if they are taking any medications and, if so, the types prescribed. If they are unable to provide this information, ask their family member, guardian, or mental health service provider. Make sure that victims have access to water, food, and toilet facilities, as side effects of the medications can include thirst, urinary frequency, nausea, constipation, and diarrhea.

- Conduct your interview in a setting that is free of people or distractions upsetting to victims. If possible, only one officer should interview victims.

- Keep your interview simple and brief. Be friendly and patient and offer encouragement when speaking to victims. Understand that a logical discussion may not be possible on some or all topics.

- Remember that even victims who are experiencing delusions, paranoia, or hallucinations may still be able to accurately provide information that is outside of their false system of thoughts. This can include details related to their victimization, as well as informed consent to medical treatment and forensic exams.[13]

RESPONDING TO VICTIMS WITH A MENTAL ILLNESS

WHAT TO DO AND TO AVOID

HOW TO RESPOND TO VICTIMS WITH MENTAL ILLNESS

- Back off and allow victims time to calm down before intervening if they are acting excitedly or dangerously but there is no immediate threat to anyone's safety. Outbursts are usually of short duration.
- Break the speech pattern of victims who talk nonstop by interrupting them with simple questions, such as their birth date or full name, to bring compulsive talking under control.
- Do not assume that victims who are unresponsive to your statements cannot hear you. Do not ignore them or act as if they are not present. Be sensitive to all types of response, including victims' body language.
- Acknowledge victims' paranoia and delusions by empathizing with their feelings; but neither agree nor agitate victims by disagreeing with their paranoid or delusional statements. For example, if victims tell you that someone wants to hurt them, reply with "I can see that you're afraid. What can I do to make you feel safer?" Be mindful, however, that victims who say that others are trying to harm them may indeed be the victims of stalking or other crimes.
- Understand that hallucinations are frighteningly real to victims. Never try to convince victims that their hallucinations do not exist. Instead, reassure victims that the hallucinations will not harm them and may disappear as their stress lessens.
- Be honest with victims. Getting caught by victims in your well-intentioned untruth will only increase their fear and suspicion of you.
- Assess victims' emotional state continuously for any indications that they may be a danger to themselves or others.
- Arrange for victims' care by a family member, guardian, or mental health service provider before leaving them. But, again, remember that these persons could themselves be the offenders, or may try to protect the offenders.[12]

AVOID THE FOLLOWING CONDUCT IN YOUR ACTIONS AND BEHAVIOR WITH VICTIMS:

- **Avoid** circling, surrounding, closing in on, or standing too close to victims.
- **Avoid** concealing your hands.
- **Avoid** sudden movements or rapid instructions and questioning.
- **Avoid** whispering, joking, or laughing.
- **Avoid** direct, continuous eye contact, forced conversation, or signs of impatience.
- **Avoid** any touching.
- **Avoid** challenges to, or agreement with, victims' delusions, paranoia, or hallucinations.
- **Avoid** inappropriate language, such as "crazy," "psycho," and "nuts."[12]

MYTHS VS. FACTS

Accurate and timely information provides an indispensible public service by debunking common misconceptions about mental health-related issues. The following myths and facts may help to clarify mental health issues and underscore the need to address the priority messages regarding stigma, hope, integration of healthcare, parity, and decriminalization of those with mental health conditions.

MYTHS	FACTS
There is no hope for people with mental illnesses.	There are increasing numbers of treatments, strategies, and support systems for people with mental health conditions that help them lead active, productive lives.
I cannot do anything for someone with mental health needs.	There are countless ways to help, beginning with simple actions and words. You can help to nurture an environment that builds on peoples' strengths and promotes mental health treatment and support.
People with mental illnesses are violent and unpredictable.	The majority of people with mental health conditions are no more violent than those without mental health conditions. In fact, they are more often the victims than they are the aggressors.
Mental illnesses cannot affect me.	Mental illnesses are common, affecting almost every family in America. They do not discriminate against age, sex, religion, or lifestyle.
Mental illnesses are brought on by character weaknesses.	Mental illnesses are a product of the interaction of biological, psychological, and social factors. Genetic and biological factors are associated with schizophrenia, depression, and alcoholism. Social influences, including loss of a loved one or a job, can also contribute to the development of various disorders.
People with mental illnesses cannot hold down a job.	In essence, all jobs are stressful to some extent. Productivity is maximized when the right fit is found for the employer and the individual, regardless of mental illness or mental health.
Once people develop mental illnesses, they will never recover.	Most people being treated for their mental illnesses get better, and many recover completely.
Children do not experience mental illnesses. Their actions are just products of bad parenting.	A report from the President's New Freedom Commission on Mental Health showed that in any given year, 5-9% of children experience serious emotional disturbances. Just like adult mental illnesses, these are clinically diagnosable health conditions that are a product of the interaction of biological, psychological, and social factors.
Those who do not "get better" are not actively engaged in the recovery process.	No one can be blamed for the effectiveness of his or her recovery from an illness. Many people work hard on finding the right way to manage the disease and continue to suffer the symptoms until the best treatment is found. Assuming that a person who continues to suffer is not "trying" to get better is unfair and counterproductive.[35]

HOW TO AVOID USING STIGMATIZING LANGUAGE

LEAD BY EXAMPLE

It is important to avoid language that enhances the negative connotations associated with mental illnesses and their symptoms. Here are a list of "Do's and Don'ts" from the Mental Health America in Allegheny County, PA[22]:

DO

DO focus on what a person can do, not on what they can't do.

DO stand up to people if they show a stigmatizing attitude.

DO describe mental illness as a biological or chemical disease.

DO contact expert resources to explain facts related to mental illness or to ask how to handle mental illness.

DO respect a person's right to privacy for treatment.[22]

DO NOT

DO NOT label people by their illness. For example, a person should not be called a "schizophrenic," but rather, "a person with schizophrenia."

DO NOT use a diagnosis casually. Use only exact and correct medical words. For example, do not use the word "schizophrenia" to describe an incident of delusional or hysterical thoughts or behaviors.

DO NOT portray a successful person with disabilities as "superhuman".

DO NOT use terms that label people such as "retarded" or "mentally ill".

DO NOT use language such as "crazy" or "weirdo".[22]

POLICE RESPONSE TO PEOPLE WITH MENTAL ILLNESS

PROGRAMS THAT ARE POLICE-BASED INCLUDE

- **Crisis Intervention Teams** - A cadre of officers trained to identify signs and symptoms of mental illness, de-escalate the situation and bring the person in crisis to an efficient, round-the clock treatment center.

- **Co-Responders** - An officer pairs with a mental health professional to respond to the scene of a crisis involving mental illness.[13]

CORE ELEMENTS OF A CRISIS INTERVENTION TEAM OR CIT:

The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in Memphis and has spread throughout the country. It is known as the "Memphis Model." CIT provides law enforcement-based crisis intervention training for assisting those individuals with a mental illness, and improves the safety of patrol officers, consumers, family members, and citizens within the community. CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness. The CIT Model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.[23]

BASIC GOALS

- Improve Officer and Consumer Safety

- Redirect Individuals with mental illness from the Judicial System to the Health Care System

In the City of Pittsburgh, the CIT program has been used since 2007. The Pittsburgh Bureau of Police under its Crisis Intervention Team (CIT) has trained and certified over one hundred officers to provide service to the citizens of Pittsburgh who may experience mental illness challenges.[30]

According to CIT Coordinator, Officer Patricia Melendez, as of April 2011, there were 162 CIT certified Pittsburgh Bureau of Police Officers, 93 Allegheny County municipal officers, and 16 Corrections Officers, with additional training classes in spring 2011.

DRAMA IN THE THEATER

For a suburban police officer, it came in as an unusual call.

A theater manager calls 911 for help in removing an unruly patron, who is screaming during a performance, prompting dozens of theater-goers to complain.

When Officer Tim Jones* arrives at the scene, he finds the manager in the lobby, along with two parents, and a 12 year old boy in a wheelchair.

The parents feel they and their son are the real victims. The father explains his son has a physical and co-occurring mental condition that cause him to vocalize uncontrollably at times, even with medication. This is a case, the father argues, of stereotyping and discrimination. They should not be forced to leave the theater; they have paid for three tickets.

But the manager claims and a disclaimer on each ticket attests, to management's right to remove anyone causing a disturbance from the theater. The manager offers to refund the families ticket purchase price in full, and he looks to the police officer to manage a tense situation that is spiraling out of control.

This incident did happen several years ago, and as the officer looks back now, he still remembers the boy's face and the parent's deep humiliation and anger.

"The father was embarrassed, the theater was packed, it was very hard, very emotional," the officer now says. "I felt sorry for the child, he couldn't control his actions. I tried to handle it with sensitivity, trying not to further embarrass the family. But legally, the theater owner had the right to refund the money, and ask the family to leave." So, the officer says, he did his job, and the family left, threatening to sue both the theater and the police.

No lawsuit was ever filed, the night became another in an endless stream of encounters police face where they encounter mental health issues on the job. "We have many different types of training, but it's not adequate for situations like this. We have classes we go to, but it's never enough."

QUESTIONS FOR DISCUSSION:

- What would you do in a similar case?
- Are there any new legal decisions that would affect the handling of this case today?
- Are there any potential ADA challenges to this decision?

** Name changed due to sensitive nature of this true story*

PREMISE ALERT

A FORM TO HELP FIRST RESPONDERS

The Premise Alert form assists first responders by giving them advanced information, both medical and behavioral, that helps them be better prepared and more knowledgeable before they enter a residence or interact with an Individual with special needs. This advanced knowledge leads to more accurate assessments and appropriate responses in emergency situations. (*This information was taken from the Premise Alert System. For more information see below (page 18)*)

The underlying principle of the Premise Alert Program is that the more First Responders know about a situation or individual before they respond, the more likely they will achieve a positive outcome during the interaction.

Click on link below to go to the downloadable Premise Alert form online:
http://papremisealert.com/images/form.pdf

WHAT IS THE PREMISE ALERT SYSTEM?

The Premise Alert System provides families with a uniform method to alert first responders about special needs individuals. It also provides first responders with advance knowledge, allowing for quick and educated responses during crises, evacuations, and disasters. The form is provided free of charge to families through DPW and MH/MR Case Managers and can be found at www.papremisealert.com. Police Chief Kevin McCarthy, Sr. along with Susan F. Rzucidlo, advocate, created this program. It was implemented as a Chester County, PA program in Nov. 2004. The Premise Alert System is currently on track to become a statewide program.

WHO CAN USE IT?

Anyone who has a special need, health challenge or disability such as, but not limited to, Alzheimer's Disease, Autism, Mental Health Challenges, Mental Retardation, a complex or rare medical condition, who would like first responders such as police, ambulance and fire department to know of their special needs. HIV/AIDS IS NOT CONSIDERED A RELEVANT MEDICAL CONDITION FOR THE PURPOSES OF THIS FORM, THE PREMISE ALERT SYSTEM AND PROGRAM. UNDER NO CIRCUMSTANCES SHOULD INFORMATION RELATED TO AN INDIVIDUALS HIV/AIDS STATUS BE DISCLOSED ON THIS FORM BY ANYONE.

DO I HAVE TO GIVE MY FOSTER CARE CHILD'S NAME ON THE FORM?

No, it can be processed without a name but someone with authorization needs to sign the form.

PREMISE ALERT

A FORM TO HELP FIRST RESPONDERS

WHO CAN FILL OUT THIS FORM?

- Individuals with special needs can fill it out for themselves.
- Parents of minor children
- Guardians of minor children
- Current Foster Care Parents (child's name isn't required)
- Those with LEGAL guardianship for another
- Those with the Power of Attorney for another

If you do not have a legal right to provide this information you should NOT fill out this form or provide this information

DO I HAVE TO FILL IT OUT?

No, it is VOLUNTARY. You do not have to provide any information you do not want First Responders to know or use.

HOW DO I USE THE FORM?

Fill out the form with as much information as you would want put into the 911 database, sign it, and then take a copy to your local police department. They will review it and send a copy to the County 911 center. The information will be put into the system for future use.

WHAT IF I LIVE IN AN AREA THAT USES BOTH A MUNICIPAL POLICE DEPARTMENT AND A STATE POLICE DEPARTMENT?

If you are in an area that is served by both municipal and state departments, then you need to make two copies and take one to each department. Take time to talk to an officer about your form.

THE FORM ASKS FOR A RECENT PHOTOGRAPH, WHAT KIND OF PICTURE IS BEST?

Any picture is better than no picture. What is best is a close up picture of the persons face, like a passport picture or school picture. It is best if the background is plain. That will be easiest for police departments to use. The pictures used on the "smile safe picture cards" from school will work. You can also make an appointment at your police department and an officer will take a digital picture to attach to the form, free of charge.

WILL I RECEIVE PREFERENTIAL TREATMENT BY USING THIS FORM? *NO*

- Providing this information does not entitle anyone in a household to preferential

treatment. It is simply an attempt to provide emergency response personnel with information that may be helpful when providing service to residents or occupants if it can be utilized by responders.

- Providing information in advance may allow first responders to react and treat in a way that can reduce the possibility of poor outcomes.

HOW OFTEN DO I NEED TO FILL OUT A PREMISE ALERT FORM?

This form is good for 1 to 2 years depending on the system it is filed in. If you move or need to make changes in the information just fill out another form and submit it. Any of the systems will automatically use the new information.

HOW CAN I GET MORE COPIES?

Case manager can mail a copy to you or additional copies can be found on-line at www.papremisealert.com

WHAT IF I NEED HELP FILLING OUT THE FORM?

Your case manager, school social worker, guidance counselor, or local advocacy group would be happy to help you fill out the form.

END NOTES:

The Premise Alert System and Form is a collaboration between Chief Kevin McCarthy, Susan F. Rzucidlo, Law Enforcement Entities, disability advocates, parent volunteers, educators, State & County Officials and other interested parties. It is owned by SPEAK Unlimited Inc. and is protected by copyright laws. It has been given free of charge to the state of Pennsylvania.

MENTAL HEALTH in the CORRECTIONAL SYSTEM

Mental health is a major issue for state and federal correctional facilities. Each day, 300,000 to 400,000 people with mental illnesses are incarcerated in the Unites States. More than 500,000 individuals are currently in the correctional system. Prisoners with mental illnesses are vulnerable to the conditions of correctional facilities, such as lack of adequate diet, harassment from other prisoners, or the experience of solitary confinement. Overcrowding and insufficient staffing of correctional facilities deteriorates the quality of mental health care.[21]

It is important to keep in mind the role mental health can play with the correctional system. At the local level, there may not be many resources about mental health issues for law enforcement officials. Cities generally have larger populations and experience a wider variety of mental health conditions. Rural communities may not have as many mental health resources.

POLICE AND THE AMERICANS WITH DISABILITIES ACT

Under the Americans with Disabilities Act (ADA), people who have disabilities are entitled to the same services law enforcement provides to anyone else. They may not be excluded or segregated from services, be denied services, or otherwise be treated differently than other people. The following compliance assistance materials will help state and local law enforcement officers understand how to interact with victims, witnesses, suspects, and others who have disabilities.[9]

POLICE RESPONSE TO PEOPLE WITH DISABILITIES, EIGHT-PART SERIES

Designed for use in roll-call training, this videotape addresses law enforcement situations involving people who have mobility disabilities, mental illnesses, mental retardation, epilepsy or seizure disorders, speech disabilities, deafness or hard of hearing, and blindness or low vision. The eight segments range from 5 ½ to 10 ½ minutes in length.

To View Part 3 – Mental Illness: http://www.ada.gov/policevideo/sect3qtbb.htm

DID YOU KNOW...?

- Over half of all inmates in state prison suffer from a mental disorder for at least a year.
- Federal prison has 44.8% of inmates that suffer from a mental disorder.
- Nearly two-thirds (64.2%) of inmates in local jails suffer from mental disorders.[20]

INTRODUCTION TO MENTAL ILLNESSES

DID YOU KNOW...?

- Over a quarter of people in the US aged 18 and older are believed to have a mental disorder in any given year.[5]
- Nearly half of those suffering with mental disorders have more than one mental illness they are dealing with.[5]
- Of the people with mental disorders, approximately 1 in 17 have a serious mental illness that significantly interferes with their daily functioning.[5]
- About 1 in 10 children live with a serious mental disorder.[4]

For law enforcement officers in Southwestern PA and across the nation, it is a critical challenge and a daily dilemma; how to handle the growing number of calls involving crime victims and crime suspects who have some form of mental illness.

Why the influx? It may be that a series of events over time, have now resulted in a perfect storm that has put law enforcement on the front line of America's mental health system.

In the 1960's and 70's, state psychiatric hospitals began to discharge large numbers of patients, moving them into community-based services. In recent years, particularly in the wake of a national recession, the community safety net of services has been under fiscal siege. Federal, state and local budget cuts have pulled the plug on vital mental health services to tens of thousands of adults and children. The result: a reduction in community and hospital-based psychiatric care, housing and access to medications.[35]

Dealing with a mental disorder is more than just treating the condition. People diagnosed with mental illness must face the stigmas attached to these conditions. Many people do not seek treatment due to fear of being called crazy, violent, or being assigned inaccurate character flaws. Most people with mental illness live productive lives. They go to school, work, and raise their families just as anyone without a mental disorder would. The following sections will act as an overview for common mental illnesses including post-traumatic stress disorder, depression, suicide, and bipolar depression.

POST-TRAUMATIC STRESS DISORDER (PTSD)

WHAT IS PTSD?

It is important to explain that PTSD is a syndrome, or cluster of symptoms, that develops following some type of traumatic event. These events have a range of probabilities that PTSD will subsequently manifest. These events range from high (e.g., after rape or torture), to moderate (e.g., after serious injuries), to low (e.g., after natural disasters). Other examples of traumatic events include kidnapping, war, or serious accidents, such as airplane crashes.[32]

WHAT ARE THE SYMPTOMS OF PTSD?

- Constant feelings of reliving the traumatic event
- Emotional numbing
- Persistent anxiety
- Exaggerated startled reactions
- Difficulty concentrating
- Nightmares and insomnia
- Avoidance of reminder situations that provoke intense distress or panic attacks

TREATMENT

Psychotherapy, or counseling with a licensed mental health professional, helps many people with PTSD regain a sense of control over their lives. Support systems, such as support groups or family and friends, help in the recovery process. Sometimes anxiety-reducing medications or antidepressants may help to alleviate symptoms. It is important to understand that successful treatment incorporates multiple treatment options.[32]

DID YOU KNOW...?

Anyone that has experienced, witnessed, or participated in a tragic event may develop PTSD, even children.

POST-TRAUMATIC STRESS DISORDER (PTSD)

DIAGNOSING PTSD AND OTHER MENTAL DISORDERS

Mental health professionals that are licensed to diagnose (e.g., psychiatrists and psychologists) refer to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The DSM-IV is published by the American Psychiatric Association (APA) and lists the standard criteria for each mental disorder that must be exhibited to have a confirmed diagnosis.

There are several factors that must be true for a diagnosis of PTSD. These factors include a history of exposure to a traumatic event and symptoms from three different categories: intrusive recollections, avoiding and numbing symptoms, and hyper-arousal symptoms.[2]

To view a complete list of criteria, visit:
http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp

For more information about PTSD, visit:
http://www.eiconline.org/resources/publications/z_picturethis/63306_PTSD%20Book.pdf

POST-TRAUMATIC STRESS DISORDER (PTSD)

PERSONAL STORIES

PTSD is thought of as a mental illness constrained to war veterans. This condition can affect any person, regardless of their background. Below you will find accounts of people living with PTSD from different backgrounds with unique circumstances.

MILITARY SERVICE

"ONE DAY, HE SNAPPED..."

Not long after Lance Cpl. James Simmons returned from Iraq, the Marines dispatched him to Quantico, Va., for a marksmanship instructor course. Mr. Simmons, then a 21-year-old Marine Corps Reservist from Utah, had been shaken to the core by the intensity of his experience during the invasion of Iraq. Once a squeaky-clean Mormon boy who aspired to serve a mission abroad, he came home a smoker and drinker, unsure if he believed in God. In Quantico, he reported to the firing range with a friend from Fox Company, the combined Salt Lake City-Las Vegas battalion nicknamed the Saints and Sinners. Raising his rifle, he stared through the scope and started shaking. What he saw were not the inanimate targets before him but vivid, hallucinatory images of Iraq: "the cars coming at us, the chaos, the dust, the women and children, the bodies we left behind."

Each time he squeezed the trigger, Mr. Simmons cried, harder and harder until he was, in his own words, "bawling on the rifle range, which marines just do not do." Mortified, he allowed himself to be pulled away. Not long after, the Marines began processing his medical discharge for post-traumatic stress disorder, severing his link to the Reserve unit that anchored him, and sending him off to seek help from veterans' hospitals. The incident on the firing range was the first "red flag," as the prosecutor in Tooele County, Utah, termed it, that Mr. Smith sent up as he gradually disintegrated psychologically. At his lowest point, in March 2006, he killed Nicole Marie Speirs, the 22-year- old mother of his twin children, drowning her in a bathtub without any evident provocation or reason.

"There was no intent," said Gary K. Searle, the deputy Tooele County attorney. "It was almost like things kept ratcheting up, without any real intervention that I can see, until one day he snapped."

POST-TRAUMATIC STRESS DISORDER (PTSD)

PERSONAL STORIES

The following stories and more can be found on Post Traumatic Stress Disorder Today, an online community for people living with PTSD. For more information, visit: http://www.mental-health-today.com/ptsd/story.htm

FLASHBACKS

"I STARTED HAVING FLASHBACKS..."

I was raped when I was 25 years old. For a long time, I spoke about the rape as though it was something that happened to someone else. I was very aware that it had happened to me, but there was just no feeling.

Then I started having flashbacks. They kind of came over me like a splash of water. I would be terrified. Suddenly I was reliving the rape. Every instant was startling. I wasn't aware of anything around me, I was in a bubble, just kind of floating. And it was scary. Having a flashback can wring you out.

The rape happened the week before Thanksgiving, and I can't believe the anxiety and fear I feel every year around the anniversary date. It's as though I've seen a werewolf. I can't relax, can't sleep, don't want to be with anyone. I wonder whether I'll ever be free of this terrible problem.

DEPRESSION

Depression is more than just feeling a little blue every now and then…

WHAT DEPRESSION IS

Depression involves consistent feelings of sadness that interfere with daily life, normal functioning, and causes pain for the affected person and those who care about him or her. Sometimes, these prolonged feelings can lead to suicide attempts. Clinical depression is the overarching term used for the many different types of depression that can be diagnosed, some of the different types are seasonal affective disorder (SAD), postpartum depression, or major depressive disorder.[33]

WHO CAN GET DEPRESSION?

Depression affects both men and women; however, more women are diagnosed with depression than men. Depression also tends to run in families. A stressful or unhappy life event, such as the loss of a job or death in the family, may also trigger depression. Depression may also occur after pregnancy, which is known as postpartum depression. [33]

TREATMENT FOR DEPRESSION

Treating depression often involves a combination of treatment options. These may include medications, talk therapy, or lifestyle changes.[6]

For more information about depression and suicide prevention, visit: http://www.eiconline.org/resources/publications/z_picturethis/Disorder.pdf

DEPRESSION

SIGNS AND SYMPTOMS OF DEPRESSION

- Prolonged sadness or unexplained crying spells
- Significant changes in appetite and/or sleep patterns
- Irritability, anger, worry, agitation, anxiety
- Pessimism, indifference
- Loss of energy, persistent lethargy
- Feelings of guilt, worthlessness
- Inability to concentrate, indecisiveness
- Inability to take pleasure in former interests, social withdrawal
- Unexplained aches and pains
- Recurring thoughts of death or suicide[33]

If any of these symptoms last for more than 2 weeks, a medical professional should be contacted.

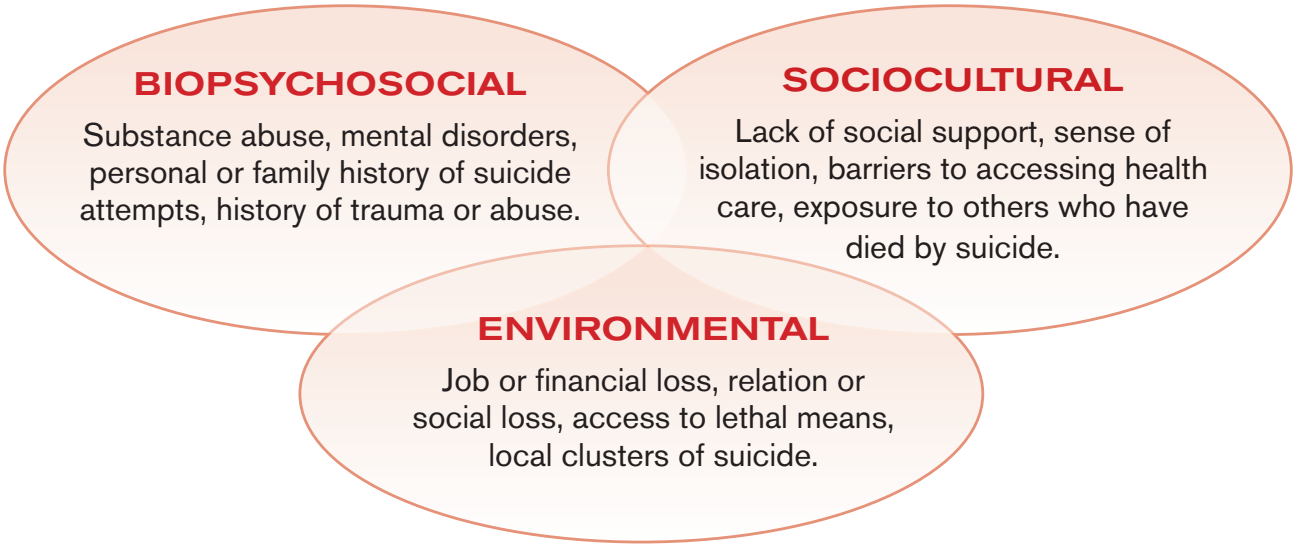
SUICIDE

WHAT IS SUICIDE

Suicide is the act of a human being intentionally causing his or her death. It may be the result of experiencing tragic circumstances; feelings of hopelessness, worthlessness, or as if there is no reason to live; mental illnesses such as depression can also be a cause of suicide.

RISK FACTORS FOR SUICIDE

Risk factors for suicide are a combination of individual, relational, community, and societal factors. Risk factors are characteristics associated with suicide–they may or may not be direct causes.[31]



RESPONDING TO THE WARNING SIGNS OF ANOTHER OFFICER

If you believe that another officer is thinking of harming him- or herself, you can ask directly, in private, if this is the case. If the officer admits to having such thoughts, or if the officer denies it but you are still concerned, there are a number of steps you can take[3]:

- Express your concern to an appropriate person, such as a line supervisor or the department's mental health professional (if the department is large enough to have one).
- Ask the officer to call the National Suicide Prevention Lifeline at (800) 273-TALK (8255).

- Offer to help the officer find, or accompany the officer to, a mental health professional who is better able to evaluate the officer's risk and to recommend next steps.

- Help the officer's family and friends develop a plan so that someone is with him or her at all times until the crisis is resolved. [3]

WARNING SIGNS FOR LAW ENFORCEMENT

Experts have identified other warning signs that a fellow officer may be thinking of harming him - or herself. Officers at risk of suicide may do one or more of the following [36]:

- Announce that they are going to do something that will ruin their careers, but that they don't care.

- Admit that they feel out of control.

- Appear hostile, blaming, argumentative, and insubordinate OR appear passive, defeated, and hopeless.

- Develop a morbid interest in suicide or homicide.

- Indicate that they are overwhelmed and cannot find solutions to their problems.

- Ask another officer to keep their weapon OR inappropriately use or display their weapon.

- Begin behaving recklessly and taking unnecessary risks, on the job and/or in their personal lives.

- Carry more weapons than is appropriate.

- Exhibit deteriorating job performance (which may be the result of alcohol or drug abuse).[36]

There is no "fail safe" method of judging whether a person is at immediate risk of attempting suicide. However, most of these warning signs indicate that an officer is experiencing some sort of emotional stress.[36]

SUICIDE

HOW TO PREVENT SUICIDE

One of the most important aspects of preventing suicide is understanding the risk factors, warning signs and intervening as soon as possible. Interventions may include one-on-one therapy and/or drug therapy. Additional support systems, such as support groups, family therapy, or online communities may be utilized as coping methods.[33]

CURRENT NATIONAL STRATEGIES

The **National Action Alliance for Suicide Prevention** is a group comprised of public and private co-chairs, executive committee members, task forces, advisory groups and staff. Their mission is to advance the National Strategy for Suicide Prevention by (1) championing suicide prevention as a national priority, (2) catalyzing efforts to implement high priority objectives of the NSSP, and (3) cultivating the resources needed to sustain progress.[8]

For additional information on the Action Alliance, visit: http://www.actionallianceforsuicideprevention.org

When talking about suicide, remember that the **National Strategy for Suicide Prevention** (NSSP) is the nation's framework for preventing suicide in the United States, and it should be mentioned. The NSSP recognizes the toll that suicide takes on society and presents developed goals, objectives, and strategies for addressing this public health issue. Countless individuals including leading stakeholders, grassroots organizations, public servants, private individuals, and governmental agencies developed the strategy[7].

To view the goals and objectives for the NSSP, visit: http://store.samhsa.gov/shin/content//SMA01-3517/SMA01-3517.pdf

SUICIDE

PERSONAL STORY

A TRAGEDY HITS HOME

In the first three weeks on the job, Officer Jack Martin* was called to his first suicide, a scene still vivid in his head.

Over the next 30 years, he'd respond to so many, he would lose count. Suicides from gunshots, overdoses, hangings, carbon monoxide poisoning. Many seemed so senseless, some, so very sad; a young girl who hung herself because she didn't want to go to summer school.

They all affected him in different ways, but none hit so close to home, as the one that claimed the life of a fellow officer.

"I worked with him the night before, worked 3 to 11," the Officer recalls, noting they were part of a team investigating a potential homicide case. "We made plans to meet at noon the next day. The last thing he said to me was 'I'll meet you tomorrow'."

The meeting never took place. "I didn't notice one thing wrong with him. I never would have even expected any problem, not one thing. I totally expected to come to work and talk to him the next day. Within a 12 hour period, he decided to kill himself."

Martin passed the officer's house on his way to work the next day. Police cars and ambulances were parked outside.

"He was one of the closest people to me. I didn't believe it was suicide at first. It affected me for a very long time; he was somebody that I liked that much."

Later, as more details came to light, a picture would emerge of an officer under great emotional stress. He had dealt with it himself, until he could deal with it no more.

"They do teach you in the academy not to take your problems home. They tell you that's the worst thing you can do. Sometimes I worry when guys or girls on the force are going through breakups and divorce, I think that's the biggest thing, when home life or a relationship becomes a stress on top of your job," Martin now says.

"I used to think about him a lot more…I got emotional a few times. 'What were you thinking? Why would you do that?' It's one thing about suicides, you never know what's going on in someone's head, and you can't go back and ask them, because they're not there."

Martin took a deep breath, and slowly exhaled. "Every time we get a call, it's because someone is having a problem. Who do we call when we are having a problem?"

** Name changed due to sensitive nature of this true story*

BIPOLAR DEPRESSION

WHAT IS BIPOLAR DEPRESSION?

Bipolar depression, commonly referred to as bipolar disorder, is a mental health condition in which a person experiences drastic mood changes from periods of high elation to depression. It interferes with a person's daily life and normal functioning.[34]

WHAT ARE SYMPTOMS OF BIPOLAR DEPRESSION?

The depressive phase of bipolar depression mirrors the symptoms for clinical depression *(see page 26)*. Manic symptoms or the period of extreme elation may include:

- Inappropriate sense of euphoria
- Reckless behavior, poor judgment
- Excessive energy, little sleep needed
- Racing thoughts, talking too much and too fast
- Out of control spending and other abnormally increased activity (including sexual activity)
- Irritability, difficulty concentrating[34]

WHO CAN GET BIPOLAR DEPRESSION?

Bipolar depression usually surfaces in late adolescence or early adulthood. It can also begin in childhood or even later into adulthood. Symptoms may be different depending upon the age of onset.[34]

BIPOLAR DEPRESSION

DIAGNOSING BIPOLAR DEPRESSION

Bipolar depression is a difficult disorder to diagnose, and is usually done during a depressive phase. It is often misdiagnosed as major depressive disorder or as other conditions such as schizophrenia. Close monitoring of symptoms is key to a proper diagnosis. The diagnosis process can take up to 10 years. [34]

TREATMENT OF BIPOLAR DEPRESSION

Bipolar depression is most successfully managed when a wide range of treatment methods are implemented. Treatment can also address psychological factors and include medication. Daily monitoring of moods, symptoms, treatments, sleep patterns, and life events can help patients and their families cope with this condition.[34]

For more information on bipolar depression, visit: http://www.eiconline.org/resources/publications/z_picturethis/Pict_This_Web.pdf

and *http://www.eiconline.org/resources/publications/z_picturethis/Bipolar_FINALw%20linking.pdf*

BIPOLAR DEPRESSION

PERSONAL STORIES

Bipolar depression can effect any person, regardless of their background. Below you will find accounts of people living with bipolar depression from different backgrounds with unique circumstances.

TOM'S STORY

Tom B. lived the high life. He flew from Atlanta to Tampa, rented a Porsche, flew to Toronto, and went on a $27,000 shopping spree for new clothes. On a whim, Tom would hop on a jet to New York, Ft. Lauderdale, St. Louis, or anywhere else that seemed interesting. The problem was that Tom couldn't afford his lifestyle–and until recently, he had no control over it.

Tom B. has been hospitalized seven times. He was diagnosed with bipolar disorder at age 40. At age 45, Tom moved in with his parents to avoid homelessness. Only four years ago did Tom's doctors find the right combination of medications that worked for him.

As a board director for a mental health center and an advisor to the Montana State Board of Visitors, Tom points out that his struggles with finding the right treatment were not the result of improper medical care. The psychiatrists and counselors he saw over the years tried as hard as they could to treat him.

Tom's case is not atypical, and it highlights the difficulty of treating bipolar disorder. Often, effective treatment today is identified only through trial and error--but treatment is possible and can save lives.

LINDA'S STORY

Linda owns and operates an Amish taxi service in Missouri. She was diagnosed with bipolar disorder at 35. Her treatment includes seven psychiatric medications and visits to a counselor she started seeing 20 years ago who lives 200 miles away.

Mental illness isn't just Linda's problem. She is only one of many generations in her family that suffers from a mental disorder. Her daughter has schizoaffective disorder.

"We are still in the dark ages when it comes to social acceptance of mental illness," Linda says. During one of her daughter's hospitalizations, Linda's co-workers confessed that they were uncomfortable with the situation and didn't know what to do. "Do what you do when someone breaks a leg. Send a card, call and say you care, take food to the family, offer to baby-sit," she told them. Linda runs a successful business and has been married for 42 years.

"I would, without hesitation, be willing to tell anyone I have a mental illness...I have ended up having a very good life in spite of severe bipolar disorder...I want people to know there is every reason to have hope."

REACHING OUT TO THE MEDIA

FREQUENTLY ASKED QUESTIONS

As a police officer you want to convey to the community your knowledge and experience surrounding mental health. However, you might be unsure of exactly how to disseminate these points. The media is an effective and inexpensive way to reach large audiences quickly. This section will give you an overview of how the various media outlets work and what to do when you contact them or after receiving a call back.[10]

WHO SHOULD I CONTACT?

Some questions when deciding upon a point of contact are:

- What specific reporters cover medical stories?
- Who is the Director of Community Affairs?
- Who produces the local morning show?
- Who is the Assignment Manager?[10]

By contacting the correct individual the first time, you increase your chances of pursuing your topic in the media. It is important to do your research on individuals prior to contacting them.

Try to contact individuals directly and avoid "information" e-mails or phone and fax numbers.

HOW DO I COMMUNICATE WITH THE MEDIA?

Keep in mind media representatives are busy and you should communicate with them as clearly and concisely as possible. There are several ways you can communicate with the media:

- **Pitch letters:** A personalized letter 'pitching' a topic or event that is newsworthy.

For tips on writing pitch letters, visit:
http://www.afterschoolalliance.org/mediaTipsPitch.cfm

- **Press releases:** A two to three-page report detailing the specifics of an event that has or will take place.

- **Media kits:** A quick overview of what your organization has to offer or what it is that you want covered by the media. This may include photos, background information on your organization and the topic, and contact information.[10]

REACHING OUT TO THE MEDIA

HOW DO I GET MY MESSAGE ACROSS?

Framing your message properly is the key to being noticed and obtaining media time. Consider the following:

- What is your goal? What do you want to accomplish? Be specific.
- Decide upon a core message and key points parallel with your goals. This message should promote understanding and education about mental illnesses.
- Incorporate your key points in multiple areas within your materials to ensure the media representative does not overlook them.[10]

WHEN SHOULD I REACH OUT?

Topics of interest may include mental health related events, personal stories, research breakthroughs, or new and enlightening statistics, research, and development.

Only reach out to the media when you have something that is newsworthy, interesting to the population, or when you can contribute your knowledge to a story already in the news. Contact the media when you see something negatively or inaccurately portrayed on mental illness. Remember, not everything can be labeled as newsworthy.[10]

INTERVIEWING WITH THE MEDIA

You have reached out to one or more various media outlets and have finally received a reply. Your interview is scheduled—what do you do next?

When local law enforcement provides information to the media, it must be presented in ways that are understandable to journalists, as well as the public. Here are some things to consider:

- **Consider the audience:** What is pertinent and interesting to them?
- **Avoid jargon:** Eliminate all the technical terms that you can without affecting your message. If you are presenting a scientific term, follow with a brief, easy-to-understand phrase.
- **Do not patronize:** Although journalists may not be experts in your field, pandering or patronizing them will undermine your credibility.
- **Use metaphors, similes, and examples:** These are great ways to explain information so the audience can understand your message. Try to relate measurements to everyday objects or common knowledge.
- **Eliminate statistics:** Personalizing data makes it more relatable to the audience.
- **Be personal:** Relay your personal story, offer emotion, and let your personality and enthusiasm for the topic shine through.
- **Be straightforward:** Label the news as good or bad to be clear for the consumer. For example, "this is good news for people who suffer chronic back pain."
- **Back up your words:** Show your credibility by mentioning affiliations, credentials, and qualifications. Also take note that it is okay to say you do not know the answer to a question!
- **Rehearse:** Rehearse prior to the interview; however, do not ask to review a story ahead of time. This is often not possible.[29]

INTERVIEWING WITH THE MEDIA

TIME-TESTED TECHNIQUES FOR TOUGH QUESTIONS

When interviewing with the media, you may be put on the spot or asked tough questions. Here is an overview of how you can quickly turn those around.

HOOKING: Grab a reporter's attention by making a statement that influences the next question.
Example: "We are undertaking a program to correct the situation."

BRIDGING: Answer the question and quickly move to the key message.
Example: "Yes, but…" or "No, in fact…"

FLAGGING: Emphasize key points and guide the reporter to them.
Example: This is important news because…"

BULLETING: Burn the points of your message into the memory of the reporter.
Example: "There are two things to remember…"

In the media, when you do not know the answer, there are only 3 responses journalists find acceptable:

- I have the answer, here it is.
- I do not have the answer, but will get it for you.
- I have the answer, but cannot provide it at this time.[29]

MENTAL HEALTH TERMINOLOGY

ANXIETY: Anxiety is used to describe the feelings associated with a category of mental disorders composed of multiple physical and psychological symptoms, but all conditions concerning anxiety have common feelings of apprehension, tension, or uneasiness. Among the anxiety disorders are panic disorder, agoraphobia, obsessive-compulsive disorder, post traumatic stress disorder, and generalized anxiety disorder.

BEHAVIORAL HEALTH: Personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behavior patterns, actions, and habits that relate to health maintenance, to health restoration, and to health improvement.[25] In this context, it is the person's response to mental health and substance abuse.

COGNITIVE BEHAVIORAL THERAPY: An empirically supported treatment that focuses on patterns of thinking that are maladaptive and the beliefs that underlie such thinking. Therapists using Cognitive Behavioral Therapy are active, problem-focused, and goal-oriented.[24]

DEPRESSION: An illness that involves the body, mood, and thoughts. It affects the way a person eats and sleeps, feels about oneself, and thinks about things. Symptoms include: sadness, lack of interest in activities and others that were once enjoyable. These feelings can last for weeks, months, or years without adequate treatment. [14]

DEMENTIA: Dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. People with dementia have significantly impaired intellectual functioning that interferes with normal activities and relationships. They also lose their ability to solve problems and maintain emotional control. They may even experience personality changes and behavioral problems such as agitation, delusions, and hallucinations. While memory loss is a common symptom of dementia, memory loss by itself does not mean that a person has dementia. Doctors diagnose dementia only if two or more brain functions - such as memory, language skills, perception, or cognitive skills, including reasoning and judgment - are significantly impaired without loss of consciousness. [26]

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM): The standard classification of mental disorders used by mental health professionals in the United States. The most recent edition as of 2000 is the fourth edition, or DSM-IV-TR.[2]

EMOTIONAL HEALTH: The ability of the emotional system to help individuals regulate and negotiate their environment in an adaptive way. [15]

MANIA: Some symptoms of mania are an inappropriate sense of euphoria (excitement), reckless behavior, a need for little sleep, excessive energy, racing thoughts; talking too much, out of control spending, difficulty concentrating, irritability, abnormally increased activity, including sexual activity, poor judgment, and aggressive behavior.[34]

MENTAL HEALTH TERMINOLOGY

MENTAL DISORDER: A mental or nervous condition diagnosed by a practitioner according to the criteria in the DSM-IV and limited to severe impairment of a person's mental, emotional, or behavioral function on a daily basis.[16]

MENTAL DISTRESS: A disturbing or unpleasant mental or emotional state. This term refers to a wide range of experiences, from fear to chronic and severe conditions.[17]

MENTAL HEALTH: Can be categorized as good or poor (for poor see *mental illness*). A state of successful mental performance and functioning, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.[18]

MENTAL ILLNESS: An umbrella term that refers to all of the diagnosable mental conditions that prevent an individual from experiencing mental health (see *mental health*).[18]

PARANOIA: A perception or suspicion that others have hostile or aggressive motives while interacting with them, when in fact there is no observable reason for these suspicions.[19]

PSYCHOANALYSIS: Long-term therapy meant to "uncover" unconscious motivations and early patterns to resolve issues and to become aware of how those motivations influence present actions and feelings.

STIGMA: Stereotyping or labeling a term or a condition, which gains a negative connotation. Stigmas can also lead to misconceptions about the illness or condition that they are describing.

STRESS: The emotional and physical strain caused by internal (e.g., overall health) or external (e.g., job) factors. [27]

TRAUMA: In mental health, referring to an experience that is emotionally painful, distressful, or shocking, and often results in lasting mental and physical effects. [28]

LOCAL AREA MENTAL HEALTH RESOURCES

Active Minds http://www.activeminds.org/ 202.332.9595	Family Behavioral Resources http://www.familybehavioralresources.com/ 724.850.8118
Allegheny Coalition for Recovery http://www.coalitionforrecovery.org/ 412.325.0369	Family Services of Western PA http://www.fswp.org/ 888.222.4200
Allegheny HealthChoices Inc. http://www.ahci.org/ 412.325.1100	Greater Pennsylvania Alzheimer's Association http://www.alz.org/pa/ 412.261.5040
Autism Society of America www.autismsocietypgh.org 412.856.7223	The Greater Pittsburgh Psychological Association http://www.gppaonline.org/ 412.441.7736
Center for Mind and Body Wellness http://www.mind-body.org 814.333.5060	Heritage Valley Health System http://www.heritagevalley.org/ 412.741.6600
Children's Hospital of Pittsburgh http://www.chp.edu/CHP/Home 412.692.5325	International Society for Bipolar Disorders http://www.isbd.org 412.802.6940
Community Psychiatric Centers http://www.communitypsychiatriccenters.com 877.899.6500	IRETA Institute for Research, Education, and Training in the Addictions http://www.ireta.org/ 412.391.4449
Consumer Health Coalition http://www.consumerhealthcoalition.org/ 412.456.1877	Jewish Family & Children's Service of Pittsburgh http://www.jfcspgh.org/ 412.422.7200
Department of Human Services Allegheny County http://www.alleghenycounty.us/dhs/ 412.350.5701	Mel Blount Youth Home of PA http://www.melblount.com/ 724.948.2311
Depression and Bipolar Society of America, Pittsburgh Chapter http://www.dbsalliance.org 800.826.3632/412.246.5588	Mental Health America, Allegheny County http://www.mhaac.net/ 412.391.3820/877.391.3820
Duquesne University School of Nursing http://www.nursing.duq.edu 412.396.6550	Picture This: Mental Health in Pittsburgh http://www.eiconline.org/resources/publications/z_localapproach/Pittsburgh%20Bklt.pdf
Facing Bipolar http://www.takeondepression.com/bipolar-disorder 1.800.236.9933	The Plea Agency http://www.plea-agency.org/compeer.html 412.243.3464
Mercy Behavioral Health http://www.mercybehavioral.org/ 877.637.2924	Pressley Ridge http://www.pressleyridge.org/ 412.872.9400

LOCAL AREA MENTAL HEALTH RESOURCES

Milestone Centers Inc. http://www.milestonecentersinc.org/ 412.243.3400	S'eclairer http://www.seclairer.com/ 724.468.3999
National Alliance on Mental Illness Southwestern Pennsylvania http://www.namiswpa.org 888.264.7972/412.366.3788	Shepherd Wellness Community http://www.swconline.org/ 412.683.4477
National Black Nurses Association, Inc. http://nbna.org 301.589.3200/800.575.6298	Turtle Creek Valley Mental Health/Mental Retardation Inc. http://www.tcv.net/ 412.351.0222
Obsessive Compulsive Foundation of Western Pennsylvania http://www.ocfwpa.org/ 412.363.6231	UCLID at University of Pittsburgh http://www.uclid.org 412.692.6300
PA/MidAtlantic AIDS Education and Training Center http://www.pamaaetc.org/ 412.624.1895	University of Pittsburgh Center for Minority Health http://www.cmh.pitt.edu 412.624.5665
Pennsylvania Training & Technical Assistance Network (PaTTAN) http://www.pattan.k12.pa.us 412.826.2336	Department of Epidemiology http://www.epidemiology.pitt.edu 412.246.5953
People's Oakland http://www.peoplesoakland.org/ 412.683.7140	University of Pittsburgh Institute on Aging http://www.aging.pitt.edu/ 866.430.8742
Persad http://www.persadcenter.org/ 412.441.9786	University of Pittsburgh Medical Center http://www.upmc.com/Pages/Home.aspx 412.647.8762/1 800.533.8762
Pittsburgh Action Against Rape http://www.paar.net 412.431.5665	University of Pittsburgh School of Medicine http://www.medschool.pitt.edu/ 412.648.8975
Pittsburgh AIDS Task Force http://www.patf.org/ 888.204.8821/412.345.7457	UPMC Western Psychiatric Institute http://wpic.upmc.com/ 412.624.1000/877.624.4100
Pittsburgh Mercy Health System http://www.pmhs.org/ 412.232.7920	The Watson Institute http://www.thewatsoninstitute.org/ 412.741.1800
Pittsburgh Regional Health Initiative http://www.prhi.org/ 412.586.6700	West Penn Allegheny Health System http://www.wpahs.org/ 866.680.0004
Pittsburgh Social Anxiety Support Group http://www.pittsburghsocialanxiety.com/ 412.255.1155	Staunton Farm Foundation http://www.stauntonfarm.org/ 412.281.8020

NATIONAL RESOURCES

AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION (AMHCA)

A Professional organization composed of almost 6,000 mental health counselors with the mission of enhancing the profession of mental health counseling.

www.amhca.org ■ 703-548-6002 ■ W. Mark Hamilton President and CEO ■ mhamilton@amhca.org

AMERICAN PSYCHIATRIC FOUNDATION

A professional organization focused on the advancement of public understanding surrounding mental illnesses, as well as promoting awareness, and the effectiveness of treatment.

www.psychfoundation.org ■ 703-907-8512 ■ Paul T. Burke, Executive Director ■ pburke@psych.org

THE ENTERTAINMENT INDUSTRIES COUNCIL, INC. (EIC)

To bring the power and influence of the Entertainment Industry to bear on communication about health and social issues.

www.eiconline.org ■ 703-481-1414

MENTAL HEALTH AMERICA (MHA)

The MHA is a not-for-profit advocacy organization addressing mental health issues and their effects nationwide. This organization works to inform, advocate, and enable access to quality behavioral health services for all Americans.

www.nmha.org ■ 703-642-7722

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

NAMI is a mental health advocacy organization dedicated to offering hope, reform, and help to the American community though awareness, education, and advocacy focusing on Mental Illness.

www.nami.org ■ 703-524-7600 ■ Media Relations: Bob Corrolla ■ bobc@nami.org

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

A division of the National Institutes of Health (NIH) with a mission to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.

www.nimh.nih.gov ■ 866-615-6464

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA is a government agency focused on the mission of reducing the impact of substance abuse and mental illness on America's communities.

www.samhsa.gov ■ Media Services: 240-276-2130 ■ Director of Communications: Hardy Stone ■ Hardy.stone@samhsa.hhs.gov

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