Are alcohol and drug addiction more prevalent among law enforcement officials than other professionals?

We don’t have data to conclusively answer this question. Nevertheless, alcohol and drug problems are known to affect a vast number of Americans, law enforcement officials included. Data suggests that 17% of men and 8% of women will suffer from alcohol dependence at some point in their lives. About 14% of men and 7% of women will meet criteria for a drug use disorder. Excessive alcohol and drug use contribute to short-term problems such as accidents and interpersonal violence and long-term health problems, including heart disease, cancer, and mental health problems. The U.S. Center for Disease Control (CDC) estimates that one in 10 deaths of working-age Americans is due to excessive alcohol use, making alcohol one of the primary contributors to mortality in the United States.

What causes these addictions?

Like most chronic illnesses, addiction is caused by genetic and environmental factors that interact across the course of human development. For persons with a genetic susceptibility, alcohol or drug use might cause a more powerful reward than it does for the average person. This disproportionate effect leads to more frequent use, increased emotional attachment, and ultimately, addiction. For others, alcohol or drugs are the “solution” to other mental health problems such as anxiety or depression. These symptoms can be hereditary, but might also be exacerbated by past or present environmental insults such as trauma or chronic stress. Alcohol and drugs that are used as a method of coping become a significant problem over time.

For persons in high stress jobs such as law enforcement, the local work culture might involve frequent opportunities to unwind with alcohol. A culture of drinking does not affect everyone in the same way. For those with a biological or familial susceptibility, a drinking culture can hasten the development of addiction.

How much alcohol is too much?

The CDC defines excessive alcohol use as heavy drinking or binge drinking. Heavy drinking is the consumption of 15 or more standard drinks per week for men and 10 or more for women. For men, binge drinking is the consumption of five or more drinks on any one occasion; for women, it is four or more drinks. Both heavy drinking and binge drinking are associated with mental and physical health problems.

What is addiction?

Addiction is not just about the amount or frequency of use, but the degree to which alcohol or drug use affects a person’s life. A person with addiction can use alcohol or drugs every day or as little as once every couple of weeks. The common denominator

cont. on page 2
is that use leads to negative consequences that the person suffering from addiction minimizes or ignores in order to keep using. When alcohol and drug use begins to cause problems, the person with addiction typically tries to protect his or her pattern of use through increased isolation—pushing away friends, family members, and coworkers who might get in the way of continued use. The severity of an alcohol or drug problem can be defined by the degree to which it causes an individual to compromise his or her own principles and priorities.

Why is it so hard to quit?
Because of the way alcohol and drugs affect the central reward and stress systems of the brain, persons can come to believe that alcohol or drugs are as necessary for survival as food and water. Addiction follows the typical pattern of human attachment. At first, use is typically pleasurable and fun. As addiction develops, drinking and using no longer provide much, if any, pleasure, but the attachment has become so strong that a person can’t imagine quitting. Persons entering treatment often remark, “I don’t use to experience pleasure; I just use to feel normal.”

Quitting alcohol or drug use is a grief-filled process like losing a close friend or partner. The person who successfully recovers from addiction goes through the typical stages of grief—denial, bargaining, anger and sadness—before coming to accept a sober life. This process of creating a “new normal” typically takes one to two years. By that point, persons in recovery are usually very grateful they quit; a sober life is far healthier and more satisfying than a life affected by addiction.

How do people recover from alcohol or drug addiction?
Addiction is highly stigmatized, so that persons with the illness rarely mention it to their primary care physicians or seek specialized treatment. Despite addiction’s massive cost to public health, fewer than 25 percent of persons with alcohol or drug addiction have received treatment.

The first step toward recovery is to speak with a professional. The local National Council on Alcohol and Drug Abuse can provide both referrals and assessment. Traditional treatment has often required persons to go away for 30 days of inpatient or residential treatment, but today, outpatient treatment in a person’s natural environment is thought to be best for most people. With outpatient treatment, people can receive medical detoxification, individual, group, and family therapy, and medications to reduce alcohol or drug cravings without major disruption to their daily lives. For many, participation in 12-step mutual support groups such as AA or NA is essential for ensuring long-term recovery.

What should I do if someone I care about suffers from alcohol or drug addiction?
Since people with alcohol or drug addiction often delay or refuse treatment, family members and friends are left wondering...
Behavioral Health Response (BHR) is the community’s safety net for barrier-free access to behavioral health services. This work happens 24/7 and we work tirelessly to make sure those in need receive the services available.

We cannot do this work on our own and rely heavily on other community partners such as local police departments to successfully accomplish our goals. We depend on law enforcement in various ways including welfare checks, active interventions and accompanying mobile outreach staff in outreach situations where safety is a potential issue.

BHR plus law enforcement is a powerful combination. Lt. Donnell Moore is a perfect example of this powerful combination. Donnell works part-time as a mobile outreach team member for BHR. Over the past year, he has completed more than 130 mobile outreachs, equaling over 321 hours over and above his regular schedule as a police officer for the St. Louis Police Department.

Donnell’s skills and training as a police officer, combined with his skills and training as a mental health professional, make for a powerful combination in the lives of those dealing with mental health problems. Donnell’s coworkers at BHR will often dispatch him specifically on cases where his expertise in law enforcement will be of benefit to the person in need of assistance.

On one such case, Donnell accompanied a CIT officer to a situation where the person was dealing with mental health issues and was at risk for domestic violence. Having a CIT trained officer on scene, in addition to Donnell being present, worked to the benefit of person in need. Donnell’s training as an officer helped him relate to the needs and concerns of the officer, and his training as a mental health professional helped him relate to the needs of the client. This powerful combination allowed the individual to feel safe, receive support and get connected to services that would improve his quality of life.

BHR, and the clients we serve, are fortunate to have Donnell as part of our Mobile Outreach Team. We’re grateful for his assistance and are happy to recognize his work In The Limelight!

IN THE LIMELIGHT: LT. DONNELL MOORE

By Angela Tate, M.Ed., LPC

Ned Presnall is a Licensed Clinical Social Worker. He is executive director of Clayton Behavioral Treatment Programs and an adjunct professor at Washington University—St. Louis’ Brown School of Social Work. He is passionate about reducing the stigma of addiction and improving treatment outcomes though discourse and public engagement. Ned can be reached at 314-222-5896 or at ned@claytonbehavioral.com. He provides free confidential consultations to individuals and family members seeking treatment for addiction and co-occurring conditions.
Dec 3, 1997 was a night which Narcotic Detectives would have called routine. Set up a deal to buy drugs, make an arrest and move on. But, as they say in police work, there is no such thing as routine.

That night, I experienced a traumatic event: being shot in the line of duty while attempting to arrest a suspected drug dealer. My bullet proof vest saved my life. Rationalization and thinking were rapidly overcome by my training and instincts. My world moved in super slow motion, yet it lasted only seconds. I experienced tunnel vision. I was no longer in control of what was happening. Fear rapidly overcame me! I was in fear for my life, fear I did something wrong, fear of litigation, fear of leaving loved ones behind and fear of retaliation and needing to protect my family. I experienced anger. I was angry the situation happened, that he tried to take my life, angry he put me in the situation to shoot him and angry at the judicial system for having him free. I felt shock, anxiety, worry, sadness, disbelief, guilt and confusion.

I felt overwhelmed; I was traumatized.

Trauma, by definition, is the result of an extraordinarily stressful event that fragments your sense of security, making you feel helpless and vulnerable in a dangerous situation. It can create a loss of faith that there is any safety, predictability or meaning in the world. Trauma impacts your feelings, thoughts, relationships, behaviors, attitudes, dreams and hopes.

However, the definition and experiences aren’t inclusive. What might be traumatic for one person may not be for another. You can be directly involved or many miles away. You may know or love the person(s) involved or be a complete stranger(s). Many factors play a role in how we handle the experienced trauma. Some include prior exposure to trauma, gender, age, family stability, genetics, duration of event, its meaning to you, type of involvement, spirituality and whether the event is intentional (man-made) or natural.

Surviving a traumatic event is a very difficult responsibility. Bringing together the shattered pieces of the puzzle of our “normal” life can be emotionally and physically wearing. Trying to put the pieces of my life back together was very daunting. I was fearful my life was never going to be the same.

Several factors helped me move healthily through my traumatic event. The most impactful factor, I believe, was allowing myself to express anger. That night, I went into the hotel bathroom and punched the door several times, yelling expletives. It was a big sense of relief for me.

I also kept normality in my life. I went shopping the next day, did house chores and played with my one-year-old daughter. What also helped was telling the story over and over. The more I told the story, the more I recalled and gained a better understanding of the choices I made. Each time I told the story, different emotions surfaced, such as sadness, anger, remorse, hurt and worry. As they surfaced I didn’t deny them. Rather, I gave into them. I cried, I screamed, I punched, I prayed and I talked through them. Expressing my emotions and sharing my thoughts made the situation clearer.

Finally, and most importantly, I sought professional help. Speaking to someone with objectivity and knowledge of trauma made me realize what I was experiencing was normal and expected. It gave me the tools to cope positively and return to a healthier state of being.

Trauma is a very difficult experience. Its effects have many dimensions and are unique to each of us.
Trauma is emotionally and physically wearing. But, professional help, expression of thoughts and emotions, and having the strength to retell the story, there is a greater chance in recovering to a healthy and happy life.

Craig Politte, a former Police Officer with ten years of service, was also a Field Training Officer, Narcotics Detective, Evidence Technician, Detective and Corporal. Now, as a Licensed Professional Counselor, Craig provides therapy for children, adolescents, young adults and adults who experience Anxiety, Obsessive Compulsive Disorder, Depression, Grief and Loss, Trauma and Abuse, and Computer/Electronic Addiction. He continues his work with First Responders by assisting them with the difficulties they face on the job and in their relationships.

AT YOUR SERVICE: P.O.S.T. TRAINING FOR DEPARTMENTS

By Christine Patterson, Ph.D.

The Community Mental Health Liaisons (CMHLs) have developed trainings specifically for law enforcement because officers are often the first responders in a mental health crisis.

There is also increasing evidence that providing mental health training to peace officers results in better outcomes for individuals with behavioral health issues. Other excellent mental health trainings exist, such as Crisis Intervention Team (CIT) and Mental Health First Aid. However, sending officers to a training that lasts from one to five days is not always feasible for smaller departments.

Consequently, the CMHLs developed shorter (1 to 3 hours), locally-presented P.O.S.T-approved trainings that can be customized to meet the needs of your department. This saves travel costs, reduces the number of hours officers are off the streets, assists officers in earning their P.O.S.T hours, and increases the number of officers who can recognize the signs and symptoms of a person in a mental health crisis.

Starting in September, the following are available:

- Understanding Co-Occurring Conditions: Substance Use Disorders and Mental Health (2 hrs.)
- Recognizing Warning Signs of Suicide and Self-Harm (3 hrs.) – Using a “chain of survival” approach similar to CPR, this training uses QPR, which stands for Question, Persuade and Refer. It teaches officer how to recognize and respond positively to someone exhibiting suicide warning signs and behaviors. Taking QPR a step further, it explains non-suicidal self-harm and identifies community resources which may be available to assist individuals in need.
- Understanding Civil Involuntary Detention (96-Hour Hold) & Hospital Procedures (2 hrs.) – Topics include differentiating types of risk, writing an effective affidavit, hospital procedures to encourage more efficient processing, where to find a notary, and documents required for detainment. Includes Q&A about local procedures.
- De-Escalation: Responding to Individuals in a Mental Health Crisis (2 hrs.) – Emphasizes effective communication as the primary skill in any de-escalation effort. Participants will gain an understanding of the impact mental health conditions can have on communication. Additionally, participants will identify factors that lead to the escalation of emotions and behavior, and will be introduced to communication skills that build rapport, de-escalate intense emotions and behavior, and result in better outcomes during a mental health crisis.

By Christine Patterson, Ph.D.
NEW TRAINING: FOR 911 DISPATCHERS

By Chris Trittler, PSDII

 Dispatchers handle heavy call volumes and a wide variety of calls on a daily basis. An important aspect of their job is to identify traits and characteristics of the person police are contacting to help. Dispatchers are encountering more people with mental illness and understanding how to handle these calls is a crucial first step to a successful resolution of the situation. For years, officers have been specifically trained how to handle these types of encounters. Now, after months of preparation, the St. Louis County Police Academy will offer a 16-hour initial CIT (Crisis Intervention Team) training class for dispatchers on October 29 and 30.

We know you have questions about the training and we hope to answer them here.

Why should I or our department’s Dispatchers take this class? This class is tailored to help dispatchers develop specific strategies for interacting with a person in a mental health crisis.

Who will teach this class? We have several guest speakers with extensive training in the segment they teach.

Is the class P.O.S.T. certified? Yes, this class is P.O.S.T. certified.

What topics will be covered? Skill-building topics include:

- How to identify signs and symptoms of mental illness
- Learn skills to assess and manage a caller’s risk for suicide
- Effective communication strategies when handling a call involving potential suicide

The training also includes self-care topics:

- Understanding the importance of self-care by identifying signs and symptoms of work-related PTSD (Post-Traumatic Stress Disorder)
- An introduction to Critical Incident Stress Management (CISM) and its role in relieving critical incident stress

Will there be any role play? We often hear this question, and the answer is yes. Dispatchers will also have the opportunity to participate in a panel discussion with consumers from NAMI-St. Louis (National Alliance on Mental Illness). Talking about their experiences in living with mental illness, the panelists will provide a personal perspective on the different types of disorders.

How do I learn more about the training or register to attend? You can call Becky Murphy at the St. Louis County & Municipal Police Academy at 314-889-8600 or Sgt. Jeremy Romo, CIT Coordinator for St. Louis County Police at 314-615-7117.

We look forward to seeing you in October!

Chris Trittler, PSDII, works in the St. Louis County Police Department’s Communications Division. He has been a dispatcher for 17 years and a Supervisor for 12. He is also a Certified Instructor for the St. Louis County & Municipal Police Academy.

cont. from page 5

- Resiliency and Battlemind: How Officers Cope (1 hour) - Designed to teach the concepts of battlemind and resiliency, unhealthy and healthy ways to cope, and the challenges and barriers to self-care. Techniques that promote resiliency will be taught and demonstrated.

Starting in November, a 2-hour training titled Recognizing Trauma, Stress Responses and PTSD will be available. The CMHLs are working on additional topics such as Domestic Violence, Suicide by Cop, and Understanding Mental Health & Youth.

All CMHL trainings are provided free of charge. For more information, contact your Community Mental Health Liaison or you can contact me at 573-634-4626 or cpatterson@mocmhc.org.

Christine Patterson, PhD, is the Community Liaison Coordinator for Missouri Coalition for Community Behavioral Healthcare.