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ABOUT THE NORTH CAROLINA JUSTICE ACADEMY

The North Carolina Justice Academy is a division of the North Carolina Department of Justice. Created in 1973, the Academy’s enabling legislation establishes its duties as providing training programs for criminal justice personnel, providing technical assistance upon request to criminal justice agencies to aid them in the discharge of their responsibilities and developing, publishing and distributing educational and training materials. Program areas for these services are defined through the five centers of the Training Division: Legal; Law Enforcement Leadership; Commission/In-service; Tactical/Traffic; and Investigations. In addition, the Support Division operates the Learning Resource Center, conducts research, produces video and other graphic and printing services, coordinates institutional development and supports the campuses as a training environment for Academy courses as well as those of other state and local agencies.

The Academy’s eastern campus in Salemburg is situated on a site with a long educational history. Established in 1875 as Salem Academy, the campus has subsequently functioned as Pineland School for Girls, Pineland Junior College, Edwards Military Institute and finally Southwood College. The campus still utilizes the Blanchard Learning Resource Center, the Royal Classroom Building, the Jones Auditorium, a cafeteria and an office building from the Southwood campus. Added over the years have been a new classroom building and learning resource center, dormitories, an administration building, a support services building, a maintenance building, a new state-of-the-art gymnasium, classroom additions, firearms ranges, a driving track and other practical exercise areas.

In September 1998, the Academy’s western campus opened in Edneyville. Later, in 2004, it was named the Larry T. Justus Western Justice Academy in honor of Representative Larry T. Justus. The western campus in Edneyville is located on the former site of the Edneyville High School complex. Renovations have resulted in modern classrooms, office space, a gymnasium, dormitory and cafeteria. A state-of-the-art indoor firearms range opened on campus in 2011. Both campuses have wireless Internet access and onsite computers for student usage.

Please let us know about your needs and the quality of our service. Your input will help us determine what we should continue to do and guide us into areas of change.
NORTH CAROLINA JUSTICE ACADEMY

Mission

To improve the quality and effectiveness of criminal justice services to the citizens of North Carolina through research, education, training, and support for criminal justice and related personnel.
Core Values

Everyone at the North Carolina Justice Academy is dedicated to meeting your needs in the best possible way. In everything we do, we strive to build a quality conscious organization that attends to your training needs. The following Core Values establish inviolable standards of quality and professionalism and let you know what you can expect from us.

We will provide quality training to our students. It will be current, consistent, correct, and applicable to on-the-job experience.

We will put our students’ interests first. We will help them achieve their goals by putting their needs first. We will seek their input in all that we do.

We encourage and support our staff’s creative, innovative ideas and practices. We are committed to a quality work environment and the professional development of each employee. Our staff is our greatest resource.

We will treat all people fairly and in an unbiased manner and will establish an environment conducive to this. All persons with whom we interact will be treated with respect and courtesy.

We will ensure that our learning environment is comfortable and clean and attends to both the routine and special needs of the students.

We believe that students learn best when they can practice skills and apply them to their job setting. Our training will emphasize "hands on" experiences in the classroom.

We are representatives of the Academy and Department of Justice. We will act and look professional at all times.

We will strive to be the leaders in innovative practices, programs, and technology; assisting our clients in addressing present and future needs of the citizens of this state.

We'll not forget that we ultimately serve the citizens of North Carolina and therefore we will manage our organization's resources effectively and efficiently.
Course Development History:

This project was supported by subgrant No. PROJ007988 awarded by the state administering office for the STOP Formula Grant Program. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the state or the U.S. Department of Justice, Office on Violence Against Women.
Catherine Johnson is an Instructor/Training Coordinator with the North Carolina Justice Academy assigned to develop and implement training for law enforcement on violence against women.

Prior to joining the N.C. Justice Academy Catherine was a senior detective assigned to the Sex Crime Section of the Special Victims Unit within the Kansas City Missouri Police Department. Catherine has over ten years of law enforcement experience with the Kansas City Missouri Police Department and has had over 400 hours of training in advanced police studies; specifically in sex crimes investigations and crisis intervention. Catherine served as a member of the Intimate Partner Violence Taskforce with Truman Medical Center and served as an Advisory Board Member with the Kansas City Alliance Against Human Trafficking. While in Kansas City, Catherine served as a board member for COVERSA (Collection of Victim Evidence Regarding Sexual Assault) and as a Distinguished Fellow with the Missouri Chapter of the International Association of Forensic Nurse. Catherine is currently an Associate Board Member of Project GHB and serves on the Board of Directors with End Violence Against Women International.

While employed with the Kansas City Missouri Police Department Catherine assisted in training new officers for the Crisis Intervention Team as well as recruit officers on what to expect if they are asked to handle a call involving a victim of rape. She has developed multiple training courses regarding the investigation of sexual assault. These trainings have been delivered at multidisciplinary conferences around the country, including Kansas City, MO; Columbia, MO; New Orleans, LA, Choctaw, MS, Denver CO, and the U.S. Virgin Islands. In addition, Catherine developed training for sexual assault nurse examiners and advocate volunteer training in the Kansas City area on what to expect from law enforcement during a sex crimes investigation.

Catherine has received several awards in recognition for her excellence, commitment, dedication, and tireless devotion to victims of sexual assault. Catherine received a Certificate of Appreciation from Crimestoppers; a Meritorious Service Award, two Certificate of Commendations, and the CIT Officer of the Year Award from the Kansas City Missouri Police Department; a Visionary Award from St. Luke’s Hospital Forensic Care Program in 2009; CIT Officer of the Year from NAMI (National Alliance for the Mentally Ill); and the Sara Andrasek Memorial Award from Platte County Prosecutor’s Office.
Course Orientation

This course is intended to provide a basic understanding of the actual prevalence of false reports within sexual assault investigations and how true false reports can affect future investigations. This lesson will address common red flags that cause investigators to believe a report is false and help to develop an understanding on how law enforcement can inadvertently create a false report.
Title: Investigations Involving Mental Illness and High Risk Lifestyles

Lesson Purpose: Sexual assault is a very challenging crime to investigate for a myriad of reasons. Perpetrators choose victims they think are vulnerable and will not be believed. This workshop will discuss the basics of mental illness, drug and alcohol addictions, homelessness, and prostitution and how these things can create a vulnerability to victimization. The workshop will address the challenges mental illness and high risk behaviors may create within the investigation. Participants will be provided with techniques to assist in overcoming these challenges and assist in the prosecution of these challenging cases.

Training Objectives: At the end of this block of instruction, the student will be able to achieve the following objectives in accordance with information received during the instructional period:

1. Describe the common responses associated with victims of rape.
2. Identify common symptoms of mental illness.
3. Explain at least two methods law enforcement can use to get women engaging in high risk behaviors (such as homelessness, addictions, and prostitution) to participate in the investigation.
4. Discuss ways to overcome the various challenges presented in these investigations and present better case files to the District Attorney’s Office.

Hours: 90 minutes

Instructional Method: Conference

Materials Required: Handouts
Pen/pencil

Training Aids: Handouts
LCD Projector/Laptop Computer
PowerPoint Slides
Videos

*Designing Women*, You Tube. [2012] (2:00)
ER, You Tube. [2012] (2:21)

The Accused, You Tube. [2012]

Veronica’s Voice, Kansas City Missouri Police Department. [2012] (3:39)

References:


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Training Coordinator I
North Carolina Justice Academy

Date Prepared: May 2013
I. Introduction (10 minutes)

A. Opening Statement

B. Training Objectives

C. Reasons

Rape is a vastly under-reported violent crime. Because rapists attack an average of six times, one failed response can equal five more victims.\(^1\) Societal biases, myths, and stereotypes combined with a lack of understanding with regards to the dynamics of sexual assault can create challenges for first responding officers and investigators. This workshop is intended to provide first responders and investigators information an understanding of the dynamics of sexual assault as well as tools to combat the challenges investigators commonly face for the purpose of yielding more successful resolutions.

II. High Risk Populations

A. Drugs and Alcohol.

1. Alcohol and drug use can impair a person’s judgment; a person’s ability to fight back or resist; as well as reducing a person’s sense of danger. The victim is considered an “easy” target. Alcohol and drugs can affect perceived credibility. Who believes the “drunk girl?” Witnesses may perceive behavior as consensual.

2. 66.6% of female rape victims reported the offender was under the influence of drugs or alcohol at the time of the rape. 19.8% of female rape victims report using drugs or alcohol at the time of the rape.\(^2\)

B. Prostitution\(^3\)

1. The average age of a woman entering prostitution is thirteen to fourteen years of age. They are typically recruited or coerced.

2. 80% of women surveyed stated they left home due to childhood abuse.

3. Out of 475 women surveyed, 62% reported incidents of rape and 73% reported incidents of physical abuse while being used in prostitution. 72% reported periods of homelessness and 92% reported wanting out of the life.

4. Women being used in prostitution are typically considered high risk because of their lifestyle. They are on the streets at all hours of the day and night.
5. It is common for these women to get in and out of vehicles with strangers.

6. They are frequently homeless and have a substance abuse problem.

7. As previously stated, drug and alcohol abuse can cause a loss of inhibition and decrease their ability to detect risks.

8. Mental illness, including post-traumatic stress disorder, often plagues these women.

9. Few of these women have a family or support system outside of the streets and may disappear for days, months, or even years without being missed.

10. The mortality rate for a woman being used in prostitution is 40 times greater than the national average.

C. Homeless Population

1. According to the National Law Center on Homelessness and Poverty approximately 3.5 million people (1.35 children) will experience homelessness. The National Alliance to End Homelessness conducted a point in time study in January of 2005. The study revealed an estimate of 744,313 people experiencing homelessness.

2. The rate of homelessness has risen in large part due to a shortage of affordable rental housing while poverty has increased.

3. Other factors that appear to contribute to the homeless population are a lack of affordable health care, domestic violence, mental illness, and addiction disorders.

   a) According to the Network to End Domestic Violence approximately 63% of homeless women have experienced domestic violence. Consider the dynamics of a domestic violence relationship. The abuser isolates their victim from family, friends, and the community. When the victim makes the decision to leave they are often faced with having nowhere to go.

   b) Mental illness is a strong contributor to the homeless population. Mental illnesses, when untreated, affect a person’s ability to carry out normal daily functions. In addition, mental illness can affect a person’s ability to form and maintain stable relationships.
c) Addiction disorders contribute to the homeless population. Individuals that are poor and addicted are at a higher risk for homelessness.

d) According to the National Coalition for Homeless Veterans approximately 271,000 veterans are without shelter each day.

D. Mental Illness

“A mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.”

1. Common Symptoms of Mental Illness

Like most physical illnesses, mental illness does not typically appear without some warning. The warning signs (or symptoms) exhibited may differ depending on the type and severity of the mental illness. The symptoms listed below are not intended to be all-inclusive. A more detailed look at specific types of illness will follow. Knowledge of the symptoms and early intervention and treatment can help delay or prevent a mental break.

a) Symptoms of mental illness include a marked personality change and/or an inability to cope with simple problems or daily activity. This may present itself with young adults by them failing at schoolwork, quitting extra-curricular activities such as sports, or having a difficult time performing tasks that are familiar to them.

b) Signs of excessive anxieties, prolonged depression and apathy, or an exhibition of strange or flamboyant ideas and behaviors are symptoms.

c) Uncharacteristic, peculiar behavior, a distinct change in eating or sleeping patterns, or a deterioration in personal hygiene can be a warning sign of mental illness.

d) Extreme highs and lows, excessively angry, hostile or violent behavior, as well as thought or talk of suicide are indicative of mental illness.

e) Substance abuse is prevalent among those suffering from mental illness as they attempt to self-medicate in an effort to eliminate other symptoms.
f) These behaviors in isolation cannot predict mental illness, but when seen in conjunction with one another need to be evaluated by a professional. Obviously suicidal and homicidal thoughts or actions **must** be attended to immediately.

g) If the symptoms of mental illness are left untreated the risk of a psychotic episode increases. During a psychotic episode a person may suffer from delusions, hallucinations, disordered thought and speech, and they may lose touch with reality.

2. Bipolar Disorder

a) Bipolar disorder is a long-lasting medical illness with repeated episodes of highs (mania) and lows (depression). The illness affects mood, energy, and the ability to think clearly. The cycles of mania and depression follow an irregular pattern different from the normal “ups and downs” most people experience in their lives.

b) Approximately 10 million Americans have been diagnosed with bipolar disorder. Bipolar disorder is difficult to diagnose, but it appears to affect men and women equally. More than half of those diagnosed with bipolar disorder are between the ages of 15-25. It is common for bipolar disorder to run in families.

c) The manic state is characterized by feelings of extreme irritability and/or euphoria, reduced need for sleep, talkativeness, pleasure-seeking and increased risk taking behavior. The depressive state is characterized by extreme sadness, hopelessness, and loss of energy. Symptoms and severity vary person to person.

d) Bipolar disorder presents unique challenges because the manic state can be attractive. People are hesitant to seek treatment because they do not want to feel lifeless, boring, or less creative.

e) Symptoms of bipolar include the following:

1) Increased energy, activity, and restlessness.

2) Excessively euphoric mood.

3) Extreme irritability.

4) Racing thoughts, fast talk, and jumping from one idea to another.

5) Inability to concentrate.

6) Poor judgment.
7) Increased sex drive.

8) Substance abuse.

9) Provocative, intrusive, or aggressive behavior.

f) During a manic state a person living with bipolar disorder may feel very good, but make impulsive (and often poor) choices that negatively impact their life. Some of the effects include a decline in job and/or school performance.

g) It is common for a person living with bipolar disorder to stop taking their medications when they feel “better” or to self-medicate using drugs and/or alcohol.

3. Depression

a) Depression is a biological, medical illness. The cause of depression is a chemical imbalance between the three neurotransmitters in the brain; norepinephrine, serotonin, and dopamine. Neurotransmitters are chemical messengers that transmit electrical signals between brain cells.

b) Major depression is the leading cause of disability in the United States. The risk for developing depression increases when there is a family history of the illness.

c) Depression occurs twice as frequently in women as men and affects approximately 15 million American adults per year. The frequency and severity of symptoms increases without treatment.

d) Life events such as death of a loved one, major loss or change, chronic stress, substance abuse, serious illness, and medication can trigger a depressive episode.

e) There are three well established types of treatment: medication, psychotherapy, and electroconvulsive therapy (ECT). These treatments may be provided individually or in combination with one another.

f) Antidepressants are a common mode of treatment; however they can take approximately two to four weeks to begin to have an effect. It can take up to six to twelve weeks for the antidepressants to achieve their full effect. As a result, it is not uncommon for someone experiencing depression to self-medicate using drugs or alcohol.

g) There are two primary modes of psychotherapy; cognitive
behavioral therapy and interpersonal therapy.

1) Cognitive behavioral therapy works to change the negative thinking and unsatisfying behavior associated with depression while teaching the person how to unlearn the behavioral patterns that contribute to their illness.

2) Interpersonal therapy focuses on improving troubled personal relationships and on adapting new life roles that may have been associated with the person’s depression.

4. Anxiety Disorders

a) Anxiety disorders are a group of mental illnesses including panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, phobias, generalized anxiety disorder, and social anxiety disorder.

1) These disorders cause people to feel excessively frightened, distressed, or uneasy when most people would not experience these feelings.

2) These disorders can be severely impairing if left untreated.

3) About 20% of the American population is affected by an anxiety disorder.

b) Anxiety disorders may be genetic in nature, but it has not been proven whether biology or environment is the bigger factor in the development of the disorder. Some disorders, such as Obsessive Compulsive Disorder (OCD), have a very clear genetic link.

c) Medical illness and brain injury can also be a cause of anxiety disorders. Scientists have shown certain areas of the brain, including the amygdala, work differently in individuals suffering with anxiety disorders.

d) Substance abuse (self-medicating) is common with individuals with anxiety disorders. Alcohol and other drugs including benzodiazepines (e.g. diazepam, alprazolam, clonazepam, etc.) and opiates (pain killers, heroin, etc.) are used to help reduce anxiety. The drugs help make a person feel less anxious, but the anxiety increases when the effects of the drugs or alcohol wear off.

e) Anxiety disorders can be treated with therapy and medications. Some of the common medications used for treating anxiety disorder include paroxetine (Paxil), fluoxetine (Prozac), sertraline (Zoloft), citalopram (Celexa), and escitalopram (Lexapro).
5. Schizophrenia

a) Schizophrenia is a medical illness that interferes with a person’s ability to think clearly, make decisions, manage emotions, and relate to others. It affects men and women equally.

b) Schizophrenia is not caused by bad parenting or personal weakness. A person living with schizophrenia does not have a “split personality.”

c) The specific cause of schizophrenia is difficult to determine because the cause and course of the illness appears to be unique to each person. Most researchers agree that it appears to be caused by a combination of problems.

1) Aspects of brain chemistry and structure along with environmental influences appear to play a role in the development of the disease.

2) Research has shown that the brain of a person with schizophrenia is different than the brain of a person without schizophrenia.

d) Certain genes have also been identified as increasing the risk of developing schizophrenia, but the genes alone will not cause the disease. Environmental factors (such as birth injury, severe stress, sleep deprivation, maternal infection in the second trimester, head trauma and substance abuse) occurring during an individual’s developmental stage may trigger an underlying genetic link and lead to a psychotic episode. This vulnerability may be increased in individuals who have genetic pre-disposition and also smoke marijuana.

e) Schizophrenia is one of the ten most debilitating mental illnesses affecting human beings according to the World Health Organization. It affects approximately 2.4 million American adults over the age of 18. Symptoms of schizophrenia most often present themselves with men in their late teens or early twenties but in women it tends to appear in their late twenties or early thirties.

f) The majority of those living with schizophrenia do not engage in violent behavior. A study funded by the National Institute of Mental Health (NIMH) found that positive symptoms (hallucinations and delusions) increased the odds for serious violence threefold. The odds were only one-fourth as high when the patient had negative symptoms (reduced emotions and behaviors). Serious violence was also associated with symptoms
such as depression, conduct problems (in childhood), victimization (physical or sexual) with co-occurring substance abuse.\textsuperscript{7}

g) A person living with schizophrenia is at a higher risk for suicide than the general population. Proper medication reduces the suicide risk significantly.

h) Substance abuse increases the risk of developing psychosis in some individuals. The younger the person the higher the risk when using drugs. Substances linked to possible psychosis include marijuana, hash, THC, methamphetamine, PCP, psilocybin, LSD, ketamine, steroids, amphetamines, and stimulants.

i) Studies have shown that individuals living with schizophrenia do not want to participate in treatment and take their medications in part because they do not believe they have an illness. This lack of insight into their illness, also known as Anosognosia, is not willful denial, but part of the illness itself.

j) Symptoms of schizophrenia can be divided into three areas: positive, negative, and cognitive.

1) Positive symptoms refer to having overt symptoms that should not be there such as delusions or hallucinations.

   (a) Hallucinations can appear in the form of auditory (hearing voices), visual (seeing people that are not there), or rarely with smell.

   (b) Individuals with delusions think people are reading their minds, are plotting against them, are secretly monitoring and threatening them, or think they can control other individual’s minds.

   (c) Delusions are commonly seen with other cognitive issues such as problems with concentration, confused thinking, and feeling like one’s thoughts are blocked.

2) Negative symptoms refer to a lack of certain characteristics that should be there. Negative symptoms are characterized by a flat affect (lack of expressions), an inability to start and follow through with activities, brief speech lacking content, and a lack of pleasure or interest in life.

3) Cognitive refers to the thinking process. The symptoms are characterized by a difficulty in prioritizing tasks, difficulty
with some memory functions, and difficulty organizing thoughts.

k) Schizophrenia affects a person’s mood. Some individuals will become depressed while others may have mood swings or bipolar-type behavior. When the mood instability becomes a major part of the illness it is called schizoaffective disorder. Schizoaffective disorder may be a distinct condition or just a sub-type of schizophrenia.

l) There is no known cure for schizophrenia but it is treatable. Recover and family support, hospitalization, medications, and substance abuse counseling are all helpful forms of treatment.

1) Antipsychotic medications are typically used to help relieve the positive symptoms by helping to correct an imbalance in the chemicals that enable brain cells to communicate with one another.

2) Conventional antipsychotics include Thorazine, Prolixin, Haldol, Navane, Stelazine, Trilafon, and Mellaril. Side effects include dry mouth, blurred vision, drowsiness, constipation, and movement disorders such as stiffness, a sense of restless motion, and tardive dyskinesia (a condition marked by involuntary movements of the tongue and facial muscles).

3) Atypical Antipsychotics reduce the positive and negative symptoms of schizophrenia. Atypical Antipsychotics include Risperdal, Clozapine, Zyprexa, Seroquel, and Ziprasidone. Side effects include weight gain and an increased risk of diabetes.

6. Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is an anxiety disorder that can occur after someone experiences or witnesses a traumatic event that involves a persistent fear, helplessness, or horror such as war, natural disasters, serious accidents, captivity, physical abuse, or sexual assault.

a) Approximately 10% of women and 5% of men will be diagnosed with PTSD in their lifetime. Approximately 1 in 30 adults in the United States are diagnosed each year. The statistic is higher among war veterans.

b) Women experience PTSD at more than twice the rate of men. Women serving in the military are twice as likely as male soldiers
to experience PTSD due in part to the various types of trauma they are exposed to such as: war, sexual harassment, and sexual assault. Women take longer to recover and are 4 times more likely than men to suffer long-lasting PTSD.

c) The likelihood of developing PTSD is greater when someone is exposed to multiple traumas or traumatic events early in life (or both). This is especially true when the trauma is long-term or repeated.

d) Children who develop PTSD express the symptoms differently than adults because their brains are still developing the ability to process ideas both physically and emotionally. PTSD in children will be demonstrated by a difficulty regulating emotional reactions, establishing and maintaining relationships, aggressive behavior, and/or low self-esteem and problems in school.

e) The way the brain functions changes after experiencing a traumatic event. The biological mechanisms that promote the “fight or flight” response can create problems later. Severe or repeated exposure to trauma can initiate a pattern in which the person feels like the event is happening repeatedly and prevent the brain from healing. This creates a pattern which can cause anxiety, sleeplessness, anger, and lead to substance abuse.

f) PTSD can occur after a single traumatic event or as a result of ongoing trauma such as abuse. The person’s proximity to the traumatic event can determine the likelihood of developing PTSD (i.e. being a witness versus the victim of trauma). PTSD is unpredictable and can appear unexpectedly.

g) To be diagnosed with PTSD the symptoms must be present and active for more than one month. The symptoms of PTSD can be combined into three clusters: persistent re-experiencing, avoidant/numbness response, and increased arousal.

1) During the persistent re-experiencing cluster a person will experience one or more of the following:

   (a) Recurring nightmares or flashbacks.

   (b) Recurring images or frequent upsetting thoughts or memories of the event. This often occurs without the person actively thinking of the event.

   (c) Intense distress or reminders of the trauma.
(d) Physical reactions to triggers. These triggers symbolize or resemble the event.

2) During the avoidant/numbness response cluster a person will experience three or more of the following:

(a) Attempts to avoid feelings of, or triggers associated with, the trauma.

(b) Attempts to avoid activity, places, or people that remind the person of the trauma.

(c) An inability to recall an important aspect of the trauma.

(d) A marked disinterest in activities they previously enjoyed.

(e) Feelings of a lack of involvement or detachment from others.

(f) Limited variety of feelings.

(g) Trouble thinking about the long-term future. This can present itself with risk-taking behaviors because the person does not believe they will be alive for a normal lifespan.

3) During the increased arousal cluster a person must experience two or more of the following:

(a) Change in sleep patterns. A person will have difficulty falling asleep or difficulty staying asleep.

(b) Irritability or a sudden display or outbursts of anger.

(c) Difficulty concentrating.

(d) Increased awareness that may not be well adapted within their lifestyle.

h) It is common for individuals living with PTSD to have co-occurring disorders such as depression, anxiety, sleep disorders, and substance abuse.

7. There are two primary reasons understanding mental illness is important in a sex crimes investigation. The first is to recognize the vulnerability of those affected by mental illness. The second is to understand the effects sexual assault has on victims and how their response may present itself
during the investigation.

a) Individuals living with a mental illness that is not treated (or when they are self-medicating) are more vulnerable to sexual assault. The very symptoms and behaviors that cause some to believe individuals living with mental illness are not credible are exactly what cause a perpetrator to choose them as a victim.

b) The effects of sexual assault on a victim put them at increased risk for developing depression (three times more likely), post-traumatic stress disorder (six times more likely), alcohol abuse (thirteen times more likely), drug abuse (twenty-six times more likely), and risk of attempting or completing suicide (four times more likely).

III. Conclusion

A. Questions from Class

B. Closing Statement
NOTES


5 National Alliance on Mental Illness. [On-line]. Available at: [www.nami.org](http://www.nami.org) [July 2012].

6 Ibid.