

# **MENTAL HEALTH GUIDE** **for** **UNIT & CONTINGENT LEADERS**



2019 WORLD SCOUT JAMBOREE  
The Summit Bechtel Reserve – West Virginia (USA)  
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## **PREFACE**

Unless indicated otherwise, much of this information best applies to persons in mid-adolescence through early adulthood (ages 15-25). A significant portion of the information may, however, be applied to older adults but the impact is likely to be markedly different (e.g., less serious, frequent, and shorter duration).

It is recognized that culture, ethnicity, and faith can play a tremendous role in shaping an individual's mental health. Unfortunately, the relative brevity of this GUIDE compels considerable generalization, largely based upon Western ethos and mental health principles and practices.

As such, they are statements that suggest or recommend a course of action, but with the understanding that they may not apply in every situation. *Guidelines* are neither mandatory, exhaustive, or definitive. Moreover, they are not intended to take precedence over the reasonable judgment of an experienced Unit or Contingent Leader.

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## INTRODUCTION

The 2019 World Scout Jamboree will be an amazing experience that involves fun and fellowship for Scouts from around the World. There will be lots of opportunities for sharing of cultures and customs, but we recognize there can be challenges as well. Space can be tight, customs and foods of others may seem strange, getting from one place to another may take time, directions can be confusing, the lines at activities long and tiresome, and familiar supports may be hard to find.

Despite these challenges, with some preparation, planning and the support of the onsite staff we believe every participant can have a safe, enjoyable, rewarding experience.

## PROACTIVE STRATEGIES FOR CONTINGENT LEADERSHIP

### Pre-Jamboree

#### Know your Group

The adult leadership must make it a priority to get to know every one of their participants. In doing so, potential problems such as pre-existing medical and mental health issues can be identified and planned for. In addition, the critical task of pairing scouts up into “Buddy Teams”, will be made easier if at least one adult leader has some personal insights into the history and personality of every scout.

Important information to be obtained from a contingent member and/or at least one of his/her parents:

1. Motivation for attending the Jamboree
2. History of being away from home
3. Mental and physical health history
4. Typical daily functioning (e.g. diet, sleep, exercise and personal hygiene),
5. Personality style, social interests, daily electronic usage,
6. Familiarity of other contingent members
7. Fitness and energy level

#### Use Pre-Jamboree Events to Build a Group Culture

It is beneficial that contingents periodically meet and have occasional pre-jamboree group activities. Any contingent activity, including meetings, will typically provide an invaluable opportunity to observe and improve how participants function.

For example:

- How does the participant function around his/her peers? What is his/her interaction style, energy level, motivation & enthusiasm, ability to establish friendships with other participants, adherence to rules/authority, does he/she need to be asked to join the work, a leader or follower?
- Contingent activities provide participants an opportunity to become familiar with other contingent members, and possibly befriend, or identify someone, to 'hang with'. Contingent activities are particularly helpful to contingent members who don't know any of the other scouts &/or the contingent leadership. For example, noting which scouts naturally band together and which are left on the sidelines and how, if at all, the two groups interact provides important insights into potential interpersonal problems at the jamboree. Moreover, this and other related information should be useful in determining *Buddy Teams*.
- Contingent activities also provide the participants an opportunity to conduct their own appraisal of the adult leadership – hopefully answering a variety of critical questions such as:
  - Who is approachable? If I was distressed or had a problem would I be comfortable talking to any particular adult?
  - Are my leaders fair and reasonable? Can I rely on this leader's judgment?
  - Who seems the most knowledgeable? Most capable? What expertise does each leader bring to the unit?
  - Am I comfortable with their guidance and feel sufficiently secure that they could be relied on in the event of an emergency?
- Lastly, contingent activities afford the adult leadership the opportunity to assess itself in terms of cohesion, leadership & interaction style, strengths & weaknesses, role assignment, health and stability (e.g., mental and physical), ability to communicate with and listen to contingent members.

### **Establish Self Care**

For any participant to be at his or her best throughout the jamboree will require daily engagement in four simple, but highly effective, self-care practices, prior to and during the Jamboree:

<u>Diet</u>	Three reasonably nutritious meals daily; fruit &/or raw vegetables for snacking during the day and/or mid-evening.
<u>Sleep</u>	7-9 hours of restful sleep
<u>Exercise</u>	30-60 minutes of meaningful exercise at least 5 days/week (e.g., vigorous walking) to prepare for the activity needed on site
<u>Hydration</u>	2 ½ 750 ml bottles of water daily (2L total) <b>or</b> eight 8-ounce glasses (64 oz total) Increase consumption whenever thirsty.

The significant reduction or elimination of any form of smoking and/or the consumption of alcohol for adults and reduction or elimination of “junk food” and high sugar/high caffeine drinks is also highly recommended for all.

### **Use a Buddy System**

Encourage the scouts to identify a partner for the event or assign one based on your assessment as described above. This practice can facilitate socialization, encourage trying a new activities or experiences and adds a level of support and security. Pairings are commonly based on similarity of interests, energy level, fitness, and temperament.

### **Establish Contingent/Unit Policies**

It is in the best interest of a jamboree contingent to develop clear policies and procedures regarding subjects that it deems is vital or essential to the cohesion, management, security, and enjoyment of the group as a whole. Having a clear set of rules and consequences will reduce stress and conflict particularly if the participants contribute to their development.

*Contingent Policies & Procedures* are more likely to be adhered to if three elements are followed:

1. Subjects - The subject matter of all policies must support one or more policy objectives: cohesion, management, security, or group enjoyment. Any member may propose a policy topic, but the final form should generally be at the discretion the contingent leadership.
2. Procedures – A clear description of each policy, and especially the procedures, will be plainly summarized on a document solely pertaining to contingent policies & procedures. A copy should be given to each member and, if under 18, to at least one parent. Any questions should be timely answered.
3. Agreement - Each contingent member will sign a form attesting to their understanding and agreement to abide by all CONTINGENT POLICIES & PROCEDURES. If the member is under 18, or considered a minor, then at least one parent must also execute the agreement.

Common policy topics may include:

- Appearance (e.g., wearing scout uniform, especially when traveling to and from the jamboree)
- Buddy System – What is it, how will it be applied, expectations of buddy teams
- Conduct – what is expected of all participants while traveling & at the Jamboree.
- Consequences– what is unacceptable behavior and the corresponding disciplinary consequences, including dismissal.
- Emergency Action Plan – what to do in the event of several probable natural and man-made traumatic events (e.g., lost contingent member, severe weather emergency)
- Electronics – what is permitted, when it can be used, for what purpose, consequences for violations of policy

- Legal Considerations – awareness of federal and/or state law that may affect mobility into and out of the US; as well as illegal behavior while at the jamboree & possible consequences. Examples include smoking, alcohol consumption, illicit drug use, illegal medicinal products (e.g., “medical marijuana or THC”) and sexual activity involving someone under 18. See **SAFE FROM HARM Module** regarding *Code of Conduct and State Law*.
- Medication & Assistive Devices – develop a system for the secure storage and accurate and timely distribution of all medication and/or assistive devices.
- Possessions – what to bring and what is to be left at home (anything expensive or irreplaceable; items that are forbidden at airports, currency)
- Safe From Harm/Youth Protection considerations

## Be Aware of Pre-Existing Mental Health History

### Health History

- It is important that IST staff and all contingent members (scouts and leaders) be complete and truthful regarding their physical and mental health. It is possible that the stress of the event may cause an increase in symptoms in a previously well controlled condition. This information can be important to providing the right intervention. Mental health history should include past or current involvement in any form of previous treatment. Medication that will be taking during the jamboree (e.g., prescribed, over the counter, and herbal preparations) should be fully listed.
- Information should also include any mental health medications that have been discontinued within a month from departure for the jamboree and the medical reason for doing so.
- All appropriate information about an individual’s medical and mental health history should be disclosed in the WSJ HEALTH HISTORY.

This information should be accurate, current, complete, and relevant.

- Accurate - The information provided (especially dates and doses) must be correct.
- Complete – The information provided, especially regarding vaccines, medications, and mental health history, must be complete (all that is relevant). This should include any medications that have been discontinued within a month from departure for the jamboree and the medical justification for doing so.
- Current – All information should not only be complete and relevant but also up to date. Generally, huge gaps in the dates of any form of health visit or medical care are concerning.
- Relevant - The information disclosed is the type of information that is explicitly or implicitly sought and should be included in the health history.

### TIP

One of the contingent leaders should be tasked with managing health care matters. Probably the two most critical responsibilities involve health histories and medications.

Regarding **health histories** it is essential that all relevant medical information is completed.

- At a minimum, all health forms should be collected from the scout participants, ISTs, and the adult leadership checked to meet the four criteria summarized above.
- One way of greatly increasing the likelihood that the four essentials of a health history, including medication and aides, has been met is to personally speak to one or both parents. By explaining the reason for the information, how it will be used and by whom should allay most concerns.

Regarding **medication** it is incumbent upon the contingent leadership to:

- Identify who will require medication during the jamboree (e.g., scout, IST, and adult leadership).
- Ensure that that appropriate medications and quantities have been packed in a participant's luggage. It is important to keep the medicine in its original packaging and keep it with carry-on luggage to avoid it being lost.
- Determine who will be responsible for taking of medication each day (e.g., individual or the unit). If the unit is responsible, it must devise a system for the timely dispensing of medication. This system should include: safekeeping, distribution, and the routine assessment that medication is being taken as prescribed.

## During The Jamboree

### **Contingent Screening & Mental Health Survey**

As a part of your contingent's entrance to THE SUMMIT, all contingent and unit vehicles will be screened to determine if any of the passengers represent a public health risk. At the same time a questionnaire requesting the identification of any members who recently or currently are exhibiting signs of emotional distress, mental illness, &/or anti-social behavior will be provided. The Mental Health Survey is not used for screening. It is simply a survey and an opportunity to alert and/or engage the appropriate level of the on-site mental health staff for support of the scout and his/her leadership group. A sample of the Mental Health Survey is found in **Appendix I**.

### **Daily Check-In**

A benefit of the Buddy System is the opportunity to conduct a quick assessment of each individual and the cohesion of their team by a daily scheduled check in with an adult leader. The purpose would include:

- Addressing questions &/or concerns regarding any topic raised by one or both team members.
- Observation and inquiry into the physical and psychological well-being of each scout, their level of enjoyment and their cooperation as a team.

The checking in process is often relatively brief, so long as both parties feel that each has had adequate time to meet their respective needs. Private conversations between one

Buddy Team member and the adult leader should generally be limited to circumstances in which there is concern about the mental health of either scout. It is recommended that requests to “change buddies” be made during a normal “Checking In” session in order to allow the adult leader to make an effort at retaining the current team arrangement, if such a decision is reasonable.

The total sum of information should be sufficient to enable the adult leadership to do the following during the jamboree:

- **Recognize** when a participant is “not him or herself” and/or that “something is likely wrong”. Timely recognition of a mental health problem is the first of two essential factors needed to typically prevent a minor issue from blowing up into a serious problem. The other is a *reasonable response*.
- **Respond** to the distressed individual in an empathetic and supportive manner. If necessary, the involvement of a meaningful member of the unit (e.g., friend from home, jamboree “buddy”) may be useful.
- **Utilize** jamboree resources. Depending upon the nature and potential seriousness of the behavior it could benefit from either a consultation with the SUB-CAMP CHAPLAIN assigned to the contingent that will be visiting your site, going to the Listening Ear Stations located in the Base Camp near your site or in the event of a serious concern for safety, escorting the scout to the BASE CAMP MEDICAL FACILITY.

## Identification of Mental Health Concerns

### Change in Functioning

Probably the single greatest warning sign of potential mental health issues, including the risk of suicide is an **unexplained change** in a person’s daily functioning. These changes are usually gradual but can be sudden, especially if the individual has experienced a recent trauma or significant stressor (e.g., breakup with girl/boyfriend or partner).

Common changes includes:

- *Biological* (e.g., sleep, appetite, energy)
- *Cognitive* (e.g., memory, attention, thought process)
- *Social* (e.g., less involvement with peers &/or the contingent; withdrawal, disinterest in previously pleasurable activities, conflict and/or apathy with peers, avoidance; excessive use of technology)
- *Psychological* (e.g., mood swings, excessive fears & worries, expressions of helplessness, hopelessness, easily stressed, overt nervousness, diminished emotional expression)
- *Physical* (e.g., withdrawal from group activities, easily fatigued, unexplained aches & pains, deterioration in the ability to perform daily tasks, thinking of &/or engaging in behavior harmful to self or others)

- Spiritual (e.g., conflict with or disinterest in matters of faith, especially if previously active spiritually).

### **At Risk Individuals may include the following Behavior “Types”**

- *The Loner* - individuals who appear ‘alone’ (e.g., without a ‘buddy’ to participate in jamboree activities together) or is often by him/herself during jamboree activities (e.g., not part of an identifiable group of contingent members or IST staff).
- *The Easy Target* - individuals who stand out in an awkward, less than flattering way (e.g., due to weight, disability, physical appearance, immaturity, personal hygiene, uncoordinated, un-athletic, and/or habits or behaviors that may be viewed as abnormal)
- *The Pious* - individuals who actively engage in religious beliefs &/or cultural practices – especially if foreign to or likely misunderstood by the majority of the contingent (e.g., openly praying several times a day) pious
- *The Language Deficient* - individuals with noticeable difficulty communicating with his/her peers (e.g., limited language fluency)
- *The Outsider* – individuals who appear nervous, shy, quiet, and tend to hang back during jamboree activities. Quite often these are scouts not from the area where the majority of the contingent is from. As a result, they likely do not know anyone, including any of the contingent leadership.
- *The Digitally Connected* – These are contingent members and/or IST staff who are constantly connected with a smart-phone (e.g., texting, checking/responding to e-mails, surfing the web, engaged with chat rooms) and some other electronic device (e.g., laptop and gaming software). They seem to prefer, and appear more comfortable, connecting with virtual ‘friends’ as opposed to interacting with other contingent members or IST. These individuals have an elevated risk of being digitally bullied, harassed, and/or the victim of a humiliating cyber rumor. It is not uncommon for this individual to feel more comfortable expressing feelings of angst, conflict, fear, alienation, and any other demoralizing sentiment online rather than doing so personally (peer or contingent leader).
- *The Fragile* – persons with health conditions or considerations that can affect daily functioning. The condition can be *physical* (e.g., use of an inhaler, walking with a cane, taking numerous medications, requires special treatment) and/or *psychological* (e.g., noticeably anxious, easily stressed, tends to be pessimistic, prone to complain, reports a variety of aches, pains, and/or ailments with no discernible cause or basis).

### **Dysfunctional Interpersonal Interaction may predict concerns**

- Participants who are treated poorly by his/her peers. For example:
  - Not invited to participate in a group activity
  - The victim of false rumors, hurtful pranks,
  - The butt of unflattering ‘jokes’

- If the adult leadership fails to timely address any foreseeable discrimination and/or harassment within the unit their inaction only reinforces the belief that they do not matter or are worth sticking up for.
- Contentious interactions with popular contingent members as exhibited by:
  - Expressions of anger, jealousy, provocation, and divisive threats.
  - A primary reason for this behavior is often an “affair of the heart” (e.g., two participants who feel affection for the same gal or guy).
- Anti-Social Behavior/Conduct Disordered Behavior
  - Difficulty adhering to contingent rules &/or policies and procedures – such as:
    - Failing to do assigned work or doing it in an unacceptable manner
    - Defiantly challenging the decisions of the contingent leadership
    - Privately complaining about: the need for unit policies and procedures; questioning why they should be adhered to; criticizing how they are administered.
    - Exhibiting open disrespect for authority
  - Theft and/or the Destruction of Property
    - Theft or the destruction of personal property within the contingent camp site can quickly undermine the group’s cohesion and sense of security.
    - Generally, the restoration of the “group psyche” and general sense of order and security can only be accomplished, if at all, by the timely identification and public disciplining of the perpetrator (e.g., restitution, a sincere and public apology, and an appropriate penalty is generally the “least” that can be done.

**TIP** A carefully crafted contingent policy regarding VALUABLES would at least limit the potential for the loss or destruction of anything that is expensive (e.g., jewelry, laptop) personally treasured, or difficult to replace. Such a policy could also apply to safeguarding large amounts of currency.

### Serious Violations Impact Others

- Serious Violations of Rules, Regulations or Laws
  - Behavior involving serious violations of jamboree policies (e.g., SAFE FROM HARM, BSA YOUTH PROTECTION, and/or the WSJ CODE OF CONDUCT) &/or West Virginia law.
  - This includes the abuse or exploitation of an underage Scout (e.g., providing alcohol or selling drugs to a minor, engaging in sexual activity with a minor).
- Threatening Behavior
  - Any acts that represent a reasonable risk of harm to self or others is one of the most serious precursor behaviors likely to be exhibited at the jamboree.

Contingent leaders and IST staff that suspect or are aware of potentially harmful or exploitive conduct are required to promptly report it. Calling 911 will engage the

appropriate response from the Jamboree Command Center and ensure victims receive the appropriate support.

## Common Mental Health Concerns

### Stress

Emotional or physical demands that push the limits of one's ability to cope can result in difficulties and impair function. A stress reaction can be induced *internally*, by thoughts and emotions, as well as *externally*, by the environment.

### Adjustment Disorders –

This class of mental conditions generally refers to a temporary emotional reaction to stress. They may also involve anxiety, depression, and/or disruptive behavior. Homesickness is typically a 'mild' example of an Adjustment Disorder.

### Anxiety Disorders –

These are the most common type of mental disorder. Commonly characterized by an intense fear or feelings of nervousness and worry that is associated with a certain objects, environments, or situations. Avoidance of exposure to whatever triggers this response is also typical. Examples of distinct anxiety disorders include:

- Panic disorder – extreme terror and/or sense of imminent danger that happens abruptly and typically only lasts for a few minutes
- Phobias – fear of and/or an irrational aversion to a particular object and/or set of circumstances. Phobic reactions range from relatively mild (e.g., exaggerated or disproportionate), fixed and irrational, to extreme and delusional.
- Obsessive-Compulsive Disorder (OCD) – constant, reoccurring stressful thoughts (obsessions) coupled with a powerful urge to engage in repetitive acts (compulsion).
- Post-Traumatic Stress Disorder (PTSD) – following exposure to an extremely traumatic event an individual is subsequently prone to re-experiencing the event in one or more characteristic ways –
  - recurrent and intrusive recollections of the event
  - intense distress when exposed to any reminder of the traumatic event
  - persistent avoidance of anything resembling the traumatic event
  - increased levels of arousal (e.g., easily startled, hyper-alert, difficulty relaxing).

### Mood Disorders (also referred to as depressive or affective disorders)-

Mood disorders are primarily characterized by a disturbance in feelings and emotions. 'Depression' or 'depressive' may describe a mood, symptom, or a serious mental illness. Common types of major mood disorders include:

- Dysthymia (also known as ‘persistent depressive disorder’) is characterized by a mild, chronic depression. The symptoms are similar to *Major Depression* but less severe and generally not debilitating.
- Major Depression (also referred as ‘clinical depression’) is characterized by prolonged feelings of sadness, loss of energy, motivation, and interest in activities that were once pleasurable, feelings of guilt or low self-esteem, disturbed sleep and/or appetite, and loss of concentration. It can be long lasting or recurrent. It is serious condition that is capable of substantially impairing the ability to cope with the demands of daily life. At its most severe depression may lead to suicidal behavior.
- Bipolar Disorder (previously referred to as *Manic Depression*)-

Bipolar Disorder is characterized by episodes of elation and hyperactivity (mania) that inevitably switches to despair and despondency (depression).

### **Personality Disorders –**

*Personality* generally reflects distinct patterns of behavior, thoughts, and emotions that characterize how an individual perceives and interacts with his/her environment. Think of personality as reflecting an individual’s unique behavioral style and view of the world. A personality disorder, of which there are at least 10 recognized subtypes, is not a mental illness. Instead, it refers to when that style and view is distorted and dysfunctional. As a result, the individual will typically have, to varying degrees, life-long problems coping with different aspects of daily living.

### **Thought Disorders –**

Thought Disorders are the most serious mental illnesses. The primary characterization of a thought disorder is the disconnection with reality and profound distortions in thinking, perception, emotions, and/or sense of self.

Examples may include:

- *Hallucinations* - hearing, seeing, feeling, smelling, &/or tasting things that are not present (e.g., seeing someone/something that isn’t present; hearing commands to do something; feeling insects crawling inside the skin)
- *Delusions* - fixed false belief systems despite evidence to the contrary (e.g., believing to be from another planet, universe, or time in history; possessing special powers)

Many medical conditions may result in these sorts of symptoms that increase and decrease in severity over time (delirium).

## Risks of Harm to Self &/or Others

### Self-Injury

#### Introduction

Self-Injury and suicide know no national boundaries and is not delineated by race, culture, or socio-economic status. This behavior is a serious public health problem in all countries. Anecdotal reports of suicidal ideation, cutting, and other forms of self-harm from the 2015 World Jamboree and 2017 (U.S.) National Jamboree, though rare, would nonetheless suggest that not even Scouting is immune from acts of self-harm.

#### Description

For the purpose of this GUIDE *Self-injury* (SI) can be defined as the intentional, direct injury of a portion of the body that is done without suicidal intent. The most common form of self-harm involves cutting or stabbing the skin with a sharp object (e.g., knife, razor, or piece of glass). However, the range of self-injurious behavior is not limited to cutting. Other means include burning, scratching, hitting body parts, excessive skin picking, hair pulling, the ingestion of toxic chemicals.

#### Incidence

The incidence of self-harm is global. It is thought to be most common between the ages of 12 and 24. It is more common in females and the risk among young women is five times greater in the 12-15 age range. Boys, however, are not immune. A significant percentage of teens and young adults in countries around the world engage in some form of self-injury.

#### Cause

The reason or motivation to self-injure is complicated and varied. Some engage in it to communicate distress; while others seek temporary relief from intense feelings of chronic stress, depression, emotional numbness, poor self-worth, feeling alone, perceiving oneself as a burden and pathological grieving. It is notable that significant percentage of individuals with developmental disabilities, such as Autism Spectrum Disorders, are likely to engage in head banging, hand biting, and skin picking. Lastly, self-injury can also occur in high functioning persons with modest emotional issues but no underlying mental disorder. Pain and blood appears to be one way of “feeling something real” or “feeling alive”.

#### Signs & Symptoms

The belief that self-injury is solely a means of getting attention would be inaccurate in most cases. Many who self-harm are very conscious of their injuries (e.g., wounds, scabs) and feel guilty about their behavior. As a result, they tend to take extra care to conceal their injuries from others. For example, their wounds are often in areas of the body that is easily hidden. They will be bandaged and, if necessary, covered by clothing (e.g., long sleeve shirt, sweater).

Some signs that an individual may be engaging in self-injurious behavior includes:

- Unexplained difficulties with interpersonal relations
- Unpredictable behavior

- Consistently wearing inappropriate clothing (e.g., long sleeves and pants in hot weather)
- Observable signs of cutting including scarring (especially multiple marks) and freshly bandaged wounds of questionable origin
- Self-doubt regarding their worth and identity (e.g., value as a member of a group, such as Scouting)
- Statements conveying despair, helplessness, hopelessness, regrets, guilt, feeling overwhelmed, and/or “no future”

### Relationship with Suicide

Generally, the individual who self-injures is not intending upon killing him or herself. Nonetheless, the relationship with suicide is complex, since self-injuring behavior may become life threatening.

## Suicide

### Description

Anecdotal evidence from the 2015 WSJ and the U.S. National Jamborees from 2010-2017, indicated that vague, as well as direct references, to death, dying, and suicide typically meant something other than a desire to kill him/herself. These and related references are a relatively common way that distressed adolescent scouts and younger staff members (20's) communicate their perception of the depth of emotional pain that they were experiencing at that time. Do they intend to act on the thoughts and end their life? **Not necessarily.** If not, is this serious? **Absolutely and requires intervention!**

It is worth noting that at the 2019 WSJ any reference to *death, dying, suicide &/or words or actions suggesting or implying injury to self or others* will be treated as a **top mental health priority**. This response will be initiated **without** consideration of whether a reasonable risk of *injury to self or others* is obvious to those present. In other words, the person's intent may be considered but it is not necessary to trigger a timely health care response.

This policy will likely result in a number of 'suicide' related complaints being 'false-positive' or 'false alarms' that do not require hospitalization. Despite this outcome, safety of all participants is the primary concern and a careful evaluation by mental health professionals is indicated.

### Incidence

Suicide is the greatest danger of a troubled young person's life and is one of the leading causes of death in adolescence and early adulthood worldwide. Generally, girls attempt suicide approximately three times more frequently than boys, but boys are more often successful, likely due to the greater use of firearms. These findings are even more alarming when one considers the easy access to information on the internet regarding *how to successfully commit suicide*.

## Risk-Factors & Warning Signs

Suicide is a complex behavior. There is no single cause, experience, or stressor that can explain or predict a suicidal act. Instead, the basis for prevention and intervention is an understanding what likely puts a person at risk.

“*Risk Factors*” refer to factors that generally indicate an increased likelihood of attempting suicide at some point in time. “*Warning Signs*”, on the other hand, reflect the immediate risk of attempting suicide. Typically, risk factors can be generalized to an entire demographic and occur more frequently in certain communities and cultures. Warning signs, however, are specific to an individual who is in crisis and requires immediate professional attention. **Appendix II** summarizes some of the most common risk factors and warning signs associated with suicide.

## Threats Directed at Others

### Introduction

Threats of harm to a third party are quite rare at scouting events. Nonetheless, in addition to the over 50,000 scouts from around the world there will be an untold number of visitors on the jamboree grounds every day. Visitors can range from persons in the community and literally anywhere in the United States to family, friends, curious onlookers from anywhere in the world. The fact is that anyone can gain admission to the jamboree and move around the grounds with ease. Threats of random, as well as specifically targeted, urban violence around the world seem to be occurring with increased regularity. It would be foolhardy and naïve to believe that the World Jamboree would be immune from an internal (someone registered with the jamboree) or external (e.g., visitor) threat of harm.

### Types of Threats

For the purpose of this section of the GUIDE a **threat** is *any expression of the intent to do harm or act out violently against a person or something* (e.g., statute, facility).

Important details about a threat include:

Form of expression - written, spoken, digitally conveyed, or symbolic.

Directness - explicit or implied.

Victim /Object - ranges from:

- a specifically identified individual or thing (e.g., building, statute)
- any member of an identifiable group or the group itself
- a generalized threat in which there is no identifiable entity (e.g., hapless bystander who becomes the victim of a random act of violence).

Lethality - ranges from:

- “*transient*” - generalized expression of emotion such as anger, stress, frustration, etc. that is diffusible)
- “*potentially lethal*” - identified person or thing, plan, and means to engage in harm
- “*actual threat*” - person is engaged in harming a person or object

Means \_\_\_\_\_ - limited only to the human imagination

Harm - ranging from:

- *significant assault/battery or damage* (e.g., beat up or hurt; bashed in car windshield)
- *serious* - severe physical injury (e.g., rape, severe bleeding, incapacitated)
- *lethal* - killed person/destroyed object **or** attempt to kill/destroy.

Timing - ranges from:

- “*Generalized Threat*” but no indication of when (explicit or implied)
- “*Conditional Factor*” (e.g., the next time something that is identified occurs such as an ex-spouse is seen with a new love interest)
- “*Imminent*” (e.g., anytime soon or anytime soon based upon some implied or explicitly identified event)

## Response to a Potential Threat

Who Should Act -

Anyone who reasonably suspects there is a risk of harm to someone or something.

What to Do -

**Known Person** – immediately report information regarding the suspicion of risk of harm (include as much of the following as possible)

- Who - name of individual
- What - the basis for suspecting that there is a risk of harm generally or toward an identified 3d party or object – such as:
  - What did the individual do (e.g., action or behavior)?
  - What did you hear the individual say?
  - What was read (e.g., something posted online)
  - Where- where did you perceive the threat (seen/read/heard)?
  - When - what day and time was the perception perceived?
  - How - (if known) how is the suspected harm to occur?
- When to Act - Immediately
- Where
  - If inside unit site – report to a Contingent Leader
  - If outside unit site – call 911 or report to BASE CAMP MEDICAL CLINIC (BCMC) or LISTENING EAR STATION (whichever is quicker)
- How - Verbally to any of the following:
  - 911 operator
  - Base Camp Medical Facility Staff or Base Camp Mental Health Staff
  - LISTENING EAR Staff

- Why - Because it is the *right thing to do* and public safety is everyone's responsibility.

**Unfamiliar Person** – focus on the individual (from a distance) & dial 911

- Calmly provide your name and state that you are calling from the jamboree
- State your belief that there is an unfamiliar person who appears likely to do harm & the basis for it
- Identify where the person is (if known) and a description & anything extraordinary
- Answer all questions to the best of your ability. Afterwards, go to the nearest LES or BCMC inform the CMO/ACMO or a BCMH Staff Member what you reported to the 911 operator. Hang around you will very likely be interviewed by some public health/safety authority (e.g., local police).
- If the suspected person remains in the area –
  - Take a picture with smart phone (full body & zoom in on the face)
  - immediately go to a BCMC or LE STATION (if one is in the near vicinity) and make the same report (**or**) if either facility is more than a 3-5 minute walk **Dial 911**.

NOTE: If a report is made in good-faith, but turns out to be false (which the great majority are), the reporter should be thanked for his/her courage in doing the right thing.

## JAMBOREE MENTAL HEALTH SERVICES

Jamboree Mental Health Services will be provided at three levels plus two ancillary services that will be available in the event a participant is hospitalized and/or emotional care following a *critical incident* is needed.

### CLINICAL SERVICES

The *initial* or *primary* level of coverage will be delivered by two distinct, but complementary, approaches – *Listening Ear (LE)* and *Sub-Camp Chaplains (SSC)*. Each is intended to timely identify relatively minor emotional and/or behavioral issues and facilitate their effective management or resolution either by the individual (e.g., LE client) or by supporting the efforts of the contingent leadership. Notification and engagement with Unit and Contingent Leaders will occur for any individual who presents with a major emotional and/or behavioral issue.

#### Tier 1A - Listening Ear (LE)

*Listening Ear* is a service historically provided at large international events, most notably the World Scout Jamboree. Typically, the purpose of LE is to provide any participant a secure and relatively comfortable environment for personal respite, relaxation, and the opportunity to express whatever is on his/her mind. The role of the LE staff is to be emotionally present, empathetic, and unconditionally receptive to discussing whatever the participant discloses. If necessary, appropriate guidance and/or advice may be shared with the participant.

A secondary, but equally important responsibility is the identification and referral of any problems or issues that could reasonably have an adverse effect on the health, welfare, and/or safety of the participant and/or any foreseeable third parties. If, during an interaction with a participant, the LE IST forms a reasonable suspicion that a mental health or youth protection problem is at issue procedures will be in place to timely refer and personally escort the participant to the appropriate staff service (e.g., Base Camp Medical Facility, Mental Health Clinic, and/or contact YOUTH PROTECTION/SAFE FROM HARM). There will be multiple *LE Stations* in each Base Camp, as well three LE Bases at CENTRO MONDIAL. In addition, there will be several “mobile” teams of two LE staff on foot serving relatively high traffic areas during daylight programming hours.

Locations of **LE Stations** can be found in **Appendix III**. **Jason O’Brien, EdS, LPC** is the Primary Lead and Coordinator of all LISTENING EAR services.

#### Tier 1B - Sub-Camp Chaplains (SCC)

The other primary level of care is provided at the contingent level within the 20 sub-camps for participants and their leaders. There will be at least one team of two experienced members of the Chaplaincy Staff assigned to each sub-camp. In addition to their primary responsibilities in the Faith and Beliefs area, the Chaplains have experience with support and conflict resolution and can assist with the most common and least serious emotional reactions that are experienced at a jamboree. This includes homesickness, interpersonal

or socialization difficulties, conflict resolution within the contingent, and non-threatening conduct issues. These matters will typically be dealt with at the contingent site and involve “assisting” the adult contingent leadership in arriving at a suitable solution.

**Rev. Thomas Martin** and **Fa. Eric Tosi** will serve as the Primary Leads and Coordinators of all SUB-CAMP CHAPLAIN (SCC) services.

## **Tier 2 - Base Camp Mental Health (BCMh)**

Significant mental health and behavioral matters will be referred to the **second** level of coverage – the *Base Camp Mental Health Liaison Officer (BCMHLNO)*. Within the six BASE CAMP MEDICAL CLINICS (BCMC) will be licensed mental health staff dedicated to the residents of that base camp. Psychological problems and related behavioral concerns that cannot be remedied within a contingent unit will be attended to at this level. Intervention will typically be provided at the Base Camp Medical Center.

**Brian Hissom, LPC** is the Primary Lead and Coordinator of all BASE CAMP MENTAL HEALTH SERVICES.

## **Tier 3 - Mental Health Clinic (MHC)**

In the event of serious psychopathology and/or potentially life-threatening conditions referral is made to the **third** and highest level of coverage, the MENTAL HEALTH CLINIC. Timely evaluation of the nature, seriousness, and any potential lethality is conducted at the *Clinic* by one of several licensed mental health professionals. In addition, consultation regarding psychotropic medication and youth protection, as well as critical decision-making associated with possible voluntary or involuntary hospitalization and/or dismissal from the jamboree is addressed at this level.

The **Mental Health Clinic** is located at the Jamboree Health Center complex in Sub Camp D1. **Bob Chayer, MD** is the Director of the MENTAL HEALTH CLINIC.

## **ADDITIONAL SERVICES**

### **Hospital Outreach (HO)**

Jamboree participants who are treated overnight at a local hospital will be provided emotional and spiritual support as needed. Moreover, coordination with an assigned *Sub-Camp Chaplain*, will be provided in order to facilitate a participant’s return to his or her unit.

These services will be directed by **Rev. Jeff Thompson**, WSJMH Primary Lead for Hospital Outreach.

### **Critical Incident Stress Management (CISM)**

In the event of a critical or traumatic event, which could range from the death or serious injury of a single individual to a mass evacuation because of man-made (e.g., active shooter) &/or natural causes (e.g., wild fire), a select group of staff will be prepared to

address the psychological stress that is a foreseeable consequence of these phenomena. Experienced members within the Mental Health Department will comprise the jamboree's *Critical Incident Stress Management Response Team*. This team will coordinate with first responders as part of the *WSJ EMERGENCY MANAGEMENT PLAN*.

The **CISM Team** is available 24/7, at all times. **J. D. Southall** is the WSJMH Primary Lead for Critical Incident Stress Management.

## CONCLUSION

### There will be Issues and Problems

It is estimated that approximately 20% of the world's children and adolescents have diagnosable mental disorders or problems. Add that to a two week event involving 50,000+ adolescents and adults from 160+ nationalities engaged in almost non-stop activities, new experiences, and learning opportunities **each day** and it is inevitable that a variety of medical injuries, illnesses, and mishaps will occur. Moreover, a portion of the participants, leaders, and IST staff will have difficulty coping with the barrage of new, different, strange, unfamiliar, and unpredictable experiences that challenges their emotions, psyche, and stability with no support from familiar family and friends or comfortable respite at a favorite hang-out. These experiences could conceivably produce or activate the reappearance of a range of modest, moderate, and serious psychological reactions.

### The Power of One

If you observe someone in distress, take a moment to attend to them. Your actions may be as simple as inquiring if they need assistance (e.g., they appear lost), offer him/her a bottle of water (e.g., its hot and he/she is sweating), or invite them to sit with you (e.g., they look tired). If a person seems visibly troubled (e.g., crying, talking to him/her self, sitting alone away from everyone else) or physically injured (e.g., evidence of blood, bruising, &/or some overt physical dysfunction such as a limp) offer to walk with them to the nearest *Listening Ear Station* or *Base Camp Medical Clinic*. While walking introduce yourself and where you are from. Maintain a light conversation, encouraging your 'brother and new friend' to share a little about him/herself. These modest expressions of assistance, interest, and concern, no matter how brief, can have a meaningful impact....on both of you.

### Your Mental Wellness is Our Priority

No matter the emotional reaction, interpersonal conflict, or possible mental disorder JAMBOREE MENTAL HEALTH SERVICES will be available at all times.

Want to talk about a problem, recite some personal poetry, or express your attraction for a scout in another contingent ... **and** not feel judged or self-conscious? Feel free to stop by any one of many *Listening Ear Stations* located throughout THE SUMMIT.

If there is a spiritual concern or you feel more comfortable speaking with someone of faith, *Chaplains* from a broad range of denominations will be a significant presence in every sub-camp.

If someone in your contingent experiences a serious meltdown, is inconsolably homesick, or having difficulty coping with the frenzied pace of the jamboree ... don't worry! Licensed mental health professionals at each *Base Camp Medical Clinic* will attend to him or her.

On those rare occasions when a problem seems "unmanageable" and personal safety becomes a serious concern, the experienced professionals at the *Mental Health Clinic* are prepared to intervene.

Thank you for reading this guide and considering how to keep your Contingent or Unit healthy by attending to both their physical and mental health needs.

## Appendix I: Mental Health Survey

### 2019 World Scout Jamboree Unit Mental Health Survey

(please print legibly)



Jamboree Troop #: \_\_\_\_\_

NSO: \_\_\_\_\_

Jamboree Unit Leader: \_\_\_\_\_

Is there anyone in the Unit that the adult leadership believes may need the assistance of Jamboree Mental Health Services because of reported and/or observed problems with any of the following – check all that apply?

- \_\_\_\_\_ **BEHAVIOR CONTROL OR ACTING OUT** (antisocial, defiance, or uncontrolled hyperactivity)
- \_\_\_\_\_ **SEPARATION DIFFICULTIES** (homesickness, withdrawal, disengagement)
- \_\_\_\_\_ **SOCIALIZATION** (bonding with and/or appropriate interaction with peers)
- \_\_\_\_\_ **AFFECT OR MOOD** (extraordinary sadness, unhappiness or hyper-emotionality or excitability)
- \_\_\_\_\_ **SIGNIFICANT PSYCHOLOGICAL PROBLEMS** (difficulty perceiving reality; irrational beliefs that affect daily functioning)
- \_\_\_\_\_ **NEUROLOGICAL OR DEVELOPMENTAL CHALLENGES** (*Autism, Asperger's, intellectual disability* - requires significant leader attention)
- \_\_\_\_\_ **RISK OF HARM** (any concern regarding being a potential danger to self or others)
- \_\_\_\_\_ Any other behavior, problem, or issue in which **CLOSE AND/OR CONTINUOUS SUPERVISION** may be needed.

If you have “checked” any of these questions the Mental Health Team will be in touch with you within 24-hours to see how we can assist you. If you have a mental health issue that is of an urgent nature, you should relay that information to the medical staff at the Sub Camp Check-In.

\_\_\_\_\_ **NONE** of these conditions or situations apply.

Thank You,  
2019 WSJ Mental Health Staff

## Appendix II: SUICIDE - Risk Factors & Warning Signs<sup>1</sup>

### COMMON RISK FACTORS (sample)

- Ages 15-24, age 55+
- \*Access to lethal means
- \*Mental illness or signs of mental deterioration, especially if recurrent (e.g., depression, chronic PTSD, schizophrenia)
- Social isolation and/or alienation
- \*\*Suicidal behavior, previous (e.g., ideation, attempts)
- Substance abuse (e.g., alcohol, drugs)
- \*Transgender & Gender Non-Conforming individuals with a history of being harassed, discriminated against, &/or stigmatized
- Traumatic life event/experience - including but not limited to:
  - Abuse (physical &/or sexual)
  - Breakup (bad) with girl/boyfriend or partner
  - \*Cultural stigma and harassment (e.g., mental health, mental illness, gender identification, &/or suicide)
  - Cyber bullying (several forms)
  - Death of a loved one (e.g., spouse, partner, child)
  - Disruption of life due to disaster, serious medical condition
  - Divorce (personal or parents)
  - Financial changes, significant debt
  - Job loss (premature, late in life)

### COMMON WARNING SIGNS (sample)

- \*Abuse, history
  - Bullying, physical &/or cyber
  - Discrimination
  - Harassment
  - Stigma
- Anhedonia (loss of enjoyment in anything previously pleasurable such as people, places, activities)
- \*Behavior, risky or dangerous pursuits especially if out of character (e.g., abusive relationship, anonymous &/or unprotected sex)
- Disposal of possessions, especially items with special meaning
- \*Hopelessness, statements (“no reason to live”; “no one will miss me if I die”)
- Self-harming behavior (e.g., cutting)
- \*Self-medicating or active substance use (alcohol, drugs, medication not prescribed for that person)
- Stressor, major in the past 3 months (see above “Traumatic Life Event”)

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<sup>1</sup> \* = enhanced risk of suicide NOTE: Past suicidal attempts are the single greatest risk factor.

## Appendix III: Listening Ear Locations

### Alpha Base Camp

- Sub Camp A1
- Sub Camp A4

### Bravo Base Camp

- Sub Camp B3
- Sub Camp B4

### Base Camp Charlie

- Sub Camp C1
- Sub Camp C2
- Sub Camp C3
- Sub Camp C4

### Base Camp Delta

- Sub Camp D2
- Sub Camp D4

### Base Camp Echo

- Sub Camp E2
- Sub Camp E3

### Base Camp Foxtrot

- Sub Camp F2

### Centro Mondial

- Legacy
- Faith and Beliefs Area
- Action Point South